FUNDAMENTALS OF CARE

THE FINAL FRONTIER

Your guides

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- Professor Debra Jackson AO
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  - Editor-in-Chief, Journal of Clinical Nursing.
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  - Deputy Director, Centre for Evidence-based Practice, South Australia.
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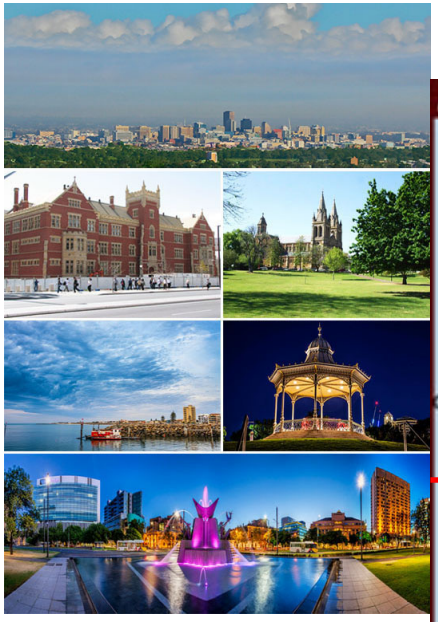
  - *Senior Clinical Scientist, Lunenfeld-Tanenbaum Research Institute, Sinai Health Systems, Toronto, Canada*



Distance from Sydney to Adelaide = 854 miles, (1374 km.)

Seminar Outline

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- Informed provision of fundamental care
  - Presenter: Alison Kitson
- Methodologies to capture the impact of fundamental care
  - Presenter: Debra Jackson
- Defining responsibility for fundamental care delivery
  - Presenter: Tiffany Conroy
- Group discussion

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Informed provision of fundamental care.

Professor Alison Kitson

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In the beginning…the fundamentals

- Delivering high-quality fundamental care in high pressure and throughput-focussed healthcare environments is challenging.
- Recent global media and public scrutiny highlights growing concern over the way basic or fundamental care is delivered in healthcare settings and how it is experienced by patients.
- Despite an increasing number of standards and approaches to the delivery of fundamental care, there is a tendency to disaggregate this care, which can result in a task-based approach to care delivery.
- We need evidence!

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Plotting our course through the universe

- Evidence–based practice is a professional requirement
- Evidence should guide policy and point of care delivery
- However:
  - A systematic review by Richards et al (2018) suggests the existing evidence for fundamental care interventions is miserably inadequate and highlights the crucial “lack of evidence of effectiveness for interventions in core areas such as elimination, nutrition, mobility and hygiene”.

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The challenge, should you chose to accept it…

- The challenge for researchers remains to either focus on one fundamental (for example, hydration or dignity), or to try to explore the overall cumulative impact of fundamental care which integrates the patient's physical, relational and psychosocial needs.
- An integrated approach reflects the reality of nursing practice.
- Previous research has illustrated the difficulty in separating the physical impact from psychosocial and relational elements of nursing interventions related to the fundamentals of care (Kitson, Dow, Calabrese, Locock, & Athlin, 2013; Kitson & Muntlin Athlin, 2013).

One small step for mankind…

- The first step towards developing a robust evidence base was to ensure there was a common understanding of, and definition for, fundamental care.
- We needed an agreed definitive theoretical basis for the teaching, delivery, evaluation and exploration of the fundamentals of care.
- We also needed to expand our vision to encompass the delivery of fundamental care beyond the hospital setting and across all care trajectories.

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Finding our way…

- Who cares about fundamental care?
  - The genesis of the International Learning Collaborative
- Where do we start?
  - Undertaking a meta-narrative review
- Reclaiming and redefining fundamental care
  - Developing the Fundamentals of care Framework
- Refining and defining the Fundamentals of Care
  - Delphi

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The International Learning Collaborative

- 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.
- Since 2008, the ILC has held an annual international three-day Conference and Summit, where members discuss key issues in relation to the research, education, practice and policy of fundamental care.

Follow Us

Follow @ILCconnect2care

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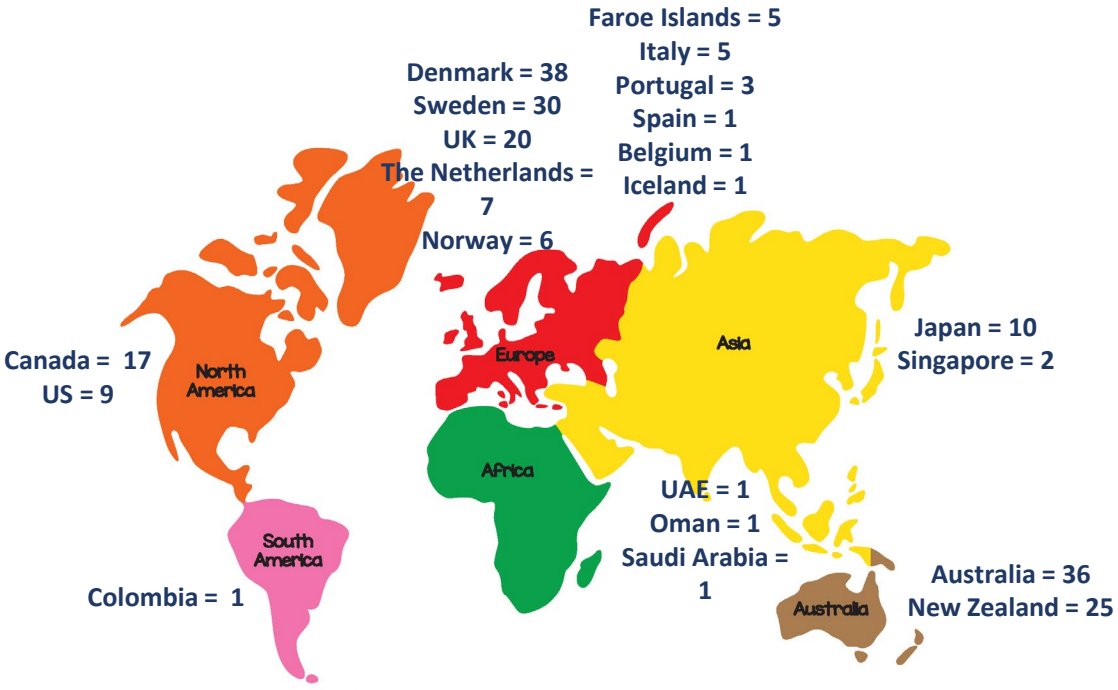
ILC Membership

As of June 2019 we have 220 members from 21 countries
(2018 = 112 members, 18 countries)



https://intlearningcollab.org/

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Narrative review

- In 2010 a meta-narrative review was undertaken to establish what was considered to be the fundamental aspects of patient care and what research evidence there was in the literature that could inform nursing practice.
- The seminal texts and other documents relating to nursing practice were reviewed.

INTERNATIONAL JOURNAL of NURSING PRACTICE

Full Access

SCHOLARLY PAPER: Defining the fundamentals of care

Alison Kitson RN BSc (Hons) DPhil FRCN FAAN, Tiffany Conroy RN BN MNSc FRCNA, Yvonne Wengstrom OCN PhD, Joanne Profetto-McGrath PhD RN, Suzi Robertson-Malt BHSc (Hons) PhD

First published: 22 July 2010 | https://doi.org/10.1111/j.1440-172X.2010.01861.x | Cited by: 80

FindIt@Flinders

SECTIONS PDF TOOLS SHARE

Abstract

Kitson A, Conroy T, Wengstrom Y, Profetto-McGrath J, Robertson-Malt S. *International Journal of Nursing Practice* 2010; **16**: 423–434

Defining the fundamentals of care

A three-stage process is being undertaken to investigate the fundamentals of care. Stage One (reported here) involves the use of a met a-narrative review methodology to undertake a thematic analysis, categorization and synthesis of selected contents extracted from seminal texts relating to nursing practice. Stage Two will involve a search for evidence to inform the fundamentals of care and a refinement of the review method. Stage Three will extend the reviews of the elements defined as fundamentals of care. This introductory paper covers the following aspects: the conceptual basis upon which nursing care is delivered; how the fundamentals of care have been defined in the literature and in practice; an argument that physiological aspects of care, self-care elements and aspects of the environment of care are central to the conceptual

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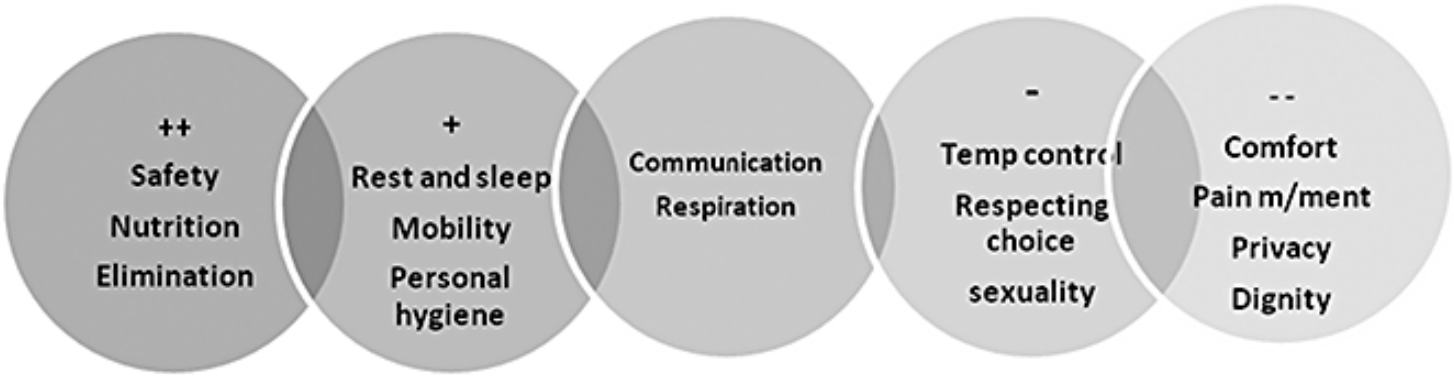
Consistency of concepts across the seminal texts



Kitson, Conroy, Wengstrom, Profetto-McGrath, Robertson-Malt 2010

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The Fundamentals of Care Framework (v1)

- In 2012, the annual ILC event was structured around a specific agenda: to develop, using a participatory, consensus-generating approach, a framework that outlines how fundamental care should be delivered in care settings globally
- The discussions from the three-day event, followed by subsequent refinement of the themes emerging from these discussions, culminated in the first edition of the Fundamentals of Care Framework.
- The Fundamentals of Care Framework was subsequently validated through patient stories and experiences (Kitson, Dow, Calabrese, Locock, & Muntlin Athlin, 2013; Kitson & Muntlin Athlin, 2013), and has become the cornerstone of the ILC and its work.

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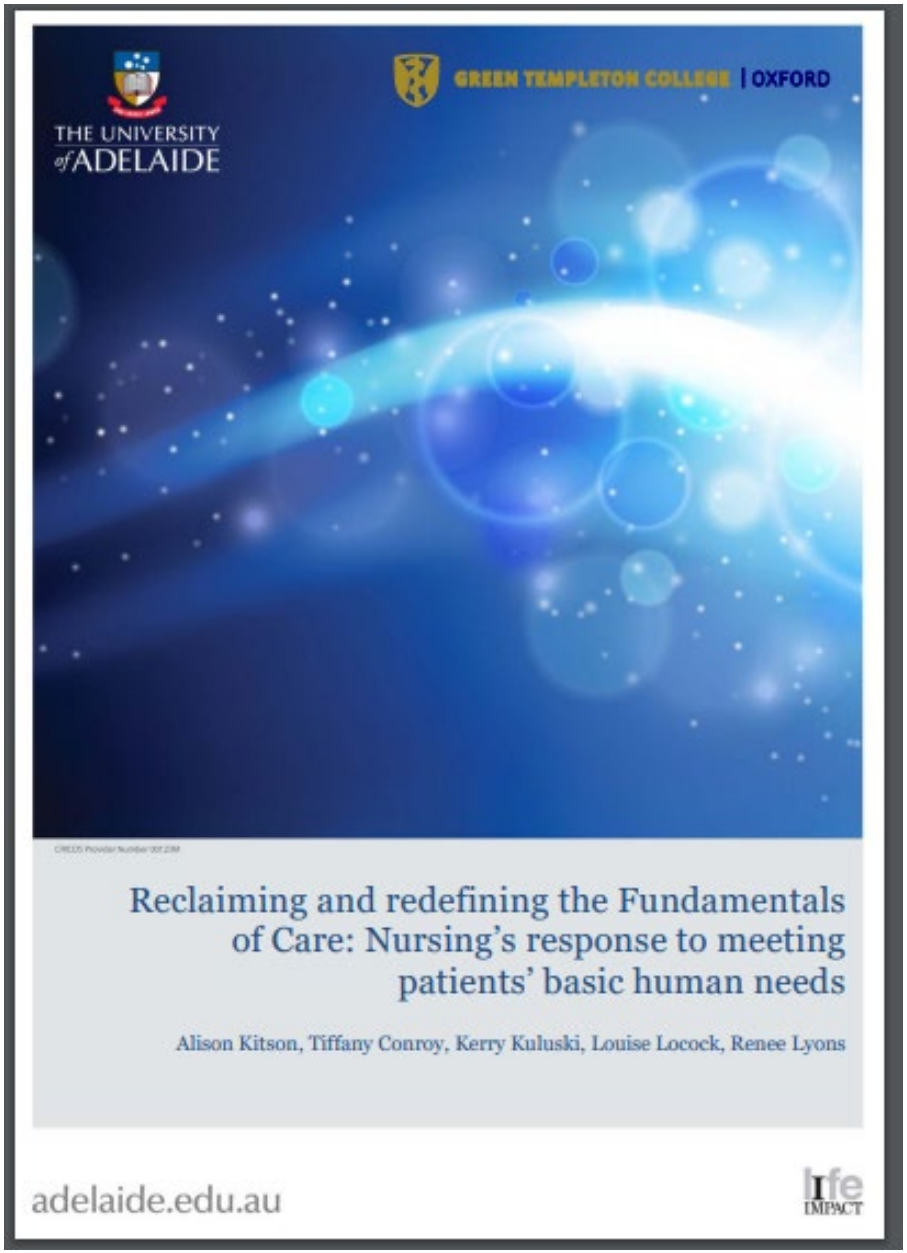

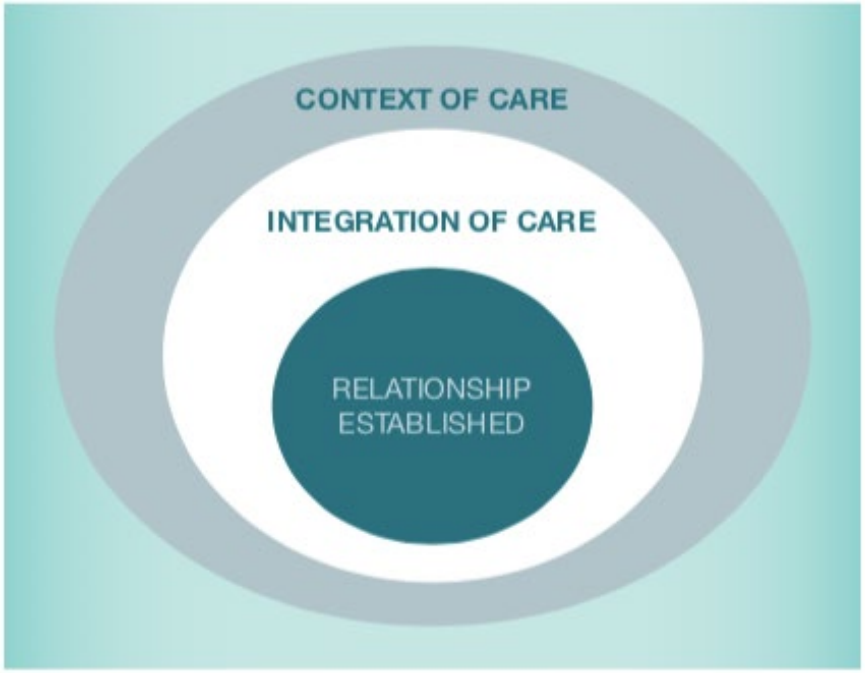

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Refining the Fundamentals of Care Framework

- In 2016 a modified Delphi study was conducted to develop a standardised definition for fundamental care that reflects the Framework's conceptual understanding, as well as agreement on the elements that comprise such care.
- Three phases: (1) engaging stakeholders via an interactive workshop; (2) using workshop findings to develop a preliminary definition for, and identify the discrete elements that constitute, fundamental care; and (3) gaining consensus on the definition and elements via a two-round Delphi approach.

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Where did we land?

- The Delphi study validated and explained the acknowledged complexity of how to define fundamental care and how to identify the discrete elements of such care.
- The definition and elements developed were a crucial step in generating agreed conceptual understanding for policy, research, education and clinical practice.

JCN Journal of Clinical Nursing
The International Voice of Nursing Research, Theory and Practice

SPECIAL ISSUE FUNDAMENTAL CARE - ORIGINAL ARTICLE | Full Access

Towards a standardised definition for fundamental care: A modified Delphi study

Rebecca Feo PhD, BPysch Hons, Tiffany Conroy RN, BN, MNSc, Eva Jangland PhD, RN, CNS, Åsa Muntlin Athlin PhD, RN, Maria Brovall PhD, RN, Jenny Parr RN, MSc ... See all authors

First published: 26 December 2017 | https://doi.org/10.1111/jocn.14247 | Cited by: 8

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SECTIONS PDF TOOLS SHARE

Abstract

Aims and objectives

To generate a standardised definition for fundamental care and identify the discrete elements that constitute such care.

Background

There is poor conceptual clarity surrounding fundamental care. The Fundamentals of Care Framework aims to overcome this problem by outlining three core dimensions underpinning such care. Implementing the Framework requires a standardised definition for fundamental care that reflects the Framework's conceptual understanding, as well as agreement on the elements that comprise such care (i.e., patient needs, such as nutrition, and nurse actions, such as empathy). This study sought to achieve this consensus.

Design

Modified Delphi study.

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Defining fundamental care

- Working definition

  Fundamental care involves actions on the part of the nurse that respect and focus on a person's essential needs to ensure their physical and psychosocial wellbeing. These needs are met by developing a positive and trusting relationship with the person being cared for as well as their family/carers.

- The Fundamentals of Care Framework is used to illustrate the components and the complex nature of fundamental care delivery.

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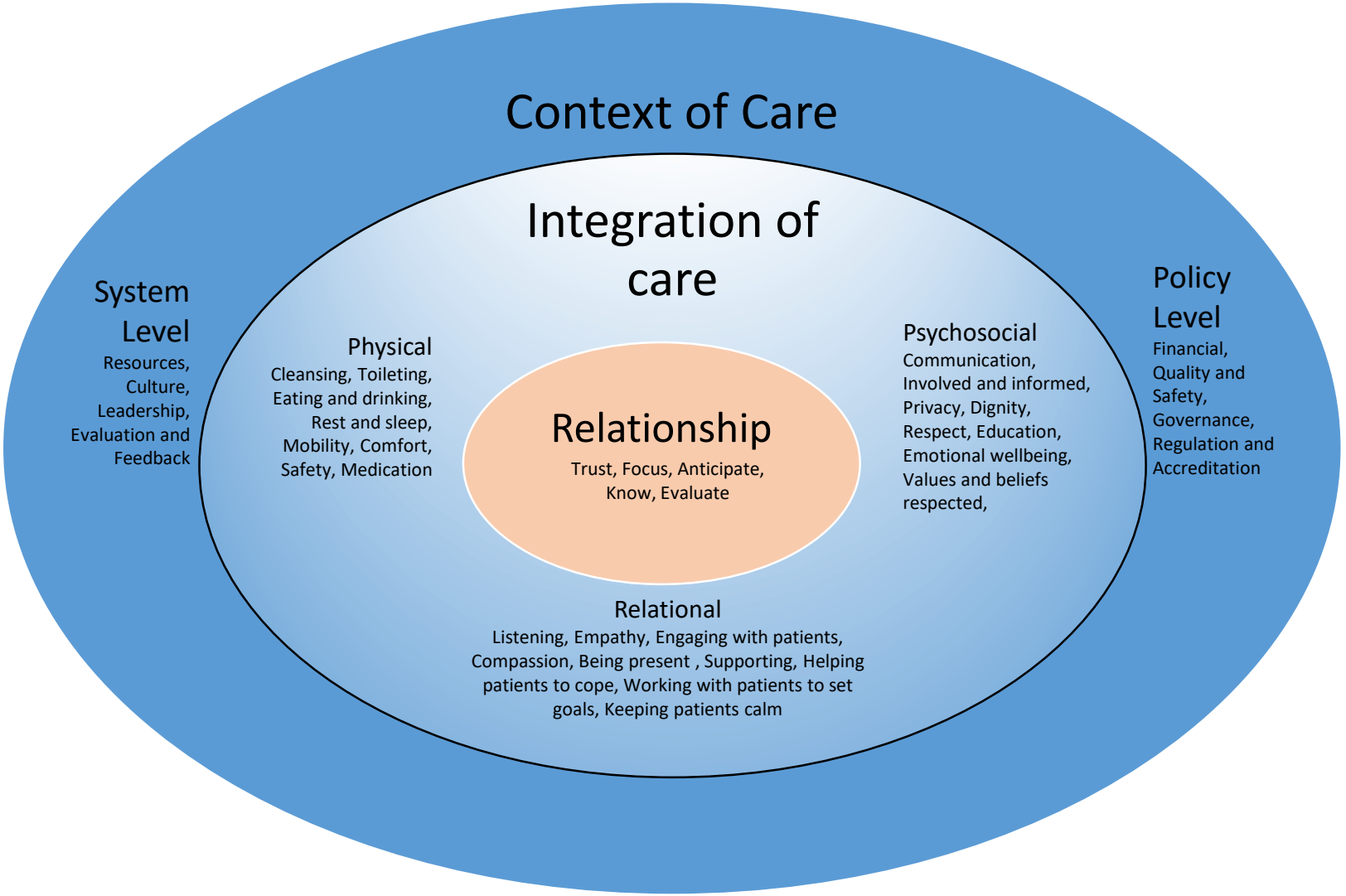
The Fundamentals of Care Framework



Revised 2018. Feo R, Conroy T, Jangland E, Muntlin Athlin Å, Brovall M, Parr J, Blomberg K, Kitson A. 2017 Towards a standardised definition for fundamental care: A modified Delphi study. Journal of Clinical Nursing, doi: 10.1111/jocn.14247.

Consequences

- Biennial special issue of the Journal of Clinical Nursing focussing on fundamental care.

- Position paper
  - Fundamental care as a human right

- Symposiums, summits, world domination!

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Conclusion

- Fundamental care is a universal need.
- We have an agreed definition for this.
- Now we need agreed measures

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Methodologies to Capture the Impact of Fundamental Care

Professor Debra Jackson

From material prepared by Dr Lianne Jeffs

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Key Questions to Address …

How best to leverage and adapt existing and create new measures and methods that more accurately capture the impact of fundamental care on patient, provider, organization and system outcomes?

How best to align and advance minimum data sets for fundamentals care within the global technological and safety/quality platforms?

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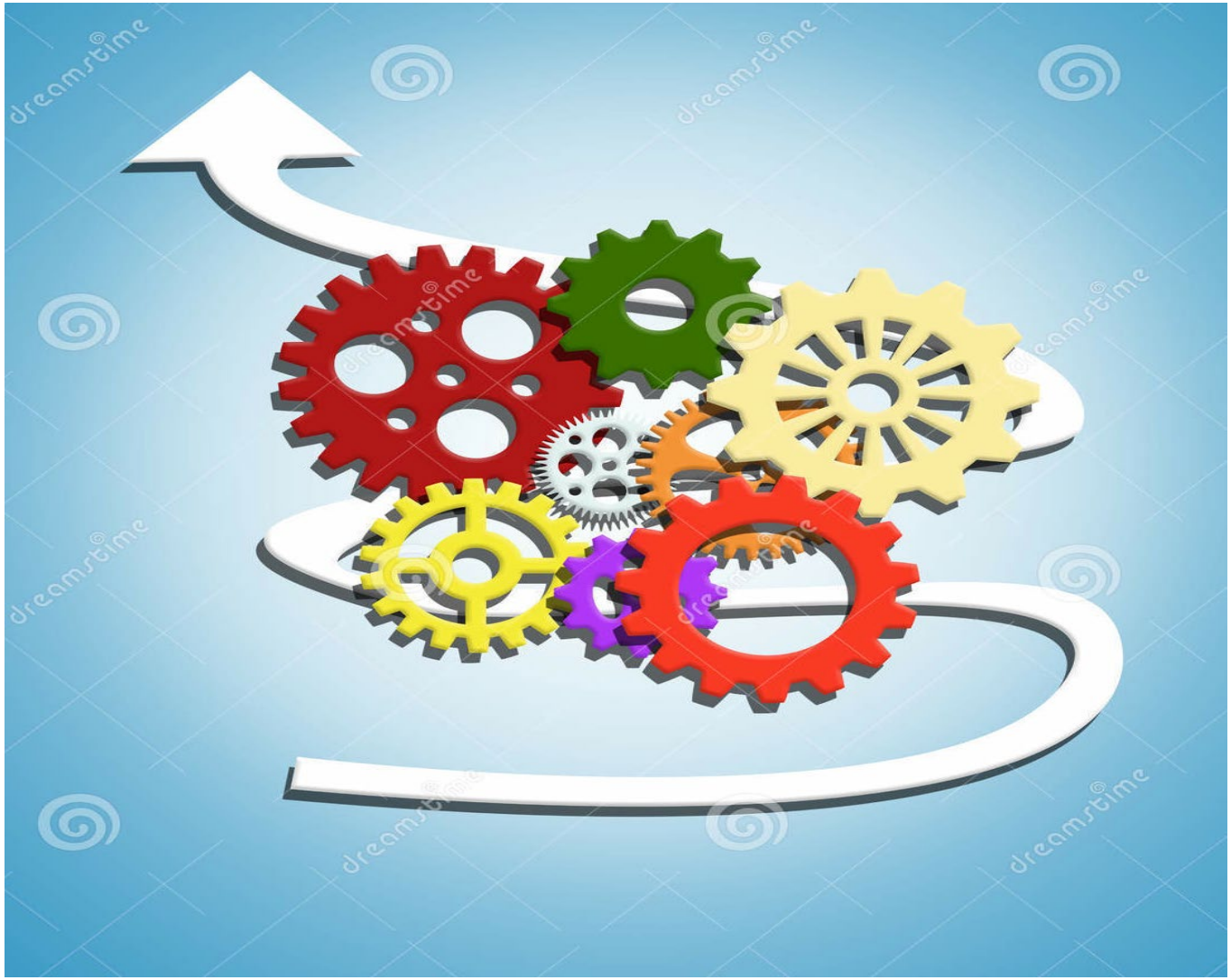
What to Measure? Our Current Context



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What, How and When We Measure is Influenced by Our Larger Universe

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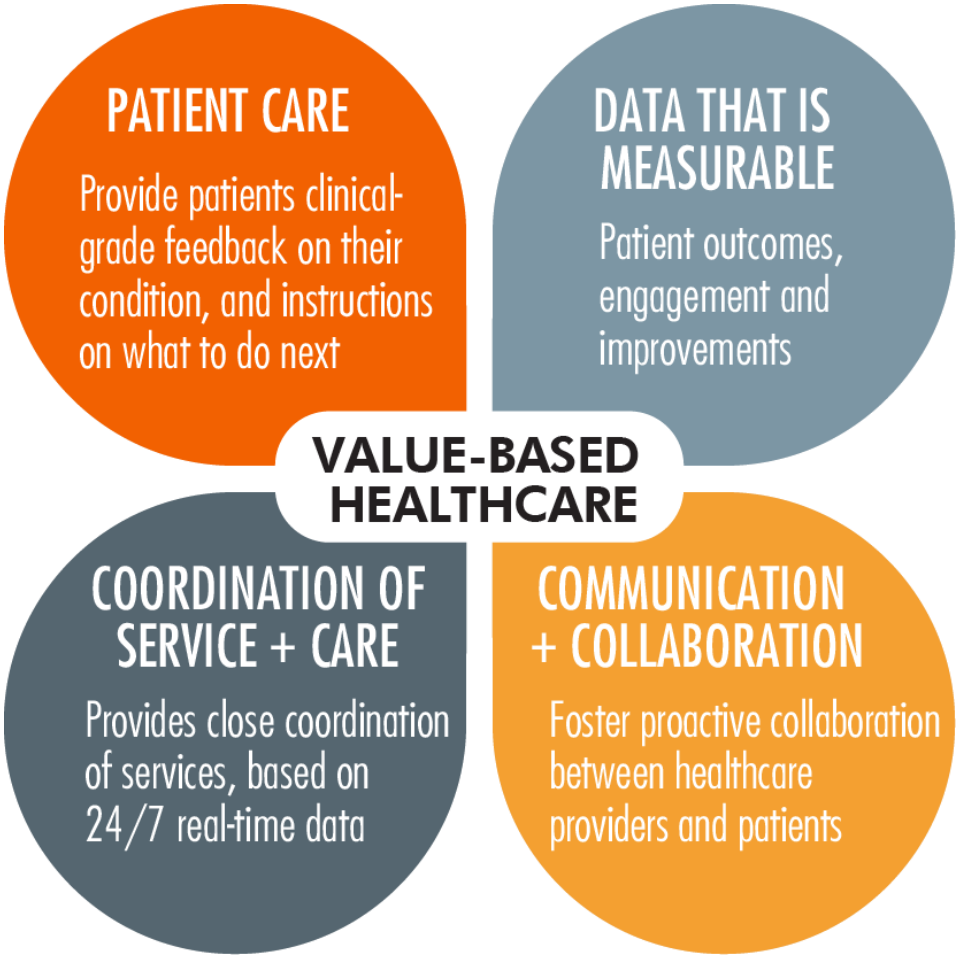
Increasing Patient Complexity and Comorbidities

Dillon&Prokesch in *Harvard Business Review*

Shifting Towards Integrated, Value-based Models of Care



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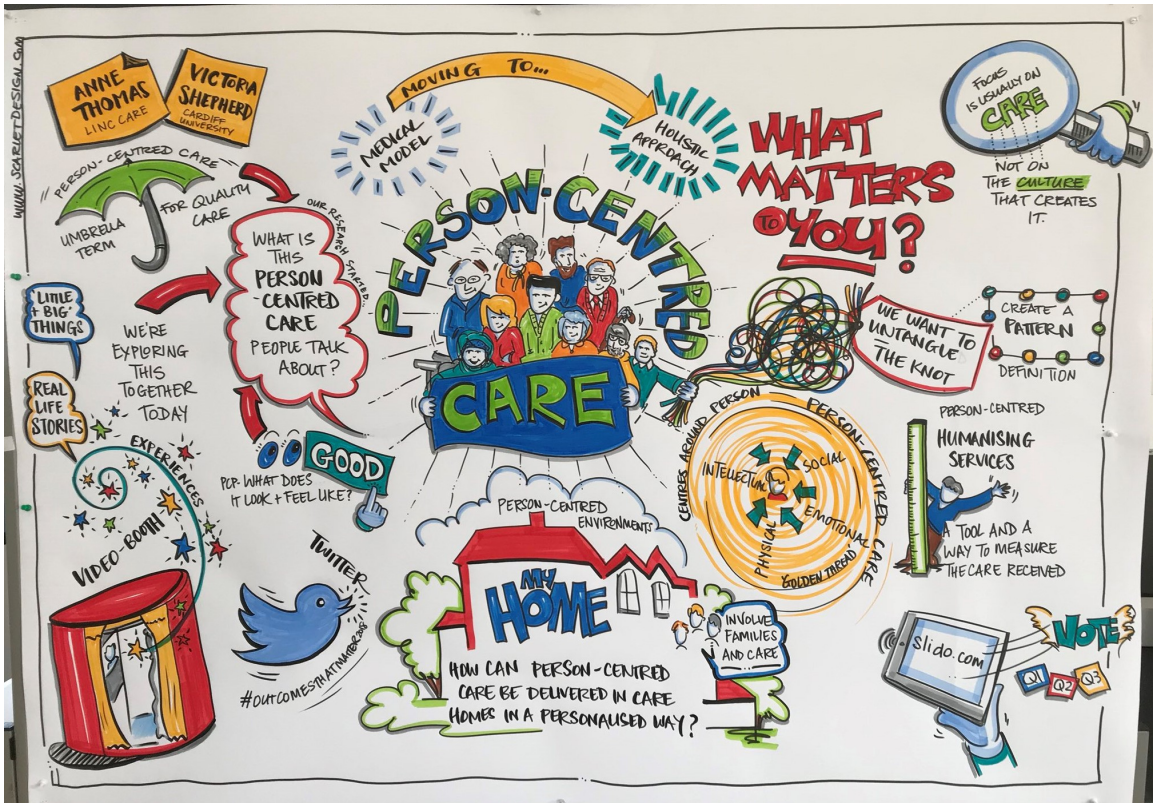
Enhancing Person-centred Care through Engagement and Quality Experiences



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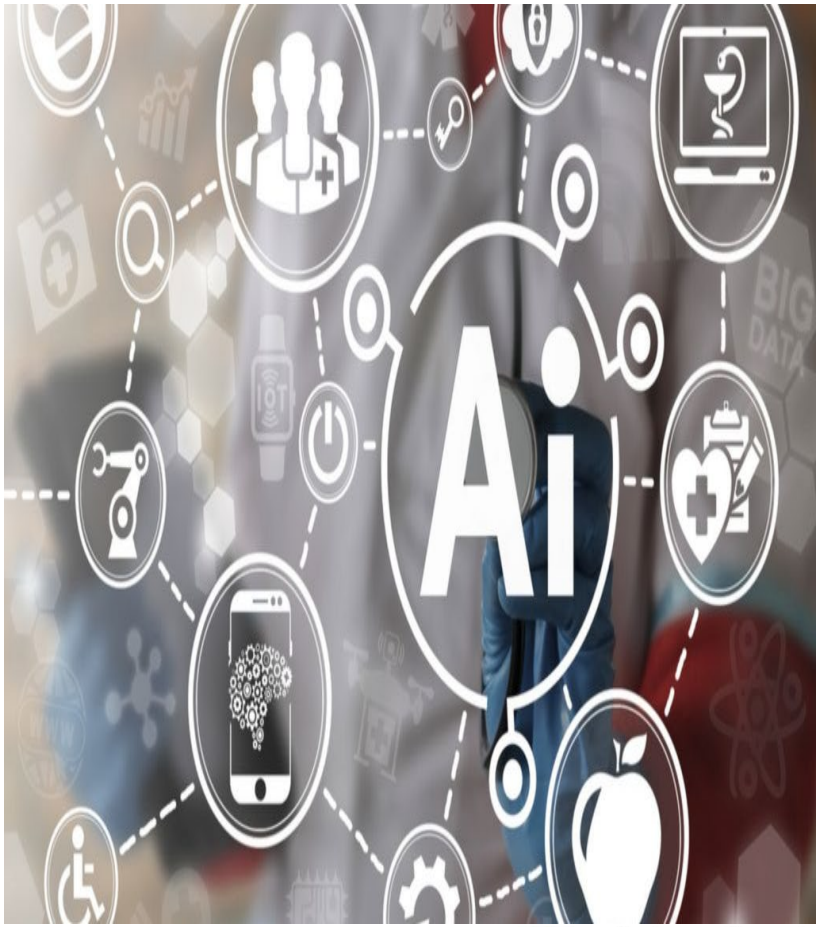
Advancing Electronic Platforms and Analytics



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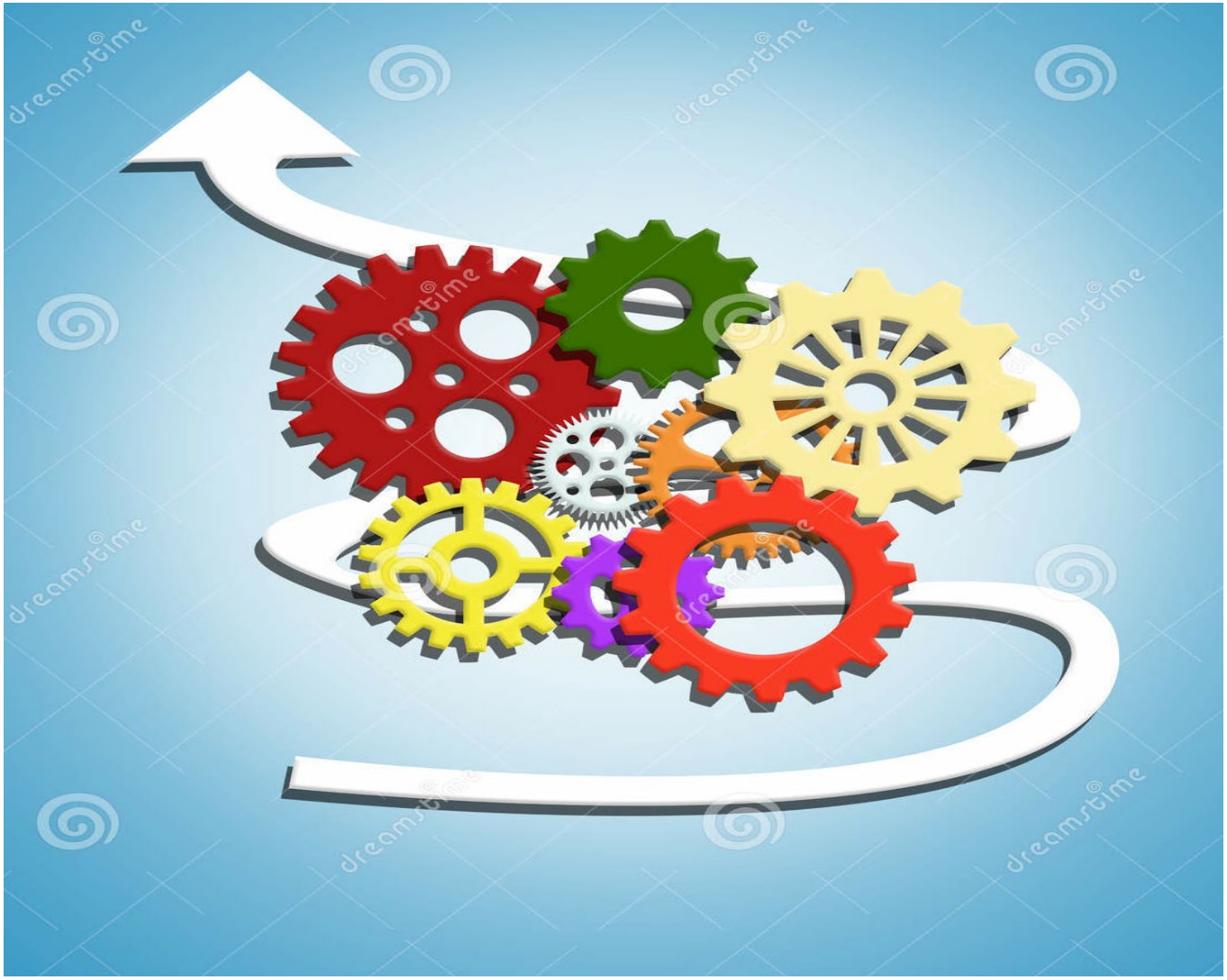
What to Measure? Leveraging and Co-designing Measures



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Aligning with PREMs & PROM Measures

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction survey results

National Patient Satisfaction Survey Questions	National Average	National Top 10%	Baptist Health Overall	Baptist Hospital	Doctors Hospital	Homestead Hospital	Mariners Hospital	South Miami Hospital	West Kendall Baptist Hospital
Percent of patients **highly satisfied**	71	82	77	75	75	75	85	74	75
Nurses always **communicated** well	79	86	83	80	81	82	88	85	81
Doctors always **communicated** well	82	89	84	82	86	81	89	84	82
Patients always received **help** as soon as they wanted	68	80	67	62	61	67	82	68	60
Pain was always well-controlled	71	78	73	72	69	71	72	78	75
Staff always explained about **medicines**	65	72	68	66	61	70	78	69	66
Patient's room and bathroom always kept **clean**	74	84	77	73	76	79	82	73	81
Patient's room always kept **quiet** at night	62	74	69	62	64	74	73	69	71
Patients given **information** about **recovery** at home	86	91	85	86	84	84	88	84	84
Patients would **definitely recommend** this	71	83	80	79	79	75	87	81	76

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Advancing Symptom Science

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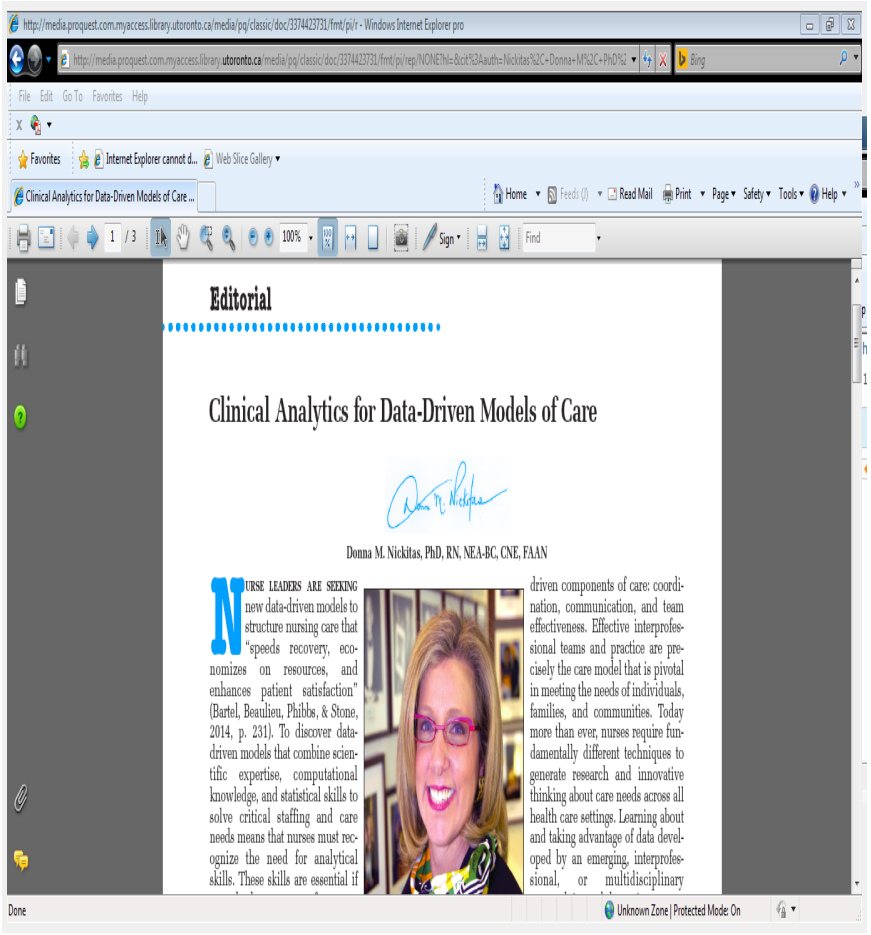
Linking with Context: Staffing Science & Models of Care

RN4CAST
nurse forecasting in Europe



Editorial

Clinical Analytics for Data-Driven Models of Care

Donna M. Nickitas, PhD, RN, NEA-BC, CNE, FAAN

NURSE LEADERS ARE SEEKING new data-driven models to structure nursing care that "speeds recovery, economizes on resources, and enhances patient satisfaction" (Bartel, Beaulieu, Phibbs, & Stone, 2014, p. 231). To discover data-driven models that combine scientific expertise, computational knowledge, and statistical skills to solve critical staffing and care needs means that nurses must recognize the need for analytical skills. These skills are essential if

driven components of care: coordination, communication, and team effectiveness. Effective interprofessional teams and practice are precisely the care model that is pivotal in meeting the needs of individuals, families, and communities. Today more than ever, nurses require fundamentally different techniques to generate research and innovative thinking about care needs across all health care settings. Learning about and taking advantage of data developed by an emerging, interprofessional, or multidisciplinary

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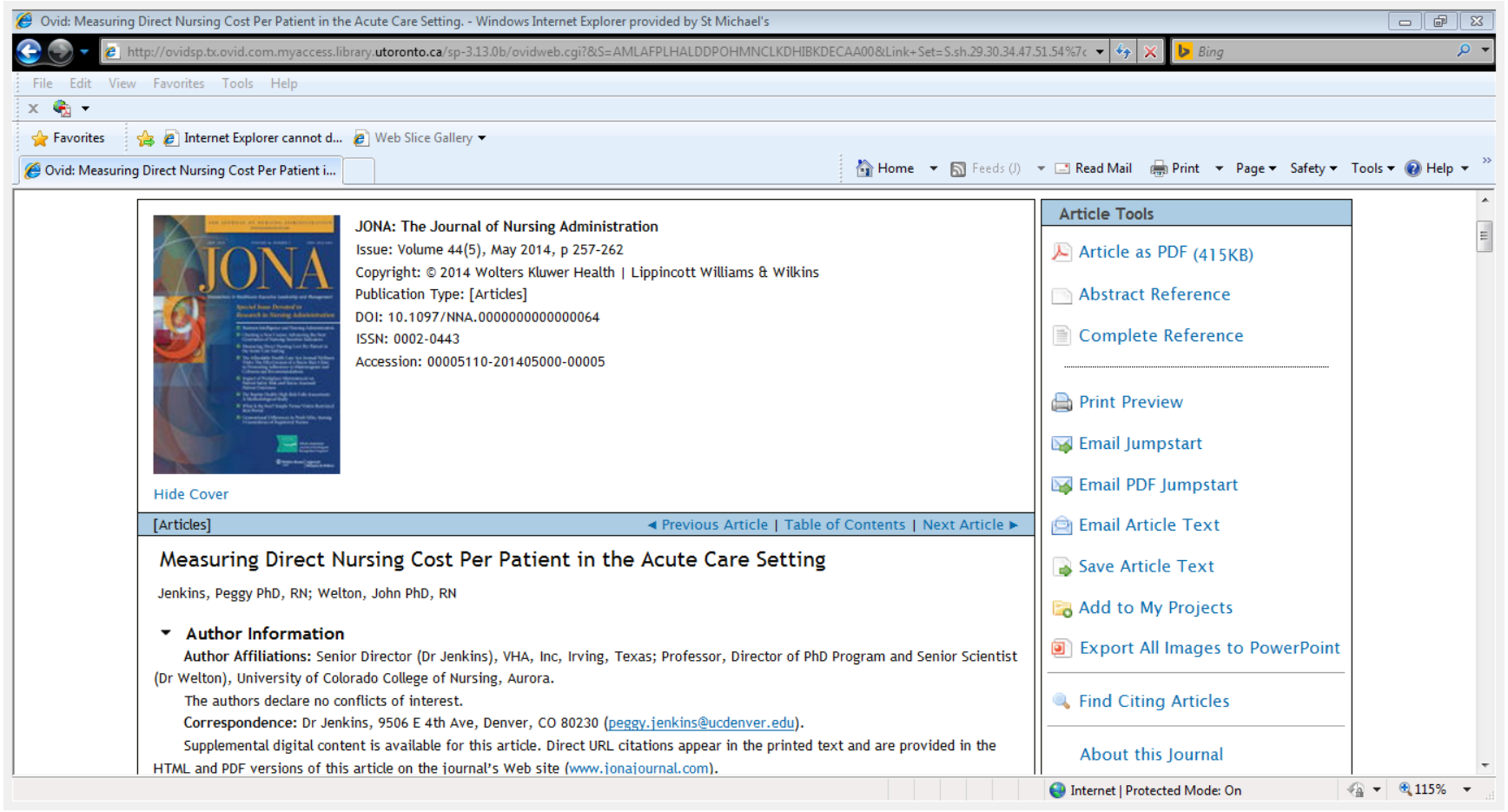
Measuring Cost of Care/Return on Investment



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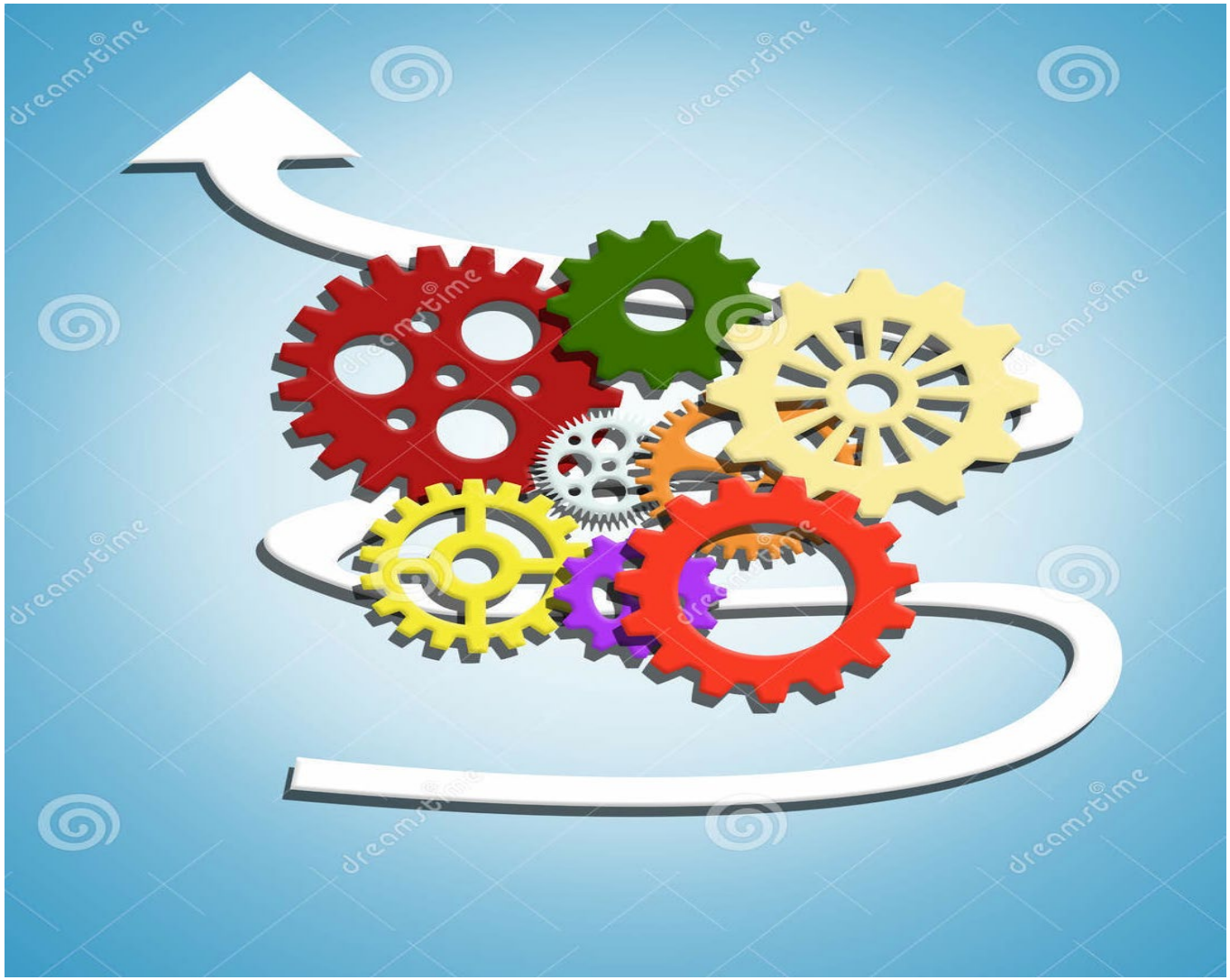
Current Data Set Sources for Fundamental Care

- **Experience Measures** – NRC Picker, HCAPHS Survey, Canadian Patient Experiences Survey
- **Outcome Measures** – event tracker (reported and aggregate), discharge abstract summaries (documented and coded), financial reports, registries etc.

Initiatives such as Magnet Designation - National Database Nursing Quality Indicators (e.g. Nursing Foundations for Quality of Care and outcome data) and NICHE (e.g. Geriatric Institutional Assessment Profile) can serve as potential data sources

How to Measure?



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Varying Perspectives on Measures

Open Medicine, Vol 6, No 2 (2012)

ANALYSIS AND COMMENT

The use of quality indicators to promote accountability in health care: the good, the bad, and the ugly

ALAN J FORSTER, CARL VAN WALRAVEN

Alan J. Forster, MD, FRCPC, MSc, is Scientific Director, Performance Measurement, The Ottawa Hospital; Associate Professor of Medicine, University of Ottawa; Senior Scientist, Ottawa Hospital Research Institute; Scientist, ICES@uOttawa; and Executive in Residence, Telfer School of Management, University of Ottawa, Ottawa, Ontario, Canada. Carl van Walraven, MD, FRCPC, MSc, is Associate Professor of Medicine, University of Ottawa; Senior Scientist, Ottawa Hospital Research Institute; and Site Director, ICES@uOttawa, Ottawa, Ontario, Canada.

Selecting Measures

1) Structure, Process vs. Outcome Indicators - Outcome indicator important to patients, prominent, powerful for performance improvement, but not under control of the healthcare provider as structure or process related ones.

2) Composite vs. Individual Indicators – Composite useful for comparing providers, institutions, systems and are reader-friendly, but give an oversimplified picture.

Health Quality Ontario 2014

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Selecting Measures

3) Qualitative vs. Quantitative Indicators – Qualitative useful in capturing usually-overlooked elements of performance; richer data; helpful for generating ideas, but with issues of reliability and validity.

4) Individual Providers' vs. Organizational Level Indicators – Organizational level gives a simplified measure of complex data and doesn't reflect individual providers' level differences.

Tensions to Address

Determining **WHAT** & **HOW** to measure requires reconciling:

- ✓Focus on negative deficit vs. health
- ✓Measure others not us view
- ✓Outcome measure is not a sound measure
- ✓Relevancy vs. feasibility trade-off
- ✓Divergent perspectives of what matters as outcomes measures
- ✓Multiple data sources – lack of integration

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Tensions to Address

Determining **WHAT** & **HOW** to measure requires reconciling:

- ✓How best to measure cost
- ✓Single indicator vs. index/composite
- ✓Specificity vs. sensitivity within the interprofessional context
- ✓Large system transformation vs. local innovation
- ✓Standardized data set vs. no “one size fits all” approach

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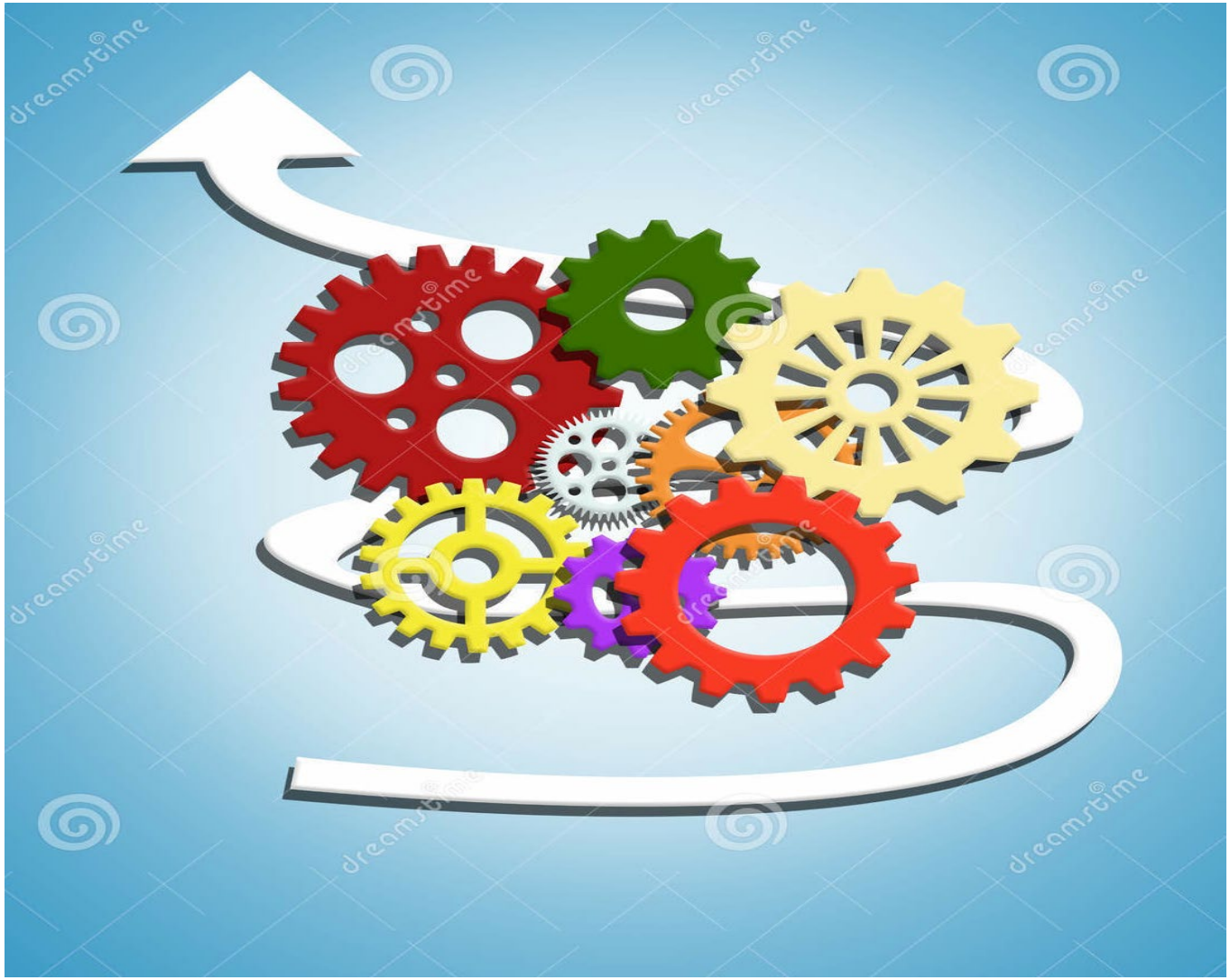
When to Measure?



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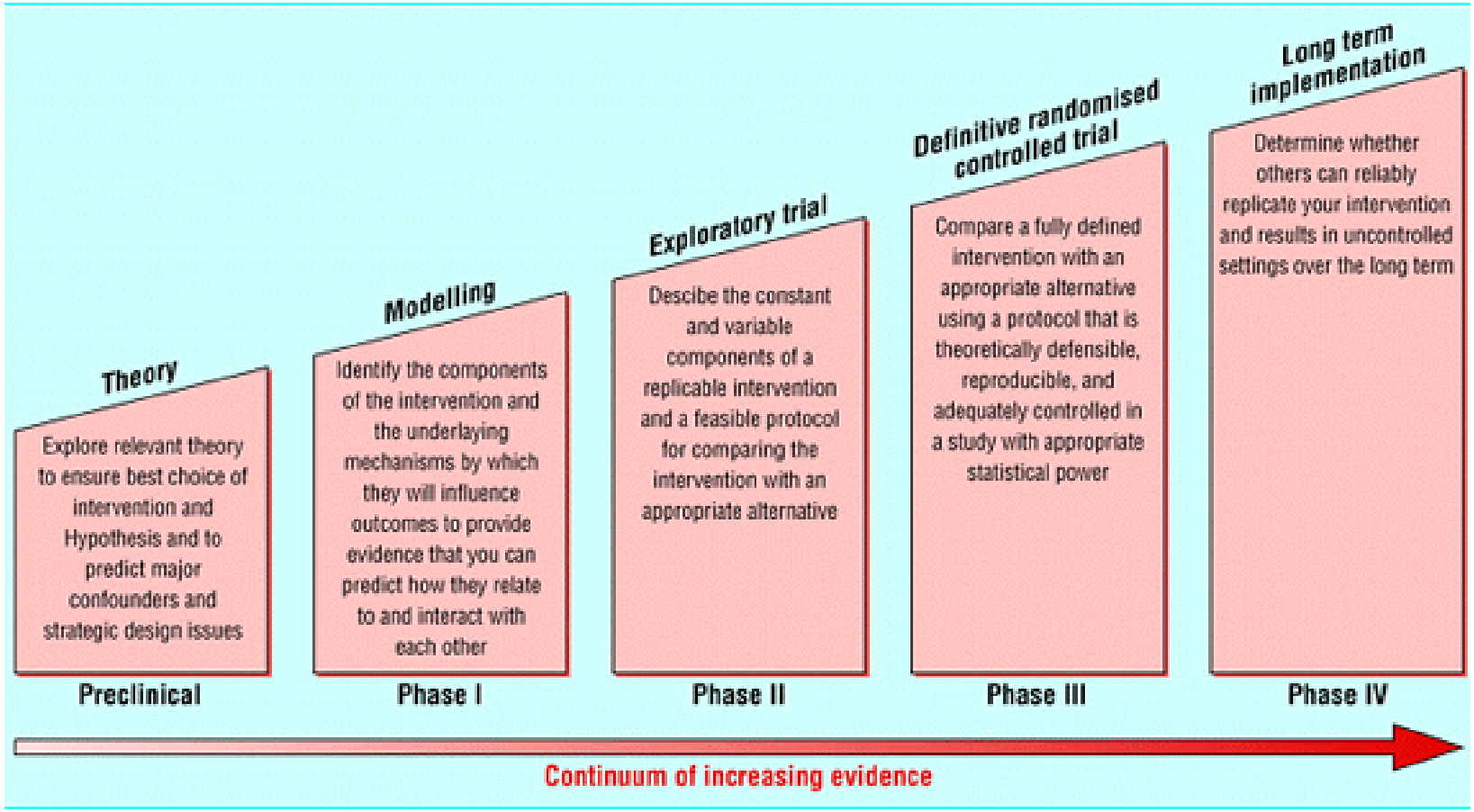
MRC Evaluation Framework for Evaluating Complex Interventions



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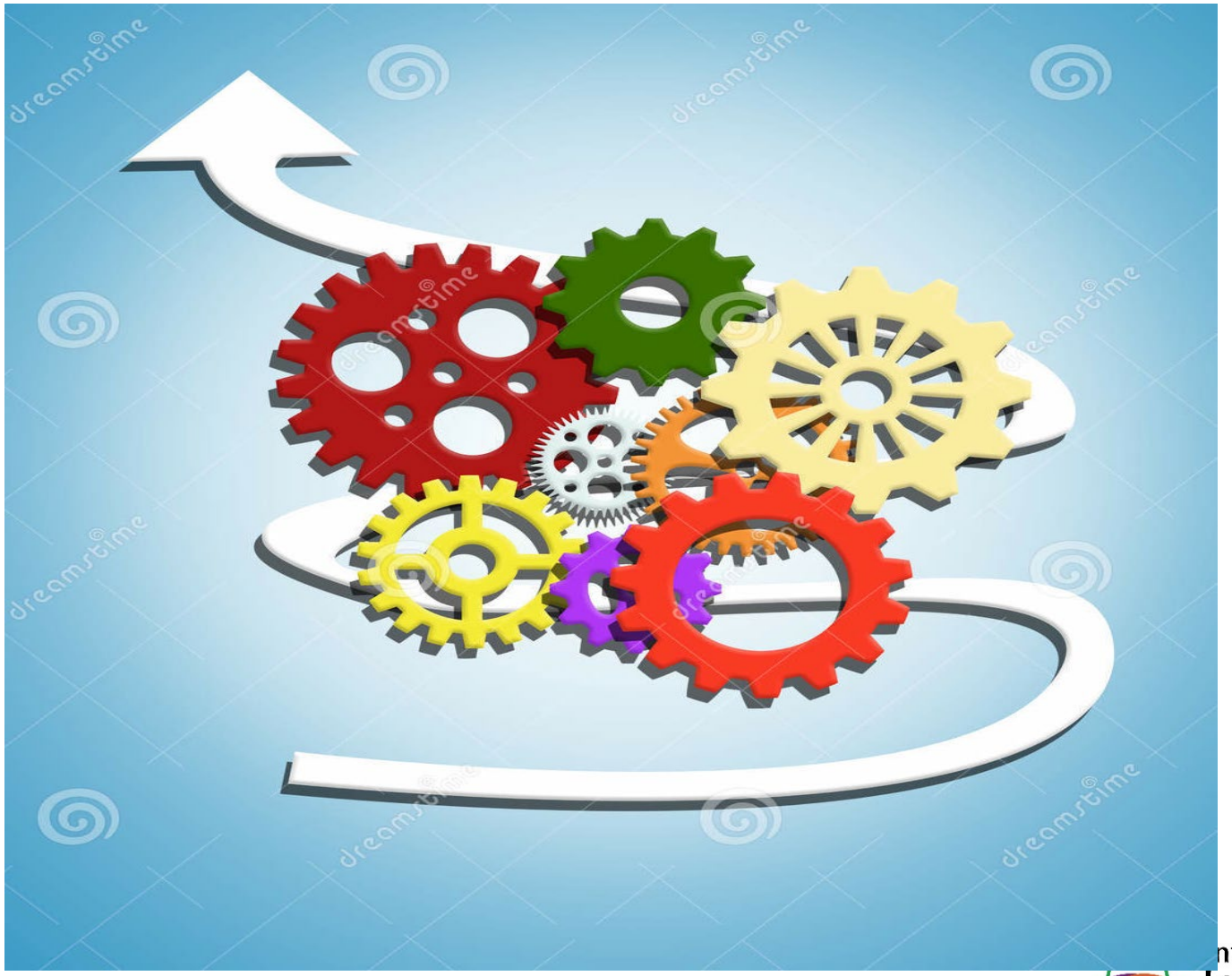
Generating Minimum Data Sets for Fundamental Care



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Aligning Measures with the Fundamental Care Conceptual Definition

Fundamental care involves actions on the part of the nurses that respect and focus on a person's essential needs to ensure their psychological wellbeing. These needs are met by developing a positive and trusting relationship with the person being cared for as well as their family/carers.

Feo 2018 et al.

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Framing Measures within the Fundamental Care Formula

Outcome		Process	Structure (Context)
Patient-centred fundamental care	=	Practice processes (Relationships + integrated Fundamentals of care + Context)	

Fundamental care measurement framework

Jeffs et al 2018

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Key Questions to Address …

How best to leverage and adapt existing and create new measures and methods that more accurately capture the impact of fundamental care on patient, provider, organization and system outcomes?

- What needs to be measured from a variety of stakeholders including patients and caregivers and how can it be linked to minimum datasets?
- For each data element – does it exist already, ***if yes*** how do we access it at @ reasonable cost with low burden? ***if no***– how do we access/extract in reasonable time @ reasonable cost @ reasonable burden? [how to overcome barriers?]
- How can data sets for assessment, practice, and research be maintained and accessible?
- How can we collaborate around developing minimum data sets at system (e.g. integrated) and sector (e.g acute care) levels?

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Key Questions to Address …

How can we best align and advance a standardised data set for fundamental care with evolving trends in the population, models of care, technological and analytical advances in data, and person-centred approaches?

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DOI: 10.1111/jocn.14308

DISCURSIVE PAPER

WILEY Journal of Clinical Nursing

Building the foundation to generate a fundamental care standardised data set

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Aim and objectives: This paper provides an overview of the current state of performance measurement, key trends and a methodological approach to leverage in efforts to generate a standardised data set for fundamental care.

Background: Considerable transformation is occurring in health care globally with organisations focusing on achieving the quadruple aim of improving the experience of care, the health of populations, and the experience of providing care while reducing per capita costs of health care. In response, healthcare organisations are employing performance measurement and quality improvement methods to achieve the quadruple aim. Despite the plethora of measures available to health managers, there is no standardised data set and virtually no indicators reflecting how patients actually experience the delivery of fundamental care, such as nutrition, hydration, mobility, respect, education and psychosocial support.

Conclusions: Given the linkages of fundamental care to safety and quality metrics, efforts to build the evidence base and knowledge that captures the impact of enacting fundamental care across the healthcare continuum and lifespan should include generating a routinely collected data set of relevant measures.

Relevance to clinical practice: This paper provides an overview of the current state of performance measurement, key trends and a methodological approach to leverage in efforts to generate a standardised data set for fundamental care. Standardised data sets enable comparability of data across clinical populations, healthcare sectors, geographic locations and time and provide data about care to support clinical, administrative and health policy decision-making.

KEYWORDS
cost of care, health services research, integrated care, nurse-patient relationship

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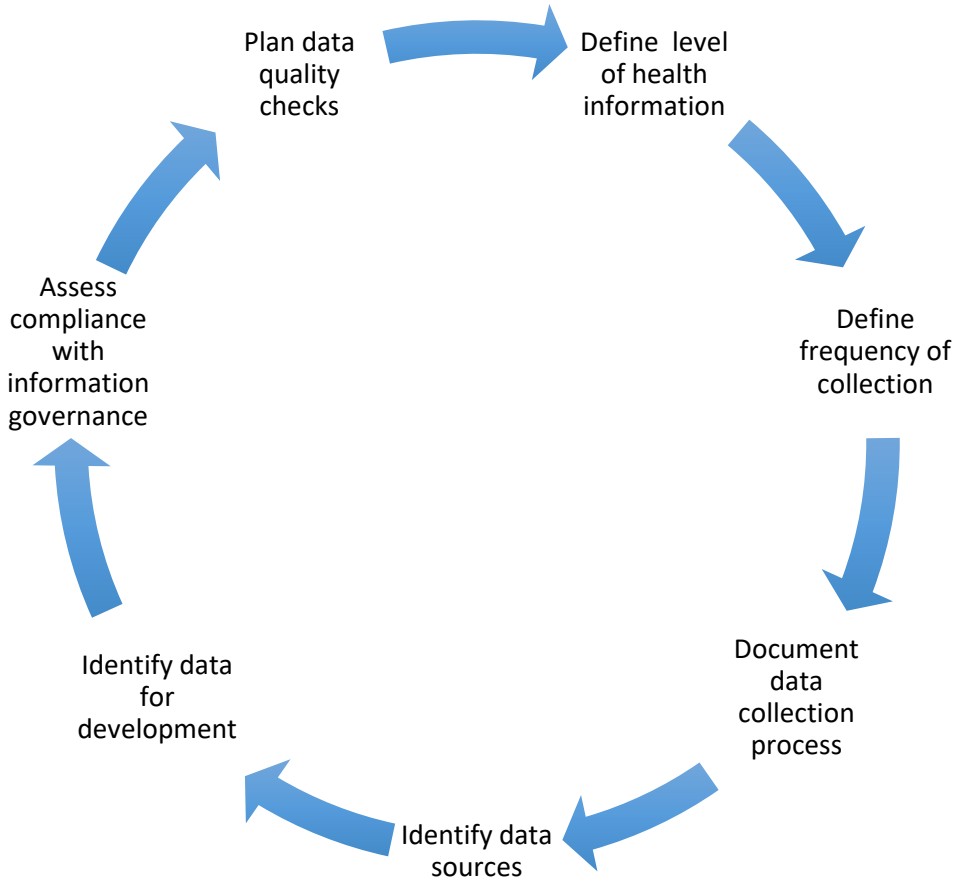
Criteria to Determine Fundamental Care Indicators

- Important to stakeholders in the healthcare system
- Sound scientifically, including clinical logic and measurement properties
- Measurable and feasible to collect
- Risk-adjusted (if an outcome measure to enable comparability across settings)

Agency for Healthcare Research and Quality, 2016; Griffiths, Jones, Maben, & Murrells, 2008

Developing a Minimum Data Set for Fundamental Care



Health Information and Quality Authority (2013)

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Defining responsibility for fundamental care delivery

Dr Tiffany Conroy

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Research Questions

1. *Which fundamental care needs are detected by participants when presented with different care scenarios?*
2. *How do participants' abilities in detecting fundamental care needs compare based on their level of study?*
3. **Who do participants identify as being responsible for addressing each of these fundamental care needs?**

Q's 1 and 2 published: Jangland E, Mirza N, Conroy T, Merriman C, Suzuki E, Nishimura A, Ewens A, 2018 Nursing students' understanding of the Fundamentals of Care: A cross-sectional study in five countries. J Clin Nurs. vol. 27, no. 11-12, pp. 2460-2472.

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Method and Data Collection

- A cross-sectional, descriptive study design was used in 5 universities in 5 different countries.

- All nursing students (pre and post registration) were invited to participate and data collected included previous nursing experience, program of study, and year of study data.

- 3 patient scenarios were developed by the research team and provided in English, Swedish and Japanese. The scenarios underwent a content validity process. For each care scenario, participants were required to identify and indicate the Fundamentals of Care relevant to the scenario.

- 3248 nursing students were invited to participate and 371 fully completed the survey. Data was collected between February and November 2016.

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Scenario 1

Reza is an 85 year old Iranian man who was admitted to a busy Emergency Department 4 hours ago with abdominal pain for investigation. A family member accompanies him. He has been fasting since he arrived and he has not been to the toilet since he was admitted. He is now becoming restless and has been trying to get out of bed by climbing over the bedrails. He speaks Persian only.

Safety, prevention and medication 45%	Rest and sleep
Communication and education 85%	Comfort (including pain management) 68%
Respiration	Dignity 5%
Eating and drinking	Privacy
Elimination 67%	Respecting choice
Personal cleansing and dressing	Mobility
Temperature control	Expressing sexuality

% indicates the number of respondents who identified this 'correct' care need

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Scenario 2

Katarina is a 42 year old woman who suffered a stroke ten days ago. She has right-sided weakness and it is difficult for her to express her needs verbally (aphasia). Due to her weakness, she requires two people to assist with standing and can do a step transfer from bed to chair. She is able to eat and drink safely, but is embarrassed by her facial weakness which is causing her to dribble when drinking fluids. She is increasingly frustrated by her communication difficulties but is extremely motivated to participate in her rehabilitation.

Safety, prevention and medication 15%	Rest and sleep
Communication and education 76%	Comfort (including pain management) 29%
Respiration	Dignity 8%
Eating and drinking 45%	Privacy 6%
Elimination	Respecting choice 76%
Personal cleansing and dressing 20%	Mobility
Temperature control	Expressing sexuality

% indicates the number of respondents who identified this 'correct' care need

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Scenario 3

Cindy is a 13-year-old teenager who is performing poorly in her studies. Her mother brought Cindy to the Health Clinic because Cindy has lost 10 kg in the last four months due to her poor eating habits. Cindy is afraid that if she eats, she will become obese. Cindy tells the nurse that she is only trying to stay fit and do what all of her friends are doing. Since Cindy's boyfriend is always talking about slim girls on TV, Cindy wants to become slimmer. To achieve this goal, Cindy has started to skip breakfast and lunch. Cindy also tells the nurse that she has difficulty sleeping due to hunger, and that she eats some popcorn and chocolates every time her hunger gets out of control.

Safety, prevention and medication 12%	Rest and sleep 11%
Communication and education 55%	Comfort (including pain management) 55%
Respiration	Dignity 35%
Eating and drinking 64%	Privacy 1%
Elimination	Respecting choice 5%
Personal cleansing and dressing	Mobility
Temperature control	Expressing sexuality

% indicates the number of respondents who identified this 'correct' care need

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Frequently identified fundamental care needs

Communication and education was identified frequently in all scenarios as a fundamental of care.

This may indicate that nursing curricula are doing a good job at ensuring nurses see their role as requiring skills in communication and education.

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Infrequently identified fundamental care needs

Fundamental care needs not frequently identified were *Privacy* and *Respecting choice*.

This could be interpreted in several ways.

This may have been because students didn't think these broader care needs required specific identification.

It could reflect uncertainty that students had about what constitutes a fundamental care need.

The students may have been more focussed on the physical aspects of care.

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Responsibility for meeting care needs

- Research question
  - Who do participants identify as being responsible for addressing each of the fundamental care needs?

- Questions we asked of the data
  - Are there differences between countries in who is identified by participants as being responsible for various fundamentals of care?
  - Are there differences between pre and post registration participants in who they identify as being responsible for each fundamental of care?
  - Does who is identified as responsible for each fundamental of care change from scenario to scenario?

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Responses from each country

Country	Pre registration (n=)	Post registration (n=)
Australia	35	32
UK*	31	8
Sweden	57	58
Japan*	138	11

* comparisons not made between pre and post due to unequal numbers

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Scenario 1: Safety Prevention and medication (% of responses, more than one response was accepted thus some >100%)

Roles	JAPAN (n=50)	AUSTRALIA (n=42)	SWEDEN (n=31)	UK (n=17)
AN/HCA/ Care assistant	0	0.0	61.3	17.6
Family	4	7.1	0.0	0.0
Interpreter	6	0.0	0.0	0.0
Other	6	2.4	0.0	5.9
Physician	28	19.0	16.1	17.6
PT	2	0.0	0.0	0.0
RN	86	88.1	87.1	35.3
SALT	0	0.0	0.0	5.9
Team	0	0.0	3.2	5.9

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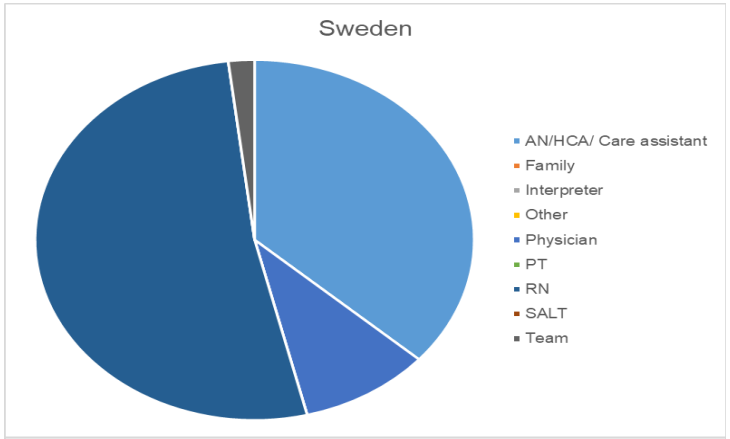
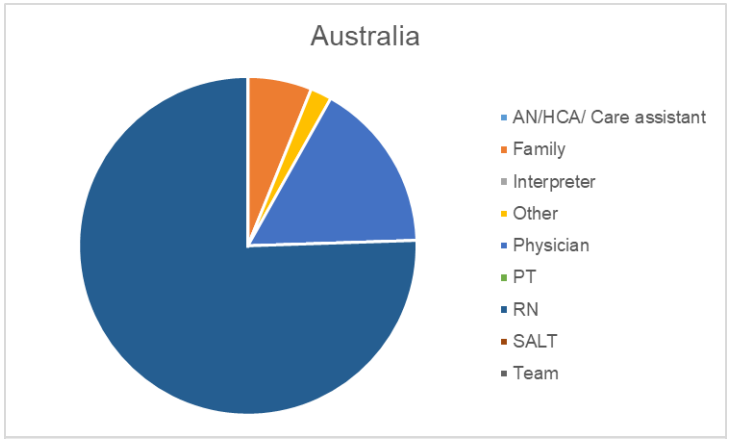
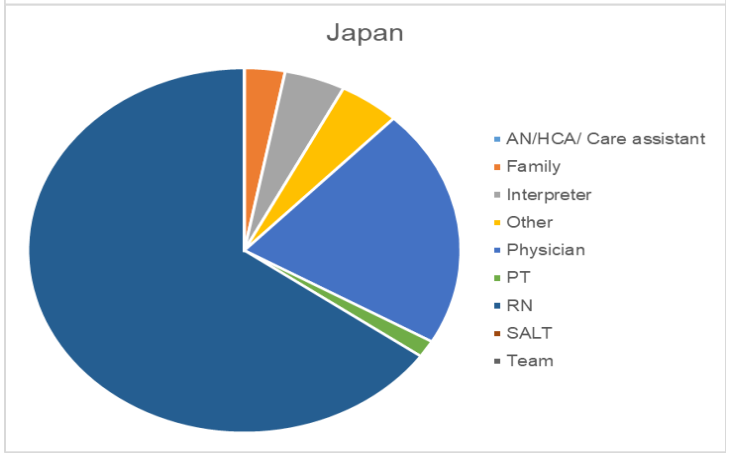
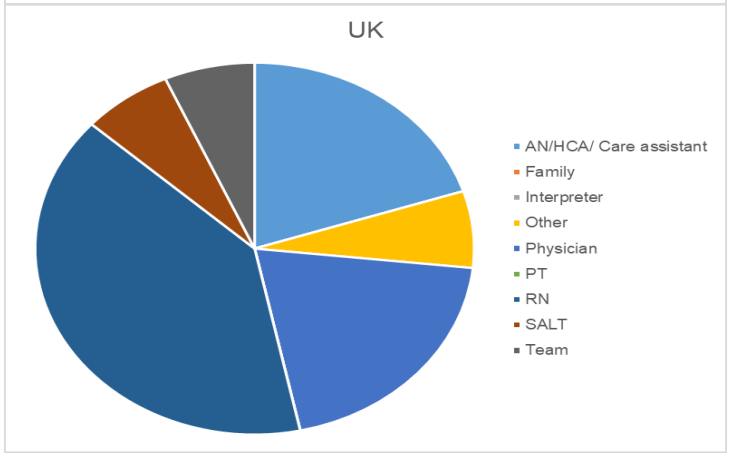
Scenario 1: Safety Prevention and medication









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Differences between pre and post registration participants Safety etc.

Scenario 1 (Australia and Sweden only)

ROLE	SWEDEN PRE (n=15)	SWEDEN POST (n=16)
AN/HCA/ Care assistant	53.3	68.8
Physician	13.3	18.8
RN	93.3	81.3
Team	0	6.2

ROLE	AUSTRALIA PRE (n= 21)	AUSTRALIA POST (n=21)
Family	0	14.3
Other	0	4.8
Physician	23.8	14.3
RN	100	76.2

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Scenario 2: Safety Prevention and medication (% of responses, more than one response was accepted thus some >100%)

Roles	SWEDEN (n=12)	AUSTRALIA (n=17)	UK (n=9)	JAPAN (n=17)
AN/HCA/ Care assistant	16.7	0.0	0.0	0.0
Dietician/nutritionist	0.0	0.0	0.0	0.0
Family	0.0	5.9	0.0	0.0
OT	8.3	5.9	22.2	17.6
Other	0.0	0.0	11.1	5.9
Physician	8.3	17.7	11.1	23.5
Psychologist	0.0	0.0	0.0	0.0
PT	8.3	5.8	0.0	23.5
RN	58.3	76.5	22.2	94.1
SALT	0.0	0.0	0.0	11.8
Social Worker	0.0	4.9	0.0	0.0
Team	8.3	17.65	0.0	0.0

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Differences between pre and post registration participants Safety etc.

Scenario 2 (Australia and Sweden only)

ROLE	SWEDEN Pre (n=3)	SWEDEN Post (n=9)
AN/HCA/ Care assistant	0.0	22.2
OT	33.3	0.0
Physician	0.0	11.1
PT	33.3	0.0
RN	66.7	55.6
Team	0.0	11.1

ROLE	AUSTRALIA Pre (n=11)	AUSTRALIA Post (n=6)
Family	0.0	16.7
OT	9.1	0.0
Physician	27.3	0.0
PT	9.1	0.0
RN	72.7	83.3
Team	18.2	16.7

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Scenario 3: Safety Prevention and medication (% of responses, more than one response was accepted thus some >100%)

ROLES	SWEDEN (n=0)	AUSTRALIA (n=14)	UK (n=12)	JAPAN (n=12)
Dietician/nutritionist	0	7.1	0.0	0.0
Other	0	14.3	33.3	41.7
Physician	0	35.7	33.3	50.0
Psychologist	0	14.3	8.3	0.0
PT	0	7.1	0.0	0.0
RN	0	64.3	25.0	75.0
SALT	0	0.0	0.0	0.0
Social Worker	0	0.0	0.0	0.0
Team	0	21.4	16.7	0.0

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Differences between pre and post registration participants Safety etc.

Scenario 3 (Australia only, no Swedish answers)

Roles	AUSTRALIA Pre (n=10)	AUSTRALIA Post (n=4)
Dietician/nutritionist	0	25
Other	10	25
Physician	30	50
Psychologist	0	50
PT	0	25
RN	70	50
Team	30	0

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Scenario 1: Comfort

(% of responses, more than one response was accepted thus some >100%)

Roles	SWEDEN (n=101)	AUSTRALIA (n=58)	UK (n=34)	JAPAN (n=115)
AN/HCA/ Care assistant	9.9	0.0	0.0	0.0
Family	0.0	7.5	0.0	11.1
Interpreter	0.0	1.9	3.6	6.0
Other	0.0	0.0	3.6	17.1
Physician	70.4	52.8	32.1	45.3
RN	85.9	84.9	42.9	59.8
Social Worker	0.0	1.9	0.0	0.0

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Differences between pre and post registration participants Comfort Scenario 1

(Australia and Sweden only)

Roles	SWEDEN Pre (n=47)	SWEDEN Post (n=54)
AN/HCA/ Care assistant	0	17.9
Physician	87.5	69.2
RN	87.5	92.3

Roles	AUSTRALIA Pre (n=30)	AUSTRALIA Post (n=28)
Family	12	3.6
Interpreter	4	0.0
Physician	48	57.1
RN	80	89.3
Social Worker	4	0.0
Team	12	0.0

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Scenario 2: Comfort

(% of responses, more than one response was accepted thus some >100%)

Roles	SWEDEN (n=2)	AUSTRALIA (n=28)	UK (n=12)	JAPAN (n=50)
AN/HCA/ Care assistant	50	0.0	0.0	0
Family	50	32.1	8.3	2
OT	0	3.6	16.7	28
Other	0	17.9	0.0	12
Physician	0	25.0	0.0	6
Psychologist	0	21.4	0.0	0
PT	0	10.7	8.3	30
RN	50	71.4	8.3	84
SALT	0	3.6	0.0	8
Social Worker	0	21.4	0.0	2
Team	0	10.7	8.3	2

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Differences between pre and post registration participants Comfort Scenario 2

(Australia and Sweden only)

Roles	SWEDEN Pre	SWEDEN Post (n=2)
AN/HCA/ Care assistant	0	50
Family	0	50
RN	0	50

Roles	AUSTRALIA Pre (n=11)	AUSTRALIA Post (n=17)
Family	27.3	35.3
OT	0.0	5.9
Other	18.2	17.6
Physician	36.4	17.6
Psychologist	18.2	23.5
PT	9.1	11.8
RN	90.9	58.8
SALT	0.0	5.9
Social Worker	18.2	23.5
Team	27.3	0.0

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Scenario 3: Comfort

(% of responses, more than one response was accepted thus some >100%)

Roles	SWEDEN (n=0)	AUSTRALIA (n=29)	UK (n=27)	JAPAN (n=60)
Dietician/nutritionist	0	3.4	0.0	3.3
Family	0	37.9	3.7	8.3
Other	0	24.1	7.4	55.0
Physician	0	20.7	0.0	35.0
Psychologist	0	20.7	3.7	0.0
RN	0	72.4	0.0	75.0
Social Worker	0	17.2	0.0	1.7
Team	0	13.8	0.0	0.0

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Differences between pre and post registration participants Comfort Scenario 3 (Australia only, no Swedish answers)

Roles	AUSTRALIA Pre (n=14)	AUSTRALIA Post (n=15)
Dietician/nutritionist	7.1	0.0
Family	35.7	40.0
Other	14.3	33.3
Physician	28.6	13.3
Psychologist	14.3	26.7
RN	78.6	66.7
Social Worker	14.3	20.0
Team	21.4	6.7

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Discussion

- Are there differences between countries in who is identified by participants as being responsible for various fundamentals of care?
  - YES
- Are there differences between pre and post registration participants in who they identify as being responsible for each fundamental of care?
  - YES (but why?)
- Does who is identified as responsible for each fundamental of care change from scenario to scenario?
  - ??

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Limitations

- Response numbers decreased from Scenario 1 to Scenario 3.
- Over all response numbers are small and statistical significance is unclear.

So now what?

- What are the implications of these findings for education and clinical practice?
- Does this shift in view from pre to post registration regarding responsibility for fundamental care matter?
- Does nursing ‘own’ fundamental care?
- How can we engage our medical and allied health colleagues in highlighting and improving fundamental care delivery?

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Symposium Summary

- Fundamental care is a human right that all recipients of health services can and should expect to receive.
- A global adoption of fundamental care across all sectors relating to the delivery of healthcare is required.
- Fundamental care is foundational to all caring activities, systems and institutions. (value)
- Fundamental care has to be explicitly articulated in all these arenas. (talk)
- Fundamental care has to be deliberately and systematically actions in all these arenas. (do)
- Fundamental care is your, my and everyone's business. (own)

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Questions