Assess Importance of Nurse Patients Good Relationship on Health Care Achievement

Eidhah Abdullah Alshalawi[1], Samirah Ghuwayzi Aljuaid[2], Sultan Zayed Alharthi[3], Ahmed Mohammed Alzahrani[4], Asrar Mohammed Alharthi[5], fahhad juman Alghamdi[6], Mohammed Yahya Khater Alzahrani[7], Mastour Abdullah Alkhudaydi[8], Saad hamoud Alotaibi[9], Abdulrahman Hameed Alsuwat[10], Ahmed Abdullah Alamri[11], Fawaz sawad Alotaibi[12]

[1]Nursing technician, Albaha Health Cluster
[2]Nursing technician, Taif Health Cluster
[3]Nursing technician, Albaha Health Cluster
[4]Nursing technician, Albaha Health Cluster
[5]Nursing specialist, Directorate Health Affairs Taif
[6]Nursing technician, Albaha Health Cluster
[7]Nursing technician, Albaha Health Cluster
[8]Nursing Specialist, Taif Health Cluster
[9]Nursing specialist, Makkah Health Cluster
[10]Nursing specialist, Albaha Health Cluster
[11]Nursing specialist, Directorate Health Affairs Taif
[12]Nursing technician, Makkah Health Cluster

ABSTRACT

Background
The nurse-patient relationship is central to the practice of nursing, fostering therapeutic outcomes and holistic care. Despite its significance, modern healthcare systems often prioritize efficiency and cost reduction, overshadowing the humanistic essence of nursing care. While nurses perceive themselves as compassionate caregivers, task-oriented approaches often result in unmet patient expectations for personalized care. This study investigates importance of nurse patients good relationship on health care achievement

Methods
This study was conducted at a hospital with A total of 446 participants—291 patients hospitalized for at least 48 hours and 155 nurses assigned to their care—were surveyed using the Caring Nurse-Patient Interactions Scale (CNPI-70), rooted in Watson's Theory of Human Caring. Data were collected via a structured questionnaire and analyzed using descriptive statistics, t-tests, and multiple regression to explore differences in perceptions and identify influencing demographic and situational factors.

Results
Patients and nurses differed significantly in their perceptions of the importance of caring behaviors across multiple dimensions, including humanism, emotional expression, and environment ($p < 0.05$). Patients prioritized empathy, emotional support, and individualized attention, while nurses emphasized task completion and

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procedural care. Demographic factors, such as age and gender, as well as situational factors like nurse workload, significantly influenced these perceptions. Nurses' perception of caring behaviors was positively correlated with their job satisfaction and well-being.

Conclusion

The study reveals a significant discrepancy between nurses' and patients' perceptions of caring interactions. While patients highly value humane, empathetic, and individualized care, systemic healthcare constraints often lead nurses to focus on efficiency and task completion. Addressing these discrepancies requires fostering organizational cultures that prioritize humanistic nursing practices, aligning care delivery with patient expectations, and enhancing the overall quality of healthcare. Future interventions should emphasize training nurses in patient-centred communication and creating supportive environments that balance efficiency with compassionate care.

Keywords: nurse patients, health care, and nurses

Introduction

The nurse–patient relationship represents a therapeutic and professional bond designed to enable nurses to evaluate, plan, and provide care that addresses patients' fundamental needs [1]. Prominent theorists such as Watson, Leininger, Boykin, and Swanson have emphasized in their philosophical discussions and research that "caring" is central to the practice of nursing. This concept is considered the cornerstone of meaningful and effective interactions between nurses and patients, reflecting the core of high-quality care [2,3]. Globally, initiatives focusing on person-centered care, safety, and the delivery of essential services highlight the critical role of these interactions in healthcare systems [4].

Building a foundation of trust in these relationships is key to delivering effective care. Additionally, maintaining safe and confidential communication between nurses and patients is critical for fostering satisfaction in both care delivery and treatment outcomes, benefiting both parties involved [5]. Moreover, studies have consistently shown that empathetic and humane interactions contribute positively to nurses' self-esteem, sense of accomplishment, well-being, and job satisfaction [5,6]. Research conducted by Chung et al. (2021) demonstrated a significant positive association between nurses' well-being—characterized by satisfaction, a healthy lifestyle, and joyfulness—and their ability to cultivate strong nurse–patient relationships. This finding underscores how nurses' competencies in communication and relationship-building are tied to health-promoting behaviors and satisfaction within their work environment [7].

Patients, too, benefit greatly from effective nurse–patient interactions, as evidenced by improved autonomy, quality of life, satisfaction with care, enhanced immunity, and feelings of safety. These benefits also correlate with fewer hospital readmissions [8,9,10]. While these interactions are acknowledged as a foundation for delivering quality healthcare, modern priorities in healthcare often emphasize efficiency and cost reduction over these values [11].

Research has highlighted the dominant influence of the biomedical model on nursing practices, where nurses often prioritize physician-directed tasks over fostering meaningful patient connections [12]. Although many nurses consider themselves compassionate caregivers, their focus frequently shifts toward task completion, overlooking the significance of ensuring patients feel cared for as individuals [11]. This lack of personalized and empathetic care often stems from challenging working conditions and insufficiently supportive organizational cultures in healthcare settings [11,12]. These systemic issues can lead to unfinished, neglected, or rationed care [13]. Scholars have expressed concerns over this trend, emphasizing that such task-oriented care undermines compassion and humanity in nursing, ultimately compromising patient comfort and healthcare quality [8,9,11,12,13]. From the perspective of patients, humane and compassionate care is a critical expectation, with satisfaction and trust significantly improving when such care is provided [14]. Yet, current healthcare systems often prioritize efficiency and cost-effectiveness, leading to a diminished focus on the human element of nursing care, despite its high value to patients [14].

To foster meaningful relationships, nurses must adopt a humanistic and altruistic framework that promotes an environment conducive to the growth and well-being of patients and their families. This approach enables nurses to develop a more comprehensive understanding of their patients' needs and experiences, ensuring that the care provided aligns with a holistic perspective [15].

The bond formed between nurses and patients, as well as their families, aligns with what Watson refers to as the transpersonal caring relationship [2,16]. Watson's Theory of Human Caring serves as a foundational framework for exploring nurse–patient relationships in research [16,17,18,19,20]. Within this theory, caring is described as an ethical and moral ideal intrinsic to healthcare, emphasizing interpersonal and humanistic dimensions [16]. Watson asserts that the core of nursing is not solely about procedures, tasks, or interventions but is deeply rooted in the nurse–patient relationship, which fosters therapeutic outcomes. Consequently, this concept transcends specific nursing specialties [2,16,21]. The transpersonal relationship, as articulated by Watson, requires nurses to engage fully with patients, turning each interaction into a genuine opportunity for care. This connection highlights the significance of individual values and personal identity [2,16,21]. Watson's framework also identifies 10 "carative factors," designed to guide nurses in fostering meaningful patient interactions [2,16,21]. These factors are seen as the heart of Watson's theoretical contributions, emphasizing a non-linear process for achieving humanistic care [3,16,21] Watson's carative factors are widely accepted in nursing as they emphasize the humanistic essence of healthcare and provide a framework for fostering interpersonal connections [3,16,21]. Over time, Watson expanded these factors into "clinical caritas processes," which introduce a spiritual element and a focus on love and compassion [20,22]. While caritas processes add depth and flexibility to the theory, the original carative factors remain a fundamental framework [2,20,22].

One of Watson's significant contributions is integrating diverse perspectives on care into a cohesive theory, which has led to the development of tools to assess caring quality and nurse–patient interactions [23]. Although caring is difficult to measure objectively [8], specialized instruments can evaluate aspects such as frequency, competence, and importance in these interactions [8,24,25,26]. Numerous studies have

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applied Watson's framework to analyze caring behaviors in both nurses and patients using various tools [6,8,18,24,25,26,27], with some combining multiple methods [5,18].

For instance, the Nurse–Patient Interaction Scale (CNPI-70), developed by Cossette in 2005, is a validated tool based on Watson's theory. Comprising 70 items across 10 subscales, it enables nurses to evaluate their caring practices comprehensively. The scale is versatile, being applicable to patients, nurses, family members, and nursing students, and measures the perception of importance, frequency, competence, and applicability of nurse–patient interactions [23,28].

Despite extensive research on caring, there is a notable gap in studies comparing patients' and nurses' perceptions of the importance of caring [20,29,30]. This study aims to address this gap by analyzing these perceptions and their differences. Since perceptions and attitudes significantly influence behavior patterns [30,31], these findings could improve nurse–patient interactions and encourage more humane care practices. Identifying discrepancies between patients' and nurses' views can highlight areas where nurses may not fully understand patients' expectations, potentially leading to communication barriers and challenges in delivering quality care. By identifying these perceptions in a timely manner, healthcare providers can take proactive steps to resolve such issues.

Materials and Methods

This research was performed at a large multidisciplinary healthcare institution with extensive inpatient and outpatient services. The selected facility was chosen based on its status as a primary regional provider of healthcare, offering services across multiple specialties and supporting a population base exceeding one million individuals. The institution also functions as a teaching hospital and serves as the primary clinical education site for health professionals. Researchers, who are also educators at affiliated institutions, regularly organize clinical sessions within the selected healthcare setting. A quantitative methodology was employed, utilizing a structured, closed-ended questionnaire to collect data anonymously.

The study included a total of 446 participants. The first group consisted of 291 patients who were hospitalized for at least 48 hours in selected departments, including Surgery, Otorhinolaryngology, Gynecology and Obstetrics, Internal Medicine, Urology, and Traumatology. The minimum 48-hour hospitalization criterion was established based on literature suggesting that brief encounters may hinder the formation of meaningful nurse–patient relationships rooted in Watson's Caring Theory [22,23,25,28].

The second group involved 155 registered nurses who provided care for the hospitalized patients in the aforementioned departments. For patients, inclusion criteria required a minimum 48-hour hospital stay, ensuring adequate interaction time for nursing care. Similarly, the inclusion criteria for nurses were based on their assignment to departments with a consistent provision of nursing care over a minimum period.

Sample sizes for patients and nurses were calculated using online sample size determination tools, factoring in the total eligible population from each group. Calculations used a confidence level of 95%, a 4% margin of error, and a significance level of $\alpha = 0.05$. For patients, the sample size was determined to be 213 out of 330 eligible individuals, while for nurses, it was 155 out of 209 eligible professionals.

Tools

Data collection relied on the standardized 70-item Caring Nurse–Patient Interactions Scale (CNPI-70), available in versions for both nurses and patients. Developed by Cossette et al. [28] and based on Watson's Caring Theory, this instrument evaluates caring behaviors and attitudes in clinical settings. It encompasses 10 subscales that reflect various carative dimensions: *humanism* (items 1–6), *hope* (items 7–13), *sensitivity* (items 14–19), *helping relationship* (items 20–26), *expression of emotions* (items 27–32), *problem solving* (items 33–38), *teaching* (items 39–47), *environment* (items 48–54), *needs* (items 55–64), and *spirituality* (items 65–70) [28].

The CNPI-70 scale was translated into the local language using a multi-step process. Two bilingual experts conducted independent translations, followed by back-translation by another bilingual professional to ensure semantic consistency. Adaptations were made to align with local nursing practices. Reliability testing revealed Cronbach's alpha coefficients ranging from 0.77 for the *humanism* subscale to 0.90 for the *problem-solving* subscale. The overall reliability score was 0.97, indicating high consistency. Responses were measured using a five-point Likert scale, where 1 = not at all, 2 = a little, 3 = moderately, 4 = a lot, and 5 = extremely.

Data Collection

The data collection process spanned four months, during which researchers distributed the survey to participants. Patients completed the questionnaires during their designated rest periods in the hospital, with an average completion time of 30 minutes. To ensure anonymity, a collection box was placed in the head nurse's office of each department, where nurses could deposit their completed forms. Researchers collected all responses to maximize participation rates.

Data Analysis

Categorical variables were presented as absolute and relative frequencies. The Shapiro–Wilk test assessed the normality of numerical variables. Predictor and criterion variables underwent normalization and standardization to address deviations from normal distribution and multicollinearity, given the diverse scales used. Numerical data were summarized using mean and standard deviation. Differences between independent groups were analyzed using the Student's t-test, and multiple regression analysis determined the relationships between variables. Statistical significance was set at $\alpha = 0.05$, and data analysis was conducted using IBM SPSS Statistics software (version 22.0).

Results

Among the participants, 291 individuals (62.25%) were hospitalized patients, comprising 140 (48.1%) females and 151 (51.9%) males (Table 1). The mean age of patients was 59.77 ± 15.59 years, ranging from 18 to 95 years. A majority, 146

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(50.2%), resided in urban areas, and most patients, 189 (64.9%), were high school graduates. The largest proportion of patients, 76 (26.1%), were hospitalized in the Department of Internal Medicine. Additionally, 128 patients (44%) reported being hospitalized three to five times.

The study also included 155 (34.75%) registered nurses, with 112 (72.3%) holding vocational high school education in nursing and 43 (27.7%) holding a Bachelor of Science in Nursing (BSc) degree (Table 2). The mean age of nurses was 39.95 ± 12.94 years, with an age range of 20 to 64 years. A significant majority, 130 (83.9%), were female, while 25 (16%) were male. Most nurses, 96 (61.9%), lived in urban areas, and 112 (72.3%) had formal vocational nursing training.

Patients rated the overall importance of caring nurse–patient interactions on the CNPI-70 scale (response range 1–5) with a mean score of 4.39 ± 0.48. When analyzing specific subscales of the CNPI-70 scale, significant differences were observed ($p < 0.01$). Patients assigned the highest importance to the "needs" subscale (4.62 ± 0.47), while the "problem-solving" subscale received the lowest rating (4.28 ± 0.74).

In comparison, nurses' perception of the importance of caring nurse–patient interactions on the CNPI-70 scale yielded a mean score of 4.17 ± 0.46 (Table 4). Differences among subscales were significant ($p < 0.01$), with "needs" rated as the most important subscale (4.49 ± 0.47) and "sensibility" as the least important (3.86 ± 0.47).

The overall CNPI-70 scores revealed a significant difference in perceptions between patients and nurses ($p < 0.001$). Patients rated the importance of caring interactions higher (4.39) compared to nurses (4.16) (Table 3). Moreover, nurses rated all subscales significantly lower than patients ($p < 0.05$), except for the "environment" ($p = 0.123$) and "spirituality" ($p = 0.132$) subscales, where no significant differences were observed

Sociodemographic and situational factors did not significantly influence patients' perceptions of the importance of caring interactions. The final regression model, incorporating variables such as age, gender, education level, place of residence (urban/rural), department, and frequency of hospitalizations, accounted for only 2.2% of the variance ($R^2 = 0.022$, $F (5,289) = 1.07$; $p = 0.379$), indicating insignificance

Similarly, sociodemographic and situational factors had no notable effect on nurses' perceptions of caring interactions. The regression model, which included variables like age, education level, place of residence (urban/rural), workplace, and years of service, explained just 1.8% of the variance ($R^2 = 0.018$, $F (4,154) = 0.55$; $p = 0.738$), making the model statistically insignificant

Table 1. Sociodemographic characteristics of patients (n = 291).

Respondents Characteristics		Number (%)
Gender	male	151 (51.9)
	female	140 (48.1)
Age (years)	18–40	38 (13.1)
	41–60	87 (29.9)
	61–90	166 (57.0)
Place of Residence	urban	146 (50.2)
	rural	145 (49.8)
Level of Education	elementary school	70 (24.1)
	high school	189 (64.9)
	higher education	32 (11.0)
Department	Traumatology and Orthopedics	56 (19.2)
	Surgery	22 (7.6)
	Gynecologic Oncology	30 (10.3)
	Urology	23 (7.9)
	Otorhinolaryngology	18 (6.2)
	Oncology	66 (22.7)
	Internal Clinic—Cardiology	76 (26.1)
Number of hospitalizations	1–2	123 (42.3)
	3–5	128 (44.0)
	6 and more	40 (13.7)

Table 2. Sociodemographic characteristics of nurses (n = 155).

Respondents Characteristics		Number (%)
Gender	Male	25 (16.1)
	Female	130 (83.9)
Age (years)	18–25	28 (18.1)
	26–40	54 (34.8)
	>40	73 (47.1)
Place of Residence	Urban	96 (61.9)
	Rural	59 (38.1)
Level of Education	General Nurses (VET)	112 (72.3)
	BSc nurses	43 (27.7)
Length of Service (years)	≤5	38 (24.5)
	6–20	45 (29.0)
	>21	72 (46.5)
Workplace	Traumatology and Orthopedics	40 (25.8)
	Surgery	34 (21.9)
	Gynecologic Oncology	15 (9.7)
	Urology	7 (4.5)
	Otorhinolaryngology	11 (7.1)
	Oncology	21 (13.5)
	Internal Clinic—Cardiology	27 (17.4)

Eidhah Abdullah Alshalawi, Samirah Ghuwayzi Aljuaid, Sultan Zayed Alharthi, Ahmed Mohammed Alzahrani, Asrar Mohammed Alharthi, fahhad juman Alghamdi, Mohammed Yahya Khater Alzahrani, Mastour Abdullah Alkhudaydi, Saad hamoud Alotaibi, Abdulrahman Hameed Alsuwat, Ahmed Abdullah Alamri, Fawaz sawad Alotaibi

Table 3. Patients' and nurses' perceptions of importance of Caring Nurse–Patient Interactions.

Carative Factors (F1–F10)	Patient Perception		Nurses' Perception		p *
	Average	SD	Average	SD	
F1—Humanism	4.30	0.65	4.08	0.56	<0.001
F2—Hope	4.46	0.59	4.25	0.51	<0.001
F3—Sensibility	4.28	0.70	3.86	0.64	<0.01
F4—Helping relationship	4.33	0.65	4.15	0.58	<0.01
F5—Expression of emotions	4.35	0.66	4.04	0.62	<0.001
F6—Problem solving	4.28	0.74	3.99	0.63	<0.001
F7—Teaching	4.40	0.62	4.11	0.55	<0.001
F8—Environment	4.45	0.61	4.36	0.55	0.132
F9—Needs	4.62	0.47	4.49	0.46	<0.01
F10—Spirituality	4.29	0.57	4.18	0.57	0.109
In total (CNPI-70)	4.39	0.48	4.17	0.46	<0.001

* Independent sample t-test.

Discussion

Based on the CNPI-70 scale, the average score for patients' perception of the importance of caring interactions with nurses was 4.39 out of 5, indicating a high level of significance attributed to these interactions.

This aligns with findings from studies conducted in different regions [33, 34, 35]. While patients in this study emphasized the importance of nurse–patient interactions overall, variations were observed across specific subscales. The "needs" subscale received the highest rating, highlighting the priority patients place on respectful care that fulfills fundamental human necessities. Previous research also underscores the emphasis placed on meeting physiological needs [35, 36, 37]. For instance, Merrill et al. reported that patients prioritize safe and timely fulfillment of their physiological needs [37], which aligns with findings from other studies [35]. In contrast, another study ranked "needs" lower, with "humanism" and "hope" being viewed as more critical, suggesting that patients in that research prioritized humane care and value-based support over basic physical needs [33].

In this study, the "environment" subscale was also rated highly by patients. This is consistent with findings that highlight the clinical environment's critical role in fostering therapeutic relationships [12, 36, 39]. Alongside "environment" and "hope," the "teaching" subscale was similarly valued, indicating the importance patients place on gaining knowledge and skills for self-care. Nurses often employ strategies such as clear guidelines, critical thinking, and effective communication to educate patients [16, 27]. Studies have also confirmed that patient education reduces anxiety and enhances a sense of safety [7, 8, 9, 40].

Subscales like "humanism," "sensibility," "helping relationship," "expression of emotions," "problem-solving," and "spirituality" were rated lower in importance by patients compared to other subscales. This aligns with findings from prior research, where patients viewed emotional support as a less central aspect of nursing care, primarily focusing on symptom management [41, 42]. Patients may lack awareness of the nursing role in emotional care, as reflected in studies where oncology patients did not associate emotional counseling with nursing practice [42]. Furthermore, perceptions of nurses' heavy workloads and time constraints may discourage patients from seeking emotional support, as they often hesitate to impose additional demands on busy healthcare staff [43]. Patients tend to call on nurses primarily for urgent physiological needs, often postponing discussions about emotional or non-critical concerns [41, 43].

These findings suggest the need to encourage more open communication, helping patients understand the broader scope of nursing care beyond physical needs. While emotional support might not be immediately expected by patients, it can hold significant value during challenging experiences [41, 42, 43].

The CNPI-70 scale indicated an average score of 4.17 for nurses' perceptions of the importance of caring interactions, reflecting a strong appreciation for such interactions. This is consistent with findings from similar studies [6, 34, 44].

Despite the overall high ratings, substantial differences were observed across subscales. In this study, nurses rated the "needs" subscale the highest, mirroring findings from other research that identified the frequent application of practices related to this subscale in clinical settings [30, 31]. This may be due to the significant influence of attitudes on behaviors, which encourages nurses to focus on meeting patients' physical needs.

Conversely, the "sensibility" subscale, encompassing sensitivity to self and others, was rated as least important, along with "humanism" and "hope." This contrasts with findings from other studies where these subscales were considered highly significant by nurses, who described caring as a multifaceted process involving knowledge, competence, and emotional connection [45].

Technological advancements also play a dual role in nursing care. While they enhance patient safety and reduce healthcare costs, they may inadvertently diminish interpersonal interactions, thereby impacting the human element of care [46]. This highlights the importance of balancing technological efficiency with the preservation of compassionate, face-to-face interactions in nursing practice.

Significant differences emerged in the overall perception of the importance of caring nurse–patient interactions between patients and nurses, as measured by the CNPI-70 scale. The findings suggest that nurses tend to view the nurse–patient relationship as less significant compared to patients. This discrepancy may be attributed to nurses' professional background and their deeper understanding of the care concept and its dimensions, leading them to set higher standards when evaluating caring behaviors and attitudes. Patients, on the other hand, tend to rely on intuition when assessing such interactions [47]. Over time, nurses may place less emphasis on the importance of caring behaviors, a trend supported by previous research [47,48]. This shift might

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result from workplace environments that prioritize efficiency and task-oriented performance over nurse–patient interactions, reducing the perceived value of caring behaviors [49]. Conversely, patients often associate the presence and attentiveness of nurses with safety and reassurance, heightening their perception of the importance of caring [50]. While some studies align with these results, others report no significant differences in perceptions [29] or suggest that nurses may value caring behaviors more highly than patients [34,35].

Differences across studies can be explained by variations in sample size, care models, geographical regions, cultural contexts, and the specific tools used for measurement [29,34]. Additionally, some studies involve multiple healthcare facilities or use different versions of caring behavior assessment tools, further contributing to discrepancies.

In this study, disparities between patients' and nurses' perspectives were also noted across specific subscales of the CNPI-70 scale. Nurses rated the subscales for "hope," "expression of emotions," "problem solving," and "teaching" lower than patients did. This suggests that patients highly value nurses who offer hope, accept emotional expressions, and actively listen, as these interactions provide reassurance [51]. Effective listening, characterized by engagement and feedback, is critical for meaningful communication and the patient's sense of being heard and understood [51]. Addressing patients' concerns and providing education through thoughtful dialogue fosters trust and collaboration in care [52].

The "problem-solving" subscale was rated significantly lower by nurses than by patients, which raises concerns as this dimension involves applying nursing processes to enhance patient outcomes. The use of systematic problem-solving facilitates recovery, reduces hospital stays, and increases satisfaction with care [53]. The effective implementation of nursing processes not only benefits patients but also supports nurses in performing their roles with professional autonomy and logical justification. Although widely adopted globally, the extent of nursing process application varies, reflecting differences in its integration as a standard of care [54].

Patients rated the "sensibility" subscale higher than nurses. Research suggests that patients prioritize being understood and respected by their caregivers, particularly during vulnerable periods [55]. Acknowledging and addressing patient vulnerabilities fosters ethical care practices and strengthens the nurse–patient bond [55].

The "needs" subscale was also scored higher by patients, potentially due to the ongoing influence of the biomedical model in nursing practice, which often emphasizes medical interventions over holistic care [30,41,56]. Nevertheless, focusing on physical care while simultaneously engaging in effective communication during nursing procedures can improve patients' psychological well-being, promoting a balanced approach to care delivery [41,56].

Interestingly, no significant differences were found between nurses' and patients' ratings for the "spirituality" subscale, a finding consistent with other studies [57] but differing from research that indicates varied perceptions on this aspect [17]. Both

groups rated spirituality the lowest among the subscales, possibly reflecting limited training among nurses on this type of care or patients viewing spirituality more as a religious construct, often addressed by clergy or volunteers [57,58].

Finally, the study revealed no significant relationship between participants' demographic or situational factors and their perceptions of caring interactions. This aligns with findings that caring behaviors are valued irrespective of age, gender, education, or clinical experience [29]. However, other research suggests that older nurses, those with higher education, or greater clinical experience may place more importance on these interactions [1,10,24,61,62]. Ultimately, the results underscore the universally high value placed on nurse–patient interactions across both groups, emphasizing their centrality in healthcare [29,35,60].

Conclusion

While both nurses and patients rated the importance of nurse–patient interactions highly, the study revealed notable discrepancies between their perspectives. Nurses tended to rate the significance of these interactions lower than patients. Significant differences were also observed in nearly all subscales, except for "environment" and "spirituality."

The study underscores critical areas for improvement in nurse–patient interactions, emphasizing the need for better communication, personalized engagement, and the provision of clear information to patients and their families. Enhancing physical care through effective communication and teaching fosters a holistic approach, bolsters psychosocial support, and improves overall satisfaction with healthcare delivery. Importantly, these advancements can be achieved without significant financial investments, demonstrating their feasibility and potential impact on healthcare quality.

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Eidhah Abdullah Alshalawi, Samirah Ghuwayzi Aljuaid, Sultan Zayed Alharthi, Ahmed Mohammed Alzahrani, Asrar Mohammed Alharthi, fahhad juman Alghamdi, Mohammed Yahya Khater Alzahrani, Mastour Abdullah Alkhudaydi, Saad hamoud Alotaibi, Abdulrahman Hameed Alsuwat, Ahmed Abdullah Alamri, Fawaz sawad Alotaibi

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