

# Introduction from the Guest Editors: Perspectives on Fundamental Care

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**The purpose of this** focused edition is to engage the Canadian and international nursing leadership community in scholarly dialogue around the fundamentals of care. Bringing an international group of researchers, scholars, educators and leaders in nursing together, our aim is to generate discussion and debate leading to action to improve fundamental care across our healthcare delivery systems.

We start off with a commentary from Alison Kitson (2016) about why fundamental care matters to patients and why nursing needs to think about who does it and how it is done. Brendan McCormack's (2016) presentation of caring as creative and artistic expression, enacted often within a harsh environment, communicates the everyday practical and intellectual challenges in caring. Jack Needleman (2016) builds on this artistry by considering the economic and business imperatives from within health systems that might either enhance or detract from nurses being able to engage on a personal level with their patients.

Kathleen MacMillan (2016) explores the impact of the "hidden curriculum" in nursing undergraduate programs where the value base of fundamental care is often relegated to a level of basic competence far below any "high performing" nurse. She talks about the way student nurses perceive caring activities as belonging to a hierarchy of skills. The more gadgets to be used would seem to impart more importance to the task. And conversely, the more physical contact there is between the nurse and the patient, the lower the perceived level of education required to undertake the task.

But then we are confronted with Dale et al.'s (2016) study of oral hygiene – across a health system and in an intensive care unit. Here we begin to discover the real complexity of doing simple routine self-care activities when the individual is compromised in some way. The person may be in a coma (no capability to clean their own teeth), may be slowly dementing and forgetful (some awareness but potentially complex reactions to self-care) or may be a patient undergoing chemotherapy and feeling nauseous, with a dry, ulcerated mouth, in need of information and advice. What do any or all of these patients do about their routine mouth care and is it the job of the nurse to work out with their patient how they should tackle this?

Theoretically speaking, the answer again of course is yes. Every nurse faced with answering this question would say yes it is the role of the nurse to provide this level of support, guidance and information. But as you will discover when you read Dale et al.'s paper and consider some of the safety and quality challenges identified by Jeffs (2016), the delivery and execution of this sort of care are far from straightforward in our health systems.

There is a growing body of evidence (Kalisch et al. 2011, Francis 2013, Gill et al. 2014) that demonstrates that even if nurses want to provide relationship-centred fundamental care, they face a multitude of contextual and attitudinal barriers. So what can be done to try and improve things? Would it be better for us as nurses to say we no longer have the time or the inclination to do the “body work” and that we should delegate it to assistant carers? They, after all, would have more time to provide the personalized service so that nursing in acute hospitals might begin to reflect the delegated tasks within a nursing home: a few RNs responsible for medications and care coordination and the rest of the care team would be unqualified care workers? Or perhaps even care robots. We know there are a number of innovations trialling the use of care robots to help disabled people go to the toilet or to have a shower. Which would be more desirable? To have a robot that would do the job without having an opinion or view or to take a risk on a nurse or carer who may or may not be empathetic, or kind, or competent or compassionate?

What sort of leadership is required?

Health systems around the world are facing growing challenges around multi-comorbidity, aging and lifestyle diseases. In terms of meeting the fundamental care needs, we would argue that nursing has a key role to play. Nursing leaders at every level, across every type of healthcare facility, can contribute to this agenda by starting to talk about what it means to care and how caring is negotiated within the nurse–patient encounter. Focusing on the nurse–patient encounter in no way negates the importance of the whole healthcare team and the need for multiple relationships across and between the patient, their family and the extended team.

It is important also to acknowledge that if a patient is in pain, unable to communicate, afraid, anxious, confused, hungry or dehydrated, there will be a level of clinical risk to that person that will impact the patient's presenting clinical condition. And is it not part of the nurse's contribution to the effective work of the healthcare team that these fundamental care needs are assessed, managed and met in a safe, person-centred way?

All too often, the senior experienced nurse leader will not be visible in the system supporting the right approach to this now complex set of assessments and interventions that will be enacted. They increasingly are finding themselves completing documentation, and managing system and patient flow issues. These tasks of course are also vital. As Needleman et al. (2002) and Aiken et al. (2002) have both demonstrated, losing sight of the caring work of the RN on the floor does translate into more risk for patients.

How can we as nursing leaders respond to this complex set of issues? First, like all roads to resolution, is the acknowledgement that we have a challenge, a problem on our hands. Next is to start the multiple constructive conversations with key stakeholders to try and understand what has led to the problem and how we might begin to tackle it. Networks such as the International Learning Collaborative (Kitson et al. 2013) can help facilitate such conversations. Then, we need to tackle the divide between academic nursing and clinical practice so that our practice is enriched and informed by research evidence, scholarship and excellence in the art and science of nursing care. We need to embrace the opportunities we have to establish clinical academic career pathways and more collaboration (American Association of Colleges of Nursing 2016; Department of Health 2012). And then there is the call to action. But action that is led by commitment to a set of principles around the importance of relationship-centred fundamental care as a service that is provided by nursing. Actions will be diverse and varied, reflecting the diversity of health systems, patients and healthcare teams. Importantly, we will try to capture the journey by way of developing a research and development agenda around it. That way we can ensure that what we learn from this journey can be passed on to the next generations of nurses coming after us.

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