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'No more heroes': The ILC Oxford Statement on fundamental care in times of crises

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Abstract

Aim: To outline the International Learning Collaborative (ILC) Oxford Statement, explicating our commitment to ensuring health and care systems are equipped to meet patients' fundamental care needs during times of unprecedented crisis.

Design/Method: Discussion paper. The content was developed via a co-design process with participants during the ILC's international conference.

Key Arguments: We, the ILC, outline what we do and do not want to see within our health and care systems when faced with the challenges of caring for patients during global pandemics and other crises. Specifically, we want fundamental care delivery to be seen as the minimum standard rather than the exception across our health and care systems. We want nursing leaders to call out and stand up for the importance of building fundamental care into systems, processes and funding priorities. We do not want to see the voices of nursing leaders quashed or minimized in favour of other agendas. In turn, what we want to see is greater recognition of fundamental care work and greater respect for the people who do it. We expect nurses to have a 'seat

at the table' where the key health and care decisions that impact patients and staff are made.

Conclusion: To achieve our goals we must (1) ensure that fundamental care is embedded in all health and care systems, at all levels; (2) build on and strengthen the leadership skills of the nursing workforce by clearly advocating for person-centred fundamental care; (3) co-design systems that care for and support our staff's well-being and which foster collective resilience rather than overly rely on individual resilience; (4) improve the science and methodologies around reporting and measuring fundamental care to show the positive impact of this care delivery and (5) leverage the COVID pandemic crisis as an opportunity for transformational change in fundamental care delivery.

KEYWORDS
carers, nurse roles, art of nursing

1 | BACKGROUND

The world has been in the throes of a pandemic that has challenged normal life across the globe. No institution, system or community has been spared. Our health and care systems and the staff working in them have been profoundly affected. As we begin to move beyond the epicentre of the pandemic and start to return to a new 'normal' post pandemic, we need to take stock and reflect on what we have learned about delivering fundamental care in times of crises. Fundamental care is defined as actions on the part of a nurse that respect and focus on a person's essential needs to ensure their physical and psychosocial well-being. These needs are met by developing a positive and trusting relationship with the person being cared for as well as their family/carers (Feo et al., 2018, p. 2295).

Evidence shows that missed fundamental care (also called basic nursing or essential care), including physical, psychosocial and relational elements, compromises patient safety, care quality and patient experience (Kitson et al., 2019; Richards et al., 2018) and this has been amplified during the COVID-19 pandemic (Sugg et al., 2021, 2022). There are multiple reasons for missed nursing care and in particular missed fundamental care, including workforce and economic constraints (Raso et al., 2021), which will intensify as the shortage of nurses persists (Registered Nurses' Association of Ontario, 2021). As we recover from the pandemic, a focus on nursing retention and the profession's ability to provide quality patient care is paramount given nurses represent the largest global healthcare workforce providing direct patient care (Stemmer et al., 2022). Now more than ever, there is a pressing need for nursing leaders across research, education, clinical practice and policy to influence a humane, compassionate evidence-informed approach by focusing on restoring fundamental care as part of the organizational mandate (Richards et al., 2021; Sugg et al., 2021, 2022).

The International Learning Collaborative (ILC) is the global community of fundamental care experts whose mission is to promote improvements in person-centred fundamental care through generating practical resources, investing in research and educational innovations, and shaping policy and practice. The theme of the 13th meeting of the ILC in 2022, held in Oxford, UK, was 'Fundamental Care in times of Crises'. Experts in disaster and pandemic management as well as front-line nursing and other leaders shared their experiences in coping with the COVID pandemic and the lessons learned. In this paper, we synthesize these discussions and the expertise of global nursing leaders to form the 'ILC Oxford Statement'. The statement outlines what must and must not happen, both during times of crises and beyond, to ensure safe, quality fundamental care delivery and the health and well-being of our patients, their families/carers, nurses and health and care systems.

Whilst several statements and position papers relating to COVID-19 have been produced by various individuals and organizations, focusing on the roles, rights, responsibilities and safety of nurses when caring for patients with COVID-19 (e.g., Australian College of Nursing, 2021; Fawaz et al., 2020; National Council of State Boards of Nursing, 2021; New South Wales Nurse and Midwives' Association, 2021), no other statement has focused explicitly and specifically on the central role of fundamental care.

2 | DESIGN AND METHOD

This discussion paper outlines the 'ILC Oxford Statement'. This statement is the product of participants' discussions and deliberations over the two-day ILC conference in Oxford. The content of the statement reflects the experiences and sentiments of over 100 international participants. Participants were from 14 countries, representing acute, aged care and community settings, with research, educator and executive leadership roles. The two-day conference centred around the theme of 'Fundamental Care in Times of Crises', focusing on individual and workforce responses to COVID-19 and other infectious diseases, environmental issues (e.g., climate change/global warming), humanitarian crises (e.g., refugee, vulnerable and

other at-risk populations) and managing scare healthcare resources. The central theme was explored via keynote presentations and plenary discussions, both face-to-face and virtual, each with a separate Q&A and small facilitated group work sessions.

The statement was generated through a collaborative co-design approach facilitated by the lead author (AK) and refined by the other named authors on behalf of all participants (identified in the acknowledgements). Over the course of the two-day event, participants continually contributed live feedback and comments to word clouds, the contents of which were summarized and presented to all participants. Dedicated time in the conference program was allocated for small groups to meet, discuss and prioritize the issues and actions arising. In group discussions, participants were explicit about the things they never wanted to see happen again within health and care systems, the type of care they wanted to promote instead, and the actions, checks and balances required to achieve this. They were determined to use this collective reflection and learning to generate a new set of actions that ILC members can implement in their work environments and professional bodies. AK and TC took notes of these discussions, which they then collated and synthesized.

This synthesis and the central ideas arising from it were workshopped and refined with participants in the afternoon of the conference's second day, with the explicit aim of creating the 'ILC Oxford Statement'. Participants were explicitly asked to identify things that they did not want to go through or experience again; what they had learned from their experiences and how they could share those learning more widely across the nursing profession. These data were collated in large sheets of paper which were then analysed into themes. Following the conference, these themes were further refined by AK and TC, with AK constructing them into a coherent line of argument. Members of the ILC who attended the event were asked to volunteer to be critical readers (and therefore authors) of the statement, contributing further to its development. Keynote presenters were also invited to comment on statements attributed to them in the document and to confirm that they had been interpreted correctly. The synthesis of participants' discussions represents the key arguments and actions outlined in this statement.

3 | DISCUSSION

3.1 | The context: 'here be dragons'…

One of our keynote speakers, Professor Paul Arbon, Director of the Flinders' University Torrens Resilience Initiative and world expert in system responses to natural and other disasters, reminded us that the frequency and severity of disasters, and in particular health emergencies, will increase (World Economic Forum, 2022). These events are rarely local and focussed, instead, they are prolonged and system-wide, having complex and cascading consequences, characterized by unpredictability and uncertainty. Today, we need to be prepared for the consequential impacts that we cannot always predict; the so-called "unknown unknowns" (Maden, 2020).

The problem of responding to the unknown was illustrated by early cartographers who used the phrase 'here be dragons' and a drawing of a dragon or sea monster to show parts of the map that were unexplored, unknown and potentially dangerous. More recently, software developers have used the phrase to indicate core coding that is so interconnected to other parts of the system architecture that it is no longer known what would happen if that code were altered. Facing uncertainty is part of a health professional's daily life; however, when uncertainty is escalated to the whole system and across the multiple co-dependent systems, leaders must focus on the primary objectives of care and act quickly, authoritatively and with integrity.

From participants' accounts, COVID did overwhelm or threatened to overwhelm, health and care systems. Whilst media attention was often directed to the intensive care units (ICU) in acute hospitals, nurses were also challenged with managing care for COVID and non-COVID patients across community, aged, disability and primary care areas. Dr Crystal Oldham (Chief Executive of the Queen's District Nursing Institute, UK) outlined the stress experienced by community and district nurses across the UK during the early days of the pandemic. End-of-life care delivered in the home by these nurses doubled and increasingly they were left to provide continuity of care to those they described as 'the forgotten'. Insufficient supply and rigid implementation of PPE protocols without acknowledgement of the expertise of nurses at the coalface, led to frustration, demoralization and burnout.

The ability to identify, protect and sustain what really matters in and across systems are what, according to Professor Arbon, makes them more resilient and able to cope well with the disaster challenge. Leaders need to know how to manage the unthinkable and identify and protect what really matters to ensure the effective and safe running of the system. This is the primary rationale for strengthening the fundamentals of care (e.g. ensuring that patients are fed, hydrated, have their personal hygiene attended to, comfortable and know what's happening to them)—regardless of the nature, scope and scale of an event, the fundamentals have utility and effect, including when resources are scarce and technology unavailable.

As described by Dr Oldham, nursing is a 'safety critical' occupation. In times of crises, nursing leaders focus on ensuring and protecting the capacity and capability of the frontline staff delivering care. We have heard of examples where success was based on nursing and care teams having the imprimatur to make their own decisions based on unpredictable, novel and rapidly changing situations, stepping out of normal protocols, and being supported to make the right local decisions.

Managing uncertainty, increasing the speed of responses, and promoting autonomous self-organizing teams and systems is what happens in organizations that empower and enable their nursing leaders to take control of fundamental care delivery and patient safety. There were some excellent examples from health system nursing leaders who had been given or took control of the whole system response to COVID. Colleagues from Sinai Health in Toronto, Canada shared their experiences of managing an Ontario-wide

response as well as how they changed models of care in the ICU to safely accommodate the fast-changing scenarios of staff shortages and the need to quickly skill up nursing staff and continue to provide safe care (Amaral et al., 2022). They also shared how the Fundamentals of Care Framework (see Figure 1; Feo et al., 2018; Kitson et al., 2013; Kitson & Muntlin Athlin, 2013) guided policy guidance documents on provisions of care through the conventional, contingency and crisis phases of the pandemic.

Professor David Richards and colleagues' large randomized controlled trial evaluating a COVID clinical guideline across 14 hospitals in England (Richards et al., 2021; Sugg et al., 2021, 2022) confirmed that essential physical, emotional and relational aspects of fundamental care were often left unattended. Video evidence of a patient's lived experience, provided via the work of Professor Richards and his team, demonstrated that some patients with COVID felt that nurses overestimated patients' ability to self-care, and patients suffered as a result. Professor Richards also mentioned the phenomenon of survivor guilt—often recovering patients were so relieved that they had survived, they did not like to recall or talk about situations where their self-care capacity was severely compromised.

Nursing leaders at the conference described their experiences of health and care systems ill-prepared for the scale and extent of the impact of COVID. It was an unknown disease, the workforce was not pandemic prepared, nor were there plans in place to recruit, supply, support and protect the workforce. Shaky supply chains left frontline staff risking their own safety on many occasions. What began by characterizing nurses in the media as 'angels' and 'heroes,' soon changed to treating them as villains when they got tough on community and individual behaviours and promoting vaccinations. Despite these challenges, nursing teams transformed their models of care, moving from traditional unit and individual-based care to working as a wider-system nursing community. This enabled nurses to work in competency-rich teams with blended staffing models. The reality was tough—nurses talked about running out of compassion, that every single patient death took a piece out of them, and that the nursing leaders were tired of thinking "who am I going to disappoint today?"

Moral distress was experienced by nurses throughout the pandemic. This has led to an exodus from the profession, with the global nursing shortage now standing at just under six million (Buchan & Catton, 2020). Another keynote speaker, Professor Jim Buchan, an expert in health sector policy research specializing in the nursing workforce, outlined data from an International Council of Nurses (ICN) report showing health systems must generate better workforce strategies to address issues of skill-mix, retention, scope of practice and provide better psychological and emotional

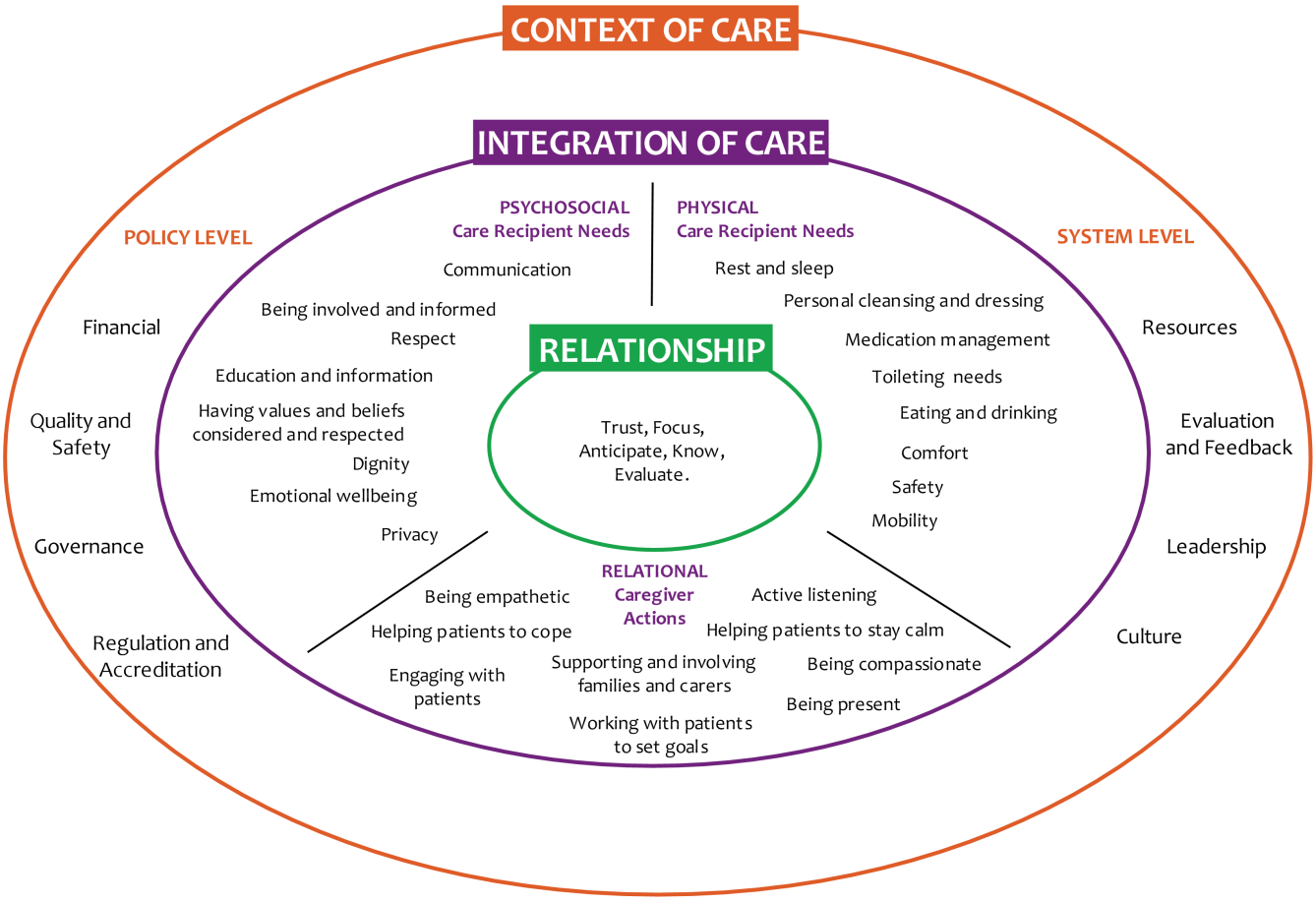

FIGURE 1 The fundamentals of care framework. Image obtained from https://ilccare.org/the-framework/ content within image derived from (Feo et al., 2018)

support for nurses (Buchan & Catton, 2020). This looming crisis leads to questions: Is the nursing workforce really valued in our health and care systems? Or is nursing perceived as dispensable, disposable and replaceable? What are our systems doing to address and manage the moral distress experienced by so many nurses?

We know that things need to change. Hence, we begin with our declaration of what we do not want to see happen again to fundamental care and to nursing. We then outline what we have learned from the pandemic and identify what we want to see more of. Finally, we set out an action plan for how we, through the ILC and our partner organizations, are going to make it happen.

3.2 | What must not happen again

3.2.1 | 'No more heroes'…

Systems deliver what they are designed to deliver (quote attributed to Edwards Deming). What was evident from participants' experiences across the pandemic was that health systems struggled even more to deliver fundamental care. Participants shared stories of how they had to overcome system design and performance failures by individual endeavours and actions. Participants were not arguing against individuals showing acts of heroism, courage and compassion but if the system is relying on this additional effort to sustain it, then it is an unrealistic expectation. The consequences of this additional activity, particularly if prolonged, manifest in terms of fatigue, burnout and moral distress for nurses and increase safety risks for patients.

Participants conveyed that they no longer would sacrifice themselves, their well-being, their mental and physical health by having to compensate for systems that had not designed appropriate processes to deliver fundamental care to their patients. How the media responded to the efforts of nurses was to laud them as heroes thus further ignoring that the problems often were systemic rather than individual. Fundamental care delivery requires nurses to demonstrate compassion, empathy, relationship building and knowing how to go the extra mile in times of emergency. (Feo et al., 2017, 2019; Feo & Kitson, 2016; Kitson et al., 2013, 2022). These fundamental care skills can be taught and improved upon, and they ought to be part of every nurse leader's essential and enduring skill set.

Identifying these as 'special' individual skills means that the systems in which these individuals work do not take responsibility for embedding them into routine procedures and processes. Failure to recognize the importance of forming and sustaining relationships with patients and enabling nurses to do this rather than have their work routines dominated by checklists and other agendas are examples of how systems do not acknowledge the human experience in care: it is perceived as an optional extra (Feo & Kitson, 2016). Single acts of heroism are to be celebrated, but pandemics or other crises cannot be managed by relying on a workforce to continually act beyond expectations and deliver fundamental care, while battling workforce and supply shortages, and poor professional and personal support systems.

Leaders must know how to focus on what matters in emergency situations and must be able to make judgements about how they can ensure that fundamental care is part of the DNA of their organizations (Kitson et al., 2022; Mudd et al., 2020). This will ensure that nurses (and other health professionals) are not asked to engage in unnecessary acts of heroism when it is the system that should be improved.

3.2.2 | 'We don't want to be on the menu, we want to be at the table'…

In response to COVID, nurses were dealing with rapidly altering models of care, to workforce and supply shortages and changes to workflow (e.g., standardized or planned processes and events) and workloads (i.e., the amount and type of work required; American Nurses Association, 2020; Anderson et al., 2020; Balluck et al., 2020; Kang Kim et al., 2020; Keeley et al., 2020; Limoges et al., 2021; Uppal et al., 2020). At the same time, nurses were trying to respond to patient fundamental care needs and safety issues. Teams experimented with team-based models of care in ICUs and nurses moved around hospital, education, aged care and community care systems to fill in gaps (Amaral et al., 2022).

Participants noted that there was a relative lack of nursing leadership or voice for fundamental care in the international media when it came to describing critical activity around the pandemic. Understandably, attention was given to the race for a vaccine and infection control and reduction of spread. We were treated to great leaders from medicine, epidemiology and public health, some of whom have become international celebrities. But it is noteworthy that there were few appearances of, or leadership roles for, the government Chief Nurses or other nursing leaders in the media coverage. Our chief nurses were in the background, but why did no one consider putting them in front of the media to role model strong leadership for care during the pandemic? Was there a perception that care was under control because PPE was being managed and the public health physicians were reminding us of safe distancing? How can supply chains, investment decisions, safety issues, health and well-being of staff issues be considered appropriate if there are no experienced voices for person-centred fundamental care at the table?

This is not to say that the voices of nursing leaders were entirely absent. There were notable contributions from Elizabeth Iro, Chief Nursing Officer (CNO) for the World Health Organization (Catton & Iro, 2021; Parish & Iro, 2021; Rosa et al., 2020); Carol Porter, CNO for MD Anderson (Porter, 2020); the American Organization for Nursing Leadership (2020); and Deb Baker, Senior Vice President for Nursing at Johns Hopkins Health System and Vice President of Nursing and Patient Care Services for Johns Hopkins Hospital (Johns Hopkins Nursing, 2020a, 2020b). However, adequate, and appropriate representation of the central role that nurses were undertaking

in the pandemic by nurse leaders remained a challenge. Given the volume of input from healthcare leaders across health disciplines, the voices of nurses were relatively rare and did not reflect the huge effort being put in at the front line by the global nursing workforce.

Of course, one might argue that not all nursing leaders will necessarily have the expertise or experience to comment on fundamental care, including how its delivery might be impacted during an infectious disease pandemic. However, we argue that questions must be asked about whether leaders can be considered representative of the nursing profession if they are not able to competently comment on, nor understand and value, an aspect of nursing that is vital to *all* people that nurses care for – fundamental care. This indeed is a question that runs deep into the identity of nursing as a profession and how it sees its contribution to society.

3.2.3 | We don't want to 'keep calm and carry on (as if nothing happened)' …

Nursing is facing a global shortage. One in six of the world's nurses is set to retire by 2032, which translates to a 4.7 million replacement challenge from 2022. Many countries before the pandemic were facing workforce challenges which have been exacerbated by the pandemic. This has led to increased absenteeism, stress and increasing mental health and well-being issues across the workforce (Buchan & Catton, 2020). What is also known is what factors affect nurse retention. These include a positive and appropriate work environment that is conducive to the care work that nurses do; the ability to form meaningful relationships with patients throughout their care journey; appropriate working conditions (equal opportunities, flexibility, career opportunities); responsive managers and nurses feeling able to work to their full scope of practice and to be able to take the lead on matters relating to nursing care (Buchan & Catton, 2020). Given that we know what keeps nurses in the workforce we need to ask why we have a looming crisis.

Retaining nurses in the workforce and using their skills protects and keeps patients safe (Aiken et al., 2017; Assaye et al., 2021; Ball et al., 2018; Griffiths et al., 2018; Harrison et al., 2019; Li & Cimiotti, 2021). Organizations such as the ICN are calling for global nursing workforce strategies that are ethical and sustainable and each jurisdiction needs to respond appropriately. Policy solutions need to be negotiated at every level of decision-making if we are to act responsibly and appropriately to these challenges. At national level, we need clarity around safe staffing levels that have factored in the nurse's responsibility for delivering on and co-ordinating patients' fundamental care needs. We need organizations to undertake workforce impact assessments, so they understand how best to support and sustain a healthy work environment where nurses and patients flourish. At international level, we need to look at how we address what will only continue to be an increase in the need for nurses globally. This will require a different mindset from policymakers, funders and health leaders—rather than seeing nurses as dispensable and easily replaceable, nurses need to be listened to in terms of how best to shape the way we deliver care and in particular, fundamental care.

Participants talked about the need to recognize nursing's worth and contribution. This is the beginning of a transformational journey that will strengthen nursing into the future and will protect our commitment to fundamental care. We can start on our healing journey for ourselves and our systems and know how to leave behind the trauma that we have experienced because of the pandemic. Participants talked about how they wanted to take control and rather than just staying quiet and thinking they had to 'keep calm and carry on' as if they would not been through one of the most challenging experiences of their professional career, they were going to make it count by speaking up.

First was the need to generate better ways to manage and process the distress and burnout caused by the many extreme and challenging situations brought about by the pandemic. Second was the need to look at how to redesign our health and care systems, so they do have patients' fundamental care needs at the centre. And third, participants were clear that their workplaces had to more explicitly embrace cultures and practices that support staff to self-care, engage in self-reflection and have time to recover and refresh.

How can our collective experiences lead to improvements in health and care systems?

3.3 | What we want to see more of

3.3.1 | Recognition of fundamental care work

It is hard to lose an argument if the focus is on the needs of the patient. We need to ensure that our nursing leaders develop competencies for succinct, structured communication about the clinical and fiscal impact of person-centred fundamental care assessment, delegation and delivery. It is important that we re-think how we educate nurses at all levels. They are the nursing leaders of tomorrow and need to be prepared to lead and deal with crises much earlier in their education. We must ensure that fundamental care is at the core of their education and that students are skilled to deliver this care when they graduate.

We need to accept and embrace the trust attributed to nurses by society and use this mandate as a platform to challenge decisions made that we know will compromise person-centred, humane care. We should never take no for an answer, when we know that we are advocating for, and with, our patients to ensure they receive appropriate fundamental care. We know the argument around the importance of providing person-centred fundamental care can be won, so we must keep talking until we have achieved our goals of ensuring that our systems are responsive to, respectful of and resource fundamental care.

3.3.2 | Respect for the people who do fundamental care work

Nurses are the glue that keeps health and care systems running. Nurses are change champions. We can create change across health

and care systems; we cross professional, linguistic, cultural and system boundaries to ensure holistic experiences of care for our patients. Our work is intimate and sensitive, embracing human frailty and vulnerability in moments of great sorrow and distress but also in times of great joy and fulfilment. Recovery, healing, agency, independence and quality of life cannot happen unless nurses do their caring work in ways that are person-centred, respectful and evidence based. It is getting the so-called simple self-care or caring elements right that has nursing as the pre-eminent, safety-critical profession.

3.3.3 | Representation of fundamental care work at appropriate decision-making tables

What is the 'new-normal' for fundamental care delivery post-pandemic? Who is going to generate the appropriate fundamental care policies for our health and care systems if there are no chief nurses at the decision-making tables and there are no experienced voices who know what fundamental care is or how to deliver it? How do we prepare our staff to respond to isolation, separation, anxiety and navigate managing risk with existential sense-making at a life-defining moment? How do we enable our nursing profession to celebrate and take responsibility for high-quality fundamental care delivery on behalf of the multidisciplinary health team and patients? This responsibility gets pushed down the priority hierarchy and we need to understand why this happens and turn it around. Overcoming these issues requires appropriate nursing representation. Representation means having the right people around the right tables making the right decisions for person-centred fundamental care. So, prepare for more governance, managerial and leadership positions where nursing leaders can confidently and competently expound and enact the virtue of high-quality fundamental care.

3.3.4 | Resources to support fundamental care work

An overriding message from our international participants was that we need to move beyond thinking about individual resilience to pandemic challenges to thinking about how we build and sustain system resilience. This means considering the material, human and intellectual capacity at our disposal. Despite the acknowledged workforce shortages, the capability and capacity in our health and care systems are significant, but we do not know (a) whether we are using them appropriately to solve this problem or (b) whether we need more. So, these are the things we want to look at.

We believe that if more adequate consideration and prioritization were given to the following aspects of strengthening our systems to face the next crisis or challenge, then all healthcare would be in a better place.

First, we need to unite around generating a global workforce strategy that acknowledges, values and respects the fundamental care work that nurses are responsible for assessing, supervising and delivering. We need to think about how we upskill and engage patients, carers, family members and whole communities in advancing 'care literacy' programs (Kitson, 2016), so that when the next crisis arises, we will have more community preparedness to draw upon.

Experiences from highly responsive and successful health and care systems affirm the importance of investing in nursing leadership, research and emergency responsiveness training. Poorly orchestrated and managed care system responses reinforce the importance of investment strategies in developing new knowledge and innovations around fundamental care delivery as well as preparing the workforce to record what is left undone in terms of fundamental care, and then generate more accurate and sensitive fundamental care metrics.

3.4 | The action plan

By refusing to make nurses out to be 'superheroes', we choose to recognize their central contribution to the health, wealth and well-being of our health and care systems. Nurses' work and leadership contribution are pivotal, essential and of unparalleled value, contributing to the overall success of the multidisciplinary team. With the affirmation and acknowledgement to make necessary changes within health and care systems, nurses will continue to move forward with an agenda for action that will make our health and care systems stronger.

The core actions we have committed to as the ILC, the global voice for improving fundamental care, are as follows. These actions will be worked on across the ILC's regional groups to ensure the development of concrete, measurable activities that address the pressing needs of each of the ILC's regional networks:

1. **Ensuring that fundamental care is embedded in all our health and care systems**. At policy level, we will have nursing leaders explaining, identifying and influencing what is needed in government and strategic documents to protect patients and keep them safe with an appropriately educated and resilient nursing care workforce.
2. **Building on and strengthening the leadership skills of our nursing workforce** by confidently and clearly advocating for person-centred fundamental care. Nursing leaders will be at the table where key care policy and investment decisions are made and we will call out situations where the experienced, expert voice of the professional carer (the nurse) is not invited to the table. We will encourage collaboration between leaders from different specialities/departments and invest in emerging leaders who can 'speak up' at the table where decisions are made. We will no longer tolerate being 'on the menu'.
3. **Co-designing systems that care for our staff.** We will extend best practice projects such as the online listening service providing support to nurses in distress. We expect each health and care system to develop a staff support and well-being strategy that will manage the

experiences of COVID in appropriate ways as well as start to build system resilience. Staff support systems will refresh professional development activity to ensure that person-centred fundamental care assessment, delegation and delivery skills are highlighted as well as emergency and disaster preparedness training.

4. **Improving the science and methodologies around reporting and measuring fundamental care**. Fundamental care elements are routinely not recorded and if they are recorded as safety failures such as falls, pressure injuries, infection and constipation (Jeffs et al., 2018). We need to turn this into a conversation that showcases the positive impact of getting person-centred fundamental care right, which can improve patient recovery, well-being and quality of life, and positively address length of stay and fiscal bottom lines. The ILC is actively working with international research teams to develop the next generation of nurse/fundamental care-sensitive indicators that can become part of the routinely collected measures to define and describe quality-of-care interactions.
5. **Leveraging the COVID pandemic crisis as an opportunity for transformational change in the way we respect, understand and deliver fundamental care**. Multiple health and care systems have had to respond to the pressures of the pandemic by designing and trialling new models of care. This included changing roles, responsibilities and skill mix; introducing more technology-assisted care; and extending the role of the informal carer or assistant in care. We must build on these experiences and work out what to keep and what to refine. The need for person-centred fundamental care far outstrips our ability to deliver and this gap will only increase. It is a societal responsibility of the nursing profession to work out how we close this gap in ways that ensure quality, safety, integrity and value for money.

4 | IMPACT ON NURSING SCIENCE, PRACTICE OR DISCIPLINARY KNOWLEDGE

This statement provides clear guidance for how healthcare systems and nurses can work together to ensure that safe, high-quality, person-centred fundamental care does not become a long-term casualty of the COVID pandemic. Neglecting the core actions identified in this statement will adversely impact the safety, experiences and outcomes of patients, their families/carers and nurses as well as the performance of health and care systems. By prioritizing the core actions, we will generate the evidence required to develop educational and practice-based interventions as well as professional development activities and training that equip current and future nurses and nurse leaders with the skills to advocate for fundamental care across systems and during times of unprecedented change and challenges.

5 | CONCLUSION

In the past few years, we have borne witness to the devastating impact associated with the erosion of fundamental care and the frustration and moral distress of our nursing profession, yet the 13th ILC event was transformational, challenging and riveting. We acknowledge and applaud the incredible work of every nurse whose contribution has helped us all to move through the various waves and initial recovery from the pandemic. We are now calling for a more challenging and courageous commitment from nurses across the world. We need you as part of a larger collective experience to clearly identify what we will not tolerate in our health and care systems anymore; what we will work together on to achieve; what actions we will take through the ILC to achieve this; and what measures will demonstrate we made an impactful difference. Together, we will build a more resilient workforce and health and care systems globally that ensure quality person-centred fundamental care is delivered every day.

AUTHOR CONTRIBUTIONS

All authors (ALK, TC, LJ, DC, GJHW, AM, EJ, MG and JP) contributed to the conception of the work and the ideas contained within the manuscript. AK contributed to the original manuscript draft preparation. All authors (ALK, TC, LJ, DC, GJHW, AM, EJ, MG and JP) contributed to reviewing and editing the manuscript. All authors (ALK, TC, LJ, DC, GJHW, AM, EJ, MG and JP) provided final approval of the manuscript version to be submitted and published.

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CONFLICTS OF INTEREST

The authors do not have any conflicts of interest to declare.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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