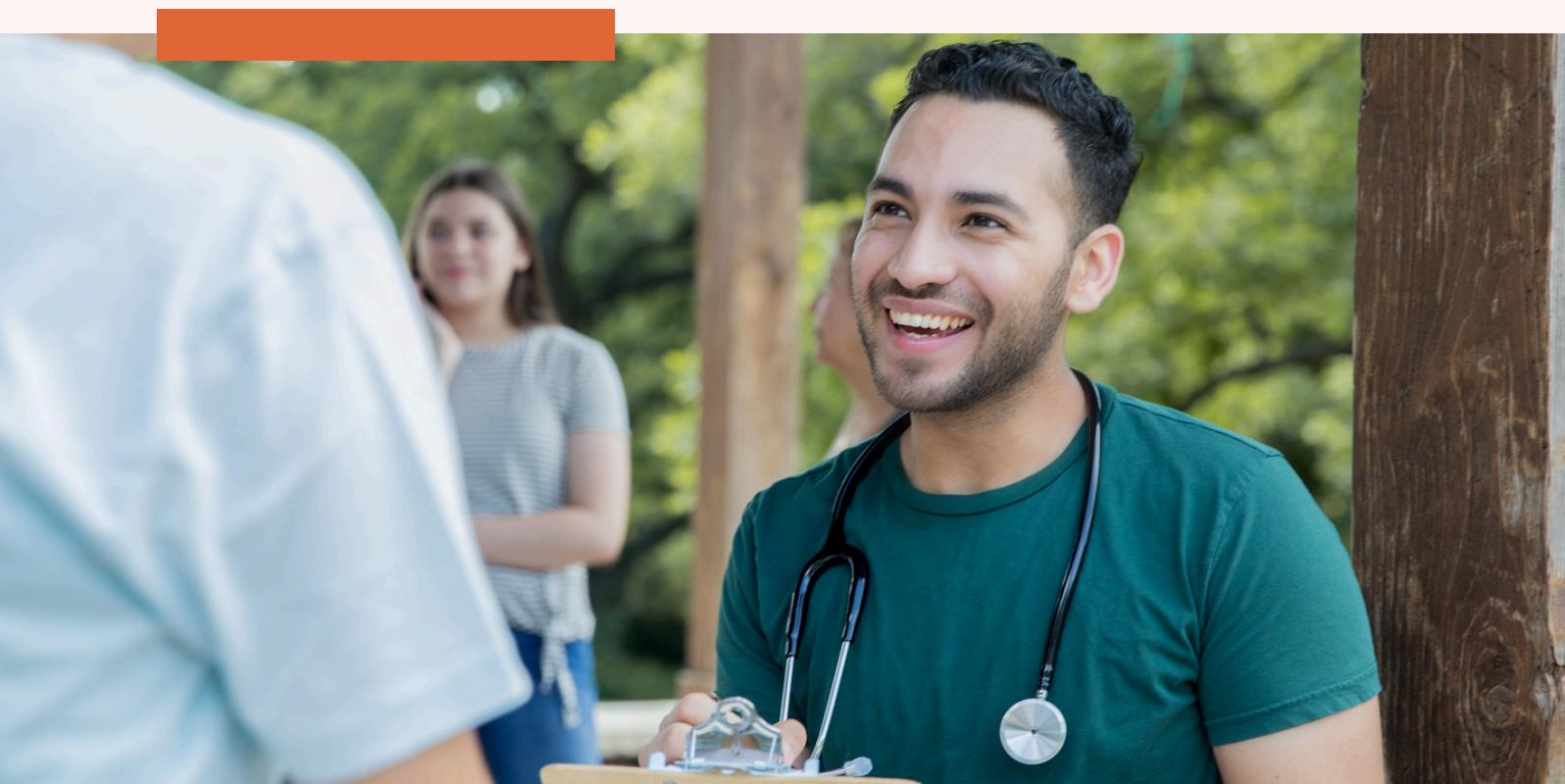


SHAPING THE CARE ECONOMY DEBATE: HOW PERSON-CENTRED FUNDAMENTAL CARE SHAPES QUALITY, SAFETY, AND EVIDENCE-BASED PRACTICE SUCCESS

THE INTERNATIONAL LEARNING COLLABORATIVE (ILC) GENOA 2025 STATEMENT



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The International Learning Collaborative (ILC) is promoting a new way for health systems across the globe to shape the care economy debate by getting person-centred fundamental care right. This care is essential to human life, and foundational to safety, quality, and human dignity.

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The ILC Genoa Statement 2025

Shaping the Care Economy Debate: how person-centred fundamental care shapes quality, safety and evidence-based practice success.

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Abstract

Objective/Aim: To present the fifth International Learning Collaborative (ILC) position statement summarising the main messages from the ILC 2025 International Conference and outlining the ambition to demonstrate how person-centred fundamental care shapes quality, safety and evidence-based practice success through redefining the care economy debate.

Background: Despite significant investments, supported by governments and the healthcare industry alike, we still have not managed to eradicate many of the most common safety and quality challenges in our health and care systems. The ILC is a global organisation dedicated to transforming care by valuing, prioritising and implementing person-centred fundamental care. Its mission is to embed person-centred fundamental care into everyday practice, reshaping relevant policies and advocating for change in education, research and interprofessional practice. The organisation has built a robust foundation of new knowledge and resources, with a growing global membership. The ILC annual conference generates a position statement each year to address a specific priority topic of international relevance.

Design/Method: Analysis and synthesis of key information and data from the 2025 conference co-hosted by the University of Genoa, Italy. The conference theme was Global Collaboration, Local Action for Fundamentals of Care Innovations. Keynotes, oral and poster presentations together with three specific workshops representing the areas of practice, education and research shaped the conference program and content.

Results/Key Arguments: The ILC's 2025 annual conference brought together the global community of fundamental care experts and champions. Conference delegates comprised 247 participants representing 17 countries from across four continents. . Strategies to promote the theme were identified as a set of action statements which included: Shaping the (person-centred

fundamental) care economy debate; Making (person-centred fundamental) care work more visible; Measuring what matters to patients; Redistributing and reconnecting so that nurses can focus on care; and Advancing person-centred care systems to promote safer care.

Conclusion: Nurses and care professionals need to be driving and shaping the care economy debate. Person-centred fundamental care must become embedded in our health and care practices, policy and systems, building a culture of caring as ‘business as usual’. There is a need to make a stronger case for demonstrating how person-centred fundamental care practices are foundational to good societal and economic care transformation as well as helping to improve safety and quality outcomes. The ILC Genoa Statement builds on the previous ILC position statements and provides a set of aspirational targets that can be used to continue or start important conversations with patients, their families, and colleagues to shape the quality, safety and evidence-based practice agendas globally.

What is already known about person-centred fundamental care and the care economy debate:

- Meeting patients' fundamental care needs is essential for patients' safety, recovery, and positive experiences within a healthcare setting.
- Delivering person-centred fundamental care is often missed or neglected in busy, operations-driven, stressful environments
- Despite nurses and other healthcare professionals acknowledging its importance there needs to be concerted effort at local, regional, national and global level to promote the foundational value of getting person-centred care right for patients, families and caregivers.

What this paper adds

This fifth ILC position statement proposes strategies for shaping the care economy debate by bringing care to the forefront and the voices of nurses and care professionals to the table where those debates happen. The strategies are:

- Making (person-centred fundamental) care work more visible.
- Measuring what matters to patients and care recipients.
- Redistributing and reconnecting so that nurses can focus on care.
- Advancing person-centred care systems to meet safety and quality expectations.

Keywords: Person-centred fundamental care; safety; quality; evidence-based practice; missed nursing care; fundamentals of care framework.

1.0. Introduction

1.1 *An Inconvenient Truth*

In the 25 years since healthcare systems embraced a safety and quality mandate, spurred on by landmark publications such as ‘Crossing the Quality Chasm’ (Institute of Medicine Committee on Quality of Health Care in America, 2001) and ‘To Err is Human: Building a Safer Health System’ (Institute of Medicine Committee on Quality of Health Care in America, 2000), much investment and organizational change has taken place. New structures, systems and processes have been introduced across health systems globally, significant progress has been made in terms of measuring quality and safety elements and whole industries that set national standards and undertake accreditation activities have developed.

Despite these significant investments, supported by governments and the healthcare systems alike, we, as nurses and healthcare professionals, still have not managed to eradicate many of the most common safety and quality challenges in our health and care systems (World Health Organisation, 2024). The WHO report summarised the following key facts which indicate our approach to safety and quality can still be improved. They state that around 1 in every 10 patients continues to be harmed in health care, and more than 3 million deaths occur annually due to unsafe care. In low-to-middle income countries, as many as 4 in 100 people die from unsafe care (Slawomirski & Klazinga, 2022). Greater than 50% of harm (1 in every 20 patients) is preventable; half of this harm is attributed to medications (Hodkinson et al., 2020; Panagioti et al., 2019). This means that 50% of unnecessary harm experienced by patients is related to other care interactions, and is often linked to missed nursing care (Ausserhofer et al., 2014; Mainz et al., 2025).

In addition to medication errors, common nursing or specifically person-centred fundamental care related adverse events include health care-associated infections, patient falls, pressure ulcers, and patient misidentification. Patient harm potentially reduces global economic growth by 0.7% a year (Slawomirski & Klazinga, 2022). Investment in reducing patient harm can lead to significant financial savings, and more importantly better patient outcomes (Slawomirski et al., 2017). An example of a good return on investment is patient engagement, which, if done well, can reduce the burden of harm by up to 15% (Auraaen et al., 2018)

In addition to safety activity, quality improvement approaches are now commonly embedded in healthcare systems. A scoping review however, indicated there are still challenges including cultural (i.e., resistance/reluctance to quality-focused culture and fear of blame or punishment), technical, structural (related to organizational structure, processes, and systems), and strategic (inadequate planning and inappropriate goals) related barriers that were commonly reported during the implementation of continuous quality improvement (CQI) approaches (Endalamaw et al., 2024). These challenges align with what we know are the main causes of safety failures that have been

classified into system and organisational, technological, human, patient and external factors (World Health Organisation, 2024).

The evidence-based practice movement (EBP) which also builds on safety and quality principles continues to grapple with the fact that it still takes on average 17 years for a piece of evidence (such as a clinical guideline) to be successfully implemented into practice (Rubin, 2023). Research on implementation effectiveness now suggests much more participatory, co-design approaches that attempt to bridge the gap between what we know and what we do to shift the mindset of how health systems respond to and operate contributes to safety, quality and evidence-based practice (Rubin, 2023).

1.2 Taking a different perspective on care

It is in this policy and practice space that we wish to promote taking a different approach to thinking about how our health systems describe, measure and deliver care, and particularly person-centred fundamental or intimate bodily care that is essential to human life, safety, dignity and quality. It is usually the case that this sort of care is assumed to happen within our systems – personal hygiene, eating, drinking, sleeping, resting, breathing properly, relaxing, moving around, talking and feeling comfortable, listened to and respected. It is similarly assumed all care professionals work as a team towards wellness, recovery or peaceful death (de Gans et al., 2023).

It's also the type of person-centred and personal care that is an antecedent to those nursing care related adverse events including pressure ulcers, hospital acquired infections, patient falls, misidentification, hospital acquired delirium, and deconditioning due to inadequate food and fluid intake (Cahill et al., 2023). Not addressing a person's basic self-care needs in a consistent, evidence-based way exposes them to potential risks. While nurses undertake multiple risk assessments as part of their role (Redley & Raggatt, 2017) research also shows that when there are workforce shortages or other system or organisational factors in play, care such as ambulation, turning patients and mouthcare (Mainz et al., 2025) tends to be missed.

Global demographic trends indicate that our healthcare systems will be dealing with older, potentially more vulnerable people with multiple comorbidities. These people will be at greater risk of deconditioning when they are admitted to acute hospital systems and will therefore pose greater safety risks if we cannot work out how to provide consistent person-centred fundamental care. Studies have demonstrated that by focusing on key elements of fundamental care such as nutrition, mobility and social engagement that the risk of hospital acquired delirium significantly reduces (Fong et al., 2023; Mudge et al., 2022). Other studies have shown that stroke outcomes can be improved when patients' temperature, glucose level and hydration are assessed in the Emergency Department and interventions commenced to stabilise patients (Middleton et al., 2017). However,

research also shows that challenges remain in the scale up and wider implementation (translation) of such evidence into practice (Cassier-Woidasky et al., 2025).

1.3 How person-centred fundamental care can benefit patient safety and quality as well as shape the care economy debate

The International Learning Collaborative (ILC) is a global organisation whose mission is to promote the effective implementation of person-centred fundamental care into health and care systems (www.ilccare.org). Acknowledging the foundational importance of getting fundamental care right, the ILC has worked with organisations, teams and individuals to raise awareness and work together to embed a more systematic approach to person-centred fundamental care delivery. Position statements have been produced (Kitson et al., 2019; Kitson et al., 2024; Kitson et al., 2023; Muntlin et al., 2025), which outline how nursing leaders can work with colleagues to ensure person-centred fundamental care is acknowledged, valued and delivered. The ILC has also led the refinement of how person-centred fundamental care is described, moving from a list of actions (Kitson et al., 2010) to recognising it as a complex, multidimensional set of activities that cut across three key dimensions – establishing trusting relationships with patients; knowing how to integrate physical, psychosocial and relational aspects of fundamental care; and taking account of the setting or context where care is being delivered (Feo, Conroy, et al., 2018; Kitson et al., 2013; Kitson & Muntlin Athlin, 2013).

Work has continued in terms of understanding how person-centred fundamental care principles can help deliver better and safer patient care whether it has been through a whole systems approach to person-centred fundamental care as part of the professional practice model in a hospital system (Merkley et al., 2022; Parr et al., 2018) or by embedding person-centred fundamental care into nursing curricula (Feo, Donnelly, et al., 2018; Jangland et al., 2022; Voldbjerg et al., 2018).

Each year the annual ILC conference selects a theme which resonates with participants, and from the interaction a position statement is developed. In 2025 the ILC conference theme was ***Global Collaboration, Local Action for Fundamentals of Care Innovations***. The purpose of this paper is to provide a summary of the main messages in the form of the 2025 ILC Genoa Statement entitled *Shaping the Care Economy Debate: how person-centred fundamental care shapes quality, safety and evidence-based practice success*.

2.0. Method

The co-chair of the ILC Strategy and Policy Forum (S Weeks) worked with the Head of School University of Genoa (A Bagnasco) and the Chair of the ILC (A Kitson) to lead the analysis and synthesis of the key messages coming from the conference (speakers, participants and workshops). A sub-group of the Conference Organising Committee developed a small group activity during the

Conference. All Conference participants were assigned key words to discuss in groups of 4-5 people. Participants were also asked to 'leave your reflections on what the Genoa Statement should focus on at the conference registration desk – it will be used to inform the Genoa Statement' This formed one of the main data sources.

Comments were collected and themed by A Kitson and shared with the Statement co-leads for sense checking based on reflective conversations with conference organising committee members and other participants. Statements were recorded onto an Excel spreadsheet and were themed according to five main areas of interest that were generated by the co-leads (Weeks, Bagnasco and Kitson).

3.0 Results

3.1 Key themes from conference speakers

Co-hosted by the University of Genoa, the conference attracted 247 participants from 17 countries. Speakers included Professor Linda Aiken who spoke about the importance of contextual factors, and particularly nurse: patient ratios which may influence the quality of the patient's experience of care. Professor Loredana Sasso shared preliminary outcome data from the Mauriziano Hospital study (CONFORM Study) (Bagnasco et al., 2025) showing that the length of stay for complex care patients in four wards that had implemented person-centred fundamental care had significantly reduced (by approximately two days), indicating substantial savings for the hospital (data not yet published). Professor Alison Kitson outlined the work of the ILC¹ over the past 10 years since the publication of a paper in the International Journal of Nursing Studies (Feo & Kitson, 2016). Global collaboration has indeed manifested itself in local action for fundamental care improvements. Nadine Gray, Chief Nurse of New Zealand, shared her journey of leading significant organisational change for the whole New Zealand health system and how important it is to support fundamental care principles.

From these selected presentations the prevailing message coming through was how context – politics, policy reform, organisational priorities - profoundly influence nurses' ability to deliver person-centred fundamental care . This was also confirmed by one of the presentations where, using predictive modelling techniques, the international team confirmed that the dimension 'context' influenced 'relationship' development which then was a predictor of how well person-centred fundamental care was delivered through the 'integration of physical, psychosocial and relational' elements of the framework (see also Allande-Cussó et al) .

¹ <https://ilccare.org/>

A total of 35 separate reflections from groups of 4-5 participants were handed into the registration desk. The majority were handed in after a group activity on the first day with multiple participants contributing to each reflection. A total of 120 discrete comments was collected via this means. Subsequent comments came from members of the conference planning committee (n=3) adding a further 35 separate or unique statements.

3.2. Key findings

The 155 unique statements were aggregated into one of five themes that had been identified by the co-leads after the first day of the conference and reviewed at the end of the conference. The themes included: Shaping the (person-centred fundamental) care economy debate; Making (person-centred fundamental) care work more visible; Measuring what matters; Redistributing and Reconnecting; and Advancing Person-centred Care Systems.

3.2.1. *Shaping the (Person-centred Fundamental) Care Economy Debate*

The World Economic Forum (WEF) (2024) report served as the impetus for this first statement as identified by Kitson in her keynote address. The participants were clear that we needed to continue to argue for care to be seen as a benefit and a strategic economic investment rather than seen as a cost. While the WEF report talked about care in generic terms (across the life span, undertaken by multiple people, both professional and unpaid) it did outline the importance of governments, businesses and local communities to work together to create the right values, principles, value propositions and investment strategies that would put care and caring at the centre of our societies. person-centred fundamental care was framed by participants as a foundational societal and economic asset that needed to be more clearly recognised and embedded into our health and care systems globally.

The ICN International Nurses Day 2024 Report (Stewart et al., 2024) highlights that investing in nursing generates substantial economic returns, with every USD 1 invested in better health yielding between USD 2 and USD 4 in economic benefit. Moreover, poor health drains 15% of global GDP annually (Remes et al., 2020). These macro-economic arguments reinforce the ILC's perspective that person-centred fundamental care is not a cost but a strategic societal investment that strengthens health systems, boosts workforce productivity, alleviates poverty and supports global economic resilience (Stewart et al., 2024).

Recognising that our care systems are not designed to manage the current and future demands requires us to think differently. With investments in the safety, quality and EBP movements still not showing significant and sustained shifts in some of the high-risk patient safety issues, the opportunity exists to look more systematically at person-centred fundamental care delivery. There

are opportunities to build on earlier position statements, and these were identified by several participants at the conference. Messages such as valuing, talking about, doing, owning and researching person-centred fundamental care were identified as central (Kitson et al., 2019) as was stepping up to the leadership challenge (Kitson et al., 2023; Muntlin et al., 2025) and shifting the conversation from one of deficit and blame to one of affirmation and determination to move forward (Kitson et al., 2024).

Another strong subtheme to emerge from the focus on how we positively shape the care economy debate was to use existing international objectives such as the UN Sustainable Development Goals (United Nations, 2015) and in particular Goal 3 (Health and Wellbeing); Goal 4 (Quality Education) and Goal 17 (Partnerships to achieve Goals) to argue for person-centred fundamental care . the diversity, equity and inclusion debate also needs to be considered alongside person-centred fundamental care and how nurse leaders facilitate more equity, capacity building and sustainable knowledge exchange across cultures and countries. While the focus of the conference was global collaboration, several comments from participants did raise the fact that there were few representatives from Africa, Asia or South America as ILC members.

Despite this lack of global representation, members from those countries which were represented talked about the excellent innovative local initiatives and growing cross border collaboration, and the importance of forming strong cross border research collaborations. This enables ILC members to embrace diverse cultural perspectives which ensures that the person-centred fundamental care agenda responds appropriately to varied cultural and systemic contexts, enhancing person-centred fundamental care's relevance and applicability. This in turn fosters innovation and shared learning which enable the spread of good ideas, their scaling up across systems and processes and helping to sustain any quality improvements that have been achieved.

Participants identified several potential strategies that could be used to shape the care economy agenda. These included continuing to establish long-term partnerships between universities, health and care institutions and research centres to promote research and scholarship into person-centred fundamental care and to provide more evidence of impact. Second, to identify and collaborate with like-minded organisations whose agenda for person-centred care and societal wellbeing aligned with the ILC. Organisations such as WHO, ICN, national nursing organisations, the European Academy for Nursing Science, and research initiatives such as ERASMUS and other European Union and international research initiatives were identified. From an educational perspective, international teaching modules, exchange programs for students and faculty were seen as great enablers for changing attitudes towards person-centred fundamental care .

3.2.2. *Make (Person-Centred Fundamental) Care Work More Visible*

The second theme to emerge was around making care work more visible in our health and care systems. This may sound like a strange statement – care is one of the most overused words in our professional vocabulary – so why is what we are talking about – person-centred fundamental care – so poorly understood and why is person-centred fundamental care so often the first care to be missed in busy health and care systems? There were many comments around this from participants. The continued invisibility of person-centred fundamental care in documentation, both written and electronic, potentially undermines patient safety, workforce engagement and innovation in person-centred fundamental care practices.

Greater visibility of person-centred fundamental care can be achieved using common language and frameworks to create consistency in approaches, and in particular through the Fundamentals of Care (FoC) framework, shift work routines from a ‘task and time’ mentality to relationship-based care activity (also termed ‘thinking and linking’) (Kitson et al., 2014). This consistent and systematic approach to describing person-centred fundamental care assessment, and interventions means that person-centred fundamental care can be embedded into clinical records, metrics and policy. Participants described things that nurses can do to make person-centred fundamental care more visible including consistent messaging from leaders and managers about the importance of person-centred fundamental care actively shifting the care culture from tasks to relationship-centred care, and the importance of acknowledging that getting fundamental care right was everybody’s business. There were multiple comments from participants about the interdisciplinary nature of delivering high quality person-centred fundamental care based on effective relationships, not just between nurses and patients, but between nurses, patients and their family members; between nursing teams to ensure continuity of care and between nurses and other members of the healthcare team. There were also many comments about the importance of acknowledging the theoretical foundations of the Fundamentals of Care (FoC) framework – embedded in the nursing theories of Nightingale (Nightingale, 1860), Henderson (Henderson, 1966; Henderson, 1978), Orem (Orem, 2001), Benner (Benner, 1982) were names cited by participants. Also, participants were keen to acknowledge that what the FoC framework had been able to do was shift discussions about abstract theory into something that was practical and pragmatic (Mudd et al., 2020).

Participants commented that hearing colleagues from across the globe affirming the importance and value of person-centred fundamental care and hearing how others are changing their care practices to embrace more relationship-centred activity, was very heartening. It also spoke to the importance of having person-centred fundamental care leaders and mentors in every system so they could role model how to make person-centred fundamental care happen in their organisation and be an inspiration to their students and junior staff.

Making care more visible is an ongoing task that requires belief, vision, commitment, resources, support and good learning materials. These were characteristics identified by participants to be manifested in leadership roles, in organisational priorities and in the ILC strategy.

3.2.3. *Measuring What Matters*

Without fail, at every ILC conference the topic of metrics comes up. It is a well-known truism that if you cannot measure something in a system it is hard to a) demonstrate that it exists and b) argue why it matters. This was the theme that had most responses for participants, but this year's comments were interesting in that participants talked about the sorts of things they wanted to see being measured rather than talk about how to shape existing metrics such as risk assessments, and nurse sensitive indicators and outcomes, to better incorporate person-centred fundamental care factors.

The 'what' we should be measuring list is summarised in Table 1. The 'what' was categorized into new content in terms of aspects of the FoC framework that needed more consideration. These elements are summarised in Section A of Table 1. Then there were several comments around the further development and refinement of new FoC tools, where participants commented on ways to capture and quantify the presence, quality and complexity of the Fundamentals of Care elements (Section B). A third section (C) requested more information and support on how to use discrete aspects of the Fundamentals of Care Framework to illustrate quality improvement and safety initiatives. A final set of comments (Section D) were on the need to generate more evidence of return on investment (ROI) of investing in person-centred fundamental care, building the evidence base for person-centred fundamental care and its impact, making sure that there is more systematic reporting of person-centred fundamental care activities system wide and using gaps in the clinical knowledge base to move the person-centred fundamental care agenda forward. This work aligns closely with other related initiatives (Curley et al., 2024).

Table 1. Identified robust measures required for person-centred fundamental care

What to measure
Section A Fundamentals of Care Framework elements needing more investigation
'Trust' in a client-professional relationship
Family involvement in person-centred fundamental care of children
'Relationship' is key to understanding a person's person-centred fundamental care needs
Relationships with clients and their families
Relationships with other members of the nursing team
Relationships with interprofessional team members
Effective application of T-FAKE
'Staying calm' in nurses and patients – understanding what this means and how to do it
Empathy – what it is, how to do it and how to teach it
Emotional wellbeing in patients
Emotional wellbeing in staff
Relationships between two, three or more key care recipients and those delivering care

Active listening skills
Making GOAL setting much more explicit in the framework and being able to integrate it into measures of effective person-centred fundamental care achievement
Section B Existing tools that need further testing and utilisation
Tools measuring FoC Framework in its entirety <ul style="list-style-type: none"> ○ Matrix work (Conroy et al., 2023) ○ Clinical co-ordinators/managers instrument (Lombardi Fortino et al., 2024) ○ FoCAT-CP (Feo et al., 2025) ○ FoC-IMT (Allande-Cussó et al)
Section C Specific measurements tools to support quality and safety evaluations
Tools using FoC Framework to measure specific concept <ul style="list-style-type: none"> ○ Perioperative User Participation questionnaire (POUP) (Kymre et al., 2023) ○ Person-Centred Pain Management questionnaire (Avallin et al., 2023)
Section D Suggested new evidence generation
ROI tools
Person-Centred Fundamental Care impact
Person-centred fundamental care reporting
Using gaps in clinical knowledge to move person-centred fundamental care agenda forward

What is clear from the reflections from participants at the conference is that to move the person-centred fundamental care agenda forward, much more coordinated work needs to be done around generating and testing appropriate measures that describe and evaluate the impact of person-centred fundamental care on patient care, on safety and quality indicators and on return on investment for organisations.

3.2.4 *Redistributing to Reconnect*

Care must be reclaimed by nurses via the redesign of workflows and appropriate delegation of non-nursing tasks, prioritising high value relational activities. This was a strong message coming from participants across the conference and from the reflective comments. Participants were also strongly advocating for a more interdisciplinary team approach to tackling person-centred fundamental care improvements. There were several detailed comments about extending the ILC work to medical and allied health professional colleagues and acknowledging that as several presentations demonstrated, improvements in fundamental care activity such as providing oral hygiene or ensuring that patients were able to eat and swallow safely required an interdisciplinary perspective.

How nursing leaders at the clinical level were able to facilitate this was also commented upon by several participants. Strategies included knowing how to effectively involve the different stakeholders – the patient, their relatives and key carers, other professionals – at different times and in different contexts where care was happening. Showing how taking a person-centred approach to fundamental care delivery was described as a real leadership skill as it required the ability to keep the relationship central, the skills to integrate physical, psychosocial and relational aspects of care for patients and to do this in fast-paced demanding contexts where many other priorities were being

played out. What was deemed to be important was how nursing leaders held onto their authority and power to shape the systems they were working in and not to give in to other pressures that were not person-centred in their philosophy. The exhortation was that nursing leaders and managers want to stay true to this professional commitment to deliver high quality person-centred fundamental care and not just obsess about numbers.

There were also several comments about the safety and quality agenda being utilised as a driving force for improved person-centred fundamental care delivery. These comments reflected earlier observations around measures and ways to show how getting person-centred fundamental care embedded in systems and professional routines can improve safety and quality outcomes. The fact that ILC members had created and were using a common language to describe fundamental care was seen as a positive as were the translations of the framework into multiple languages.

There were also acknowledgements of the value of networking at regular ILC conferences and events which provided participants with the opportunity to learn from each other and to share successes and learn from failures. These learnings reflected the conference theme – the to-and-froing of knowledge and experience to inspire and embolden individuals to want to do a better job at local level. Others commented on the importance of using technology and artificial intelligence to help redesign care systems, particularly in taking low-value care activities away from nurses and helping them focus on higher quality and safety return activities such as working closely with patients and their relatives to manage effective recovery and safe discharges.

3.2.5. *Advancing Person-Centred Care Systems*

The last theme to be generated from the reflections from conference participants related to how nurses could embrace the need to redesign their systems to be more person-centred. This was phrased as *'how to keep the patient at the centre, hearing their voice and acknowledging their lived experience'*. Respondents acknowledged that person-centred care systems started with the principle 'first do no harm' and build the system around meeting basic human needs. Florence Nightingale's principles (Nightingale, 1860) of hygiene, cleanliness, fresh air, sanitation, rest and sleep, creating an atmosphere of tranquillity and calm and actively involving and engaging the patient in their care and recovery were elements that were identified by participants.

They also reflected on how the fundamental care practice process (Conroy et al., 2016; Rey et al., 2020) could be more clearly and consistently articulated and practiced. Establishing the relationship was the first step, followed by observing the situation, asking relevant questions, listening, planning, doing and documenting – aspects of any nursing process or PDSA (Plan, Do, Study, Act) approach but tailored to help protect the centrality of the patient experience. Characteristics of taking a person-centred fundamental care approach included helping patients to self-care and to set recovery goals, involving significant others and relatives in this process and knowing how to

establish and manage trusting relationships, whether that was between the nurse and the patient, with the nurse, patient and their key carers, or across a wider set of relationships with other professionals.

The 'critical thinking' role of the nurse was acknowledged along with their role as a leader in embedding and protecting the person-centred care ethos as well as working effectively with other professionals. If nurses see themselves as champions of promoting person-centred fundamental care in every organisation, a strong mandate for transformational change will be created across the whole system. Such a vision would also naturally embrace the equity and inclusion agenda because focusing on the person at the centre of care means tailoring activity to meet their unique, individual needs for care. Reassuring nursing leaders that these actions are within their spheres of control and influence was another reflection from participants and demonstrated a desire to use pockets of good practice across the globe as inspiration to improve systems and processes in their own backyard. As one group of participants responded, *'if you're not at the table you're on the menu'*.

4.0. Discussion

Consistent with previous conferences, the Genoa participants reflected enthusiasm and determination to continue the mission of improving how person-centred fundamental care is embedded in our health and care routines and systems. New perspectives to emerge included the need to make a stronger case for demonstrating how person-centred fundamental care practices are foundational to good societal and economic care transformation as well as helping to improve safety and quality outcomes. Continuing to build on the messages from previous conferences was an important strategic action. Position statements act like calls to action and therefore can be used by nursing leaders to enthuse staff and help them identify the opportunities for improving fundamental care delivery.

The ILC membership will need to move into a wider policy and political influencing area. So far, the ILC has established networks of stakeholders across leadership, practice, research, and education. Building a critical mass of influencers will aid in advancing the care economy debate locally, nationally and internationally, and generating an evidence base that will ensure changes person-centred fundamental care innovations are rigorous and evaluated. The ILC's organisational structure and global membership base will need to invest further in moving this agenda forward. Table 2 reflects what success will look like as we move the Genoa Statement into action.

Shaping the care economy debate

Demonstrating the Economic and Social Value of Person-Centred Fundamental Care

Fundamental care supports not only individual dignity and wellbeing, but also underpins broader economic stability by promoting better health outcomes and reducing preventable complications.

Collecting and Showcasing Case Studies

Case studies can clearly illustrate the direct impact of person-centred fundamental care on both individuals and health systems, and delivering such care at scale.

Addressing Safety and Quality through Foundational Work

By targeting issues related to missed care, we aim to improve outcomes for patients and reduce risks associated with inadequate fundamental care.

Alignment with International Goals

The ILC will ensure that our initiatives are leading or closely aligned with established international objectives that seek to improve economic conditions, health outcomes, and overall wellbeing.

Fostering Collaborative Partnerships

The ILC will actively seek out partnerships with organisations that share our vision, working together to realise the full potential of person-centred fundamental care for all.

Making Care visible

Building on the Fundamentals of Care Framework

The ILC will further develop and utilise the standardised language provided by the Fundamentals of Care Framework, ensuring that person-centred fundamental care is clearly described and can be effectively communicated across a diverse range of languages.

Emphasising the Centrality of Relationships

Central to person-centred fundamental care is the establishment of a trusting relationship. We emphasise that care must address integrated physical, psychosocial and relational needs, while also considering the specific environment and context in which care is delivered.

Strengthening Interdisciplinary Collaborations

We continue to honour the significant contributions of nursing theorists who have historically described the essence of care. In addition, we actively seek collaboration with our interdisciplinary colleagues, with the shared goal of enhancing the experiences of people receiving person-centred fundamental care.

Measuring what matters

Driving Research and Measurement in Person-Centred Fundamental Care

Ongoing efforts to unite clinicians, leaders, academics, and research teams will assist in refining and measuring the concepts and interventions that underpin person-centred fundamental care.

Setting an International Collaborative Research Agenda

The ILC will establish an international research agenda focused on collaborative activities across several key domains:

- Measuring critical aspects of the Fundamentals of Care Framework for consistent application.
- Developing tools to measure clinical interventions linked to specific Fundamentals of Care elements
- Undertaking more cost benefit and return on investment studies that demonstrate the value of investing in person-centred fundamental care.

Redistributing and reconnecting

Leading the Redesign of Workflows for Relationship-Based Care
Driving the redesign of clinical workflows, with a particular emphasis on delivering high quality, relationship-based care, while delegating non-nursing tasks through the effective use of technological solutions

Fostering Shared Learning – Interdisciplinary and International
Fostering a culture of shared learning through the authentic exchange of real-world experiences, facilitating collective growth and ongoing development within the nursing profession.

Advancing person- centred care systems

Embedding Person-Centred Fundamental Care in Practice
A steadfast commitment to keeping the patient and their families at the centre of all that we do, by prioritising the integration of the Fundamentals of Care practice process across all aspects of nursing. Make certain that the work of the ILC and its Members is carefully documented and accessible to the broader healthcare system, enabling shared learning and continuous improvement.

Partnering With Care Recipients/Patients/Clients
Actively listen to patients, valuing their voices and recognising the importance of their lived experiences in shaping the care they receive. The ILC will work in partnership with care recipients and their established care networks.

These action statements build on the previous ILC position statements and provide a set of aspirational targets that can be used to continue or start important conversations with patients and other colleagues. The ILC's five-year strategic plan also reflects these aspirations and reassuringly we know from the reflections from ILC participants at the Genoa conference that what they have articulated is indeed what the strategic direction of the ILC is. Now we can continue to work together to realise our vision.

5.0 Conclusion

More than ever, governments, businesses and local communities need to work together to create the right values, principles, value propositions and investment strategies that will place care and caring at the centre of our societies. This is an urgent requirement given what we know about demographic change, illness patterns and the rise in the need for high quality, safe, evidence-based respectful person-centred fundamental care.

Our care systems are not designed to manage the current and future demands and will require different strategies to solve the problems around who is going to deliver person-centred fundamental care and how we are going to do it. With investments in the safety, quality and evidence-based practice movements still not showing significant and sustained shifts now is the time to consider new approaches to combine fundamental care innovations at local, regional, national and global levels. The ILC Genoa Statement calls for action through shaping the (person-centred fundamental) care economy debate, making (person-centred fundamental) care work more visible, measuring what matters to patients and their families around the delivery of person-centred fundamental care, redistributing nursing workloads and reconnecting nurses and other members of the interdisciplinary care team to focus on patients as human beings and advancing person-centred care systems.

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