

Factors Influencing Nurses' Delivery of the Fundamentals of Care in Acute Hospital Wards

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Declaration

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List of related publications and presentations

Publications

Conroy, T 2017 A beginner's guide to ethnographic observation in nursing research, *Nurse Researcher*, vol. 24, no. 4, pp. 10-14.

Conroy, T, 2018 Factors influencing the delivery of the fundamentals of care: Perceptions of nurses, nursing leaders and healthcare consumers, *Journal of Clinical Nursing*, DOI: 10.1111/jocn.14183, online ahead of print issue.

Presentations

Conroy, T, 2013 Factors influencing nurses' delivery of the Fundamentals of Care, *University of Adelaide Faculty of Health Sciences Research Seminar, Adelaide South Australia* (Poster Presentation)

Conroy, T, 2014 Reclaiming and redefining the Fundamentals of Care: Nursing's response to the patient-centred care agenda. Nursing's challenge in meeting patients' fundamental care needs, *RCN International Nursing Research Conference, Glasgow, Scotland, April* (Oral Presentation).

Conroy, T, 2014 Factors influencing nurses' delivery of the Fundamentals of Care in the Acute hospital setting, *International Learning Collaborative Summit, Oxford, England, June* (Oral Presentation).

Conroy, T, 2015 Factors influencing nurses' delivery of the Fundamentals of Care in the Acute hospital setting, *Nurse and Midwives Research Symposium, Adelaide, South Australia, May* (Oral presentation).

Conroy, T, 2017 Factors influencing nurses' delivery of the Fundamentals of Care, *International Learning Collaborative Summit, Uppsala, Sweden, June* (Oral Presentation).

Abstract

Background

There is an ongoing challenge facing the nursing profession in ensuring that the ‘basics’ of care are carried out optimally. These ‘basics’ or ‘fundamentals’ - which include ensuring appropriate nutrition, hydration, personal hygiene, sleep, rest and dignity to name but a few - traditionally have been the responsibility of the nurse on behalf of the healthcare team. There is evidence from patients, the public and nurses themselves that the nursing profession has not been able to provide quality basic nursing – or the fundamentals of care – as consistently or adequately as needed. The Fundamentals of Care Framework was developed to illustrate the need to develop a trusting nurse-patient relationship and to integrate the patients physical, psychosocial and relational needs. However, there had not yet been an empirical exploration of the factors that influence nurses’ delivery of the fundamentals of care. This study aimed to address this gap.

Aim and research questions

The aim of the study was to explore the factors that facilitate or hinder the delivery of the fundamentals of care in the acute care setting by answering the following questions:

- What factors are observed to influence the delivery of the fundamentals of care in an acute care hospital?
- What factors do nurses working in an acute care hospital describe as influencing the delivery of the fundamentals of care?
- What factors do patient representatives from an acute care hospital describe as influencing the delivery of the fundamentals of care?

Methods

A focused ethnography, utilising a three-stage iterative approach was undertaken. Stage 1 consisted of direct observation of nurse-patient interactions related to the delivery of the fundamentals of care in the acute care setting. Stage 2 involved focus groups of patient representatives and nurses to explore their respective perceptions of factors influencing the delivery of the fundamentals of care using scenarios derived from stage 1 as a prompt. Stage 3 involved interviews with clinically based nursing leaders to explore their strategies for moderating some of the factors influencing the delivery of the fundamentals of care.

Findings and Conclusions

Complex interactions between and among the physical, relational, psychosocial and contextual elements involved in delivering the fundamentals of care were observed. Although each focus group provided its own perspective on the factors influencing the delivery of the fundamentals of care, there was consistency in the factors they described. These factors include the influence of the nurse-patient relationship, nursing leadership and the context of care delivery. Also described was the importance of involving patients and ensuring they understand their care, while respecting their care choices. Other factors include the need for good communication and the ability to negotiate priorities for care while recognising the specific care needs and characteristics of the patient. The influence of nursing leadership on these and other factors was noted and explored with clinical nursing leaders. This enabled the generation of an empirically based set of evidence-based strategies that can be used by clinical nursing leaders to promote delivery of the fundamentals of care in the acute care setting.

Chapter 1

Introduction

Introduction

The fundamentals of care, as identified by their name, are the essential care requirements for all patients, regardless of diagnosis or care setting. These care needs may be attended to by a variety of healthcare professionals, family members or paid carers, in hospitals, private homes, residential care facilities or in other healthcare settings. However, in the hospital environment, it is typically the nursing staff who are seen to be responsible for meeting these care needs. While these fundamental care needs are sometimes referred to as 'basic', they are a vital part of both the patient's experiences of, and outcomes from, their hospitalisation. Ensuring these needs are met in an appropriate, safe and acceptable manner is essential. This research sought to identify the factors that can enhance or impede nurses' delivery of the fundamentals of care in the acute hospital setting.

Chapter outline

This chapter will provide background information to introduce the topic of this research study. The research purpose and aims will then be described. An overview of the research design is then outlined, and the theoretical framework used in the research will be explored. The terms that are used in this thesis will be defined and an outline for each of the chapters in this thesis will be provided.

Background to the research

The fundamentals of care

As the largest healthcare professional group globally, nursing has a central role to play in ensuring that the fundamentals of patient care are carried out in an appropriate manner. The fundamentals of care – which include ensuring adequate nutrition, hydration, personal hygiene, sleep, rest, and dignity,

to name a few – have traditionally been the responsibility of the nurse on behalf of the healthcare team. These responsibilities are not a new phenomenon, indeed as far back as 1860, Florence Nightingale identified these care activities as a core component of the nurse's role Nightingale (1860/1980).

The central importance of getting these basics, or fundamentals, of care correct, and thereby supporting patient safety and welfare, is affirmed by international reports such as Crossing the Quality Chasm (Institute of Medicine 2011) and the World Health Organization Safety Strategy (World Health Organisation 2005). Importantly, these reports indicate this care is an integrated concept and not limited to the relief of physical symptoms. As stated by the Institute of Medicine, the desired outcomes of care are:

“improvement (and prevention of deterioration) of health status and health-related quality of life, and management of physical and psychological symptoms. Desirable outcomes also include attention to interpersonal aspects of care, such as patients' concerns and expectations, their sense of dignity, their participation in decision making, and in some cases reduced burden on family and caregivers and spiritual well-being.” (Institute of Medicine 2001) (p. 44)

If these fundamentals of care are not delivered appropriately, the consequences need to be considered. We know, from international and local healthcare reports, that failure to ensure that these aspects of care are provided in a desirable manner, might lead to patient safety issues and, in some cases, mortalities.

For example, in one health trust in the United Kingdom, inadequate assistance with feeding and toileting, accompanied by denial of dignity and privacy was found to lead to malnutrition, dehydration and patient and family perceptions of a “callous indifference” to patient suffering by nursing staff (The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013)(p. 13).

There have also been more recent reports providing evidence that there are some continuing deficiencies in the delivery of the fundamentals of care. In South Australia, the inappropriate regular use of physical restraint, ostensibly to prevent patient falls, in an inpatient, older persons, mental health

service has been linked to patient injury, violation of patients' independence and death (Groves *et al.* 2017). An independent enquiry into the care provided in this facility found some of the patients were:

“not treated with respect, left soiled and un-bathed, were not adequately fed and hydrated, confronted with a “show of force” to undertake routine tasks of daily living, mocked, ridiculed, spoken to as if they are children, dressed inappropriately, left unkempt, and treated with little personal dignity.” (Groves *et al.* 2017)(p. 82).

The health industry and healthcare professionals must address the need to provide safe, effective and affordable care while incorporating an approach that respects and protects the individual patient and their family. In Australia, increased demand for services has put pressure on nursing and the entire healthcare sector (4102.0 Australian Bureau of Statistics 2013). These demands include an ageing population and healthcare workforce, increased consumer expectations, increased patient acuity, budgetary restrictions, and a system-wide focus on throughput. Global trends in health care such as an exponential increase in chronic illness and lifestyle-related illnesses such as obesity and addiction disorders, increase the demand on the health industry and therefore on nurses.

Nursing and the fundamentals of care

Nurses, both historically and currently, have a recognised responsibility to attend to a patient's fundamentals of care regardless of the patient's clinical condition and the healthcare setting. Given their level of representation and responsibility in the healthcare system, it is inevitable that any changes occurring within these systems will impact on nursing. The way nurses perceive their role in terms of “protecting, maintaining and promoting dignified, respectful”, evidence-based patient-centred care, is a core component of their preparedness to manage the fundamental care needs of their patients and address their presenting clinical condition (Kitson *et al.* 2010)(p. 424). Nurses have reported needing to ‘choose’ between meeting a patient's physical needs and attending to their psychological or emotional needs, due to a high workload and the unpredictable nature of patient care requirements (Maben *et al.* 2012a). For example, if two staff were required to assist a patient to walk safely to the toilet, and these staff were not available, a nurse might resort to offering a commode at the bedside, which attends to

one fundamental care need, but not other needs such as dignity, privacy, choice and mobility (Maben *et al.* 2012a). These situations are undesirable and unfortunate and highlight some of the factors impacting on nurses' ability to deliver the fundamentals of care. Yet there are likely many instances where some nurses are able to deliver this care in an integrated and patient-centred manner and exploring the factors that support them to do so, may yield useful information.

The research presented in this thesis was conducted in the Australian healthcare setting, where the majority of nursing care is provided in acute hospitals. Acute hospital settings include those where treatment is provided to patients for a severe injury or illness that cannot be treated outside of the hospital setting. The Australian Institute of Health and Welfare (2017) highlight the important role hospitals play in the healthcare landscape in Australia, as in other countries, where they account for 40% of the healthcare expenditure in this country. The typical Australian acute care hospital setting has experienced changes in demand, patient acuity and length of stay over the past 15 years (Schlesinger 2016). For example, where previously a patient might be admitted the day prior to gall bladder surgery and stay for five to seven days post-surgery, they now arrive on the ward post-operatively and may be discharged home the following day. In 2015-16 there were approximately 9.5 million acute care hospital admissions in Australia, from a population of approximately 24 million people (Australian Institute of Health and Welfare 2017). Nearly 60% of these hospitalisations were in public hospitals, which are funded by the Australian Government for the services they deliver. However, the Australian government has recently announced an initiative aimed to improve the quality of hospital care and reduce overall costs, by withholding payment where patients have avoidable complications. These complications include infections acquired during the hospitalisation, pressure injuries and falls, all of which could be linked to the delivery of the fundamentals of care (Independent Hospital Pricing Authority 2017).

The patient perspective of the fundamentals of care

While nurses are the primary providers of the fundamentals of care, and exploring the factors that aid and/or impinge on their ability to deliver these is important, there are also recommendations suggesting the need to explore the delivery of care from the patient's perspective (Vincent & Coulter

2002). These authors have illustrated the importance of considering care recipients' interpretations, suggesting that the patient's perspective provides vital information about "access to care, responsiveness and empathy, good communication, clear information provision, appropriate treatment, relief of symptoms, improvement in health status" (Vincent & Coulter 2002)(p. 76).

The patient experience related to the delivery of the fundamentals of care has been explored for patients with several conditions, such as cancer (Muntlin Athlin *et al.* 2018), abdominal pain (Jangland *et al.* 2016) and stroke (Kitson *et al.* 2013d). However, these studies are based on patients' recollections of their care and therefore do not provide comprehensive descriptions of the entire interaction between the patient and the nurse. Within these publications, data are also lacking about the contextual factors surrounding these interactions and the specific language that was used. Furthermore, the focus of the interviews from which the data were collected in several of these studies was not explicitly on the fundamentals of care, rather it was collected to explore the entire experience of care provided throughout the patient's diagnosis and treatment.

It has also been suggested that patients might regard the provision of high quality 'technical' care as a given, therefore their perspective of care might be more strongly influenced by the interpersonal care they receive from the nursing staff (Johansson *et al.* 2002). This interpersonal care might depend on the type of nurse-patient relationship that has been established. Research has demonstrated that if the nurse does not have the skills, desire or support to develop a therapeutic nurse-patient relationship (Maben *et al.* 2012a), or the patient chooses not to engage with the nurse, a core requirement for delivery of the fundamentals of care will be missing, putting these patients at risk of receiving lower quality care. While patient satisfaction is frequently assessed in many healthcare environments, what is not often explored is what patients see as the factors that might influence the way the fundamentals of care are delivered. These different perceptions are sought to provide a broad assessment of this topic, as research by Zeitz *et al.* (2011) has indicated that patients and nurses might have different perspectives and expectations of care. If these perspectives align, this might provide a greater impetus if change is required to address this factor.

The Fundamentals of Care Framework

The importance of focusing on the fundamentals of care has been attracting increasing international interest. In 2008, the International Learning Collaborative (ILC) was founded at Green Templeton College, University of Oxford, England, with the primary goal of exploring the challenges and solutions for the delivery of person-centred fundamental care. The founders were an international group of nurse leaders, health policy makers, healthcare researchers and clinicians, led by Professor Alison Kitson of the University of Adelaide. This group, which included the author of this thesis, met for their annual seminar at the University of Oxford in June 2012 to discuss integrating the fundamentals of care into the patient-centred care 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 or fundamental care needs of many patients due to a range of complex factors. As a result of the two-day seminar, a position paper was published describing the participatory and collaborative development of the Fundamentals of Care Framework (Figure 1) (Kitson *et al.* 2013a). The process of developing the Framework began with detailed notes being taken from presentations and discussions on the first day of the seminar and these were analysed for emerging themes and issues. This summary was then presented to the group on the second day, who were tasked with generating a conceptual framework based on these themes. The proceedings from the second day were written up immediately by two group members, Professor Kitson and the author of this thesis.

The record of the proceedings was then checked for consistency and intelligibility by three other group members. From these records, the proposed Fundamentals of Care Framework emerged. A first iteration of the Framework was circulated to all group members in September 2012 for comment and feedback. Following this, a refined version was circulated in December 2012, with the final version edited in January 2013 and published on behalf of the ILC by the University of Adelaide. Thus, the Framework reflects the research, theoretical, practical and clinical experience and expertise of the members of the ILC.

The focus of the Fundamentals of Care Framework is on enabling the patient and the nurse to confidently and competently assess, plan, implement and evaluate the fundamentals of care. This is the foundation of effective nursing care and is achieved through the alignment of three dimensions: establishing a therapeutic relationship with the patient; being able to integrate the patient's physical, psychosocial and relational care needs; and ensuring that the wider health system or context is committed and responsive to these central responsibilities. The Framework relies upon the ability of the nurse to develop a relationship with the patient and, through that relationship, be able to meet, or help the patient themselves meet, their fundamental care needs. This Framework was used as the conceptual framework for the research presented in this thesis. More detail about the Framework is presented in Chapter 3 (Methodology).

Summary

The importance of ensuring the safe, appropriate and effective delivery of the fundamentals of care is clear. The need to deliver this care in an integrated manner might be implied but is not clearly explicated. An empirical examination of the factors influencing nurses' delivery of the fundamentals of care, including exploring the complexity of this care and seeking the perspectives of those who deliver and receive this care, is required. Exploring how nurses can best be supported to deliver the fundamentals of care by investigating what helps and or what hinders their delivery of this care, might reveal possible solutions or supports to promote the delivery of the fundamentals of care.

Purpose of the research

The purpose of this research is to: explore and describe nurse delivery of the fundamentals of care in acute hospital wards; identify what facilitates or hinders the provision of the fundamentals of care; determine if these factors can be moderated; and potentially contribute to developing strategies to promote patient-centred fundamental care delivery.

The research presented in this thesis focusses on the real time interactions between nurses and patients related to the fundamentals of care across a variety of acute care settings, thus providing data

overtly relevant to these activities. This research then uses these real-life examples, gathered by observing actual care delivery, to determine what patients and nurses describe as the factors influencing the delivery of the fundamentals of care.

Research aim

The aim of this research is to identify the factors influencing nurses' delivery of the fundamentals of care from the perspective of the nurse and the patient in acute hospital wards; ascertain those factors that facilitate or hinder the provision of the fundamentals of care; and explore if these factors can be moderated.

This research study seeks to answer the following questions.

- What factors influence nurses' delivery of the fundamentals of care in the acute hospital setting?

More specifically:

- What factors are observed to influence nurses' delivery of the fundamentals of care in an acute hospital?
- What factors do nurses working in an acute care hospital describe as influencing nurses' delivery of the fundamentals of care?
- What factors do consumer representatives of an acute care hospital describe as influencing nurses' delivery of the fundamentals of care?

Overview of the research

Research design

This research used a focused ethnographic methodology to guide the research process. This methodology guided the choice of data sources and data collection methods. Three iterative data collection stages were used to explore the research questions. The research began with developing a detailed description of the delivery of the fundamentals of care using non-participant observation. These data were then analysed using the Fundamentals of Care Framework (outlined below) to identify the

fundamentals of care that are represented in these care interactions. Data from the observation stage were then used in focus groups to explore with the various stakeholders their perspectives of the factors influencing the delivery of the fundamentals of care. These findings were thematically analysed to identify the influencing factors. Clinical nursing leaders were then interviewed and asked to identify their strategies for moderating the factors identified by the focus group participants as influencing the delivery of the fundamentals of care.

Definition of terms used in the thesis

Fundamentals of care

The fundamentals of care refer to the items identified as the care needs of the patient in the Fundamentals of Care Framework.

Patient

Throughout this research, the term 'patient' will be used to refer to the person for whom the fundamentals of care are provided. This is the term used for the recipients of care in the acute care hospital where the study was conducted.

Registered Nurse

A Registered Nurse is a person who has completed the prescribed education preparation, demonstrates competence to practise and, in Australia, is registered under the Health Practitioner Regulation National Law as a Registered Nurse (Nursing and Midwifery Board of Australia 2016). Registered Nurses are responsible for ensuring the quality of nursing care through their involvement in care provision, teaching, competence assessment, supervision and the evaluation of patients' outcomes.

Level 1 Registered Nurse

In the hospital where this research was conducted, Level 1 Registered Nurses typically directly deliver nursing care to patients, or delegate the care to another healthcare worker, while remaining accountable for that care.

Level 2 Registered Nurse

A Level 2 Registered Nurse has at least three years post-registration experience and, in the setting for this study, has a specific portfolio responsibility, such as infection control.

Level 3 Registered Nurse

A Level 3 Registered Nurse is a clinical nursing leader. In the setting for this study, these nurses oversee the care delivery for an entire ward or unit.

Outline of Chapters

Chapter 1 provides an introduction to the thesis, and to the topic of this research. The purpose and aims of the research are described. An overview of the research design and the definitions for terms used in the thesis is also provided, along with an outline of each of the other Chapters in this thesis.

Chapter 2 provides a critical review of the literature relating specifically to the fundamentals of care and extrapolates the key concepts from this literature. Links between the fundamentals of care and other nursing frameworks or models are explained. The findings from the literature are summarised, and any emerging patterns explored. An explanation is then provided for how the research reported in this thesis could address gaps in the existing knowledge base for the fundamentals of care.

Chapter 3 explores the conceptual framework for the research and explains the choice of ethnographic methodology for this research study. It then explores how focused ethnography helped to shape the design of the research methods and the analysis of the resulting data.

Chapter 4 describes and explains the iterative design used in this research, where consequent stages of the study were informed by the previous stages. It then describes the data collection methods

for each stage of the study including the aims of each method, the development of the data collection tools, sampling, and the recruitment of participants.

Chapter 5 presents the findings from Stage 1 of the research. Demographic details about the participants are described. The data coding and analysis processes and results from the observation stage are detailed. The predominant findings from this stage will be highlighted.

Chapter 6 presents the findings from Stage 2 and 3 of the research. Demographic details about the participants at both stages of the study are described. The data coding and thematic analysis processes and results from the focus groups and interviews are also detailed. The predominant findings from these stages will be highlighted along with a summary of the findings from all three stages of the research.

Chapter 7 discusses the findings of the research, comparing these with the findings of previous work in the field. The meanings and potential implications of the findings are explored. These are discussed in relation to the both the literature explored in Chapter 2 and more recent, relevant literature on this topic.

Chapter 8 provides a summary of the research, and conclusions are drawn about the research findings. The research questions are re-visited, and the significance of the research highlighted. The contribution made by this research to the existing knowledge about the fundamentals of care is explored. The limitations of the research are discussed, and recommendations are made for practice and further research.

Appendices providing further information are referred to in the relevant chapters. The reference list contains all the citations from the thesis.

Summary

This chapter has introduced the topic for this research study. The research purpose and aims and an overview of the research design is provided. The theoretical framework used in the research has been identified and the terms being used in the thesis have been defined. The next chapter will provide an overview of the literature relating specifically to the fundamentals of care.

Chapter 2

Literature review

Introduction

In this chapter, literature relevant to the fundamentals of care, published prior to commencement of this research in 2013, will be explored. As defined in Chapter 1 (Introduction), the fundamentals of care refer to the care needs of the patient. A historical overview of the literature relating specifically to the fundamentals of care will be presented via a timeline, along with critique identifying the strengths and weaknesses of past research. The key concepts extrapolated from this literature will be described and discussed.

The relationship between the fundamentals of care and earlier, seminal nursing models will then be examined. This chapter will then explore the links between the fundamentals of care and other related concepts including: basic nursing care; patient-centred care; missed care and care rationing. This will be accompanied by a critique of the seminal literature related to each concept. In conclusion, this chapter will summarise the findings of the literature review, identify emerging patterns, and explain how further research, specifically the research reported in this thesis, could contribute to the existing knowledge base for the fundamentals of care.

The fundamentals of care

A search of the US National Library of Medicine, National Institutes of Health, PubMed database and the Elsevier Scopus® database was conducted using the term 'fundamentals of care'. Table 1 provides an overview of the publications retrieved identifying the fundamentals of care. These publications will be described in chronological order to illustrate the development of the fundamentals of care as a concept.

Table 1 Publications identifying the fundamentals of care

Year	Country	Publication authors	Publication type
2003	UK	Welsh Assembly Government	Policy document
2004	UK	Arblaster et al	Project evaluation
2004	USA	Rantz & Zwygart-Stauffacher	Discussion paper
2006	UK	Carlick & Price	Research report
2009	USA/Australia	Vollman	Editorial
2009	Australia	Wiechula et al	Knowledge Translation research
2010	International	Kitson et al	Meta narrative review
2011	UK	Sprinks & Waters	Meeting Report
2013	USA	Vollman	Discussion paper
2013	Australia	Kitson et al	Methodology paper
2013	UK/Australia	Kitson et al	Research- Secondary analysis
2013	UK/Australia	Kitson et al	Framework development
2013	International	Kitson et al	Position paper and Framework development
2013	Australia	SA Health	Practice Framework

The term 'fundamentals of care' entered the literature in 2003, when the Welsh Government (Welsh Assembly Government 2003) used the term 'Fundamentals of Care' to refer to the standards and indicators it would use to assess the quality of health and social care in Wales. Twelve aspects of care were delineated, these being: communication and information; respecting people; ensuring safety; promoting independence; relationships; rest and sleep; ensuring comfort, alleviating pain; personal hygiene, appearance and foot care; eating and drinking; oral health and hygiene; toilet needs; and preventing pressure ulcers. The 12 aspects of care were derived from "a range of statutory, mandatory and professional requirements and national policies" and "where gaps have been identified from a literature search and extensive consultation" (Welsh Assembly Government 2003)(p. 4). The parties who were involved in the consultation process are not identified. The need for the standards and indicators arose due to the identification of inconsistency in the quality of care across settings, a perceived emphasis on service efficiency and cost minimisation, common themes arising in complaints, increasing expectations of service users, a greater focus on regulation, and awareness of the 'Essence of Care' patient focused benchmarks, which had been published two years earlier in England (Welsh Assembly Government 2003).

Essence of Care was published by the United Kingdom (UK) Department of Health in 2001 and reflected the government's strategy to improve the quality of the core aspects of nursing care due an unacceptable variation in the standards of care across the UK (Department of Health 2001). Patients, carers and healthcare professionals "worked together to agree and describe good quality care and best practice" (p. 1), which resulted in benchmarks for eight areas of care: continence and bladder and bowel care; personal and oral hygiene; food and nutrition; pressure ulcers; privacy and dignity; record keeping; safety of clients with mental health needs; and principles of self-care. The Welsh policy document acknowledges the English document and the two were similar in nature, however the language used and the focus of care varied.

The Nursing Directorate of the Welsh Government has continued to publish annual compliance data related to each of the 12 aspects of care for each NHS organisation in Wales, that are responsible for delivering all the healthcare services within a defined geographical area. These data incorporate information about the (adult) patient experience derived from a patient satisfaction survey, and an operational element, which is completed by the clinical nursing leader of each ward or site (Nursing Directorate 2013). The standards and indicators have been developed to evaluate the patient experience of the process of care, as well as the outcomes, thus recognising the equal importance of each. These data are collected and self-reported by each health service in selected consecutive months and reflect the experiences and responses of the patients who were audited during that period. However, the response rates for the satisfaction survey are not provided in the compliance data and using patient satisfaction scores might not provide a completely realistic perspective of care, as research has indicated that patient satisfaction scores might represent a "limited and optimistic picture" (Jenkinson *et al.* 2002) (p. 338).

The reaction to the Welsh government 'Fundamentals of Care' document was reportedly mixed, and Carlick & Price (2006) argued that these 12 aspects of care were not new to nursing. However, these authors believed the implementation of the framework using the standards and indicators raised the "profile and value of caring" (p. 37) and their use supported "continuous improvement and ...increased

the potential to improve care and the patient experience” (p. 38). Their report, outlining the awareness of the framework and the subsequent improvements in patient care in a large NHS organisation, differentiated the Fundamentals of Care from Essence of Care by claiming the former is different because “it can be integrated into existing models and service delivery across a range of health and social care settings” (Carlick & Price 2006) (p. 36). However, an explanation for this perceived differentiation was not provided by these authors.

The fundamentals of care, as identified in the 2001 Essence of Care document (Department of Health 2001), were also the focus of a report outlining a training programme developed for healthcare support workers (HCSW) at a NHS Trust in Coventry in the UK (Arblaster *et al.* 2004). The HCSW were viewed in this Trust as the “front line of patient care delivery” (p. 33) and the providers of the fundamentals of care. The authors indicated this HCSW role was introduced to fill the gaps created by the transition of student nurses from the hospital to the tertiary education setting and the introduction of supernumerary status during their clinical placements. The seven-day programme included eight key aspects of care: principles of self-care; food and nutrition; personal and oral hygiene; continence and bladder and bowel care; pressure ulcers; record keeping; and privacy and dignity. Competency in these skills was assessed and this assessment was initially conducted by registered nurses, thus implying that registered nurses remained accountable for these aspects of care. However due to “pressure of work” (p. 35) for the nurses, the assessment was devolved to trained HCSW. These ‘pressures’ for the registered nurses are not identified or elaborated, therefore it is unclear what factors are impacting on their ability to deliver the fundamentals of care themselves, or their ability to assess the competence of the HCSW who have been delegated these duties.

In 2004, and where for the first time they were described as such in the United States, a focus on the fundamentals of care in long-term care facilities was the impetus for a discussion paper outlining the development of a ‘Roadmap to Improve Nursing Home Care Quality’ (Rantz & Zwygart-Stauffacher 2004). These authors highlighted the need for the fundamentals of care to be the primary focus when seeking to improve care quality in nursing homes. They referred to a research project, which had been

previously conducted by a team including these authors, that observed and compared the processes of care delivery in 92 care facilities in Missouri in the United States with 'good', 'average' or 'poor' resident outcomes (Rantz *et al.* 2003). These outcomes, which were referred to in the primary research as 'basics', included falls, incontinence, weight loss and use of restraints, among others. Prospective, qualitative data collection was conducted by nurses experienced in long-term care, who were blinded to the facilities' resident outcome results, thus reducing any observer bias. Data included descriptions of the care delivery on day, evening and nights shifts in each facility and the results were then compared. A theoretical model was derived with "Getting the Basics of Care Done" (p. 21) seen as the key to improving outcomes for residents (Rantz *et al.* 2003). Facilities with 'good' outcomes demonstrated major differences in what the authors refer to as "basics of care delivery" (Rantz *et al.* 2003) (p. 19). These 'basics' exclusively focus on physical care needs and included promoting ambulation, nutrition and hydration, toileting and bowel care, preventing skin breakdown and pain management. The authors also suggested consistent nursing leadership, having a team focus and the presence of an active quality improvement program as factors supporting better resident outcomes. The researchers concluded,

"this study illustrates the simplicity of the basics of care that residents in nursing facilities need.

The results also illustrate the complexity of the care processes and the organizational systems that must be in place to achieve good outcomes" (Rantz *et al.* 2003) (p. 24).

Thus, these authors seem to suggest the fundamentals of care are both simple and complex, even when limited to physical needs. A lack of consideration of other aspects of the fundamentals of care, such as dignity, support and respect, and the disaggregation of the physical fundamentals of care that could potentially interact, for example ambulation and toileting, might limit the applicability of these findings. The change in terminology from 'basics' in the primary research to 'fundamentals of care' in the discussion paper is not explained but might reflect the researchers increased awareness of the complexity of this type of care and the systems that are required to support its delivery.

The need for an international focus on the fundamentals of care was next highlighted in a guest editorial authored by Vollman, in *Australian Critical Care* in 2009. Vollman, a critical care nurse

specialist, educator and consultant in the United States, called for the nursing profession to “reclaim the fundamentals of nursing care” (p. 152) and stated that a recognisable name and framework were required to provide a way to describe the unique contribution that nursing makes to healthcare. Vollman also suggested these fundamental care practices had been devalued due to limited enforcement and the lack of a reward or recognition structure (Vollman 2009). A consequence of this was that these “care practices and their value have been ‘conditioned’ out of the nurse” (p. 152). The fundamental nursing care practices that were described as having a significant impact were hygiene and mobility interventions, specifically those related to preventing falls and healthcare acquired infections. This call for an increased focus on these care practices is not linked to any previous literature mentioning the fundamentals of care, and the lone reference provided for the need to refocus nursing care is the “To err is human..” report from the Institute of Medicine, published in 1999 (Institute of Medicine 1999). Vollman developed a framework called ‘Interventional Patient Hygiene’ to describe how care practices related to this aspect of nursing care in the critical care area are grouped together. There were no outcome data reported, nor were staff observed to determine if the framework was being operationalised in practice. Vollman stressed the importance of adequate resources and systems to successfully reconnect nursing with the fundamentals of care, however the transferability of this ‘framework’ to other aspects of nursing care provision is not explored.

Around the same time, in Australia, a project focused on the fundamentals of care was conducted by Wiechula and Kitson et al in 2009 in a South Australian tertiary hospital. According to Wiechula *et al.* (2009), this was in response to a state government initiative, aimed at improving the care of older people in the acute care setting. These authors suggested that assessment of older people, ensuring their nutrition, hydration and elimination needs, and undertaking required actions to reduce the risk of functional decline, were being overlooked due to pressure on staff to deliver organisational targets aimed at reducing length of stay and improving patient throughput. The authors referred to anecdotal feedback from unit managers who reported that the nursing staff felt ‘helpless’ to address these issues because these fundamental aspects of patient care were not valued by the system and were subsequently under resourced. A participative and evaluative project was initiated using multiple

interventions, derived from knowledge translation methodologies, to improve and evaluate the care of the older person. Seven teams of clinicians were established to address distinct areas of concern. Three phases - 1. preparation, 2. intervention development and implementation, and 3. review and consolidation - were used with the teams, supported by expert facilitators. Some improvements in patient outcomes were achieved. However, the issues that were presented in the rationale for the project as the dominant barriers to care delivery, that is the organisational pressures on staff and their beliefs pertaining to the lack of value placed on these aspects of care by the 'system,' were not targeted, bringing into question the sustainability of the intervention. Indeed, the authors highlighted that lack of funding, resources and the pressure on staff due to high-bed occupancy and acuity contributed to poorer than expected improvements. The term 'fundamentals of care' is used throughout the paper, but no references are provided for where this term might have originated or why it was chosen.

The fundamentals of care were then further explored by Kitson et al (2010) via a meta-narrative review of the seminal nursing literature. The author of this thesis was a co-author of this review, and this represented their initial research collaboration focusing on the fundamentals of care. This project, which was lead from South Australia, but included an international team, was in response to what the authors indicate was "little ontological and therefore epistemological clarity around the concept of fundamentals of care" (Kitson *et al.* 2010) (p. 425). This need for clarity referred to the use in the nursing literature of inconsistent definitions and terminology, and a lack of conceptual consensus. The aim of the meta-narrative review was to map the diversity of perspectives and approaches. The initial search for texts to include was led by intuition, informal networking, and browsing for nursing textbooks and other documents in a University library. Information from these texts was extracted where it related to 'activities of living' as described by Roper *et al.* (1980). Textual information was reviewed chronologically, commencing with Florence Nightingale's *Notes on Nursing* (Nightingale 1860/1980).

Each text was examined and data, in the form of words and related text, were extracted. The primary descriptor terms that were extracted were those that were used most frequently in the texts. Team members also checked the international applicability of the terms.

There were nine seminal nursing textbooks included in the review, limited to those available in English, from which the data were extracted and thematically analysed. The review reported “Marked variation in elements identified under the broad term activities of living or fundamentals of care and marked variation in the language used to describe these elements.” (p. 426).

When these elements were thematically analysed, that is the relevant concepts were bundled together (for example: nutrition, eating and drinking, diet, feeding etc. were deemed to be one bundle), the review found “strong agreement for the areas of care relating to safety, nutrition and elimination and moderate agreement for the areas of rest/sleep, mobility and personal hygiene. There was little consistent presentation of concepts such as comfort, pain management, privacy and dignity.” (p. 428).

In addition, it was highlighted that each fundamental of care could be considered from a physiological, self-care or environmental perspective. There were 14 fundamentals of care identified: Safety, Nutrition, Elimination, Rest and Sleep, Mobility, Personal Hygiene, Communication, Respiration, Temperature Control, Respecting Choice, Sexuality, Comfort (including pain management), Privacy and Dignity. This review was subsequently acknowledged as the current best representation of what constitutes basic or fundamental care by Theo van Achterberg in his call for papers for a special edition of the *Journal of Nursing Scholarship* examining this topic. van Achterberg (2012) also stated this “review arrived at a first set of elements to illustrate what basic care or the fundamentals of care are about” (p. 313).

Concerns about ‘basic care’ were continuing to make headlines in the UK. A meeting of nurses, academics, regulators, representatives from the various nursing colleges, patient representatives and media commentators in the UK was held in London in 2011, in response to a perceived deterioration in the UK public’s confidence in nursing (Sprinks & Waters 2011). This apparent lack of confidence was linked to the highly publicised inquiry into the Mid Staffordshire NHS Foundation Trust, which was first conducted by the Healthcare Commission in 2008 (Healthcare Commission 2009), and whose final findings were published in 2013 (The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013). This inquiry revealed major failings in care delivery for patients in that Trust, including nutrition, hydration,

toileting and providing pain relief along with “an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities” (p. 3).

The authors of the report from the 2011 London meeting described a ‘strong feeling’ among attendees that the value placed on the fundamentals of nursing care by both nurses and organisations needed to be increased, and the contextual factors that might impact on nurses’ delivery of the fundamentals of care were also highlighted (Sprinks & Waters 2011). Pressure on nurses to take on “more complex tasks” (p. 22) was seen by the meeting attendees as a reason why the fundamentals of care might be neglected (Sprinks & Waters 2011). The meeting also concluded that fundamental care was a core task for nursing and should be viewed as a “baseline requirement, and a privilege to provide” (Sprinks & Waters 2011) (p. 22). However, the suggestion that the fundamentals are less ‘complex’ and a ‘task’, might not reflect the increased ‘value’ that attendees stated was required.

In 2013, Vollman published an expanded reflection on the interventional patient hygiene conceptual framework, described earlier. Vollman referred to a “positive movement” occurring within the nursing profession to “get back to the basics or fundamentals of care” in order to improve patient outcomes (Vollman 2013) (p. 251). This discussion paper also included a framework called “Sustaining Nursing Clinical Practice” which aimed to ensure “reintroduction and valuing of evidence basic [sic] nursing care” (p. 250). The framework is comprised of three components: the resources and systems to deliver care and determine effectiveness, the skills and knowledge of the nurse, and their attitude and accountability. Vollman suggested the framework is critical for the reintroduction and valuing of fundamental care practices and urged nurses to reclaim the ‘basics of nursing care’. Examples of these ‘basics’ provided in the paper are bathing, incontinence and mobility. Results from an unpublished survey of critical care nurses in the US were presented and demonstrate an awareness of the interventional patient hygiene model. However, the respondents did not then demonstrate comparable knowledge of the nursing interventions to promote patient outcomes. The response rate for the survey was low (15% of 2954) and does not provide a clear indication for how the framework will encourage or support nurses to provide the fundamentals of care.

Also in 2013, the fundamentals of care were recognised as a distinct field of investigation by the Cochrane Collaboration, with the establishment of the Fundamentals of Care node to “identify universal aspects of patient care as they relate to and potentially affect the application of the results of systematic reviews” (Kitson *et al.* 2013c) (p. 109). This recognition was prompted via lobbying of the Cochrane Nursing Care Field by a team lead by Alison Kitson, of which the author of this thesis was a member. In order to identify the aspects of patient care described above, the Fundamentals of Care Template was developed to review systematic reviews in the Cochrane Database for their applicability to nursing and the fundamentals of care. This was based on the meta-narrative review conducted in 2010 by Kitson *et al.* (2010). The Template identifies 14 fundamentals of care including safety; communication; respiration; eating and drinking; elimination; personal cleansing and dressing; temperature control; comfort (including pain management); dignity; privacy; respecting choice; mobility; expressing sexuality; and rest and sleep. The node also had the responsibility to identify, via a ‘tagging’ system, the systematic reviews that were relevant to nursing by identifying the area of nursing clinical specialty the review was most relevant for and to which fundamental of care the review was related. The aim of the tagging was to create a database where nurses could access relevant reviews in a timely and targeted manner and therefore potentially increase the integration of review findings into nursing practice. This article described the methodology for using the Template and how the tagging would be implemented; however, as these were novel initiatives, there was yet to be any evaluation or research exploring either process.

A team of researchers, again led by Kitson, then used the Fundamentals of Care Template to conduct a secondary analysis of data from a sub-sample of interviews with 57 stroke survivors to explore their accounts of their recovery and recollections of events related to the fundamentals of care (Kitson *et al.* 2013d). The original database of interviews was compiled by the Health Experience Institute in the UK, utilising a maximum variation sampling technique, and the interviews had been collected originally for a, then unpublished, study exploring what it was like to live with a stroke [later published by Kuluski *et al.* (2014)]. A purposive sub-sample was selected from the database to maximise the variation in participant age, gender, impact of the stroke (moderate to severe impairment)

and experiences of care (Kitson *et al.* 2013d). Fifteen interviews were analysed and coded using the 14 fundamentals of care from the Fundamentals of Care Template (Kitson *et al.* 2013c). The authors indicate that the stroke survivors described their experiences of physical aspects of fundamentals of care in conjunction with psychosocial and relational aspects, thus demonstrating the interrelationship between these three dimensions of care. However, as the original data were not collected to address the focus of the research, and the experiences being recounted had mostly occurred more than ten years previously, the results might not have reflected the complete or current picture of patients' experiences related to the fundamentals of care. Yet, the Template did appear to provide one way to explore the Fundamentals of Care from the patient's perspective.

Building on the above research, an additional exploration of the experiences related to the fundamentals of care for stroke survivors was undertaken (Kitson & Muntlin Athlin 2013). This contributed to the development of a conceptual framework to describe the interrelationship between the physical, psychosocial and relational dimensions of the fundamentals of care. The authors tested this framework with hypothetical situations and then re-analysed three of the fifteen interviews from the stroke survivors to determine if they described physical, psychosocial and relational aspects of their care (Kitson & Muntlin Athlin 2013). The three cases were purposefully selected for their 'rich descriptions', however the specific criteria for selection is not reported. Each of the three aspects - physical, psychosocial and relational - was then stratified on a scale from low to high quality. For the physical aspects of care, a failure to meet these needs in a timely and appropriate way and without setting mutual goals was considered "low". The converse was considered 'high'. Psychosocial factors such as dignity, respecting choice, privacy, communication and education needed to be present for psychosocial aspects to have been considered "high". Relational aspects were assessed as 'low' if the patient was not engaged with in a respectful manner, or if their physical and psychosocial aspects of care were not achieved in a supportive and empathic manner.

The authors suggested their conceptual framework could help to categorise incidents of positive and negative experiences of the fundamentals of care and they also highlighted the complexity of

delivering 'good' fundamental care. However, the broader applicability of the framework could not be confirmed given the data used to trial the framework was retrospectively collected, and thus might be affected by recall bias, and the sample was extremely small and therefore not representative. This original Fundamentals of Care Framework (Figure 1) was proffered by the authors as a method of "integrating multiple interactions into an explanatory framework" and potentially "useful as a predictive framework to indicate when care will not be integrated or person-centred" (p. 11), however, further testing and refinement of the framework was required (Kitson & Muntlin Athlin 2013) .

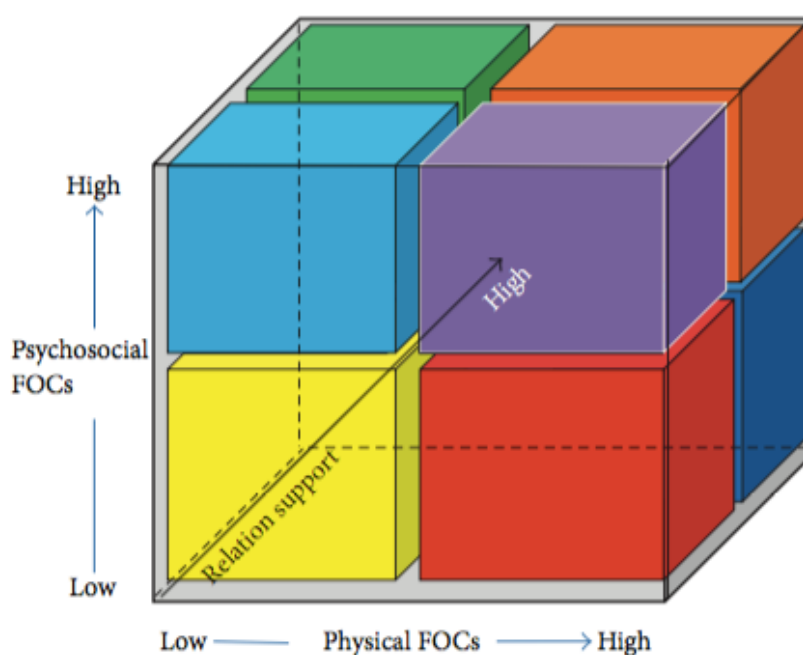


Figure 1 The Original Fundamentals of Care Framework

In 2008, the International Learning Collaborative was established, with the primary goals of exploring the challenges and solutions for the delivery of person-centred fundamental care; integration of clinical practice, research and education to promote excellence for the delivery of the fundamentals of care; and sharing the best evidence, policy and practice around the fundamentals of care (www.intlearningcollab.org). Alison Kitson, based in South Australia, was the initiator of this collaborative, which included members from the United Kingdom, Sweden, Australia, the United States, Canada and Singapore. An International Learning Collaborative seminar at Oxford University, held in June 2012, was attended by a group of international nurse leaders, health policy makers, health care

researchers and clinicians. The focus of the two-day seminar was the integration of the fundamentals of care into the patient-centred care agenda. At the seminar, it was 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 patients due to a range of complex factors. However, attendees also reported being “inspired and energised by accounts of compassionate, respectful, transformative care” (Kitson *et al.* 2013a) (p. 27).

As a result of the seminar, a position paper was published describing the participatory and collaborative development of a redeveloped version of the original Fundamentals of Care Framework (Kitson *et al.* 2013a). This framework was based on the research, theoretical, practical and clinical experience and expertise of the members of the International Learning Collaborative (ILC). The ‘list’ of the fundamentals of care, contained within the Framework, was derived from the Fundamentals of Care Template developed by (Kitson *et al.* 2010). The Framework describes three dimensions of care: the establishment of a nurse-patient relationship; the integration of physical, psychosocial and relational care; and the influence of the context in which care is delivered. The position paper also described an implementation strategy aimed at stimulating discussion and debate. This Fundamentals of Care Framework was used as the conceptual framework for this thesis and is explored in greater detail in Chapter 3 (Methodology).

Concurrently, and probably influenced by their proximity to the team led by Kitson in South Australia, the South Australian government department responsible for health reform, public health services, health and medical research, policy development and planning - SA Health - produced a Nursing and Midwifery Professional Practice Framework in 2013 (SA Health 2013). This framework introduced ‘Caring with Kindness’, which aimed to ensure that care and compassion were at the heart of the nursing profession in the state (SA Health 2014). Some SA Health staff were also members of the International Learning Collaborative and thus this might have influenced the development of this Professional Practice Framework. The Practice Framework highlighted the need for a ‘cultural change’ and identified person-centred care, respect, integrity and accountability as the core values and

behaviours required for nurses to deliver the fundamentals of care in a patient-centred manner. Fundamental care is described as “the basis upon which care is provided in a patient-focused and structured way to meet the fundamental care needs, including the activities of daily living, for patients” (SA Health 2014) (p. 5) and consists of relational, psychosocial, clinical and physical elements. These elements are similar to those originally identified in the Fundamentals of Care Template (Kitson *et al.* 2013c), but were modified for the local context.

The relational elements in the Practice Framework are dignity, respecting choice, privacy and cultural diversity. Psychosocial elements include comfort, safety and communication. Nutrition, hydration, elimination, hygiene, respiration, temperature control, skin integrity, pain management and symptom management are the clinical elements. Physical elements include rest and sleep, mobility and cleanliness. The policy document does not provide any references; thus, the original source of the information is not acknowledged. A range of key outcomes for each group of elements is provided, however, no data evaluating the influence of the local Practice Framework on patient outcomes, culture change or nurses’ perceptions of care delivery has been published, thus the impact and effectiveness of the Practice Framework is unknown.

Summary of the fundamentals of care literature

There has been a modest incremental chronological increase in publications related to the fundamentals of care given the agreed importance of these aspects of care for patient wellbeing and safety. The majority of the literature, as has been described, pertains either to government policy or to the development and application of various frameworks. The level of involvement by consumers of healthcare in the development of these policies and frameworks is not explicit.

The more recent literature included this literature review relies heavily on the seminal investigative review of the literature conducted by Kitson *et al.* (2010) and these authors, through their subsequent publications extrapolating the concept, have contributed to the popularisation of the term ‘fundamentals of care’ and have dominated the discourse on this topic (Kitson & Muntlin Athlin 2013, Kitson *et al.* 2013c, Kitson *et al.* 2013d). There is overlap in the descriptions for the individual

fundamentals of care across the publications, and there seems to be some agreement regarding the interrelationship between the physical, psychosocial and relational aspects of this care. However, despite the local and international focus on the fundamentals of care, they remain an evolving concept and a definitive description for the components of this care has not been confirmed.

Relationships between the fundamentals of care and other care concepts and terminology

While the fundamentals of care are a relatively recent concept reported in the literature, it is important to recognise that a focus on the provision of appropriate nursing care is not new. This section of the literature review will explore the relationship between the fundamentals of care and some earlier seminal nursing models. Other care concepts that can be aligned with the fundamentals of care literature, including basic care, patient(person)-centred care, missed care and care rationing, will be reviewed along with a critique of the seminal literature related to each concept.

Nursing models and the fundamentals of care

Models for nursing aim to describe the particular purpose of nursing and as indicated by Murphy *et al.* (2010):

“formal models of nursing were considered as ways of representing what nursing is, what it aimed to achieve and the different components of nursing that could then be taken apart, analysed and understood. a nursing model could be defined as “a picture or representation of what nursing actually is” (p.18)

An in-depth exploration of all of the nursing models and frameworks is beyond the scope of this literature review. However, it is important to recognise the potential impact some of these might have had on the discourse surrounding the fundamentals of care. The fundamentals of care could be viewed as a modern version of previous conceptions for nursing practice. Indeed, Florence Nightingale’s ‘Notes on Nursing’ (Nightingale 1860/1980) and Virginia Henderson’s 14 components of nursing activity outlined in ‘Principles and Practice of Nursing’ (Henderson & Nite 1978) were two of the seminal texts

that contributed to the development of the descriptors for the fundamentals of care by Kitson *et al* (2010). Kitson *et al* (2013a) also acknowledge Henderson's work as providing a clear direction for the development of the Fundamentals of Care Framework. The meta-narrative review of seminal nursing texts conducted by Kitson *et al* (2010) describes the individual elements from each model, thus they are not explicated here. Other seminal models such as the Roper-Logan-Tierney Model for Nursing centred on 12 Activities of Living, and provided a refinement of the ideas outlined by Virginia Henderson (Tierney 1998) with the application of the nursing process, that is, assessment, planning implementation and evaluation (McCrae 2012).

The focus of these models has altered over time from those focused towards identifying required nursing actions, including Nightingale and Henderson, to those focused on identifying the individual, or person-centred, needs of the recipient of care, such as Roper-Logan-Tierney. The Fundamentals of Care Framework incorporates both perspectives, with a focus on the individual's needs when considering the physical and psychosocial elements identified in the Framework, and on the required nursing actions when considering the relational elements. This progression from a nursing actions focus, to a patient-centred focus, and then a merging of these two perspectives might reflect a continuing divergence from the medical model of care. It might also reflect a desire to represent the unique and complex nature of care in a manner that is relevant both to the care providers and to the care recipients. The Fundamentals of Care Framework, which was framed using core conceptualisations from prior nursing models and frameworks, provides the most current, and arguably the most comprehensive, representation of care delivery.

Basic care and the fundamentals of care

As illustrated in the literature on the fundamentals of care described previously, some authors use the terms basic care and fundamentals of care interchangeably (Kitson *et al*. 2013a, Rantz *et al*. 2003, Rantz & Zwygart-Stauffacher 2004, van Achterberg 2012, Vollman 2013). Indeed, it has been argued that a lack of conceptual clarity about both terms, along with others such as patient-centred care and essentials of care, is contributing to the challenge in developing a nomenclature and thus agreed

measures for this important aspect of nursing care (Kitson *et al.* 2010). However, given the acknowledged complexity of the fundamentals of care, and the postulated requirement to integrate the physical, psychosocial and relational aspects of this care, to term this 'basic', thus implying it is straightforward or simple, seems incongruous and might potentially devalue this care.

Patient-centred care and the fundamentals of care

As illustrated in the description of the evolution of nursing models and frameworks, there is an increasing emphasis on providing a model or framework to guide practice that is perceived to be patient-centred. Hence, it is important to explore how the fundamentals of care fit within this concept. Patient-centred care has been defined as providing care the patient requires, in the way the patient wants, at the time that the patient wishes (Rathert *et al.* 2012). The Institute of Medicine defines care that is patient-centred as “providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions” (Institute of Medicine 2001) (p. 6).

A search of the Scopus© abstract and citation database in November 2017 showed the first time the term 'patient-centred care' was indexed to a publication was in 1952 (Leino 1952), thus it is not a new concept. The year by year data from this database for the index term 'patient centred care' demonstrated a pattern of 1-5 indexed publications per year from 1952- 1991, increasing to between 10 to 466 per year from 1992-2005, and then a steady upturn from 567 in 2006 to 1671 in 2013. This increase in the profile of patient-centred care has been linked by Heidenreich (2013) to a swing away from a “past indifference to patient satisfaction” to the use of patient satisfaction as a “dominant metric” to evaluate the provision of care in healthcare systems (Heidenreich 2013) (p. 2). In 2001, the Institute of Medicine (IOM) released their seminal report highlighting the “chasm” between “the healthcare we have and the care we could have” (Institute of Medicine 2001) (p. 1). The need for significant change in the American healthcare system was stressed. This 'call to arms' might also have led to an increase in the profile of patient-centred care.

Conceptual descriptions for what patient-centred care should look like in practice, and how it is understood by those who deliver and receive care, vary. At the same time as the IOM was highlighting the need for a patient-centred care approach in the Crossing the Chasm report, the concept of patient-centred care was described by Stewart as “widely used, but poorly understood” and as better understood for “ what it is not - technology centred, doctor centred, hospital centred, disease centred”(Stewart 2001) (p. 444). More than ten years later, there was still some confusion about what comprises patient-centred care. Prompted by “the rhetoric around patient- centred care” and the lack of a “common definition” (p. 4), a narrative review seeking to identify and synthesise the core common elements of patient-centred care was conducted by Kitson *et al.* (2013b). The review included 60 seminal texts and publications, published between 1990 and 2010. Publications from patient organisations, as well as policy documents and medical and nursing research were included. Of note was the finding of a lack of common definitions being used by policy makers and within medicine and nursing. Three core themes were derived from the review synthesis. These themes: patient participation and involvement; the relationship between the patient and the healthcare professional (regardless of professional group); and the context where care is delivered, are suggested by the review authors to have possibly emerged from a common conceptual source. However, as the authors state:

“Health policy commentators and nurses tend to focus as much on the wider system and contextual issues as the professional-patient relationship while the medical discourse is constructed around a very clearly delineated therapeutic relationship between the individual medical professional and the patient” (p. 12).

The narrative review also highlighted the tendency for nursing to emphasise respecting patient values and beliefs while medicine has focused on understanding the informed decision-making process. This divergence between the professional groups was also illustrated in an analysis of the discourse surrounding patient-centred care, first published online in 2013 by Kreindler, which identified 85 reports related to the concept (Kreindler 2015). The findings from this analysis indicated the discourse used by managers, physicians and nurses was designed “to imply that their own group was patient-centred while

other group(s) were not.” (p. 1139). These intergroup tensions were described as a barrier towards attaining a patient-centred healthcare system.

Views on how to achieve care that is patient-centred also differ between patients and organisations. A phenomenological exploration of patients’ view of patient-centred care found, that although they might not always explicitly be aware of the concept of patient-centred care, patients value emotional support, care coordination, participation, attention and comfort (Marshall *et al.* 2012). Organisations, on the other hand, feel that patient-centred care is best achieved through payment reforms, sharing in decision making, cost effective care and the process of care delivery (Rathert *et al.* 2012, Reed *et al.* 2012).

The fundamentals of care are clearly a significant part of the patient’s perspective of patient-centred care. However, they are rarely made explicit in the literature related to patient-centred care. If organisations, nurses and patients differ in their interpretations of what is required, this might create conflict and misunderstanding. If a patient’s fundamental care needs are not met or are not delivered in a way that maintains dignity and allows for the patient’s participation and comfort, then the goal of patient-centred care is unachievable. Additionally, if the fundamentals of care are not prioritised by healthcare workers, ensuring the delivery of patient-centred care is challenging.

Missed care and care rationing

The fundamentals of care are frequently identified as the activities that are missed or omitted by nurses due to competing priorities or limited resources. Missed nursing care is defined as “any aspect of required patient care that is omitted (either in part or whole) or significantly delayed” (Kalisch *et al.* 2011) (p. 291). In her seminal study, published in 2006, Kalisch (2006) describes nine elements of missed nursing care that were described by nurses and nursing assistants working in two hospitals in the US. This qualitative study collected data using 25 focus groups and included 173 participants. The types of care the participants described as being ‘missed’ align with the fundamentals of care, and included ambulation, repositioning of patients to prevent pressure injuries, assistance with feeding, provision of patient education, discharge planning, emotional support, hygiene including bathing and mouth care, documentation of intake and output and visual observation. The participants in the focus

groups stated they were not able to provide all the nursing care the patients needed and expressed high levels of subsequent regret, guilt and frustration. The reasons the participants provided for the missed care included insufficient staff, the intervention requiring a 'long time', ineffective use of staff resources, the perception that the care required was 'not their job', ineffective delegation, habit or getting used to not providing that aspect of care, and denial or not acknowledging the care was not delivered.

These findings were supported by a similar study that was also conducted in the US (Bittner & Gravlin 2009). The consequences of this missed care were adverse patient outcomes including pressure ulcers, hospital acquired infections and patient falls (Kalisch *et al.* 2011). Kalisch *et al.* (2011) called for "increased discussion in a non-punitive context" (p. 297) to develop strategies to address this problem. However, exploring this issue utilising the self-reported, retrospective recollections from nurses might introduce 'recall bias' where participants' experiences, those that were either overwhelmingly positive or negative, colour their responses.

Missed or omitted care can also be linked to care rationing, where nurses implicitly decide to prioritise certain types of care and limit other care activities (Schubert *et al.* 2008). The Schubert *et al.* (2008) study, a cross sectional survey of patients (n=779) and nurses (n=1338), explored the link between rationing of nursing care and the relationship to patient outcomes in 118 medical, surgical and gynaecological units across eight hospitals in Switzerland. There were six dependant variables, five were nurse reported and included medication administration errors, patient falls, nosocomial infections, critical incidents and pressure ulcers. The final variable was patient-reported satisfaction with care. Despite nurses reporting they rationed care rarely, rationing of nursing care was reported as a "significant predictor" for all six outcomes. Again, however, this is a self-reported retrospective view of care and focusses exclusively on adverse events.

Care rationing or discretionary care, is described by Maben *et al.* (2012a) as

“staff having to choose between, for example, meeting the toileting needs of one patient or supporting another with feeding. At times staff had to compromise the dignity of a patient to ensure that they met their physical care needs quickly and safely” (p. 86).

In their case study, conducted in the UK, they explored the relationship between staff well-being, motivation, observable expressions of emotion, and patients' experiences of care. This study reports that staff manage their self-perceived inability to deliver all the required care for all of their patients by focusing their care on the patients they 'enjoy caring for' and on those who they feel will receive the most benefit. Patients requiring complex care, or those with whom the staff did not have a mutually conducive relationship, were at risk of receiving less personalised care (Maben *et al.* 2012a).

The Maben *et al.* (2012) study also suggests the individual nurse characteristics that impact on the patient experience of care include staff wellbeing and job satisfaction. The study authors suggest there are organisational, service and ward-based factors that influence nurses' efforts to provide care. These include a focus on throughput and pace accompanied by task and technology instead of quality; ward leadership promoting the importance of caring; the team environment; and the level of emotional support provided to staff. Multiple sources of data were used for this research including staff surveys (66 responses), patient surveys (26 responses), interviews with staff (18), interviews with patients and carers (18), and non-participant observation of care interactions (41 hours), thus it presents a comprehensive and multi-faceted picture of care delivery. However, the context was limited to a medical service focused on older people, thus the transferability of these findings across the acute care setting is not established.

In summary, the studies describing missed care and care rationing explore the 'barriers' to care provision but provide few indicators for when nurses do not, or do not feel the need to, ration care delivery. That is, due to their focus on adverse events and recall, they do not contain data pertaining to when things are done well. Exploring the enablers for 'good' care delivery may provide an alternative viewpoint. It is important to explore how to support nurses to deliver the fundamentals of care; given the

acknowledged complexity and interrelationship between the physical, relational and psychosocial dimensions of this care, the omission of a single element could have broader consequences.

Conclusions

There has been a lack of research investigating the fundamentals of care, and the literature that does exist is not clearly focused, with Kitson and colleagues, in their various publications, providing the most comprehensive account of the concept. During the timeframe for this literature review, the 'fundamentals of care' concept was still under development. The importance of the fundamentals of care and related concepts such as patient-centred care has been explored in discussion papers and enshrined in government policies and reports. Yet, there is an 'untidy' relationship between and among these similar, but poorly defined, concepts. Much of the research and other literature such as government policy and reports, utilises a retrospective, deficit focused, and occasionally punitive, evaluation of care with few measures or appraisal of when care delivery is considered 'adequate'. Within the research literature, outcome measures for care are frequently disaggregated, with little examination of the structures and processes required to support nurses to deliver the fundamentals of care.

From this review of the literature relating to the fundamentals of care, the following conclusions are drawn.

First, exploring the process of delivering the fundamentals of care requires a focus on those who deliver this care. Within the literature, nurses and healthcare assistants are generally seen to bear the responsibility for delivering the fundamentals of care. Internationally, a division in care delivery has been intimated, with registered nurses carrying out technical, treatment or cure-directed acts, while healthcare assistants focus on providing fundamental or basic care (Darbyshire & McKenna 2013, Willis 2012). The Australian Nursing and Midwifery Council (2006) competency standards indicate that registered nurses should take the leadership role in the coordination of nursing and health care to facilitate optimum health outcomes for the recipients of care. Thus, as the coordinators of patient care, it

is important to understand what factors these nurses believe influence their ability to deliver the fundamentals of care.

Second, exploring what factors might influence the delivery of the fundamentals of care from both the care provider and the care recipient standpoint, could provide a more holistic and potentially realistic view of care delivery. There has been some empirical research investigating missed care and care rationing, with the study by Maben *et al* (2012) utilising observation of care interactions to provide an indication of the complexity involved when nurses decide if, how and when to attend to an older patient's fundamental care needs. Direct observation of interactions between nurses and a more diverse patient group could provide a comprehensive picture of what occurs, who is involved, and which fundamentals of care are being delivered. These descriptions of fundamental care delivery could then be examined from the point of view of both patients and nurses, as they might have different perspectives and expectations of care. Seeking the nurse and patient perspective could assist in developing further insights into the factors influencing the delivery of care beyond those already identified in the literature. Once identified, further exploration of these factors can occur, moving beyond mere description of these factors, towards developing strategies that can be used to promote nurses' delivery of the fundamentals of care.

Potential for further research

The fundamentals of care, as a concept, are still undergoing refinement. These refinements, which have occurred after the timeframe for this literature review, are explored in Chapter 7 (Discussion). However, as a framework for patient care, this concept appears to resonate with nurses, professional organisations, other healthcare professionals and the wider healthcare system. To explore the factors that influence nurses' ability to deliver the fundamentals of care, an alternative to previous research and discussion focusing on deficits in care, negative patient outcomes, and the use a retrospective approach, is proposed. An empirical examination of the factors influencing nurses' delivery of the fundamentals of care using a prospective, real time approach exploring the complexity of this care, seeking the perspectives of both those who deliver and receive this care, and exploring how nurses can

best be supported to deliver this care, is important for generating evidence on what helps and/or what hinders the delivery of this care, and to suggest possible solutions or supports that might be required. To date, the Fundamentals of Care Framework published by Kitson *et al* (2013a) is the most complete configuration of the fundamentals of care, hence this framework was deemed to be the most appropriate to utilise for this research.

Chapter 3

Methodology

Introduction

As indicated by the literature review in the previous chapter, the fundamentals of care and the factors influencing their delivery are not explicitly understood. This study set out to explore the factors influencing the delivery of the fundamentals of nursing care in the acute hospital setting. A methodological framework is necessary to guide the research process to ensure that data collected are appropriate for answering the research questions. This chapter explores the conceptual framework for the research and then explains why an ethnographic methodology was chosen for this research study. This chapter then explores how focused ethnography helped the design of the research methods and the analysis of resulting data. The pathway from the framework, to the methodology and methods is outlined in Figure 2.

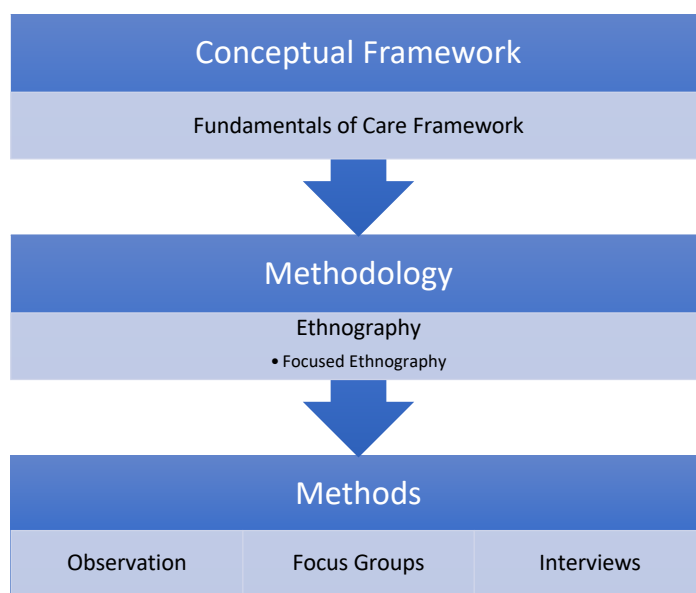


Figure 2 Methodological Pathway

The Conceptual Framework - The Fundamentals of Care Framework

It is important for a researcher to outline the concepts, assumptions, expectations, beliefs, and theories that support and inform their research. Conceptual frameworks are defined by Miles and Huberman (1994) as a visual or written product, one that “explains, either graphically or in narrative form, the main things to be studied—the key factors, concepts, or variables—and the presumed relationships among them” (p. 18).

The Fundamentals of Care Framework (Kitson *et al.* 2013a) comprises three core dimensions: the relationship between the nurse and the patient, the way the nurse and the patient integrate the fundamentals of care, and the contextual and system requirements needed to support the delivery of the fundamentals of care. The dimensions of the Fundamentals of Care Framework encompass 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. The Framework does not focus on clinical diagnosis, treatments or therapeutic outcomes. The fundamentals of care are defined in the Framework and include physical elements such as keeping the patient clean and comfortable, psychosocial elements such as keeping the patient involved and dignified, and relational elements such as the nurse being compassionate and respectful. The Framework is presented in Figure 3.

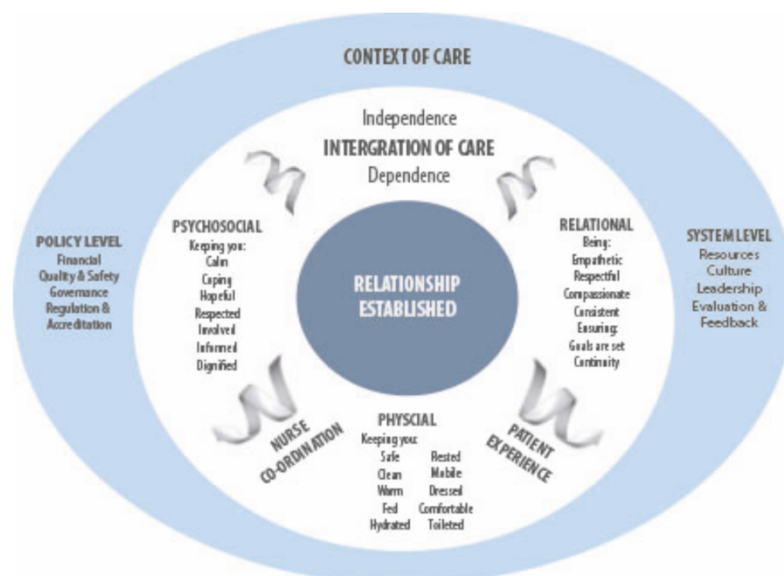


Figure 3 The Fundamentals of Care Framework (Kitson *et al.* 2013a)

Other conceptual models for nursing care exist including, among others, Martha Rogers's Science of Unitary Human Beings (Rogers 1990); Dorothea Orem's Theories of Self-Care, Self-Care Deficit and Nursing Systems (Orem 1995); Roper, Logan and Tierney's Elements of Nursing (Roper *et al.* 1980) and Callista Roy's Adaptation Model (Roy 1984). These models variously refer to some of the elements of the fundamentals of care and highlight the importance of nurse-patient relationships. However, the Fundamentals of Care Framework provided a conceptual representation of the theoretical interactions between the physical, psychosocial and relational fundamentals of care elements; the relationship established between nurses and patients for each care encounter; and was applicable in any healthcare context. The Framework was therefore used as the conceptual starting point for the research. The Framework depicts a comprehensive description of the fundamentals of care, but as it is a conceptual framework, it had not been applied to the delivery of the fundamentals of care in clinical practice. The interactions between each of the fundamentals of care had also not been directly observed or described.

The Fundamentals of Care Framework (see Figure 3) illustrates that when providing any care there is a need for the nurse to establish a trusting relationship with the patient, and to integrate and address the patient's physical, psychosocial and relational requirements. The Fundamentals of Care Framework shows how the nurse connects with the patient and helps them to meet their fundamental care needs. It focuses on enabling the patient and the nurse to confidently and competently assess, plan, implement and evaluate care around the fundamental care needs.

Dimensions of the Fundamentals of Care Framework (the three rings)

The Fundamentals of Care Framework diagram shows of a series of concentric circles, each consisting of an interrelated dimension. These dimensions illustrate the integration of the relationship elements at the centre of the Framework (Relationship Established), with the second dimension of activity where the nurse's initial assessment is used to construct a series of practical actions around the fundamentals of care (Integration of Care). The third dimension, the outer ring (Context of Care),

demonstrates how the relationship and the nursing actions are dependent on the wider healthcare system or context.

Elements of Fundamentals of Care framework (the 'lists' in each ring)

Within each dimension of the Framework, there are specific elements described. For the Establishing the Relationship dimension these are Trust, Focus, Know, Anticipate and Evaluate. In the Integration of Care dimension, there are specific elements for the Physical, Relational and Psychosocial care needs of the patient. The Context of Care dimension identifies both Policy and System level elements.

Fundamentals of care

The fundamentals of care refer to the items identified as the elements in each of the dimensions of the Fundamentals of Care Framework. These are also identified as the care needs of the patient.

Choosing the most appropriate methodology

A methodology is a constructive framework that guides research, ensuring the research is performed in a logical and coherent manner that maximises validity and authoritativeness. Methodologies contain theoretical principles and guide the researcher in choosing the data collection methods that best suit the line of inquiry (Carter & Little 2007). Methodologies can be qualitative, quantitative, or use mixed methods.

The quantitative researcher asks questions structured in way that can be analysed and measured using numbers, percentages and statistics and seeks to demonstrate a cause and effect relationship between the variables being studied (Richardson-Tench *et al.* 2011). This type of research aims to dissociate itself from the “distorting influences of people” (Richardson-Tench *et al.* 2011) (p. 6). Conversely, the qualitative researcher focuses on finding answers to questions centring on “social experience, how it is created, and how it gives meaning to human life” (Streubert & Carpenter 2011)(p. 4). As stated by Creswell, “a qualitative researcher relies on views of participants, and discusses their views within the context in which they occur, to inductively develop ideas.” (2007) (p. 248). This

research sought to explore the factors influencing nurses' delivery of the fundamentals of care from the view of the nurses and the recipients of the nursing care within a defined context. Thus, a qualitative methodology was indicated.

Carter and Little suggest "methodologies can be combined or altered, providing that the researcher retains a coherent epistemological position and can justify the choices made" (2007) (p.1326). Both grounded theory and ethnography, in their various interpretations, could potentially be used to answer the research question. Grounded theory methods are used to move the research towards the development of a theory specifying the causes and consequences of a process. In contrast, ethnography aims to develop a full description of a group of people. The two methodologies can even be used concurrently, with ethnographers using grounded theory to make connections between events by focusing, structuring and organising their data. However, Charmaz and Mirtchell (2001) specify in their description of using grounded theory in ethnography that this approach assumes the existence of multiple realities and the mutual creation of knowledge by researchers and research participants. This did not align with the aim of this researcher to employ an objective manner and to attempt to observe the genuine attitudes, motivations, and beliefs of the participants.

Ethnography and grounded theory also differ in their area of research inquiry. Ethnography is used to develop a holistic view of a specific culture and aims to understand the lifeways of individuals in a group, while grounded theory aims to obtain a deeper understanding of psychological processes and to build a theory to explain what is going on (Streubert & Carpenter 2011). Table 2 compares the approaches used in grounded theory and ethnography and summarises information presented by Charmaz (2005), Polit and Beck (2012) and Streubert and Carpenter (2011).

Table 2: Ethnography and Grounded Theory

	Ethnography	Grounded theory
Area of inquiry	Holistic view of a culture; studies cultural patterns and experiences.	Social structure process within a social setting; seeks to describe and understand key social and structural processes.
Discipline	Anthropology	Sociology
Domain	Culture	Social settings
Assumption	Every human group evolves a culture that guides the members' view of the world and the way they structure their experiences. The essence is to determine what an observed behaviour is or what a ritual means in the context of the group being studied.	Values the experience of the individual and suggests theoretical processes are always impacting, but that these are obscure to the untrained eye. This method is a way to discover the unseen processes. Chosen when there is an observed social process that requires description and explanation.
Aim	Purpose is to understand the lifeways of individuals connected through group membership. The ethnographic approach can be used to discover grounded theories.	Purpose is to develop a theory that is grounded in the data, not to test the theory. Aims to gain a deeper understanding of the psychological processes and build a theory to explain what is going on in the area. Accounts for actions in an area from the perspective of those involved.
Data collection	Researcher as an instrument. Fieldwork. Cyclical nature of data collection and analysis. Unique elements for ethnography are a focus on culture, cultural immersion and reflexivity.	Take a broad perspective. Reduce preconceptions. Interviews, observations. Flexible guidelines to enable focused data collection.
Analysis	Fetterman (2010) states "Analysis has no single form or stage in ethnography" (p. 112). Various methods can be employed including Spradley's steps, which include domain analysis, taxonomic analysis and componential analysis. Other analytical methods include qualitative or quantitative content analysis, nonparametric statistics for quantitative data, conversation analysis, forms of discourse analysis and hermeneutics (Till 2009).	Data can be interpreted through a framework. Concurrent with data collection. Coding Constant comparison to develop and refine categories. Build mid-range theories through successive levels of data analysis.

This research sought to describe the factors influencing nurses' delivery of the fundamental of care. To do so, it was necessary to obtain a descriptive and interpretive account from the perspectives of those who are involved. Data needed to be collected to provide an insight into the norms, beliefs and perceptions of the group who are directly involved, that is, those who deliver and receive this care. Group members are said to develop a culture that guides how they view their world and how they structure their experiences (Polit & Beck 2012) and hospital settings are known to develop their own indigenous cultural rules (Finkler *et al.* 2008). Ethnography focuses on cultural groups and examines their learned and shared values, behaviours and beliefs (Creswell 2007). Thus, this was the methodology that was most appropriate for this research.

Ethnography

A contemporary focused ethnography was adopted as the specific methodology for this research as this facilitated obtaining a holistic view of the complex issues influencing the delivery of the fundamentals of care in the acute hospital cultural setting.

Ethnography is seen as a way to systematically investigate the factors influencing the delivery of the fundamentals of care, and thereby contribute to nursing knowledge and potentially directly influence care delivery (Robinson 2013). The proposed phased nature of the study, outlined in Chapter 1, (Introduction), could be considered to affiliate more closely with that of a grounded theory methodology. However, the research questions focus on 'what' are the factors influencing the delivery of the fundamentals of care, and this is consistent with the types of questions used in ethnography as described by Higginbottom *et al.* (2013), whereas grounded theory focusses on the type of questions that ask 'why?' (Charmaz & Mirtchell 2001).

Providing a succinct description for ethnography is challenging and as stated by Hammersley (2005), it can be difficult to draw "tight boundaries" around the term. (p. 1). Ethnographic research has its roots in anthropology and is considered to be the oldest qualitative research methodology (Streubert & Carpenter 2011). Ethnography has been used since the early 1900's with Malinowski establishing the use of observation for data collection (de Laine 1997). Ethnography can be considered to be "the work

of describing culture” (Spradley 1980) (p. 3) or a “full or partial description of a group... as a means of identifying common threads” (Goulding 2005) (p. 299). Roper and Shapira (2000) (p. ix) indicate ethnography is a method that involves “learning about people by learning from them” and Spradley (1980) agrees, describing ethnography as more than the study of people, as it involves absorbing knowledge from them.

The use of ethnography in nursing research is not a recent phenomenon but, as indicated by Gelling (2014), this approach has not been adopted as widely as other qualitative approaches. He suggests this is due to the challenges involved in using this approach, which include the time required to access the research site, and the duration and complexity of data collection (Gelling 2014). Streubert and Carpenter (2011) advocate for the use of ethnography in conducting nursing research and explain how using ethnography in the natural or real-world situation supplies nurse researchers with a view of how the world is, rather than how they would like it to be. Ethnographic research explores the study situations “in real-time, ...as they occur in their natural setting, to gain an in-depth perspective” (Higginbottom *et al.* 2013) (p. 1).

Observation has been used to collect ethnographic data since the early 1900s (de Laine 1997). These observations, recorded as field notes, remain a primary source of data for ethnographic research (Robinson 2013). Observation has been defined as “the systematic description of events, behaviours, and artefacts in the social setting chosen for study” (Marshall & Rossman 1989) (p. 79), and can describe the communication patterns, workflows and tasks of the clinicians in a specific work environment (Horsky & Mamykina 2012). Observation is also an important part of nursing and has been used since the time of Florence Nightingale to collect data aimed at improving care outcomes (Robinson 2013).

The influence of conducting observation from the perspective of either a participant (‘emic’) or a non-participant/observer (‘etic’) view needs to be considered (de Laine 1997). This is explored in the literature along with descriptions of the various possible roles of the observer (Baker 2006, Gold 1958, Spradley 1980), which can range from being a participant who conceals their being a researcher to being an observer of whom participants are unaware (‘complete observer’). Ethnographers differ on the

merits of these various roles (Fetterman 2010, Spradley 1980), while Baker (2006) suggested various roles can be used during observations. Observation might also be supplemented or replaced by hypothetical scenarios which are used to elicit participant views (Higginbottom *et al.* 2013).

There are central characteristics for ethnographic research, some of which are also shared with other qualitative research methodologies. The shared characteristics include the researcher as instrument (the acceptance that the researcher is part of the study), fieldwork, and the cyclic nature of data collection and analysis (Streubert & Carpenter 2011). The characteristics described as unique to ethnography are the focus on culture, cultural immersion in a specific context, and the tension between researcher as the researcher and researcher as a cultural member, also referred to as reflexivity (Streubert & Carpenter 2011). The concepts of culture, context and reflexivity are discussed below.

Culture

Ethnography focusses on trying to understand people who have something in common and are thereby connected by being members of a group (Streubert & Carpenter 2011). Spradley (1980) states ethnography is “the work of describing culture’ (p. 3). Culture, a somewhat nebulous concept, is defined by Creswell as “something researchers attribute to a group when looking for patterns in their social world” (2007) (p. 71). Culture refers to the way humans act toward things on the basis of the meanings those things have for them. These meanings come from the social interactions that people have with each other, and are handled and modified through an interpretive process. To obtain a holistic perspective of a culture, ethnographic research attempts to “capture the breadth of activities, knowledge, and beliefs of the group under study” (Roper & Shapira 2000) (p. 3). The culture of a group is learned by observing, listening and making inferences about the behaviours and language the group members use (Spradley 1980).

Ethnographic research is not limited to describing or analysing a culture, as the essence of ethnography is described by Hammersley (2005) as being a tension between trying to understand the perspective of those within the culture, the emic view, and also observing them and their behaviour from an outsider or etic viewpoint. Other qualitative research methodologies frequently describe the etic

perspective, with the researcher applying their own understanding and interpretations to the data. An additional level of understanding and interpretation of the data is obtained when the ethnographic researcher tries to understand the cultural scene from the insider's perspective. This emic perception is important when the researcher is attempting to accurately describe the meanings and constructions that members of the culture give to their own world (Fetterman 2010, Whitehead 2005). However, Hammersley (2010) suggests then even when ethnographers attempt to emphasise the cultural members' perspective, it might never be possible for the researcher to truly achieve this.

Context

Ethnography aims to study the phenomenon being researched in its natural context, and therefore tries to avoid interrupting the natural setting. Aldiabat and Le Navenec (2011) suggest this enables the behaviour being studied to be understood within the everyday context in which it naturally occurs. Indeed, Hammersley distinguishes ethnography from experimental research by stressing the need for the researcher to study the participants first hand in their everyday context, not in artificial conditions that might be created by the researcher (Hammersley 2005, 2010).

To contextualise the findings from ethnographic research, Roper and Shapira (2000) and Hammersley (2005) stress the need for the researcher to describe how they will consider the interplay between micro and macro level processes. For example, when considering the findings derived from the research, the observations from the research setting and the participants' comments could be presented in tandem with details about the wider system in which they occur. Alternatively, the researcher might choose to focus on the detail of what participants do in their local context. A focused ethnography emphasises "the local world and practices of individuals in relation to specific issues of health and illness" (Roper & Shapira 2000)(p. 6-7). The use of this type of contextually limited ethnography is common in nursing research where there is focus on a particular health-related issue with a small number of participants (Robinson 2013).

Reflexivity

Struebert and Carpenter (2011) describe the difficulty between being a researcher and becoming a member of a culture as 'reflexivity'. These authors highlight the struggle for the nurse who tries to maintain an 'outsider relationship' as an objective researcher in the healthcare setting. Interestingly, Fetterman (2010) suggests all ethnographies are conducted on a spectrum from the emic, or insider view, to the etic or external scientific perspective. He suggests collecting data from the emic/insider view then trying to interpret the data in terms of both the insider's view and the researcher's own scientific analysis. Ethnographic researchers should attempt to guard against their internal biases, and make these explicit, while trying to view the culture being examined in an impartial manner (Fetterman 2010). Indeed, Savage (2000) states the extent to which the reflexivity is considered as an important criterion for assessing the quality of ethnographic research. She suggests the influence of the research design and strategy on the study findings must be explored by the researcher. Roberts (2009) concurs and recommends researchers demonstrate self-awareness of any of their potential biases that could have influenced the data collection and/or analysis. While agreeing with the principles of reflexivity, Till (2009) highlights the difficulty with determining how transparent a researcher is being about their influence on the data and questions if it is even possible for a researcher to achieve transparency. Hammersley (2010) suggests ethnographers who are conducting their research in areas with which they are accustomed, try to make the "familiar strange" by suspending their background assumptions that might "immediately give apparent sense" to what they experience (p. 387). Using strategies such as triangulation and a non-judgmental orientation is required to reduce the influence of the researcher's biases (Fetterman 2010). Pellat (2003) highlighted the need to be conscious of any potential biases, which for the author of this thesis included being a Registered Nurse, being a past employee of the observation site, and being an active researcher and co-author of papers relating to the fundamentals of care (see (Kitson *et al.* 2013a, Kitson *et al.* 2010, Kitson *et al.* 2013c, Kitson *et al.* 2014).

Types of ethnography

Ethnographic research can be conducted on a micro (mini) or macro (maxi) scale (Leininger 1985). The scale of the study will dictate the type of ethnography used. A micro or mini ethnography, alternatively called a focused ethnography, focuses on a distinct problem, studied within a single context with a limited number of individuals (Streubert & Carpenter 2011). A study examining culture in a broader context, over a longer period of time, and potentially involving multiple institutions, is considered by Spradley (1980) to be a macro or maxi ethnography. As this research project focused on the factors influencing delivery of the fundamentals of care in a single acute care setting, it fitted best with the scale for a micro or focused ethnography.

Focused ethnography

Focused ethnography is applicable “whenever there is a desire to explore specific cultural perspectives held by sub-groups of people within a context-specific and problem-focused framework” (Higginbottom *et al.* 2013) (p. 1). Roper and Shapira (2000) highlight the shared commitment between focused and more traditional ethnographies to conducting observation within a naturalistic setting, asking questions to determine what is happening and using the available sources of information to obtain an understating of the research objective that is as complete as possible. Cruz and Higginbottom (2013) champion the application of focused ethnography to distinct issues in specific settings and this is supported by Robinson (2013) who states this type of ethnography is expected to gather useful information that is practically applicable for those in the healthcare professions. The key characteristics and methods of focused ethnography, described by Higginbottom *et al.* (2013), are: a focus on a discrete organisation, the conceptual orientation of a single researcher, involvement of a limited number of participants, being problem focused and context specific, seeking participants with specified knowledge, and using episodic observation.

Focused ethnography is distinguished from conventional ethnography by Knoblauch (2005) and Cruz and Higginbottom (2013) and some of these differences include the duration of the field visits, the intensiveness of the data collection, the focus of the data collection, and the roles adopted by the researcher during the observation periods. These, and other differences are outlined in Table 3.

Table 3: Comparison between conventional ethnography and focused ethnography (adapted from Knoblauch 2005)

Conventional ethnography	Focused ethnography
Long-term field visits (approx. 1 year)	Short-term field visits
Experientially intensive	Data and analysis intensive
Time extensity	Time intensity
Writing	Recording
Solitary data collection and analysis	A group of researchers providing input to the data analysis
Open	Focused
Participant role	Field-observer role
Insider knowledge	Background knowledge
Notes	Notes and transcripts
Coding	Coding and sequential analysis

Different forms or types of ethnography have different intentions and thus suit different research questions. The use of critical ethnography could also have been considered for this research. The goal of critical ethnography is not restricted to gaining an understanding or knowledge of a culture, but aims to critique the power imbalances present and seeks to empower participants to change these imbalances through that knowledge (Marshall 2015). Thomas (2003) contends that:

“at its simplest, critical ethnography is a way of applying a subversive world view to more conventional narratives of cultural inquiry... it offers a more reflective style of thinking about the relationship between knowledge, society, and freedom from unnecessary social domination” (p. 45).

It is the focus of critical ethnography on “issues of injustice and oppression” that is its distinguishing factor (Streubert & Carpenter 2011) (p. 169). The primary purpose of this research was to identify and describe the factors influencing the delivery of the fundamentals of care rather than to critique the structures that oppress either the nurses delivering the care or the patients receiving the care. Therefore, critical ethnography was not a suitable methodology for this study.

Epistemology

Consensus among ethnographic researchers about the agreed epistemological position for an ethnographic study is lacking, and it is suggested by Savage (2000) that ethnographers also differ about what constitutes legitimate knowledge. One way to approach the research questions for this study was to attempt to understand the reality of fundamental care delivery in a way that was as transferable as possible. The presupposition would then have been that the researcher could access participants' genuine beliefs, attitudes, and knowledge about the factors influencing the delivery of the fundamentals of care (Carter & Little 2007). Through conducting non-participant observations and asking questions in a non-leading, depersonalised manner the researcher would then aim to observe the real attitudes, motivations, and beliefs of the participants.

Conversely, exploring these research questions could also be undertaken by jointly creating knowledge in collaboration with the participants, where the knowledge was produced by the interactions and relationships between the researcher and the participants. In this case the researcher would be inextricably imprinted on the research as they would have been an active participant from beginning to end care (Carter & Little 2007). Thus, the researcher must have constantly reflected on this process, and been transparent about their own subjectivity.

The epistemological position taken in this research lies somewhere in the middle of the two perspectives described above. Although ethnographers differ regarding the prescribed epistemological position for ethnographic research, there is broad agreement that this type of research combines the perspectives of the researcher and the participants (Savage 2000). For this study, the researcher could be seen to have had an impact on the research and this will be acknowledged and explored in Chapter 4 (Methods). However, attempts to maintain objectivity were also considered worthwhile and necessary in order to obtain a genuine view from the participants and to potentially promote the broader relevance or generalisability of the research findings. The methods used to achieve this will also be described in Chapter 4 (Methods).

Ethnographic analysis

Ethnographic analysis uses an iterative process in which cultural ideas that arise during active involvement 'in the field' are transformed, translated, or represented in a written document. It involves sifting and sorting through pieces of data to detect and interpret thematic categorisations, search for inconsistencies and contradictions, and generate conclusions about what is happening and why (Thorne 2000). Traditional ethnographic analysis described by Spradley (1980) involves domain analysis, taxonomic analysis and componential analysis then discovering cultural themes. These themes might include social conflict, cultural contradiction, social control, interpersonal relationships, status of the participants and problem solving (Streubert & Carpenter 2011). Roper and Shapira (2000) describe their steps of ethnographic analysis as coding the data, identifying patterns, generalising constructs and noting personal reflections and insights, although they acknowledge that progressing through these steps is not linear. However, Fetterman (2010) states "analysis has no single form or stage in ethnography" (p. 112) and Till (2009) identifies other analytical methods that might be used including qualitative or quantitative content analysis, nonparametric statistics for quantitative data, conversation analysis, forms of discourse analysis and hermeneutics.

Content analysis is concerned with "meanings, intentions, consequence and context" (Elo & Kyngas 2008) (p. 109) and is described by these authors as method that might be used with qualitative data in a deductive or inductive way. The use of deductive content analysis is dependent on the existence of a previous knowledge base or model. An inductive approach is recommended if there is a lack of knowledge about the phenomenon being investigated. The process of data analysis for focused ethnography requires the researcher to "engage in an iterative, cyclic, and self-reflective process, as preliminary interpretations are challenged and data are continually revisited to plan for further data collection" (Higginbottom *et al.* 2013) (p. 6). These authors also indicate the steps in the analysis should be focused on the development of answers to the research questions. A deductive approach to content analysis might be useful when the aim is to move from a general to a more specific description of the data. Focused ethnography might also use an inductive approach when there is scarce information about an issue or problem.

Trustworthiness

Consensus for assessing the quality of qualitative research is lacking, perhaps due to the diversity of methodology and methods employed (Leung 2015). The trustworthiness of an ethnographic or indeed any qualitative research study might be determined by the level of detail provided for the actions and elaborations of the researcher at each stage of their research (Ryan *et al.* 2007). Creswell (2007) lists eight strategies to promote what he describes as the “validation” of qualitative research, and he suggests qualitative researchers engage in a least two of these. These eight strategies include prolonged engagement and persistent observation in the field, triangulation of data from multiple sources, peer review and debriefing, negative case analysis, making researcher biases explicit, member checking, use of rich thick descriptions, and external audits. However, it has been suggested by Streubert and Carpenter (2011) that there is no single set of criteria that can be used to determine the rigour for every research study. These authors do however agree that the goal of qualitative research is to accurately represent the participants’ experiences and views, and several of the criteria described by Creswell (2007) would facilitate this. Fetterman (2010) suggests no researcher can be completely sure about the validity of their research conclusions. His suggestions for how to promote validity in ethnographic research include gathering sufficient data, ensuring that data are accurate, and spending extensive time working with the research participants. When considering the data analysis, comparing information sources as well as using thick descriptions and verbatim quotations, add to the face validity of ethnographic research (Fetterman 2010). Using diverse methods, such as observation and interviews, and analysing the data from these multiple sources might also contribute to a sense of trustworthiness (Reimer 2009).

There were several strategies that were used to promote trustworthiness in this research. Engagement in the field might not be considered prolonged as there were ten hours of observation at each site. However, these observation data were later used to explore the perceptions of the participants in the focus groups and interviews, thus it was compared and triangulated with other sources that, arguably, would be seen as ‘trustworthy’ by the nurses and patients who had been observed. The researcher and author of this thesis engaged in regular, at least monthly, debriefing with

their supervisors throughout all stages of the data collection and analysis process. The researcher has also explicitly considered her potential biases and these have been identified. Thick descriptions and verbatim quotations are presented in the Chapter 5 (Findings) to support the themes identified in the data analysis. These strategies have been used to enable readers to assess the credibility of the research findings (Creswell 2007).

Summary

This chapter has described the choice of Fundamentals of Care Framework as the conceptual framework for the research. The options for the study methodology have been explored and the reasons for the use of ethnography, specifically focused ethnography, to answer the research questions have been presented. This chapter has also defined the epistemological position adopted by the researcher and explained how this has informed the methods used for data collection and analysis. The strategies employed to promote the validity of the research are also described.

The following chapter will outline the research study design, ethical review and explain the specific methods used at each of the three stages of the research.

Chapter 4

Methods

Introduction

In the previous chapter the reasons for approaching the study from an ethnographic perspective were explained. When framing a research study using focused ethnography, data should be obtained from multiple sources. This study explored the factors influencing the delivery of the fundamentals of care in the acute hospital setting using various data sources. These various sources are consistent with what Schensul and LeCompte (2013) identify as 'essential data collection' for ethnography, and included direct observation of fundamental care delivery, employing focus group conversations and interviewing key informants. These multiple sources aimed to ensure the topic was explored in sufficient depth and breadth (Schensul & LeCompte 2013).

The study setting was a 650-bed metropolitan tertiary hospital in South Australia. The study, as will be explained in this chapter, was conducted in three stages. This chapter reiterates the research aims and research questions, then describes the design of each stage of the research study including the rationale for selecting each method and a description of how each method was used. The ethical issues at each stage of the research will then be explored.

Research aims and research questions

This project aims to find out what is influencing nurses' delivery of the fundamentals of care in acute hospital wards. It was envisaged that by explicating what facilitates or hinders the provision of the fundamentals of care in acute care wards, evidence will be generated to improve patient outcomes.

Research questions

The research questions this study sought to answer included:

- What factors influence the delivery of the fundamentals of care in the acute hospital setting?

More specifically:

- What factors are observed to influence the delivery of the fundamentals of care in an acute care hospital?
- What factors do nurses working in an acute care hospital describe as influencing the delivery of the fundamentals of care?
- What factors do patients of an acute care hospital describe as influencing the delivery of the fundamentals of care?

Research study design

The iterative, three-stage research design used data from each Stage of the study to inform and direct the next Stage. Stage 1 aimed to identify, via observation, the fundamentals of care that were being delivered, who was involved and when and where these fundamentals of care were being delivered in the acute care setting. Once this data had been collected, Stage 2 sought a variety of perspectives on the factors influencing the delivery of the fundamentals of care in a range of acute care scenarios. That is, what the participants thought was happening and why. The possible strategies to moderate these factors were then explored in Stage 3. Thus, this stage asked what can be done to facilitate the delivery of the fundamentals of care. Details of each stage are provided in Figure 4.

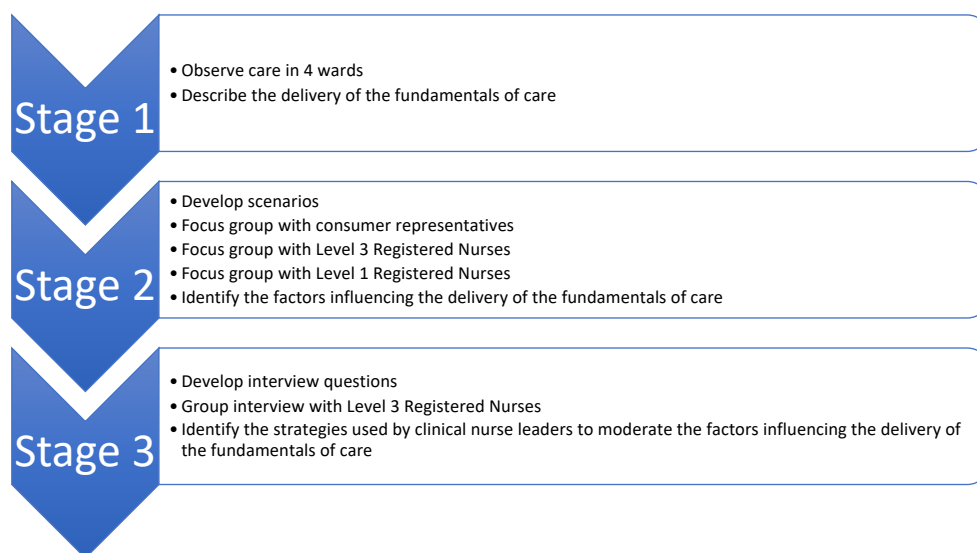
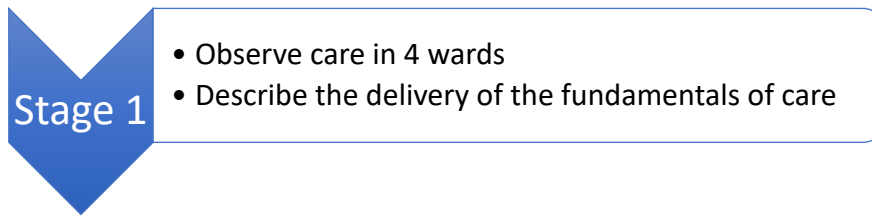


Figure 4 The three stage iterative research design

Stage 1. Observation: Describing the delivery of the fundamentals of care



Observation is considered integral to ethnography as it provides the best opportunity to view participants' behaviour in the context of the 'real world' (Fetterman 2010). Thus, this method was chosen to observe the delivery of the fundamentals of care and to begin to explore some of the factors influencing this process.

Objectives

The objective of the observations was to obtain 'real life' descriptions of the interactions between nurses and patients linked to the delivery of the fundamentals of care. The observations sought to collect data that:

1. Revealed who was involved in these interactions including nursing staff, other hospital staff, patients and their visitors
2. Described what prompted the interactions related to fundamental care delivery, as well as when and where these interactions were occurring
3. Illustrated which fundamentals of care were being addressed

Preparing to observe: Participant versus non-participant

The influence of conducting observation from the perspective of either the emic (participant) or the etic (non-participant/observer) was considered. These various perspectives are described in Table 4.

Table 4: Observer roles (Conroy 2017)

Role type	Researchers' role
The complete participant	Be fully part of the setting. Observation is often hidden from those being observed.
The participant as an observer	Has access to the research setting by having a natural, non-research reason for being present
Moderate role or peripheral member	Balance between participation and observation. Interacts with those being observed and engages in similar activities. Not considered a member of the group.
The observer as a participant	Only minimal involvement in the research setting. More observation than participation.
The complete observer (passive participation)	Does not take part in the setting at all. Role is to listen and observe.
Non-participation	Not present at the setting.

The observation in this research might be described as 'complete observation', given the researcher was not directly responsible for care (Baker 2006, Gold 1958, Spradley 1980). However, because the researcher is a Registered Nurse and did occasionally assist participants in minor ways, such as helping to make beds and fetch equipment, it could be argued that they were a participant. Potentially, then, the researcher was a 'passive participant', according to Spradley's (1980) types of participant/observer, which he suggested is a valuable way for researchers to understand the cultural rules that people follow. The researcher could also have been considered an 'observer as a participant' given that participants were aware the researcher was observing them, and the researcher participated in some nursing activities, such as assisting with bedmaking. The primary focus of the researcher, however, was recording what occurred in as much detail as possible. The researcher took the 'observer as a participant stance' which facilitated both the taking of extensive field notes about the various care events being observed and also opportunities to contribute to a slight reduction in the nurse participants' workload, which might have helped to develop a positive relationship with the observation site and those being observed.

Observation tool design

Although participant observation is mentioned in most ethnographic textbooks, specific details regarding its use in nursing research and the practicalities to be considered are not always explained. Kawulich (2005) provided a comprehensive overview of participant observation; however, this is more

than ten years old and is not specific to nursing research. There are many seminal texts that describe the theoretical basis and methodology for ethnography (de Laine 1997, Hammersley & Atkinson 2007, Murchinson 2010, Schensul & LeCompte 2013, Spradley 1980), however, there are few publications that address the practical experiences of engaging in ethnographic research (Gelling 2014). The researcher has attempted to bridge this gap with a publication based on their experiences, exploring the beginner's perspective of ethnographic observation (Conroy 2017) (Copy in Appendix 1).

Taking field notes is 'part of the invisible oral tradition' of ethnography (Hammersley & Atkinson 2007) (p.142). Sampson (2004) supported the piloting of data collection before ethnographic fieldwork as a way to improve the quality of a study. Before the first period of observation for this research, an initial practise observation session was performed to trial the collection of data. For this session, a draft tool was developed that included prompts for recording of information about the events to be observed, including location, date, time and the participants involved. An area for free text was also included. The tool was piloted by the researcher in one of the proposed observation sites, in tandem with an experienced nurse researcher (PhD co-supervisor). Both documented their findings and recorded their reflections on the trial. It became apparent that verbatim descriptions of every detail of the observed events would generate considerable data, so observation would need to be targeted and focused on the research questions. To minimise the amount of writing required, a list of codes and abbreviations for commonly observed phenomena were developed. The data collection tool was revised to incorporate these changes (see Appendix 2). This was then used to record the observation data.

The researcher was known at the pilot observation site as she had once been employed there, although this was more than ten years before this research study. This site (Ward 1) was also used as the first data collection site for the research. These pre-existing relationships were of benefit to the researcher and enabled the initial data collection to occur in an environment where the researcher was welcome. It was helpful to be in a relatively familiar environment with friendly faces when beginning the observation process. It enabled the development of a routine for data collection, as well as opportunities

to practice asking for consent and explaining the purpose of the research. Moving to unfamiliar sites after this experience was less daunting because the researcher had her 'pitch' and processes practiced.

Recruitment and data collection

Study sites

Observations were conducted at four sites (wards) self-nominated by their clinical nursing leaders (nurses who are responsible for the delivery of care across an entire ward or unit) following a request sent to all acute inpatient care areas in the hospital by the hospital's Director of Nursing on behalf of the researcher. The four volunteer wards where observation was conducted represented a broad perspective of acute care and included specialised and general surgical and medical wards. To avoid potentially identifying these wards the specific clinical specialties involved are not disclosed here. Before commencing observations, the researcher met with each of the clinical nursing leaders of the wards and as many staff as possible to describe the study and obtain their support. These leaders were reassured that comparison of care delivery between the various sites was not an aim of the study.

Recruitment

The inclusion criteria for Stage 1 were Registered Nurses who were engaged in direct patient care in one of the four acute inpatient wards. The recruitment method was similar in each ward. Prior to commencing any observation in the ward, the researcher attended ward shift handover meetings to explain the study and distribute information about participation. At the beginning of each observation period, which usually coincided with a shift change, the researcher introduced themselves to the nursing leader for the shift and to the other nursing staff and reminded them of the study. The nursing shift leader was asked to nominate a staff member for the researcher to approach and seek permission to observe. The researcher then sought verbal consent from the staff member for the observation. Observation occurred for a two-hour period, daily, for five days in each ward area. Observation periods were scheduled for the times of day when the fundamentals of care were more likely to be a predominant focus of the nursing activity. Table 5 details the observation times for each ward.

Table 5 Observation periods and timing

Ward 1		Ward 2		Ward 3		Ward 4	
Observation period	Timing	Observation period	Timing	Observation period	Timing	Observation period	Timing
1	7.00am-9.00am	6	7.00am-9.00 am	11	7.00am-9.00 am	16	7.00am-9.00 am
2	7.00am-9.00 am	7	7.00am-9.00 am	12	7.00am-9.00 am	17	6.30pm-8.30 pm
3	7.00am-9.00am	8	7.00am-9.00 am	13	7.00am-9.00 am	18	7.00am-9.00 am
4	7.00pm-9.00pm	9	7.00am-9.00 am	14	5.00pm-7.00pm	19	7.30am-9.30 am
5	7.00am-9.00am	10	7.00pm-9.00pm	15	7.00am-9.00 am	20	7.00am-9.00 am

Data collection

Forty hours of observation was conducted, ten hours in each ward area (see Table 5 for details). As the focus of the study was on a topic area where there was little previous research, the researcher tried to maximise the variety of observations. Different participants and care environments, at different times of the day were observed, to obtain a broad overview of practice (Lambert & Loiselle 2008). An individual nurse was observed while they attended to the patients they had been allocated to care for during that shift. Data were recorded on the data collection tool (see Appendix 2) in free text. Data included the date of the observation, the type of the nurse(s) being observed (Registered, Enrolled, Student, and their level), a description of the layout of the environment where the patients were receiving care from the nurse(s) being observed (for example the number of beds in the ward or the location of the single room in comparison to other patients being cared for by the same nurse), the time of each observation event, the designation of any other staff in the event, a free text description of the event including what or who prompted the event, any verbatim statements from the nurse or the patient that were overheard by the researcher, the frequency and duration of the interactions, any informal conversations between the researcher and the participants and any precipitating factors for the fundamentals of care, such as a call bell or a request from a visitor or family member. Observation data were collected chronologically, that is as they occurred, and were transcribed into a word document immediately after each observation session.

It must be acknowledged that being watched might have changed the behaviour of the nurse(s) being observed. An effort was made not to be intrusive and not to become involved in potentially sensitive or irrelevant activities. For example, a bed-to-bed handover, which described each patient's diagnosis and care plans, was conducted in each area in the morning observation periods. However, because this information was not directly relevant to the data being collected, the researcher chose not to take part in this. Observation was undertaken at a distance, such as from the corridor outside the room, and the researcher did not accompany the nurses behind closed doors or curtains.

Data analysis Stage 1: Deductive content analysis

Deductive analysis is used when the researcher works from more general information to the more specific and uses a source of previous knowledge to inform the analysis (Elo & Kyngas 2008). The Fundamentals of Care Framework was used as this source of previous knowledge (Kitson *et al.* 2013a). As mentioned previously, the observation data were collected chronologically. This provided a picture of the complexity of the nursing role and how they manage to deliver care to multiple patients concurrently. However, the chronological data did not provide a coherent picture of the interactions relating to the fundamentals of care between individual patients and nurses. Data were then reordered from chronological into individual patient stories, then collated into patient-specific events for analysis. The events were based on the prompt for or focus of the interactions. Where data were not related to one particular patient, such as when a participant chose to interact directly with the researcher, this was labelled as 'other observations'. Figure 4 describes the reallocation of the data.

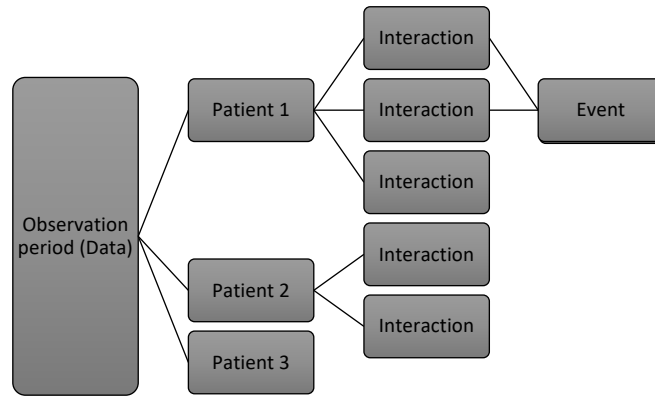


Figure 4 Process used to sort observation data prior to coding

Data from each period of data collection were identified using numbers to indicate the observation period, individual patient story, and events related to specific aspects of the fundamentals of care. Within each patient story there might be multiple events and within each event there might be multiple observations. Thus, the first event occurring in observation period 2, with patient 3 was numbered 2(period). 3(patient). 1(event), i.e. 2.3.1.

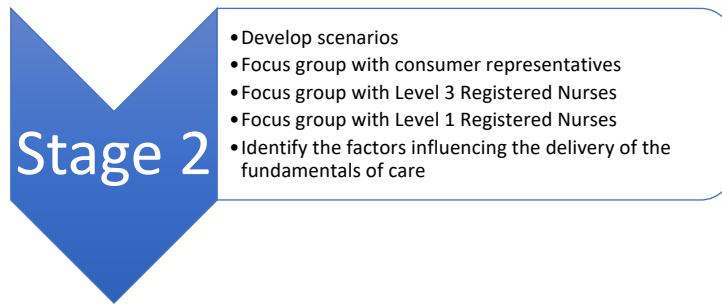
These events were then coded using the elements from the Fundamentals of Care Framework to identify the fundamentals of care that were being addressed. These elements are defined as the physical, relational, psychosocial and contextual dimensions of the Framework. Where there were no existing fundamentals of care elements, new codes were created to highlight these. Codes also indicated if the event had addressed a fundamental of care in a positive (+ve) or negative manner (i.e., it was ignored or overlooked) (-ve). All codes that were relevant to the individual event were applied. Consequently, each event has multiple codes. An example of the coding is shown in Figure 5.

Event 8.2.2	Physical	Relational	Psychosocial	Context
<p>7.25am RN tells me, referring to pt in pod 1, 'We don't have a fan to cool his temperature.' RN wets a bath towel and takes it to pt, says to pt 'Put this on your head, your temperature is up.' Places towel on pt head. Says to me 'I'm going to get him some ice'. Goes away and brings back ice chips for pt. Pt is lying on bed, head of bed slightly elevated and eyes closed.</p> <p>7.42am EN brings fan for pt in pod 1, says to me 'Bringing reinforcements'. RN draws curtain closed, gives pt medication while talking to pt.</p>	<p>Comfort (+ve) Hydration (+ve)</p>		Informed +ve	Resources /equipment (-ve)

Figure 5 Example of coding process

Events were recorded verbatim from what the researcher saw and heard. Some events had positive or negative emotional effects on the researcher. These events included a nurse showing particular concern for the comfort of a patient and their visitor, which elicited a positive feeling, and a patient in obvious distress being ignored by staff, which had a negative effect. When transcribing the data, these events were reflected upon by the researcher and the researcher's responses to them was recorded. These events could have influenced which examples were extracted to demonstrate certain themes when conducting the analysis and presenting the findings. To avoid this, a moderation process was required that involved other researchers who were familiar with the data but not present during observation. Strategies used by the researcher to address possible biases included making reflective notes after each observation period, regular debriefing and discussion with PhD supervisors, and reorganising the data. The data from this stage informed the next stages of the research, which provided an opportunity for triangulation and additional opportunities to address these biases.

Stage 2. Focus groups: Identifying factors influencing the delivery of the fundamentals of care



Using focus groups in ethnographic research enables the researcher to explore the interpretations derived from observational data (Picken 2009). Using scenarios as an initiator for the focus group discussion might be seen as a way for focus group participants to explore potentially sensitive topics in a less threatening manner than being directly asked about their own personal experiences or views (Braun & Clarke 2006). The use of hypothetical scenarios in focused ethnography is also supported by Higginbottom *et al.* (2013), who suggests they could be used to replace participant observation.

Focus groups were used to explore the perspectives of nurses and consumer representatives of the factors influencing the delivery of the fundamental of care. Participants were asked to read scenarios based on actual care delivery that was observed in Stage 1, then describe and discuss the factors they thought were influencing the care delivery. Focus groups facilitate participant discussion about their experiences, feelings, opinions and ideas (Brondani *et al.* 2008). The interaction between group members allows for the exploration of contrary opinions and might generate new understandings. For this reason, to avoid any potential perceived power imbalances and the problem of 'social desirability' (Grimm 2010) where the participant gives the most socially acceptable response, separate focus groups were held for consumer representatives, Level 1 Registered Nurses and Level 3 Registered Nurses. The groups were held separately to encourage open and frank discussion about issues the group members might be reluctant to share otherwise.

Objectives

The objective of the focus groups was to explore the factors influencing the delivery of the fundamentals of care in the scenarios as described by nurses – Level 1 Registered Nurses and Level 3 Registered Nurses (those in clinical nursing leadership roles) – and healthcare consumer representatives. The participants in each focus group were presented with four care scenarios. The aim was not to reach consensus about the issues that were discussed, but to obtain data relating to a variety of views and experiences (Kvale & Brinkmann 2009).

Design-development of scenarios

The four scenarios were used to encourage the participants to draw on their own experiences to explore the factors they felt were influencing the care described in the scenario (Jenkins *et al.* 2010). These scenarios were based on combinations of frequently observed situations of actual care provision that had been observed during Stage 1 of this research. The relevance and realism of scenarios are seen as important by Hughes and Huby (2004), who argued that scenarios are more effective when they engage the participants' interest, are relevant, and appear realistic. Using the de-identified real-life examples from the observation data promoted the internal validity of the scenarios (De Wit *et al.* 2011, Hughes & Huby 2004). Internal validity is defined by Hughes and Huby (2004) as the extent to which the scenario content "captures the research topics under question" (p. 37). The scenarios were piloted with two external healthcare consumers and two Registered Nurses who were not included in the research as participants, to evaluate the clarity of the scenarios and to gain an estimate of the time required for the relevant questions to be explored. Each person involved in the pilot read the scenario and commented on the areas where they thought clarification was required. Grammatical and layout changes were made, and some medical terminology was removed from the scenarios as a result. The consumers and nurses participating in the pilot were then asked the questions that were planned for the focus groups and their answers were recorded and timed to determine the approximate time required for each focus group. Extra time was allocated to allow for the expected discussion in the focus group. The Registered Nurses were also asked to comment if they thought the scenarios identified any particular ward or clinical specialty. This was not perceived, and no further changes were required. The

Scenarios are presented in Appendix 3. The scenarios were then used to elicit data about the focus group participants' beliefs and experiences.

Recruitment and data collection

Recruitment

All participants responded to a call for volunteers. The call for nursing volunteers was disseminated by email, forwarded by the Assistant Nursing Directors of the hospital, to the inpatient areas they oversee. Nursing staff from the observation sites were also informed about the opportunity to be involved in the focus groups during the observation period in their ward area. Consumer representatives were invited to participate via the Consumer Experience Manager for the hospital. Participants either worked at the hospital as Level 1 or Level 3 Registered Nurses or attended meetings as members of the Consumer Advisory Council, these being individuals from the community with direct experience of the services of the healthcare facility, either as a patient, family member or carer. Consumer representatives were selected in preference to inpatients in the facility for several reasons. While current inpatients would have recent experience of the delivery of the fundamentals of care, literature suggests patient representatives are able to draw on a wider range of experiences, provide different perspectives, are less influenced by perceived power imbalances with healthcare professionals, and have established communication skills (Baillie *et al.* 2011, De Wit *et al.* 2011, Van Wersch & Eccles 2001). The involvement of patient representatives or 'patient research partners' as De Wit *et al.* (2011) refer to them, is seen as valuable - incorporating their "experiential knowledge during all phases of the project can contribute to the relevance, quality and validity of the research outcomes" (p. 724).

Level 1 Registered Nurses typically directly deliver nursing care to their allocated patients or delegate care to another healthcare worker while remaining accountable for that care. It was important to explore their perspective as these are the nurses who are at the forefront of fundamental care delivery. A Level 3 Registered Nurse is a clinical nursing leader who coordinates the care delivery for an entire ward or unit. It was considered important to explore their perspective of the factors influencing

fundamental care delivery as they are in a position of influence and have the ultimate responsibility for the care delivery in their ward or unit.

Data collection

Every nurse and consumer who volunteered to participate had the opportunity to attend a focus group, thus no volunteers were excluded. There were three focus groups, one for each participant type. Details of the groups are presented in the Chapter 6 (Findings Part 2). More focus groups were planned; however, it was not possible to recruit any more volunteers despite repeated attempts. The focus groups were held in a quiet private meeting room adjacent to the hospital. The groups were led by the researcher who was accompanied by an observer. All participants in each group were presented with the scenarios, one at a time. After allowing a few minutes for the participants to read each scenario they were asked the following questions:

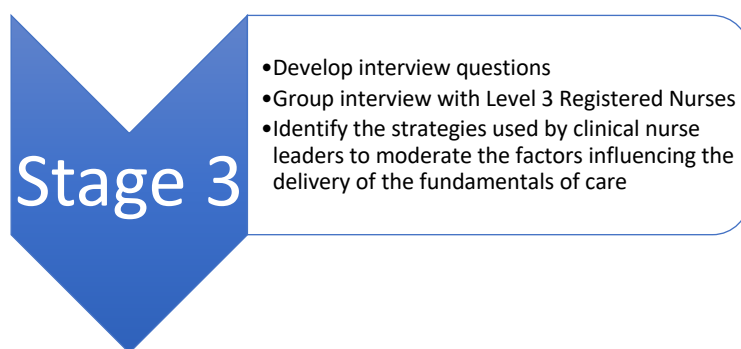
- Level 1 Registered Nurse group only: How long have you been a Registered Nurse?
- Level 3 Registered Nurse group only: How long have you been in the Level 3 role?
- Consumer advisory council member group only: Was your experience with hospitalisation as a patient or as a carer or family member? How recent was this?

Questions for each scenario:

- What do you think was happening in this scenario?
- What are the differences between these 2 situations? *Asked only if there was a comparison to be made (i.e., Scenario 1 and Scenario 4)*
- What are the needs of the patients in the scenario?
- What could be influencing the nursing care?

Each focus group was audio recorded and transcribed verbatim. Transcription was conducted by an experienced external commercial confidential service. Data from both Stage 2 and Stage 3 were analysed using inductive content analysis, which is described below after Stage 3 of the research has been explained.

Stage 3. Group Interview: Strategies to promote nurses' delivery of the fundamentals of care



A group interview differs from a focus group as the interviewer has a more overt role in asking the participants specific questions. A group interview is a highly structured technique designed to keep personal interaction at a minimum level during the process of new idea generation, while maximising the individual contribution of each respondent (De Ruyter 1996). Each participant is individually invited to reflect upon and provide their responses to each question when asked by the group facilitator. Utilisation of a highly structured interview is described by Higginbottom *et al.* (2013) as consistent with the focused ethnographic methodology, and can aid in validating observations and collecting data on issues that cannot or have not been observed (Roberts 2009).

Objectives

The purpose of the group interview was to explore the strategies used by nurses in clinical leadership positions to support nurses' delivery of the fundamentals of care. Participants were presented with findings from the focus groups and asked to describe how they support their nursing staff to deliver the fundamentals of care. The group interview was used to explore the strategies used by clinical nursing leaders to moderate the factors influencing the delivery of the fundamentals of care that had been identified in the focus groups. The analysis of the focus group data revealed consistency in the factors that were described, and the potential for nursing leadership to influence many of these factors. Thus, how some of these factors could be addressed was explored with clinical nursing leaders. These factors are explored in Chapter 6 (Findings Part 2).

Recruitment

All participants responded to a call for volunteers. The call for nursing leader volunteers was disseminated via email direct from the researcher to those nurse leaders who had expressed an interest in being interviewed during the previous two stages of the research. Another call for volunteers via email was also forwarded to the nursing leadership group by the Nursing Director of the hospital.

Data collection

The call for volunteers recruited six participants who became the members of the single group interview. Every volunteer had the opportunity to attend the group interview, thus no volunteers were excluded. Further volunteers were sought with repeated email requests, but none were successfully recruited. The group interview was held in a quiet private meeting room adjacent to the hospital. The topics for the group interview were derived from the analysis of the focus group data. There were factors identified in all three focus groups where further exploration could reveal some strategies to promote the delivery of the fundamentals of care at the point of care. These topics were then explored in the group interview. Each topic for discussion was introduced with a preamble and then each participant in the group was individually asked about the strategies they would use to promote or address that issue. The preamble and questions are described in full in Appendix 4. The interview questions were:

1. What can nurse leaders do to promote positive nurse-patient relationships?
2. What kinds of things do you do as a nurse leader to promote effective nurse-patient communication?
3. What strategies do you use to help nurses to keep patients involved in their care and ensure their choices are respected, without provoking anxiety?
4. What suggestions would you as a leader give to nurses who are new to your area for how to prioritise patient care?
5. What advice would you give to a new CSC (Clinical Service Coordinator, the clinical nursing leader) around delivery of high-quality patient-centred fundamentals of care taking into consideration the resource constraints?

6. Do you think in ten years' time or fifteen years' time the nurses and the CSCs (nurse leaders) will actually be responsible for fundamental care or will it be delegated to a health care worker, assistant in nursing or a relative? Do you get a sense that this work is so intrinsic to nursing that it won't ever be challenged?

Data Analysis Stages 2 and 3: Inductive content analysis

An inductive method was used for coding the focus group and group interview data. Inductive analysis derives the codes from the data and is recommended if there is insufficient knowledge about a phenomenon (Elo & Kyngas 2008). Open coding was employed, where descriptions are written in the margins of the transcript to describe the statements made by the participant. This can also be considered latent coding (Russell Bernard & Ryan 2010) as it involves interpretation and reading for meaning, as well as taking the context into account.

The first stage of inductive content analysis was to choose the unit of analysis and then to code the data. The codes were then grouped into sub-categories as a way of describing their meaning. Similar descriptive codes were grouped and an overarching description for them developed. Each descriptive code was allocated to a single sub-category. The next step in the analysis was to abstract the sub-categories and group them based on similarity. Sub-categories were grouped into generic categories and the generic categories then grouped into main categories with the abstraction continuing 'as far as reasonable and possible' (Archibald 2006, Elo & Kyngas 2008). The aim of this categorisation was to describe the phenomena under investigation (Archibald 2006).

Stage 2: Focus groups

The units of analysis were the individual focus group participant's statements, the individual reply to the interview question or a discussion between participants in the focus groups or the group interview that expressed any opinion or reflections on any factor that might influence nursing care delivery. This might have been in the form of a single sentence or a brief paragraph from the transcript.

When determining how to begin the focus group analysis a decision was made not to fragment to data into the individual scenarios or to the individual questions asked by the facilitator. It would have been difficult to determine which of the participants' comments were directly related to the individual scenarios, and which drew on their past experiences or reflections. Thus, each of the focus group transcripts were analysed as a single source (Europe & Tyni-Lenne 2004). The findings from each of the three focus groups were combined in the third stage of the analysis. To obtain a holistic and descriptive view of the factors influencing the delivery of the fundamentals of care described by the consumer representatives and both nursing groups, the final stage of the data analysis was then to compare the main categories that had been created for each of the three groups.

Stage 3: Group interview

The group interview sought information about the strategies nurse leaders use to facilitate fundamental care delivery in their area of responsibility. As each participant was responding to the same direct question, the individual participant responses to each interview question were combined and data were analysed on a question by question basis. The unit of analysis was the individual interviewee's statement in response to a direct question, or a discussion between group interviewees, that expressed any opinion, comment or suggestion for how to moderate the factors influencing the delivery of the fundamentals of care. This might have been in the form of a single sentence or a brief paragraph from the transcript.

The answers to each question were coded and categorised separately. The generic categories for each question were then used to identify the strategies nursing leaders use to moderate the factors influencing the delivery of the fundamentals of care. As a final stage of the analysis, these strategies were then themed to determine if there was any applicability to the various dimensions of the fundamentals of care framework. That is, the results of the analysis were explored to identify the strategies used to moderate individual factors applicable to the three dimensions of the framework.

Ethical approval

The predominate ethical issues for this study included informed consent and maintaining participant and patient confidentiality and privacy. How these were addressed for each stage of the study is explained below. It was not anticipated that this study would lead to any distress for the participants, and this did not eventuate. In the unlikely event that this had occurred, the data collection for that period would have ceased and the participant referred to an appropriate support such as the hospital staff counselling service.

Stage 1: Observation

A blanket ethical approval was sought and received for the observation stage with an opt-out option for any staff or patient not wanting to be observed. Thus, it was vital to ensure all potential observees were aware of the observation being conducted in their workplace or ward. All potential participants including nursing staff as well as the patients in the observed areas were made aware of the research and the option to withdraw without prejudice was explained. Information sheets specifically developed for both patients and nursing staff were distributed prior to and during the observation periods (see Appendix 5 for Participant Information Sheets for patients and Appendix 6 for Participant Information Sheets for staff). Posters indicating the observation was in progress were displayed in the areas where data collection was occurring (see Appendix 7 for Poster). For any patients who were unable to read the information sheets, such as those who were cognitively impaired or those for whom English was not their preferred reading language, the information sheets were provided to their carer or chosen decision-maker and a verbal explanation of the project was provided by the researcher. It was considered important to attempt to include these patients in the observation as they might be at a higher risk of inadequate care delivery due to their potentially impaired ability to communicate.

Stage 2: Focus Groups

During the observations stage (Stage 1), information about Stage 2 of the study was also distributed within the hospital asking for nursing volunteers to participate in focus groups. An information sheet describing the purpose of the focus groups and how any data will be de-identified and kept confidential

was provided. The option to withdraw from the study at any time without prejudice was also explained (see Appendix 8 Participant Information Sheet for Nurses). Individual consent from each participant who volunteered for the focus groups was obtained (see attached Consent Form, Appendix 9). There were separate focus groups for Level 1 Registered Nurses, Level 3 Registered Nurses and for representatives from the Consumer Advisory Council. To be included in the focus groups the nurses had to either work in areas where the observation occurred or within other acute care areas of the hospital. The consumer representatives could be included if they were members of the Consumer Advisory Council of the hospital and, as such, had experience of the acute care setting as either a patient or as a family member of a patient. Expressions of interest to participate in the focus groups were circulated to consumer representatives via the coordinator of the Consumer Advisory Council for the hospital along with a copy of the Participant Information Sheet for Consumer Representatives (Appendix 10). Nurse and consumers who were interested in participating were invited to contact the researcher directly to arrange their participation.

Stage 3: Group Interview

During and after the focus groups stage (Stage 2), information was distributed via email across the facility asking for Level 3 Registered Nurse (clinical nursing leaders) volunteers to participate in the group interview. To be included in the group interview, the Level 3 Registered nurses had to either work in areas where the observation has occurred or within other acute care areas of the hospital. They may or may not have participated in the focus groups. An information sheet describing the aim of the interviews and how any data will be de-identified and kept confidential was provided. The option to withdraw from the study at any time without prejudice was also explained (see Appendix 11 for Participant Information Sheet for Clinical Nursing Leaders). Individual consent from each Level 3 Registered nurse who volunteered for the interviews was obtained (See Appendix 12 for Consent Form).

Prior to the study commencing, the draft research study proposal was submitted to the Hospital's Research Ethics Committee (HREC) for consideration in early June 2013. Feedback was received and

as a result some changes were made to the Participant Information Sheets to improve readability and a clause specifying the recording of the focus groups and interviews was included in the consent form. The study proposal was resubmitted to the HREC and final approval was obtained in late June 2013 (Protocol No. 130618). Site Specific Approval, which explores and identifies the 'actual' and 'in-kind' resources required for the conduct of the study was received in September 2013. A copy of the approved study proposal was also submitted to the Human Research Ethics Committee of the university where the researcher was registered for her PhD, for their records. This committee was not required to formally approve the study as it recognised the ethical approval from the Hospital Ethics Committee.

Strengths and limitations of the design and methods

The exploratory nature of the research questions, due to the lack of pre-existing knowledge about the factors influencing nurses' delivery of the fundamentals of care, led the researcher to determine this topic was not amenable to a more empirical type of research enquiry.

The findings of this research were generated using a novel three-stage approach. The first stage used direct observation to describe the complexity of the delivery of the fundamentals of care as they occur in real time, instead of disaggregating the care delivery into individual fundamentals of care or focusing on one specific aspect of care. Another strength of this study was the scenario-based focus group methodology which enabled participants to explore and discuss factors that influence the delivery of the fundamentals of care. Scenarios based on real-life examples of care from within the facility where the focus group participants had personal experience provided a contextual congruity for their reflections and comments. It could be argued that this could have been achieved during the observation by directly asking those who were being observed. However, the focus groups were beneficial in eliciting less reactive and clichéd or stereotypical responses and in facilitating the sharing and exploration of a variety of experiences and views between the participants, thus providing a broader perspective. The third stage used a group interview to explore with clinical nursing leaders their responses to the factors identified in the focus groups and to elicit a set of actions that could then

potentially be tested. Consulting the clinical nursing leaders in this stage allowed for the views and experiences of those who oversee and direct care delivery for an entire ward to be extrapolated.

The replicability of ethnographic research is a potential limitation as the specific setting in which the study occurred cannot be duplicated. While conducting the observation it is possible the researcher might have misinterpreted an activity or care event due to their preconceived ideas or biases. The observation periods were weighted towards the morning and observations were limited to those that were not provided out of direct sight. This may limit the applicability of the findings to other timeframes and one on one care situations. This study was conducted in one healthcare facility and with a small number of participants, impeding data saturation, which could be considered limitations. However, this study was exploratory rather than representative. The detailed descriptions of the nurse and patient interactions related to the delivery of the fundamentals of care, and the reflections from the focus groups and interviews, have provided an extensive and rich data set. Moving beyond a description of the factors influencing the delivery of the fundamentals of care and asking nurses in clinical leadership positions to provide strategies to potentially improve care delivery and thus patient outcomes is seen as a strength. The findings from the research are described in the next chapter.

Summary

Data should be obtained from multiple sources when using focused ethnography and this chapter has described how this study has incorporated multiple data sources to explore the factors influencing nurses' delivery of the fundamentals of care in the acute hospital setting. The use of a three stage, iterative approach to data collection utilising observation, focus groups and interviews to gather in-depth data, along with the use of various perspectives, enables the comparison and contrasting of findings, which are presented in the following chapter.

Chapter 5

Findings Part 1-Stage 1

Introduction

The next 2 chapters present the results of the study, this chapter has the findings from Stage1 and the next chapter has the findings from Stages 2 and 3. This chapter details the findings from the direct observation that was undertaken to describe the delivery of the fundamentals of care. These data then informed the development of the scenarios that were used in the focus groups to explore and identify the factors influencing the delivery of the fundamentals of care, the findings from which will be presented in the following chapter. An overview of the three research stages is shown in Figure 6.

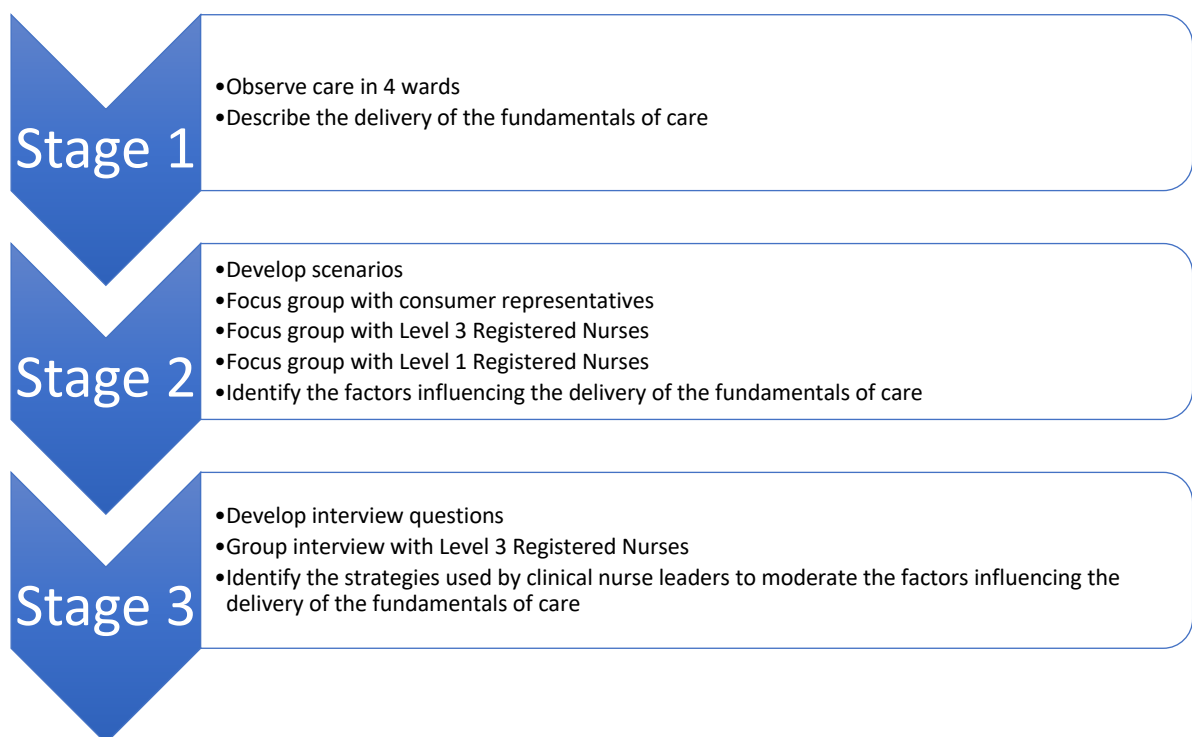
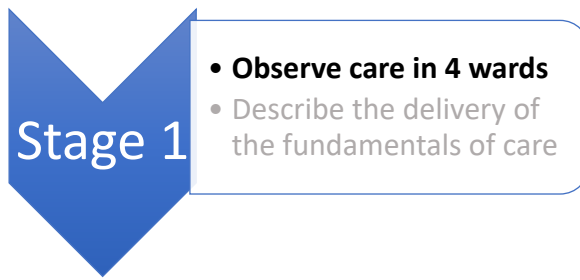


Figure 6 Diagram describing each stage of the study

The following chapter (Findings -Part 2) will conclude with a summary of the findings from the entire study.

Stage 1: Observation Results



Objectives

The objective for Stage 1 was to explore the delivery of the fundamentals of care through direct observation in order to establish which fundamentals of care are delivered, by whom and in which combinations, in acute hospital wards. This section presents the data and findings generated via these observations.

Data collection

Participants

Nursing staff and patients in the 4 study wards were informed about the study and verbally consented to participate. One nurse declined to be observed, citing being 'too busy' as a reason. Episodes of care involving interactions relating to the fundamentals of care between more than 80 staff and 90 patients were observed. The specific numbers cannot be calculated as data that could individually identify staff members or patients across multiple observation time periods was not recorded. It is possible the same patient might have been cared for by two different nurses in different observation periods, or that a nurse who had been observed in one observation period might have interacted with a nurse being observed in another observation period. More information about the participants who were observed is provided below in the overview of the data collection for each ward.

Settings

The four observation sites were adult inpatient acute care wards that varied in their clinical specialties and physical environment. To avoid potentially identifying them, the specific clinical specialty details of each individual site are not revealed. The care environments in the four sites differed. One of the four

sites had a mix of single bed rooms, and four-bed rooms or 'bays' with curtains that could be drawn between each bed. One site was all single rooms. Two sites had a mix of single rooms, six-bed rooms/bays with curtains that could be drawn between each bed, and 'pods'. Pods are converted six-bed rooms/bays that now have four patient bed areas with solid partitions between each area in place of curtains. These were developed as an infection control measure by the hospital. An overview of the data collection in each site is provided below and a summary of the model of nursing care and ward layout for each site is provided in Table 6.

Ward 1

Data collection was conducted in this ward in November 2013. The experience levels of the Registered Nurses who were directly observed ranged from newly graduated to more than ten years' experience as a Registered Nurse. The newly graduated Registered Nurse was accompanied by a student Enrolled Nurse. Others who are mentioned in the data due their interaction with the nurse being directly observed, and/or the patients that nurse was caring for, or who spoke directly with the researcher/observer, included the shift coordinator (the Registered Nurse coordinating the entire ward for that shift), medical staff, patient visitors and family, other Enrolled and Registered nurses, the Associate Clinical Services Coordinator (deputy clinical nursing leader for the ward), orderlies, ancillary staff delivering meals and other patients. Observations were conducted in all care environments of the ward including six bed bays, four bed pods, and single rooms. The model of care delivery was total patient care where each nurse is allocated specific patients and is to address all their care needs.

Ward 2

Data collection was conducted in this ward in December 2013. The experience levels of the Registered Nurses who were directly observed ranged from newly graduated to five years' experience as a Level 2 Registered Nurse. The model of care was team nursing in which, unless the nurse was allocated a patient for one-to-one care, nurses worked with other Registered or Enrolled nurses to provide the care for an allocated number of patients. Others who are mentioned in the data due their interaction with the nurse being directly observed, and/or the patients that nurse was caring for, or who spoke directly with

the researcher/observer, included the shift coordinator (the Registered Nurse coordinating the entire ward for that shift), medical staff, patient visitors, other Enrolled and Registered nurses, the Clinical Services Coordinator (the clinical nursing leader, responsible for the ward), student nurses, the Associate Clinical Services Consultant (deputy clinical nursing leader for the ward), cleaners, and ancillary staff delivering meals. Observations were conducted in all care environments of the ward including 6 bed bays, 4 bed pods, and single rooms.

Ward 3

Data collection was conducted in this ward in January and February 2014. One period of observation followed an Enrolled Nurse at the direction of the shift coordinator. Of the other Registered Nurses who were directly observed, one had one year of experience and was working with another nurse who had ten years' experience. Two other nurses had one and six years' experience respectively in another clinical specialty and were relieving from their usual ward for the shift. The nurse with one year's experience from another ward also had a nursing student accompanying them. The model of care for this ward varied from total patient care to team nursing. Others who are mentioned in the data due their interaction with the nurse being directly observed, and/or the patients that nurse was caring for, or who spoke directly with the researcher/observer, included the shift coordinator (the Registered Nurse coordinating the entire ward for that shift), medical staff, patient family members and visitors, other Enrolled and Registered nurses, the Clinical Services Coordinator (the clinical nursing leader for the ward), student nurses, the Associate Clinical Services Consultant (clinical nursing leader for the ward), ancillary staff delivering meals and restocking supplies in the ward, and the nurse education facilitator for the specialty. Observations were conducted in all care areas of the ward including 4 bed bays and single rooms.

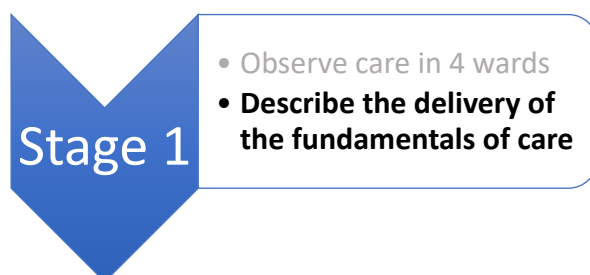
Ward 4

Data collection was conducted in this ward in March 2014. The experience levels of the five nurses who were directly observed ranged from two to more than ten years as a Registered Nurse. Two of the nurses were accompanied by student nurses. The model of care was total patient care. Others who are mentioned in the data due their interaction with the nurse being directly observed, and/or the patients that

nurse was caring for, or who spoke directly to the researcher, included the shift coordinator (the Registered Nurse coordinating the entire ward for that shift), medical staff, patient visitors, other Registered nurses, the Clinical Services Coordinator (the clinical nursing leader responsible for the ward), the Associate Clinical Services Consultant (deputy clinical nursing leader for the ward), a pathology collector, an infection control nurse, a cleaner, radiographers, ancillary staff delivering meals and restocking supplies in the ward, and the nurse education facilitator for the specialty. Observations were conducted exclusively in single rooms as this is the only type of patient accommodation on this ward.

Table 6 Characteristics of each ward

Ward	Model of care	Ward layout
1	Total patient care	6 bed bays, 4 bed pods, single rooms
2	Team nursing	6 bed bays, 4 bed pods, single rooms
3	Total patient care or team nursing	4 bed bays, single rooms
4	Total patient care	Single rooms



Coding

Data from each period of data collection (see Table 5 for details about the data collection periods) were identified using numbers to indicate the observation period, individual patient story, and events related to specific aspects of the fundamentals of care. Within each patient story there might be multiple events and within each event there might be multiple observations. Thus, the first event occurring in observation period 1, with patient 1 is numbered 1 (period). 1 (patient). 1 (event), i.e. 1.1.1.

Presence of the fundamentals of care elements

Physical elements

All the physical elements from the Fundamentals of Care Framework were present in the data.

Relational elements

All the relational elements, from the Integration of Care dimension of the Fundamentals of Care Framework were present in the data. Respectful is a relational element and Respected is a psychosocial element. To distinguish these, the criteria for an event to be coded as Respectful relied on whether the nurse did or did not consider the patient's perspective, efforts or input.

Psychosocial elements

All the psychosocial elements were present in the data. For an event to be coded as Respected, this was distinguished by nurses seeking permission (or not) from patients to enter their space and to perform care activities.

Context of care elements

The Context of Care dimension of the Fundamentals of Care framework includes elements for the System and Policy level. Elements were present for items in the System Level area of the Framework with the most frequent being Resources and Leadership. The code for Policy was used when nurses indicated to either the patient or the researcher they were required to follow hospital policy and that this was influencing their ability to deliver the fundamentals of care.

Establishing the relationship-Commitment to care elements

The data analysis also included the Trust, Focus, Anticipate, Know and Evaluate elements from within the 'Relationship Established' central dimension of the Fundamentals of Care Framework. There were no events coded to Focus in the observation data.

Analysis of combined ward data

As the findings are explored, extracts from the observation data are provided to illustrate the relationships between the fundamental of care elements being described. These illustrations include the

abbreviations used by the researcher when transcribing the field notes. To assist the reader to understand the illustrations, please refer to the table below (Table 7 Abbreviations used in observation data events) for common abbreviations used in the observation data extracts. Illustrations provided in the findings are numbered with observation period, then the number of the patient 3, then the event number. Event descriptions are presented in shaded text. The events coded with a physical fundamental of care are explored initially.

Table 7 Abbreviations used in observation data events

Abbreviation	Explanation
EN	Enrolled Nurse
ACSC	Associate Clinical Services Coordinator, Level 2 Registered Nurse, (deputy clinical nursing leader for a ward)
BP	Blood Pressure
BSL	Blood Sugar Level, Blood Glucose Monitor(ing)
CN	Clinical Nurse
CSC	Clinical Services Coordinator, Level 3 Registered Nurse (clinical nursing leader in charge of a ward)
FOC	Fundamentals of Care
IV	Intravenous
L2 RN/CN	A Registered Nurse with at least 3 years post registration experience, and who has a specific portfolio responsibility, such as infection control.
Me/I	Refers to the researcher
MO	Medical Officer/Physician
MRSA	Methicillin-Resistant Staphylococcus Aureus
Obs	Vital signs
PPE	Personal Protective Equipment (gloves, gown and goggles)
RN (1,2-10)	Level 1 Registered Nurse, number indicates years of experience
SEN	Student Enrolled Nurse
SC	Shift Coordinator (Nurse coordinating care for the ward on this shift)
Sc	Subcutaneous
SN	Student Registered Nurse

Physical fundamentals of care

Most observations were coded to at least one physical fundamental of care. This is not surprising as the observation periods were chosen to capture these interactions. A physical care need is frequently the

initiator for any interactions between nurses and patients. Therefore, the analysis commenced with the data that were coded to the most frequently occurring physical fundamental of care, Safety. To maximise the diversity of observation events that were examined, the events associated with Clean and Hydration were then analysed as these two elements were less likely to be co coded with Safety or with each other.

Safety

Most events for Safety were coded to either Safety related to medication or Safety relating to monitoring. A sub group analysis for both of these topics was then conducted.

Safety related to medication

Events could be coded as positive (demonstrated) or negative (ignored or overlooked) for safety and/or for any of the other codes linked to that event. When considering all these events the most common non-physical fundamental of care co-codes were Communication, Involved, and Leadership. Other commonly associated codes were Teamwork, Patients prompting the Fundamentals of Care and Shortcuts and Work arounds. These were coded as 'other' because they're not in the Framework. How each of these codes interacts with medication safety is described below and illustrated in Figure 7 Links between safety related to medication and codes.

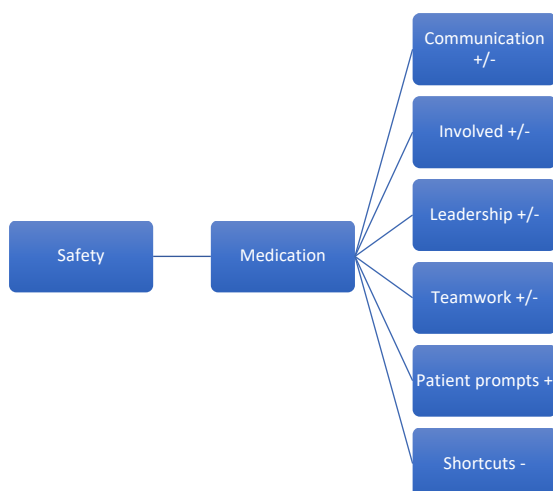


Figure 7 Links between safety related to medication and codes

It was observed that involving the patient in their care was frequently associated with medication safety. This was demonstrated by communicating and consulting with patients about what medications they take, for which conditions, and when they take them. The following events illustrate positive Safety related to medication which include communication and involvement.

Event 9.8.2 - 8.33am. EN talking to patient in side room 2 about their medication "You will have that this evening", "Do you take that now?", "Have you ever had a ???(cannot hear this)" Patient replies "Yep." EN asks "Is it for depression this one?" Patient nods in reply, is eating breakfast.

Event 1.4.3 - 8.45am. RN indicates to SC some issues with medication for patient in side room. SC suggests checking with pharmacists. RN checks with patient about delivery, can they be administered together? SC asks patient, "Is that what you do?" Patient confirms this.

Event 10.3.3 - 20.05pm. EN and student nurse are getting medication out of drawer for patient in bed 6. They are discussing each one with the patient and checking what she takes.

Event 18.1.1 - 7.30am. RN knocks on door of room 2 "Good morning, how are, you? I've got some tablets for you." Goes into room, shows the patient the packet with the tablets inside, asks the patient when they usually have them "You had them last night." Patient replies, "I will take them then, they will last until next week." RN continues talking to patient while taking BP, asks patient if they have any pain, and what they need, consults with patient regarding medication and how they want things delivered. Patient gets out of bed and stands on scales in room. Nurse touches them on the shoulder in a reassuring manner as they get off the scales. RN asks patient about something. Patient replies "She will be in round about 3 this afternoon." RN says "We will have a shower first", discusses with patient which medication

to take, RN says "I will get that one now, do you take one?" Patient replies "Yes, and I take it with ??(cannot hear this)." RN "Ok."

Where patient involvement in their care and communication was seen as lacking, medication safety could also be compromised as patients might not have known what they were being given. For example:

Event 1.1.1 - 7.50am. RN gives patient in bed 1 heparin injection, says to patient "A needle in your leg." Patient has English as a second language but appears to understand what is said. RN uncovers patient thigh and gives a subcut injection into patient leg, replaces bedclothes and leaves bedside, nothing else is said.

8.05am. RN giving bed 1 patient medication, "One little tablet", hands patient tablet which patient swallows with a drink of water. RN leaves area, nothing else is said.

Teamwork is a necessity for safe medication administration due to the need for many medications to be checked by two nurses. In many cases it is the Shift Coordinator (SC) who is available to provide assistance. The following three events illustrate how Safety related to medication administration is positively impacted by Teamwork and Leadership.

Event 17.1.5 - 19.39pm. RN and SC outside room 1, RN applies PPE (Personal Protective Equipment), SC asks "You ok with that?" RN replies "Yes." RN goes into room, comes out and removes PPE, SC applies goggles, and cytotoxic PPE, asks RN "Do I need a flush?" RN replies "It's been flushed." SC "Oh good" and goes into room, RN outside room documenting on chart.

19.45pm. SC comes out of room 1, removes PPE and discards into plastic bag, walks to pan room past RN who says "Thanks". SC replies "Sure".

Event 18.2.1 - 7.42am. RN at cupboard outside room 1, checking chart and dispensing medication. Leaves and goes down corridor.

7.44am. RN returns to room 1 with a glass ampule and a syringe, applies PPE and gloves, enters room. Visitor to room follows RN and is carrying a plastic pot of food. SC brings the trolley for chemotherapy outside of the room. RN gives medication to patient and is chatting to patient and visitor. Removes PPE. SC is preparing an IV infusion on the trolley outside the room. RN leaves room and documents on chart, goes back into the room and takes patient BP and pulse oximetry, leaves room and documents on chart. Takes medication chart to nurse station and photocopies it, returns chart to folder on cupboard outside room.

Event 19.3.3 - 8.18am. RN outside room 3 who has call bell activated. Documenting on patient chart outside room. Checks IV medications with SC and says "He only has one jelco." SC replies "Get up what you can and you can catch up later, I think he will be coming back here, we can have it all ready." RN sees another RN coming down corridor and indicates via gestures for her to check IV medications. RN says "4.5" other RN says "4.5 for 8 o'clock, ok."

Teamwork can contribute to medication safety without effective communication either with the patient or with other nurses, as seen below:

Event 3.3.1 - 7.55am. Check required on pain relief medication pump for patient in bed 2. Patient on mobile texting in bed lying flat. EN assists with check, no interaction with patient by either nurse.

Event 8.6.1 - 8.05am. RN1 is in the drug room preparing the insulin for patient in pod 3. RN3 from next bay comes and checks medication, shortly after RN1 is calling for RN3, "Rachel, Rachel? She didn't

sign." Both nurses meet in nurses' station and recheck, RN1 takes meds to pod 3. Closes curtain and talks to patient.

Teamwork and leadership can also impact on medication safety in other ways. In the next example, the ward leader knows the patient and is advising the RN of relevant information, but almost takes the meal tray with the patient's medication on it, potentially compromising medication safety.

Event 9.3.3 - 8.38am. CSC says to RN about patient in bed 3, "Her family is coming down." While CSC is clearing patient meal tray, she asks "what's this bubbly one?" Indicating a styrofoam cup on the tray, RN replies, "I will get her up and ready." CSC takes the cup off tray and returns it to patient overway.

Demonstrating leadership through supporting and mentoring student nurses in the process of ensuring medication safety was demonstrated in the following events:

Event 16.1.3 - 8.14am. RN and SN are reviewing obs chart outside room 1. Discussing medications - SN has been looking these up on the computer in the corridor - RN is checking SN's understanding. SN knocks on door and enters room. Says to patient, "Good morning, I have tablets for you." Both nurses laugh with visitors and patient. SN gives tablets. RN says to SN "I am going to get his toast" and leaves room.

Event 20.1.2 - 8.10am. RN and SN outside room 3. RN asks SN if she knows why the patient is taking a particular medication. SN is not sure. RN explains dose and mechanism of action of drug, why it is needed in this case and why the dose and frequency ordered are not usual. RN continues to review medication chart. RN and SN go to drug room. Pathology collector dons PPE and enters room with a syringe, turns on lights "It's only me" to patient. Closes door. Exits room with a syringe of blood, dispenses into vials and applies labels, removes PPE, leaves area with samples and trolley.

Event 20.2.1 - 7.41am. RN and SN outside room 1. RN says "You get started on the tablets, I will get the trolley". SN begins to dispense tablets from the cupboard outside the room. RN collects trolley for administering cytotoxic medication and prepares IV fluids. Goes into room and speaks to patient, comes out, goes to store room and returns with IV line. Primes IV line with fluid, moves closer to SN to check the medications, says to SN "Good job." Explains medications to SN and asks SN to calculate a drug dose, observes SN dispense correct number of tablets for dose. Goes into the room, patient in bed, removes breakfast tray. SN takes tablets into room. RN asks SN "Has she had (inaudible)?" SN replies "Yes."

Event 20.3.1 - 7.50am. Outside room 2, RN says to SN "You start on the tablets, I will get the acyclovir." RN goes to drug room, collects medication and places on a trolley outside of room 1. Then goes to nurses' station and asks another nurse "When you get a chance can you check some (inaudible) for me?" Returns to observe SN dispensing medications, says to SN "Ok, happy with that?" SN replies "Yes." RN "Ok, you can give them." SN enters room, leaves tablets exits room and closes door.

Events where patients had prompted nursing staff about their medication requirements were associated with positive medication safety. These patients knew what medications they needed to take and when and reminded the nurses about this. They also offered suggestions on how and when medications could be administered.

Event 9.6.2 - 8.05am. Patient in bed 6 and bed 1 are chatting about going home today, patient from bed 1 is standing next to bed 6. RN asks EN to check medication for patient in bed 6. EN checks medication and patient from bed 1 goes back to her chair, RN is chatting to patient in bed 6. Gives sc medication into abdomen, goes to locker next to bed and opens medication drawer, gets medication out of drawer and is talking to patient. Patient says "I have to have that lemony stuff."

Event 10.4.1 - 18.49pm. Patient from bed 4 comes to nurses' station and talks to me waiting outside, I ask "how are you?" patient replies "Oh I am sore, I've come to ask them for some pills, I don't like to take them but sometimes you need them, the girls are good here." CN (Clinical Nurse) says to patient "Yes, sure we will get it for you." Patient walks back to bed, CN and EN go to bedside, check patient ID "Any allergies?" says CN to patient. They give medication, RN pulls curtains closed around the bed.

Event 15.3.1 - 7.56am. RN is with patient in bed 1, "We need to get some pills out for you." Patient replies, "I won't take them until later, I have to wait for them to take the blood." RN "Haven't they been yet?" Patient "No, I will take them about 8.30." RN says "OK'."

Event 16.2.2 - 7.43am. RN is accompanied by another RN and they come to outside of room 2. RN dons PPE, other RN holds patient chart, RN knocks on door, patient eating, checks patient armband and calls out patient ID number and asks when the patient last had this medication. RN outside confirms details. RN gives medication via IV tells patient it might hurt. Patient says "I know it stings, I know what to expect." Patient is sitting on chair, says to RN "that wasn't bad" RN replies "oh good!" Patient says "If you go slow it spreads the pain." RN removes PPE. Patient asks for a drink of cola, nurse says "yes that's fine", leaves room and tells patient "I shall be back." Patient now connected to IV infusion pump....

Patients would also ask nursing staff questions about their medications. These events might suggest that patients having knowledge about their condition and treatment could contribute to medication safety.

Event 11.2.2 - 7.39am. EN is talking to patient in bed 2 while giving medication, "I will go and check what this one is for", Patient asks "What is the other name on it?"

Event 12.1.1 - 7.31am. RN and SN discussing and checking medications outside of room 1. Patient is on barrier precautions, SN dons PPE and enters room.

7.34am. SN enters room 1, says "Hello" to patient. RN at door to room, both talking to patient about their medications, SN puts light on and takes patient observations with machine. RN counts respiratory rate from door of room while SN taking BP. Patient is sat up in bed, SN asks patient and then opens blinds. Patient asks about a medication. RN "No, they are holding that, they held that yesterday and will review it this morning." Both leave room, SN removes PPE.

Shortcuts and work arounds were associated with negative medication safety. Both these events related to nurses taking medication from one patient's supply to give to another patient.

Event 8.2.4 - 8.13am. RN1, talking to me, says "I will borrow it from here, it will save me going back down there" she indicates the other end of the ward. She takes medication from drug cupboard for pod 1 and prepares this for patient in pod 3.

Event 13.4.2 - 8.10am. RN10 enters room 5 with pill bottle, goes to drug cupboard, dispenses medications, leaves room with tablets in a pill cup.

Safety related to monitoring

Safety related to monitoring applies to nursing care related to conducting assessments such as vital signs, weighing patients, pain assessment, screening for infections and monitoring fluid balance. It was only coded when it occurred as it was not possible to determine if it should have happened but did not.

Non-physical fundamental of care codes frequently associated with monitoring were: - Involved, Informed, Knowing and Resources. Other codes frequently associated with monitoring were Communication, Leadership, Privacy, Teamwork, Reassurance and the need to wear Personal Protective Equipment (PPE) due to the patient's infectious status. Figure 8: Links between safety related to monitoring and other codes, demonstrates these links. Events illustrating each linked code are described below.

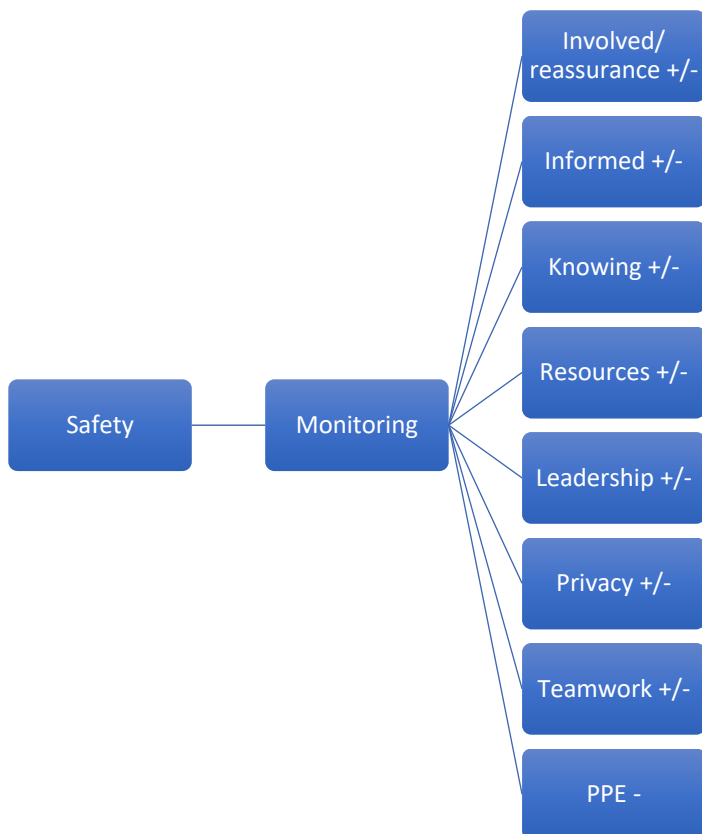


Figure 8: Links between safety related to monitoring and other codes

Involving patients in their monitoring was demonstrated by asking them how they are feeling, when and where they would prefer the monitoring to occur, if it had occurred and consulting them about how they were feeling.

Event 9.4.2 – 7.42am. RN with patient in bed 4, taking patient observations, asks patient "Are you ok?" Patient is rubbing her hand across her upper abdomen.

Event 11.2.3 - 7.41am. Patient in bed 2, "I want a paper, will they come round?" EN answers "Yes they will a bit later, I will just check your blood sugar", goes for BSL machine. Asks patient "How often do you check it at home?" Patient replies "Sometimes once a day, sometimes twice a day, sometimes 4 times a day." EN asks "Which hand do you want me to use?" Patient says "Use the right one." EN asks, "Does it get a bit sore?" Patient replies, "Yes sometimes."

Event 12.2.6 - 8.56am. CSC to patient in room 2 "Bob, did you have blood taken this morning? No? Ok good."

Event 14.4.4 - 17.57pm. RN returns to outside room 3 with blankets, dons PPE, takes blankets and thermometer into room. "I've got some blankets for you", spreads one blanket over patient in bed, "I have brought 2 because you seem cold, I will take your temperature, do you want another one?" Spreads second blanket over patient. Takes patient temp with tympanic thermometer in ear, does vital signs, discards thermometer cover and wipes with cloth, removes PPE and documents in chart.

Reassurance was also linked with involvement and being informed in the following event.

Event 9.6.1 - 8.00am. Obs machine is connected to patient in bed 6. RN reviews reading and says "Gosh, you're good!" to patient. Patient asks about how she can be discharged. RN replies "You have got ambulance haven't you? We will do an ambulance transfer."

8.13 RN is on phone in nurses' station talking about patient in bed 6, "she is medically stable, I will check with her how mobile she is." Goes to patient, tells her she has ??(cannot hear this) on the phone

and asks about patient's mobility, returns to phone, finishes conversation then comes back to patient, and says "They will come and get you."

Informed was distinguished from Involvement, as when patients were informed they were not necessarily consulted, but were told what would happen.

Event 12.3.5 - 8.34am. SN dons PPE and enters room 3 "I will do your blood pressure". Connects patient to obs machine, patient indicates arm to be used, RN waits at the door to document obs, talking to patient. SN tells RN BP, then writes something on patient whiteboard (I cannot see this).

Event 13.1.3 - 8.11am. RN 1 collects weigh chair from corridor. Says to patient in bed 1, "We have to do your weigh, I will be back in a minute, I just need to get my gown on." Dons PPE and takes weigh chair into room, weighs patient, removes PPE, asks patient if they have had coffee or tea, documents in chart.

Patients not being informed might lead to a loss of trust and impact on monitoring.

Event 14.2.1 - 17.35 RN dons PPE and goes into side room 1. Says to patient "So, take your blood sugar again?" Talking to patient, patient not making eye contact with nurse or visitor, seems reluctant and unhappy, hard to determine why. Visitor and RN try to convince patient to comply, patient withdraws hands, RN opens blinds in room. Patient says "The other lady said that, and she didn't come back." Nurse removes dinner tray and removes PPE, BSL not performed. Asks patient and visitor from doorway "How are the dogs?" Reply inaudible.

Knowing was defined as being aware of the patient's name, medical history and preferences. Knowing the patient can assist other staff in recognising what monitoring interventions may or may not be required.

Event 9.7.2 - Medical round is at side room 1. EN is saying "Valmai, Valmai?" in a loud voice. Patient is hard to rouse. EN says "She has had no sedation." MO says "She has had this all her life she told me yesterday, the last time was six months ago." CSC says "She has done this before, remember?"

Knowing the patient and their history can also reassure the patient and provide encouragement. In the following event the CN refers to the patient's progress and check that previous interventions have had the desired effect.

Event 10.1.1 - 19.28pm. Doctor comes to see patient in bed 1, chats briefly then draws curtain around the bed, CN comes to curtains calls "Hello?" and goes in. Doc leaves, CN opens curtains and administers medication to patient, gets obs machine and takes patient obs chatting to patient, says "No, you are doing very well Ruth, how's your pain, are you feeling a bit better?" Patient replies "A bit better thanks after those 2 tablets you gave me". CN asks "Do you want more pain relief?" Patient replies "I will wait, thanks love". CN replies "Alright my dear, you seem more comfortable now, can I have a look at your tummy?" Closes curtains, says to patient "They have done a lovely job" opens curtain and says "Thank you" to patient.

Monitoring safety is also linked to resources including equipment and the environment. The impact of equipment choices for blood pressure assessment on monitoring safety is highlighted in the following event.

Event 10.7.1 - 19.07pm. EN is sitting in a chair at the end of the bay laughing and chatting with patients in beds 3,4 & 5 and student nurse. Student nurse is doing obs on patient in bed 5 manually (not using obs machine).

19.15pm. I ask the student why they are taking obs manually? Student replies "They tell us to use it on the post ops" I ask "who is they, the University or the ward?" Student says "We are taught manual but

they all told me here to do it too on the post ops, we did one on the lady in bed 6 the other night on the machine and it was 90 but she looked fine, the manual was 120, that's a big difference, we did one on the lady who was in bed 5 last night, she had to go to get a bit of metal taken out (indicates throat area) the machine said 220, manual was still 200. But it's still a big difference."

A senior nurse educator also highlights the influence of equipment used for monitoring.

Event 15.0.2 - 8.08am. NEF for area is talking to me in the corridor, "I would like to see those gone (points to automatic BP machine). I tell them it's important to have human contact, I get them to try it and see how hard it pumps, you need to feel someone's pulse."

The potential impact of the structural environment on monitoring safety is indicated in the following event.

Event 9.0.4 - 7.50am. I am talking to an RN about the study and the new hospital under construction being all single rooms. RN says "My only gripe is how are we going to keep an eye on all the post op patients? It's a good idea for infection control, the pods have shown that." I suggest CCTV as an option. RN says "We need to hear not just see, if they are (makes a wheezing sound while breathing in) we won't hear that."

Leaders can support and advise less experienced staff when they have concerns about monitoring safety. Access to more experienced staff appears to be an influence on safety related to monitoring as demonstrated in the following events.

Event 8.2.1 - 7.22am. Patient in pod 1 has vital signs outside of normal range, RN comes to nurse station to check with shift coordinator, SC says "He has a modification in place, he has been unwell for a long time, put 'see chart 3'" indicating where RN should write that.

Event 19.3.1 - 8.04am. RN outside of room 3, asks SC about need for blood test, "Has he had his platelets?" SC replies "I think they are still going." RN goes to cupboard and checks timing of something with SC. SC says "8.45." RN replies "8.45, right" prepares tablets and checks chart on cupboard outside of room, says to SC "Can he have his meds? He's still fasting" SC replies "What's he got? Anything major?" They both look at chart. SC says "He can have them with a sip of water." RN dons PPE, leaves and come back with labels for IV medication, places one outside of room 2 and takes one to room 3. Checks chart, puts on gloves and knocks on door, goes into room. Pours patient a glass of water and moves overway into patient reach. Patient asks for something, RN replies "I will find out what's going on." Comes to door of room and looks down corridor, no one is in view. RN "I will double check with Kirstie (SC) about that, I will double check what's the deal with that and come back."

Event 20.3.4 - 8.50am. SN is outside room 2 with 2 different swabs, asks RN "Which is for MRSA? This is a new one." RN explains one swab type is used for viral specimens and which to use for MRSA. SN goes into room 2 and closes door.

Monitoring can impact on patient privacy. Drawing the curtains around individual beds in bays and closing doors from side rooms on to the corridor were methods nurses used to protect privacy.

Event 10.7.3 - 20.10 pm. CN and student are with patient in bed 5. CN says "Ready for some pain relief?" CN takes bag with IV medication into the cubicle, EN brings in an IV pole, curtains are drawn on each side of the cubicle, 5 minutes later CN goes back to patient "How are you going?"

Event 16.3.3 - 8.25 am. RN and SN are checking meds outside room 3 with chart on cupboard in corridor. RN asks SN "Obs were ok?" SN nods and replies "her temp was 37.4" Both enter room and close door. Both leave room a few minutes later.

Privacy and dignity can also be impaired during the monitoring process.

Event 15.1.1 - 7.38 am. Patient is on a shower chair in the middle of the bay with their naked back and buttocks exposed to corridor and other patients in bay. RN strips linen from bed 3 and then goes for more linen. Pump alarms for patient in bed 2, RN stops alarm and makes bed 3. I help make bed.

7.44 am. RN moves shower chair close to weigh chair in bay. Applies brakes on the weigh chair. Asks patient to stand and transfer from the shower chair to the weigh chair. Patient rises with difficulty, after rocking forward several times in shower chair. Patient sits in weigh chair. RN then asks patient to stand to transfer back to their bed, bed 3. Patient stands and holds on bed while walking from end to side of bed. Sits on side of bed and lays down, very exposed and gown has ridden up to waist.

A patient's infectious status was seen to impact on their privacy and how monitoring activities were communicated. Nurse are required to don (put on) PPE to enter a patient's room when patients are infectious or are immuno-compromised. Communication often occurred from doorways to avoid nursing staff having to apply PPE. This also has an impact on patient privacy.

Event 17.1.1 - 18.39pm. RN and MO return to outside room 1. RN documenting on case notes and chart on cupboard outside room. Knocks on door says to patient from doorway "You alright? You will be having an X-ray." Patient reply inaudible. RN says "I will give you some antiemetic before I go at 9. Anything else I can do for you? Just buzz if you need me ok?" Leaves door of room (patient is being barrier nursed)

Teamwork and its links to the model of care delivery are also related to monitoring safety in the event below.

Event 15.0.2 - 8.08am. NEF for area is talking to me in the corridor, I ask about allocation which she previously said is good here. "We have team nursing which is good, individual nursing is not fair, they end up running around asking for help. We get new nurses to focus on what's important, that the patient is comfortable, happy and breathing, they can fall back on their basic skills. Give new staff the bay, focus on what they know then the other layers can build on that."

This is supported by the following event, in which the environment is also mentioned.

Event 17.1.2 - 19.10pm. An RN from elsewhere in the ward goes into room 1. RN is at the door to the room and says "I think it needs a flush," applies PPE, knocks on door and does into room. Other RN comes out of room, removes PPE and talks to me "What are you doing? A survey?" I tell her about the FOC and ask what makes it easy and what makes it hard, she replies "Everything makes it hard!" Says single rooms and total patient care takes away the camaraderie between nurses, team work evaporates, they have a buddy system but only to cover meal breaks, patients are isolated, "I wouldn't want to be here for 6-8 weeks."

A perceived lack of support from the medical team was linked to patient safety, monitoring and reporting requirements.

Event 10.0.2 - 20.30pm. I am talking to the CN who tells me "I am sick of being talked to like a piece of shit, these new obs charts are stressing out the medical staff, I can't get someone reviewed overnight, I call them and they are too busy, I have to wait and call a MET (medical emergency ?team?) call, they then say 'how dare you call a MET call, I don't need to review them'."

Staff might minimise the number of times they enter and exit the room to avoid applying and removing PPE. This might impact on the monitoring safety for the patient. They might also rely on other staff to assist them from outside of the room.

Event 13.3.2 - 8.12am. Patient in room 3 rings bell. RN10 "What can I do for you, I can come in, I want to know what I can do for you", dons PPE and goes into room. Comes out of room and asks RN1 "Has she been weighed at all?" RN1 replies, "Oh, ok I will just clean it," RN 1 cleans weigh chair and brings to room 3.

Minimising entry into the rooms might also impact on supervision of students undertaking monitoring activities.

Event 16.3.4 - 8.40 am. SN enters room 3 with specimen swab, closes door, comes out and shows to RN who is waiting outside room. RN says "Beautiful, that can go in here" indicates pathology envelope. "Do you know where they go?" SN replies "In the cupboard?" RN "Yep." SN goes back into room and retrieves patient meal tray, says to RN "She drank all the tea." RN replies "I will let you do that" SN documents in chart.

Events coded with other Physical fundamental of care codes: Clean and Hydration

In order to maximise the scope of the data analysis, that is to maximise the diversity of events for analysis and thus obtain a broader perspective of the data, two fundamentals of care elements with less overlap (i.e. that is they were not co-coded in the same events as Safety and with each other) in the data were then analysed. As a result, all the events that had been coded to Clean or Hydration as a physical fundamental of care were explored. These two elements were chosen as there was considerable overlap in events coded as Clean with the other physical fundamentals of care, such as Fed, whereas there was less overlap between Clean and Hydration.

A tally was made of the frequency of codes from the other fundamental of care elements in each of the Clean and Hydration events. The most frequent non-physical fundamental of care aligned with 'Clean'

was Involved+/- . The most frequent non-physical fundamentals of care aligned with 'Hydration' were equally Involved+/- and Informed+/- . There were also two other codes - 'Infectious status of the patient' and 'Personal Protective Equipment (PPE)' - that were frequently aligned with 'Hydration' .

Given the consistency of the alignment of both physical fundamentals of care (Clean and Hydration) with the code Involved+/- , and the frequency of one or both of these fundamentals in all of the wards, these were explored in more detail.

Analysis was undertaken for where Involved had been coded as positive and negative. The language used and who was taking part in the event was explored, as well as who had initiated the event. Where patients were seen as being Involved staff asked the patient if, when, and how they would like the fundamentals of care to be delivered; suggested ways for this to happen' gave options' asked what the patient would usually do; and enquired about when the patient was ready or was finished.

Example from 'Clean'

Event 12.1.3: 8.21 am. RN to patient in room 1 from doorway, "Sonia, when did you want your shower?" Patient replies "In an hour or so, when will the doctors come?" RN replies "I think they come about 11." Patient says, "that's alright then."

Example from 'Hydration'

Event 9.8.1: 7.20 am. Patient in side room 2 rings bell, EN from night duty goes to door of room " how can I help you? " Patient requests a drink, "Sure, do you just want water? " EN retrieves patient drink jug and brings fresh drink back to patient, places cloth on patient's forehead.

Where involvement was not evident, staff asked what the patient had done, told the patient what they (the patient) needed to do, stated what the staff would do and did not acknowledge patient concerns. An

item of note relating to the language used was the use of the term 'we' which often indicated the staff rather than including the patient.

Examples from 'Clean'

Event 3.5.1: 8.25 am. EN is with patient in bed 5. EN "Have you had a shower this morning?" Patient "I don't have any clean clothes." EN "That's ok, we can get you a gown." Patient " Am I having a CT scan, what time?" EN, "We don't know yet, radiology will call us."

Event 11.2.6: 8.37 am. Medical round go to patient in bed 2. Curtain partially closed, patient's walking frame is outside curtain and close to bed 1. MO to patient "We are going to have to take the toe off, it's not going to heal, you need surgery, there is no other option." Patient responds "I was hoping.....but I am ready for it." MO says "at least it's not infected." Patient says "I might be lord hop along, might I?" MO replies "we need to check your veins, the surgeon will see you later." Doctors, all six, leave. SC chats to patient, "I can get that for you, what would you like some toast?" EN moves walking frame closer to patient bed "after breakfast you can get up for a shower, alright?" Patient says "I can go to the shower, the water will be getting colder and colder, but I have had cold showers before." EN replies "We don't want that."

Event 5.3.5 Son of patient in side room 3 goes to get bed linen, RN sees him in the corridor and says "We will make the bed in a minute, we want to take him to the shower first, we will do it." Later the RN tells me, "We don't want him to stay in bed all day, if we make the bed he will get back in."

Examples from 'Hydration'

Event 2.6.1 "You can only have a drink" RN to patient in side room 1. Talking loudly to patient, unable to hear patient response.

Event 15.2.2 MO arrives and talks to patient's daughter. Introduces self, daughter replies "I met you last night." MO apologises for not remembering. MO to patient "We are going to do the scope again, can you give consent?" Daughter says to patient "You have to give consent dad." MO is holding form in front of patient and offers pen "Can you sign here" patient says "I can't see." Nurse offers glasses and sits patient up, patient puts these on. MO holds paper "Just here" hands pen and points "It doesn't have to be neat" patient signs and asks "Can I have a drink?" MO replies "A little bit of water, that's fine, I will tell them." MO leaves bay and tells EN in corridor "He can have small sips of water, he could even have ice chips'."

Physical fundamentals of care: Summary

Analysis of the events associated with physical fundamentals of care demonstrated the interrelatedness between the three dimensions and the physical, psychosocial and relational elements of the Fundamentals of Care Framework. Safety was a prominent focus of the observed events, and in this data was predominately linked to medication administration and monitoring. Other physical elements explored were related to patient hygiene and hydration. These physical elements were linked with other relational, psychosocial and contextual elements from the Fundamentals of Care Framework, including keeping the patient informed and involved, while providing reassurance and maintaining communication with the team involved in patient care. These linkages illustrate the complex nature of the delivery of the fundamentals of care.

Events not coded with a Physical fundamental of care

There were events observed that did not have a direct link to a specific physical fundamental of care. All these events that were not coded to a physical fundamental of care were explored. The most frequent codes were for elements such as Leadership and Resources, both from the Context dimension of the Fundamentals of Care Framework and these are discussed here.

Leadership

Within the events coded under leadership there were co-codes relating to modelling of behaviours and setting expectations. Behaviour modelling and setting expectations can occur simultaneously.

Modelling can be demonstrated by those in formal leadership positions and by Registered and Enrolled nurses towards student nurses and new graduates. Figure 9 illustrates the codes linked to Leadership.

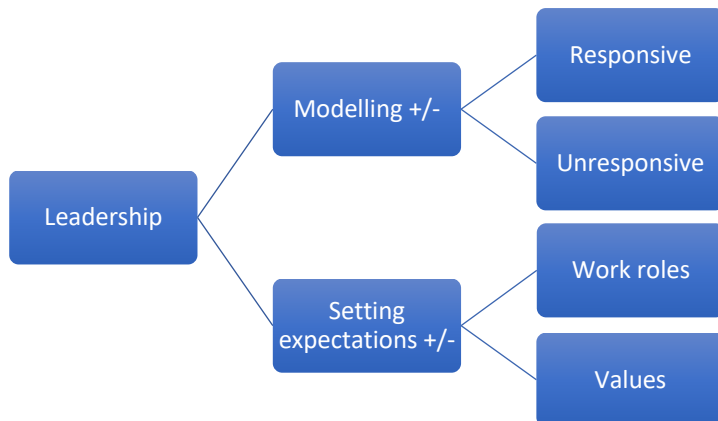


Figure 9 Links between Leadership and other codes

Modelling

Examples of modelling behaviour included being responsive or unresponsive to patient requests for assistance, knowing the patient, and interacting with other staff.

Being responsive and setting expectations was demonstrated by the following event.

Event 8.1.1 - 7.11am. I asked the CSC (Clinical Services Coordinator – nurse in charge of a ward) about the lack of call bells being activated in ward, "I can't stand them, if I am in my office and I can hear them going I get distracted, I come out and get it myself or get someone, they sometimes start to say, 'it's not mine' but when they see my face they go and answer it, we are here for the patients. The rounding should decrease the amount of bells, they did a study that showed that."

7.33am CSC comes out from her office, a bell had been active for approximately 2 minutes, she goes to side room at other end of the ward, talks to patient then dons PPE and enters room.

Being unresponsive while setting expectations was demonstrated by the following event where call bells are not prioritised by the shift coordinator.

Event 16.0.1 - 7.28am. *I arrived in the ward, call bells going, handover in progress, some nurses at the other end of the corridor not attending to bell, SC orienting a relieving RN to the ward, handover complete*

7.35. *RN who was being oriented dons PPE and enters room which had the call bell active throughout the orientation.*

Being unresponsive was demonstrated in the following events.

Event 14.3.1 - 17.15pm. *Visitor in side room 2 comes to door of room, IV pump in room is alarming says to RN "Excuse me, it's making the beep beep beep, does that mean it's finished?" RN says "Yes." Visitor says "It's saying something about air." RN replies "I will be there in a minute." RN walks down corridor. Pump still alarming. RN comes back says "I will be there in a sec" to visitor.*

17.22 *SN (Student Nurse) and another RN are in corridor and hear alarm from side room 2. RN says to SN "No hurry for that." Both walk away.*

17.23 *Another nurse dons PPE and prepares a syringe of fluid outside to side room 2. Goes into room, stops pump alarm, disconnects IV, visitor asks nurse "How are you, alright?" Response from nurse inaudible. Flushes IV port in patient arm, leaves room, visitor says "Thank you." RN removes PPE and leaves.*

Knowing the patient and being responsive was demonstrated by the following events.

Event 6.2.1 - 7.05am. *CSC to patient in bed 1 "Morning Arthur, how are you today?" Comes to nurses' station, "He is good today" to other RN. Patient (an elderly man) has been disoriented. On previous days he has said "I can't be here, I have to work today." He was a construction worker. CSC said to him then "It's ok you have a day off today, hot weather policy."*

Event 13.5.1 - 7.35am. ACSC goes into room 6. "Morning Linda, how are you this morning?" Comes out of room walking with patient down corridor.

Modelling of both positive and negative ways to interact with other staff was reflected in these events.

Event 2.0.4 - 8.20am. RN from a non-English speaking background from side room 3 is asking ACSC for something, ACSC did not understand, and she turns to me, rolls her eyes and says to me "Put down 'language is sometimes a barrier to the fundamentals of care'."

Event 6.0.1 - 7.45am. Student nurse from other bay is looking on the computer in the nurses' station looking up the medications for her patients. EN (Enrolled Nurse) from that bay asks the student if she knows about MIMs (an electronic medicines information resource), shows her where it is on the computer desktop, says to the student "You can get all the details." Student replies "Awesome, thanks."

Setting expectations

A leader's influence in setting expectations and having these followed was reflected in event 8.1.1 above (Modelling: Being responsive and setting expectations) and in the following events.

Event 9.0.1 – 7.00am. Staff are beginning handover, CSC says to staff "Make sure you check the board behind you, the written is also part of handover, the auditors will check that" indicating a whiteboard in the nurse station that has patient name, clinic, allied health referrals, pre-hospital profile, discharge destination, comments, and estimated discharge date (EDD). EDD is indicated by coloured magnets: yellow for 2-3 days, red for > 3 days, all patients are red or yellow on the board.

Event 11.0.1 – 8.15 am. Discussion with CSC regarding ward attendant role being reviewed for the new hospital, nurses do this job on weekends and public holidays, restocking and cleaning. CSC “When we moved here we refused to have nursing staff clean beds between patients, those at the top didn't know this was what was happening. We are the only ward that doesn't do this, those at the top need to know. It's hard to stop nurses doing tasks that others such as ward clerk and ward attendant can do, if they didn't do these things they could brush someone's teeth.”

Leaders' expectations and values can also imply some patient groups are more deserving or worthy of more experienced staff. Staff can also feel pressured to achieve the requisite level of experience. The complexity of care needs for patients with chronic conditions was not always reflected in the allocation of experienced staff or the provision of clinical supervision.

Event 15.0.1 - 7.35am. I check in with the CSC. She tells me “We have transplants so the babies (junior staff) are this end and all the relievers.” She suggests I observe the relieving nurse looking after patients in the 4 bed bay. (Relieving staff are from other wards in the hospital who have been allocated to this ward for this shift due to workload imbalances).

Event 19.1.3 - 7.47am. RN checks patient chart and is preparing medications outside room 2. Another RN comes and asks, “Big day?” RN replies “His hydration wasn't put up so I will connect him soon, he is in the toilet” referring to patient in room 1. Other RN reviews patient chart outside room 1. “It's an ABO mismatch so he needs lots of fluids beforehand.” RN says to her “I might not get to do it after all.” Continues preparing tablets for room 2. Patient in room one is scheduled for a stem cell transplant, the RN was hoping to 'special' this patient one-on-one as she hadn't done this procedure before. She tells me it is a free flow through a PICC line and can take a long time, during the infusion the patients need to be closely observed.

Sometimes less experienced staff had expectations about what information or support they needed and they had to prompt more senior staff to provide these.

Event 12.0.1 - 7.40am. EN from another part of ward comes to RN (reliever from another ward) and talks about ward routine, "That will happen about 11, do you want me to get you a pamphlet on how we do things here?" RN nods. EN goes for pamphlet and gives it to RN, "Have you been shown around?" RN says "No."

8.25am. RN says to ACSC "Tour time?" ACSC replies "Huh?" RN, "Are you going to show me around?" ACSC says "Ok grab your bag, we can do that now."

Resources

Resource issues included the environmental impact on patients and care delivery, relying on medical staff, equipment, and infrastructure. The link between these codes is illustrated in Figure 10 Links between Resources and other codes.

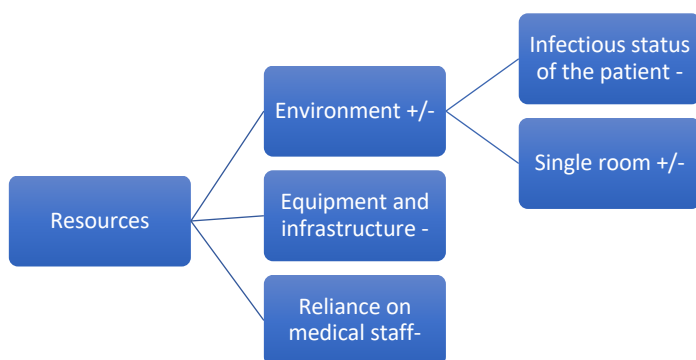


Figure 10 Links between Resources and other codes

Environment

Some nurses believed individual private rooms might be detrimental to patients and have a negative effect on nurses' workload. The following events illustrate this.

Event 5.0.1 – 7.35 am. Conversation with RN and EN “There is better social interaction in bays, less focus on own issues than when in side rooms. Patient in side room 3 used to communicate better when he was in a pod before we knew he had MRSA.”

Event 5.0.4 – 7.40 am. Conversation with RN and EN “Patients are more demanding in side rooms.”

Event 9.0.5 - 8.16am. EN from other bay is talking to me near the pan room, "I am scared of us going to all single rooms." I ask "why?" EN says "Wondering about what can go wrong, some patient will hate it and feel isolated but some will love it because they are isolated, it might be more work for us."

The requirement for patients to be cared for in single rooms due to infectious status or clinical condition links to nurse-patient communication and the nursing workload. As noted previously when discussing the links between safety and patient privacy, communication between the patient and nurse might occur from the doorway to avoid application of PPE.

Event 5.3.1 - 7.27am. The son of the Patient in side room 3 asks the RN for something, I can't hear. RN replies "Yes, sure, it will be in 2 minutes." 4 min later SEN says to patient "Morning, how are you?" from outside room. Patient is being barrier nursed. RN and SEN are outside the room preparing medications, they leave the medication with the son on the patient's overway, and go to drug room together.

Applying and removing PPE repeatedly was also said to impact on nurses' workload.

Event 11.0.3 – 8.10 am. Discussion with nurse educator, “The way they allocate here is good, nurses are exhausted with all the donning and doffing of PPE, I don't care what people say, that constant action tires people out.”

Equipment and Infrastructure

Equipment and infrastructure deficits are linked to nurses' ability to deliver the fundamentals of care.

Event 1.0.2 – 7.30 am. Nightshift RN tells me “The bedside telephone system was supposed to let patients make their own calls, but it has never worked, we spend a lot of time making calls for patients.”

Event 14.3.3 - 17.41 pm. Another nurse to me “This is what takes us so long too, looking for equipment.” RN and another nurse are looking for an IV pole. “There's a pole in side room 2.” Other nurse to RN “I've got 15 minutes of antibiotics.” RN replies, “I will need it soon, he has IV antibiotics soon.” RN dons PPE and goes into side room 2. Patient asks something, RN replies “No, we just want a pole.” Other nurse says from door “By the time yours is set up mine should be finished”. RN brings pole to door, other nurse cleans pole and takes into bay.

Relying on medical staff

Relying on medical staff to complete their tasks might limit nurses' ability to deliver required care.

Event 3.2.2 – A new medication chart needed, RN says “If I leave this in the office they might write a new one, we live in hope.” There is a large red card on the front of the chart indicating the need for a new medication chart to be prepared by the doctors.

Non-physical fundamentals of care: Summary

The examination of the observed events that were not linked to the physical fundamentals of care illustrated clinical leadership at the ward level and the availability of resources as key items. Clinical leaders' role modelled expected behaviours, such as being responsive to patient requests for

assistance, related to the delivery of the fundamentals of care and they set the expectations for care delivery in their area of responsibility. Resource issues included the perceived impact of the care environment, and the availability of equipment.

Stage 1 Summary

The analysis of the observational data from Stage 1 of the study has illustrated the complex interaction between the physical, relational, psychosocial and contextual elements and dimensions of the Fundamentals of Care Framework when nurses are observed delivering the fundamentals of care. It was clear that each 'fundamental' or element was not delivered in isolation.

Analysing the events associated with both the physical and non-physical fundamentals of care enabled a broad exploration of the data. Safety, a physical fundamental of care, linked to medication and/or monitoring was a prevailing and frequently observed element. Other physical fundamentals of care explored were related to patient hygiene and hydration. These physical fundamental care needs might initiate an event, which could then also incorporate relational elements such as knowing the patient and their needs and preferences, and psychosocial elements such as involving the patient in their care and keeping them informed. These events might also be linked with environmental, contextual and resource items. Events that were not associated with or prompted by a physical fundamental of care illustrated the links to the contextual elements of resources and leadership. The combined results from this analysis of the observation data are illustrated in Figure 11 Combined analysis of observation data.

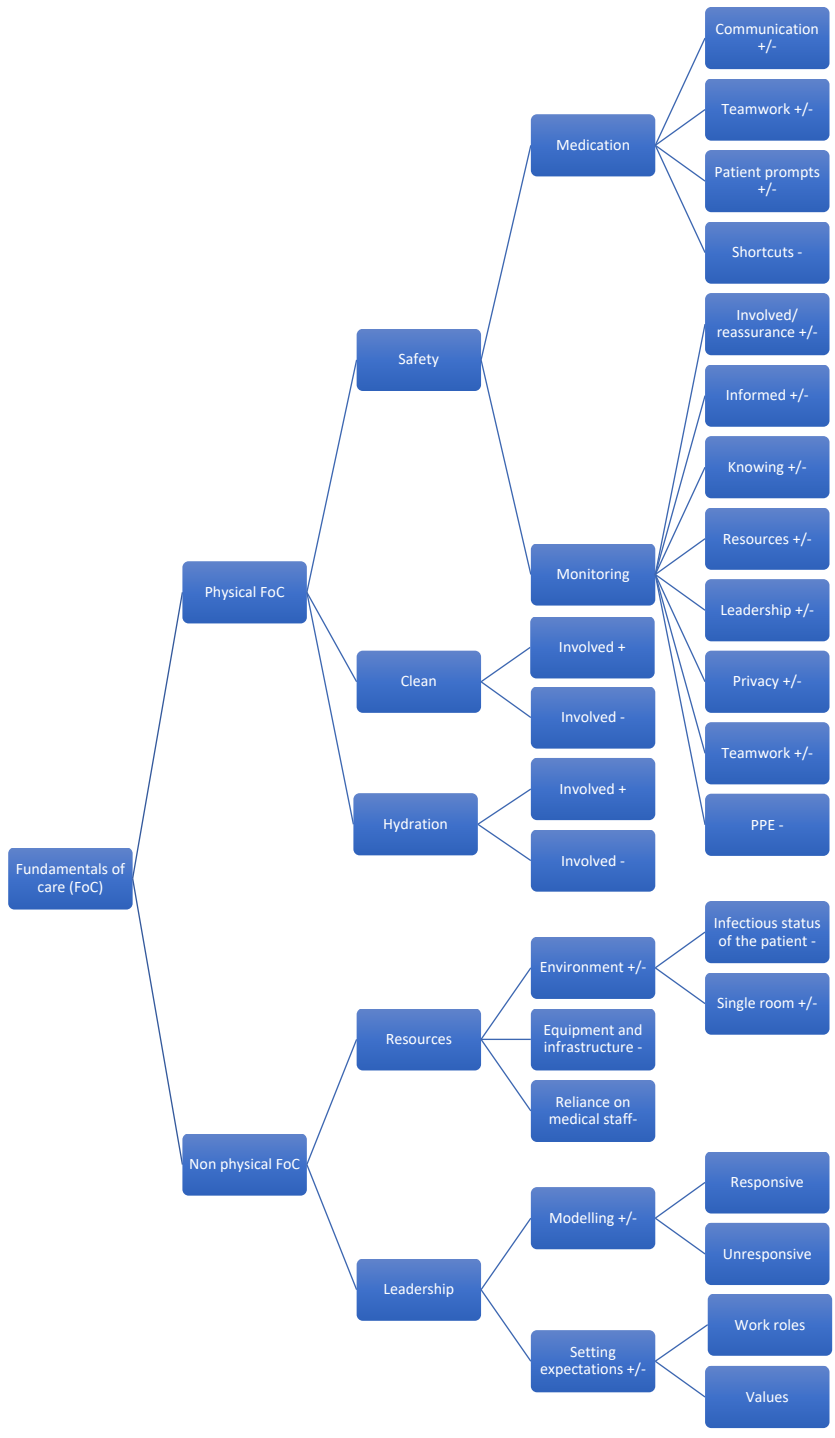


Figure 11 Combined analysis of observation data

Although there was considerable variation in the individual actions, interactions and activities involved in nurses' delivery of the fundamentals of care, the complexity of this care was evident in most events. The observed activity illustrated this complexity by revealing how nurses engage in multi-tasking; managing challenges in the environmental layout; using shortcuts; consideration of organisational factors; developing and maintaining relationships with patients, their families and other healthcare professionals; being cognisant of the prevailing values and expectations of the ward; and working with the constraints of the available resources.

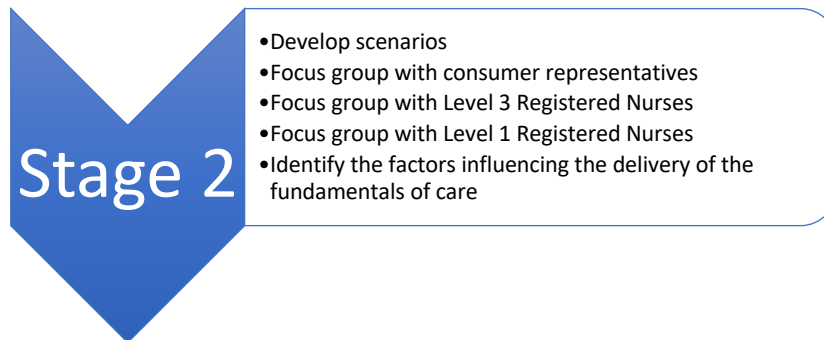
The findings from this stage are descriptive and exclusively based on the interpretation of the researcher. They contribute to identifying which fundamentals of care are delivered, by whom and in which combinations.

The next stage of this research explored nursing and consumer perspectives of common events presented in scenarios that were derived from the observed data. These participants were not tasked with identifying the fundamentals of care but rather to consider what was happening in the events described in the scenarios and to postulate on why this might be occurring.

Chapter 6

Findings Part 2-Stages 2 and 3

Stage 2: Focus groups results



Objectives

The objective of this stage of the research was to explore the delivery of the fundamentals of care from a nursing and consumer perspective, in order to generate deeper insight into how stakeholders interpret what is occurring with the care delivery and what they think may be causing this to happen. The observation data from Stage 1 was used to develop scenarios that incorporated frequently observed combinations of the fundamentals of care elements from the Fundamentals of Care Framework.

The original purpose of the focus groups was to elicit participants' responses to four individual scenarios (See Appendix 3) that were presented (i.e. what they thought was happening in the scenario and what they thought might have influenced the care delivery). However, once the participants read the scenarios their discussion not only related to these scenarios, but also routinely incorporated their own personal reflections and experiences of care delivery. Thus, the scenarios acted as prompts to elicit focus group participant explanations for why the care delivery issues in the scenarios might occur. The resultant discussion within the focus groups provided further insight into potential factors influencing care delivery as participants explored alternative explanations.

Development of scenarios

The aim of Stage 2 was to explore what nurses and consumers thought was happening when they reviewed the observation-based scenarios. The scenarios were constructed by the researcher based on the rich descriptions of nurses' delivery of the fundamentals of care from Stage 1, which illustrated different cues or prompts for delivery of the fundamentals of care from Level 1 Registered Nurses, Level 3 Registered Nurses in clinical leadership positions and from patients, the consumers of healthcare. Thus, each different stakeholder group was asked to independently interpret and provide their responses to the de-identified scenarios. The participants in each focus group were presented with the same four scenarios. A brief description of each scenario follows.

Scenario 1 describes the story of two patients; a patient with a non-English speaking background receiving their medication from a nurse who 'borrows' medication from another patient's supply, and another patient who has a different nurse administering their medication while asking the patient when it should be given, what it is for and how the patient prefers to take it.

Scenario 2 describes a visitor looking for a nurse to attend to a medication pump that has the alarm sounding, while another patient is crying and calling for help from their room. While this is happening medical and nursing staff are laughing about an unrelated matter in the corridor and several staff walk past the rooms where the patient is crying and where the pump is alarming.

Scenario 3 describes a patient being barrier nursed in a single room and their feedback about their care to a nurse administering an intravenous medication.

Scenario 4 describes the nursing allocation and medical interactions with two patients, one with a long-term chronic condition and one who is a tissue donor.

During the focus groups the participants were asked to read the scenarios in full (one at a time) and to reflect on factors that they thought might have contributed to the delivery or non-delivery of care in each scenario. Focus group participants also incorporated their own personal reflections and experiences of care delivery into the focus group discussion. Thus, the scenarios acted as a prompt to

elicit focus group participant explanations for why the care delivery issues in the scenarios, and indeed any care delivery issues, might occur.

Data collection

Three focus groups were conducted: One for consumer representatives (n=4), one for Level 1 Registered Nurses (RN) (n=7) and one for Level 3 RNs (n=7). See Table 8 for the participant characteristics. The small number of participants in each group facilitated detailed discussion and provided the opportunity for all group members to contribute.

Table 8: Focus group participant characteristics

Focus group participants	n=	Experience in the role
Consumer representatives	4	3 as a patient and a carer/family member, 1 as a carer/family member
Level 1 Registered Nurses	7	5 months to 15 years
Level 3 Registered Nurses	7	1.5 to 12 years

The focus groups were held in a quiet, private meeting room adjacent to the hospital. Participants were offered light refreshments. The focus group facilitator (researcher) who asked the questions, and an assistant/observer, were present at each session. The focus groups were held in April 2016. The focus groups continued until all scenarios had been reviewed and the group discussion was complete. The duration of the focus groups was 60 minutes for the Level 1 RN group, 88 minutes for the Level 3 RN group and 99 minutes for the consumer representatives.

Analysis

Coding

As described in detail in Chapter 4 (Methods), inductive content analysis was used to analyse the data. The first stage was to choose the unit of analysis and then to code the data. The codes were then grouped into sub-categories then further abstracted into generic categories and ultimately into main categories. The aim of the categorisation was to describe the phenomena under investigation, that is, the

factors the participants suggested might be influencing the delivery of the fundamentals of care. Therefore, the selection of the statements to be coded was focused on those that addressed the research questions. For the individual group analysis, statements that referred to factors the focus group participants suggested might have influenced the delivery of the fundamentals of care were coded. Statements were assigned more than one code if multiple influences on care delivery were mentioned. The main categories generated from the data analysis for each group are presented below. The data from each group were initially analysed individually to explore participants' diverse perspectives-. These data were then aggregated to identify the factors influencing nurses' delivery of the fundamentals of care.

Individual focus group findings

This section provides a brief overview of the initial findings from the individual focus groups before exploring the comprehensive analysis of the combined focus group data. Main and generic categories, with supporting excerpts from the transcripts, are provided for each of the three focus groups. Following the description of the individual group findings, the rationale for combining the data for the comprehensive analysis is explained. The focus of the analysis is then directed toward the data aggregated from all three focus groups. As focus group participants were assured that, while information gained during the study might be published, they would not be identified. Thus, to ensure participant confidentiality, direct quotes are not ascribed to individual contributors and no personal or identifiable information has been included

Consumer representative focus group findings

There were six main categories derived from the data from the consumer representative focus group. These are:

1. Contextual influences on care delivery
2. Individual nurse and patient characteristics that influence care delivery
3. Patients' perceptions and responses to care
4. Care focused on patient needs and wants
5. Understanding and knowing each other
6. The nurse-patient relationship

Each main category is overviewed below. See Table 9: Consumer focus group main and generic categories with example quotes, for supporting data from the consumer focus group. More than one quote is used to illustrate some generic categories.

Overview of main categories from the consumer representative focus group

1. Contextual influences on care delivery

Consumer representatives were aware of the external influences on care delivery. The impact of inadequate resources, high workload, work patterns (shift work) and staffing levels were recognised as factors. When nurses were seen as spending time to keep patients informed or, as being focused on an individual patient's care, it was assumed they were not under stress. Consumer representatives felt the leaders in the clinical care areas must take responsibility for role modelling appropriate behaviour and care delivery.

2. Individual nurse and patient characteristics that influence care delivery

The consumer representatives suggested the personality, behaviour and individual circumstances for the nurse or the patient can impact on care. Nursing was seen as a profession that requires certain personal characteristics and as a role that might be influenced by circumstances outside the workplace. Representatives argued that, in some circumstances, patients who are emotionally or physically demanding might exhaust the nurse's ability to provide fundamental care.

3. Patients' perceptions and responses to care

Consumer representatives valued nurses who show they care and who do not focus solely on a task. A lack of response to a patient request for assistance was seen as 'not caring'. The consumer representatives indicated patients want to feel some control over their bodies, and are fearful if they do not know what is happening to them, or when they sense a lack of empathy from nursing staff. Patients might also fear the consequences for speaking out about nursing behaviour. When patients and their families were anxious or fearful this further influenced their perceptions of their care.

4. Care focused on patient needs and wants

Consumers felt all patients have constant care needs and would not be in hospital unless this was the case. They recognised that nurses and patients might have different care priorities but believed the patient's needs and wants must take precedence. Patient or consumer focused care was valued. To promote patient focused care, the consumers indicated if they were a visitor or family member they might prompt nursing staff.

5. Understanding and knowing each other

The consumer representatives wanted nurses to know them and what was needed for them. They also wished to be kept informed about their care. Constant checking with the patient was seen as a way to engage with patients and check their understanding, however it could also be interpreted as the nurse 'not knowing', which could provoke patient anxiety. Communication barriers and a lack of rapport were seen to impact on patient understanding and also increased anxiety. Nurses were expected to liaise between patients, their families and other healthcare professionals.

6. The nurse-patient relationship

A relationship based on respect and compassion was valued by consumer representatives and could reduce patient anxiety, but was seen as an 'added extra' rather than an integral part of care delivery. Consumers argued that patient choices should be respected where possible, but nurses were also expected to do what is best for the patient rather than what the patient wants.

Table 9: Consumer focus group main and generic categories with example quotes

Main category	Generic categories	Consumer Focus group quote examples
Contextual influences on care delivery	Influence of workload, shift, time of day	“All the beds could be full, there could be a crisis in Emergency, they may be having to take someone who should be in another ward but there was a spare bed there, or someone may have been sick and didn’t show up and they haven’t got the agency or whatever coverage...”
	Leaders as role models	“... it’s probably come down the line, particularly the coordinators and the clinical supervisor. But the guys that are standing in the passage should be actually showing the young interns, the young trainees, this is what you do and go and do it...”
	Organisational influences on care delivery	“In a nursing home situation as a visitor I’ve been through something like that and called out for the person in the room next to my mum and was told, <i>it’s okay, she’s wearing a pad</i> , and I found that very undignifying, but I appreciate the constraints I suppose, the resource constraints. So yeah there is a dignity issue but I’ve never been there so I don’t know how it works”
Individual nurse and patient characteristics that influence care delivery	Characteristics of the individual nurse	“Could also be personality. Some people do not have a good bedside manner, doesn’t matter how good a nurse they are, and that’s where I think a little bit more training or a bit of performance management just might open that up and get them to think before they act abruptly, and that’s just some people”
	Characteristics of the individual patient	“maybe this patient number one has created fuss all day and been absolutely horrific, pain in the backside”
Patients’ perceptions and responses to care	Not responding is seen as not caring	“...bells are rung for a reason and it’s demonstrating a level of care whether you attend it or not”
	Nurse showing concern when attending to care needs	“Assist in sitting up, not just ask about the wash or shower, assisting in sitting up and places the pillow for the coughing I thought that was really good”

	Patient perceptions of care	"The midwives kept coming back to me because I kept saying <i>I'm having the baby, I'm having the baby. No, you're not, no you're not, get a magazine, get your knitting, do something, you're not having the baby.</i> I rang the bell again when I had another contraction and I'm nearly pushing the end out of this bed, and I said <i>I'm having the baby, you're not, you're not, just read magazines, just forget all this, get on with your knitting.</i> Well then there was a doctor, a lady doctor interviewing her patient whose baby she was going to deliver the next morning by C section. Well these two nurses had an absolute gutful of me and asked her [doctor] to come over and assess me and she took one look at me and said my God she's fully dilated, get up to labour, labour was on the next floor"
	Patients want to feel in control	"It's also allowing the patient have control over the process where Nurse One you've got no control. That's really important for us as patients to know that we do have some control about what's going on with our bodies"
	Patients feeling frightened	"And they're standing there laughing and I would say <i>don't you have work to do</i> , and my little sister would say, <i>don't talk to them like that, they've got to look after me.</i> She would also be scared of that and I was like, <i>no they've got work to do, they shouldn't be gossiping</i> , and they'd go off and do their job and come back"
	Perceptions of care influenced by patient anxiety	"I wonder if that's worse when the observer or the patient or the carer visitor is already stressed, because if I'm anxious and trying to rush to this meeting for example and the butcher's giving me the run around about what I did or didn't order, so translating this to here, well here I am anxious and my patient or I, my relative or I need immediate attention, how dare you laugh now, I think is something that could be considered"
	Task focus not seen as patient focused	"...patient care has been forgotten and they're too busy trying to get things done..."
	Patients want choices	"...being advised that you have the choice"
Care focused on patient needs and wants	Care needs are constant for all patients	"I think the needs aren't different, the circumstances might be and it feels for all four scenarios the situation that the nurses are in and the doctors seem to vary but there's a platform, a baseline if you like of constant need. Intensive care might vary too but I don't see too many people being in hospital if they don't really need to be there..."
	Different priorities for nurse and patient	"When someone's wailing loudly and you can hear that out in the passage and then there's medical staff laughing loudly with two other nurses, well is that level of care, you're not there to have fun, you're there to do your job and it's about caring for people"

	Different priorities for nurse and patient	"They can't leave their meal break because if they leave their meal break they're going to expect it all the time for them to leave their meal break, or the patient could be the person if you put on the toilet you can't leave on her own"
	Importance of patient/customer focused care	"Nurse One needs to be taken aside and given some training in customer service and dealing with people and communication"
	Prompts for FoC delivery	"So, we had a real bad experience with that and she was always crying, and she was my baby sister and it's pretty hard without her and I was getting angry, they wouldn't shower her, they wouldn't bath her. In the end I walked in and I said to this young lad, <i>James, is that your name?</i> , he said yes, [I said] <i>my sister needs a shower. If you don't shower her and I go and do it and I hurt myself I'll sue this hospital</i> "
Understanding and knowing each other	Importance of knowing	"The nurse should be the one, in my opinion, who knows what's going on and not relying on a patient"
	Checking with patients about their care	"...the nurse also asks the patient about when they usually take their medication, now that could be taken two ways, do they not know or is it a form of interaction and confirming when they either last took their medication or the usual time"
	Need for both parties to understand each other	"There seems to be a bit more understanding"
	Communication between nurse and patient	"And I think if a patient has English as a second language depending at the level of it you might get an interpreter in to make sure that the patient understands"
	Nurse role as a 'go between'	"I don't think we can do anything about that but it must be difficult if a nurse is caught in the middle because the patients would be seeing the nurses and the patients would be saying, <i>but I thought I had eighteen months</i> whereas they only had three or something like that"
	Involving significant others in care decisions	"...but the nurse could arrange it, so say <i>can I get doctor to talk to you next time, or could you be here between 7 and 8 [o'clock] when the doctor's doing his rounds, or whatever, and then that just minimises confusion and pretence that there is an option, we're not pretending, we're hoping for options</i> "

The nurse-patient relationship	Indicators of nurse involvement and engagement with patient	"I thought the nurse really showed empathy and compassion and it was like she was part of the family, really involved and engaged"
	Nurse must balance empathy with providing needed care	"There is a point too where you can be too empathetic and therefore not be firm enough to say, <i>look you have to stay in bed</i> , there has to be a balance with the nursing, you can't always..."
	Nurse must balance respecting patient choices and providing needed care	"But there is a point where you have to say to the patient, <i>in your best interest we need to do 1, 2, 3, 4</i> and give the options or whatever"
	Nurse-patient relationship development	'Nurse Two, I would hope that she knows what she's doing and not relying on the person, but she is opening up a conversation and making it a more personable approach"
	Relationship is valued but seen as an extra to clinical care	"It's not just clinical"
	Respect is valued but not expected	"I thought that was patient service over and above, that was giving the patient choice but then you don't know the situation of the patient but I thought that was really good and really, really nice, amicable, friendly, respect."

Level 3 Registered Nurse focus group findings

There were four main categories derived from the Level 3 Registered Nurses focus group.

These are:

1. Contextual factors including leadership, the organisational culture and investing time
2. Nurse-related factors
3. Patient-related factors
4. Factors relating to the nurse-patient relationship

Each main category is explored below. See Table 10: Level 3 Registered Nurse focus group main and generic categories with example quotes, for supporting data from the Level 3 Registered Nurse focus group.

Overview of main categories from the Level 3 Registered Nurse focus group

1. Contextual factors including leadership, the organisational culture and investing time

Level 3 nurses recognised the responsibility they had for setting care standards. The impact of organisational pressure to meet targets was said to contribute to a lack of communication and consideration of the patient perspective. The individual ward environment and the broader context of care was seen to impact on nurses' ability to provide the fundamentals of care. The need to moderate medical staff behaviour and advocate for patients was suggested as an important role for nurses. Time to attend to patient requests for assistance or to resolve small issues was seen to 'pay off' in the long run and might relieve pressure on the nurse. It was also suggested that the nurse's perception of the time available might be skewed and that a lack of time might be used as an excuse not to deliver the fundamentals of care.

2. Nurse-related factors

The Level 3 nurses indicated there were specific skills needed by nurses to deliver the fundamentals of care. These included good communication, being able to evaluate the outcomes of care, sound

knowledge and skills to understand what care is being delivered and why it is required, and an ability to focus on the patient and not on the task-at-hand. It was suggested that the pressure of the nursing role can impact on a nurse's ability to cope with and manage care delivery, and that nurses might become desensitised as a way of coping with this pressure. Delegation of care tasks and ensuring appropriate staff skill mix were indicated as ways to help with the pressure. Some nurses were seen to restrict their care delivery to their allocated patient load. However, the Level 3 nurses felt all nurses must attend call bells and can help keep all patients reassured, informed and safe. Level 3 nurses argued that all nurses need to reflect on the patient perspective as the perceptions of the nurse and the patient regarding care delivery might vary.

3. Patient-related factors

Level 3 nurses stressed the importance of communicating and consulting with patients about what they want, and then addressing these individual needs. It was acknowledged that nurses need to spend time with patients to understand their concerns and priorities. The nurses argued that patients need to know who was delivering their care and what was being done, however, it was seen as important to respect the patient's choice to know or not know about their condition and prognosis. The need for holistic care that involved maintaining patients' dignity and ensuring they feel, and are, safe was highlighted. Individual patient characteristics such as having English as a second language, being reluctant to 'speak up', feeling powerless to influence their care, or having an infectious disease requiring isolation might adversely influence care delivery. The Level 3 nurses recognised that patients who were viewed as compliant with nursing instructions, who attended to their own fundamental care needs, or who had an interesting or 'special' diagnosis might be perceived as being more desirable to care for.

4. Factors relating to the nurse-patient relationship

The Level 3 nurses indicated that knowing the patient, focusing on them and their needs, and keeping promises were ways to influence care delivery. It was acknowledged that knowing the patient takes time. Checking with the patient about what they understand about their care and about what is planned was seen as important. However, the Level 3 nurses were aware that this checking can also be construed by

the patient as the nurse not knowing what is needed. Nurses valued positive responses and expressions of gratitude from patients and their visitors.

Table 10: Level 3 Registered Nurse focus group main and generic categories with example quotes

Main category	Generic category	Level 3 RN Focus group quote example
Contextual: Leadership, organisational and cultural influences	Contextual influences of the care environment	"And also, you don't know the situation on a Ward, this day it might've been much calmer than the scenarios one and two; no screaming patients"
	Influence of Leadership – organisational culture	"I mean you could possibly and I don't think you should but forgive the CSC for walking past if something else was going on, maybe the shift co-ordinator but not really, but there were other nurses that walked past the bed, I mean no-one should walk past a patient's bed but something might've been happening, but at least you should've popped in and said, and done something"
	Contextual influences of the organisation	"Why have they not gone, get them out, it's every day, it's huge, we've got to cut beds, the budget's overblown, it's not a small thing"
	Influence of other healthcare professionals	"Especially ones that come in, not the home Ward, the home Ward you can modify their (medical staff) behaviour, but when you've got, I'm not saying this is, but it is difficult when they are seeing someone not in their own Ward and you don't know what time they're coming, you're less inclined, I mean if you were standing there you would certainly advocate for the patient, but if you're not there it's difficult"
	Time taken to deliver the fundamentals of care might be seen as an investment in future care delivery	"It is surprising though what you get when you do, so you stop and for that spending five minutes or ten minutes gives the rest of the person's shift will be easier because that person's needs are being met and you know what the plan is for them"
	Perspectives about the available time differ	"I sometimes think we hide behind that (time) because it doesn't take very long to introduce yourself and do your hand hygiene and explain what you're doing and do it really in that injection one"(referring to Scenario 1)
Nurse-related factors	Nursing skills needed to deliver the fundamentals of care	"Is it because we become so familiar with tasks that we don't actually then think about the impact that that has on the patient. You have your day tasks planned or what your work is and you actually forget about the patient as a human being just like we are and the focus is towards the task"
	Who is responsible for the fundamentals of care?	"It reads terribly and that's a bad nurse for doing that, that's a reality for nurses working day after day with those patients, how do we help them manage that, how do we allocate appropriately or do something different so that they don't ignore that patient"
	Whose needs (nurse or patient) get priority when delivering the fundamental of care is not always clear	"...I guess that just stood out to me where you're saying the patient is eating their dinner, and we may be going in doing a procedure and not really respecting that opportunity for them to perhaps eat their meal because suddenly they'll stop that while we go in and do a procedure because it works with our timing"
Patient-related factors	The fundamental care needs of the patient	"And it's spending that time, you know just having a chat to them, listening to what they think, what their concerns are, what their questions are and addressing those and maintaining their dignity"
	Individual patient characteristics	"But that comes back again to why are they the favourite patients, we have to be real about what's creating that culture, then how do we support nurses more that they feel that they can look after the person with the infected toe as well as the renal patient"

Factors relating to the nurse-patient relationship	Involvement of patients in their care delivery	"They're also involving that patient. The nurse then asks the patient if they have any pain and what they might need to relieve it, so what they would normally take as opposed to just saying I'll get you some pain relief and the nurse decides"
	The nurse-patient relationship	"It seems to me that each time something is happening here it's being explained so the needs are probably being recognised and met; some of it verbally and some of it non-verbally in a way, and then saying they're going to do something and they actually come back with what they've gone off to do. It's not just a drink, it's a box of juice or something like that, so yeah following through on what you say you're going to go and do it"
	Positive feedback for nurses for care delivery	"I think we've all been a patient though or a family member so to remember that all the time with staff. I know that I wasn't a particularly fantastic relative at times so it's good for us to remember what we were like in those situations and that's what these people need help with"

Level 1 Registered Nurse focus group findings

There were five main categories derived from data from the Level 1 Registered Nurse focus group. These are:

1. Contextual factors including leadership and time management
2. Nurse-related factors
3. Connections within and across the fundamentals of care
4. The nurse-patient combination
5. Relational factors

Each main category is overviewed below. See Table 11: Level 1 Registered Nurse focus group main and generic categories with example quotes, for supporting data from the Level 1 Registered Nurse focus group.

Overview of main categories from the Level 1 Registered Nurse focus group

1. Contextual factors including leadership and time management

This category relates to the external influences on the delivery of the fundamentals of care. The Level 1 nurses believed the nursing leadership should model expected behaviours, set the 'tone' of the ward, and be responsible for the staffing skill mix and workload allocation. Ward culture, such as if people help each other or work as individuals, was perceived to be an influence. Workload and 'being busy' influenced the availability of nurses to respond and their attitudes towards care provision. Feeling tired and undervalued might negatively impact on nursing care delivery. The care environment including the ward routines and the constant presence of call bells and alarms might influence nurses' delivery of the fundamentals of care and their responses to patient requests for assistance. The Level 1 nurses recognised their perception of the priority of patient requests for assistance might not correspond with the patients' perceptions. However, the Level 1 nurses felt that not responding is unacceptable, and there 'must be a reason' for this lack of response, such as a higher priority need elsewhere.

2. Nurse-related factors

This category represents the factors that Level 1 nurses indicate might influence care delivery and which are specific to the individual nurse. If nurses were tired, disengaged or feeling burnt out, this might impact on the care they provided. A focus on tasks or a mechanistic style of care delivery could result. Debriefing and provision of emotional support for nurses was suggested as a way to address this. Patients need nurses with the relevant specialist knowledge and skills to provide the care they require; however other nurses should not be excluded from caring for these patients and should be supported to develop these specialist skills. New experiences and exposure to novel care needs might reinvigorate nurses. Students were seen to have a 'fresh' perspective on care delivery but needed to be encouraged to challenge existing practices.

3. Connections within and across the fundamentals of care

The Level 1 nurses were aware that individual fundamentals of care did not exist in isolation. Each physical fundamental care need was seen to be linked with other physical, psychosocial and relational needs. Many factors, such as the patient diagnosis, provision (or not) of care interventions, and patient co morbidities (including multi resistant organisms) were argued to impact on care delivery. Nurses agreed that they are responsible for patient care and see responding to patient requests for assistance as an essential fundamental of care.

4. The nurse-patient combination

This category encompasses the factors the Level 1 nurses believed would vary depending upon the combination of the individual nurse and patient. These issues might be influenced by and, in turn, might also influence some of the relational factors described below. For example, if there is clear, two-way communication between the nurse and the patient; this facilitated knowing the patient and ensuring they were kept informed. However, if patients were perceived to be resistant or aggressive towards nursing staff this could impact on how comfortable, or inclined, nurses felt to advocate for, or to provide emotional support for, the patient. The Level 1 nurses were aware that patients' perceptions of their care might differ from the nurses' perspectives and that patients might feel their care needs were not being prioritised.

Good communication between the nurse and the patient was suggested as a way to address this. Clarification of each parties' needs and responsibilities might assist in setting mutual priorities.

5. Relational factors

This category describes elements of the nurse-patient relationship that Level 1 nurses indicated could impact on the delivery of the fundamentals of care. Involving patients by keeping them informed as well as engaging with them to ensure they understand what is happening, and agree with their care choices, was viewed as important. The Level 1 nurses believed that if they know their patients they can better deliver appropriate care, and felt responsible to advocate for their patients. The Level 1 nurses understood they are in a position of trust and foster this trust by not making promises they cannot keep. Emotional support for patients and their families, and empathy with their situation, was viewed as important throughout the patient journey

Table 11: Level 1 Registered Nurse focus group main and generic categories with example quotes

Main category	Generic categories	Level 1 RN Focus group quote example
Contextual factors including leadership and time management	Context of care, routines	"If you worked on the patient's time we'd probably get nothing done, you know, <i>I don't want a shower right now I want to do this, I want to do that</i> , I'm like <i>okay but when you're ready for a shower we [nurses] might not be ready that's the thing</i> "
	The context of care, ward level	"I think it starts from the top. You always can feel it when you go into a Ward whether it's got a good feeling and whether people help each other out and things get done or if people say, <i>oh that's not my patient</i> and walk away"
	Nurse might become desensitised to alarms and call bells	"We hear the monitors going off all day long and you do, you become slightly complacent and then you're <i>like oh that's my monitor</i> , but you can see your patient they're right there and they're fine, it's just they've taken their sats probe off. But it's going all day, the monitors are going all day so I'm just trying to maybe think maybe on that Ward the pump's going off all the time"
	Impact of leadership	"And if all the seniors are up at the A end why isn't the nurse in charge helping the juniors down the B end. Because it's easy up the A end, why go down the B end, that's where she put all the babies [junior staff]"
	Impact of workload and skill mix	"Have they got lack of staff there too? I think most, every Ward in the hospital doesn't have enough staff on really, if we wanted to do our job perfectly, like we're nit-picking all of this stuff and yes it's wrong most of it but if we wanted to do it absolutely perfectly we'd have one staff member to one patient, because then we can do exactly what we wanted"
	Influence of other healthcare professionals on nursing care delivery	"...they (medical staff) won't go tell the nurse who is looking after the patient they'll just walk off and won't care. They won't come back to pass it on, they'll just assume that they'll read the notes and you don't always get a chance to read the notes straight away, they don't tell you they just write it in the notes and then three hours later you might find out <i>oh yeah they're fasting now</i> and they've already eaten something"
	Taking 'time', time management	"The nurse two one it seems like they've got more time even though they might not physically have time, they've taken the time, they're able to time manage so I think they're able to take time to work out what tablets..." (referring to Scenario 1)
	There must be a reason why nurses do not respond	"I'd like to think that in every one of these scenarios that something else is going on, you know like something else is actually happening and there's a reason for it, that's what I'd like to think"
Nurse-related factors	Characteristics of the nurse	"Maybe they just need re-training. They've obviously become complacent, become a little bit unprofessional, they might need a little bit of, or maybe they've lost interest in their jobs that's influencing their care and causing them to be a little bit unprofessional which is very sad because they shouldn't be in that job"
	Focus on the task	"Maybe that the nurse has just gotten into a routine and has decided, she clearly needs to be pulled up"
	Need for emotional support for the nurse	"Sometimes that is important too though for debriefing to have those moments where you can. I know there's a lot going on here but our health and mental health is important too, it's not only about the patients, you can't look after someone else if you don't look after yourself that's what I think".

	Nurse knowledge and skills	"Sometimes you have to be especially ... trained to take care of transplant patients, so maybe that's the reason why certain staff members had to work down that end of the Ward..."
	Students have a responsibility to question care	"...the student obviously has just done what they were told in regards to <i>leave that or no hurry for that</i> when maybe it wasn't important, maybe there was bloods running and maybe the student could've spoken out. That sometimes doesn't happen"
Connections within and across the FoC	Awareness of inter-related needs, physical and emotional	"...because we're talking about fundamentals of care, nutrition and all the other aspects of care that you look at because he might be diabetic, is he diabetic and if he's in a renal ward he probably is diabetic. You know all the other parts and what sort of lifestyle will the other patient, the donor, what sort of diet will they need, and what else are the fundamentals of care, all aspects of nursing basically"
	Being aware of impact of diagnosis and care on patient	"Because they can feel isolated I guess can't they?"
	Impact of infectious status on patient care and experience	"Yeah they can feel quite isolated just talking from the door because you don't want to gown up, you should still make that effort to go in there and do your bedside communication"
	Nurses are responsible for patient care and safety	"...so if the nursing staff was keeping a bit more of an eye out, I know it's hard but they actually should be able to notice what's going and that the person walking past would've had to intervene. And I suppose as they say now, it's a falls risk"
	Responding to a call bell is a fundamental care issue	"If something is beeping you obviously need to be, needs to be attended to and the longer it's beeping the more it's disrupting the patient, they're ringing and if it's night-time they might wake more patients"
The nurse-patient combination	Care priorities might differ between nurse and patient	"...a priority to you may not be a priority to that patient and that's where the problem comes into it"
	Communication between nurse and patient	"There's very little communication here in general though when she goes to cancel the call bell and she doesn't say anything to the patient and just walks away and then they re-ring the call bell".
	Family/visitor responsibilities towards patient	"So it's really hard if, you have ten visitors surrounding a patient, it's really hard to do your stuff and especially puts more pressure on you. If they're the one saying or noticed something like the pump is beeping, it puts more pressure on you, or they say <i>my mum needs some medication for pain</i> , it's sort of like, it's actually the patient to be asking for meds..."
	Patient response to care delivery	"She might be really frustrated with that patient that's been abusive in the side room and you've come in now and walked in and switched off that pump and gone back because you've actually got to deal with someone that's swearing at you and abusing you somewhere else..."
	Recognising individual patient needs	"So there could be a background of why they're so anxious as well, they might have other things they want to do"
Relational factors that impact on FoC delivery	Advocacy and support from nurses	Speaker 1: "There could've been a nursing staff...Or family. Speaker 2: Yeah or family so at least, because the doctors won't be there to answer the questions, they'll answer a few but then they'll have to run off whereas at least the nursing staff they might be able to clarify a few more things or get more questions to them to speak to the doctors".
	Emotional support and empathy for the patient	"And the person down the B end is pre-op and probably needs a bit more emotional support to get them through because as we said they might be a bit confused, but they're not, knowing that they're going to lose a toe and all

		the things that could happen after that and what change in their life could happen from losing a toe, it's not a huge operation but depending on what toe you lose it could make them lose their balance and whatnot"
	Ensure patients understand their care/condition	"And as a nurse I think maybe if it wasn't mentioned here something could be explained to the patient about, you know, a little bit of education in regards to what they've got and why you're wearing your gown and I'm only wearing this because this and this. Patient information sheets can be given to individuals just so they're a bit more informed"
	Interacting with patients. Engaging with them.	"Well nurse two at least interacted with their patient, nurse one didn't even allow that to happen"
	Involving patients in their care delivery	"Maybe just even a little bit more trying to involve the patient because it says the patient appears to understand, just because English is a second language doesn't mean there's no understanding, she just needs to maybe include the patient a little bit more in what she's doing instead of running and doing what she needs to do and getting out, maybe making it a little bit more about the patient and involving them in their own care"
	Keeping patients informed	"Not a lot of information, proper information being given to the patient in regards to what sorts of things are going on, what medications they're having and if there are any concerns"
	Knowing the patient impacts on care delivery	"...the patient may have been there for months, that's what I meant, and they may know all that stuff but it's still that little snip but it's wrong, but there's always a background story to everything"
	Respecting patient choices	"Nurse two cares, makes an effort and asks, gives the patient a little bit of autonomy, bit of respect I guess"
	Trust between nurse and patient	"I suppose a good thing is in one section where it says about the drink, the nurse actually followed through with that because how many times...?"

Combined focus group data analysis

Integration of data

To obtain a holistic and descriptive view of the factors influencing the delivery of the fundamentals of care described by the consumer representatives and both nursing groups, the final stage of the data analysis was to compare the main categories that had been created for each of the three groups. When considering the generic categories from the three groups there were many similarities in the factors the three groups described as influencing the delivery of the fundamentals of care. However, it became clear there were differences between the three data sets with how some generic categories had been allocated to main categories. The allocation of generic categories to main categories, on the basis of similarity in meaning, was rational for each individual focus group. However, similar generic categories had been allocated to different main categories across all three groups. For example, the influence of the different care priorities perceived by patients and nurses was described by consumer representatives and nurses, however, the main categories this factor was allocated to by the researcher differed across the groups. These main categories were 'The nurse-patient combination' for the Level 1 RN group and for the consumer group it was 'Care focussed on patient needs and wants'. This might reflect how each focus group data were analysed, without a predetermined position from the researcher about the possible influencing factors. It might also reflect the diversity of the perspectives from each group.

In order to develop a cohesive, narrative description of the factors influencing the delivery of the fundamentals of care, the generic categories from each group were reanalysed to generate a new set of combined main categories. Table 12: Aggregation of all three focus groups generic categories, illustrates the allocation of the generic categories from each focus group into the main categories for the combined data.

Table 12: Aggregation of all three focus groups generic categories

Combined Main Categories	Generic Categories		
	Consumers	Level 1 Registered Nurses	Level 3 Registered Nurses
Nursing leadership	-Leaders as role models	-Impact of leadership	-Influence of Leadership – organisational culture
The context of care delivery	-Influence of workload, shift, time of day -Organisational influences on care delivery	-Context of care, routines -Context of care, ward level -Nurse might become desensitised to alarms and call bells -Impact of workload and skill mix -Influence of other healthcare professionals on nursing care delivery	-Contextual influences of the care environment -Contextual influences of the organisation -Influence of other healthcare professionals
Time		-Taking 'time', time management	-Time taken to deliver FoC might be seen as an investment in future care delivery -Perspectives about the available time differ
Care needs of the patient	-Not responding is seen as not caring -Nurse showing concern when attending to care needs -Care needs are constant for all patients -Importance of patient/customer focused care	-There must be a reason why nurses do not respond -Family/visitor responsibilities towards patient -Recognising individual patient needs -Awareness of inter-related needs, physical and emotional -Being aware of impact of diagnosis and care on patient -Impact of infectious status on patient care and experience -Nurses are responsible for patient care and safety -Responding to a call bell is a fundamental care issue	-The fundamental care needs of the patient
Nurse characteristics	-Characteristics of the individual nurse	-Characteristics of the nurse -Focus on task -Need for emotional support for the nurse -Students have a responsibility to question care	
Patient characteristics	-Characteristics of the individual patient		-Individual patient characteristics

The nurse-patient relationship	<ul style="list-style-type: none"> -Indicators of nurse involvement and engagement with patients -Nurse must balance empathy with providing needed care -Nurse-patient relationship development -Relationship is valued but seen as an extra to clinical care -Respect is valued but not expected -Patients feeling frightened 	<ul style="list-style-type: none"> -Advocacy and support from nurses -Emotional support and empathy for the patient -Interacting with patients, engaging with them -Knowing the patient impacts on care delivery -Trust between nurse and patient -Patient response to care delivery 	<ul style="list-style-type: none"> -The nurse-patient relationship -Positive feedback for nurses for FoC delivery
Involving the patient, ensuring their understanding and respecting their choices	<ul style="list-style-type: none"> -Importance of knowing -Checking with patients about their care -Need for both parties to understand each other -Involving significant others in care decisions -Nurse must balance respecting patient choices with providing needed care -Patients want choices -Patients want to feel in control 	<ul style="list-style-type: none"> -Ensure patients understand their care/condition -Involving patients in their care delivery -Keeping patients informed -Respecting patient choices 	<ul style="list-style-type: none"> -Involvement of patients in their care delivery
Communication	<ul style="list-style-type: none"> -Communication between nurse and patient -Nurses' role as a 'go between' 	<ul style="list-style-type: none"> -Communication between nurse and patient -Nurse knowledge and skills 	<ul style="list-style-type: none"> -Nursing skills needed to deliver FoC
Priorities	<ul style="list-style-type: none"> -Perceptions of care influenced by patient anxiety -Task focus not seen as care focused -Different priorities for nurse and patient -Prompts for the delivery of the fundamentals of care -Patient perceptions of care 	<ul style="list-style-type: none"> -Care priorities might differ between nurse and patient 	<ul style="list-style-type: none"> -Who is responsible for the fundamentals of care? -Not always clear whose needs (nurse or patient) get priority when delivering the FoC

Results

Ten new main categories were derived from the combined analysis of the data from the three focus groups. These main categories related to three topics: Organisational factors; Individual nurse or patient factors; and Interpersonal factors. All focus group participants were assured that while information gained during the study may be published, they would not be identified, and no personal results would be divulged, therefore direct quotes are not ascribed to individual contributors. Exchanges between focus

group participants are presented as Speaker 1, Speaker 2, etc., identifying the order in which the exchange took place. The three topics and their respective main categories are described below.

Organisational factors

This topic has three categories: Nursing Leadership; The context of care delivery; and Time.

Nursing leadership

All three focus groups highlighted the importance of the nursing leadership in the ward or unit where the care is being delivered. Participants agreed that leaders should role model expected behaviours and set the 'tone' for the ward. As stated by a participant in the Level 3 RN group *"I think myself if I walk past it, I then can't really have a go [sic, means to remonstrate] at someone else walking past it."* One consumer representative remarked when referring to scenario 2 *"it's probably come down the line, particularly the coordinators and the clinical supervisor. But the guys that are standing in the passage should be actually showing the young interns, the young trainees, this is what you do and go and do it"*.

The two nursing groups saw leaders as responsible for the staffing skill mix and the allocation of patient care responsibilities, with both factors seen to impact the delivery of the fundamentals of care. When referring to scenario 4, a participant in the Level 1 RN group remarked, *"I think first of all the nurse in charge shouldn't have grouped the staff already and referred to staff in the words that she did, that can upset many of us, and although they might be juniors they might still be knowledgeable."*

The context of care delivery

Participants in all three focus groups were aware of the external influences on care delivery, highlighting inadequate resources, high workload, work patterns (shift work) and staffing levels as influencing factors. Level 1 RNs suggested the ward culture had an impact, such as if people helped each other or worked as individuals. As an example, when referring to an unanswered call bell in Scenario 2, one Level 1 participant stated, *"I'm just saying, they heard it but they didn't hear it because it's their Ward, that's how they roll, they're just like, 'oh God that pump again I'm just going to walk past'"*.

Workload and 'being busy' were seen to influence both the availability of nurses to respond to requests for assistance and their attitudes towards care provision. For example, one Level 3 RN explained *"most days we can't give the level of care we want to so as a self-protective mechanism. I think you do probably get a bit, become a bit hardened to it because if you didn't you'd just go home and cry every night. I feel every day like we don't give the level of care we'd like to but we can't, we do the best we can but it's hard."*

Level 3 RNs highlighted other organisational factors that might influence care delivery, such as pressure to meet targets and a focus on throughput and budgets. This is highlighted in the following conversation from the Level 3 focus group:

Speaker 1: ...we all get the emails about reduce length of stay and get the patient out, I have to do this, do that and I think that could potentially filter down and maybe it does get lost.

Speaker 2: And we are putting a lot of pressure on the staff, discharge stuff is massive in the hospital; cutting beds, cutting, you know, and EDs and that constant battle but the whole hospital is so, it is huge.

Speaker 1: Why have they (the patients) not gone, get them out, it's every day, it's huge, we've got to cut beds, the budget's overblown, it's not a small thing.

Consumers also acknowledged the potential impact of work patterns. One consumer participant remarked, *"... I wonder at the seven, eight hour shifts that people do. Sometimes twelve hour shifts. So I wonder if the quality of life for the nurses translated then to the quality of life for patients would be better if there were shorter shifts, I don't know."*

Time

Both nursing groups described the potential influence of time, or a lack thereof, on care delivery, as explained in this quote from a Level 3 RN, *"there's never been time to sit with a patient and chat to them and a lot of things we used to do when we had time when we were younger"*. However, some nurses saw spending time with patients to explain and explore their care needs as an investment that reduces patient

anxiety and subsequent calls for assistance. As stated by one Level 3 RN, *“It is surprising though what you get when you do, so you stop and for that spending five minutes or ten minutes gives the rest of the person’s shift will be easier because that person’s needs are being met and you know what the plan is for them”*.

Nurses demonstrate awareness that their perceptions of the time taken to respond to patient requests for assistance might not correspond with patients’ perceptions. This was discussed by the Level 3 focus group in the following exchange

Speaker 1: Ten minutes though is a long time.

Speaker 2: And you know the nurse saying I’ll be there in a sec they probably think they haven’t been that long but they probably have.

Speaker 1: And if you’re the patient it seems much longer.

Nurses value time-management skills but it was also acknowledged that not having the time to provide the desired level of care for their patients does not always reflect poor time-management skills. A Level 1 RN explained, *“I think time is often a factor. You don’t have to have poor time management to not be able to do the things that you want to do or give the care that you want to give”*.

Individual nurse or patient factors

This topic has three categories: Care needs of the patient, Nurse characteristics; and Patient characteristics.

Care needs of the patient

Consumers believed all patients have constant care needs and would not be in hospital unless this was the case. They appreciated nurses who show they care and who do not focus solely on a task. A lack of response to a patient request for assistance was seen as not caring.

Level 1 RNs were aware that patients’ individual fundamental care needs do not exist in isolation but that each physical fundamental care need is linked with other physical, psychosocial and relational needs.

For example, one Level 1 RN explained, *“if they were still connected to the drip they might’ve wanted to go to the toilet and they could’ve ended up incontinent because they couldn’t go to the bathroom because they were connected to everything. So that could’ve made them embarrassed and feel upset”*.

Both nursing groups agreed that patient factors, such as their diagnosis and presence of co-morbidities, which include being colonised with multi resistant organisms (MRO), can impact on care delivery. This is illustrated in the following exchange in the Level 3 focus group:

Speaker 1: We get quite a few (patients) going “they just yell at me from the door, what do you want?”

Speaker 2: And that’s their perception.

Speaker 1: And they do say that, there’s some research around, what’s a patient’s experience of being an MRO, it’s extremely different than not because you’re gowning up and even how you present and how you look.

Speaker 3: You don’t just walk in there.

Speaker 1: And I think the worst thing is it’s almost like you’re being punished for what we did (if the infection was hospital acquired) essentially.

Level 1 RNs also indicted that nurses are responsible for patient care and saw responding to patient requests for assistance as an essential fundamental of care. By contrast, not responding to these patient requests was seen as unacceptable and something for which there ‘must be a reason’. One Level 1 RN explained, *“I’d like to think that in every one of these scenarios that something else is going on, you know, like something else is actually happening and there’s a reason for it, that’s what I’d like to think”*.

Nurse characteristics

Consumers and Level 1 RNs discussed the potential impact of the individual characteristics of the nurse on care delivery. Consumers indicated the personality, behaviour and individual circumstances for the nurse could impact on care delivery. One consumer remarked, *“Could also be personality. Some people do not have a good bedside manner, doesn’t matter how good a nurse they are, and that’s where*

I think a little bit more training or a bit of performance management just might open that up and get them to think before they act abruptly". The consumers viewed nursing as a profession that requires certain personal characteristics and one where fulfilling the role might be influenced by "life factors" and circumstances outside the workplace.

Level 1 RNs suggested if nurses are tired, disengaged or feeling burnt out or undervalued, this can impact on the care they provide, resulting in a focus on tasks or a mechanistic style of care delivery. Debriefing and provision of emotional support for nurses were suggested as ways to address this. One Level 1 RN commented "*Sometimes that is important too though, for debriefing, to have those moments where you can. I know there's a lot going on here but our health and mental health is important too, it's not only about the patients, you can't look after someone else if you don't look after yourself, that's what I think*".

Patient characteristics

Consumers and Level 3 RNs discussed the influence of the individual patient. Consumers described how the personality and behaviour of the patient might impact care delivery and suggested that patients who are emotionally or physically demanding can exhaust the nurse's ability to provide fundamental care. When referring to scenario 1, a consumer argued, "*maybe this patient...has created fuss all day and been absolutely horrific, pain in the backside*".

The Level 3 RNs described other factors such the patient's ability to communicate effectively in English, their willingness or ability to contribute to care decisions, and whether nurses regard the patient's behaviour as positive or negative. Positive behaviours included being compliant with care; being seen as independent, therefore potentially reducing the nursing workload; and presenting with a condition seen as 'interesting' or 'special'. For example, one Level 3 RN stated "*there's also like this favouritism, like the patient who's got an infected toe isn't as important as the other patient*".

Interpersonal factors

This topic has four main categories: The Nurse-patient relationship; Involving, ensuring understanding and respecting choices; Communication; and Priorities.

The nurse-patient relationship

Participants viewed the nurse-patient relationship as comprised of knowing, advocating, supporting, and being trustworthy. Both nursing groups believed that if they know their patients well they can better deliver appropriate care; however, they acknowledged that getting to know patients takes time. Nurses reported feeling responsible to advocate for their patients, as indicated by a Level 1 RN responding to scenario 4, “... *the patient unfortunately doesn't have a nurse with him and I'm sure if there was a nurse with him they would've supported him through all that*”.

Both Level 1 and Level 3 RNs understood that they are in a position of trust and that they can foster this trust by avoiding making promises they cannot keep. This is illustrated by the following exchange in the Level 1 RN group:

Speaker 1: I suppose a good thing is in one section (scenario 3) where it says about the drink, the nurse actually followed through with that because how many times...

Speaker 2: I always try and tell the patient I'll do my best to get back as soon as possible.

Emotional support for patients and their families, and empathy with their situation, were viewed by all three groups as important throughout the patient journey. Positive feedback and appreciation from patients and their families is valued by nurses. If patients are resistant or aggressive towards nursing staff this could impact on how comfortable or inclined nurses feel to advocate for, or provide emotional support for, the patient. A relationship based on respect and compassion is also valued by consumers and can reduce anxiety; however this is seen as an ‘added extra’ rather than an integral part of nursing care as illustrated in this quote from one consumer “*I thought that was patient service over and above, that was giving the patient choice but then you don't know the situation of the patient but I thought that was really good and really, really nice, amicable, friendly, respect*”.

Patients reported being fearful when they sense a lack of empathy from nursing staff and fear the consequences for speaking out about nursing behaviour. One consumer participant recounted a previous experience with her family member, “*And they're standing there laughing and I would say, 'don't you have*

work to do', and my little sister would say, 'don't talk to them like that, they've got to look after me.' She would also be scared of that and I was like, no they've got work to do". This is supported by a quote from the Level 3 focus group, "Just approaching someone and then undertaking an invasive procedure without any conversation could be very scary for a patient and sometimes in hospital people are reticent to speak out because there's an implied trust, and I think sometimes we're at risk of taking advantage of that because of that very thing. A person, once they become a patient, is just that and may feel they don't have any rights to say stop what it is that you're doing there."

Involving the patient, ensuring their understanding and respecting their choices

The consumer representatives wanted nurses to know them and understand their needs. They also wished to be kept informed about their care and wanted to feel some control over their bodies, *"That's really important for us as patients to know that we do have some control about what's going on with our bodies"*. Patients reported they were fearful if they did not know what was happening to them. Level 1 RNs valued involving patients by keeping them informed as well as engaging with them to ensure they understand what was happening. For example, when referring to scenario 2, one Level 1 RN stated, *"I think a patient was ringing his bell because he was anxious about what this machine was doing, he needed reassurance. It might've needed to be stopped and he did ask, and nobody attended to it or explained if they were going to come back"*.

Constant checking with the patient was seen as a way to engage with them and to check their understanding, but the Level 3 RNs and the consumers also considered this might be interpreted by the patient as the nurse not knowing what is required, thereby provoking patient anxiety. Level 1 RNs felt patients should agree with their care, however consumers felt patient choices should be respected where possible, whilst also expecting nurses to do what is best for the patient even if this might contradict what the patient wants. This is illustrated in the following exchange in the Consumer focus group:

Speaker 1: But there is a point where you have to say to the patient, 'in your best interest we need to do 1, 2, 3, 4' and give the options or whatever.

Speaker 2: It's not always about what the patient wants.

Speaker 1: Yes. So, doesn't matter how empathetic you can be.

Speaker 2: It's still about what the patient needs.

Communication

Consumers believed communication barriers and a lack of rapport between the nurse and the patient impacts patient understanding and increases anxiety. Nurses are also expected to liaise between patients, their families and other healthcare professionals. Level 1 RNs similarly suggested if there is clear, two-way communication between the nurse and the patient this will facilitate knowing the patient and ensure they are kept informed. They suggest good communication between the nurse and the patient as a way to avoid a patient feeling that their care needs are not being prioritised. One consumer representative stated, *"the nurse could arrange it, so say 'can I get doctor to talk to you next time, or could you be here between 7 and 8 [o'clock] when the doctor's doing his rounds', or whatever, and then that just minimises confusion and pretence that there is an option; we're not pretending, we're hoping for options"*.

Clarification of each party's needs and responsibilities might assist in setting mutual priorities. Level 3 RNs highlighted some specific skills as core requirements for nurses to encourage positive interactions. These included being able to communicate effectively with patients and their families, knowing how to evaluate whether care has the expected outcomes, and the necessary knowledge about what care is being delivered and why it is required. One Level 3 RN explained, referring to scenario 1 *"I think the second nurse she's having a conversation with the patient, she's involved with the patient, she's involving them in their care and essentially just using good communication skills."* If nurses lack these skills this impacts on their comfort and ability to respond to patient requests for information.

Priorities

Level 3 RNs argued that patients' care needs should and can be addressed by any nurse, however they acknowledge that some nurses do not feel responsible for patients they have not been directly allocated to care for. They also recognised that the priorities for care delivery might differ between nurses, and between nurses and patients, however they conceded that the nurse usually sets the care priorities

and patients might have to conform to the nurses' schedule: *"I guess that just stood out to me where you're saying the patient is eating their dinner, and we may be going in doing a procedure and not really respecting that opportunity for them to perhaps eat their meal because suddenly they'll stop that while we go in and do a procedure because it works with our timing"*.

The need to consider the patient perspective is highlighted in this comment from another Level 3 RN referring to scenario 2, *"I guess if you're looking at the other part of that question where it's saying that the visitor is saying that it's beeping and it's saying something about air, and so in our minds we're thinking not much air will go in, it will be okay, whereas to a patient or a visitor what does that actually mean. So sometimes I think we normalise a lot of things that are happening in our work place but they are frightening to the patient."*

Level 1 RNs were also aware that patient perceptions of their care might differ from the nurses' perspective. Consumers recognised that nurses and patients might have different care priorities but believed the patients' needs and wants must take precedence. When patients and their families are anxious or fearful this will further influence their perceptions of their care. One consumer indicated this factor was not limited to being a patient, *"I wonder if that's worse when the observer or the patient or the carer visitor is already stressed, because if I'm anxious and trying to rush to this meeting for example and the butcher's giving me the run around about what I did or didn't order, so translating this to here, well here I am anxious and my patient or I, my relative or I, need immediate attention, how dare you laugh now, I think is something that could be considered"*.

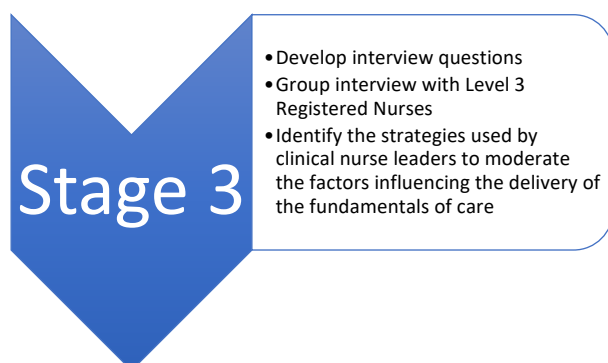
Combined analysis summary

There was considerable overlap in the factors influencing care delivery that were described by the three different focus groups. Data from all three groups were represented in seven of the ten main categories describing factors that were perceived as influencing the delivery of the fundamentals of care.

As highlighted by the participants, organisational factors such as nursing leadership, the context of care delivery and time were seen to impact on care delivery. Leaders are seen to be responsible for role modelling expected behaviours and for providing resources to support care delivery. Participants described external pressures impacting on care delivery and identified the need for strategies to minimise the effect of these factors. As with any human interaction, the characteristics of the individuals involved can challenge or facilitate care delivery. Individual nurse and patient factors influencing the delivery of the fundamentals of care that were identified by the participants included the specific care needs of the patient, as well as individual nurse and patient characteristics. These were seen to play a pivotal role in the delivery of fundamentals of care. Interpersonal factors, including the nurse-patient relationship; involving the patient, ensuring their understanding and respecting their choices; communication; and setting mutual priorities, all underpin care delivery. These interpersonal elements play an integral role in developing and maintaining a therapeutic and mutually beneficial nurse-patient relationship. The findings from stage of this research have been published elsewhere (Conroy 2018) (copy in Appendix 13)

The next stage of the research aimed to ask clinical nursing leaders how they could address some of factors influencing the delivery of the fundamentals of care and to identify the strategies they use to moderate these factors.

Stage 3: Interview results

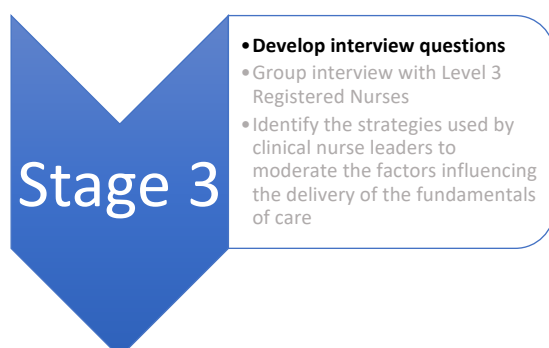


Objectives

The overall objective for this research was to explore the factors influencing nurses' delivery of the Fundamentals of Care in the acute hospital setting. Stage 2 of identified some of these factors using focus groups of nurses, nursing leaders and consumer representatives. The objective for Stage 3 was to ask nursing leaders how they could address the factors identified in Stage 2, and to identify the strategies they use to moderate these factors.

Data collection

Development of interview questions



As the overall research questions focused on both patients and nurses, it was deemed appropriate to focus on the seven factors described by all three focus groups as influencing the delivery of the fundamentals of care. These factors were nursing leadership, the context of care delivery, the specific

care needs of the patient, the nurse-patient relationship; involving the patient, ensuring their understanding and respecting their choices; communication; and setting mutual priorities. Of these factors, two - the context of care delivery and the care needs of the patient - were considered beyond the capacity of nurses to moderate or influence on an immediate or individual basis. Thus, there were five factors influencing the delivery of the fundamentals of care where further exploration could reveal some strategies to promote fundamental care delivery at the point of care. These were nursing leadership; the nurse-patient relationship; involving the patient, ensuring their understanding and respecting their choices; communication; and setting mutual priorities. The interview questions were framed to address these factors.

Data collection



When reflecting on the factors derived from the aggregated results of the three focus groups, where further investigation might reveal strategies that could be used to promote fundamental care delivery at the point of care, there was one - nursing leadership - which had the potential to influence the remaining four. Therefore, clinical nursing leaders were interviewed to explore their strategies for moderating each of these factors.

One group interview for nurses in clinical leadership roles was held. The participants in the group interview were each asked individual questions about the factors that had been identified in Stage 2.

Participants

The group interview was held in February 2017. The duration of the group interview was 84 minutes. The group interview was held in a quiet private meeting room adjacent to the hospital. Light refreshments were provided.

The participants were all female, Level 3 Registered Nurses in clinical leadership positions who were working in acute care areas. These areas included specialty medical and surgical wards, cancer care, emergency departments, and day surgery areas. Their duration of experience in the leadership role varied from 3 months to 20 years (see Table 13: Interviewee experience in the clinical nursing leadership role). Three participants (CD, DH, LK) had also participated in the Level 3 Registered Nurse focus group. To avoid potentially identifying the interviewees, the specific details of their individual clinical area are not provided. Individual participant responses have been allocated a pseudonym.

Table 13: Interviewee experience in the clinical nursing leadership role

Interviewee pseudonym	Experience in a nursing leadership role
CA	3 months (had also acted in the position on several previous occasions)
DC	15 years
HD	7 years
KL	2 years
MG	20 years
VT	18 years

Analysis

As described in detail in Chapter 4 (Methods), inductive content analysis was used to analyse the data (Elo *et al.* 2014). The unit of analysis was the individual interviewee's statement in response to a direct question, or a discussion between group interviewees, that expressed any opinion, comment or suggestion for how to moderate the factors influencing the delivery of the fundamentals of care. This might have been in the form of a single sentence or a brief paragraph from the written transcript.

The answers to each question were coded and categorised separately. The generic categories for each question were then used to identify the strategies nursing leaders use to moderate the factors influencing the delivery of the fundamentals of care. As a final stage of the analysis, these strategies were reviewed to determine if there was any applicability of these strategies to the various dimensions of the Fundamentals of Care Framework. That is, whether certain strategies used to moderate individual factors could be identified in the various dimensions of the framework.

Findings

This section explores the responses from the nurse leaders to the individual interview questions. The sub categories and generic categories that were developed in the analysis will be provided, along with supporting data from the interview. Following the presentation of these responses, the findings will be aggregated to discuss how the strategies described by the clinical nursing leaders might align with the three dimensions of the Fundamentals of Care Framework. The six interview questions are presented in Table 14: Group interview questions.

Table 14: Group interview questions

Question number	Question
1	What can nurse leaders do to promote positive nurse-patient relationships?
2	What kinds of things do you do as a nurse leader to promote effective nurse-patient communication?
3	What strategies do you use to help nurses keep patients involved in their care and ensure their choices are respected, without provoking anxiety?
4	What suggestions would you, as a leader, give to nurses who are new to your area for how to prioritise patient care?
5	What advice would you give to a new Clinical Services Coordinator (CSC: a clinical nursing leader) around delivery of high quality patient-centred fundamentals of care, taking into consideration the resource constraints?
6	Do you think in ten years' time or fifteen years' time the nurses and the CSCs will actually be responsible for fundamental care?

Responses to interview questions

What can nurse leaders do to promote positive nurse patient relationships?

The nurse leader interviewees described feeling responsible for supporting their staff to develop positive nurse-patient relationships. They endeavoured to create a conducive environment for relationships to develop and to support their staff to achieve these relationships. Their strategies include encouraging their staff to focus on the patient rather than on the task, encouraging staff to ask for help if they need it, and valuing the time their staff spend developing the nurse-patient relationship.

KL: I think staff with less experience, often they lose sight of the fact that there's a story behind that patient, that they're coming in, yes, we have to do their obs and admission and blah, blah, blah and all those tasks, but while you're doing that you can be having a nice conversation with the patient. They'll often have a family member there and you're also developing that relationship with the family member as well.

The interviewees also highlighted the importance of good communication in developing a positive relationship and described strategies to facilitate open and honest communication between staff and patients.

HD: I would really encourage people to be open and honest about what we can do

The clinical nurse leaders encourage their staff to keep the perspective of the patient at the forefront of their care. They use strategies to prompt their staff to know their patients and not to focus on tasks.

VT: I'll say "tell me something about your patient", and they go "oh they've got leukaemia" or whatever, and I'll say "you've been in that room, you've just spent a few hours with the patient, you've made that bed, you've made sure that they've had their shower and everything, but tell me something, are they married, do they have grandchildren, what do they like to do, just give me something"...we're not to lose sight of all the tasks and you've got to remember that there's a person at the end of those tasks.

As leaders, the interviewees spoke about the importance of them, as the clinical nursing leaders, knowing the patient and their expectations, and of being known to the patient. They described the strategies they use to facilitate this knowing and the challenges they face in managing patient expectations.

AC: It's just a matter of being a patient advocate and being there for the patient when they need you, answering their questions and introducing yourself so they know who they can refer to.

The interviewees described how they saw themselves as responsible for setting the core values and demonstrating the standard for acceptable behaviours and attitudes. It was seen as important to have a 'passion' for the leadership role and to role model and lead by example.

DC: You have to like what you do and you have to present that way I think, it's really important to have a passion for what you do and lead by example and want the best for every patient like you would want for your own relative

One clinical nursing leader interviewee described the strategies they use to find ways to improve care experiences which can help contribute to developing positive nurse-patient relationships.

KL: We do see patients multiple times and you do get a bit of feedback from patients going, "this is much better than last time or this is worse than last time because I got seen straight away", they'll have those little bits of feedback. We try really hard to engage with our patients', ... we do regular questionnaires just to get that feedback from them about how they were cared for, what could we have done better.... I guess as leaders we try our very best to review what we have in place to see how we can improve things.

Table 15: Generic and sub categories for promoting positive nurse patient relationships, illustrates the generic and sub categories developed from the responses to this question.

Table 15: Generic and sub categories for promoting positive nurse patient relationships

Generic category	Sub category	Quote examples
Creating a conducive environment and supporting staff	Support staff to develop relationships	HD: "...show them that we value that and try and give them the time to do it properly"
	Value staff and create a positive environment	KL: "I think how I try to go about it in my unit is positivity, I think if staff feel valued and appreciated and they enjoy what they do then that's going to shine through in their work."
	Value time spent getting to know patients	HD: "...valuing things like talking to patients"
Facilitate open communication between staff and patients	Engage in honest communication with patients	HD: "I would really encourage people to be open and honest about what we can do"
Keep patient perspectives at the forefront of care	Focus on patient not on task	KL: "...there's a patient there but we're not to lose sight of all the tasks and you've got to remember that there's a person at the end of those tasks."
Know and be known to patients	Be known to the patient	CA: "...and introducing yourself so they know who they can refer to"
	Consider the patient perspective	DH: "...so they've either been told that a bed's been organised or that's what they've heard so I can say to the triage staff <i>the doctor may not have said to them there's a bed but that's what they wanted to hear so that's what they heard...</i> "
	Know what patients want	CA: "...being a patient advocate"
	Patient expectations need to be known and managed	MG: "Customer service I think is really challenging because the public expect far more than they did when I started nursing."
Look for ways to improve care experiences	Strive to continually improve	KL: "I guess as leaders we try our very best to review what we have in place to see how we can improve things."
Set and demonstrate the standard for acceptable behaviours and attitudes	Need to care, need to have a passion	DC: "You've got to have a passion and show that you really care about what you're doing."
	Professional manner and appearance	MG: "...how people conduct themselves because the patients are right there and watch everybody all the time"
	Role model expected behaviours	CA: "...role modelling appropriate behaviour for your colleagues as well so that they can also promote those positive patient relationships."
	Set core values	VT: "...making sure that staff are fully aware of how business is conducted."

What kind of things do you do as a nurse leader to promote effective nurse-patient communication?

This question highlighted some areas of overlap with the strategies used to develop nurse-patient relationships that have been described in question 1. Nurse leaders reiterated the need for open communication and highlighted the need for this communication to be fair and respectful towards patients and staff. They also described communication strategies they use to pre-empt potential problems. The importance of being open and honest, even when the message might not be welcome, was highlighted.

DC: You just have to be open and honest and really if something goes wrong say "I'm really sorry this has happened, we're doing our best to fix it". It's not easy, it's never straight forward.

DC: As a leader you're always on high alert, walking around, doing your rounding or whatever you want to call it, you're always looking for trouble before it's big trouble and you can tell when patients and their family are a bit edgy, things aren't flowing smoothly and if you can increase the communication for that group in particular it often stops nasty flare-ups.

Knowing and involving the patient and carer in the planning and evaluation of care was also seen as a way to promote good communication. Taking time to ensure that patients and carers know what is happening and encouraging their input were strategies use by the interviewees.

KL: We always encourage... one on one with the carer, making sure that the patient understands what they are to do, their responsibilities as a patient ... So is quite a few things that we try to engage in and promote for our patients and we also promote to try to get patients to ask questions... it's to ask questions, you're allowed to ask questions.

The nurse leader interviewees stressed the need to take time to ensure patients and their carers know what is happening and what is expected, and this is seen as of particular importance when the first language of these people is not English.

CA: ...they are usually unaware of the expectations because I guess when the interpreter comes in they're booked for thirty minutes to an hour but you really need someone there more often because it's more often those patients that come in with a simple procedure and out with a post-operative ileus, pneumonias because they are resting in bed rather than getting out of bed because you just can't communicate...

To promote effective communication, the interviewees use strategies to ensure the patient is the focus of inter-professional communication. They believe all professionals involved in the patient's care need to know the patient and their story and use strategies to overcome communication difficulties between these other healthcare professionals and the patient.

KL: As nurses, we worry about our patients, the social side, a patient is not just having a bowel section, they've got limited supports at home or they've been acopic...

The nurse leaders referred to the problems that occur when patients receive mixed messages from other members of the healthcare team. They identified strategies to facilitate consistent and clear communication between the patient and all the healthcare professionals involved in patient's care. They acknowledged however, that very often this consistent and clear communication is not always achieved.

MG: So I've found since we've been doing huddles and getting the drill on, I mean I can't believe my whole career you've just been chasing around doctors, eavesdropping and might get a little bit on this patient and a little bit on that one and now it's formalised, it's just the best invention ever and so we can drill the doctors, we can quiz them, we can make them accountable... so everyone's on the same page which can get blurred... the surgeon comes in and says" oh I think you can go home today from the surgical point of view but from the pharmacological and clinical other side, no". Just a simple comment like that causes great confusion.

Nurse leader interviewees recognise how issues in the healthcare or organisational system and the medical hierarchy can help or hinder communication. They described how they try to overcome and

moderate these issues and the difficulties they face. A perceived pressure on patient throughput was seen as adversely impacting on effective communication.

MG: It's dealing with that medical ladder, for instance you talk to the resident, they know nothing and then the registrar's too scared because he's not allowed to upset the consultant at certain times, then you find you're ringing the consultant all day long and then they get their act together because they keep getting calls. And in many ways the pressures and the stresses of the system have helped pull the medical staff into line.

The following exchange between the interviewees illustrates the frustration that nurse leaders feel at times.

HD: Do you think it's an issue that nurses are often held accountable whereas medicine's not?

DC: Yes, I would say that infection control I'm right under the pump at the moment, I'm being hammered for some mishaps.

KL: We have that SLS (incident reporting) system and I think nurses report really, really well. You try and feed that SLS report off to a medical staff member and you'll be waiting eighteen months.

HD: And you're not allowed to show them.

LK: I mean we, I'd be made accountable if I had SLSs still sitting there from my Head, why aren't they, why aren't they being held accountable?

Table 16: Generic and sub categories for promoting effective nurse patient communication, illustrates the generic and sub categories developed from the responses to this question.

Table 16: Generic and sub categories for promoting effective nurse patient communication

Generic category	Sub category	Quote examples
Be transparent and fair in all communication	Be honest and open	DC: "You just have to be open and honest and really if something goes wrong say <i>I'm really sorry this has happened, we're doing our best to fix it.</i> " VT: "So, it's that, you know, having very honest and transparent discussions with patients about this sort of stuff."
	Use same skills for communication with patients and staff	MG: "I think to have that [good nurse-patient communication] you've got to have good medical nursing communication because if you don't know what each other are doing then how is the patient going to find out."
	Be a role model for good communication	DC: "Their (the medical students) role models, the new interns they don't know how to do it either so they haven't got someone guiding them"
Ensure the patient is the focus of inter-professional communication	Ensuring those who deliver care know the patient's story	VT: "One of the expectations is the shift coordinators that they understand the pain of the patient at the huddle and that's an evolving thing, the conflicts of the shift coordinator with the discussion with the doctors."
	Nurses need to prompt communication between the patient and other HCP	VT: "Nurses end up having to, I think sometimes have to put out the fires or have to deal, because we sit there going, you know, <i>what is the communication strategy, what do we say to our patients?</i> "
Knowing and involving the patient and carer	Take time to ensure patients and carers know what is happening	KL: "...we always encourage, I guess when we're sitting down doing discharge instructions with patients it's very much one on one, one on one with the carer, making sure that the patient understands what they are to do, their responsibilities as a patient ..." DC: "...as a leader you have to do a lot of explaining and reassuring that we will help you but it might not be quite the way you thought." VT: "The other thing that's really challenging and I don't know whether experience is, it's a cultural thing, the refugee patient that has no family, can't speak English, can't read and can't write and you're trying to discharge them with complex discharge instructions, it is very, very difficult and even though you may have interpreters it is extremely difficult and really challenging, you know."
	Encourage patient input	KL: "...we start that early on when we're admitting the patient making sure that they have got a family member to collect them or a friend to collect them, having those conversations early..." VT: "The ward rounds, I think nurses on the ward rounds, when you leave a ward round and move out of the room your last conversation is, <i>do you understand what's going on, do you have any questions?</i> "
	See the patient's perspective	KL: "...it's just that they're completely bombarded with information or that they just don't understand, sometimes there's a language barrier there as well."
	Need to know the patient and their condition	DC: "And chasing up visiting medical staff, for example, if we have a renal patient in the Ward, making sure that we are comfortable with whatever is not written is quite challenging and that's the communication and you're out of your comfort zone for a patient."

Recognise how the system can help or hinder communication	Where formal structures exist, use those that work	VT: "...the big white walls, the journey board into each of the patient's side rooms and that is just fantastic ... but it gets used by the doctors in teaching, it's an opportunity for patients to write up their questions and even the nurses will write up the questions for them, when the nurses have to introduce themselves every day and patients do see a lot of nurses and sometimes I go in and say, <i>Who's looking after you today</i> , and they'll go, and they look at the board because the nurses have to write their name on the board so they know which nurse is looking after them."
	Need to overcome systemic barriers to improved communication	VT: "...weekly Ward meetings with the doctors, that's multi-d, but that's pure rhetoric that is because allied health can't get there, they try to get to the huddle, they'll get there a couple of times a week but sometimes it's really, you know. I'd like to see a consultant occasionally at those huddles..."
	Moderate system impacts on communication	MG: "So, there's DRGs for patients and you've got to get them in and get them out but it's not that simple, there's a whole lot of stuff going on behind the scenes that the bean counters just don't see."
	Need to overcome systemic barriers to improved communication	KL: "We have that SLS system and I think nurses report really, really well. You try and feed that SLS (incident) report off to a medical staff member and you'll be waiting eighteen months...I mean we, I'd be made accountable if I had SLSs still sitting there from my Head, why aren't they, why aren't they being held accountable."
Seek consistency and clarification from all HCP involved in patient's care	Managing mixed messages due to medical miscommunication	DC: "Ward patients see a lot of different nurses every day, every shift, the longer you're there you see the same ones twice but that is a huge thing. A lot of medical staff come through and they'll say one thing, <i>yes you're ready for discharge</i> , well that isn't quite true because another clinic says <i>you need longer</i> , so they get very confused."
	Facilitate communication between other HCPs	VT: "...sometimes they're not on the same plan of these patients and it is very difficult when you've got the people who are responsible for care don't agree with the previous consultant's plan and then won't make the decisions and that is extremely difficult."
Use communication skills to pre-empt potential problems	Know that communication can be complicated	DC: "It's not easy, it's never straight forward."
	Be alert and look for potential communication issues	DC: "...as a leader you're always on high alert, walking around, doing your rounding or whatever you want to call it, you're always looking for trouble before it's big trouble and you can tell when patients and their family are a bit edgy, things aren't flowing smoothly and if you can increase the communication for that group in particular it often stops nasty flare-ups."

What strategies do you use to help nurses keep their patients involved in their care and ensure that their choices are respected, without provoking anxiety?

The nurse leaders who were interviewed highlighted some strategies for involving patients and respecting their care, which are similar to some of the strategies they use to promote communication. These include involving and informing patients, so they can act as partners in their care, and moderating the system factors and medical hierarchy that can adversely impact on patient choices.

VT: And I think sometimes it's important to ask permission, you know, "are you okay to have your shower now or what would you like for us to do."

Nursing leaders want their nursing staff to be considerate of patient requests and choices and recognise that this responsiveness can be influenced by the environment in which care is being provided and the nurse's perception of who is responsible for the patient. One strategy they use to address this is to model the behaviour they expect to see. This is illustrated in the following exchanges:

VT: The side room issue does change the way that... nurses communicate

MG: I don't have a problem with the bell situation, nurses don't see bells as everybody's responsibility

DC: Well they do when I start walking out

VT: I think every day I have to remind somebody go answer that bell and I find that really sad, I find that very sad, I think they get so hung up on allocation and "oh it's somebody else's patient"

MG: I think they don't hear it, they're all just absorbed in their work

DH: You do get so much noise you tend to...

CA: It could be.

Reminding and supporting all levels of nurses and other healthcare professionals to prioritise the patient's needs and wants is a source of frustration for the nurse leaders and they identify some strategies to moderate this.

KL: I think that's one of the biggest frustrations isn't it, you can see how, with more effective communication between the medical and nursing, just utilising them, but also allied health, just having them contactable and ready to have a plan and be open with that plan and be open with their team, I think a patient's journey would be expedited, it would be smoother and the patient would feel more satisfied.

Table 17: Generic and sub categories for involving patients in their care and respecting choices, illustrates the generic and sub categories developed from the responses to this question.

Table 17: Generic and sub categories for involving patients in their care and respecting choices

Generic category	Sub category	Quote examples
Be responsive to patient requests and adapt how you respond according to the care environment	Be conscious of the environmental impact on communication priorities	VT: "...it's about changing the way you communicate and conversations and they need to also be aware of what's happening outside or outside that room and that was a bit of a challenge when we actually moved in. The side room issue does change the way that you... even the way nurses communicate and with each other."
	Prioritise and role model being responsive to patient needs	VT: "...every day I have to remind somebody go answer that bell and I find that really sad, I find that very sad, I think they get so hung up on allocation and <i>oh it's somebody else's patient.</i> "
Involve and inform patients as partners in their care	Seek input and confirmation from patients	HD: "...we always encourage if we have people that come in with chronic conditions I always say <i>listen to what they say because they know their condition, they're living with it, they know their bodies so we will absolutely take on-board what they say.</i> " VT: "And I think sometimes it's important to ask permission, you know, <i>are you okay to have your shower now or what would you like for us to do.</i> "
	Keep patients informed and reassured about why you need to know	DC: "...you can be in control and still say <i>I've not looked after you before, you guide me how you like to be showered and if there's anything particular, especially with people with chronic...they know and I think you can do it very respectfully.</i> "
	Explain care priorities to patients (a nurse's own and other patients)	DC: "I think to be honest with patients and say, <i>look I'm really sorry I've got a bit of situation out here, I'll be with you shortly, if you think you really need I can help you but just caught up with a bit of trouble.</i> I mean they're not silly, they know when there's a blue cone and a trolley coming down."
	Balancing patients want to be 'known' and the need for formal identification	DC: "And you should be checking every handover two or three times and we struggle with that a bit because we all know J over there. Doing a narcotic is different, but at handover you just teach to say hello but you get stung if you're having any form of clinical handover, and then sometimes the patients don't necessarily want you do be doing the three identifiers."
Remind and support all HCP in the healthcare team to prioritise the patient's needs and wants	Support patients and staff to overcome perceived power imbalances that prevent patient choices being considered	MG: "...know for a young junior in an area where everyone's got post grad degrees they might think what they've got to offer is not meaningful so it's important to make them, the new TPPPs (graduate nurses) and students, aware that they can speak up because of the pecking order or they feel that no-one wants to listen to them maybe." DC: "I just don't know that I would be too comfortable with four consultants standing around, standing up and I'm in the bed, you've already got that difference."
	Provide support and encouragement for patients to question their care	CA: "...giving the patient the confidence that they can actually interrupt and ask questions if they do have questions."
	Remind other HCP to focus on patient involvement and agreement	MG: "I found if you drag the medical staff back they sort of soon learn how to communicate."
	Effective inter-professional communication will enhance patient satisfaction	KL: "...you can see how with more effective communication between the medical and nursing, just utilising them, but also allied health, just having them contactable and ready to have a plan and be open with that plan and be open with their team, I think a patient's journey would be expedited, it would be smoother and the patient would feel more satisfied."

System factors and medical hierarchy can adversely impact on patient choices	Lack of medical accountability prevents patient choices being considered or prioritised	KL: "We have one consultant who likes to bring his patients in, he has an afternoon list, in by 9 o'clock and they don't have to come in, 11 o'clock is probably, so patients aren't waiting around 9 o'clock just for him to bring his medical students in and I've had a real problem with that. I've tried to escalate it and it's gotten so far and it's not like it's every time, it was like an expectation that he had to have his patients in at 9 o'clock just in case he came."
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What suggestions as a leader do you give to your nurses, or the nurses who work in your areas, who are new for how they can prioritise patient care?

The interviewees reiterated the need for the patient perspective to be the guide when determining the priorities for care and suggested that a focus on tasks might adversely impact on the prioritisation of care. Nursing leaders are conscious of the potential for nurses and other healthcare professionals to focus on tasks rather than on the patient and thereby lose sight of the patient perspective.

MG: They come in to a patient while they're eating and I just say, "excuse me but they're having their lunch can you just come back?"

They also recognise that each patient might have a unique view of their care and condition and nurses need to be flexible to accommodate this, as illustrated in the following quote.

KL: ... be flexible with their priorities, some patients need you, there might be that one anxious patient that's pacing so their priority might be you need to check on them, just have a conversation with them every half an hour whereas the other patient and their family around the corner they might need extra discharge instructions.

Nursing leaders recognise the need to balance nursing needs and patient needs; however they indicate the patient's needs should take priority, which is not always seen as easy task.

TV: Getting nurses off to lunch at midday is a nightmare because medications and obs are due at 12 [o'clock], meals are being delivered, if you've got a lot of patients that need to be fed.

A possible strategy for overcoming this clash between nursing breaks and patient care needs was suggested by another participant but this did not seem to be welcomed by the other interviewees.

DH: in ED we don't send our nurses to lunch until 1 o'clock when there's double staff on.

TV: That's handover.

DH: Yeah, we do handover and then they go to lunch. We never could get people off to lunch because that's when we're the busiest that we are.

CD: I let my lot plan when they're going to do it and they seem to do it when it suits them but at 1 o'clock there are different demands.

DH: It wasn't a criticism it was just a question.

Another strategy to accommodate nursing needs was also suggested.

MG: ...years ago when we were at another hospital we moved away from when nurses were having breaks so we do it at 11, 4 and 9; 6, 11, 4 and 9.

There was also a suggestion that some of the care priorities are based on historical practice rather than patient needs. Some tasks are also seen as a 'non-negotiable' priority.

MG: But nurses love to make the beds, I said to one nurse "what did you make the bed for they're going home?", "I like it to be tidy." So I don't know where they get it from, it was ingrained into us to have the wheels pointing a certain way and all that sort of thing.

VT: But you just sit there and think to yourself they are so driven by the tasks that the other stuff just gets left behind and the simple questions, "have you brushed your teeth today" or "have you done your mouth care", there's sometimes assumptions being made and they will prioritise their fundamental care or their tasks according to what they see as the priority and for us will always be, drugs and blood products and fluids and obs...

To assist nursing staff to set care priorities the nurse leaders felt it was important they were available and accessible to their staff.

VT: ...it's about maintaining a presence and knowing that they can come and chat and know who you are and I think that's really important.

For new or less experienced staff who are struggling with prioritising care, the interviewees indicated the importance of addressing this challenge and suggested it might be overcome with support and education. Providing this support though is not factored into the workload of the staff involved.

DC: I'm struggling with a junior staff member who really is struggling in the whole role of nursing... I don't know quite where to begin, I mean we've got strategies in place but priorities, prioritising care it is very difficult.

CA: It sounds to me his passion wasn't nursing, it's just something he did.

HD: I think no-one's addressed the issues earlier.

DC: We are addressing, it's not the first time this has happened in the past but it is very difficult.

VT: Because you can teach the stuff, ...but it's their personality, the skills stuff we can work on... But you can get lost very quickly and it is very time consuming having to invest because that does take a lot of time performance managing or trying to work and that's stuff that's not factored into your every day.

Table 18: Generic and sub categories for prioritising care, illustrates the generic and sub categories developed from the responses to this question.

Table 18: Generic and sub categories for prioritising care

Generic category	Sub category	Quote example
A focus on the patient perspective should direct nursing priorities	Need to negotiate patient needs and nursing needs (breaks)	VT: "Getting nurses off to lunch at midday is a nightmare because medications and obs are due at 12 [o'clock], meals are being delivered, if you've got a lot of patients that need to be fed."
	Personal relationships should not influence care delivery	VT: "...it's those friendship groups, whereas the nurse that's not involved in it is out there spending time with their patient whereas when there's a moment to be done they're spending time with each other and not with the patients."
	Set clear expectations about priorities when tasks are complete	GM: "Yesterday they all wanted to go early and I said well go and find a patient to talk to if you haven't got anything to do."
	Nursing care is always public, treat all patients as if it is being recorded	VT: "We've had a number of patients that have done blogs, you know blogs about their treatment and stuff like that and everybody goes into a panic and I sit there going you should treat every patient as if they're all writing a blog and why should they be any different. They feel like they're under the microscope as soon as the patient starts blogging but every patient should be treated I think as if, you know, it shouldn't make any difference."
	Prioritise the patient's perspective	KL: "...doctors walk in with their cup of coffee to read patients' notes, I'm like all these patients around you are fasting, they don't need to smell a beautiful coffee."
	Staff can set their own priorities	VT: "...when there's an emergency like there's a MET call and that, that's when the nurses shine, you're just sitting there and you go and just step back..."
A task focus or having pre-determined priorities might impact on FOC	A focus on tasks can negatively impact on fundamental care	VT: "...think to yourself they are so driven by the tasks that the other staff just gets left behind and the simple questions, <i>have you brushed your teeth today or have you done your mouth care...?</i> "
	Some priorities are pre-determined	DC: "Nurses do have certain deadlines; vital signs need to be done in the correct manner as do medication administration."
Leaders need to be accessible	Encourage staff to seek support from the leaders	VT: "...maintaining a presence and knowing that they can come and chat and know who you are and I think that's really important."
Learning to prioritise is a skill that can be taught	Support and mentorship is needed for new staff	VT: "I generally, I constantly, <i>are you okay, are you okay</i> , and they go <i>I'm okay</i> , it's that informal shadowing stuff that they know that you're there, they know that you're present, <i>are you being looked after, are you okay?</i> "
	Problems with prioritisation can be overcome with leader support	VT: "...sometimes recognising at the end of the day they sit there and go <i>oh my God that is rough</i> and acknowledging I think sometimes, they sit there going <i>I'm not coping</i> and you go <i>well that was pretty tough what you had to do today, maybe let's look at trying tomorrow an easier day</i> and try to support them through that..."
	Monitor new staff and intervene early if required	DC: "We are addressing (the problems with prioritisation...), it's not the first time, this has happened in the past, but it is very difficult"
	Nursing is evolving and this might impact on care priorities	VT: "...the complexity of nursing is so much different."
	Some priorities are historical and need to be revised	MG: "I'll do everything for the patient in the morning."
	Be flexible and recognise priorities differ from patient to patient	KL: "...be flexible with their priorities, some patients need you, there might be that one anxious patient that's pacing so their priority might be you need to check on them, just have a conversation with them every half an hour whereas the other patient and their family around the corner they might need extra discharge instructions."

		DC: "What's important for one patient is not for another."
Problems with prioritising need to be addressed to minimise their impact on others	If a staff member has difficulties with prioritising care, this can impact on other staff and patients	VT: "And it impacts on other staff. Absolutely because they pick up the extra, they pick up the workload."

What advice would you give to a new CSC (clinical nursing leader) around the delivery of high quality patient centred fundamentals of care, while taking into consideration resource constraints?

The interviewees restated their belief for the nursing leader to role model the behaviours they want to see and to set the accepted standard for fundamental care. They suggested the following strategies for role modelling:

DC: I'd say be out on the floor and lead by example and don't be afraid to do any task, nothing's beneath you and gain respect and the rest will come.

HD: I think just being really clear about what your expectation is and you can't go back and get angry with someone if you've never made it clear what you wanted in the first place.

Some strategies suggested by the interviewees for nursing leaders to encourage staff included recognising their efforts and celebrating the 'good' things.

KL: I think those little wins we have to celebrate them. Another colleague and I we do a little chocolate round, not every day but just go around and praise your staff, or a minty, just to touch base with them and maybe often in the afternoon when it's been a shitty day and I think they really appreciate that.

While wanting to celebrate positive issues it was also suggested nursing leaders need to be alert for potential problems and address these as they arise.

MG: I'd probably say that as well as deal with any sort of issues with staff straight away, don't think it will go away and keep notes, so if someone does something crazy pull them aside. Encourage your staff to let you know if those issues occur and get them in and just ask them what's their reason, because if

people know they're called to account they are more likely to not take short cuts than if "oh the boss doesn't care"...

The interviewees indicated it was important that nursing leaders be seen to be honest and unbiased.

CA: I think to be fair, equal, neutral, be consistent with your decisions, have the same rules for everybody as you've said, like if there's a bell ringing there's no reason why a CSC cannot answer, assist on the floor, be fair and flexible, friendly but still have that boundary with your staff.

There were indications from the interviewees that the role of the nursing leader was no longer a desirable position due to competing organisational and administrative demands and the perceived decrease in clinical focus.

VT: It's because we are being so, we're becoming less and less at clinical focus because of all the other stuff that you are expected to do.

KL: You know you go into the job with a certain expectation of what you think, ...and I think the level 3 position you're damned if you do and you're damned if you don't a lot of the time.

Nursing leaders might need to establish their own support systems and must recognise when they require assistance. Strategies such as peer support were suggested:

KL: You get pressure from your staff below, you have pressure from the top so I mean, I suggest you make sure you've got a peer that you can go to and have a closed door and tear your hair out to let it out because it is a really, really tough job.

Table 19: Generic and sub categories for new clinical nursing leader, illustrates the generic and sub categories developed from the responses to this question.

Table 19: Generic and sub categories for new clinical nursing leader

Generic category	Sub category	Quote example
Be alert for potential problems and address these as they arise	Do not ignore problems, address them early	MG: "...deal with any sort of issues with staff straight away, don't think it will go away and keep notes, so if someone does something crazy pull them aside."
	Be accessible and encourage staff to come to you with their concerns about care delivery	MG: "Encourage your staff to let you know if those issues occur and get them in and just ask them what's their reason, because if people know they're called to account they are more likely to not take short cuts than if <i>oh the boss doesn't care or we'll just invent our own way of doing something.</i> "
	Recognise the influence of staff relationships on how they might report problems with care delivery	VT: "...the popular one [nurse] that people forgive when they forget to do their charts but the one that's not popular they crucify..."
	Seek feedback on care delivery from other areas outside your immediate circle	KL: "...it's nice to know what else is going on with your guys, because some of those things, you know the feedback from say your renal patient that on admission they didn't do this, that's really handy stuff for us to know"
Be honest and fair, admit when you need help/support	Seek respect from your staff, do not try to be friends	VT: "...but I suppose the issue is that you've got a job to do and I think your staff don't have to like you but respect."
	Treat staff consistently, fairly and equally	CA: "I think to be fair, equal, neutral, be consistent with your decisions, have the same rules for everybody..."
	Acknowledge your mistakes	KL: "I think it's really important that when you stuff up you apologise, you acknowledge that you are going to get it wrong."
Focus on the positive outcomes and use these as examples	Recognise and celebrate the 'good' things	KL: "I think those little wins, we have to celebrate them."
Nursing leaders need support to fulfil the demands of their role	Need to manage competing priorities	VT: "...you have to not expect your staff to do stuff."
	Leadership role is not appealing	MG: "We're not going to get new CSCs because I don't know anyone that wants the job."
	Need to manage competing priorities	VT: "It's because we are being so, we're becoming less and less at clinical focus because of all the other stuff that you are expected to do."
	Create and use your own support network	KL: "You get pressure from your staff below, you have pressure from the top so, I mean, I suggest you make sure you've got a peer that you can go to and have a closed door, and tear your hair out to let it out, because it is a really, really tough job."
Set the standard for the FOC and show staff how it should look	Role model expected behaviours	DC: "I'd say be out on the floor and lead by example."
	Make your expectations clear	HD: "I think just being really clear about what your expectation is and you can't go back and get angry with someone if you've never made it clear what you wanted in the first place..."
	Seek continuous improvement	KL: "Just continually try to improve your area, do the best by your patients, the best by your staff, but it's probably one of the toughest gigs going..."

Do you think in ten years' time or fifteen years' time the nurses and the Clinical Services Coordinators will actually be responsible for fundamental care?

While this question was not specifically seeking strategies to facilitate fundamental care delivery, it sought to elicit the clinical nursing leaders' views about how they perceived fundamental care delivery in the future. The interviewees were emphatic about the fundamentals of care being defined as a core part of the nursing role and indicated nursing must remain focused on fundamental care delivery. The way nursing integrates all the various aspects of care delivery was also described but was not seen to always be valued by others.

HD: For me, it's our core business, but I know that where I work, that we every day are getting pressured to do other things like take blood and send it off for a blood test and, yes, it's very important but if we are focused on that we are not doing our other core nursing things ...and I think it's up to us to have that voice that says "this is important" and to do things like teach someone, asking patients what's important to you and bringing it back.

DC: I think with medication administration now my niece can pop out tablets out of a bottle, no idea what they are and so, to me, a nurse who gives out tablets connects with, "okay this is for this and what am I looking out for." The same as doing a head to toe skin assessment, I can shower someone and I'm looking at them, immediately I can tell you if there's something wrong in that department.

The nurse leaders described systems pressures, such as patient throughput, that impact on care delivery and questioned if fundamental care is valued by this system.

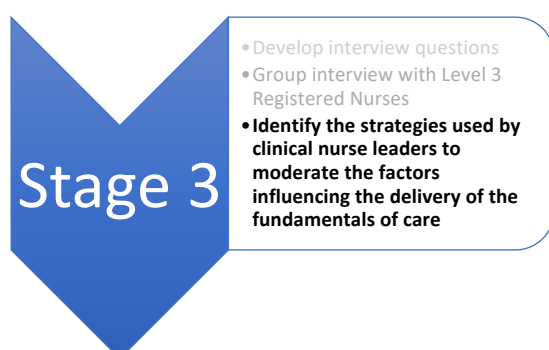
HD: ...so it's about the pressure within the organisation to meet targets... SA Health is forever talking about patient centred care so sometimes they need to put their money where their mouth is if they really value that.

Table 20: Generic and sub categories for the nursing's future responsibility for the fundamentals of care, illustrates the generic and sub categories developed from the above responses to this question.

Table 20: Generic and sub categories for the nursing's future responsibility for the fundamentals of care

Generic category	Sub category	Quote example
FOC must be defined as part of the nursing role	A clear role description will help define the FOC as a nursing responsibility	VT: "...with the ENs with the IVs and I think, whereas before it was the RN that used to give the IVs and they will do the other stuff, they're (the RN's) struggling with their patient because they're now having to do the other stuff and they're really struggling with that to do it all. I actually think it's a bit of a challenge."
Involve patients to highlight the importance of nursing and the FOC	Involving patients to highlight the importance of the FOC	"...asking patients <i>what's important to you?</i> and bringing it back."
Nursing must remain focused on the delivery of the FOC	FOC are core business for nurses, even when under pressure	HD: "...it's our core business, but I know that where I work that we every day are getting pressured to do other things like take blood and send it off for a blood test and, yes, it's very important but if we are focused on that we are not doing our other core nursing things..."
	Nursing needs to fight to retain ownership of the FOC	HD: "I think it's up to us to have that voice that says this is important and to do things like teach someone."
	Only nurses have the skills to integrate FOC delivery	VT: "...a health care worker is not going to be looking at the same things we're going to be looking at."
	Only nurses have the skills to integrate FOC delivery	DC: "I think with medication administration now my niece can pop out tablets out of a bottle, no idea what they are and so, to me, a nurse who gives out tablets connects with, <i>okay this is for this and what am I looking out for.</i> The same as doing a head to toe skin assessment, I can shower someone and I'm looking at them, immediately I can tell you if there's something wrong in that department."
The FOC need to be prioritised/valued by healthcare systems	FOC delivery is influenced by organisational pressure	HD: "...the pressure within the organisation to meet targets."
	The FOC need to be recognised as important	VT: "When you do a bed bath it's not menial stuff it's important stuff."

Identification of strategies



The strategies suggested in the nurse leaders' responses to the interview questions and represented by the generic codes, were then analysed to determine their applicability to the various dimensions of the Fundamentals of Care Framework. That is, whether certain strategies used to moderate the factors influencing the delivery of the fundamentals of care were evident in the three dimensions of the

Framework. These dimensions are Establishing and maintaining a relationship, Integration of Care, and Context. The alignment of each of the strategies to the three dimensions of the Fundamentals of Care Framework is demonstrated in Table 21: Strategies to support nurses' delivery of the fundamentals of care.

Strategies for establishing and maintaining a relationship

The strategies identified for this dimension came from the responses to the questions exploring how to promote positive nurse-patient relationships and effective nurse-patient communication. These strategies include focusing on the patient's perspective and keeping this at the forefront of care to direct nursing priorities; knowing and being known to patients and carers; involving patients and carers in planning and evaluating care; and using communication skills to pre-empt potential problems.

Strategies for integration of Care

The strategies for this dimension were derived from responses to all of the questions in the group interview. The strategies identified by the nursing leaders that relate to this dimension of the Framework include establishing and demonstrating the standard for acceptable behaviours and attitudes towards care delivery while being alert for potential problems and addressing these as they arise; ensuring the patient is the focus of inter-professional communication while reminding and supporting all in the healthcare team to prioritise the patient's needs and wants; facilitating open communication between staff and patients to involve and inform patients as partners in their care; being responsive to patient requests for assistance or information; keeping nurses focused on the delivery of the fundamentals of care; recognising individual patient care priorities might change over time; and being aware that nurses who have a task focus or predetermined priorities might adversely impact on the delivery of the fundamentals of care.

Strategies for context

The strategies identified for this dimension were derived from responses to all of the questions in the group interview. The strategies identified by the nursing leaders that relate to this dimension of the

Framework include those that are related to the System Level elements of the Framework including resources, culture, leadership, and evaluation and feedback.

Strategies linked to resources included support required for nursing leaders as well as the healthcare system impact on the delivery of the fundamentals of care. Strategies to address cultural elements included managing interactions with other healthcare professionals, creating a conducive environment and supporting staff, recognising how the system can help or hinder communication and moderating the system factors and medical hierarchy that can adversely impact on patient choices. Another strategy used by nurse leaders was to seek consistency and clarification from all healthcare professionals involved in the patient's care. Leadership focused strategies included having clear role definitions that define the fundamentals of care as a core part of the nursing role and ensuring support for nursing leaders. Leaders also need to ensure staff learn how to prioritise, and that problems with prioritising are addressed to minimise their impact on other nurses. Evaluation and feedback strategies included seeking to improve patient care experiences, establishing priorities for care, and focusing on the positive outcomes and using these as examples. Involving patients was suggested as a way to highlight the importance of nursing and the fundamentals of care and to create awareness that the fundamentals need to be prioritised/valued by healthcare systems

Table 21: Strategies to support nurses' delivery of the fundamentals of care

Fundamentals of Care Framework dimension	Strategy
Context	Be transparent, honest and fair when communicating
	Leaders need to be accessible and create a conducive environment to support staff to deliver the fundamentals of care
	The fundamentals of care must be defined as part of the nursing role and need to be prioritised/valued by healthcare systems. Patients can be involved to highlight the importance of nursing and the fundamentals of care.
	Look for ways to improve care experiences. Focus on the positive outcomes and use these as examples.
	Problems with prioritisation need to be addressed to minimise their impact on others. Learning to prioritise is a skill that can be taught.
	Nursing leaders require support to fulfil the demands of their role and need to admit when they need help/support
	System factors and medical hierarchy can adversely impact on patient choices. Recognise how the system can help or hinder communication. Seek consistency and clarification from all healthcare professionals involved in the patient's care.
Integration of care	Set and demonstrate the standard for acceptable behaviours and attitudes and show staff how the fundamentals of care should be delivered
	Priorities might change over time and between patients, therefore focusing on tasks or on predetermined priorities might impact on the delivery of the fundamentals of care. Nursing must remain focused on the delivery of the fundamentals of care through positive nurse-patient relationships.
	Be responsive to patient requests and adapt how you respond according to the care environment
	Remind and support all professionals in the healthcare team to prioritise the patient's needs and wants
	Involve and inform patients as partners in their care by facilitating open communication between staff and patients and ensuring the patient is the focus of inter-professional communication
Establishing and maintaining a relationship/Integration of care	Be alert for potential problems and use communication skills to pre-empt or address these as they arise
Establishing and maintaining a relationship	A focus on the patient perspective should be at the forefront of care and direct nursing priorities
	Know and be known to patients and their carers to involve them in their care

Stage 3 Summary

This Stage explored the strategies clinical nurse leaders suggest moderate the influence of five factors influencing the delivery of the fundamentals of care. These five factors are nursing leadership; the nurse-patient relationship; involving patients in their care and ensuring their understanding while respecting their choices; communication; and negotiating and setting priorities. Mapping these strategies to the dimensions within the Fundamentals of Care Framework has illustrated where each strategy might be applied during the delivery of the fundamentals of care. In the dimension relating to Context, the clinical nursing leaders identify strategies related to their own responsibilities to promote the fundamentals of care, as well as ways to address the organisational and system influences. Role-modelling and being supportive and responsive to staff and patients are some of the strategies related to the Integration of Care dimension. Being proactive and having good communication skills are suggested as strategies to assist in integration of care and in the development and maintenance of the nurse-patient relationship. This relationship is also influenced by strategies that promote a focus on the patient perspective and ensure patients are involved in their care.

Summary of findings from all 3 Stages

This study adopted a multi-stage iterative approach combining direct observation of fundamental care delivery with focus groups and interviews with consumers, nurses and clinical leaders. The overall research question was to better understand the factors that either enable or mitigate the delivery of fundamental care to patients and how these factors might be moderated.

Stage1 explored how the fundamentals of care were delivered in four acute care settings in one hospital. Findings from this stage of the research illustrated the diverse nature of nurses' delivery of the fundamentals of care, and the complex interactions between the elements in the physical, relational, psychosocial and contextual dimensions in the Fundamentals of Care Framework. It was evident that each 'fundamental' was not delivered in isolation. The interactions between nurses, patients, family members, visitors and the other members of the healthcare team created an additional layer of complexity when delivering the fundamentals of care. The physical environment where the fundamentals of care are

delivered provides an extra intricacy for nurses, patients and their families to negotiate. Patients with English as a second language or those located in a single room due to an infectious disease might find their fundamentals of care delivered in a less integrated way. Analysis of events associated with the physical fundamentals of care showed that safety linked to medication administration or monitoring was the predominate element observed during the delivery of the fundamentals of care. Non-physical elements such as resources and leadership were also prevalent.

The complex and diverse nature of the delivery of the fundamentals of care observed in Stage 1, was incorporated into the 'real life' examples of fundamental care delivery presented as scenarios to the three different focus groups in Stage 2. The scenarios were used to generate separate and composite descriptions from the three focus groups of how they interpreted what was happening in a given scenario and what might be causing that to happen. The scenarios were used to prompt an open and frank discussion and to minimise any defensive or social desirable responses. All three groups offered unprompted judgements about the quality of care in the scenarios, and the consistency with how they defined this quality of care was remarkable.

Similarly, the congruity between all three groups in identifying the factors influencing the delivery of the fundamentals of care illustrates a common perspective from consumers and nurses. The overlaying of the participants' personal experiences on to generic care scenarios helped to elicit rich, diverse data relating to the description of potential factors that influenced the delivery of the fundamentals of care in a broad range of circumstances, beyond the scenarios that were presented. Key findings from Stage 2 include the influence of the nurse-patient relationship, nursing leadership and the context of care delivery. Also described was the importance of involving patients and their carers in their care; ensuring they understand their care, including why it is required; and respecting their care choices. Other key factors include the need for good communication and the ability to negotiate mutually satisfying priorities for care while recognising the specific individual care needs and characteristics of the patient. The individual characteristics of the nurse were also considered a factor, and perhaps not surprisingly, the nurses suggested the availability of sufficient time and their time management abilities also influenced the

delivery of the fundamentals of care. Seeking the perspective of the people involved in delivering and receiving the fundamentals of care showed a shared understanding of the factors influencing the delivery of the fundamentals of care.

When considering these influencing factors, the potential for clinical nursing leadership to influence many of the other factors was noted. These factors included the nurse-patient relationship; communication; negotiating mutually satisfying priorities for care; and involving patients and their carers, ensuring their understanding, and respecting their care choices. It was concluded that clinical nursing leaders were in a position to critically influence the delivery of the fundamentals of care via their day-to-day leadership in clinical practice. Stage 3 explored the strategies clinical nurse leaders suggest as ways to moderate these influencing factors. Of note was the clinical nursing leaders' views of the importance of the fundamentals of care and their firm belief that these remain a primary focus for nurses and nursing. Nurse leaders' suggested strategies can be applied to all three dimensions of the Fundamentals of Care Framework.

In the following chapter the findings the research will be discussed in greater detail, including exploring their relationship to previous research and the current literature relating to the fundamentals of care.

Chapter 7

Discussion

Introduction

This chapter begins with a brief summary of the research reported in this thesis, and then the main findings are reiterated. Following this, the topics that will be explored in this discussion chapter will be identified and considered.

The study

The literature review conducted for this study demonstrated an increasing focus on the fundamentals of care in parallel with an increasing emphasis on patient-centred care. What was clearly lacking was an empirical exploration of the fundamentals of care, including establishing which fundamentals of care are delivered, by whom, when and where; what factors impact on how these fundamentals are delivered; and if these factors can be moderated. This led to development of the research questions for this study.

The questions this research sought to answer were:

What factors influence the delivery of the fundamentals of care in the acute hospital setting?

More specifically:

- What factors are observed to influence the delivery of the fundamentals of care in an acute hospital?
- What factors do nurses working in an acute care hospital describe as influencing the delivery of the fundamentals of care?
- What factors do patients of an acute care hospital describe as influencing the delivery of the fundamentals of care?

A focused ethnographic methodology was utilised to conduct this research, with a three-stage iterative approach employed to address the research questions. Stage 1 consisted of direct observation of nurse and patient interactions related to the delivery of the fundamentals of care in the acute care setting, conducted in four diverse wards of one hospital. Stage 2 utilised focus groups to explore the respective perceptions of factors influencing the delivery of the fundamentals of care from consumer representatives; Level 1 Registered Nurses, who are the primary nursing care providers; and Level 3 Registered Nurses, who are the clinical nursing leaders responsible for care delivery across an entire ward or unit. Stage 3 of the research involved a group interview with clinical nursing leaders to explore their strategies for moderating some of the factors identified by the focus group participants as influencing the delivery of the fundamentals of care.

This research is unique as it involved conducting a prospective observation of direct care delivery; using these data to create realistic care scenarios; the inclusion of the perspective of consumer representatives, registered nurses and clinical nursing leaders; and the subsequent exploration of practical strategies used by clinical nursing leaders to promote nurses' delivery of the fundamentals of care.

Main findings

The main findings from this research are summarised below.

1. This research has illustrated the complex interactions between and among the physical, relational, psychosocial and contextual elements involved in delivering the fundamentals of care.
2. Factors influencing the delivery of the fundamentals of care are described by nurses and the consumer representatives. Seeking the perspective of the people involved in delivering and receiving the fundamentals of care showed a shared understanding of the factors influencing the delivery of the fundamentals of care. These factors included the influence of the nurse-patient relationship and the clinical nursing leadership.

3. Nursing leadership was considered not only an independent influencing factor, but as a factor that might impact on developing and maintaining the nurse-patient relationship; involving the patient, ensuring their understanding and respecting their choices; communication; and priority setting.
4. With the aim of being solution focused, this research has developed of a list of strategies suggested by the clinical nursing leaders to moderate the factors influencing nurses' delivery of the fundamentals of care.

Discussion topics

From these findings, four topics have been identified for discussion.

First, the complexity surrounding nurses' delivery of the fundamentals of care, and thus the factors influencing this care delivery, are worthy of further exploration, particularly as this type of care often has been referred to in the literature as 'basic'.

Second, as this complexity was explored and identified using the Fundamentals of Care Framework, the usability, relevance and comprehensiveness of this framework compared to other nursing models requires consideration. As the Framework has the development of a nurse-patient relationship at its core, and the importance of this was reinforced by the findings from this research, the relevance of this aspect will also be discussed.

Thirdly, this research used a novel method to explore multiple perspectives of care delivery and to contribute to the existing knowledge about the factors influencing the delivery of the fundamentals of care. The benefits and limitations of seeking these diverse perspectives will be examined.

Fourthly, the influence of clinical leadership on both the development of the nurse-patient relationship, and more broadly, on the delivery of the fundamentals of care, is a recurrent finding from this research. This will be explored in more detail as will the potential impact on clinical nursing leaders of the priority placed on these care activities by the healthcare organisation.

The complexity of the fundamentals of care

This research has illustrated the complexity involved in delivering the fundamentals of care. Direct observation of the interactions between nurses and patients related to these care activities has revealed the intricate and overlapping nature of the various dimensions of the fundamentals of care and has provided examples of how patients and nurses navigate and negotiate this process. The integrated nature of nurses' delivery of the fundamentals of care and the multidimensional contextual and relational factors influencing this care delivery have also been identified by the participants in this research. The complex interactions between each of the fundamentals of care, in addition to the findings from this research about the importance of the nurse-patient relationship and the context of care, demonstrate the difficulty in articulating, evaluating and exploring these fundamentals. This complexity is in contrast to common perceptions that the fundamentals of care represent the 'basics' of nursing care (Vollman 2013). Indeed, a team of researchers in this field (Kitson *et al.* 2014), including the author of this thesis, suggest the fundamentals of care are 'anything but basic' and instead require a "systematic approach ... that combines the physical, psychosocial, and relational dimensions of the care encounter within the wider context of the care environment" (p. 337).

A lack of awareness of the complexity involved in delivering the fundamentals of care in an integrated manner might be linked to the invisibility of the integrated nature of this care in the way care is evaluated. Previous research investigating various elements of the fundamentals of care has often disaggregated these elements, possibly to facilitate their evaluation (Rantz *et al.* 2003, Vollman 2013). While this approach allows for a more focused investigation and easier measurement, it does not reflect the complexity of the interactions between and among each of the fundamentals of care. In addition to research, there are also care initiatives focusing on individual fundamentals of care, such as dignity (SA Health 2016) and respecting choices (Coalition To Transform Advanced Care 2018). These fundamentals of care are promoted as being applicable in all aspects of care delivery, and arguably overlap in that they both support and encourage the patient feeling respected and valued. This overlap between what are promoted as distinct concepts, or elements of the fundamentals of care, likely also contributes to difficulties in describing, exploring and monitoring these fundamentals.

The findings in this research have shown that while physical fundamental care needs frequently initiated a nurse-patient interaction, these physical elements were often linked with other relational, psychosocial and contextual elements from the Fundamentals of Care Framework. Yet, physically focused patient outcomes such as the incidence of falls, pressure areas, wound infections and other nurse sensitive outcomes, have long been considered markers of the quality of nursing care (Heslop & Lu 2014). These outcomes are mirrored in the Australian government's recent announcement regarding withholding payment from public hospitals when patients experience infections, pressure injuries and falls during their hospitalisation (Independent Hospital Pricing Authority 2017). While the use of measurable outcomes as markers of care is not in itself a problem, considering this data in isolation might not provide a complete evaluation. Exploring the fundamentals of care related to each of these outcomes in an integrated manner might provide a holistic and comprehensive view of the care required to potentially reduce these adverse events. The Fundamentals of Care Framework might provide one way to facilitate this exploration, however the metrics are yet to be developed.

Frameworks and models

This research utilised the Fundamentals of Care Framework as a tool to analyse the interactions between nurses and patients related to the fundamentals of care and to subsequently identify the integrated nature of the fundamentals of care elements. The Framework's multiple dimensions were used to explore the multifaceted nature of nurses' delivery of the fundamentals of care. However, other nursing models and frameworks are also seen to integrate the 'fundamental concepts' of care (Murphy *et al.* 2010).

One of the earliest models used in nursing was the biomedical model. This model, which focusses on diagnosis, treatment and cure, and which typically view the body as discrete systems, is still viewed as an important influence on nursing practice (McKenna *et al.* 2014). Other models, more specific to nursing, have since been developed to "try to identify the core concepts central to nursing" (Murphy *et al.* 2010)(p. 19). In 1955, Virginia Henderson presented nursing as a "response to human functional needs" and identified nursing activities for 14 fundamental needs: breathing, eating and drinking,

eliminating, mobilising, sleeping and resting, dressing, maintaining body temperature, cleaning and grooming, avoiding injury, communicating and expressing emotions, worshipping, working, playing and learning (McCrae 2012)(p. 223). Another model developed in 1980, by Roper, Logan and Tierney developed a “model for nursing...based on a model of living” (p. 20) focusing on ‘12 Activities of Living’ (Roper *et al.* 1990). This varied from Henderson with its driver being the individual patient’s needs and problems with activities of living for patients rather than on nursing activities.

These models, among others, illustrate a systematic approach to the provision of nursing care, however; these apparent strengths were described by McCrae (2012) as making them “prone to compartmentalised, concrete thinking...etched in tablets afoot patients’ beds” (p. 225). Utilisation of a ‘checklist approach’ with the various components from these prominent nursing models might also predispose the disaggregated evaluation of each fundamental or element of care. Novel methodologies to explore the integrated nature of the physical, psychosocial and relational fundamentals of care are required to overcome these predispositions and, as the research in this thesis demonstrates, the Fundamentals of Care Framework might facilitate this process.

Using the Fundamentals of Care Framework in the data analysis helped to identify the fundamentals of care and to explore if and how nurses deliver this care in an integrated manner. Although the Framework illustrates the complex nature of fundamental care, there is no current literature describing the use of the Framework to effectively promote this integrated manner of care delivery in clinical practice. Thus, the transferability of the conceptual Framework to clinical nursing practice is currently unexplored. Further investigation of the practical applicability and effectiveness of the Framework in promoting the delivery of the fundamentals of care in an integrated way is warranted.

Since this research commenced in 2013, the Framework and the individual fundamentals of care elements have been the subject of ongoing debate, modification and refinement. A lack of agreement around the discrete fundamental care elements was perceived to contribute to negative consequences for nursing research, education and care delivery (Feo *et al.* 2018). To address this, a team led by Feo *et al.* (2018), of which the author of this thesis was a member, sought to generate a standardised

definition for the fundamentals of care and to identify the discrete elements that constituted such care. Feo *et al.* (2018) claim the study “helped to shape ongoing, crucial dialogue around how we conceptualise fundamental care, and made significant advances in generating consensus on a concept central to nursing” (p13). The need to distinguish between ‘fundamental care’ and the ‘fundamentals of care’ and ensure consistent use of terminology was highlighted by these researchers. Feo *et al.* (2018) suggest fundamental care is achieved by “enacting the dimensions of the Fundamentals of Care Framework (i.e. establishing a relationship, addressing fundamental needs and considering the care context)” (p12). The term ‘fundamentals of care’ is then used to refer to the “discrete elements of fundamental care, that is, patients’ fundamental physical and psychosocial needs (e.g., nutrition) and the nurse actions required to address these needs (e.g., engaging with patients)” (p 12). This distinction between these two concepts might aid clarity when further exploration of care delivery is conducted.

At the core of the Fundamentals of Care Framework is the establishment of a therapeutic, trusting relationship, and the importance of this was reinforced by the findings from this research. All three participant groups (consumers, Level 1 nurses and Level 3 nurses) suggested this relationship was a key factor influencing nurses’ delivery of the fundamentals of care. This dimension of the Framework is also supported by Mason *et al.* (2015), who explored the common factors from 39 other models of nursing care, that were recognised by the American Academy of Nursing as “innovative models of care designed to promote health and manage illness across diverse and underserved populations” (p 540). This diversity, albeit exclusively from within the United States, included populations such as the aged, pregnant women, parents, youths with diabetes, Latina youth, poor African American families, and people with mental illness, with services provided in the home, community, hospital, transitional care, free standing birthing units, and regional ageing centres. A patient-centred approach, utilising relationship-based care, was a core feature of these nurse-designed models of healthcare, and the integration of physical psychological, social and spiritual aspects of care was also highlighted (Mason *et al.* 2015). The Fundamentals of Care Framework incorporates these features in the two inner dimensions of the Framework, with the additional consideration of the contextual influences on care. This suggests the Framework might be applicable in most health care settings, however this has not

been empirically evaluated. The importance of the nurse-patient relationship will now be discussed in more detail.

Importance of the nurse-patient relationship

The findings from the focus groups in this research indicated there is a requirement for a good nurse-patient relationship to be present for care delivery to be perceived as satisfactory by both parties. Emotional support for patients and their families, and empathy with their situation throughout the patient journey, were viewed as important by all three participant groups. This might not be considered novel information and indeed might sound clichéd. However, as illustrated in recent local care failures, such as those that occurred at the Oakden Older Persons Mental Health Service in South Australia (Groves *et al.* 2017), if a therapeutic relationship does not exist, or is not perceived to be a necessity, the consequences can be devastating. It is hard to believe that nurses and other care staff who have a relationship with those they care for could then neglect and, at times even abuse, their patients. An increased risk to patient safety has also been linked by Conroy *et al.* (2017) and Feo *et al.* (2017b) to the lack of a therapeutic nurse-patient relationship, and therefore should not be seen as an 'optional extra' as it was to the consumer representatives in this research, but as an integral requirement for optimal patient outcomes.

The importance of the nurse-patient relationship has also been highlighted internationally. A meta-ethnography of 16 studies from Australia, Europe and North America, explored nurses' experiences of nurse-patient relationships (Bridges *et al.* 2012). The development of these relationships appears to require both investment and commitment on behalf of the nurses. Bridges *et al.* (2012) found nurses might choose not to establish relationships with those patients they find more difficult to care for, to perhaps then spare or protect themselves from the 'guilt' associated with not providing the level of care they feel is required. This might expose some patients to a higher risk of poor outcomes, and these patients need to be identified and protected.

Despite there being few measures of its effectiveness or quality, both patients and nurses appear to be able to perceive if the nurse-patient relationship is implicitly acceptable. The research in this thesis

has highlighted how clinical nursing leaders who act as role models, influence the level of support and encouragement for the development of the nurse-patient relationship. If we accept the importance of a good nurse-patient relationship, then we need to support nurses to establish and maintain these relationships, and develop methods to evaluate the quality of these relationships. Feo *et al.* (2017a) identified a series of recommendations for the development and maintenance of the nurse-patient relationship using a method called holistic interpretive synthesis. The list of recommended behaviours aims to provide nurses with “practical guidance for establishing positive, trusting relationship with patients to deliver person centred, fundamental care” (p. 8). These authors, including the author of this thesis, suggest that while the recommended behaviours have apparent strong ‘face validity’ this is yet to be established empirically and they recommend further research to establish the content and construct validity of the recommendations. Further research is vital to devise explicit methods to support nurses to develop nurse-patient relationships along with objective measures of the quality of the relationship. This could increase the profile of, and provide support for, this core requirement for delivering the fundamentals of care.

This research explored the perspectives of Registered Nurses and consumer representatives, however the perspectives of other members of the interdisciplinary healthcare team were not sought, although some of their behaviours were observed in the first phase of this research. Despite nursing attempts to preserve sleep and privacy and dignity, healthcare workers were observed to interrupt patients’ rest and medical staff were observed, on occasion, to violate patients’ privacy. The clinical nursing leaders interviewed in this research shared their views about the negative influence of the medical hierarchy and the lack of interdisciplinary communication and teamwork on their ability to deliver the fundamentals of care, and to ensure the focus of care was patient-centred. Engaging with medical professionals and allied healthcare staff to explore their perceptions of the importance of these relationships might provide further support for this concept and thereby encourage organisations to apportion greater value to this core requirement for the delivery of the fundamentals of care.

Seeking multiple perspectives of care delivery

This research used novel methods to explore diverse perspectives about the factors influencing nurses' delivery of the fundamentals of care. Seeking the perspective of the people involved in overseeing, delivering and receiving care showed a shared understanding of the factors influencing the delivery of the fundamentals of care. The inclusion of the three distinct groups of participants enabled the findings of the research presented in this thesis to present a multifaceted view of care delivery and allows the reader to assess the credibility and transferability of the findings.

Engaging with patients and clinicians is supported by Janamian *et al.* (2016) as an effective way to explore the values of stakeholders and end users and to facilitate translation of research evidence into policy and practice. Indeed, these authors state that without this input “the researcher may lack insight into the end users' specific needs and values..., making the research outcomes difficult to implement and often unsustainable in the real-world setting” (p. S5). Zeitz *et al.* (2011) have also highlighted the need for staff and consumers to be involved in conversations about how to improve care delivery and state it is “a useful approach to involve consumers and clinicians in structured dialogue about understanding and changing care” (p. 53).

This research utilised a unique method of observation-based, scenario-led focus groups of nurses, clinical nursing leaders and consumer representatives. This method of seeking a variety of perspectives on identical care scenarios might have helped the participants to be more objective in their reflections as they were not being asked to recall and comment on events that had directly impacted upon them personally. However, the participants routinely referred to past experiences when they were describing possible factors influencing the delivery of care. The overlaying of the participants' personal experiences on to the generic care scenarios helped to elicit rich, diverse data relating to the description of potential factors that influenced the delivery of the fundamentals of care in a broad range of circumstances, beyond the scenarios that were presented.

All three groups offered unprompted judgements about the quality of care in the scenarios, and the consistency with how participants defined this was noteworthy. For example, all three groups

considered not responding to patients calls for assistance to be an indicator of poor quality care. Similarly, the congruity between all three groups in identifying the factors influencing the delivery of the fundamentals of care illustrates a common perspective from consumers and nurses. This was demonstrated by data from all three groups being represented in seven of the ten factors identified as influencing nurses' delivery of the fundamentals of care. However, this congruity in the 'themes' from each group needs to be considered in light of research conducted by Gill *et al.* (2011) who suggests that the meaning that diverse participant groups attribute to various themes might differ. The phenomenological study conducted by Gill *et al.* (2011) involved 29 interviews with managers (n=3), providers (n= 11) and clients (n= 15) in the community aged care setting in Australia. These researchers acknowledge the limitations of their relatively small and homogenous sample; however, is it important to consider that similar findings may occur in other care contexts (Gill *et al.* 2011). Thus, the three diverse focus groups in this research might have assigned different meanings to the factors they suggested as influencing the delivery of care and further investigation of these potential differences might be warranted.

Clinical leadership

This research has illustrated the vital role the clinical nursing leaders play in promoting the delivery of the fundamentals of care. The influence of the nursing leadership in the care environment was also recognised by both levels of nurses and the consumer representatives who participated in this research. Due to the small sample size, the findings from this research are considered as indicative rather than conclusive; however, these findings are supported by evidence from other researchers.

The clinical nursing leaders in this research were each responsible for ensuring care delivery in a distinct ward or clinic, and fulfilled the description of clinical leadership defined by Mannix *et al.* (2013) as "leaders or experts in a very local clinical arena"(p. 4), "gaining much of their knowledge for their role from practice"(p. 5). The importance of nursing leadership to promote care delivery has been established by previous research. For example, as early as 1999, in an ethnographic study exploring contemporary leadership, effective leadership was recognised by Antrobus and Kitson (1999) as "a

vehicle through which both nursing practice and policy can be influenced and shaped“ (p. 736). Nearly 10 years later, another ethnographic study conducted by Sorensen *et al.* (2008), claimed “nursing leadership is coming to the fore” and charges the nursing leadership with “assuming a crucial role that ties in with doing the right thing for consumers” (p. 543). The relationship between nursing leadership and patient outcomes has also been also explored in a systematic review conducted by Wong *et al* (2013) who found evidence of a positive relationship between a transformational leadership style and patient outcomes, although these authors suggest the specific leadership models influencing the outcomes required further investigation.

The research in this thesis went beyond the original remit of describing the factors influencing nurses’ delivery of the fundamentals of care. When this research highlighted the influence of the clinical nursing leaders on many of the factors that had been identified in the focus groups, it was deemed prudent to move beyond mere identification of these influencing factors, towards exploring if, and how these leaders addressed them. Rather than present a ‘list’ of the factors influencing nurse’ delivery of the fundamentals of care and then suggest these needed to be further explored, this research, with the aim of being solution focused, developed of a list of strategies suggested by the clinical nursing leaders to moderate the factors influencing nurses’ delivery of the fundamentals of care.

The clinical nursing leaders described strategies for moderating the contextual factors influencing the delivery of the fundamentals of care, as well as strategies to promote the integration of the physical, psychosocial and relational elements of care. Furthermore, these clinical nursing leaders were able to describe the strategies they use to establish and maintain nurse-patient relationships. These strategies, while currently untested, might be useful for inexperienced leaders who are looking for guidance for how to promote delivery of the fundamentals of care.

The interrelationships between nursing leadership, the context of care, integration of care and the promotion of nurse-patient relationship are discussed below.

Leadership and contextual factors

The clinical nursing leader participants in this research described many contextual and organisational factors that impact on the delivery of the fundamentals of care. They described an ongoing need for the fundamentals of care to be prioritised and valued by healthcare systems and indicated they required support to fulfil the demands of their role. Maben *et al.* (2012b) conducted an extensive research project exploring patients' experiences of care across four NHS organisations in the UK. Their mixed methods study involved interviews with 55 senior managers, 498 patient experience surveys, 301 staff wellbeing surveys, 86 staff interviews and 206 hours of observation, and confirmed that "ward/team leaders have a critical role in setting expectations of values, behaviours and attitudes" (p 18), and "the leadership skills and approaches of ward sisters [UK equivalent of clinical nursing leaders] were noted as especially important to patient care..." (p95). Maben *et al.* (2012b), recommend organisations "systematically measure and monitor levels of quantitative job demands; invest in unit level leadership and supervisor support" (p 18). Thus, while clinical nursing leaders might be viewed by some researchers as responsible for establishing the value attributed to care delivery, if the organisation in which they work does not similarly value this care and provide the required support, this places them in a difficult position. As stated by one of clinical nurse leaders in the group interview, "*you know you go into the job with a certain expectation of what you think, ...and I think the level 3 [clinical nursing leader] position you're damned if you do and you're damned if you don't a lot of the time*".

Leadership and integration of care

The clinical nursing leaders in this research were steadfast in their belief that the fundamentals of care must be defined as part of the nursing role. However, this might be at odds with the division in care delivery that has been suggested as a way to address a shortage of Registered Nurses. The suggestion is Registered Nurses carry out technical, treatment or cure-directed acts, and healthcare assistants focus on providing some of the fundamentals of care such as personal hygiene, nutrition and mobilisation (Darbyshire & McKenna 2013, Willis 2012). While some might agree it is heartening that nurses want to retain responsibility for these fundamental care activities, the focus of the care delivery must remain patient centred: delivery of this care must be appropriate; and patient outcomes must not

be adversely affected. If nursing staff are otherwise engaged, then it is vital to ensure this care, regardless of who delivers it, is delivered properly. If this type of care is to be delegated to healthcare assistants, further research is needed to explore how nurses determine which fundamental care needs are required, how and to whom these care activities are delegated, and how the care delivered will be evaluated.

The research in this thesis did not explore the role of the healthcare assistant, as these were not routinely employed in the patient care areas in the hospital where this research was conducted. As Registered Nurses remain the coordinators of patient care, it was important to understand what factors these nurses believe influence their ability to deliver, or which ensure the delivery of, the fundamentals of care. Further research exploring the role of the healthcare assistant in the delivery of the fundamentals of care is warranted, including if and how these workers manage the integrated nature of this type of care, which would include developing positive relationships with care recipients.

Leadership and the nurse-patient relationship

The clinical nursing leaders in this research indicated they utilise several strategies to establish and promote a nurse-patient relationship including prompting their staff to focus on the patient perspective and ensuring that they, the leaders, know and make themselves known to the patient and their carer. However, they did not describe organisational support or acknowledgement for these activities. The value placed upon developing therapeutic relationships and delivering the fundamentals of care in an appropriate and mutually acceptable way, might depend on the culture of the organisation where the care is delivered. The most influential factor shaping the culture in the healthcare environment is reported to be leadership (Quinn 2017).

Organisational demands related to patient throughput, length of stay and staffing skill mix were mentioned by participants in this research as impacting on the clinical nursing leaders' ability to shape the workplace culture, manage workload and facilitate the development of therapeutic nurse-patient relationships. However, what has not yet been established is whether developing a relationship takes more time than not developing the relationship, and whether this relationship-development can be

incorporated into the physical care delivery process. The requirement for additional time to develop a good nurse-patient relationship was reported by both the Level 1 Registered Nurses and the Level 3 clinical nursing leaders in this research. However, this need for additional time has been questioned by other researchers. Pearcey (2010), for instance, who conducted a grounded theory study exploring caring as part of the nurse-patient relationship, asked “If there is physical interaction with someone, why would it take extra time to do it in a caring way? It might take extra effort, but surely not extra time” (p. 54). Nurses in Pearcey’s study also felt unable to achieve the type of care delivery they wanted to provide, and again the “target-driven, goal centred health service of today” was suggested as an influencing factor (p. 55).

The study reported in this thesis did not time the interactions between nurses and patients or explore the perceived quality of the nurse-patient relationships from either perspective, however the importance of these relationship was reinforced by all participant groups. Further research exploring the effect of the ‘manner’ of nurse-patient interactions versus their duration on the development of these relationships is warranted.

Summary of discussion points

Delivering the fundamentals of care is complex, and this research has demonstrated this type of care is certainly not ‘basic’. Unveiling the integrated nature of this care might lead to wider recognition for the need for this care to be evaluated in an inclusive manner.

The complexity of this care was explored and identified using the Fundamentals of Care Framework. At the heart of the Fundamentals of Care Framework is the establishment of a therapeutic, trusting nurse-patient relationship, which was viewed as a core requirement for the delivery of the fundamentals of care by the participants in this research who oversee, deliver and receive this care. Seeking these multiple perspectives of care delivery has revealed a multifaceted and remarkably congruent perceptions about the factors influencing the delivery of the fundamentals of care.

Clinical nursing leaders are arguably in the best position to promote the delivery of the fundamentals of care and foster the establishment and maintenance of the nurse-patient relationship by acting as role-models. Further efforts to promote the development and maintenance of these relationships will require objective measures to evaluate the relationship quality from each participant's perspective.

The final chapter will explore the significance of the research findings. The strengths and limitations of this research will also be described. Conclusions are presented, and recommendations are then made for practice and for further research.

Chapter 8

Conclusions

There is evidence from patients, the public and nurses themselves that the nursing profession has not been able to provide the fundamentals of care as consistently or adequately as needed.

There has not been any systematic exploration of the factors that influence nurses' delivery of the fundamentals of care and the research reported in this thesis aimed to address this.

From direct observation of nurse and patient interactions, and through focus groups with patient representatives and nurses, this study has revealed some of the factors that influence nurses' delivery of the fundamentals of care. This research has highlighted the complex interactions between the physical, relational, psychosocial and contextual elements involved in delivering the fundamentals of care.

The use of multiple perspectives to explore this topic had not been reported before. Using these multiple perspectives of care highlighted a shared understanding of the factors influencing the delivery of the fundamentals of care. The congruity with which all three groups identified not only the factors influencing delivery of the fundamentals of care, but also their assessment of the quality of the care that was described in the observation-based scenarios, is an important finding.

The value attributed to the nurse-patient relationship by all parties was consistent with findings from other research, as was the impact of organisational and contextual factors on care delivery. Clinical leadership and the nurse-patient relationship were identified as the 'active ingredients' required to promote nurses' delivery of the fundamentals of care. If a good relationship is established, and these relationships are valued and modelled by clinical nursing leaders, many of the other factors influencing the delivery of the fundamentals of care can be moderated and managed.

The potential for nursing leadership to influence many of the other factors was explored with clinical nursing leaders. This research discovered these clinical nursing leaders have devised strategies for ameliorating the factors that impinge on the delivery of the fundamentals of care. Further testing of these strategies is warranted in order to transform what we know about the delivery of fundamentals of care into consistent and sustainable improvements in patient care.

This research confirmed some findings from previous literature, such as the value attributed to the nurse-patient relationship by both parties (patient and nurse) and the ways in which organisational and contextual factors can impact on care delivery. While these findings might not be completely unique, it is useful to know that those directing, delivering and receiving care are 'seeing' the same things. This then raises further questions. If the factors that influence care delivery are able to be articulated and described congruently by those involved, why are some still adversely impacting on care and how can they be effectively addressed? Alternatively, for the factors that promote care delivery, how can these be supported and encouraged?

Significance of this research

There are several areas of significance from this research.

This research has demonstrated the usefulness of the Fundamentals of Care Framework as a tool to explore the integrated nature of care delivery and using the Framework to analyse real time data describing how nurses and patients negotiate how, when and where this care is delivered was unique. This research showed that individual fundamentals of care were rarely delivered in isolation, and revealed the way physical, relational and psychosocial elements are integrated, while being influenced by the context surrounding the care delivery. Demonstrating the multifaceted nature of this care disproved the notion that this type of care can be considered 'basic'.

Using the unique method of incorporating real-life data from the observation of care delivery into the development of scenarios revealed a remarkable, and previously unreported, congruence in the factors identified by different stakeholders as influencing the delivery of the fundamentals of care. The

knowledge that these factors were recognised by clinical nursing leaders, nurses at the point of care and also by those receiving the care is significant.

This research has also generated a list of potential strategies used by clinical nursing leaders to address some of the factors influencing the delivery of the fundamentals of care. This provides an empirically derived, practical, solution-focused resource aimed to moderate these factors and promote nurse' delivery of the fundamentals of care.

Strengths and Limitations

Strengths

There were some unique features of this research that added to the strength of the findings. The use of direct observation, in four diverse acute patient care areas, accompanied by verbatim descriptions of the interactions between nurses and patients related to the delivery of the fundamentals of care, allowed the complex and integrated nature of this care to be described as it occurred, in real time. The detailed descriptions of these interactions related to fundamentals of care were analysed using the Fundamentals of Care Framework, which facilitated the exploration of the physical, psychosocial and relational dimensions of this care. This contributes to the trustworthiness of the research and presents an alternative to previous research that has tended to disaggregate care delivery into individual fundamentals of care.

The use of the 'real life' observation data to develop the four scenarios for the focus groups contributed to the credibility of the research by ensuring the scenarios were relevant and current, and represented a realistic picture of the delivery (or non-delivery) of the fundamentals of care. Exploring the diverse perspectives of the nurses who direct care, the nurses who deliver the care, and the recipients of care, provided a multifaceted, and congruent picture of the factors influencing the delivery of the fundamentals of care. The literature review did not reveal previous use of this methodology of exploring the perspectives of different stakeholders, using real-life scenarios of care delivery. This is a novel approach and might provide a model for future investigations of care delivery. The focus group

discussions might not have elicited such rich data if alternative methods such as individual interviews had been used. Interviews are prone to the problem of “social desirability” where the participant gives the most socially acceptable response. Using focus groups encourages people to be more forthcoming as they are not the sole focus of attention (Braun & Clarke 2006). Scenarios that were open to interpretation enabled the participants to “define the situation in their own terms” (Wilks 2004) (p. 83). Seeking responses to hypothetical situations rather than the reality of the participants’ own practice or situation might have allowed them to be more open in their responses (Wilks 2004).

Limitations

This research has some limitations. It was conducted in a single publicly-funded, major metropolitan acute care hospital in Adelaide, South Australia, which does not represent a universal picture of the delivery of the fundamentals of care across nursing. This limits the transferability of the findings; thus, the research results might not be applicable in other healthcare settings either elsewhere in Australia or internationally.

As discussed in Chapter 4 (Methods), there are limitations to the research design and methods. Focused ethnography has limitations, including its purposive convenience sampling. Although mentioned above as a strength of the research, the novel methodology of using scenario-led focus groups, might also mean that, due to the ‘untested’ nature of this method, the findings cannot be generalised nor transferred.

This study was exploratory rather than representative and due to the resultant small sample sizes for the focus groups and group interview, data saturation was not possible. Attention was paid to rigor and credibility in this research, however the findings are still open to potential bias due to its qualitative nature, particularly as the qualitative researcher always brings their own experiences, biases and assumptions to their research (Hammersley & Atkinson 2007, Schensul & LeCompte 2013).

The self-selection process used for recruiting both focus group participants and interview participants meant there might have been a greater chance that those who chose to participate did so

because they have an interest in, or strong opinions about, the fundamentals of care, which could have influenced or skewed the findings. The consumer representatives were not current patients of the hospital and might not have had recent experience of the delivery of the fundamentals of care.

Recommendations

The following recommendations for further research and for practice have been generated by this study.

For research

The research presented in this thesis has highlighted several areas where further research is recommended.

Research is required to identify explicit methods to support nurses to develop nurse-patient relationships, along with metrics to evaluate the quality of these relationships. Although Feo *et al.* (2017a) have interpreted and synthesised empirical evidence about the nurse-patient relationship, these recommendations, while potentially useful, have not been empirically evaluated and thus further investigation is warranted. Research is also required to establish whether developing a therapeutic nurse-patient relationship actually takes more time or if that can occur concurrently with the physical care delivery process. Thus, an exploration of the effect of the 'manner' versus the duration of these interactions may be warranted.

This research focused exclusively on nurses' delivery of the fundamentals of care. While appropriate for the setting where this research was conducted, it is conceivable that nurses might not be the primary providers of this care in the future. Further research, exploring if, how and to whom these care activities might be delegated, along with an exploration of the role of the healthcare assistant and the factors influencing their delivery of the fundamentals of care, is warranted. If and how these workers manage the integrated nature of this type of care, including the development of positive relationships with the care recipients, might also require investigation.

For practice

The Fundamentals of Care Framework might be applicable to most health care settings; however, this has not been empirically evaluated and the transferability of the conceptual framework to clinical nursing practice is currently unexplored. Further investigation of the practical applicability and effectiveness of the Framework in promoting the delivery of the fundamentals of care in an integrated way is warranted.

The practical strategies identified by the clinical nursing leaders to promote delivery of the fundamentals of care might be useful information for new leaders. However, these strategies, due to the limitations of this research, might not be applicable in other healthcare settings. Further investigation, exploring the strategies used by other clinical nursing leaders to promote the delivery of the fundamentals of care in a variety of healthcare setting is warranted.

Once identified, further testing of the strategies utilised by clinical nursing leaders to moderate the factors influencing nurses' delivery of the fundamentals of care is warranted in order to transform what we know about the delivery of fundamentals of care into consistent and sustainable improvements in patient care.

This concludes the main body of this thesis. The remaining sections comprise the reference list providing details of the literature referred to in the thesis and contain the Appendices referred to in the relevant chapters.

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Appendix 1: (Conroy 2017)

Conroy T (2017): A beginner's guide to ethnographic observation in nursing research. *Nurse Res* 24, 10-14.

A beginner's guide to ethnographic observation in nursing research

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Abstract

Background Observation is mentioned in most ethnographic textbooks, but specific details about how it should be conducted and the practicalities to be considered in ethnographic nursing research are not always explicit. This paper explores the experiences of and challenges faced by a novice nurse researcher who used observation to collect data.

Aim To provide a novice researcher's perspective of observation in ethnographic nursing research and to highlight the associated challenges.

Discussion Challenges that arose in observation began with determining which perspective to take, followed by rehearsing observation, developing and maintaining a constructive relationship with the observation site, being aware of the influence of the observer, managing interactions between the observed and the observer, and responding to ethical issues.

Conclusion Novice nurse researchers considering using observation to collect data should be aware of the potential challenges they might encounter.

Implications for practice The information presented in this paper will enable novice researchers to anticipate these issues and develop strategies to prevent or address them.

Keywords

ethnography, nursing, observation, research, novice researcher, nursing research

Introduction

This paper is a reflective commentary on conducting observation from the perspective of a novice ethnographic nurse researcher. Although participant observation is mentioned in most ethnographic textbooks, specific details regarding its use in nursing research and the practicalities to be considered are not always explained. Kawulich (2005) provided a comprehensive overview of participant observation; however, this is more than ten years old and is not specific to nursing research. There are many seminal texts that describe the theoretical basis and methodology for ethnography (Spradley 1980, de Laine 1997, Schensul et al 1999, Hammersly and Atkinson 2007, Murchinson 2010), however, there are few publications that address the practical experiences of engaging in ethnographic research (Gelling 2014).

This paper provides a perspective on conducting observation as part of nursing research. It is intended not to be a critical examination of observation as a methodology, but to provide practical tips that might help

novice ethnographic researchers, especially nurses. It describes the background to a study, for which I undertook observation, and explores the issues encountered, including determining the perspective of the observer; rehearsing observation and deciding what to document; achieving a constructive relationship with the observation site; the influence of the observer; interactions between the observed and the observer; ethical issues; and staying 'neutral'. I then use my experience of these issues to suggest matters to consider when observing and to present some strategies that could be helpful.

Background to the study

A major challenge in nursing is ensuring the 'basics' or fundamentals of care are carried out correctly. These have traditionally been the responsibility of nurses and include ensuring patients receive appropriate nutrition, hydration, hygiene, sleep and dignity (Kitson et al 2013a).

The aim of my doctoral research is to investigate the challenges in providing these

fundamentals. It involves three phases, and the methods used to collect data include observation, focus groups and interviews. The first phase – completed in 2014 – involved observing interactions between nurses and between nurses and patients that were related to the fundamentals of care. I observed participants two hours per day for five days in four different clinical areas of an acute care hospital in South Australia. This phase is the focus for this paper. Phase two involved the development of scenarios based on the findings from these data, which were presented to focus groups of nurses and patient representatives for comment. Phase three will involve interviews with nurses exploring issues raised in the focus groups.

Using ethnography and observation in nursing research

The use of ethnography in nursing research is not a recent phenomenon (Gelling 2014). Ethnography has been used since the early 1900s when the use of observation to collect data was established (de Laine 1997). These observations, recorded as field notes, remain a primary source of data for ethnographic research (Robinson 2013).

Observation has been defined as 'the systematic description of event, behaviours, and artefacts in the social setting chosen for study' (Marshall and Rossman 1989), and can describe the communication patterns, workflows and tasks of the clinicians in a specific work environment (Horsky and Mamykina 2012). Observation is considered integral to ethnography as it provides the best opportunity to view participants' behaviour in the context of the 'real world' (Fetterman 2010).

The perspective of the observer

The influence of observing from the perspective of either a participant ('emic') or a non-participant/observer ('etic') needs to be considered (de Laine 1997). This is explored in the literature along with descriptions of the various possible roles of the observer (Gold 1958, Spradley 1980, Baker 2006), which can range from being a participant who conceals their being a researcher from others ('complete participant') to being an observer of whom participants are unaware ('complete observer') (Table 1). Ethnographers differ on the merits of these various roles (Spradley 1980, Fetterman 2010), while Baker (2006) suggested various roles can be used during observations.

The observation in my research might be considered 'complete observation', for example, as I was not directly involved in

care. However, because I am a registered nurse and did occasionally assist participants in minor ways, such as helping to make beds and fetch equipment, it could also be argued I was a participant. Potentially, I was a 'passive participant', according to Spradley (1980)'s types of participant/observer, which Spradley suggested is a valuable way to understand the cultural rules people follow. I was also an 'observer as a participant': participants were aware I was observing them and I participated in activities, which might have helped to develop a positive relationship with the observation site and those being observed.

Rehearsing observation

Taking field notes is 'part of the invisible oral tradition' of ethnography (Hammersly and Atkinson 2007). As a novice observer, it is difficult to know if you are seeing what you are looking for and recording what is needed. The thought of spending many hours collecting data only to discover that they do not answer your research question is anxiety-provoking.

Sampson (2004) supported the piloting of data collection before ethnographic fieldwork as a way to improve the quality of a study. Before the first period of observation, it was valuable to me to practise observation and trial the collection of data. I developed a draft tool that included prompts for information about the events I would observe, including location, date, time and the participants involved. I also included an area for free text.

I piloted the tool in one of the proposed observation sites, in tandem with an

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TABLE 1. Observer roles

Role type	Researcher's role
The complete participant	Be fully part of the setting. Observation is often hidden from those being observed.
The participant as an observer	Has access to the research setting by having a natural, non-research reason for being present. Part of the group being studied. Actively participates in group activities.
Moderate role or peripheral member	Balance between participation and observation. Interacts with those being observed and engages in similar activities. Not considered a member of the group.
The observer as a participant	Only minimal involvement in the research setting. More observation than participation.
The complete observer (passive participation)	Does not take part in the setting at all. Role is to listen and observe.
Non-participation	Not present at the setting.

experienced nurse researcher. We documented our findings and recorded our reflections on the trial, including feeling welcomed at the site, which might have been because some of the staff knew us personally. The people we were observing were registered nurses (RNs) and, as we were RNs too, we were conscious of needing to take off our 'RN hats' when describing what we were actually seeing, not what we inferred or assumed.

For example, if a nurse approached a patient with a small syringe, lifted the bed covers to expose the patient's thigh and injected a clear substance into the patient's leg, an observing nurse might assume this was the administration of subcutaneous heparin. The observing nurse would need to acknowledge this emic view and instead consciously adopt an etic view as an outside observer.

It also became apparent that verbatim descriptions of every detail of the observed events would generate considerable data, so observation would need to be targeted and focused on the research questions. To minimise the amount of writing required, I developed a list of codes and abbreviations for commonly observed phenomena. I revised the data collection tool to incorporate these changes.

Having an experienced nurse researcher as a co-observer during the pilot also provided moral support and a way to determine if the data collected were 'fit for purpose'. A comparison of our observations confirmed the focus and depth of data needed. It also gave me some reassurance I was recording the 'right' thing.

Some researchers suggest taking detailed notes throughout a period of observation (Kneafsey et al 2013, Kjerholt et al 2014) whereas others prefer to focus on actively observing, recording the detail later (Fetterman 2010). I chose to transcribe the data from the tool immediately after each observation period, and add my recollections and reflections to each event. Data were transcribed with details of the date, time, place and participants, and a description of the event. This enabled easier recollection of what had occurred. However, the time I took to transcribe data was almost as long as the time taken to collect them, so I chose to limit all observation sessions to two hours.

Achieving a constructive relationship with the observation site

I conducted observations at sites nominated by their staff following a request sent by the director of nursing of the hospital on my behalf. Before commencing observations, I met

with each of the leaders of the ward areas and as many staff as possible, to describe the study and obtain their support. I attended ward handover meetings to explain the study and distribute information about participation.

I was known at the pilot observation site, which I also used as the inaugural site for the research. This existing relationship enabled the collection of the initial data to occur in an environment where I was welcome. It was helpful to be in a familiar environment with friendly faces, and I could practice explaining the purpose of the research and asking staff and patients for consent for observation. Moving to unfamiliar sites was then less daunting because I had my 'pitch' and processes practised and smooth.

Across all four observation sites, most nurses who were approached or were 'volunteered' by the senior staff were gracious and welcoming. Only one nurse refused to be observed, saying she was 'too busy'.

Kawulich (2005) suggested that having existing personal contacts, being recognisable to the participants and 'hanging out' at the site can develop trust and rapport. Novice observers who do not already have relationships with their observation sites should spend some time making themselves known, explaining their projects and, if possible and appropriate, helping with participants' workloads in some way (Simmons 2007). Not only will this provide an alternative perspective of the behaviour that is to be observed, it could enable the participants to become more familiar and comfortable with the researchers' presence.

The influence of the observer

Being watched can change a person's behaviour. There is a risk that those being observed censor themselves or stage performances (Monahan and Fisher 2010). Although I was attempting to obtain as much data as possible, I tried to be unobtrusive or avoid becoming involved in potentially sensitive or irrelevant activities. I observed at a distance and I did not accompany the nurses I was observing behind closed doors or curtains. This was congruent with my research question. However, if this type of information had been required, I would have needed to have negotiated access.

I used a clipboard to record events, which led to some healthcare staff assuming I was conducting an audit of hand-hygiene – several made a demonstrable effort to be seen washing their hands. Any decrease in hospital-acquired infections could not be attributed to my presence!

Those being observed would sometimes want to explain their actions and would apologise for closing doors to maintain the patients' privacy during some procedures. I reassured them these apologies were unnecessary.

Observation sites varied in whom they allocated me to observe. Some seemed keen to show off their more experienced staff to 'show me how it's done'; others seemed to want to protect their staff, so allocated inexperienced or relief staff. If sites and their staff feel their provision of care might be judged and reported to their managers, they might be less willing to be involved (de Melo et al 2014). This was not the aim of my research and I stressed this in the information supplied, but other researchers might need to reinforce this message at every observation.

Staying 'neutral'

Ethnographers must make their biases explicit – the 'ethnographer enters the field with an open mind not an empty head' (Fetterman 2010). They can also use strategies such as triangulation and a non-judgmental orientation to reduce the influence of their biases (Fetterman 2010).

Pellat (2003) highlighted the need to be conscious of any potential biases, which for me included being a RN, my previous employment at the observation site, and my prior co-authorship of papers concerning the Fundamentals of Care (Kitson et al 2010, Kitson et al 2013a, Kitson et al 2013b, Kitson et al 2014). My strategies to address these possible biases included making reflective notes after each observation period, regular debriefing and discussion with my PhD supervisors, and reorganising the data. I collected and chronologically transcribed the data, then collated them into patient-specific events for analysis. This informed the next phases of the research, which provide an opportunity for triangulation and additional opportunities to address these biases.

I recorded verbatim what I saw and heard. Some events had positive and negative emotional effects. When transcribing the data, I reflected on these events and recorded my responses to them. These events tended to be at the forefront of my recollection of the data, which could have influenced which examples I extracted to demonstrate certain themes. To avoid this, a moderation process was required that involved other researchers familiar with the data but not present during observation.

Ethical issues

When preparing for my study, I identified several potential ethical requirements.

These included obtaining informed consent from those being observed, maintaining confidentiality and anonymising participants' data.

To obtain informed consent, before beginning the observations I explained the proposed research in detail and distributed information sheets to all potential participants at each site. Patients and nurses could all refuse to be observed or choose to withdraw from the study at any time. I recorded no personal identifying information, so any potential risk of harm for participants was unlikely.

The research ethics committee at the hospital approved blanket consent for the observation, with an opt-out for any person who did not wish to be observed. When seeking ethical approval, I also needed to explain how I would react if I witnessed any risk to a participant's safety. This subsequently happened on two occasions when a patient was in distress and no one else was present: the first involved a patient attempting to climb over bed rails, the second when a patient urgently required a bedpan and was becoming distressed. Although I was recording how and when nurses responded to patients' needs, allowing actual harm and distress to occur would not be ethical behaviour for a RN, so I intervened. Having already considered how I would respond before being confronted with these situations enabled me to avoid any personal ethical conflict.

Other reflections

The focus of the study was an area where there was little previous research, so I tried to maximise the variety of observations. I observed different participants and sites at different times of day, to try to obtain a broad overview of practice (Lambert et al 2011). However, other researchers might want an in-depth understanding of only a single topic and so choose to concentrate their observations appropriately.

Observation generates considerable data: in my study, 40 hours of observation turned into more than 28,000 transcribed words. Word counts increased for each site as data collection progressed – this might reflect my familiarity with the processes and my ability to better describe the details surrounding the events or perhaps there were simply more events in the areas that I observed later in the study.

Table 2 contains a summary of these issues and some possible strategies to prevent or address them; these strategies reflect the learning of a novice ethnographer.

TABLE 2. Tips for observation

Elements of observation	Considerations
Preparing to observe	Decide how you will initially position yourself as an observer.
Rehearsing observation	<ul style="list-style-type: none"> » Practise observing and be prepared to modify what you are doing based on this experience. » Use of a co-observer in the early stages could be helpful to ensure data collected are focused on the research question.
What to record and how to record it	<ul style="list-style-type: none"> » Focus or vary your observations as required to address your research question. » Use of a data collection tool and codes for frequently occurring items could assist. » Allow time immediately or soon after the observation period to transcribe your field notes while memories are fresh. » Be prepared for a lot of data.
Achieving a constructive relationship	<ul style="list-style-type: none"> » If possible, start in a familiar site. <ul style="list-style-type: none"> – It might not affect your data collection but you will feel more comfortable. – You can develop your strategies for observation distance and duration, (non)intervention, and responding to interactions. » Be prepared for varying degrees of welcome. » If you are not in a familiar place, spend some time making yourself and your project known. » Where possible and appropriate, contribute in a helpful way.
Influence of the observer	Know that being watched might change how people behave.
Managing interactions	Ensure those being observed are clear about the aims of the research and they do not think they need to compromise patient privacy to accommodate your observations.
Ethical issues	Ensure informed consent and confidentiality.
Staying 'neutral'	<ul style="list-style-type: none"> » Reflect on your observations and record your responses. » A moderation process involving other researchers is useful.

Conclusion

Observation is a fundamental part of ethnography. This paper contains reflections from a novice ethnographer on personal experiences of observation. It provides an

overview of some of the issues that can arise during observation, highlights some of the matters to be considered, and provides strategies that other nurse researchers can use during observation.

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Appendix 2: Data collection template

Ward:

Date:

Nurse: RN/EN

Time:	Who:	Where:
Time:	Who:	Where:
Time:	Who:	Where:
Time:	Who:	Where:

Appendix 3: Focus group scenarios

Scenario 1

Nurse 1, who is holding a syringe, approaches a patient lying in bed and says to the patient "A needle in your leg". The nurse uncovers the patient's thigh, gives a subcutaneous injection into the patient's leg, replaces the bedclothes and leaves the bedside. The patient has English as a second language but appears to understand what is said. Nurse 1 then tells another nurse "I will borrow it from here, it will save me going back down there" and indicates the other end of the ward. Nurse 1 removes some tablets from the medication cupboard for a patient in another room. Later, Nurse 1 returns to the bedside and says to the first patient, "One little tablet", hands a tablet to the patient who swallows it with a drink of water. The nurse then leaves the bedside.

Nurse 2 is talking to a different patient about their medication. The nurse responds to the patient's question about one of the medications "You will have that this evening". The nurse asks the patient about another tablet, "Do you take that now?" The patient replies "Yep". The nurse asks "Is it for depression this one?" The patient nods in reply. Another nurse knocks on door of the room and says to the patient "Good morning, how are, you? I've got some tablets for you" and goes into room. The other nurse shows the patient the packet with the tablets inside, and asks the patient when they usually have them. The patient replies, "I will take them at night, they will last until next week". The nurse then asks the patient if they have any pain, and what they might need to relieve it.

Scenario 2

The medication pump attached to a patient is beeping loudly and he has rung his call bell. The Clinical Services Coordinator (nurse in charge of the ward), Shift Coordinator (nurse coordinating care for the early shift) and other nurses walk past the patient's bed. Ten minutes later Nurse 1 goes to the patient's bedside, and the call bell is turned off. The nurse leaves and the call bell is re-activated shortly after.

After a few minutes one of the patient's visitors finds Nurse 1 and says "Excuse me, it's making the *beep beep beep*, does that mean it's finished?" The nurse replies "Yes". The visitor then says "It's saying something about air". The nurse replies "I will be there in a minute" and walks away down the corridor. The alarm on the pump continues. Nurse 1 comes back and says to the visitor "I will be there in a sec".

A female patient in a room in the ward is crying loudly, "Help us, help us". The door to her room is open. In the corridor near the room are two medical staff laughing loudly with two nurses, and another nurse walks past. Nurse 1 goes to the door of the patient's room, looks inside, goes away to get some tape, comes back, applies gloves and enters the room. The patient is wailing loudly. The nurse closes the door. After a few minutes Nurse 1 leaves the room and says to another nurse "She is happier now. She was very uncomfortable, she was crying". The patient is not crying anymore. Nurse 1 goes to kitchen and returns with an ice block for the patient.

A student nurse and another nurse are in the corridor and hear the alarm from the first patient's room. The nurse says to the student "No hurry for that" and both walk away.

A few minutes later another nurse goes to the first patient, stops the pump alarm, cancels the call bell and disconnects the medication line and leaves. The visitor says "Thank you".

Scenario 3

A patient is being nursed with barrier precautions, therefore anyone who enters the room needs to apply gloves and a protective gown. Nurse 1 knocks on door of this patient's room and asks from the doorway "Hello, how are you? Do you have any pain? I can get you something." The nurse also asks the patient about when they usually take their medications.

The nurse leaves for a short time then returns to outside the patient's room accompanied by another nurse. Nurse 1 puts on gloves and a gown, while the other nurse holds the patient's medication chart. Nurse 1 knocks on the door of the room, enters the room, checks the patient's armband and calls out the patient ID number to the nurse at the door and asks them to confirm when the patient last had this medication. The nurse outside the room confirms the details. The patient is eating their dinner.

Nurse 1 gives the medication via an intravenous port and tells the patient it might hurt. The patient says "I know it stings, I know what to expect." The patient then says to Nurse 1 "That wasn't bad." The nurse replies "Oh good!" The patient says "If you go slow it spreads the pain."

Nurse 1 removes the gown and gloves and moves to leave the room. The patient asks for a drink, and the nurse says "Yes that's fine." Nurse 1 leaves the room and tells the patient "I shall be back." The patient is now connected to a medication pump. Nurse 1 returns and knocks on the open door of the room. The patient walks to the doorway pushing the pump. The nurse hands the patient a tetra pack of juice and leaves the area.

A few minutes later Nurse 1 and a medical officer return to outside of the room. The nurse is documenting on case notes and charts on a cupboard outside the room. Nurse 1 then knocks on the door says to the patient from the doorway "You alright? You will be having an X-ray. I will give you some antiemetic (*something to help with nausea*) before I go at nine. Anything else I can do for you? Just buzz if you need me ok?" Both the nurse and the medical officer then leave the doorway.

Scenario 4

The nurse in charge of the ward is allocating the nursing staff for the morning shift and says “We have transplant patients at the A end of the ward so the babies (referring to junior staff) and all the relievers will work up the B end.”

At the B end, an elderly patient rings their call bell, the bedside rails are up on his bed. The patient puts his legs out of the side of the bed and kicks off the sheet. Two nurses walk past the area and do not respond to the call bell. The patient attempts to climb out of the bed. A person who is walking past intervenes and lowers the bedside rails. The person (who is not a staff member) asks the patient “Are you OK on your feet?” There is no indication at the bedside of the patient’s mobility status. The patient replies, “Yes, but I need my walker, they said they were going to get me Panadol, my toe is painful”. A few minutes later an enrolled nurse brings some Panadol and gives it to the patient.

At the A end the nurse in charge of the ward says to a patient “You can have a wash in bed or a shower later, whatever your heart desires, whatever you want”. The nurse in charge assists the patient to sit up, places a pillow over the patient’s abdomen, and tells them “Whenever you want to cough, hold that”.

The nurse in charge comes out of the room and talks to another nurse, “They are never emotionally ready for coming in well”. The nurse in charge has tears in her eyes. The other nurse asks if the patient is a donor. The nurse in charge replies, “Yes, for his daughter, she got it last night; his wife rang this morning and wanted to talk to him. I said it was pretty early and he was still asleep, she said not to disturb him, I told her the procedure worked beautifully and she broke down, so did I”.

Back at the B end of the ward the elderly patient asks the enrolled nurse “Which ward am I in?” The enrolled nurse tells the patient. The patient asks again, the nurse confirms the ward and the bed number.

A group of six doctors approach the elderly patient’s bed. There are no nursing staff present or within hearing distance. One of the doctors says to the patient “We are going to have to take the toe off,

it's not going to heal, you need surgery, there is no other option". The patient responds, "I was hoping you wouldn't have to.....but I am ready for it". The doctor replies, "At least it's not infected". The patient says, "I might be Lord Hop-along, might I?" The doctor replies "We need to check your veins, the surgeon will see you later". The doctors leave the area.

Appendix 4: Group interview preamble and questions

- Introduce self and observer
- Welcome and thank participants, request consent forms to be signed
- Introduce research study

The overall research project is trying to determine what factors influence the delivery of the Fundamentals of Care in an acute care hospital. The first 2 stages of the study have been completed. Stage one of the study involved direct observation of the interactions between nurses and patients related to the FoC. Stage two involved 3 focus groups, one of level 3 RNs, one of Level 1 RNs and one of consumer representatives. All 3 groups were asked to reflect on 4 patient care scenarios and discuss the factors they felt were influencing the care delivery. There were 5 factors influencing the delivery of the FoC where further exploration might reveal some strategies to promote FoC delivery at the point of care. These include Nursing leadership; The nurse-patient relationship; Involving, ensuring understanding and respecting choices; Communication; and Priorities. When reflecting on these five factors there is one, Nursing Leadership, which has the potential to influence the remaining four. Therefore, this is the factor that is being explored in the final phase of this research.

- Ask each participant to introduce herself and indicate how long they have been in a Level 3 leadership position
- Proceed to questions. Each question will be preceded by the preamble below.

Preamble: Relationships

The nurses in the L1 and L3 focus groups believed that if they know their patients well they can better deliver appropriate care but stated getting to know patients takes time. A relationship based on respect and compassion was also valued by those in the consumer group and can reduce their anxiety.

Q: What can nurse leaders do to promote positive nurse-patient relationships?

Preamble: Communication

Consumers believed communication barriers and a lack of rapport between the nurse and the patient will impact on patient understanding and can also increase anxiety. The Level 1 RN group agreed and suggested if there was clear, two-way communication between the nurse and the patient this will facilitate knowing the patient and ensuring they are kept informed. The Level 3 RN group described specific skills as core requirements for nurses to encourage positive interactions. These included being able to effectively communicate with patients and their families, and having the necessary knowledge about what care is being delivered and why it is required.

Q: What kinds of things do you do as a nurse leader to promote effective nurse-patient communication?

Preamble: Respecting choices (Involving, ensuring understanding and respecting choices)

In the consumer group, they wanted nurses to know them and what is needed for them. They also wanted to be kept informed about their care to feel some control over their bodies. The Level 1 RN group valued involving patients by keeping them informed as well as engaging with them to ensure they understand what is happening. Constant checking with the patient, for example about their medication needs, is a way to engage with them and assess their understanding, but this can be interpreted by the patient as the nurse not knowing what is required, and therefore provoke patient anxiety.

Q: What strategies do you use to help nurses keep patients involved in their care and ensure their choices are respected, without provoking anxiety?

Preamble: Priorities

The Level 3 RN group considered patients care needs should, and can be, addressed by any nurse, however they acknowledged that some nurses do not feel responsible for patients they have not been directly allocated to care for. The Level 1 RN group was aware that patient perceptions of their own care priorities might differ from the nurses' perspective. The Consumer group also recognised that nurses

and patients might have different care priorities, but they believed the patient's needs and wants must take precedence.

Q: What suggestions would you as a leader give to nurses who are new to your area for how to prioritise patient care?

Preamble: Nursing Leadership

All three groups highlighted the importance of the nursing leadership in the area where the care is being delivered.

Q: What advice would you give to a new CSC around delivery of high quality patient-centred fundamentals of care, taking into consideration the resource constraints?

Additional question asked spontaneously at the end of the group interview

Q. Do you think in ten years' time or fifteen years' time the nurses and the CSCs will actually be responsible for fundamental care?

- Ask for any further comments or suggestions
- Thank participants and ask if they would like to be kept informed about the results of the study
- Close interview

Appendix 5: Patient information sheet - Observation (Stage 1)

Factors influencing nurses' delivery of the Fundamentals of Care.

The care that nurses deliver to patients in this ward is being observed as part of a research study. Your name will not be recorded. Tiffany Conroy, as part of her PhD candidature, is conducting this research. Tiffany is a Registered Nurse and a lecturer at the University of Adelaide.

If you do not want Tiffany to observe your care you should tell the nurse caring for you. If you change your mind at any stage you should tell the nurse and no more observations will be made.

The research has been approved by the Royal Adelaide Hospital Research Ethics Committee. If you would like any further information, have any concerns or would like to discuss this research in more detail please use any of the contact details below. You may also contact the Chairperson, Research Ethics Committee, Royal Adelaide Hospital on 8222 4139.

If you require further copies of this information sheet, please ask me. Thank you for taking the time to read this and for considering being part of the study.

Yours sincerely

Tiffany Conroy

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Appendix 6: Nurse information sheet - Observation (Stage 1)

Factors influencing nurses' delivery of the Fundamentals of Care.

The purpose of this information sheet is to explain the study you are being asked to participate in. The Fundamentals of Care or 'basics' of nursing care include but are not limited to ensuring appropriate nutrition, hydration, personal hygiene, sleep, rest and dignity.

Tiffany Conroy, as part of her PhD candidature, is conducting this research. Tiffany is a Registered Nurse and a lecturer at the University of Adelaide.

The overall research project is being conducted to determine what factors influence the delivery of the Fundamentals of Care in an acute care hospital.

The Royal Adelaide Research Ethics Committee and the Director of Nursing, Ms. Dianne Rogowski, have approved this study. This research will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research

This stage of the study aims to observe examples of the delivery of the Fundamentals of Care and the interactions that occur related to this care between patients and nurses. These observed interactions will then be used to write scenarios that will be used in the second stage of the project to ask patients and nurses to describe what they think about them.

Your participation in the study involves allowing me to observe you delivering care to your patients if you are on duty during one of the observation periods occurring in your ward. I may also ask you to comment on what I am observing. Although I have been granted permission to observe care in your ward, you are free to choose not to be observed. Your participation in the study is entirely voluntary and you may opt out at any time. Your decision to participate or not will remain confidential and will have no effect on your employment. Also, you may withdraw from the study at any time after it has commenced.

The possible benefits of the study are a better understanding of what things help or hinder the delivery of the Fundamentals of Care. The next stage of the research, as mentioned above, will be asking for volunteers to participate in focus groups and interviews to explore the scenarios developed from these observations. If you are interested in participating in either a focus group or interview, please contact me.

This research will be published as part of a PhD thesis and may be published in journals and presented at conferences, however there will be no release of any information that could identify individual nurses and patients. All data will be securely stored and only the researchers will have access.

If you would like any further information, have any concerns or would like to discuss this research in more detail please contact my supervisor, or the University of Adelaide Human Research Ethics Committee or me. Contact details are included below. If you wish to speak to someone not directly involved in the study about your rights as a volunteer, or about the conduct of the study, you may also contact the Chairperson, Research Ethics Committee, Royal Adelaide Hospital on 8222 4139.

If you require further copies of this information sheet, please ask me.

Thank you for taking the time to read this and for considering being part of the study.

Yours sincerely

Tiffany Conroy

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Appendix 7: Research in progress poster

The Fundamentals of Care study is currently in progress

If you have not been made aware of this study, please

contact Tiffany Conroy

Email: tiffany.conroy@adelaide.edu.au Phone: 8313 6290



Appendix 8: Nurse information sheet - Focus group (Stage 2)

Factors influencing nurses' delivery of the Fundamentals of Care.

The purpose of this information sheet is to explain the study you are being asked to participate in. The Fundamentals of Care or 'basics' of nursing care include but are not limited to ensuring appropriate nutrition, hydration, personal hygiene, sleep, rest and dignity.

Tiffany Conroy, as part of her PhD candidature, is conducting this research. Tiffany is a Registered Nurse and a lecturer at the University of Adelaide. The overall research project is trying to determine what factors influence the delivery of the Fundamentals of Care in an acute care hospital.

This stage of the study involves focus groups of Registered Nurses working in acute inpatient areas in the Royal Adelaide Hospital to review and comment on written scenarios of examples of care delivery related to the Fundamentals of Care and the interactions that may have occurred between patients and nurses. Volunteers will only need to attend one focus group. The focus groups will run for approximately one and a half hours and will be scheduled at a time that is convenient for volunteers. The focus groups will be recorded with a digital voice recorder.

Your participation is entirely voluntary and you may opt out of the focus group at any time. If you choose not to participate you may do so without any effect on your employment. Your decision not to participate will remain confidential. Also, you may withdraw from the focus group at any time after it has commenced. This research will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research. The possible benefits of the study are a better understanding of what things help or hinder the delivery of basic nursing care.

This research may be published and presented at conferences, however there will be no release of any information that could identify you. All information will be securely stored and only the researchers will have access.

If you would like any further information, have any concerns or would like to discuss this research in more detail please contact my supervisor, or the University of Adelaide Human Research Ethics Committee or me. Our contact details are included below. If you wish to speak to someone not directly involved in the study about your rights as a volunteer, or about the conduct of the study, you may also contact the Chairperson, Research Ethics Committee, Royal Adelaide Hospital on 8222 4139. If you require further copies of this information sheet, please ask me.

The next stage of the research will be asking for volunteers to participate in interviews to explore the scenarios in more detail. If you are interested in participating in the interviews, please contact me. Participants in the study may choose to be involved in either the focus groups and the interviews or both.

Thank you for taking the time to read this and for considering being part of the study.

Yours sincerely

Tiffany Conroy

Contacts

Tiffany Conroy PhD candidate School of Nursing University of Adelaide telephone: 8313 6290, mobile: 0437 844 213 email: tiffany.conroy@adelaide.edu.au	Principal Supervisor Professor Alison Kitson Head of School of Nursing University of Adelaide telephone: 8313 3595 email: alison.kitson@adelaide.edu.au	Human Research Ethics Committee Research Branch The University of Adelaide telephone: 8313 5137 facsimile: 8313 7325 email: rb@adelaide.edu.au
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Appendix 9: Consent form - Focus group (Stage 2)

CONSENT FORM

1. I have read the attached Information Sheet and agree to take part in the following research project:

Title:	<u>Factors influencing nurses' delivery of the Fundamentals of Care</u>
Ethics Approval	RAH 130618
Number:	

2. I have had the project, so far as it affects me, fully explained to my satisfaction by the research worker. My consent is given freely.
3. I have been given the opportunity to have a member of my family or a friend present while the project was explained to me.
4. Although I understand the purpose of the research project it has also been explained that involvement may not be of any benefit to me.
5. I have been informed that, while information gained during the study may be published, I will not be identified and my personal results will not be divulged.
6. I understand that I am free to withdraw from the project at any time.
7. I agree to the interview being audio/video recorded. Yes No
8. I am aware that I should keep a copy of this Consent Form, when completed, and the attached Information Sheet.

Participant to complete:

Name: _____ Signature: _____ Date: _____

Researcher/Witness to complete:

I have described the nature of the research to

(print name of participant)

and in my opinion she/he understood the explanation.

Signature: _____ Position: _____ Date: _____

Appendix 10: Consumer information sheet - Focus group (Stage 2)

Factors influencing nurses' delivery of the Fundamentals of Care.

The purpose of this information sheet is to explain the study you are being asked to participate in. The Fundamentals of Care or 'basics' of nursing care include but are not limited to ensuring appropriate nutrition, hydration, personal hygiene, sleep, rest and dignity.

Tiffany Conroy, as part of her PhD candidature, is conducting this research. Tiffany is a Registered Nurse and a lecturer at the University of Adelaide.

The overall research project is trying to determine what factors influence the delivery of the Fundamentals of Care in an acute care hospital.

This stage of the study aims to conduct a focus group of Consumer Advisory Council representatives to review and comment on written scenarios of examples of care delivery related to the Fundamentals of Care and the interactions that may have occurred between patients and nurses. The focus group will run for approximately one and a half hours and will be scheduled at a time that is convenient for volunteers. The focus groups will be recorded with a digital voice recorder. Representatives for the group would ideally have had experience of hospitalisation within the previous 12 months, however this is not essential.

Your participation is entirely voluntary and you may opt out of the focus group at any time. If you choose not to participate you may do so without any effect on your current or future medical care. Your decision not to participate will remain confidential. Also, you may withdraw from the focus group at any time after it has commenced. This research will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research.

The possible benefits of the study are a better understanding of what things help or hinder the delivery of basic nursing care, however this is not guaranteed.

This research may be published and presented at conferences, however there will be no release of any information that could identify you. All information will be securely stored and only the researchers will have access.

If you would like any further information, have any concerns or would like to discuss this research in more detail please contact my supervisor, or the University of Adelaide Human Research Ethics Committee or me. Our contact details are included below. If you wish to speak to someone not directly involved in the study about your rights as a volunteer, or about the conduct of the study, you may also contact the Chairperson, Research Ethics Committee, Royal Adelaide Hospital on 8222 4139.

If you require further copies of this information sheet, please ask me.

Thank you for taking the time to read this and for considering being part of the study.

Yours sincerely

Tiffany Conroy

Contacts

Tiffany Conroy PhD candidate School of Nursing University of Adelaide telephone: 8313 6290, mobile: 0437 844 213 email: tiffany.conroy@adelaide.edu.au	Principal Supervisor Professor Alison Kitson Head of School of Nursing University of Adelaide telephone: 8313 3595 email: alison.kitson@adelaide.edu.au	Human Research Ethics Committee Research Branch The University of Adelaide telephone: 8313 5137 facsimile: 8313 7325 email: rb@adelaide.edu.au
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Appendix 11: Participant information sheet - Group Interview (Stage 3)

Factors influencing nurses' delivery of the Fundamentals of Care.

The purpose of this information sheet is to explain the study you are being asked to participate in. The Fundamentals of Care or "basics" of nursing care include, but are not limited to, ensuring appropriate nutrition, hydration, personal hygiene, sleep, rest and dignity.

Tiffany Conroy, as part of her PhD candidature, is conducting this research. Tiffany is a Registered Nurse and a lecturer at the University of Adelaide.

The overall research project is trying to determine what factors influence the delivery of the Fundamentals of Care in an acute care hospital.

This stage of the study aims to conduct an interview with Registered Nurses working in leadership positions in the Royal Adelaide Hospital. The interviews will run for approximately one hour and will be scheduled at a time that is convenient for volunteers. The interviews will be recorded with a digital voice recorder.

This research will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research. Your participation is entirely voluntary and you may opt out of the interview at any time. If you choose not to participate you may do so without any effect on your employment. Your decision not to participate will remain confidential. Also, you may withdraw from the interview at any time after it has commenced.

The possible benefits of the study are a better understanding of what things help or hinder the delivery of basic nursing care.

This research may be published and presented at conferences, however there will be no release of any information that could identify you. All data will be securely stored and only the researchers will have access.

If you would like any further information, have any concerns or would like to discuss this research in more detail please contact my supervisor, or the University of Adelaide Human Research Ethics Committee or me. Contact details are included below. If you wish to speak to someone not directly involved in the study about your rights as a volunteer, or about the conduct of the study, you may also contact the Chairperson, Research Ethics Committee, Royal Adelaide Hospital on 8222 4139.

If you require further copies of this information sheet, please ask me.

Thank you for taking the time to read this and for considering being part of the study.

Yours sincerely

Tiffany Conroy

Contacts

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Appendix 12: Consent form -Group interview (Stage 3)

Consent Form: Interview

PROTOCOL NAME:

Factors influencing nurses' delivery of the Fundamentals of Care in the acute hospital setting

INVESTIGATOR: Tiffany Conroy, PhD candidate:

SUPERVISORS: Professor Alison Kitson, Professor Alison Tierney, Dr Kate Cameron

1. The nature and purpose of the research project has been explained to me. I understand it, and agree to take part.
2. I understand that I will not benefit from taking part in the study.
3. I agree to the interview being recorded by the researcher.
4. I understand that, while information gained during the study may be published, I will not be identified and my personal information will remain confidential.
5. I understand that I can withdraw from the study at any stage.
6. I have had the opportunity to discuss taking part in this investigation with a family member or friend.

Name of Subject: _____

Signed: _____ Dated: _____

I certify that I have explained the study to the volunteer and consider that he/she understands what is involved.


Signed: _____

Date: _____

Appendix 13: (Conroy 2018)

Conroy T (2018): Factors influencing the delivery of the fundamentals of care: Perceptions of nurses, nursing leaders and healthcare consumers. *Journal of Clinical Nursing*.(epub ahead of print, DOI 10.1111/jocn.14183

Factors influencing the delivery of the fundamentals of care: Perceptions of nurses, nursing leaders and healthcare consumers

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Funding information

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Aims and objectives: To explore the factors described by nurses and consumer representatives influencing the delivery of the fundamentals of care.

Background: An ongoing challenge facing nursing is ensuring the "basics" or fundamentals of care are delivered optimally. The way nurses and patients perceive the delivery of the fundamentals of care had not been explored. Once identified, the factors that promote the delivery of the fundamentals of care may be facilitated.

Design: Inductive content analysis of scenario based focus groups.

Methods: A qualitative approach was taken using three stages, including direct observation, focus groups and interviews. This paper reports the second stage. Focus groups discussed four patient care scenarios derived from the observational data. Focus groups were conducted separately for registered nurses, nurses in leadership roles and consumer representatives. Content analysis was used.

Results: The analysis of the focus group data resulted in three themes: Organisational factors; Individual nurse or patient factors; and Interpersonal factors. Organisational factors include nursing leadership, the context of care delivery and the availability of time. Individual nurse and patient factors include the specific care needs of the patient and the individual nurse and patient characteristics. Interpersonal factors include the nurse-patient relationship; involving the patient in their care, ensuring understanding and respecting choices; communication; and setting care priorities.

Conclusions: Seeking the perspective of the people involved in delivering and receiving the fundamentals of care showed a shared understanding of the factors influencing the delivery of the fundamentals of care. The influence of nursing leadership and the quality of the nurse-patient relationship were perceived as important factors.

Relevance to clinical practice: Nurses and consumers share a common perspective of the factors influencing the delivery of the fundamentals of care and both value a therapeutic nurse-patient relationship. Clinical nursing leaders must understand the impact of their role in shaping the delivery of the fundamentals of care.

KEYWORDS

consumers, focus groups, leadership, nurse-patient relationship, nursing care, qualitative study

1 | INTRODUCTION

Evidence from patients, the public and nurses themselves suggests the nursing profession has not been able to provide quality basic nursing as consistently or adequately as needed (Maben, Comwell, & Sweeney, 2010; The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013). Healthcare reports suggest that failure to ensure these aspects of basic care are provided might lead to wider patient safety issues and, in some cases, mortalities (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013).

The fundamentals of care (Kitson, Conroy, Kulski, Locock, & Lyons, 2013), presented in a framework developed for "basic nursing," include ensuring appropriate nutrition, hydration, personal hygiene, sleep, rest and dignity, to name a few. These care activities have traditionally been the responsibility of the nurse on behalf of the healthcare team. This study sought to explore the factors that were thought to influence the delivery of the fundamentals of care as perceived by three stakeholder groups, registered nurses (RNs), clinical nursing leaders and consumers. Identifying these factors could enable any inhibiting factors to be addressed, thus ultimately improving patient experiences and outcomes.

2 | BACKGROUND

Health care is constantly engaged in balancing the need to provide safe and affordable health care with a service that protects and respects the individual patient and their family. As the largest group of healthcare professionals globally, nursing has a central role to play in this balancing act (Institute of Medicine, 2011). As demonstrated in many publications and policy documents, nursing is committed to and involved in the patient-centred care agenda (Kitson, Marshall, Bassett, & Zeitz, 2013). However, what also comes to light is the ongoing challenge facing the nursing profession in ensuring that the "basics" or, to use other terminology, the fundamentals of care are carried out optimally (Ham, Dixon, & Brooke, 2012; Maben et al., 2010, Prime Minister's Commission on the Future of Nursing and Midwifery in England, 2010).

A meta-narrative review was undertaken to explore the fundamentals of care by Kitson, Conroy, Wengstrom, Profetto-McGrath, and Robertson-Malt (2010). This review aimed to establish a common language for the fundamentals of care and included seminal texts relating to nursing practice. The results of this investigation were then discussed at an international meeting of nurse leaders, health policy and healthcare researchers and clinicians in Oxford, United Kingdom, in 2012. This resulted in the development of the Fundamentals of Care Framework (Kitson et al., 2013). The framework comprises three core dimensions: the relationship between the nurse and the patient; the way the nurse and the patient negotiate and integrate the actual delivery 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.

What does this paper contribute to the wider global clinical community?

- The findings of this study highlight the shared understanding between nurses and consumer representatives of the factors influencing the delivery of the fundamental of care.
- The influence of nursing leadership on many factors influencing the delivery of the fundamentals of care must be recognised and strategies are required to support these leaders.
- Nurses and consumers of health care value therapeutic nurse-patient relationships, and healthcare organisations must facilitate and evaluate the development of these relationships.

The first of these dimensions was explored by (Bridges et al., 2013) who published a meta-ethnography in 2012 which included 16 studies investigating acute care nurses' experiences of the nurse-patient relationship. The findings from this study illustrated that nurses were feeling overwhelmed and not able to deliver the care they want to and that they feel their patients need. The nurse-patient relationship was further explored by Feo, Conroy, Marshall, Rasmussen, and Kitson (2017) using a holistic interpretive synthesis of both experiential and empirical data. This was a novel approach to integrate evidence from systematic reviews with evidence from experts in the form of consensus statements, to generate actions to influence practice. An extensive list of recommendations was generated in this work, each related to one or more of five relational elements; namely the importance of establishing trust; being able to focus on the individual needs of the patient; anticipating new needs; knowing the patient and their family well enough to make the right care decisions; and evaluating the encounter from both the patient and nurse's perspective (Feo et al., 2017).

The second dimension of the Fundamentals of Care Framework, the way the nurse and the patient negotiate and integrate the provision of the fundamentals of care, had not been explored in such depth. There are existing data relating to patient experiences regarding the delivery of the fundamentals of care in several clinical specialties, for example abdominal pain (Jangland, Kitson, & Muntlin Athlin, 2016) and stroke (Kitson, Dow, Calabrese, Locock, & Muntlin Athlin, 2013). However, the focus of the interviews from which the data were collected in these studies was not explicitly the fundamentals of care, rather the entire experience of the care provided throughout the patient's diagnosis and treatment. Using descriptions of real-time observations of similar interactions may assist in validating and expanding the insights into the delivery of the fundamentals of care.

The third core dimension of the Fundamentals of Care Framework, the system requirements needed to facilitate the development of the relationship and improve care delivery, were identified from

the literature as co-worker support, the work group and organisational climate, supervisor and organisational support, unit-level leadership, the work environment and staffing levels (Bridges et al., 2013; Hall, McCutcheon, Deuter, & Matriciani, 2012). A focus on a patient-centred care approach and new ways of thinking about process, systems and workflow design has been recommended (Hall et al., 2012).

Given that research has indicated patients and nurses can have different perspectives and expectations of care (Zeitz et al., 2011), the aim of this stage of the research was to investigate the factors that may influence delivery of the fundamentals of care from the perspective of healthcare consumer representatives and nurses, determine if the factors they suggest are congruent, and explore if any of the factors described may be more influential than others. Once identified, those factors that promote the delivery of the fundamentals of care may be encouraged and those that inhibit delivery be, where possible, amended.

3 | METHODS AND DESIGN

A qualitative interpretative approach was used to elicit information about the factors influencing nurses' delivery of the fundamentals of care. This study was undertaken through a PhD candidature and conducted using three stages. The first stage involved direct observation of the fundamentals of care; the second stage involved generation of scenarios based on typical fundamental care delivery observed in stage one, and the conduct of focus groups using these scenarios as a way of engaging stakeholders. The third stage undertook further exploration of the findings using interviews with nursing leaders. This paper describes the second stage of the overall research study.

Three focus groups, one each for RNs, nurses in leadership roles and healthcare consumer representatives, were held in April 2016. Data were audiorecorded, transcribed verbatim and analysed using

inductive content analysis (Elo & Kyngas, 2008). The participants in each focus group were presented with four scenarios based on 40 hr of direct nonparticipant observations of actual care provision, across four different ward areas in the healthcare facility. These observations occurred during the first stage of this research (see Conroy (2017)). These scenarios were used to encourage the participants to draw on their own experiences to explore the factors they felt were influencing the care described in the scenario (Jenkins, Bloor, Fischer, Berney, & Neale, 2010). Scenarios were based on frequently observed situations. The relevance and realism of scenarios are seen as important by Hughes and Huby (2004) as these authors consider scenarios to be more effective when they engage the participants' interest, are relevant and appear realistic. Using the de-identified real-life examples from the observation data promoted the internal validity of the scenarios (Hughes and Huby, 2004). The scenarios (Boxes 1–4) were piloted with two external healthcare consumers and two RNs who were not included in the research participants, to evaluate their clarity and to gain an estimate of the time required for the relevant questions to be explored. The scenarios were then used to elicit data about the focus group participants' perceptions and experiences. The participants were asked to comment on each scenario about what they thought was happening, what the patient(s) needs were and what could be influencing the nursing care. The aim was not to reach consensus about the issues that were discussed, but to obtain data relating to a variety of views and experiences (Kvale & Brinkmann, 2009). Participants were not asked to comment about the perceived quality of the care in each scenario.

A brief description of each scenario follows. Scenario 1 describes the story of two patients: a patient with a non-English-speaking background receiving their medication from a nurse who "borrows" medication from another patient's supply, and another patient who has a different nurse administering their medication while asking the patient when it should be given, what it is for and how the patient prefers to take it. Scenario 2 describes a visitor looking for a nurse to attend to a medication pump that has the alarm sounding, while

BOX 1 Scenario 1

Nurse 1, who is holding a syringe, approaches a patient lying in bed and says to the patient "A needle in your leg". The nurse uncovers the patient's thigh, gives a subcutaneous injection into the patient's leg, replaces the bedclothes and leaves the bedside. The patient has English as a second language but appears to understand what is said. Nurse 1 then tells another nurse "I will borrow it from here, it will save me going back down there" and indicates the other end of the ward. Nurse 1 removes some tablets from the medication cupboard for a patient in another room. Later Nurse 1 returns to the bedside and says to the first patient, "One little tablet", hands a tablet to the patient who swallows it with a drink of water. The nurse then leaves the bedside.

Nurse 2 is talking to a different patient about their medication. The nurse responds to the patient's question about one of the medications "You will have that this evening". The nurse asks the patient about another tablet, "Do you take that now?" The patient replies "Yep". The nurse asks "Is it for depression this one?" The patient nods in reply. Another nurse knocks on door of the room and says to the patient "Good morning, how are, you? I've got some tablets for you" and goes into room. The other nurse shows the patient the packet with the tablets inside, and asks the patient when they usually have them. The patient replies, "I will take them at night, they will last until next week". The nurse then asks the patient if they have any pain, and what they might need to relieve it.

BOX 2 Scenario 2

The medication pump attached to a patient is beeping loudly and he has rung his call bell. The Clinical Services Coordinator (nurse in charge of the ward), Shift Coordinator (nurse coordinating care for the early shift) and other nurses walk past the patient's bed. Ten minutes later Nurse 1 goes to the patient's bedside, and the call bell is turned off. The nurse leaves and the call bell is re activated shortly after.

After a few minutes one of the patient's visitors finds Nurse 1 and says "Excuse me, it's making the beep beep beep, does that mean it's finished?" The nurse replies "Yes". The visitor then says "It's saying something about air". The nurse replies "I will be there in a minute" and walks away down the corridor. The alarm on the pump continues. Nurse 1 comes back and says to the visitor "I will be there in a sec".

A female patient in a room in the ward is crying loudly, "Help us, help us". The door to her room is open. In the corridor near the room are two medical staff laughing loudly with two nurses, and another nurse walks past. Nurse 1 goes to the door of the patient's room, looks inside, goes away to get some tape, comes back, applies gloves and enters the room. The patient is wailing loudly. The nurse closes the door. After a few minutes Nurse 1 leaves the room and says to another nurse "She is happier now. She was very uncomfortable, she was crying". The patient is not crying anymore. Nurse 1 goes to kitchen and returns with an ice block for the patient.

A student nurse and another nurse are in the corridor and hear the alarm from the first patient's room. The nurse says to the student "No hurry for that" and both walk away.

A few minutes later another nurse goes to the first patient, stops the pump alarm, cancels the call bell and disconnects the medication line and leaves. The visitor says "Thank you".

another patient is calling for help from their room. While this is happening medical and nursing staff are laughing about an unrelated matter in the corridor and several staff walk past the rooms where the patient is crying and where the pump is alarming. Scenario 3 describes a patient being barrier nursed in a single room and their feedback to a nurse administering an intravenous medication. Scenario 4 describes the nursing skill mix and allocation and medical interactions with two patients, one with a long-term chronic condition and one who is a tissue donor.

The original purpose for the focus groups was to elicit participants' responses to the four individual scenarios that were presented

BOX 3 Scenario 3

A patient is being nursed with barrier precautions therefore anyone who enters the room needs to apply gloves and a protective gown.

Nurse 1 knocks on door of this patients room and asks from the doorway "Hello, how are you? Do you have any pain? I can get you something." The nurse also asks the patient about when they usually take their medications.

The nurse leaves for a short time then returns to outside the patient's room accompanied by another nurse. Nurse 1 puts on gloves and a gown, while the other nurse holds the patients medication chart. Nurse 1 knocks on the door of the room, enters the room, checks the patient's armband and calls out the patient ID number to the nurse at the door and asks them to confirm when the patient last had this medication. The nurse outside the room confirms the details. The patient is eating their dinner.

Nurse 1 gives the medication via an intravenous port and tells the patient it might hurt. The patient says "I know it stings, I know what to expect." The patient then says to Nurse 1 "That wasn't bad." The nurse replies "Oh good! The patient says "If you go slow it spreads the pain."

Nurse 1 removes the gown and gloves and moves to leave the room. The patient asks for a drink, and the nurse says "Yes that's fine." Nurse 1 leaves the room and tells the patient "I shall be back." The patient is now connected to a medication pump. Nurse 1 returns and knocks on the open door of the room. The patient walks to the doorway pushing the pump. The nurse hands the patient a tetra pack of juice and leaves the area.

A few minutes later Nurse 1 and a medical officer return to outside of the room. The nurse is documenting on case notes and charts on a cupboard outside room. Nurse 1 then knocks on the door says to the patient from the doorway "You alright? You will be having an X-ray. I will give you some antiemetic (something to help with nausea) before I go at nine. Anything else I can do for you? Just buzz if you need me ok?" Both the nurse and the medical officer then leave the doorway.

(i.e., what they thought was happening in the scenario and what they thought might have influenced the care delivery). It could be argued that different scenarios may have elicited different responses. However, once the participants read the scenarios, their discussion not only related these scenarios, but also routinely incorporated their own personal reflections and experiences of care delivery. Thus, the scenarios acted as a prompt to elicit focus group participant explanations for why the care delivery issues in the scenarios, and indeed any care delivery issues, might occur. The resultant discussion within

BOX 4 Scenario 4

The nurse in charge of the ward is allocating the nursing staff for the morning shift and says "We have transplant patients at the A end of the ward so the babies (referring to junior staff) and all the relievers will work up the B end."

At the B end, an elderly patient rings their call bell, the bedside rails are up on his bed. The patient puts his legs out of the side of the bed and kicks off the sheet. Two nurses walk past the area and do not respond to call bell. The patient attempts to climb out of the bed. A person who is walking past intervenes and lowers bedside rails. The person (who is not a staff member) asks the patient "Are you OK on your feet?" There is no indication at the bedside of the patient's mobility status. The patient replies, "Yes, but I need my walker, they said they were going to get me panadol, my toe is painful". A few minutes later an enrolled nurse brings some panadol and gives it to the patient.

At the A end the nurse in charge of the ward says to a patient "You can have a wash in bed or a shower later, whatever your heart desires, whatever you want". The nurse in charge assists the patient to sit up, places a pillow over the patient's abdomen, and tells them "Whenever you want to cough, hold that".

The nurse in charge comes out of the room and talks to another nurse, "They are never emotionally ready for coming in well". The nurse in charge has tears in her eyes. The other nurse asks if the patient is a donor. The nurse in charge replies, "Yes, for his daughter, she got it last night; his wife rang this morning and wanted to talk to him. I said it was pretty early and he was still asleep, she said not to disturb him, I told her the procedure worked beautifully and she broke down, so did I".

Back at the B end of the ward the elderly patient asks the enrolled nurse "Which ward am I in?" The enrolled nurse tells the patient. The patient asks again, the nurse confirms the ward and the bed number.

A group of six doctors approach the elderly patient's bed. There are no nursing staff present or within hearing distance. One of the doctors says to the patient "We are going to have to take the toe off, it's not going to heal, you need surgery, there is no other option". The patient responds "I was hoping you wouldn't have to...but I am ready for it". The doctor replies, "At least it's not infected". The patient says, "I might be Lord Hop-along, might I?" The doctor replies "We need to check your veins, the surgeon will see you later". The doctors leave the area.

the focus groups provided further insight into potential factors influencing care delivery as participants explored alternative explanations.

3.1 | Data collection**3.1.1 | Setting**

The study setting was a 650-bed metropolitan tertiary hospital in South Australia. The focus groups were held in a quiet private meeting room adjacent to the hospital. Participants either worked at the hospital as Level 1 or Level 3 RNs, or attended meetings as members of the Consumer Advisory Council. Level 1 RNs typically directly deliver nursing care to their allocated patients or delegate the care to another healthcare worker while remaining accountable for that care. A Level 3 RN is a clinical nursing leader who oversees the care delivery for an entire ward or unit. Consumer Advisory Council members are individuals from the community with direct experience of the services of the healthcare facility, either as a patient, family member or carer. Consumer representatives were selected in preference to inpatients in the facility for several reasons. While current inpatients would have recent experience of the delivery of the fundamentals of care, literature suggests patient representatives are able to draw on a wider range of experiences, provide different perspectives, are less influenced by perceived power imbalances with healthcare professionals and have established communication skills (Baillie, Lankshear, & Featherstone, 2011; De Wit et al., 2011; Van Wersch & Eccles, 2001). The groups were held separately to encourage open and frank discussion.

Participants were offered light refreshments. The focus group facilitator (author) who asked the questions, and an observer were present at each session. The duration of the focus groups was between 60–90 min.

3.1.2 | Sampling

All participants responded to a call for volunteers. Every volunteer had the opportunity to attend a focus group; thus, no volunteers were excluded. The call for nursing volunteers was disseminated via email, forwarded by the Nursing Directors of the hospital to the inpatient areas they oversee. Consumer representatives were asked to participate via the hospital's Consumer Experience Manager. A minimum of two focus groups for each type of participant were anticipated; however, due to a lack of volunteers, three focus groups were conducted: one for members of the Consumer Advisory Council ($n = 4$), one for Level 1 RNs ($n = 7$) and one for Level 3 RNs ($n = 7$). See Table 1 for participant details.

Each focus group was audiorecorded and transcribed. Transcription was conducted by an experienced external commercial confidential service.

3.1.3 | Ethics

The study was approved by the Human Research Ethics Committees of the healthcare facility and the University where the author is

TABLE 1 Participant characteristics

Focus group participants	n	Experience in the role
Consumer representatives	4	3 as a patient and a carer/family member, 1 as a carer/family member
Level 1 registered nurses	7	5 months to 15 years
Level 3 registered nurses	7	1.5–12 years

undertaking their PhD candidature and also by the Executive Director of Nursing for the hospital. A participant information sheet was supplied to every potential volunteer. Written consent was obtained from all participants prior to commencing the focus groups. Assurances were given that participation would have no effect on employment or future care. Participants were advised they could withdraw from the focus group at any time. However, they were also advised that data collected to the point of withdrawal would still be included because of the complexities of identifying and removing one voice from a focus group recording (Trajkovski, Schmied, Vickers, & Jackson, 2012). Focus group participants were assured that while information gained during the study may be published, they would not be identified and no personal results would be divulged. For this reason, direct quotes presented in this paper are not ascribed to individual contributors and exchanges between focus group participants are presented as Speaker 1, Speaker 2, etc., identifying the order in which the exchange took place.

3.2 | Data analysis

3.2.1 | Overview of data analysis stages

Inductive content analysis was used to analyse the data (Elo et al., 2014). The first stage of inductive content analysis was to choose the unit of analysis and then to code the data. The codes were then grouped into subcategories as a way of describing their meaning. The subcategories were then further abstracted into generic categories and ultimately into main categories. The aim of the categorisation was to describe the phenomena under investigation (Elo & Kyngas, 2008). The main categories were then grouped as themes. Each stage is explained in more detail below.

The unit of analysis was the individual focus group participant's statement, or a discussion between participants, that expressed any opinion or reflections on any factor that may influence the delivery of the fundamentals of care. This may have been in the form of a single sentence or a brief paragraph from the transcript. Therefore, the selection of the statements to be coded were focused on those that addressed the research questions. This is consistent with the literature relating to content analysis, which highlights the need to limit the data extracted and coded to the research question (Elo & Kyngas, 2008).

Each focus group transcript was coded separately. A decision was made not to fragment the data into the individual scenarios or to the individual questions asked by facilitator, as it would have been difficult to determine which of the participants' comments were directly related to the individual scenarios, and which drew on their past experiences or reflections. Thus, each of the focus group

transcripts was analysed as a single source (Europe & Tyni-Lenne, 2004). The findings from each of the three focus groups were combined in the third stage of the analysis.

3.2.2 | Coding the transcripts

An inductive method was used for coding the focus group data. Open coding was employed, where descriptions are written in the margins of the transcript to describe the statements made by the focus group participants (Elo & Kyngas, 2008). This can also be considered as latent coding (Russell Bernard & Ryan, 2010) as it involves interpretation and reading for meaning, as well as taking the context into account. Statements were assigned more than one code if multiple influences on care delivery were mentioned.

3.2.3 | Developing subcategories for the codes

Subcategories are where similar descriptive codes were grouped and an overarching description for them developed. Subcategories were created with the purpose of describing the codes (Elo & Kyngas, 2008). Each descriptive code was allocated to a single subcategory.

3.2.4 | Creating categories and main heading

The next step in the analysis was to abstract the subcategories and group them based on similarity. Subcategories were grouped into generic categories and the generic categories then grouped into main categories with the abstraction continuing "as far as reasonable and possible" (Archibald, 2006; Elo & Kyngas, 2008).

To obtain a holistic and descriptive view of the factors influencing the delivery of the fundamentals of care described by the consumer representatives and both nursing groups, the final stage of the data analysis was then to compare the main categories that had been created for each of the three groups. When considering the generic categories from the three groups, there were many similarities in the factors the three groups were describing. However, it became clear there were inconsistencies between the three data sources with how some generic categories had been allocated to main categories. The co-allocation for the generic categories based on similarity in meaning was reasonable for the individual focus groups but did not align with how similar generic categories had been allocated to main categories in the other groups. For example, the influence of the different care priorities perceived by patients and nurses was described by consumer representatives and nurses; however, the main categories this factor was allocated to differed across the groups. This may demonstrate how data from each focus group were analysed individually, without a predetermined position about the possible influencing factors. This lack of consistency though, made developing a cohesive, narrative description of the factors influencing the delivery of the fundamentals of care, challenging.

The solution was to "unpack" the main categories and use all the generic categories from the three focus groups to create new combined main categories. Table 2 shows how the generic categories for each focus group were aggregated to each of the main categories.

TABLE 2 Aggregation of all three focus groups generic categories

Combined main categories	Generic categories	Level 1 RN	Level 3 RN
Nursing leadership	Consumers	Impact of leadership	Influence of Leadership—organisational culture
The context of care delivery	Leaders as role models	Context of care, routines	Contextual influences of the care environment
	Influence of workload, shift, time of day	The context of care, ward level	Contextual influences of the organisation
	Organisational influences on care delivery	Nurse may become desensitised to alarms and call bells	Influence of other healthcare professionals
		Impact of workload and skill mix	
		Influence of other HCP on nursing care delivery	
The nurse-patient relationship	Indicators of nurse involvement and engagement with patient	Advocacy and support from nurses	The nurse-patient relationship
	Nurse must balance empathy with providing needed care	Emotional support and empathy for the patient	Positive feedback for nurses for FoC delivery
	Nurse-patient relationship development	Interacting with patients, engaging with them	
	Relationship is valued but seen as an extra to clinical care	Knowing the patients impacts on care delivery	
	Respect is valued but not expected	Trust between nurse and patient	
	Patients feeling frightened	Patient response to care delivery	
Involving the patient, ensuring their understanding and respecting their choices	Importance of knowing	Ensure patients understand their care/condition	Involvement of patients in their care delivery
	Checking with patients about their care	Involving patients in their care delivery	
	Need for both parties to understand each other	Keeping patients informed	
	Involving significant others in care decisions	Respecting patient choices	
	Nurse must balance respecting patient choices with providing needed care		
	Patients want choices		
	Patients want to feel in control		
Communication	Communication between nurse and patient	Communication between nurse and patient	Nursing skills needed to deliver FoC
	Nurses' role as a "go between"	Nurse knowledge and skills	
Priorities	Perceptions of care influenced by patient anxiety	Care priorities may differ between nurse and patient	Who is responsible for the fundamentals of care?
	Task focus not seen as care focused		Whose needs (nurse or patient) get priority when delivering the FoC is not always clear
	Different priorities for nurse and patient		
	Prompts for the delivery of the fundamentals of care		
	Patient perceptions of care		
Care needs of the patient	Not responding is seen as not caring	There must be a reason why nurse don't respond	The fundamental care needs of the patient
	Nurse showing concern when attending to care needs	Family/visitor responsibilities towards patient	
	Care needs are constant for all patients	Recognising individual patient needs	
	Importance of patient/customer-focused care	Awareness of inter-related needs, physical and emotional	
		Being aware of impact of diagnosis and care on patient	
		Impact of infectious status on patient care and experience	
		Nurses are responsible for patient care and safety	
		Responding to a call bell is a fundamental care issue	

(Continues)

TABLE 2 (Continued)

Generic categories		Level 1 RN	Level 3 RN
Combined main categories	Consumers	Characteristics of the nurse Focus on task Need for emotional support for the nurse Students have a responsibility to question care	
Nurse characteristics	Characteristics of the individual nurse		
Patient characteristics	Characteristics of the individual patient		Individual patient characteristics
Time		Taking "time," time management	Time taken to deliver FoC may be seen as an investment in future care delivery. Perspectives about the available time differ

4 | RESULTS

There were 10 main categories derived from the combined analysis of the data from the three focus groups. These were grouped into three overarching themes: Organisational factors; Individual nurse or patient factors; and Interpersonal factors. The themes and their categories are described in detail below.

4.1 | Theme: Organisational factors

This theme is comprised of three categories: Nursing Leadership; The context of care delivery; and Time.

4.1.1 | Nursing leadership

All three focus groups highlighted the importance of the nursing leadership in the ward or unit where the care is being delivered. They agreed the leaders should role model expected behaviours and set the "tone" for the ward. As stated by a participant in the Level 3 RN group, "I think myself if I walk past it I then can't really have a go [sic, means to object] at someone else walking past it." One consumer representative remarked when referring to Scenario 2 "it's probably come down the line, particularly the coordinators and the clinical supervisor. But the guys that are standing in the passage should be actually showing the young interns, the young trainees, this is what you do and go and do it".

The two nursing groups saw leaders as responsible for the staffing skill mix and the allocation of patient care responsibilities, with both factors seen to impact the delivery of the fundamentals of care. When referring to Scenario 4, a participant in the Level 1 RN group remarked, "I think first of all the nurse in charge shouldn't have grouped the staff already and referred to staff in the words that she did, that can upset many of us, and although they might be juniors they might still be knowledgeable."

4.1.2 | The context of care delivery

Participants in all three focus groups were aware of the external influences on care delivery, highlighting inadequate resources, high workload, work patterns (shift work) and staffing levels as influencing factors. Level 1 RNs suggested the ward culture had an impact, such as if people helped each other or worked as individuals. As an example, when referring to an unanswered call bell in Scenario 2, one Level 1 participant stated "I'm just saying, they heard it but they didn't hear it because it's their Ward, that's how they roll, they're just like, oh God that pump again I'm just going to walk past".

Workload and "being busy" were seen to influence both the availability of nurses to respond to requests for assistance and their attitudes towards care provision. For example, one Level 3 RN explained "most days we can't give the level of care we want to, so as a self-protective mechanism I think you do probably get a bit, become a bit hardened to it because if you didn't you'd just go home and cry

every night. I feel every day like we don't give the level of care we'd like to but we can't, we do the best we can, but it's hard."

Level 3 RNs highlighted other organisational factors that might influence care delivery, such as pressure to meet targets and a focus on throughput and budgets. This is highlighted in the following conversation from the Level 3 focus group:

- Speaker 1 ...we all get the emails about reduce length of stay and get the patient out, I have to do this, do that and I think that could potentially filter down and maybe it does get lost.
- Speaker 2 And we are putting a lot of pressure on the staff, discharge stuff is massive in the hospital; cutting beds, cutting you know and EDs and that constant battle but the whole hospital is so, it is huge.
- Speaker 1 Why have they not gone, get them out, it's every day, it's huge, we've got to cut beds, the budget's overblown, it's not a small thing.

Consumers acknowledged the potential impact of work patterns. One consumer participant remarked, "... I wonder at the seven, eight hour shifts that people do. Sometimes twelve hour shifts. So I wonder if the quality of life for the nurses translated then to the quality of life for patients would be better if there were shorter shifts, I don't know."

4.1.3 | Time

Both nursing groups described the potential influence of time, or a lack thereof, on care delivery, as explained in this quote from the Level 3 RN, "there's never been time to sit with a patient and chat to them and a lot of things we used to do when we had time when we were younger". However, some nurses saw spending time with patients to explain and explore their care needs as an investment that reduces patient anxiety and subsequent calls for assistance. As stated by one Level 3 RN, "It is surprising though what you get when you do, so you stop and for that spending five minutes or ten minutes gives the rest of the person's shift will be easier because that person's needs are being met and you know what the plan is for them".

Nurses are aware that their perceptions of the time taken to respond to patient requests for assistance might not correspond with patients' perceptions. This was discussed by the Level 3 focus group in the following exchange:

- Speaker 1 Ten minutes though is a long time.
- Speaker 2 And you know the nurse saying I'll be there in a sec they probably think they haven't been that long but they probably have.
- Speaker 1 And if you're the patient it seems much longer.

Nurses value time-management skills but it was also acknowledged that not having the time to provide the desired level of care for their patients does not always reflect poor time-management skills. A Level 1 RN explained, "I think time is often a factor. You don't have to have poor time management to not be able to do the things that you want to do or give the care that you want to give".

4.1.4 | Summary

As highlighted by the participants, organisational factors such as nursing leadership, the context of care delivery and time were seen to impact on care delivery. Leaders are seen to be responsible for role modelling expected behaviors and for providing resources to support care delivery. Participants described external pressures impacting on care delivery and identified the need for strategies to minimise the effect of these factors.

4.2 | Theme: Individual nurse or patient factors

This theme is comprised of three main categories: Care needs of the patient, Nurse characteristics and Patient characteristics.

4.2.1 | Care needs of the patient

Consumers in the focus group believed all patients have constant care needs and would not be in hospital unless this was the case. They appreciated nurses who show they care and who do not focus solely on a task. A lack of response to a patient request for assistance was seen as not caring.

Level 1 RNs were aware that patients' individual fundamentals of care needs do not exist in isolation but that each physical fundamental care need is linked with other physical, psychosocial and relational needs. For example, one Level 1 RN explained, "if they were still connected to the drip they might've wanted to go to the toilet and they could've ended up incontinent because they couldn't go to the bathroom because they were connected to everything. So that could've made them embarrassed and feel upset".

Both nursing groups agreed that patient factors, such as their diagnosis and presence of comorbidities, which include being colonised with multiresistant organisms (MROs), can impact on care delivery. This is illustrated in the following exchange in the Level 3 focus group:

- Speaker 1 We get quite a few (patients) going they just yell at me from the door, what do you want?
- Speaker 2 And that's their perception.
- Speaker 1 And they do say that, there's some research around, what's a patient's experience of being an MRO, it's extremely different than not because you're gowning up and even how you present and how you look.
- Speaker 3 You don't just walk in there.
- Speaker 1 And I think the worst thing is it's almost like you're being punished that we did essentially.

Level 1 RNs also indicated that nurses are responsible for patient care and saw responding to patient requests for assistance as an essential fundamental of care. By contrast, not responding to these patient requests was seen as unacceptable and something for which there "must be a reason." One Level 1 RN explained, "I'd like to think that in every one of these scenarios that something else is going on, you know like something else is actually happening and there's a reason for it, that's what I'd like to think".

4.2.2 | Nurse characteristics

Consumers and Level 1 RNs discussed the potential impact of the individual characteristics of the nurse on care delivery. Consumers indicated the personality; behaviour and individual circumstances for the nurse could impact on care delivery. One consumer representative stated, "Could also be personality. Some people do not have a good bedside manner, doesn't matter how good a nurse they are, and that's where I think a little bit more training or a bit of performance management just might open that up and get them to think before they act abruptly...". The consumers viewed nursing as a profession that requires certain personal characteristics and one where fulfilling the role may be influenced by "life factors" and circumstances outside the workplace.

Level 1 RNs suggested if nurses are tired, disengaged or feeling burnt out or undervalued, this can impact on the care they provide, resulting in a focus on tasks or a mechanistic style of care delivery. Debriefing and provision of emotional support for nurses were suggested as a way to address this. One Level 1 RN commented "Sometimes that is important too though, for debriefing, to have those moments where you can. I know there's a lot going on here but our health and mental health is important too, it's not only about the patients, you can't look after someone else if you don't look after yourself, that's what I think".

4.2.3 | Patient characteristics

Consumers and Level 3 RNs discussed the influence of the individual patient. Consumers described how the personality and behaviour of the patient might impact care delivery and suggested that patients who are emotionally or physically demanding can exhaust the nurses' ability to provide fundamental care. When referring to Scenario 1, a consumer argued, "maybe this patient...has created fuss all day and been absolutely horrific, pain in the backside".

The Level 3 RNs described other factors such the patient's ability to communicate effectively in English, their willingness or ability to contribute to care decisions, and whether nurses regard the patients' behaviour as positive or negative. Positive behaviours included being compliant with care; being seen as independent, therefore potentially reducing the nursing workload; and presenting with a condition seen as "interesting" or "special." For example, one Level 3 RN stated "there's also like this favouritism, like the patient who's got an infected toe isn't as important as the other patient".

4.2.4 | Summary

This section has shown that, as with any human interaction, the characteristics of the individuals involved can challenge or facilitate care delivery. Individual nurse and patient factors identified by the participants include the specific care needs of the patient, as well as individual nurse and patient characteristics. These were seen to play a pivotal role in the delivery of the fundamentals of care.

4.3 | Theme: Interpersonal factors

This theme was comprised of four main categories: The nurse-patient relationship; Involving the patient, ensuring their understanding and respecting their choices; Communication; and Priorities.

4.3.1 | The nurse-patient relationship

Participants viewed the nurse-patient relationship as comprised of knowing, advocating, supporting and being trustworthy. Both nursing groups believed that if they know their patients well, they can better deliver appropriate care; however, they acknowledged that getting to know patients takes time. Nurses feel responsible to advocate for their patients, as indicated by a Level 1 RN responding to Scenario 4, "... the patient unfortunately doesn't have a nurse with him and I'm sure if there was a nurse with him they would've supported him through all that".

Both Level 1 and Level 3 RNs understood that they are in a position of trust and foster this trust by avoiding making promises they cannot keep. This is illustrated by this exchange in the Level 1 RN group:

- Speaker 1 *I suppose a good thing is in one section (scenario 3) where it says about the drink, the nurse actually followed through with that because how many times...*
- Speaker 2 *I always try and tell the patient I'll do my best to get back as soon as possible.*

Emotional support for patients and their families, and empathy with their situation were viewed as important throughout the patient journey by all three groups. Positive feedback and appreciation from patients and their families are valued by nurses. If patients are resistant or aggressive towards nursing staff, this could impact on how comfortable or inclined nurses feel to advocate for, or to provide emotional support for the patient. A relationship based on respect and compassion is also valued by consumers and can reduce anxiety; however, this is seen as an "added extra" rather than an integral part of nursing care as illustrated in this quote from one consumer "I thought that was patient service over and above, that was giving the patient choice but then you don't know the situation of the patient but I thought that was really good and really, really nice, amicable, friendly, respect".

Patients are fearful when they sense a lack of empathy from nursing staff and fear the consequences for speaking out about nursing behaviour. One consumer participant recounted a previous experience with her family member, "And they're standing there laughing and I would say, don't you have work to do, and my little sister would say, don't talk to them like that, they've got to look after me. She'd would also be scared of that and I was like, no they've got work to do...". This is supported by a quote from the Level 3 focus group, "Just approaching someone and then undertaking an invasive procedure without any conversation could be very scary for a patient and sometimes in hospital people are reticent to speak out because there's an

implied trust, and I think sometimes we're at risk of taking advantage of that because of that very thing. A person, once they become a patient, is just that and may feel they don't have any rights to say stop what it is that you're doing there."

4.3.2 | Involving the patient, ensuring their understanding and respecting their choices

The consumer representatives wanted nurses to know them and understand their needs. They also wished to be kept informed about their care and wanted to feel some control over their bodies, with one stating, "That's really important for us as patients to know that we do have some control about what's going on with our bodies." Patients reported they were fearful if they did not know what was happening to them. Level 1 RNs valued involving patients by keeping them informed as well as engaging with them to ensure they understand what was happening. For example, when referring to Scenario 2, one Level 1 RN stated, "I think a patient was ringing his bell because he was anxious about what this machine was doing, he needed reassurance, it might've needed to be stopped and he did ask, and nobody attended to it or explained if they were going to come back."

Constant checking with the patient was seen as way to engage with them and check their understanding, but the Level 3 RNs and the consumers also considered this may be interpreted by the patient as the nurse not knowing what is required, thereby provoking patient anxiety. Level 1 RNs feel patients should agree with their care; however, consumers feel patient choices should be respected where possible, but also expect nurses to do what is best for the patient even if this might contradict what the patient wants. This is illustrated in the following exchange in the Consumer focus group:

- Speaker 1 *But there is a point where you have to say to the patient, in your best interest we need to do 1, 2, 3, 4 and give the options or whatever.*
- Speaker 2 *It's not always about what the patient wants.*
- Speaker 1 *Yes. So, doesn't matter how empathetic you can be.*
- Speaker 2 *It's still about what the patient needs.*

4.3.3 | Communication

Consumers believed communication barriers and a lack of rapport between the nurse and the patient will impact patient understanding and also increase anxiety. Nurses are also expected to liaise between patients, their families and other healthcare professionals. Level 1 RNs agree and suggest if there is clear, two-way communication between the nurse and the patient, this will facilitate knowing the patient and ensure they are kept informed. This lack of consistency though, made developing a cohesive, narrative description of the factors influencing the delivery of the fundamentals of care, challenging. One consumer representative stated "the nurse could arrange it, so say can I get doctor to talk to you next time, or could you be here between 7 and 8 [o'clock] when the doctor's doing

his rounds, or whatever, and then that just minimises confusion and pretence that there is an option, we're not pretending, we're hoping for options".

Clarification of each party's needs and responsibilities may assist in setting mutual priorities. Level 3 RNs highlight some specific skills as core requirements for nurses to encourage positive interactions. These include being able to communicate effectively with patients and their families, knowing how to evaluate whether care has the expected outcomes, and the necessary knowledge about what care is being delivered and why it is required. One Level 3 RN explained, referring to Scenario 1 "I think the second nurse she's having a conversation with the patient, she's involved with the patient, she's involving them in their care and essentially just using good communication skills." If nurses lack these skills, this impacts on their comfort and ability to respond to patient requests for information.

4.3.4 | Priorities

Level 3 RNs considered patients fundamental care needs should, and can, be addressed by any nurse; however, they acknowledge that some nurses do not feel responsible for patients they have not been directly allocated to care for. They also recognise the priorities for care delivery differ between nurses, and between nurses and patients; however, they conceded that the nurse usually sets the care priorities and patients may have to conform to the nurses' schedule: "I guess that just stood out to me where you're saying the patient is eating their dinner, and we may be going in doing a procedure and not really respecting that opportunity for them to perhaps eat their meal because suddenly they'll stop that while we go in and do a procedure because it works with our timing".

The need to consider the patient perspective is highlighted in this comment from another Level 3 RN referring to Scenario 2, "I guess if you're looking at the other part of that question where it's saying that the visitor is saying that it's beeping and it's saying something about air, and so in our minds we're thinking not much air will go in, it will be okay, whereas to a patient or a visitor what does that actually mean. So sometimes I think we normalise a lot of things that are happening in our work place but they are frightening to the patient."

Level 1 RNs were also aware that patient perceptions of their care may differ from the nurses' perspective. Consumers recognised that nurses and patients may have different care priorities but believed the patients' needs and wants must take precedence. When patients and their families are anxious or fearful, this will further influence their perceptions of their care. One consumer indicated this factor was not limited to being a patient, "I wonder if that's worse when the observer or the patient or the carer visitor is already stressed, because if I'm anxious and trying to rush to this meeting for example and the butcher's giving me the run around about what I did or didn't order, so translating this to here, well here I am anxious and my patient or I, my relative or I need immediate attention, how dare you laugh now, I think is something that could be considered".

4.4 | Theme summary

The final theme, interpersonal factors, contains the categories the nurse–patient relationship; involving the patient, ensuring their understanding and respecting their choices; communication; and priorities, all of which underpin care delivery. These interpersonal elements play an integral role in developing and maintaining a therapeutic and mutually beneficial nurse–patient relationship.

4.5 | Findings summary

There was considerable overlap in the factors influencing care delivery described by the three different groups. Data from all three groups were represented in seven of the 10 main categories describing factors influencing the delivery of the fundamentals of care. Of the remaining three categories, the consumer group and the Level 1 RNs discussed the individual characteristics of the nurse delivering care as a potential influencing factor; however, the Level 3 group did not. The consumer group and the Level 3 RNs discussed the individual characteristics of the patient receiving care as a potential influencing factor; however, the Level 1 RN group did not. Both nursing groups describe the influence of “time”; however, this was not discussed by the consumer group. The congruence in the factors discussed in all three groups demonstrate a shared perspective of care delivery.

5 | DISCUSSION

This study aimed to explore the factors, as described by nurses and healthcare consumer representatives, that influence the delivery of the fundamentals of care. Exploring multiple perceptions of the same care scenarios facilitated the collection of diverse data relating to the description of potential factors that were seen to influence the delivery of the fundamentals of care.

As the research questions focus on both patients and nurses, and due to the congruity between the factors described by all three participant groups, it seems appropriate to focus the discussion on the seven factors described in the results where all three groups were represented. Of these seven factors, two of them, the context of care delivery and the care needs of the patient, are not easily modifiable when looking for ways to improve fundamental care delivery. Thus, there are five factors, identified by all three participant groups as influencing the delivery of the fundamentals of care, where further exploration may reveal some strategies to promote or moderate these factors. These factors include the nurse–patient relationship; involving the patient, ensuring their understanding and respecting their choices; communication; priorities and nursing leadership. When reflecting on these five categories, nursing leadership has the potential to influence the remaining four. The development of a therapeutic nurse–patient relationship may also moderate factors such as involving patients in their care, a shared understanding of care priorities, nurse–patient communication and the possibility of patient choices being respected. The influence of leadership and the

nurse–patient relationship are discussed in more detail in the following paragraphs.

The importance of nursing leadership has been established by previous research. The relationship between nursing leadership and patient outcomes has been explored by Wong Cummings, and Ducharme (2013) who found evidence of a positive relationship between a transformational leadership style and patient outcomes, although the specific leadership models influencing the outcomes required further investigation. Nursing leadership has also been demonstrated by Squires, Tourangeau, Spence Laschinger, and Doran (2010) to have an impact on patient safety and the value of impartial leadership practices was confirmed. What was not previously known was how consumers of health care were also aware of, and could describe, the influence of the nursing leadership on the delivery of the fundamentals of care.

There has been considerable discussion by nurse leaders relating to the delivery, or more specifically the inadequate delivery, of the fundamentals of care. A group of nursing leaders, health policymakers, healthcare researchers and clinicians attended a seminar at Oxford University in June 2012 to discuss integrating the fundamentals of care into the patient-centred care 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 patients basic needs due to a range of complex factors. Authors such as Bridges et al. (2012) illustrate nurses are feeling overwhelmed and not able to deliver the care they want and which they feel their patients need. This is consistent with the comments from the Level 3 nursing leaders in this study who described feeling unable to give the level of care they want to. Organisational demands related to patient throughput, length of stay and staffing skill mix were reported by participants in this study as impacting nursing leaders' ability to shape the workplace culture and manage workload.

The nurse–patient relationship was also recognised by focus group participants as a factor influencing the delivery of the fundamentals of care. Establishing positive and trusting therapeutic nurse–patient relationships has long been recognised as an essential component of nursing practice and is important for effective care (Feo et al., 2017). The quality of the relationship between the nurse and the patient has been significantly linked to improved health outcomes such as symptom relief and improvements in clinical and functional status (Safran, Miller, & Beckman, 2006). A therapeutic nurse–patient relationship encourages effective communication and helps patients feel involved in their care, leads to a shared understanding of care priorities and enhances the possibility of patient choices being respected (College of Nursing of Ontario, 2017). Wiechula et al. (2016) conducted an umbrella review of factors influencing the nurse–patient relationship. The review illustrated the influence of nursing behaviours and attitudes and how these should align with patient values. Given the pre-existing research highlighting the importance of the nurse–patient relationship, and the congruity between consumers and nurses regarding the influence of this factor on the delivery of the fundamentals of care, it is clear that further

research exploring how nursing leaders and healthcare organisations facilitate and evaluate the development of these positive nurse–patient relationships is warranted.

Zeitl et al. (2011) have highlighted the need for staff and consumers to be involved in conversations about how to improve care delivery. Seeking a variety of perspectives on identical care scenarios may have helped participants be more objective in their reflections as they were not being asked to recall and comment on events that had directly impacted upon them personally. However, there is no doubt participants were also referring to past experiences when they were describing possible influencing factors for the care delivery. All three groups offered unprompted judgements about the quality of care in the scenarios, and the consistency with how they defined this was remarkable. Similarly, the congruity between all three groups in identifying the factors influencing the delivery of the fundamentals of care illustrates a common perspective from consumers and nurses. The overlaying of the participants' personal experiences onto generic care scenarios helped to elicit rich, diverse data relating to the description of potential factors that influenced the delivery of the fundamentals of care in a broad range of circumstances, beyond the scenarios that were presented. In the light of the shared understanding from both the providers and recipients of the factors influencing the delivery, and the evidence that these factors continue to impact on the delivery of the fundamentals of care, further research asking nursing leaders for their practical strategies to address these identified factors was required. This is being conducted in stage three of this study.

6 | CONCLUSION

This paper provides information about the factors, described by nurses, nurse leaders and consumer representatives, that influence the delivery of the fundamentals of care. This information was elicited using a unique method of scenario-led focus groups. The findings suggest that seeking the perspective of the key people involved in delivering and receiving nursing care demonstrate a shared understanding of the factors that influence care delivery. The influence of nursing leadership and the quality of the nurse–patient relationship are two of the vital factors impacting on how nurses deliver the fundamentals of care and how that care is perceived by the recipient.

6.1 | Strengths and limitations of the study

The strength of this stage of the study was the focus group methodology, which enabled participants to explore and discuss factors that influence care delivery. These discussions may not have elicited such rich data if alternative methods such as individual interviews had been used. Interviews are prone to the problem of 'social desirability' where the participant gives the most socially acceptable response. Using focus groups encourages people to be more forthcoming as they are not the sole focus of attention. Scenarios that were open to interpretation enabled the participants to 'define the

situation in their own terms' (Wilks, 2004, p. 83). Seeking responses to hypothetical situations rather than the reality of the participants' own practice or situation may have allowed them to be more open in their responses (Wilks, 2004). This stage of the study was conducted in one healthcare facility and with a small number of participants; therefore, this could be considered a limitation. However, this stage of the study was exploratory rather than representative and due to the small sample size, data saturation was not possible.

7 | RELEVANCE TO CLINICAL PRACTICE

This stage of the study explored three different perspectives of acute care scenarios using focus groups to elicit a deeper, integrated understanding of the factors influencing the delivery of the fundamentals of care. To my knowledge, this has not been done before. There appears to be some shared perspectives between nurses, nurse leaders and consumer representatives of the factors impacting on care delivery. The findings of this stage of the study highlight nursing leadership as a key factor influencing delivery of the fundamentals of care. The impact of the nurse–patient relationship on how the fundamentals of care are delivered is also recognised by nurses and consumers of health care. Further research exploring how nursing leaders and healthcare organisations facilitate the development of positive nurse–patient relationships is warranted.

CONTRIBUTIONS

Study design: TC; data collection and analysis: TC and manuscript preparation: TC.

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