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Fundamental care: bedside nurses' perspective on the definition and its elements

A QUALITATIVE GENERIC STUDY

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Summary

Background: Fundamental care involves aspects of nursing care that refer to persons' fundamental needs. Nurses have to operate in contexts where the focus is on efficiency and productivity, which pressurizes fundamental care. This results in fundamental care being delegated to allied health professionals, which is proven to influence patient outcomes negatively. Solid fundamental care is essential to improve nursing-sensitive patient outcomes. To improve these outcome measures, the Fundamentals of Care Framework (FoCF) was developed, which is based on the expertise of clinical and research members of the International Learning Collaborative but was never validated by bedside nurses.

Objective: To explore the perspective of bedside nurses on the definition of fundamental care, the elements of fundamental care, and how the FoCF can be used in clinical practice.

Method: A generic qualitative design was chosen. This study was performed in three hospitals; one university hospital and two general hospitals. Data were collected though focus groups with bedside nurses.

Results: The nurse-patient relationship was viewed as a central aspect in fundamental care. There was mentioned that fundamental care is patient-centred, trust-based, and has a holistic approach. Involving family and having respect for patients' individual needs were recognized. Three dimensions of the FoCF were recognized, but some elements were not included in the physical dimension. The FoCF was viewed as essence of nursing, and participants mentioned it could be used as a tool for nursing students and nurses to identify bottlenecks in nursing care or to provide an overall picture of patients' needs.

Recommendations: Further research must focus on the perspectives of bedside nurses working in other settings and in other countries, and it should focus on the integration of the FoCF in clinical practice to confirm the possible value of the framework in clinical practice and for nursing students.

Keywords: Fundamental care, Fundamentals of Care Framework, qualitative research.

Samenvatting

Achtergrond: Essentiële zorg heeft is gericht op basisbehoeften van patiënten. Momenteel ligt de focus in gezondheidszorg op effectiviteit en productiviteit, wat druk uitoefent op essentiële zorg. Dit maakt dat essentiële zorg vaak wordt uitbesteed aan andere zorgverleners in plaats van verpleegkundigen, wat patiëntuitkomsten negatief beïnvloed. Om deze uitkomsten te verbeteren is het Fundamentals of Care Framework ontwikkeld. Hiervoor is gebruik gemaakt van de expertise van leden van het International Learning Collaborative, maar werd niet gevalideerd door verpleegkundigen werkzaam in directe patiëntenzorg.

Onderzoeksvraag: Het verkennen van het perspectief van verpleegkundigen werkzaam in directe patiëntenzorg wat betreft de definitie van essentiële zorg, de elementen ervan, en hoe het Fundamentals of Care Framework (FoCF) kan worden toegepast in de verpleegkundige praktijk.

Methode: Voor deze studie is generiek kwalitatief design gebruikt. Deze studie is uitgevoerd in drie ziekenhuizen: een universitair ziekenhuis en twee perifere ziekenhuizen. Data werd verzameld middels het uitvoeren van focusgroepen met verpleegkundigen werkzaam in directe patiëntenzorg.

Resultaten: De relatie tussen verpleegkundige en patiënt heeft een centrale rol in essentiële zorg. De patiënt staat centraal, vertrouwen wordt als basis gezien en er is sprake van een holistische benadering. Het betrekken van familie en respect hebben voor individuele behoeften van patiënt werd als belangrijk beschouwd. De drie dimensies van het frameowork werden herkent, maar sommige elementen ontbraken nog in de fysieke dimensie. Het framework wordt gezien als de kern van essentiële zorg en zou als hulpmiddel kunnen dienen voor studenten en verpleegkundigen om valkuilen in zorg te identificeren en overzicht te krijgen in de behoeften van patiënten.

Aanbevelingen: Verder onderzoek moet zich focussen op verpleegkundigen in directe patiëntenzorg in andere settings en andere landen. Focus zou ook moeten liggen op de integratie van het framework in klinische praktijk om de toegevoegde waarde ervan voor zowel de verpleegkundigen als studenten te onderzoeken.

Trefwoorden: Essentiële zorg, Fundamentals of Care Framework, kwalitatief onderzoek.

Background

Historically, basic care is regarded as the responsibility of registered nurses[1]. Basic nursing care is also referred as 'fundamental care', 'essential care', or 'essence of care', and involves aspects of nursing care that refer to persons' fundamental needs[2,3]. In this study, 'fundamental care' is used. Fundamental care influences patients' health, medical condition, and the quality of care[4,5]. The following definition of fundamental care was developed: *'Fundamental care involves actions on the part of the nurse that respect and focus on a persons' 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'*[3].

Nowadays, nurses have to operate in contexts where the focus is on efficiency and productivity, which can result in fundamental care that is not always provided to the standards patients might deserve[2,5–7]. This demanding workload ensures fundamental care is delegated to allied health professionals, which is proven to influences patients' health outcomes negatively[1,2,6,8,9]. Therefore, several studies determined that fundamental care should be the responsibility of the nursing profession; caring is the core of this practice-based discipline[3,7,9]. Delegating fundamental care to other professionals creates confusion and results in devaluing fundamental care by nurses and nursing students[4,6,7].

Solid fundamental care can improve patient functioning, patients' self-care ability, patient safety, and patient satisfaction in care experiences[5,7,10]. Thus, fundamental care is essential to improve nursing-sensitive patient outcomes[7,10–12]. These outcomes can be identified as outcomes that are influenced by nursing and are comprehensive enough to assess the effectiveness of nursing practice[13,14].

To improve patients' experiences of fundamental care nursing-sensitive patient outcomes, a substantial shift in the conceptualization, valuing, and prioritization of fundamental care is required[3]. This shift has to begin with a more explicit embedding of fundamental care in research, nursing education, nursing practice, and health policy[3,7,15]. To initiate this conversion, it is necessary to have strong conceptual clarity about how fundamental care should be defined and which nursing proceedings it contains[4].

However, there still appears to be a lack of consensus on essential aspects of fundamental care[4]. Therefore, the Fundamentals of Care Framework (FoCF) was developed[3]. The FoCF comprises three related dimensions that are required for the delivery of fundamental care[6,8] (figure 1). The inner core of the framework represents the nurse-patient relationship, the base

of the framework[6,8]. The middle circle represents the integration of relational, psychosocial, and physical nursing care[3,6]. The outer circle relates to the influence of context of care – policy and system level – on delivering fundamental care[6,8]. Thus, the FoCF incorporates the contextual, integrative, and relational aspects of fundamental care to pursue high-quality nursing care and more consciousness of the impact of decent nursing care on nursing-sensitive patient outcomes[6].

The FoCF's development was based on the expertise of research members of the International Learning Collaborative (ILC), but it was never validated by bedside nurses[3]. Therefore, in 2018, the international Euro2Care research group was established. Within this international research group, this study is an initial step to explore bedside nurses' perspective on fundamental care and the FoCF, and to further develop the definition of fundamental care. Bedside nurses must be familiar with this perspective on fundamental care and they have to adhere and embrace the FoCF before it can be implemented in clinical practice.

Objective

The aim of this study is to explore bedside nurses' perspective on the definition of fundamental care, the elements of fundamental care, and how the Fundamentals of Care Framework can be used in clinical practice.

Method

Design

A generic qualitative design was chosen. This kind of qualitative approach aims to discover and understand the views and perspectives of the people who are involved in the study[16,17]. This study provides a thematic description of perspectives reported by bedside nurses.

Setting and participants

This study was performed in three hospitals; one university hospital and two general hospitals. The study population included bedside nurses. These participants were recruited from different wards to identify potential differences, to ensure maximum variation, and to increase generalizability of the study results. Nurses were eligible for participation by meeting the following inclusion criteria: 1) working as a bedside nurse in direct patient care (at least 24 hours per week), 2) being a registered nurse (vocational or bachelor educated), 3) having a minimum of one-year work experience, and 4) having sufficient comprehension of the Dutch language.

Data collection

Focus groups were used for data collection and were performed between February and April 2019. This method is characterized by interaction between participants from which researchers aim to discover opinions and thoughts on particular issues[18–20]. Four focus groups were conducted because the participants worked in two different types of settings. At the start of data collection, the original plan was to conduct four focus groups in two hospitals. Unfortunately, the number of applicants in the first general hospital was too low to conduct two focus groups. Therefore, a second general hospital was invited to participate. This resulted in two focus groups in the university hospital and two focus groups in the general hospitals.

To ensure data saturation, it was aimed to include at least 24 participants. This would be the optimum number to provide a variety of perspectives and small enough to not become fragmented or disorderly[18,21].

During the focus groups, a topic list was used. This topic list was composed by the Euro2Care research group and was based on the questions in an earlier conducted Delphi study[3], the FoCF and the definition of fundamental care (table 2). Prior to data collection, the topic list was tested during a NAC meeting to check clarity of the topics and the FoCF. Therefore, this meeting can be regarded as a pilot focus group and as a first preparation for the researcher to conduct a focus group.

The principle researcher facilitated the first focus group and the researcher acted as an observer. The researcher chaired the other three focus groups, and the principle researcher accompanied the process and made field notes. The focus groups took place in conference rooms in each of the three participating hospitals to ensure a familiar environment[18,21]. Focus groups were audio recorded with the permission of participants, transcribed, and field notes were made about non-verbal communication and the attitudes of the participants[18,21,22].

Data analysis

Data was analysed according to thematic analysis principles. This form of analysis is used to identify, analyse, and interpret patterned meanings or themes in qualitative data[23,24]. This analysis followed six phases; familiarizing with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report[24]. This thematic analysis was driven by the components of the topic list. Codes and themes that were formulated in the analysis phase were subdivided into one of these components. The final

content of components was compared with the current definition and the framework and its elements (table 1 and figure 1).

While proceeding through the six phases of thematic analysis, some general principles of qualitative data analysis were also applied. To enhance reliability and validity of the study, two researchers analysed data independently from each other in phase 1 (familiarizing with data) and phase 2 (generating initial codes)[18,21]. Phase 3 (searching for themes) was performed by one researcher, but resulted in reaching consensus regarding the themes by both the researchers. Phase 4 (reviewing themes), phase 5 (defining and naming themes), and phase 6 (producing the report) were performed by the researcher, and the principal researcher provided supervision. During the fourth phase of reviewing themes, substantial sections of the report were sent to participants to comment on the content. This method of performing a member check improved trustworthiness of the study[18]. Data analysis resulted in some main themes and elements, which were presented to the other researcher to determine consensus.

Data analysis was performed by using the qualitative data analysis program ATLAS.ti (version 8.3.20.0).

Procedures

Participants were approached according to the principles of purposive sampling. The researcher consulted with the Nursing Advisory Council (NAC) of the two general hospitals for participation in the study. The NAC approached eligible nurses, the researcher selected potential participants, and contacted them by email if they were willing to participate. In the university hospital, the researcher invited nurses to participate by email. The researcher made a selection, based on the criteria mentioned earlier, from the nurses who indicated an interest to participate.

A week before the focus group, participants received a pre-information letter and an official invitation to participate by email from the researcher. Directly prior to the focus group meeting, demographic data of participants were collected and participants were asked to sign an informed consent.

The researcher clarified that participants could terminate participation at any time without any consequences, and this was emphasized again during the audio recording[22]. The duration of the focus groups was 60-75 minutes and the five stages for focus groups were used: ground rules were established, participants introduced themselves, a neutral opening question was

chosen, the different areas on the topic list were discussed, and a debriefing took place at the end[18,21].

Ethical considerations

This study was conducted according to the principles of the Declaration of Helsinki[25], the Dutch Code of Conduct for Research Integrity[26], the checklist of the Consolidated Criteria for Reporting Qualitative Research (COREQ)[27], and the General Data Protection Regulation[28]. This study was not in conflict with physical and/or physiological integrity of participants, so it was not under the scope of the Medical Research Involving Human Subjects Act[29]. Nevertheless, this study received ethical approval by the local ethical review committee of the university hospital.

Results

Four focus groups were conducted. The number of participants per focus group varied between four and nine. Five participants unsubscribed from participation due to personal circumstances or without reason. This resulted in a total of 23 participants. Most nurses were female (83.3%) and more than half of the nurses (62.5%) worked in an academic hospital. Among the nurses, 78.3% were bachelor educated. The median age was 27.0 years (range = 21.0-62.0), the median of years in profession as a registered nurse was 5.4 years (range = 0.9-37.3), and the mean of years of clinical experience was 3.0 years (range = 0.9-29.3). Table 3 provides an overview of these demographic characteristics.

Nurse-patient relationship

The first aspect noted by nurses was the nurse-patient relationship. They agreed that fundamental care must be patient-centred and therefore the nurse must focus on the essential and individual needs of the patient. Respect for the individual is important. Sometimes this becomes complicated when these essential needs do not correspond with the nurse's expectations of the patient. Therefore, nurses stated that it is important to involve patients in their treatment process and to set goals together. The nurse-patient relationship must be seen as a collaboration that is based on a basic trust a patient has in nurses.

> *'The relationship between the nurse and a patient is an inseparable aspect of nursing practice (participant 18).'*

The definition has a holistic approach that takes care of the whole patient instead of just a part of the patient. In the context of the demanding workload, often only fundamental care focused on patient's physical aspects is delivered.

This nurse-patient relationship evoked some questions. Some nurses asked whether a relationship with respect for individual needs is always necessary. They determined that it depends on the setting in which the patient interacts with the nurse and duration of the contact. Additionally, nurses mentioned that some patients do not feel the need to enter an in-depth relationship and they prefer to share their thoughts and concerns with someone else. In that case, the nurse-patient relationship remains at a more superficial level. However, this kind of superficial relationship often still accompanies the patient's trust in nursing practice.

> *'Everything must be adapted for that individual patient. Essential needs from that single patient must be recognized and met by the nurse as good as possible (participant 10).'*

It is striking that some nurses mentioned that the essence of the nurse-patient relationship is not specifically applicable to the nursing profession, but that the definition of fundamental care contains elements that also could be generalizable to other healthcare professionals.

Conditions for relationship

The importance of the central role of the nurse-patient relationship was recognized. The trusting character of the nurse-patient relationship had consensus, but doubts were expressed regarding the so-called 'positive' relationship. There was uncertainty about this term and nurses asked whether a nurse-patient relationship always has to be positive, and they did not exactly know what was meant by it. Therefore, they determined that this relationship is based on trust and safety.

> *'The patient has to feel in good hands (participant 6).'*

Some conditions have to be met in order to develop a good relationship between patient and nurse, and consensus was reached on the reciprocal character of it. This means that not only do nurses have to put energy and effort in this relationship, they may also have certain expectations from the patient's side, which includes having respect for each other and each other's values and beliefs. It is also associated with having respect for a person's background, earlier experiences, and frame of reference. Another condition was having respect for and being aware of the patient's culture. This condition was omitted in both definition and framework.

'As a nurse, you have respect for your patient, you have an eye for that person, you notice specific needs on which you can take certain actions, which results in best care for that specific moment (participant 22).'

Involving family and carers

Nurses noted the importance to involve and engage patients' family or carers, which was recognized in the definition but was not included in the framework. Especially in some cultures, involving the patient's family is imperative and something that the nurse must take into account. Therefore, concretizing this so-called established triangle relationship between nurse, patient, and family more clearly in the central part of the framework was requested.

'Family is also part of the relationship (participant 2)'

Integration of care; physical, psychosocial and relational

Nurses recognized the three dimensions in the circle regarding 'Integration of Care'. They agreed on the elements of the physical dimension, but four elements were not included: monitoring vital functions, wound care, prevention, and lifestyle. Monitoring vital functions and providing wound care are essential aspects and influence patient outcomes. In addition, many nursing duties focus on prevention and lifestyle. For example, several nurses mentioned paying attention to stop patients smoking, or deploying interventions to reduce the chance of re-admission. Furthermore, an inventory of patient needs regard to physical elements has to be made.

Nurses were positive that the framework and definition specifically identify the importance of paying attention to the psychosocial wellbeing of the patient. Discussion took place about 'patients having a choice'. According to the nurses, this is linked to the patient-centred approach mentioned earlier. Patients have a choice in their treatment process and the nurse is seen as one who guides the patient throughout this period. Communication, education, information, and helping patients to cope were recognised elements. In addition, family must also be involved. However, the aspect of spirituality was excluded. More attention must be paid to the existential issues that the patient faces. Furthermore, uncertainty related to the element of 'helping patients to stay calm' was noted. This element could not be taken literally, and therefore it was agreed that it was more about providing comfort to the patient. With regard to this comfort, the nurse must pay attention to their patients, be meaningful to them, and attempt to allow them to feel

safe and heard. There was also confusion about the psychosocial and relational dimensions. These dimensions have mutual elements that do not lead to demarcated dimensions.

'Nowadays, there seems to be more focus on 'cure' instead of 'care'. This definition and framework seems to take back the focus on 'care' (participant 10).'

Context of care

'Context of Care' could be seen as conditions and a guarantee for delivery of high quality care. Conditions such as financing and governmental regulations, provision in institutions, multidisciplinary collaboration, and administration were noted. This context can influence the way in which care is delivered, but there is lack of insight and interest of nurses in this level of healthcare. They sense that they do have no influence on regulations at institutional level or even governmental regulations and legislation.

'Care delivery is determined by the context, but focus must be on nurse-patient relationship, always (participant 15)'

Framework (in clinical practice)

Most nurses regarded this framework as a means to create insight and awareness regarding the essence of fundamental care and the core of the nursing profession.

'The essence of the framework is the essence of how to provide care (participant 13).'

This framework might be useful to create an overall picture of the patient in order to assess the patient's individual needs. Furthermore, the framework is helpful to identify bottlenecks in providing care and can be used as a tool in several ways, such as a tool for (multidisciplinary) gatherings, for clinical reasoning, for clinical classes, for reporting, and to offer structure to daily care delivery. Therefore, the framework might also be helpful for nursing students. The framework will offer more insight into nursing profession and draw their attention to the importance of addressing not only physical elements of fundamental care but also the psychosocial wellbeing of their patients.

The layout is quite minimalistic, which offers little insight into the three dimensions of integration of care. Furthermore, conditions for this nurse-patient relationship were not included in this framework. The relationship in the middle needs to be more prominent, which confirms that this relationship consists of the nurse, the patient, and the patient's family. The largeness

of the circles must be reconsidered to create greater focus on the two inner circles, because that is what fundamental care is about.

Table 4 provides a schematic overview of the main findings of the study and its elements.

Discussion

The nurse-patient relationship has a central role in fundamental care and is patient-centred. It is trust-based and has a holistic approach. Collaboration takes place between the nurse and the patient, it is important that patients and their family are involved, and respect the patient's individual needs. Conditions for this relationship are trust, safety, reciprocity, and respect different values and beliefs, background, and culture. The FoCF is viewed as the essence of fundamental care, and it can be used as a tool for nursing students and nurses to identify bottlenecks in nursing care or to provide an overall picture of the patient.

Patient-centred care is a central element in this study. It is described as care that focuses on the patient and on the individual healthcare needs of the patient[30]. According to Reynolds, patient-centred care aims to empower patients and to encourage them in self-care[30]. This encouragement of patient empowerment to stay in charge of their own lives was confirmed[31]. Conditions for this empowerment include addressing the patient's individual needs and good communication skills from the healthcare providers[30]. These conditions were also mentioned in the study of Reynolds, but 'empowerment' was not mentioned once in this study. Tobiano et al stated that patients need to be motivated to participate in patient-centred care and to cultivate this motivation patient empowerment is crucial[32]. Additionally, it is vital to empower patients to participate in practice, and engaging nurse-patient relationships are required[32]. The question might be whether 'empowerment' should be mentioned in fundamental care, because it appears to be related to patient-centred care and the nurse-patient relationship.

Trust is an important condition for the nurse-patient relationship. In 2013, a literature review addressed trust in nurse-patient relationships[33]. It suggested that patients appear to have a generalized trust in nurses as professionals[33]. This was also mentioned in the findings of this study. Conditions such as respect and effective communication within this nurse-patient relationship are also mentioned in the literature review, which strengthens these findings of our study. McCabe et al also indicated the importance of effective communication in this nurse-patient relationship and even mentioned that a patient-centred approach improved the communication between the nurse and the patient[34]. Further, the review identified several

conditions for the nurse-patient relationship that were not cited during our study, for example, empathy, honesty and reliability[33].

Involving patients' family in treatment process was also a main finding in this study. Patient-centred care can be seen as organizing care around the patient, where patients' family is involved to satisfy and identify patient preferences and needs[35]. In contrast to the findings of this study, another study is questioning whether nurses might only involve the patient's family for self-interest to elicit some help in addressing needs of the patient[36]. However, do nurses also take care of the families during difficult times[36]? This aspect was not discussed in this study.

One of the strengths of this study was that data were coded by two researchers independently. To improve the trustworthiness of the study, substantial sections of the data analysis were sent to participants for comment on the content. To enhance generalizability of the findings, participants were recruited from different hospitals and wards to identify potential differences, and there was a wide variety in age and years of work experience to ensure maximum variation.

This study also had some limitations. Only nurses from Dutch hospitals were included in this study, which makes the results not generalizable to other countries because nurses there might have other perspectives on fundamental care due to different tasks and responsibilities. Furthermore, this study only studied the perspective of nurses working in hospitals, and it did not consider the perspective of nurses working in other fields, for example, home care, and nursing homes. Initially, this study wanted to include 24 participants but only 23 participants did participate. To reach this number of participants, 28 nurses were declared to be eligible for participation, but some nurses unsubscribed from participation due to personal circumstances, due to delays in their ward, or they did not arrive. Another limitation is the fact that one participant was included, even with having less than one year of working experience. However, the researcher decided to include this participant due to the few applications in the general hospitals. Additionally, as the participant was graduated recently, this inclusion was also useful because of the agreement on the potential value the framework might have during nursing education. The last limitation of the study is the fact that the researcher deviated from the topic list used. Questions were asked about differences or similarities between the old and new version of the FoCF, which was not part of the topic list, but was inadvertently used during the first focus group. Thereafter, researchers decided to continue asking this question during the other focus groups.

As a recommendation, future research must focus on the perspectives of bedside nurses working in other settings (e.g. home care, nursing homes) and in other countries. Focus must also be on the integration of the FoCF in clinical practice because this study showed that nurses confirm the value that the FoCF might have in clinical practice (e.g. clinical reasoning, multidisciplinary gatherings, reporting). Further research also should study the value the FoCF might have for nursing students and how this can be implemented in the nursing curriculum.

As a conclusion, this study has shown the perspectives of bedside nurses on fundamental care, the definition and its elements, and the FoCF. It suggested some alterations have to be made towards the definition and the layout of the framework. Integration of the FoCF can help nurses and nursing students to understand the essence of nursing care. Therewith, there is strong evidence of the potential relevance of the use of the FoCF in clinical practice which might result in more attention for fundamental care and higher quality of it.

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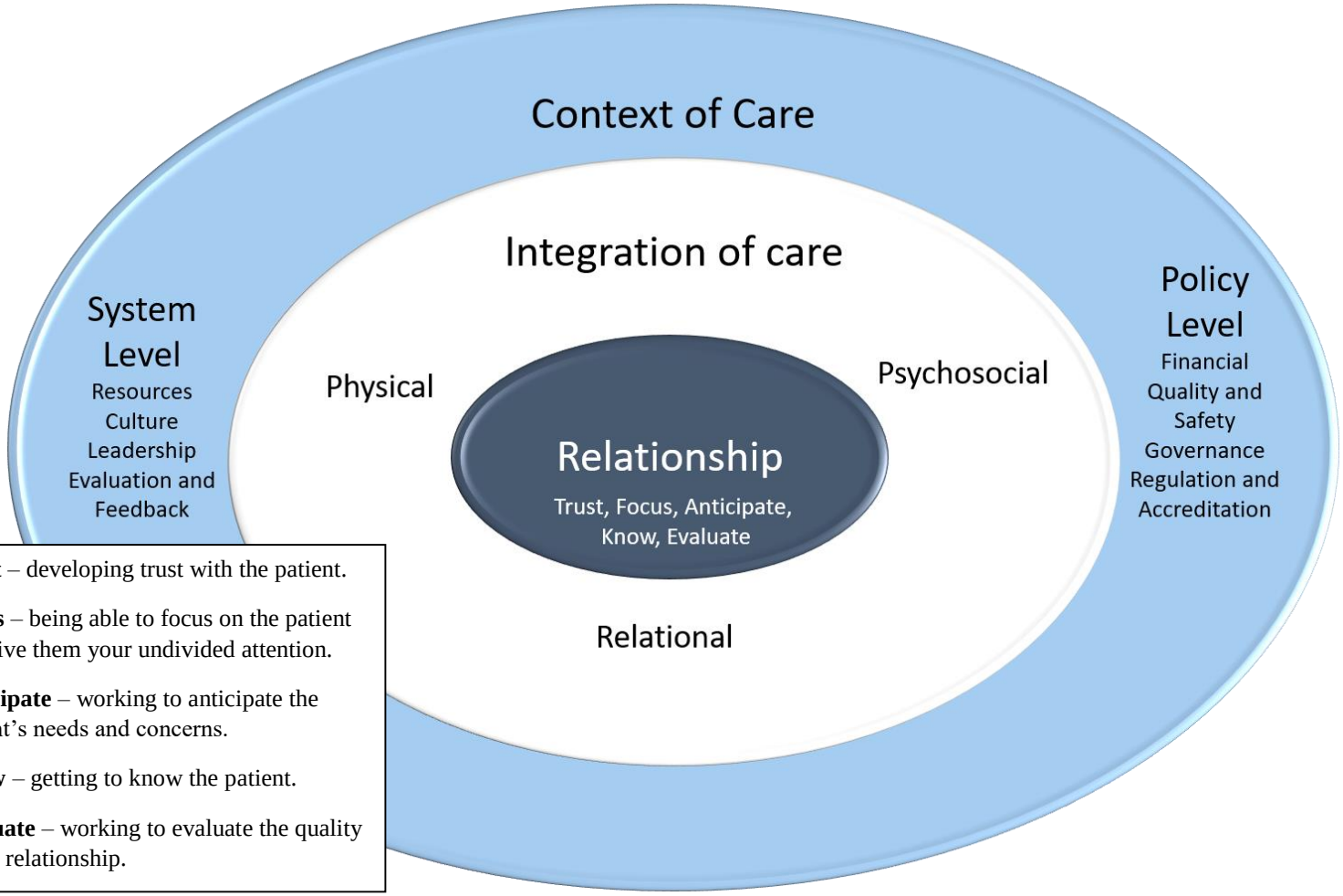

Figure 1. Fundamentals of Care Framework[3,37].

Table 1. Fundamentals of Care framework and its elements[37].

NEED/ACTION
Physical
- Personal cleaning (including oral/mouth care) and dressing - Toileting needs - Eating and drinking - Rest and sleep - Mobility - Comfort (pain management, breathing easily, temperature control) - Safety (risk assessment and management, infection prevention, minimising complications) - Medication management
Psychosocial
- Communication (verbal and nonverbal) - Being involved and informed - Privacy - Dignity - Respect - Education and information - Emotional well-being - Choice - Having values and beliefs considered and respected - Social engagement, company and support - Feeling able to express opinions and needs without care being compromised - Having interests and priorities considered and accommodated (where possible)
Relational
- Active listening - Empathy - Engaging with patients - Compassion - Being present and with patients - Supporting and involving families and carers - Helping patients to cope - Working with patients to set, achieve and evaluate progression of goals - Helping patients to stay calm

Table 2. Topic list focus groups

The overall aim is to explore European bedside nurses' perspective on the definition of fundamental care and its elements, and the Fundamentals of Care Framework.

Topic	**Primary questions**	**Supplementary/follow up questions (+ comments to guide the moderator)**
Opening question	▪ Can you tell me about your reflections about the information you received before the interview?	To moderator: just some brief reflections
Definition of fundamental care	▪ When you read the definition of fundamental care, what thoughts come to mind? ▪ How and in what way do you think the definition of fundamental care captures the main facets of nursing?	▪ Your immediate reflections? To moderator: display the definition on a whiteboard or on paper
Content of the conceptual framework	▪ We are now going to look at the FoC framework. According to this framework, person-centered and evidence-based fundamental care is an active process. This means that the nurse and the patient have to work together and that three dimensions are important to consider. When you read the three dimensions, what thoughts come to mind?	▪ Your immediate reflections on each of the following three dimensions: 1. Establishing the nurse-patient relationship 2. Integrating the Fundamentals of Care when you plan the patient's care 3. Ensuring that the setting where care is given and coordinated promotes person-centered fundamental care outcomes To moderator: use the pictures to display the framework and the elements (the dimensions are the three circles). ▪ Do you think the elements are complete?

	▪ Based on your thought and considerations, do you think the description of the Fundamentals of Care elements could be changed or refined to better describe the elements – if so, how?	▪ Are any crucial elements missing? ▪ What elements do you think should be included? <u>To moderator:</u> use the picture to display the elements within the three dimensions and especially consider (as these elements did not reach consensus at round two in the Delphi study): ▪ Choice ▪ Social engagement, company and support ▪ Feeling able to express opinions and need without care being compromised ▪ Having interests and priorities considered and accommodated (where possible).
Application in clinical practice	▪ Do you think this framework can/will influence your clinical practice? If so, in what way? ▪ How could this framework be included in your working day?	▪ Do you think it is feasible in your work?
Perspectives	▪ Do you have further comments or perspectives on the topics we have discussed? ▪ Is there anything you would like to add?	
Wrap-up question	▪ What do you think your colleagues would think about the Fundamentals of Care framework?	

Table 3. Demographic characteristics of participants

Age^ (years)	27.0 (21-62)
Sex*	
- Female	20 (87.0%)
- Male	3 (13.0%)
Education*	
- Bachelor's degree	18 (78.4%)
- Master's degree	2 (8.7%)
- Vocational educated	1 (4.3%)
- In-service educated	1 (4.3%)
- *Missing*	*1 (4.3%)*
Kind of hospital*	
- Academic hospital	15 (65.2%)
- General hospital	8 (34.8%)
Graduated as Registered Nurse^ (years)	5.4 (0.9-37.3)
Clinical experience^ (years)	3.0 (0.9-29.3)
Specialty/ward*	
- Nephrology	5 (21.9%)
- Geriatrics	2 (8.7%)
- Internal medicine	2 (8.7%)
- Rheumatology	2 (8.7%)
- Cardiac care unit	1 (4.3%)
- Cardiology	1 (4.3%)
- Day therapy	1 (4.3%)
- Neurology	1 (4.3%)
- Orthopedics	1 (4.3%)
- Recovery	1 (4.3%)
- Woundcare	1 (4.3%)
- *Missing*	5 (21.9%)

* represented as: n (%) ^ represented as: median (range)

Table 4. Main themes and its elements

Nurse-patient relationship	Patient-centred
	Patient's individual needs
	Involving patients
	Collaboration between nurse and patient
	Generalizable to other healthcare professionals
	Trust-based
	Holistic approach
Conditions for relationship	Trust
	Safety
	Reciprocity
	Respect
	Values and beliefs
	Background, experiences and frame of reference
	Culture
Involving family/carers	Established triangle relationship
Integration of care	
Physical	Monitoring vital functions
	Wound care
	Prevention
	Lifestyle
Psychosocial/relational	Mutual elements/no demarcated dimensions
	Attention for psychosocial wellbeing
	Patient's having a choice
	Communication
	Coping
	Spirituality
	Education and information
	Providing comfort
Context of care	Conditions for care delivery
	Guaranty
	Lack of insight and interest
	Feeling of having no influence
Framework	Essence of fundamental care
	Core of nursing profession
	Overall picture of patient
	Identify bottlenecks
	Framework as tool (for students)
	Layout