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DISCURSIVE PAPER

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Reflections on the implementation and evaluation of a system-wide improvement programme based on the fundamentals of care: Lessons learned

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Abstract

Aim: To demonstrate how implementing a system-wide measurement and improvement programme can make the delivery of the Fundamentals of Care visible in practice.

Design: Discussion paper.

Data Sources: A retrospective evaluation of the experience of implementing a system-wide peer review programme using the Promoting Action on Research Implementation in Health Services framework.

Implications for Nursing: Implementing this programme engages nursing leaders at all levels in fundamental care delivery, evaluation and improvement. It positions nursing leaders as accountable for and champions of fundamental care.

Conclusion: The peer review programme offers a solution to the complex challenge of measuring the fundamentals of care in practice. Successful implementations of this programme at two New Zealand inpatient sites have shown positive results in improved care and patient experience. This makes it worthy of consideration for other health organizations. Nursing leadership has proven to be critical to success. The Promoting Action on Research Implementation in Health Services framework highlights the components that assist with successful implementation and assists in presenting a case for change.

Impact: This paper addressed the problem of the lack of action and dearth of quality, integrated data, visibility of the patient experience and the contribution of nursing leadership in an inpatient setting. Findings indicate that the peer review programme is translatable, modifiable and sensitive to ethnicity and disability. Using the implementation framework to evaluate the process has provided a guide for future implementations.

KEYWORDS
evaluation research, fundamentals of care, leadership, measuring quality, nurse–patient relationships, PARIHS framework, quality of care, research implementation, research in practice

1 | INTRODUCTION

The purpose of this discussion paper is to demonstrate how implementing a system-wide measurement and improvement programme can make the delivery of the Fundamentals of Care (FOC) visible in practice. It reinforces the leadership required to own, understand and improve fundamental care (Kitson et al., 2019). We describe the adoption and implementation of the Patient Whaanau Centred Care Standards (PWCCS) peer review programme from one acute care inpatient hospital (site 1) to another hospital in the same region of New Zealand (site 2). We then use the Promoting Action on Research Implementation in Health Services (PARIHS) framework to evaluate the effectiveness of the implementation. This evaluation identifies the success criteria to increase the likelihood of successful adoption across other health systems and acts as a guide for nursing leaders. Encouraging wider adoption of the programme will provide further evidence of the programme's impact, make the delivery of fundamental care visible in practice, and contribute to a credible database of solutions to solve the wicked problem of fundamental care delivery (Kitson, 2021).

2 | BACKGROUND

2.1 | Constructing and testing a system-wide measurement and improvement programme that made the FOC elements explicit

Despite over a decade of research by the International Learning Collaborative (ILC) challenges exist in measuring the fundamentals of care in practice and demonstrating the effectiveness of interventions (Kitson, 2020). Tools have been identified which evaluate the nurse–patient relationship and measure psychosocial aspects of fundamental care (Bagnasco et al., 2020; Feo et al., 2020; Feo et al., 2021). Feo et al. (2020) found 35 tools measuring the nurse–patient relationship, however, none of these were related to the FOC framework (Feo et al., 2021).

Two initiatives reveal the implementation or adoption of organizational-wide programmes addressing FOC in practice. The most recent is a FOC matrix which provides an example of an innovative evaluation (Conroy et al., 2021). This evaluative tool informed by complexity science captures the multiple interconnected elements of the FOC framework using experience narratives. The matrix has been tested and analysed using personal statements originally collected by the Royal Commission into Aged Care. Future recommendations included capturing the information via patient surveys using computer algorithms to produce the matrix output (Conroy et al., 2021). However, strategies to elicit this type of data from individual care recipients are still being investigated.

The PWCCS is an organizational peer review measurement and improvement programme based on the FOC with an inpatient focus. It was developed in 2014 in a hospital setting in one District Health Board (DHB) in New Zealand (Parr et al., 2018), referred to in this paper as site 1. DHBs in New Zealand are responsible for the planning, funding and provision of health services in its region. The PWCCS increases the visibility of fundamental care through systematic, cyclical measurement, with each peer review cycle generating tangible evidence to inform and support improvements in care. The PWCCS drew on improvement programmes relating to FOC identified in Wales (Welsh Assembly Government, 2003), the United Kingdom (Department of Health, 2010) and Australia (NSW Government Health, 2014).

The PWCCS programme measured fundamental care against nine areas of care (Parr et al., 2018), see Table 1. Using these defined standards, the programme aimed to ensure the consistent, safe, and high-quality delivery of the fundamental aspects of care.

A strength of the PWCCS programme is that all levels of nursing leadership are involved. The participation of all levels of leadership from the chief nurse to ward and unit managers signals the importance of evidence-based practice and a commitment to improving fundamental care (Parr et al., 2018). Ward/unit managers, as frontline leaders, are particularly influential in the implementation of evidence-based practice so must be aware of the barriers to implementation and the need to provide a supportive culture (Bianchi et al., 2018).

TABLE 1 Patient and Whānau Centred care standards peer review programme (Parr et al., 2018)

Patient and Whānau Centred Care Standards
Communication
Interpersonal communication, information sharing, documentation, care coordination, team working
Clinical monitoring and management
Assessment and management of physical status, monitoring vital signs, prevent patient deterioration, timeliness of care, clinical care
Care environment
Tidiness, cleanliness, and maintenance of environment; infection prevention and control, culture
Comfort and pain management
Pain management, physical comfort, end-of-life care, rest and sleep, caring environment, involving family
Respect, privacy and dignity
Maintaining confidentiality, privacy and dignity, respect for values and beliefs, consent, informed choice
Nutrition and hydration
Assessment, care delivery, nutritional needs, food service, assistance, protected mealtimes
Safety and prevention
Risk assessment, safe environment, medication safety, staff skills
Personal care
Hygiene cares, elimination, mobility
Self-care
Patient education, discharge planning, environment

2.2 | The importance of peer review

The programme is referred to as a peer review programme because the process involves peer engagement at several levels of nursing leadership. Involvement in this programme is considered an integral part of every nurse's role as a core business. First, registered nurses from patient safety, patient experience, Māori, and Pacific health teams along with nurse educators and senior nursing and midwifery leaders are trained to undertake the role of reviewers in collecting the data. Senior nursing leaders also provide coaching and mentoring whilst undertaking the ward/unit manager interview.

Second, successful improvements in fundamental care practice are shared and recognized with peers during the weekly-organized forums with the chief nurse. Finally, ward and unit results are explored by a panel of senior nurses chaired by the chief nurse or chief midwife where appropriate. This process further encourages peers to engage together on their data, supporting any improvement opportunities along with the ward manager. The biannual reviews initiate a continuous cycle of improvement based on the FOC (Parr et al., 2018) embedding nursing leaders in the process of accountability for fundamental care.

The programme at site 1 successfully and steadily created awareness and accountability of fundamental care for health professionals and in particular nursing teams. The next step was to implement this innovative programme at site 2. In the next section, we provide an outline of the review process followed by the data sources developed using the PARIHS framework to evaluate the implementation.

2.3 | The review process

The review process involves collecting data from four measurement tools outlined in Table 2. All data, including patient demographics, are collected electronically on iPads and then analysed by the clinical quality analyst. Following this analysis, the results are provided to ward/unit managers. The participant profile from site 2 is reported in Data S1.

3 | DATA SOURCES

3.1 | Adopting and implementing a system-wide improvement programme

To inform and evaluate implementation and knowledge translation efforts, Kitson et al. (1998) developed the PARIHS framework. We chose the PARIHS framework for our evaluation because the core element of context resonated with us due to its inclusion of culture and leadership. In this section, we reflect on and evaluate the experience of transferring and implementing the programme from site 1 to site 2. The evaluation is based on the core and sub-elements of the PARIHS framework (Rycroft-Malone et al., 2004) see Table 3.

We reflected on the implementation phase of transferring the programme using the range of specified criteria in Table 3 that can either hinder or enable implementation. The likelihood of contributing to a successful implementation was rated on a low to high continuum scale. The criteria were used alongside conceptual definitions summarized by Stetler et al. (2011) to rate the readiness of site 2 for the initiative. Completing this exercise helped us to understand the factors that could impact the successful implementation of the programme for any organization. The chief nurse, nurse consultant standards of care and nurse director of research completed the reflection and evaluation process. Consensus on the rating was reached using the criteria to determine a score of high (strong), mixed (medium) or low (weak) for each sub-element.

Using the PARIHS framework allowed us to undertake a systematic evaluation of the conditions that existed at the time of implementation. They are identified as factors that might hinder, assist, or support the implementation of the peer review programme. Drawing on this evaluation, we present recommendations in Table 4 that can be of value to other organizations wishing to introduce this programme. A brief summary of the rationale behind the ratings presented in Table 4 is provided below.

TABLE 2 Peer review process

Peer review process	
Activity	**Personnel involved**
Five face-to-face patient surveys per ward	Trained reviewers
Ward manager interview • Review of ward-level systems and processes	Senior Nursing and Midwifery leaders
Observation of:	
• The environment	Senior Nursing and Midwifery leaders
• Episodes of care	Trained reviewers
• Patient & staff interactions	Trained reviewers
• Documentation review	Trained reviewers
Five staff surveys per ward/unit	Trained reviewers
Data collation, management and presentation	Nurse consultant programme lead
Data analysis	Clinical quality analyst

Core element	Evidence	Context	Facilitation
Sub—elements	Research evidence	Culture	Purpose
	Clinical experience	Leadership	Role
	Patient preferences	Evaluation	Skills & attributes
	Local information		

TABLE 3 Core and sub-elements of the PARIHS framework (Rycroft-Malone et al., 2004)

4 | RATIONALE FOR RATINGS

4.1 | Evidence

4.1.1 | Research evidence

Evidence must be systematic, robust, and credible to be rated highly for supporting implementation (Kitson et al., 1998; Rycroft-Malone, 2010). The initial assessment of our research evidence was medium. There was a lack of existing evidence about the measurement of fundamental care in practice but detailed information about the development and testing of the peer review programme had been reported (Parr et al., 2018). Additionally, a resource book had been produced for the programme detailing the best practice standards and indicators based on existing literature, patient and family feedback and national standards (Parr et al., 2018). This book, which is adaptable to the local policy was used as evidence to underpin the implementation of the programme at the site 2.

4.1.2 | Clinical experience

According to Rycroft-Malone (2004) when the perceptions and experiences of key stakeholders are solicited and recognized as part of the evidence base, clinical experience is rated to be high. Therefore, our initial assessment of the supporting evidence for clinical experience was high. This was primarily due to the chief nurses' consistent leadership and prior experience in developing and operationalizing the programme in a large health organization (site 1). Convincing key stakeholders of the need to measure fundamental care delivery was strengthened by the inclusion of consumer voices, which was a recommendation from the Francis Inquiry (2013). Embedding FOC in practice requires systematic engagement and focused conversations with key stakeholders (Kitson, 2021). To overcome initial hesitancy from some clinical nurse leaders, they were encouraged to join the ILC to understand the historical development and depth of theory that underpinned FOC. This was supplemented by a visit to the hospital where the programme was initially implemented to demonstrate first-hand how it provided a comprehensive view of quality at the ward level and to improve the likelihood of success.

4.1.3 | Patient preferences

Valuing the patient experience as relevant evidence and working in partnership supports successful implementation (Rycroft-Malone et al., 2004). Prior to implementation, the patient feedback gathered at site 2 indicated highly variable patient care and experiences. The information obtained was also not widely or systematically reported or acted on. Nor was it tailored to highlight the inequity of experiences of care due to different social identities such as ethnicity or disability.

Reviewing patient experience information is a valuable exercise that can provide a case for change. Issues of patient dissatisfaction that had previously been identified at site 2 aligned with items measured in the programme such as communication, the care environment, and managing comfort. These items are also visible in the FOC framework, which highlighted its value of it as an underpinning theoretical framework (Kitson, 2018). Staff at site 2 had expressed frustration at collecting data that was not acted on, and this is where the cyclical element of the programme began to shine. Patient experience data was systematically collected as a data source, which informed improvement cycles that responded to any negative or variable patient feedback. Consequently, the programme responded highly to the patient preference criteria of the PARIHS framework, which appealed to the staff at site 2, therefore, strengthening the evidence for its implementation.

Historically Māori, the Indigenous people of Aotearoa NZ, respond poorly to Western-based data collection methods such as surveys because they value narrative and relational face-to-face approaches (Walker et al., 2006). The programme measured patient experience using purposive sampling and face-to-face interviews, which encouraged greater participation. Wherever possible, Māori patients were interviewed by Māori staff. This demonstrated how Indigenous traditions could be included and valued.

To ensure the programme aligned with this focus on health equity, it was adapted to ensure analysis included investigation for outcome differences between social identities such as ethnicity and disability. This ability to measure and report on the different experiences of care due to social identity is a key driver for the adoption of the programme. Consideration of culture informed the patient preferences element thus strengthening the rating for this sub-element. Therefore, our likelihood of successfully implementing the programme based on patient preference criteria was considered high.

4.1.4 | Local information

According to Rycroft-Malone (2010), data, such as local information, needs to be collected routinely and systematically analysed to underpin practice. Local information was available at site 2 in the form of patient safety audit data. However, the various audit results were

TABLE 4 Implementation of the PWCCS programme to site 2. Mapped to the PARIHS framework elements and sub-elements with recommendations

Element	Sub-element	Rating	Assessment of readiness of implementation to site 2 using PARIHS elements	Recommendations
Evidence				
	Research	Medium	• Programme was based on evidenced-based standards developed in another New Zealand DHB which embodied the items in the FOC theoretical framework (relationship, integration of care, context of care).	• Obtain ethics approval with a patient consent process to generate further contextual evidence. • Use a FOC standards resource book • Value and recognize the breadth of evidence that can underpin practice.
	Clinical experience	High	• A consistent executive leader • Site visit to gather examples of previous clinical experience • Encouraged ILC membership for middle managers to widen knowledge of theoretical underpinnings of FOC.	• Network with experienced previous implementation leaders. • Undertake a site visit to understand the approach from ward to board, and to observe how the assurance and improvement aspects work in tandem. • Promote ILC membership in management levels
	Patient preferences	High	• Data from patient feedback was used as evidence • Patient perspectives supported the implementation • Variable patient experience data supported the case for change • Adapt to preferred methods of communication for the local population.	• Assess and adapt to preferred methods of communication for the local population. • Purposive sampling and face-to-face interviews to enable greater participation and provide feedback when traditional approaches reinforce inequity in outcomes. • Measure and report on the experience of care dependent on social identity (ethnicity, disability, gender)
	Local information	High	Evidence indicates a case for change such as: • Patient safety audit data not systematically reported or integrated • No board-level oversight of ward-level quality • No integrated ward-level quality data or dashboard • No indication of data being used for improvements	• Map organizational audit plans and policies to the PWCCS. • Promote the strengths of the systematic data gathering which informs continuous improvement cycles.
Context				
	Culture	High	• Learning organization which is patient centred and values continuous improvement • Organizational values built on Te Tiriti O Waitangi. • No systematic improvement activity based on patient feedback • Adoption of AIDET communication tool to AI2DET to incorporate Indigenous Māori relational preferences (The Studer Group, n.d.)	• Promote ward/unit managers use of data to identify areas of improvement, celebrate successes and share learning. • Recognize the strength and power of the voice of the consumer and ensure consumers are on implementation steering groups. • Ensure Māori consumers and Māori health teams are involved in the design and peer review • Align the goals of the programme with organizational values.
	Leadership	High	• Each level of leadership was involved in the process • Regular occurring engagement activities between each level • Resonant/Relational leadership • Executive level sponsorship	• Executive sponsorship • Active involvement of middle professional managers as peer-reviewers • Emphasize accountability for all leaders on the responsibilities in fundamental care delivery. • Take a coaching/mentorship approach to improvement • Promote the value of making care delivery at the ward-level visible, to ward/unit managers.

(Continues)

TABLE 4 (Continued)

Element	Sub-element	Rating	Assessment of readiness of implementation to site 2 using PARIHS elements	Recommendations
	Evaluation	Medium	• Lack of visible data on patient experience, ward delivery of fundamental care and ward management expectations.	• Adapt measurement tools to the local context • Commit to continuous improvement of the programme
Facilitation				
	Purpose	High	• Expert lead facilitator with experience of strategic-level organization-wide implementation. • Expert acts as guide and mentor to other facilitators • Experienced senior nurses working under the supervision of the expert facilitators provided with training • Novice facilitators work under the supervision of the experienced facilitator	• Demonstrate the programme's fitness for purpose in the organization's context. • Partner with an existing FOC organization during the pilot and first round of peer review. • Invest in dedicated resources and infrastructure: data analytics, coordination and project management
	Role	High	• Navigating individuals and teams through the complex change process • Modify approach as facilitators gain experience	• Facilitator uses a collaborative leadership approach to initiate purpose, transitioning to a partnership approach. • Implement peer-to-peer conversations.
	Skills & attributes	High	• Influence and negotiate with stakeholders • Guide teams and individuals with a relational coaching style.	• Leaders must have advanced influencing and negotiating skills. • Inspire, support and mentor teams and individuals using a relational leadership style.

not integrated, the number of audits each area conducted varied, and there was no evidence of targeted improvements. Furthermore, audit results were not systematically reported from ward to board level. The lack of routine and systematic analysis of local information strengthened the case for change, making the benefits of the innovation appealing. Therefore, we rated this element as high. The new programme provided an opportunity to map the organization's audit plan with the care standards; address variation issues and encourage consistent participation rates.

4.2 | Context

4.2.1 | Culture

A learning organization that embraces continuous improvement, promotes open communication and values a partnership approach between health provider, patient and staff groups, show characteristics of a strong culture on the PARIHS continuum (Rycroft-Malone, 2010). In our assessment, the organizational cultural readiness at site 2 was high for the adoption of the programme because patient-centred care and partnership were already being promoted, demonstrating a likely receptiveness to the proposed change (Kitson et al., 1998).

A long-standing culture of consumer involvement existed as a Consumer Council had been established at site 2. We recognized the strength and power of the consumer's voice and ensured consumers were strategically positioned on the implementation steering group to mandate change. The DHB had invested in an innovation and improvement centre aiming to develop a culture of continuous quality improvement to enhance patient care and organizational effectiveness. To strengthen this culture, an organizational-wide weekly forum was initiated by the chief nurse that enabled ward/unit managers to engage in quality work too. This provided them an opportunity to share their improvement work and it fostered shared learning and collaboration. These elements contributed to the likelihood of success for the adoption of the programme.

4.2.2 | Leadership

A successful implementation process relies on the support of leaders from every level, from the bedside to the board (Stetler et al., 2011). The rating for the leadership element of the PARIHS framework was high in site 2. The rationale supporting this rating was the involvement of each level of nursing leadership in the programme from the chief nurse to the ward manager. The chief nurse provided strategic direction to position fundamental care as a priority in the organization. Executive nursing input was essential in negotiating the need for the programme to measure fundamental care and to invest in resource and infrastructure with the hospital leadership team. The lack of visibility of the delivery of fundamental care presented a challenge though in arguing a case for change. If a problem is not visible, it is hard to negotiate the need for change. Successfully navigating these negotiations demonstrated the value of nurse executives with higher levels of education.

4.2.3 | Evaluation

Evaluation refers to the capability and potential of the implementation environment to collect and evaluate data via multiple sources and methods and disseminate data in a meaningful way in a timely fashion (Rycroft-Malone et al., 2004; Stetler et al., 2011). A positive culture for monitoring and evaluation existed in site 2 evidenced by the Patient Safety Leadership Walk Rounds programme (Wynne-Jones et al., 2020). However, there was a lack of documented evidence about patient and family experiences of fundamental care at the ward and organizational level. Ward/unit managers confirmed this finding, articulating that no evidence existed to evaluate the quality of care on their wards. Instead, they relied on their intuition or subjective means, such as staff morale. For these reasons, the capability of the implementation environment was rated as medium, which supported the case for change and built momentum.

4.3 | Facilitation

There are two purposes of facilitation, the first focuses on achieving the task or specific goal, and the second takes a holistic approach to support individuals to reflect on their attitudes to a change (Stetler et al., 2011). The facilitation of the programme's implementation was deemed high on the scale because of the fit for purpose, which was to provide visibility of FOC, the inclusion of different levels of leadership as facilitators and the skills and attributes they brought. Any implementation process requires expert and experienced facilitators who can manage the uncertainty whilst keeping novice facilitators and recipients of the initiative on track (Harvey & Kitson, 2015). Each phase of this programme included facilitators with different experience levels, from the expert leading the process (chief nurse) to the novice recipient of the change (ward/unit manager). Initially, the focus of facilitation was on directing the practical and technical elements of the implementation. As suggested by Stetler et al. (2011) the role gradually took a more collaborative and partnership approach. Novice facilitators became more experienced after receiving coaching, training and guidance from the expert facilitator.

5 | DISCUSSION

5.1 | The importance of embedding FOC into routine measures

There is a wealth of published literature on the FOC but little on methods for measuring fundamental care in practice. The peer review programme described in this paper provides tangible and relevant data for front line leaders to engage with. According to Parr et al. (2018) the programme implementation at site 1 initiated a culture change in front-line leaders and their understanding of their own leadership role in providing fundamental care.

In our experience, completing biannual reviews at site 2 became embedded in the culture becoming explicit as 'the way we do things around here' (Schein, 2010) as an expected calendar event for the clinical areas and reviewers. Consequently, there is greater recognition of the high-quality care that is delivered and identification and action on any care deficiencies. Kitson et al. (2019) presented five propositions for transforming fundamental care delivery which are: Value, Talk, Do, Own, and Research. Throughout the discussion, we demonstrate how the programme can respond to these five key propositions.

The 'Doing fundamental care' has been demonstrated since implementing the programme at site 2. Organizational results demonstrate a sustained improvement with reduced variation in care delivery a perfect example of making fundamental care explicit in health care systems and institutions. The critical success factor has been the inclusion of routine measures into the FOC measurement and evaluation programme. This has aligned the work of frontline staff to fundamental care and made it visible, from ward to board. The inclusion of social identity measures has reinforced the 'Value' and relevance of fundamental care to support these groups and highlighted the opportunities to address inequity in the delivery of fundamental care. The goal is for participating wards and units to achieve scores of 80% and higher. The overall results between the first review in 2017 and the most recent in 2021 showed a statistically significant difference with mean organizational scores rising from 77.9% (2017) to 85.9% (2021), with a 95% Confidence Interval for the mean difference between 5.7% and 10.8%. There has also been a significant improvement in eight of the nine care standards and in the four areas of measurement which can be seen in the figures presented in Data S2. These results and the importance of fundamental care are discussed at meetings from ward to board. This time 'talk' or articulation of fundamental care is systematized through the organization.

The results from both implementation sites demonstrate improvement, strengthening the evidence base from practice for future implementers. Rycroft-Malone (2004) acknowledges the value of evidence for practice as being broader than just traditional research evidence including continuous improvement and audit data. The practice evidence provided in this paper allows future nurse leaders who use the PARIHS framework to rate the 'Research' evidence criteria for implementing the programme as high. Furthermore, the available evidence from both sites can be used to convey a common understanding amongst key stakeholders and highlight the programme's relevance for making fundamental care visible and measurable, therefore demonstrating the 'value' of fundamental care.

Creating a network of health organizations that have implemented the programme also strengthens the evidence for the clinical experience element of the PARIHS framework; with continued success, the evidence for system-wide improvement programme based on FOC will be irrefutable. Having the ability to undertake site visits and partnering with an organization with an established programme provides the preparation that is required for less experienced

managers to lead the translation of evidence into practice (White et al., 2019). We recommend that measurement tools and methods be adapted to the local context and that evaluations are undertaken, thereby committing to continuous improvement of the programme. Furthermore, it is suggested that organizations who intend to adopt the programme commit to joining a governance group to share enhancements, contribute to the knowledge base and begin to develop a credible database of solutions for the wicked problem of fundamental care as highlighted by Kitson (2021).

During the COVID-19 response, two peer reviews were initially postponed and then cancelled due to resourcing demands and infection control risk. On reflection, this was a missed opportunity to measure patient and staff experience when the organization was under pressure albeit in unique conditions. Recent literature has demonstrated how fundamental care delivery has changed during the COVID-19 pandemic response (Danielis & Mattiussi, 2020; Sugg et al., 2021). Capturing those changes during the peer review programme would have been valuable and provided lessons for the future. There remains a need to embed how essential patient experience and fundamental care delivery is at all levels, so its measurement is not cast aside when the organization is challenged. Work is underway to adapt the programme for future use in the face of similar conditions.

5.2 | Leadership, scalability and sustainability

Using knowledge derived from the evidence to help articulate the importance of fundamental care is an example of effective leadership behaviour (Rycroft-Malone, 2004). Similarly, Bianchi et al. (2018) explain that nursing leaders require the knowledge to support the effectiveness of implementing evidence-based practice. In our experience, utilizing the PARIHS framework to evaluate the effectiveness of the implementation of the programme identified deficits in organizational systems and processes which provided drivers for change. However, highlighting gaps requires a systematic evidence-based approach that veers away from criticism and steers towards future opportunities for improvement. The focus of the programme was on patients, not the ward's score. It was tempting to use the programme as an assurance framework. However, encouraging a journey of improvement for patients and staff experience has connected with staff and ward/unit managers (Underwood et al., 2021). This situation calls for nurse leaders who have a strategic overview of the health system context and can blend the art and science of nursing to influence stakeholders (Lúanaigh & Hughes, 2016).

Evaluating and providing constructive feedback on the quality of fundamental care at the individual, team, and organizational level is a system and policy requirement (Kitson, 2018). This programme requires critical thinking from the reviewers and nurses at the ward and unit level encouraging them to question practice, generate evidence then improve fundamental care.

Reviewers were influenced by the opportunity to speak to patients and staff about their experience. This has enabled them to be engaged in quality improvement and their commitment has been critical to the sustainability of the programme. It has provided them an opportunity to align their work to fundamental care. Likewise, it has provided ward/unit managers with the mandate to own and focus on quality. Some senior nurse leaders initially struggled with the expectation that they would spend time reviewing other's areas. However, through experience, they developed an appreciation of the purpose of this work and how it broadened their leadership experience and accountability, therefore, 'ownership' for fundamental care.

Implementing the peer review programme provides a vehicle for relational leadership. A relational leader can connect processes, systems and people, inspiring, supporting and mentoring teams and nurses at all levels to think critically and question practice based on the best available evidence (Lunden et al., 2017).

Nursing leadership is closely connected to patient outcomes, and those who have the competency to use the available evidence can make necessary improvements (Wong et al., 2013). Nursing leaders, executives and frontline ward managers must generate, assess, and act on reviews of the quality of care and patient experience in response to issues raised in the Francis Inquiry and prevent reoccurrences. Furthermore, the measurement of patient outcomes raises the visibility of nursing leadership and the contribution to the patient experience reinforcing the value of nursing (Parr et al., 2021).

Ensuring sustainability relies on investment in necessary resourcing (Parr et al., 2018). Site 2 employed a nurse consultant to manage the programme, its components and future developments along with a clinical quality analyst. Embedding a staffing structure and process system contributes to the programme's sustainability. This is evidenced by the fact that the programme has been successfully maintained at site 1. Demonstrating how it needs to be leader driven not leader-dependent.

Utilizing project management skills such as stakeholder analysis can support long-term sustainability of an implementation (Franco-Trigo et al., 2020). In our experience, early engagement with stakeholders enabled us to identify what the potential barriers were and consider how to navigate these. Successful sustainability is dependent on strong nursing leadership blending the art and science of change management, implementation science, stakeholder management and fundamental care. Articulating the value of FOC and the measurement and evaluation programme is the role of the executive sponsor and critical to ensuring sustainability. The executive and board need to value the work to ensure the programme is seen as fundamental to understanding the quality of care provided (Kitson et al., 2019).

Parr et al. (2018) have commented on the resourcing and skill sets required to support the programme. The adoption of the programme from site 1 to site 2 using this resourcing as a basis has proven successful. To scale up the programme, economies of scale could be achieved by consolidating resourcing. Many of the recommendations in Table 4 would benefit from a more strategic consolidated approach where actions are undertaken and executive sponsorship with a mandate for the work would be required. The programme also has the potential to be expanded to other health care settings such

as the community and ambulatory services. Expansion of the programme to include the community is currently being developed at site 1 and site 2.

6 | CONCLUSION

The FOC peer review programme offers a solution to the complex challenge of evaluating the fundamental care in practice. The programme engages all levels of nursing leadership, promoting the value and visibility of nursing care from ward to board level. Two successful implementations of this programme show positive results, making it worthy of consideration for other health organizations. This paper demonstrates the sustainability and scalability of the programme. The PARIHS framework has been helpful to reflect on the implementation and provide recommendations that will assist further successful implementations of the programme.

Adopting and implementing the peer review programme provides nurses at every level the opportunity to Value, Talk, Do, Own and Research the fundamental care. Reinforcing the leadership required to own, understand and improve fundamental care (Kitson et al., 2019).

AUTHOR CONTRIBUTIONS

JP, CA, PJ: Made substantial contributions to conception and design or acquisition of data, or analysis and interpretation of data; Involved in drafting the manuscript or revising it critically for important intellectual content; Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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