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Nursing *Inquiry*

ORIGINAL ARTICLE OPEN ACCESS

The Fundamentals of Care in Practice: A Qualitative Contextual Inquiry

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Received: 14 November 2024 | **Revised:** 16 February 2025 | **Accepted:** 17 February 2025

Funding: This study was supported by the Health Research Council of New Zealand (20/1259).

Keywords: evidence-based practice | Fundamentals of Care Framework | nursing | person-centred care | qualitative research | theory to practice

ABSTRACT

Empirical evidence on the Fundamentals of Care framework and its relevance to practice is increasing. However, there is a need to understand the evidence in practice and determine how best to evaluate caring activities. This exploratory study aimed to understand current nursing practice with the Fundamentals of Care framework, how nurses understand the framework, and what is essential to patients receiving care. The objectives were (1) to observe nurses in practice and record nurse–patient interactions against the Fundamentals of Care framework dimensions, (2) to probe the nurse's understanding of the framework, (3) to explore what is important to patients when receiving care from nurses, (4) to explore the nurse's and patient's understanding of culture and spirituality, and (5) to identify the barriers and facilitators to delivering integrated care. The study identified four key findings: (1) nurse–patient interactions centred around completing tasks and the physical aspects of care, (2) there are crucial gaps in nurses' ability to connect with their patients and establish a good nurse–patient relationship, (3) integrated fundamental care was not evident in the behaviours and narratives of the nurses, and (4) the context in which care is delivered significantly impacts how nurses work particularly the challenges of using technology and electronic records. Healthcare organisations and nursing leaders need to consider the implications of nurses prioritising the organisation's efficiency-driven requirements over establishing a therapeutic relationship and integrating the patient's care needs. More work is required to support nurses in delivering integrated fundamental care.

1 | Introduction

Nurses comprise the most significant proportion of the healthcare workforce and are central to patient outcomes (Pentecost et al. 2019). Evidence from patients and nurses suggests that care is sometimes inconsistent and inadequate (Conroy 2018). International initiatives continue to situate theories and concepts of care at the centre of nursing practice; however, the literature suggests there needs to be more research evidence that evaluates these concepts and theories in practice. This study uses the Fundamentals of Care (FOC) framework to explore nursing practice at a government-funded hospital in Aotearoa, New Zealand.

The FOC framework was developed in response to healthcare reports identifying patients' unmet fundamental care needs. The priority was redefining nursing practice in an increasingly challenging healthcare environment (Kitson et al. 2010, 2013). The FOC framework is a conceptual framework premised on establishing the nurse–patient relationship and integrating the patients' physical, psychological, and relational needs, influenced by the healthcare context (Figure 1) (Feo et al. 2018; Kitson 2018). Within each dimension of the framework are elements comprising an aspect of care such as nutrition, and nurse actions such as empathy (Feo et al. 2018). At the heart of the framework is the nurse–patient relationship, which is

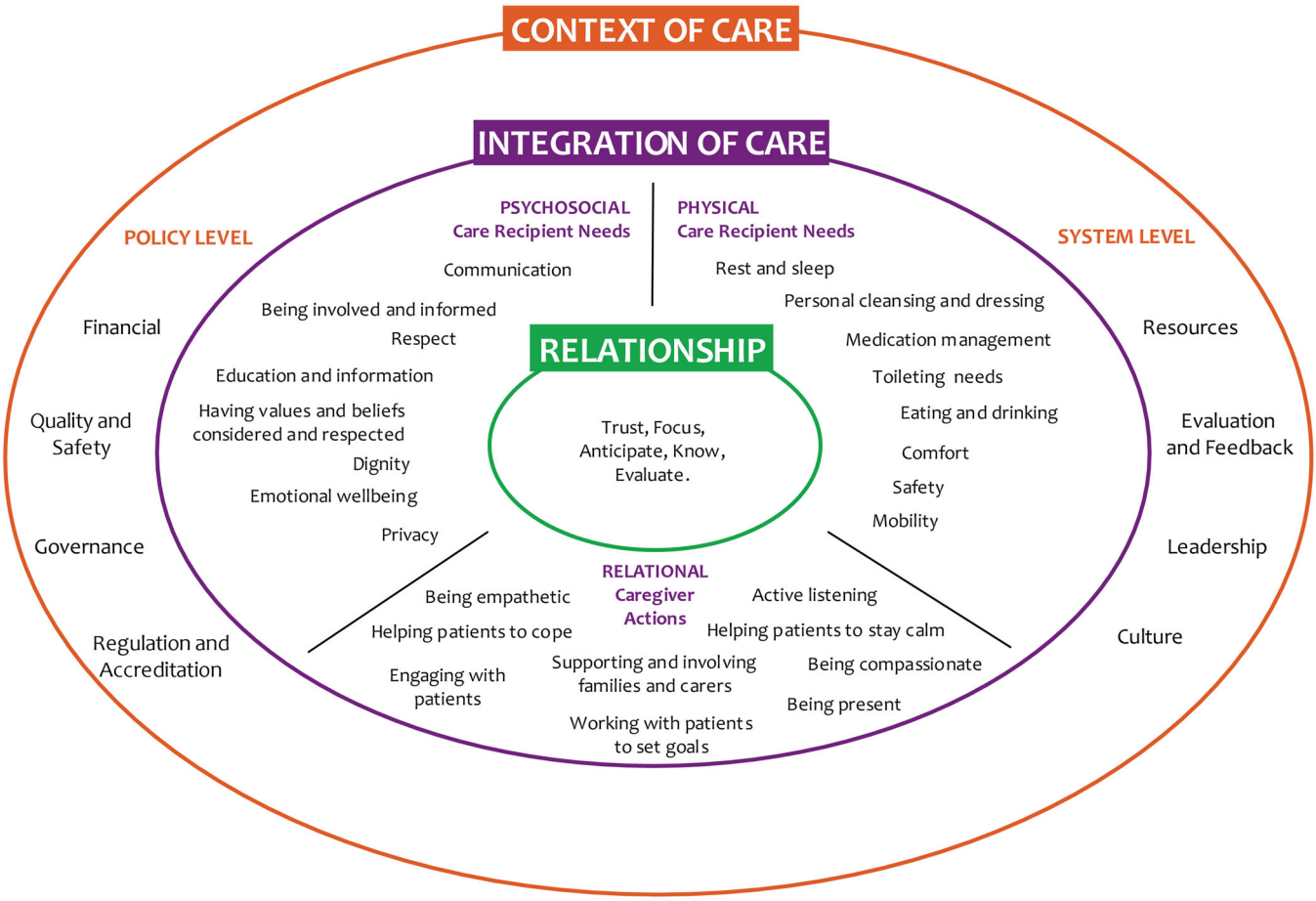

FIGURE 1 | The Fundamentals of Care Framework. *Note:* Adapted from *The Fundamentals of Care Framework*, by The International Learning Collaborative (https://ilccare.org/the-framework/). Reprinted with permission.

imperative to ensuring the psychosocial and relational needs of the patient are met. The literature has extensively discussed what happens between the nurse and the patient to establish this relationship; however, the nurse–patient relationship is still poorly understood in practice (Feo et al. 2022). Since renewing the emphasis on providing integrated fundamental care and redefining the FOC framework for nursing practice, there has been a focus on improving the science and methodologies around reporting and measuring fundamental care, particularly the behavioural aspects of care (Alhalal et al. 2020; Conroy et al. 2021; Feo et al. 2019, 2022).

Fundamentals of Care research has investigated specific patient care needs (Bundgaard et al. 2019; Pentecost et al. 2019; Rey et al. 2020; Sugg et al. 2021) and factors that influence care delivery (Bachnick et al. 2018; Conroy 2018; Jangland et al. 2017; A. Kitson et al. 2019; Kollstedt et al. 2019). There is evidence that nursing practice has shifted, with more focus on getting the task done rather than personalising care into a meaningful experience for the patient, their family and the nurse (Kitson et al. 2019; Van Belle et al. 2020; Younas et al. 2022). Evidence also suggests that nurses want to provide holistic patient care; however, the context in which they work creates a barrier to achieving this due to factors such as inadequate resources, high workload, staffing, and ward culture (Alhalal et al. 2020; Conroy 2018; Younas et al. 2022).

The equivocal nature of concepts such as dignity, respect, and trust makes measuring and evaluating the delivery of the FOC framework in practice challenging. Some tools measure and assess aspects of care, such as the nurse–patient relationship (Feo et al. 2019) and psychosocial care (Bagnasco et al. 2020). However, these tools are not aligned with the FOC framework and do not capture the integration of the elements of care. Complexity science using matrix methodology was recently used to quantify the relationships between different components within the framework (Conroy et al. 2021) with some success, and research continues to progress the matrix methodology for operationalising a way to evaluate the delivery of the FOC framework in practice.

In Aotearoa, New Zealand, the Patient and Whānau Centred Care Standards measurement and improvement programme (Parr et al. 2018) was developed in 2014 to make fundamental care visible by measuring aspects of care against nine care standards using an organisation-wide, unit-led, peer review measurement and evaluation process. This programme is embedded in two government-funded hospitals and has positively improved care and patient experience (Aspinall et al. 2023). The primary objective of this study was to explore nurses' application of the FOC framework in practice at one of these hospitals. The study objectives were based on areas for improvement identified from the results of the measurement and evaluation peer-review programme. For example, previous peer reviews at

the study site showed that consideration for patients' spiritual and cultural needs is poorly assessed and integrated into care delivery.

2 | Methods

2.1 | Study Aims and Objectives

This exploratory study aimed to understand current nursing practice with the FOC framework, how nurses understand the framework, and what is essential to patients receiving care. The objectives were (1) to observe nurses in practice and record nurse–patient interactions against the Fundamentals of Care framework, (2) to probe the nurse's understanding of the FOC framework, (3) to explore what is important to patients when receiving care from nurses, (4) to explore the nurse's and patient's understanding of culture and spirituality, and (5) to identify the barriers and facilitators to delivering integrated care.

2.2 | Design

We used the FOC framework as a theoretical lens to explore nurse–patient interactions. The research design adopted an exploratory contextual inquiry approach that involved participant observation and semi-structured questions (Beyer and Holtzblatt 1998; Privitera 2015). Qualitative contextual inquiry is a form of ethnography that requires observation and interviews with a small sample size to understand work practices and behaviours in complex environments. We complied with the Standards for Reporting Qualitative Research (Elm et al. 2007) (Supporting File 1).

2.3 | Researcher Reflexivity

All authors have worked in healthcare in a clinical or research capacity and acknowledge the different perspectives and experiences they bring to this study. The principal researcher (B.P.) is a registered nurse working at the study site with a master's degree in nursing. The principal researcher knows the organisation well; however, the study participants have never been colleagues. She has in-depth knowledge of the FOC framework and Patient and Whānau Centred Care Standards measurement and improvement programme (Parr et al. 2018).

2.4 | Participants and Recruitment

Registered nurses and patients from acute medical and surgical wards were recruited. The nurses had to be employed permanently in one of the participating wards. Patients were eligible to participate if they were being cared for by the nurse who was being observed. Patients were excluded if the nurse deemed them physiologically unstable or a cause for clinical concern or they were in restricted access, for example, COVID-19 isolation. This study occurred during the COVID-19 pandemic, and strict adherence to infection prevention and control measures meant that any isolated patient was excluded from participation. All participants were required to speak English fluently because translators were unavailable for the study.

Participants were recruited using purposive sampling (Campbell et al. 2020). Author B.P. met with each Charge Nurse Manager before the study to provide information about the research and obtain verbal consent for their ward's participation. Each Charge Nurse Manager was given a specific date for the study and asked to select a nurse to participate. The Charge Nurse Manager provided a participant information sheet and a consent form to the nurse, explaining the purpose of the study. Contact details for the researcher were included on the forms should the nurse have any questions before participation. Participating nurses were assured that although their Charge Nurse Manager assisted with recruitment, no information about their participation would be shared with the Charge Nurse Manager, and all data would be deidentified for reporting.

Author B.P. met with the nurse on the day of observation to discuss what the study entailed, answer questions and obtain written consent. Immediately following the observation period, the nurse was invited to participate in a structured interview, and if they agreed, the consent form was amended to reflect this. Patients allocated to the nurse who met the inclusion criteria were given an information sheet about the study. Author B.P. explained the purpose of the research and what their involvement would be and obtained verbal consent for observer presence. Verbal patient consent for the observation phase is appropriate when no identifying information about the patient is collected (Van Belle et al. 2020). Following the observation period, B.P. selected one patient to interview based on their availability and ability to participate in a conversation about the care they had received and obtained written consent. Based on the specificity of the experiences of our participants and the focused dialogue, we aimed for a sample of 10 nurses and 10 patients. The sample size was determined using information power (Malterud et al. 2016), which specifies that the more information the sample holds that is relevant to the study, the fewer participants required. Beyer and Holtzblatt (1998) support using a small sample size in contextual inquiry.

2.5 | Data Collection

Author B.P. observed and recorded nurse activities using the Work Observation Method by Activity Timing (WOMBAT) tool, an electronic data application usually used to capture clinician work and communication patterns (Westbrook and Ampt 2009). However, the tool was configured for this study to record everyday nurse activities, such as direct patient care and administrative tasks (Table 1). With the direct care activity option, the observer could select any combination of the elements of the FOC framework as they were observed in practice (Figure 2). The elements were categorised according to the dimensions of the FOC framework, i.e. nurse–patient relationship, physical, psychosocial, and relational. Written memos captured descriptions of the shift's staffing configuration and the environment, including the perceived busyness of the ward, interactions between staff and patients and general

TABLE 1 | Working definitions of the activity categories used in the WOMBAT tool.

Type of activity	Working definition
Direct care	Any nurse–patient interaction.
Technology/documentation	Documentation or use of clinical applications that did not occur during a nurse–patient interaction, i.e., waiting to access the electronic medication dispensing system.
Ward management	Ward or patient coordination that did not occur as part of the nurse–patient interaction, e.g., handover, patient transfer, discharge, or procedure preparation.
Assisting other staff	Assisting staff with any activity that did not involve the observed nurse's patient, i.e., assisting staff with their patient care.
Self-care	Time spent at planned meal breaks or toilet breaks.
Interruption	Any interruption to the nurse–patient interaction, i.e., the nurse stopped administering medication to answer a phone call.

observations. Following the observation, structured interviews were undertaken with consenting nurses and patients. In consideration of the nurses' workload and priorities for patient care, interviews were brief. The questions explored the nurse's understanding of the elements of the FOC framework identified as areas for improvement from the measurement and evaluation peer-review programme at the study site.

2.6 | Data Analysis

Authors BP and EK analysed the data using a modified framework method for thematic analysis (Gale et al. 2013). Gale et al.'s (2013) modified framework analysis is flexible and catalogues data deductively using a 7-step process: (1) transcription, (2) familiarisation with the interview, (3) coding, (4) developing a working analytical framework, (5) applying the analytical framework, (6) charting data into the framework matrix, and (7) interpreting the data. Author B.P. transcribed the interviews, and then all authors discussed the data to identify their initial thoughts and impressions. Authors B.P. and E.K. generated initial codes using the FOC framework as the analytical framework. Then, coded data were added to a matrix by authors B.P., E.K., and C.A. to facilitate the exploration and understanding of each data group.

2.7 | Ethical Considerations

Approval to conduct the study was obtained from the Auckland Health Research Ethics Committee (AH22224) in May 2021, and amendments to the study due to changing COVID-19 restrictions were submitted and approved in October 2021. Locality approval was obtained from the study site in June 2021 (#1421).

3 | Findings

Between 3 August 2021 and 9 December 2021, 60 h of observation over 13 days were undertaken. A total of 13 registered nurses were observed. Seven nurses and five patients participated in the structured interviews. All nurse participants were female, ranging from 20 to 39 years. The average nursing experience was 12.7 years (Table 2). Twelve nurses worked full-time. The ethnicity of participating nurses was New Zealand European ($n = 1$), Pacific People ($n = 6$), and Asian ($n = 6$). The ethnicity of participating patients was New Zealand European ($n = 3$) and Māori ($n = 2$) (Table 3). The age of the patients interviewed ranged from 60 to 69 years, and the average length of stay was 9.8 days (Table 3). The findings are presented in two parts: observations and structured interviews.

3.1 | Observation Findings

Observation findings are presented according to the nurse activities outlined in Table 1.

3.1.1 | Direct Care

This study defines direct care as any interaction between nurses and their allocated patients (Table 1). Within this activity category are the relationship and integration of care (physical, psychosocial, relational) dimensions of the FOC framework (Figure 1). Integration of the FOC framework's physical, psychosocial, and relational elements was not observed frequently. Nurse–patient interactions were more likely to occur during a physical intervention. For example, one participant performed a complex dressing for a patient that took more than an hour to complete. No conversation was observed during the procedure, and when the patient groaned in pain, there was a simple reply, 'Sorry'. When observed, the relational aspects of the integration of care occurred in very brief moments; for example, one participant did not engage in conversation with a patient but demonstrated respect by listening, being polite and showing kindness, and was efficient with their communication and care.

Individual nurses' approach to managing their workflow appeared to impact care integration. For example, when one participant went to a patient, they undertook all care and asked the patient if they required anything before moving to the next patient. As a result, their patients did not need any further nursing interventions between interactions. The nurse would

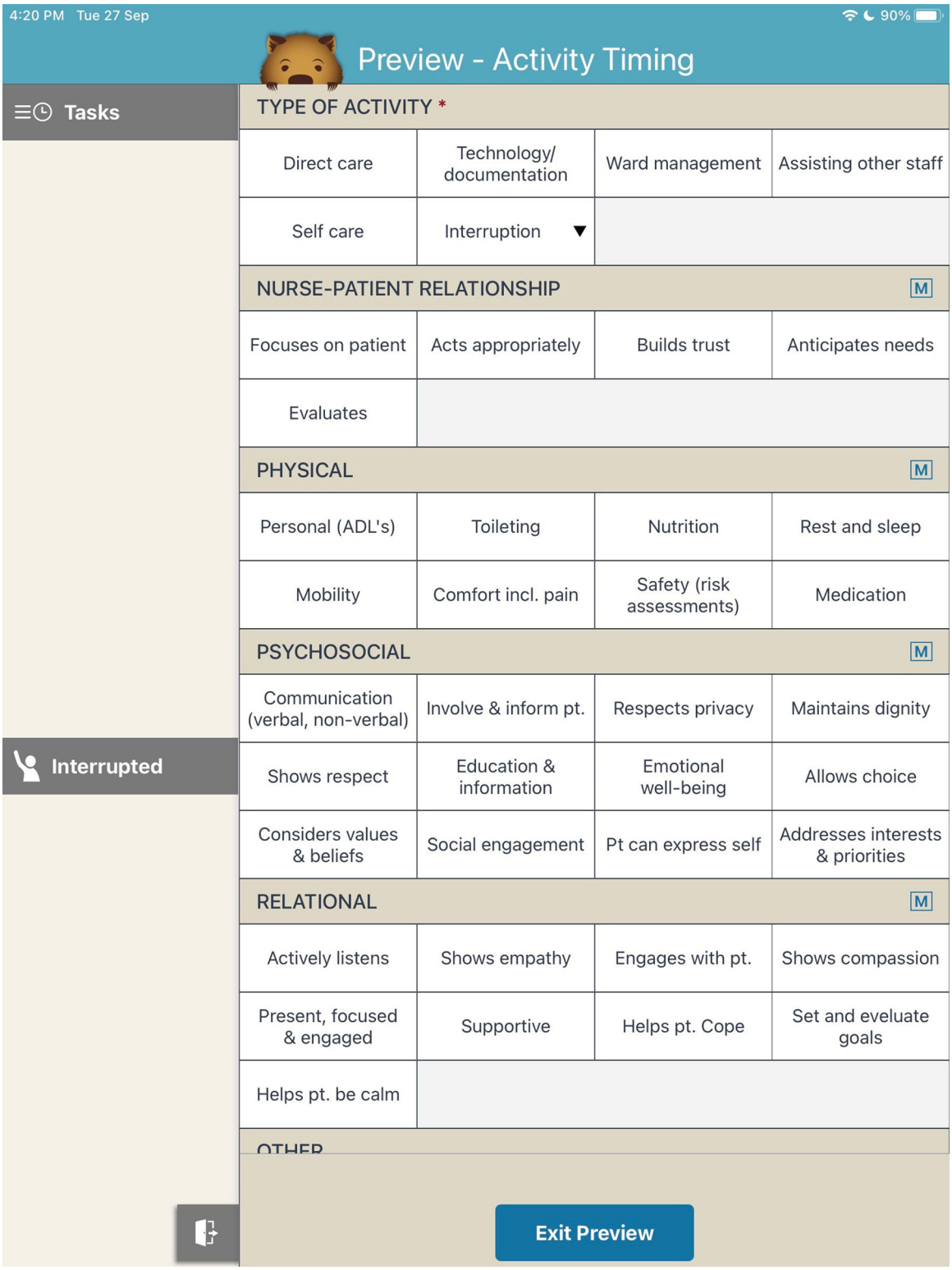

FIGURE 2 | WOMBAT tool configuration. *Note:* This figure is a screenshot showing how the WOMBAT tool was configured for use in this study.

briefly check her patients between interactions to ensure their needs were met.

3.1.2 | Technology and Documentation

Technology and documentation are any documentation or use of clinical applications that did not occur during a direct care activity (Table 1). Nurses spent significant time waiting for and accessing the electronic medication dispensing machine (PYXIS) observed more in the general medical wards than in the surgical wards. There was no identifiable process for managing the demand on the dispensing machines at peak times, and participants repeatedly queued for individual patients' medication. During their shift, participants were observed intermittently reviewing clinical

TABLE 2 | Nurse participant characteristics.

Nurse characteristics (mean)	Medicine
Female/male	13/0
Age range	20–39
Work experience (years)	12.7
Ethnicity	
NZ European	1
Māori	0
Pacific Peoples	6
Asian	6

TABLE 3 | Patient Participant Characteristics.

Patient Characteristics (mean)	Medicine
Female/Male	3/2
Age range	60–69
Length of stay (days)	9.8
Ethnicity	
European	3
Māori	2

test results and doctors' notes, which required repeatedly finding an available computer and logging in and out of each application.

3.1.3 | Ward Management

Ward management activities included any ward or patient coordination that did not occur as part of a direct care activity, such as ward handover, patient transfer, discharge, or procedure preparation (Table 1). There was variation in how wards were managed, with some having a Charge Nurse Manager present to coordinate ward management activities. Two wards had delegated shift coordinators to coordinate ward management activities that did not have a patient allocation. The shift coordinator from one ward also had an allocation of five patients. A participant from a medical ward was observed to have multiple phone calls to various healthcare professionals at the study site and to a rest home to arrange discharge for one of their allocated patients. The discharge planning process took the entire work shift to arrange.

3.1.4 | Assisting Other Staff

This category was selected when the participant assisted staff with any activity that did not involve the participant's allocated patients (Table 1). Participants assisted other staff with patient care and ward management activities when available. These activities did not interrupt direct care activities with their allocated patients.

3.1.5 | Self-Care

Self-care included any participant meal breaks or toilet breaks (Table 1). There was variation in how staff took time for a meal or toilet break. Three participants missed a meal break. One participant combined their break times to breastfeed their baby at the study site's childcare centre. They did not take any time to eat or drink.

3.1.6 | Interruptions to Care

Interruptions included pausing a direct care activity to tend to an activity that did not involve the patient, such as the nurse stopping direct care to answer a phone call (Table 1). Interruptions to direct care were infrequent; the nurse did not leave the patient's room when they occurred.

3.1.7 | Context of Care

Ward occupancy was at or above 100% on the day of observation for all the wards included in the study. It was observed that a dedicated shift coordinator supported and coordinated ward activities. The observer also noted the substantial time taken to find doctors, prepare patients for procedures or transfer, clean vital sign machines, medication trays, and devices, and don and doff personal protective equipment. The wards were noisy, and there was a lot of equipment at the bedside and in the corridor. There was a sense of busyness during observation in all the wards included in the study.

3.2 | Interview Findings

Interview findings are presented according to the objectives of the study.

3.2.1 | Nurse's Understanding of the FOC Framework

Overall, the FOC framework was understood to be an audit tool used to report areas for improvement. For example, when asked what their understanding of the FOC framework was, one participant said,

> *I think it is just a collection of concerns on the ward that have been reported on or fed back on, and you look at how you can gather information and re-evaluate and work on ways to improve things.*
>
> (Nurse 8)

All participants recognised the importance of the physical dimension of care; however, little emphasis was placed on the relational and psychosocial aspects. Some nurses prioritised reading clinical notes over conversing with their patients to determine their needs. For example, when asked how the nurse knows the needs of their patient, three participants replied,

The best way to gauge it [needs] is when I look at their notes.

(Nurse 3)

Before tending to the patient, you will just read their notes.

(Nurse 4)

Usually, when they voice certain things, like if they start complaining.

(Nurse 1)

All participants understood the elements necessary to establish and maintain relationships, but some could not give practice examples. Examples demonstrating a good understanding of the nurse–patient relationship were,

They [patients] feel comfortable talking about normal [everyday] things.

(Nurse 3)

The patient and their family are conversant and telling me stories about herself and her family.

(Nurse 4)

Treating them with respect and dignity and trying to relate to them.

(Nurse 1)

3.2.2 | What Is Essential to Patients When Receiving Care From Nurses

Overall, patients felt they had been well cared for by their nurse on the interview day. When asked about what nurses do to make patients feel good, one participant replied,

Little things like brushing my hair. I should really do it myself but that was the best thing they could have done for me.

(Patient 1)

Communication and listening to patient concerns were essential. Patients appreciated when nurses spent time with them and engaged with them. For example, when asked what nurses do to make patients feel cared about, one participant replied,

It's when they stand there and talk to me like a human, and when I'm versing back, they listen to me.

(Patient 6)

Patients were aware of the ward's busyness as a factor when their care was missed. They expressed reluctance when asking for assistance,

I was standing there and looking at how busy our nurses were. That stopped me - if I wanted help, I would rather go and try to do it myself because they are running after people far sicker than me.

(Patient 6)

Patients had a selfless concern for the wellbeing of others and self-triaged their need for care with what they perceived was happening around them. For example, when asked about things happening on the ward that affect the nurse's ability to give the care needed, one participant said,

I have noticed the past few nights that some of the patients are quite difficult. But I'm just one of the patients so I just wait my turn.

(Patient 2)

Patients were also aware when nurses were not busy and not attentive, and they found ways to ensure their needs were met. For example, when asked about things on the ward that could affect the care the nurse gives, a participant replied:

Sometimes, they [nurses] do spend a lot of time talking. I've only noticed because of the few times I've had to ring the bell, and I can hear them, and I'm thinking, 'I'll just see how long it takes', and it's not urgent for me, but I either need bed linen or something like that. I've learned to ask for a towel and flannel tonight for first thing in the morning.

(Patient 3)

3.2.3 | Nurse's and Patient's Understanding of Culture and Spirituality

All nurses knew about the admission assessment form question, "Do you need cultural or spiritual support?" However, most asked this question verbatim and could not articulate practical examples of culture and spirituality. One nurse articulated some understanding of these concepts,

Everyone's got a different spirituality and culture. So, I cannot let my beliefs and values get between me and my patients. So if they believe in something opposite to me, not having that bias and respecting their decisions and their values even though that is not something that I believe in.

(Nurse 12)

Overall, spirituality was associated with religion, and culture was associated with ethnicity; for example,

I saw that the patient was from another ethnicity, and I know that most Indians have restrictions in their diet.

(Nurse 14)

[Patient name] is nil English. He needed an interpreter, so I used Google Translate to converse safely.

(Nurse 4)

You can tell some of the religious patients that come through because they are already praying in the morning, and some ask if we have church and priest services.

(Nurse 3)

Like the nurses, most patient participants could not articulate their cultural and spiritual needs and associated these concepts with religion or ethnicity. One participant mentioned that her spirituality is an opportunity to express herself. Participant responses suggest that nurses may not explore these aspects of patient care to understand their needs,

If they ask me, I'm very confident in sharing what I believe for me.

(Patient 6)

3.2.4 | Barriers and Facilitators to Delivering Integrated Care

When asked about facilitators or barriers to providing fundamental care, four factors were identified: (1) technology, (2) ward context, (3) family involvement, and (5) student nurses.

3.2.4.1 | Technology. Technology was identified as both a barrier and an enabler. As an enabler, the vital signs and assessment system and medication charting system send reminders and alerts that medications, vital signs, or screening assessments are due. Technology-related barriers included a lack of confidence in using the technology and the time required to navigate the different applications. Ensuring data was entered at a given time because of audit trails such as the electronic vitals system (e-vitals) was prioritised over patient care.

3.2.4.2 | Ward Context. Ward barriers included a perceived lack of time to complete care, inefficient handovers, lack of staff and poor teamwork. The general busyness of the ward was said to create inefficiencies in workflow, and it was reported that, at times, ward management was prioritised over integrated care. As told by a participant,

I often find that sometimes you're so busy doing the task-oriented stuff that you don't—like the technology stuff and answering the phones, following doctors—that you don't actually get to do your showering/wash, it might just be a face and hands wash or just teeth clean, so that can often be affected.

(Nurse 8)

Having a safe and decluttered work environment and good teamwork were identified as enablers of providing integrated care. The acuity or complexity of the nurses' workload or highly dependent patients were identified as barriers to integrated care. Enablers of integrated care were described as having the time available to provide care and having a good rapport with patients, which made tasks easier and quicker.

3.2.4.3 | Family Involvement in Care. All nurse participants felt it was essential to involve the family in patient care and overwhelmingly talked of the benefits to themselves and their patients. For example, when asked how they felt about involving family and carers in the care of patients' one participant replied,

It makes it easier, especially if they are the ones who are at home, because sometimes the patients aren't always honest about how they are at home.

(Nurse 3)

Family involvement in care was recognised as a barrier when the family and patient goals were incompatible. For example,

Sometimes, you have to identify if the goal of the patient is the same as that of the family. I mean, the family's point of view and opinions are valued, but you still have to prioritise that you are looking after the patient, what they want to achieve, and what their goals are. You also have to find out from the patient if they really want family involved.

(Nurse 2)

Family involvement in care was essential for patients, but one patient felt this should be determined by the patient, not the nurse or the family,

I think whānau [family] is really important, but in saying that, I also think I'm independent, so there is a place for them, and I just don't feel for me now there is any need for them to come in.

(Patient 2)

Some patients felt family involvement was vital in planning their care, and some families respected being involved in decision-making. One family member participant alluded to nurse busyness and thought they could supplement patient care and support patient autonomy:

Because he's [patient] got dementia, for him to stay as empowered for as long as he can with the things he can do, that's important. And the girls [nurses] just wouldn't have that time because he takes a long time.

(Patient 3)

Some nurses acknowledged that COVID-19 had challenged family involvement in care because regulations restricted visiting and changed communication to digital rather than face-to-face.

3.2.4.4 | Student Nurses. The study site is a teaching hospital, and registered nurses often have student nurses working alongside them. Having student nurses was viewed as a barrier and enabler to providing care. Some staff saw student nurses as enablers because they often initiated care tasks and, nearing the end of their training, could practice almost

independently, removing some of the workload burdens of the registered nurse. For example, one participant said,

> *Today, I feel like I can do stuff because she [student] initiates – she's got initiative, which enabled me to do more for my patients.*
>
> (Nurse 2)

However, some nurses also felt that students were a barrier because of the time and energy required to facilitate their learning, which reduced the nurse's time to provide fundamental care to their patients,

> *Sometimes they [students] can be quite hard to get on and do things when you are always educating; you don't get a break from it; you always have students on the ward.*
>
> (Nurse 8)

4 | Discussion

This exploratory study aimed to understand current nursing practice with the FOC framework, how nurses understand the framework, and what is essential to patients receiving care. The findings generated three key implications for nurses, nursing leaders and healthcare organisations to consider. Firstly, nurse–patient interactions focused on task completion and the physical aspects of care. Secondly, significant gaps exist in nurses' capacity to engage with their patients and build a strong nurse–patient relationship. Thirdly, the context in which care is provided influences how nurses work and the integration of fundamental care.

Although there was some acknowledgement of caring behaviours from patients, the development of a therapeutic relationship and integration of fundamental care delivery were not evident in the behaviours and narratives of the nurses in the study. Nurse–patient interactions were centred around completing tasks and the physical aspects of care. For example, during the observed complex dressing change, there was time to connect, but the time was used to complete the task. This represented a missed opportunity to connect to the patient and tend to their psychosocial and physical needs, such as respect, dignity, comfort, and medication. While nurses can use verbal and non-verbal methods to identify their patient's needs, they rely on the patient to voice any concerns, which can be difficult when there is a power imbalance, impaired mental state, or poor health literacy. One nurse articulated how they recognised the development of a positive and trusting relationship with the patient by the patient showing respect to the nurse rather than the relationship being a mutual partnership.

Bundgaard et al. (2019) argue that the strategies used to establish and maintain a relationship are universal and rest in the ability of the nurse to verbally communicate, actively listen, and be receptive and responsive to the patient's non-verbal communication. In addition, Kornhaber et al. (2016) also believe that developing a therapeutic relationship requires reflective practice and skills such as therapeutic engagement that incorporates rapport, listening, empathy, compassion, genuineness, and trust. This was observed by the researcher and described by patients who reflected how small caring gestures significantly impacted their wellbeing, such as having their hair brushed. In contrast, the patient undergoing the complex dressing change without therapeutic engagement did not reflect the essentials Kornhaber describes as necessary for a therapeutic relationship. Kitson et al. (2014) highlight the importance of establishing relationships and relational care, which requires a culture shift to 'thinking and linking' over the 'task-and-time' driven culture evident in this study. A focus on productivity drives the task-and-time culture to comply with organisational and peer expectations, often prioritised over the individual nurse's ideals (Sharp et al. 2018).

Van Belle et al. (2020) observed that some nurses have a more person-centred approach when tending to the physical needs of patients; however, most focus on completing tasks and providing physical care. Busyness was mentioned by nurse and patient participants and appeared to be a significant factor in prioritising care activities. Dewar et al. (2024) argue that persistently busy workplaces impact nurses' temporality, which is their subjective relationship with time. Dewar et al. describe the ability to have a more person-centred approach as temporal reflexivity, whereby relational meaning ameliorates time frame pressures. Conroy (2018) also found that compounded by organisational factors, perceptions of time influenced care delivery and nurses' attitudes toward care provision. Conroy also suggested that task-focused nursing is a symptom of nurse burnout that requires emotional support. Healthcare organisations should consider the implications of organisational and peer expectations on care delivery, nurse and patient satisfaction and healthcare outcomes (Sharp et al. 2018).

Several contextual factors were identified that impacted the amount of time spent at the bedside, for example, tending to technology-based tasks, staff skill mix, teamwork and support. This finding is supported by Conroy (2018), who found that nursing leadership, the context of care delivery, and time impacted care delivery. As identified in other literature, the ward environment and resources available can create workflow inefficiencies that divert attention away from the patient (Bachnick et al. 2018; Conroy 2018; Jangland et al. 2017) as observed when nurses repeatedly waited in line for the electronic medication dispensing machine (PYXIS). The study highlighted the challenges of using technology and electronic records, an important contextual factor impacting how nurses work. Nurses in this study identified technology as a barrier and enabler to providing integrated care. Mohammadnejad et al. (2023) support this finding and argue that several factors influence how technology affects nursing workload, including nurses' acceptance and working knowledge of the technology and the training and support to use the technology. Organisations must plan for and mitigate potential workflow problems and ensure staff have adequate training and support to use the technology (Heidarizadeh et al. 2017).

Another important finding from this study was the inability of nurses and patients to articulate their understanding of culture and spirituality. The innate and multifarious nature of culture

and spirituality make these concepts difficult to articulate (Heaton 2018). Equally, the ability to understand and tend to a patient's spiritual and cultural needs depends on the nurses' ability to develop a therapeutic relationship and integrate these concepts into the care delivery. This finding lends itself to further research around nurse and patient conceptualisations of culture and spirituality and how cultural and spiritual needs can be identified and supported when admitted to the acute hospital.

Finally, the findings highlight the importance nurses place on family involvement and the impact that COVID-19 has had on their ability to involve family. COVID-19 profoundly affected family involvement in care and how nurses engaged with patients. The international literature has articulated significant implications for the meaningful involvement of family and the nurse's ability to engage the family in patient care during a crisis. These included increased racial, socioeconomic, and geographic disparities for populations lacking reliable internet access, devices, or technological literacy (Hart et al. 2020; McMillan et al. 2021).

The findings of this study have prompted areas for further inquiry and improvement in the education, delivery, and measurement of the Fundamentals of Care in practice. Overall, there were several missed opportunities to deliver integrated fundamental care. Nurse–patient interactions in the study were centred around completing tasks and the physical aspects of care. The common missing elements across each of the findings were relational and psychosocial care and the ability of the nurse to develop a therapeutic nurse–patient relationship. An insidious change in nursing culture has occurred, where healthcare organisations' focus on efficiency has left nurses without agency to deliver fundamental care (Bridges et al. 2020; Sharp et al. 2018). Kitson et al. (2013) argue that moving forward requires investment and accountability from policymakers, educators, management, and leadership. Healthcare organisations must recognise the implications of nurses refraining from building therapeutic relationships and meeting the patient's care needs, which include elements of care like spirituality and culture. A task-and-time approach to care contradicts person-centred care and is at odds with nurses' philosophical duty of care (Sharp et al. 2018). The FOC framework must be articulated and integrated into policy, education, key performance indicators and best practice standards. Nursing leaders must consider and redirect their efforts towards understanding how to incorporate the Fundamentals of Care into policy and practice to support and integrate fundamental care delivery (Bachnick et al. 2018; Sharp et al. 2018).

4.1 | Strengths and Limitations

This study is the first in Aotearoa, New Zealand, to explore the application of the FOC framework to nursing practice. Rich data were obtained using a contextual inquiry approach; however, it is essential to recognise that the study has limitations. The findings represent a snapshot of a nurse's day by observing part of a weekday morning shift and do not reflect the nuances of nurse–patient engagements that occur in the afternoon, evening, and night. This small, single-site qualitative study is not generalisable to all acute inpatient hospitals in Aotearoa, New Zealand. The nurse participants were female; no male or Indigenous Māori (Indigenous person to Aotearoa, New Zealand) nurses were recruited. As such, no distinctions between female and male or Indigenous Māori could be made concerning the study's objectives.

Three weeks into data collection, Aotearoa, New Zealand, went into a nationwide lockdown due to a COVID-19 surge and strict rules around research in clinical areas were enforced. This required data collection to be paused for several weeks, and a submission was made to ethics to revise how data collection would continue. The restrictions constrained our ability to observe family and caregiver involvement in patient care.

4.2 | Recommendations

Although many instruments are available to measure caring behaviours, there needs to be an instrument that aligns with the FOC framework that can objectively measure the subjective elements contained within the framework (Feo et al. 2022). Conroy et al. (2021) used complexity science to quantify and evaluate fundamental care with encouraging results. Their approach to measuring and evaluating the Fundamentals of Care needs refining; however, it provides a promising way to measure the multidimensional complexities of providing fundamental care.

An opportunity exists to build on this study with a larger sample size across multiple sites with multiple researchers to collect and analyse data. Research efforts should build on existing FOC framework research to understand how it can be practised consistently in complex healthcare systems. As mentioned above, further research is needed on the nurse and patient conceptualisations of culture and spirituality and how cultural and spiritual needs can be identified and supported when admitted to the hospital.

5 | Conclusion

This study has generated insights into the FOC framework in practice in the context of Aotearoa, New Zealand, and nurses' and patients' understanding of care. Nurse–patient interactions are centred around completing tasks and the physical aspects of care. The study highlighted that nurses understand the nurse–patient relationship in theory but need help understanding and evaluating it in practice. Culture and spirituality are misunderstood concepts in this healthcare setting, and more work is required to meet patients' cultural and spiritual needs; however, this depends on nurses developing a therapeutic relationship to understand the patient's care needs. Finally, healthcare organisations and nursing leaders must consider the implications of efficiency-driven care models and how they can integrate the Fundamentals of Care into policy and practice to support person-centred care.

Acknowledgments

This study was supported by the Health Research Council of New Zealand (20/1259). Open access publishing facilitated by The University of Auckland, as part of the Wiley - The University of Auckland agreement via the Council of Australian University Librarians.

Ethics Statement

Approval to conduct the study was obtained from the Auckland Health Research Ethics Committee (AHREC) in May 2021, and amendments to the study due to changing COVID-19 restrictions were submitted and approved in October 2021. Locality approval was obtained from the study site in June 2021.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The authors have nothing to report.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.