Reclaiming and redefining the Fundamentals of Care: Nursing's response to meeting patients' basic human needs

Alison Kitson, Tiffany Conroy, Kerry Kuluski, Louise Locock, Renee Lyons

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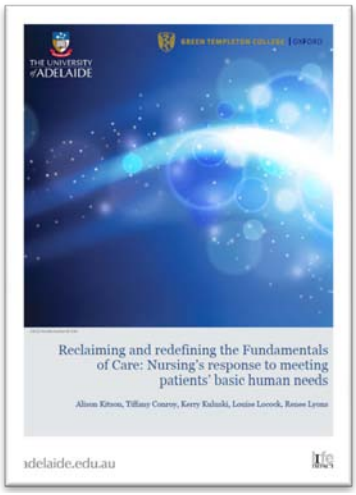

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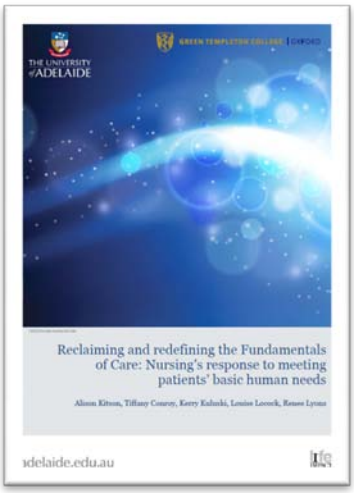

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This position paper has been produced by Alison Kitson and the team on behalf of the members of the International Learning Collaborative (ILC), a voluntary group of international nurse leaders and supporters of nursing, united by a vision for improving the fundamentals of care for patients.

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Executive Summary

A group of nurse leaders, health policy, health care researchers and clinicians attended a seminar at Green Templeton College, University of Oxford in June 2012 to debate and draw up an action plan around integrating the fundamentals of care (FOC) into the patient centred care (PCC) agenda.

Participants at the seminar acknowledged that despite significant improvements in delivering more compassionate and patient-centred care, health systems continue to face challenges in meeting the basic needs of many of our most vulnerable patients due to a range of complex factors. The invitational group, over the course of two days, discussed a number of initiatives being used by health systems to improve patient care in this area. These included issues around regulation of care; preparation and training of nurses; ways that factors such as dignity, compassion and kindness can be promoted in health systems; the use of techniques such as hourly rounding, patient involvement in systems redesign and a number of other innovations required to build and redesign the health system around the patient.

A framework to guide and shape the ongoing debate has emerged from the meeting. This framework, called The Fundamentals of Care (FOC) Framework comprises three core dimensions: statements about the nature of the relationship between the nurse and the patient within the care encounter; the way the nurse and the patient negotiate and integrate the actual meeting of the fundamentals of care; and the system requirements that are needed to support the forming of the relationship and the safe delivery of the fundamentals of care.

The group has produced an implementation plan which is meant to stimulate discussion and debate within key stakeholder groups. These suggested actions are an attempt to turn the more abstract parts of the framework into practical actions at the level of the care encounter between any nurse and any patient in any health system where nursing takes place. There are proposed actions for clinicians and managers; the educators of nurses; and for researchers and policy makers.

The framework will be further refined as part of the ongoing work of the International Learning Collaborative (ILC),one of the core groups of nurse leaders and academics who are leading this international agenda. Feedback is welcomed on this position paper. Responses can be emailed to Alison Kitson, the facilitator of the ILC group and coordinator of the Fundamentals of Care Framework paper (alison.kitson@adelaide.edu.au).

1. Background

1.1 The pursuit of Patient Centred Care

Every healthcare system is engaged in the ongoing activity of balancing safe and affordable healthcare with a service that respects and protects the individual patient and their family. Health policy guidance increasingly combines system and clinical safety with standards around the provision of patient-centred care (PCC).

As the largest global healthcare professional (workforce) group, nursing has a central role to play in ensuring safe, affordable and respectful care for its patients (Institute of Medicine 2011). As demonstrated in many publications and policy documents, nursing is committed and involved in the patient centred care agenda (Kitson et al 2013a). However, what also comes to light is the ongoing challenge facing the nursing profession in ensuring that the 'basics' of care are carried out correctly (Care Quality Commission 2010; Commission on the Future of Nursing and Midwifery 2010; National Expert Commission 2012). These 'basics' or fundamentals – ensuring appropriate nutrition, hydration, personal hygiene, sleep, rest and dignity to name but a few, have traditionally been the responsibility of the nurse on behalf of the healthcare team. Yet, we know through healthcare reports (Final Report of the Special Commission of Inquiry (The Garling Report) 2008, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (The Francis Report) 2013)) that failure to assure these aspects of basic care often lead to wider patient safety failures (e.g. figures on hospital acquired infections due to poor infection control activity and nutrition and hydration problems in older people in acute hospitals) or in some extreme cases mortalities.

Despite significant activity there continue to be challenges in assuring the alignment of safe, affordable clinical care with care that puts the patient and their family at the centre of the clinical encounter (Dieppe et al 2002). It is important for the nursing profession to recognise its contribution to this important agenda and to take the lead in transforming those aspects of patient care for which it is responsible. Nursing recognises the importance of the multidisciplinary team and the centrality of the patient and their carer in this agenda. However, there is growing evidence from patients, the public and nurses themselves that the profession has not been able to provide quality basic nursing – or the fundamentals of care – as consistently as needed. Evidence from safety reports and other research studies also confirms this observation (Institute of Medicine 2001; Care Quality Commission 2010).

1.2 The work of the International Learning Collaborative (ILC)

In order to explore these issues in more detail, an invitational seminar was held in June 2012 at Green Templeton College, University of Oxford, facilitated by members of the International Learning Collaborative (ILC) and the Health Experiences Institute (HEXI) and included a wide range of experts in patient centred care, nursing practice, health policy, and research and executives from patient associations and health care regulatory organisations (See Appendix 1). The purpose of the two day event was specifically to debate whether there was a problem in how patients experience the fundamentals of care and if so, how we could set about improving these.

The overwhelming conclusion was that we do still have major challenges in assuring safe and respectful basic care in our health systems, despite the plethora of initiatives, standards, research and policy reports and recommendations. This does not mean that nurses no longer know how to care. In fact, it is equally important to acknowledge that every day across the world many nurses provide excellent care, fundamentals and more to their patients. However, this phenomenon tends not to be as newsworthy as those situations where care is sub standard and it is in this area that we wished to focus.

From the deliberations it was clear that the nursing profession had to acknowledge the challenges in providing consistent, high quality, safe and respectful care to patients and take a more active leadership position in developing a plan of action. In choosing this particular focus we will be concentrating on nursing; this does not mean that we are ignoring the contribution of the wider healthcare team, the family, and other carers involved in the complexities of patient care. Our objective is to understand what we as nurses need to be doing. What was also clear to the participants was that new and different ways of looking at the problems facing us were needed together with more inclusive ways of mobilising the whole nursing profession to begin the transformation. In short, this position paper is a call to action.

1.3 Emerging themes from the seminar: actions not words

As was forcefully noted at the seminar, nurses have been talking about the failure of the health system to provide quality care around the fundamentals for several decades. Experienced leaders of Patients' Associations and Directors of Nursing at the seminar debated the possible reasons why such problems as lack of respect, lack of compassion and kindness continue to be identified by patients as problematic to their experiences of the health system. Seminal nursing research studies such as Menzies-Lyth's (2002) work on nurses' reliance on routines as a defence against the anxiety of developing relationships –or talking meaningfully – to patients was noted as continuing to cause challenges to contemporary nursing practices. This was discussed by Cornwell and Goodrich (Goodrich & Cornwell 2008; Goodrich 2012) in relation to their work on enabling the whole healthcare team to acknowledge the emotional work involved in care and in particular challenge the perspective taken by professionals towards patients' experiences of care.

Maben's and Bridges' work informed the group of the interrelationship between individual nursing actions and the wider context in which nursing takes place (Maben et al 2012; Bridges et al 2012; Bridges et al 2010; Bridges et al 2009a, 2009b). Maben et al's (2012) finding of how nurses classified older patients as 'poppets' (those they liked caring for) and 'parcels' (those that were harder work and more demanding) resonated uncomfortably with earlier findings from Stockwell's (1972) seminal study on how nurses labelled patients as popular and unpopular. The participants agreed that these issues were multifaceted and required new ways of thinking about the problems and, more importantly, novel ways of testing solutions.

The discussion was not confined to the UK health system: colleagues from the US identified similar issues facing the nursing profession (Needleman et al 2009a & 2009b; Pearson et al 2009). Issues around nursing skill mix, patient outcomes, health reform incentives and cost effectiveness continue to be the predominant factors driving the debate – the general conclusion being that payment needs to be better aligned with goals for quality patient centred care (Needleman et al 2006). The complexity of nurses' work requires nurse engagement in integrating new or better processes into care or changes, even evidence-based changes of proven efficacy, may not be sustained (Needleman 2008).

North American colleagues (Donaldson, Needleman & Kagan) did acknowledge that discussions about fundamentals of care would normally take place within a quality and safety or patient centred care framework. Indeed, North American participants (in particular Kagan) noted that American nursing discourse offers little direct translation of the term 'Fundamentals of Care'. Rather, the term 'fundamentals' tends to connote early didactic and practice experiences for beginning nursing students. North American nurses tend to refer to these classes and the texts used to support that learning as 'Fundamentals of Nursing'. This sensibility conjures up elementary skills and early competence. The question still remaining therefore is if these are elementary competencies, why are there such widespread problems?

Equally, participants from Canada (Lyons, Kuluski, Merkley & Jeffs) as well as Sweden (Wengstrom, Bovall, Gunningberg & Jangland) acknowledged the ongoing tensions in producing caring, compassionate nurses in a contemporary healthcare context that tends not to value these attributes and places importance on such outcome measures as throughput, waiting times and cost effectiveness (Hollander & Pringle 2008; Commission on the Reform of Ontario's Public Services 2012; Docteur & Coulter 2012).

Indeed, part of the problem may be that the fundamentals of care are no longer in the hands of nurses. This may be due to nursing not taking ownership of them or that health systems are not designed to prioritise this sort of care. Whatever the reasons, the result is a mismatch between policy, education and practice—and this great divide fuels politically guided initiatives-that have immediacy but do not get to the heart of the matter. Collaboration however, was seen to be key in addressing these challenges.

Models of best practice were identified by several speakers: those promoting specific initiatives such as intentional rounding (Bartlay 2011; Fitzsimmons et al 2011), or the co-design of services involving patients right from the start (Bate & Roberts 2007). Other participants had experience working in regulatory bodies where routine monitoring of fundamental services do continue to show significant disparities between services. One review of dignity and nutrition in acute hospitals (Care Quality Commission 2010) showed wide and unacceptable variations in performance and patient experiences. The questions posed were "Why do people's experience of care vary so widely?" and "Why is it easier for some providers to deliver high quality personalised care than others?"

Tadd's work on mapping how dignity is maintained in healthcare settings (Tadd & Calnam 2009; Tadd et al 2011a & 2009b) helped to provide possible answers to the above questions. Her program of work across several European counties and in both aged and acute care settings found that there were tensions between providers, priorities of staff and those of patients with regard to what mattered and what was important. Their work found that there was often undue emphasis on the recording of care but not on how that care was actually delivered. Common issues emerged as: complexity (interactions between organisations; complexity of people); resource issues; leadership issues; deficiencies in education/training; and demoralised staff.

Our deliberations led us to identify some general principles to guide future work:

1. There is an urgent and critical need to get the patient's voice embedded at many levels of the health system. Most importantly the patient's voice needs to be heard from the very beginning and maintained throughout the nurse-patient encounter. How can we make this happen?
2. We can't have a caring environment for patients if we don't have the same environment for the staff as well. How do we ensure that both staff and patients benefit from this transforming work? And what would success look like?

3. We need concrete descriptions of how we start to redesign care around the patient and then how these descriptions shape what's written at health system and policy level. How do we do this?
4. The misalignment between staff, patients, senior staff, organisational leadership, regulators, and payers, over how care is valued and delivered needs to be addressed. How do we create the appropriate alignment?

What are the flaws in our health systems which continue to frustrate nurses and patients? Nurses often can't do what they need to do, for patients, for staff, for systems. The multiple reform initiatives, many of which were discussed at the seminar, tend to lead to fatigue with a sense of resignation that the situation will not improve. This led participants to reflect on whether the cause of the problem lay deep in the psyche of the nursing profession itself. Has something happened to the way modern nursing views and values caring? Indeed, is nursing in danger of losing its claim to care (Kitson 2010)? In the desire for modernisation and professionalisation, have we lost sight of the core values and activities central to patient care? Or is this a broader social pattern where individuals are less inclined to show kindness, compassion, and care for others even if it is a necessary requirement of the job?

There is international agreement that nursing is facing a series of challenges to the way it operationalises caring. Despite the commitment to more patient centred care initiatives there continues to be a mismatch between the policy rhetoric and what patients experience. Across the globe, the nursing workforce is becoming more chronically fatigued by multiple initiatives, not just in the UK, but in Canada, the US, Australia, and Sweden to name but a few. However, none of these initiatives seems to be working to the extent we would desire. We need to reclaim the fundamentals of care and work out how we ensure the safe, competent, compassionate delivery of them to our patients. We are targeting key nursing and other healthcare leaders in order to create a shared vision and shared accountability for the reframing and redefining of the fundamentals of care.

1.4 The proposed solution

The purpose of this document therefore is to provide a new vision of what professional nursing practice should like around the fundamentals of care. It will address the gap between the rhetoric and the reality of patient centred care as it relates directly to the fundamentals of patient care. The document's focus is on nursing in the acute hospital setting and around fundamentals of care. It acknowledges the important contribution of all other members of the healthcare team, the health system and wider family and care networks. However, the primary focus is on fundamentals of care and what nurses do about them.

By reframing how nursing thinks about the fundamentals of care, there is more chance of nursing contributing to the wider healthcare transformation agenda. It is important to recognise the uniqueness and therefore variability of patient needs and how the system is designed to provide this or not. Does good care look the same for the nurse, or the patient, or the system? We have responsibility to think analytically and objectively about care but also to construct a meaningful and integrated experience moderated between the patient (and their family and carers) and the nurse in real time.

The proposed framework is intended to act as a way of encouraging discussion and dialogue around the core elements of providing patient centred fundamentals of care. It is not intended to be a comprehensive nursing framework; rather it focuses primarily on how nursing can put the fundamentals of care at the centre of its activity. The action plan is also intended to help nurses have meaningful conversations with colleagues,

patients, and health system managers and leaders about delivering high quality fundamentals of care.

2. Defining the Fundamentals of Care

A subgroup of the Oxford seminar participants (see Appendix 1) worked on developing the proposed new Fundamentals of Care Framework. The work is preliminary and will be refined as we receive feedback and meet at our next event in Stockholm in May 2013. Our working definition of the Fundamentals of Care was implicitly agreed as encompassing those aspects of Virginia Henderson's (1966, p. 15) description of nursing care: that it was the unique function of the nurse:

To assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge.

Nursing, Henderson believed, provides the 'basis for physical comfort', which underlines the importance of the patient's subjective experience for an encompassing understanding of health and healthcare (Henderson 1988, p.18). Adding to the physical comfort dimension, we also incorporated the patient's need for psychosocial support and the establishment of a meaningful encounter or relationship with the nurse (Kitson et al 2013b).

A working list of fundamentals of care was shared at the sub-group meeting. This was based on work undertaken by the ILC group between 2008 and 2010 (Kitson et al 2010). Appendix 2 provides a summary of this work.

2.1 Approach to developing the fundamentals of care framework

The approach taken was participatory and collaborative. From the presentations and discussions on the first day a sub-group of volunteers from the ILC group agreed to work on the data that had been generated from the wider group. Three rapporteurs (Paul Yerrell (PY), Kerry Kuluski (KK) and Tiffany Conroy (TC)) took detailed notes of the first day's discussion and then together with the lead facilitators (Alison Kitson (ALK), Louise Locock (LL) and Renee Lyons (RL)) the data was analysed for emerging themes and issues. This summary was then presented to the volunteer sub-group of Day 2. Its task was to work together on several of the discrete themes that emerged from Day 1 and to generate a conceptual framework.

Four major areas were identified: issues relating to how the initial nurse patient relationship is established within the clinical encounter; further work on what fundamentals of care consisted of; consideration of the wider contextual (health system and wider policy, political and regulatory frameworks) environment that impacts on care and finally work on the action plan (which again was divided up into actions for clinicians, researchers, educators and policy makers).

The data from this second day was written up immediately by ALK and TC and checked for consistency and intelligibility with KK, LL and RL. From this data, the proposed Fundamentals of Care Framework together with the Action Plan have emerged. A first iteration of the paper was circulated to the Day 2 participant sub-group members in September 2012 for comment and feedback. Following this a refined version was circulated to all seminar participants for comment and feedback in

December 2012. The final version was edited in January 2013 and published on behalf of the ILC by the University of Adelaide.

2.2 A new perspective on an age old challenge

The dimensions of the Fundamentals of Care Framework rotate around the nurse, the patient, the family and the health system or context. The fundamentals of care are multidimensional and are mediated by the relationships between the care provider (nurses) and the recipients of that care (patients) as they are transacted within each encounter. In describing the fundamentals of care it is also important to consider a number of other questions. For example, in assessing how well a fundamental of care was carried out, is it important to consider discrete episodes of care (e.g. one experience of going to the toilet or eating a meal); the patient's whole experience of how their physical and psychosocial needs were met during their entire hospital stay or for each encounter with the nurse?

It is also important to recognise the tension between the private complexity (of undertaking self-care tasks) versus the public simplicity (as perceived in institutional settings) when delivering the fundamentals of care. A self-care activity which has been routinely and independently undertaken by an individual in their lifetime (e.g. bathing) with little need for deliberate thought or reflection may, in an instant, become something that is both challenging and embarrassing. This may not be acknowledged by the nurses or the system in which the patient finds themselves as the self-care task itself is often perceived as straightforward and not requiring great intelligence or skill to execute. However, this could not be further from the reality: there is a cultural, social and personal history surrounding every fundamental of care, e.g. consider the private process of going to the toilet and how this is exposed and challenged within a healthcare setting.

Caring is more than doing things to people. It is a series of interactions mediated through relationships. Focusing on who is in front of you is integral, not optional. The ability to engage, focus on the other person, and see their self-care need from their biographical perspective are essential skills. This requires the nurse to be able to deconstruct a caring situation and reconstruct it in an instant in order to protect the integrity of the other person needing their support and help. And it is not just the rare or isolated occasion which requires this ability. The nurse may have to constantly reframe and refocus on the fundamental care needs of multiple patients in a shift and indeed on multiple care needs of one patient for the duration of a shift.

The ability to demonstrate empathy and establish meaningful encounters were also identified by the group as essential to the Fundamentals of Care Framework. It is axiomatic that for care to be patient-centred and personal, the patient needs to be the focus of the care: not the illness or treatment but the whole person. This requires the nurse to be able to integrate every task (e.g. helping a person eat or drink) with their ability to engage with that person on a human level. This act requires the ability to concentrate on the particular and the mundane in order to maintain the integrity of the other person. If the nurse is feeling overwhelmed and stressed in terms of the demands of the job and insufficient resources, then how will this integration and mutual engagement take place?

This is why issues around the fundamentals of care will need to be viewed, not just as elements of the relationship between the nurse and the patient, but within the wider context (its cultural norms, and its resources) which will impact upon the quality of the caring relationship. When nurses are working in contexts which are not designed to provide patient-centred fundamentals of care they find themselves conflicted and compromised. Effectively they must exercise a choice in how they allocate the scarce

resource of their time and expertise to the care of their patients in real time. The reflective question for many nurses will be "How can I minimise the potential harm I could do today?" Written so starkly, one is challenged to consider how resources and rationing become part of the daily experience of the nurse, prioritising one patient's care needs over another's.

This constitutes part of the complication of delivering the fundamentals of care but not the complexity. Complexity lies in the multiple encounters between nurse and patient and their ability to engage authentically and effectively within seconds and for brief moments of time. If this skill is not evident, then additional resources may still not achieve improvements. Equally, staff ratios are more of a complication rather than a complexity in the equation; staffing is an enabler rather than an integral part of the fundamentals of care debate. What is essential is the ability to balance tasks with the time available. However, the prior question is what type of care does the system want, is it task oriented or humane engagement?

The nurse requires expert mentorship to be able to balance the demands of assessing and providing fundamentals of care with the other responsibilities of the nursing role. If they do not experience good role models and unit level leadership they will be less likely to know how to balance the competing priorities in their patient care. The question "How can I minimise the potential harm I could do to my patient?" becomes more realistic as they are faced with multiple patient needs without the capability of making informed judgments.

Mentorship, support, role modelling and guidance in providing the fundamentals of care will establish a way of caring for patients that redefines their centrality in care and legitimises their importance in the therapeutic process. Equally, prioritising the fundamentals of care also acknowledges the importance of such activities for the whole workforce. Respecting nursing care and giving it time and resources in the system will lead to stronger systems to care for staff. Nurses who role model expert care around the fundamentals know how to prioritise between patients and how to engage in meaningful therapeutic encounters. They can draw meaning from each episode of care and facilitate the healing process for the patient. They use a combination of inductive and deductive reasoning and can evaluate the impact of their care thus providing evidence of what works and why it works.

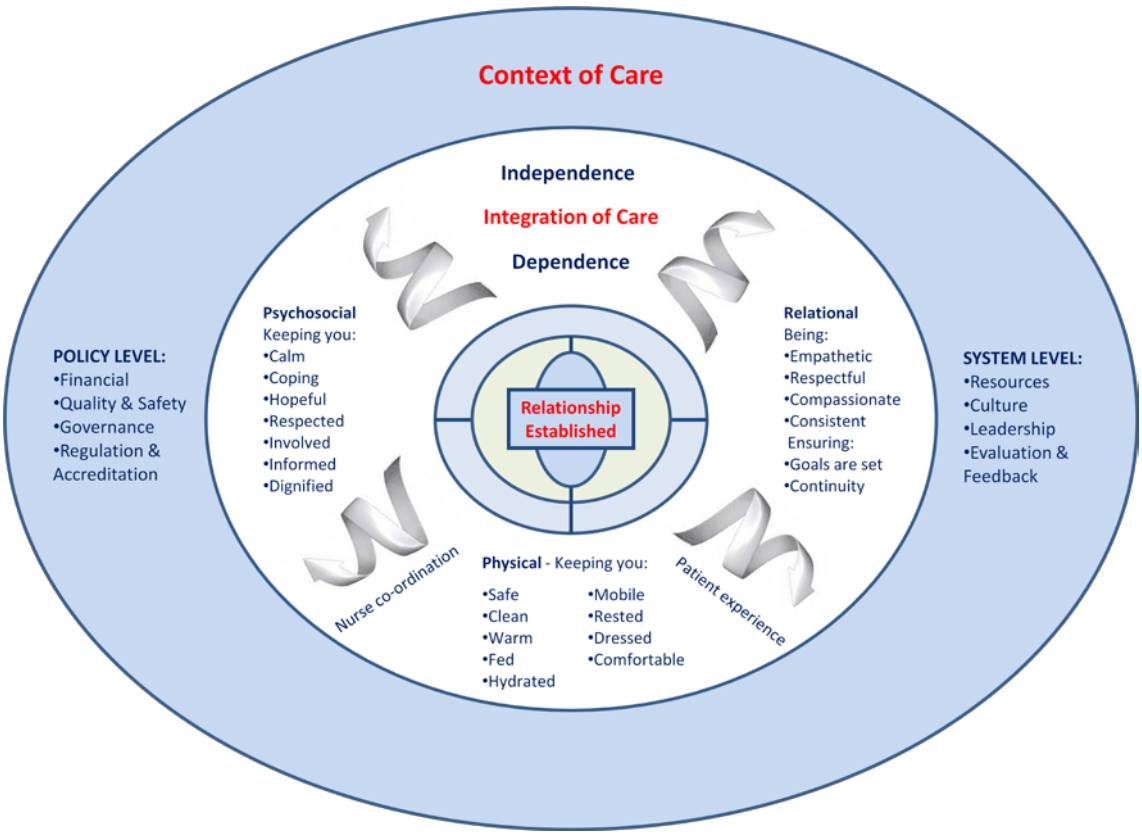
Patients generally equate the type and quality of care they receive with the staff who provide it (Marshall et al 2012; Kitson et al in 2013b). Reviews of the patient centred care literature (Kitson et al 2013a) also confirm the central importance of patient participation and involvement in their care where the patient participating is acknowledged as a respected and autonomous individual; the care plan is based on the patient's individual needs and the care addresses the patient's physical and emotional needs. The relationship between the patient and the healthcare professional was found to require the following elements independent of professional allegiance: having and maintaining a genuine clinician-patient relationship; open communication of knowledge, personal expertise and clinical expertise between the patient and the professional; health professional having appropriate skills and knowledge; and having a cohesive and co-operative team of professionals providing care.

All of the above elements will be part of the emerging Fundamentals of Care Conceptual Framework.

3. The emerging Fundamentals of Care Conceptual Framework

Consistent with the defining parameters outlined above, the Fundamentals of Care Framework rests upon the ability of the nurse to connect with the patient and through that connection be able to meet or help the patient themselves meet their fundamental care needs. The framework does not focus on clinical diagnosis, treatments or therapeutic outcomes. Its focus is on enabling the patient and the nurse to confidently and competently assess, plan, implement and evaluate care around the fundamental care needs. Whilst clinical condition will affect the performance of fundamentals of care, we argue that the contribution of nursing to the patient's journey is facilitating the effective execution of such basic needs in a way that is competent, respectful, personal and empathetic. This is the bedrock of effective nursing care and is achieved through the conscious alignment of three core elements: establishing the relationship with the patient; being able to integrate the patient's care needs; and ensuring that the wider health system or context is committed and responsive to these core tasks. Figure 1 summarises the framework.

Figure 1 The Fundamentals of Care Framework: Relational, Integrative and Contextual Dimensions



The Fundamentals of Care Framework is made up of a series of concentric circles that integrate the core relational elements at the centre with the outer system requirements at the periphery (Figure 1). Central to the framework is the relationship between the patient and the nurse (Figure 2). This relationship is based on a commitment by the nurse to care for the patient (and significant others). The nurse also has a commitment to communicate the information about the patient to other staff, relevant carers and family members. This ensures consistency and continuity of care as the patient moves from dependency to independence in self-care activities (or indeed, continues to be dependent on others).

Equally, as the nurse hands over responsibility for direct care to other colleagues across shifts and during the time the patient is in the system, it is vitally important to ensure consistency and a patient-focused approach. The inner core of the framework is where the commitment to the relationship with the patient is established and where a series of statements are implicitly or explicitly made between the nurse and the patient.

Unique to the Fundamentals of Care Framework is the second circle (Figure 3 for a detailed articulation) where the nurse's initial assessment (core circle See Figure 2) is used to construct a series of practical actions around the fundamentals of care: addressing the physical aspects such as keeping clean, warm, fed, hydrated, dressed, comfortable, mobile and safe as well as the psychosocial dimensions of care including keeping calm and coping, feeling respected, involved, informed and dignified. The physical and psychosocial dimensions of the fundamentals of care are mediated through the relationship or each encounter between the staff member (nurse) and the patient. Characteristics of this encounter are the ability of the nurse and patient to set mutual goals for each fundamental of care and for the nurse to demonstrate empathy, respect, compassion, consistency and continuity.

The outer circle of the whole framework (Figure 4) reflects the co-dependency between the nurse-patient relationship and the wider healthcare system or context. This is where a number of resource, staffing, leadership and broader policy and regulatory issues can impact upon the quality of the nurse patient relationship.

Each of these circles will be described. The challenge for the patient, nurse and health system is to be able to move through each of these steps in order to achieve lasting and sustainable improvements in patients' experiences of the fundamentals of care.

3.1 The Fundamentals of Care Framework: Committing to and establishing the relationship

Figure 2 Protecting and communicating the nature of the relationship to others

In the assessment process the central core of the framework is the ongoing commitment to the way the relationship is protected and communicated to others. Five core elements are established at this point. They are focusing, knowing, trusting, anticipating and evaluating.

This is enacted through the following questions (see Table 1):

Table 1 Protecting the relationships

Focusing	***How do I give you my undivided focus/attention?*** How does the nurse develop the skill of focusing on the patient in real time without being distracted? Focusing may only involve very short bursts of time but are hugely important in terms of surveillance, anticipation, detecting changes in patient state.
Knowing	***What do I need to know about you and why you are here?*** The nurse has to balance the need to know information with the patient's sense of control, privacy and dignity. Having the patient repeat the same information to numerous staff is disrespectful to the individual patient.
Trusting	***How can we develop a trusting relationship?*** There may be numerous staff caring for the individual patient so how does trust between two people become established if the encounters are short, intermittent and infrequent?
Anticipating	***How best can I help guide you on this journey?*** The nurse, by asking this question will be able to consider the proposed course of action and start discussing this with the patient as part of the recovery process.
Evaluating	***How will we know it is working?*** Both the patient and the nurse should be continuously reviewing progress and giving feedback to each other how things are going. The patient and the nurse also negotiate who else need to be involved in this review process (e.g. relative or carer).

The role of the nurse initiating this relationship is to ensure this information is communicated to all other members of the healthcare team. This means that the nurse is responsible for ensuring both the clinical information and the integrity of the ongoing relationship are communicated and maintained.

3.1.2 Commitment to the caring relationship

The central portion of the framework represents the commitment to the relationship between the nurse and the recipient of care, be that the individual patient and/or family (see Table 1). This relationship is built on a set of values that are made explicit through the following statements, from both parties drawn from the work of the Institute of Health Improvement (see Table 2) but resonant with several other patient-centred care reviews (Kitson et al 2013a):

Table 2 Commitment to the caring relationship

Patient statements **(acknowledging the need for help and their own vulnerability and potential loss of control)**	**Nurse statements** **(commitment in this initial encounter and acknowledging the potential anxiety and fear of loss of control the patient may experience)**
'Be nice to me' Treat me as a person and respect and involve me in my care	***'I will be nice to you'*** I will commit to treating you as a person and will respect you and involve you in your care
'Keep me safe' I trust you to have the right knowledge, skill and expertise to know how to keep me from any harm	***'I will keep you safe'*** I will commit to acknowledging to you if I do not feel competent and confident to protect you from harm
'Help me to heal' Base your care on my individual physical and emotional needs and help me to set goals that maintain my hope and spirit to get better and to feel better	***'I will help you to heal'*** I will base my care of you on your individual physical and emotional needs and will work with you to set goals that maintain your hope and spirit to get better and to feel better

3.1.3 Establishing the assessment process

Following the initial encounter, the nurse enacts this commitment (see Table 2) by assessing the following areas of need, actively engaging the patient and drawing on their perspective of what it means to be ill (what's wrong with me?), why they have had to seek care (where am I?) and what support they will need (what do I need help with and what can I ask for help with?). This assessment is not a formal clinical nursing assessment of the patient; it is more about establishing the trust and shared understanding of the patient's worldview in order for the nurse to be able to provide the right type and level of support as the relationship develops (see Table 3).

Table 3 Establishing the assessment process

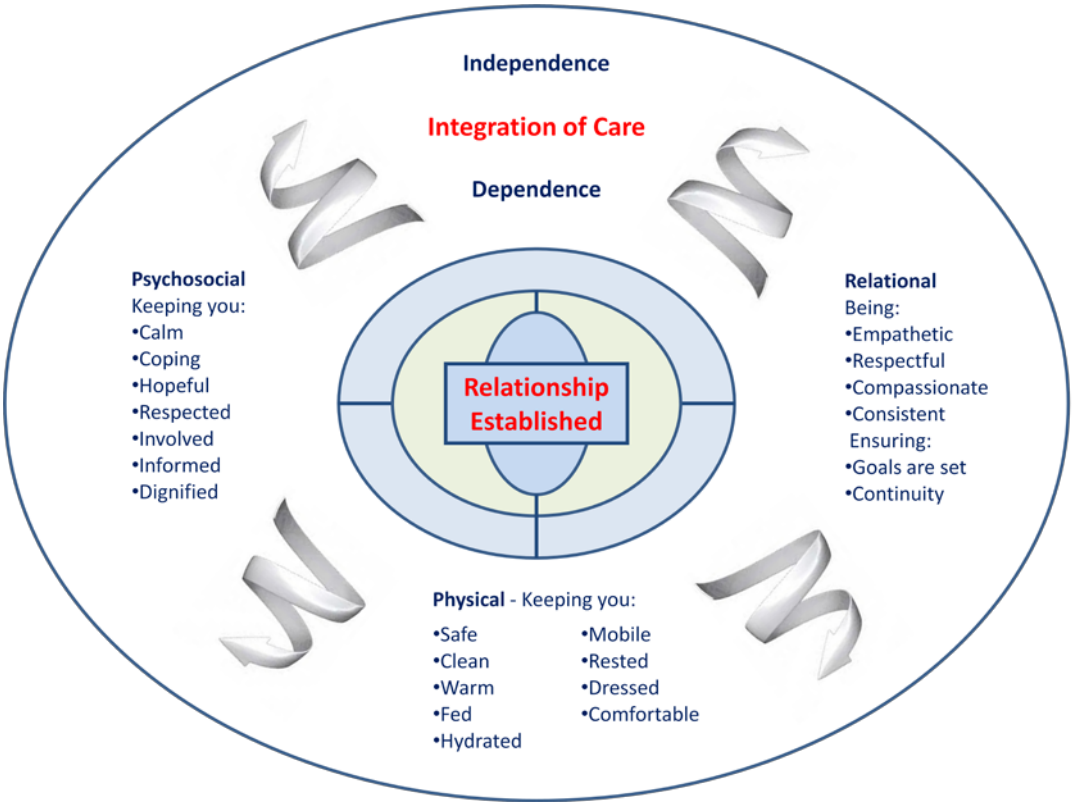
Patient questions	Nurse responses
Where am I?	***Welcome to X; my name is Y and I will be caring for you…***
This addresses the environment or location where the patient finds themselves	The nurse actively seeks to settle and reassure the patient, addressing them by their preferred title and helping them to settle
What's wrong with me?	***Can you tell me a bit about how you have been feeling lately and why you think are here?***
This addresses the physiological and psychological needs the patient may have	The nurse can assess the patient's level of understanding of their clinical condition
What do I need help with?	***Tell me how you normally look after yourself and whether there are things you would like me to help you with?***
This addresses the self care needs of the patient exploring the private world of how they normally would look after themselves and any anxieties they may have about their loss of independence	In this interaction the nurse can ascertain both the potential need for support and how the patient is likely to react to needing help

3.2 The Fundamentals of Care Framework: Integration of Care

From the initial stage of establishing the relationship, the patient's journey is characterised by the nurse and the patient working together to integrate the fundamentals of care. There are three significant aspects of the encounter to integrate: the ongoing relationship; the physical, psychosocial and the relational aspect of the care itself; and finally the negotiation of the patient's journey from dependence to independence or managing dependence (see Figure 3). This translates to nurses directly delivering care, facilitating independence or return to optimal wellbeing and coordinating care.

It is also acknowledged that some patients will stay dependent or become more dependent during the encounter and these possibilities also have to be managed in respectful, dignified ways. Similarly, many patients may have cognitive impairment or communication difficulties and as a result of these factors might place greater demands on the nurse and the need to draw on other parties to achieve the integration of care.

Figure 3 The Fundamentals of Care Framework: Integration of care



The dynamic being described in this part of the framework is the patient's journey from potentially being totally dependent upon the nurse to help them with all their fundamental of care needs to the patient being fully independent and autonomous in their self care needs. The role of the nurse in this part of the framework would be to undertake an assessment with the patient of their fundamental care needs and then develop a joint plan that would help the patient move from dependence to independence (or acknowledged support) where the nurse would take on more of a facilitating and co-coordinating role, helping, educating, supporting the patient and/or other members of their immediate caring network to perform the self-care activities to a safe and acceptable standard. If the patient remained fully dependent then the role of the nurse would be to work with them and their wider caring network to ensure ongoing safe, dignified, respectful care.

The assessment process for the fundamentals of care involves three dimensions: the physical needs of the patient; their psychosocial needs and finally an assessment of the type of relationship between the nurse and the patient, established to meet the patient's needs. This relationship is distinct from the initial encounter. The first encounter (described in Figure 2) is a reflection of the general commitment and standards of engagement between a professional nurse and their client. At the fundamental of care level, the nurse is more deliberate and methodical in the way they will support the fundamental care needs of their patient. They will use the three dimensions of physical, psychosocial and relational interaction to help them co-create the individualised care plan with the patient (Table 4).

Table 4 The three dimensions of the Fundamentals of Care

Patient Perspective	Nurse Perspective
Physical includes keeping me safe, warm, clean, fed, dressed, comfortable and pain free, rested, mobile and hydrated	***Physical*** includes keeping you safe, warm, clean, fed, dressed, comfortable, rested, mobile and hydrated
Psychosocial means keeping me able to cope, calm, respected, involved, dignified, understood and informed	***Psychosocial*** means keeping you able to cope, calm, respected, involved, dignified, understood and informed
Relational means feeling that I am part of the team, involved, respected, and supported. I can ask the questions I need to ask and don't feel embarrassed or stupid. I feel that I am being helped along this journey by nurses who understand and empathise with me	***Relational*** encompasses being empathetic, respectful and compassionate, being consistent, ensuring continuity across delivery, facilitation and coordination of care and facilitating goal setting. These relational activities will occur between the nurse and patient, the nurse and the nurse, the nurse and the team and the nurse and the other healthcare providers

For the nurse and patient this part of the journey is about setting realistic targets and goals for recovery and optimal independence and wellbeing (mindful that not all patients will achieve independence). It is also about ensuring the integrity between the physical, psychosocial and relational aspects of every experience of care. One humiliating experience a patient may have (e.g. being incontinent because a nurse has failed to respond to a call bell or missing a meal because the patient could not reach the food) will undermine the trust and confidence the patient has in the nurse and detract from their belief that the environment is one that is helping them get better. These very real challenges lead to the final part of the framework: the outer circle – the context in which care is enacted.

3.3 The Fundamentals of Care Framework: Contextual Factors

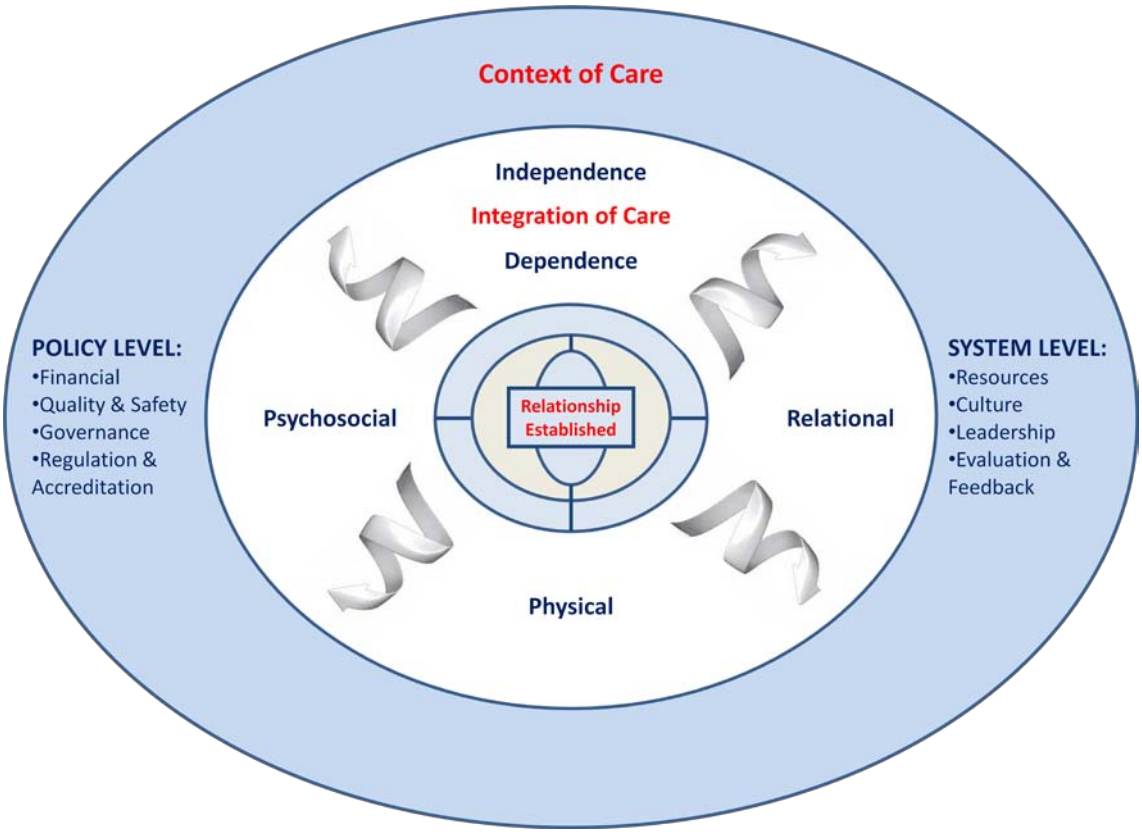
The rationale of the fundamentals of care framework is that if the initial relationship between the nurse and patient is established, and if a positive rapport is established, then the likelihood of the patient's fundamental care needs being met in a consistent, appropriate way is greater. This means that one of the key factors – the ability of the nurse to establish the relationship is addressed. However, we know that an equally important influencer is context. This will now be addressed.

The quality of the nurse patient relationship is as dependent upon the wider contextual factors within the healthcare system as it is upon the skill, commitment and abilities of the individual nurse. Evidence demonstrates the link between quality patient care and quality nursing staffing systems (Needleman et al 2006; Maben et al 2012). Therefore, in order for the Fundamentals of Care Framework to deliver on its commitments to patient centred care; there are a number of conditions that are required at both the system and policy level. None of these elements are novel. What is novel in this debate is the need for every healthcare system to engage its nursing workforce together with

its patients in determining how it chooses to allocate its resources to provide high quality care around the fundamental needs of patients.

Figure 4 identifies contextual factors at the system level and at the policy level which will enable the delivery of FOCs:

Figure 4 The Fundamentals of Care: Contextual Factors



3.3.2 Contextual factors: system level enablers

Four main types of system level enablers have been identified:

- ***Resources*** – this includes physical resources in terms of environment, equipment, infrastructure as well as human resources including skill mix and staffing.
- ***Culture*** – this encompasses the values and norms of the system and in particular seeks explicit statements about the goals of the organisation, how staff are respected and valued; and the organisation's explicit commitment to innovation and learning (both formal and informal education).
- ***Leadership*** – this relates to the explicit and implicit styles of leadership that are promoted in the organisation; how enabling leadership is; how roles are defined and supported and how staff are mentored and coached.
- ***Evaluation and feedback*** – this requires processes at individual, team and organisational levels that provide feedback in a supportive, constructive way. It also requires patient sensitive metrics around the FOCs and staff sensitive metrics that measure fatigue, burnout and other signs of staff stress.

Important in this debate is to frame the sorts of questions that nurses and patients need to ask managers, leaders and policy makers at each level of the system. Table 5 summarises the sorts of questions patients and nurses needs to ask about how resources are being utilised.

Table 5 Contextual factors: System level enablers

Patient Perspective	Nurse Perspective
Resources	***Resources***
Do you have the right environment, equipment and staff numbers here to keep me safe and help me get better?	Part of my commitment to you is to keep you safe, care for you and help you get better. I will ensure that you are in the right place to recover and that we support you with the right people and equipment.
Culture	***Culture***
Do you value caring for people like me? How does the organisation care for you?	Our organisation is committed to providing patient centred care. We do this by... Our organisation is committed to caring for all our staff. We do this by...
Leadership	***Leadership***
How do I know who's in charge? Can I trust them to keep me safe?	My job is to enable you to feel secure and comfortable in your recovery. You will be told about our nursing leaders and will be introduced to our lead nurses, doctors and other members of the healthcare team.
Evaluation and feedback	***Evaluation and feedback***
How do I know I'm getting better? If I want to give feedback on my experience how do I do this?	There are a series of regular feedback processes where we look at individual patient care (and you are involved in this), care for the unit, care around certain clinical indicators and broader performance measures. All of this information is publically available to staff and patients. It is about creating a learning environment where we set targets based on feedback on how we are performing. Your views and feedback are really important to us.

3.3.4 Contextual factors: policy enablers

A broader set of factors can influence the health system. These are government, regulatory, political and financial factors. Often perceived to be beyond the direct influence or control of the individual nurse or patient, they nonetheless need to be identified and discussed in the ongoing debate about improving the fundamentals of care.

Table 6 summarises the main areas and the sorts of conversations patients and nurses might have around these issues.

Table 6 Contextual factors: Policy enablers

Patient Perspective	Nurse Perspective
Financial incentives	***Financial incentives***
How do I know that the money invested in health is really going to the right places?	How does nursing ensure that the financial models used to drive performance are based on the values of patient centred care and delivering high quality personalised service?
Quality and safety agendas	***Quality and safety agendas***
Where do I get information about the safety and quality record of this organisation and how can I be reassured that it is a good place to be cared for?	Our nursing quality and safety systems are based on the best evidence around nursing sensitive patient outcome indicators. This tells you about how well nursing is delivering the fundamentals of care.
Governance processes and accountability	***Governance processes and accountability***
How do you deal with complaints from staff and or patients? How do you deal with whistleblowers? Who will listen to me about what I want and how I think things could be better? Who can help me if I feel I am not being included in my care?	Our organisation is committed to providing patient centred care. Our nursing leadership at all levels of the organisation seeks feedback from patients, relatives and staff on matters around fundamentals of care. We are keen to work with you to ensure that you feel involved and consulted in your own care and the care of your loved ones.
Regulation and Accreditation	***Regulation and Accreditation***
How would I be able to tell how well this organisation is performing compared to other similar health care organisations?	We view accreditation and regulation processes as positive ways of receiving feedback on our performance. We work with all members of the healthcare team to ensure the process is a positive, learning one

Viewed in this way, the conversations nurses and patients can have about some of the wider policy issues could shape and influence strategic planning and accountability processes within the health system.

4. The Fundamentals of Care Action Plan

Having outlined the core elements of the framework, we want to describe the action which we believe will both test and refine the framework as well as move the Fundamentals of Care agenda forward.

There are four key stakeholder groups that need to consider what action they may take. These include: clinicians and managers; educators; researchers and policy makers. Tables 7-10 summarise this and the call to action.

Table 7 The Fundamentals of Care Action Plan: Clinicians and Managers

Who takes action	What do they need to do	Specific Actions
Clinicians **managers**	Articulate importance of the fundamentals of care work	Link fundamentals of care to organisational Key Performance Indicators (KPIs) Link to PCC and quality agenda Identify cost of getting FOC wrong Ensure overall strategic alignment of FOC with organisational goals by targeting the healthcare facility board and the senior executive team
	Define the role of nursing within the healthcare facility	At all levels of nursing: Identify the impact each nursing role has for patients Create job descriptions, role accountability and performance metrics to reinforce centrality of FOC within nursing roles
	Refine recruitment and selection process to focus on delivery of the FOC	Interview processes and values assessment based on a philosophy of patient centred care for all nursing staff
	Develop integrated (academic/clinical/research) roles that facilitate the effective delivery of the FOC	Identify and develop role models and mentors Have coaching systems The healthcare system to facilitate the

		exploration of FOC delivery
	Develop nurses capability with inductive and deductive reasoning and other critical thinking approaches to embrace the FOC	Explore experiential learning in the workplace and integrate such methods into CPD initiatives Use narrative based enquiry Identify ways to share these sources of learning
	Develop tools and measures to determine the effect of the above on delivery of the FOC	Competency tools Assessment tools that tap into physical, psycho-social and relational needs of the patient Use of intentional rounding and bedside handover Reflective practice Patient story telling Direct observation of care Local audits Staff satisfaction/wellbeing Patient involvement Nurse to patient communication, nurse to family communication, nurse to nurse communication, nurse to HC team communication Link knowledge translation strategies to FOC delivery, know how to prioritise care
	Contribution of senior nursing leaders	Develop and recognise role modelling of FOC delivery Responsibility to 'sell' FOC to frontline nursing staff Shift focus from 'clock time' to 'narrative time' for understanding patients experiences Facilitate the value of patient narrative to inform FOC delivery
	Provide inspirational leadership	The critical nature of personal and interpersonal aspects of care should be emphasised by ward/team leaders whose role is vital in delivering and maintaining care standards.

		Value reflection and reflective stories Using continuous feedback on FOC to identify solutions and to overcome any problems Celebrate successes Assist nurses to embody and understand what nursing is all about
	Redesign the nursing day to include fundamentals of care	The time and activities around establishing the relationship and integrating the care need to be institutionalised and integrated into the work routine

Table 8 The Fundamentals of Care Action Plan: Educators

Who	What	Specific Action
Educators	How FOC are integrated into undergraduate and postgraduate nursing curricula	How are the FOC taught in terms of inductive and deductive reasoning Further exploration of mentor/clinical facilitator roles. Role of clinical simulation in enhancing/impeding of PCC delivery and the FOC
	Explore student recruitment procedures	Explore how prospective students interpret patient narratives in terms of metaphor and layers of understanding
	Develop appropriate tools and techniques for education re the FOC	Putting yourself in the patient's position, patient experiences How to educate nurses and professionals to understand and pay attention to the first person experience of illness and to work in partnership

Table 9 The Fundamentals of Care Action Plan: Researchers

Who	What	Specific Action
Research and policy; the case for research funding	Develop a framework for research into the FOC	Identify approaches to be used, e.g. case study, nurses' experiences, patient experience Use of existing nurse sensitive indicators linked to FOC to inform research Development of a new range of tools fit for the purpose of evaluating the delivery of the FOC will be required Mapping the boundaries of the FOC may be facilitated by exploring concepts such as 'missed care' Explore the use of existing frameworks such as Medical Research Council complex interventions framework Patients/service users need to be involved in developing tools to measure patient experience/care quality Evaluate the effectiveness of workforce preparation and explore how staff maintain appropriate values and approaches to care in challenging environments
	Undertake a scoping review of the FOC	What is the state of the science around the key elements of the FOC? The focus should be on the factors that promote positive care experiences, gathering evidence to explain and translate these to reduce the variability
	Feasibility/intervention studies	What are the 'easy wins' to start to map the evidence base around the FOC, e.g. analysing patient complaints or quality data already in the public domain across collaborating sites
	International research collaboration	Build on existing relationships from ILC Explore the feasibility of doctoral and post doctoral student exchanges for FOC research collaborative Continue to build links with patient experience work such as HEXI to continue to embed patient voices in FOC research

Table 10 The Fundamentals of Care Action Plan: Policy Makers

Who	What	Specific Action
Chief Nursing Office at national, regional and state level	National Framework to align financial incentives and fundamentals of care	Explore the role of accountability frameworks and funding models in the health system in allowing/hindering the adoption of FOC principles and practice.
Policy makers	Play a role in developing/identifying the appropriate levers to ensure that the FOC can be met in practice	Policy makers should adopt a facilitative rather than a dictatorial stance by disseminating best practice and emphasising the standards to be achieved and the responsibility of providers for both planning and delivering better outcomes for service users and staff. How to raise awareness around dysfunctional behaviours and stop them from shaping care environments and practices How to keep empathy alive in industrial conditions of work
		Find hooks into the broader agendas for health care improvement in each country. In the US, the hooks are payment reform emphasising pay for performance and pay for quality, efforts to bundle payment for accountable care organisations and patient centred medical homes, and the research agenda of the Patient Centred Outcomes Research Institute (PCORI). Do these incentive approaches translate to other health systems?

5. Summary

This paper is the product of two intensive days debating the Fundamentals of Care and nursing's contribution to the patient centred care agenda. Challenged by many distressing stories, we were also inspired and energised by accounts of compassionate, respectful, transformative care around the fundamentals. We do not believe 'getting it right' 24 x 7 x 365 days a year is a simple or straight forward thing to do, hence our action plan. We would like you to think about the content of this short paper and then come and work with us to transform care.

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7. Appendices

Appendix 1: Fundamentals of Care Delegate List

Day 1 and 2 Attendee List: 18-19 June

Participant	Organisation	ILC (√) affiliation
Alison Kitson (facilitator)	University of Adelaide/University of Oxford	√
Ann Ewens	Oxford Brookes University	x
Eva Jangland	Uppsala University, Sweden	√
Jack Needleman	UCLA, Los Angeles	√
Jane Merkley	Bridgepoint Health Canada	√
Jenny Gordon	Royal College of Nursing	x
Kerry Kuluski (rapporteur)	Bridgepoint Health Canada	√
Lena Gunningberg	Uppsala University, Sweden	√
Lianne Jeffs	Keenan Research Center, Toronto	√
Louise Lucock (facilitator)	Oxford University	H
Maria Bovall	University of Gothenburg, Sweden	√
Nancy Donaldson	UCSF Center of Evidence-based Patient Care and Quality Improvement	√
Paul Yerrell (rapporteur)	Baker IDI, Adelaide Australia	√
Renee Lyons	Bridgepoint Health Canada	√
Sarah Kagan	University of Pennsylvania	√
Tiffany Conroy (rapporteur)	University of Adelaide	√
Yvonne Wengstrom	Karolinska Institute, Sweden	√

Day 1 Attendee List: 18 June

Participant	Organisation	ILC (√) affiliation
Amanda Sherlock	Care Quality Commission	x
Anne-Marie Rafferty	Kings College, London	√
Annette Bartley		x
Caroline Shuldham	Royal Brompton & Harefield NHS Foundation Trust	√
Elaine Strachan-Hall	Oxford University Hospitals Trust	√
Emily Ang	National University Cancer Institute	√
Gigi Yebra	Oxford University Hospitals Trust	x
Jackie Bridges	University of Southampton	x
Jill Maben	Kings College London	x
Joanna Goodrich	Point of Care Programme, King's Fund	x
Jocelyn Cornwell	Point of Care Programme	x
Katherine Murphy	The Patients Association	x
Liz Westcott	Oxford Brookes University	√
Martin Westwood	Oxford University Hospital Trust	x
Sue Dopson	Oxford University	H
Suzanne Shale	Oxford University	H
Tom Sandford	Royal College of Nursing	x
Win Tadd	Cardiff University	x

Appendix 2: Fundamentals of Care Template

Source: Kitson et al (2010)

Fundamental of Care	Patient Experience
Safety, prevention and medication	
Communication and education	
Respiration	
Eating and drinking	
Elimination	
Personal cleansing and dressing	
Temperature control	
Rest and sleep	
Comfort (including pain management)	
Dignity	
Privacy	
Respecting choice	
Mobility	
Expressing sexuality	