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The Impact of Paramedic Communication with Patients and Their Families on Patient Satisfaction, Trust, and Prehospital Care Quality: A Systematic Review

أثر تواصل المسعفين مع المرضى وأسرهم في رضا المرضى وثقتهم وجودة الرعاية المقدمة قبل الوصول إلى المستشفى: مراجعة منهجية

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Abstract:

Background: Emergency medical services (EMS) encounters involve clinical decisions made under time pressure, but also depend on patients and families understanding the situation, trusting responders, and participating appropriately in care. Communication may shape satisfaction and perceived care quality even when objective clinical outcomes are uncertain.
Objective: To examine how paramedic communication with patients and their families relates to satisfaction, trust, perceived safety, and quality of prehospital care, and to identify practical implications for emergency ambulance services.
Methods: This evidence-informed manuscript maps 14 identifiable publications on ambulance patient and family experiences, including qualitative studies, surveys, a satisfaction-scale validation study, and evidence syntheses. Findings were organised narratively by communication behaviour, reassurance and trust, family involvement, and communication during non-conveyance. The source files did not contain a review protocol, completed screening log, or risk-of-bias assessments; therefore, the document does not represent a completed PRISMA-verified systematic review.
Results: Across qualitative evidence, patients repeatedly valued being listened to, receiving understandable explanations, reassurance, dignity, and shared decision-making. A 2023 qualitative meta-synthesis of 13 studies identified trust, communication, and dignity as central to person-centred ambulance care. A 2023 scoping review of 35 publications similarly identified communication as a key determinant of family and bystander experience. A prehospital satisfaction scale validated in 202 patients included explanation and communication as a distinct domain. Direct evidence that improving communication reduces adverse clinical events remains limited.
Conclusion: Communication should be treated as a core dimension of prehospital care rather than a courtesy added to technical treatment. Training, family-inclusive explanations, safety-netting, and patient-reported experience measures are promising priorities, but causal effectiveness and Saudi-specific applicability require prospective evaluation.

Keywords: paramedics; emergency medical services; patient satisfaction; trust; patient-centred communication; family-centred care; prehospital care quality; ambulance; shared decision-making

الملخص

الخلفية :تتضمن حالات التعامل مع خدمات الطوارئ الطبية قرارات سريرية تُتخذ في ظل ضغوط الوقت، إلا أنها تعتمد أيضاً على مدى فهم المرضى وأسرهم للحالة، وثقتهم بمقدمي الخدمة، ومشاركتهم بالشكل المناسب في الرعاية. وقد يؤثر التواصل في مستوى رضا المرضى وتقييمهم لجودة الرعاية المقدمة، حتى في الحالات التي لا تكون فيها النتائج السريرية الموضوعية مؤكدة.
الهدف :دراسة كيفية ارتباط تواصل المسعفين مع المرضى وأسرهم بمستويات الرضا والثقة والشعور بالأمان وجودة الرعاية المقدمة قبل الوصول إلى المستشفى، وتحديد الدلالات والتطبيقات العملية ذات الصلة بخدمات الإسعاف والطوارئ.
المنهجية :تتناول هذه المخطوطة، المستندة إلى الأدلة العلمية، 14 منشوراً محدداً يتعلق بتجارب المرضى وأسرهم مع خدمات الإسعاف، بما في ذلك الدراسات النوعية، والاستقصاءات، ودراسة التحقق من صلاحية مقياس الرضا، ومراجعات الأدلة العلمية. ونُظمت النتائج سردياً وفقاً لسلوكيات التواصل، والطمأنة وبناء الثقة، وإشراك أفراد الأسرة، والتواصل في حالات عدم نقل المرضى إلى المستشفى. ولم تتضمن الملفات المصدرية بروتوكولاً للمراجعة، أو سجلاً مكتملاً لعملية فرز الدراسات، أو تقييمات لخطر التحيز؛ ولذلك لا تمثل هذه الوثيقة مراجعة منهجية مكتملة تم التحقق منها وفق معايير PRISMA.
النتائج :أظهرت الأدلة النوعية أن المرضى يقدّرون بصورة متكررة حسن الاستماع إليهم، وتقديم تفسيرات واضحة ومفهومة، والطمأنة، واحترام الكرامة الإنسانية، والمشاركة في اتخاذ القرارات المتعلقة بالرعاية. وقد حددت دراسة تركيب تلوي نوعية منشورة عام 2023، وشملت 13 دراسة، الثقة والتواصل والكرامة بوصفها عناصر محورية في الرعاية الإسعافية المتمحورة حول الفرد. كما حددت مراجعة استكشافية للنطاق منشورة عام 2023، وشملت 35 منشوراً، التواصل بوصفه أحد المحددات الرئيسية لتجارب أفراد الأسرة والشهود الموجودين في موقع الحادث. كذلك، تضمن مقياس لرضا المرضى عن الرعاية المقدمة قبل الوصول إلى المستشفى، جرى التحقق من صلاحيته على عينة مكونة من 202 مريض، بُعداً مستقلاً يتعلق بالتفسير والتواصل. ومع ذلك، لا تزال الأدلة المباشرة التي تثبت أن تحسين التواصل يؤدي إلى تقليل الأحداث السريرية السلبية محدودة.
الخاتمة :ينبغي التعامل مع التواصل بوصفه بُعداً أساسياً من أبعاد الرعاية المقدمة قبل الوصول إلى المستشفى، وليس مجرد مجاملة تُضاف إلى الإجراءات العلاجية والفنية. ويُعد التدريب على مهارات التواصل، وتقديم التفسيرات التي تراعي مشاركة الأسرة،

وإرشاد المرضى بشأن إجراءات السلامة والمتابعة بعد انتهاء التدخل الإسعافي، واستخدام مقاييس تقييم تجربة المرضى، من الأولويات الواعدة. إلا أن إثبات الفعالية السببية لهذه الممارسات ومدى قابليتها للتطبيق في السياق السعودي يتطلب إجراء تقييمات مستقبلية.

الكلمات المفتاحية :المسعفون؛ خدمات الطوارئ الطبية؛ رضا المرضى؛ الثقة؛ التواصل المتمحور حول المريض؛ الرعاية المتمحورة حول الأسرة؛ جودة الرعاية قبل الوصول إلى المستشفى؛ خدمات الإسعاف؛ اتخاذ القرارات المشتركة.

Introduction

Prehospital emergency care is often delivered in unfamiliar environments and within minutes of sudden illness, injury, or emotional crisis. Paramedics must assess risk, stabilize the patient, determine destination and urgency, and explain their decisions to people who may be frightened or overwhelmed. A successful encounter is therefore both a technical intervention and an interpersonal exchange. Patients judge care not only by arrival time or the treatment provided, but also by whether their symptoms are acknowledged, procedures are explained, and future steps are understandable [1,2].

Patient satisfaction, patient trust, and quality of care are closely related but not interchangeable concepts. Satisfaction concerns whether the service meets expectations and perceived needs; trust reflects confidence in the clinician's competence, intentions, and judgement; and quality encompasses safety, effectiveness, timeliness, patient-centredness, coordination, and equity. Positive communication may improve reported experience without necessarily establishing a reduction in mortality or preventable harm. Conversely, technically appropriate assessment can feel unsafe to a patient who does not understand why transport was declined or whose concerns were dismissed [3,4].

Families can act as essential communication partners by providing history, translating patient preferences, comforting children, and supporting difficult decisions. However, their presence may also create confidentiality challenges, competing demands, and conflicting preferences during resuscitation or non-conveyance. Qualitative research suggests that family involvement is most useful when responders communicate clearly about what is happening, seek consent when possible, and manage emotional distress respectfully [5,6].

This paper focuses on communication directed towards patients and their families at the scene, during assessment and transport, and when EMS leaves a patient at home. It does not primarily address technical handover between ambulance crews and receiving hospitals. The review addresses: (1) which communication behaviours patients and families value; (2) how those behaviours relate to trust and satisfaction; (3) how communication contributes to non-conveyance and family participation; and (4) which service improvements merit evaluation within the Saudi Red Crescent Authority.

Literature Review

Communication, Reassurance, and Patient Experience

Togher and colleagues [2] interviewed 22 ambulance users and eight spouses in England. Participants regarded reassurance as a central outcome of care and described calm professionalism, being listened to, explanations, and continuity as important pathways to confidence. This finding challenges an exclusively response-time-based view of ambulance quality, although the small qualitative sample cannot establish population-wide effects.

In an earlier London ambulance survey, Halter et al. [1] received 888 responses after distributing 1,658 questionnaires. Overall ratings were broadly positive for both traditional ambulance practitioners and emergency care practitioners, but the latter group received higher ratings for explaining what would happen next and the thoroughness of assessment. The study illustrates that patients can distinguish interpersonal and informational aspects of an encounter, while its nonrandomized comparison limits causal conclusions.

Rantala et al. [7] reported that older Swedish patients connected trust and safety to the perceived competence of ambulance clinicians. King et al. [8], studying Australian non-conveyance experiences, also found that compassionate, thorough care reinforced trust and supported patients' confidence in managing after the encounter. Across these settings, empathy and technical credibility were complementary rather than opposing features of good care.

Family and Bystander Perspectives

Satchell et al. [5] synthesized 35 studies of family and bystander experiences. Their themes included emotional extremes, the importance of clear communication, family partnership, and the need for support after the ambulance response. Relatives described distress when clinicians failed to explain what was occurring, even when a sizeable professional team was present. This review provides substantial descriptive evidence for including relatives in appropriate communication, but its studies were heterogeneous and cannot yield a single effect estimate for satisfaction.

Risson et al. [9] interviewed ten paramedics about interactions with significant others during or after attempted resuscitation and patient death. Communication objectives changed as circumstances evolved, from maximizing patient outcomes toward minimizing psychological harm to relatives. Grønlund et al. [6], interviewing 11 specialist prehospital providers, found that relatives could support clinical decisions through history and patient comfort, while at other times influencing treatment in problematic ways. Together, these studies support flexible, ethically aware family communication rather than an inflexible rule that every relative must participate in every decision.

Participation and Safety-Netting During Non-Conveyance

Non-conveyance illustrates why clinical reasoning and communication must be integrated. In interviews with 15 patients and seven relatives, van Doorn et al. [10] described fear, confidence in decision-making, post-event coping, and the need for later evaluation. Reassurance without understandable reasoning or clear follow-up can leave both patients and relatives uncertain. King et al. [3], in a scoping review of ten studies, similarly noted that reassurance and participation were valued, while invalidated concerns produced poorer experiences and the evidence base remained methodologically weak.

Granlund et al. [11] interviewed 14 ambulance nurses describing 30 incidents and identified communication, information-sharing, confident manner, and person-centred collaboration as influential in non-conveyance encounters. This professional-perspective evidence complements patient accounts but does not independently establish whether these behaviours reduce subsequent emergency reattendance or clinical deterioration.

Measurement and Distinct Patient Groups

Haruna et al. [12] developed and validated the Prehospital Emergency Care Patient Satisfaction Scale using responses from 202 ambulance users in Japan. Exploratory factor analysis yielded domains including teamwork, explanation and communication, physical treatment and psychological support, transport speed, and ambulance environment. The scale provides a useful model for broader quality measurement, although local language adaptation and psychometric validation are necessary before using it in Saudi Arabia.

A qualitative meta-synthesis of 13 studies by Tikkanen and Sundberg [4] identified the care relationship, decision-making, and barriers to person-centred ambulance care as overarching themes. Bowling and de Jong [13] subsequently synthesized ten studies on community care following ambulance assessment and emphasized communication, rapport, and reassurance. In paediatric head injuries, Alsuwais et al. [14] interviewed 14 parents and three children; trust was shaped by explanations and emotional tone, and children appreciated being addressed directly. These studies suggest that language, age, and the patient's ability to participate should influence the communication approach, not whether communication is offered at all.

Methods

Review Design and Reporting Status

The requested manuscript has the form of a systematic-review article, but the two supplied Group Q files contain only the review title and authors' names. They do not provide a registered protocol, saved database strategies, search/export files, a duplicate-removal log, independent screening decisions, full-text exclusion reasons, or formal critical-appraisal forms. Consequently, the present work is a structured, evidence-informed narrative synthesis and a draft framework for a future fully reproducible systematic review. It does not report a fabricated PRISMA flow diagram, pooled effect size, or number of formally included studies. The PRISMA 2020 statement is used as a reporting standard to guide completion, not as evidence that all review steps have been performed [15].

Research Question and Eligibility Framework

The review question is: Among patients and family members receiving emergency ambulance care, how are paramedic interpersonal communication behaviours associated with patient satisfaction, trust, perceived safety, and prehospital care quality?

- Population: people receiving emergency ambulance assessment, treatment, transport, or non-conveyance, together with involved family members or bystanders; staff perspectives may supplement but not substitute for these accounts.
- Exposure or intervention: listening, empathy, explanation, language accessibility, consent, shared decision-making, emotional reassurance, family communication, and safety-netting.
- Outcomes: patient-reported satisfaction, trust, perceived safety, understanding, willingness to accept decisions, and process or clinical safety outcomes where available.
- Designs: original qualitative, quantitative, and mixed-methods studies; evidence syntheses mapped separately to prevent double-counting of their underlying studies.
- Time frame and language for a future formal review: January 2006 to November 2026, with transparent recording of English and any additional languages searched.

Information Sources and Search Strategy

For an auditable systematic review, prospective searches should be run in PubMed/MEDLINE, CINAHL, Scopus, Web of Science, and PsycINFO. A proposed MEDLINE search combines prehospital terms (paramedic* OR ambulance* OR emergency medical service* OR prehospital), communication terms (communicat* OR empath* OR reassurance OR shared decision-making OR family-centered care), and outcomes (patient satisfaction OR trust OR patient experience OR quality of care OR patient safety). Search dates, full strings, interface settings, and export counts must be retained. This manuscript draws on identifiable publisher and PubMed records used to support the narrative; such verification is not a substitute for a database search executed and documented according to a protocol.

Study Selection and Data Extraction

A completed review would require two independent screeners to assess titles and abstracts and then full texts, resolve disagreements, and record exclusion reasons. A piloted extraction template should capture author/year/country, design, sample, setting, communication domain, satisfaction or trust measure, safety-related outcomes, and key limitations. The evidence chart below summarizes selected, verifiable publications for discussion. Its row count is not a PRISMA final-inclusion number; several rows represent prior reviews containing overlapping primary studies.

Risk of Bias and Evidence Synthesis

For a final review, qualitative studies should be appraised using the JBI qualitative checklist or CASP, cross-sectional studies with design-appropriate JBI tools, and reviews with AMSTAR 2 where appropriate. No completed appraisal scoring or independent consensus records were provided, so no study is labelled high or low quality here without an actual assessment. A narrative synthesis was preferred for this draft because designs, populations, and outcomes are not sufficiently comparable for a defensible meta-analysis. Findings are separated into patient experience, family experience, non-conveyance decisions, and measurement considerations.

Results

Evidence Overview

Table 1 maps 14 identifiable publications directly relevant to the topic. They include primary qualitative studies, an ambulance-user survey, a satisfaction-scale validation, and several secondary syntheses. These publications were selected to illustrate the range of available evidence and should not be described as a complete or independently screened set of included studies. The findings are discussed thematically and no cross-study denominator or pooled prevalence is calculated.

Table 1. Evidence chart of relevant publications (not a PRISMA inclusion table)

Publication	Design / setting	Communication-related finding	Interpretive caution
Halter et al. (2006) [1]	London postal survey; 888 responses	Explaining next steps and assessment thoroughness differed between practitioner models.	Nonrandomised and self-reported.
Togher et al. (2015) [2]	Qualitative; 22 users, 8 spouses	Reassurance linked to calm professionalism, explanation and continuity.	Small, one-service sample.
King et al. (2021) [3]	Scoping review; 10 studies	Participation and reassurance valued in non-conveyance.	Review reports weak underlying research.
van Doorn et al. (2021) [10]	Qualitative; 15 patients, 7 relatives	Confidence, fear and follow-up concerns shape non-conveyance experience.	Context-specific interviews.
Rantala et al. (2023) [7]	Older-patient qualitative interviews	Trust connected with perceived clinical competence and feeling safe.	Not generalizable to all ages.
Satchell et al. (2023) [5]	Scoping review; 35 publications	Family experience strongly shaped by communication, inclusion and support.	Heterogeneous and partly overlapping literature.
Haruna et al. (2023) [12]	Scale validation; 202 patients	Explanation and communication emerged as a patient-satisfaction domain.	Requires cross-cultural validation.
King et al. (2023) [8]	Grounded theory; 21 Australian patients	Compassionate and thorough assessment built trust in non-conveyance.	Qualitative, single-system sample.
Risson et al. (2023) [9]	Interviews; 10 paramedics	Goals shift toward relatives' psychological wellbeing during end-of-life events.	Staff perspectives only.
Grønlund et al. (2023) [6]	Qualitative; 11 clinicians	Relatives may support history, comfort and treatment decisions.	Provider perspectives; complex ethical cases.
Tikkanen & Sundberg (2024) [4]	Meta-synthesis; 13 qualitative studies	Trust, communication and dignity central to person-centred ambulance care.	Secondary literature overlaps other reports.
Granlund et al. (2024) [11]	Qualitative; 14 nurses, 30 incidents	Information sharing and collaborative communication important in non-conveyance.	Professional report, not causal trial.
Bowling & de Jong (2025) [13]	Scoping review; 10 studies	Rapport, empathy, reassurance emphasized in community ambulance care.	Different models and patient populations.
Alsuwais et al. (2026) [14]	Qualitative; 14 parents, 3 children	Clear explanations and age-appropriate interaction support trust and perceived safety.	Small, UK paediatric context.

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Theme 1: Communication and Satisfaction

The most consistently reported elements of a positive encounter were attentive listening, respectful verbal and nonverbal behaviour, clear explanation of clinical actions, and reassurance [1,2,4,12]. These findings concern patient-reported experience, not necessarily objective treatment success. The validation of a dedicated prehospital satisfaction instrument reinforces the importance of measuring communication separately from transport speed or technical treatment [12].

Theme 2: Trust and Perceived Safety

Trust appeared to develop when patients perceived both competence and compassion. Older patients emphasized confidence in assessment [7], while qualitative non-conveyance research indicated that careful examination and explanations can restore self-confidence [8]. In paediatric cases, parents described communication tone and being taken seriously as important for confidence in paramedic decisions [14]. These converging accounts suggest a plausible relational pathway from communication to trust; however, they do not quantify a causal effect on patient safety events.

Theme 3: Family Inclusion, Crisis Communication and Decision-Making

Family members frequently wanted timely information and meaningful involvement [5]. Qualitative evidence involving resuscitation and critically ill patients shows that relatives can provide clinical history and emotional support while also requiring sensitive management of distress and conflicting preferences [6,9]. The presence of family is therefore not sufficient by itself. Clear role assignment, explanation of procedures, attention to privacy, and compassionate bad-news communication are necessary operational considerations.

Theme 4: Non-Conveyance and Continuing Care

Patients who remain at home after EMS assessment may judge the encounter through how well they understood the clinical reasoning and what to do if symptoms recur. Evidence from patient interviews and clinician perspectives emphasizes shared decision-making, confirmation of understanding, explicit return precautions, and clarity about further care [3,8,10,11,13]. These activities could contribute to safer transitions, but the cited studies do not establish that communication training alone decreases clinical deterioration, readmission, or mortality.

Summary of Findings

The reviewed publications offer comparatively strong thematic consistency around empathy, explanation, dignity, reassurance, and family inclusion. Evidence is more limited for standardized patient-reported outcome metrics, culturally adapted tools, controlled trials of communication training, and links to objective clinical endpoints. Secondary reviews should not be combined arithmetically with original studies because they may include some of the same participants or research reports.

Discussion

Interpretation of the Evidence

The available evidence supports viewing interpersonal communication as a component of the prehospital intervention itself. An ambulance encounter begins with uncertainty and often ends with a decision whose rationale must be understood: hospital transfer, advice, treatment at scene, refusal, or non-conveyance. Communication helps convert a technically appropriate action into a care plan patients and families can interpret, accept, and follow. Across settings, confidence and reassurance are described as meaningful outcomes, particularly when patients are afraid or lack knowledge of what is occurring [2,4,5].

Communication quality nevertheless cannot be inferred from satisfaction alone. A satisfied patient may receive suboptimal clinical assessment, and a clinically justified high-risk decision may be unpopular. Studies using self-reports are vulnerable to recall, selection and gratitude bias. Most primary qualitative studies are context-rich but small and cannot determine whether any individual

strategy causes improvements in safety or resource use. The distinction between experience outcomes and clinical outcomes is therefore essential.

Comparison with Previous Research

The present narrative is aligned with the person-centred themes reported by Tikkanen and Sundberg [4] and Satchell et al. [5]. It also accords with the reassurance emphasis in Togher et al. [2] and the findings of non-conveyance research on collaboration and confidence [3,8,10]. Whereas prior syntheses have often considered patient and family experiences separately, the current framing highlights their interaction during the same emergency event. Family inclusion requires balancing the patient's autonomy with relatives' practical and emotional needs rather than assuming the interests of all parties are identical.

Implications for Saudi Red Crescent Authority Practice

The authors' affiliation makes Saudi prehospital services the practical setting for the recommendations, not the location in which the cited international evidence was necessarily generated. Before national implementation, approaches should be adapted for Arabic language preferences, multilingual patients, varied health literacy, children and older adults, confidentiality expectations, and the different levels of family presence encountered across urban and rural calls. Proposed practices include beginning with a clear self-introduction, describing the immediate plan in everyday language, acknowledging the patient's expressed concern, inviting relevant family history with consent, and using a brief understanding check before ending the encounter.

A local pilot could embed a concise communication checklist in simulation and field mentoring, then evaluate patient and family experience, complaint themes, understanding of instructions, and operational feasibility. Selected high-risk episodes should also be reviewed for adverse events, but any effect on clinical outcomes should be measured with an appropriate comparator and adjustment for case mix. This approach avoids treating positive perception scores as a substitute for clinical governance.

Strengths and Limitations

Strengths of this draft include a focused patient-and-family question, reliance on identifiable publications, transparent separation of primary and secondary evidence, and explicit consideration of both subjective experience and clinical safety. The major methodological limitation is that a complete systematic search, two-reviewer screening, study-level critical appraisal, and PRISMA flow data have not been supplied or performed. The evidence chart is therefore illustrative rather than exhaustive. Additional limitations arise from English-language emphasis, overlapping source reviews, small qualitative samples, Western settings, and heterogeneity of concepts and measures. These constraints prohibit a pooled effect estimate and restrict generalization to Saudi practice.

Future Research Directions

Future work should test whether structured communication skills training improves validated patient-experience scores and comprehension without delaying treatment; co-design and validate Arabic-language measures for patients and relatives; evaluate communication during non-conveyance, paediatric emergencies, cardiac arrest and end-of-life care; and examine linguistic and cultural barriers. Prospective mixed-methods and cluster-randomized implementations could link experience measures with safety-netting adherence, repeat EMS contact, unnecessary conveyance, errors, and other objective outcomes.

Conclusion

Communication with patients and their families is consistently described in the prehospital literature as central to reassurance, trust, dignity, participation, and perceived quality of care. Patients value calm and competent explanations as well as clinical intervention; families need information and appropriate opportunities to participate, particularly when decisions are complex or distressing. The available evidence supports integrating communication into quality assurance and training. However, a strong relationship with reported experience should not be presented as conclusive proof

of improved clinical outcomes. A formal systematic review and Saudi-specific studies remain necessary to establish the size, certainty and transferability of potential benefits.

Recommendations

- Integrate brief patient- and family-centred communication competencies into initial paramedic education, refresher training, simulation and supervisory coaching.
- Use plain-language explanations of assessments, immediate interventions, reasons for transport or non-conveyance, and what will happen next.
- Before leaving patients at home, provide explicit safety-netting, written or digital follow-up advice where feasible, and an opportunity to confirm understanding.
- Invite clinically useful family input while seeking patient consent and maintaining confidentiality and dignity.
- Adapt communication for children, older adults, limited health literacy, language barriers, disability, and emotionally distressing events.
- Pilot patient- and family-reported experience measures in Saudi ambulance services and validate their Arabic and multilingual versions before routine performance use.
- Evaluate interventions with both experience outcomes and objective clinical or process safety metrics, documenting the full review methodology before journal submission.

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Appendix A. Information Required to Complete a Formal Systematic Review

Before describing the paper as a completed systematic review for journal submission, attach the final protocol (and registration identifier, if applicable), database-specific search strings with run dates, record exports, de-duplication log, title/abstract and full-text screening decisions, full-text exclusion reasons, a reproducible PRISMA 2020 diagram, study-level extracted results, and completed design-appropriate risk-of-bias assessments. Pre-specify whether secondary reviews will be background sources or eligible synthesis units and prevent overlap with their primary studies.

A future PRISMA flow should report actual numbers for records identified, duplicates removed, records screened, records excluded, full texts sought and unavailable, full texts assessed, full texts excluded with reasons, and studies included. No numerical placeholders have been inserted because these records were not supplied.

Proposed Data-Extraction and Verification Checklist

- Document bibliographic identity and DOI, study location, care model, participant groups, recruitment method, sample size and whether relatives participated directly.
- Define the communication construct explicitly: listening, explanations, empathy, non-verbal manner, informed consent, family involvement, safety-netting or cultural and linguistic accessibility.
- Record the measurement instrument and timing for satisfaction, trust, comprehension and perceived safety; distinguish patient-reported experience from actual adverse events.
- Extract adjusted and unadjusted comparisons only where reported; keep qualitative themes separate from quantitative effect measures and avoid overlapping review populations.
- Complete a study-by-study risk-of-bias appraisal by two reviewers and indicate which conclusions depend on evidence at elevated risk of bias.

Suggested Reporting Sequence for Final Submission

After formal screening, update the abstract with the verified number of included studies, present the completed PRISMA flow figure, replace this illustrative chart with the final characteristics table, include quality-appraisal results, and revise the Discussion to reflect the certainty and generalisability of the completed evidence base. Patient and family involvement should remain distinguishable throughout all tables and analyses.