BMJ Open

BMJ Open is committed to open peer review. As part of this commitment we make the peer review history of every article we publish publicly available.

When an article is published we post the peer reviewers' comments and the authors' responses online. We also post the versions of the paper that were used during peer review. These are the versions that the peer review comments apply to.

The versions of the paper that follow are the versions that were submitted during the peer review process. They are not the versions of record or the final published versions. They should not be cited or distributed as the published version of this manuscript.

BMJ Open is an open access journal and the full, final, typeset and author-corrected version of record of the manuscript is available on our site with no access controls, subscription charges or pay-per-view fees (http://bmjopen.bmj.com).

If you have any questions on BMJ Open's open peer review process please email info.bmjopen@bmj.com

BMJ Open

Speaking Up for Fundamental Care: A Position Statement from the 2019 International Learning Collaborative (ILC) Meeting, Aalborg, Denmark

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2019-033077.R1
Article Type:	Communication
Date Submitted by the Author:	25-Jul-2019

Complete List of Authors:	Kitson, Alison; Flinders University, College of Nursing and Health Sciences Carr, Devin; Michigan Medicine, University Hospital and Frankel Cardiovascular Center Conroy, Tiffany ; Flinders University, College of Nursing and Health Sciences Feo, Rebecca; Flinders University, College of Nursing and Health Sciences Grønkjær, Mette; Aalborg University, Department of Clinical Medicine; Aalborg University Hospital, Clinical Nursing Research Unit Huisman-de Waal, Getty; Radboud Universiteit Jackson, Debra; University of Technology Sydney Jeffs, Lianne; Sinai Health System, Lunenfeld-Tananbaum Research Institute; University of Toronto, Lawrence S. Bloomberg Faculty of Nursing Merkley, Jane; Sinai Health System; University of Toronto, Lawrence S. Bloomberg Faculty of Nursing Muntlin Athlin, Åsa; Uppsala University; Uppsala University Hospital Parr, Jennifer; Counties Manukau District Health Board Richards, David; University of Exeter, Medical School Sørensen, Erik; Aalborg University Hospital, Clinical Nursing Research Unit; Aalborg University, Department of Clinical Medicine Wengström, Yvonne; Karolinska Institutet, Neurobiology Care Science and Society, Nursing

Primary Subject Heading:	Nursing
Secondary Subject Heading:	Nursing
Keywords:	Health & safety < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Quality in health care < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, HEALTH SERVICES ADMINISTRATION & MANAGEMENT

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 **Title page**
4
5
6
7
8 **Title**: Speaking Up for Fundamental Care: A Position Statement from the 2019 International Learning
9
10 Collaborative (ILC) Meeting, Aalborg, Denmark
11
12
13
14 **Authors**
15
16
17 Alison Kitson
18
19 College of Nursing and Health Sciences, Flinders University, Adelaide, SA, Australia
20
21
22
23 Devin Carr
24
25
26 University Hospital and Frankel Cardiovascular Center, Michigan Medicine, Ann Abor, MI, US
27
28
29
30 Tiffany Conroy
31
32 College of Nursing and Health Sciences, Flinders University, Adelaide, SA, Australia
33
34
35
36
37 Rebecca Feo
38
39 College of Nursing and Health Sciences, Flinders University, Adelaide, SA, Australia
40
41
42
43 Mette Gronkjaer
44
45
46 Department of Clinical Medicine, Aalborg University and Clinical Nursing Research Unit, Aalborg
47
48 University Hospital, Aalborg, Denmark
49
50
51
52 Getty Huisman-de Waal
53
54
55 Radboud University Medical Center, Radboud Institute for Health Sciences, IQ Healthcare, Nijmegen,
56
57 The Netherlands
58
59
60

For peer review only

Debra Jackson

Faculty of Health, University of Technology, Sydney, Australia

Lianne Jeffs

Lunenfeld-Tananbaum Research Institute, Sinai Health System, Toronto, Canada

Jane Merkley

Lunenfeld-Tananbaum Research Institute, Sinai Health System, Toronto, Canada

Åsa Muntlin Athlin

Department of Emergency Care and Internal Medicine, Uppsala University Hospital, and Department of Medical Sciences, Uppsala University, Uppsala, Sweden

Jenny Parr

Manukau District Health Board, Auckland, New Zealand

David Richards

College of Medicine and Health, University of Exeter, Exeter, UK

Erik Sørensen

Aalborg university and Aalborg University Hospital, Aalborg, Denmark

Yvonne Wengström

Division of Neurobiology Care Science and Society, Nursing, Karolinska Institutet and Radiumhemmet, Karolinska University Hospital, Stockholm, Sweden

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Corresponding author

Name: Alison Kitson

Postal address: GPO Box 2100, Adelaide 5001, South Australia

Email: alison.kitson@flinders.edu.au

Telephone: +61 8 82013492

Keywords: nursing care, health care quality, patient care

Word count (excluding title page, abstract and references): 2436

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Abstract

Objective. The International Learning Collaborative (ILC) is an organization dedicated to understanding why fundamental care fails to be provided in healthcare systems globally. At its 11th annual meeting in 2019, nursing leaders from 11 countries, together with patient representatives, confirmed that patients' fundamental care needs are still being ignored and nurses are still afraid to 'speak up' when these care failures occur. Whilst the ILC's efforts over the past decade have led to increased recognition of the importance of fundamental care, it is not enough. To generate practical and sustainable solutions to this wicked problem, we need to substantially rethink fundamental care and its contribution to patient outcomes and experiences, staff wellbeing, safety and quality, and the economic viability of our healthcare systems.

Key arguments. We present five propositions for radically transforming fundamental care delivery:

1. Value: Fundamental care must be foundational to all caring activities, systems and institutions
2. Talk: Fundamental care must be explicitly articulated in all caring activities, systems and institutions
3. Do: Fundamental care must be explicitly actioned and evaluated in all caring activities, systems and institutions
4. Own: Fundamental care must be owned by each individual who delivers care, who works in a system that is responsible for care or who works in an institution whose mission is to deliver care
5. Research: Fundamental care must undergo systematic and high-quality investigations to generate the evidence needed to inform care practices and shape health systems and education curricula

For peer review only

Conclusion. To achieve radical transformation within health systems globally, we must move beyond nursing and ensure all members of the healthcare team – educators, students, consumers, clinicians, leaders, researchers, policy-makers, and politicians – value, talk, do, own and research fundamental care. It is only through coordinated, collaborative effort that we will, and must, initiate and sustain real change.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

THE 'WICKED PROBLEM'

One would think, with all the resources health systems continue to put into safety and quality initiatives; the implementation of more patient-centred care policies; and the proliferation of agencies to regulate and demand better fundamental care for patients (such as the Care Quality Commission in the UK), that the tide would be turning. However, this still does not seem to be the case, as illustrated by recent reports of continued poor practices.[1] A nurse turning away from a patient in a single episode of suffering is worrying in itself. However; when this action becomes the norm, when it is tolerated and even normalised within teams and institutions, it is necessary to reflect critically on why patients are treated in such dehumanising ways.[2]

The International Learning Collaborative (ILC) is an organisation set up to understand why fundamental care fails to be provided in our healthcare systems. At its 11th annual meeting in 2019, hosted by Aalborg University and Aalborg University Hospital in Denmark, nursing leaders from 11 countries, together with patient representatives, confirmed that fundamental care is still failing to be delivered consistently. Patients are still being ignored and 'commodified' and nurses are still afraid of 'speaking up' when fundamental care failures happen.

Personal experiences from nursing colleagues and patients outlining fundamental care breeches were all too readily available. One nurse recounted her story of being in an Emergency Department caring for a patient who needed a CT scan. The patient had to be moved to the X-ray department and then to a ward. Before this happened, he was incontinent of urine, soaking the bed and himself. The nurse went to find clean linen and pyjamas but was told by the nurse-in-charge that there was no time to do this as the department would fail its 4-hour discharge target if there was a delay. She ignored the instruction from the nurse-in-charge, instead meeting the patient's fundamental care needs, but was made to feel she had done something wrong. Another nurse told the story of her father-in-law who lost several kilos in weight over the course of a 10-day stay in hospital. He was

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

discharged frail, weak and vulnerable, with no guidance or support offered to the patient and family. Even as a nurse she felt unable to challenge what was happening to him.

Patient representatives at the meeting confirmed that these types of dehumanising actions were familiar to them. One cancer survivor spoke about having survived but was traumatised by the experience of care. Another survivor recounted a conversation with a nurse who, when starting chemotherapy, said to the patient that if it had been her, she would not have agreed to the treatment. These stories resonated with nursing leaders attending the ILC meeting from Australia, New Zealand, Japan, Iceland, Norway, Sweden, Denmark, the Netherlands, Canada, the US, and the UK.

This would seem to indicate that we continue to have a problem; not an isolated one, but one that has infected every health system globally. It would also seem that we cannot solve it by doing more of the same. We need to rethink fundamental care and its contribution to patient and staff wellbeing, patient safety and quality, and the economic viability of our healthcare systems.

THE PROPOSED SOLUTION…

In addition to trying to understand the reasons for the fundamental care failures in our healthcare systems, at the ILC meeting we worked on finding different ways of addressing the issue, moving to practical and sustainable solutions. We identified five essential ingredients needed for this transformation. These are presented as five propositions:

1. Value Fundamental Care: Fundamental care is foundational to all caring activities, systems and institutions
2. Talk Fundamental Care: Fundamental care must be explicitly articulated in all caring activities, systems and institutions

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

3. Do Fundamental Care: Fundamental care must be explicitly actioned and evaluated in all caring activities, systems and institutions
4. Own Fundamental Care: Fundamental care must be owned by each individual who delivers care, who works in a system that is responsible for care or who works in an institution whose mission is to deliver care
5. Research Fundamental Care: Fundamental care must undergo systematic, high-quality investigations to generate the evidence needed to inform care practices and shape health systems and education curricula

1. Value Fundamental Care

The ILC has been systematically developing definitions around fundamental care[3] and has developed an evidence-based framework[4, 5] to help nurses implement fundamental care in a more consistent way. The Fundamentals of Care Framework consists of three dimensions: nurse-patient relationship; integration of physical, psychosocial and relational elements of care; and consideration of the context where that care happens.[5]

Our argument is that regardless of clinical condition, age, acuity, complexity, or care setting, every patient will require their fundamental care needs to be assessed and met for them to be safe and to recover optimally. Current failures in our health systems, including the poor level of remuneration for nurses delivering fundamental care, are directly related to the lack of value placed on fundamental care as a foundational cornerstone to safety and quality.

Our proposal is that if executive boards and shareholders in caring and healthcare businesses recognised and acknowledged the importance of fundamental care to their financial success, then appropriate systems and processes would be put in place, and would be more effective and efficient, leading to improved patient outcomes and better staff satisfaction.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

2. **Talk Fundamental Care**

Only after executive leaders and shareholders understand the value of delivering fundamental care consistently to all patients (customers) will the language of fundamental care be more readily accepted and understood. Commonly, nursing care patient notes are regarded as 'fluffy notes', rarely referred to by other members of the healthcare team. The 'knowledge hierarchy' cascades from the medical to allied health notes and finally to nursing notes (where some aspects of patients' fundamental care needs are recorded). Consequently, nursing activities tend to relate to risk assessments, safety reports or concerns over clinical/medical activity.

This reality carries with it profound risks both to patients and nurses. When nothing or very little about fundamental care is documented in patients' records then it is impossible to tell what has been provided and what has not. Electronic patient records do not solve this problem as they have been constructed within the medical hierarchy, hence fundamental care is still invisible.

Our argument is that by using the core elements of the Fundamentals of Care Framework (relationship, integration of care and context), we can generate consistent and meaningful summaries of patients' fundamental care needs. By investing in infrastructure and workflow systems that comprehensively record patients' fundamental care needs we will be able to document what interventions were undertaken and what impact they had. Then we will be able to teach fundamental care more consistently, addressing the 'theory-practice' gap that still exists.[6]

Our proposal is to extend the complex mapping work needed to generate consistent terminology around fundamental care and how it is documented, and to invite interdisciplinary colleagues, managers and educators to engage in this dialogue.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

3. Do Fundamental Care

Having fundamental care valued by organisations and having done the work around conceptual frameworks, terminology and education, we then need to commit to making fundamental care happen in a consistent, safe, person-centred way for all patients, independent of care setting. This will require a significant shift in culture for many nurses (and every other member of the care team). Traditionally, nurses have been rewarded for the speed with which they can accomplish multiple tasks within rigid timeframes. This 'task and time' mentality is the antithesis to the values of fundamental care delivery based on relationship and integration.[5] How whole nursing teams (and consequently interdisciplinary care teams) must re-design their fundamental care delivery systems will be a huge transformational activity. It will require re-design teams to work collaboratively with nurses, patients and other key stakeholders to turn fundamental caring systems and processes 'up-side-down.' It will also require the development of standardised ways of measuring fundamental care that are embedded in patient records and can inform risk assessments, safety, quality and outcome metrics.[7]

Our argument is that because the 'task and time' culture is so deeply embedded in nursing and healthcare culture, there needs to be a paradigm shift in work processes related to fundamental care delivery. We must move from a 'task and time' mentality to a 'thinking and linking' mental model, where registered nurses are able to integrate and coordinate patients' fundamental care with their other care needs across their healthcare experience.[8]

Our proposal is to call for collaborating healthcare organisations and universities to work with the ILC to systematically and rigorously undertake this transformation, generating evidence of impact through cultural change and the development of appropriate measures as we work together to improve patients' fundamental care experiences.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

4. Own Fundamental Care

We have to ask ourselves what would healthcare organisations look like if we put fundamental care at the centre of all that we do. Certainly, there are flagship institutions where patients are satisfied with their care, where nurses feel happy and fulfilled in their caring roles and where medical and quality-of-life outcomes are exemplary. However, these are the exception rather than the rule and we need urgently to own the agenda to make fundamental care more visible in our health systems. There are many practical things we can do such as ensuring fundamental care stories (good and bad) are presented to executive board members and to local and national politicians; having fundamental care elements explicitly embedded in policies, safety and quality standards, educational standards and research tenders; and making sure that nursing leaders globally speak up for fundamental care.

Yet, we know that in many countries, nursing is facing severe shortages. Nurses are leaving the profession, citing burn out and stress as reasons[9] Many talk about the disappointment and disillusionment of wanting to care for patients in an holistic way but being unable to do this in the systems in which they work. Increasingly, international research is identifying that what nurses prioritise is technical care over fundamental care, which leads to missed care[10, 11] or, worst case scenario, patient neglect or harm.[12]

However, workforce shortages cannot be an excuse for failure to address fundamental care needs. Neither can the mantra of busyness. Fundamental care is core to nursing values and nursing work. Nurses should not be 'too busy' to deliver it. Devaluing fundamental care and its importance devalues nursing and its importance. The notion that core nursing work can be performed by cadres of lower-educated care assistants is only burying the problem. This might solve a workforce shortage but it will increase the risk of harm to our patients. Our recent ILC meeting reflected the concern that patients also have with these issues. As stated by one of the patient representatives at the

For peer review only

1
2
3 meeting: more nurses are not the only answer – there needs to be a total redesign of how
4
5 fundamental care is valued in the system.[see also 1]
6
7
8
9
10 ### 5. Research Fundamental Care
11
12 Recent reports have identified poor fundamental care practices with care being standardised and
13
14 patients being objectified (see Journal of Clinical Nursing Special Issue on *Fundamental Care: The*
15
16 *Last Evidence-free Zone,* 2018, https://onlinelibrary.wiley.com/toc/13652702/2018/27/11-12).
17
18 Fundamental care tends to be devalued, and the delivery of safe, person-centred care is challenged.
19
20 Although studies have stressed that nursing care is important for patient safety, recovery and
21
22 positive patient experiences,[13, 14] there is a pressing need to generate studies that demonstrate the
23
24 effects and benefits of fundamental care in order to strengthen the evidence base. For example, in a
25
26 recent systematic review,[15] the authors note in their quality appraisal of 149 experimental studies
27
28 into nursing care for nutrition, hygiene, toileting and mobility, that all but 13 studies had significant
29
30 biases and only one had clear practice implications for delivering fundamental care in routine
31
32 nursing care environments.
33
34
35
36
37
38 We also need systematically to evaluate the re-design of care delivery systems that put the patient
39
40 and their fundamental care needs at the centre. We need sound economic evaluation of the
41
42 investment required and off set that with improvements in health outcomes, throughput, and safety
43
44 and quality indicators. We need to research how we teach fundamental care to our nursing
45
46 students[16-20] and we need to understand how fundamental care is embedded in our policies and
47
48 legislation at national and local levels.[21]
49
50
51
52
53
54 Our argument is that the current problems healthcare systems are facing could be solved by more
55
56 investment in research programs that investigate how to deliver high-quality fundamental care in
57
58 multiple contexts and how to embed this evidence into future nursing (and other) healthcare
59
60

For peer review only

curricula. There are some exemplars of this, including the Basic Care Revisited research program in the Netherlands,[22] the fundamental care theme of the National Institute for Health Research's Collaboration for Leadership in Applied Health Research and Care Wessex,[23] and the pioneering work of ILC members (see Journal of Clinical Nursing Special Issue), but this work needs to be scaled up and coordinated in a way that will start to offer solutions to healthcare systems sooner rather than later. We must stop wasting tax payers' money in every country by thinking fundamental care failures can be fixed by (at best) naive or (at worst) knee-jerk policy initiatives that do not address the underlying problems.

Our proposal is to work with national governments, national and international nursing associations, healthcare organisations, research funding bodies and universities to generate a collaborative research and implementation program on fundamental care.

THE CALL TO ACTION

We need to recognise the profoundly complex nature of the challenge facing all healthcare systems globally. We need to acknowledge that how we are trying to fix the problem is not working and we need to think differently. We need a call to action that connects the valuing, talking, doing, owning and researching of fundamental care.

Whilst the ILC has grown in recent years, now totalling more than 200 members from 21 countries, and making significant inroads, it is clear we cannot do it alone. And whilst other commentators have identified the need for action around 'reconciliation, refocus and research'[1, p.151] on fundamental care, we need a more concerted, explicit approach.

For the Call to Action to work we must move beyond nursing and involve all members of the healthcare team: educators; students; consumers; clinicians; executives, managers and leaders;

For peer review only

1
2
3 researchers; policy-makers; the general public and politicians. We must all work together to initiate
4
5 and sustain real change and must do so in a coordinated, collaborative way.
6
7
8
9
10 Our proposal therefore is precisely the Call to Action for Fundamental Care.
11
12
13
14 If you want to Value, Talk, Do, Own and Research Fundamental Care, please contact us at
15
16
17 intlearningcollaborative@gmail.com or https://intlearningcollab.org/
18
19
20
21 **Contributorship statement**
22
23 AK, DC, TC, RF, MG, GH, DJ, JP, ES and YW all made substantial contributions to the conception and
24
25
26 design of the manuscript and its central argument during the ILC 2019 meeting.
27
28 AK drafted the initial manuscript.
29
30 AK, DC, RF, MG, GH, DJ, LJ, JM, AMA, DR, ES and YW all contributed to drafting of the manuscript and
31
32
33 critical revision of its intellectual content.
34
35 AK, DC, TC, RF, MG, GH, DJ, LJ, JM, AMA, JP, DR, ES and YW all approved the manuscript for
36
37 publication and agreed to be accountable for all aspects of the work, including ensuring that
38
39 questions related to the accuracy or integrity of any part of the work are appropriately investigated
40
41 and resolved.
42
43
44
45
46 **Competing interests**
47
48 None declared
49
50
51
52
53 **Funding**
54
55 The authors have not declared a specific grant for this research from any funding agency in the
56
57 public, commercial or not-for-profit sectors.
58
59
60

For peer review only

References

1. Richards DA, Borglin G. 'Shitty nursing' – The new normal? *Int J Nurs Stud*2019;91:148-52.

2. Hutchinson M, Jackson D. Troubling fragments and small stories: An analysis of public commentary on nursing through a web blog. *Collegian*2014;21:81-8.

3. Feo R, Conroy T, Jangland E, et al. Towards a standardised definition for fundamental care: A modified Delphi study. *J Clin Nurs*2018;27:2285-99.

4. Feo R, Conroy T, Alderman J, et al. Implementing fundamental care in clinical practice. *Nurs Stand*2017;31:52-62.

5. Kitson A, Conroy T, Kuluski K, et al. 2013. Reclaiming and redefining the Fundamentals of Care: Nursing's response to meeting patients' basic human needs. Adelaide, South Australia: School of Nursing, The University of Adelaide.

6. MacMillan K. The hidden curriculum: What are we actually teaching about the fundamentals of care? *Can J Nurs Leadersh*2016;26:37-46.

7. Jeffs L, Muntlin Athlin A, Needleman J, et al. Building the foundation to generate a fundamental care standardised data set. *J Clin Nurs*2018;27:2481-8.

8. Kitson A, Muntlin Athlin Å, Conroy T. Anything but Basic: Nursing's Challenge in Meeting Patients' Fundamental Care Needs. *J Nurs Scholarsh*2014;46:331-9.

9. Sasso L, Bagnasco A, Catania G, et al. Push and pull factors of nurses' intention to leave. *J Nurs Manage*2019;27:946-54.

10. Mandal L, Seethalakshmi A. Experience of prioritizing in nursing care in India: A qualitative study. *Indian Journal of Public Health Research and Development*2019;10:103-7.

11. Jones TL, Hamilton P, Murry N. Unfinished nursing care, missed care, and implicitly rationed care: State of the science review. *Int J Nurs Stud*2015;52:1121-37.

12. Gillespie A, Reader TW. Patient-Centered Insights: Using Health Care Complaints to Reveal Hot Spots and Blind Spots in Quality and Safety. *Milbank Q*2018;96:530-67.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

13. Griffiths P, Maruotti A, Recio Saucedo A, et al. Nurse staffing, nursing assistants and hospital mortality: Retrospective longitudinal cohort study. *BMJ Qual Saf*2018;28:609-17.

14. Aiken LH, Sloane D, Griffiths P, et al. Nursing skill mix in European hospitals: Cross-sectional study of the association with mortality, patient ratings, and quality of care. *BMJ Qual Saf*2017;26:559-68.

15. Richards DA, Hilli A, Pentecost C, et al. Fundamental nursing care: A systematic review of the evidence on the effect of nursing care interventions for nutrition, elimination, mobility and hygiene. *J Clin Nurs*2018;27:2179-88.

16. Jangland E, Mirza N, Conroy T, et al. Nursing Students' understanding of the Fundamentals of Care: A cross-sectional study in five countries. *J Clin Nurs*2018;27:2460-72.

17. Feo R, Donnelly F, Frensham L, et al. Embedding fundamental care in the pre-registration nursing curriculum: Results from a pilot study. *Nurse Educ Pract*2018;31:20-8.

18. Feo R, Frensham L, Conroy T, et al. "It's just common sense": Preconceptions and myths regarding fundamental care. *Nurse Educ Pract*2019;36:82-4.

19. Huisman G, Feo R, Vermeulen H, et al. Students' perspectives on basic nursing care education. *J Clin Nurs*2018;27:2450-9.

20. Alderman J, Kastelein C, Feo R, et al. Prioritizing the fundamentals of care within pre-licensure nursing curriculum. *Journal of Nursing Education*2018;57.

21. Parr JM, Bell J, Koziol-McLain J. Evaluating fundamentals of care: The development of a unit-level quality measurement and improvement programme. *J Clin Nurs*2018;27:2360-72.

22. Zwakhalen SMG, Hamers JPH, Metzelthin SF, et al. Basic nursing care: The most provided, the least evidence based – A discussion paper. *J Clin Nurs*2018;27:2496-505.

23. Ball J, Ballinger C, De longh A, et al. Determining priorities for research to improve fundamental care on hospital wards. *Research Involvement and Engagement*2016;2:1-17.

For peer review only

BMJ Open

Speaking Up for Fundamental Care: A Position Statement from the 2019 International Learning Collaborative (ILC) Meeting, Aalborg, Denmark

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2019-033077.R2
Article Type:	Communication
Date Submitted by the Author:	15-Oct-2019
Complete List of Authors:	Kitson, Alison; Flinders University, College of Nursing and Health Sciences Carr, Devin; Michigan Medicine, University Hospital and Frankel Cardiovascular Center Conroy, Tiffany ; Flinders University, College of Nursing and Health Sciences Feo, Rebecca; Flinders University, College of Nursing and Health Sciences Grønkjær, Mette; Aalborg University, Department of Clinical Medicine; Aalborg University Hospital, Clinical Nursing Research Unit Huisman-de Waal, Getty; Radboud Universiteit Jackson, Debra; University of Technology Sydney Jeffs, Lianne; Sinai Health System, Lunenfeld-Tananbaum Research Institute; University of Toronto, Lawrence S. Bloomberg Faculty of Nursing Merkley, Jane; Sinai Health System; University of Toronto, Lawrence S. Bloomberg Faculty of Nursing Muntlin Athlin, Åsa; Uppsala University, Department of Medical Sciences; Uppsala University Hospital, Department of Emergency Care and Internal Medicine Parr, Jennifer; Counties Manukau District Health Board Richards, David; University of Exeter, Medical School Sørensen, Erik; Aalborg University Hospital, Clinical Nursing Research Unit; Aalborg University, Department of Clinical Medicine Wengström, Yvonne; Karolinska Institutet, Neurobiology Care Science and Society, Nursing; Karolinska University Hospital, Theme Cancer
Primary Subject Heading:	Nursing
Secondary Subject Heading:	Nursing
Keywords:	Health & safety < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Quality in health care < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, HEALTH SERVICES ADMINISTRATION & MANAGEMENT

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Title page

Title: Speaking Up for Fundamental Care: A Position Statement from the 2019 International Learning Collaborative (ILC) Meeting, Aalborg, Denmark

Authors

Alison Kitson

College of Nursing and Health Sciences, Flinders University, Adelaide, Australia

Devin Carr

University Hospital and Frankel Cardiovascular Center, Michigan Medicine, Ann Abor, US

Tiffany Conroy

College of Nursing and Health Sciences, Flinders University, Adelaide, Australia

Rebecca Feo

College of Nursing and Health Sciences, Flinders University, Adelaide, Australia

Mette Grønkjær

Department of Clinical Medicine, Aalborg University and Clinical Nursing Research Unit, Aalborg University Hospital, Aalborg, Denmark

Getty Huisman-de Waal

Radboud University Medical Center, Radboud Institute for Health Sciences, IQ Healthcare, Nijmegen, The Netherlands

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Debra Jackson

Faculty of Health, University of Technology Sydney, Sydney, Australia

Lianne Jeffs

Lunenfeld-Tananbaum Research Institute, Sinai Health System, Toronto, Canada

Jane Merkley

Lunenfeld-Tananbaum Research Institute, Sinai Health System, Toronto, Canada

Åsa Muntlin Athlin

Department of Emergency Care and Internal Medicine, Uppsala University Hospital, and Department of Medical Sciences, Uppsala University, Uppsala, Sweden; College of Nursing and Health Sciences, Flinders University, Adelaide, Australia

Jenny Parr

Counties Manukau District Health Board, Auckland, New Zealand

David A Richards

College of Medicine and Health, University of Exeter, Exeter, UK

Erik Elgaard Sørensen

Department of Clinical Medicine, Aalborg University and Clinical Nursing Research Unit, Aalborg University Hospital, Aalborg, Denmark

Yvonne Wengström

For peer review only

Division of Neurobiology Care Science and Society, Nursing, Karolinska Institutet and Theme Cancer,

Karolinska University Hospital, Stockholm, Sweden

Corresponding author

Name: Alison Kitson

Postal address: GPO Box 2100, Adelaide 5001, South Australia

Email: alison.kitson@flinders.edu.au

Telephone: +61 8 82013492

Keywords: nursing care, health care quality, patient care

Word count (excluding title page, abstract and references): 2822

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Abstract

Objective. The International Learning Collaborative (ILC) is an organization dedicated to understanding why fundamental care, the care required by all patients regardless of clinical condition, fails to be provided in healthcare systems globally. At its 11th annual meeting in 2019, nursing leaders from 11 countries, together with patient representatives, confirmed that patients' fundamental care needs are still being ignored and nurses are still afraid to 'speak up' when these care failures occur. Whilst the ILC's efforts over the past decade have led to increased recognition of the importance of fundamental care, it is not enough. To generate practical, sustainable solutions, we need to substantially rethink fundamental care and its contribution to patient outcomes and experiences, staff wellbeing, safety and quality, and the economic viability of healthcare systems.

Key arguments. We present five propositions for radically transforming fundamental care delivery:

1. Value: Fundamental care must be foundational to all caring activities, systems and institutions
2. Talk: Fundamental care must be explicitly articulated in all caring activities, systems and institutions
3. Do: Fundamental care must be explicitly actioned and evaluated in all caring activities, systems and institutions
4. Own: Fundamental care must be owned by each individual who delivers care, works in a system that is responsible for care or works in an institution whose mission is to deliver care
5. Research: Fundamental care must undergo systematic and high-quality investigations to generate the evidence needed to inform care practices and shape health systems and education curricula

Conclusion. For radical transformation within health systems globally, we must move beyond nursing and ensure all members of the healthcare team – educators, students, consumers, clinicians,

For peer review only

leaders, researchers, policy-makers, and politicians – value, talk, do, own and research fundamental care. It is only through coordinated, collaborative effort that we will, and must, achieve real change.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

THE 'WICKED PROBLEM'

One would think, with all the resources health systems continue to put into safety and quality initiatives; the implementation of more person-centred care policies; and the proliferation of agencies to regulate and demand better fundamental care for patients (e.g., Care Quality Commission in the UK, US Agency for Healthcare Research and Quality, and Australian Commission on Safety and Quality in Health Care), that the tide would be turning. However, this does not seem to be the case, as illustrated by recent reports of continued poor practices.[1] A nurse turning away from a patient in a single episode of suffering is worrying in itself. However; when this action becomes the norm, when it is tolerated and even normalised within teams and institutions, it is necessary to reflect critically on why patients are treated in such dehumanising ways,[2] and what can be done to ensure patients receive safe, dignified care for their fundamental needs.

The International Learning Collaborative (ILC) is an organisation set up to understand why fundamental care fails to be provided in our healthcare systems. At its 11th annual meeting in 2019, hosted by Aalborg University and Aalborg University Hospital in Denmark, nursing leaders from 11 countries, together with patient representatives, confirmed that fundamental care is still failing to be delivered consistently. Patients are still being ignored and 'commodified' and nurses are still afraid of 'speaking up' when fundamental care failures happen.

Personal experiences from nursing colleagues and patients outlining fundamental care breeches were all too readily available. One nurse recounted her story of being in an Emergency Department caring for a patient who needed a CT scan. The patient had to be moved to the X-ray department and then to a ward. Before this happened, the patient was incontinent of urine, soaking the bed and himself. The nurse went to find clean linen and pyjamas but was told by the nurse-in-charge that there was no time to do this as the department would fail its 4-hour discharge target if there was a delay. The nurse ignored the instruction from the nurse-in-charge, instead meeting the patient's

For peer review only

fundamental care needs, but was made to feel she had done something wrong. Another nurse told the story of her father-in-law who lost several kilos in weight over the course of a 10-day hospital stay. He was discharged frail, weak and vulnerable, with no guidance or support offered to the patient and family. Even as a nurse, she felt unable to challenge what was happening to him.

Patient representatives at the meeting confirmed that these types of dehumanising actions were familiar to them. One cancer survivor spoke about having survived but was traumatised by the experience of care. Another survivor recounted a conversation with a nurse who said to the patient, when about to start chemotherapy, that if it had been her, she would not have agreed to the treatment. These stories resonated with nursing leaders attending the ILC meeting from Australia, New Zealand, Japan, Iceland, Norway, Sweden, Denmark, the Netherlands, Canada, the US, and the UK. These stories are also strongly supported by existing empirical evidence, spanning more than a decade of research, regarding patients' views and experiences of care across a range of healthcare settings and systems.[3, 4] This research demonstrates the central importance that patients place on their relationships with care providers, and the need for nurses to display not only technical competence in relation to physical aspects of healthcare but also relational competence, where patients' psychosocial needs are integrated and addressed in every episode of care.[5-12]

This existing evidence – both empirical and anecdotal – would seem to indicate that we continue to have a problem; not an isolated one, but one that has infected every health system globally. It would also seem that we cannot solve it by doing more of the same. We need to rethink fundamental care and its contribution to patient and staff wellbeing, patient safety and quality, and the economic viability of our healthcare systems.

THE PROPOSED SOLUTION…

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

In addition to trying to understand the reasons for the fundamental care failures in our healthcare systems, at the 2019 ILC meeting we worked on finding different ways of addressing the issue, moving to practical and sustainable solutions. We identified five essential ingredients needed for this transformation. These are presented as five propositions:

1. Value Fundamental Care: Fundamental care must be foundational to all caring activities, systems and institutions
2. Talk Fundamental Care: Fundamental care must be explicitly articulated in all caring activities, systems and institutions
3. Do Fundamental Care: Fundamental care must be explicitly actioned and evaluated in all caring activities, systems and institutions
4. Own Fundamental Care: Fundamental care must be owned by each individual who delivers care, who works in a system that is responsible for care or who works in an institution whose mission is to deliver care
5. Research Fundamental Care: Fundamental care must undergo systematic, high-quality investigations to generate the evidence needed to inform care practices and shape health systems and education curricula

1. **Value Fundamental Care**

The ILC has been systematically developing definitions around fundamental care[13] and has developed an evidence-based framework[14, 15] to help nurses implement fundamental care in a more consistent way. The Fundamentals of Care Framework consists of three core dimensions. These are: 1) the development of a positive, trusting relationship between the nurse (or other care provider) and patient; 2) integrating and attending to, in every episode of care, a patient's physical (e.g., nutrition), psychosocial (e.g., dignity) and relational needs (e.g., empathy); and 3) being cognizant of how the context in which care takes place can facilitate or hinder the accomplishment of the first two activities, working to mitigate or enhance these impacts where possible.[15]

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Our argument is that regardless of clinical condition, age, acuity, complexity, or care setting, every patient will require their fundamental care needs to be assessed and met for them to be safe and to recover optimally. Current failures in our health systems, including the poor level of remuneration for nurses delivering fundamental care, are directly related to the lack of value placed on fundamental care as a foundational cornerstone to safety and quality.

Our proposal is that if executive boards and shareholders in caring and healthcare businesses recognised and acknowledged the importance of fundamental care to their financial success, then appropriate systems and processes would be put in place, and would be more effective and efficient, leading to improved patient outcomes and better staff satisfaction.

2. Talk Fundamental Care

Only after executive leaders and shareholders understand the value of delivering fundamental care consistently to all patients (customers) will the language of fundamental care be more readily accepted and understood. Commonly, nursing care patient notes are regarded as ‘fluffy notes’, rarely referred to by other members of the healthcare team.[16] The ‘knowledge hierarchy’ cascades from the medical to allied health notes and finally to nursing notes (where some aspects of patients’ fundamental care needs are recorded). Consequently, nursing activities tend to relate to risk assessments, safety reports or concerns over clinical/medical activity.

This reality carries with it profound risks to both patients and nurses. When nothing or very little about fundamental care is documented in patients’ records, it is impossible to tell what has been provided and what has not. Electronic patient records do not solve this problem as they have been constructed within the medical hierarchy, hence fundamental care is still invisible.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Our argument is that by using the core dimensions of the Fundamentals of Care Framework (relationship, integration of care and context), we can generate consistent and meaningful summaries of patients' fundamental care needs. By investing in infrastructure and workflow systems that comprehensively record these needs, we will be able to document what interventions were undertaken and what impact they had. Then we will be able to teach fundamental care more consistently, addressing the ever-present 'theory-practice' gap.[17]

Our proposal is to extend the complex mapping work needed to generate consistent terminology around fundamental care and how it is documented, and to invite interdisciplinary colleagues, managers and educators to engage in this dialogue.

For peer review only

3. Do Fundamental Care

Having fundamental care valued by organisations and having done the work around conceptual frameworks, terminology and education, we then need to commit to making fundamental care happen in a consistent, safe, person-centred way for all patients, independent of care setting. This will require a significant shift in culture for many nurses (and every other member of the care team). Traditionally, nurses have been rewarded for the speed with which they can accomplish multiple tasks within rigid timeframes. This 'task and time' mentality is the antithesis to the values of fundamental care delivery based on relationship and integration of care.[15] How whole nursing teams (and consequently interdisciplinary care teams) must re-design their fundamental care delivery systems will be a huge transformational activity. It will require re-design teams to work collaboratively with nurses, patients, and other key stakeholders to turn fundamental caring systems and processes 'up-side-down.' It will also require the development of standardised ways of measuring fundamental care that are embedded in patient records and can inform risk assessments and safety, quality and outcome metrics.[18]

Our argument is that because the 'task and time' culture is so deeply embedded in nursing and healthcare, there needs to be a paradigm shift in work processes related to fundamental care delivery. We must move from a 'task and time' mentality to a 'thinking and linking' mental model, where nurses are able to integrate and coordinate patients' fundamental and other care needs across their healthcare experience.[19] To be effective, this shift must occur at all levels of healthcare systems: the micro level (e.g., in nurses' attitudes, behaviours and everyday interactions with patients), meso level (e.g., in the culture and policy of a single organization, including at a unit/ward level) and macro level (e.g., in national health policies and nursing accreditation standards for clinical practice and education). This shift is crucial if healthcare systems worldwide are to achieve the goal of person-centred care, which is at risk of becoming merely rhetoric. Delivering high-quality fundamental care is a key prerequisite for working with patients in a person-centred way. If we are to move beyond mere rhetoric, healthcare professionals must have the tools to achieve person-centred fundamental care in practice and to move their care delivery from a series of tasks to a coordinated, integrated, relationship-centred healthcare encounter.

Our proposal is to call for collaborating healthcare organisations and universities to work with the ILC to systematically and rigorously undertake this transformation, generating evidence of impact through cultural change and the development of appropriate measures as we work together to improve patients' fundamental care experiences.

4. Own Fundamental Care

We must ask ourselves what would healthcare organisations look like if we put fundamental care at the centre of all that we do. Certainly, there are flagship institutions where patients are satisfied with their care, where nurses feel happy and fulfilled in their caring roles and where medical and quality-of-life outcomes are exemplary. However, these are the exception rather than the rule and we need urgently to own the agenda to make fundamental care more visible in our health systems.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

There are many practical things we can do such as ensuring fundamental care stories (good and bad) are presented to executive board members and to local and national politicians; having fundamental care explicitly embedded in policies, safety and quality standards, educational standards and research tenders; and making sure that nursing leaders globally speak up for fundamental care.

Yet, we know that in many countries, nursing is facing severe shortages due to issues such as poor recruitment into the profession and poor retention during nursing education and early career employment; an ageing population, which is creating greater demand for health services; an ageing nursing workforce; and strategic understaffing of registered nurses within healthcare systems in a bid to reduce healthcare costs.[20-22] Perhaps most worrying, the shortage is also underpinned by many nurses' decision to leave the profession, citing burnout, stress, understaffing, high workloads, minimal job satisfaction, emotional exhaustion, and poor patient safety as reasons.[23-28] Many nurses talk about the disappointment and disillusionment of wanting to care for patients in an holistic way but being unable to do this in the systems in which they work.[29] Increasingly, and perhaps unsurprisingly, international research is identifying that what many nurses prioritise is technical care over fundamental care,[30] which leads to missed care[30, 31] or, worst case scenario, patient neglect or harm.[32-34]

However, workforce shortages cannot be an excuse for failure to address fundamental care needs. Neither can the mantra of busyness. Fundamental care is core to nursing values and nursing work. Nurses should not be 'too busy' to deliver it. Devaluing fundamental care and its importance devalues nursing and its importance. The notion that core nursing work can be performed by cadres of lower-educated care assistants is only burying the problem. This might solve a workforce shortage but it will increase the risk of harm to our patients. Our recent ILC meeting reflected the concern that patients also have with these issues. As stated by one of the patient representatives at the

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

meeting: more nurses are not the only answer – there needs to be a total redesign of how fundamental care is valued in the system.[see also 1]

5. Research Fundamental Care

Recent reports have identified poor fundamental care practices with care being standardised and patients being objectified (see Journal of Clinical Nursing Special Issue on *Fundamental Care: The Last Evidence-free Zone,* 2018, https://onlinelibrary.wiley.com/toc/13652702/2018/27/11-12). Fundamental care tends to be devalued, and the delivery of safe, person-centred care is challenged.[35] Although studies have stressed that nursing care is important for patient safety, recovery and positive patient experiences,[36, 37] there is a pressing need to generate studies that demonstrate the benefits of fundamental care in order to strengthen the evidence base. For example, in a recent systematic review,[38] the authors note in their quality appraisal of 149 experimental studies into nursing care for the fundamentals of nutrition, hygiene, toileting and mobility, that all but 13 studies had significant biases and only one had clear practice implications for delivering fundamental care in routine nursing care environments.

For peer review only

We also need systematically to evaluate the re-design of care delivery systems that put the patient and their fundamental care needs at the centre. We need sound economic evaluation of the investment required and off set that with improvements in health outcomes, throughput, and safety and quality indicators. We need to research how we teach fundamental care to nursing students[39-43] and we need to understand how fundamental care is embedded in policies and legislation at national and local levels.[44]

Our argument is that the current problems healthcare systems are facing could be solved by more investment in research programs that investigate how to deliver high-quality fundamental care in multiple contexts and how to embed this evidence into nursing (and other) healthcare curricula.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

There are some exemplars of this, including the Basic Care Revisited research program in the Netherlands,[45] the fundamental care theme of the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care Wessex,[46] and the pioneering work of ILC members (see Journal of Clinical Nursing Special Issue), but this work needs to be scaled up and coordinated in a way that will start to offer solutions to healthcare systems sooner rather than later. We must stop wasting tax payers' money in every country by thinking fundamental care failures can be fixed by (at best) naive or (at worst) knee-jerk policy initiatives that do not address the underlying problems.

Our proposal is to work with national governments, healthcare organisations, research funding bodies, universities, and national and international nursing associations, to generate a collaborative research and implementation program on fundamental care.

THE CALL TO ACTION

We need to recognise the profoundly complex nature of the challenge facing all healthcare systems globally. We need to acknowledge that how we are trying to fix the problem is not working and we need to think differently. We need a call to action that connects the valuing, talking, doing, owning and researching of fundamental care.

Whilst the ILC has grown in recent years, now totalling more than 240 members from 22 countries, and making significant inroads, it is clear we cannot do it alone. And whilst other commentators have identified the need for action around 'reconciliation, refocus and research'[1, p.151] on fundamental care, we need a more concerted, explicit approach.

For the Call to Action to work we must move beyond nursing and involve all members of the healthcare team: educators; students; consumers; clinicians; executives, managers and leaders;

For peer review only

researchers; policy-makers; the general public and politicians. We must all work together to initiate and sustain real change and must do so in a coordinated, collaborative way.

Our proposal therefore is precisely the Call to Action for Fundamental Care.

If you want to Value, Talk, Do, Own and Research Fundamental Care, please contact us at intlearningcollaborative@gmail.com or https://intlearningcollab.org/

Contributorship statement

AK, DC, TC, RF, MG, GH, DJ, JP, ES and YW all made substantial contributions to the conception and design of the manuscript and its central argument during the ILC 2019 meeting.

AK drafted the initial manuscript.

AK, DC, RF, MG, GH, DJ, LJ, JM, AMA, DR, ES and YW all contributed to drafting of the manuscript and critical revision of its intellectual content.

AK, DC, TC, RF, MG, GH, DJ, LJ, JM, AMA, JP, DR, ES and YW all approved the manuscript for publication and agreed to be accountable for all aspects of the work, including ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Competing interests

None declared

Funding

The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Acknowledgements

The authors would like to thank the patient representatives at ILC 2019 – Morten Klessen and Birgitte Schouw Pedersen – for sharing their experiences.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

References

1. Richards DA, Borglin G. 'Shitty nursing' – The new normal? *Int J Nurs Stud*2019;91:148-52.

2. Hutchinson M, Jackson D. Troubling fragments and small stories: An analysis of public commentary on nursing through a web blog. *Collegian*2014;21:81-8.

3. Jangland E, Kitson A, Muntlin Athlin Å. Patients with acute abdominal pain describe their experiences of fundamental care across the acute care episode: A multi-stage qualitative case study. *J Adv Nurs*2016;72:791-801.

4. Blakey E, Jackson D, Walthall H, et al. What is the experience of being readmitted to hospital for people 65 years and over? A review of the literature. *Contemp Nurse*2017;53:698-712.

5. Feo R, Donnelly F, Muntlin Athlin A, et al. Providing high-quality fundamental care for patients with acute abdominal pain: A qualitative study of patients' experiences in acute care. *J Health Organ Manag*2019;33:110-23.

6. Corbin J. Is caring a lost art in nursing? *Int J Nurs Stud*2008;45:163-5.

7. Bridges J, Flatley M, Meyer J. Older people's and relatives' experiences in acute care settings: Systematic review and synthesis of qualitative studies. *Int J Nurs Stud*2010;47:89-107.

8. Kitson A, Dow C, Calabrese JD, et al. Stroke survivors' experiences of the fundamentals of care: A qualitative analysis. *Int J Nurs Stud*2013;50:392-403.

9. Kuluski K, Hoang SN, Schaink AK, et al. The care delivery experience of hospitalized patients with complex chronic disease. *Health Expectations*2013;16:e111-e23.

10. Robert G, Cornwell J, Brearly S, et al. 2011. What matters to patients? Developing the evidence base for measuring and improving patient experience. . Coventry, UK: University of Warwick.

For peer review only

11. Sharp S, McAllister M, Broadbent M. The vital blend of clinical competence and compassion: How patients experience person-centred care. *Contemp Nurse*2016;52:300-12.

12. Muntlin Athlin Å, Brovall M, Wengström Y, et al. Descriptions of Fundamental Care needs in cancer care – An exploratory study. *J Clin Nurs*2018;27:2322-32.

13. Feo R, Conroy T, Jangland E, et al. Towards a standardised definition for fundamental care: A modified Delphi study. *J Clin Nurs*2018;27:2285-99.

14. Feo R, Conroy T, Alderman J, et al. Implementing fundamental care in clinical practice. *Nurs Stand*2017;31:52-62.

15. Kitson A, Conroy T, Kuluski K, et al. 2013. Reclaiming and redefining the Fundamentals of Care: Nursing's response to meeting patients' basic human needs. Adelaide, South Australia: School of Nursing, The University of Adelaide.

16. Hripcsak G, Vawdrey DK, Fred MR, et al. Use of electronic clinical documentation: Time spent and team interactions. *Journal of the American Medical Informatics Association*2011;18:112-7.

17. MacMillan K. The hidden curriculum: What are we actually teaching about the fundamentals of care? *Can J Nurs Leadersh*2016;26:37-46.

18. Jeffs L, Muntlin Athlin A, Needleman J, et al. Building the foundation to generate a fundamental care standardised data set. *J Clin Nurs*2018;27:2481-8.

19. Kitson A, Muntlin Athlin Å, Conroy T. Anything but Basic: Nursing's Challenge in Meeting Patients' Fundamental Care Needs. *J Nurs Scholarsh*2014;46:331-9.

20. Buchan J, Duffield C, Jordan A. 'Solving' nursing shortages: Do we need a New Agenda? *J Nurs Manage*2015;23:543-5.

For peer review only

21. Flinkman M, Salanterä S. Early career experiences and perceptions - a qualitative exploration of the turnover of young registered nurses and intention to leave the nursing profession in Finland. *J Nurs Manage*2015;23:1050-7.

22. Health Workforce Australia. 2012. Health workforce 2025. Doctors, nurses and midwives. Vol. 1. Canberra: Australian Government.

23. Sasso L, Bagnasco A, Catania G, et al. Push and pull factors of nurses' intention to leave. *J Nurs Manage*2019;27:946-54.

24. Heinen MM, van Achterberg T, Schwendimann R, et al. Nurses' intention to leave their profession: A cross sectional observational study in 10 European countries. *Int J Nurs Stud*2013;50:174-84.

25. Jiang H, Ma L, Gao C, et al. Satisfaction, burnout and intention to stay of emergency nurses in Shanghai. *Emerg Med J*2017;34:448-53.

26. Lee YW, Dai YT, McCreary LL. Quality of work life as a predictor of nurses' intention to leave units, organisations and the profession. *J Nurs Manage*2015;23:521-31.

27. Leone C, Bruyneel L, Anderson JE, et al. Work environment issues and intention-to-leave in Portuguese nurses: A cross-sectional study. *Health Policy*2015;119:1584-92.

28. Halter M, Boiko O, Pelone F, et al. The determinants and consequences of adult nursing staff turnover: A systematic review of systematic reviews. *BMC Health Serv Res*2017;17.

29. Eley R, Eley D, Rogers-Clark C. Reasons for entering and leaving nursing: An Australian regional study. *Australian Journal of Advanced Nursing*2010;28:6-13.

30. Mandal L, Seethalakshmi A. Experience of prioritizing in nursing care in India: A qualitative study. *Indian Journal of Public Health Research and Development*2019;10:103-7.

31. Jones TL, Hamilton P, Murry N. Unfinished nursing care, missed care, and implicitly rationed care: State of the science review. *Int J Nurs Stud*2015;52:1121-37.

For peer review only

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

32. Gillespie A, Reader TW. Patient-Centered Insights: Using Health Care Complaints to Reveal Hot Spots and Blind Spots in Quality and Safety. *Milbank Q*2018;96:530-67.

33. Ball JE, Bruyneel L, Aiken LH, et al. Post-operative mortality, missed care and nurse staffing in nine countries: A cross-sectional study. *Int J Nurs Stud*2018;78:10-5.

34. Ball JE, Murrells T, Rafferty AM, et al. Care left undone during nursing shifts: Associations with workload and perceived quality of care. *BMJ Qual Saf*2014;23:116-25.

35. Feo R, Kitson A. Promoting patient-centred fundamental care in acute healthcare systems: A discussion paper. *Int J Nurs Stud*2016;57:1-11.

36. Griffiths P, Maruotti A, Recio Saucedo A, et al. Nurse staffing, nursing assistants and hospital mortality: Retrospective longitudinal cohort study. *BMJ Qual Saf*2018;28:609-17.

37. Aiken LH, Sloane D, Griffiths P, et al. Nursing skill mix in European hospitals: Cross-sectional study of the association with mortality, patient ratings, and quality of care. *BMJ Qual Saf*2017;26:559-68.

38. Richards DA, Hilli A, Pentecost C, et al. Fundamental nursing care: A systematic review of the evidence on the effect of nursing care interventions for nutrition, elimination, mobility and hygiene. *J Clin Nurs*2018;27:2179-88.

39. Jangland E, Mirza N, Conroy T, et al. Nursing Students' understanding of the Fundamentals of Care: A cross-sectional study in five countries. *J Clin Nurs*2018;27:2460-72.

40. Feo R, Donnelly F, Frensham L, et al. Embedding fundamental care in the pre-registration nursing curriculum: Results from a pilot study. *Nurse Educ Pract*2018;31:20-8.

41. Feo R, Frensham L, Conroy T, et al. "It's just common sense": Preconceptions and myths regarding fundamental care. *Nurse Educ Pract*2019;36:82-4.

42. Huisman G, Feo R, Vermeulen H, et al. Students' perspectives on basic nursing care education. *J Clin Nurs*2018;27:2450-9.

For peer review only

43. Alderman J, Kastelein C, Feo R, et al. Prioritizing the fundamentals of care within pre-licensure nursing curriculum. *Journal of Nursing Education*2018;57.

44. Parr JM, Bell J, Koziol-McLain J. Evaluating fundamentals of care: The development of a unit-level quality measurement and improvement programme. *J Clin Nurs*2018;27:2360-72.

45. Zwakhalen SMG, Hamers JPH, Metzelthin SF, et al. Basic nursing care: The most provided, the least evidence based – A discussion paper. *J Clin Nurs*2018;27:2496-505.

46. Ball J, Ballinger C, De Iongh A, et al. Determining priorities for research to improve fundamental care on hospital wards. *Research Involvement and Engagement*2016;2:1-17.

For peer review only