Visible and invisible caring in nursing from the perspectives of patients and nurses in the gerontological context

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Aim: Just as in many countries all over the world, the number of older people in Italy has increased rapidly. Consequently, an increasing number of nurses are engaged in the care of older patients. However, due to a lack of understanding of how nurses and patients perceive caring, nursing care may be compromised. The aim of this study is to explore, describe and compare the perceptions of gerontological nurses and patients related to the dimensions of caring in nursing in an Italian hospital setting.
Methods: In this qualitative descriptive study, a variety of analytic techniques were used to analyse semi-structured interview data from a purposeful sample of 20 nurses and 20 patients from geriatric units in two different Italian hospitals.
Findings: Although both nurses and patients gave rich descriptions of caring experiences, patients described features of caring in nursing that were visible (including nurses' caring gestures, giving attention and being competent) while nurses predominantly emphasised aspects of caring that were relatively invisible (such as reflecting on the patient's past needs, evaluating the nursing care rendered, planning for more appropriate future nursing care, taking multiple complex contextual factors into account to protect the patient and being competent).
Conclusion: Our data revealed more nuanced insight into the meaning of invisible and visible caring in nursing within the gerontological context than has been previously reported in the literature. This has implications for nursing education and practice because it may help nurses meet the actual needs of older patients in hospital settings.

Keywords: older people, grounded theory, nursing, caring, research, qualitative approach, interview, hospital, geriatric unit.

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Introduction

A major social transformation in the 21st century is the ageing of the population. Between 2000 and 2050, the percentage of the world's population over 60 years of age will double from about 11 to 22%. Due to population ageing, the number of people living with disability also is increasing. Already, this has had an effect on hospitalisation rates. A recent WHO report (1) has noted that due to the greater risk of chronic health problems in older age, every fifth hospitalised patient is 65 years or older (2).

Just as in many countries all over the world, the number of older people in Italy has increased rapidly. In 2011, individuals aged 65 years and older represented 20.8% of the population, compared to 18.7% in 2001. This percentage is still rising, especially for people over 85 years. After Germany, Italy is the country with the second highest number of older people in Europe (3). Because the likelihood of developing health problems and chronic diseases increases with advancing age, the demand for health-care resources escalates with an ageing population. As a consequence, an increasing number of nurses are engaged in the care of older patients in Italy.

Caring in nursing has been a controversial and disputed topic for decades. The meaning of caring has been explored from qualitative and quantitative perspectives

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(4, 5). Caring has been described as a human trait, a moral imperative, an affect (6) and the essence of nursing practice (7). In her meta-synthesis of 49 studies, Finfgeld-Connet (5) defined caring as a social process involving interpersonal sensitivity in the physical and emotional aspects of the relationships of nurses and patients and the ability to identify the nuanced meaning of patients' clinical conditions through expert, competent assessment.

However, there is no agreed-upon definition of caring (4, 5). This concept in nursing remains largely unspecified and for this reason, constant efforts to capture its meaning in different contexts and from different perspectives are recommended (8).

However, research has shown that patients have emphasised technical caring skills and professional knowledge while nurses perceived emotional and relational aspects to be more important to caring. These findings raise the caution that nurses may not accurately understand patients' perceptions, expectations or needs for caring which could be compromising care that is offered (9–11).

Consequently, research about the potential congruency of perspectives about caring between patients and their nurses could improve patient outcomes (11) and may create feelings of respect, dignity and confidence in each other (2).

Most of the studies about the experience of caring in nursing have been conducted in North American or Northern European cultures. In a systematic review of 29 studies on caring in different nations, Papastavrou et al. (8) found that factors varied between countries including organisational structures, systems and models of nursing care delivery. Furthermore, the education and training programmes of the Scandinavian countries differed from those in the mid-European region and the Mediterranean countries. These issues as well as different cultural and historical backgrounds were noted to have influenced caring in nursing in different ways in these nations.

Various scales have been developed to measure caring in nursing (12) but only the 42-item Caring Behaviours Inventory (CBI; 13, 14) has been tested and validated in Italy with nurses and patients, although in a modified 24-item form (11). The Italian version was created along with versions in five other languages by Papastavrou et al. (11) so they could do a comparative analysis across six countries. The authors reported that patients' perceptions and expectations of caring actions differed from those of nurses. Specifically in relation to Italy, Papastavrou's team found that Italian nurses valued caring actions overall more than patients in Italy did. However, little is known about why because no known qualitative research has been conducted to investigate nurses' or patients' perceptions of what kinds of caring in nursing are valued in the Italian context. Therefore, the purpose of this study was to explore, describe and compare the perceptions of gerontological nurses and their patients related to the dimensions of caring in nursing in an Italian hospital setting.

To deepen our understanding, the specific questions that guided the research were the following:

How is caring in nursing perceived by older people in the hospital context?

How is caring in nursing perceived by gerontological nurses working with these patients?

Methods

Design and sample

This qualitative descriptive study (15) involved interviews from a purposive sample of 20 Registered Nurses (RN's) and 20 patients. The sample was recruited from June to July 2010. Eligibility criteria included hospital geriatric patients who were 65 years or older, were able to speak Italian, were not suffering from cognitive disorders or dementia and had been in the hospital for at least 3 days. RN's with at least 1 year of experience in the geriatric field were eligible for the study if they were specifically identified as 'good nurses' by patients or their nurse managers. All 20 of the patients and all 20 of the RN's who were invited, agreed to participate. No incentive was given for participation. See Tables 1 and 2 for demographical information of our sample.

Setting

The study was conducted in two northern Italian hospitals on a geriatric unit that routinely admitted patients older than 65 years with a variety of acute health conditions. One was a city hospital with 40 beds and the other was a teaching hospital with 35 beds. The average lengths of stay at the hospitals were 11.76 (SD ± 6.3) days and 13.14 (SD ± 9.6) days, respectively. It is possible that the length of stay was shorter at the city hospital because, unlike the teaching hospital, it is located in a very large urban area that is connected to an extensive network of community care and long-term care service providers.

Table 1 Demographics of patient participants

N (%)	20 (100%)
Gender	
Female	18
Male	2
Age in years: range (66–80)	
66–70	8
71–75	6
76–80	6

Table 2 Demographics of nurse participants

N (%)	20 (100%)
Gender	
Female	20
Male	0
Age in years: range (24–50)	
24–30	4
31–40	8
41–50	8
Education	
Bachelors Degree in Nursing	20
Masters Degree in Gerontological Nursing	0
Years of Experience in Gerongological Nursing	
1–5	10
6–10	6
11–15	4

Ethics review

Because this was a qualitative study, we were not required to undergo an ethics review, as is common in some parts of Italy. Nonetheless, this study was approved by the managers of both hospitals as well as by the lead physicians and nurse managers of both units where data were collected. All participants were informed about the purpose and procedures of the study including that their participation would be voluntary and that they had the right to withdraw from the study at any time. Prior to the interview, written informed consent was obtained from all participants. To protect anonymity, no names or identifying information were collected and confidentiality was ensured by the researchers. All interviews were conducted individually (1 : 1), in a hospital room, with the door closed in order to maintain privacy.

Data collection

Data for this qualitative descriptive study (15) were collected through semi-structured interviews by the principal investigator (PI; first author) who is a native Italian-speaking RN. All interviews were conducted in Italian and were audio-taped with the participants' permission. The PI asked participants to relate their experiences of caring interactions in everyday experience by answering open-ended questions such as, 'Please tell me about your experience as a patient receiving caring from nurses', or alternatively, 'Please tell me about your experience as a nurse providing caring.' Additional questions were asked to encourage the participants to expand upon their experiences, and included questions like, 'Could you give me an example of caring actions you received from nurses during your stay in hospital?', or alternatively, 'Could you give me an example of caring actions you delivered to the patients?' After each interview, the PI wrote about her observations and impressions in field notes (16).

Data analysis

For this qualitative descriptive study (15), all interview tapes were transcribed verbatim in Italian by the researchers (first and last authors). Then, transcripts were checked for accuracy by the PI. Analysis proceeded first in Italian. A variety of analytic strategies were used starting with one to two careful readings of each interview to get a sense of each participant's experience. Then, episodes of caring interactions were identified in the text, after which initial coding of each episode was done independently by the PI and the last author. As recommended by Charmaz (17), each researcher did initial coding by using 'words that reflect action' (p. 48) in the codes. That is, codes were not nouns that assigned a name or label to data; rather, codes were written using gerunds because 'they prompt thinking about actions – large and small' (p. 136) from the perspective of the participants who were narrating their experience. This kept the researchers focused on the participants as actors engaged in caring interactions and protected against projecting stereotypes onto the participants or labels onto their words as if their experiences were static. The initial codes generated by the researchers were discussed to identify particular aspects of each caring episode. Then the strategy of constant comparison (16, 18) of data with data was done to compare each incident of caring in nursing to the others. Through this, incident-by-incident coding (17, p. 53) was generated to more fully analyse the caring incidents in as much detail as possible in relation to each other. This also allowed us to identify and describe particular attributes of each episode of caring in nursing.

The major theme found in our analysis was caring in nursing in the gerontological context and it had two major aspects: visible caring and invisible caring. After this theme was identified, we used the analytic technique of asking specific questions of the data (16) to break the data down and sift it to clarify the properties of visible and invisible caring in the gerontological context. This allowed us to describe the phenomena more fully. Self-reflexive memos were written about the researchers' descriptions of the data in relation to possible meanings. Subsequently, the authors engaged in critical discussion to heighten our sensitivity and ability to reduce bias in data analysis (16, 17); this was all done in Italian. Ultimately, the final analysis of our data and the writing of the manuscript were done in English and involved all authors (all of whom speak English).

Findings

Caring in nursing in the gerontological context refers to the ways that the older patients and nurses in our sample experienced caring in nursing. Demographic information

about the patients and nurses of our sample is presented in Tables 1 and 2 respectively. Although both nurses and patients gave rich descriptions of caring experiences, patients described features of caring in nursing that were visible while nurses predominantly emphasised aspects of caring that were relatively invisible.

Patients' perspectives on caring in nursing in the gerontological context

Patients recognised that a caring relationship existed between them and the nurses when they actually saw nurses' caring gestures and experienced the effects of nurses' actions in a tangible, helpful way. From the patients' point of view, caring nurses were the ones who actively demonstrated that they were focused on them in noticeable ways and gave them attention. Patients described witnessing the nurses' competence which deepened their sense that the nurses were caring for them in valuable ways. In this analysis, visible caring in nursing had three attributes including caring gestures, giving attention, and being competent as seen from the perspective of the patients in our sample.

Visible caring in nursing as caring gestures

Participants appreciated when nurses treated them as individuals, got to know them as a unique person and showed respect for their feelings and dignity. Patients expected the nurses to pay attention to their tangible physical needs during daily activities, such as bathing, toileting and feeding, and when they did, patients described the nurses as caring. This sample of older patients considered their generation to be 'prudish', which was why their needs for help with their personal hygiene embarrassed them. This was more evident when the interviewee was a woman and the caregiver was a man. A 75-year-old woman said, 'Both women and men help us during personal hygiene even when it is difficult because we [patients] are embarrassed, but they [nurses] do so always respecting our dignity.'

Other patients also made specific positive comments about nurses who were 'friendly', 'warm', 'kind', 'concerned' and 'sensitive'. Patients appreciated nurses who had positive attitudes and were cheerful, with a happy disposition. Patients noted that the nurses never talked to them 'in a bad manner' (80-year-old woman) and that there was a calming aspect to the way that the nurses helped them.

Patients were particularly sensitive to nurses' facial expressions and esteemed nurses who smiled while they did their work. A typical comment from a patient was as follows, 'They [nurses] are always smiling when they enter in your room. They look and smile at you' (70-year-old woman).

Visible caring in nursing as giving attention

Patients valued the time nurses took to engage in conversation with them. It was especially important that the nurses chose to spend time talking to the patients rather than just talking to other staff. Patients also noticed how nurses would spend time listening to them. This simple act was seen as essential for good communication and understanding. During nurse–patient encounters, patients praised nursing staff who had an unhurried approach and took time to learn the stories of their lives.

This dynamic, however, was not experienced as only going one way; patients appreciated nurses who shared personal details about themselves and their family. A 67-year-old woman said, 'Nurses often enter in my room and tell me something about their kids and families' which made the patient feel recognised. Those who were available, accessible and approachable were experienced as caring nurses.

Caring in nursing also involved giving attention to the patient's daily experience as a human being living in an ageing body. Patients noted when nurses paid attention to the patients' body language. When patients' emotions could be understood by the nurses without words having to be spoken, patients felt cared for. Patients felt that this silent language of understanding was very common to the nurses. A 79-year-old woman confided, 'They [nurses] are always ready to help if they see you embarrassed by something.'

For those patients who expressed a complete sense of contentment with the nurses' work, caring was described as a sense of uninterrupted satisfaction. A 76 years old woman said, 'They [nurses] do everything that you ask them and spend much time helping you with everything you need.' However, patients understood it was not possible for the nurses to satisfy all of their requests immediately. Patients valued the nurse who remembered his/her need and kept a promise: "When the nurses tell you 'I can't help you now, I'll come later', they are sincere. They don't tell you 'I'll come' and then don't return anymore" (76-year-old woman). These episodes of 'promise keeping' were experienced as a kind of fidelity between the patients and nurses.

Visible caring experienced through the 'competence' of nurses

Many of the patients reported how important it was to be cared for by nursing staff who promptly recognised signs, symptoms, or changes in their clinical condition. In describing this, a 70 year old man added, 'They [nurses] are so competent….They [nurses] came to me and made me feel better with my heart'. Patients appreciated when, during daily practice, nurses kept them informed about what intervention was being done, when, where and why. Nurses who made efforts to increase the patient's

understanding by intentionally explaining what the patient would feel or what could happen to him/her using simple language, were valued. A 70-year-old man said, 'The nurses spoke to me continuously while they were doing the dressing, describing to me the stages… They [nurses] came and explained to you, explained everything.'

Nurses' perspectives on caring in the gerontological context

In contrast to the patients of our sample who saw caring in nursing as comprised of visible properties, the nurses of our sample emphasised caring as a combination of actions that were invisible. This included thinking about the patient in relation to their past needs and evaluating the care that they gave to the patient in the past in order to plan and implement more appropriate caring actions for the present and the future (i.e., looking back and beyond). In addition, nurses felt that caring involved taking multiple complex contextual factors into account so that not only the needs of the patient were met, but also the patient's advocacy and protection needs were met. Just as it was for the patients, the nurses regarded competence to be a pivotal component of caring in nursing. In this analysis, invisible caring in nursing had three attributes from the perspective of the nurses including looking back and beyond, dealing with the context to protect the patient and being competent.

Invisible caring in nursing as looking back and beyond

Nurses reported that a caring relationship requires an intense reflexivity to look back and constantly ask themselves whether their caring actions were adequate or not for this unique patient and his/her particular situation. Caring in nursing in the gerontological context included complicated family dynamics. Sometimes, it included the situation when a caregiver who did not speak Italian fluently or did not have caregiving experience was employed by the family. A nurse described this as, 'complex… they [the foreign hired caregiver] need to be trained to do a lot of stuff like how to mix a medication or measure a blood pressure …. you know this takes a lot of my work time' (30 years old, 7 years experience).

Nurses explained that when they took time to reflect during an intervention, they were able to immediately change how they intervened in a situation. Also, when they looked back upon their actions after the event, they were able to appraise their care. This reflection involved anticipating what might happen to patients and problem solving in advance. All of these efforts to look back and reflect as well as to analyse their clinical work was considered caring by the nurses.

The nurses reported that caring in nursing involved being able to look ahead to the future on behalf of the patient. To do this they needed to have a plan for the patient's care. They set both short- and long-term objectives that were achievable. When describing caring in nursing care, nurses emphasised this as an aspect of individualised care: 'For some patients you can define short-term objectives within their discharge, others need more time and so you should carry out long-term objectives' (29 years old, 5 years experience). They intentionally designed a plan to engage patients at the highest level of their capabilities and noted caring in nursing involved their motivation to further develop the patients' abilities.

Invisible caring in nursing involves dealing with the context to protect the patient

To the nurses of our sample, exploring the world of the patient was needed for a caring intervention. After having learned contextual information about the patient, they started to ask themselves questions and hypothesise some ways to begin to relate to the patient, as a nurse said, 'Taking care of a lonely 90-year-old lady with chronic obstructive pulmonary disease is different from taking care of another person who is 70 years old and has a good family network, because you have to act in a different way' (30 years old, 11 years experience).

The priority was to succeed in communicating with the patient, to capture his/her attention to understand him/her. Therefore, multiple possibilities of ways to interact with a patient would be considered.

The nursing staff felt that caring in nursing involved paying attention to the patients' safety. For this reason, collaborating with colleagues and other health professionals was necessary. Nurses cared by summarising their observations and passing this information on to the team at the 'nursing hand-off' or transition of the shift. For example, a nurse might suggest 'strategies to help a patient with dementia to fall asleep' (32 years old, 8 years experience).

Sometimes keeping the patient safe was accomplished by nurses advocating on his/her behalf to the rest of the team including the physicians: 'I remember a patient who was going to be discharged from the ward without any caregiver at home who could take care of him. I opposed that decision and prolonged his stay until the situation was sorted out' (28 years old, 4 years experience). To this end, it was essential to succeed in not being imprisoned by other people's opinions about the patient, but to continue to look out for the patient's best interest. Coming against others' stereotypes of older people was cited as necessary; a nurse reported, 'Many colleagues say, 'They are old, what do you want to do?' To me, this is a wrong idea' (49 years old, 15 years experience).

Also, nurses deemed it important to provide family-centred care to older people even if there was conflict in

the family. Nurses recognised that each member of the family was valuable in many ways and put in effort to bring harmony to families that were estranged. Examples included working with a patient and her niece to bring about reconciliation even though the two had not spoken for what was reported to be 'a long time' (34 years old, 7 years experience).

It was important that the family was perceived as a part of the care team. Therefore, nurses tried to facilitate the constant presence of the family in the hospital during the day. The nurses worked with families to reduce the 'sensation of powerlessness' and tried to 'involve them in choices' about the care of their loved ones (29 years old, 4 years experience). Nurses needed information about the patients' lives to be able to better understand their situation. To gain such a comprehensive view meant putting a priority on listening to their families and assisting the patients to get the best help possible while in the hospital or after their discharge. Sometimes it meant providing patients and their families with a comforting and relaxed atmosphere for the dying period.

Invisible caring in nursing as being 'competent'

Nurses reported that being attentive to personal needs, being present as well as using both their personality and clinical knowledge represented crucial aspects of being competent in the care of older patients. Here, nurses had similar views to those of the patients. Nurses valued using their clinical skills for reducing risks, preventing emergency situations for their patients and being 'competent, to quickly recognise the signs and symptoms of an emergency situation for the patient' (26 years old, 2 years experience).

Having a strong knowledge about different conditions for patients with different diseases meant that nurses could appropriately treat patients. Being able to impart accurate, comprehensible information to the patient allowed nurses to re-educate patients about their activities of daily living. In particular, washing, dressing and walking were seen as essential parts of promoting patients' independence. This teaching–learning action required 'competence' and was perceived as caring by the nurses. Informing patients about any improvement in their condition was seen by nurses as necessary to help the patient participate in his/her care. In order to be able to assure that a patient was learning, a nurse explained that, 'it is important to explain to the patient what I'm doing, and observe what he is able to understand' (30 years old, 6 years experience).

Discussion

As the population of Italy ages, a deeper and more nuanced understanding of caring in nursing from the perspective of older patients in hospital is needed. However, our findings suggest that if nurses and researchers desire to understand how caring in nursing is perceived in the gerontological context, the use of previously developed scales such as the CBI or the modified CBI (11) will not provide sufficient insight. In fact, our findings showed that several properties of caring in nursing that were valued by the older patients in our sample are not listed among the items on such quantitative scales that measure caring in nursing. Examples from our data include the facial expressions of nurses, nurses' use of simple language to tell the patient what is happening during an intervention, nurses' ability to silently understand the patient's feelings or body language, nurses' willingness to share personal details about their own children and nurses' demonstration of promise keeping as part of daily interactions in the hospital. These are all unique findings that seem to tap into the particular, specific and tangible meanings of caring in nursing for the older patients of our sample.

It is striking that a systematic review of 29 studies in 2011 comparing patients' and nurses' views of caring in nursing, reported that patients linked it to technical and practical skills (e.g. 'knows to give a shot, IVs and manage equipment') while nurses linked it to the emotional and relational aspects of their work with patients (8). In contrast, as has already been briefly noted, our data showed that patients from our sample valued the more visible and social, emotional and tangible aspects of nurse's actions such as smiling, acts of kindness and preserving dignity. However, the nurses of our sample did not mention these aspects.

Unlike nurses of the other studies (18, 19), the nurses in our sample did not describe emotions as the key aspect of caring in nursing. Rather, they emphasised the invisible aspects of caring pertaining to a complex phenomenon of care planning that took into account the individual characteristics of each patient (looking back and forward) and managing multiple contextual factors with the goal of maximising the patient's safety and well being (dealing with context to protect patient).

Nonetheless, both the patients and nurses of our sample considered being competent to be crucial to caring in nursing, as was also found across the 29 studies in the 2011 systematic review (8). Furthermore, both the patients and the nurses of our sample described competence as involving prompt recognition of signs and symptoms. In addition, the continuous provision of clear information was valued by patients because it allowed them to participate in decision-making. This was similar to the findings from several other studies (5, 20, 21). One example is the multimethod study by Roberts (22) wherein quantitative data were gathered through questionnaires from 260 elders and qualitative data were gathered through interviews of 30 elders, each aged 70

and higher. In the Roberts study, participants highly valued having an active role in decision-making specifically because it allowed them to become co-producers of their care. Various scholars have grappled with the current debate related to an emphasis on partnership rather than paternalism in patient care situations. In particular, Zomorodi and Foley (23) did a concept analysis of the nature of advocacy vs paternalism and they noted that when meaningful communication occurred between nurses and patients, advocacy prevailed over paternalism. The authors noted that patients felt the benefits of advocacy when their opinions and values were taken into account which helped them make informed decisions.

Among the nurses of our sample, advocacy not only referred to maximising the patient's ability to participate in decision-making, but it also involved speaking up when the objectives of the healthcare team were not consistent with those of the patient. Several other studies have resulted in similar findings (24, 25). Consequently, authors such as Zomorodi and Foley (23) have called upon nurses to have open discussions with physicians and other nursing staff to raise awareness and advocate for patients. They described specific communication strategies that minimise paternalism in nursing situations, including the intentional use of easily understood language with patients, giving of patient education in small amounts and taking time to answer patients' or families' questions.

Our results related to caring in nursing in the gerontological context, taken together with those of other studies done in various types of hospital settings, suggest that competence is not only crucial, but it is a necessary antecedent to caring in nursing (5, 26, 27). This is especially important in Italy because in 2001, nursing education moved to the university level; this led to recent educational and professional advancements in the Italian nursing profession wherein the traditional definition of competence based on technical aspects of care was heavily criticised. To date, an intense debate over the meaning of the competence of nurses is still going on in Italy. Thus, our findings are timely and appeal to the holistic concept of competence described by Dellai and colleagues (28), as going beyond the technical aspects to combine knowledge, abilities, attitudes and values.

Other ways that our findings were in concert with those of other studies involved the patients' appreciation of nurses who treated them with dignity, showed respect for their emotions and values, and paid attention to their physical needs through caring gestures, especially during bathing, toileting and feeding. Just as was reported by Hall et al. (2), this was important to patients so they felt they were valued individuals despite their sense of vulnerability due to their need for support in daily activities.

Previous studies on caring (2, 20, 29–32) corroborated what our findings revealed about caring gestures that patients highly regarded; this included when nurses were cheerful, happy and smiling while they worked.

Just as the patients of our sample interpreted the attention given to them by nurses as indicators of tangible, visible caring in nursing, various other samples of patients reported a high value for nurses' ability to give attention to patients (20, 30, 32, 33). However, as already noted, patients of our sample particularly valued nurses who volunteered personal insight into themselves and their family to patients for the sole purpose of sharing; this was seen by patients as caring in nursing. This distinct aspect of caring in nursing has not, to date, been included in other studies that we know of.

Another unique aspect of our findings included the high regard nurses in our sample displayed for the invisible work of reflection and critical thinking when it was linked to evaluating the quality of care nurses offered to patients (looking back and forward). This critical reflexivity on the nurses' part was described as involving the analysis of complex family dynamics, which could differ in different contexts. In the Italian context, it is not uncommon for families to hire foreign caregivers to take care of an older person at home. Because these caregivers may not speak Italian fluently or might not have previous caregiving experience, the nurses noted that their role in training the caregivers was important to protect/guarantee continuity of care after discharge. Although such training was considered important, it was also time consuming and stressful for the nurses, perhaps in part because of not only the visible but also the invisible aspects of caregiving that the nurses were attempting to teach.

The caring work described by the nurses in our sample involved creating a care plan with objectives that enhanced the continuity of care for the older patient after discharge; it also required them to see the family members as a resource in the care of older people and to involve them in the caring process. At times, this included the establishment of a supportive relationship with the family, to improve co-operation among all the actors engaged in the caring process. For example, a family may need information and support from nurses, but in return, nurses can get crucial information about the older person's earlier life which will help them increase the quality of care rendered to these patients. These results are in line with what emerged from other caring studies in the literature (27, 34–36).

Limitations of the study and recommendations for further studies

This study only described the experiences of caring in nursing from the perspectives of nurses and patients in two Italian geriatric units. Further exploration in different clinical settings such as outpatient or long-term facilities is needed in order to understand Italian culture-

based differences and similarities related to caring in the gerontological context overall. Also additional research using a mixed-method approach or triangulation that would include data from participant observation would provide interesting insights into the phenomenon of caring in nursing in the gerontological context in Italy because it would show not only what nurses or patients say, but also what they do.

Conclusion

The results of this study, combined with other research on the growing population of older patients in Italy, provide new knowledge that is necessary to successfully engage our changing world in gerontological nursing. The demographical changes in society require a rethinking of how caring in nursing is valued and rewarded in health-care settings that specifically target older patients. If older patients expect caring in nursing to be visible and tangible, but nurses focus predominantly emphasise less noticeable meta-skills such as reflecting and critical thinking, efforts to bring about a more balanced delivery of care and continuity are needed. The convergence of value placed on 'being competent' by both patients and nurses is a common point of understanding. From there, nursing care models, healthcare organizations, and nursing education programmes can work to foster a healthcare culture that succeeds in promoting the fusion of the visible and invisible aspects of caring in nursing, including what is important not just to nurses but to older patients as well.

Author contributions

By submitting this manuscript, we certify that all the authors have made a direct and substantial contribution to the work reported in the manuscript. In particular, Luigina Mortari and Luisa Saiani contributed to the conception and design of the study, to the supervision of data collection, analysis and interpretation. Federica Canzan and Elisa Ambrosi contributed to the data collection, analysis and interpretation and the writing of the manuscript. MarySue V. Heilemann contributed to the revision of the method, the data analysis and the writing of the revised manuscript. All authors (Federica Canzan, Mary-Sue V. Heilemann, Luisa Saiani, Luigina Mortari, Elisa Ambrosi) contributed to the critical revision of the manuscript and approved the final version.

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References

1 World Health Organization. Knowledge Translation Framework for Ageing and Health. 2012, http://www.who.int/world-health day/2012/toolkit/background/en/index3.htm (last accessed January 2013).

2 Hall EOC, Høy B. Re-establishing dignity: nurses'experiences of caring for older hospital patients. *Scand J Caring Sci* 2012; 26: 287–94.

3 Istituto Nazionale di Statistica (Istat). *Risultati 15° Censimento Generale Della Popolazione e Delle Abitazioni* (*15th General Survey of the Italian population*). 2011, http://censimentopopolazione.istat.it/i-risultati/default.html (last accessed January 2013).

4 Watson R. Editor's choice. *J Adv Nurs* 2012; 19: 961–2.

5 Finfgeld-Connett D. Metasynthesis of caring in nursing. *J Clin Nurs* 2008; 17: 196–204.

6 Morse JM, Solberg SM, Neader WL, Bottorff JL, Johson JL. Concepts of caring and caring as a concept. *ANS Adv Nurs Sci* 1990; 40: 25–35.

7 Watson J. *Nursing: The Philosophy and Science of Caring*. 1985, Colorado Associated University Press, Boulder, CO.

8 Papastavrou E, Efstathiou G, Charalambous A. Nurses' and patients' perceptions of caring behaviours: quantitative systematic review of comparative studies. *J Adv Nurs* 2011; 67: 1191–205.

9 Papastavrou E, Efstathiou G, Tsangari H, Suhonen R, Leino-Kilpi H, Patiraki E, Karlou C, Balogh Z, Palese A, Tomietto M, Jarosova D, Merkouris A. Patients' and nurses' perceptions of respect and human presence through caring behaviours: a comparative study. *Nurs Ethics* 2012; 19: 369–79.

10 Berg L, Danielson E. Patients and nurses experiences of the caring relationship in hospital: an aware striving for trust. *Scand J Caring Sci* 2007; 21: 500–6.

11 Papastavrou E, Efstathiou G, Tsangari H, Suhonen R, Leino-Kilpi H, Patiraki P, Karlou C, Balogh Z, Palese A, Tomietto M, Jarosova D, Merkouris A. A cross-cultural study of the concept of caring through behaviours: patients' and nurses' perspectives in six different EU countries. *J Adv Nurs* 2012; 68: 1026–37.

12 Watson J. *Assessing and Measuring Caring in Nursing and Health Science*. 2002, Springer Publishing Company, New York, NY.

13 Wolf ZR. The caring concept and nurse identified caring behaviors. *Topics in Clinical Nursing* 1986; 8: 84–93.

14 Wolf ZR, Giardino ER, Osborne PA, Ambrose MS. Dimensions of nurse caring. Image. *Int J Nurs Educ Scholarsh* 1994; 26: 107–11.

15 Sandelowski M. Whatever happened to qualitative description? *Res Nurs Health* 2000; 23: 334–40.

16 Corbin J, Strauss A. *Basics of Qualitative Research*, 3rd edn. 2008, Sage Publication, Thousand Oaks, CA.

17 Charmaz K. *Constructing Grounded Theory. A practical Guide Through Qualitative Analysis*. 2006, Sage Publication, Thousand Oaks, CA.

18 O'Connell E, Landers M. The importance of critical care nurses' caring behaviours as perceived by nurses

and relatives. *Intensive Crit Care Nurs* 2008; 24: 349–58.

19 Tuckett A, Hughes K, Gilmour J, Hegney D, Huntington A, Turner C. Caring in residential aged-care. Qualitative findings from an e-cohort sub-study. *J Clin Nurs* 2009; 18: 2604–12.

20 Jonasson L-L, Berterö C. The importance of "approaching" older people: a grounded theory. *Int J Older People Nurs* 2012; 7: 29–36.

21 Andersson L, Burman M, Skär L. Experiences of caretime during hospitialization in a medical ward: older patients' perspectives. *Scand J Caring Sci* 2011; 25: 646–52.

22 Roberts K. Exploring participation: older people on discharge from hospital. *J Adv Nurs* 2002; 40: 413–20.

23 Zomorodi M, Foley BJ. The nature of advocacy vs. paternalism in nursing: clarifying the 'thin line'. *J Adv Nurs* 2009; 65: 1746–52.

24 Chiovitti RF. Nurses' meaning of caring with patients in acute psychiatric hospital settings: a grounded theory study. *Int J Nurs Stud* 2008; 45: 203–23.

25 Burhans LM, Alligood MR. Quality nursing care in the words of nurses. *J Adv Nurs* 2010; 66: 1689–97.

26 Fagerberg I, Kihlgren M. Registered nurses' experiences of caring for the elderly in different health-care areas. *Int J Nurs Pract* 2001; 7: 229–36.

27 Murphy K. Nurses' perceptions of quality and the factors that affect quality care for older people living in long-term care settings in Ireland. *J Clin Nurs* 2007; 16: 873–84.

28 Dellai M, Mortari L, Meretoja R. Self-assessment of nursing competences – validation of the Finnish NCS instrument with Italian nurses. *Scand J Caring Sci* 2009; 23: 783.

29 Berardinelli LMM. Gestures of care in nursing. *Online Braz J Nurs* 2005; 4. http://www.objnursing.uff.br/index.php/nursing/article/view/125 (last accessed 10 May 2013).

30 Harrefors C, Savenstedt S, Axelsson K. Elderly people's perceptions of how they want to be cared for: an interview study with healthy elderly couples in Northern Sweden. *Scand J Caring Sci* 2009; 23: 353–60.

31 Webster C, Bryan K. Older people's views of dignity and how it can be promoted in a hospital environment. *J Clin Nurs* 2009; 18: 1784–92.

32 Randers I, Mattiasson AC. The experiences of elderly people in geriatric care with special reference to integrity. *Nurs Ethics* 2000; 7: 503–19.

33 Attree M. Patients' and relatives' experiences and perspectives of 'Good' and 'Not so Good' quality care. *J Adv Nurs* 2001; 33: 456–66.

34 Iranmanesh S, Axelsson K, Savenstedt S, Haggstrom T. Caring relationship with people who have a cancer. *J Adv Nurs* 2009; 65: 1300–8.

35 Wiman E, Wikblad K. Caring and uncaring encounters in nursing in an emergency department. *J Clin Nurs* 2004; 13: 422–9.

36 Wiman E, Wikblad K, Idvall E. Trauma patients' encounters with the team in the emergency department – a qualitative study. *Int J Nurs Stud* 2007; 44: 714–22.