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Promoting patient-centred fundamental care in acute healthcare systems

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ABSTRACT

Meeting patients' fundamental care needs is essential for optimal safety and recovery and positive experiences within any healthcare setting. There is growing international evidence, however, that these fundamentals are often poorly executed in acute care settings, resulting in patient safety threats, poorer and costly care outcomes, and dehumanising experiences for patients and families. Whilst care standards and policy initiatives are attempting to address these issues, their impact has been limited. This discussion paper explores, through a series of propositions, why fundamental care can be overlooked in sophisticated, high technology acute care settings. We argue that the central problem lies in the invisibility and subsequent devaluing of fundamental care. Such care is perceived to involve simple tasks that require little skill to execute and have minimal impact on patient outcomes. The propositions explore the potential origins of this prevailing perception, focusing upon the impact of the biomedical model, the consequences of managerial approaches that drive healthcare cultures, and the devaluing of fundamental care by nurses themselves. These multiple sources of invisibility and devaluing surrounding fundamental care have rendered the concept underdeveloped and misunderstood both conceptually and theoretically. Likewise, there remains minimal role clarification around who should be responsible for and deliver such care, and a dearth of empirical evidence and evidence-based metrics. In explicating these propositions, we argue that key to transforming the delivery of acute healthcare is a substantial shift in the conceptualisation of fundamental care. The propositions present a cogent argument that counters the prevailing perception that fundamental care is basic and does not require systematic investigation. We conclude by calling for the explicit valuing and embedding of fundamental care in healthcare education, research, practice and policy. Without this re-conceptualisation and subsequent action, poor quality, depersonalised fundamental care will prevail.

What is already known about the topic?

- International evidence shows that the delivery of fundamental care is variable across acute healthcare systems with such failures resulting in adverse patient outcomes and poor care experiences.
- Scholars are attempting to understand why fundamental care is being poorly delivered and many healthcare organisations have begun implementing strategies to address the problem.

What this paper adds

- The paper argues that fundamental care is poorly delivered in acute care due to the invisibility and

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subsequent devaluing of such care across entire acute healthcare systems.
- Fundamental care is rendered invisible and devalued by: (1) the dominance of the biomedical model, (2) managerial approaches to care, and (3) the devaluing of fundamental care by nurses.
- For a substantial shift in the delivery of fundamental care to occur, these widely-held beliefs must be challenged. This can be achieved through: (1) re-conceptualising the value of fundamental care, (2) developing the evidence base behind the fundamentals, (3) creating metrics for the fundamentals of care, (4) greater role clarification, (5) systematically embedding the fundamentals of care into nursing and other healthcare curricula; and (6) increased community involvement.

1. Introduction

People engage in a range of self-care activities, such as eating and personal hygiene, on a daily basis to ensure their survival, health and wellbeing. In the context of acute or chronic illness, injury or disability, an individual's capacity to perform these vital and intimate care activities can be compromised, necessitating support from nurses and other health professionals. 'Fundamentals of care' (or fundamental care) is one of the many terms – and the one used in this paper – given to these care activities that are required for every person, regardless of their clinical condition or healthcare setting (Kitson et al., 2010). The term *fundamental* reflects the centrality of these activities to reducing harm, optimising recovery (Kitson et al., 2013a; Rantz and Zwygart-Stauffacher, 2004; Vollman, 2013), and ensuring positive patient experiences (Garling, 2008; Kitson and Muntlin Athlin, 2013; Kitson et al., 2013b). Traditionally in acute settings, discrete fundamental care activities, such as helping people with eating, drinking and elimination, have been carried out by nurses on behalf of the wider healthcare team (Kitson et al., 2013a).

Whilst fundamental care is not a new concept, in recent years increasing attention has been placed on the ways in which such care is delivered in practice, particularly by nurses (Vollman, 2009). One reason for this renewed focus is the increased emphasis on patient-centred care,[1] which has become the cornerstone of quality healthcare in many developed countries and is explicitly referenced in healthcare policies (Department of Health, 2012; MacKinnon, 2011; NSW Department of Health, 2009; SA Health, 2015). Patient-centred care focuses on healthcare that involves patients via greater decision-making and choice, and which is sensitive to patients' unique physical, psychosocial, cultural and emotional needs (Kitson and Muntlin Athlin, 2013; Kitson et al., 2013c). Attention is now turning to the ways in which people can be better supported to participate in the delivery and management of their fundamental care needs as a means of providing respectful, dignified patient-centred care (Kitson et al., 2013b). In addition to the patient-centred care movement, the higher burden of disease brought about by an ageing population; global migration; complex health conditions characterised by multi-morbidities; and increases in chronic, incurable illnesses, is creating higher demand for high-quality fundamental care and placing increased scrutiny on the way in which such care is delivered in acute care settings.

However, the renewed focus on fundamental care is underpinned mostly by growing evidence of recurrent failures to attend to people's fundamental care needs, resulting in poor patient safety and quality of care. Studies of acute healthcare settings in Australia, the US, UK and Canada have reported deficits in numerous fundamentals of care, including nutrition and hydration, with people unable to reach water and not receiving adequate assistance to eat (Bureau of Health Information, 2014; Francis, 2013; Garling, 2008; Kalisch, 2006). Problems have been noted around elimination, with an enquiry into acute hospital care in the UK hearing that patients were routinely left in soiled bed clothes for lengthy periods and did not receive help in their toileting, despite persistent requests (Francis, 2013). Nurses also report regularly missing ambulation and pressure area care, with patients turned every 4, 6, or 8 h rather than the recommended two (Kalisch, 2006; Kalisch et al., 2009, 2011). Personal hygiene, including oral care, is also routinely missed, with nurses in one US study reporting that patients were often not bathed for two or three days (Kalisch, 2006; Kalisch et al., 2009, 2011).

Patients' psychosocial and cultural needs are also routinely overlooked (Kalisch, 2006; SA Health, 2012). Basic communication, such as introducing oneself to patients and families, often does not occur, whilst patients who require an interpreter do not always have access to one (Bureau of Health Information, 2014; SA Health, 2012). Many patients and families report a lack of adequate information from health professionals, who often do not explain aspects of care in ways that patients can understand (Bureau of Health Information, 2014; Garling, 2008; Gill et al., 2014; SA Health, 2012). Dignity, respect and privacy are also compromised, with patients reporting being spoken to in a condescending or dismissive manner (Care Quality Commission, 2011; Francis, 2013). Emotional support, in particular, is an area where irregularities and inconsistencies are common. Patients in hospital report being unable to find a staff member to talk to about their worries (SA Health, 2012), whilst nurses report that they do not attend to patients' emotional or psychosocial needs consistently (Kalisch, 2006).

The breadth of evidence concerning poor quality fundamental care in acute care settings across a number of countries indicates the significance of the problem. These are not rare or isolated incidents of poor care but systematic failures across and within acute healthcare systems. Given this evidence, two central questions arise: (1) why is this happening? And (2) what can be done about it? In attempting to uncover the reasons behind the

[1] Whilst the term patient-centred is often used interchangeably with person-centred, the latter represents a holistic approach to care, predicated on viewing the person as a whole rather than as a patient with a condition. We therefore use the term patient-centred to represent current biomedical and managerial approaches to care, which we explore in this paper.