Person-centered fundamental care in the emergency room – Patient and registered nurse perspectives

Patients who suffer from life-threatening illness or injury – experiencing conditions such as cardiac arrest, breathing problems, or trauma – are cared for at emergency rooms within the emergency department. In the emergency room, the registered nurse is responsible for those patients, who are exposed, vulnerable and have complex needs. The biomedical focus may however reinforce a culture that value the medical-technical aspects of nursing. To meet patients fundamental care needs in a person-centred way seems challenging in emergency rooms. The overall aim of this thesis was to explore how person-centered fundamental care needs are met for patients with life-threatening illness or injury in emergency rooms, from both patient and registered nurse perspectives.

In summary, the results show that the organizational prerequisites contribute to a task-oriented and instrumental way of working. Patients did not have their fundamental care needs fully met. Fundamental care is not being promoted or prioritized as the organization and responsibilities for providing person-centred fundamental care are unclear, unspecified, and lacking in direction for how to be performed – the organization and the culture does not support the registered nurses work and profession. The provision of person-centered fundamental care in emergency rooms needs to be prioritized, not only by the registered nurses but also by management and leaders.

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PERSON-CENTERED FUNDAMENTAL CARE IN THE EMERGENCY ROOM

PATIENT AND REGISTERED NURSE PERSPECTIVES

Veronica Pavedahl

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Abstract

Patients who suffer from life-threatening illness or injury – experiencing conditions such as cardiac arrest, breathing problems, or trauma – are cared for at designated emergency rooms within the emergency department. In the emergency room, the registered nurse is responsible for those who are exposed and vulnerable and have complex needs. In these rooms, the biomedical focus may reinforce a culture that values the medical-technical aspects of nursing. Meeting patients’ fundamental care needs, such as respect, information, and toileting, in a person-centered way seems challenging in emergency rooms. When care is not provided correctly, the consequences for the patient’s health can be serious, for instance resulting in physical complications in the form of pressure injuries from breathing masks and spine boards or psychological complications such as worry, anxiety, or post-traumatic stress syndrome. Little is known about how person-centered fundamental care is made visible and valued both for and by patients in emergency rooms. In this thesis the understanding of fundamental care is guided by the Fundamentals of Care framework, in order to maintain an optimal person-centered care that considers the patient’s fundamental care needs with a holistic view of the patient. The overall aim of this thesis is to explore how person-centered fundamental care needs are met for life-threateningly ill patients in emergency rooms, from both patient and registered nurse perspectives.

Study I explored how fundamental care needs of life-threateningly ill or injured patients were met by observing the daily activities of registered nurses in the emergency room, through 108 observations. The results showed that registered nurses were initially engaged and active in meeting patients’ needs, but that this decreased over the duration of the care. Registered nurses met the patients’ physical needs to a greater extent than their psychosocial and relational ones. The environment affected the registered nurses’ ability to meet the patients’ fundamental care needs.

To describe fundamental care needs in the emergency room, based on life-threateningly ill patients’ experiences, an interview study (Study II) was conducted with 15 persons who had been cared for in an emergency room. The interviews were analyzed using deductive content analysis based on the Fundamentals of Care framework. The results showed that relationship, timely and personalized information, and existential needs were identified as essential fundamental care needs, which were not (or only partly) met. The physical environment limited patients in having their fundamental care needs met, and they adopted a “patient role” to avoid adding to healthcare professionals’ stress.

Study III described registered nurses’ work approach and prerequisites for meeting life-threateningly ill patients’ care needs from the perspective of a person-centered fundamental care framework, through 14 interviews. The results revealed that registered nurses structure their work approach in meeting patients’ fundamental care needs based on prevailing organizational and personal prerequisites.

In Study IV the content of guidelines governing the registered nurses’ work in the emergency room was investigated. The results revealed that the registered nurses’ work in Swedish emergency rooms was guided by an instrumental and task-oriented approach to care. The guidelines lacked guidance in providing for patients’ fundamental care needs, and did not support the registered nurses in conducting holistic, comprehensive patient assessments and interventions.

The organizational prerequisites contribute to a task-oriented and instrumental way of working, and patients are not having their fundamental care needs fully met. Fundamental care is not being promoted or prioritized, as the organization and responsibilities for providing person-centered fundamental care are unclear, unspecified, and lacking in direction for how it is to be performed – neither the organization nor the culture supports the registered nurses’ work and profession.
Abstract

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**Keywords:** emergency care; emergency nursing; emergency room; fundamental care; person-centered care; life-threatening illness or injury
“But in both, let whoever is in charge keep this simple question in her head (not, how can I always do this right thing myself, but) how can I provide for this right thing to be always done?”
Nightingale, 1860/2017, pp. 40-41

To my beloved family
List of papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.


II  Pavedahl, V., Muntlin, Å., von Thiele Schwarz, U., Summer Meranius, M., & Holmström, I.K. (202x). Having medical needs met is not enough even when life is at stake: An interview study of patients’ experiences of fundamental care needs in the emergency room. Submitted to journal


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Abbreviations

ABCDE=Airway, Breathing, Circulation, Disability, Exposure
ATLS=Advanced Trauma Life Support
ED=Emergency department
ILC=International Learning Collaborative
PTSD=Post-traumatic stress disorder
RN=Registered nurse
WHO=World Health Organization
Prologue

Two sides of the story

“I was on my way to work; I had just left my daughter at preschool and my wife at work. I was in a hurry, I only had ten minutes before my meeting started. Suddenly a loud noise, followed by what was probably my own scream. I heard words like ambulance and emergency room and was placed on a stiff board. It was cold, I was in horrible pain, no one talked to me, and my clothes were cut off without anybody telling me. I tried to call for attention and kept asking what was going on, but no one answered me. The situation was overwhelming, I started crying”.

…”

“The trauma alarm went off – car accident. Of course, I was at the front, this was always exciting. After only a few minutes, the trauma was rolled into the emergency room where I was called as an intensive care nurse. The patient was connected to monitoring equipment, prescriptions were thrown out, clothes were taken off, catheters were put in and medication was given. I briefly noticed that the patient was crying and kept asking, “What’s going on, what’s happening to me?” However, no one answered; we were busy saving the man’s life”.

…”
Introduction

Patients who suffer from life-threatening illness or injury – experiencing conditions such as cardiac arrest, breathing problems, or trauma – are cared for at designated emergency rooms (called resuscitation rooms or trauma rooms in some countries) within the emergency department (ED). The focus in emergency rooms is often biomedical, with an emphasis on technology and medical decision-making over nursing care (Sweet & Foley, 2020), increasing the risk of fundamental care needs being neglected (Richards & Borglin, 2019). When patients’ fundamental care needs are neglected, suffering might occur (Francis, 2013; Kitson et al., 2019).

Patients in an emergency room are in an extremely delicate state, facing life-threatening illness or injury and frightening situations (McDowald et al., 2017) and not always able to express their needs (Varndell et al., 2017). They need medical care along with having their fundamental care needs met in order to relieve their suffering and receive good and safe care. However, there is a lack of guidance specifically in regard to fundamental care in the emergency room.

The emergency room context places high demands on the healthcare professionals as patients may present a variety of non-specific signs and symptoms, often without a prior medical diagnosis, and the scenario can change quickly (Connell et al., 2021; Kuster et al., 2019; Pines & Griffey, 2015). The environment is time-sensitive and demanding, with a diverse spectrum of needs to be met, and it can be challenging to provide patients with optimal care (Bull et al., 2021; Østervang et al., 2021).

This thesis focuses on person-centered fundamental care for patients suffering from life-threatening illness or injury, and on the registered nurse (RN) who cares for these patients in the emergency room. This context, emergency care, is characterized by quick decisions and care in a vulnerable care environment for both patients and RNs. An understanding of both patient and RN perspectives on person-centered fundamental care is vital for the future development of care provided in emergency rooms.

In this thesis, the term life-threatening will be used to describe the condition a patient in the emergency room suffers from. The Swedish National Board of Health and Welfare (2023) describes a life-threatening condition as one that, due to illness or injury, poses a danger to a person’s life. Swedish MeSH (n.d.) defines it as “An acute or prolonged illness usually considered to be life-threatening or with the threat of serious residual disability.
Treatment may be radical and is frequently costly”. As described earlier, a life-threatening illness or injury in the emergency room can be exemplified as trauma, breathing problems, or cardiac arrest. However, a life-threatening condition can also entail, among other things, intoxication, severe or persistent vomiting, hypoglycemia, or anaphylaxis that is considered so serious that the patient’s life is threatened if they do not receive immediate care (Sweet & Foley, 2020).

In this thesis the term **fundamental care** refers to the care provided, and **fundamental care needs** refers to the various needs a person has in this regard. **Fundamental care** includes key factors and outcomes involved in nursing care that address persons’ **fundamental care needs** (Feo et al., 2018). **Person-centered fundamental care** refers to an optimal care that considers the patient’s fundamental care needs and sees them through a holistic view of the patient. Working based on the Fundamentals of Care framework enables the patient to receive person-centered fundamental care. These concepts will be further described in the text below.
Background

The primary task within emergency care is to examine and treat patients who need immediate care, while prioritizing safety and timeliness: Those with the greatest need for healthcare should be prioritized (SFS, 2017:30). Access to the right competence within the right amount of time can mean the difference between life and death (National Board of Health and Welfare, 2020). However, in recent years healthcare (including emergency care) has come under pressure due to a shortage of RNs and hospital beds, a growing older population, and new challenging illnesses such as COVID-19 (World Health Organization, 2020). The work in an emergency room is regulated in the first paragraph of the Health and Medical Services Act (SFS, 2017:30), with the conclusion that every citizen in the welfare state of Sweden has the right to good care on equal terms. Care must be provided with respect for the equal value and dignity of the individual.

In nursing, which has its starting point in the human sciences, there is an understanding of health and suffering and the right to good and safe care in all healthcare (International Council of Nurses, 2021). Health is a human right (WHO, 1948/2023), and good health is a prerequisite for people’s ability to reach their full potential and to contribute to society (United Nations, n.d.). In emergency care, ill health can mean that a patient is between life and death. Being suddenly exposed to an illness or injury leads to a separation from daily life and reality, which affects the patient’s experience of their own health (Airosa et al., 2016; Rehnsfeldt & Arman, 2016).

Being a patient suffering from life-threatening illness or injury in the emergency room

Just like for the person in the prologue, the path from being someone simply living their life to becoming a patient in the emergency room is an unplanned situation, occurring during a time of stress and uncertainty and leaving the patient more exposed, dependent, and vulnerable than in other care situations, due to for example hemodynamic instability, variable consciousness, and difficulty self-reporting (McDowald et al., 2017). Patients who are life-threateningly ill or injured need a quick and comprehensive physical examination without delay, as correct initial treatment of this group of patients is important.
in order to reduce both short-term and long-term mortality and morbidity (Pearce et al., 2023). Therefore, both internationally and nationally, the initial assessment in an emergency room is based on the Airway-Breathing-Circulation-Disability-Exposure (ABCDE) approach as well as Advanced Trauma Life Support (ATLS). These approaches provide a systematic, organized way of working in order to provide optimal care (American College of Surgeons, 2018).

Previous research focusing on patients who are cared for in emergency rooms has shown that these patients cannot always express their needs, due to shock or severe pain (Varndell et al., 2020) or because they are unconscious (Cooksley et al., 2018) or are unable to move freely (Bruijns et al., 2013), leading to discomfort and suffering. The quick and systematic ABCDE approach adopted in the initial assessment, in which the examination sometimes includes being treated by more than 15 healthcare professionals at the same time, takes place in a high-tech environment (American College of Surgeons, 2018). Patients have described the emergency room environment as stressful (Bull et al., 2021; Bull et al., 2022). Being met by an extensive alarm team working together from different directions is an unpleasant and unfamiliar situation, and usually creates a feeling that one’s illness or injury is of a serious nature (Granstrom et al., 2019; Kaufman et al., 2017). The patient risks losing their dignity, and the experience of vulnerability is reinforced (Bailleie, 2009; Fiori et al., 2022). Feelings of vulnerability and discomfort can arise when one is cared for in the emergency room, for example when one’s clothes are cut off (Granstrom et al., 2019; Kaufman et al., 2017). Even though it is common for patients suffering from life-threatening illness or injury to have feelings of stress, anxiety, and fear in an emergency situation, they tend not to share their emotional concerns with the RN; and even patients who are satisfied with their treatment and care describe these feelings (Østervang et al., 2021). It has been observed that receiving continuous information and communication creates a feeling of security and facilitates a perception that one understands things and is in control (Granstrom et al., 2019; Kaufman et al., 2017; Sandström et al., 2017; Skene et al., 2017). However, even when research has shown that the healthcare professionals on a team are caring, supportive, and coaching, at the same time patients can feel abandoned, ignored, and left without information after the initial care (Granstrom et al., 2019; Skene et al., 2017).

The rapid and protocol-driven ABCDE approach to care offers little space for identifying and addressing personal concerns. Even though the care in the emergency room is naturally focused on saving lives, it needs to involve more than simply lifesaving procedures (Elmqvist et al., 2012a), as suffering can occur when care is not provided or one’s personal needs are overlooked (Arman, 2022). A previous study within the ED context has shown that patients experience suffering from many different sources, such as pain, anxiety or worry, discomfort, uncertainty, hunger or thirst, and mobility problems (Body et al., 2015). Therefore, having one’s fundamental care needs met may be
important for relieving suffering and preventing both physical complications, such as pressure injuries from breathing masks or spine boards (Han et al., 2020), and psychological complications such as anxiety or post-traumatic stress disorder (PTSD) (Joseph et al., 2020). As the encounter takes place due to the patient’s need for care, a power imbalance between patient and healthcare professionals is created (Bull et al., 2021), which might affect the patient’s situation and contribute to an experience of feeling objectified, passive, or not being taken seriously or perceived as an adult or a capable human being (Kristenssson Uggla, 2020; Todres et al., 2009).

Taken together, the patient in the emergency room is in a vulnerable position in need of receiving urgent care and of having their fundamental care needs met. These two aspects are not obviously easy to reconcile, and how this is done has not yet been studied.

**Being an RN in the emergency room environment**

Just like for the RN in the prologue, RNs’ experiences in providing emergency care involve caring in an unpredictable and complex context, where they are subject to a range of stressors (Abraham et al., 2018; Adriaenssens et al., 2015; Wolf et al., 2020). The emergency room is a uniquely challenging healthcare environment, and places high demands on RNs’ ability to prioritize the work and make correct decisions under time pressure, without compromising patient safety or quality of care (Kuster et al., 2019; Wolf et al., 2017). One of the more advanced tasks of the RN in the emergency room is to make adequate assessments in order to be able to anticipate patients’ care needs. The RN in the emergency room makes autonomous and complex decisions for patients with life-threatening illness or injury, and is responsible for the ongoing assessment, symptom management, and monitoring of them. The RN has a leading and coordinating function. It is commonly the RN who makes the initial assessment and then summons and informs the physician responsible for the alarms, who in turn controls the prioritization of the patients based on the RN’s assessment (Sweet & Foley, 2020). In addition, the RN has an ethical and moral responsibility for the encounter, assessments, and decisions (International Council of Nurses, 2021). Ethical problems may arise due to patients not being able to communicate and/or being unconscious (Cooksley et al., 2018), which might be challenging to handle in the emergency room due to the urgency of the situation and (sometimes) the fact that one is caring for an unknown patient, which risks compromising the patient’s integrity and privacy (Fiori et al., 2022; Kellezi et al., 2020).

In the emergency room, the RN provides care aimed at achieving a stable state or condition, and there are many unpredictable life-threatening conditions that may require care in this setting (Sweet & Foley, 2020). RNs in the emergency room can be responsible for patients with life-threatening illness
or injury who may require mechanical ventilation, continuous intravenous analgesia and sedation, or vasopressor medication (Considine et al., 2018). Despite this, medical-technical skills on their own are not enough when caring for patients who are life-threateningly ill or injured; in a certain sense, the work of RNs also involves communication and listening to the patient’s voice and wishes (Hermann et al., 2018), which is important for the patient’s fundamental care needs. However, RNs appear to assign relatively low priority and value to fundamental care (Feo & Kitson, 2016). Previous studies have shown that RNs within emergency care viewed their role as that of one who saves lives, and believed they were there to deal with emergencies and acutely ill patients, which they found rewarding and exciting (Elmqvist et al., 2012b; Kim et al., 2022; Tegelberg et al., 2020). Recent research has demonstrated that RNs at EDs tend to omit fundamental care when they lack the time required to complete it, perceive it as difficult, or manage multiple competing priorities beyond those related to direct patient care, such as documentation (Duhalde et al., 2023; Eriksson et al., 2018). In addition, RNs fail to deliver fundamental care when their department is understaffed or when they are preoccupied, or do not prioritize certain tasks, resulting in poor quality of care and patient safety (Ball et al., 2017; Richards & Borglin, 2019), with the risk of harming the interpersonal relationship between RN and patient (Jangland et al., 2018).

The aim of caring is to relieve suffering and promote health and well-being (Arman et al., 2015). Within emergency care, the care should be characterized by a person-centered approach whereby both the person affected by sudden ill health and their relatives are seen as unique persons with personal needs (Riksföreningen för Akutsjuksköterskor & Svensk Sjuksköterskeförening, 2017). The relationship is essential, and without a relationship between the patient and the healthcare professionals caring cannot take place (Arman et al., 2015). However, if the RN is unwilling to share in the person’s suffering, the prerequisite for a caring relationship is not present (Berg & Danielson, 2007; Berg et al., 2006). When perceiving the RN as caring, competent, and concerned, the patient feels empowered and their sense of well-being and health increases. A lack of professional caring reduces patients’ sense of well-being and health (Halldórsdóttir, 1996, 2008). Research has shown, however, that there are challenges involved in establishing a relationship in technologically advanced facilities during time-limited encounters (Bundgaard et al., 2019), such as the emergency room.

The RN is expected to balance complex assessments and interventions with simultaneously dealing with ethical dilemmas that may arise and caring for a patient’s relatives, all based on the best evidence-based practice – to master this, there are guidelines that direct clinical practice and govern RNs’ work in an emergency room. Evidence-based healthcare is established as a fundamental element and key indicator of high-quality patient care (Lehane et al., 2019). It is necessary to use evidence-based clinical practice guidelines in order to be
able to secure quality of care and patient safety; in addition, evidence-based clinical practice guidelines should assist RNs in their assessments of and interventions for patients (Beauchemin et al., 2019). When guidelines are followed benefits can be achieved, such as improving the quality of care for patients, consistency in care, and the quality of clinical decisions made by healthcare professionals. In addition, this makes the care more equal for all patients (SFS, 2017:30). However, Tegelberg et al. (2020) showed that healthcare professionals tend not to follow guidelines in clinical care, instead using their personal experience and common sense to guide their care for the patient. Furthermore, Muntlin Athlin et al. (2017) state that there is also a lack of guidelines for RNs’ work, and Lam et al. (2016) showed that inadequate organizational and administrative support made it difficult to use guidelines in practice, putting patients at risk of not receiving equal care.

### The emergency room organization and environment

Commonly, the work in an emergency room is performed in teams made up of a diversity of healthcare professionals, each with their own specific task in the assessment of and care for the patient (Sweet & Foley, 2020). Depending on the severity of the condition, patients may arrive at the emergency room in different ways and with different alarm levels (Henricson et al., 2022). In Sweden, Trauma Level 1 is the alarm for the highest level of preparedness, with a full trauma team – a multidisciplinary group of individuals from specialties of emergency medicine, anesthesia, orthopedics, surgery, and nursing (Georgiou & Lockey, 2010; Murphy et al., 2019). An emergency alarm indicates an acutely ill patient who often, for medical reasons, needs urgent help. Depending on the type of alarm, the team consists of different healthcare professionals (physicians, RNs, assistant nurses) from different specialties. This interprofessional teamwork places demands on the team members as they face rapid changes and variations in workflow in an unpredictable and hectic environment (Milton et al., 2022; Milton, Gillespie, et al., 2023), along with a diversity of needs to be met, constituting many possible obstacles to providing an optimal care, treatment, and patient experience (Sonis et al., 2018; Stevens et al., 2019).

The (both physical and psychosocial) environment is strongly connected to the well-being, or ill-being, of both patients and healthcare professionals (Anderson et al., 2021; Demidenko et al., 2018; Fay et al., 2018; van der Zwart, 2021). The way the healthcare is organized forms the environment in which nursing care in the emergency setting takes place, and the environment should strengthen the feeling of security and safety (Johnston et al., 2016; Petrino et al., 2023; Watson, 2008). However, this rarely applies to today’s emergency room environment as it delivers care to the ever-changing patient load traversing the system. A recent review showed that a patient’s fundamental care,
assessments, and follow-up were missed in the ED due to the design of the department and the patient load (Duhalde et al., 2023).

The emergency room is staffed and equipped for the reception and treatment of persons requiring immediate care, but not for longer care periods. Although advanced care can be provided in the emergency room, patients who are considered critical after the initial assessment in the emergency room (i.e., their injury or illness is still life-threatening) might be transferred to the operating room or intensive care, with consistent monitoring by a team of healthcare professionals (Schell et al., 2018). However, Siletz et al. (2017) state that the numbers of critical patients spending prolonged time in the emergency room have increased in recent decades. Due to unpredictable patient flow, as well as patient load, a lack of in-hospital beds, and the current status of the ongoing RN shortage, a patient’s transit time from the emergency room can range from a few minutes to several hours. Research states that prolonged stays in the emergency room impede appropriate patient care for life-threateningly ill patients (Morley et al., 2018). In addition, studies have shown worse outcomes for these patients, including a risk of multiorgan failure, the need for admission to an intensive care unit, increased hospital stay, and mortality (Morley et al., 2018; Pines, 2013; Singer et al., 2011); but also, a deteriorated work environment for RNs with an increased risk of anxiety, depression, and burnout (Adriaenssens et al., 2011). During the transit time that waiting for a hospital bed may entail, RNs must still care for life-threateningly ill or injured patients boarding in the emergency room, in addition to new patients arriving (Wolf et al., 2020; Wolf et al., 2017). Therefore, nursing care in the emergency room is both challenging and important from the perspectives of care quality and patient safety – caring for life-threateningly ill or injured patients who should be cared for at a different level of care in an organization that is not designed for this purpose might lead to an increased patient safety risk and a risk of adverse events. Overall, care in emergency rooms involves a wide variety of patients and scenarios, and patients are at risk of both physical and psychosocial complications.
An emergency room. Photo: Åsa Muntlin
Fundamental care

Common to all humans are fundamental needs, such as food and water, elimination, rest, pain management, and information – these must be met in order to maintain or regain health. Fundamental care refers to the care required by everyone for survival, health welfare, maintenance, protection, or a peaceful death, regardless of the presence or type of clinical condition or the setting in which care is being provided (Kitson et al., 2013). However, fundamental care needs are sometimes ignored, not prioritized by RNs, or not performed at all (Ausserhofer et al., 2014; Duhalde et al., 2023; Kalisch & Xie, 2014; Recio-Saucedo et al., 2018).

Fundamental care is not a new concept, but is variously defined in the literature as, for instance: basic care; essential care; essential needs; and basic nursing care (Kitson et al., 2010). Fundamental care has long been researched and described, and various nursing theorists have worked to define and describe nursing. Early on, Nightingale (1860/2017) referred to the fundamentals of care as essential elements in providing basic nursing care. Later, Henderson wrote the International Council of Nurses’ Basic Principles of Nursing Care, in which basic nursing care refers to helping the patient with 14 human needs (Henderson, 1961). It focuses on individualized care and describes the RN’s role in assisting the patient in their daily activities, thus contributing to their health and recovery (Henderson, 1964, 1978). A recent review by Ottonello et al. (2022), aimed at reporting on an analysis of the concept of fundamental care, concluded that there is no consistent definition of the concept of fundamental care. Even though numerous studies examine fundamental care and fundamental nursing care, various terms are used.

In this thesis, the understanding of fundamental care is guided by the Fundamentals of Care framework (Feo et al., 2018). A recent review (Mudd et al., 2020) explored the relationship between seminal nursing theories and fundamental care with the aim of investigating whether existing nursing theories fully provide for high-quality fundamental care. The review showed that 25 of the 29 included theories directly or implicitly noted the importance of the nurse-patient relationship. Furthermore, regarding the integration of care, existing theories lack a specific and explicit focus. The concept of context was poorly developed within existing theories (Mudd et al., 2020). Even though the relationship, integration of care, and context of care are features shared across a number of nursing theories, no single theory depicts these collectively to the same extent as the Fundamentals of Care framework does (Feo et al., 2018; Mudd et al., 2020).

There is currently a working definition, generated by Feo et al. (2018), that reads: “Fundamental care involves actions on the part of the nurse that respect and focus on a person’s essential needs to ensure their physical and psychosocial wellbeing. These needs are met by developing a positive and trusting relationship with the person being cared for as well as their
family/carers” (p. 2,295). However, the definition might need to be developed and improved, as it currently does not include the dimension of context of care (Muntlin et al., 2023). It should not be seen as “simple” but rather complex, and at times challenging, for RNs to ensure fundamental care (Kitson, 2018; Kitson et al., 2013). Consequently, fundamental care needs can be understood as universal activities that are essential for life, rather than being associated with specific health issues (Feo et al., 2019). These needs should be met by RNs, not as purely physical activities but rather in a physical, psychosocial, and relational sense (Feo et al., 2017).

More recently, greater attention has been paid to fundamental care as a response to global deficiencies in nursing that have had devastating consequences for patients (Francis, 2013). Traditionally, fundamental care has been seen as the responsibility of RNs, yet it is often delegated to other healthcare professionals.
The theoretical foundations of this thesis are person-centered care and the Fundamentals of Care framework. Patients suffering from life-threatening illness or injury can be helped with a personal approach whereby they are cared for based on their personal preferences rather than their diagnosis; therefore, person-centered care was chosen for this thesis. The Fundamentals of Care framework was chosen because it has a comprehensive perspective in which care needs and relational nursing interventions are coordinated in a dynamic process (Kitson, 2018; Kitson et al., 2013; Kitson et al., 2014). While a patient’s needs can be of different degrees of urgency and have different focuses within different contexts, regardless of the diagnosis or injury all patients have the same fundamental needs.

Person-centered care is described in the text below, as is the Fundamentals of Care framework. Person-centered care and the Fundamentals of Care framework relate to each other in certain respects, and can complement each other. Both person-centered care and the Fundamentals of Care framework take their starting point in the relationship/partnership, and share the goal of meeting patients’ personal needs. The Fundamentals of Care framework embraces the core values of person-centeredness, emphasizing the trusting relationship and the supportive context, while the integration of care needs directs the focus at fundamental care, which is not explicitly explained in person-centered care (Feo et al., 2018; Kitson, 2018; McCormack & McCance, 2017). Therefore, in this thesis the Fundamentals of Care framework can be seen as a guide to providing fundamental care that is person-centered.

Person-centered care – theoretical foundation

While person-centeredness can be defined in different ways, it has its roots in humanistic psychology. During the 1960s, psychologist Carl Rogers (1961/1995) emphasized the person’s perspective on and experience of their situation. Person-centered care is connected to, for example, the philosophy and view on human beings of Ricœur (1992), stating that every human being is capable and that responsibility can be attributed to their own actions, even if they are very weak or sick. To enable person-centered care as a contextualized form of person-centeredness, one is compelled to recognize person-centeredness as a non-discipline-specific philosophical standpoint. Ricœur (2011)
describes a person as a cohesive continuity between the following intertwined discontinuous structures: the narrative and action; the vulnerable and capable; the free and responsible; and the recognizing and acknowledging human being.

Person-centeredness has permeated, and been researched in, various healthcare settings. It has entailed an extensive theoretical and conceptual development, but to capture the complexity of person-centered care in practical care environments further research is needed (Ekman et al., 2011; Håkansson Eklund et al., 2019; McCormack & McCance, 2017).

Person-centered care

The World Health Organization (WHO) emphasizes person-centeredness as a key component of good quality care and a core competency for all healthcare personnel, which entails a paradigm shift in the way health services are funded, managed, and delivered (World Health Organization, 2007).

Person-centered care is described as an ethical approach to care, taking a holistic view of the entire person (Ekman et al., 2011). Respect, understanding, and the person’s right to have an impact on decisions concerning their care are core values of person-centered care (McCormack & McCance, 2017).

As person-centered care is a development based on the concept of patient-centered care, the two concepts are sometimes used interchangeably (Ekman et al., 2011; Holmström, 2022; Håkansson Eklund et al., 2019). They also share several common attributes, but a recent synthesis review (Håkansson Eklund et al., 2019) revealed that what distinguishes them is that patient-centered care focuses on the patient living a functional life while person-centered care focuses on the patient living a meaningful life.

The person-centered care approach places the person receiving care at the center and focuses on their needs, strengths, and weaknesses (Ekman et al., 2011; Håkansson Eklund et al., 2019), and views the patient as an active part in the care and decision-making instead of viewing them as a passive target of the care (Ekman et al., 2011; Holmström, 2022). A patient’s narrative is central to a patient-provider partnership. Ekman et al. (2011) state that the person-centered care approach can be operationalized by creating the partnership through sharing information – the patient is invited to share their narrative, working in a partnership through shared decision-making and safeguarding the partnership through documentation. These steps are relevant in the emergency room context; however, it is not specifically stated how the RN’s work should be carried out. Therefore, the Fundamentals of Care framework, which contains caregiver actions and care recipient needs related to the work of the RN, was chosen in this thesis to complement the person-centered care approach.
The Fundamentals of Care framework

The Fundamentals of Care framework was designed and developed by the International Learning Collaborative (ILC) as a response to global deficiencies in nursing care (Feo et al., 2018; Kitson et al., 2013; Kitson et al., 2010; Kitson et al., 2014). The ILC was founded by nurse clinicians, healthcare leaders, researchers, and educators who united to collaborate around improving the delivery of fundamental care. The Fundamentals of Care framework is seen as a theoretical pragmatic explanatory framework that is easy to understand and is intended to guide practice, research, education, and politics around person-centered fundamental care, with the potential to improve the quality of care for patients (Kitson, 2018; Kitson et al., 2013). It represents a valid, comprehensive, evidence-based description of fundamental care (Mudd et al., 2020).

The Fundamentals of Care framework is constituted of three interrelated dimensions: 1) establishing the caring relationship with the patient; 2) assessing and delivering physical, relational, and psychosocial fundamental care; 3) and conditions in the form of factors at the system and policy levels for delivering these elements in a wider care context; see Figure 1 (Feo et al., 2018). By approaching the patient in a personal way, the nurse-patient relationship can be established. The RN needs to develop a relationship of trust with the patient, focus on the patient, anticipate the patient’s needs, get to know the patient, and in cooperation with the patient continuously evaluate and reflect on the quality of the relationship (Feo et al., 2018; Feo et al., 2016). Based on the relationship, the RN can then work to meet the patient’s relational, physical, and psychosocial fundamental care needs in an integrated way. The context, which includes system- and policy-level factors, can either enable or hinder the delivery of fundamental care. The three dimensions are interrelated and interdependent, and none can be excluded when the goal is to achieve person-centered fundamental care (Feo et al., 2018). During the work of creating a definition for fundamental care and identifying the discrete elements that constitute such care, existential needs did not meet consensus (Feo et al., 2018). Yet, existential issues arise in regard to patients with life-threatening conditions.

According to Kitson (2018), for the patient to receive fundamental care that is person-centered, the empirically developed theoretical Fundamentals of Care framework can explain and guide practice around such care. This type of care ensures that the patient’s personal experiences are respected and taken into account, and that their fundamental care needs are met (Kitson, 2018; Muntlin & Jangland, 2022; Muntlin & Jangland, 2020). However, Feo and Kitson (2016) argue that fundamental care is poorly delivered in acute care due to its invisibility and subsequent devaluing across the entire acute healthcare system. In addition, Mudd et al. (2022) state that fundamental care
is considered important by leaders but that they often lack the ability to articulate its perceived importance into clear intentions and actions.

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**Fig. 1.** The Fundamentals of Care framework (Source: Feo et al. (2018), reprinted with permission).

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**Person-centered fundamental care in relation to care in the emergency room context**

Within the person-centered approach, a power balance between patient and healthcare professional is strived for (McCormack & McCance, 2017). However, the patient ends up at a threefold disadvantage: institutionally, due to being placed far down in the healthcare organization, which is strongly hierarchical; existentially, due to the vulnerability associated with being a patient; and cognitively, which usually characterizes one’s situation as a patient, typically inevitably at a knowledge disadvantage (Kristensson Uggla, 2020). This threefold disadvantage, along with being exposed, means a vulnerability that can be experienced as devastating and overwhelming (Österberg Almerud et al., 2023).

For the patient in the emergency room, the impacts of life-threatening illness or injury and treatment can be additional causes of being at a disadvantage. Shock, pain, pharmaceuticals, and fluctuating consciousness are just a few examples of things that can affect the patient’s ability to express themselves optimally and understand information. According to Ekman et al. (2011) and Feo et al. (2016), having one’s fundamental care needs met in a
person-centered way makes a difference to the patient, mainly by helping them to feel safer and more satisfied, and to recover more quickly. Kitson (2018) states that the Fundamentals of Care framework endorses the core values of person-centeredness and guides the practice of person-centered fundamental care. In other words, working based on the Fundamentals of Care framework enables the patient to receive person-centered fundamental care.

Research on person-centered care at EDs is sparse, and previous studies show that it has been difficult to implement person-centered care in these settings (Kim et al., 2022; McConnell et al., 2016; Walsh et al., 2022), which should therefore also be applicable to the emergency room context. Challenges to providing person-centered care in EDs included, among other things a lack of training and expertise, communication barriers, and complex patient needs. Accordingly, challenges at EDs reflected a lack of person-centered care (Walsh et al., 2022). Furthermore, Kim et al. (2022) showed that RNs working in emergency rooms tended to regard person-centered care as an ideal that was difficult to implement in the emergency room, as their primary objective was to perform tasks dealing with patients’ life and safety in a busy work environment. However, implementing person-centered components (e.g., trust and respect, involvement of patient/family in information-sharing and decision-making, emotional support and communication) had many benefits, including higher patient satisfaction (Walsh et al., 2022). Yet, person-centered care entails a risk when excessive empathy is shown toward certain patients, as patients who for some reason are not able to voice their needs in the right way may not receive the same attention (Summer Meranius et al., 2020). This might be challenging in an emergency room situation with a patient possibly fluctuating in consciousness, and the person-centered care approach can be particularly challenging in a technical environment (Andersson 2021), with nursing described as task-oriented and based mainly on the patient’s medical needs (Falk et al., 2019).
Rationale

According to previous research, patients in the emergency room are in a vulnerable situation and at risk of complications. While meeting fundamental care needs through a person-centered approach is of importance for patients’ health and well-being and a way to ensure good care research is scarce in the emergency room context. There is a need to explore and map what person-centered fundamental care entails in emergency rooms, and how it is visible and valued both for and by patients in these settings.

The emergency room is a challenging healthcare environment, which places high demands on RNs’ ability to prioritize and make correct decisions under time pressure. The RN is expected to balance complex assessments and interventions based on the best evidence-based practice. Research has shown that RNs sometimes lack the prerequisites and abilities to identify patients’ personal needs or assess when fundamental care assessments and interventions are necessary. And even though evidence-based guidelines should assist RNs in their assessments and interventions recent research has shown a lack of guidance for RNs in emergency rooms. Little is known of RNs’ work approach and prerequisites in meeting life-threateningly ill patients’ fundamental care needs in a person-centered way. In addition, research focusing on guidelines governing the RN’s work in the emergency room is lacking.

To promote health and well-being a deepening of the understanding of what person-centered fundamental care in emergency rooms means is necessary. To achieve that, the three dimensions of the Fundamentals of Care framework are used, together with the perspectives of patients, RNs, and the organization. The overall goal of the current research is to contribute to optimal fundamental care in a person-centered way – in clinics, education, and further research.
Aim

The overall aim of this thesis is to explore how person-centered fundamental care needs are met for life-threateningly ill patients in emergency rooms, from both patient and RN perspectives.

Study I
To explore how fundamental care needs of critically ill patients are met in emergency rooms

Study II
To describe fundamental care needs in the emergency room, based on life-threateningly ill patients’ experiences

Study III
To explore how RNs in the emergency room describe their work approach and prerequisites for meeting life-threateningly ill patients’ care needs, from the perspective of a person-centered fundamental care framework

Study IV
To investigate the content of locally developed Swedish guidelines governing RNs’ work in the emergency room
Qualitative and quantitative approaches have been used in the studies, with different data collection and analysis methods (Table I). The research design is descriptive and explorative, in order to acquire new and in-depth knowledge and understanding.

An overview of the included studies and their design is displayed in Table I. The different methods made it possible to investigate the phenomenon under study (i.e., fundamental care in the emergency room). Studying the phenomenon in a combined way, using both qualitative and quantitative methods, strengthens the design of the thesis by allowing for the gaining of comprehensive knowledge about the care for patients suffering from life-threatening illness or injury in emergency rooms from both the patient’s and the RN’s perspective (Polit & Beck, 2021).

Table I. Overview of included Studies I–IV.

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<tr>
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<td>All 66 EDs in Sweden that are open around the clock; 190 guidelines</td>
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Setting and participants

The collection of data for Studies I–III was conducted at an emergency room within an ED at a university hospital in Sweden. Study IV did not involve a specific emergency room, but rather all EDs in Sweden that are open around the clock and have an emergency room/work with alarm patients. In Sweden there are 66 EDs of this type, based at university hospitals (n=7) and county hospitals (n=59).

The ED where the data for Studies I–III were collected is one of the largest in Sweden, generating a high number of alarms. It has about 54,000 visits annually, over 3,000 of which involve visits to the designated emergency room. Various healthcare professionals work in teams in the emergency room, each team consisting of one RN and one nurse assistant – each with their own specific task in the assessment of and care for the patient – and the physicians who are on call. In the emergency room, the RN is responsible for nursing care but can delegate certain tasks to the assistant nurse, such as inserting a urinary catheter or taking blood samples. A single team can be responsible for an unlimited number of patients. Depending on the type of alarm, other specialists are called to assess the patient.

The studied emergency room has space for six patients. The RNs’ workstations are located behind the patient beds, with the patient facing the corridor. To both the left and right of the patient bed are booms with monitoring equipment, oxygen, intravenous support systems, and suction equipment. The healthcare professionals can screen off between the patient beds, using curtains or folding walls. While it is spatially crowded between most of the beds, two of them have more space – patients called in on a trauma alarm are preferably placed here. The environment is noisy, with alarms from monitoring equipment, healthcare professionals’ communication, telephones, etc.

In the following, the participants and setting will be presented in relation to each study.

Study I participants

The aim of the first study was to explore how the fundamental care needs of critically ill patients are met in emergency rooms. The inclusion criterion was RNs working in the emergency room, and the exclusion criterion was RNs not working in the emergency room. Potential participants (RNs working in the emergency room during the shifts chosen for observation) were informed about the study at a staff meeting, and an informational e-mail was sent to all potential participants. Fifty RNs were eligible to participate, and 23 (19 females and 4 males) were ultimately observed during the observation period. The 27 who were not observed did not work the days or shifts during which observations were conducted. Few of the RNs had specialist training in emergency care or any other specialist training. However, all of them had
experience in all sections of the ED and had completed mandatory training (i.e., theory, practical elements, theoretical examination, and simulation exercises).

Study II participants
The aim of the second study was to describe fundamental care needs in the emergency room based on the experiences of life-threateningly ill patients. The inclusion criterion was persons who had been life-threateningly ill or injured and cared for in the emergency room. The exclusion criteria were persons who were still admitted to the hospital; expected persistent cognitive failure, suicide attempt, or intoxication; were <18 years of age; or were not able to understand or speak Swedish. With help from administrative staff at the ED, potential participants were identified through the ED’s patient tracking system. Potential participants were informed about the study and invited by letter to participate. A week after the letter was sent the patients were phoned and asked to participate in the study, and were given the opportunity to ask questions and get more information about the study. The information letter was sent during a specific time period to 54 persons, 15 of whom agreed to participate. The participants comprised six females and nine males, aged 32-84 years (mean 65.0).

Study III participants
The aim of the third study was to explore how RNs in the emergency room describe their work approach and prerequisites for meeting life-threateningly ill patients’ care needs, from the perspective of a person-centered fundamental care framework. The inclusion criterion was RNs working in the emergency room, and the exclusion criterion was RNs not working in the emergency room. Information was provided to all RNs (n=50) via email, as well as verbally at a staff meeting. Those who were interested in participating in the study, and who worked in the emergency room, responded to the interviewer (me) by email to choose a time and place for the interview.

The sample consisted of 14 RNs (11 females and 3 males), aged 28-61 years (mean 40.2). Work experience in the emergency room ranged from 1 to 14 years (mean 6.1). A total of seven of the RNs had specialist training in emergency care.

Study IV participants
The aim of the fourth study was to investigate the content of locally developed Swedish guidelines governing RNs’ work in the emergency room. A total sample approach was used. A total of 66 Swedish hospital-bound EDs for adults (having an emergency room/working with patients on alarm), based at
university hospitals (n=7) and county hospitals (n=59), were identified and approached for inclusion. Information was provided to the heads/nurse managers at these EDs. Responses were received from all EDs that were contacted regarding participation.

Data collection

In the following text, the data and data collection are presented in relation to each study. Studies II and III were conducted with the same research approach, however, and will therefore be presented together.

Conducting observations – Study I

In Study I data were collected through non-participant observation inspired by Spradley (1980). Data were collected from May to November 2019, spread over four random weeks and covering all days of the week and types of shifts. It was calculated that four weeks, spread over the year, would cover all conceivable types of alarms and different scenarios that arrive at the emergency room. This sample size was based on the fact that approximately 240 patients per month are cared for in the emergency room. As it was not possible to observe on a round-the-clock basis, it was estimated that about 120 observations would be covered during the four weeks. A randomized sampling approach was used to select the data collection periods, followed by a purposive sample of days and shifts to achieve variation during the predetermined weeks. In total, 150 hours (n=108 events) were documented with a focus on the RNs’ everyday tasks. Before the data collection started, a pre-study was undertaken in the emergency room to become familiar with the role of observer, the observation protocol, and the work there.

Observations

According to Spradley (1980), observations are used when the researcher wants to understand the world, relationships, and interactions in a new way. Observations are performed using all one’s senses when perceiving a phenomenon, not only via vision. There are different kinds of observational research. Spradley (1980) describes observations as ranging on a scale from non-participation to complete participation. In non-participant observation, the researcher has no clinical care responsibility but holds purely a researcher role; as a non-participant observer, one observes activities, processes, and interactions without active involvement in the care (Fry et al., 2017). Non-participant observation is well suited in situations that do not allow participation or when involvement is to be avoided. Inspired by Spradley (1980), the adoption of a non-participant observer role was assessed to be appropriate for conducting
real-life observations of the RNs’ work in the unpredictable and complex context of the emergency room, in order to avoid influencing those being studied. During the observed events the observer’s position was in the background, with a view over the emergency room. The role of non-participant observer involved wearing private clothing with a tag labelled “observer”, and not taking part in any nursing activities. The focus during the observation was on the RNs’ daily work in the event of an alarm.

**Observation protocol**

Data were documented using an observation protocol based on the Fundamentals of Care framework (Feo et al., 2018); one observation protocol was used for each event, with one event equaling one patient arriving on alarm.

The protocol provided a specification of fundamental care needs: physical, psychosocial, and relational. Variables such as being present with the patient, communication, privacy, active listening, and toileting needs were observed, with the response alternatives of yes, no, partially, and not applicable. The protocol also provided prompts for information about observed events, such as the day of the week and the time and how many persons were present at the alarm. It also had space for fieldnotes, which were taken in order to understand what was observed and provide context for the quantitative data provided in the observation protocol. The fieldnotes were written from the observer’s perspective. To limit researcher bias, the fieldnotes were typed during or directly after each event (Spradley, 1980). Documented in the fieldnotes were the observer’s own reflections and thoughts about the event and notes about the setting, the activities that occurred, the atmosphere in the emergency room, the environment (furnishings, smells, sounds), and interactions among the team.

The situations studied were those in which the RN received an alarm to the emergency room. There were two RNs stationed in the emergency room, each responsible for every other alarm, although they asked each other for help if needed. A specific RN was observed. What was studied and documented was the RN’s work and care in connection with a patient coming in on alarm. If the RN needed to accompany the patient to X-ray, for example, or was interrupted to help a colleague, “RN interrupted by xxx” was noted in the fieldnotes.

The observation protocol was adapted from a previous pilot study (Westerlund & Jansson, 2015). As the pilot study had a different aim and did not include all elements from the Fundamentals of Care framework (Feo et al., 2018), the observation protocol was adjusted and refined with a timeline for communication and elements from the Fundamentals of Care framework were added.
Conducting interviews – Studies II and III

In Studies II and III, data were collected through interviews. To access the participants’ experiences, the interviews were conducted using open-ended questions. A semi-structured interview guide was used.

In Study II the introductory question explored the patients’ experiences of their fundamental care, having been life-threateningly ill or injured and treated at an emergency room. Examples of questions include: “Can you describe your experience of being cared for in the emergency room?”; “Can you describe what needs you experience that you had?”; and “Now that you have some perspective – do you see something that could have been done differently for you in the situation you were in?”. Follow-up questions were asked, and the patients were asked to freely relate to their experiences of being cared for in the emergency room. Conducted via telephone due to the COVID-19 situation, the interviews lasted 13-40 minutes and were audiotaped and transcribed verbatim. Data were collected from April to May 2022.

In Study III the introductory question explored the RNs’ experiences of how a patient’s fundamental care in the emergency room is performed. Examples of questions include: “Can you describe how you work to meet the patient’s fundamental care needs?”; “Can you describe conditions that are present/not present for meeting the patient’s fundamental care needs?”; and “Can you describe what works well and/or needs to be developed in the care for patients in the emergency room?”. The RNs were encouraged to freely relate to their experiences of caring for patients suffering from life-threatening illness or injury in the emergency room. In addition, follow-up questions were asked to obtain more detailed information. Interviews were conducted with one participant at a time. While most of the interviews were performed in an office near the RNs’ workplace, five were conducted via telephone due to difficulty finding a convenient time to meet in person. The interviews lasted 26-62 minutes and were audiotaped and transcribed verbatim. Data were collected from May to November 2019.

Collecting guidelines – Study IV

In Study IV, data were collected through guidelines. The purpose of the sampling procedure was to obtain a national blend, with a wide geographical range of what governs RNs’ way of working in the emergency room/with alarm patients. To identify guidelines, an e-mail describing the study was sent to the managers of each ED in Sweden that is open around the clock, asking them to send in all guidelines, documents, policies, etc. that governed RNs’ work in the emergency room/with alarm patients. A first e-mail was sent in January 2022. Two reminders were sent, with a four-week interval. Four weeks after the second reminder, a phone call was made to those who had not responded to the e-mails. The long interval between invitation and reminders was due to...
the extreme heavy workload at the EDs in connection with the COVID-19 pandemic. All (n=66) EDs responded to the e-mail or phone call. A total of 61% (n=40) EDs consented to participate, of which 93% (n=37) – comprised of university hospitals (n=4) and county hospitals (n=33) – sent guidelines. Among the 39% (n=26) of EDs that responded but declined to participate, most referred to an overall high workload. Data collection was carried out between January 2022 and May 2022. A total of 357 guidelines were collected.

The retrieved guidelines were recorded on an Excel spreadsheet, with information including the name of the hospital, the name of the ED, and the type of guideline document as well as its name, author (if presented), and a brief description of its content. The study’s aim guided the process of inclusion/exclusion. The guidelines were manually searched and reviewed in two steps. A first reading was done independently by the person who received the guidelines (me), after which I re-read and discussed the documents with one of the supervisors (ÅM) until consensus was reached. The guidelines that were included were those directing the RNs’ work in the emergency room/with alarm patients. Guidelines were excluded when they did not concern the emergency room context (n=73) or the RN’s perspective/performance (n=73), and those describing children were also excluded (n=21). A total of 167 guidelines were excluded, and the final number of included guidelines was 190. These were sorted and added to a new Excel spreadsheet with supplementary information on whether they were RN-specific, team-specific, process-focused, diagnosis-focused, and national or locally developed. Guidelines were marked with an asterisk when they described nursing care and/or used a person-centered perspective in their text.

Analysis

In the studies of this thesis, four methods have been used for analyzing the data; they are presented below in relation to each study.

Study I analysis

In Study I data were analyzed through descriptive statistics, using frequency ratings and percentages for nominal-level data and means and standard deviations for continuous data (Field, 2018). All analysis was performed using IBM SPSS Statistics 24.0 (SPSS Inc., Chicago, IL, USA).

Fieldnotes were written in direct connection with the observations, and were then transcribed verbatim on an Excel spreadsheet. They were read and re-read several times to gain a deepened understanding of the quantitative data collected in the observation protocol, along with an increased understanding of the phenomenon observed.
Study II analysis

The data in Study II were analyzed using deductive content analysis (Elo & Kyngäs, 2008). The Fundamentals of Care framework (Feo et al., 2018) was used as an explanatory background to guide the interpretation and understand the data. A categorization matrix based on the Fundamentals of Care framework was constructed, and each transcript was read and re-read to become familiar with the dataset. The transcripts were examined for content, and meaning units belonging to the three dimensions (relationship, integration of care, and context of care) of the Fundamentals of Care framework (Feo et al., 2018) were extracted and coded under the corresponding dimensions. Derived from the deductive analysis, the findings were then organized into subcategories considering the research objectives. During the analysis there was a constant moving back and forth within the dataset.

Study III analysis

In Study III, reflexive thematic analysis according to Braun and Clarke (2020) – used through six phases to identify, analyze, and report patterns within data – was used. In Phase 1 the authors read and re-read the transcripts to familiarize themselves with the dataset. Notes were made and ideas for codes were marked. Phase 2 involved generating initial codes from the data. In Phase 3 initial themes were generated by sorting different codes into potential themes, and a mind map was used to organize them into theme piles. Phase 4 involved developing and reviewing themes. The authors discussed, reviewed, and refined the themes. In Phase 5 the themes and subthemes were refined, defined, and named, and the essence of each theme was identified. In Phase 6 the report was written up. The analysis involved a constant moving back and forth within the entire dataset. All researchers discussed the analysis repeatedly, and disagreements were settled through negotiated consensus. Throughout the research process a reflective attitude was sought (Braun & Clarke, 2020), questioning any preunderstandings. My preunderstanding as an RN with experience working with patients with life-threatening conditions was discussed and reflected on with the other researchers beforehand.

Study IV analysis

In Study IV, in order to follow a validated structure, guidelines were reviewed and described based on the quality categories and items of the AGREE II instrument (AGREE, 2017). As the guidelines varied considerably in performance, the quality categories of the AGREE II instrument were responded to with the alternatives yes/no (whether or not the item was present in the guidelines) instead of the rating scale 1-7.
Data were analyzed through descriptive statistics, using frequency ratings and percentages for nominal-level data (Field, 2018). A thematic synthesis according to Thomas and Harden (2008) – described as an approach to the synthesis of findings of qualitative research – was used to analyze the qualitative data. In the guidelines, the qualitative data consisted of a few words up to a couple of sentences. All guidelines were carefully read and, based on the research questions, text that in some way described the RNs’ work in the emergency room/with alarm patients and/or included a person-centered perspective was marked and extracted. The extracted text was sorted and added to the Excel spreadsheet and was then coded inductively according to its meaning and content. Similarities and differences between the codes were sought in order to start grouping them into themes, and then analytic themes were generated.

The analysis process was thoroughly discussed among the participating researchers until consensus was reached.

Ethical considerations

The project was carried out in accordance with the ethical principles of the Declaration of Helsinki (World Medical Association, 2013), and was approved by the Swedish Ethical Review Authority (Dnr 2019-00506). The ethical principles guiding the project are the three principles of beneficence, respect for human dignity, and justice (Polit & Beck, 2021).

When conducting research, the principle of beneficence (Polit & Beck, 2021) states that researchers have a responsibility to minimize harm and maximize benefit. Before the data collection began, permission was obtained from the hospital department manager. Information about participants, written consent, and observation protocols was stored separately in a locked safe at Mälardalen University. As being observed while caring for patients suffering from life-threatening illness or injury in the emergency room might be perceived as stressful and/or intrusive, the RNs were given time to consider their participation (I). Even though some time had passed since the patients’ episode in the emergency room (II), they were considered vulnerable. Special consideration was given regarding patients narrating about possibly traumatic experiences of being treated and cared for in an emergency room, as being interviewed might cause memories to emerge that are difficult to process. There was a possibility to guide to professional support if emotional distress or other consequences arose during the telephone interview. The person being interviewed was given time to recover if emotions arose. All participants were informed of my profession.

The principle of respect for human dignity (Polit & Beck, 2021) was upheld by providing participants with both verbal and written information describing the studies’ aims and contexts. They were informed that their participation was voluntary and that they could leave the study at any time without
providing a reason and without consequences. Informed consent was obtained from those who participated in the studies.

The principle of justice refers to participants’ right to fair treatment and privacy (Polit & Beck, 2021). In Study I, it was the RNs and their work that were observed based on a structured protocol. No patient characteristics were collected; the focus was solely on the RNs’ daily work. The Swedish Ethical Review Authority approved this procedure. Before conducting the observations, there were numerous discussions among the research team regarding ethics and how to act in the case of an extremely acute situation. Being a non-participant observer, it was determined that I would not interfere in the care unless there was an immediate threat to the patient’s life (e.g., if a cardiac arrest occurred when the observed RN was not bedside).

In Study IV no ethical approval by a committee or governmental authority was sought, as no personal information or sensitive details about human beings were collected. An ethical approach was adopted to ensure that no material was fabricated, falsified, and plagiarized (Polit & Beck, 2021). Information about the study was provided to all ED managers, and their informed consent was obtained.

All collected data have been handled according to the General Data Protection Regulation (GDPR) (European Parliament & The Council of the European Union, 2018), and are stored separately in a locked safe at Mälardalen University. All interview transcripts have been pseudo-anonymized. Personal information, such as informed consent and observation protocols, are stored in a locked safe, and electronic data are stored on a computer with a password. To prevent identification, information about the participants’ identities is stored separately from the audio-recorded data. Results have been presented on group level, meaning that no individual can be linked to any specific information.
Results

Emergency care is characterized by an organization whose foremost goal and resources are focused on lifesaving procedures. The results of this thesis reveal that emergency care, seen from both a patient and an RN perspective, involves more than simply life support measures. Study I explored how person-centered fundamental care was provided by RNs in the emergency room. Study II focused on patients who had been life-threateningly ill and treated at emergency rooms, and their experiences of how their fundamental care needs had been met. Study III explored the RNs’ work approach and prerequisites for meeting life-threateningly ill patients’ care needs. Study IV investigated the content of guidelines for RNs’ work in an emergency room/with patients on alarm.

Observations of person-centered fundamental care in the emergency room: Study I

The results from Study I showed that RNs in the emergency room are initially committed and active in both the medical treatment and nursing of patients’ needs, but that this commitment decreases with the length of a patient’s stay in the emergency room. The results were divided into three sections (according to the Fundamentals of Care framework and observational protocol): aspects of relationship, aspects of integration of care, and aspects of context of care.

Aspects of relationship

The study showed that the RN was present with the patient in 82% (n=89) of the events, evidenced by active listening and eye contact. In addition, the RN was bedside at the beginning in 63% (n=61) of the events and communicated with the patient while there. After the initial assessment, there were episodes of the RN not having contact with the patient. In 36% (n=39) of the events the RN involved the patient in the event, and in 39% (n=42) of the events the RN requested the patient’s active participation.

Aspects of integration of care
The RN’s communication with the patient seemed to contribute to meeting physical needs to a greater extent, as the conversation contributed to a nursing history-taking in which the RN asked about the patient’s nutritional habits, toileting, and comfort. The RN asked the patient about pain in 42% (n=45) of the events, the majority being trauma alarm patients. Not all patients who answered yes to the question of whether they were in pain received pain relief. Psychosocial fundamental care needs, such as privacy, were partially protected. For example, the RNs shielded a total of 54% (n=58) of patients from the environment (facing the corridor, using curtains), and 66% (n=71) of the patients were shielded using clothes or blankets.

Aspects of context of care

The environment affected the RN’s ability to meet patients’ fundamental care needs. The RN’s workstation was located behind the patient, and the RN had difficulty communicating with the patient while sitting at the computer. The RNs were often interrupted in their work. In connection with trauma alarms there was a great number of people in the emergency room at the start of the alarm, but after the initial assessment the occupational categories that were not needed for the patient’s further care often left the room.

Patients’ experiences of having their fundamental care needs met in the emergency room: Study II

In Study II, patients described experiences related to three dimensions of the Fundamentals of Care framework – relationship, integration of care, and context of care – as described below. Each dimension included several subcategories.

When one’s life was at stake, a feeling of trust was crucial. Even though assessment and interventions had to be done quickly and systematically, patients expected to be treated kindly and with respect. Healthcare providers who had knowledge about the patient and provided thorough and comprehensive care built trust in the patient. Trust promoted the relationship and generated a sense of security and of “being seen” in a vulnerable situation. One of the functions symbolizing the relationship in the emergency room was that the healthcare providers focused on the patient. Healthcare providers who gave the appearance of focusing on devices rather than the patient created a feeling of not being interesting, taken seriously, or seen as a person. Being referred to by the name of one’s medical condition was perceived as dehumanizing and objectifying. Patients wanted to grasp the entire situation in a holistic manner and not only be medically treated. Experiences of physical, relational, and psychosocial fundamental care needs were vividly described by the patients who had been life-threateningly ill or injured.
The experience of fundamental care needs in the emergency room was associated with a lack of privacy and integrity. Although patients were curtained off, they could hear everything that the healthcare providers and other patients said. Lying there and listening without wanting to hear was uncomfortable, as it felt like eavesdropping and intruding in someone else’s life. Because of the monitoring equipment connected to them patients were placed in a supine position, which dramatically reduced their mobility, field of vision, and comfort. Staring at the ceiling without being able to turn and see the healthcare providers or what was going on in the room was anxiety-provoking and discomforting. The need for information was frequently brought up. Although information was given, there was a need for clear, repeated, personalized information rather than a standard “one-size-fits-all” explanation. Receiving information when one was unreceptive or in a vulnerable position led to increased anxiety and misunderstanding. Not receiving optimal pain relief made the situation seem unbearable and caused the patient to feel powerless:

It was strange, one moment you’re healthy and the next you’re life-threateningly ill with wires and tubes all over your body. And people, they were everywhere, doing different things to different parts of me. I tried to keep up with what was happening but didn't understand much. I would have liked more information about what they were doing and why. I remember being hungry after a couple of hours, but I don't think there was any food. I asked but didn’t get any. Also, I needed to pee, but I was told I wasn’t allowed to go to the toilet and was instead offered a bottle. It didn’t feel possible to lie down and pee (Participant no. 9).

Being a patient in the emergency room environment was characterized by various ambiguities. Due to the environmental challenges of the emergency room, patients were prevented from calling attention to and expressing their needs. After the initial care, or when their condition had improved, patients came to realize that they were no longer the most interesting case and often had to wait to be addressed. During the wait it was unclear to the patient who was responsible for their care, which was perceived as a lack of organization and leadership. Hearing other patients fight for their life and die in the room was traumatic, while at the same time a feeling of gratitude that one’s own circumstances were better was described. Shocking events involving fellow patients made a strong impression; the emergency room, and the situation they were in, evoked existential thoughts.

Prioritizing and meeting life-threateningly ill patients’ fundamental care needs in the emergency room – from an RN’s perspective: Study III

In Study III, the RNs’ descriptions of their work approach and prerequisites for meeting patients’ fundamental care needs emerged as three themes and seven subthemes. The three themes were: *Task-oriented nursing care based*
on structured guidelines and checklists; Fundamental care not being promoted or prioritized in the emergency room; and The organization of and responsibilities for providing person-centered fundamental care are unclear.

Findings showed that, from the RNs’ perspective, they structure their work approach based on prevailing organizational prerequisites as well as personal ones. The RNs described that nursing care in the emergency room was task-oriented and based on structured guidelines and checklists. Saving lives in the emergency room was expected to follow a flow-based structure and to take place within a limited amount of time, as the organization had a focus on patient flows without requirements for meeting fundamental care needs. New patients were admitted to the emergency room regardless of whether the RNs had control over the situation involving the patients who were already there:

I don’t do good nursing care in the emergency room, but I don’t really get the prerequisites to do it either, given the high influx of patients we have and the resources we have for it. At the same time, you get disappointed that we have such a system where we identify a risk with a patient, but then we don’t have the prerequisites to ensure that this doesn’t happen (Participant no. 4).

Meeting patients’ fundamental care needs was described as not always being prioritized; patients’ physical needs were met to a greater extent than their relational and psychosocial needs. It was described that it was easier to address the needs of patients who themselves asked for attention and addressed specific needs, or needs that were addressed in the guidelines or checklists, for example inserting a catheter. There was a lack of routine and structure focused on making the patient feel safe and calm in an alarming situation.

The RNs did not prioritize fundamental care when the organization did not. Not having been introduced to fundamental care when they began working in the emergency room had made it unclear to them whether they were expected to perform this type of care there. The organizational structure did not clearly state that fundamental care should be performed in the emergency room.

Guidelines governing RNs’ work in the emergency room: Study IV

The results from the 190 included guidelines from the 37 participating EDs showed that there was a variation in design and content within and between emergency rooms.

The RN was clearly reported as the target user in 15% (n=29) of the guidelines. In 13% (n=25) of the guidelines, their development groups did not clearly state whether an RN had been involved. None of the guidelines specifically described the population to whom they were meant to apply, but rather referred to the diagnosis/condition the patient was suffering from. A total of 84% of the guidelines were dated (n=160); however, 7% (n=13) had expired.
In 17% (n=32) of the guidelines there was an explicit link between recommendations and supporting evidence. Most guidelines were locally adapted (85%, n=165) and had a focus on processed-focused alarms (53%, n=101). No hospital submitted any national guidelines separately, but some were included in a compendium or a manual. A vast number of the guidelines consisted of bulleted lists, which made them easy to read; however, the guidelines did not follow a uniform structure, even within the same emergency room. The included guidelines ranged from a one-sided sheet, describing who should stand where in relation to the patient in the event of an alarm, to a 107-page document containing the entire trauma procedure for all categories of healthcare professions. Several of the guidelines were of poor quality according to the quality categories and items of the AGREE II instrument.

The thematic synthesis resulted in three themes: *Instrumental work*, *Organizational work*, and *Work without the patient’s perspective*. The content of guidelines directing RNs’ work in the emergency room had an instrumental, task-oriented perspective with a focus on the initial assessment, without further guidance in how the RN should care for the patient initially, during, and after the ABCDE medical assessment. Nursing performance in the guidelines was commonly addressed in a bulleted list of tasks to be checked/ticked off. The bulleted lists contained a wide range of points, often related to specific interventions to be done (e.g., insert peripheral catheter, assist the physician) rather than an assessment of the patient. It was clearly stated what the RN was supposed to do, but not how tasks should be done in the assessment and treatment of the patient.

A number of guidelines regarding nursing performance had an organizational perspective. These were on an overall level and were not specifically aimed at direct assessment and care for the patient. Guidelines stated that the RN should assess and handle life-threateningly ill patients in need of immediate care by having a coordinating role. None of the guidelines defined nursing care.

Furthermore, there was a lack of patient perspective: The patient was commonly presented in the form of the word “patient” but was not personalized. Patients’ physical needs were more commonly addressed compared to relational and psychosocial needs, which were missing.

A summary and elaboration on person-centered fundamental care in emergency rooms

The overall aim of this thesis was to explore how person-centered fundamental care for life-threateningly ill patients in emergency rooms was met, from both patient and RN perspectives. Nursing care in the emergency room appeared to be heavily influenced by organizational structures and priorities,
overshadowing the importance of person-centered fundamental care. The organizational structure in the emergency room did not emphasize fundamental care, resulting in a gap in meeting patients’ fundamental care needs. The findings in Study IV can be seen as explanatory regarding those in Studies I–III. When the organization and its leadership are the ones who set the agenda for what is to be considered care, the organization has already left its mark on the care, the values, and the leadership: It seems like the RN is not given the right conditions to provide patients with fundamental care that is person-centered – despite the fact that it should be the patient’s agenda that shapes the care. The knowledge from the included studies provides an indication of what aspects are missing in the guidelines in order for them to be adapted to provide fundamental care that is person-centered. The Fundamentals of Care framework can therefore be seen, used, and understood as a guide to provide fundamental care that is person-centered.

Study I–IV creates a whole within person-centered fundamental care in emergency rooms. The main findings from each study, in relation to the dimensions of the Fundamentals of Care framework, together with conclusions and elaboration, are presented in Table II.

Table II. Summarizing explanation and elaboration on person-centered fundamental care in emergency rooms.

<table>
<thead>
<tr>
<th>Observation Study I</th>
<th>Aspects of Relationship</th>
<th>Aspects of Integration of Care</th>
<th>Aspects of Context of Care</th>
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<tr>
<td>In 82% of the events (n=89) the RN was present with the patient, demonstrating active listening and maintaining eye contact. Following the initial assessment, instances occurred in which the RN did not have contact with the patient.</td>
<td>Communication primarily contributed to addressing physical needs, with conversations aiding in nursing history-taking. The RN asked the patient about pain in 42% (n=45) of the events, predominantly focusing on trauma alarm patients. Psychosocial fundamental care needs, such as privacy, were partially protected.</td>
<td>Communication challenges arose as the RN’s workstation was positioned behind the patient, hindering effective communication while using the computer. At the outset of the alarm, there was a significant influx of persons in the emergency room. After the initial assessment the occupational categories that were not needed for the patient’s ongoing care left the room. RNs were often interrupted in their work.</td>
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| Patient perspectives Study II | Establishing trust was paramount for patients, fostering a sense of security and validation during vulnerability. Patients found being referred to by their medical condition dehumanizing and objectifying; they sought a comprehensive understanding of their situation, beyond mere medical treatment. | Fundamental care needs were compromised due to a lack of privacy and integrity. Patients, constrained by monitoring equipment and a supine position, experienced restricted mobility, limited field of vision, and discomfort, causing anxiety. The need for personalized information and communication was frequently brought up, reflecting a significant patient need. Pain and pain relief needs were often unmet. | Challenges within the emergency room environment hindered patients from calling attention to and expressing their needs. After the initial care, or upon condition improvement, patients realized a shift in attention, feeling less prioritized and sometimes neglected, leading to uncertainty regarding who had control over their care. While waiting, patients struggled to discern their responsible caregiver, perceiving a lack of leadership and organizational structure. |

<p>| Registered nurses’ | While the RNs recognized the necessity of establishing a relationship, the occupational categories that were not needed for the patient’s ongoing care left the room. RNs were often interrupted in their work. | Patients’ fundamental care needs were not consistently prioritized. | The organization primarily focused on medical conditions, leading to a fragmented understanding of the patient’s situation. |</p>
<table>
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<tr>
<th>Perspectives Study III</th>
<th>Study IV</th>
<th>Conclusion Studies I-IV</th>
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<td>relationship, the work process did not facilitate this effectively. Creating a relationship was notably absent during alarming situations. There was a lack of routine and structure focused on making the patient feel safe and calm, indicating a gap in the emergency room procedure.</td>
<td>There was a stronger emphasis on addressing physical needs rather than relational and psychosocial ones. Addressing the needs of patients who actively sought attention or those outlined in guidelines was more manageable, reflecting a task-oriented approach rather than personalized assessment and treatment.</td>
<td>task-oriented approach and a preference for medical tasks and interventions as more rewarding. The organization and leadership within the emergency room lacked a focus on fundamental care, and there was a lack of clarity regarding expectations on the RNs in relation to performing fundamental care.</td>
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<tr>
<td>Place the patient in front of the RN’s workstation.</td>
<td>The focus in guidelines was primarily on medical care, with limited guidance regarding RNs’ responsibilities for patient care during and after the initial assessment. The guidelines did not effectively support the RNs in making comprehensive patient assessments, revealing a lack of guidance throughout the care process.</td>
<td>None of the guidelines offered a clear definition of nursing care, underscoring an organizational perspective. Guidelines regarding RNs’ work were not always authored by RNs. The guidelines were perceived to have low quality, further highlighting the need for improved guidance and clarity.</td>
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<th>Guidelines</th>
<th>Conclusion Studies I-IV</th>
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<tr>
<td>Patients were often addressed using generic terms rather than personalizing the care. However, guidelines related to caring for relatives during traumatic events or unexpected death primarily emphasized relational and psychosocial aspects.</td>
<td>The importance of trust, focus, and holistic approaches was highlighted. However, patients were commonly referred to using generic terms instead of providing personalized care, suggesting a potential need for more personalized communication. Establishing meaningful relationships in short encounters and high-stress situations remains a challenge that warrants attention and improvements to emergency room practices.</td>
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<td>Nursing care in the emergency room is task-oriented, following a flow-based structure, potentially lacking personalized assessment and treatment. The care is based on the initial medical care and physical needs without further guidance in how the RN should care for the patient during and after the initial assessment. There is a need for more comprehensive pain management, enhanced attention to psychosocial needs, improved communication, and the development of clear guidelines defining nursing care in this context. In order to do this, there is a need for RNs to work bedside but also to be given the prerequisites to play an active role in the development of the guidelines governing their work.</td>
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<td>Nursing care in the emergency room appeared to be heavily influenced by organizational structures and priorities, potentially overshadowing the importance of person-centered fundamental care. The organization and leadership in the emergency room did not seem to emphasize fundamental care, potentially resulting in a gap in meeting patients’ fundamental care needs. There are challenges in the context of care within the emergency room, including organizational priorities, unclear role expectations, and the quality of guidelines – addressing these issues may improve the overall quality of care and patient experiences in the emergency room.</td>
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<tr>
<th>What could be included in order to improve guidelines?</th>
<th>Aspects of Relationship</th>
<th>Aspects of Integration of Care</th>
<th>Aspects of Context of Care</th>
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<tr>
<td>Introduce yourself to the patient. Focus on the patient – make eye contact, make the patient feel seen and not like an object by referring to them rather than their condition. If/when the patient’s condition allows – ask the patient</td>
<td>Make a comprehensive assessment – take your starting point from the patient, integrating their physical, psychosocial, and relational needs. Communicate and inform in a personalized way.</td>
<td>Define nursing care and the RN’s role in the emergency room. Prioritize, value, and make fundamental care visible in guidelines. Place the patient in front of the RN’s workstation.</td>
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<td>“What is important to you right now?” and evaluate along with the patient, based on their condition, e.g., “Are you still in pain?”, “Do you feel like information is lacking?”</td>
<td>For patients who are restrained on a trauma transfer, as far as possible, set aside a person who the patient can see. Ensure patient integrity and dignity, shield the patient, if possible lower your voice when talking about sensitive information. Evaluate interventions.</td>
<td>If/when waiting occurs – ensure that the patient knows who is responsible for them.</td>
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Discussion

This thesis aimed to explore how person-centered fundamental care needs are met for life-threateningly ill patients in emergency rooms, from both patient and RN perspectives. The results reveal that person-centered fundamental care in the emergency room is complex and multifaceted. Lifesaving is the priority, but needs to be integrated with meeting fundamental care needs. Not all patients had their fundamental care needs met in the emergency room, and RNs expressed values and attitudes involving notions that nursing care and meeting a patient’s fundamental care needs depend on personal and organizational prerequisites. Furthermore, the results showed complexities for RNs delivering person-centered fundamental care in the emergency room environment based on prevailing organizational conditions and a lack of clear, evidence-based, comprehensive guidelines. The results are discussed in relation to theories and previous research under the headings Building a trustful patient-provider relationship; Providing patients who are life-threateningly ill with task-oriented nursing care; Organizational prerequisites and barriers; and What happens when fundamental care is omitted in the emergency room.

Building a trustful patient-provider relationship

In Studies I, II, and III the importance of a trusting relationship between RN and patient was highlighted. However, even though the establishment of a relationship was considered important, it was often overlooked due to medical-technical tasks and lifesaving procedures (II, III, IV). This happened despite the fact that it could be achieved through means as simple as introducing oneself to the patient, not talking over the patient’s head, and having a focus on the patient. When RNs adopted a task-oriented approach the patient felt objectified, seeing their personal needs left unmet. This is also seen in trauma care, with patients reporting that interactions with healthcare personnel were a key factor influencing their feeling of safety in a frightening situation, in which feelings of being abandoned arose when personal contact was lacking (Granstrom et al., 2019). It has been confirmed that a trusting relationship is essential to care outcomes (Feo et al., 2016; Jangland et al., 2016). The Fundamentals of Care framework cites the establishment of a relationship as a core component of successful fundamental care (Feo et al., 2018), and from a person-centered care perspective, partnership is fundamental (Ekman et al.,
The lack of a caring relationship can cause suffering, and how patients experience the caring relationship may be affected by the prevailing care culture (Kasén, 2002). RNs who are communicative, knowledgeable, and supportive contribute to patients’ perceptions of high-quality nursing care (Edvardsson et al., 2017; Wiechula et al., 2016), which is confirmed in the relational dimension and elements of the Fundamentals of Care framework (Feo et al., 2018; Feo et al., 2016).

The studies (I, II, III) revealed that a relationship was established but was difficult to maintain. As the establishment of a relationship was not improved even when patients spent hours in the emergency room (I, III), a task-oriented approach may degrade care. Difficulties in establishing or prioritizing a relationship have also been shown in ambulance care, in which RNs did not consider a relationship to be prioritized in the acute phase (Svensson et al., 2019). Yet, the establishment of a relationship contributed to a feeling of safety as well as of being valued and cared for in a vulnerable situation (Bull et al., 2022; Milton, Åberg, et al., 2023), which is in line with a caring encounter (Halldórssdóttir, 1996). Nevertheless, there seem to be some elements of uncaring behaviors that influence the encounter, especially after the patient’s physical condition has been assessed (II). It has been argued that it is challenging to establish a relationship based on trust in time-limited encounters (Bundgaard et al., 2019) such as in the emergency room, where the RN has a limited time to discern a patient’s expectations and needs. Establishing a relationship with the patient is not necessarily a matter of time, however; a relationship can be established immediately at the first meeting (Kitson et al., 2013), even without verbal communication (Svensson et al., 2019). Yet, extra attention might have to be placed on non-verbal ways of communicating in these time-limited encounters, in which the time for verbal communication is compressed (Bundgaard et al., 2019). For care to be person-centered within the emergency room context, the healthcare providers have a responsibility to treat patients as persons, and meet their needs in a holistic manner; that is, not focus only on medical aspects. Therefore, there is a need for extra focus on how fundamental care can be promoted in a person-centered way during and after the initial assessment in the emergency room. Lifesaving interventions must be prioritized in patients with life-threatening illness or injury; however, the relationship should be integrated – not seen as two separate responsibilities but as needs to be met in parallel.

Providing patients who are life-threateningly ill or injured with task-oriented nursing care

Apparent in all four studies (I-IV) was the focus on tasks – e.g., inserting a peripheral venous catheter, blood sampling, documentation, medication
administration – and most often on medical-technical tasks and within the initial care for the patient. The RN’s own values, attitudes, and approach involving fundamental care, along with organizational prerequisites (III), influenced whether or not nursing care was provided. A task-oriented way of working may be considered effective in the short term (Forsberg et al., 2015). However, such an approach is known to increase the risk of fundamental care being neglected in acute care (van Belle et al., 2020) and to challenge the person-centered approach (McCormack & McCance, 2017), and may threaten patients’ health and well-being from both a short- and long-term perspective.

In Studies I, II, and III it was evident that in several aspects the care took place on the healthcare professionals’ terms. This is troublesome, as patients in a life-threatening situation may lose control over their own situation and become totally dependent on the healthcare professionals, whereupon the RN plays a decisive role in identifying the patients’ needs and making a plan for their care by getting to know who the person is and what they need or might need. Adapting to the patient role in the emergency room affected the patients’ ability to express fundamental care needs (II). As stated before, within the person-centered care approach, a power balance between patient and healthcare professional is sought (McCormack & McCance, 2017); however, the RN has a certain amount of power over the patient and how this power is used affects the care for the patient; this is confirmed by the “threefold disadvantage” described by Kristensson Ugglia (2020). It is quite alarming that even when there were both time and resources in the emergency room, nursing care was not always provided (III). This is in line with a review by Duhalde et al. (2023), which revealed that fundamental care was not provided at EDs due to RNs waiting for potential incoming patients with acute care needs. This approach to care might contribute to the patient’s feeling of not being taken seriously and the threefold disadvantage. By only making the role of patient (instead of person) visible, we have immediately made a difference between “us and them” and established a perspective of power by referring to the patient as sick, without discussing this with the patient.

The differences in the RNs’ experiences (III), along with the results from observations (I) and guidelines (IV), indicate that the RN’s role in the emergency room is not clear. As patients in the emergency room are in a vulnerable situation, nursing care should be better clarified and receive more emphasis. Notably, the initial care for patients in the emergency room with life-threatening conditions is structured and systematic through the ABCDE concept and ATLS (American College of Surgeons, 2018), but the results from this thesis reveal a lack of structure and clarity regarding fundamental care. There is no consensus on how (or even whether) patients’ fundamental care needs should be met, or what RNs’ roles and responsibilities in the emergency room are. Within the context of emergency care and ambulance care, RNs tend to regard their professional role as vague, and being medically competent seems to count as professionalism (Furaker, 2008; Svensson et al., 2019). More clearly
describing the competence and knowledge of RNs in the emergency room may help in making their role clearer; this needs to be an organizational commitment, as well as a task for each individual RN. If the nursing profession stood up more for the profession and its competencies, this could affect the organization. However, without the necessary prerequisites for meeting fundamental care needs in a person-centered way, RNs are at risk of simply following routines, leading to patients not receiving the personalized care they need. Therefore, there is a need for extra focus on how fundamental care can be promoted in a person-centered way in the emergency room, so that the care does not become a matter of simply checking off tasks.

Guidelines are important in the emergency room, as they should offer support to the RN in making decisions in patient care and serve as recommendations aimed at promoting quality and reducing practice variability (Institute of Medicine, 2011). Guidelines should also provide equal chances for the best care. However, it is evident in Study IV that there is a lack of evidence-based guidelines in Swedish emergency rooms, and also that guidelines do not support the RN in making comprehensive patient assessments, as they do not include the psychosocial, relational, or existential aspects of patient care. This is in line with Falchenberg et al. (2021), who show that aspects of patients’ well-being are not regarded as equally important in guidelines, as the focus within emergency care is on medical needs. As shown in Study III, RNs structure their work based on guidelines (among other things). Study IV revealed that guidelines are of low quality according to the AGREE (2017) II instrument, one example of which is that several of the guidelines had expired. Organizing work based on outdated guidelines could have consequences for patient safety in the form of the patient not receiving correct, safe care based on the latest evidence. Also, when guidelines do not address nursing care it might be unclear to RNs whether they are expected to perform this type of care. Basing assessments on experience and common sense instead of evidence-based knowledge and the latest research and theoretical models entails risks to quality and safety (Schwarz et al., 2021). There is also a risk that the care will not be provided on equal terms and not be person-centered (McCormack & McCance, 2017; SFS, 2017:30). How the patient, and health, are viewed in the care matters: Objectifying the patient and seeing health as merely avoiding death and eliminating illness, rather than something more (Eriksson, 2018), runs the risk that the care provided to the patient will not be person-centered or lead to a meaningful life. Developing guidelines for making a comprehensive assessment might reduce risks and increase patient safety (Ricciardi & Cascini, 2021). Therefore, applying the Fundamentals of Care framework (Feo et al., 2018; Kitson et al., 2013) in guidelines might contribute to reinforcing comprehensive assessment as it considers the patients’ needs, the RN’s actions, and the context in which the care is provided. None of these perspectives can be excluded when the goal is to achieve person-centered, high-quality care.
Patients highlighted the importance of paying attention to patients’ existential needs, as the emergency room evoked such thoughts. Hearing or witnessing traumatic events in the emergency room needs to be addressed with adequate emotional support (II). A lack of emotional support could cause extra suffering and loneliness in already stressed patients. Care suffering can refer to different dimensions of human life (Eriksson, 2015), and a lack of care is a common form of care suffering. The results in this thesis show that within the context of the emergency room, it seems that patients’ physical suffering is taken care of to a greater extent while their existential suffering is commonly ignored. As stated before, even though RNs in the emergency room are naturally focused on saving lives, care in the emergency room needs to go beyond lifesaving procedures and the RN plays a decisive role in identifying patients’ needs and planning their care; even those who are truly life-threateningly ill or injured have more than simply physical needs – precisely because life-threatening circumstances are also a source of existential trauma. Patients did not seem to focus on physical care needs, but rather on psychosocial and relational ones (II). Perhaps because the former type of care is seen as more obvious, patients take it for granted that they will receive the highest level of medical care. Thus, having one’s medical needs met could be described as being necessary but not sufficient. In addition, as Study II revealed that persons who have been life-threateningly ill or injured and treated in an emergency room experienced and talked about existential needs, which is not a dimension or element of the Fundamentals of Care framework (Feo et al., 2018), a contribution to theory development might entail how this can be incorporated into the framework.

Organizational prerequisites and barriers

Fundamental care not being provided was explained by organizational conditions; the organizational structure in the emergency room did not facilitate either RNs’ work approach in meeting patients’ fundamental care needs or patients’ experience of care (I-IV). The physical environment of the emergency room limited patients’ ability to have their fundamental care needs met; proximity to strangers and the RN’s apparent work stress made the patient adopt a patient role (II). When care-contextual factors fail in an organization this can be conveyed to the patient, who risks suffering consequences in the form of insufficient or omitted nursing care (Avallin et al., 2018; Jangland et al., 2018). It has been noted in previous studies that patients adopt a patient role despite experiencing inadequate care (Jangland et al., 2016). Their suffering can then increase, when the environment does not allow them to share or express their suffering, causing a type of double suffering (Arman, 2022). As the emergency room space is designed for efficiency and patient flow rather than communication, it can be challenging to provide person-centered care in
this context (Walsh et al., 2022). It is the rules of the emergency room that control the situation, and the patient is subordinated to the system (Elmqvist & Frank, 2015). The physical environment needs to be designed so that there are adequate areas for the healthcare professionals to work together in teams, as face-to-face meetings are essential for good teamwork (Gharaveis et al., 2018). The physical as well as psychological environment is connected to both the patient’s and the healthcare professional’s well-being (Eijkelenboom & Bluyssen, 2022). The healthcare professional’s work environment, health, and commitment are important for providing the best possible conditions for promoting patients’ health (Strömgren et al., 2016). However, RNs working on the frontline, with life-threateningly ill or injured patients, are exposed to both primary and secondary trauma with attendant sequelae in both their work and personal spheres, and report a high level of secondary traumatic stress (Wolf et al., 2020). Additional factors might be the ongoing high nursing turnover and RNs leaving the profession, which might lead to burnout, compassion fatigue, and PTSD (McDermid et al., 2020). Chronic, cumulative trauma has been described as affecting relational nursing care and social connections (Wolf et al., 2020). It seems as if in today’s healthcare, care is produced based on the organization’s conditions rather than the patient’s needs. As the relationship between the care and the environment affects patients’ well-being and health, it is time to focus on meeting the needs of the patients within the organization instead of the needs of the organization itself. The patient’s needs should guide the care, and the organization must acquire the conditions to be able to deliver it. Omitting fundamental care has consequences for the organization, as patients’ unmet fundamental needs may risk contributing to overcrowding in the emergency room, which in turn leads to reduced patient safety and poorer patient satisfaction (King et al., 2021). The lack of organizational support and evidence-based guidelines to support RNs in making comprehensive assessments of the needs of patients suffering from life-threatening illness or injury (III, IV) confirms the importance of the contextual dimension of the Fundamentals of Care framework (Feo et al., 2018).

Culture, more than professional responsibility or competence, guided the RNs in managing fundamental care; the findings here contribute to showing how this is expressed by RNs in the emergency room (I, III), and clearly show how difficult it is to deliver fundamental care in a person-centered way when the cultural focus is on something else. Seeing a person in need of holistic care versus seeing the patient as a name or condition to be removed from a list as quickly as possible are quite different approaches to nursing care. When it is necessary to prioritize, there is a risk that the RN’s own perception of what is important will control which care is not prioritized (III). In the long run, the RN’s own perception can be incorporated into norms and habits, which might result in a suboptimal culture and work environment. Care culture is a contextual factor that affects care practice, and can be seen in a context where people exchange patterns, beliefs, and prejudices (Rytterström, Arman, et al., 2013;
Rytterström, Unosson, et al., 2013). Recent research indicates that an important prerequisite is the culture within the unit; that is, the values that prevail in the organization (Francis, 2013). The principal factor in improving fundamental care in the emergency room is a deliberate change in the culture that guides practice. Kitson (2018) states that the organizational structure plays a crucial part in helping or hindering the delivery of person-centered fundamental care, and that the direct decisive factor is that there is an organization that prioritizes and creates the conditions. Within the Fundamentals of Care framework, the context of care should be seen in terms of the prerequisites and resources needed to ensure safe and high-quality fundamental care (Feo et al., 2018). The theoretical perspective of person-centered care describes the importance of the whole healthcare organization striving for person-centered care (McCormack & McCance, 2017). When the organization does not prioritize nursing care and the RNs themselves express that they work in the emergency room to avoid nursing (III), it shows the impact of culture. It seems that changes are required in nursing culture in the emergency room, as is an increased emphasis on the importance of person-centered fundamental care. Thus, the RN alone cannot change the culture and routines in the emergency room; this needs to be done in collaboration – care-contextual conditions are considered a key factor, and a direct decisive factor is the organization prioritizing and creating these conditions. RNs, patients, relatives, and nursing leaders agree that nursing care is important, and identify similar factors that need to be addressed (Conroy, 2018). However, other research indicates that leaders and managers fail to address and remedy these problems (Mudd et al., 2022; Richards & Borglin, 2019). McCormack (2016) states that one of the contextual challenges involved in developing person-centeredness in emergency care settings is the environment itself. Therefore, person-centered fundamental care must be prioritized not only by RNs but also by management and leaders.

The key to the effective provision of fundamental care is the relational leadership, and leaders face challenges in reconciling organizational, patient and nursing requirements (Pattison & Corser, 2022). If the system does not facilitate the RN in what should be done, and thus also not in what is expected to be done, it is not even certain that the RN understands that they are omitting doing certain things. If different outcomes and improvements in the emergency care context are desired, we may have to rethink and redirect our processes – as noted by Berwick (1996): “every system is perfectly designed to achieve the results it achieves” (p. 619).
What happens when fundamental care is omitted in the emergency room

Nursing care in the emergency room appeared to be heavily influenced by organizational structures and priorities, potentially overshadowing the importance of person-centered fundamental care (I-IV).

Caring for patients in the emergency room who are life-threateningly ill or injured is advanced and requires medical, technical, and nursing knowledge, areas of knowledge that should not be seen as separate from each other but rather as integrated and going hand in hand. The RN needs solid theoretical knowledge in anatomy, physiology, microbiology, and pharmacology (Sweet & Foley, 2020) to be able to anticipate the patient’s needs and what consequences omitted fundamental care might have. In addition, it is necessary to learn how to optimally manage medical-technical equipment. If the RN does not have knowledge of how the patient reacts physiologically to, e.g., a bolus dose of potent pharmaceuticals via the medical-technical equipment and what the patient needs to be informed about in connection with the pharmaceuticals they are given, there may be consequences. However, adopting a task-oriented way of working in which the focus is only on checking off tasks might lead to the RN focusing on the routines of the medical care and forgetting the individual person in the encounter (van Belle et al., 2020). A patient who arrives at the emergency room, life-threateningly ill or injured, is most likely in need of rapid, structured assessment and treatment. But what happens to this patient – strapped to a trauma transfer, with the ability only to look straight up at the ceiling and met by a team of 15 healthcare professionals – if fundamental care is omitted? If no one also introduces themselves to and communicates with the patient but instead performs assessments and interventions simultaneously on various parts of their body? What are the consequences for the patient when their clothes are cut off and their sphincter tone is checked without anyone informing them before this is done? What are the consequences for the patient if no one creates trust, focuses, anticipates, has knowledge of, and evaluates their care? Among those who experience a highly severe, life-threatening, and traumatic event, about one in four are diagnosed with PTSD afterwards (SBU, 2022). From a societal and welfare perspective, PTSD has resulted in large costs for healthcare and increased care needs (von der Warth et al., 2020). When a person with PTSD goes untreated, the risk is greater for co-morbidity with both psychiatric and somatic diseases such as depression, anxiety, exhaustion, alcohol abuse, cardiovascular disease, stroke, diabetes, and gastrointestinal diseases, which not only cost money and resources but also create suffering for the individual person (Davis et al., 2022; Sullivan et al., 2017).

Also, in Sweden, care injuries – e.g., failure of vital functions, care-related infections, or pressure injuries – cause extended care times, which resulted in a cost of SEK 7-8 billion in 2019 (SKR, 2020). In addition, the current high nursing turnover is an ongoing problem. High nursing vacancy rates have many potential detrimental effects, including overcrowding, longer waiting
times, an increase in ambulance diversions, lower patient satisfaction, and an inability to implement evidence-based patient care (Burke et al., 2022; McDermid et al., 2020; Winters, 2016). This ultimately has a negative impact on the quality of patient safety. Improving patient safety thus has strong financial incentives, as well as those involving reduced suffering for affected patients. Therefore, by prioritizing fundamental care within the emergency care organization and giving RNs the right prerequisites in the form of resources, leadership, culture, and knowledge to meet patients’ fundamental care needs this may be able to be prevented, instead of having to be remedied when it has already occurred. In the end, one can wonder what omitted fundamental care costs when it comes to the patient’s trust?

In summary, integrating fundamental care in the emergency room is important, both for the individual patient but also for the organization and society. Therefore, the Fundamentals of Care framework (Feo et al., 2018) can be seen and used as a guide to provide fundamental care that is person-centered, avoiding the omission of fundamental care.

Methodological considerations

Different methodologies were used to respond to the various aims in the thesis and contribute to more comprehensive knowledge regarding the phenomenon (Polit & Beck, 2021). In determining an appropriate methodological design, the aims as well as the theoretical underpinnings guided the choice of methods (Streubert & Carpenter, 2010). Methodological considerations address the overall design and methodology of the project, and a variety of quality criteria are used when discussing methodological considerations. Considerations regarding ethics are addressed in the following.

Observations

In Study I and prior to entering the field, I had to decide whether I would conduct the observations as a participant or non-participant. In Study I, I observed the nursing activities as an insider – someone who shared the characteristics and experiences of those being observed (Creswell & Creswell, 2018) but had no familiarity with the hospital or the ED, and no relationship with the healthcare professionals working in the emergency room. Non-participant observation for collecting data is described in various ways. According to my reading of Spradley (1980), non-participant observation involves not participating in the care. However, being an insider meant that I had a professional and moral duty to intervene. If this had happened, my observer role would have changed from non-participant to passive observer, according to the scale of participation types in Spradley (1980). No such events arose.
The presence of an observer might have affected the RNs in Study I. Observations can introduce bias (e.g., reactivity) (Polit & Beck, 2021). The RNs I observed knew my professional identity – which, along with knowing they were being observed, might have affected their behavior. Observed participants changing their behavior to what they believe is desirable is referred to as the Hawthorne effect (Rezk et al., 2021). However, my perception is that the participants in Study I did not seem bothered by my presence; nor did they look at me while caring for the patient. Thus, one can argue that they did not change their behavior due to my presence.

Observation bias also has to be considered when conducting observations (Polit & Beck, 2021). The observation protocol was developed for Study I and was used for data collection for the first time there; however, it was based on the Fundamentals of Care framework (Feo et al., 2018). It was simple to use, with tick-boxes for the fundamental care observed, and pre-observations were conducted. Nevertheless, it cannot be ruled out that errors may have been made at some point. In Study I, fieldnotes were used to allow a greater understanding of the studied context and phenomenon and to understand the sequence of events in the observations. The fieldnotes offered inspiration and contributed knowledge for forming follow-up questions for Studies II and III, which deepened the conversation with participants in these studies. Furthermore, the fieldnotes provided valuable knowledge regarding consistency between what actually happened in the emergency room during an event (I) and what was then said by participants in the interviews (II, III).

Study I was referred to as having an ethnographic approach. However, in retrospect it might have been more appropriate to think of it as observational research as the observations were conducted for a brief period, in contrast to ethnography, which can require living with research participants for years.

Trustworthiness in qualitative research

In qualitative research, trustworthiness is a quality criterion, assessed through confirmability, dependability, credibility, and transferability (Lincoln & Guba, 1985; Polit & Beck, 2021). To strengthen trustworthiness, a series of strategies were used. Studying person-centered fundamental care from different perspectives and situations provided a deeper understanding of the phenomenon in question, which can strengthen the trustworthiness.

In Studies II and III the consolidated criteria for reporting qualitative research (COREQ) checklist were used to ensure adequate trustworthiness and transparency (Tong et al., 2007). Participants in both Studies II and III were aware that the interviewer (me) was an RN, who however did not work at the hospital in question. For patients (II), the knowledge that one is being interviewed by a healthcare professional can be seen as involving a power imbalance, and may contribute to a reluctance to share one’s experiences (Polit & Beck, 2021). Participants were given information about voluntary
participation and the possibility to cancel the interview at any time. Nonetheless, they openly shared their experiences, which can be seen as strengthening the material’s trustworthiness (Polit & Beck, 2021).

*Credibility* refers to the results’ truthfulness; i.e., whether the studies are described well in terms of design and analysis with the risk of bias (Polit & Beck, 2021). To reflect the typical population of the emergency room, the project strived to include participants varying in gender, age, ethnicity, diagnosis (in Study II), and work experience in the emergency room (in Study III) (Graneheim et al., 2017). Participants in Study III were persons with prolonged knowledge of the studied phenomenon. Work experience from the current workplace was collected; however, there was no requirement to have worked for a certain amount of time in order to participate in the study. In Study I, the same RN may have been observed several times. However, each event was unique and provided variation, even if the same RN was involved. A total of seven participants from Study I also chose to participate in Study III. Participants in Study II varied in age, gender, and diagnosis, which may have contributed to a richer variation of the studied phenomenon (Graneheim & Lundman, 2004). A potential threat to the credibility is that all interviews in Study II were conducted via telephone, due to the COVID-19 pandemic. Not being able to perform interviews face-to-face excludes non-verbal communication (Novick, 2008). However, there is research that concludes that the results are substantially the same when interviews via telephone or videoconference technologies are used, but that the richness of information is lower (Johnson et al., 2021).

*Dependability* refers to the stability and consistency of data over time and situations (Polit & Beck, 2021). To enhance the dependability of the studies (II, III), participants were interviewed using an interview guide with open-ended questions. Participants in each study were asked the same opening question, and an effort was made to conduct the interviews in a similar way. In the analysis process (II, III), two interviews were coded separately by me and one of my supervisors and were then compared.

*Confirmability* concerns the objectivity of the results (Polit & Beck, 2021). To strengthen confirmability, all researchers from the research group have been involved throughout the analysis process, continuously discussing the process and the emerging categories, subcategories, and themes (II, III). An audit trail was maintained with details of the processes of data collection, analysis, and interpretation. The results are presented using representative quotes (II, III).

All studies (I-IV) have also been critically reviewed at research seminars outside the current research group.

*Transferability* refers to whether the results can be transferred to other groups or contexts. The researcher can offer suggestions for how findings can be transferred, leaving it to the reader to decide (Polit & Beck, 2021). Transferability was enhanced by rich descriptions of findings, along with a thorough
description of context, participants, and analysis processes, which can guide the reader in judging the transferability (Graneheim et al., 2017).

**Reflexivity** Throughout the research process a reflective attitude was strived for, questioning any preunderstandings. As the project progressed, my own knowledge of the phenomenon being studied increased. My preunderstanding as an RN was written down, discussed, and reflected on with my supervisors beforehand, and I collected comprehensive notes in a personal diary. However, having an understanding related to the situations both patients (II) and RNs (III) discussed during the interviews may have caused me to miss information that both the participants and I thought was unimportant to elaborate on. Regarding the sample in Study IV, the preunderstanding my supervisor (ÅM) and I had of the emergency room context may have contributed to my ability to sort through the guidelines when many of them were unclear. Thus, more documents may have been included due to my preunderstanding of the emergency room context. The results in the thesis (I-IV) might have been influenced by the order in which the studies were conducted and the information that was already available when analyzing the data in the next study.

**Ethical discussion**

When involving persons in research, there is always a need for ethical consideration (Polit & Beck, 2021).

Being an RN with many years’ experience caring for patients with life-threatening conditions and conducting non-participant observation, I encountered several ethical challenges, such as observing omitted nursing care without the possibility to intervene. Being an RN comes with a professional ethical responsibility to alleviate patients’ suffering, which highlights the complexity of being both an RN and a researcher in connection with the data collection in the current context. As mentioned earlier, before data collection began in Study I, it was determined that the observer role could be waived in the event of a cardiac arrest, as I had a professional and moral duty to intervene.

Patients with life-threatening illness or injury are considered vulnerable research participants, and therefore require thorough ethical consideration (Polit & Beck, 2021; World Medical Association, 2013). According to Swedish legislation, patients are autonomous and are therefore able to make their own decisions regarding consent to participate in research. During Study I, I was aware of the vulnerability of patients being cared for in the emergency room and the need to protect their rights and dignity (SFS, 2014:821). This fact was problematized in the application form for ethical approval (Dnr 2019-00506). One question that was raised was whether informed consent should be obtained from patients even though they were not study participants. As the focus of the observations was on the RNs working in the emergency room and their activities, no informed consent was required from relatives or patients.
This interpretation may not be in line with other countries’ research ethics regulations, but complied with those governing the setting of the study (I), in this case Sweden. Even so, I needed to take an ethical approach to these persons and thus strove to conduct the research without doing harm (Vetenskapsrådet, 2019). My ethical approach therefore consisted of taking my place in the background and trying to minimize the risk of being exposed to information about the patient. My approach was to preserve the patients’ integrity and dignity despite the fact that they were not the subject of the research. Also, participants in Study I were informed that they could stop me from entering the room, or ask me to leave the room, at any time if needed. This was a way to protect not only the participants but in this case also the patients from harm and discomfort, and to be sensitive to them (Polit & Beck, 2021). No such events arose.

In Study II, persons who had been admitted for intoxication and/or a suicide attempt were excluded, as it is often the case that these persons are unconscious upon arrival at the emergency room. This might have affected the results, as suicide attempts and intoxication are common reasons for seeking care at Swedish EDs/emergency rooms. Persons unable to understand or speak Swedish were also excluded from Study II, as the project could not afford an interpreter. This might have affected the results, as 20% of the population of Sweden was born abroad (Statistics in Sweden, 2022). Recruiting participants for Study II involved some challenges as it turned out that, as some patients had been readmitted to the hospital and some did not recall the actual emergency room period, which excluded them from participation. Furthermore, in Study II there was a period of 14-30 days between hospital discharge and participant recruitment, potentially introducing recall bias (Polit & Beck, 2021). However, this period was necessary because interviewing participants who were still admitted to the hospital would have been impractical and unethical as it might have interrupted their care. This is a way to protect participants from potential risks (Polit & Beck, 2021).
Conclusions

This thesis provides a comprehensive view of how person-centered fundamental care is provided in the emergency room, and what is missing. The present thesis shows that it is challenging for RNs to meet patients’ fundamental care needs in a person-centered way in the emergency room. It is evident that both individual RNs as well as the organization need to strengthen the provision of person-centered fundamental care in emergency rooms. The following conclusions can be drawn based on the results from the studies:

- Nursing care in the emergency room is task-oriented, instrumental, and follows a flow-based structure, lacking personalized assessment and treatment. The care is based on the initial medical care and physical needs without further guidance in how the RN should perform a comprehensive care during and after the initial assessment. Fundamental care is not integrated in the structured assessment of the patient.

- Organizational prerequisites do not emphasize fundamental care, potentially resulting in a gap in meeting patients’ fundamental care needs. The organization of and responsibilities for providing person-centered fundamental care were unclear, unspecified, and lacking in direction for how to be performed – the organization and the culture did not support the RNs’ work and profession. More clearly describing the RNs’ competence, knowledge, and responsibility to uphold high-quality nursing care in the emergency room may make their role clearer.

- RNs structured their work based on personal and organizational prerequisites – but there is a lack of organizational support and evidence-based guidelines to support RNs in making comprehensive assessments of the needs of patients suffering from life-threatening illness or injury.

- For a patient in a vulnerable and exposed situation, relationship, timely and personalized information, and existential needs were identified as essential. The emergency room context evoked existential
thoughts in patients, albeit expressed vaguely. This might challenge RNs’ attentiveness in the provision of emotional support. Existential needs are not an element of the Fundamentals of Care framework, which indicates that the framework needs further development.
Clinical implications

Meeting patients’ fundamental care needs in a person-centered way has proven challenging for RNs in emergency rooms for various reasons. The results of this thesis can contribute to an awakening as to how person-centered fundamental care in the emergency room setting can be facilitated, taking patients’ needs as a point of departure with an ultimate goal of avoiding omitted nursing care. Meeting fundamental care needs in the emergency room is possible and often welcomed by patients, even in cases of short, challenging visits. This thesis is a strong indication of how important nursing care actually is for those for whom the care is intended. It disturbs patients if this piece of the puzzle is missing in the emergency room.

The establishment of a relationship based on trust is crucial. In the emergency room encounter, this can be as simple as introducing oneself to the patient, making eye contact and making them feel seen by referring to them as a person rather than their condition. In order to establish a patient-nurse relationship, the RN should work bedside. Yet, there is a need for improvement in maintaining the relationship during the care period. One thing the organization could contribute in order to create conditions for this is to allow the patient to lie facing the RN rather than away from them. Furthermore, the results contribute to creating an awareness of the importance of also meeting patients’ existential needs in the emergency room. Nursing must be prioritized not only by RNs but also by management and leaders. For the RN to be able to prioritize fundamental care in the emergency room, nursing leaders need to provide organizational support for this, for instance resources and leadership as well as feedback and evaluation, but also a caring culture.

There is a need to improve the guidelines in order to support RNs in assessing, treating, and providing fundamental care for patients with life-threatening illness or injury in an equal, evidence-based, person-centered way. The results of this thesis show what is missing in guidelines, from a national perspective, and can be used in the development process to create guidelines with a uniform structure within the unit where fundamental care is integrated. It is time to prioritize and value fundamental care, and make it visible in guidelines – something that would require neither a particularly great effort nor cost.

The results can also be used to design education and teaching to better meet patients’ needs and for students and the interprofessional team in the emergency room to better understand and value fundamental care within the context. The results should serve as an impetus to put the whole team
(representatives of all professions and managers) on the task of clarifying what the RN’s role should look like in order for the team to succeed in both medical and fundamental care, not just one or the other. More clearly describing the competence, knowledge, and responsibilities of RNs in the emergency room, may make their role clearer; this needs to be an organizational commitment, in collaboration with each individual RN. It should be clear to everyone on the team what the RN’s role is – and is not.

As described by Kitson et al. (2019), it is through coordinated, collaborative effort that real change is achieved. A contribution of this thesis would be if RNs, nursing leaders, and organizations used its results to value, talk, do, own, and research fundamental care, in order to radically transform fundamental care delivery in the emergency room.
Future research

The present results can be used in intervention studies, to help implement person-centered care and provide fundamental care in emergency rooms. For carrying out systematic and structured assessments and measures of the patient’s fundamental care needs, a standardized concept linked to nursing can be developed. Also, interventions can be created to study how person-centered fundamental care affects patient outcome.

The organizational structure has proven essential in supporting RNs in providing person-centered fundamental care. Further research into how leaders value and prioritize person-centered fundamental care within the emergency room context is warranted.

The healthcare environment can promote health and well-being, but can also cause healthcare-related illnesses and problems among patients. Research is needed regarding the environment’s role in the patient’s experience of their care episode in the emergency room.

Which particular fundamental care needs a person perceives to be important might differ between cultures. In Sweden, approximately 20% of the population was born abroad (Statistics in Sweden, 2022). In Study II, persons unable to understand or speak Swedish and those who had been admitted due to a suicide attempt and/or intoxication were excluded. There is a need for research on fundamental care for those who were not heard in this study. This includes persons with different ethnic backgrounds and persons who have attempted suicide.

Patients who had been life-threateningly ill or injured and treated in an emergency room experienced and talked about their existential needs, which is currently not a dimension or an element of the Fundamentals of Care framework. There is a need for further research on how existential needs can be incorporated into the framework.

The presence of a bystander (family/relative) during a life-changing event has been viewed as positive. Within the emergency context there are established concepts for their presence; however, this has not been extensively researched
in this context. Further studies of the significance of relatives’ presence for the patient in the emergency room are needed in order to explore future needs.


I delstudie IV genomfördes en tvärsnittsstudie av innehållet i riktlinjer som vägleder sjuksköterskans arbete på akutrum / med larmpatienter. Sveriges alla dygn- runt öppna akutmottagningar kontaktades och ombads skicka in riktlinjer. Totalt inkom 357 riktlinjer, varav 190 inkluderades i resultatet. Data analyserades med beskrivande statistik och tematisk syntetisering. Resultaten visar att sjuksköterskors arbete på akutrum styrdes av ett instrumentellt och uppgiftsorienterat förhållningssätt till vårdandet. Riktlinjer saknade väg- ledning för att tillgodose patienters grundläggande vårdbehov och stödjer inte sjuksköterskor i att genomföra holistiska, heltäckande patientbedömningar
och interventioner. Riktlinjerna var av bristande kvalitet och saknade patientperspektiv.

Epilogue

And Karl, the person in the car accident from the prologue – a 39-year-old healthy man, husband, and dad, whose biggest fears and main concerns in the emergency room were being stuck to the monitoring equipment, the uncertainty of his injury’s severity, and the feeling of loneliness despite the presence of staff? Well, Karl had surgery that fixed his open tibia fracture. With adequate pain relief for his bruised ribs, he was able to go home to his wife, daughter, and dog after a couple of days in the hospital. And you know what: Karl was actually the one who made me, the intensive care nurse, realize the importance of seeing the person as a whole and not an object, seeing the person behind the patient.

During my time as a PhD student I have continued to work clinically as an RN, a few shifts every month. And as my thesis has grown, I have also continued to develop as an RN. This journey has for sure made me a more competent RN as I have come to realize the importance of person-centered fundamental care.
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References


Braun, V., & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis? Qualitative Research in
Psychology, 18(3), 328-352.
https://doi.org/10.1080/14780887.2020.1769238

https://doi.org/10.1017/S1049023X13000034

https://doi.org/10.1136/emermed-2020-210634


https://doi.org/10.1016/j.auec.2020.07.008

https://doi.org/10.1111/jocn.14183

https://doi.org/10.1016/j.auec.2018.03.001

https://doi.org/10.7861/cimedicine.18-1-88


https://doi.org/10.1016/j.aenj.2017.01.001
https://doi.org/10.1111/j.1365-2834.2008.0872.x
https://doi.org/10.1016/j.nedt.2017.06.002
https://doi.org/10.1016/j.nedt.2003.10.001
https://doi.org/10.1111/j.1471-6712.2007.00568.x
https://doi.org/10.1111/iwj.13266


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


Østervang, Jensen, Coyne, & Dieperink. (2021). What are the needs and preferences of patients and family members discharged from the emergency department within 24 hours? A qualitative study towards a family-centred approach. *BMJ Open*, 11(11). https://doi.org/10.1136/bmjopen-2021-050694
Appendix A, Observationsprotokoll
Att utforska hur fundamental care tillgodoses av sjuksköterskan i det dagliga arbetet

Veckodag, start / sluttid ________________________

Hemgång / tid (tid för beslut?) □ ________ (____)
Till avdelning, operation / tid (tid för beslut?) □ _________(____)
Överflyttas till torget / tid (tid för beslut) _____(____)

Larmorsak
☐ Akutlarm vuxen/barn ☐ Kirurgiskt larm ☐ Rädda-hjärnan larm
☐ Traumalarm vuxen nivå 1 ☐ Traumalarm vuxen nivå 2
☐ Barntraumalarm nivå 1 ☐ Barntraumalarm nivå 2
☐ Sepsisalarm

Hur många personer är närvarande vid larmstart? ____________________

Kommunicerar sjuksköterskan med patienten?
Ofta  Ibland  Aldrig  N/A

Timeline (kryss för antal gånger sjuksköterskan kommunicerar med patienten):
Start---------------------10 min---------------------20 min --------------------30 min -------------------------
40 min--------------------50 min --------------------60 min -----------------------70 min ----------------------

Låter sjuksköterskan patienten ta del av händelseförloppet?
Ja  Ibland  Nej  N/A

Skyler sjuksköterskan patienten med kläder/filt?
Ja  Ibland  Nej

Avskärmning mot omgivning?
Ja  Ibland  Nej

Är takvärmen på?
Ja  Nej

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Frågar sjuksköterskan patienten om smärta?
| Ja | Nej | N/A |

Om ja, får patienten smärtlindring?
| Ja | Nej |

Frågar sjuksköterskan om patienten är törstig?
| Ja | Nej | N/A |

Parenteral vätsketillförsel?
| Ja | Nej | N/A |

Frågar sjuksköterskan om patienten behöver gå på toaletten?
| Ja | Nej | N/A |

Kateter?
| Ja | Nej | N/A |

Hjälper sjuksköterskan patienten med eliminationen på annat sätt (om ej kateter)?
| Ja | Nej | N/A |

Efterfrågar sjuksköterskan patientens medverkan?
| Ja | Nej | N/A |

Är anhöriga med på akutrummet?
| Ja | Nej |

Respekterar sjuksköterskan patientens önskemål?
| Ja | Nej | N/A |

Tillgodoser sjuksköterskan patientens välbefinnande? (tex bra sängposition, lugnande information/kommunikation, hudkontakt)
| Ja | Nej | Delvis | N/A |

Använd fritext för att specificera hur

Är sjuksköterskan närvarande? (tex aktivt lyssnande, ögonkontakt)
| Ja | Nej | Delvis | N/A |

Händelseförlopp:

Observatörens upplevelse av situationen:
Appendix B, Intervjuguide – patienter som vårdats på akutrummet

Fråga åter om deltagande i studien samt informera enligt informations-samtyckeskonfirmerings- och nyttjandekravet. Tacka för att personen ställer upp. Informera om syftet med studien (det övergripande syftet är att undersöka hur grundläggande behov tillgodoses för livshotande sjuka/skadade patienter som vårdas på akutrum).

Om du behöver en paus är det bara du säger till
Har du några frågor inledningsvis?
Informera om att jag sätter på bandspelare och önskar spela in samtycke till att delta i studien.
Samtycker du att delta i studien?
Hur gammal är du?

Inled med stor öppen fråga – om du går tillbaka i tankarna: kan du berätta om situationen som gjorde att du hamnade på akutrummet?
- Berätta mer hur det gick till vid ankomst till akutmottagningen/rummet – vad hände?
- Vad gjordes?

Kan du berätta om din upplevelse av att bli vårdad på akutrummet, av den vården du fick allra först?
- Hur upplevde du mötet/relationen med sjuksköterskan? (eller personalen)
- Om du återigen tänker tillbaka – vilka behov skulle du säga att du hade?
- Hur upplevde du att dina behov tillgodosågs?

Låt patienten prata!
Exempel på frågor utifrån hur personen pratar om sina behov på akutrummet

_Fysiska:_
fick du gå på toaletten? hur kändes det då (om personen inte fick hjälp med toalettsbesök)
fick du något att äta/dropp?
hur var det med smärtlindring?
kunde du vända dig som du ville? fick du hjälp att ligga bekvämt?

_Psykosociala:_
upplevde du att personalen kommunicerade med dig?
upplevde du att du fick information? den information du behövde?
kände du dig delaktig i vården? kan du beskriva på vilket sätt?
hur var det med integriteten? skyldes du med kläder/filtar?

_Relationella behov:_
när du pratade med sjuksköterskan, upplevde du då att hen lyssnade?
när du pratade med sjuksköterskan, upplevde du då att hen var närvarande?
Hade du närstående med dig? Har du någon uppfattning av om de blev stöttade och involverade?

Hur upplevde du miljön på akutrummet (ljud/ljus/hårda britsar osv)?
Var det något du tyckte fungerade bra?
Nu när du kanske fått lite perspektiv på händelsen – ser du något som kan utvecklas?
Vad skulle kunna gjorts annorlunda för dig i den situationen du befann dig i?

Följfrågor:
Hur kändes det att/när…
Vad betyder det/menar du när du säger…?
Kan du förklara/berätta mera?

- Jag har inga fler frågor – har du något mer att fråga eller ta upp innan vi avslutar intervjun?

Tacka för medverkan och stäng av bandspelaren
Appendix C, Intervjuguide – sjuksköterskor som arbetar på akutrummet

Fråga åter om deltagande i studien samt informera enligt informations-samtyckes-konfidentialitets- och nyttjandekravet. Tacka för att personen ställer upp. Informera om syftet med studien ( hur beskriver sjuksköterskor som arbetar på akutrum sitt arbetssätt och förutsättningar för att tillgodose grundläggande (fundamental) omvårdnad för patienter som är livshotande sjuka/skadade och vårdas på akutrum?)

Har du några frågor inledningsvis?
Informera om att jag sätter på bandspelare.
Hur gammal är du?
Hur länge har du arbetat som sjuksköterska på akutmottagningen?
Hur länge har du arbetat på akutrummet?
Har du någon specialistutbildning?
Inled med en öppen fråga – kan du berätta för mig hur ett omhändertagande av patient på akutrummet går till?
  • Är det här du beskriver ett typiskt omhändertagande av patienten/går omhändertagandet av patienten alltid till så här?
Vad gör du som sjuksköterska på akutrummet?
  • Hur ser det ut med omvårdnaden? (om de beskriver ett mer medicinskt omhändertagande)

Kan du tänka på någon patient du vårdade på akutrummet ditt senaste arbetspass:
Kan du beskriva hur du arbetar för att tillgodose patientens grundläggande vårdbehov?
Skiljer det sig mellan olika patienter?
Spelar det någon roll vem man jobbar med?
Vad ser du som fungerar bra i omvårdnaden?
Hur tydligt är det för dig att du förväntas jobba med omvårdnad på akutrummet?
Ser du något som kan utvecklas/förbättras i omvårdnaden?
Berätta om någon gång du kände dig riktigt nöjd med omvårdnaden?
Berätta om någon gång du kände dig riktigt missnöjd med omvårdnaden?

Följdfrågor
Utveckla – förklara mer?
Vad menar du när du säger…
Kan du berätta mer konkret vad du gör?
Vad hände?

Jag har inga fler frågor – har du något mer att fråga eller ta upp innan vi avslutar intervjun?
Tacka för personens medverkan. Stäng av inspelingen