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REVIEW

Patients' and Nurses' experiences of caring in nursing: An integrative literature review across clinical practices

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Abstract

Aim: To summarise, interpret and synthesize research findings on patients' and nurses' experiences of caring in nursing across clinical practices.

Background: Caring is a universal element of nursing; however, economic restrictions often negatively impact health services, and time shortages and limited numbers of staff may characterize care encounters. It is unclear how these contextual conditions affect patients' and nurses' experiences of caring.

Design and Methods: This integrative literature review covers papers published between 2000 and 2022. Four databases—PubMed, PsycINFO (via Ovid), MEDLINE (via Ovid) and CINAHL (via EBSCO)—were systematically searched for eligible papers in May 2022. The included studies were critically appraised. Content analysis was performed to interpret and synthesize the findings. In accordance with the EQUATOR guidelines, the PRISMA 2020 and PRISMA-S checklists were used. An Integrative review methodology guided the process.

Findings: In total, 33 studies were included in the review. Three themes captured the experiences of caring in nursing: (1) the complexity of the nursing care context, (2) the professionalism of the nurse, and (3) the trusting patient–nurse relationship.

Conclusion: The experience of caring in nursing depended on nurses' competence and discretion in the personal encounter framed by the nursing context. The caring relationship was based on reciprocity, but it remains asymmetrical, as the nurse had the power and responsibility to empower the patient. Barriers, such as increased demands for efficiency and resource scarcity, may hinder the experience of caring in nursing.

Implications for the profession and patient care: By promoting an ongoing discussion of caring in nursing, nurse management can systematically support nurses in reflecting on their practice in diverse and complex clinical contexts.

Patient or public contribution: No patient or public contribution was made due to the study design.

KEYWORDS
caring, experience of caring, integrative review, nursing, patient perspective, patient–nurse relationship, perceived care, person-centered care

1 | INTRODUCTION

The wounded and homesick soldiers of the Crimean War experienced caring and hope as Florence Nightingale (1820–1910), the 'Lady with the Lamp', made her rounds in the hospital wards at night. Nightingale stated that a competent and caring nurse was an essential part of the treatment and care of the sick and wounded, and she demonstrated this through scientific methods (Pfettscher, 2022). Nightingale (1859/1946) argued that nursing interventions, such as the adaption of environmental conditions, were crucial for recovery, and when these were carried out in a caring way, they made a difference to the patient's well-being and the outcome of the treatment.

Knowledge of caring in nursing is essential for developing nursing practice and healthcare quality. Increased knowledge of and opportunities for treating complex diseases, as well as the growing number of elderly and frail people with complex health conditions, represent challenges for health services in terms of delivering quality treatment and nursing care. Dealing with the emotions, trauma and loss of patients and their next of kin during and after caring can leave nurses feeling emotionally drained and generate difficult-to-manage feelings (Missouridou, 2017). The concept of compassion fatigue describes the price of caring in the encounter with the suffering patient (Missouridou et al., 2022).

Technological innovations enhance the possibilities for more appropriate uses of resources, but—if not adequately adapted to the user and the task—they can complicate the nurse's workflow (Adams, 2016; Fuglseth & Sørebø, 2014). Over time, a consensus has been reached that caring is the primary and universal element of good nursing care (Meleis, 2018). Swanson (2013, p. 218) defined caring in nursing as a 'nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility'. Caring has been described both as a noun—the act of care—and as an adjective—a caring nurse (Adams, 2016). In the latter sense, the nurse offers competent and individually adapted compassion, kindness and concern.

Existing research on the experience of caring in nursing includes the perspectives of either patients or nurses and is mainly limited to one clinical setting or a homogeneous group of participants. For example, Alander et al. (2021) explored the caring needs of young adults diagnosed with cancer, while Halldorsdottir and Hamrin (1997) described nursing and healthcare services from the perspective of cancer patients. Wallerstedt and Andershed (2007) studied the experiences of nurses caring for dying patients, while Carter et al. (2008) explored the caring culture of a medical ward.

A few systematic reviews were identified regarding descriptions of caring in nursing. Based on seven studies, Drahošová and Jarošová (2016) investigated the concept of caring in nursing from the points of view of patients, nurses, students and nursing teachers. Caring in nursing was described as an individual and empathetic relationship that helped protect the patient's autonomy, dignity and comfort. Furthermore, the authors argued that caring required maturity from the nurse and was influenced by the work environment. Therefore, the nurse's personal qualities and professional competence were crucial for the patient. The integrative review by Leyva et al. (2015) explored caring in nursing from a global perspective on the basis of 86 studies. The authors framed caring as behaviours expressed in patient–nurse interactions. Caring was influenced by the nurse's personality and culture as well as the general environment. This review included studies from all over the world, but mainly from North America and Europe, and it aimed to answer a wide range of research questions. The review of Papastavrou et al. (2011) found differences between what nurses described as caring behaviours and what patients perceived as caring behaviours. The patients emphasized instrumental behaviours that demonstrated competence, while the nurses focused on expressive behaviours based on psychological skills. So far, research has concentrated on descriptions of the concept of caring or caring behaviours, with limited attention being paid to patients' and nurses' experiences. Research on the experience of caring in nursing among patients and nurses across clinical settings can add to our knowledge of the importance of care in the context of economic and environmental constraints.

What does this paper contribute to the wider global clinical community?

- This integrative review offers an overview of patients' and nurses' experiences of caring in nursing across clinical practices.
- Nurses' professional competence, ability to build a trusting relationship and awareness of patients' basic needs positively influence patients' experiences of caring.
- The context of the caring encounter frames the experience of care. This requires nurse management to create a conducive environment by ensuring professional training and reducing workflow stressors.

1.1 | Background

The American nursing theorist Swanson (2013) formulated her theory of caring in nursing, describing how to practice nursing in a caring manner. The central concepts of Swanson's theory are *maintaining belief*, *knowing*, *being with*, *doing for* and *enabling*. These are all fundamental elements of the nurse–patient relationship, which aims to promote the patient's well-being as an outcome.

The Norwegian nurse philosopher Martinsen (2006) stated that caring in nursing has relational, practical and moral aspects, which are intertwined (see also Alvsvåg & Martinsen, 2022). Caring is directed toward the situation of the other, and the nurse–patient relationship is the most fundamental element of caring. The mutual trust between a patient and a nurse is vital for the caring relationship (Martinsen, 2006). Furthermore, moral practice in nursing is present when empathy and reflection work together in nurse–patient encounters (Alvsvåg & Martinsen, 2022). When nurses use their senses, knowledge and experiences, they exercise professional judgement and discernment in caring for persons in specific situations (Martinsen, 2006). The American nursing theorists Boykin and Schoenhofer (1993) described the dynamics of this caring relationship and emphasized that nursing involves a lived experience shared by the care recipient and the nurse, as caring enriches personhood. According to these authors, nursing is a caring service communicated through authentic presence (Boykin & Schoenhofer, 1993, p. 36).

Trust is described as a crucial precondition of caring in nursing. Trust is what allows the presence of vulnerability in the nurse–patient relationship, where the two parties are fundamentally dependent on each other. The caring encounter presupposes a mutual surrender to this relationship (Delmar, 2012). The nurse's professionalism incorporates power in the caring relationship, and this power must be used with the patient's best interests as the goal. Finfgeld-Connett (2007) conducted a meta-synthesis of caring in nursing, emphasizing the nurse's mature knowledge, skills and competence as fundamental factors in caring. Moreover, caring in professional practices requires a favourable environment and a valuing attitude from the healthcare system and local management. This includes nurses being supported by and experiencing the care of their team members in order to validate caring and reduce workflow stressors (Finfgeld-Connett, 2007).

Kim (2015) stated that competence in nursing is action-oriented because knowledge, skills and attitudes merge and are expressed in nurses' decision-making, interactions and clinical approaches. To a great extent, excellence in nursing consists of high levels of these qualities. Competence and expertise are generic in that they appear as characteristics of the nurse and are processed in a specific clinical situation to ensure the quality of care (Kim, 2015, p. 206). Roach (2002) emphasized that competence is the product of knowledge and practice—the ability to act correctly—and that competence cannot be separated from care. Competence is about having the knowledge, skills and experience to respond with professional accountability: 'Compassion presupposes and operates from a competence appropriate to the demands of human care' (Roach, 2002, p. 54). Benner (1984) noted that experience forms expertise and that clinical knowledge develops over time. The nurse's competence results from education, reflection, experience and continuous learning in clinical practice (Nieminen et al., 2011).

For the purpose of this review, caring in nursing is understood as a mode of being directed toward the situation of the other. Thus, it is a relational, moral, contextual and practical process. Caring is based on trust and involves a mutual relationship between a professional, competent nurse who is authentically present and the patient in need of caring, as well as their family.

1.2 | Aim

This integrative review aims to summarize, interpret and synthesize experiences of caring in nursing across clinical practices, covering the period 2000–2022. Two research questions guide the review's aim: (1) How do patients, as receivers of healthcare, experience caring in nursing? (2) How do nurses experience caring in nursing?

2 | METHOD

This review included both quantitative and qualitative studies. It drew on the methodology set out by Whittemore and Knafl (2005) and was conducted in four stages: problem identification, systematic search of the literature, evaluation and data analysis. The study was guided by the PRISMA 2020 Guideline for reporting systematic reviews (Page et al., 2021) (See Appendix S4). Finally, the findings were synthesized through content analysis (Graneheim & Lundman, 2004).

2.1 | Search strategy

A team of six researchers with diverse clinical nursing backgrounds and research experience was established. The search strategy began by refining the research questions. The SPIDER (sample, phenomenon of interest, design, evaluation and research) framework (Cooke et al., 2012) was used to outline the details of the search terms (see Table 1).

The main headings and search strings were formulated by a librarian experienced in conducting systematic reviews. The main electronic search was conducted in May 2022; the following four databases were used: PubMed, PsycINFO (via Ovid), MEDLINE (via Ovid) and CINAHL (via EBSCO) (see Appendix S1). The search terms included words related to caring in nursing and the experiences of the patient and the nurse (see Table 1). The concepts and search terms were discussed by the research team to ensure consensus regarding the final terms and combinations. A pilot search was conducted before the librarian and the first author carried out the electronic search. A systematic and thorough search is critical for enhancing the rigour of the review (Whittemore & Knafl, 2005). In addition to the search terms described above, the team discussed and defined criteria for inclusion and exclusion (see Table 2). The search produced a total of 3419 studies published between 2000 and 2022. The librarian used EndNote20 to check for duplicates, and 1295 were thus removed. Finally, 2124 articles were uploaded for screening.

TABLE 1 Search terms according to the SPIDER framework (Cooke et al., 2012).

S		P I		D		E		R
Sample		**Phenomenon of interest**		**Design**		**Evaluation**		**Research type**
	AND		AND	Survey	AND	Patient experience	AND	Qualitative
OR		OR		OR		OR		OR
Nursing		Nursing caring		Interview		Nurse experience		Quantitative
OR		OR		OR		OR		OR
Concepts of nursing		Caring in nursing		Focus group		Patient attitude		Mixed methods
OR		OR		OR		OR		OR
Nursing theory		Essence of caring		Observation study		Nurse attitude		Triangulation
		Person focused care		Observational study				
				Nonexperimental studies				
OR		OR		OR		OR		OR
Essence of nursing		Patient centred care		Grounded theory		Perceptions		
OR		OR		OR		OR		OR
		Nurse–patient relation		Phenomenology				
		Caring		Ethnography				
				Anthropology, cultural				
OR		OR		OR		OR		OR
		Art of caring		Intervention study				
				Experimental studies				

TABLE 2 Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
Research papers on nursing, including description and/or assessment of care/caring in nursing	Caring in an educational context Students' experiences/perceptions Health practitioners' experience/perceptions, or patients' experience of general health practitioners Descriptions of being a nurse related to specific topics
Papers exploring the nurses' personal, individual ability to caring and assess or increasement of this Papers exploring the patient and/or the nurses' experience, attitude or perception of caring	Caring from the view of relatives/next of kin Caring from a leader/management perspective Caring as self-care Caring for children/family or in a midwifery context (pregnancy/birth) Caring in a euthanasia context
Published between January 2000 and March 2022	Published before January 2000 and after March 2022
Research papers published in a peer-reviewed journal Government papers (official documents in Norway) describing nursing Literature describing nursing care (concepts and theories on nursing care)	Abstracts, discussion articles, non-research articles, systematic reviews, anecdotal reports or editorials, conference proceedings, dissertations and concept analysis
Published/dealing with Europe (incl. UK, Irland), Australia, New Zealand and North America (USA, Canada)	Studies from South America, Africa, Eastern countries and Turkey
Published in English, Norwegian, Swedish or Danish language	Unpublished literature, early view

2.2 | Screening and study selection

All six team members were engaged in the screening process; they used the web-based software platform Rayyan to select eligible papers. The identified 2124 papers were divided into three groups, and three pairs of researchers screened their titles and abstracts individually and blinded in accordance with the inclusion and exclusion criteria. After the initial screening, the double-blinding option in Rayyan was switched off. The same pairs of researchers then discussed disagreements and discrepancies. The whole research team discussed the eligible articles, and 64 were included for full-text reading. The papers were divided into three piles, and the same pairs of researchers screened their pile of full-text articles for eligibility. Finally, the team discussed the remaining papers and agreed to include 33 of these in the review. All the included studies were published in peer-reviewed journals. The outcome of the literature search and study selection was performed according to the PRISMA-S: An Extension to the PRISMA Statement for Reporting Literature Searches in Systematic Reviews (see Appendix S3) (Rethlefsen et al., 2021). Figure 1 illustrates the search and selection process used to identify the eligible articles.

2.3 | Quality appraisal

Each paper was evaluated by two researchers based on its design, methodology, ethical quality, analysis and discussion. To assess the rigour, credibility, relevance and methodological quality of the included articles, the research team used the checklist of the Critical Appraisal Skills Programme (CASP, 2018) (see Appendix S2). The limitations of the reviewed papers included poorly reported relationships between researchers and participants and a lack of strategies to clarify the researchers' influence on participants. In some articles, the data analysis was considered to be only partially rigorous. Papers whose CASP score suggested weaknesses were not excluded if the team thought that the findings could still contribute to the understanding of the phenomenon of interest. The CASP score for each article is presented in Table 3.

2.4 | Data abstraction and synthesis

The search strategy included published papers with a variety of methodological approaches. However, the majority of studies had qualitative designs, and all except three used interviews to collect data. Finfgeld-Connett (2014) suggested the use of content analysis to build knowledge and generate theory in qualitative systematic reviews. The present review was guided by Graneheim and Lundman (2004) description of qualitative content analysis to examine and synthesize the findings of the included studies. The research team members read the papers individually and extracted the main findings in pairs. In close cooperation with the team, the first author conducted an in-depth analysis of the results after reading all the papers and the extracted findings. The process of analysis started by sorting the papers with Microsoft Excel into three groups: patients' perspective, nurses' perspective and a small group of articles that described both perspectives. The coding of the main findings in Excel led to descriptive categories with low levels of abstraction and interpretation. Repeated discussions of these preliminary categories and their underlying content by the research team led to themes with higher levels of abstraction and interpretation of patients' and nurses' experiences of caring

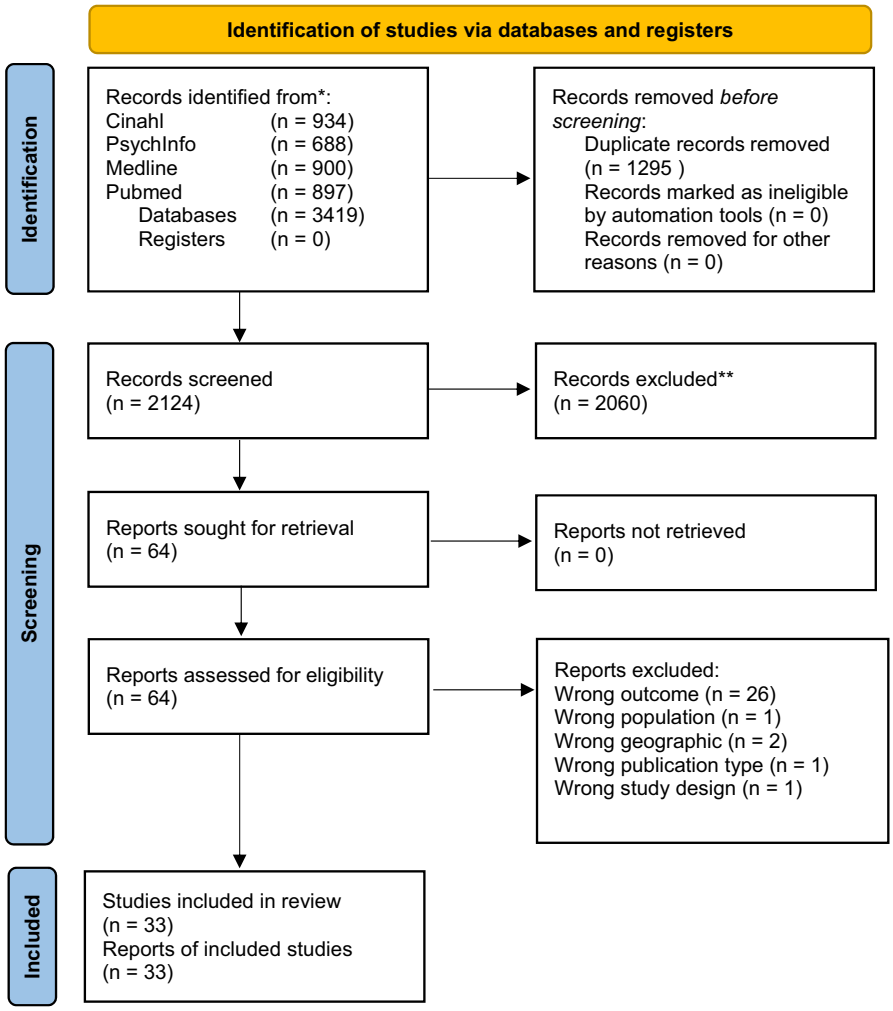

FIGURE 1 *PRISMA 2020 flow diagram for search results* (Page et al., 2021).

(Finfgeld-Connett, 2014; Graneheim et al., 2017; Graneheim & Lundman, 2004; Lindgren et al., 2020).

3 | FINDINGS

The 33 papers included in this review offered detailed descriptions of patients' and nurses' experiences of caring in nursing. Three themes emerged after the studies' findings were synthesized: (1) the complexity of the nursing care context, (2) the professionalism of the nurse, and (3) the trusting patient–nurse relationship. Subthemes serve to detail the content of each theme.

3.1 | Characteristics of the included studies

The 33 reviewed articles were published between 2000 and 2022. Table 3 offers an overview of the characteristics of the articles. A total of 19 papers reported on the perspectives of patients. In 12 papers, nurses were interviewed, while two articles documented the perspectives of both patients and nurses. The studies were conducted in diverse cultural contexts, but all focused on the Global North. North America, Europe and Australia are comparable in terms of many aspects of healthcare services and nursing education; however, differences are present regarding the financing of such services. North America is dominated by the private financing of healthcare. The majority of studies were carried out in the following European countries: Sweden (seven), Italy (three), Norway (three), the Netherlands (two), the Czech Republic (one), Denmark (one), Finland (one), Germany (one), Iceland (one), Ireland (one), Switzerland (one) and the United Kingdom (one). The remaining studies elicited findings from Australia (five), Canada (three), the United States (one) and New Zealand (one).

3.1.1 | Clinical care practices

This integrative review aimed to investigate patients' and nurses' experiences of caring in a broad range of clinical care practices. Eight studies explored a home or municipal care contexts (Dostálová et al., 2022; Gustafsson et al., 2009; Holmberg et al., 2012; Leipert et al., 2011; Murphy, 2007; Norell Pejner et al., 2015; Tarberg et al., 2020; Turjamaa et al., 2014). Three studies described caring in nursing homes (Hedman et al., 2019; Irvine, 2000; Nakrem et al., 2011). One study was conducted in a psychiatric setting (Schröder et al., 2006), while nine studies were carried out

TABLE 3 Summary and characteristics of the included studies.

First author, year and country	Study aim	Study design	Sample/population	Context	Instrument	Main findings	Critical appraisal score (H/M/L)
Andersson et al. (2015), Sweden	To describe Registered Nurses conseptions of caring	Qualitative design, phenomenographic approarch	21 nurses in coronary care, hospital	Hospital, coronary ward	Interviews	Four descriptive categories, reflecting the nurses conceptions of caring: (1) Caring as person-centredness (2) Caring as safe-guarding the patients best interests (3) Caring as nursing interventions (4) Caring as contextually intertwined	H
Blomberg et al. (2015), Sweden	To describe operating theatre nurses' perceptions of caring in perioperative practice	Qualitative descriptive design, phenomenographic analysis	15 operating theatre nurses	Hospital, Operating theatre	Interviews	One main category: To follow the patient all the way. Two descriptive categories: (1) To ensure continuity of patient care, subcategory A: Getting to know the patient, B: To be responsible for the patient and (2) Keeping a watchful eye, subcategory C: To protect the patients' body and D: To preserve the patients' dignity	H
Bove et al. (2019), Denmark	To explore the lived experiences of patients suffering from alcohol use disorders (AUD) who are cared for during a short stay in an acute medical unit	Qualitative design, phenomenological and hermeneutical	15 patients suffering from alcohol use disorder(AUD), in an acute medical unit, hospital	Hospital, medical ward	In-depth interview	Two stages in experience of scheduled care, as caring and as noncaring, depending of the alcohol level in the patients blood. First stage experienced as caring is experienced as being in a safe haven, autentic precence and a trusting relationship. In the second stage scheduled care is describes as noncaring, as being in a chaotic place and being on your own.	M
Bramley and Matiti (2013), United Kingdom	To understand how patients experience compassion within nursing care and explore their perceptions of developing compassionate nurses	Qualitative, explorative descriptive	10 hospital inpatients	Hospital, medical ward	In-depth, semi-structured interviews	The connection between compassion and caring was strong, many of the participants did not delineate between the two, substituting caring, care and compassion. Three overarching themes: (1) What is compassion: knowing me and giving me your time. (2) Understanding the impact of compassion: how it feels in my shoes. (3) Being more compassionate: Communicating and the essence of nursing.	H

(Continues)

TABLE 3 (Continued)

First author, year and country	Study aim	Study design	Sample/population	Context	Instrument	Main findings	Critical appraisal score (H/M/L)
Canzan et al. (2014), Italy	To explore, describe and compare the perceptions of gerontological nurses and their patients related to the dimentions of caring in nursing in an Italian hospital setting	Qualitative, descriptive	20 Registered Nurses and 20 geriatric patients	Hospital, geriatric ward	Semi-structured interviews	Two categories, caring from the patients view and from the nurses view. The main difference was that patient describes features of caring as visible while nurses predominantly emphasised aspects of caring that were relative invisible. Patients perspectives: (1) Caring in nursing as caring gestures (2) Caring in nursing as giving attention (3) Caring experienced through the competence of nurses. Nurses perspectives: (1) Invisible caring in nursing as looking back and beyond (2) Invisible caring in nursing involes dealing with the context to protect the patient (3) Caring in nursing as being competent	H
Dostálová et al. (2022), Czech Republic	To explore the experiences and needs of frail older people receiving home healthcare	Exploratory descriptive qualitative design, content analysis	15 older people receiving home care	Municipal/private home care	Semi- structured interviews	One main theme: Quality of care. Three categories with seven subcategories: (1) Safe and secure care A: Education and experience of nurses B: Information C: Continuity of care in terms of personnel continuity and regular care (2) Autonomy D: Decision-making andcooperation E: Self-sufficiency (3) Relationship with professionals F: Personality of nurse G: Partnership	H
Grover et al. (2018), Canada	To explore how patients experience «being known» in a busy ambulatory chemotherapy unit	Qualitative descriptive design	10 patients with various cancer diagnosis	Hospital, ambulatory chemotherapy unit.	Semi-structured Interviews	Three larger themes: (1) Feeling truly welcome in the cancer care environment, (2) Being provided with person- and situation-responsive care. (3) Being acknowledged as a person with occupational and social interests that go beyond the 'sick role'.	M
Gustafsson et al. (2009), Sweden	To elucidate municipal night Registered Nurses experiences of the meaning of caring in nursing	Qualitative design, phenomenological-hermeneutic	7 experienced night duty nurses	Municipal home care	Open interviews	Three themes: (1) Caring for by advocacy, (2) Superior responsibility in caring, (3) Consultative nursing service	M

TABLE 3 (Continued)

First author, year and country	Study aim	Study design	Sample/population	Context	Instrument	Main findings	Critical appraisal score (H/M/L)
Hedman et al. (2019), Sweden	To describe Registered nurses experience of caring for older people in nursing homes to promote autonomy and participation.	Qualitative, descriptive, phenomenological design	13 registered nurses from 10 different nursing homes	Nursing homes	Semi- structured individual interviews	Three constituents: (1) Awareness of older people's frailty and the impact of illness, to support health and well-being, (2) Awareness of acknowledgement in everyday life and trusting relationships. (3) Reflections on challenges in caring to promote older peoples right ot autonomy and participation.	H
Hofhuis et al. (2008), The Netherlands	Firstly to evaluate the perceptions of patients regarding nursing care in the intensive care unit, secondly to explore patients' perceptions and experiences of ICU stay	Qualitative design (phase 1) and quantitative (phase 2) design, analysis: Maso's approach	11 patients (Phase 1) admitted to the ICU	Hospital, Intensive care unit (ICU)	Semi- structured focused interviews (Phase 1)	Themes phase 1 (Phase 2 not relevant for this review); Key theme: Support (a continuum from the feeling being supported by the nurse to not being supported). Three categories: (1) Providing the seriously ill patient with information and explanation (2) Placing the patient in a central position (3) Personal approach by the nurse.	H
Hogan (2000), Australia	To describe patients expectations and experiences of the nurse–patient relationship, provision of information and nursing ability	Qualitative descriptive design	6 general surgical patients	Hospital, surgical ward	Semi-structured individual interviews	Three themes: (1) Nurse–patient relationship. Four categories; Personality, good communicator, competent and facilitator. (2) Provision of information. (3) Nursing ability.	L
Holmberg et al. (2012), Sweden	To describe patient's experiences and perceptions of receiving nursing care in their private homes	Qualitative design, interpretive, descriptive analysis	21 patients recieving home care nursing	Municipal home care	Open-ended interviews	Three main themes with subthemes: (1) To be a person A: To defend ones privacy, B: To make choices, C: Participating in fellowship, D: Social benefit (2) To have trust E: Need for continuity, F: Trust in the nurses skills (3) To have self-esteem G: Not to surrender, H: Not to be a host.	H
Irvine (2000), Australia	To explore and describe the experiences of the Registered nurse working in a nursing home in caring for the resident dying of cancer	Qualitative single case design, thematic analysis	5 registered nurses in one nursing home	Nursing home	Unstructured interviews and reflective journals	Four major themes: (1) The exclusivety of the relationships (2) Difficulties in the management of pain (3) The expectations of the registered nurse (4) The impact of caring on the nurse	H

(Continues)

TABLE 3 (Continued)

First author, year and country	Study aim	Study design	Sample/population	Context	Instrument	Main findings	Critical appraisal score (H/M/L)
Kelly et al. (2020), New Zealand	To answer the question: 'What is the lived experience of hospitality during a patient's hospital stay for elective surgery?'	Qualitative, hermeneutic phenomenological methodology	7 patients, elective surgery, inpatients	Hospital, surgical ward	Semi-structured, face to face interviews	Three notions: (1) Experiencing hospitality as feeling 'really' cared about. (2) Being at ease. (3) Being healed.	H
Kobleder et al. (2017), Switzerland	To explore the experiences of women with vulvar neoplasia with care delivered by an Advanced Practice Nurse (APN) during the six months following surgical treatment	Qualitative design, thematic analysis	13 women with vulvar neoplasia	Home care follow-up by an Advanced Practice Nurse	Narrative interviews	Four main themes with subthemes: (1) A trusting relationship, with subthemes A: Personality of the APN, B: Personal contact, C: APN as a woman (2) Accessibility, D: Possibility to contact the APN, E: Lower barrier, (3) Feeling safe and secure, F: Information, G: Organisation and coordination, H: Taking time (4) Feeling someone is there for you I: Not being alone, J: Possibility to dump the story, K: Psychososial support.	H
Kvåle and Bondevik (2008), Norway	To get insight in patients with cancers' perceptions of the importance of being respected as partners and share control of decisions about interventions and management of their health problems and the reasons behind their wishes	Qualitative design, Giorgis approach to phenomenology	20 patients in an oncology ward	Hospital, oncology ward	Interviews	Three themes: (1) Empowerment (being respected, listened to, given honest information and being valued) (2) Shared decision-making about treatment of the disease and (3) Partnership in nursing care	H
Leipert et al. (2011), Canada	To explore rural women's experiences with rural Primary Health Care Nurse Practitioners	Qualitative design, interpretive descriptions with a feminine lens	9 women from a rural area	Primary health care in a rural district	In-depth interviews	Access to healthcare, nursing knowledge, time, thoroughness is the foundation. Trust and respect is important. Collaborative partnership is the overall outcome of pt experiences. Barriers and facilitators to the nurse practitioner's practice is also provided.	H

TABLE 3 (Continued)

First author, year and country	Study aim	Study design	Sample/population	Context	Instrument	Main findings	Critical appraisal score (H/M/L)
Marchetti et al. (2019), Italy	To describe nurses' perceptions of the role of their bodies and the bodies of patients during body care	Qualitative design, descriptive and phenomenological	11 nurses, highly educated (PhD), various clinical experience	Various clinical settings	Open-ended interviews	One overarching theme: Body care is the heart of nursing. Four themes, with total 13 subthemes: (1) Body care encompasses the essence of person A: Body care originates from basic needs, B:Distinguishing between body and embodiment concepts is difficult, C: The body manifests the person. (2) Body care touches the heart of person D: Body care generates negative sensations, E: Body care generates more negative emotions than positive, F: Body care generates more positive feelings than negative. (3) The body generates contrasting care strategies G: Body care is difficult, H: The body is avoided, I: Body care requires a relationship that goes beyond the technique. (4) In time, the body 'nourishes' the helping relationship J: The body is communication, K: The contact goes beyond the physical barrier, L: The body 'teaches' and M: Care is mediated by time.	H
McCallum and McConigley (2013), Australia	To gain more information about how nurses deliver a dignified end-of-life experience in Open High Dependency Units	Qualitative, descriptive, explorative design	5 Registered Nurses who had worked in the open critical care unit for more than 12 months and who had cared for dying patients in the unit.	Hospital, Critical Care Unit	Semi-structured interviews	One core theme: The nurse as protector. Two other themes related to the core theme: (1) Conflict of care and (2) Peace and quiet.	H

(Continues)

TABLE 3 (Continued)

First author, year and country	Study aim	Study design	Sample/population	Context	Instrument	Main findings	Critical appraisal score (H/M/L)
Murphy (2007), Ireland	To determine nurses' perceptions of the attributes of quality care and to identify the factors that facilitated or hindered high-quality nursing care in long-term care settings	Qualitative design, influenced by hermeneutic phenomenology	20 nurses in long-term care settings	Different long-term care	Interviews	Three major themes: (1) It should be like home, (2) Striving for excellence and (3) Making a difference.	M
Nakrem et al. (2011), Norway	To explore mentally luicid residents' understanding of quality of nursing care in nursing homes	Descriptive, explorative design	15 mentally lucid residents	Nursing homes	In-depth interviews	Three categories with subcategories: (1) Care for and alleviation of medical, physical and psychological needs, A: General and specialized care, B: Health promotion and prevention of complications, C: Too old and sick to be prioritized? (2) Protecting the resident's integrity D: Self-determination and dependency, E: Altered role from homeowner to resident, F: Fear of indignity and depreciation of social status. (3) Psychosocial well-being G: Balancing the need for social contact and to be alone and H: Preserving the social network	H

TABLE 3 (Continued)

First author, year and country	Study aim	Study design	Sample/population	Context	Instrument	Main findings	Critical appraisal score (H/M/L)
Norell Pejner et al. (2015), Sweden	To explore older patients' experiences of the emotional support received from Registered Nurses and to gain deeper knowledge about the process of how getting the support they need is managed by the patient	Qualitative design, Grounded theory	18 patients living at home (n = 12) or in sheltered houses (n = 6)	Municipal home care/sheltered houses	Interviews	One core category with three subcategories: A sense of being able to hand over (their emotions). The reasons why the old person felt they could hand over their emotions to the RN was as follows: (1) Meets my needs when I am irresolute, A: By advicing and B: By providing the help I need, (2) Meets my needs when I am vulnerable, C: Because I know she's there, D: Because it happens on my terms, (3) Meets my needs when I am in need of sympathy, E: Becuse I cannot, or do not want to, involve my social network.	H
Piredda et al. (2020), Italiy	To explore palliative care nurses' experiences and perceptions regarding dependence on care	Qualitative design, Georgi's descriptive phenomenological method	16 nurses caring for dependent patients in palliative care	Palliative care center	Interviews	Four themes with sub-themes. (1) Care dependence is an experience of regression and powerlessness, (2) Care dependence exceeds the boundaries of life, (3) Nurses are required to go beyond their personal limits and (4) Care dependency is a relation of mutual growth	H
Radwin et al. (2005), USA	To analyse cancer patient descriptions of nurses and nursing care	Qualitative design, grounded theory	461 patients, in active treatment for cancer from a haematology-oncological clinic	Hospital, haematology-oncology clinic	Written answers to an open question	Four concepts with definitions and labels of categories: (1) Laudable, commendable qualities of the nurse and nursing care, (2) Caring, showing compassion, concern and kindness, (3) Professional; holding the standards expected of a nurse in knowledge, skills and demeanour, (4) Outcomes, the affective, cognitive or physical effects credited to nursing care.	H

(Continues)

TABLE 3 (Continued)

First author, year and country	Study aim	Study design	Sample/population	Context	Instrument	Main findings	Critical appraisal score (H/M/L)
Remmers et al. (2010), Germany	To find out the spesific strains influencing the situation of women with breast cancer in the stage of surgical primary therapy, and the needs and expectations they had of the nurses	Qualitative design	42 women at an early stage of breast cancer	Hospital, breast care centre	Semi-structured interviews	Four categories of strains: (1) Immediate strains regarding the surgery, (2) Fear through uncertainty, (3) Change of self-perception and (4) The strains caused by the social environment. Care needs can be divided into three categories: Wishes for A: The relationship to the nurses, B: Professional competence and C: The external conditions of care.	L
Schröder et al. (2006), Sweden	To describe how patients perceived the concept of quality of care in psychiatric care	Qualitative design, phenomenographic approach	20 adult patients with a psychiatric diagnosis	Psychiatric in-patient and out-patient care	Individual interviews	Five descriptive categories emerged: (1) The patient's dignity is respected, (2) The patient's sense of security with regard to care, (3) The patient's participation in the care, (4) The patient's recovery, and (5) The patient's care environment.	L
Sharp et al. (2016), Australia	To examine acute nursing care from the perspective of the person receiving care and to interpret the meaning of this care in relation to the concept of person-centred care	Qualitative design	10 adults persons after receiving care	Public hospital	Semi-structured individual interviews	Themes that revealed important for participants' experience of good care (1) Compassionate care: the ability of nurses to complete the task in a compassionate way, (2) Therapeutic relationships: the foundation for being known, (3) Ordinariness of good nuring care: the very ordinary ways that people experienced good care, (4) The importance of moving beyond the problem to solutions.	M
Tarberg et al. (2020), Norway	To explore how nurses experience compassionate care for patients with cancer and family caregivers in different phases of the palliative pathway	Qualitative design, hermeneutical approach.	21 female nurses from primary care and nursing homes, from both urban and rural areas, experienced in palliative care	Municipal home care, Nursing homes	Focus groups (4), 3–7 nurses in each group	Three themes expressing compassionate care related to different phases of the palliative pathway: (1) Information and dialogue (first and second phase of the clinical pathway), (2) Creating a space for dying (first and second phase) and (3) Family caregivers' acceptance of death (second and third phase).	H
Thorsteinsson (2002), Iceland	To investigate how individuals with chronic illnesses perceive the quality of nursing care in order to enhance the quality of care	Qualitative design, phenomenological approach	11 persons living with various chronic illnesses.	Various clinical settings	Semi-structured individual interviews	Professional caring is the most important part of quality of care as perceived by individuals with chronic illnesses: Five themes: (1) Skills of nurses who provided high quality nursing care, (2) Effects of high quality nursing care, (3) Lack of good quality nursing care and its effects (4) Ancillary factors, and (5) The art of being a patient.	M

TABLE 3 (Continued)

First author, year and country	Study aim	Study design	Sample/population	Context	Instrument	Main findings	Critical appraisal score (H/M/L)
Turjamaa et al. (2014), Finland	To describe the current structure of home care for older clients and to explore the enablers supporting living at home for this group	A descriptive qualitative design, analysis using inductive content analysis	Two different groups of participants: (1) 14 practical nurses working in home care services with older clients. (2) 23 older home care clients, with home visits at least once a day.	Municipal home care	Stimulated recall interviews. Videotaped situations from the home visits aimed to recall and review the original situations	The results is presented in two main categories: (1) The structure of older client's home care, with subcategory A: Organisationally driven care and B: Individual encountering at the multifaceted system. (2) Elements that promote clients living at home, with subcategory C: Individually designed care.	H
Wassenaar et al. (2015), The Netherlands	To describe and understand intensive care unit (ICU) nurses' views regarding their role in ICU patients' perception of safety	Qualitative design, Grounded theory approach	13 intensive care units nurses employed in different IC units	Hospital, Intensive care unit (ICU)	In-depth interviews	One core category: Building a bond of trust to provide good and comfortable care, arose from four main categories: (1) Explaining and informing ICU patients, (2) Using patients' family bond, (3) ICU nurses' attitudes and expertise, (4) Creating physical safety.	M
Yonge and Molzahn (2002), Canada	To capture the caring behaviours not previously documented	Qualitative, grounded theory design	18 nurses who were identified as exceptional caring nurses	Various clinical settings	Interviews, semistructured, longitudinal, 1–3 times with the same nurse	Caring practice was describes as: The process of giving (concrete gifts, time, presence and responsibility), Responsibilities and choice, Teaching, Vulnerability, Preserving dignity, Caring with and for coworkers, Truly present, There is always a way.	M
Yorke and Cameron-Traub (2008), Australia.	To explore patients'experiences of nursing care and how they believed their care needs were, or could be, met by transplant nurses, while they were on the heart and/or lung transplant waiting list	Qualitative exloratory study design, thematic analysis	22 patients waiting for a transplant from one organ transplant centre	Various clinical settings	Semistructured interviews, three interviews with 1–2 weeks between interviews	Five major themes: (1) Need for being informed by the nurses about all aspects of the transplant process. (2) Need for regular contact with the nurses. (3) Need for familarity. (4) Need for positive thinking. (5) Need for compassion.	M

in a variety of hospital ward contexts (Andersson et al., 2015; Bove et al., 2019; Bramley & Matiti, 2013; Canzan et al., 2014; Hogan, 2000; Kelly et al., 2020; Piredda et al., 2020; Remmers et al., 2010; Sharp et al., 2016). Four studies took place in high-dependency departments, including an operating theatre (Blomberg et al., 2015) and intensive care units (ICUs) (Hofhuis et al., 2008; McCallum & McConigley, 2013; Wassenaar et al., 2015). Four studies investigated cancer care settings, of which one was based in an outpatient chemotherapy unit (Grover et al., 2018) and three in oncology wards (Kobleder et al., 2017; Kvåle & Bondevik, 2008; Radwin et al., 2005). The following four studies were conducted across clinical practices: Marchetti et al. (2019) and Yonge and Molzahn (2002) interviewed experienced nurses with various clinical background; Thorsteinsson (2002) analysed the experiences of caring for persons living with chronic illnesses, and Yorke and Cameron-Traub (2008) investigated patients' perceived care needs while waiting for an organ transplant.

3.2 | Theme 1: The complexity of the nursing care context

The analysis of the reviewed studies revealed the conditions that promoted or inhibited the experiences of caring in nursing. Two subthemes elaborate this theme: (a) the prerequisites for caring and (b) the barriers to caring.

3.2.1 | Prerequisites for caring in nursing

Patients and nurses agreed that a personalized and appropriate environment was crucial for the experience of being cared for in situations of serious illness. A quiet, calm and secure setting characterized by slowness and enough time, room for personal space and pleasant surroundings was described as conducive to caring in situations of palliative care (Tarberg et al., 2020), psychiatric care (Schröder et al., 2006) and intensive care (McCallum & McConigley, 2013). In long-term care, a friendly and homely atmosphere enhanced the experience of caring (Murphy, 2007). In the study of Turjamaa et al. (2014), patients and nurses named a safe, tailored environment as a cornerstone of living at home with an illness.

In a rural district health service, patients argued that caring was enhanced by the accessibility of a nurse practitioner (Leipert et al., 2011). Likewise, nursing home residents (Nakrem et al., 2011) and patients receiving follow-up care after cancer (Kobleder et al., 2017) said that good caring equated to nurses' availability when emotional support was needed.

From the nurses' perspective, good leadership, correct staffing levels, a mix of skills in the team, structural facilities, enough time and an sociable environment were decisive factors in creating a caring environment (Andersson et al., 2015; Murphy, 2007). Operating theatre nurses emphasized care planning and calm and peace in a high-tech environment as conducive to caring in nursing (Blomberg et al., 2015).

3.2.2 | Barriers to caring in nursing

Different factors were identified as barriers to patients' and nurses' experiences of caring. From the patients' perspective, overly hasty nurses were experienced as uncaring (Nakrem et al., 2011). Similarly, a lack of personal interest and minimal nurse contact were felt as uncaring behaviour (Hogan, 2000). The patients in Bove et al. (2019) experienced fixed, scheduled care as cold and detached. Some patients stated that nurses could not replace family members, even when they acknowledged individuals' needs, as they were too hasty and short of time (Kvåle & Bondevik, 2008). Disturbing noises from medical devices and loud talking in the ICU could decrease the feeling of being cared for (Hofhuis et al., 2008). From the nurses' perspective, a heavy workload and inadequate staffing led to less face-to-face time with the patient (Andersson et al., 2015; Canzan et al., 2014). When work duties hindered time for individualized care, this was experienced as physically and mentally draining (Murphy, 2007). Irvine (2000) described how nurses had high expectations of the care provided to dying nursing home residents and expressed a sense of failure and disappointment when it did not proceed as expected due to factors such as the absence of pain relief assessment, lack of time and inexperienced staff. When residents passed away, nurses described the high personal cost of emotional involvement, as there was no counselling and limited emotional support for them from the management. This lack of support was experienced as a barrier to optimal care. The nurses in the study of McCallum and McConigley (2013) reported an conflict of care and an ethical dilemma when aggressive medical treatment was prescribed that would not improve the patient's condition.

3.3 | Theme 2: Professionalism of the nurse

The second theme in this review points to the importance of nurses' professional competence as an essential element of nursing care. This theme comprises two subthemes: (a) the discretionary use of skills and knowledge and (b) the nurse's acknowledging attitude.

3.3.1 | Discretionary use of knowledge and skills

Patients emphasized nurses' professional approach to their medical and physical needs as a key aspect of caring (Bove et al., 2019; Canzan et al., 2014; Dostálová et al., 2022; Hogan, 2000; Nakrem et al., 2011; Radwin et al., 2005; Remmers et al., 2010; Schröder et al., 2006; Sharp et al., 2016; Thorsteinsson, 2002). Being at the center of the nurse's attention (Hofhuis et al., 2008) and receiving compassionate care through ordinary nursing interventions were described as a blend of competence and compassion (Sharp et al., 2016). Professional, competent nurses were described as laudable, responsible and coordinative (Radwin et al., 2005); committed (Schröder et al., 2006); and endowed with restorative presence (Kelly et al., 2020). Patients described the importance of nurses' organizational skills and ability

to assess the situation (Kobleder et al., 2017). Furthermore, care for psychosocial well-being and attention to emotional needs were underlined in several studies (Kelly et al., 2020; Nakrem et al., 2011; Norell Pejner et al., 2015; Remmers et al., 2010; Yorke & Cameron-Traub, 2008). Patients stressed the significance of being protected and feeling safe (Canzan et al., 2014; Dostálová et al., 2022; Kobleder et al., 2017; Remmers et al., 2010; Schröder et al., 2006). Conveying information and customized explanations were appreciated (Dostálová et al., 2022; Grover et al., 2018; Hofhuis et al., 2008; Yorke & Cameron-Traub, 2008). Nurses' actions to safeguard patients' dignity (Schröder et al., 2006) as well as integrity and respect for the patient (Kvåle & Bondevik, 2008; Nakrem et al., 2011) were highly valued.

Nurses described different elements of their professional competence. They emphasized the importance of nursing interventions that led to the relief of suffering and distressing symptoms and enhanced well-being (Andersson et al., 2015; McCallum & McConigley, 2013; Tarberg et al., 2020). Safeguarding the patient's dignity was essential (Andersson et al., 2015; Blomberg et al., 2015; Gustafsson et al., 2009; McCallum & McConigley, 2013; Murphy, 2007; Yonge & Molzahn, 2002). The same is true of taking care of patients' safety, protecting their bodies and enhancing their feeling of security (Andersson et al., 2015; Blomberg et al., 2015; Canzan et al., 2014; McCallum & McConigley, 2013). Nurses acknowledged the patient's family as a resource in performing professional care (McCallum & McConigley, 2013; Wassenaar et al., 2015). Information, tailored explanations and dialogue were necessary for good care (Tarberg et al., 2020; Wassenaar et al., 2015). Nurses described their efforts to enhance patients' independence, autonomy and empowerment by including them in their care (Gustafsson et al., 2009; McCallum & McConigley, 2013; Murphy, 2007).

A study of municipal night nurses' experiences of the meaning of caring showed how nurses' competencies were demonstrated during patient encounters and in their organization of night shifts. Nurses described caring as a superior responsibility that involved collaboration and assessment of the patient and the situation through brief encounters (Gustafsson et al., 2009). Furthermore, coordinating (Blomberg et al., 2015), finding solutions (Yonge & Molzahn, 2002) and conducting invisible actions, such as planning nurse care and evaluating nursing actions (Canzan et al., 2014), were described as aspects of professional competence and responsibility.

3.3.2 | The nurse's acknowledging attitude

The reviewed articles show that nurses' attitudes made a difference in the experience of caring in the nurse–patient encounter, with personalized attention enhancing this experience. From the patients' perspective, this meant being welcomed to the outpatient clinic and being acknowledged as persons (Grover et al., 2018). In a caring nurse encounter, the patient felt that someone was there for them (Kobleder et al., 2017). When nurses attended to individual needs (Nakrem et al., 2011; Sharp et al., 2016; Yorke & Cameron-Traub, 2008), listened to patients (Kvåle & Bondevik, 2008) and acknowledged the other as a person (Holmberg et al., 2012) and as an intelligent human being (Hogan, 2000), good care in nursing was present. Bramley and Matiti (2013, p. 2794) stated that compassion was an example of personalized care—'To know me and give me your time'. This is in line with the findings of Schröder et al. (2006), who underlined the importance of being confirmed as a person. This made inpatients and outpatients with psychiatric diagnoses feel normal, and it helped reduce the shame of being mentally ill.

After interviewing chronically ill patients, Thorsteinsson (2002) argued that high-quality care involved nurses' genuine concern for the persons in their care. According to several studies, the nurse's attitude and interpersonal competence played a significant role in the quality of care (Dostálová et al., 2022; Hofhuis et al., 2008; Hogan, 2000; Kobleder et al., 2017; Thorsteinsson, 2002). Humour and positive thinking were valued in times of illness (Thorsteinsson, 2002; Yorke & Cameron-Traub, 2008). Patients also stated that paying attention and offering compassionate care were vital nursing skills (Bramley & Matiti, 2013; Kelly et al., 2020; Sharp et al., 2016; Thorsteinsson, 2002). Compassionate care was not described as a specific action but as how an act was performed—that is, with concern and kindness (Bramley & Matiti, 2013; Radwin et al., 2005; Sharp et al., 2016). Likewise, when nurses showed compassion and a comforting personality, patients felt valued and empowered (Kvåle & Bondevik, 2008; Sharp et al., 2016).

From the nurses' perspective, it was crucial to know the patient as a person (Blomberg et al., 2015; Hedman et al., 2019; Murphy, 2007; Piredda et al., 2020; Radwin et al., 2005). Acknowledging the patient as an individual and understanding their perspective were vital to caring (Gustafsson et al., 2009; Hedman et al., 2019). Yonge and Molzahn (2002) interviewed nurses considered to be exceptionally caring. They described personalized attention as involving time, presence and responsibility, as well as concrete actions based on the nurse's identification of the needs of the individual patient in a particular situation. Nurses explained this not in terms of certain behaviours but as an attitude—a way of being (Yonge & Molzahn, 2002).

3.4 | Theme 3: The trusting patient–nurse relationship

The reviewed articles highlighted the nurturing elements of the patient–nurse relationship. In particular, both patients and nurses identified trust and mutuality as essential to the experience of caring.

Different terms were used to describe the relationship between patient and nurse. *Trust* was mentioned repeatedly by both groups (Bove et al., 2019; Hedman et al., 2019; Holmberg et al., 2012; Kobleder et al., 2017; Leipert et al., 2011; Remmers et al., 2010; Tarberg et al., 2020; Thorsteinsson, 2002; Turjamaa et al., 2014; Wassenaar et al., 2015). Empathetic and open-minded nurses strengthened patients' trust (Kobleder et al., 2017). Patients and nurses involved in long-term home care described the confidential and long-lasting patient–nurse relationship found in that setting as strong and based on daily interaction, continuity, reciprocity and

trust. This relationship enabled shared humour, mutual respect and space for sharing personal opinions and stories (Turjamaa et al., 2014). The importance of this individualized attention and time to talk was confirmed by several studies (Bramley & Matiti, 2013; Canzan et al., 2014; Grover et al., 2018; Leipert et al., 2011; Sharp et al., 2016).

From the patients' perspective, continuity in caring actions and personnel was essential (Dostálová et al., 2022; Holmberg et al., 2012). Time was crucial, and regular contact allowed patients to become familiar with nurses, thus facilitating the caring experience (Yorke & Cameron-Traub, 2008). A caring relationship was built on reciprocity, which was described by patients as a partnership (Dostálová et al., 2022) and as a collaboration based on trust and respect (Leipert et al., 2011). Patients explained that an interpersonal connection required a positive relationship in which the nurse's compassionate acts acknowledged the patient and invited them to become a partner in their care (Kelly et al., 2020; Sharp et al., 2016). In some long-term care settings, the patient–nurse relationship was described as growing and developing into something profound and mutual. It was a close, family-like connection, and nurses substituted for family members if these were absent or the patient did not want to involve their next of kin (Holmberg et al., 2012; Norell Pejner et al., 2015).

Nurses emphasized genuine presence and continuity in patient-centered encounters (Andersson et al., 2015; Blomberg et al., 2015; Canzan et al., 2014; Yonge & Molzahn, 2002). Managing individualized care enhanced the experience of caring (Yonge & Molzahn, 2002). In long-term care, nurses strived to combine personalized and family-centered care in a friendly, kind and gentle way (Murphy, 2007). Marchetti et al. (2019) explained that the contact between patient and nurse was established through bodily care. Nurses' care of patients' bodies 'nourished' the trusting relationship because such care was communicative; this contact went beyond corporeal barriers and touched the person's heart (Marchetti et al., 2019, p. 83).

4 | DISCUSSION

This integrative review aimed to summarize, interpret and synthesize research findings on patients' and nurses' experiences of caring in nursing. It covered publications from 2000 to 2022. The synthesis of the 33 included articles resulted in three main themes: (1) the complexity of the nursing care context, (2) the professionalism of the nurse and (3) the trusting patient–nurse relationship. Below, these themes are discussed in relation to professional caring in complex nursing contexts, visible and invisible caring in nursing and the mutuality of caring encounters. Finally, we reflect on the strengths and limitations of this review.

4.1 | Professional caring in complex nursing contexts

The studies included in this review underscored the variety of clinical practices and the complexity of nurses' practice, which involved the handling of complicated patient situations, various environmental conditions and often a lack of resources (Andersson et al., 2015; Hofhuis et al., 2008; Irvine, 2000; McCallum & McConigley, 2013; Piredda et al., 2020; Tarberg et al., 2020; Wassenaar et al., 2015). Patients emphasized nurses' ability to create an overview of the situation, and they found the nurses organizational skills to be crucial in doing so (Kobleder et al., 2017). The development of new options for advanced treatment and the growing number of older people across the world increase the complexity of nursing care. New technological systems that require sophisticated training and knowledge (Fuglseth & Sørebø, 2014) and economic constraints on healthcare compound this complexity. For example, in the study of McCallum and McConigley (2013), nurses strived to ensure a dignified death in the ICU by using their competence to protect the patient and relieve their suffering in a highly technological, treatment-focused environment. Similarly, the night nurses of Gustafsson et al. (2009) held a high degree of responsibility for their patients during the night shift, when they assessed patients' needs and problems based only on brief encounters or collaboration with other care staff.

Murphy (2007) found that nurses involved in long-term care strove for holistic, individualized and family-centered care but lacked time to offer emotional care. These complex care situations in ICUs, municipal home care and other long-term care settings required advanced skills and knowledge, as well as mature competence in assessing and accommodating the needs of individual patients. Each nurse has a unique personality, and some nurses have histories of trauma or loss that may affect their attitudes to care. This may turn the encounter with the suffering patient into an emotionally draining event; it can also generate compassion fatigue (Missouridou, 2017; Missouridou et al., 2022). In a study of care providers conducted during the COVID-19 syndemic, Missouridou et al. (2022) explained how frustration and stress were transformed into increased compassion satisfaction through knowledge and experience, organizational support (e.g. debriefing), and clinical supervision, as well as the creation of a supportive culture in the hospital ward. To discern the needs of the individual in a specific situation, the nurse must use professional judgement and discernment (Martinsen, 2006). According to Kim (2015), the nursing practice encompasses scientific, technical, ethical, aesthetical and existential dimensions, which are integrated into nurses' ways of thinking and doing. Each of these dimensions has standards for actions, and nurses need to tailor their actions to patients and concrete situations. In addition to these dimensions, Tronto (2015) argued for the importance of considering the political, juridical and organizational contexts of care.

Several patients underlined how the experience of caring is enhanced when the person in need of care is met by a nurse who knows them and offers time and compassionate care through ordinary actions (Bramley & Matiti, 2013; Radwin et al., 2005; Sharp et al., 2016; Yonge & Molzahn, 2002). The professional competence described in the reviewed studies underlines how nurses are engaged in managing illnesses and the required interventions. Simultaneously, they support the person and the family through individualized care as part of the complexity of the nursing context. This implies that caring in

nursing cannot be understood as independent of nursing actions and contextual conditions. The simultaneous need to handle nursing interventions and personalize the care approach requires the nurse's competence and clinical discretion (Martinsen, 2006; Roach, 2002).

The nurse's responsibility in the nursing context calls for a favourable environment and support, including correct staffing levels, training and guidance, in order to show that caring is valued and to reduce workflow stressors and compassion fatigue (Finfgeld-Connett, 2007; Leyva et al., 2015; Missouridou, 2017). Some of the studies in this review (Dostálová et al., 2022; Hofhuis et al., 2008; Hogan, 2000; Thorsteinsson, 2002) indicate that the quality of caring in nursing is demonstrated in clinical practice by the integration of professional competence as a characteristic of the nurse and the ability to tailor care to the specific patient and situation (Kim, 2015, p. 206). This competence is based on the nurse's experience and is conveyed through clinical practice (Benner, 1984; Nieminen et al., 2011; Roach, 2002).

4.2 | Visible and invisible actions of caring

The papers included in this review evoke patients' and nurses' experiences of caring in nursing. In the study of Canzan et al. (2014), patients and nurses from the same geriatric hospital ward shared their encounters with care. The patients described caring as visible actions, including gentle gestures, paying attention, sharing personal details and establishing a kind relationship. By contrast, the nurses emphasized caring as invisible actions, such as evaluating and analysing their work and planning care delivery. As Canzan et al. (2014) looked at patients and nurses from the same ward, it is likely that the nurses also conducted the visible actions explained by the patients. The nurses in question related the concept of caring to their professional competence rather than specific actions in their encounters with patients. This is supported by nurses' statements in other studies included in this review (Andersson et al., 2015; Blomberg et al., 2015; Gustafsson et al., 2009; McCallum & McConigley, 2013; Tarberg et al., 2020). Patients valued the expression of caring (Canzan et al., 2014), while nurses emphasized the responsibility that stood behind this expression, which may mean that some of the nurses' actions are invisible to patients.

Papastavrou et al. (2011) reported contradictory findings, as the patients in their study repeatedly valued instrumental and technical skills and behaviours as the most important elements of caring. However, the nurses concentrated on their expressive and psychological skills, trusting relationships and comfort. This is in line with other articles in this review, which found that patients emphasized nurses' competence and professional approach to their medical and physical needs as essential elements of caring in nursing (Bove et al., 2019; Dostálová et al., 2022; Hogan, 2000; Nakrem et al., 2011; Radwin et al., 2005; Remmers et al., 2010; Schröder et al., 2006; Sharp et al., 2016; Thorsteinsson, 2002). Patients appreciated nurses' competent approach and compassionate attitude, which did not view care as a mechanical, instrumental procedure.

The examined articles reveal that a nurse's competent attitude was a crucial factor in the experience of caring in nursing (Dostálová et al., 2022; Hofhuis et al., 2008; Hogan, 2000; Kobleder et al., 2017; Thorsteinsson, 2002). Furthermore, nurses' compassionate, comforting personalities and stances underline the caring aspect of nursing actions (Adams, 2016; Bramley & Matiti, 2013; Kelly et al., 2020; Kvåle & Bondevik, 2008; Radwin et al., 2005). Thorsteinsson (2002) described high-quality care as involving a nurse's genuine concern for the other as a patient *and* a person. The patients in the study of Sharp et al. (2016) explained that good care was demonstrated in everyday actions and how the act of good care was carried out by blending competence and compassion. These perspectives illustrate caring as 'a way of being' (Yonge & Molzahn, 2002, p. 403) that presupposes professionalism and skills used competently. Therefore, competence and compassion are tightly intertwined, and the compassionate demonstration of competence is evident when nurses weigh their expressive approach. However, this nuance was not described by Papastavrou et al. (2011). The caring expressed in nursing incorporates genuine presence and is personal rather than abstract (Boykin & Schoenhofer, 1993). It is not based on the nurse's goodwill but is expressed through a caring relationship embedded in practical knowledge and moral practice. To summarize, nursing makes little difference if it is only a technique because caring entails a kind-hearted and attentive approach (Alvsvåg & Martinsen, 2022; Martinsen, 2006).

4.3 | The mutuality of caring encounters

The reviewed studies evoked caring as a relationship in which both patient and nurse contribute to the caring encounter (Dostálová et al., 2022; Hedman et al., 2019; Leipert et al., 2011; Piredda et al., 2020; Sharp et al., 2016; Turjamaa et al., 2014). Patients and nurses in home-care settings appreciated this strong relationship. They described their daily interactions as a form of friendship that included communication, reciprocity and chatting about everyday issues (Turjamaa et al., 2014). In the study of Dostálová et al. (2022), frail elders receiving home care spoke of nurses as a part of their lives; they also said that they had developed relationships with them. Nurses were partners whom clients looked forward to meeting. Their professional competence and acknowledging attitude were fundamental in building trusting relationships in all aspects of the care encounter.

This is in line with the experiences of patients in a cancer follow-up program managed by an advanced practice nurse (APN) discussed in Kobleder et al. (2017, p. 460), who described these experiences as 'feeling [that] someone is there for you'. The accessibility of the APN and the trusting relationship between patients and the APN were essential to this feeling. According to Martinsen (2006), unity between the perceiver and the perceived can be created by being open to the other. This kind of relationship creates community and makes the nurse sensitive to the patient's concerns. The life of the person in need of care is handed over to the nurse with an appeal to enhance

life courage and reveal suffering and pain. Martinsen named this sensitivity as seeing 'with the eye of the heart' (Martinsen, 2006, p. 71).

Boykin and Schoenhofer (1993) described the reciprocity of the caring encounter as living in a responsible relationship, where caring is a process of shared lived experience between the care recipient and the nurse. However, even though the caring relationship is mutual, it is still asymmetrical. The issue of reciprocity was directly or indirectly highlighted by several of the included studies (Dostálová et al., 2022; Hedman et al., 2019; Holmberg et al., 2012; Leipert et al., 2011; Sharp et al., 2016; Turjamaa et al., 2014). By contrast, asymmetry was mentioned less often. According to Delmar (2012), the nurse possesses power in the caring relationship. Hence, including the patient as a partner can redistribute some of that power. This strengthens the patient's agency and experience of security because the nurse promotes the patient's opportunity to grow and use their recovery resources. This reciprocity means that the nurse must be aware of the often-unconscious exercise of power caused by distance, paternalism and overprotection. Surprisingly, only a few of the studies in this review (Gustafsson et al., 2009; McCallum & McConigley, 2013; Murphy, 2007) demonstrated that nurses strived to enhance patients' independence, autonomy and empowerment by including them in their own care.

By being sensitive to the patient's situation, with a lingering presence, the nurse can support the patient's growth (Delmar, 2012). This professional judgement is enhanced through training; however, doing so requires the nurse to be conscious of their emotions so that they can control them (Delmar, 2012; Martinsen, 2006). Gustafsson et al. (2009) highlighted the nurse's responsibility to protect the patient's autonomy, while Murphy (2007) described the nurse's obligation to promote patient independence in long-term care. Swanson (2013) proposed the balance between *doing for* and *enabling* as a central element of her theory of caring. The responsibility for the other in the asymmetric patient–nurse relationship opens the door to caring as a mutual process, thus strengthening empowerment, and avoiding paternalism.

4.4 | Strengths and limitations

This integrative review examines 33 studies of caring in nursing published between 2000 and 2022. The 22-year period of publications on this theme is a major strength. The themes presented above represent a synthesis of findings on the core of nursing care as experienced by patients and nurses over a long time. Furthermore, the review was conducted by a team of six researchers with a broad range of experiences in clinical practice and research. All the team members considered ethical and methodological issues to ensure transparency, and they worked systematically on the data. The research questions aimed to explore the experiences of patients and nurses. The adopted integrative approach broadened the literature search to include both qualitative and quantitative studies; however, the included articles all had qualitative designs. Different types of research questions and other wordings and search terms could have resulted in the inclusion of more quantitative studies.

Furthermore, the inclusion criteria may have restricted the review's findings, as the omitted studies may have added other perspectives on the experiences of caring in nursing. Still, despite the lack of repeated searches, within the framework of our search terms and restrictions, we obtained a sample of 33 empirical publications on the care experiences of patients and nurses based on diverse clinical practices, time ranges and countries.

5 | CONCLUSION

This integrative review summarizes, interprets and synthesizes research on patients' and nurses' experiences of caring in nursing across clinical practices spanning 22 years (2000–2022). Three main themes were identified that capture essential aspects of caring in nursing: (1) the complexity of the nursing care context, (2) the professionalism of the nurse and (3) the trusting patient–nurse relationship. These three essential aspects should be attended to in the future development of health services.

Caring in nursing is a vulnerable constellation of elements, which is dependent on the nurse's competence and responsibility in the encounter with the patient. The context of the caring encounter frames the experience of care. Barriers, such as increased demands for efficiency, resource scarcity and reduced access to competent personnel, may harm the experience of caring in nursing. Caring in nursing is contextual and complex. Patients' experiences confirm the importance of knowledgeable and skilled nurses and a mutual, kind relationship. When nurses lack the time to be present or show little interest, patients' experience is that of an uncaring setting. Nurses must be aware of the reciprocity and asymmetry found in the caring relationship, as power and responsibility rest on their shoulders. Therefore, nurses are challenged to use the caring encounter as an opportunity for the empowerment and growth of patients. Future research should explore the spaces and limits of caring encounters, especially in mental healthcare; it should also investigate how to make healthcare managers aware of the visible and invisible elements that constitute caring in nursing.

5.1 | Recommendations and implications for practice

The findings of this integrative literature review are important in terms of developing research-based strategies for caring across clinical practices. Caring in nursing presupposes professional competence related to the patient group and the ability to build a trusting relationship. By facilitating an ongoing discussion of caring in nursing, nurse managers can systematically support nurses in reflecting on their practice in diverse and complex clinical contexts, as well as sustain a favourable environment, by ensuring professional training and reducing workflow stressors. Doing so can enhance compassion satisfaction. Finally, it is essential to be aware of the visible and invisible aspects that constitute caring in nursing, as these are key to building a mutual and trusting relationship in the caring encounter.

AUTHOR CONTRIBUTIONS

Ingerd Irgens Hynnekleiv (IIH), Tove Giske (TG) and Kristin Heggdal (KH) initiated the study conception and design, and KH led the team in the review process. All authors contributed to the search strategy, screening and review of retrieved articles. A librarian and IIH performed the literature search. IIH performed data analysis supported by the research team (JJ, TG, HL, EM and KH). IIH wrote the first draft of the manuscript except for the method chapter that JJ drafted. All co-authors contributed to revising the manuscript critically for important intellectual content. All authors have approved the final version of the manuscript.

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