Patient To Nurse Correlation : A Systematic Review Of Relating Studies

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Abstract

Aims and Objectives: To accumulate the current knowledge on the meaning of trust as it relates to patients' perception of nursing. The review question was "How do patients describe the meaning of trust in the nursing relationship?" Background: Trust is crucial in nursing as it offers a way by which the human being can develop trust, optimism and purpose in life as well as provide a way of encountering the world. Trust is an interpersonal and essential element of all patient-nurse relationships and therefore it is important for nurses to develop trust with the patients. Design: This article is a systematic qualitative literature review. Methods: The database search was conducted for the period of August 2024 to October 2024 and updated in the month of January 2014. 20 papers were included. Results: Four categories emerged: Attitudes related to trust, highlighting the fact that trust is inevitable and inherent; Experiences of trust, the mechanicals of identifying trust; The patient-nurse relationship, revealing the characteristics of the person who generates trust; and Where trust occurs, identifying the contexts of trust. Conclusions: The trust that patients place in nursing is a function of the knowledge that the nurses have, the amount of effort that the nurses are willing to put in the process of developing the relationship and other contextual factors. Im- plications for nursing practice: It is essential to think about the trust that the patient has for the nurse in order to gain a better understanding of what trust in nursing actually means. Clinical nurse researchers nurse supervisors, managers and nurse educatorsshould ensure that they discuss various aspects of trust during the course of nursing supervision and focus-group meetings as well as with the nursing graduates in order to enhance the nurses' understanding on how to establish a trusting relationship with the patient.

Keywords: Patient-Nurse correlation, Relating Literature Review, Trust

INTRODUCTION

It is argued that trust is crucial within the health care professional patient relationship [1-3]. The concept of trust as an interpersonal and necessary component of every patient-nurse relationship was the most evident conclusion in a review of literature on trust and trustworthiness. Trust was defined as a process that develops and changes over time and included reliance on others as well

as risk and vulnerability. Trust between patient and nurse is crucial in order to help patients feel less anxious and to help them feel more in control of their situation [5]. Caring is based on relationships and an ethical stance that has to be developed in the day to day activity. The nurse in her/his actions and practices provides a standard of care that makes the patient rely on her/him [6]. The concept of trust is connected to power and is present in all the caring relationships, and it affects the direction of the patients' choices The following are unable to care for themselves in times of vulnerability and have to rely on the nurses' good intentions which are involved in their lives closely. [8].

There are many definitions of trust [9]; as both a process and an outcome in clinical and organisational con- texts [10], between families and professionals [11], as well as in interdisciplinary literature [12]. Previous litera- ture has pointed out four key features of trust: What it is, why it matters, on what it is based, and the danger of trust, concluding that management is important for generating trust in the healthcare system [13]. One literature review discuss four factors that influence patient trust; 1) potential for shame and humiliation,

2) the power im- balance in the relationship, 3) failure of understanding of how the patient is suffering from the illness and 4) failure of understanding of the patients' suffering due to the treatment [1]. The results reveal that patients are best cared for in a setting where disease is understood, medical problems treated and that the patient is accom- panied through the illness experience. Such a setting requires an appreciation of the challenges to the experience of trust resulting from the special characteristics of the patient-nurse relationship.

Trust has the potential to create opportunities for the human being to gain faith, hope and meaning in life as well as open up for new experiences [14]. When a person trusts another person it means opening up for an action and expecting the other (trustor) to act in accordance with his/her (trustee's) wishes, interests or will. Trust is often defined as the opposite of power. Trust, choice and power are important areas in mental healthcare as pa- tients expect to participate in the treatment process. The power issue between patients and nurses can cause some patients not to avail of healthcare services [15]. One study explored the limitations of communication the- ory by considering the different perspectives of researchers, clinicians, patients and teachers, revealing that re- searchers focus on communication mechanics and techniques while "patients seek relationships in which they experience trust, the right amount of autonomy, caring and expertise" (p. 272). They argue that nurse educators and leaders should ensure that nurses develop attitudes and knowledge as a basis for the creation of a trusting patient-nurse relationship. Reflection on the conceptual understanding of trust in nursing is essential [16].

Trust is an important aspect of nursing and has been the focus of nursing theory and research. There is a need for theoretical research on trust in nursing with an international perspective. A synthesis of available evidence might provide a starting point. A concept analysis of trust provides a greater understanding of its role in the pa- tient-nurse relationship [17]. However, there is a gap in the understanding of the meaning patients attribute to trust and how the development of trust should be facilitated based on empirical studies [18]. The large body of literature on trust within nursing lacks depth, research evidence and focuses on the potential benefits of a pa- tient-nurse relationship [12]. The present review was conducted to contribute a deeper clinical understanding of patient-oriented phenomena in order to enhance nursing care [19], by means of a synthesis of available qualita- tive evidence of patients' experiences of trust and its meaning in nursing.

Aim

The purpose of this review was to compile the current research findings of with trust the in focus relation of to understanding patients' the perceptions concept of nursing care. The review question was "In what manner do a the descriptive patients and explain analytical the design meaning for of this trust paper, in which the is nursing appropriate relationship

METHODS

A systematic review was conducted on qualitative evidence in order to increase understanding of what trust means from the patient's perspective which allowed for a more descriptive and less analytical approach to the subject [21, 22]. The authors are eight nurses who work at different clinical facilities which are hospitals located in Makkah Saudi Arabia.

The study employed a thematic data-driven analysis and the findings of different studies were summarized under thematic headings. The analysis was done in stages, the first of which was to identify themes from each study and then organise the themes in terms of their major point and classification. Last, we developed the descriptive themes by discussing, naming and comparing them in order to ensure that they were robust. The were process named was as conducted meaning with units, the categories help as of a the group review of question content in with mind shared [20, commonality 23]. and Codes themes as a "unified concept" (p. 107) [23]. Patient trust was considered and analyzed based on the objective of the research**.**

Inclusion Criteria

The inclusion criteria were: the patients' perspective of the patient-nurse relationship, trust as an outcome, qua- litative studies, English language, last 10 years:

Search Strategy

A search was conducted in the following databases; PubMed, CINAHL, PsycINFO and Embase with the search period from August 2024 to October 2024, AND patient trust* AND experience*. The search strategies used in this study were developed in conjunction with the experts from the Hospital records. Furthermore, lists of sources that were included in the present analysis were reviewed.

An overall number of (954) abstracts were reviewed. A qualitative method filter was employed when searching the Psychinfo (85), CINAHL (121) and Embase (161) databases. In the process of the search, three of the authors reviewed the abstracts of 806 articles that were searched from PubMed and from all the databases and 23 met the inclusion criteria. Three were excluded because they did not concentrate on the patient-nurse relationship (Figure 1). The results were structured by theme as in a thematic analysis [20] [23]. Four categories and eight sub-categories were formulated as shown below.

Assessment of Methodological Quality

Data Abstraction and Assessment of Methodological Quality

The methodological quality of the included papers was assessed and rated according to the Critical Appraisal Skills Program (CASP), a methodological checklist of key criteria relevant to qualitative studies [24].. Agreement was reached by re-reading and discussing the studies in the light of the various criteria. The three researchers reached a final decision of low methodological quality for three, moderate for 10 and high for seven of the 20 studies. No paper was ex- cluded. The final assessment and example is presented in **Appendix 1** and

Different Methodological and Analytical Approaches in the Reviewed Studies

The included papers employed different qualitative approaches such as ethnographic, interpretative phenome- nological, interpretative descriptive, reflexive inquiry and Grounded Theory. Data were collected from partici- pant observations as well as the following types of interview; in-depth semi-structured video-recorded, ethno- graphic, grounded theory, conversational, narrative, telephone, open-ended structured, semi-structured and un- structured in addition to discussions.

Different analysis methods were employed in the papers; interpretative phenomenological, grounded theory, narrative, the NVivo computer program, textual, qualitative content, qualitative inductive,

thematic, hermeneutic, systematic, the phenomenological processes of immersion, incubation, illumination, explication and creative analysis, Van Mannens' phenomenology approach and the NUD*ST ATLAS computer program.

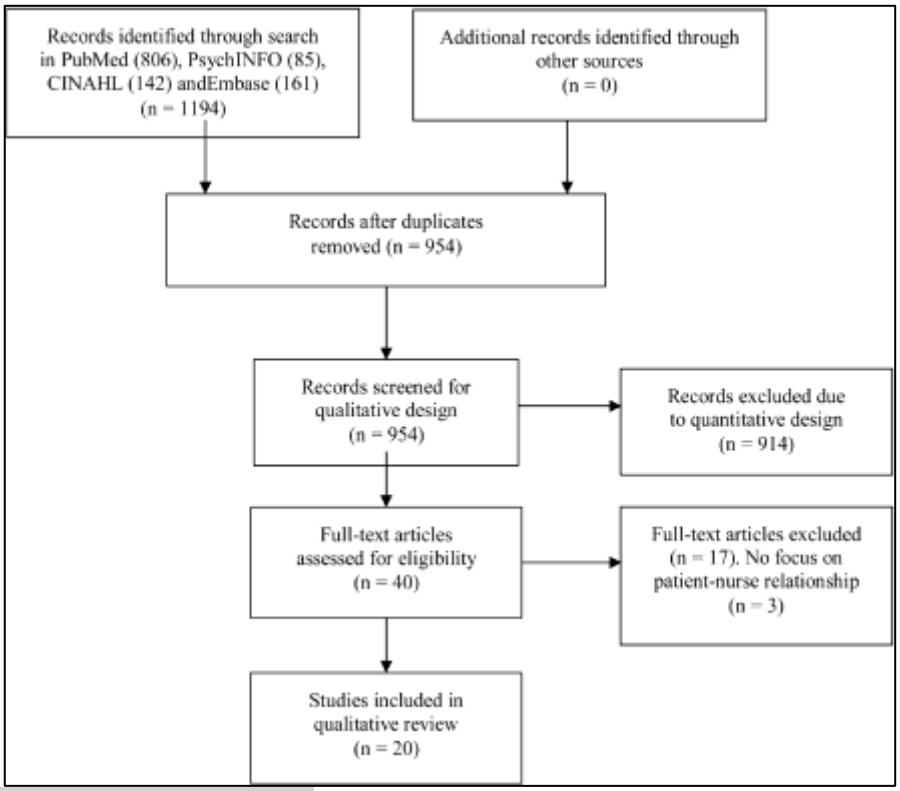

Figure 1. Literature identification process.

Study Selection

According to the inclusion criteria qualitative studies focusing on patients' experiences of trust in the encounter with nurses, describing nursing that influences patients' experiences of trust and which was published in peer reviewed English language journals were selected. The abstracts of the studies were read, after which duplicates, reports, editorials, textbooks, unpublished dissertations, quantitative studies, studies on professionals other than nurses, peer experiences and in which patient experiences were not in focus were excluded. Thereafter the tree researchers read the titles and abstracts of the remaining research papers and selected20 papers to read in full.

RESULTS

20 papers were included and assessed in this review (**Table 1**). The following categories were identified to an- swer the review question about patients' experiences of the meaning of trust in nursing (**Table 2**).

Attitudes Related to Trust

The results described trust-related issues as emotional and rational attitudes. Factors that fostered and facilitated trust were thoroughly described.

Trust as Emotional, and Rational

Core features of trust as a phenomenon were described as emotional and rational. As trust grew, persons with schizophrenia began to believe that the nurses were interested in and cared about them [25]. When patients with chronic kidney disease trusted the healthcare staff they felt no need to question decisions [26]. The importance of trust in the caring relationship in a home care setting was described [27]. This was demonstrated in a logical way in the context of palliative care; when the nurse responded to the patient in a trustworthy manner, a trusting relationship developed [28].

A study on service users admitted to a psychiatric hospital described trust as important for a positive experience and related to "safety" and "coercion" as it was described in situations where the patients felt that their safety were at risk [29]. Trust was described as a key enabler in helping obese patients to lose weight [30].

No / Year	Author / Title	Objective / Aim / Research questions	Methods	Key results / conclusion related to trust
1 / 2012	Cain et al. *Patient experiences of transitioning from hospital to home: An ethnographic quality improvement project*	To develop a richly detailed, patient-centred understanding of patient and caregiver needs during the hospital-to-home transition	Ethnographic approach; participant observation; in-depth semi-structured video-recorded interviews with 24 adult inpatients	Feeling connected to and trusting providers was a key supportive experience during transition and may help reduce readmissions
2 / 2012	Gunther et al. *Barriers and enablers to managing obesity in general practice*	To identify barriers and enablers to implementing NICE recommendations for obesity management in general practice	Qualitative study; semi-structured interviews; thematic framework analysis with GPs, nurses, and patients	Trust between practitioners and patients was identified as a key enabler to implementing obesity management

No / Year	Author / Title	Objective / Aim / Research questions	Methods	Key results / conclusion related to trust
				guidelines
3 / 2011	Brown et al. *Actions speak louder than words: the embodiment of trust by healthcare professionals in gynaecological oncology*	To explore how trust is embodied and enacted in gynaecological oncology care	Qualitative study; semi-structured interviews with cervical cancer patients	Trust was built or undermined through body work; physical care was closely linked to emotional labour and future-oriented trust
4 / 2012	Nygårdh et al. *The experience of empowerment in the patient–staff encounter*	To explore empowerment in patient–staff encounters from the patient perspective	Qualitative interview study; latent content analysis with 20 patients with chronic kidney disease	Trust in healthcare staff competence was a core component of empowerment; overall theme was creation of trust and learning through encounters
5 / 2008	Alsén et al. *Patients' illness perception four months after a myocardial infarction*	To explore patients' illness perceptions four months after myocardial infarction	Qualitative interviews; grounded theory methodology with 25 patients	Two core categories identified: trust in oneself and trust in others; trust influenced illness reasoning and self-management
6 / 2008	Gilburt et al. *The importance of relationships in mental health care*	To explore service users' experiences of admission to acute psychiatric hospital care	User-led participatory qualitative study with 19 service users	Trust in relationships shaped experiences of treatment, freedom, and the care environment
7 / 2007	Piippo & Aaltonen *Mental health care: trust and mistrust in different caring contexts*	To identify factors enabling trust in public mental health care systems	Qualitative grounded theory study with 22 psychiatric patients	Trust developed through acceptance of patient expertise, openness, shared knowledge, autonomy, and balanced power
8 / 2008	Wiersma & Pedlar *The nature of relationships in alternative dementia care environments*	To examine relationships in long-term care and alternative dementia care settings	Participant observation and interviews with 7 residents	Trust emerged through equality, reciprocity, personal interaction, and supportive relationships
9 / 2007	Hordern & Street *Issues of intimacy and*	To explore issues of intimacy and sexuality	Reflexive qualitative inquiry; semi-structured	Trust in health professionals enabled

No / Year	Author / Title	Objective / Aim / Research questions	Methods	Key results / conclusion related to trust
	sexuality in the face of cancer	from the patient perspective	interviews	negotiated communication and supported autonomy
10 / 2007	Sacks & Nelson *A theory of nonphysical suffering and trust in hospice patients*	To explore experiences of non-physical suffering and what was helpful during this time	Qualitative grounded theory study with 18 chronically ill patients	Trust was central to non-physical suffering; nurse trustworthiness reduced emotional and energy burden
11 / 2007	Mauleon et al. *Patients experiencing local anesthesia and hip surgery*	To explore patients' experiences of local anesthesia during hip surgery	Interpretive phenomenological method (Benner); interviews with 7 patients	Trust helped patients maintain control despite pain, alienation, and uncertainty during surgery
No / Year	**Author / Title**	**Objective / Aim / Research questions**	**Methods**	**Key results / conclusion related to trust**
12 / 2007	Ekman I., Ekstrand L., Schaufelberger Pulmonary oedema – a life-threatening disease	To describe patients' health history after pulmonary oedema and investigate how they perceive their condition and treatment	Qualitative interviews focusing on illness conception, current situation, and impact on daily life	Five categories identified, including trust in care providers; pulmonary oedema was anxiety-provoking and trust was essential for coping and feeling safe
13 / 2006	Donnelly & Wiechula The lived experience of a tracheostomy tube change	To investigate patients' lived experiences of a tracheostomy tube change	Phenomenological study; interviews analysed using hermeneutic analysis based on Ricoeur's theory	Trust in nursing staff and perceived competence were essential for patients' psychological preparation and ability to cope
14 / 2006	Brown et al. Waiting for a liver transplant	To explore the meaning of waiting for a liver transplant from the patient perspective	Phenomenological study; nine in-depth interviews	Trust and faith in the transplant team were crucial for surviving the uncertainty and emotional strain of waiting
15 / 2006	Lindgren, Hildingsson & Rådestad Parents'	To describe how parents assess risks related to home birth	Semi-structured interviews analysed using a	Parents demonstrated fundamental trust in the natural birth

No / Year	Author / Title	Objective / Aim / Research questions	Methods	Key results / conclusion related to trust
	assessment of risks in home births		phenomenological approach	process and the woman's ability to give birth, which guided their decision for home birth
16 / 2005	Leiphart & Barnes The client experience of assertive community treatment	To explore client experiences of assertive community treatment (ACT)	Qualitative study using in-depth interviews and grounded theory	Trust developed as providers assisted with practical needs, fostering belonging, relationships, and positive engagement with treatment
17 / 2005	Langley & Klopper Trust as a foundation for therapeutic intervention for patients with borderline personality disorder	To develop a practice-level model for facilitating mental health care for patients with borderline personality disorder	Qualitative, exploratory, interpretive descriptive study	Trust emerged as the foundation of therapeutic intervention, alongside holding, caring, accessibility, professionalism, and hope
18 / 2004	Thomas et al. The caring relationships created by nurse practitioners and the ones nursed	To uncover caring as experienced in nurse practitioner–patient relationships	Phenomenological study using Schoenhofer's caring research praxis; 14 interviews	Trust was a core theme, along with love, respect, mutuality, spirituality, and enhanced personhood
19 / 2004	Mok & Chiu Nurse–patient relationships in palliative care	To explore aspects of nurse–patient relationships in palliative care	Qualitative unstructured interviews with 10 hospice nurses and 10 terminally ill patients	Forming a relationship of trust was a central category influencing care quality and patient experience
20 / 2003	Battaglia et al. Survivors of intimate partner violence speak out	To identify provider behaviors that facilitate trust among survivors of intimate partner violence	Qualitative grounded theory study; semi-structured interviews with 27 female IPV survivors	

Categories	Attitudes related to trust	Experiences of trust	patient-nurse relationship	Where trust occurs
Sub-categories	Trust as emotional and rational Facilitating and fostering trust	Experiences of trust through predictability and empowerment Experiences of trust through feeling safe, accepted and cared for	The trustor's qualities, skills, and behavior Communication between the trustor and the trustee	Trust related to situations, role and competence Trust related to organizational level

Trust in oneself was associated with belief in one's own ability to influence and control illness, which could be related to prevention (heart attack) [31]. However, trust in others may be associated with being less active and motivated to improve one's health situation. Less interest or confidence in one's own ability to control the illness was described. In this situation the patients trusted the actions and care of powerful others, such as healthcare professionals and relatives, rather than their own efforts [31].

Facilitating and Fostering Trust

In the context of survivors of intimate partner violence, various facilitators for trust were described: nurses' openness and willingness to talk; professional competency; practice style, interest, concern, confidentiality, shared control; caring, nonverbal, non-judgmental empowerment and persistence in addition to emotional equal- ity as well as willingness and ability to engage on a personal level [32]. In persons with schizophrenia, meeting pragmatic needs and listening to the patient fostered trust [25]. The creation of a dialogical process between nurses and patients with psychiatric illness created trust [33]. Views of patients with borderline personality dis- orders on certain essential conditions for developing trust were described: being available, understanding, caring and a feeling of being emotionally as well as physically safe [34]. A trusting relationship was outlined in four themes: 1) understanding the patient's needs; 2) exhibiting caring actions and attitudes; 3) providing holistic care; and 4) acting as the patient's advocate [28].

Experiences of Trust

This category described factors related to when and how trust can be sensed as well as factors enabling trust.

Experiences of Trust through Predictability and Empowerment

A study on home birth risk assessment found that parents who had been well prepared by a familiar midwife felt that they could cope with the forthcoming birth [35]. In contrast, stress and anxiety were reported among elderly people after hip surgery under local anaesthesia when they had no sense of trust and their lack of knowledge about surgery made it difficult to keep track of and participate in their own situation [36]. Trust made the par- ticipants with schizophrenia value early detection of symptoms and provided a feeling of managing life better, which meant that they were more open to encouragement and advice to push themselves more towards im- provement [25].

A link was described between trust and empowerment and that trust helped to prevent embarrassment and shame in survivors of partner violence [32]. Trust in the care providers assisted

patients who had undergone lo- cal anaesthesia and hip surgery to feel in control even when the treatment was difficult to understand [36]. Hope emerged as trust developed and patients began to trust themselves and others [34].

Experiences of Trust through Feeling Safe, Accepted and Cared for

Feeling safe was related to basic needs such as having someone to rely on; the provision of shelter and a home- like setting, being sure that one's needs will be met and feeling cared for. Experiences of trust was associated with feeling safer, more confident, being heard and less angry; the participants felt accepted, cared about and a sense of belonging [25]. The risk of complications in home births was counterbalanced by confidence in the midwife [35]. Experiences of trust were also related to being respected, feeling accepted as a person, not objec- tified [34] and confidentiality [32]. Trust in a transplant team was judged to be "a positive element for 'surviving' on the waiting list" (p. 126) when waiting for a liver transplant [37].

In patients with myocardial infarction, trust in powerful others led to less interest in their own ability to con- trol the illness [31]. For older adults in long term care, trust meant opening up to the nurses on a summer holiday for people suffering from dementia about issues they might otherwise not have revealed to others [38]. Trust was central for patients suffering from chronic mental illness [39]. Trust can be shattered by suffering and linked to believing in one's own constructed reality, which enabled hope and provided meaning. Three categories of trust were developed in this context: the dynamic experience of trust, losing trust and dealingto regain trust [39].

The Patient-Nurse correlation

Trust was fundamental for caring in the patient-nurse relationship [27], essential for the establishment and maintenance of a therapeutic alliance [34]. In the context of the transition from hospital to home, one participant expressed that she needed to trust someone familiar with her own experiences and that she tried to stick to one person (p. 97) [40]. In a study on patients with dementia, two types of relationships were categorised: functional and supportive; "functional relationships focus on tasks, while supportive relationships are characterized by a sense of trust" (p. 103) [38]. In the present review, this category had two sub-categories:

The Trustor's Qualities, Skills and Behavior

The trustors' skills and behavior that enabled the development of trust in the relationship with survivors of inti- mate partner violence were outlined in five dimensions: 1) nurses being willing to discuss the abuse; 2) nurses demonstrating competence by asking the right questions and being familiar with medical and social histories; 3) nurses being practical, accessible, confident, and promoting shared decision making; 4) nurses being caring, non-judgmental and compassionate, providing empowerment as well as being persistent and committed; and 5) nurses sharing personal feelings and friendliness [32]. In patients with dementia, trust had to be present between the patients and nurses "for flirting, openness, sharing personal stories and physical affection"(p. 106) [38]. The trustor's qualities, skills and behaviour with gestures and body language indicating caring, attention, warmth and patience [32]. Trust was associated with nurses taking time, sitting down and answering questions, exhibiting interest and showing concern as well as sharing experiences and emotions [32]. Trust was created by nurses who demonstrated caring by positive attention [25], caring actions and attitudes [28]. In patients with chronic kidney disease, the sense of security was nurtured when the staffs were available and the feeling of trust was nurtured through the dialogue between the staff and the patient [26]. Providing holistic care and exhibiting genuine inter- est as well as specific care in accordance with individual needs were described. Understanding the patient's needs and suffering created trust [28]. Other important issues concerned the qualities of the trustor such as per-sistence and not giving up [32]; initiating and taking part in the intellectual and emotional process [35]; relying on the team's insight and proactive treatment [25]; keeping in contact not only when difficulties arise

[25]; being non-judgmental, confirming the patients' experiences, not shaming or blaming but encouraging, remaining hopeful, being aware of the options, being willing and able to engage on a personal level and sharing their own life experiences and emotions [32]; as well as being honest, flexible calm, empathetic [34] and emotionally ac- cessible [35].
The patients with pulmonary oedema reported high trust in the care providers, particularly in their medical expertise [41]. Confidence in midwives was highlighted as it counterbalanced the risk of possible complications [35]. One study described that when a nurse responded to a patient in a trustworthy way, a relationship charac- terized by trust and connection developed [28].

Communication between the Trustor and Trustee
Trust was described as being in tune with the other [35]. This may be associated with communication such as nurses informing about risk, maintaining confidentiality, interacting with and relating to patients as adults, act- ing as advisor or patient advocate, being engaged and providing assistance. Prior friendship with the midwife was described as a great emotional benefit, while trust was related to being a good friend, a part of the family
[28] or being familiar [32]. Being heard and understood in such a relationship was important for trust, as were openness and willingness to talk and listen [32]. The need to engage in conversation was highlighted, for in- stance trying to clarify the content, adopting a listening attitude and demonstrating that one is trying to under- stand [34].

Where Trust Occurs
In the context of psychiatric patient in the outpatient setting, one study claimed that trust can be created in the traditional caring context when patients feel that they are participating in their care process, which is dependent on the nurse's behavior. Here, trust refers to an individual professional as opposed to the care system. Patients reported increased autonomy and the emergence of trust in such two-way relationships [33]. The following two sub-categories were described:

Trust Related to Situations, Roles and Competence
In the context of gynae-oncology, one study claimed that trust is likely to vary across different clinical settings as they relate trust to "a particular physiological, emotional, clinical, cultural and gendered context of body work" (p. 292) and reported that gender may influence the embodied phenomenon of trust in patients with cervical cancer [42]. For those with schizophrenia, the act of bringing service to the patient in a caring manner may result in fostering trust. Patients with schizophrenia who trusted in the nurses believed that the team cared about them [25].
Several papers illuminated the link between trust and competence. Trust was nurtured by the patient-nurse dialogue, that the participants trusted in staff members' competence and a majority felt they were receiving the best care possible [26]. Trust was linked to competent nurses who managed situations [29]. Trust was related to reliance on the team's insight and proactive treatment [25]. Other issues related to competence were discussions about medical issues and abuse, being knowledgeable and thorough as well as a long-term caring relationship that made the provider familiar with and interested in each individual [32]. One study associated trust with pro- fessional factors such as maintaining confidentiality and interacting with patients as adults[34], while others re- ferred to the need to respond in a trustworthy way [28]. In the context of tracheostomy tube change, patients needed to prepare themselves psychologically, which required trust that the nurses had the necessary compe- tence to perform such a complex task [43]. Nurses who were experienced as professional, flexible, empathetic, confidential, related to the patient as an adult and remained calm were deemed trustworthy whereby a founda- tion for the therapeutic contract could be laid [34].

Trust Related to the Organizational Level

Organizational issues were mentioned such as staff being instant accessible [25]; availability and easy to contact [32]. A set time to contact the therapist and negotiation of a formal agreement between patient and therapist were described [34]. Time was an issue because it is required to develop the relationship [34] and to sit down and listen [32]. A study of factors that enable trust in the context of public mental healthcare highlighted the importance of creating trust through dialogue and not through the system, stating that the participants in their study never mentioned trust in the latter [33].

DISCUSSION

The aim of this study was to report a synthesis of the literature on the meaning of trust in the context of patients' experiences of nursing, and the review question was: How do patients describe the meaning of trust in nursing? This review illuminates the meaning of trust described from the patients' personal experiences which vary across the clinical setting as demonstrated in the different studies. The review report the patients' view of the meaning of trust, as it is described and related to a variety of attitudes, experiences, relationship and context.

Attitudes related to trust are based on the patients' view of an emotional and rational experience. The gap in the understanding of the depth [12] and meaning of trust [18] can be reduced by an exploration of clinical stu- dies illuminating patients' own descriptions. These experiences comprise both a feeling and an awareness of trust as described in this review. Such core features are reasonable and lead to the feeling of being taken care of, dispensing with the need to ask questions, relying on the other, feeling safe and better able to manage the illness, thus these features constitute a key enabler in overcoming problems. However, one should be aware of the find- ing that the patient may be less motivated to engage in his/her own situation and make decisions as a conse- quence of complete trust in the nurse.

Facilitating and fostering trust are related to communication, nurses being open, competent, practical, inter- ested, concerned, confident and sharing control, which is in line with literature which describes trust as a process and outcome [10]. The review demonstrates that nurses who facilitate trust are engaged, listen and create a dia- logical process, are available and act in a safe, holistic manner as the patient's advocate. These actions are op- portunities to create faith, hope and meaning as described in previous literature [14].

Experiences of trust are essential for caring; the trustee believes that the trustor will safeguard his/her interest. Predictability and empowerment are created when patients are informed, prepared or know in advance, leading to early detection of symptoms, better ability to manage life, trust in oneself, hope and being more open to pushing oneself. Patient empowerment prevents embarrassment and shame by providing a sense of control over the treatment, while a lack of trust gives rise to anxiety, stress as well as difficulty understanding, keeping track of and participating in one's own situation.

Trust has been characterized as reliance on and confidence in others and its basic attributes as time, reliance, risk and fragility [8]. Feeling safe, accepted and cared for is fundamental for the establishment and maintenance of the therapeutic relationship and led to the patient being open about issues he/she might not reveal to others. Feeling safe, being provided with shelter and a home-like environment are associated with a sense of confidence and respect.

The patient-nurse correlation is intimate and personal for the latter. For nurses to be experienced as trust- worthy, they must exhibit the following qualities: communication skills, competence, practical skills and behave in a caring and non-judgmental way, as well as being friendly, warm and patient.

The review reveals the importance of communication between the trustor and trustee for the creation of trust. Issues such as information, confidentiality, advice, being the patient's advocate or being familiar with the nurses are crucial for a trusting relationship. Being heard and understood is essential

for the patient. Previous findings highlight trust as the basis of the relationship between healthcare professionals and patients [1]-[3]. Gestures and body language associated with care, attention, warmth and patience indicate a trustworthy character. The patient opens up when she/he expects the nurse to act in a trustworthy manner. This is in line with previous literature which illuminates factors related to the potential for shame, humiliation and power imbalance and demonstrates that the best caring actions take place in a setting where the patient receives understanding, treatment and the nurse remains by the patient's side [1].

The contextual aspects of trust are illuminated in the category Where trust occurs. In a traditional caring con- text, the development of trust is dependent on the nurse's behavior. Trust is related to situations, roles and com- petence. In certain contexts, patients sense that nurses care about them and trust can be nurtured. Trust occurs in a setting where nurses exhibit competence and knowledge, share information and maintain confidentiality. Trust related to the organizational level demonstrate some external issues of importance for trust on the part of the pa- tient; easy access, time, level of knowledge and caring. This is in accordance with literature which highlight the importance of management including recruitment, training and developing moral understanding and motivation in the health workers, when generating trust in the healthcare system [13]. Trust should not only be developed by the individual nurse at an interpersonal level, as economic and social structures are also important [9].

Methodological Considerations

The present review only includes a synthesis of qualitative studies only. Literature argues that both quantitative and qualitative methods are necessary in order to make policymakers understand healthcare barriers. A mixed-method design and an interdisciplinary research paradigm would highlight other aspects of patients' ex- periences of trust, thus differing in terms of epistemological and ontological foundations [20].

The analysis of the present review was deemed interpretative, although the interpretation was not on a high level, as the categories were intended to reflect the different focuses of trust experienced by patients. Literature highlights the importance of clarifying the aim and procedure of the review as well as whether the thematic analysis is descriptive or interpretative [20].

Issues related to the limitations of the included papers as well as the methodological considerations of the present review study may be discussed according to the checklist of the methodological quality of published lit- erature [24]. The review has some weaknesses, such as failure to discuss saturation or some of the weak aspects in the included papers; the relationship between the researcher and participants, the researchers' own role and potential bias during data collection or information about how ethical standards were maintained [24]. Data analyses should be sufficiently rigorous, meaning that they describe the analysis process and the development of the themes or categories. This aspect was deemed weak in some of the papers that failed to critically examine the researchers' own role, potential bias and influence (**Appendix 1** and **Appendix 2**). According to the CASP [24], critical criteria are that the recruitment strategy is appropriate for the aims of the review and that the au- thors provide a detailed description of the selection of participants. Information about how and where the inter- views were performed, whether or not they were audio-taped, the interview guide and any modifications to it should be provided as well as a discussion of the credibility of the research questions. An overview and the re- sults of quality assessment of the included studies may be found in **Appendix 1** and an example of assessment may be found in

Appendix 2.

CONCLUSION

A typical nursing approach can be difficult to identify as nurses and nursing seems to be concealed in collective terms such as care givers, healthcare professionals, staff, personnel, practitioners, providers etc. It is important to highlight and develop nursing approaches. Failure to do so will marginalize the influence of nursing and nursing research in healthcare. Patients' experiences of trust in nursing are dependent on nurses' knowledge and en- gagement in the dialogue as well as on ad hoc meetings in a safe context.Nursing practice and trust should be investigated due to the intimate patient-nurse relationship.

Implications for Nursing Practice

An informed debate should be stimulated among clinical nurse researchers and nursing graduates in contexts such as nursing supervision and focus groups. Reflection on a trusting relationship with the patient is necessary for a deeper conceptual understanding of trust in nursing. Nurse educators and leaders should ensure that nurses develop attitudes and knowledge as a foundation for establishing a trusting patient-nurse relationship.

Clinical nurse researchers, nurse supervisors, managers and nurse educators should discuss different areas of trust during nursing supervision and focus-group meetings as well as with nursing graduates to ensure that nurses develop knowledge of how to create a trusting patient- nurse relationship.

Clinical studies should highlight and present evidence of trust as fundamental for all nursing interventions. Patient descriptions of the meaning of trust should be of interest to clinical nurse researchers due to the fact that such descriptions are individual and influenced by each patient's own history and context.

References

9. Seetharamu, N., Iqbal, U. and Weiner, J.S. (2007) Determinants of Trust in the Patient-Oncologist Relationship. Pal- liative & Supportive Care, **5**, 405-409.
10. http://dx.doi.org/10.1017/S1478951507000600
11. de Raeve, L. (2002) The Modification of Emotional Responses: A Problem for Trust in Nurse-Patient Relationships?
12. Nursing Ethics, **9**, 465-471. http://dx.doi.org/10.1191/0969733002ne536oa
13. Belcher, M. and Jones, L.K. (2009) Graduate Nurses Experiences of Developing Trust in the Nurse-Patient Relation- ship. Contemporary Nurse, **31**, 142-152.
14. http://dx.doi.org/10.5172/conu.673.31.2.142
15. Dinc, L. and Gastmans, C. (2012) Trust and Trustworthiness in Nursing: An Argument-Based Literature Review. Nurs- ing Inquiry, **19**, 223-237. http://dx.doi.org/10.1111/j.1440-1800.2011.00582.x
16. Pask, E.J. (1999) Trust: An Essential Component of Nursing Practice—Implications for Nurse Education. Nurse Edu- cation Today, **15**, 190-195. http://dx.doi.org/10.1016/S0260-6917(95)80105-7
17. Martinsen, K. (2005) Samtalen, skjønnet og evidensen (no.). Akribe, Gjøvik, 166.
18. Delmar, C. (2012) Utvecling av en omvårdnadsteori om livsfenomen—med Kari Martinsens omsorgsfilosofi som för- ståelseshorisont. In: Jörgensen, B.B. and Steenfeldt, V.Ö., Eds., Omvårdsteori Som Referensram, Kina, Forfattarna och Liber AB, 86-101.
19. Dinc, L. and Gastmans, C. (2013) Trust in Nurse-Patient Relationships: A Literature Review.Nursing Ethics, **20**, 501-516. http://dx.doi.org/10.1177/0969733012468463
20. Connell, N.A. and Mannion, R. (2006) Conceptualisations of Trust in the Organisational Literature: Some Indicators from a Complementary Perspective. Journal of Health Organization and Management, **20**, 417-433. http://dx.doi.org/10.1108/14777260610701795

[21] Johns, J.L. (1996) A Concept Analysis of Trust. Journal of Advanced Nursing, **24**, 76-83. http://dx.doi.org/10.1046/j.1365-2648.1996.16310.x
[22] McHale, D. and Deatrick, J. (2000) Trust between Family and Health Care Provider. Journal of Family Nursing, **6**, 210-230.
[23] Hupcey, J.E., Penrod, J., Morse, J.M. and Mitcham, C. (2001) An Exploration and Advancement of the Concept of Trust. Journal of Advanced Nursing, **36**, 282-293. http://dx.doi.org/10.1046/j.1365-2648.2001.01970.x
[24] Gilson, L. (2006) Trust in Health Care: Theoretical Perspectives and Research Needs. Journal of Health Organization and Management, **2**, 359-375.
[25] http://dx.doi.org/10.1108/14777260610701768
[26] Lindstrom, U. (2001) Psykiatrisk sykepleie: Teori, verdier og praksis / Unni Å. Lindström; Oversatt av Inger Aanderaa. Gyldendal Akademisk, Oslo.
[27] Laugharne, R. and Priebe, S. (2006) Trust, Choice and Power in Mental Health: A Literature Review. Social Psy- chiatry and Psychiatric Epidemiology, **41**, 843-852.
[28] http://dx.doi.org/10.1007/s00127-006-0123-6
[29] Epstein, R.M. (2006) Making Communication Research Matter: What Do Patients Notice, What Do Patients Want, and What Do Patients Need? Patient Education and Counseling, **60**, 272-278. http://dx.doi.org/10.1016/j.pec.2005.11.003
[30] Bell, L. and Duffy, A. (2009) A Concept Analysis of Nurse-Patient Trust. British Journal of Nursing, **18**, 46-51. http://dx.doi.org/10.12968/bjon.2009.18.1.32091
[31] Hupcey, J.E. and Miller, J. (2006) Community Dwelling Adults' Perception of Interpersonal Trust vs. Trust in Health Care Providers. Journal of Clinical Nursing, **15**, 1132-1139.
[32] http://dx.doi.org/10.1111/j.1365-2702.2006.01386.x
[33] Hansen, B.S., Rørtveit, K., Leiknes, I., Morken, I., Testad, I., Joa, I., et al. (2012) Patient Experiences of Uncertainty— A Synthesis to Guide Nursing Practice and Research. Journal of Nursing Management, **20**, 266-277. http://dx.doi.org/10.1111/j.1365-2834.2011.01369.x
[34] Dixon-Woods, M., Agarwal, S., Jones, D., Young, B. and Sutton, A. (2005) Synthesising Qualitative and Quantitative Evidence: A Review of Possible Methods. Journal of Health Services Research & Policy, **10**, 45-53.
[35] Noyes, J. and Popay, J. (2007) Directly Observed Therapy and Tuberculosis: How Can a Systematic Review of Quali- tative Research Contribute to Improving Services? A Qualitative Meta-Synthesis. Journal of Advanced Nursing, **57**, 227-243. http://dx.doi.org/10.1111/j.1365- 2648.2006.04092.x
[36] Ring, N., Jepson, R., Hoskins, G., Wilson, C., Pinnock, H., Sheikh, A., et al. (2011) Understanding What Helps or Hinders Asthma Action Plan Use: A Systematic Review and Synthesis of the Qualitative Literature. Patient Education and Counseling, **85**, e131-e143. http://dx.doi.org/10.1016/j.pec.2011.01.025
[37] Graneheim, U.H. and Lundman, B. (2004) Qualitative Content Analysis in Nursing Research: Concepts, Procedures and Measures to Achieve Trustworthiness. Nurse Education Today, **24**, 105-
[38] 112. http://dx.doi.org/10.1016/j.nedt.2003.10.001
[39] CASP, Critical Appraisal Skills Programme (2013) 10 Questions to Help You Make Sense of Qualitative Research. Critical Appraisal Skills Programme (CASP), Oxford. http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf
[40] Leiphart, L.R. and Barnes, M.G. (2005) The Client Experience of Assertive Community Treatment: A QualitativeStudy. Psychiatric Rehabilitation Journal, **28**, 395-397.
[41] http://dx.doi.org/10.2975/28.2005.395.397
[42] Nygardh, A., Malm, D., Wikby, K. and Ahlström, G. (2012) The Experience of Empowerment in the Patient-Staff En- counter: The Patient's Perspective. Journal of Clinical Nursing, **21**, 897-904.

43. http://dx.doi.org/10.1111/j.1365-2702.2011.03901.x
44. Thomas, J.D., Finch, L.P., Schoenhofer, S.O. and Green, A. (2004) The Caring Relationships Created by Nurse Practi- tioners and the Ones Nursed: Implications for Practice. Topics in Advanced Practice Nursing eJournal, **4**.
45. Mok, E. and Chiu, P.C. (2004) Nurse-Patient Relationships in Palliative Care. Journal of Advanced Nursing, **48**, 475-483. http://dx.doi.org/10.1111/j.1365-2648.2004.03230.x
46. Gilburt, H., Rose, D. and Slade, M. (2008) The Importance of Relationships in Mental Health Care: A Qualitative Study of Service Users' Experiences of Psychiatric Hospital Admission in the UK. BMC Health Services Research, **8**,-12.http://dx.doi.org/10.1186/1472-6963-8-92
47. Gunther, S., Guo, F., Sinfield, P., Rogers, S. and Baker, R. (2012) Barriers and Enablers to Managing Obesity in Gen- eral Practice: A Practical Approach for Use in Implementation Activities. Quality in Primary Care, **20**, 93-103.
48. Alsen, P., Brink, E. and Persson, L.O. (2008) Patients' Illness Perception Four Months after a Myocardial Infarction.
49. Journal of Clinical Nursing, **17**, 25-33. http://dx.doi.org/10.1111/j.1365-2702.2007.02136.x
50. Battaglia, T.A., Finley, E. and Liebschutz, J.M. (2003) Survivors of Intimate Partner Violence Speak Out: Trust in the Patient-Provider Relationship. Journal of General Internal Medicine, **18**, 617-623.http://dx.doi.org/10.1046/j.1525-1497.2003.21013.x
51. Piippo, J. and Aaltonen, J. (2008) Mental Health Care: Trust and Mistrust in Different Caring Contexts. Journalof Clinical Nursing, **17**, 2867-2874.
52. http://dx.doi.org/10.1111/j.1365-2702.2007.02270.x
53. Langley, G.C. and Klopper, H. (2005) Trust as a Foundation for the Therapeutic Intervention for Patients with Border- line Personality Disorder. Journal of Psychiatric and Mental Health Nursing, **12**, 23-32. http://dx.doi.org/10.1111/j.1365-2850.2004.00774.x
54. Lindgren, H., Hildingsson, I. and Radestad, I. (2006) A Swedish Interview Study: Parents' Assessment of Risks in Home Births. Midwifery, **22**, 15-22.
55. http://dx.doi.org/10.1016/j.midw.2005.04.002
56. Mauleon, A.L., Palo-Bengtsson, L. and Ekman, S.L. (2007) Patients Experiencing Local Anaesthesia and Hip Surgery.Journal of Clinical Nursing, **16**, 892-829.
http://dx.doi.org/10.1111/j.1365- 2702.2007.01771.x
57. Brown, J., Sorrell, J.H., McClaren, J. and Crewell, J.W. (2006) Waiting for a Liver Transplant. Qualitative Health Re- search, **16**, 119-136.
58. http://dx.doi.org/10.1177/1049732305284011
59. Wiersma, E.C. and Pedlar, A. (2008) The Nature of Relationships in Alternative Dementia Care Environments. Cana- dian Journal on Aging, **27**, 101-108. http://dx.doi.org/10.3138/cja.27.1.101
60. Sacks, J.L. and Nelson, J.P. (2007) A Theory of Nonphysical Suffering and Trust in Hospice Patients. Qualitative Health Research, **17**, 675-689.
61. http://dx.doi.org/10.1177/1049732306298524
62. Cain, C.H., Neuwirth, E., Bellows, J., Zuber, C. and Green, J. (2012) Patient Experiences of Transitioning from Hospi- tal to Home: An Ethnographic Quality Improvement Project.
63. Journal of Hospital Medicine, **7**, 382-387. http://dx.doi.org/10.1002/jhm.1918
64. Ekman, I., Ekstrand, L. and Schaufelberger, M. (2007) Pulmonary Oedema—A Life Threatening Disease. European Journal of Cardiovascular Nursing, **6**, 259-264.
65. http://dx.doi.org/10.1016/j.ejcnurse.2006.11.003
66. Brown, P.R., Alaszewski, A., Swift, T. and Nordin, A. (2011) Actions Speak Louder Than Words: The Embodiment of Trust by Healthcare Professionals in Gynae-Oncology. Sociology of Health & Illness, **33**, 280-295. http://dx.doi.org/10.1111/j.1467- 9566.2010.01284.x

67. Donnelly, F. and Wiechula, R. (2006) The Lived Experience of a Tracheostomy Tube Change: A Phenomenological Study. Journal of Clinical Nursing, **15**, 1115-1122. http://dx.doi.org/10.1111/j.1365-2702.2006.01384.x

Appendix 1. Results of quality assessment of the included studies based on the The Critical Appraisal Skills Program-checklist for qualitative studies (CASP 2013). (Y: yes, N: no, U: unclear).

Author1	2	3	4	5	6	7	8	9	10	Assessment
1 Cain 2012 Y	Y	Y	Y	Y	N	U	Y	Y	U	Moderate
2 Gunther et al.Y 2012	Y	U	Y	Y	Y	N	U	U	U	Low
3 Brown et al.Y 2011	Y	Y	Y	Y	N	Y	U	Y	Y	Moderate
4 Nygardh et al.Y 2011	Y	Y	Y	Y	N	Y	Y	Y	Y	High
5 Alsen et al.Y 2008	Y	Y	Y	Y	N	Y	Y	Y	Y	High
6 Gilburt et al.Y 2008	Y	Y	Y	Y	Y	N	Y	Y	Y	High
7 Pippo & AaltonenY	Y	Y	Y	Y	N	Y	Y	Y	Y	High
2008										
8 Wiersma & PedlarY	Y	Y	Y	Y	N	U	Y	Y	Y	Moderate
2008										
9 Hordern & StreetY	Y	Y	Y	Y	N	U	Y	Y	Y	Moderate
2007										
10 Sacks & NelsonY	Y	Y	Y	Y	N	Y	N	Y	Y	Moderate
2007										
11 Mauleon et al.Y	Y	Y	Y	Y	N	Y	Y	Y	Y	High
2007										
12 Ekman 2007 U	U	U	Y	U	N	Y	N	N	U	Low
13 Donnelly Y &Wiechula 2006	Y	Y	Y	U	U	Y	Y	Y	Y	Moderate
14 Brown et al.Y 2006	Y	Y	Y	Y	Y	Y	Y	Y	Y	High
15 Lindgren etY	Y	Y	Y	Y	Y	Y	Y	Y	Y	High
al.2006										
16 Leiphart& BarnesY 2005	Y	Y	U	U	N	N	U	U	U	Low
17 Langley &Y	Y	Y	U	U	N	Y	U	Y	Y	Moderate
Klopper 2005										
18 Thomas et al.Y	Y	Y	Y	Y	N	N	Y	Y	U	Moderate
2004										
19 Mok & ChiuY	Y	Y	U	Y	N	Y	Y	Y	Y	High
2004										
20 Battaglia et al.Y	Y	Y	Y	Y	N	N	Y	Y	Y	High
2003										

Appendix 2. Example of assessment The Critical Appraisal Skills Program [24], a methodological checklist of key criteria relevant to qualitative studies. (Y: yes, N: no, U: unclear).

Author	1) Was there a clear statement of the aims of the research?			2) Is a qualitative methodology appropriate?			3) Was the research design appropriate to address the aims of the research			4) Was the recruitment strategy appropriate to the aims of the research addressed the research			5) Were the data collected in a way that addressed the research issue?		
	Y	U	N	Y	U	N	Y	U	N	Y	U	N	Y	U	N
Brown et al. 2006	*			*			*			*			*		

Author	6) Has the relationship between researcher and participants been considered?			7) Have ethical issues been taken into consideration?			8) Was the data analysis sufficiently rigorous?			9) Is there a clear statement of findings?			10) How valuable is the research?		
	Y	U	N	Y	U	N	Y	U	N	Y	U	N	High	Moderate	Low
Brown et al. 2006	*			*			*			*			*		