

**ORIGINAL RESEARCH:
EMPIRICAL RESEARCH - MIXED METHODS**

Barriers and enablers to embedding fundamental nursing care for older patients—Implications of a mixed methods study for nursing leadership

Laurie Grealish^{1,2,3}  | Kristen Ranse^{1,2} | Jo-Anne Todd¹ | Lyn Armit³ | Stephen Billett⁴ | Leigh Collier³ | Kasia Bail⁵ | Wendy Moyle^{1,2}

¹Menzies Health Institute Queensland, Australia

²School of Nursing & Midwifery, Griffith University, Australia

³Gold Coast Health, Australia

⁴School of Education and Professional Studies, Griffith University, Australia

⁵University of Canberra, Australia

Correspondence

Laurie Grealish, Menzies Health Institute Queensland, Building 40, Griffith University, 1 Parklands Drive, Southport, 4215, Australia.
Email: l.grealish@griffith.edu.au

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Abstract

Aims: To understand the enablers and barriers for delivering fundamental care to hospitalized older patients.

Design: Explanatory sequential mixed methods design, with qualitative data used to elaborate quantitative results.

Methods: Set in one medical and one surgical unit of a tertiary hospital in southeast Queensland, Australia. Observations of nursing practice using the Work Sampling Technique were conducted over two 2-week periods in 2019. Data were analyzed and presented to groups of nurses who appraised the findings of the observations.

Results: There were 1176 and 1278 observations of care in the medical unit over two time periods and 1380 and 1398 observations over the same period in the surgical unit. Fundamental care activities were recorded in approximately 26% (i.e. medical) and 22% (i.e. surgical) of all observations. Indirect care was highest, recorded in 41% (i.e. medical) and 43% (i.e. surgical) of observations. Nurses prioritized the completion of reportable activities, which is perceived as a potential enabler of fundamental care. Potential barriers to fundamental care included frequent delays in indirect care and difficulty balancing care requirements across a group of patients when patients have high fundamental care needs.

Conclusion: The cultural acceptance of missed nursing care has the potential to erode public confidence in health systems, where assistance with fundamental care is expected. Relational styles of nurse leadership should focus on: (1) making fundamental care important work in the nurses' scope thereby offering an opportunity for organizational change, (2) promoting education, demonstrating the serious implications of missed fundamental care for older patients and (3) investigating work interruptions.

Impact: Fundamental care is necessary to arrest the risk of functional decline and associated hospital-acquired complications in older patients. However, nurses commonly report fundamental care as missed or omitted care. Understanding the

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challenges of implementing fundamental care can assist in the development of nurse leadership strategies to improve older patients' care. Fundamental care was observed between 22% (i.e. surgical) and 26% (i.e. medical) of all observations. Nurses explained that they were focused on prioritizing and completing reported activities, experienced frequent delays when delivering indirect care and found balancing care requirements across groups of patients more challenging when patients had fundamental care needs. Clinical nurses working in acute health services with increasing populations of older patients can lead improvements to fundamental care provision through relational leadership styles to demonstrate how this work is in nurses' scope of practice, promote education about the serious implications of missed fundamental care and investigate the root cause of work interruptions.

KEYWORDS

acute care, leadership, mixed method design, older people

1 | INTRODUCTION

Fundamental care, the physical, psychosocial and relational work to meet essential patient needs (Feo, Conroy, Jangland, et al., 2017), is often considered to be basic (Dale et al., 2016) or 'common sense' (Parke & Hunter, 2014) care. While the terms 'fundamental', 'basic' and 'common sense' imply 'easy', embedding fundamental care into acute hospital care practice presents a significant implementation challenge related to the complexity of context (Feo et al., 2019). However, while this complexity raises difficulties, addressing contextual factors is essential for delivering fundamental care, particularly important for older patients at risk of functional decline.

The association between fundamental care and patient outcomes has emerged by analyzing missed nursing care in hospital settings (Ausserhofer et al., 2014; Kalisch & Xie, 2014). Explanations arising from these analyses suggest that poor health outcomes for hospitalized older patients are directly related to missed fundamental care (Bail & Grealish, 2016; Thornlow et al., 2009). Therefore, the impact of hospital care, incorporating missed fundamental care, on outcomes for older patients is an important area for researcher attention and healthcare leadership and practice.

In a recent meta-analysis of randomized trials, quasi-experimental and prospective studies, researchers found that 30% of patients aged 65 and older experienced hospital-associated functional disability, independent of the length of stay (Loyd et al., 2020). An Australian study found that four hospital-acquired complications (i) urinary tract infections, (ii) pneumonia, (iii) pressure areas and (iv) delirium have been associated with 6.9% of the total estimated cost of hospital episodes in patients aged 50 years and older and 24.7% of the estimated additional cost of the above-average length of stay in hospital for older patients (Bail et al., 2015). Increasing fundamental care for older patients may maintain their functional ability and reduce hospital-acquired complications (Bail & Grealish, 2016). In addition, adequate nurse staffing can offset costs associated with an extended length of stay and adverse events (Needleman, 2016).

Nurse leadership, the context of care delivery and availability of time (i.e. workforce) were identified as three key organizational factors influencing the delivery of fundamental care (Conroy, 2018). Although an inadequate workforce to deliver care has been the focus of research to date (Jones et al., 2015; Schubert et al., 2013; Willis et al., 2015), there is limited data on other possible barriers and enablers to the delivery of fundamental care to older patients. Given that fundamental care is central to arresting the functional decline of older patients in hospitals, focusing on clinical goals and processes is required. Understanding the challenges of implementing fundamental care to older patients can assist in developing nurse leadership strategies that can improve the care of older patients.

1.1 | Background

A key challenge for implementing fundamental care in acute hospital settings is that preventing functional decline is still not perceived as a safety threat (Dahlke et al., 2019). The seminal concept of 'failure to rescue' outlined how death in a hospital occurs due to hospital-acquired complications, often associated with medical procedures (Silber et al., 1995). In a systematic review, the root causes for failure to rescue were grouped into: (i) individual clinicians unable to recognize a patient is unwell, (ii) poor communication limits relaying information about changes and (iii) institutional reluctance to investigate when recovery deviates from normal (Burke et al., 2020). There has been significant research into simulation training (Harvey et al., 2014; Schubert, 2012) for individual clinicians and early warning systems (Roney et al., 2015) and patient handover (Müller et al., 2018) to address poor communication. However, the institutional tolerance of delayed functional recovery for older patients awaits exploration concerning culture.

The concept of 'failure to maintain' describes how hospital-acquired complications may be related to missed fundamental nursing care for older patients (Bail & Grealish, 2016). In a study of the care of older patients with cognitive impairment and falls prevention,

adherence to fundamental nursing care practices for nutrition and hydration was high, mobility and elimination were variable, and pain assessment was low, thereby illuminating this variability (Grealish et al., 2019). Further research into the causes of missed fundamental care for older patients is now required.

A perennial challenge for implementing fundamental care is the lack of consensus about what it comprises (Feo, Conroy, Jangland, et al., 2017; Feo et al., 2018). In a systematic review focused on the definitions of fundamental care, a concomitant discourse around compassionate care was found that delineated that care from fundamental care (Feo & Kitson, 2016). These parallel lines of inquiry are unhelpful. For clinicians, the shared focus on, and interest in, the nurse–patient relationship cannot be delineated into the moral element (i.e. compassion) and the procedural element (i.e. fundamental care) of care. A review of seminal nursing theories found that integrating the physical, psychological and relational aspects of care was poorly described and explained, potentially rendering fundamental care less visible (Mudd et al., 2020).

The invisibility of fundamental care is reinforced in organizational record systems such as electronic medical records that privilege the capture of accounting of medication administration and procedures (i.e. reportable events). In addition, the dominance of the biomedical model and managerial approaches to health service delivery, evident in how health encounters are recorded, are threats to the value of fundamental care (Feo, Conroy, Alderman, et al., 2017). The threat to fundamental care is reinforced by minimally trained care workers or ‘sitters’ in the care of older patients when they are at risk of falling (Lang, 2013). The delegation of care to these workers is characterized by limited communication between these assistants and registered nurses delegating that care (Graham et al., 2021), rendering fundamental care invisible.

A range of programs is available that incorporate fundamental care for older patients. For example, delirium prevention programs hold promise (Siddiqi et al., 2016) but require additional support such as a volunteer program (Inouye et al., 2000) or an additional nursing or allied health assistant (Mudge et al., 2013). The evidence from other programs incorporating fundamental care is, however, less promising, with researchers conducting systematic reviews reporting limited evidence for programs for reducing frailty (Bakker et al., 2011), functional loss (Ley et al., 2019) and adverse outcomes (Richards et al., 2018).

For those nurse leaders operating in hospitals, understanding the barriers and enablers for delivering fundamental care is a critical first step to improving older patients’ care. This gap in understanding motivated this investigation.

2 | THE STUDY

2.1 | Aims

This study aimed to explore the barriers and enablers to delivering fundamental care for hospitalized older patients.

2.2 | Design

An explanatory sequential mixed methods design was employed, whereby the qualitative data were used to elaborate and explain the quantitative results (Creswell & Plano Clark, 2017). For the first, quantitative phase, the objective was to describe nursing activities undertaken in a medical or surgical unit. In the second, qualitative phase, the findings from these observations were shared with nurses in groups to seek an explanation of what was observed. Thus, Phase 1 adopted a postpositivist orientation, and Phase 2 adopted a constructivist orientation. Overall, however, a co-constructivist approach was adopted, placing the nurses centrally in the inquiry processes.

2.3 | Sample/participants

One medical and one surgical unit from a tertiary hospital service in Southeast Queensland were the settings for the study. The units had similar patient profiles, with at least 50% of admitted patients aged 65 years or older and similar infrastructure about a nurse, allied health, and medical staffing. A convenience sampling strategy (Polit & Tatano Beck, 2017) was used, in which nurses working during the data collection period were recruited into both phases of the study. Information about the study was shared in staff meetings and briefings. For Phase 1, nurses caring for older patients were invited to participate, and if interested, a formal informed consent process was undertaken. For Phase 2, nurses were advised that the usually scheduled in service was replaced by the research activity and could choose to attend; a formal informed consent process was then undertaken.

2.4 | Data collection

Data for all patients admitted to the medical and the surgical units for 13 months (01 August 2018–30 August 2019) were collected and analyzed to describe the patient cohort (e.g. average age, average length of stay and number of comorbidities).

In Phase 1, Work Sampling Technique was used. This technique is premised on the laws of probability, whereby a sample of observations of staff activities can be generalized to depict how they spend their daily or weekly time (Pelletier & Duffield, 2003). This technique helps obtain accurate information about nursing work activities in hospital settings (Chaboyer et al., 2008). Trained research assistants record the primary activity being observed at predetermined times, known as fixed interval sampling (Blay et al., 2014). In this study, the nurses caring for older patients (65 and older) were observed at 10-min intervals.

A structured list of nursing work practices was adapted from Roche et al. (2017), consisting of 38 activities in five categories: Direct care—fundamental (15 items), Direct care—other (8 items), Indirect care (7-items), Unit related (7 items) and Personal (1 item). The activity categories are outlined in Table 1.

Observations were conducted over two observational periods, each day over 2 weeks each (July–August 2019; November 2019).

TABLE 1 Work sampling activity categories^a

Direct care—fundamental	Direct care—other	Indirect care	Unit related	Personal
<ul style="list-style-type: none"> • Assess and optimize oxygenation • Assess for infection • Assess for pain • Hygiene • Mobility • Nutrition • Hydration • Elimination • Optimize the environment • Educate patient, family/carer • Introduce cognitively stimulating activities • Facilitate regular visits from family and friends • Provide a clock or calendar • Reorient the person to place and time • Check sensory aids in place 	<ul style="list-style-type: none"> • Admission and assessment • Medication and IV administration • Conduct procedure • Assist with procedure • Specimen collection and testing • Transport patient • Provide pressure reducing mattress • Tidy room—reduce bedside clutter 	<ul style="list-style-type: none"> • Verbal report and handover • Communication and information • Medicine and IV preparation • Progress/discharge notes • Computer—data entry/retrieval • Coordination of care—planning/pathway • Coordination of care—rounds and team meetings 	<ul style="list-style-type: none"> • Staff education and in-service • Supplies, check stock • Errands off unit • Meetings and administration • Clerical work • Room or equipment set up and cleaning • Environmental cleaning 	<ul style="list-style-type: none"> • Meal or other personal break

^aAdapted from Roche et al. (2017).

Observations were conducted in 2-h blocks at differing times of the day between 07:00 h and 20:00 h, for 40 h per unit (weekdays only) over 2 weeks. As per previous research using this technique, observations were restricted to 2-h blocks to minimize data collection fatigue (Chaboyer et al., 2008). Two observation periods and observations at different times of day were aimed at reducing the risk of bias.

Five research assistants with a nursing background who had undertaken 5 h of training with two research team members (LG and KR) undertook the observations. These observers were allocated observational periods based on their availability. They moved around the unit, recording the observed activity of up to six nursing staff.

Group interviews were conducted in Phase 2 and focused on staff perspectives of the findings from the observations. The sessions were conducted in November 2020 on each of the units in the usual in-service time by one of two experienced female doctoral-qualified academic members of the research team (LG or KR). Both held joint research appointments between the health service and the local university and had worked with staff on previous projects. The groups were held in the unit handover room and were limited to 10 participants. In addition, nurses who attended voluntarily and those who were unable to attend were provided with the opportunity for an individual interview. However, no one chose this option. The questions guiding the interview are outlined in Table 2. Interviews were digitally audio recorded, and researchers made brief field notes in 2 h of the interview.

2.4.1 | Ethics considerations

This study was approved by the hospital (QGC 2019/53577) and university (2019/439) Human Research Ethics Committees. The

TABLE 2 Group interview format

Part 1: Focus activity—List of activities (see Table 1) and clean paper provided
1. Using the list of activities provided, please estimate how much time you spend on each type of activity over a day shift?
2. Now draw this into a pie chart, with each of the four types of activities clearly marked
Part 2: Summary of findings presented in slides
Part 3: Discussion (audio recording begins)
3. As you listened to the presentation, and saw the data, what were your first impressions of what you heard about care?
4. In what ways are the ward-based accounts the same or different to your personal practice?
5. In what ways is the provision of fundamental care to older patients different in comparison with other care types. What are some of the barriers to providing more fulsome fundamental care to older patients?
6. Given the business of the ward, how fundamental care can be achieved is also interesting to us. What can enable staff to provide fundamental care to older patients more effectively?
7. What does 'missed care' mean to you and how can it be avoided?

nurses consented to be observed, and patients were informed that the nurse providing their care was being observed. However, observations were not conducted when patients did not assent to being observed.

During Phase 1, the research assistants were advised to observe care practices. If not consistent with policy or safety, the research assistant was expected to report their observations to the senior nurse on duty, Nurse Unit Manager or Clinical Nurse, and make a report to the Chief Investigator (LG). Phase 2 focused on the participants' shared interpretation of the observation findings. The practice of critical reflection on team performance was expected for nurses in this jurisdiction and presented a low risk.

2.5 | Data analysis

De-identified hospital data about the patient cohort were used to describe average age, the average length of stay, gender, number of comorbidities and percentage of patients identified as Aboriginal and Torres Strait Islander.

For the observation data, descriptive statistical methods were conducted to capture the frequency of each of the 38 activities observed and the frequency of the five categories of care delivered on each unit over each of the two-week periods. Percentages of observed activities were calculated based on the frequency of those activities divided by the frequency of all recorded activities. These percentages then provided an estimate of the proportion of time spent by nurses on each activity (Blay et al., 2014). Quantitative data analyses were conducted using IBM SPSS version 26.

Digital audio interview recordings were professionally transcribed. Interviews were subjected to qualitative content analysis, focusing on manifest and latent content (Graneheim & Lundman, 2004). Two researchers (LG; LA) inductively analysed the interviews independently and thematically and then met to discuss and moderate areas of convergence and divergence to assist reliability in analyses and reporting.

The three sets of data (i.e. descriptive patient cohort, observations, and interviews) were then presented to the research team in a formal meeting. Through discussion and moderation, conclusions about the consensus of the meaning of the findings were achieved.

2.5.1 | Validity and reliability/rigour

For the work sampling process, inter-rater reliability tests were conducted between a member of the research team (KR) and each observer with Cohen's *kappa* between 0.89 and 0.98. These measures indicate high levels of reliability in the analyses of the data.

For the interview process, data saturation was reached by the fourth group interview, with repeated themes consistently emerging across interviews. Therefore, a fifth focus group was conducted to confirm data saturation. Those participants who requested a transcript of the group interviews ($n = 9$) were provided with the word

version of the transcript via email, and no feedback was provided. Trustworthiness of the qualitative data was enhanced by a detailed description of the context for the findings and confirmation of the findings through discussion with academic and clinical members of the research team.

As a mixed methods study, inference quality is a recognized criterion for rigour (Polit & Tatano Beck, 2017). Furthermore, the believability and accuracy of the findings (Polit & Tatano Beck, 2017) were confirmed through presenting our early analysis to nurses working in both units.

3 | RESULTS/FINDINGS

The analysis of the hospital data on patient admissions to both the medical and the surgical units showed that 68% of all admissions were 65 years and over and 55 years and over Aboriginal and Torres Strait Islanders (ATSI). Table 3 shows the average age, length of stay and the percentage of patients with eight or more comorbidities of the patient cohort for each unit.

In Phase 1, 33 nursing staff on each medical and surgical units ($n = 66$) were observed in the first observation period. In the second

TABLE 3 Patient cohort data

	Medical	Surgical
Age (years)		
Mean (SD)	73.8 (15.7)	66.7 (16.9)
Median (IQR)	77 (66–85)	70 (56–79)
Length of stay (days)		
Mean (SD)	7 (10.1)	6 (7.5)
Median (IQR)	4 (2–8)	4 (2–7)
Eight or more comorbidities		
Frequency (%)	65	49.5

Note: Mean (SD) and median (interquartile range) for age, length of stay and number of comorbidities for patients admitted to the Medical and Surgical Units between August 2018 and August 2019.

observation period, 29 and 32 nursing staff were observed on the medical and surgical units, respectively ($n = 61$). In the medical unit, the observed participants at each time point were registered nurses (90%, 87.8%), enrolled nurses (4%, 12.2%) and assistants in nursing (6%, 0%). In the surgical unit, the observed participants were registered nurses (91.4%, 98.3%), enrolled nurses (3.7%, 1.7%) and assistants in nursing (5.6%, 0%). There is no significant difference in qualifications (chi-square analysis) between the medical and surgical groups. The number of times each nurse was observed varied from one to four observations. Most nurses were observed at least twice. Fifteen nurses (medical unit) and 16 nurses (surgical unit) were observed at both time points.

In Phase 2, five group interviews were conducted, with 37 nursing staff in attendance. Interviews lasted 25–30 min. Three group interviews were held in the surgical unit ($n = 9$ [S1], $n = 9$ [S2], $n = 7$ [S3]) and two held in the medical unit ($n = 7$ [M1], $n = 5$ [M2]). Twelve staff in the surgical unit and eight in the medical unit participated in both the observations and group interviews.

3.1 | Phase 1 observations

For each data collection period (T1 and T2), there were 1176 and 1380 and 1278 and 1398 observations of nursing activities on the medical and surgical units, respectively. Overall, the frequency of fundamental care activities, as a percentage of all observed activities, was approximately 26% (in the medical unit) and 22% (in the surgical unit). The frequency of indirect care activities was approximately 41% (in the medical unit) and 43% (in the surgical unit). Table 4 details the frequency of observations for each care category for each unit over both the two-week observation periods.

In regard to indirect care activities related to communication, nurses were observed on the computer most frequently. Unit-related activities, such as checking and acquiring stock, setting up rooms and equipment and attending meetings and in-service sessions attributed to less than 10% of activities. It is important to note

Care categories ^a	Number of observations frequency (%)			
	Time 1		Time 2	
	Medical	Surgical	Medical	Surgical
Direct–fundamental care	328 (27.9)	279 (20.3)	299 (23.4)	324 (23.3)
Direct care–other	210 (17.9)	261 (19.0)	178 (13.9)	300 (21.5)
Indirect care	469 (39.9)	623 (45.3)	534 (41.8)	545 (39.1)
Unit-related	74 (6.3)	76 (5.5)	109 (8.5)	92 (6.6)
Personal	70 (6.0)	115 (8.4)	126 (9.9)	122 (8.8)
Door closed	24 (2.1)	22 (1.6)	32 (2.5)	10 (0.7)
Total	1176	1278	1380	1393

TABLE 4 Percentage frequency of care activities observed on the medical and surgical unit at two time points

^aRefer to Table 1 for category descriptions.

that closure of the door was respected as a need for privacy, and no data were collected in these cases.

3.2 | Phase 2 group interviews

Three themes were identified: (1) important to prioritize and complete all reportable activities, (2) frequent delays in indirect care reduce the time for fundamental care and (3) balancing care requirements across a group of patients is difficult when patients have high fundamental care needs.

3.2.1 | Important to complete more activities and prioritize those that are reported

These nurses talked about prioritizing those tasks for each patient that took less time to do. For example, completing an electronic assessment was faster than helping with a meal (M1) and administering medication was faster than providing a complete wash (S3). For these nurses, the quantum and extent of the kinds of nursing care were disregarded, with each activity considered as a reportable task that was counted as completed or not. For example:

...you're more sort of task-driven with the computer and getting on with the tasks, getting things done, things are due at certain times (M1).

Overall, care completion appeared to be based on the principle of completing as many kinds of care as possible during the shift. This was evident in the general agreement that a key solution was to have more nurses complete more tasks (M1, M2, S2, S3).

There was a shared view amongst these nurses about what care should be prioritized and missed (Table 5).

The kinds of care that should be prioritized are recorded in the electronic medical record, including pain assessment and management, clinical procedures, assessments and care plans, medication administration and emergent changes in vital signs. In Table 5, care that could be missed included several fundamental care activities.

Not searching for equipment that can prevent complications, for example finding a specific type of mattress to prevent pressure injury, is also related to fundamental care.

In looking for possible solutions, nurses suggested that the medical record could be used in some way to monitor fundamental care delivery (M1), with a specific question about how to record the provision of a male facial shave (S3). In this way, these nurses suggest that the imperatives of the hospital's reporting systems were privileging certain kinds of care over others, with potentially detrimental consequences for older patients.

3.2.2 | Frequent delays in indirect care reduce the time for fundamental care

The nurses reported valuing fundamental care, noting it provided an opportunity to increase the quality of assessments of skin and cognition (S2, S3). Some stated that they perceived missed fundamental care as neglect (S2) and contributing to delayed discharge (M2). However, there was acceptance in every focus group discussion that missed fundamental care did occur on most shifts. For example

...I know it sounds terrible, but like if you had that [patient who has come from intensive care] and you had another three patients, I wouldn't be looking to find their hearing aids. I'd just be making sure they were breathing properly, clean, eating, drinking, blood pressure was fine (S3).

The challenges these nurses reported relating to fundamental care delivery were often related to limited time. When explored further, time was reported as being constrained by the unnecessary delays associated with the provision of indirect care. These nurses reported that unplanned time was required to:

- learn to use the new electronic record system (S3, M1),
- wait for all the nurses to arrive to start handover (S1),
- coordinate discharge requirements with other staff when they are not easily contactable (S1, S3, M1),

TABLE 5 Shared view on what is prioritized and what can be missed

Should be prioritized	Can be missed
<ul style="list-style-type: none"> • Comfort (M1, S1) • Clinical procedures (S2, S3) • Complete assessments and planning (S1, S3) • Emergent change in medical condition (S1) • Help with meals (M2, S2) • Time-dependent care such as medications (M1) 	<ul style="list-style-type: none"> • Educate family (S2) • Finding equipment that can prevent complications (M2) • Hair washing (S2) • Mobilize (M2) • Put in/check hearing aids (S2) • Providing psychosocial care or cognitively stimulating activities (M2) • Shower (M2, S2 and S3) • Tidy room (M2) • Tooth brushing (S2)

Abbreviations: M, Medical; S, Surgical; Numbers refer to the specific focus group.

- leave the ward [unit] to accompany one patient to off the ward for a medical procedure (S1),
- look for equipment that is not in the ward (S3) and
- secure the appropriate medications after hours (M1).

Suggested strategies to address these delays included a routine check of medications by pharmacy on admission (M1) and updating the electronic record system to auto-populate information from one field to relevant other fields (S1). So, these nurses reported understanding and valuing the importance of fundamental care and were conscious of unhelpful distractions in fulfilling the requirements of this care.

3.2.3 | Balancing care requirements across a group of patients is difficult when patients have high fundamental care needs

The nurses acknowledged that fundamental care activities could take longer for older people who move slowly (S1, S2) or have cognitive impairment (S2, M1; M2). However, when one patient requires more direct care, either fundamental or clinical, in one group, the nurses expressed concern about their ability to meet the care needs of other patients (M1, M2, S1, S2). For one participant:

...the biggest concern at present, is a small number of patients monopolising staff time... and others are not getting the appropriate time to meet their needs (M1).

When invited to make suggestions about how to address the needs of all patients, nurses suggested using the technology available in the electronic record to make reminders about fundamental care completion (M1, M2), increasing staff numbers for assistance with fundamental care delivery (M1, M2, S2, S3) or taking over some indirect care work, such as managing the discharge process (M1) and engage the family to assist (M1; M2; S2). In this way, the available time versus the kinds and extent of tasks to be completed shaped how these nurses practised fundamental care.

4 | DISCUSSION

This study found that these nurses who worked in medical and surgical units were routinely delivering a range of fundamental care to older patients in hospital, with that care delivery recorded between 20% and 25% of nurses of all observed activities. In nurses' discussions of fundamental care delivery, there was an apparent preference to complete less time-consuming activities or those that were reportable first. This may mean that fundamental care activities that take more time, such as showers, mouth care and mobility, were at risk of being missed. A key barrier to fundamental care delivery was delayed in indirect care activities, which constituted 39%–45% of observations. Finally, nurses reported feeling challenged about balancing a few patients' high fundamental care needs with other more ambulant patients' medical and clinical needs, presenting another

potential barrier to fundamental care delivery. In this discussion, the implications of these findings for nurse leaders are explored.

The preference to complete more activities appeared to influence the prioritization of activities so that those that were less time consuming were completed first. Completing shorter activities so that more activities can be done, resonates with the practice known as 'cutting corners'. This common practice includes the partial or complete omission of care, delays in care provision and incorrect completion of activities (Jones et al., 2016), which occurred to complete more activities in our study. However, as necessary workarounds become accepted, there is a risk that such normalized practices can become dangerous for patients over time (Churrua et al., 2018) and must be addressed.

Adopting relational leadership styles, those focused on people and relationships rather than tasks (Cummings et al., 2018), may provide a foundation for nurse leaders to collaborate with others to explore the meaning of 'cutting corners' practices. A leadership focus on making fundamental care important (Conroy, 2018) could include partnering with nurse educators and clinical leaders to recast fundamental care as critical to preventing hospital-acquired complications common in older patients, such as delirium, pressure injuries, pneumonia and urinary tract infection. Clarifying the possible meanings, such as making time for more practices or limited understanding of the effects of repeated omissions, can assist in identifying strategies for increasing fundamental care. In a scoping review, researchers found that nurses' awareness of the potential harm of missed fundamental nursing care may help them collaboratively develop strategies to reduce missed care (Kalánková et al., 2020). When nurse leaders adopt relational leadership styles, they focus staff attention on the future and show how care practices can be transformed to make time for fundamental care such as mouth care (Dale et al., 2016).

In addition to completing activities quickly, nurses identified those activities that required recording as important. Prioritizing recorded activities, such as providing prescribed medication, attending a wound dressing and completing assessments, was widely accepted. Activities known to prevent complications, including mobilization, family education, room tidying and tooth brushing, were not routinely recorded and were more probably to be unattended.

Current hospital record systems have a limited capacity to record actual fundamental care interventions (Bail et al., 2020). For example, an Australian team is investigating how to reduce duplication across systems (Redley & Raggat, 2017) and include care that is particularly important to prevent complications in older patients, such as continence, nutrition and cognition (Redley & Baker, 2019).

Internationally, researchers in Ireland and Australia have been exploring the use of person-centred key performance indicators to record fundamental care work (McCance et al., 2020). By designing a measurement system, the IMPAKT App, researchers could collect and analyze evidence of performance against each indicator (McCance et al., 2015). This innovative technology offers new ways for nurses to record and monitor fundamental care initiatives and is worthy of further research and development. As nurse researchers develop a standardized framework for fundamental nursing care

(Feo, Conroy, Jangland, et al., 2017), there are opportunities for nurse leaders to advance the inclusion of these cares in future electronic medical record systems (Bail et al., 2020).

Indirect care activities constituted around 40% of observations. Indirect care included team communication, both verbal and through the patient records, which were focused on coordinating others in the healthcare team. Repeated communication with multiple health team members is associated with the unstable complexity of older patients with multi-morbidities (Hunter et al., 2019). Communication amongst team members increases as hospital stays become shorter and movement between hospital units increases (Duffield et al., 2009). While it is acknowledged that this continual movement of unstable complex patients into, between, and out of hospital units contributes to increases in nursing workloads (Chiarella & Roydhouse, 2011), how time spent communicating is counted in workload is not well developed. Time and motion studies, with more sophisticated instruments, such as the Work Observation Method by Activity Timing (WOMBAT) tool (Westbrook & Ampt, 2009), may assist with a richer description of how nurses engage in team communication.

In this study, nurses attributed more indirect care activities (and therefore less time on fundamental care) to interruptions related to system failures. Interruptions to nursing work in hospitals due to system failures are a long-standing issue that has become more pronounced over time, with an average of 8 interruptions *per day* reported in 2006 (Tucker & Spear, 2006) and up to 13 interruptions *per hour* reported in 2018 (Bellandi et al., 2018). Jones et al. (2021) suggest that nurses exercise their professional autonomy to address these system failures by rationing fundamental nursing care. For nurse managers, root cause analyses of missed care events may identify systems problems that can be rectified through administrative or structural means including staffing plans that address limited nursing resources, providing staff education on the expected standard of care for older patients, support teamwork in the unit and enhancing access to necessary equipment (Jones et al., 2021).

In this study, nurses accepted care rationing as unavoidable, with fundamental care sometimes given lower priority and considered less important than time-effective and reportable activities and, therefore, more probably missed than indirect and clinical care. Identifying potential enablers and barriers to fundamental care delivery is a first step in exploring alternatives to care rationing, which constitutes a critical ethical dilemma for the nursing profession (Scott et al., 2019). In addition, the dynamic nature of nursing work requires leaders who can work with complexity and system instability; leaders who exhibit relational leadership styles such as transformational or resonant leadership.

4.1 | Limitations

There are several limitations to this study. Firstly, while this study provides important insights into the fundamental care of older

patients in hospitals, its generalisability is limited as it was conducted in one health service. Secondly, while convenience sampling is efficient, the risk of over-representation of specific groups is a risk (Polit & Tatano Beck, 2017). In this study, we collected information about nurses' experience or classification but not about other demographic details such as age and gender. This should be considered in future studies to avoid potential sampling bias. Thirdly, the selected observation method provided a good overview of the frequency of different types of activities undertaken by nurses but did not indicate the time spent on those activities. Fourthly, we are aware that in the group interviews, we asked nurses to discuss their practice in a group frankly and that there may be some social desirability response bias (van de Mortel, 2008). Finally, we were unable to report on the characteristics of the nurses who participated in the focus group discussions, which is required in the COREQ guidelines (Tong et al., 2007), this may limit generalisability.

Nonetheless, this approach achieves our goal to provide insights into practice that can inform nurse leadership. Further, the work sampling instrument used for observations in this study included sensory aids, which are missing from all international missed care tools. The use of sensory aids is widely recognized as important in the care of older patients.

5 | CONCLUSION

We sought to understand the challenges of implementing fundamental care for older patients. With the acceptance of missed nursing care as necessary in the context of efficiency and limited resources, the emerging institutional culture has eroded community expectations about nursing care; that fundamental care will be provided. Going forward, relational styles of nurse leadership focused on a vision for fundamental care as important work in nurses' scope is recommended, as is ensuring that fundamental care is prioritized alongside reportable activities. Nursing education focused on the short, medium and long-term consequences of missed fundamental care for older patients is urgently required to recast fundamental care as essential hospital care.

Nurse leaders are well placed to advocate for increased investment in fundamental care for older people. Further research and development in fundamental care should include developing relational leadership in clinical nurses and managers and investing in research focused on economic analysis of fundamental care and older patient outcomes.

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CONFLICT OF INTEREST

The authors have declared no conflict of interest.

AUTHOR CONTRIBUTIONS

All authors contributed to study design and manuscript preparation. LG, KR, JT and LC contributed to data collection. LG, KR, JT and LA contributed to data analysis. WM, SB and KB contributed to data analysis and interpretation.

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DATA AVAILABILITY STATEMENT

Authors do not wish to share the data.

ORCID

Laurie Grealish  <https://orcid.org/0000-0002-0699-2886>

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