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Title
TOWARDS A STANDARDISED DEFINITION FOR FUNDAMENTAL CARE: A MODIFIED DELPHI STUDY

Concise title
Developing a Standardised Definition for Fundamental Care

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TOWARDS A STANDARDISED DEFINITION FOR FUNDAMENTAL CARE: A MODIFIED DELPHI STUDY

ABSTRACT

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

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

Design. Modified Delphi study.

Methods. Three phases: (1) engaging stakeholders via an interactive workshop; (2) using workshop findings to develop a preliminary definition for, and identify the discrete elements that constitute, fundamental care; and (3) gaining consensus on the definition and elements via a two-round Delphi approach (Round 1 *n*=38; Round 2 *n*=28).

Results. Delphi participants perceived both the definition and elements generated from the workshop as comprehensive, but beyond the scope of fundamental care. Participants questioned whether the definition should focus on patient needs and nurse actions, or more broadly on how fundamental care should be delivered (e.g., through a trusting nurse-patient relationship), and the outcomes of this care delivery. There were also mixed opinions whether the definition should be nursing specific.

Conclusions. This study has initiated crucial dialogue around how fundamental care is conceptualised and defined. Future work should focus on further refinements of the definition and elements with a larger, international group of practising nurses and service users.

Relevance to clinical practice. The definition and elements, through ongoing refinement, will contribute to a robust evidence base that will underpin policy development and the systematic and effective teaching, delivery, measurement and evaluation of fundamental care.

SUMMARY BOX

'What does this paper contribute to the wider global clinical community?'

- This study has validated and further explicated the acknowledged complexity of how to define fundamental care and identify the discrete elements of such care.
- The absence of a definition for fundamental care and lack of agreement around the discrete elements have negative consequences for nursing research, education and care delivery. The definition and elements developed in this study are crucial for generating agreed conceptual understanding for policy, research, education and clinical practice.
- This study incorporates the perspectives of healthcare clinicians, service users, leaders, researchers and educators, ensuring broad applicability of the consensus-based definition and elements.

Keywords: Fundamental care, fundamentals of care, basic nursing care, definition, Delphi study

INTRODUCTION

Widely publicised failures in fundamental care globally (Bureau of Health Information, 2014; Care Quality Commission, 2011; Francis, 2013; Kalisch, Xie, & Dabney, 2014; SA Health, 2012) have led to a proliferation of policies, standards, and interventions designed to improve the quality and safety of (primarily) nursing care (e.g., NHS, 2014; Vollman, 2013). Despite these efforts, the concept of fundamental care remains poorly understood, with no global, agreed definition and a lack of agreement on the discrete elements that comprise such care (Kitson, Conroy, Wengstrom, Profetto-McGrath, & Robertson-Malt, 2010; Merrett, 2013; Schneider & Ruth-Sahd, 2015). Poor conceptual clarity and the absence of a definition undermine the development of a robust evidence base, resulting in inconsistent and inadequate healthcare policies, care delivery, and nursing curricula; a problem not easily overcome by additional policies and standards. The aim of this study is to tackle this conceptual inconsistency by generating consensus on a definition for fundamental care and the discrete elements (i.e., patient needs and nurse actions) that constitute such care.

BACKGROUND

As a concept, fundamental care is subject to different interpretations – it can refer to a person's fundamental needs (e.g., toileting); aspects of nursing care (e.g., being empathic); the outcome of addressing a person's fundamental needs; and/or the individual and system-level factors required to address these needs (Ball et al., 2016). Multiple terms also exist to describe fundamental care, including essence of care, essentials of care and basic nursing care, many of which are poorly articulated and inconsistently interpreted (Kagan, 2013; Kitson et al., 2010). Furthermore, whilst historically seen as the responsibility of Registered Nurses, increasingly fundamental care is delegated to other care staff, including care assistants and allied health professionals (e.g., dieticians, occupational therapists) (Darbyshire

& McKenna, 2013; Wolf, 2014). This has created confusion as to whether fundamental care refers to the work of Registered Nurses or to the work of any healthcare professional.

Given this lack of conceptual clarity, an agreed definition for fundamental care does not exist, nor is there agreement on the discrete elements that constitute such care. Definitions are crucial for operationalising concepts, setting parameters for inquiry, identifying variables for analysis, and developing measurement tools (Pleasant et al., 2016). Poor conceptual clarity and the absence of a standardised definition mean members of the healthcare system (researchers, clinicians, educators, policy-makers and managers/leaders) are not working from an agreed set of parameters and variables. In turn, this affects our ability to measure, monitor and evaluate fundamental care systematically, impeding aggregation of data and comparison of findings from different studies, and undermining the development of a robust evidence base. The end result is poor and inconsistent policies; variable care assessment, planning and delivery; and diverse nursing curricula, which might or might not focus explicitly on fundamental care. As an illustration of the problem, poor conceptual clarity around person-centred care has resulted in wide variations in measurement (Epstein & Street Jr, 2011; McCormack et al., 2011); difficulties in implementation (Lawrence & Kinn, 2012); and inconsistent results regarding effectiveness (Smith, Dwamena, Grover, Coffey, & Frankel, 2011).

Whilst there has not been consistent uptake of a definition for fundamental care, efforts have been made to articulate the key principles of such care through the Fundamentals of Care Framework (Kitson, Conroy, Kuluski, Locock, & Lyons, 2013), leading to more consistent use of fundamental care elements in empirical studies (e.g., Feo et al., 2016). The Framework was developed from the clinical and research expertise of members of the International

Learning Collaborative (ILC) (http://intlearningcollab.org/), using a participatory, consensus-generating approach. Participants at the ILC's 2012 annual conference (researchers, educators, clinicians, policy-makers and service users) engaged in discussion around how to improve patients' experiences of fundamental care. A sub-group of ILC members took notes of this discussion and analysed the data for emerging themes. From these themes, the sub-group developed a preliminary conceptual framework, which was circulated to all ILC members for comment and feedback (for more on the Framework's development, see Kitson, Conroy, et al., 2013).

The Framework describes three inter-related dimensions: (1) nurse-patient relationship, (2) integration of care needs, and (3) context in which care is delivered (see Figure 1). The delivery of high-quality fundamental care is seen to be underpinned by a positive, trusting nurse-patient relationship, illustrated in Figure 1 by the circle 'relationship established'. The dimension 'integration of care' outlines that, once this relationship is established, the nurse can work to meet the patient's fundamental needs, conceptualised as both psychosocial and physical in nature. Meeting these needs is mediated by the nurse's relational skills, such as being empathetic (Kitson, Dow, Calabrese, Locock, & Muntlin Athlin, 2013; Kitson & Muntlin Athlin, 2013). Hence, a range of physical, psychosocial and relational fundamentals of care must be integrated in a given care episode. The dimension 'context of care' argues that the context of care delivery, including policy- and system-level factors, can hinder or enable the delivery of high-quality fundamental care. Despite debate around whose role it is to deliver fundamental care, the Framework places this responsibility on nurses given they have traditionally been responsible for delivery of fundamental care, and are held accountable in most health systems for failures in such care (e.g., falls, pressure area care, malnutrition, dehydration and infections) (see e.g., Francis, 2013).

The Framework does not contain a definition for fundamental care, and only the central dimension ('relationship established') has been tested empirically (Feo et al., 2016). Hence, to use the Framework in research, practice, education and policy, we must develop a standardised definition for fundamental care that reflects the Framework's conceptual understanding, and refine the dimension 'integration of care', including generating consensus on the physical, psychosocial and relational elements[1]. This paper reports on a study that aimed to provide a standardised definition of fundamental care and its elements through a modified Delphi approach involving international experts.

METHODS

Design

The lead author assembled a research team of representative ILC members interested in undertaking further work in this area. Members were from Australia, Sweden and New Zealand. A modified Delphi method was used. The Delphi method involves repeated, anonymous surveying of experts in a field to reach consensus on topics where it is lacking, or when there is a limited body of knowledge on which to build a scientific study (Clibbens, Walters, & Baird, 2012; Fox et al., 2016; Thompson, McArthur, & Doupe, 2016). The modified method can involve face-to-face discussion amongst participants (Eubank et al., 2016; Foth et al., 2016), a technique used in this study. The phases employed to reach consensus on a definition for fundamental care and the discrete elements are described below and illustrated in Figure 2.

[1] The dimension 'context of care' is currently being tested by ILC members.

Data collection

Phase 1: Stakeholder engagement. To engage stakeholders, the lead author ran a workshop at the ILC 2016 conference, Oxford University, UK. Thirty-nine participants engaged in discussion to (1) define fundamental care, and (2) agree on the discrete elements that constitute such care. Workshop participants were 32 healthcare (primarily nursing) researchers, educators, clinicians, leaders, and students from Australia, Canada, Denmark, Faroe Islands, Japan, New Zealand, Sweden, UK, and US, as well as seven lay contributors[2] from the UK. Lay contributors were patients, carers and members of the public recruited from Patient and Public Involvement (PPI) units in the UK and the Collaboration for Leadership in Applied Health Research and Care, Oxford (CLAHRC). Lay contributors had experience with research, either as board members; members on project advisory or steering groups; co-applicants on research projects and grants; or by assisting with research design, analysis and interpretation.

To assist with defining fundamental care, the lead author provided workshop participants an outline of the Fundamentals of Care Framework. In five smaller groups, participants generated a definition for fundamental care. Each group presented their definition to the wider group. To identify the discrete elements of fundamental care, the lead author provided participants a list of the 23 patient needs and nurse actions outlined in the Fundamentals of Care Framework (see Figure 1) (Kitson, Conroy, et al., 2013). In the same small groups, participants generated a list of elements, and presented their discussion to the wider group. Two team members (TC and AK) took notes on the wider group discussions.

[2] This term is currently used in the UK.

Phase 2: Developing preliminary definition and elements for the Delphi study. The lead author compiled the notes from the ILC workshop and generated a preliminary definition for fundamental care and a list of elements for use in the Delphi study. These were refined following discussion with team members.

Phase 3: Delphi study. Sixty-four experts from 14 countries were invited to participate in the Delphi expert panel. These experts included ILC 2016 conference participants, including the seven lay contributors; ILC members who did not attend the conference; experts identified via team members' networks; and experts identified via a scoping review on fundamental care conducted concurrently by three authors of this paper (paper under review; reference removed for anonymity). All invited participants had extensive knowledge of fundamental care and met at least one of the following inclusion criteria: experience as a patient or carer (as evidenced by involvement with a PPI unit or CLAHRC), author on publications relating to fundamental care (all invited participants working in a research capacity had published at least one peer-reviewed journal article), leadership (e.g., Chief Nurse or equivalent) and/or clinical practice (i.e., currently working as a Registered Nurse). The diversity of expertise and nationalities, and the inclusion of lay contributors, ensured a participatory, co-design process, whereby the definition and elements were created by, and hence suitable to, all potential stakeholders (researchers, educators, clinicians, leaders and service users). The Delphi study involved two separate rounds.

Delphi Round 1. Participants were invited, via email, to complete an electronic survey that sought their feedback on a preliminary definition and elements. Questions relating to the definition were:

- Does it capture the main facets of fundamental care?
- Is it complete or missing a crucial component?
- Is it understandable by clinicians, researchers, educators, service users, students, and policy-makers?
- Should it be changed in any way?

Participants were asked to provide a yes/no response to each question and detailed free-text comments.

Participants were then presented lists of patient needs and nurse actions to determine whether they constituted discrete elements of fundamental care. In keeping with the Fundamentals of Care Framework, these needs/actions were categorised as physical, psychosocial and relational. It was explained to participants that the physical and psychosocial elements constituted needs a patient might have, whereas the relational elements constituted nurse actions designed to address these needs. Participants were asked whether each of the needs/actions was:

- a discrete element of fundamental care (response options: 'yes', 'no', 'unsure');
- listed under the appropriate headings (i.e., 'physical', 'psychosocial' and 'relational'. Response options: 'yes' or 'no'. Participants were able, via a comments box, to modify where the needs/actions were placed within these categories or to suggest alternate categories.);
- redundant (response options: 'yes', 'no'); or
- sufficient (response options: 'yes' or 'no'); and
- if any other changes were needed (response options: 'yes', 'no').

Participants were provided space for detailed comments.

Delphi Round 2. In Round 2, participants again completed an electronic survey. Results from Round 1 were aggregated and presented to participants. Although Delphi studies often involve controlled feedback, where a participant's individual score is provided in addition to total scores (Clibbens et al., 2012), it was not possible to provide such feedback in this study due to the anonymous nature of the survey. The survey was kept anonymous given that some of the expert panel were members of the ILC, as was the research team.

Round 2 asked the same questions as Round 1, with an additional question ascertaining whether the definition in Round 2 was an improvement over that in Round 1 (response options: 'yes', 'no'). Only the needs/actions that were reworded or added after Round 1 were included in Round 2 for participants to rate (participants were provided the same response options: 'yes', 'no', 'unsure'). Participants were provided two weeks to respond in each survey round.

Data analysis

Multiple-choice questions were analysed descriptively in terms of frequency. For multiple-choice questions regarding whether a need/action constituted a discrete element of fundamental care, consensus was defined as 70% agreement (i.e., 70% of participants answered 'yes'). There is no single definition of consensus in the Delphi method (Jorm, 2015), however, previously, researchers have argued that 70% agreement is adequate (Hsu & Sandford, 2007). Free-text responses were analysed using inductive content analysis (Elo & Kyngäs, 2008), focusing on frequently recurring patterns/themes in participants' feedback. The lead author undertook the initial coding of free-text responses, identifying potential themes. These themes were refined following discussion with the team.

Ethical considerations

Ethical approval for the Delphi study was granted by The University of Adelaide (H-2016-233). Recruitment emails and the survey contained information about the purpose of the study, the voluntary nature of participation, the anonymous nature of data collection, and the assurance that (non) participation would have no influence on current or potential status as an ILC member. Completion of the survey was taken as evidence of consent.

RESULTS

Phases 1 & 2: Stakeholder engagement and developing preliminary definition and elements

During their group discussion, ILC workshop participants developed five possible definitions for fundamental care (see Box 1).

Based on these definitions, the team developed the following definition for use in Round 1 of the Delphi survey:

> Fundamental care is care that respects and focuses on a person's essential and unique needs in order to ensure their safety, health, and wellbeing. These needs are met through timely and responsive care and the negotiation and integration of the person's physical, psychosocial and relational needs. Meeting these needs involves developing a trusting and positive relationship with the person being cared for, whilst understanding their culture, level of dependency, context of care, and clinical condition.

In total, workshop participants identified 47 patient needs and nurse actions they perceived to be discrete elements of fundamental care. The team removed needs/actions with duplicate descriptions, and reduced the list to the 42 in Table 1. These needs/actions were used in Round 1 of the Delphi survey.

Terminology was discussed in-depth at the ILC workshop. For instance, the workshop lead used the term 'elimination' to refer to excretion of bodily waste. Lay contributors suggested this could be seen as killing a patient, and so preferred the term 'toileting'. Following discussion amongst the team, this was refined to 'toileting needs'. Workshop participants also noted that the terms 'fundamental care' and 'fundamentals of care' were used interchangeably, and debated whether there was a difference between the two. This issue is explored in the discussion section.

Phase 3: Delphi study

Results pertaining to the definition are displayed first (both Rounds 1 and 2), followed by the results pertaining to the discrete elements of fundamental care (Rounds 1 and 2).

Definition.

Delphi Round 1. There were 38 complete responses (response rate 58.5%). Most participants (57.9%) identified their role as primarily academic research, 18.4% as primarily academic education, and 13.2% as primarily managerial/leadership. One participant identified as working primarily in the clinical area and three as lay contributors (7.9%).

More than three-quarters of participants (76.3%) agreed the definition captured the main facets of fundamental care, however, half (50%) thought it was missing a crucial component. Less than half (47.4%) thought the definition would be understandable by clinicians, researchers, educators, service users, students, and policy-makers, and 73.7% stated they would change something about the definition. Participants' free-text comments illuminated these findings. The three main themes identified from these comments are described below.

Theme 1: The definition is comprehensive but generic. Most participants agreed that defining fundamental care is challenging but that the definition captured the main facets of such care. Participants described the definition as 'generous', 'comprehensive' and 'inclusive', and saw the strength of the definition as its focus on the varied needs and conditions that must be considered when providing fundamental care. Participants also argued, however, that the definition was 'generic' and 'all-encompassing'. This had two implications. First, it was not clear that the focus was (or should be) nursing. Instead, the definition could describe medical care. Second, the definition moved beyond the scope of fundamental care (see Box 2).

Theme 2: The definition does not describe fundamental care as an activity. Participants argued that the definition did not explain what constitutes a discrete element of fundamental care (e.g., nutrition), nor the actions required to deliver such care. As stated by one participant "*I am not sure that if you gave this to anyone who does not already know about the FOC [fundamentals of care] they would be able to give examples*". As such, participants generally agreed that the definition outlined the conditions for, or principles of, providing quality fundamental care rather than being action-oriented (see Box 3).

Theme 3: The reading level of the definition is too high. Most participants argued that service users would not understand the definition. Some terminology was seen to be vague and abstract, and the sentences too long. Some participants also stated the definition would be too complex for students, and might imply to policy-makers that nurses are responsible for all aspects of patient care. One participant acknowledged that there are challenges with developing a definition understandable by health professionals, academics and service users: "*I don't know if it is plausible to try to simplify it to such a level that everyone will always understand it. In that simplification some of the meaning will be lost.*"

Delphi Round 2. There were 28 complete responses in Round 2 (response rate 43.8%). Similar to Round 1, most participants identified their role as primarily academic research (75%) and 14.3% as primarily managerial/leadership. Fewer identified as primarily academic education (3.6%). One participant identified as working primarily in the clinical area and one as a lay contributor.

The Round 1 definition was modified by reducing its length, removing jargon, focusing on tangible actions, and specifying the focus on nursing. The definition provided to participants in Round 2 was:

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

Most participants (82.1%) thought the new definition was an improvement and captured the main facets of fundamental care (82.1% compared to 76.3% in Round 1). Less than half (42.9%) thought it was missing a crucial component, compared to 50% in Round 1. Most participants (71.4%) thought the definition would be understandable by clinicians, researchers, educators, service users, students, and policy-makers (47.4% in Round 1). Fewer participants (64.3%) stated they would change something about the definition (73.7% in Round 1). Participants' free-text comments again helped to elucidate these findings. The main themes from these comments are below.

Theme 1: The definition is concrete but might have lost some of its meaning. Participants appreciated the more concise definition, describing it as 'clear', 'better organised and more concrete', 'easy to understand', 'focused' and 'less complex'. However, its reduced length led some participants to question whether the definition had lost some of its meaning. Specifically, some participants called for the inclusion of terms such as 'health' and 'wellbeing', whilst others wanted a focus on 'safety' and how the clinical condition and care environment impact care delivery. The terms 'safety', 'health' and 'wellbeing' were not included in the Round 2 definition in order to reduce its length and remove terms that participants identified in Round 1 as abstract.

Theme 2: The first sentence of the definition is sufficient. Participants typically agreed that the second sentence of the definition was problematic and that the definition could be reduced to the first sentence only. Participants argued that the nurse-patient relationship (emphasised in the second sentence of the definition) is only part of what is involved in the delivery of high-quality fundamental care; professionalism, knowledge and skill are equally important (see Box 4). One participant also argued that not only must a relationship be developed, it

must be maintained. Some participants suggested that, rather than removing the second sentence, it should be reworded to include words such as 'partnership' or 'collaboration' rather than 'relationship'.

Theme 3: The definition is still too complex. Participants typically perceived the term 'psychosocial' as problematic, arguing it requires clarification to be understood by service users. One suggestion was to separate 'psychosocial' into its component parts – psychological and social. One participant again stated that it might not be possible to develop a definition readily understood by academics, clinicians and service users: "*I am not sure how feasible it is to get a definition that is understandable by everyone*".

Theme 4: Disagreement over the inclusion of nursing. Some participants argued that the addition of 'nurse' was important whilst others argued the definition should be broader in scope to include other professional and lay carers who provide fundamental care: "*If the idea is to provide a definition on fundamental care I rather do not think it should be restricted to nurses.*"

The discrete elements of fundamental care.

Delphi Round 1. As shown in Table 1, of the 42 needs/actions presented to participants, 26 achieved consensus. All needs/actions listed under 'physical' achieved consensus. Of the 20 needs/actions under 'psychosocial', 11 achieved consensus. Most needs/actions that did not achieve consensus received a high proportion of 'unsure' responses, including those related to cultural safety (31.2% unsure), hope (29.0%), sexual needs (29.0%), religious needs (26.3%), spiritual needs (26.3%), and existential needs (26.3%). Of the 14 needs/actions under 'relational', seven achieved consensus. Most

needs/actions under 'relational' that did not achieve consensus also received a high proportion of 'unsure' responses: ensuring patients are able to cope (34.2%); vigilance (26.3%); ensuring continuity across the care system (26.3%); equality (around power imbalance in relationships) (23.7%); and ensuring patients are calm (21.1%).

Table 1 here

More than three-quarters of participants (78.9%) thought the needs/actions were under the right headings, and less than half (47.4%) thought some were redundant or overlapping. Only 23.7% thought a need/action was missing. The main themes from participants' free-text comments are outlined below.

Theme 1: The wording of some needs/actions asks too much of nurses. Participants indicated that words such as 'ensuring' (e.g., ensuring patients are calm), 'building' (e.g., building agency and self-determination) and 'meeting' (e.g., acknowledging, enabling the expression of and meeting religious needs), place unrealistic demands on nurses. Participants saw nurses as facilitators; providing the support and creating the conditions needed for patients to feel calm, develop self-determination and so on (see Box 5). Only one of the 11 needs/actions using the words 'ensuring', 'building' or 'meeting' achieved consensus (acknowledging, enabling the expression of and meeting cultural needs).

Theme 2: The lists confuse patient needs and nurse actions with the principles of providing fundamental care. Participants argued that it was important not to confuse the elements of fundamental care (e.g., nutrition, hydration) with the individual and system-level conditions

required to perform fundamental care or the outcomes, for patients, of delivering such care. A key example where participants saw these lines being blurred was around 'comfort' and 'safety', which they argued were umbrella terms that describe the outcomes of fundamental care rather than constituting discrete elements of such care.

Theme 3: The lists contain too many needs/actions, rendering the concept 'fundamental' meaningless. Most participants perceived the lists of needs/actions to be comprehensive (only 23.7% thought a fundamental was missing). However, much like the definition, participants indicated that the lists moved beyond the scope of fundamental care (see Box 6).

In addition to the above themes, some participants indicated that the meaning of terms 'cultural safety', 'emotional health', 'relieving boredom', and 'existential needs' was unclear. Participants also perceived spiritual, existential and religious needs as overlapping concepts. Some participants called for the inclusion of an element focused on loneliness and helping patients to stay distracted and feel occupied. These concepts are arguably covered in 'relieving boredom', however, this term did not resonate with participants (only 47.4% agreed it was a fundamental).

Delphi Round 2. Table 2 shows the needs/actions retained, reworded or removed following Round 1. Those needs/actions that did not reach consensus were removed unless participants' comments indicated they should be reworded.

To address participants' concern that the lists confused patient needs and nurse actions, all elements under the heading 'relational' were written as nurse actions (i.e., from the nurse's perspective), and those under 'psychosocial' and 'physical' were written from the patient's

perspective. This more closely reflected the Fundamentals of Care Framework, where the relational elements represent the actions nurses employ to meet patients' fundamental physical and psychosocial needs. None of the elements listed under 'relational' needed to be reworded to reflect this change, however, 'enabling choice', 'enabling expression' and 'knowing and accommodating a patient's/person's priorities and interests' (under 'psychosocial') were reworded. Needs/actions using the words 'ensuring', 'building' or 'meeting' were reworded to reflect participants' concern that this was asking too much of nurses. This was the case even for those needs/actions that did not achieve consensus (e.g., 'ensuring goals are set', 'ensuring patients are calm', and 'ensuring patients are able to cope'). Our aim was to determine whether rewording these needs/actions was sufficient to achieve consensus. 'Ensuring continuity across the system' was removed given participants' concern that this was beyond the remit of the individual nurse (see Box 5).

'Emotional health' was reworded to 'emotional wellbeing' to address participants' concern that the former term was not easily understood. 'Medication management' was removed from 'safety' and became a standalone element. Not all recipients of care require medication, hence considering it a discrete element of fundamental care required reconsideration. Having it as a standalone element helped to gauge participants' opinion as to whether 'medication management' constituted a discrete element of fundamental care. 'End-of-life care' was removed from 'comfort' given not all patients require such care. 'Breathing easily' was added to 'comfort' rather than remaining as a standalone element. Our reasoning was that having 'breathing' as a standalone element necessitated elements referencing other body systems (e.g., the circulatory system), which we perceived to be beyond the scope of fundamental care. However, we perceived breathing easily as crucial to patients' physical comfort (it also achieved consensus in Round 1). 'Providing company and support (including to family

members/carers)' was reworded to 'social engagement, company and support' and moved to 'psychosocial' to reflect participants' call for the inclusion of an element focusing on loneliness and helping patients to feel occupied.

Of the 12 needs/actions provided to participants in Round 2, eight achieved consensus (see Table 2). All needs/actions under 'physical' and 'relational' achieved consensus, however, only two of the six under 'psychosocial' achieved consensus. Those that did not achieve consensus typically had higher proportions of 'unsure' responses (ranging from 21.4% to 37%). Participants' free-text comments again helped to explicate these findings. The main themes from these comments are outlined below.

Table 2 here

Theme 1: The needs/actions are beyond the scope of fundamental care. Similar to Round 1, participants argued that some of the needs/actions were the processes associated with delivering fundamental care or the outcomes of doing so, rather than discrete elements *per se*. Safety and comfort were again key examples of this (see Box 7).

Theme 2: Some of the needs/actions are overlapping or redundant. Similar to Round 1, participants perceived some of the needs/actions under 'relational' and 'psychosocial' as overlapping, although they did not agree on which to remove. One participant argued that 'having interests and priorities considered and accommodated (where possible)', 'choice', 'feeling able to express opinions and needs without care being compromised' and 'having values and beliefs considered and respected' could be expressed as only one element.

In addition to the themes above, some participants identified issues with the wording of 'helping patients to cope' and 'helping patients to stay calm'. Alternate suggestions included 'creating the conditions that help patients to cope' and 'supporting patients to be in control of their situation'. One participant also suggested 'helping patients to cope' is encapsulated under 'comfort' (although 'comfort' is listed under 'physical' in the Fundamentals of Care Framework). Nonetheless, both 'helping patients to cope' and 'helping patients to stay calm' achieved consensus, however, 'helping patients to stay calm' did have the highest proportion of 'no' responses in Round 2 (21.4%). One participant also indicated that a patient might not want to stay calm in some situations and the nurse should not insist they do. Another participant made a similar argument for 'social engagement', stating it is important for nurses not to force company and social engagement on an individual who does not want it. Finally, some participants indicated that 'choice' and 'emotional wellbeing' required clarification.

The final definition and list of fundamental care elements developed from the Delphi study are shown in Table 3. Those elements that did not achieve consensus in Round 2, and around which further clarification and refinement is required, are marked with an asterisk.

DISCUSSION

This study aimed to generate consensus on a definition for fundamental care and the discrete elements of such care. The acknowledged complexity surrounding how to define fundamental care (Ball et al., 2016) was reflected in participants' responses. Participants highlighted a number of issues regarding the conceptualisation of fundamental care that merit further exploration.

The first issue concerns what is it we are attempting to define. Participants appeared to make a distinction between patient needs and nurse actions as opposed to a broader concept encompassing the individual and system-level factors required to deliver fundamental care and the outcomes of this care delivery (what participants typically referred to as the conditions or principles of fundamental care). Participants appeared to display a preference for defining the former (i.e., patient needs and nurse actions). Previous research has adopted a similar approach (e.g., Pipe et al., 2012). Englebright, Aldrich, and Taylor (2014) defined basic nursing care for use in an electronic health record as actions that are needed by all hospitalised adult patients, not related to a specific health problem, and not directed to a specific health goal. In our study, the aim was to define fundamental care – a broad concept that encompasses not only patient needs and nurse actions, but how such care should be delivered in practice and the factors central to this delivery (e.g., trusting nurse-patient relationships). Participants' responses seem to reflect the broader state of play in fundamental care, where the focus is on discrete tasks rather than on understanding fundamental care as a complex, multi-dimensional construct (Kitson, Muntlin Athlin, & Conroy, 2014).

Participants' preference for defining fundamental care in terms of patient needs and nurse actions was also evident in their Round 2 feedback to retain only the first sentence of the definition. This preference could also reflect a lack of agreement about the centrality of the nurse-patient relationship in the delivery of fundamental care, as encapsulated in the definition's second sentence. However, it could reflect problems with terminology. Whilst some participants wanted the second sentence removed, others suggested it should be reworded to incorporate terms such as 'collaboration' or 'partnership'. Hence, for some participants, the second sentence appeared to imply that patients are passive recipients of care (i.e., people 'being cared for'), and did not make explicit their role as active collaborators.

Hence the definition likely needs to be re-worded to better fit with the person-centred care paradigm, which emphasises patient involvement in care delivery (Kitson, Marshall, Bassett, & Zeitz, 2013).

It is clear from these findings that we require clarity around fundamental care as a concept. One way to achieve this clarity is distinguishing between 'fundamental care' and 'fundamentals of care'. Whilst the two terms are often used interchangeably, we argue that they represent different concepts. The term 'fundamental care' is best used to represent a broad concept that encompasses the key factors involved in, and outcomes of, nursing care that attends to people's fundamental needs. Fundamental care can be seen as the outcome we are trying to achieve by enacting the dimensions of the Fundamentals of Care Framework (i.e. establishing a relationship, addressing fundamental needs, and considering the care context). By contrast, 'fundamentals of care' is best used to refer to the discrete elements of fundamental care, that is, patients' fundamental physical and psychosocial needs (e.g., nutrition) and the nurse actions required to address these needs (e.g., engaging with patients).

A second issue is how we define what constitutes a discrete element of fundamental care (what we argue should be called a 'fundamental of care'); the nurse's behaviour; the patient's need; or the outcome, for the patient, of addressing that need? After Round 2, participants still perceived the lists of elements as confusing patient needs and nurse actions, despite attempts to rectify this following Round 1. Both survey rounds explained to participants that the elements listed under 'physical' and 'psychosocial' constituted needs a person might have, whilst those under 'relational' were nurse actions designed to address these needs. Accordingly, the actions under 'relational' were written from the nurse's perspective, and the needs under 'physical' and 'psychosocial' from the patient's. Participants' responses could

again reflect a lack of agreement on the key tenets of the Fundamentals of Care Framework, namely the ways in which the physical, relational and psychosocial intersect, although there is empirical evidence to support this conceptual understanding (Kitson, Dow, et al., 2013; Kitson & Muntlin Athlin, 2013). Participants' responses could also reflect a preference for wording the fundamental care elements as patient needs *or* nurses' actions, not a combination of both.

The third issue concerns who the definition is for and from whose perspective it should be written – patient or nurse. This was also a pertinent discussion at the ILC 2016 workshop. Whilst most Delphi participants argued that the definition is not likely to be understood by service users, some argued it was not feasible to develop a single definition that is understandable by all stakeholders. In an attempt to enhance readability, we shortened the definition and removed jargon for Round 2, however, this resulted in comments that some of its explanatory value had been lost. Between Rounds 1 and 2, the team discussed the possibility of creating separate definitions for different stakeholders; however, this was seen to create unnecessary complexity. First, it would complicate the task of translating the definitions into other languages. Second, many people have dual roles – clinicians, policy-makers, leaders, educators, and/or researchers. In these situations, it might be unclear which definition to use.

A final issue is whether the definition should be nursing specific. Some participants stated the Round 1 definition could be seen as a description of good medical care. Hence, in Round 2, we included the word 'nurse' in the definition. This inclusion, however, drew comments that restricting the definition to nurses would exclude other care providers involved in fundamental care delivery. These comments again reflect the current state of play of

fundamental care – such care is often relegated to nursing assistants and carers (Darbyshire & McKenna, 2013; Hasson, McKenna, & Keeney, 2013; Wolf, 2014), increasingly disaggregated, with different aspects of such care (e.g., nutrition, mobility) delivered by different health professionals (e.g., dieticians, occupational therapists) (Feo & Kitson, 2016). As such, there is general confusion about who should take ownership for fundamental care, and what role Registered Nurses play in its delivery (Kalisch, 2006; Pipe et al., 2012; Sonde, Emami, Kiljunen, & Nordenram, 2011).

The debate around ownership of fundamental care is not new (Darbyshire & McKenna, 2013; Feo & Kitson, 2016; Kitson, 2016). More than a decade ago the Royal College of Nursing debated whether care assistants should deliver the caring component of nursing to enable Registered Nurses to focus on treatment and technical tasks (Scott, 2004). However, we appear to be no closer to solving the problem. Advances in technology, increased demands for nurses to undertake documentation and complex technical skills, and requirements for higher efficiency and productivity (e.g., shorter lengths of stay) will only create further role confusion. Adding to this complexity, in the UK, healthcare assistants must now complete a Fundamental Care certificate. With these changes, we also have to be clear on the difference between the delivery of, and responsibility for, fundamental care; if fundamental care is delivered by a healthcare assistant or allied health professional, are they, or a Registered Nurse, responsible when it is not delivered appropriately? Whilst the issue of ownership is complex, our view is that nursing is typically held to account when fundamental care is poorly delivered. This was evident following the inquiry into care in the Mid Staffordshire NHS Trust in the UK. Hence, we argue that it is crucial to distinguish Registered Nurses as the primary providers of fundamental care and, at the very least, as responsible for overseeing and managing the delivery of fundamental care by all care staff.

This study has made significant progress in generating consensus on defining fundamental care and provided a catalyst to initiate a vital conversation on this topic. There is still work to be done. For instance, the high proportion of 'unsure' responses in Round 2 for those needs/actions that did not achieve consensus indicates that, rather than not being discrete elements of fundamental care, they might simply require rewording. To advance consensus we must test and refine the definition and elements with practising nurses (particularly those who do not have a joint role in academia), other members of the multi-disciplinary healthcare team, and service users from different countries. This can be achieved via in-depth focus groups that incorporate q-sort methodology. Such feedback will determine whether the definition and elements are understandable and can be used in clinical practice, and will assist in understanding the respective roles that nurses and other members of the healthcare team play in the delivery and management of fundamental care.

Limitations and strengths

This Delphi study involved two rounds. One or two additional rounds might have generated stronger consensus and conceptual clarity. The 70% consensus cut-off was arbitrary, however there is evidence to support it as reasonable (Hsu & Sandford, 2007). Most Delphi participants identified academic research as their primary occupation; few identified as working primarily in the clinical area or as lay contributors, raising questions about the applicability of the study findings to practising nurses and service users. It is possible that many participants had dual roles that involved clinical work; however, our response options did not capture this. The number of participants, however, is sufficient – the Delphi method typically achieves stable results with panels of 20 experts (Jorm, 2015).

Questions have been raised about the Delphi method's use of experts and the level of evidence that such studies produce (Foth et al., 2016). Expert opinion is typically considered the lowest level in the hierarchy of evidence (Burns, Rohrich, & Chung, 2011). As such, findings from Delphi studies require further testing prior to implementation (Foth et al., 2016). Whilst there might be questions about the validity of evidence produced from experts, the Delphi approach has many advantages. Translating findings into practice is typically easier with Delphi studies given they deal with questions closely related to practice, and potential stakeholders in implementation are involved in the research at an early stage (Jorm, 2015). Indeed, the present study investigated an issue central to nursing practice and involved key stakeholders from the outset. This study has a number of other strengths: we sought feedback from a large, international group of participants and generated much-needed dialogue on the nature of fundamental care; we illustrated a number of complexities that must be addressed, including deciding from whose perspective the elements should be written; and we made significant steps in achieving consensus on a core nursing concept. Future work should focus on refining the definition and elements in Table 3 with a larger, international group of service users and practising nurses.

CONCLUSION

Generating a standardised definition for fundamental care is essential for developing a rigorous evidence base that will allow for the effective implementation and evaluation of best practices for such care. This study has helped to shape ongoing, crucial dialogue around how we conceptualise fundamental care, and made significant advances in generating consensus on a concept central to nursing.

RELEVANCE TO CLINICAL PRACTICE

The study findings have implications for clinical practice, leadership and education. Once refined, performance measures and other forms of assessment can be created around the key components of the definition and each of the elements. The definition, elements and associated measures can then be incorporated into nursing and other healthcare curricula, policies, guidelines, strategic frameworks and reflective practice tools, providing nursing students, practising nurses, healthcare managers, and policy-makers a systematic means to assess and improve fundamental care delivery at individual, team and organisational levels. The definition and elements can also support healthcare managers in developing models of care that highlight the importance of focusing on, and improving, fundamental care, and which demonstrate the impact to broader organisational (not just nursing) performance of failing to deliver such care to a consistently high standard. This study also has implications for research. The definition and elements will be incorporated into the Fundamentals of Care Framework, providing researchers a standardised conceptual framework that can underpin research activities. This will facilitate comparison and aggregation of findings across studies, contributing to the development of a robust evidence base.

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Box 1. Definitions generated from the ILC 2016 workshop.

1. Respecting and attending to the essential and unique needs of human beings through relationships and relational care and the negotiation and integration of physical, psychosocial and relational needs, while understanding culture, level of dependency and clinical context.
2. The connecting of the professional knowledge of the nurse and personal knowledge of the patient through an established relationship to identify and meet the physical, psychosocial and relational needs of the patient.
3. A personalised, timely, responsive and integrated approach to supporting the physical, emotional, psychological and social aspects of daily living in order to maintain quality of life during health and illness. Fundamental care requires the individual attention of the nurse.
4. Essential interventions comprising physical, emotional and relational care to provide health and wellbeing.
5. What nurses do with and on behalf of people and the healthcare team to preserve life; ensure safety; enhance comfort; and optimise function, wholeness and dignity, in a reciprocal caring relationship.

Box 2

"Very all-encompassing and describes all of nursing care not just as I would see it essential care"

"It is generic and therefore not necessarily exclusively about nursing care. Couldn't this also be a description of good medical care?"

"Based on the definition it is not clear, if fundamentals of care refers to nursing care or interdisciplinary care"

Box 3

"There is nothing tangible in here that relates to care behaviour. It is more about the principals [sic] of providing care rather than what the care looks like."

"It is outlining the conditions of fundamentals of care, what might be missing is what are we really talking about, communication, nutrition etc."

"Although it mostly captures the main facets at an academic level, the definition is rather inactive. What does it mean for the individual? What about the interpersonal aspects of the caregiver, empathy, kindness, etc."

"Fundamentally, it lacks an applied statement about nursing that could be understood by the practising nurse"

Box 4

"Nursing is more than relationships. Nursing demands skills, knowledge and competencies to deliver care meeting essential human needs."

"Need to refer to care provision informed by knowledge and skill ... a positive and trusting relationship is not enough on its own."

Box 5

"Ensuring is a difficult word – because I can try – the patient may not be able to achieve the coping or calm

"I am not sure that the nurse can ensure continuity across the whole system! Or ensure that patients are calm."

"Not sure that ensuring patients can cope is always possible"

"Some of the concepts are excessive and beyond the reach of one person (e.g., continuity across the care system). This is where frontline clinicians will turn away from this kind of definition as they will experience it as ideology."

Box 6

"These are potential elements of good patient centred care, not fundamentals of care per se. We would like to take these things into account in identifying how someone wants to be cared for, but they are not essential for someone's survival."

"This was more difficult than expected. I have marked some no or not sure, not because I don't think these are needed but I don't consider them fundamental."

"These are all of course important but not sure they are all part of fundamentals of care which I fear if all this is included describes good nursing care and so becomes rather meaningless"

Box 7

"These [the relational elements] seem like possibilities of how to meet people's basic care needs, but of course not everyone will need all of these, and so not 'fundamental' i.e., absolutely essential."

"Comfort is an outcome not a physical fundamental."

"Safety is rather limited here, because every nursing actions or omissions have a safety issue involved and this is not only for nursing activities but also for plans prescribed by others."

	Need/action	Yes (%)	No (%)	Unsure (%)	Decision for Round 2
Physical	Personal cleansing (including oral/mouth care) and dressing	100*	0	0	Kept
	Toileting needs	100*	0	0	Kept
	Eating and drinking	100*	0	0	Kept
	Rest and sleep	94.7*	0	5.3	Kept
	Mobility	94.7*	0	5.3	Kept
	Comfort (including pain management, end-of-life care, temperature control)	94.7*	0	5.3	Reworded
	Safety (including medication, risk assessment and management, infection prevention, minimising complications)	81.6*	2.6	15.8	Reworded
	Breathing	89.5*	2.6	7.9	Included under 'comfort'
Psychosocial	Communication (verbal and non-verbal)	97.4*	2.6	0	Kept
	Being involved and informed	92.1*	7.9	0	Kept
	Privacy	79*	10.5	10.5	Kept
	Dignity	79*	10.5	10.5	Kept
	Respect	79*	10.5	10.5	Kept
	Education and information	76.3*	13.2	10.5	Kept
	Emotional health	81.6*	5.3	13.2	Reworded
	Enabling choice	81.6*	10.5	7.9	Reworded
	Enabling expression (i.e., patient/person feels able to express opinions during a care episode without compromising care)	81.6*	7.9	10.5	Reworded
	Knowing and accommodating a patient's/person's priorities and interests	73.7*	10.5	15.8	Reworded
	Acknowledging, enabling the expression of and meeting cultural needs	71.1*	10.5	18.4	Reworded
	Building resilience	68.4	21.1	10.5	Removed
	Acknowledging, enabling the expression of and meeting religious needs	63.2	10.5	26.3	Removed
	Acknowledging, enabling the expression of and meeting spiritual needs	63.2	10.5	26.3	Removed
	Acknowledging, enabling the expression of and meeting existential needs	63.2	10.5	26.3	Removed
	Acknowledging, enabling the expression of and meeting sexual	60.5	10.5	29.0	Removed

	needs				
	Building agency and self-determination	60.5	18.4	21.1	Removed
	Hope	57.9	13.2	29.0	Removed
	Cultural safety	55.3	13.2	31.2	Removed
	Relieving boredom	47.4	29.0	23.7	Removed
Relational	Active listening	89.5*	7.9	2.6	Kept
	Empathy	86.8*	7.9	5.3	Kept
	Engaging with patients	86.8*	7.9	5.3	Kept
	Compassion	86.8*	7.9	5.3	Kept
	Being present and with patients	79*	7.9	13.2	Kept
	Supporting and involving families and carers	84.2*	5.3	10.5	Kept
	Ensuring goals are set	68.4	15.8	15.8	Reworded
	Ensuring patients are calm	63.2	15.8	21.1	Reworded
	Ensuring patients are able to cope	52.6	13.2	34.2	Reworded
	Equality (around power imbalance in relationship)	68.4	7.9	23.7	Removed
	Consistency within and between staff	65.9	15.8	18.4	Removed
	Vigilance (providing undivided attention)	60.5	13.2	26.3	Removed
	Ensuring continuity across the care system	60.5	13.2	26.3	Removed
	Providing company and support (including to family members/carers)	73.7*	10.5	15.8	Moved to 'psychosocial'

*consensus achieved

Table 1. Needs/actions used in Round 1 of the Delphi study and participants' ratings as to whether they constitute a discrete element of fundamental care

	Need/action	Yes (%)	No (%)	Unsure (%)
Physical	Comfort (pain management, breathing easily, temperature control)	96.4 *	3.6	0
	Safety (risk assessment & management, infection prevention, minimising complications)	78.6 *	10.7	10.7
	Medication management	71.4 *	14.3	14.3
Psychosocial	Emotional wellbeing	78.6 *	10.7	10.7
	Having values and beliefs considered and respected	78.6 *	10.7	10.7
	Social engagement, company and support	64.3	10.7	25.0
	Choice	57.1	17.9	25.0
	Feeling able to express opinions and needs without care being compromised	57.1	21.4	21.4
	Having interests and priorities considered and accommodated (where possible)	44.4	18.5	37.0
Relational	Helping patients to cope	78.6 *	17.9	3.6
	Working with patients to set, achieve and evaluate progression of goals	71.4 *	10.7	17.9
	Helping patients to stay calm	71.4 *	21.4	7.1

* achieved consensus

Table 2. Needs/actions used in Round 2 of the Delphi study and participants' ratings as to whether they constitute a discrete element of fundamental care

Working definition:	***Fundamental care involves actions on the part of the nurse that respect and focus on a person's essential needs to ensure their physical and psychosocial wellbeing. These needs are met by developing a positive and trusting relationship with the person being cared for as well as their family/carers.***
	Need/action
Physical	Personal cleansing (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 & management, infection prevention, minimising complications)
	Medication management
Psychosocial	Communication (verbal and non-verbal)
	Being involved and informed
	Privacy
	Dignity
	Respect
	Education and information
	Emotional wellbeing
	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

*did not achieve consensus in Round 2

Table 3. Final definition for fundamental care and discrete elements of fundamental care.

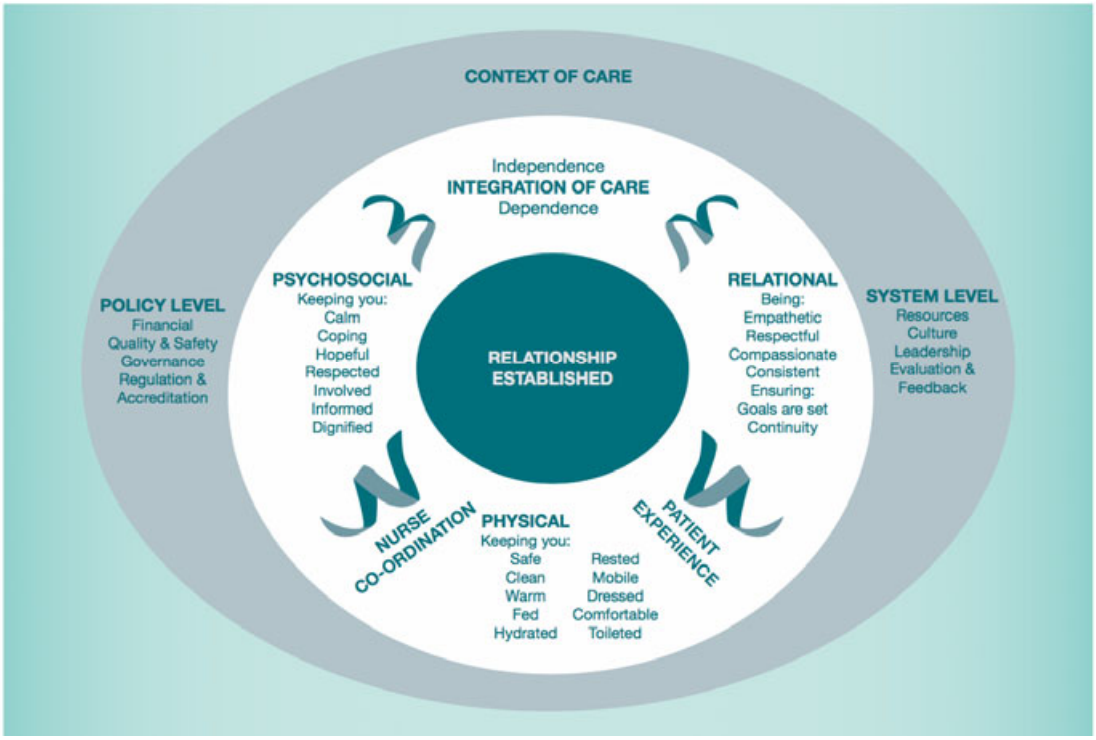

Figure 1. The Fundamentals of Care Framework. Reprinted from Conroy, T., Feo, R., Alderman, J., & Kitson, A. (2016). Building nursing practice: The Fundamentals of Care Framework. In J .Crisp, C. Douglas, G. Rebeiro & D. Waters (Eds.), *Potter & Perry's Fundamentals of Nursing 5e.* Elsevier Australia, pp. 15-29.

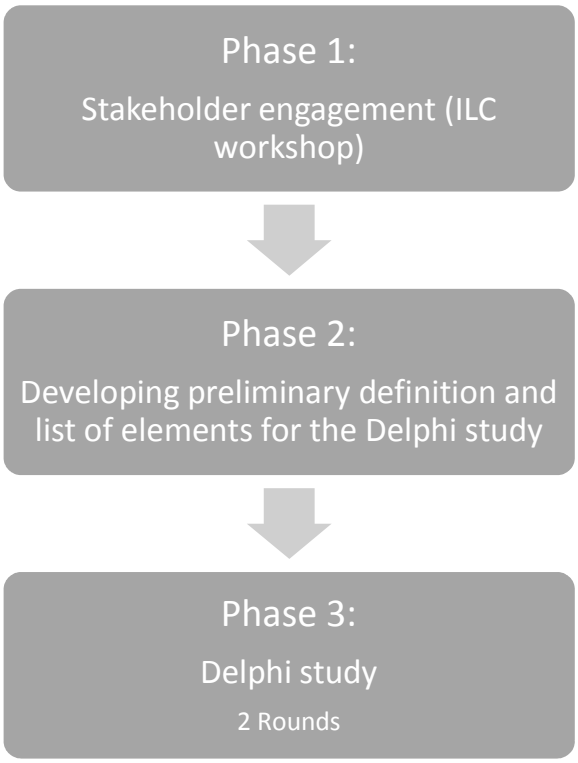

Figure 2. Phases to develop the definition and discrete elements for fundamental care