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Fundamental care guided by the Careful Nursing Philosophy and Professional Practice Model©

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Aims and objectives: To propose the Careful Nursing Philosophy and Professional Practice Model© as a conceptual and practice solution to current fundamental nursing care erosion and deficits.

Background: There is growing awareness of the crucial importance of fundamental care. Efforts are underway to heighten nurses' awareness of values that motivate fundamental care and thereby increase their attention to effective provision of fundamental care. However, there remains a need for nursing frameworks which motivate nurses to bring fundamental care values to life in their practice and strengthen their commitment to provide fundamental care.

Design: This descriptive position paper builds on the Careful Nursing Philosophy and Professional Practice Model© (Careful Nursing). Careful Nursing elaborates explicit nursing values and addresses both relational and pragmatic aspects of nursing practice, offering an ideal guide to provision of fundamental nursing care.

Method: A comparative alignment approach is used to review the capacity of Careful Nursing to address fundamentals of nursing care.

Conclusions: Careful Nursing provides a value-based comprehensive and practical framework which can strengthen clinical nurses' ability to articulate and control their practice and, thereby, more effectively fulfil their responsibility to provide fundamental care and measure its effectiveness.

Relevance to clinical practice: This explicitly value-based nursing philosophy and professional practice model offers nurses a comprehensive, pragmatic and engaging framework designed to strengthen their control over their practice and ability to provide high-quality fundamental nursing care.

KEYWORDS
Careful Nursing, fundamental care, Ireland, NANDA International, philosophy, professional practice model, spiritual, standardised nursing languages

1 | INTRODUCTION

There is growing momentum in the literature urging nurses to reconsider fundamental nursing care as a crucial component of good nursing practice. Aspects of care considered fundamental are those that focus on personal safety, human dignity, self-care and comfort within a healthcare context. Often these involve minimal technological intervention; or technology is used as a tool to assist nurses in

the provision of fundamental care, for example recording body temperature. Always they involve emphasis on the nurse–patient relationship and nurses' ability to engage directly with patients in sensitive and respectful ways. Examples of fundamental care needs include those that are physical, such as assistance with toileting, skin care and mobility; those that are psychosocial, such as recognising human dignity and fostering calmness and hopefulness; and those that are relational, such as nurses being respectful, empathic and compassionate (Feo & Kitson, 2016; Kitson, Conroy, Kuluski, Locock, & Lyons, 2013; Kitson, Conroy, Wengstrom, Profetto-McGrath, & Robertson-Malt, 2010).

Growing awareness that fundamental care must be highlighted as an essential element of nursing practice is due to a variety of circumstances. First, several widely published national and media reports in the United Kingdom (Department of Health, 2013), the United States (Gallagher, 2011) and elsewhere internationally (Aiken et al., 2012) point to deficient fundamental care. There is evidence of "care erosion" whereby core elements of care are overlooked, possibly due to organisational constraints, and become ignored (de Vries & Timmins, 2016, p. 5). There is also international evidence that "missed care" is a real phenomenon whereby fundamental care is regularly not attended to because of nurses' competing demands (Ausserhofer et al., 2014; Jones, Hamilton, & Murry, 2015). What these studies have uncovered is that internationally, and particularly in the context of limited resources or poor working environments, nurses leave professional care responsibilities undone. Ausserhofer et al. (2014) observe that typically nurses choose to prioritise care such as physical treatments, procedures and medication management at the expense of oral hygiene, skin care, re-positioning patients with limited mobility, and communicating with and comforting patients. There is also a belief that modern health services are more focused on managerialist efficiency and budgeting priorities rather than essential human relational aspects of care delivery "with the belief that a competitive, business-focused ethos will somehow create a better environment for care" (Crawford, Gilbert, Gilbert, Gale, & Harvey, 2013, p. 719).

At a practice level, fundamental care is also not given the attention it requires as nurses may carry it out in a ritualistic way, rather than an individualised relational way (Thompson & Kagan, 2011). Responsibilities completed efficiently in the name of quality and cost-saving targets may be lacking in interpersonal attentiveness, for example assisting patients with eating and drinking, which are also social activities. Many older people are already malnourished on admission to acute care hospitals and often feel intimidated and fearful about asking nurses for assistance with selecting food and eating and drinking (Best & Hitchings, 2015). Best and Hitchings propose that this example of a fundamental care needs requires particular attention because poor nutrition and dehydration can lead to low blood pressure leading to increased risk for falls, risk for depressed mood and confusion, and risk for skin damage and pressure ulceration. While there appears to be widespread agreement that failure to provide fundamental care exists with much debate about the

> ## What does this paper contribute to the wider global clinical community?
>
> - Provides an explicit philosophy and professional practice model framework which can comprehensively structure and guide fundamental nursing care and measure its ongoing effectiveness.
> - Highlights the vital importance of using the standardised nursing languages of NANDA International, Nursing Outcomes Classification and Nursing Interventions Classification to name fundamental care accurately and consistently and to guide comprehensive assessment of patients' fundamental care needs.
> - Highlights spirituality as a historically inherent aspect of how nurses practice and as an important aspect of how nurses may currently practice, particularly in relation to providing fundamental care.

reasons for this, focused solutions to improving practice are also needed.

There are isolated examples of approaches underway aimed at strengthening fundamental nursing care. Such initiatives include identifying research priorities focused on improving fundamental care, for example respecting and maintaining patients' dignity; assisting with nutrition, hydration and elimination; protecting patients' skin; improving communication; and examining nurses' attitudes to and relationships with patients (Ball et al., 2016). Initiatives are also taking place to help nurses strengthen their expression of values such as competence, compassion and commitment (Department of Health, 2012, O'Halloran, Wynne, & Cassidy, 2016). The importance of nursing education necessary to support nurses' control over their practice and delivery of high-quality patient care has also been highlighted (Kitson et al., 2013). Work has begun to help nurses reframe their thinking in ways that better enable provision of fundamental care (Feo, Conroy, Alderman, & Kitson, 2017). Kitson, Athlin, and Conroy (2014) argue that for nurses to meet their challenge to provide for patients' fundamental care needs, there is an urgent "need for an integrated way of thinking about the fundamentals of care from a conceptual, methodological, and practical perspective" (p. 332); a way of thinking that not only addresses pragmatic aspects of nursing practice but also provides a structure for nurses' thinking, reflection and assessment of patients' fundamental care needs.

This is an interesting argument because the deficits in fundamental care that exist have arisen at a time when confidence in nursing conceptual models is at an all-time low in the United States (Jacobs, 2013). Most attempts to implement a nursing conceptual model in the United Kingdom and Ireland have led to it becoming mainly synonymous with paperwork (McCrae, 2012) and increasingly replaced with care pathways or other quality initiatives. Most nursing conceptual models do not emphasise nursing values

(Cody, 2015) even though values are the main drivers of compassionate, high-quality health care (Dewar & Christley, 2013). Recent healthcare scandals that highlighted deficits in fundamental care in the United Kingdom (Department of Health, 2013) and Ireland (Aras Attracta Swinford Review Group, 2016) led to implementation of widely publicised nursing and midwifery values strategies (Department of Health, 2012; O'Halloran et al., 2016). The Ireland strategy emphasised the values of compassion, care and commitment while the United Kingdom strategy emphasised the values of care, compassion, competence, communication, courage and commitment, heralded as the 6C's strategy. Commentators on the United Kingdom 6C's strategy (Baillie, 2015) observe their remarkable similarity to the 5C's strategy; compassion, competence, commitment, confidence and conscience; proposed twenty years earlier by Canadian nurse theorist Simone Roach (1992) but little recognised since that time. Indeed, Gallagher (2013) questions whether stating these values is enough. Nursing has a long history of a strong value-based core. What nursing needs is a conceptual, methodolog- ical and practical structure that will bring nursing values to life in nurses' practice, particularly in their provision of fundamental care (Feo & Kitson, 2016).

In contrast to nursing conceptual models, recent and emerging nursing professional practice models originate directly from and are informed by nursing practice. Nurses who wish to develop a professional practice model for their organisation establish a committee which represents all levels of nurses. The committee's aim is to develop and implement a strategic plan designed to enhance the organisation's nursing practice environment and nurses' control over and delivery of nursing care (Basol, Hilleren-Listerud, & Chmielewski, 2015). All nurses are asked to reflect on their professional practice and values and the mission and values of the organisation. The nursing literature and a range of nurse leaders are widely consulted regarding concepts such as relationship-based care, leadership, shared governance, evidence-based decision-making, professional independence and collaborative practice. The committee's analysis and synthesis of this information enables it to formulate a professional practice model which is then used to guide nurses towards achieving the aim of the committee (Basol et al., 2015; Slatyer, Coventry, Twigg, & Davis, 2016). Thirty-six of the 38 professional practice models identified in the literature have been developed in this way; but professional practice models can also be developed without reference to a specific organisation as long as they are designed according to professional practice model principles and aims (Jacobs, 2013; Slatyer et al., 2016).

The original purpose of professional practice models was to frame and specify the standard of nursing knowledge and practice required for the American Nurses Credentialing Center (2014) Magnet Model© recognition programme, internationally recognised as a definitive standard for exemplary nursing practice. Professional practice models are designed to achieve their aim by embracing the central role of nursing in a healthcare organisation's structure. Indeed, the core aim of professional practice models is to merge their nursing values into their organisation's values such that nursing practice excellence becomes the essence of the organisation (Jacobs, 2013).

Professional practice models are well suited to provide a value-based conceptual, methodological and practical structure for nurses' provision of patients' fundamental care needs. In fact, use of a professional practice model has been recommended to help address fundamental care-related patient safety issues and care erosion in the United States (Stallings-Welden & Shirey, 2015) and Ireland (O'Ferrall, 2013).

The Careful Nursing Philosophy and Professional Practice Model© (Careful Nursing) (Meehan, 2012; Murphy, Mc Mullin, Brennan, & Meehan, 2017) offers one possible conceptual and practice solution to current fundamental care erosion and deficits. Careful Nursing is designed for use in any hospital or healthcare system internationally and appears to be the professional practice model that emphasises incorporation of standardised nursing languages and found to be effective in accurately identifying and documenting patients' care needs, interventions and outcomes (Tastan et al., 2014). Developed in Ireland, based on the skilled practice of early to mid-19th century Irish nurses (Meehan, 2012), Careful Nursing has been used and evaluated both nationally (Murphy et al., 2017) and internationally (Ellerbe & Regen, 2012). In a recent study of implementation of the philosophy and dual clinical practice dimensions of Careful Nursing, nurses demonstrated increased control over their practice and increased adherence to hospital nursing documentation standards, compared to before implementation (Murphy et al., 2017). Qualitative data indicated that implementation of Careful Nursing made nursing more visible to nurses, increased their attention to patient assessment and allowed them additional time to spend listening to and talking with patients, all factors known to help prevent erosion and omission of fundamental care. Over a subsequent 12-month period, Careful Nursing wards demonstrated on average an 11% improvement in national nursing quality care planning metrics, compared to non-Careful Nursing wards (Donohoe & Dooley, 2017).

1.1 | Aim

The aim of this study was to provide a pragmatic response to fundamental care erosion and deficits by proposing and elaborating the capacity of Careful Nursing to expressly provide an integrated way of thinking about and addressing fundamental nursing care needs.

2 | METHOD

A comparative alignment approach is used to review the capacity of Careful Nursing to address fundamental care. Key elements of Careful Nursing are introduced in alignment to key concepts of the Fundamentals of Care Framework (FOC Framework) (Feo et al., 2017; Kitson et al., 2013, 2014). In addition, fundamentals of care needs as

they are provided for by the duel clinical practice dimensions of Careful Nursing are aligned to definitions of fundamentals of care (Feo & Kitson, 2016).

2.1 | Design

This descriptive position paper is informed by Careful Nursing, highlighting use of its dual clinical practice dimensions to operationalise clinical nurses' pragmatic provision of fundamental care.

2.2 | Careful Nursing

Since the initial publication of Careful Nursing (Meehan, 2012), revisions have been made to enhance its specificity and clarity (Murphy et al., 2017) and are included in Figure 1 and Table 1.

Figure 1 illustrates the schema of Careful Nursing with its three philosophical principles surrounding its professional practice model, composed of four dimensions and their total of twenty concepts. The philosophy and the professional practice model are integral and inseparable. Table 1 lists these key elements of Careful Nursing in

alignment to related key elements of the FOC Framework (Feo et al., 2017; Kitson et al., 2013, 2014). This alignment allows for appraisal of the capacity of Careful Nursing to address fundamental care.

The three philosophical principles explicitly inform the professional practice model in the neo-Aristotelian intellectual tradition of Aquinas (1265-1274/2007) and contemporary and modern philosophers in this tradition, for example, Maritain (1966), DeYoung, McCluskey, and Van Dyke (2009) and MacIntyre (2016). These principles are important because they provide nurses with a framework for understanding human persons as unitary (holistic) beings, and for thinking holistically about themselves, the people they care for, and their practice. In emphasising the nature of human beings as persons, in the original philosophical meaning of person, these principles make Careful Nursing profoundly person-centred. Further, nurses are guided to think and practice from a philosophical perspective that is consistent with the nature of nursing as a nurturing, relational profession (Meehan, 2012), rather than being dominated by biomedical thinking prevalent in healthcare organisations (Mazzotta, 2016). Careful Nursing supports the vital importance of nurses' collaboration with biomedical care but is concerned primarily with how nurses
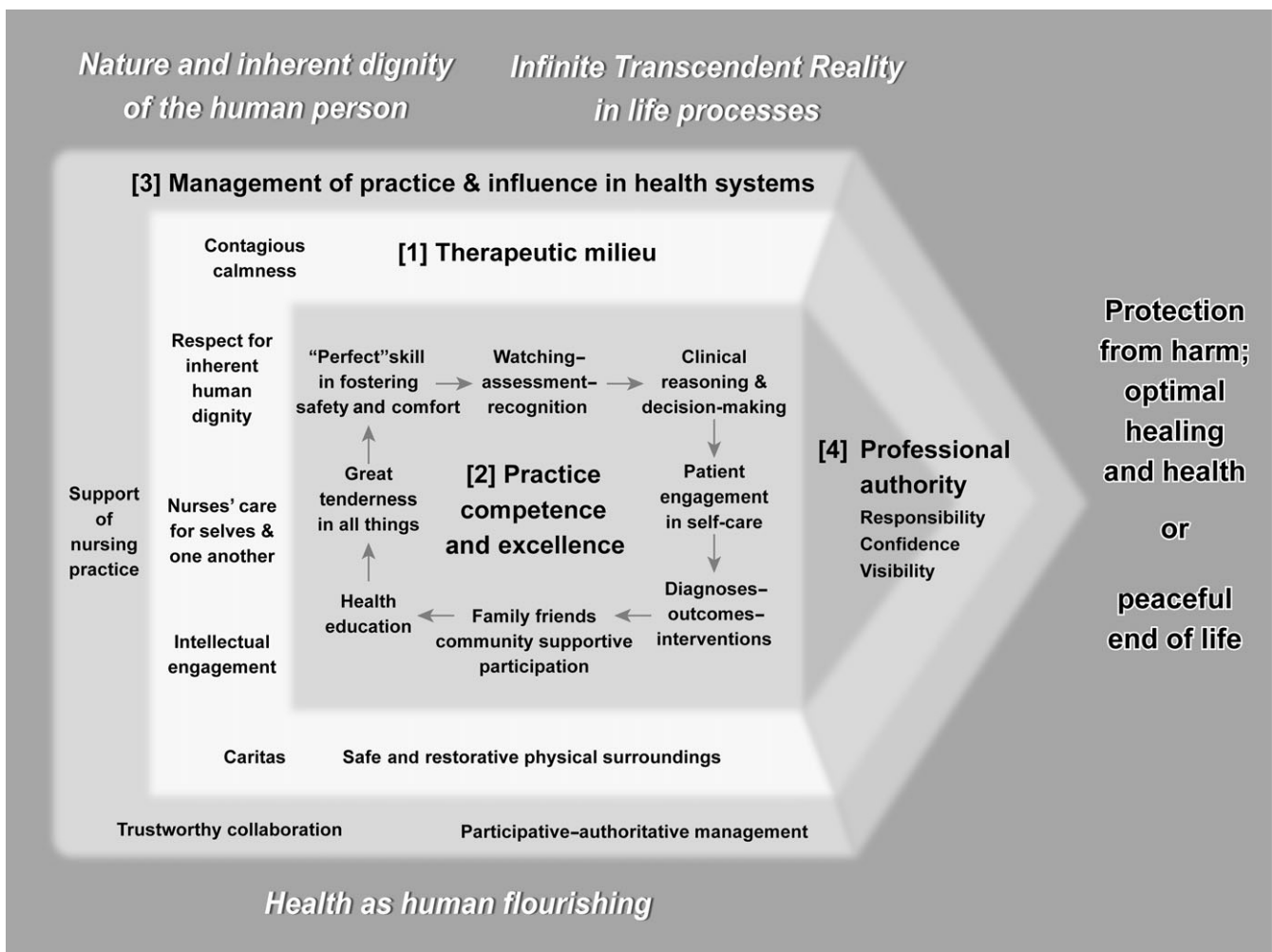

FIGURE 1 The Careful Nursing Philosophy and Professional Practice Model©

TABLE 1   Key elements of Careful Nursing as they are proposed to align to key elements of the Fundamentals of Care Framework

Key elements of Careful Nursing	Key elements of Fundamentals of Care Framework
Three philosophical principles	
Nature and inherent dignity of the human person A unitary (holistic) being with a deeply relational spiritual nature and inherent dignity. All persons are equal in inherent dignity, the highest human value. Within their unitary being persons have two distinguishable realities, an outward reality of body and senses and an inward reality of mind and spirit	A holistic approach to care that combines the physical, psychosocial and relational dimensions of care. Recognition of and respect for human dignity. Seeing the patient as a person; person-centred care
Infinite Transcendent Reality in life processes The creative, abundantly loving spiritual source of life which can be perceived intuitively through brief daily meditative practice of "stillness." Stillness predisposes nurses to be calm in all circumstances. Calmness enables nurses' patience, kindness, generosity of spirit, compassion and desire to help and heal themselves and others	Spirituality or the human spirit is not a recognised element. Still, a holistic approach to nursing care encompasses a body-mind-spirit unity, suggesting logically the presence of spirituality
Health as human flourishing An expression of the natural human desire to flourish despite, frailty, illness, disability or unavoidably difficult living circumstances. Flourishing is motivated by values such as hope, patience, courage, perseverance and prudence, by which persons' desire and seek the highest human good and to find meaning and purpose in life	Bio-psychosocial-relational integrity. Encouraging patients to participate in decision-making about their care. Guiding patients to set goals that will help them feel hopeful about their situation, care and well-being
Four professional practice model dimensions and their concepts	

[1] Therapeutic milieu (TM): A nurse-created, nurse-led safe and healing culture, rich in therapeutic interpersonal relationships and cooperative attentiveness to patients
    Contagious calmness
    Respect for inherent human dignity
    Nurses' care for selves and one another
    Intellectual engagement
    Caritas
    Safe and restorative physical surroundings
	Context of care: The immediate and wider care environment. Relationship established. Meaningful nurse–patient encounter
	
	    Keeping patients calm
	    Keeping patients dignified and respected
	    Capability to effectively establish therapeutic patient encounters
	    Ideas, facts and tacit knowledge to develop working hypothesis
	    Sensitive, empathetic, kind, compassionate
	    Keeping patients safe

[2] Practice competence and excellence (PCE): Nurses' attitudes/activities of direct clinical care, using the nursing process with renewed meaning and greater depth
    Great tenderness in all things
    "Perfect" skill in fostering safety and comfort Watching–assessment–recognition
    Clinical reasoning and decision-making
    Patient engagement in self-care
    Nursing diagnoses–outcomes–interventions
    Patient's family, community supportive participation in care
    Health education
	Integration of care: Care processes consistent with the nursing process are emphasised and elaborated in detail
	    Establishing a meaningful clinical encounter
	    Keeping patients safe and comfortable
	    Patient assessment based on working hypothesis
	    Ongoing clinical reasoning process
	    Keeping patients involved in their care
	    Working hypotheses and clinical reasoning
	    Patient and family at centre of clinical encounter
	    Keeping patients informed

[3] Management of practice and influence in health systems (MPIHS): Nurses' support of nursing and key role in system-wide management of care
    Support of nursing practice
    Trustworthy collaboration
    Participative–authoritative management
	Context of care: Interprofessional coordination of meaningful patient experiences and nurses' implementation of core tasks
	    Support of nursing practice in face of competing demands
	    Interprofessional, integrative care coordination
	    Role of nursing assistants not included

[4] Professional authority (PA): The power, relative autonomy, and intellectual and political influence achieved when nursing's distinctive service is exemplary
    Responsibility
    Confidence
    Visibility
	Publications calling attention to the nature and importance of fundamental care and how its full provision can be achieved
	
	    Being accountable for care
	    Nursing profession takes some responsibility
	    Researching, debating and writing about fundamental care

think differently about patients and have a different sphere of professional responsibility.

In the schema of Careful Nursing shown in Figure 1, the layout of the four professional practice model dimensions, numbered [1] through [4], with their twenty respective concepts, indicates how they relate to one another. Although distinct, the dimensions and concepts are not mutually exclusive but are interwoven with and complement one another as they are implemented in practice.

Importantly, each dimension and concept is considered a nursing value, that is, a motivating factor (Stein, 1922/2000) which contributes to its meaningful implementation in practice. For each dimension shown in Table 1, its listed concepts indicate how it is operationalised. All dimensions and concepts are proposed to be important for fundamental care, however, the dual clinical practice dimensions; the therapeutic milieu (TM) and practice competence and excellence (PCE); are highlighted in this study because they are proposed as the core of Careful Nursing's pragmatic response to fundamental care erosion and omission.

3 | THE CAPACITY OF CAREFUL NURSING TO ADDRESS FUNDAMENTAL CARE

3.1 | Careful Nursing as a whole

3.1.1 | The philosophy

In beginning the body of work underway to strengthen the conceptualisation and implementation of fundamental care, Kitson et al. (2010) discuss the importance of ontology in this process. To explore the essential meaning of fundamental care and how it relates to human existence, Kitson et al. (2010) developed a list of terms proposed to represent fundamental care as a philosophical concept. The Careful Nursing philosophy, summarised in Table 1, may also contribute to the ontology of fundamental care because it explores the nature of patients as human persons who need fundamental care and posits how fundamental care relates to their existence. For example, Careful Nursing views human persons as unitary beings, highlighting the original meaning of holism, often overshadowed in nursing by interpretation of holism as an addition of parts. While some fundamental care activities concern apparent parts of patients, patients' experience their care as unitary beings and the all-important nurse–patient relationship is experienced by nurses and patients as a unitary process. Careful Nursing also provides an ontological explanation for inherent human dignity as a central nursing value, why all human persons are equal inherent dignity, and how dignity relates to human existence. These contributions could be important, considering the central importance of holism and human dignity in the FOC Framework.

Careful Nursing could contribute to exploring whether spirituality has meaning in fundamental care. Although spirituality is not included in the FOC Framework, it is widely recognised as being integral in holistic nursing practice (McSherry & Jamieson, 2013). McSherry and Jamieson found that nurses express spirituality in practice through core values, particularly through attitudes and behaviours which reflect kindness, compassion and respect for human dignity, qualities particularly meaningful in fundamental care. Importantly, Careful Nursing is inclusive of all conceptions of spirituality; whether nurses have a theist, polytheist or atheist worldview, all can understand themselves as spiritual beings in their own way (McSherry & Jamieson, 2013). Thus, all nurses could practice stillness daily, a meditative practice considered essential to developing

contagious calmness which, in turn, enables nurses to enact other Careful Nursing concepts.

Careful Nursing could also contribute ontologically to clarifying the meaning fundamental care has for patients' experience of health. Health and health care are mentioned frequently in the FOC Framework and a nursing-related definition of health is important. The Careful Nursing definition of health as human flourishing gives additional meaning to the patient–nurse mutual engagement in the need for, and provision of, fundamental care. In this engagement, patients and nurses can share in seeking to flourish or achieve the highest human good; for patients, well-being despite frailty, illness and disability and for nurses the happiness of practicing nursing well. In Table 1, the three Careful Nursing philosophical principles are aligned to key elements of the FOC Framework that imply its philosophical assumptions. Spirituality is considered an unrecognised assumption of the FOC Framework because of its holistic approach to care.

3.1.2 | The professional practice model

Table 1 also shows how the Careful Nursing professional practice model's four practice dimensions and their total of twenty concepts align to the FOC Framework's three dimensions and associated concepts (Feo et al., 2017). However, the details of how the respective Careful Nursing and FOC Framework concepts are defined and implemented differ in some ways. The Careful Nursing practice model concepts are highlighted as values which motivate nurses and are grounded in the Careful Nursing philosophical understanding of human persons and the spiritual in nursing, and on the assumption that at least some nurses have adopted the personal practice of stillness each day, a practice which has a positive influence on how nurses implement the TM and PCE dimension concepts (Donohoe & Dooley, 2017).

The first two professional practice model dimensions listed in Table 1, the TM and PCE, are considered dual clinical practice dimensions because they complement one another closely in their implementation. A similar dual relationship is evident between the FOC Framework relationship established and integration of care dimensions (Feo et al., 2017). The TM dimension of Careful Nursing reflects the traditionally established responsibility of nurses to take the lead in creating and managing the protective, healing quality of hospital wards. In this respect, the TM dimension aligns with key elements of care included in the FOC Framework's third dimension, context of care, focused on the importance of the environmental context within which nurses practice and their coordinating role in supporting this context (Feo et al., 2017). The TM extends this coordinating role to a leading role.

The six TM concepts listed in Table 1 focus mainly on the subjective, relational aspects of nurses' practice and aim to strengthen and support nurses in themselves in order to enhance their capacity to engage in healing relationships with one another, patients and others. These concepts align with key elements of care included in the FOC Framework's first dimension, relationship established, in

which psychological and relational concepts are especially emphasised because of their importance in establishing meaningful clinical encounters between nurses and patients (Feo et al., 2017). The TM concepts align closely with the relational concepts of the FOC Framework. However, as Kitson et al. (2014) observe, there is debate about whether nurses should focus on themselves or patients in seeking to establish meaningful, relationships with patients. Kitson et al. (2014) propose that focusing on a patient "requires a capability to effectively establish a therapeutic encounter with the patient" (p. 336), and it is nurses' capability to establish this therapeutic encounter that the TM concepts aim to foster. In a certain sense, Careful Nursing views nurses as therapeutic instruments who must be cared for and finely tuned to practice well.

The FOC Framework recognises keeping patients calm as an important psychosocial concept of the relationship established dimension (Feo et al., 2017). In Careful Nursing, contagious calmness is the keynote concept of the TM dimension, empowering nurses to create a therapeutic milieu and engage in therapeutic encounters with patients by allowing them to step back from stress (Murphy et al., 2017). Stepping back from stress enables nurses to recognise and respect their own inherent dignity, the dignity of one another and the dignity of the patients they care for (Donohoe & Dooley, 2017). In turn, recognition of human dignity enables nurses to care for themselves and one another. Logically, especially in the light of the extensive literature on the negative effects of disruptive relational behaviour among nurses in the workplace (Moore, Sublett, & Leahy, 2017), nurses' care for themselves and one another is a prerequisite for their therapeutic encounters with patients. Contagious calmness also enables nurses to have the patience necessary for caritas, that is, expression of generosity of spirit through being attentive, empathic, kind and compassionate in their interactions with patients (Donohoe & Dooley, 2017). These relational concepts are also of central importance in the FOC Framework (Feo et al., 2017). In addition, meditation-fostered calmness is linked to improved thinking and decision-making ability (Sun, Yao, Wei, & Yu, 2015) and could also enhance nurses' intellectual engagement, critical thinking and attention to patient safety issues. In an interesting divergence, the FOC Framework's relationship established concepts focus on patients' meaningful experience of care provided by nurses while the TM concepts focus on nurses' capacity to establish meaningful relationships with patients. The TM dimension also prepares nurses for effective implementation of the PCE dimension.

In Table 1, the PCE dimension of the professional practice model, with its eight concepts, can be observed to focus mainly on the objective procedural aspects of nurses' practice. This dimension aligns with key elements of care included in the FOC Framework's second dimension, integration of care, concerned with the process of meeting patients' psychosocial, relational and physical fundamental care needs (Feo et al., 2017). In provision of care, Careful Nursing and the FOC Framework share the nursing process as their guiding practice principle even though the details of how their respective concepts are defined and implemented differ in some respects. The first two PCE concepts, great tenderness in all things and "perfect"

skill in fostering safety and comfort, are TM-like relational concepts that are predominantly procedural. The aim of these two concepts is to enhance patients' meaningful experience of procedural aspects of care. The last two PCE concepts concerning patients' supportive care and health education, long-established nursing practice concerns, are also important elements of the FOC Framework.

The four central concepts listed for PCE dimension in Table 1 comprise a critically important practice process which encompass an expanded understanding of patient assessment, the complex process of clinical reasoning and decision-making, and incorporation of the patient's self-care wishes, leading to identification of nursing diagnoses, nursing-sensitive patient outcomes and nursing interventions. Similarly, the FOC Framework (Feo et al., 2017) follows a critically important care practice process developed by Conroy, Feo, Alderman, and Kitson (2016), encompassing identification of initial ideas, facts and tacit knowledge about a patient, consideration of appropriate theories, development of a working hypothesis about care interventions needed, and clinical reasoning and decision-making. This process enables nurse and patient to assess, plan and evaluate patients' fundamental care needs.

A notable difference between the Careful Nursing and FOC Framework care processes is Careful Nursing's use of the internationally recognised standardised nursing languages; NANDA International (NANDA-I) nursing diagnoses (Herdman & Kamitsuru, 2018), Nursing Outcomes Classification (NOC) (Moorhead, Johnson, Maas, & Swanson, 2012) and Nursing Interventions Classification (NIC) (Bulechek, Butcher, Dochterman, & Wagner, 2013). Kitson et al. (2013) observe that the FOC Framework "does not focus on clinical diagnosis, treatments or therapeutic outcomes" (p. 11). It is possible that Kitson et al. are referring to medical-like diagnoses. But, while NANDA-I diagnoses complement medical diagnoses from a patient care point of view, they unquestionably and exclusively concern nursing. A nursing diagnosis is a clinical judgement concerning an "undesirable human response" or "susceptibility . . . for developing an undesirable human response to health conditions/life processes" (italics original) (Gallagher-Lepak, 2018; p. 35). A nursing diagnosis is not the condition or life process event itself. For example in fundamental care, a patient's health condition may be a stroke, diagnosed and treated by medicine. Related fundamental care nursing diagnoses will include the patient's undesirable responses to the stroke health condition, such as feeding self-care deficit or impaired mobility. A health promotion nursing diagnosis may also be made concerning a patients' motivation to enhance their well-being. The term nursing diagnosis is used instead of the term nursing problem because the word diagnosis refers to accuracy and nursing accuracy is just as important as medical accuracy. Of the 244 NANDA-I nursing diagnoses available for selection, over 80 name fundamental care needs. Each nursing diagnosis is linked to a measurable nursing-sensitive NOC patient outcome, and appropriate NIC nursing interventions often used in combination with hospital protocols. NANDA-I diagnoses, NOC and NIC are peer-reviewed and mostly evidence-based. Used together, these languages structure and document nursing care planning, and enable ongoing measurement of patients'

nursing care experiences or nursing-sensitive outcomes, making nursing practice and patients' experience of effects of nurses' care, visible.

Use of NANDA-I, NOC and NIC has two further important advantages. One advantage is that each diagnosis is identified by its physical and psychosocial-spiritual defining characteristics and related factors, and each outcome has specific measurement indicators. Together these details indicate the high level of patient assessment that is required for fundamental care. The second advantage is that documenting nursing practice using standardised nursing languages enables nursing to be represented clearly in electronic health records, a vital requirement for visibility of fundamental nursing care in health care.

The third dimension of the professional practice model shown in Table 1, management of practice and influence in health systems (MPIHS) aligns with key elements of care include in the FOC Framework's third dimension, context of care, concerned with the policies and management systems of the organisations within which nurses practice. The MPIHS dimension is rooted in 19th century Irish nurses' internationally influential assumption that skilled nurses have an essential central role in the management of hospitals (Meehan, 2012). Loss of the meaning of this assumption in some contemporary health systems appears evident in the finding of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Department of Health, 2013) that nurse managers had mostly been eliminated and replaced by career managers. The Careful Nursing and FOC Frameworks strongly support nursing management of practice but appear to diverge on some aspects of how nurses engage in hospital or health system management and patient care planning.

While the FOC Framework takes an interprofessional or interdisciplinary, integrative approach to health system management and patient care planning (Feo & Kitson, 2016), Careful Nursing takes a multiprofessional or multidisciplinary, collaborative approach, specified by the concept of trustworthy collaboration. Careful Nursing favours this approach because multiprofessional collaboration means that each profession's contribution to care and achievement of patient outcomes is distinctive (Clarke & Forster, 2015). In turn, each profession's contribution is visible and each maintains control over its practice, allowing for objective mutual recognition, respect and trust among the professions as they collaborate in patients' best interest. This approach enables nurses to articulate clearly the profession's distinctive contribution to health care (Fealy & McNamara, 2015) and to take the lead in creating the hospital or health system culture necessary to support provision of fundamental care. An integrative element has a place in multiprofessional collaboration but an interprofessional integrative approach alone leaves nursing vulnerable to contemporary professional problems; namely that nursing practice is poorly differentiated (Fealy & McNamara, 2015) and that nursing is so important in healthcare organisations 24/7/365 that, paradoxically, it is easily taken for granted and overlooked (O'Brien, 2017). If this is the case then fundamental care is vulnerable to being poorly distinguished, taken for granted, and its importance overlooked until there are national crises about its absence.

The Careful Nursing MPIHS dimension also addresses the issue of inclusion of nursing care assistants in provision of fundamental care, in its concept of participative–authoritative management. While the FOC Framework is not designed to address this issue, Feo and Kitson (2016) observe that handing over provision of fundamental care to care assistants has become linked to professional nurses' devaluing fundamental care in favour of technical care and that greater role clarification is needed to solve this problem. Twigg et al. (2016) observe that nursing assistants have long been employed to assist in provision of fundamental care and are currently employed in either a complementary or a substitutive role. The MPIHS concept of participative–authoritative management describes how nurses use their professional authority and judgement to engage nursing assistants in a complementary role by delegating to them some fundamental care in selected circumstances. In doing so, nurses retain accountability for care provision and role model how assistants are to provide the care with sensitivity and procedural skill.

The fourth dimension of the professional practice model shown in Table 1, professional authority (PA), concerns the nursing profession's authority at-large over its practice and recognition of its authority. This dimension does not refer in any way to nurses' relationships with patients; it refers to the authority normally accorded to a professional discipline with its own body of knowledge and sphere of practice responsibility. Careful Nursing assumes that it has control over provision of fundamental care because it is nursing care. The FOC Framework recognises the reality that fundamental care may "no longer be in the hands of nurses" (Kitson et al., 2013; p. 5) and aims to reclaim and redefine fundamental care. Development of the FOC Framework represents a major step in reclaiming and redefining fundamental care and, most importantly, providing practical guidance to clinical nurses on provision of fundamental care (Feo et al., 2017). The Careful Nursing PA dimension represents the nursing profession's power to ensure that erosion and omission of fundamental care are prevented, power to be exercised with prudence and graciousness, but power nonetheless.

3.2 | Careful Nursing dual clinical practice dimensions

The working definitions of fundamentals of care developed by Feo and Kitson (2016) provide the opportunity to align fundamentals of care with the concepts of the Careful Nursing dual clinical practice dimensions, the TM and PCE. This alignment, shown in Table 2, enables review of the capacity of the dual clinical practice dimensions to provide directly for patients' fundamental care needs.

Table 2 shows that all TM and PCE concepts underpin nurses' attention to all fundamentals of care and that some concepts are specific to some care needs. The PCE concept, diagnoses–outcome–interventions, is shown to have a prominent role in addressing patients' fundamental care needs because NANDA-I nursing diagnoses have the capacity to accurately identify actual and potential care needs. Selected diagnoses lead care planning, intervention and measurement of care outcomes (Johnson et al., 2012). Physical

TABLE 2 Fundamentals of care needs as they are provided for by the Careful Nursing dual clinical practice dimension concepts

Fundamentals of care Feo and Kitson (2016, p. 4)	Fundamental care needs provided for by the therapeutic milieu (TM)	Fundamental care needs provided for by practice competence and excellence (PCE)	
	All TM concepts underlie nurses' provision for all needs and are listed only where they are specific to the need	All PCE concepts underlie nurses' provision for all needs and are listed only where they are specific to the need; all needs and need changes are identified by ongoing use of the watching–assessment–recognition concept	
		*Selected NANDA-I nursing diagnosis (Herdman & Kamitsuru, 2018) which specifically name problem-focused, at-risk and health promotion fundamental care needs available for use according to individual patient needs	
Physical care			
Safety (physical, psychosocial, environmental harm)	Safe and restorative physical surroundings	*Risk for injury (p. 393) *Risk for infection (p. 382) *Risk for falls (p. 390) *Risk for pressure ulcer (p. 404)	*Risk for aspiration (p. 385) *Risk for impaired oral mucus membrane integrity (p. 399) *Risk for dry eye (p. 388)
Comfort (pain and nausea relief, warmth, rest)	Safe and restorative physical surroundings	*Impaired comfort (p. 442) *Readiness for enhanced comfort (p. 443) *Acute pain (p. 445) *Nausea (p. 444)	*Risk for ineffective thermoregulation (p. 444) *Insomnia (p. 213) *Disturbed sleep pattern (p. 216) *Readiness for enhanced sleep (p. 215)
Nutrition and hydration (adequate food and drink are assisted as required, dietary requirements respected)		*Impaired swallowing (p. 173) *Feeding self-care deficit (p. 245) *Imbalanced nutrition: less than body requirements (p. 157) *Readiness for enhanced nutrition (p. 158)	*Deficient fluid volume (p. 184) *Risk for deficient fluid volume (p. 185) *Risk for compromised human dignity (p. 268)
Mobility (assessed and assisted as required)		*Impaired bed mobility (p. 218) *Impaired physical mobility (p. 219) *Impaired sitting (p. 221)	*Impaired standing (p. 222) *Impaired transfer mobility (p. 223) *Risk for disuse syndrome (p. 217) *Risk for compromised human dignity (p. 268)
Hygiene and personal dressing (preferences and right to privacy respected)		*Bathing self-care deficit (p. 243) *Dressing self-care deficit (p. 244)	*Risk for compromised human dignity (p. 268)
Elimination and continence (assistance as required)		*Toileting self-care deficit (p. 246) *Impaired urinary elimination (p. 189) *Functional urinary incontinence (p. 190)	*Risk for dysfunctional gastrointestinal motility (p. 206) *Risk for constipation (p. 199) *Constipation (p. 197) *Risk for compromised human dignity (p. 268)
Psychosocial care			
Feel calm (particular concerns; noise and distraction diminished)	Contagious calmness Safe and restorative physical environment		
Able to cope (talking in plain language and listened to; emotions recognised)		*Fear (p. 337) *Anxiety (p. 324) *Risk for relocation stress syndrome (p. 321) Family, friends, community supportive participation	*Ineffective coping (p. 327) *Readiness for enhanced coping (p. 328) *Readiness for enhanced family coping (p. 334) *Readiness for enhanced health management (p. 152)
Feel hopeful (goals addressed)		*Hopelessness (p. 266) Great tenderness in all things	*Readiness for enhanced hope (p. 267)
Be respected (choices; cultural practices)	Respect for inherent human dignity	*Risk for compromised human dignity (p. 268) Patient engagement in self-care	

(Continues)

TABLE 2 (Continued)

Fundamentals of care Feo and Kitson (2016, p. 4)	Fundamental care needs provided for by the therapeutic milieu (TM)	Fundamental care needs provided for by practice competence and excellence (PCE)	
Be involved and informed (consulted; able to contribute to self-care decisions)		*Impaired memory (p. 261) *Impaired verbal communication (p. 263) *Impaired resilience (p. 346) *Powerlessness (p. 343) Patient engagement in self-care	*Deficient knowledge (p. 259) *Readiness for enhanced knowledge (p. 260) *Readiness for enhanced self-care (p. 247) *Readiness for enhanced decision-making (p. 366)
Dignified (treated with dignity re-personal characteristics)	Respect for inherent human dignity	*Risk for compromised human dignity (p. 268)	
Relational (nurse attitudes and actions)			
Being empathic	Contagious calmness Respect for inherent dignity Nurses' care for selves and one another Intellectual engagement Caritas		
Being respectful	Contagious calmness Respect for inherent dignity Nurses' care for selves and one another Intellectual engagement Caritas		
Being compassionate	Contagious calmness, Respect for inherent dignity Nurses' care for selves and one another Intellectual engagement Caritas	Great tenderness in all things	
Being consistent		Structured by NANDA-I diagnoses-guided nursing care plans	
Ensuring goals are set		Structured by NANDA-I linked measurement of desired patient outcomes, every 12 hr unless otherwise specified; ongoing reassessment and possible revision of NANDA-I diagnoses if indicated	
Ensuring continuity		Structured by NANDA-I nursing care plans created and managed by 24/7 clinical nurse teams and shared collaboratively with multidisciplinary team	

fundamentals of care concerning safety and comfort are provided for by the TM concept of nurses' creation of a safe and restorative physical surrounding. These fundamentals of care are provided for specifically by fifteen NANDA-I nursing diagnoses concerned with patient safety and comfort. The remaining physical fundamentals of care; concerning patients' nutrition and hydration, mobility, hygiene and personal dressing, and elimination and continence; are also provided for specifically by twenty-one NANDA-I nursing diagnoses concerned with these fundamentals of care. Notably, the NANDA-I diagnosis of risk for comprised human dignity is included as a choice for each of these fundamentals of care.

The psychosocial fundamental of care, to feel calm is described by Feo and Kitson (2016) as "Patients' concerns and frustrations are addressed. Noise and distraction are minimised" (p. 4), thus the TM concepts of contagious calmness and a safe and restorative physical

surrounding provide for this need. These two TM concepts suggest that patients' need to feel calm may also be, to some extent, a relational fundamental of care because contagious calmness is communicated to patients by nurses in the nurse–patient relationship. On the other hand, the fundamental of care to be able to cope is provided for by PCE concepts. Seven NANDA-I nursing diagnoses are shown to provide for patient coping, including three which address coping directly and three which address emotions related to coping. In addition, the PCE concept of family, friend, community, supportive participation in patient care can have a significant role in helping patients to cope with their situation. The fundamental of care to feel hopeful is provided for by two NANDA-I nursing diagnoses which directly address hope. Hope may also be provided for by the PCE concept of great tenderness in all things because, with its helping, compassionate intention, it can bring hope to patients. The

fundamental of care, to be involved and informed can, again, be provided for by eight NANDA-I diagnoses which address aspects of this care need; the PCE concept, patient engagement in self-care, specifically provides for this need. Both psychosocial fundamental care needs, to be treated with dignity and to be respected, are provided for by the TM concept of respect for inherent dignity and the NANDA-I diagnosis, risk for compromised human dignity.

The relational fundamentals of care shown in Table 2, the need for professionals to be empathic, respectful and compassionate, are provided for either directly or indirectly by the five interwoven, deeply relational TM concepts. In addition, the PCE concept of great tenderness in all things aims to enhance compassion in procedural practice. These three relational fundamentals of care also provide for patients' psychosocial fundamentals of care needs to be treated with dignity and to be respected. The three additional relational concepts, shown at the end of Table 2, concern the wider influence of relationships among nurses, and with and among the multidisciplinary team; they guide close collaboration among all concerned with provision of fundamental care.

The fundamentals of care which guide nurses to be empathic, respectful and compassionate are crucially important, but they are not easy to address because they concern deeply lived value experiences which nurses can be reluctant to discuss (Murphy et al., 2017). In addition, it is commonly known among nurses that some colleagues who ostensibly value these relational fundamentals of care surreptitiously dismiss them as "soft stuff" in comparison with procedural and critical care. In fact, these fundamentals of care can be thought of rather as having a certain kind of soft power; in themselves, they take no additional time and cost nothing to provide, they operate under the radar of missed care, and when left undone, they can compel attention to their crucial importance only by their deeply distressing absence. As values, such relational fundamentals of care reside in the human spirit and will, and appeal to nurses to be motivated by them. These values also appeal for investigation of the process underlying their expression in practice and whether they could provide insight into the "something amiss" (Kitson et al., 2014, p. 332.) in the way fundamental care is delivered.

For nurses not familiar with the use of NANDA-I nursing diagnoses, NOC outcomes and NIC interventions, they may at first seem a perplexing and unnecessary challenge in their assessment of patients need for and provision of fundamentals of care. But, when faced with this challenge, clinical nurses practicing in acute care hospital wards have found use of NANDA-I, NOC and NIC achievable, stimulating and a source of new-found professional confidence and visibility (Donohoe & Dooley, 2017; Murphy et al., 2017).

3.3 | Careful Nursing-guided education for fundamental care

Careful Nursing can be integrated into academic nursing education relatively easily. It is attractive to nursing students because they are drawn to its values, attitudes and activities which they expect to learn about. Even if students are initially drawn to critical care

components of nursing, they can learn to be drawn to the critical component of fundamental care nursing for all patients. Careful Nursing merges reasonably easily with most undergraduate nursing curricula content, for example, the bio-physical reality of body and senses with basic science modules and the psycho-spiritual reality of mind and spirit with psychology and liberal arts modules. Exploration of values as they motivate nursing practice can be incorporated into all modules. Modules can be organised according to NANDA-I diagnosis domains and classes (Herdman & Kamitsuru, 2018). Or, the defining characteristics and related factors of NANDA-I diagnoses, the NOC outcomes indicators, and NIC interventions can substantially inform the scope and organisation of learning content in modules which already exist, for example, in nursing assessment and clinical practicum modules. The concepts of all Careful Nursing dimensions address the details of clinical practice in any nursing practice component or specialty area, and fundamental care can be included in all components and areas. In keeping with the nature of a higher education, Careful Nursing is intellectually stimulating, particularly its philosophy which emphasises use of disputation, a specialised method of critical thinking.

In hospitals and healthcare organisations nurses can engage in Careful Nursing-designed classroom or online learning modules closely related to nurses' clinical practice experiences. Nurses' use of NANDA-I, NOC and NIC will ensure that fundamental care is included in all learning experiences. Nurses in practice settings have access to a wide range of practice experiences which they can use to deepen their understanding of all components of nursing, including fundamental care. Nurses can use their practice experiences to develop small projects such as case studies, which can be evaluated when they apply for clinical advancement.

4 | DISCUSSION

As a nursing philosophy and professional practice model, Careful Nursing is expected to address all components of nursing knowledge and practice, especially the crucial component of fundamental care. In this study, Careful Nursing has tested this expectation by comparing its capacity to address fundamental care with the FOC Framework designed specifically to address fundamentals of care. Overall, Careful Nursing has been found to have a good capacity to address fundamental care in ways that align with the thinking and practice of the FOC Framework. In some respects, Careful Nursing and the FOC Framework are broadly similar in how they address fundamental care. At the same time, as might be expected due to the diversity of nursing ideas, differences between Careful Nursing and the FOC Framework emerge.

Careful Nursing posits explicit philosophical assumptions which may be thought unnecessary when what is needed is a solution that will improve provision of fundamental care. The FOC Framework's implicit philosophical assumptions may appear sufficient. Yet, provision of fundamental care is a deeply human, value-laden, holistic undertaking and implicit assumptions about the nature of human

persons and health, and the meaning of holism can leave questions for practicing nurses about what these concepts actually mean for how they think about patients, themselves as nurses, and how they provide for patients' fundamental care needs. Implicit assumptions may also impede nurses' explicit recognition of the values which motivate their practice.

The conceptual structure of the Careful Nursing professional practice model and that of the FOC Framework are broadly similar. Both structures include dimensions concerned with nurse–patient relationships, nurses' clinical provision of care to patients, and the context within which care is provided. Careful Nursing and the FOC Framework share a deep concern with enhancing the healing or therapeutic quality of nurse–patient relationships and both are concerned with the capacity of nurses to establish healing relationships with patients. The FOC Framework expects nurses to have this capacity while Careful Nursing focuses very much on enabling nurses to fortify and maintain their healing capacity.

Careful Nursing and the FOC Framework take different approaches to nurses' provision of care and nurses role in the broader healthcare organisation context. Careful Nursing differs from the FOC Framework on these aspects of practice for the same underlying reason; concern for nurses' control over their practice and care delivery. Regarding nurses' approach to provision of care, the FOC Framework advocates a care practice process, but how the accuracy and other details of this process are documented and communicated is unclear. As a professional practice model concerned with nurses' provision of care, Careful Nursing aims specifically to promote nurses' control over their practice and applies this aim to fundamental care. One way nurses can take control of their practice is to use NANDA-I, NOC and NIC to name and define the care they provide accurately and measure its effects on patients' experiences of care. Because this process is used for nursing care planning, it provides a means of close communication among nurses and a permanent record of nurses' practice which can be entered into electronic health records. Use of NANDA-I, NOC and NIC are especially important for fundamental care because of its current low visibility. When fundamentals of care are named by nurses in an accurate and consistent way, they are claimed by nurses, and patients' experience of care can be measured. Only when fundamentals of care are named, claimed and measured along with other components of nursing, will fundamental care become visible and valued, both in human terms and economic terms. In addition, this process shows that, without question, provision of fundamental care requires knowledge and skill. Common use of the word task, rather than skill, to refer to provision of fundamental care devalues this requirement. The word task does not reflect a nursing value. A task, with its mechanical undertone and suggestion of a chore, has no place in fundamental care.

Regarding nurses' role in the broad context of care in an organisation, the FOC Framework favours an interprofessional, integrative approach in which nurses take a coordinating role, while Careful Nursing favours a multiprofessional, collaborative approach in which nurses take a leading role regarding nursing care. An interprofessional, integrative approach is in keeping with the management of many healthcare organisations, but it assimilates nurses into an interprofessional team, often led by the medical profession, and weakens nurses' ability to ensure that the distinctive nursing contribution of fundamental care is heard and understood. Careful Nursing emphasises its firmly held assumption that the nursing profession has a central role in the management of patient care in healthcare organisations from the boardroom to the bedside, so to speak; a role enacted through trustworthy multidisciplinary collaboration with other health professions and with career managers. In areas which are nursing-focused, such as wards, nurses not only coordinate care, they take the lead in relation to the care environment and care provision. This approach ensures that the importance of nursing, especially its component of fundamental care, is recognised and respected.

Careful Nursing and the FOC Framework have different but complementary responsibilities in furthering recognition and development of fundamental nursing care. Careful Nursing can examine how best to integrate and prioritise fundamental care with the acute and critical care components of nursing. Careful Nursing can also examine whether all fundamentals of care are represented appropriately in the NANDA-I, NOC and NIC standardised nursing languages. Likewise, Careful Nursing can work to advocate that all fundamental care-specific elements of these standardised nursing languages are entered into national electronic health records, so that fundamental care will be recorded and visible along with other components of nursing practice. The FOC framework has considerable capacity to further promote awareness of the importance of fundamental care and to conduct clinical research specific to fundamental care. Both Careful Nursing and the FOC Framework can work to embed education on fundamental care in meaningful ways in academic and practice nursing education. Both Careful Nursing and the FOC Framework can contribute to bringing fundamental care forward to a prominent place in nursing practice, education and research.

5 | CONCLUSIONS

Careful Nursing has good capacity to address fundamentals of care needs when compared with the FOC Framework (Feo et al., 2017; Kitson et al., 2013, 2014). Careful Nursing's explicit philosophy has the capacity to broaden nurses' thinking about the relational aspects of fundamental care and the values which motivate their provision of fundamental care. As a professional practice model, Careful Nursing can help nurses to strengthen their control over and delivery of fundamental care and the environment in which they deliver this care. The dual clinical practice dimensions of the professional practice model provide nurses with a relational and objective structure for their pragmatic provision of fundamental care. Careful Nursing's adoption of the NANDA-I, NOC and NIC standardised nursing languages provides nurses with a comprehensive guide to identifying fundamentals of care needs specifically, accurately and consistently and, thus, for the pragmatic provision of fundamental care in clinical practice. Overall, Careful Nursing has both intellectual and practical

capacity to strengthen and support nurses to prioritise fundamental care in their practice.

6 | RELEVANCE TO CLINICAL PRACTICE

Careful Nursing is a distinctively nursing approach to nursing practice and embraces unconditionally its certain responsibility for provision of fundamental care. Careful Nursing offers nurses an approach to providing fundamental care that is both intellectually stimulating and grounded in the pragmatics of caring for sick, injured and vulnerable people. Careful Nursing's explicit philosophical foundation offers nurses the opportunity to reflect on what knowledge guides their practice and whether it is consistent with the nature of nursing. The philosophy also prompts nurses to review how they understand the influence of human spirituality in nursing and to consider how the philosophy corresponds to their personal experience of spirituality in nursing. When the dimensions and concepts of the professional practice model are considered as nursing values, nurses can think of them as motivators of fundamental care and consider to what extent their practice reflects these values. Careful Nursing challenges nurses to consider or reconsider use of NANDA-I, NOC and NIC standardised nursing languages and the potential they offer for addressing fundamental care in a consistent, accurate and measurable way. Recognition of the importance of nurses' knowledge of the explicit philosophy guiding their care and use of clearly defined standardised nursing languages to articulate and measure their provision of fundamental care calls for recognition of these factors in nursing education programmes in practice and academic settings.

CONTRIBUTIONS

Study design: TCM, FT; data collection and analysis: TCM, JB; manuscript preparation: TCM, FT, JB.

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REFERENCES

Aiken, L. H., Sermeus, W., Van den Heede, K., Sloane, D. M., Busse, R., McKee, M., … Kutney-Lee, A. (2012). Patient safety, satisfaction, and quality of hospital care: Cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. BMJ, 344, e1717. https://doi.org/10.1136/bmj.e1717

American Nurses Credentialing Center (ANCN) (2014). Magnet application manual. Silver Springs, MD: ANCN.

Aquinas, T. (1265-1274/2007) Summa theologiae. Cambridge, UK: Cambridge University Press.

Aras Attracta Swinford Review Group (2016). Time for action: Priority actions arising from national consultation. Dublin, Ireland: Health Service Executive.

Ausserhofer, D., Zander, B., Busse, R., Schubert, M., De Geest, S., Rafferty, A. M., … Schwendimann, R. (2014). Prevalence, patterns and predictors of nursing care left undone in European hospitals: Results from the multicountry cross-sectional RN4CAST study. BMJ Quality & Safety, 23, 126–135. https://doi.org/10.1136/bmjqs-2013-002318

Baillie, L. (2015). Perspectives: We need to talk about the 6Cs: Perspectives on a recent debate. Journal of Research in Nursing, 20, 331–336. https://doi.org/10.1177/1744987115585642

Ball, J., Ballinger, C., De Iongh, A., Dall'Ora, C., Crowe, C., & Griffiths, P. (2016). Determining priorities for research to improve fundamental care on hospital wards. Research Involvement and Engagement, 31, 1–17. https://doi.org/10.1186/s40900-016-0045-8

Basol, R., Hilleren-Listerud, A., & Chmielewski, L. (2015). Developing, implementing, and evaluating a professional practice model. The Journal of Nursing Administration, 45, 43–49. https://doi.org/10.1097/NNA.0000000000000153

Best, C., & Hitchings, H. (2015). Improving nutrition in older people in acute care. Nursing Standard, 29(47), 50–57. https://doi.org/10.7748/ns.29.47.50.e9873

Bulechek, G. M., Butcher, H. K., Dochterman, J. M. & Wagner, C. (Eds.) (2013). Nursing interventions classification (NIC) (6th ed.). St Louis, MO/London, UK: Mosby/Elsevier.

Clarke, D. J., & Forster, A. (2015). Improving post-stroke recovery: The role of the multidisciplinary health care team. Journal of Multidisciplinary Healthcare, 8, 433–442. https://doi.org/10.2147/JMDH

Cody, W. K. (2015). Philosophical and theoretical perspectives for advanced nursing practice (5th ed.). Burlington, MA: Jones & Bartlett Learning.

Conroy, T., Feo, R., Alderman, J., & Kitson, A. (2016). Building nursing practice: The fundamentals of care framework. In J. Crisp, C. Douglas, C. Rebeiro & D. Waters (Eds.), Potter and Perry's fundamentals of nursing – Australian version (5th ed., pp. 15–28). Chatswood, AU: Elsevier.

Crawford, P., Gilbert, P., Gilbert, J., Gale, C., & Harvey, K. (2013). The language of compassion in acute mental health care. Qualitative Health Research, 23, 719–727. https://doi.org/10.1177/1049732313482190

Department of Health (2012). Compassion in practice: Nursing midwifery and care staff: Our vision and strategy. London, UK: The Stationary Office.

Department of Health (2013). Report of the mid Staffordshire NHS Foundation Trust public inquiry. London, UK: The Stationary Office Limited.

Dewar, B., & Christley, Y. (2013). A critical analysis of compassion in practice. Nursing Standard, 28(10), 46–50. https://doi.org/10.7748/ns2013.11.28.10.46.e7828

DeYoung, R. K., McCluskey, C., & Van Dyke, C. (2009). Aquinas's ethics. Notre Dame, IN: University of Notre Dame Press.

Donohoe, C., & Dooley, J. (2017). A Busy Medical Ward Milieu – The Meaning of Careful Nursing. Invited paper presented at the Nursing and Midwifery Values in Practice Conference, Dublin Castle, Dublin, 16 May. Available from the Office of the Nursing & Midwifery Services Director, Department of Health, Dublin, Ireland.

Ellerbe, S., & Regen, D. (2012). Responding to health care reform by addressing the Institute of Medicine Report on the Future of Nursing. Nursing Administration Quarterly, 36, 210–216.

Fealy, G., & McNamara, M. (2015). Transitions and tensions: The discipline of nursing in an interdisciplinary context (Editorial). Journal of Nursing Management, 23, 1–3. https://doi.org/10.1111/jonm.12282

Feo, R., Conroy, T., Alderman, J., & Kitson, A. (2017). Implementing fundamental care in clinical practice. Nursing Standard, 31(32), 52–61. https://doi.org/10.7748/ns.2017.e10765

Feo, R., & Kitson, A. (2016). Promoting patient-centred fundamental care in acute healthcare systems. International Journal of Nursing Studies, 57, 1–11. https://doi.org/10.1016/j.ijnurstu.2016.01.006

Gallagher, L. G. (2011). The high cost of poor care: The financial case for prevention in American nursing homes. Washington, DC: The National Consumer Voice for Quality Long-Term Care.

Gallagher, A. (2013). Values for contemporary nursing practice: Waving or drowning? Nursing Ethics, 20, 615–616. https://doi.org/10.1177/0969733013496362

Gallagher-Lepak, S. (2018). Nursing diagnosis basics. In T. H. Herdman & S. Kamitsuru (Eds.), Nursing diagnoses definitions and classifications 2018–2020 (pp. 34–44). New York, NY: Thieme Publishers.

Herdman, T. H., & Kamitsuru, S. (Eds.) (2018). Nursing diagnoses definitions and classifications 2018–2020. New York, NY: Thieme Publishers.

Jacobs, B. B. (2013). An innovative professional practice model. Advances in Nursing Science, 36, 271–288. https://doi.org/10.1097/ANS.0000000000000002

Johnson, M., Moorhead, S., Bulechek, G. M., Butcher, H. K., Maas, M. L., & Swanson, E. (2012). NOC and NIC linkages to NANDA-I and clinical conditions (3rd ed.). St. Louis, MO: Mosby.

Jones, T. L., Hamilton, P., & Murry, N. (2015). Unfinished nursing care, missed care, and implicitly rationed care: State of the science review. International Journal of Nursing Studies, 52, 1121–1137. https://doi.org/10.1016/j.ijnurstu.2015.02.012

Kitson, A. L., Athlin, A. M., & Conroy, T. (2014). Anything but basic: Nursing's challenge in meeting patients' fundamental care needs. Journal of Nursing Scholarship, 46, 331–339. https://doi.org/10.1111/jnu.12081

Kitson, A., Conroy, T., Kuluski, K., Locock, L., & Lyons, R. (2013). Reclaiming and redefining the Fundamentals of Care: Nursing's response to meeting patients' basic human needs. Adelaide, SA: School of Nursing, the University of Adelaide.

Kitson, A., Conroy, T., Wengstrom, Y., Profetto-McGrath, J., & Robert-son-Malt, S. (2010). Defining the fundamentals of care. International Journal of Nursing Practice, 16, 423–434. https://doi.org/10.1111/j.1440-172X.2010.01861.x

MacIntyre, A. (2016). Ethics in the conflicts of modernity: An essay on desire, practical reasoning, and narrative. Cambridge, UK: Cambridge University Press. https://doi.org/10.1017/9781316816967

Maritain, J. (1966). The person and the common good. South Bend, IN: University of Notre Dame Press.

Mazzotta, P. C. (2016). Biomedical approaches to care and their influence on point of care nurses: A scoping review. Journal of Nursing Education and Practice, 6, 93–101.

McCrae, N. (2012). Whither nursing models? The value of nursing theory in the context of evidence-based practice and multidisciplinary health care. Journal of Advanced Nursing, 68, 222–229. https://doi.org/10.1111/j.1365-2648.2011.05821.x

McSherry, W., & Jamieson, S. (2013). The qualitative findings from an online survey investigating nurses' perceptions of spirituality and spiritual care. Journal of Clinical Nursing, 22, 3170–3182. https://doi.org/10.1111/jocn.12411

Meehan, T. C. (2012). The Careful Nursing philosophy and professional practice model. Journal of Clinical Nursing, 21, 2905–2916. https://doi.org/10.1111/j.1365-2702.2012.04214.x

Moore, L. W., Sublett, C., & Leahy, C. (2017). Nurse managers speak out about disruptive nurse-to-nurse relationships. The Journal of Nursing Administration, 47, 24–29. https://doi.org/10.1097/NNA.0000000000000432

Moorhead, S., Johnson, M., Maas, M. L., & Swanson, E. (2012). Nursing outcomes classification (NOC) (5th ed.). St. Louis, MO/London, UK: Mosby/Elsevier.

Murphy, S., Mc Mullin, R., Brennan, S., & Meehan, T. C. (2017). Exploring implementation of the Careful Nursing Philosophy and Professional Practice Model© in hospital-based practice. Journal of Nursing Management. https://doi.org/10.1111/jonm.12542

O'Brien, E. (2017) Now I see the true value of nurses. The Sunday Times (Ireland Edition), April 12, 19.

O'Ferrall, F. (2013). The crisis in caring: An evidence based response. Studies: An Irish Quarterly Review, 102, 324–335.

O'Halloran, S., Wynne, M., & Cassidy, E. (2016). Position paper one: Values for nursing and midwives in Ireland. Dublin, Ireland: Department of Health.

Roach, M. S. (1992). The human act of caring: A blueprint for the health professions. Ottawa, ON: Canadian Hospital Association.

Slatyer, S., Coventry, L., Twigg, D., & Davis, S. (2016). Professional practice models for nursing: A review of the literature and synthesis of key components. Journal of Nursing Management, 24, 139–150. https://doi.org/10.1111/jonm.12309

Stallings-Welden, L. M., & Shirey, M. R. (2015). Predictability of a professional practice model to affect nurse and patient outcomes. Nursing Administration Quarterly, 39, 199–210. https://doi.org/10.1097/NAQ.0000000000000106

Stein, E. (1922/2000). Philosophy of Psychology and the Humanities. In M. Sawicki & M. C. Baseheart (Eds.), The collected works of Edith Stein (Vol. 7, pp. 1–329). Washington, DC: ICS Publications.

Sun, S., Yao, Z., Wei, J., & Yu, R. (2015). Calm and smart? A selective review of meditation effects on decision making. Frontiers in Psychology, 6, 1059. https://doi.org/10.3389/fpsyg.2015.01059

Tastan, S., Linch, G. C. F., Keenan, G. M., Stifter, J., McKinney, D., Fahey, L., … Wilkie, D. J. (2014). Evidence for the existing American Nurses Association-recognized standardized nursing terminologies: A systematic review. International Journal of Nursing Studies, 51, 1160–1170. https://doi.org/10.1016/j.ijnurstu.2013.12.004

Thompson, H. J., & Kagan, S. H. (2011). Clinical management of fever by nurses: Doing what works. Journal of Advanced Nursing, 67, 359–370. https://doi.org/10.1111/j.1365-2648.2010.05506.x

Twigg, D. E., Myers, H., Duffield, C., Pugh, J. D., Gelder, L., & Roche, M. (2016). The impact of adding assistants in nursing to acute care hospital ward nurse staffing on adverse patient outcomes: An analysis of administrative health data. International Journal of Nursing Studies, 63, 189–200. https://doi.org/10.1016/j.ijnurstu.2016.09.008

de Vries, J., & Timmins, F. (2016). Care erosion in hospitals: Problems in reflective nursing practice and the role of cognitive dissonance. Nurse Education Today, 38, 5–8. https://doi.org/10.1016/j.nedt.2015.12.007