Why Do We Need to Study the Fundamentals of Care?

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Abstract
This paper makes the case for revisiting our understanding and valuing of basic or fundamental nursing care. Despite the interest in movements such as the person-centred or patient-centred care agenda, there continues to be concern about patient safety, quality of experience and getting the simple things right. Part of this debate is around whether meeting patients’ fundamental care needs (such as personal hygiene, elimination and eating and drinking) within acute care settings constitutes legitimate nursing responsibilities or whether these needs ought to become part of “hotel services” executed by care assistants with elementary training or, as in many lower-income health systems, undertaken by relatives.

The case is made for nursing to recommit to this responsibility. Addressing patients’ fundamental care needs requires a new analytic lens that is built upon the importance of relationship-centred fundamental care. The interplay of physical care with its impact upon the psychosocial well-being of the patient and the impact this has on the relationship between the nurse and the patient cannot be underestimated. Emerging theoretical and empirical work is outlined that supports these claims.

How the nursing profession responds to these challenges and debates is itself a major leadership challenge. Creating a collaborative where this debate and dialogue can happen is seen as an important contribution to generating better ways of thinking about and delivering better fundamental care.

Why the Fundamentals of Care Matter...
“Fundamentals of care” (or fundamental care) is one of the many terms given to care activities that are required for every person, regardless of their clinical
condition or healthcare setting (Kitson et al. 2010). The term “fundamental” communicates the centrality of these activities for human welfare, optimizing recovery when ill (Kitson et al. 2013a, Vollman 2013) and ensuring positive patient experiences (Kitson et al. 2013b, Kitson and Muntlin Athlin 2013). Traditionally, in acute settings, discrete fundamental care activities, such as helping people with eating, drinking and elimination, have been carried out by nurses on behalf of and with patients (with or without their carers) on behalf of the wider healthcare team (Kitson et al. 2013a).

Whilst fundamental care is by no means a new concept, there has been growing attention on the ways in which such care is delivered in practice, particularly by nurses (Vollman 2009). One reason for this renewed focus is the increased emphasis on patient-centred care. Patient-centred care focuses on healthcare that involves patients in greater decision-making and choice, and which is sensitive to patients’ unique physical, psychosocial, cultural and emotional needs (Kitson et al. 2013b, Kitson and Muntlin Athlin 2013). In addition to the patient-centred care movement, the higher burden of disease brought about by an aging population, global migration, complex health conditions characterized by multi-morbidities and increases in chronic, incurable illnesses is creating higher demand for high-quality fundamental care and placing increased scrutiny on the way in which such care is delivered in acute care settings (Feo and Kitson 2016).

**Fundamental Care Through a Personal Lens**

To centre the discussion on the person or the patient, I wish to share a personal experience of fundamental care (Box 1). In using this as an illustration, I wish to explore some of the practical, interpersonal, systemic and leadership questions it raises. The reflection is not a criticism of individual nursing actions but an analysis of the multi-layered complexity of nursing’s work.

**Box 1. A personal reflection on fundamental care**

A close relative had been in a car accident. He had spent time in intensive care and a number of wards in several different hospitals. After he had come out of the critical stage, the whole intent was to get him back to as normal and productive a life as he could manage. In one incident, his partner asked me why the nurses hadn’t thought of washing his hair, three weeks after his accident and during which time he had moved out of intensive care and onto two different wards. His partner was particularly concerned because, for her, the person she saw in front of her was not the man she had married and she couldn’t understand why this basic need had been overlooked when the rest of his care had been so good. Her concern also was around his identity and dignity. She was distressed by how he looked and she could not understand why no one was addressing this by doing something as fundamental as giving him a shower. As the nurse in the family she asked me why the nurses who were looking after him, had not prioritized this. She then asked me to ‘fix it’. I subsequently ended up facilitating the event in the ward, negotiating a shower and a hair wash. The result was quite profound: after the shower and hair wash (which totally exhausted him) he went into a deep natural sleep, the first for several weeks.
So, was it a nursing duty to look after the personal hygiene (and by default, the identity and the psychological well-being) of the patient? Presented in this way, the response will inevitably be “yes, it is a nurse’s duty to make sure their patient is clean and well presented. The nurse will either do it her or himself or ensure it is done by someone in the nursing team.” But if that is a given, why did I have the particular experience with my relative? Was it a one-off, an aberration that reflected a breakdown in a particular system rather than something more complex?

What does this story tell us about the way nursing is transacted in today’s healthcare systems? Are we moving to a point where we really ought to acknowledge that nurses no longer have the time or the inclination to provide personalized care to their patients? And if that is the case, what does that mean to the way nursing views such ideas as patient or person-centred fundamental care? Feo and Kitson (2016) have argued that the central problem lies in the invisibility and subsequent devaluing of fundamental care. Such care is perceived to involve simple tasks that require little skill to execute and consequently are assumed to have minimal impact on patient outcomes and thus rendered unimportant and invisible. These multiple sources of invisibility and devaluing surrounding fundamental care have meant that the concept is underdeveloped and misunderstood both conceptually and theoretically.

The Work of the International Learning Collaborative
What we need to do is think about how we can generate more constructive and meaningful dialogue around the way care is conceptualized, understood and valued in our complex healthcare systems. The International Learning Collaborative (ILC) is a group with this agenda. It is attempting to generate a shared understanding of what constitutes fundamental care requirements (independent of clinical condition) and then to systematically generate evidence around how this care is most effectively delivered. The agenda is to move the discourse around fundamental care from descriptive and anecdotal to something that reflects the multilayered complexity of such seemingly straightforward actions.

To date, a number of papers have been produced (www.intlearningcollab.org) that outline ILC members’ thinking and propositions to be tested. A significant piece of work was the generation of a conceptual framework called the Fundamentals of Care Framework by ILC members at their 2012 summit meeting.

Defining the Fundamentals of Care
The Framework was developed inductively from the research and clinical experience of 30 multi-disciplinary healthcare experts who attended an ILC meeting in Oxford in 2012 (Kitson et al. 2013a). It consists of three interrelated dimensions: (1) establishing the relationship, (2) delivering fundamental care in an integrated way and (3) the context of care delivery (Figure 1). At the core of the Framework
is the nurse–patient relationship. The ability of the nurse to “connect” with the patient is essential to safeguarding both the patient and the nurse in the subsequent encounters. Being assisted with fundamental care needs, such as toileting or personal cleansing, can be a source of embarrassment and distress. Minimizing or avoiding these outcomes requires nurses to connect meaningfully with patients and treat them with compassion and respect (Kitson et al. 2013a; Kitson et al. 2014). Fundamental care needs are more likely to be met in a personalized, therapeutic way when a trusting nurse–patient relationship has been established (Wiechula et al. 2015).

The Framework’s second dimension – delivering fundamental care – is conceptualized as complex; quality fundamental care involves more than attending to a physiological need (i.e., providing food to stop hunger). It requires that a number of psychosocial (i.e., being treated with respect) and relational (i.e., receiving compassion) needs are managed by the nurse and healthcare team. The challenge here is that for every physical activity (i.e., helping someone to the bathroom), there is an equivalent psychosocial (i.e., was this physical act done in such a way that the patient’s dignity was maintained?) and relational (i.e., did the nurse demonstrate empathy and compassion?) dimension to be managed in order for the patient to have a quality experience. Kitson and Muntlin Athlin (2013) tested the number of hypothetical permutations there could be around each of the main physical fundamentals of care and how they were integrated with psychosocial and relational elements. It’s also important to note that the way the nurse and patient interact is contingent upon the patient’s level of independence and the involvement of other relatives or designated carers.
The third dimension demonstrates that the nurse–patient relationship and fundamental care are inevitably impacted by the context in which care is provided. The crucial role context plays in care delivery has been widely recognized in the research literature (Wiechula et al. 2015). What is important in the Framework is to try and operationalize for the nurse in every care encounter, how they are going to optimize the environment and the wider contextual factors. Thus, for example, nurses providing care to a patient in their own home will operate very differently than if they were undertaking the same activity in an acute care setting or in an ambulatory setting.

The Framework provides a platform for exploring the complexity of fundamental care and articulating the personal-, relational-, policy- and systems-level factors required to achieve it. The Framework is well-integrated and developed, with empirical evidence to support its conceptual understanding, such as that fundamental care involves physical, psychosocial and relational elements (Kitson et al. 2013b).

Towards a Clearer Understanding of “Care Literacy”

What we also need to be considering is how we can package this theoretical and conceptual work around fundamental care (and the Fundamentals of Care Framework) into a set of tangible products that will enhance the well-being and experience of care of people when they come in contact with the health system. Just as we have “health literacy” (the importance of ensuring that people understand their health needs and know how to keep healthy and manage their disease), so we need to understand how we communicate the core elements of fundamental care. This is where we need to create a clearer understanding of “care literacy” (the importance of ensuring that people understand their self-care needs and know how to care for themselves and family and that nurses know how to support patients in this journey), both in healthy situations as well as when illness or disability strike. Care literacy skills and products evolve from the systematic investigation of how fundamental care is delivered and what skills, attributes and knowledge are needed by the nurse, patient and their carers to ensure ongoing competence and quality.

Care literacy is a concept that resonates with some of nursing’s most famous leaders: Florence Nightingale (1970) was of the view that society poorly understood the essential elements of nursing and had a vision of writing a book that would be a “manual” for every household to impart the basic rules of caring and self-care. Equally, more contemporary nursing theorists such as Orem (1985), Henderson (1966) and Roper et al. (1974) have all attempted to combine aspects of the transaction of direct physical care with levels of independence, knowledge and capability of the patient. Implicit in much of these writings were the centrality of the relationship and the importance of the psychosocial impact of the physical acts on the well-being of the patient.
We have yet to complete the work Nightingale and colleagues identified. While some groups have enthusiastically embraced this challenge (Dossey 2008), there has been less focus on what nursing needs to do to develop care literacy products that will equip individuals, carers, family members and paid personal support workers to help people care for themselves more effectively. Many so-called training/support packages that have been developed (Lewis and Fricker 2008a, 2008b) are beginning to do this. Of course the next step will be to develop the Apps and assistive technologies that will help us.

But we cannot do any of this effectively if we don’t think that caring and developing the evidence base that will inform our teaching of these matters is central to nursing’s societal responsibility. And this is where leadership is crucial and where our own sense of the destiny of nursing matters.

**Rerunning the Personal Experience**

What difference would any of this talk about new frameworks or care literacy have made on my personal account shared in this paper? Would my relative have had his hair washed early on during his stay in hospital? As he recovered, would someone (the nurse responsible for his care) have chosen to talk with his partner to check how she was coping? To find out what could be done to help her cope with the shock? Could his daily self-care regimen have become part of the recovery plan so that as he began to find himself again he could set small personal goals around his self-care, self-respect and resilience?

Is this level of care too exacting, too idealistic? Should we have been satisfied with the fact that he survived, that he did not pick up an infection or a pressure sore? Or is it what we would term person-centred care? However, the challenge we have as nurses is that to embrace the patient-centred care agenda does mean that we have to understand the minute moment-by-moment transactions that have to be performed to keep people alive and healthy. Nurses may not be able to or need to do them all but, I would argue, they do need to understand and value them and to make sure they are performed in a relationship-centred, integrated way. Otherwise, we forfeit our responsibility to care.

**Conclusion**

To rediscover the importance of fundamental care is exciting. It is an exciting agenda because nurses all over the globe are saying it is time to reclaim and reconnect to care. We need to do it in a systematic, theoretically informed and pragmatic way and in ways that both inform our thinking and our actions. This calls for strong leadership at every level of the health system and in our research and academic settings.
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References


