

A Heideggerian analysis of good care in an acute hospital setting: Insights from healthcare workers, patients and families

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Abstract

This study articulates the relational constituents of good care beyond techno-rational competence. Neoliberal healthcare means that notions of care are readily commodified and reduced to quantifiable assessments and checklists. This novel research investigated accounts of good care provided by nursing, medical, allied and auxiliary staff. The Heideggerian phenomenological study was undertaken in acute medical-surgical wards, investigating the contextual, communicative nature of care. The study involved interviews with 17 participants: 3 previous patients, 3 family members and 11 staff. Data were analysed iteratively, dwelling with stories and writing and rewriting to surface the phenomenality of good care. The data set highlighted the following essential constituents: authentic care: caring encompassing solicitude (*fürsorge*); impromptu care: caring beyond role category; sustained care: caring beyond specialist parameters; attuned care: caring encompassing family and culture; and insightful care: caring beyond assessment and diagnosis. The findings are clinically significant because they indicate the importance of nurse leaders and educators harnessing the potential capacity of all healthcare workers to participate in good care. Healthcare workers reported that participating in or witnessing good care was uplifting and added meaning to their work, contributing to a sense of shared humanity.

KEYWORDS

auxiliary healthcare staff, good care, healthcare assistants, health professionals, Heidegger, hospital care, nurses, phenomenology

1 | INTRODUCTION

Globally, substantive efforts have been made by researchers, theorists, policymakers and practitioners to conceptualise what counts as good care. These endeavours are at times in response to widespread, systemic exemplars of devastating failures of care (see, e.g., Newdick & Danbury, 2015) and include breakdowns in collaborations and

communication (Freshwater et al., 2014). These failures predominantly include the absence of fundamental physical, sociocultural and emotional care (Feo & Kitson, 2016). Interventions to enhance good care include dynamic data collection such as TrendCare for workforce planning and workload management systems; safety systems' analysis such as Reason's (1997) Swiss Cheese model; and the interRAI suite of assessment tools that purport to provide a full understanding of the

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needs of older adults living in residential care (Iduye et al., 2022). Humanistic approaches encompass strategies to implement concepts of person-centred care, wherein the person is an active partner in care, and care ethics, which emphasises providers' moral engagement with patients, that is relational and context-bound (Tomaselli et al., 2020). However, there are ongoing concerns that there are multiple threats to good care. These include the techno-rational agenda of biomedical healthcare; neoliberal approaches focused on the commodification of persons as units of economic productivity; and care rationing. These contexts risk reducing good care to a series of provider-driven communications involving predetermined assessments and checklists (Hutchinson et al., 2018; Khademi et al., 2017; Tronto, 2010; Waterfield & Barnason, 2022). While techno-rational skill acquisition is a fundamental requirement of good care in modern healthcare, this article adds to the extant empirical literature about the importance of relational aspects of care not being subsumed by biomedicalisation and specialisation. Additionally, our study highlights that in contemporary care-rationed environments, it is essential to conceptualise the healthcare providers able to provide care as more than nursing and medical staff. This study includes the capacity of allied and nonprofessional healthcare workers to contribute to good care. Given that nurses are care coordinators of sustained patient care networks (Allen, 2014), it is useful for nurse leaders to recognise, harness and affirm that caregiving relationships can be significant between patients and nonclinical staff such as cleaners, dietary assistants and clerks, as well as health professionals. We concur with Wei and Watson (2019, p. 22) that '...developing a caring-value-based literacy among team members may promote interpersonal relationships and help team collaborations'. Good care matters to caregivers as well as care receivers because its provision ameliorates moral distress caused by impediments to act, enhances job satisfaction and contributes to the organisational moral climate (Cerit & Özveren, 2019; Waterfield & Barnason, 2022).

2 | BACKGROUND

The impetus for this research came from the lead author's experiences in a senior nursing role that involved leading complaints investigations and reconciliation meetings with patients and family members. What these conversations typically highlighted was in effect a failure of caring unrelated to the usually cited triggers such as clinical complexity, time pressure, care rationing and poor techno-rational skills. In the extant literature, poor care is typically spotlighted. Thus, this study focuses on identifying the subjective experiences of the presence of good care. Additionally, the authors concur with Gallagher (2020) that the recent preoccupation with moral distress and healthcare workers' emotional frailty may detract from nurse leaders noticing and affirming accounts of caring that reflect resilience and creativity in healthcare and public trust in care received.

The current context of healthcare practice is an increasingly complex environment that involves individuals, systems and relationships (Gordon, 2017). In recent decades, greater emphasis on

healthcare workers treating the patient as a whole person has been reinvigorated as a counterpoint to concerns about the potentially dehumanising effects of technological and specialised healthcare environments (Archibald & Barnard, 2018; Bennett, 2011; Stayt et al., 2015). These studies note the significant and mediating effects of caring with the coalescence of technology and healthcare. Older models of paternalism are being replaced by models that emphasise negotiation and partnership (Greenfield et al., 2014).

The concept of good care has a multifaceted genealogy. What follows is a brief overview that is used to locate the current study's contribution to the literature. Historically, two distinct models of care have been in place. The first focused on diagnosis and treatment of the patient as a condition. This view of providing healthcare focused on what works for the providers of care, from individual healthcare workers to healthcare systems. The second model focuses on the patient as the centre of care and includes concepts of understanding the lived experience such as patients' emotions, struggles and worldview. There is burgeoning interest in considering the patient as a whole person rather than categorising people according to their diagnosis. There are efforts to codesign care in ways that encompass the individuality of the person and are inclusive of their family. This orientation endeavours to disrupt episodic, siloed biomedical care (Angel, 2022; Byrne et al., 2021; White et al., 2021). Care partnerships between professionals and families have a significantly positive impact on families' perceptions of good care when family members' expertise about their loved one is recognised (Andersen et al., 2020; Quinney et al., 2018).

The philosophical concept of good care has its roots in centuries-old vocational approaches to ministering to the sick and as such has historically been linked to virtuous aspirations. Florence Nightingale continues to be acknowledged as an exemplary nursing practitioner who was equally committed to caring and the scientific advancement of nursing (Gallagher, 2020). In contemporary healthcare, secularised values of caring continue and, despite technological advances, patients typically emphasise the components of good care as a social and physical process involving interactional and interpersonal attributes resulting in the felt sense of being both cared for and cared about (see, e.g., Baguley et al., 2022; Sharp et al., 2016). Classic contemporary feminist caring theorists include Gilligan (1982), Noddings (1984) and nursing's caring theorists, Watson (1979), Benner and Wrubel (1989) and Tronto (1993, 2010), all of whom emphasise care as morally adaptive relational understandings and actions involving reciprocity, rather than the application of abstract predetermined rule-bound approaches.

An overarching Heideggerian approach was used to theorise care because Heidegger's perspective enables the delving into and the illumination of the substantive effects of everyday interactions that often go unnoticed. From a Heideggerian position, at the root of what it is to be a human being is care before any action has been taken. Care comes from genuine concern for the other that Heidegger (2008) refers to as *sorge* or caring. Such care is an ethical stance expressed in authentic existence based on being there and thus gives meaning to existence (Cestari et al., 2017; Smythe et al., 2018).

Heidegger's term, translated as *solicitude*, means showing signs of active caring. When we care for others, it is important to recognise that it is in the context that we as human beings share a mutual concern. To Heidegger, both occupation (being with another) and *solicitude* (showing signs of active caring) are essential aspects of caring.

Heidegger considered that being in relationship involves the balancing of 'leaping in for' and 'leaping ahead of' others (Heidegger, 2008, p. 158). Leaping in is acting for another and can result in the removal of their responsibility for the act (Gullick et al., 2020; O'Brien, 2014). Leaping in is not necessarily excessively paternalistic but does require astute judgement to avoid the latter. The carer may judge the moment when leaping in is felt in a positive way by the other. Examples of leaping in span from healthcare workers' everyday assistance with fundamental care to urgent interventions with a deteriorating patient. Moen and Nâden's (2015) study identified that intensive care patients reported that they felt their dignity had been maintained by nurses who anticipated their needs without them having to ask and, in many instances, when they were unable to ask. Leaping ahead is aimed at paving the way for the other to take responsibility for their actions in the future (Gullick et al., 2020). Leaping ahead is a type of anticipatory caring described by Heidegger as authentic *solicitude*. Leaping ahead is a type of scaffolded care that can have the effect of encouraging patients' confidence, resourcefulness and preparation for independence (O'Brien, 2014).

The research question guiding this study is as follows: What are the experiences of good care in a general medical-surgical hospital setting? This setting was chosen because these wards are consistently busy with high-acuity patients, but unlike specialised units, have a wide range of workers providing care. Our research seeks to reveal the whole experience of good care from a range of perspectives: from those being cared for; those providing care; and those who may not directly see themselves or be seen as part of this caring process, yet, by their presence, may impact care. In this article, notions about good care are illuminated by drawing together stories from patients, family members and professional and auxiliary staff. The research was undertaken in Aotearoa New Zealand. Thus, the experiences of Māori (indigenous people of New Zealand) are included.

3 | DESIGN

The study is informed by phenomenology because this approach investigates what is familiar and everyday in the experiences of being human. Heidegger described self, being-in-the-world as *Dasein*. *Dasein* for Heidegger means 'the self as the there (*Da*) of being (*Sein*), the place where an understanding of being erupts into being' (Davis, 2010, p. 44). Thus, this Heideggerian notion presents the opportunity to examine face-value assumptions, to consider what might lie behind individual staff or patient responses to a situation. A phenomenological approach assists to guard against jumping to

conclusions about actions and to examine what it might be like to be people involved in the giving and receiving of care.

3.1 | Recruitment and participants

Senior colleagues and the Māori health team assisted with participant recruitment, passing on the recruitment flyer to potential participants. Community-dwelling past patients also responded to information on a church noticeboard. Participants were given information about the study and how to contact the researcher if they wished to participate. Nursing staff who operationally reported to the lead researcher were excluded. The lead researcher's role did not include direct patient contact. There were 17 study participants: 3 recent past patients, 3 family members and 11 staff members from nursing, medicine, physiotherapy, chaplaincy, occupational therapy, social work, cleaning services, food services and healthcare assistant groups. There were 5 New Zealand Māori participants, 10 New Zealand European participants, 1 Irish participant and 1 Chinese participant. Four men and 13 women participated. Pseudonyms are used for all participants.

3.2 | Data collection

After gaining informed consent, interviews were conducted by the lead researcher in a private setting, agreed upon by the participant. The conversation was recorded and transcribed. Through the interview process, participants were encouraged to tell stories, elaborate on details and describe how they felt. Interviews lasted approximately 1 h. Examples of staff interview prompts are as follows: tell me about a recent situation that you were involved in that positively impacted on good care; tell me a story that stays in your mind about care that was outstandingly good. Interview prompts to patients and family members included the following: tell me about what made you/your family member feel that you were receiving good care; who were the people providing care and what did they do? These stories were then transcribed using the intelligent verbatim approach, removing repetitions and hesitations (Crowther et al., 2016), and were returned to the participant for affirmation that the transcription was true to the intended meaning.

3.3 | Data analysis

Data analysis was carried out with reference to Gadamer's (Debesay et al., 2008; Gadamer, 2004) hermeneutic circle, a phenomenological approach where the researchers' understandings, the ideas expressed by the participants and the environment in which care takes place all influence the development of a new understanding of the phenomenon. The concept of fusion informed the findings of this research and is understood as the point where 'original understanding is surpassed and integrated into a broader, more informed understanding'

(Vessey, 2009, p. 540). Through the fusion of patient and staff voices; the cited literature, Heideggerian philosophical notions of *sorge*, *fürsorge*, *Dasein*; and the lead researcher's reflexivity, a written work was constructed to illuminate understanding of the phenomenon of good care. Working with the data was a process of writing, reflecting and rewriting to produce a precise description of the phenomenon. Throughout this process, there was rhetorical movement, correcting and modifying existing fore-structures through the hermeneutic circle of interpretation to gain understanding (Debesay et al., 2008). Through the researcher's understanding of positionality alongside the text, the text was illuminated to form new horizons of understanding (Bradshaw, 2013; Gadamer, 2004).

3.4 | Ethical considerations

The study received ethics approval from the Auckland University of Technology Human Ethics Committee to conduct in-depth interviews on the experience of good care within a New Zealand setting. The committee was satisfied that the lead researcher, with her clinical expertise in facilitating dialogue about care quality, was well-placed to undertake these potentially sensitive interviews. The participant information sheet provided information about readily accessible, free support services if the interviews triggered significant emotions. No participants were overtly distressed with the interview process and appeared to appreciate contributing.

4 | FINDINGS

The data set highlighted that the phenomenon of good care had the following essential constituents: authentic care: caring encompassing solicitude (*fürsorge*); impromptu care: caring beyond role category; sustained care: caring beyond specialist parameters; attuned care: caring encompassing family and culture; and insightful care: caring beyond assessment and diagnosis. Together, these constituents draw attention to the experiences of shared humanity between staff, patients and families that had qualities of sustaining and uplifting participants' morale. Significantly, healthcare workers recounted that the capacity to provide good care reflected not only intrinsic values but also what they had learnt during their personal and professional lives, pointing to the importance of education and guided reflection.

4.1 | Authentic care: Care encompassing solicitude (*fürsorge*)

It was clear that the registered nurses who were interviewed incorporated caring as part of their care coordination role. One participant in a senior night shift role gave an example that encompassed caring for the patient, her nursing colleagues and the on-call junior doctor. What is significant about this quotation is that in her description, she draws attention to her purposefulness in

demonstrating care to make a potential emergency with a deteriorating patient go as well as possible for all concerned:

[Good care means] supporting your colleagues who work with you on night shifts so that they can come to you first and then approach the doctor. They really appreciate that. I had a lady who had a [rectal] bleed, and she dropped her blood pressure, was tachycardic, no one had kept a fluid balance chart.... and her haemoglobin was 93. We rang the doctor and he was [busy] but when he got there we had done a group-and-hold, an INR, a full blood count, an ECG, drawn up fluids, we checked the drug chart she wasn't on [medications] so we'd got those drawn up in case he did want to chart them. We'd got some fluids primed so when he got there and said, 'this lady needs [medication] and she needs the transfusion', it's all right here. He didn't have to do much other than have a look at her and order it... He was lovely about it.... I think the humbler you are with the way that you've assessed things, the more accepting they [medical colleagues] are. (Jenny, Registered Nurse)

What is interesting about the above excerpt is that for the senior nurse, this preparation, entailing leaping ahead, is described in terms of values such as support and humility as well as outlining the clinical skills involved in care coordination. The participant appeared in effect to refer to cultivating an ethical climate when she went on to state, 'you support them as junior doctors and then they become registrars and they remember that.'

Although some participants were able to articulate values that informed their caring, care recipients at times found that the ingredients of caring eluded language. The following participant, who had been a recent patient, described the benefits of the felt sense of being cared for:

It's hard to put in words but that emotional connection you feel it when it's there and you notice it when it's not, and you feel more cared about and more valued by that nurse when it's happening. When I was lying in the bed the things that touched my heart and made me feel better, the things that made me feel valued and cared about, were actually the acts of kindness, of going the extra mile and I guess to me that said, they care enough to put their effort in, thoughtfully. (Debra, patient)

The following participant gave an example of this felt sense of being cared for when having a conversation with the nursing staff and a surgeon about advance care planning and end-of-life care. In her recounting of a conversation, she included that the surgeon had called her 'darling' and this intimate language, although it could be construed as an overstepped boundary, appeared to give the participant the sense of being met and seen:

And I didn't have to feel frightened or, you know when you're told you're going to die, you get this fear of, what's going to happen next or, whatever. 'When is it going to happen? How is it going to happen?' You get all those sorts of questions come into your head. And, I didn't have any of that because they [nursing and medical staff] were right there to tell me exactly and they even told me that if they did do the operation, if they had to, this is only if they had to in an emergency, he [surgeon] said that I could end up in ICU and he said, 'you could end up with brain damage, you could', and he said, 'you don't want that darling.' And I said, 'no I don't'. I said, 'I'd rather go like I am now, then'. (Huia, patient)

The above quote highlights the significance of authentic care. In this instance, being met reduced the fear associated with dying and death. Authentic care includes the capacity to empathise with a person's distress and to experiment with a partial remedy. In the following account, a healthcare assistant spoke of the major difference that her intervention had, providing a sensory fidget blanket for a very unwell patient who was living with dementia:

We had a very, very sick patient wringing the sheets in her hands. So, I thought, 'oh, I wonder if I've got these fiddles?' In [a rehabilitation ward] they make these blankets like this. And they've got buttons, button-holes.... So, I brought it in, and I put it on her bed. And she picked it up and started playing with it because they had different things on it that she could use. Because she was delirious. Buttonholes and beads.... She went for it. She always wanted it. You know she'd look. And even her family started giving it to her... Oh they were so happy they go 'we've never seen mum [so settled], she's let go the sheet now and she's got her own toy'. Plus, it was like a barrel, she could put her hands in, keep her hands warm ... And that to me, that was worth a million dollars ... I don't ask anyone if I could do it. To me I just take it upon myself, and I do these little things. (Aroha, Healthcare assistant)

The above example indicates that with colleagues in roles where they officially provide care under the delegation of the registered nurse, it is important to recognise that they nevertheless independently notice need and respond with care. These qualities can be valued and harnessed in teams.

4.2 | Impromptu care: Caring beyond role category

Across the data set, there were accounts from participants of having witnessed what they perceived was a colleague's good care, which appeared to contribute to staff morale. In the following account, a

chaplain recounted an apparently spontaneous interaction between a nurse and a frail older patient:

And there was a little old lady in that bed and she was clearly suffering ... and it was like time stood still because a nurse came ... out of nowhere and she was in that present moment and she went over to the bed, and she picked up this woman's hand and she knelt beside the bed. And she kissed the woman on the cheek. Now she obviously knew this woman [as a long-term patient] and knew what was going on, and I thought, 'oh my god, there's a gap in the universe'. You know it was that kind of moment, and I thought, wow and this woman's face just lit up you know and she just kind of murmured to the nurse and the nurse put her hand down and then ... she was there to provide some care but it was an act of appropriate love and appropriate touch in that moment. (Robyn, Chaplain)

Across the data set, good care appeared to depend mainly on personal qualities and values, rather than on the person's designated healthcare role. Margaret, a food service assistant, described her impromptu caring interaction with a patient:

There was a lady who I went to get a cup of tea for and pulled back [the curtain] and she was just sobbing on the end of the bed and I just thought, you can't shut the curtain, because they need someone right there and then. I know I'm not medical, but I just sat beside her and said, 'are you okay love?' And she said oh, she was panicking about going home, about the way she was feeling. And I just got her hand and I said to her, 'you know we have to take baby steps, just day by day, little bit by little bit'. I said, 'if you look at the big picture like you are, it just looks too big'. She said, 'I know, I know'. When she left, she came and said, 'thank you so much for what you said'. (Margaret, food service assistant)

This participant made it clear that although she perceived she may be crossing a boundary into nursing work, she felt compelled to care:

So it's very hard to be just the person who delivers a meal because often you're there, when the nurse can't be because they are so rushed, I just got that feeling that, that person really needs someone now. And I just feel, if that was me, I would really like someone at that point, to just sit with me, someone who cares. I'm kind of the neutral person. (Margaret, food service assistant)

The participant was aware that superficially, her role seemed to be a series of transactional tasks, but she recognised moments when she could meet an unmet need by offering care.

4.3 | Sustained care: Caring beyond specialist parameters

The data highlighted that healthcare workers' expressions of caring transcended a focus on their level of technical skill and area of specialisation. The following two exemplars illustrate how skilled practitioners harnessed their assessment and technical skills to complement their ability to leap in and leap ahead (Heidegger, 2008) in actively supporting optimal care. A clinical nurse specialist described some of the steps that she took to support the independence of a patient with multiple co-morbidities who had shifted from a fixed address to a life of the move:

I was able to say, 'oh, I notice you've changed your address', and she's now living on a bus which made me think, oh my goodness [this is not ideal]. So it's a mobile bus, with no handrails, no running water, so I escalated the OT [occupational therapist] to see her today, because she's come in with a mechanical fall and she's almost gone backwards in terms of her living conditions. She walks with a stick anyway and she's got a mobility frame and now she's living on a bus! With stairs like that [indicates steep steps] so, I guess I didn't really need to do that, but because I was able to have a dialogue with her because I know her, I thought actually this is an opportunity, they're going to be moving around with this bus, so she potential will get lost as well in the system. (Lisa, Senior Registered Nurse)

The participant went on to give a detailed account of her actions, which reflect a type of leaping in that is aimed at being empowering rather than paternalistic; the nurse aimed to support the woman in her lifestyle choice and contribute usefully to ameliorate the precarity of having no fixed abode:

I also said to her, 'you are keeping your records of all your hospital events because they're so complex', and she said, 'when we moved from the house I've lost all my records', so I've just printed off her last few letters so that she can keep a file and she's got that continuity because potentially she'll visit other [hospitals] and her condition is so complex they may not be able to access our clinical portal so I felt that was good, because it will enable hopefully her care after here and I guess if I didn't know her as well, I probably wouldn't have had all that. (Lisa, Senior Registered Nurse)

This excerpt is interesting because the participant was able to recall and evaluate the quality of the care given. What follows is an exemplar of a doctor's account of giving good care that involved fostering a depth of relationship with a seriously ill patient and her

family. The decision to be with patients over time can build a sense of connectedness, empathy and compassion.

I remember looking after Mary. It was difficult for her because of the magnitude of the diagnosis and the sheer volume of medical teams giving her information. She had six different specialities all coming in from their own perspective. She was under my team under general medicine. She had the oncologist and the radiation therapist ... There was the renal team ... she also had the cardiologists involved.... And then the surgeons were involved as well because they wanted to discuss future treatment for the pericardial fusion. Having different specialities all coming in from their own perspective was very overwhelming for her and her family. Each one was only willing to talk about their small aspect. Their stock answer for if she wanted to talk about something else that was outside their remit was to say, 'oh well cardiology will come back to that but from a renal point of view this is what I think we should be doing'. It was difficult keeping a track of everyone's opinion. I don't regret for a moment spending all that time with her and her family trying to collate all that information and explaining to them in an easy understandable way what was happening. (Andrew, Doctor)

Significantly, the participant went on to recount the benefits not only to the patient but also to himself—that through providing good care through numerous admissions, the doctor's own morale was enhanced:

That was probably one of my proudest moments, trying to guide her through this process.... When I heard she was in ED [emergency department] I went to make sure she was being well treated. She came in with more complications unfortunately and again went to hospice, then she passed away. Throughout the process, I think it was nice that I could be involved to help guide her and make sure that she understood what was going on, just because it was so complex. (Andrew, Doctor)

The above exemplar points to the importance of caring that incorporates and extends beyond specialist expertise. In this instance, the participant acted as a navigator for the family. Such actions align well with Heidegger's (2008) notion of leaping ahead, in this instance paving the way for palliative and end-of-life decision-making.

4.4 | Attuned care: Caring encompassing family and culture

Across the data set, it was apparent that all participants perceived that caring included the patients' significant people. There were numerous examples of advocating for patients and family members

whom colleagues deemed problematic. In the following quote, an occupational therapist described gently challenging colleagues about interpreting grieving as an unrelated behavioural problem:

We've got a client in the community whose daughter is assertive, to the point of aggressive ... Yells at people etc. Comes from a space of, not high socioeconomic background, comes from a challenging background and her mum has got MND [motor neurone disease] and her mum is actively dying. So, trying to remind staff who can quickly get off the phone and go, 'god, that lady is so rude and so demanding', and saying, 'if I had MND I could probably be quite demanding and as well you know we need to remember this lady is, she's watching her mother's demise to the point that she's probably going to drown in her own [vomit] absolutely she's angry and we need to remember that and she's only being angry to advocate for her mum'. (Sam, Occupational Therapist)

This example highlights Heidegger's (2008) point that caring is about being with others. By imagining having MND, this occupational therapist was able to express empathy for both the mother and the daughter. The following account of end-of-life care highlights that good care is more than individualised care and encompasses consideration of the patient's network of significant people. Good care does not depend on a well-established connection. The participant, a nurse who identified as Māori, described an experience on a night shift where the patient was an elderly Māori woman, accompanied by 50 whānau (extended family). Moana described this situation as overwhelming for several reasons. Although she was recognisable as Māori, she knew the family may distrust her status within a biomedical healthcare context. Also, the ward was not set up for 50 whānau to be present, and yet, Moana knew that their presence was vitally important culturally. She first established which family members to liaise with, as was culturally appropriate:

There is one lady who passed away on my shift, she wasn't with us long but I did everything I could for her and the family. Being Māori—when you look after Māori patients sometimes it's not that easy. Sometimes, I get the impression they might be looking at me like I think I'm better than them, so it can be quite difficult to not be that person and just be me. This was a humungous whānau [extended family] that came in. I knew it was really important to figure out who I'm talking to straight away. I asked, 'who am I talking to?' And it was the daughter and son, so two people. There were a lot of babies and kids, so I got them settled in the lounge with colouring-in stuff. I didn't realise at the time, this 100-year-old lady, she's done amazing things, a very important lady. Her tangi (funeral ritual) was actually on the news, it was such an honour to

look after her. I involved them in her cares as much as they wanted to be. They had specific things they asked for. They didn't want me touching her body after she passed, they said that she had brought them up, taught them the old ways and no one was to touch her body apart from the family, just respecting those wishes ... (Moana, Registered Nurse)

Despite the challenges, the participant emphasised that the caring was more than a one-way transaction and is an authentic relationship:

I really felt like I was meant to be that person, because that night I got sent to another ward and then I got sent back ... And then this lady came in and I was looking after her and I just feel like I was meant to be looking after her. (Moana, Registered Nurse)

These examples draw attention to the breadth of the participant's caring, from attending to the practicalities of 50 family members; upholding cultural values and practices; and keeping children occupied. This way of being with others exemplifies Heidegger's (2008) notion of *Dasein*. The following two quotations from family members show the felt sense of being cared for that they experienced through being included and acknowledged by staff rather than prior experiences that felt dismissive. The daughter of a patient spoke of the happiness that she felt at being seen as relevant:

The overall thing for me was not being treated like I was in the way. Because there's been a few times when mum's in the hospital and I've been treated like oh, like you can hear them sighing like 'umph' like all that sort of thing like you know you're in the way that's just how they, make you feel sometimes but up there [on the ward], none of that. They made me feel like part of the staff because I was mum's carer so they just involved me in everything - that was great. Even when the doctors and nurses came to talk, they talked to both of us, not just one person. They included me in everything, I was so happy about that. (Marama, daughter of patient)

The above participant's felt sense that she was part of the team speaks of the level of respect and inclusivity. This communicative authenticity reflects Heidegger's (2008) overarching concept of *Dasein*, the awareness that what we conceptualise as the world is always shared with others. The following quote demonstrates that a family member's emotional shift from feeling unseen to feeling met can occur through a brief but qualitatively different communicative engagement:

And he [doctor] didn't really, kind of answer so I was left feeling a little bit shattered. And the nurse was

absolutely lovely. She just put her arm around me, and she said, 'this is what's going to happen, what are your questions?' And she answered them all for me which was really nice, because he [doctor] was busy and he'd obviously gone onto the next person but she was delightful she was just rubbing my arm and telling me it's going to be alright and, and what the procedure was going to be which were the things that I needed to know, my own sanity. You know [husband] was just going to go and take it as it came but I wanted to know. (Dorothy, wife of patient)

This reflects a type of leaping ahead, wherein the nurse briefly took charge, helping a family member to create a coherent narrative about the journey ahead for her husband with reassurance communicated verbally and through touch. In the above account, although the wife recounts that her husband is willing to surrender to the leaping in clinical care, she needed to have a greater sense of control through understanding what lay ahead.

4.5 | Insightful care: Caring beyond assessment and diagnosis

Insightful leaping ahead care comes from identifying a person's uniqueness. Sam, the occupational therapist, spoke of the learning that he drew from witnessing his parents not being fully seen when they were orientated to residential care after his mother became a resident due to advancing dementia:

When my mum went into care with dementia, I got quite frustrated. People were talking about, 'this is what happens in this rest home, this is what the rules are, this is how we do this'. And very few people actually sat down and wanted to really get mum and dad's story. They did the classic, 'we want Eileen's storybook so that people can flick through that'. But that wasn't really telling a story. He [dad] wanted to just be able to talk. Tell the story, where they'd come from, what they'd been, what her likes were, what her dislikes were, who she was as a younger woman. I was thinking, you just need to listen. (Sam, Occupational Therapist)

In this quote, the participant recognised that to feel met requires different engagement than receiving imparted information. Heidegger's concept of care includes authentic discourse wherein dialogue supports meaningful engagement. Sam went on to describe how the experience with his parents had shaped his practice:

I think good care is about not getting caught up in the detail of people's clinical presentation. On the referral it says things like 'doesn't take insulin', 'doesn't like

needles', 'is a self-proclaimed drinker', 'doesn't really believe that medicines really do a lot anyway'. Well, there's not much point in me going in and talking lots about the concerns of her blood pressure and how to manage blood pressure because she doesn't buy that. So [I ask], 'what concerns have you got about how you're managing at home?' So, then she went off down the tangent of her house being cold acknowledging that that's important to her and that needs to be sorted at some point. It's getting a picture of who's in front of us more than just diagnosis. What makes this person tick. (Sam, Occupational Therapist)

It is important to note that what constitutes good care does not only come from a person's intrinsic qualities. The above participant identified that a personal life experience created a learning opportunity about what good care means that went on to inform his practice. Meeting people where they are appeared to be a significant aspect of good care in this context. In the following example, a physiotherapist acknowledged that authentic discourse played a large part in physical transformation:

There's certain presentations, one for example would be conversion disorder or functional movement disorder, where they [patients] present with a physical disability but it's more related to stress. There is a physical element to the treatment, but majority of it is emotional. Talking, a lot of talking through things. I feel like it's more of a counselling service at times rather than a physical, physio treatment. This young gentleman came in with quite severe back pain and lost all use of his legs and arms and just could not move. And, yeah just two treatments, I got him walking and discharged him from hospital but majority of that treatment was very much talking therapy. (Eleanor, Physiotherapist)

Across the data set, good care, as conceptualised by healthcare workers and family members, involved care that expanded beyond the person's designated role and was far more than competent technical care. Willingness to leap in and leap ahead and to engage in authentic dialogue at times led to a type of boundary crossing, wherein rigid rules about roles dissolved and people met with their shared humanity.

5 | DISCUSSION

This study drew from several core Heideggerian notions to explore good care in an acute hospital setting. The novel contribution made in this study is a synthesis of professional and auxiliary staff perceptions of good care, along with patients' and family members' experiences. These notions included *sorge* or authentic caring, which, from

Heidegger's perspective, is a fundamental mutual concern expressed through action that is part of being fully human. Related ideas of leaping in and leaping ahead are ways in which caring activity can be expressed, through helping and paving the way to increase the likelihood that a person will be able to act for themselves. The findings of the study echo and build on the extant literature, discussed below, about good care. Importantly, engaging in and witnessing good care appeared to boost healthcare workers' morale and collegiality, thus contributing to a positive ethical climate in the workplace. Receiving good care tangibly informed patients' and families' perception of quality care, with an enhanced sense of control and alleviation of suffering when facing uncertainties and even death.

While it was clear that practitioners' education and technical skill significantly enhanced their capability to provide good care through clinical assessment and decision-making, good care also included a desire to foster meaningful connections, however brief. Through our study's findings, we concur with Tronto (2010) that using consumer-like measures of good care neither translates well into ensuring the provision of good care nor satisfaction for caregivers. We consider that Tronto's view echoes that of Heidegger, that caring is a fundamentally relational activity that sustains caregivers and care receivers:

On the most general level, we suggest that caring be viewed as a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web. (Tronto, 1993, p. 103)

Our findings highlighted that providing good care appeared to bolster healthcare workers through a sense that they were meaningfully connected to others by shared caring moments and that this iteratively informed and developed their practice. We agree with Cestari et al. (2017) and Gullick et al. (2020) that providing good care through authentic connection is a type of caring for oneself because it affirms the carer's ethical stance as a being in relation to other beings. Our study highlighted this type of role transcendence in the meaning that participants made of caregiving.

Our data showed that at times, when describing good care, participants gave examples of actions that moved into the realm of what is commonly referred to as blurred professional boundaries. These actions included intimacies offered as comforting, such as hugging and kissing patients. Family members and patient participants spoke of appreciating these gestures as evidence of being seen in their suffering. Although we consider that professional boundary maintenance is vital and requires critical reflection, we recognise that from a Heideggerian perspective, these moments may be an expression of shared meaning, being-in-the-world with another (Gullick et al., 2020). The Smythe et al. (2018) study of nonregulated mental health support workers points to the emphasis in healthcare

education on exemplars of boundary breaches, without consideration that rigid notions of professional boundaries may lead to under-involvement—what Heidegger (2008) refers to as inauthentic care. Smythe et al.'s study recommends that nurses who are guiding the care of nonregulated staff need to respect that these colleagues may have high-trust relationships with service users and as such may have knowledge to share with the professional team members. We consider that these elements of trust and knowing were reflected in the reports of care offered by auxiliary staff.

Significantly, in the current study, health professionals recounted actions that took into consideration what patients and their families wanted, rather than what clinicians thought was best for people generically. This orientation typifies the tailoring of care recommended by Tronto (2010) rather than a decentering of patient caring through an administrative focus on risk (Hutchinson et al., 2018). The data provided wide-ranging examples of healthcare workers' experiences where participants drew from their caring values to inform the balance of leaping in and leaping ahead of patients and families (Heidegger, 2008). These contexts were as broad as managing a deteriorating patient, supporting lifestyle choices in the face of disabling health issues and ensuring that palliative and end-of-life care reflected patient and family wishes. We agree with Gullick et al. (2020) that optimal clinician judgement that avoids abuse of power when leaping in and leaping ahead requires practitioners' willingness to know and be known.

In our study, it was evident that auxiliary staff contributed purposefully to good care. We concur with Lindh Falk et al. (2018) that the scholarly and practice emphasis on the importance of interprofessional collaboration overlooks contributions made by the broader group of healthcare workers. Lindh Falk et al. focused on nursing assistants (also known internationally as healthcare assistants). The authors note the importance of nurses and medical colleagues providing positive feedback to nursing assistants to bolster their confidence in their capacity to contribute knowledge. Our data similarly reflect the capacity of auxiliary staff to make an on-the-spot assessment of needs and to respond with care. We identified that these participants also drew from a sense of shared humanity to intervene. We acknowledge that it is essential that healthcare assistants and other auxiliary staff work with the guidance of registered nurses. Anderson et al.'s (2005) nursing home case study identified that nurse assistants' work was typically informed by the Golden Rule—helping by treating others as one would like to be treated, and mother-wit—drawing on caring expertise that came from personal experiences of providing care, such as mothering. Although these approaches often had positive consequences, they did not necessarily lead to person-centred good care focused on the uniqueness of the person and instead could be paternalistic. The authors also noted that although motivated to provide good care, the assistants sometimes misinterpreted undiagnosed conditions and worked with limited communication with registered nurses. Our study confirms Gray et al.'s (2016) findings, which indicate that assistants are able to support their work ethos through self-validation of the good care that they give. However, these authors also highlight

the importance of external validation to sustain and retain these workers. The results of these studies support our argument for nurses, who typically lead care coordination (Allen, 2014), to recognise, guide and harness the caring capacity of healthcare assistants and other auxiliary staff. We consider that although caring values may be intrinsic, there is evidence that good care can be learnt through role modelling (Hunter & Cook, 2018).

In the current study, patients and families had a felt sense of the presence of good care that encompassed being seen and included. Staff spoke of recognising that for family members, it was essential to be noticed and affirmed as significant caregivers and that exclusion was potentially harmful. The significance of this recognition was also evidenced in Quinney et al.'s (2018) study of nurses who provide long-term care for a family member. In our study, family members appeared to consider that caring for loved ones was a fundamental reciprocal practice and that they also had an advocacy role. These findings echo those in Andersen et al.'s (2020) study, where they detail the care that adult children provide to chronically ill older parents. Andersen et al. contend that adult children may have a complex relationship with healthcare systems and staff as they navigate providing care—*fürsorge*—for their parents and themselves. Andersen et al. draw attention to the juggling that family members do in assessing when to leap in and leap ahead as they endeavour to uphold autonomy and dignity. Significantly, in the current study, staff listening deeply to patients appeared to alleviate suffering. We concur with Angel (2022) that good care includes healthcare workers' willingness to listen as part of bridging the gap between clinical facts and how the patient perceives this information in relation to their life.

5.1 | Limitations

The in-depth nature of phenomenology limits the number of participants. A wider range of voices may have brought forth additional insights. This study focused on individuals' accounts of good care but did not examine caring from organisational, leadership and educational perspectives, which we recommend as avenues for further research.

6 | CONCLUSION

The experiences of giving and receiving good care cannot be measured through consumerist metrics but rather through considering that care is fundamental to human being and human relating. Good care in this study was identified as the willingness to connect with another, human to human. Technical and organisational skills enhanced good care but were not a substitute. Caring in healthcare is vital not only for care receivers but also for caregivers. This study highlighted that healthcare workers' experiences of providing good care had long-term benefits for them because these moments iteratively informed their practice. Witnessing good care was also morale-boosting for colleagues and family members, thus

contributing to a positive moral climate. Given the challenges of care rationing, it behoves nurses who coordinate care to recognise and affirm the value of the caregiving capacity of all healthcare workers and to guide and harness these contributions. This valuing of teamwork is not to undermine the importance of nurses' presence, but rather to make visible the ways in which healthcare colleagues can work cooperatively for the benefit of all. Our data highlight that good relational care enhanced situations as broad as managing a critical incident, advanced care planning, end-of-life care, discharge planning for a patient with a complex illness, comforting and educating a distraught relative and challenging peers by advocating for a relative who had been labelled demanding. Our data show that good care for clinicians meant that they saw they had more to offer than the parameters of their specialised knowledge. Auxiliary staff, in their good care actions, also expressed their life wisdom beyond the confines of their job description.

Good care matters. It alleviates suffering. More than that, it brings a human-to-human connection of meaning, of feeling understood, of feeling cared for and cared about.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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