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Prioritizing and meeting life-threateningly ill patients' fundamental care needs in the emergency room—An interview study with registered nurses

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Abstract

Aim: To explore how registered nurses in the emergency room describe their work approach and prerequisites for meeting life-threateningly ill patients' care needs from the perspective of a person-centred fundamental care framework.

Design: A descriptive, qualitative interview study.

Method: Individual interviews were carried out with 14 registered nurses with experience of working in an emergency room in Sweden, during 2019. Data were analysed using thematic analysis, according to Braun and Clarke. The COREQ checklist was used for reporting the findings.

Results: Three themes were identified: *Task-oriented nursing care based on structured guidelines and checklists*; *Fundamental care not being promoted or prioritized in the emergency room*; and *The organization and responsibilities for providing person-centred fundamental care are unclear.* Results showed that registered nurses structure their work approach based on prevailing organizational prerequisites as well as personal ones. Meeting patients' fundamental care needs was not always prioritized; their physical needs were met to a greater extent than their relational and psychosocial needs. Registered nurses did not prioritize fundamental care when the organization did not.

Conclusion: From the registered nurses' perspective, they structured their work based on the prevailing conditions for meeting patients' fundamental care needs. The organizational structure does not clearly state that fundamental care should be performed in the emergency room, and the registered nurses' work approach there for meeting patients' fundamental care needs is not adapted to provide patients with person-centred care.

Impact: To date, little is known about registered nurses' work approach and prerequisites in meeting life-threateningly ill patients' fundamental care needs in the emergency room. Our findings indicate that the organizational structure is pivotal in supporting

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registered nurses to provide person-centred fundamental care. The knowledge from this study can be used in emergency care settings to facilitate person-centred fundamental care and thereby avoid fundamental care being missed.

KEYWORDS
emergency nursing, emergency room, fundamentals of care, interview study, person-centred care

1 | INTRODUCTION

The primary task in emergency departments (EDs) is to examine and treat patients who need immediate care in the shortest time possible, with safety being a constant priority (National Board of Health and Welfare, 2019). Within EDs, there are special rooms (emergency rooms) intended for life-threateningly ill and injured patients, suffering from for example, cardiac arrest, breathing problems or trauma. The focus is often biomedical, with an emphasis on technology and medical decision-making over nursing care, and fundamental care is occasionally delivered inadequately (Richards & Borglin, 2019). The field of nursing care is concerned with the promotion, maintenance and restoration of health and the care of ill and dying people. Feo et al. (2018) have defined the fundamentals of care as the basic elements of nursing care. When nursing care is done well, the patient's fundamental care needs are addressed. Research indicates that registered nurses (RNs) fail to deliver fundamental care when their department is understaffed or when they are preoccupied or do not prioritize certain tasks resulting in poor quality of care and patient safety (Richards & Borglin, 2019).

Internationally, extended length of stay and overcrowding in EDs are described as being prerequisites the most comprehensive patient safety challenges in modern emergency care (Forero et al., 2019). It is also considered to have negative effects on the RNs' workload and work satisfaction (Eriksson et al., 2018). Previous studies have shown that patients in the ED often report lack of information, long waiting hours, poor pain management and limited participation in treatment decisions. As the length of their stay increases, patients can become more anxious out of a fear of suffering from a serious medical state (Skene et al., 2017). Patients in the emergency room are vulnerable due to for example hemodynamic instability, variable consciousness, and difficulty self-reporting and in need of both medical care and nursing care. To prevent complications in the emergency room (such as pressure injuries from breathing masks and spine boards), each patient's needs should be met. When a person-centred care approach (Ekman et al., 2011) and holistic care using the Fundamentals of Care Framework (Feo et al., 2018) are adopted, patients' care needs and the importance of nursing care provided in emergency rooms can be highlighted.

1.1 | Background

Person-centred care and fundamentals of care share common features, as both take a holistic view on the person and share the goal of meeting patients' needs. The Fundamentals of Care Framework represents a valid, comprehensive, evidence-based description of fundamental care (Mudd et al., 2020). It is constituted of three interrelated dimensions: establishing a caring relationship with the patient; assessing and delivering physical, relational and psychosocial fundamentals of care; and delivering these elements in a wider care context (Feo et al., 2018). Person-centred fundamental care is achieved through the RN creating a relationship with the patient and assessing and meeting their physical, psychosocial, and relational needs, with the context contributing to optimizing the results. The Fundamentals of Care Framework is displayed in Figure 1. Adopting a person-centred approach, together with the explanatory Fundamentals of Care Framework, carries the potential to improve the quality of care (Feo & Kitson, 2016).

To provide safe and high-quality nursing care, resources and prerequisites are needed at both the organizational and the policy level (Aiken et al., 2017). RNs, patients, relatives, and nursing leaders agree that nursing care is important, and identify similar factors that need to be addressed (Conroy, 2018). Despite this, however, other research indicates that leaders and managers fail to address the problem (Richards & Borglin, 2019). As healthcare is undergoing changes, with patients suffering from comorbidity and complex conditions, along with an increased inflow of patients and reduced outflow due to a lack of access to appropriate hospital inpatient beds, higher demands are being placed on RNs and nursing care when it comes to prioritizing and making assessments (Aiken et al., 2017; Forero et al., 2019). For the RN to be able to deliver fundamental care in a person-centred way, care-contextual conditions are considered a key factor and the direct decisive factor is that the organization prioritizes and creates these conditions (Aiken et al., 2017).

A high level of professional competence among RNs is associated with improved patient outcome and lower mortality rates (Aiken et al., 2017). To enable the skilful assessment and management of critical illness, its treatment and patients' fundamental care, the RN in the emergency room needs a broad knowledge base in both medicine and nursing. However, previous studies have shown that RNs in the ED viewed their role as that of one who saves lives, and believed they were there to deal with emergencies and acutely ill patients, which they found rewarding and exciting (Tegelberg et al., 2020). About emergency situations, Singer et al. (2011) described that the RNs in the ED had a high level of expertise but often lacked the ability to identify patients' personal care needs or assess when

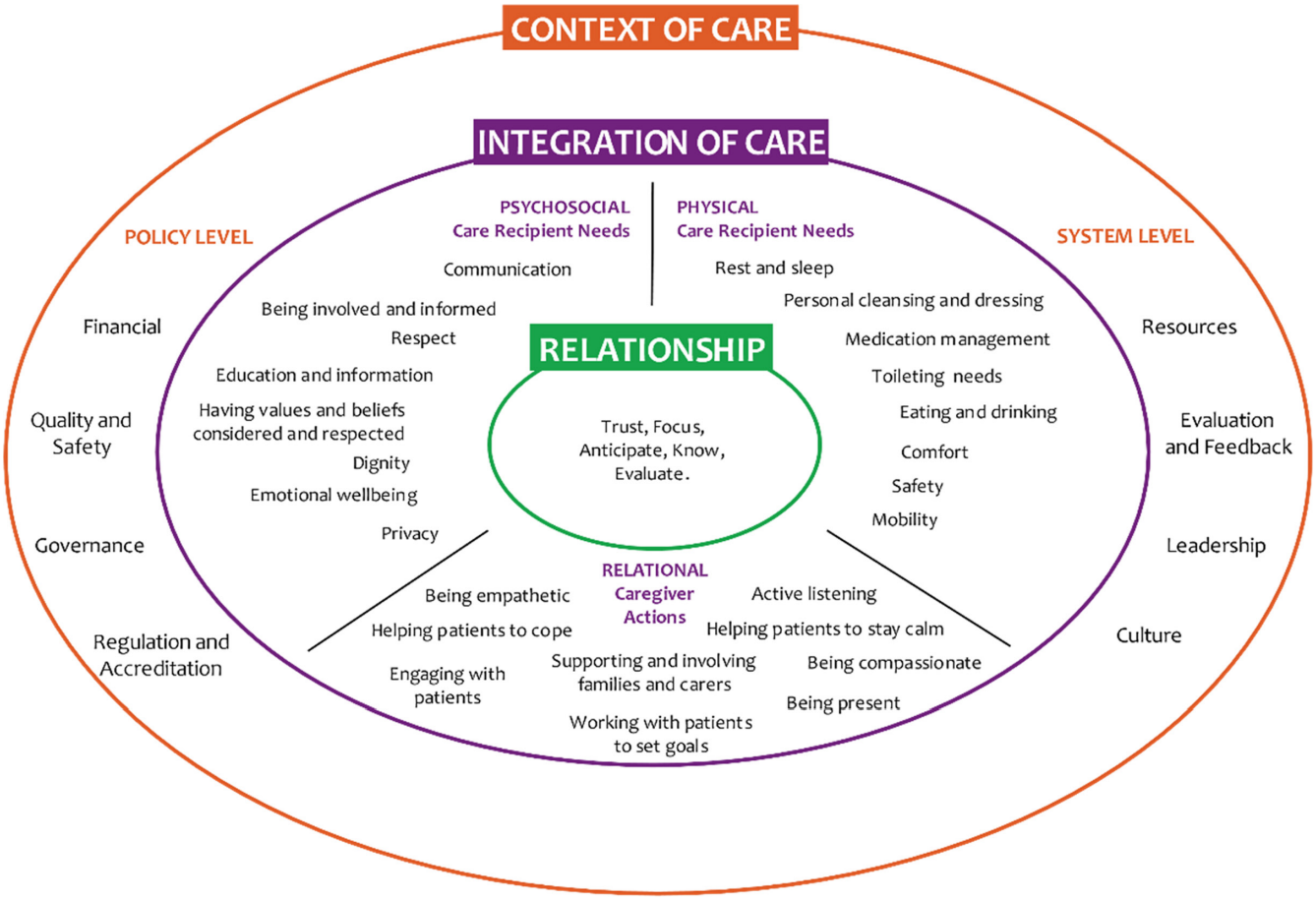

FIGURE 1 The Fundamentals of Care Framework (Source: Feo et al. (2018), reprinted with permission)

fundamental care assessments were necessary. Life-threateningly ill patients are sometimes left in the designated emergency room for several hours due to crowding, extended length of stay or a shortage of hospital beds or RNs (King et al., 2021). Nursing care in emergency rooms is both challenging and vital to quality of care and patient safety. However, RNs can omit fundamental care because they lack the time required to complete it or perceive it as difficult (Eriksson et al., 2018).

To our knowledge there is no research focusing on person-centred fundamental care from the RN's perspective within the emergency room context, and there are currently only a few studies describing the impact of appropriate and high-quality nursing care for life-threateningly ill patients.

2 | THE STUDY

2.1 | Aim

The aim of this study was to explore how RNs in the emergency room describe their work approach and prerequisites for meeting life-threateningly ill patients' care needs from the perspective of a person-centred fundamental care framework.

2.2 | Design

The study had a descriptive design with a qualitative approach (Bradshaw et al., 2017) employing individual interviews with RNs as there is limited knowledge about RNs' work approach and prerequisites for meeting patients' fundamental care needs. A qualitative approach was used to investigate RNs voices and existing barriers and facilitators for meeting patients' fundamental care needs. Thematic analysis according to Braun and Clarke (2020) was applied. The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was used for reporting the findings.

2.3 | Sample/participants

The study setting was an emergency room in an ED at a university hospital in Sweden with approximately 54,000 visits annually, of which more than 3,000 involved visits to the emergency room. In the emergency room, various health professionals work in teams. Each team consists of one RN and one nurse assistant, each with their own specific task in the assessment and care of the patient and the physicians who are on call. The RN (baccalaureate level) is responsible for the nursing care but can delegate certain tasks, such as

inserting a urinary catheter, to the assistant nurse (upper secondary education in practical nursing care). In Sweden, there is no requirement for specialist training in emergency nursing for RNs working in the emergency room, but there is a specialist training in emergency nursing for RNs. The clinical nurse specialist education program is 60 European Credit Transfer System (ECTS) and at advanced level. It contains both theory and practice.

Information about the study was given to the ED managers, and permission was obtained. The inclusion criterion was RNs currently working at the emergency room. No minimum work experience was needed, however, as a RN in the ED you are not allowed to work in the emergency room without first having prior experience from another ED or mandatory internal training through a preceptorship program. Information was provided to all RNs ($n = 50$) via email, as well as orally at a staff meeting. The RNs who were interested in participating in the study, and who worked in the emergency room, responded to the first author by email to choose a time and place for the interview. All of the participants had experience in all areas of the ED (i.e., surgical, medicine, orthopaedic), were deemed qualified by the employer, and had completed mandatory on the site training.

2.4 | Data collection

A semi-structured interview guide was used, and to obtain more detailed information the interviewer asked follow-up questions and requested clarification when needed. The introductory question explored the RNs' perceptions of how a patient's fundamental care is performed in the emergency room. Examples of questions include: *Can you describe how you work to meet the patient's fundamental care needs; Can you describe conditions that are present/not present for meeting the patient's fundamental care needs*; and *Can you describe what works well and/or needs to be developed in the care for patients in the emergency room.* The interview guide was piloted with one participant (not included in the study), and thereafter only minor modifications were made. The RNs were encouraged to freely share their experiences of caring for a life-threateningly ill patient in the emergency room. The first author (VP) conducted all interviews. VP is an RN with extensive experience in caring for life-threateningly ill patients, but was not familiar with the hospital or any of the participants beforehand. Most of the interviews were held at a single location adjacent to the workplace, with five instead being conducted by telephone due to difficulties in finding a convenient time to meet in person. According to Malterud, Siersma, and Guassora, (2016) information power indicates that the more information the sample holds (relevant for the study), the lower amount of participants is needed. After 11 interviews, data saturation or 'information power' was reached and thus the recruitment of RNs ended after 14 interviews. The interviews, which lasted 26–62 min (mean 42.7), were audiotaped and transcribed verbatim by the first author. Data collection was conducted from May to November 2019.

2.5 | Ethical considerations

The project followed the guidelines of the Helsinki Declaration (World Medical, 2014), and was approved by the Swedish Ethical Review Authority (Dnr. 2019–00506). The RNs were given verbal and written information about the study, and informed, written consent was obtained prior to each interview. Participants were informed that their participation was voluntary and that they could cease their participation in the study at any time. Data were processed and stored in a manner that ensured confidentiality. Personal data, such as informed consent, were stored in a locked safe. Electronic data were stored on a computer with a password to which only the first author had access.

2.6 | Data analysis

Thematic analysis was used to analyse interview transcripts, following the process described by Braun and Clarke (2020). This method is used to identify, analyse and report patterns within data, incrementally through six phases. In the first phase the authors read and re-read the transcripts to get an overview of the data, looking at patterns of meaning and potential interest in the data. Notes were made and ideas for codes were marked. The second phase involved generating initial codes from the data. In Phase 3 the first author searched for themes by sorting different codes into potential themes, and a mind map was used to organize them into theme piles. After a set of candidate themes had been devised, the fourth phase began. The authors discussed, reviewed and refined the themes. In the fifth phase the themes and subthemes were defined and named, and the essence of each theme was identified. The sixth phase involved the final analysis and writing the report. The analysis involved a constant moving back and forth within the entire data set. All researchers discussed the analysis repeatedly, and disagreements were settled through negotiated consensus. See Table 1 for the steps of the data analysis.

2.7 | Rigour

Throughout the research process the authors strived for a reflective attitude (Braun & Clarke, 2020) questioning any preunderstandings. The first author's preunderstanding as an RN was discussed and reflected on with the other researchers beforehand. The co-authors experience covers research and clinical work in nursing in general and emergency care in particular as well as a broader health service perspective. Credibility was supported by following systematically the guidelines of Braun and Clarke (2020) during the coding sessions and involving all team members in continuous discussion about the interpretations of the data, throughout the analysis process. To accomplish dependability, an audit trail was maintained. To enhance confirmability, quotes are used to demonstrate the grounding of the findings in the data. Transferability was ensured through purposive sampling, and in-depth interviewing provided thick descriptions.

TABLE 1 Examples of coding of text and establishing themes and subthemes

Quote	Code	Subtheme	Theme
It is frustrating when you have not been able to prioritize nursing care. I know when I had an anxious patient. We watched the patient but then a new patient arrived. And, this anxious patient manages to step out of bed and tears out the catheter, so it became both a fall and a hematuria. You get so disappointed that we have such a system, we identify the risk, but we do not have the prerequisites to ensure that it does not happen	Lacking conditions to remedy risks	Standardized versus personalized assessment and treatment	Task-oriented nursing care based on structured guidelines and checklists
Well, the relationship with the patient is important. It is short encounters, many things happens at the same time, in a short time and several professionals are involved. The patient needs to be involved in what happens, but we take it for granted that we can do this and that with the patient without talking to the patient because that is how we work	Relationship overshadowed by workflow	The work process in the emergency room does not facilitate fundamental care	Fundamental care not being promoted or prioritized in the emergency room
There are very few who actually eat in there. We often become unsure whether they can eat or not. What does the physician think, is it a condition where the patient should not actually eat, or is it a condition where the patient might eat, it may even be good to do so? All surgical patients; we assume that no one is allowed to eat	Uncertainty in assessing and meeting personal needs	Uncertainty in the RNs' space of action	The organization and responsibilities for providing person-centred fundamental care are unclear

TABLE 2 Themes and subthemes describing registered nurses' description of their work approach and prerequisites to meet life-threateningly ill patients' fundamental care needs

Subtheme	Theme
Adapting to a flow-based structure Standardized versus personalized assessment and treatment	Task-oriented nursing care based on structured guidelines and checklists
Fundamental care is subordinate to the biomedical tasks A clear profession with unclear duties The work process in the emergency room does not facilitate fundamental care	Fundamental care not being promoted or prioritized in the emergency room
Structuring fundamental care is up to the individual RN Uncertainty in the RNs' space of action	The organization and responsibilities for providing person-centred fundamental care are unclear

3 | FINDINGS

The sample consisted of 14 RNs (11 females and three males), aged 28–61 years (mean 40.2). Mean working life experience in the emergency room ranged between 1 and 14 years (mean 6.1). To meet patients' fundamental care needs in the emergency room, RNs reported structuring their work approach based on prevailing organizational prerequisites and personal prerequisites. A prerequisite was defined as the necessary logic, priorities and resources for the delivery of patient care. Three themes were identified: *Task-oriented nursing care based on structured guidelines and checklists*; *Fundamental care not being promoted or prioritized in the emergency room*; and *The organization and responsibilities for providing person-centred fundamental care are unclear*. Seven subthemes were identified. Work approach and prerequisites are present in all the themes. See Table 2 for an overview of the themes and subthemes.

3.1 | Theme: Task-oriented nursing care based on structured guidelines and checklists

The RNs described that nursing care in the emergency room is task-oriented and based on structured guidelines and checklists. Saving lives in emergency rooms is expected to follow a flow-based

structure, and to take place within a limited amount of time. This theme includes the subthemes *adapting to a flow-based structure* and *standardized* versus *personalized assessment and treatment*.

The RNs described that they were *adapting to a flow-based structure* as the organization had a focus on patient flows without requirements for fundamental care needs. It was described that new patients were admitted to the emergency room regardless of whether the RNs had control over the situation involving the patients who were already there. New incoming patients were prioritized over helping existing patients with their fundamental care needs.

Addressing fundamental care needs was perceived as different from task-oriented activities and as an obstacle to the flow, leading to a frustrating neglect of fundamental care needs. However, there were also descriptions of fundamental care as an approach rather than simply activities one performs. This type of care becomes a direct threat to the flow-based structure; for example, a patient needing to urinate or requiring help turning over in bed is an obstacle, stopping the flow.

> *I wouldn't say that we sort of care whether the patient's allowed to get up and take care of their needs; even if they can, the focus is on getting the flow going. You do a quick-fix like 'You can pee in a bottle instead' quite simply* (Interview 10).

Different patient situations are characterized by brief, standardized encounters and care in the emergency room. RNs described it as the *standardized* versus *personalized assessment and treatment*, as providing person-centred fundamental care came to be overshadowed by routines and was perceived as difficult. With a constant in-flow and a prioritization of medical interventions, failing to meet patients' fundamental care needs could have consequences not only through their remaining in the emergency room a longer time, but also for the patients themselves.

> *Within acute care there are a lot of guidelines and checklists. We have, for example, the whole A-E concept. Therefore, it's very easy for us to fall into structures as well, but I don't think it's possible to do that with a person, to structure a person. If this patient requires a lot of time, yes, then I have to take the time. I can't do everything on routine and quickly* (Interview 5).

Guidelines and checklists, for both medical and nursing care assessment, were only used in the initial phase. Therefore, long stays in the emergency room could lead to patients having to wait to urinate, being left alone, and not having their personal needs prioritized. It was described that it was easier to address the needs of patients who themselves called for attention and addressed specific needs, or needs that were addressed in the guidelines or checklists, for example inserting a catheter. There was a lack of routine and structure focusing on making the patient feel safe and calm in an alarming situation. The establishment of a relationship, which is a part of both person-centred and fundamental care, was often absent in such situations. Some RNs described that seeing the whole patient and not simply checking off tasks was important for the patients. However, there was variation among the RNs, with some not perceiving the relationship important as the patient was supposed to spend only a limited time in the emergency room.

3.2 | Theme: Fundamental care not being promoted or prioritized in the emergency room

The focus on medical measures in the emergency room and the lack of nursing care might create new medical problems. This theme includes the subthemes *fundamental care is subordinate to the biomedical tasks*, *a clear profession with unclear duties* and *the work process in the emergency room does not facilitate fundamental care*.

Due to life-saving procedures, nursing care is usually done in parallel to or after the A-E assessment. The RNs described that the organization was built on having a primary focus on the patient's medical condition, and that *fundamental care is subordinated to the biomedical tasks*. The clinical practice guidelines for the emergency room were not designed to assess and evaluate all fundamental care needs but had a strong focus on specific tasks, such as those involving medical technology. Some RNs perceived medical tasks and interventions as more rewarding and interesting than fundamental care. Once they were in control of the medical procedures, they could relax.

Some RNs stated that patients were no longer perceived as interesting when there were no medical tasks to perform.

> *In the end the patient died and was still almost completely covered in feces and (silence) so then when you express the words that 'Now we'll do nothing more' it feels like many [of the staff] also sort of release the patient, but there was a lot left to do for the patient to give them a dignified death, but (silence). There was a new alarm on both Unit 1 and Unit 2 at the same time, so…* (Interview 9).

The RNs described *a clear profession with unclear duties*. Not being introduced to fundamental care when they were introduced into the emergency room made it unclear to the RNs whether or not they were expected to perform this type of care there. There was an attitude among some RNs that they were trained to deal with acute care, and that their main task in the emergency room was to assist the physician, and insert peripheral catheters. Some RNs stated that they worked in the emergency room to avoid nursing care, and that the assistant nurse was the one responsible for providing and performing fundamental care. An RN's own values, attitudes and approach involving fundamental care influenced whether or not nursing care was provided.

> *We do the best we can but then it's a little like, kind of an attitude question from the staff that you don't devote much to nursing care in the emergency room; it's like an attitude that prevails so it's a little dependent on the individual too. It is, after all, the assistant nurses who have the nursing eye* (Interview 11).

Even though the care episode often consists of short encounters, the RNs described that a relationship with the patient needs to be established, in line with the Fundamentals of Care Framework. Despite this, *the work process in the emergency room does not facilitate fundamental care*. Many of the tasks in the emergency room take place with a medical focus and on a routine basis, which could lead to, for example, clothes being cut off without informing the patient what was going to happen and why. Talking over the patient's head often occurred. In the RNs' opinion, patients were not involved in or informed about their care, and communication and information were often done in a one-way direction.

As the RN's workstation was placed behind the patient's head, it did not feel natural or easy for the RN to communicate with the patient as the patient's face was not visible. Meeting the patient's fundamental care needs in the emergency room while maintaining their dignity and integrity was perceived as difficult; despite privacy shielding (e.g., curtains), other staff would step in without regard for the patient who might be, for example, having a catheter inserted.

> *The integrity, it's nonexistent and unfortunately it's partly the premises themselves that make it this way. Then it's actually also we ourselves who contribute to that, we talk loudly and clearly about the patients. We can talk about sensitive things around the patient [when we're] at the computer, even though the patient's head is just a meter away* (Interview 11).

3.3 | Theme: The organization and responsibilities for providing person-centred fundamental care are unclear

The RNs describe the emergency room as being established to save lives, which requires medical treatment. But in the moment when surviving turns into living, no matter how short or long this moment is, the patient also requires nursing care. Providing nursing care in the emergency room was characterized by various ambiguities.

The RNs described that *structuring fundamental care is up to the individual RN*, as the organizational structure and the coordination of nursing care were seen as being separate from each other. The RNs described that the organizational structure was built on receiving patients in potentially life-threatening condition and stabilizing and transferring them; but in reality, the patient could remain in the emergency room for several hours. Long stays or having few patients in the emergency room did not automatically lead to meeting patients' fundamental care needs, which was explained by the fact that it was up to each individual RN to structure their daily work in the emergency room.

> *We shouldn't need to have patients lying in there for ten hours; then the nursing care won't be that good, which is quite interesting considering that the patient is in front of us for ten hours and we're there almost all the time* (Interview 11).

It was described that there was *uncertainty in the RNs' space of action* about some of the nursing care tasks. For example, patients eating in the emergency room was described as not being a problem, and the RNs were aware of the importance of nutrition as one of a patient's fundamental care needs. Even so, patients were usually not allowed to eat. This was described as being related to the notion that seriously ill patients should be fasting and that therefore patients received appropriate intravenous fluids before enteral administration.

Reliance on one's own knowledge and competence entailed a risk that the assessment and treatment of pain was not done in a systematic and uniform manner. RNs stated that their own values and attitudes about patients affected their pain relief, which is another fundamental care need. The RNs considered themselves to be more generous with pain relief in surgical patients compared with medical patients, as surgical patients were described as more often seeking help for surgical conditions that the RNs knew from experience were associated with pain.

4 | DISCUSSION

The aim of this qualitative descriptive study was to explore how RNs in the emergency room describe their work approach and prerequisites for meeting life-threateningly ill patients' care needs from the perspective of a person-centred fundamental care framework. The main finding was that RNs structure their work approach in meeting patients' fundamental care needs based on prevailing organizational prerequisites as well as their personal prerequisites.

This study highlights the complexities involved with RNs delivering person-centred fundamental care in the emergency room. Findings indicate that RNs in the emergency room focus on the task aspects of care, and do not frequently involve patients in their own care. In line with Andersson et al. (2012), this indicates that patients are more exposed, dependent and vulnerable in the emergency room than in other care situations, which poses a challenge to RNs in the emergency room to address issues related to patient assessment, participation and influence over care. In the present study, it was described as easier and more common to meet patients' physical fundamental care needs than their psychological and relational ones, confirming a dominant biomedical focus in emergency care (Feo &

Kitson, 2016). However, there are few situations in the emergency room when it is only the patient's physical needs that need to be met. Physical and psychosocial fundamental needs must be met, in addition to relational needs, through an established nurse–patient relationship. Recio-Saucedo et al. (2018) explain that failing to assess patients according to their personal care needs may lead to undesired consequences, such as incomplete nursing care and adverse health events.

Failure to assess and address patients' fundamental care needs in the emergency room has consequences for them (e.g. risk of injury to the bladder due to overfill). However, neglecting fundamental care needs also has consequences for the organization, as patients' unmet fundamental needs may risk contributing to overcrowding in the emergency room. Overcrowding in emergency departments has been shown to lead to poorer patient satisfaction and reduced patient safety (King et al., 2021). Adopting a holistic approach and shifting from a task-oriented strategy to a more person-oriented one may decrease the risk of fundamental care being neglected (McCormack, 2016). In this way, RNs can determine a patient's fundamental care needs based on their personal needs rather than procedures. Guidelines and checklists offer a structured way of working, but need to be complemented by ensuring that patients' personal fundamental care needs are met.

According to our results, meeting patients' fundamental care needs was not always prioritized. Establishing a relationship with the patient was considered important but was often overlooked, due to medical and technical tasks and lifesaving procedures. In line with Feo and Kitson (2016), the challenge emergency room RNs experienced in the present study indicates that they are encouraged to develop relationships with patients, although this is often not supported by the system or environment. Previous studies have also shown that patients are often initially seen as interesting cases but that this interest seems to decrease over time, which creates feelings of insecurity in the patient. Establishing a nurse–patient relationship is the basis for delivering person-centred fundamental care but is often lacking in several settings (Feo & Kitson, 2016). However, establishing a relationship with the patient is not necessarily a matter of time; a relationship can be established immediately at the first meeting.

Another finding showed that the RNs cited nursing care as their profession, but it was still clear that their focus was on life-saving procedures. Furthermore, the findings indicate that an RN's own values, attitudes and approach involving fundamental care influenced whether or not nursing care was provided. Culture, more than professional responsibility or competence, guided the RNs in managing fundamental care. Tegelberg et al. (2020) indicate that staff tend not to follow guidelines in the provision of fundamental care; instead, they use their personal experience and common sense to guide their care for the patient. Recent research indicates that an important prerequisite is the culture within the unit; that is, the values that prevail in the organization (Francis, 2013). Our findings confirm the need for an increased emphasis on the importance of person-centred fundamental care within the ED organizational structure. As patient outcomes, including length of stay and mortality, are negatively impacted by missed care, nursing leadership is needed in this domain (Recio-Saucedo et al., 2018).

The principal approach to improving fundamental care in the emergency room may be a deliberate change in the organizational culture guiding practice. Despite that, according to Francis (2013), hospital leaders may prioritize performance metrics, such as wait times, over fundamental patient care needs including the provision of empathetic communication and comfort. Waiting times and crowding, albeit important, are only one aspect of patient safety in the emergency room. Sonis et al. (2018) indicate that inadequate communication, a lack of patient privacy, poor pain control and uncomfortable ED environments are associated with suboptimal patient experiences and outcomes. Beyond patient outcomes and malpractice risk, there also exist growing financial implications of poor patient experience in the ED (Sonis et al., 2018). According to Feo and Kitson (2016), the organizational structure plays a crucial part in helping or hindering the delivery of person-centred fundamental care, and the direct decisive factor is that the organization prioritizes and creates the conditions. Our findings contribute to showing how this is expressed in the emergency room by RNs, and clearly show how difficult it is to deliver fundamental care when the cultural focus is on something else.

An identified area for improvement in this study was the room design, which RNs did not consider to provide opportunities to satisfy and maintain patients' fundamental care needs (e.g., privacy and dignity). Practical and ethical dilemmas could arise in situations when RNs had to ignore a patient's dignity, for example, offering them a bottle to urinate in instead of helping them get to the toilet. This is congruent with Forero et al. (2019), indicating that patients left in the emergency room risk being neglected due to the RNs needing to focus on deteriorating patients and the influx of new incoming patients. A lack of environmental privacy and impaired health impact a loss of patient dignity. In already stressed patients, a lack of integrity and dignity can cause additional suffering and loneliness. McCormack (2016) state that one of the contextual challenges in developing person-centredness in emergency settings is the environment itself.

4.1 | Limitations

The interviews were held at a large university hospital, which makes transferability of the findings to other similar emergency departments possible. A limitation is that, as the interviewer (VP) herself is an RN, her own professional experiences might have affected the interview situation and analysis. To avoid excessive influence on the analysis, she shared her preunderstandings with the larger research team.

5 | CONCLUSION

This qualitative descriptive study described RNs' experiences of their work approach and prerequisites for meeting life-threateningly

ill patients' fundamental care needs in the emergency room. An organizational focus on patient flow and the promotion of guidelines and checklists provide a structured approach for the initial care of patients, but are not adapted to provide them with person-centred care. The RNs' work approach in the emergency room, to meet patients' fundamental care needs, depends on personal and organizational prerequisites. To provide person-centred fundamental care in the emergency room, nursing care needs to be prioritized not only by the RNs, but also by management and leaders.

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CONFLICT OF INTEREST

None declared.

AUTHOR CONTRIBUTIONS

VP, ÅM, MSM, UvTS, IKH: Made substantial contributions to conception and design, or acquisition of data or analysis and interpretation of data; VP, ÅM, MSM, UvTS, IKH: Involved in drafting the manuscript or revising it critically for important intellectual content; VP, ÅM, MSM, UvTS, IKH: Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; VP, ÅM, MSM, UvTS, IKH: Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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Author elects to not share data.

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