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# Factors triggering the progressive detachment of nurses toward the fundamental needs of patients: findings from a qualitative study

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## Abstract

The progressive desensitization of nurses in relation to fundamental needs (FNs) has been documented in anecdotical, scientific, and policy literature with nurses spending limited time at the bedside, thus affecting the quality of care and clinical outcomes. A potential reason that has been recognized is the limited nursing staff available in the units. However, other cultural, social, and psychological factors which have not been investigated to date may have a role in triggering the phenomenon. To investigate nurses' perceptions of the reasons that progressively detach clinical nurses from the FNs of patients, was the main intent of the study. In 2020, a qualitative study based on grounded theory following the Standards for Reporting Qualitative Research guidelines was performed. Purposeful sampling was adopted, by including 22 clinical nurses designated as 'good nurses' according to the perception of nurses working in executive and academic position. All agreed to be interviewed face-to-face. The detachment of nurses from the patients' FNs has been explained by three main factors that are interconnected: namely '*Being personally and professionally convinced regarding the role of FNs*', '*Being progressively detached from the FNs*', and '*Being forced to be detached from FNs*'. Nurses also identified a category including strategies aimed at preventing detachment and '*Rediscovering the FNs as the core of nursing*'. Nurses are personally and professionally convinced about the relevance of the FNs. However, they distance themselves from the FNs due to: (a) factors mainly attributable to internal personal and professional forces, such as the emotional fatigue that daily work entails; and (b) external forces related to the work environment where nurses work. To prevent this detrimental process that may result in negative outcomes for patients and their relatives, several strategies at the individual, organizational, and educational levels should be implemented.

**Keywords** Fundamentals of care · Fundamental needs · Grounded theory · Nursing · Qualitative research

## Abbreviation

FN Fundamental needs

## Introduction

Traces of the progressive desensitization of nurses toward patients have been documented since 1994, when students were already being shown to demonstrate detached behaviors during their education; this was in line with observations of them by nurses in their clinical practice [1]. In recent times, an increased perception of this phenomena has been reported with nurses devoting limited time to the fundamental needs of patients (e.g., physical, emotional), especially older ones [2]. Anecdotical (e.g., [3]), governmental (e.g., [4, 5]), professional, and scientific data (e.g., [5, 6]) have all documented that nurses have struggled to deliver care for fundamental needs (FNs). These include staying with patients, educating them, helping in basic needs (e.g., eating and drinking, ensuring mobilization), and ensuring comfort (pain management included)—all the aspects recognized by patients as being the most important [7], and thus fundamental or essential [7]. The same concept of 'Basic nursing care' has been debated to highlight that when this requires applied knowledge and clinical judgment acquired by a long education, such as that achieved by nurses at the university levels, the care delivered is not simply 'basic' [8], but it is a 'fundamental'. The Fundamentals of Care concept originated by Kitson and colleagues in 2010 [7] and later developed in the Fundamentals of Care Framework embodies three core

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dimensions: the need to develop a trusting therapeutic relationship between the patient and the nurse, the integration of all physical, psychosocial, and relational needs, specifically in a context of care that is supportive of the relationship development and care integration [9]. However, despite the recently established clarity in the concept of 'Fundamentals of Care' as being different to that of 'Basic care', with the former expected of nurses and the latter by other professionals (e.g., nursing aides), the perception of detachment is still present. Patients and families have been reported to perceive the progressive erosion of the time that nurses spent at the bedside [10]; fundamentals such as talking with patients and helping them to walk, are largely missed [11], affecting the quality of care, and ultimately clinical outcomes.

Some factors have been identified as potential causes of the phenomenon, such as the progressive reduction of the nursing staff available in the units, high workloads, the limited number of newly graduated nurses and, more recently, the lack of vocations for nursing among prospective students about this profession [12], and the increased number of nurses who leave the job [13]. However, alongside some well-known structural factors, there is a perception that other not-investigated cultural, social, and psychological factors have a role in this phenomenon [14]. Contributing to the in-depth understanding of the phenomenon might inform strategies to prevent its further proliferation, which could not only affect the quality of care perceived by patients, but also the willingness of nurses to remain and invest in the profession. Therefore, the main objective of the study was to identify the factors influencing the detachment of clinical nurses from FNs, as perceived by clinical nurses.

## Methods

### Study design

To detect perceptions of nurses and key cultural, social, and psychological processes [15] affecting the progressive detachment of nursing from the FNs, a qualitative study was performed based on grounded theory [16]. We used this methodology given that there is no existing theory that explains the phenomenon under investigation [17]. The Standards for Reporting Qualitative Research (SRQR) [18] have been followed as reported in the Supplementary Table 1.

### Research setting and participants

An e-mail to all members of a Provincial Nursing Board ($N=4289$) located in the Northeast of Italy was sent to present the research protocol to stimulate awareness and motivation on the topic. Purposeful sampling was used [19], by identifying a first list of 20 registered nurses (RNs) of the same Nursing Board, as 'extraordinary examples' of clinical nurses' role models, according to the perception of nurses working in executive (nurse managers, nurse directors) and academic positions (professor and nurse educators). Specifically, nurses were approached based on their designation as 'good nurses', who always showed attention to human needs, compassion, capacity to (actively) listen while being respected by the community of nurses.

The eligible nurses were approached by e-mail and then telephone to assess their willingness to participate after the main aims of the study and its procedures had been explained to them. The sampling of nurses continued until no new codes were emerging [20], as judged independently by two researchers. As reported in Table 1, 22 nurses were interviewed (21 of them female) with an average age of 41.4 (SD 12.6) and with 17.5 (SD 13.5) years of experience. They were mostly clinical nurses (19 out of 22), educated at university level (13 out of 22), and working in different units where they cared for an average of 12 patients (ranging from 1 to 35) a shift. At the end of the process, member checking of the findings [19] was performed with an additional two male nurses, to ensure gender balance, and no additional codes emerged, thus confirming the findings.

### Data collection

In accordance with the recommendations of the literature [4, 6, 8], a plan for a semi-structured interview was developed (Table 2) to be administered face to face. In the first two interviews, the questions were also piloted, and no changes were required in terms of comprehensibility and acceptability. Subsequently, the interviews were conducted in 2020 by researchers (EV, [RN, Master of Nursing Science Student], MI [RN, Bachelor of Nursing], GP [RN, Bachelor of Nursing], MS [RN, Bachelor of Nursing]). A preferred setting was chosen with each participant nurse, which was protected from distractions (e.g., the presence of other people, noises) [21], and sufficient time was allowed for the interviews in order to balance professional and personal responsibilities. After an introduction, it was established that the interviewers had no previous relationship with the participants, and the study aims and procedures were explained. After this, written consent was obtained. During the interview, the questions were only used as a guide, leaving participants free to share their experiences [22]. Each interview was tape recorded and then immediately transcribed verbatim by the same researcher.

### Data analysis

Inductive data analysis was performed based on a constructivist epistemological position [16]. One researcher

**Table 1** Participants' characteristics

| N | Gender | Age | Nursing education | Current Role | Department | Experience as a nurse, years | Nurse-to-patient ratio (nurse:patients) in the last shift |
|---|---|---|---|---|---|---|---|
| I1 | F | 49 | Nursing Diploma | Clinical nurse | Specialistic surgical day-hospital | 29 | 1:8 |
| I2 | F | 25 | Bachelor in Nursing | Clinical nurse | Cardiology | 2 | 1:19 |
| I3 | F | 55 | Master degree | Ward manager | Mental Health | 36 | NA |
| I4 | F | 60 | Nursing Diploma | Clinical nurse | Medical | 25 | 1:30 |
| I5 | F | 47 | Nursing Diploma | Clinical nurse | Dialysis | 25 | 1:3 |
| I6 | F | 32 | Bachelor in Nursing | Clinical nurse | Hematological | 9 | 1:6 |
| I7 | F | 54 | Bachelor in Nursing | Clinical nurse | Cardiological | 35 | 1:1 |
| I8 | F | 28 | Bachelor in Nursing | Clinical nurse | Medical | 5 | 1:16 |
| I9 | F | 30 | Bachelor in Nursing | Clinical nurse | Hematological | 7 | 1:8 |
| I10 | F | 28 | Bachelor in Nursing | Clinical nurse | Emergency | 4 | 1:8 |
| I11 | F | 37 | Bachelor in Nursing | Clinical nurse | Dialysis | 13 | 1:4 |
| I12 | F | 62 | Master Degree | Ward manager | Pediatric | 42 | NA |
| I13 | F | 50 | Nursing Diploma | Clinical nurse | Nursing home | 27 | 1:5 |
| I14 | F | 35 | Bachelor in Nursing | Clinical nurse | Nursing home | 0.6 | 1:35 |
| I15 | F | 57 | Nursing Diploma | Clinical nurse | Surgical | 38 | 1:20 |
| I16 | F | 54 | Nursing Diploma | Clinical nurse | Medical | 24 | 1:10 |
| I17 | F | 49 | Nursing Diploma | Clinical nurse | Medical | 24 | 1:10 |
| I18 | F | 33 | Bachelor in Nursing | Clinical nurse | Emergency | 7 | 1:3 |
| I19 | F | 24 | Bachelor in Nursing | Clinical nurse | Nursing home | 0.6 | 1:35 |
| I20 | F | 25 | Bachelor in Nursing | Clinical nurse | General Practitioner Ambulatory | 1.5 | 1:15 |
| I21 | M | 41 | Bachelor in Nursing | Clinical nurse | Intensive care | 18 | 1:2 |
| I22 | F | 36 | Bachelor in Nursing | Clinical nurse | Semi-intensive surgical | 13 | 1:8 |

*F* female, *I* interview, *M* male, *NA* not applicable, *N* number

**Table 2** Face-to-face interview schedule

| |
|---|
| (a) Initial question to align the concepts |
| What comes to your mind when I mention FNs? May you describe in your last shift, how you or your team provided the care to these needs in your unit? |
| (b) The central part of the interview |
| How do you feel when you take care to the patients according to his/her FNs in daily practice? |
| There is a widely perception that nurses are detached, away up to refuse to give attention to the fundamental needs. What is your experience with this regard? |
| What are in your experience, the factors influencing the willingness of nurses to consider the FNs of the patients as the core of their profession and daily practice? |
| (c) The final questions |
| Do you have other reflections or insights around this topic? |
| Can you fill in the social-demographic form to describe the main features of the nurses involved? |

*FN* fundamental need

transcribed the narratives verbatim immediately after each interview resulting in 45 pages of transcripts. Then, the following steps were conducted: (a) open coding: two researchers coded the transcribed narratives line-by-line [23], extracting significant units and then labeling them simultaneously in order to categorize them [24]; (b) axial coding: at this time, we used the most significant or frequent initial codes to sort, synthesize, integrate, and organize data, through the focused coding aim to use the most significant and frequent codes [16], by drawing connections between codes; and (c) selective coding: using the codes, we defined the major categories that explicated ideas, events, or processes, subsuming common themes and patterns in several codes [16]. Consequently, a total of four categories and 14 codes emerged. Exemplary quotes from interviews have been extracted to support each category/code, and reported in anonymised fashion (e.g., I6, Participant Interviewed number 6).

All researchers analyzed data independently and then agreed on the findings. All authors discussed the categories together until they reached agreement. The constant comparison procedure was used to develop and theoretically refine relevant concepts and categories [15]. The supplementary Table 2 shows the strategies adopted to ensure rigor.

## Ethical considerations

All participants received written and verbal information regarding the study; participants signed a written consent form. All phases of the study complied with the principles enshrined in the Helsinki declaration, and no formal permit from an ethics committee was required [25], as participation in the study was on a voluntary basis, no interventions were administered to participants and no information was asked about nursing care for specific individuals or contexts. All data were treated anonymously and confidentially.

## Results

The progressive detachment of nurses regarding the FNs of patients has been explained by three main factors, which are interconnected, namely 'Being personally and professionally convinced regarding the role of FNs', 'Being progressively detached from the FNs', and 'Being forced to be detached from FNs'. Nurses also identified a category including strategies aimed at preventing detachment and 'Rediscovering the FNs as the core of nursing' (Fig. 1).

### Being personally and professionally convinced regarding the role of the FNs

Participants reported that FNs are essential and unavoidable aspects of care, without which nursing as a discipline and profession does not exist. Nurses believe that attending to the needs of patients means (a) '*Being close to the essence of nursing'*, (b) '*Feeling proud and satisfied*' and ultimately, (c) '*Feeling [like] a full nurse'*. First, taking care of the patient holistically, is described as essential to deepen the knowledge of his/her needs, and to shape the best quality care; in fact, '*basic care reveals many things about the patient*' (I14). For this reason, dealing with the FNs represents the essence of caring, and is therefore essential in nursing care. Feeling responsible for the holistic care also brings out experiences of '*great satisfaction*' (I16), '*because ultimately you work for that*' (I6), as also recognized by the '*families*.' (I6). Finally, nurses are considered full nurses when they integrate a perspective based on the FNs as a fundamental component of their clinical care: '*If doing hygiene means observing the patient, and not simply doing tasks, it changes the approach, it becomes a moment of clinical investigation, an active part of the patient care to identify issues*' (I22). However, many factors push nurses being away from the patient and this progressive estrangement has consequences both on the patient and on the nurses themselves '*The loser is the patient, and perhaps you too professionally*' (I16).

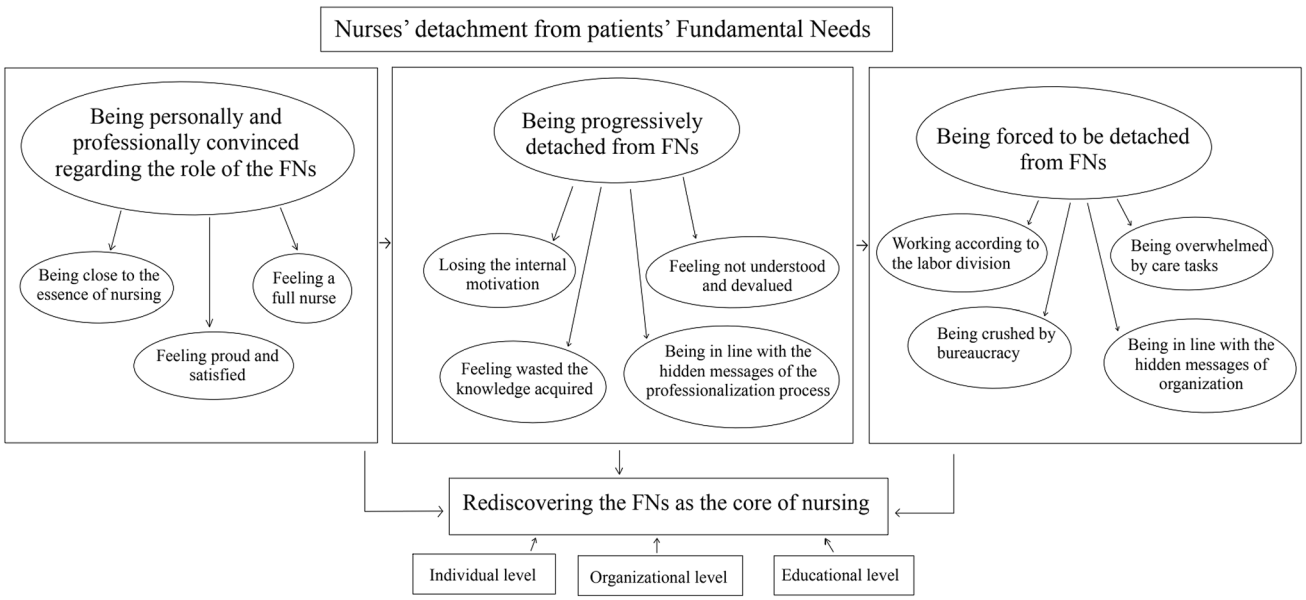


**Fig. 1** Categories and codes

## Being progressively detached from FNs

In contrast to the well-recognized value of the FNs, several internal personal and professional factors have been reported as being implicated in detaching nurses from taking care of the FNs, as narrated by participants.

- '*Losing the internal motivation'*: the emotional heaviness of nursing care emerges as a relevant aspect, where any distancing strategy is perceived as an opportunity for professional respite: '*The fundamental point is that being close to the person who is ill is heavy*.' (I3). Close contact with sick bodies also generates emotional fatigue, which requires support, although this does not seem to be acknowledged, either in the clinical context or in society '*The body is an ambiguous, a dense presence: as a patient I offer my body to her, but my body is my life, it's that something that speaks for me when I can't give voice to certain feelings and emotions. And this encounter with this dense corporeality engages those who approach it very much, because in turn it needs to be supported*.' (I12). The accumulation of fatigue triggers an avoidance strategy of taking refuge in technical skills as a sort of salvation: '*After years of working you are tired*' (I15).
- '*Feeling [I] wasted the knowledge acquired'*: if the FNs are simple helping acts, in which knowledge is not applied, the nurses perceive that they are dealing with non-nursing tasks. '*You don't need to spend a lot of time studying to do this job. You don't need a nurse to do accurate hygiene*.' (I6). It therefore depends on the amount of knowledge that is available, and which can be applied. FNs attract limited space in undergraduate, postgraduate, and also continuing education programs. This generates the perception that they have no value as there is no knowledge to apply and, therefore, they are simple acts of help.
- '*Feeling not understood and devalued'*: when nurses devote attention to FNs they feel not recognized in their competences because '*These things are substantially considered non-nursing tasks*.' (I2, I3). This is also a social process; nurses who would dedicate time to these needs are considered outdated, '*antiquated*.' (I9). The other professions do not attribute importance to these activities as if they are considered meaningless; they do not ask for information on basic needs, as if they had no relevance in the clinical pathway.
- '*Being aligned with the hidden messages of the professionalisation process'*: the detachment is also triggered by the ambiguous messages hidden in the professionalisation process of nurses, where little dedication is devoted towards the FNs. In the progressive growth of the nursing profession, teaching, practice, and research of the FNs are of little relevance, and this is a hidden message interpreted by nurses who detach themselves from the FNs.

## Being forced to be detached from FNs

Some external factors more related to the organizations where nurses work have been reported as forcing them to stay away from the FNs up until the COVID-19 pandemic, when a further worsening of the detachment process from the patient occurred due to the protective barriers, the distancing rules, and the absence of caregivers: '*COVID-19 has triggered an increased closure and detachment of the profession from patients and their needs*' (I12). The following external factors have emerged:

- '*Working according to labor division*': the division of work especially in the hospital context, stratifies the activities into a list of tasks and roles. For example, the care hygiene is routinely entrusted to the nurses' aides consolidating the idea that are activities '*no longer the responsibility of nursing*' (I4, I2). This is also the case among the future generations of nurses. The prevalence of attention to the work organization and its priorities (e.g., times for carrying out tasks) has reduced the importance of patients and the centrality of their care. Therefore, in this labor context what revolves around the patient seems to have no meaning.
- *'Being overwhelmed by care tasks'*: the decision not to stay away from patients is also forced by the prioritization of care, where several tasks are in competition with each other, where some are seen as being higher priorities than others—: *'Personally I would take a long time, I wouldn't know how to do it: it would be difficult to get even that one*.' (I6). The high workloads perceived by nurses prevent global nursing care: '*Things to do have tripled, everything is accelerated, there is less time to be with the patient*' (I3).
- '*Being crushed by bureaucracy*': the time devoted to bureaucratic tasks is seen to be very demanding and time-consuming. This distances the nurses tremendously from the patients and their direct care: '*there are 20–30 phone calls during the morning shifts, 90% of which are not related to the patients you have in the ward, but they are strictly administrative matters*' (I9).
- *'Being in line with the hidden messages of the organisation'*. There are also some hidden messages that derive from the organization: priority is given to quantity and not to quality of care delivered, prompting the idea that staying close to the patient is wasting time. All things are measured, as the time spend in administering the medications. Those nurses who can interpret this model are valued and considered. In addition, several other activities that have been introduced to the organization (e.g.,

related to the accreditation processes), and '*this slice of work has fallen a lot on the shoulders of nurses*.' (I12). Therefore, nurses are forced to leave the core of nursing care to fulfill these tasks.

### Rediscovering the FNs as the core of nursing

According to participants, rediscovering the FNs of patients both professionally and personally is possible through some strategic actions that should be implemented on three levels: individual, organizational, and educational.

At the individual level, nurses should be educated from the beginning of their undergraduate education to reflect individually on the meaning of nursing and nursing care: '*I am used to reflecting, and this helps me to keep in mind the relevance of the FNs*.' (I1). At an organizational level, strategies should be found to ensure nurses the opportunity to share the meaning of nursing and nursing care within the working group, in order to engage and influence those who are more detached. This would allow nurses the opportunity to share their reflections on the FNs, giving their vision a value, and transforming their personal perception it into a group culture and habit: '*There are very good professionals who should be valued and who can teach [others] how to be close to patients over time*.' (I3).

Nurse Managers should support nurses in fully considering FNs, by ensuring formal opportunities (e.g., continuing education) for their individual and collective reflections: '*Nurses should be helped to find spaces for reflection on their clinical practice contextualized in the here and now*.' (I12). The functional model, in which the tasks are divided among the nurses available on shift, but the patient is not seen for '*all his/her needs*' (I21), should be avoided, whereas teamwork should be promoted. Nurse Managers should also negotiate an adequate human resource allowing nurses '*to dedicate themselves to the needs, and to dedicate time to patients*' (I2). Workloads should be balanced not only inside the unit, but also across the hospital where there is often an ineffective distribution of resources, with some departments well equipped and others not. According to participants, '*Reducing and redistributing the workload would allow for a more complete care for of the patient*.' (I18). In this context, recruiting administrative staff to delegate the activities performed by nurses, and rendering free valuable time for the FNs '*is important to prevent the huge number of bureaucratic-administrative tasks by which the nurses are often overwhelmed*.' (I14) New technologies will help by '*reducing the bureaucratisation of nursing care, with more agile approaches that would allow nurses [to] focus more on patients*' (I22). Therefore, investing in digitisation would increase the time savings from administrative and sometimes repetitive activities (such as documenting tasks in several paper and pencil records).

Overall, the system and the working environment should incorporate attention to the needs of professionals: they cannot maintain concentration on patients' FNs if '*their [i.e., nurses'] needs are not considered in the structure in which they work*' (I20).

Finally, at the educational level, there is the need to rethink undergraduate education: participant nurses are convinced that to increase attention with regard to the FNs, a full reconsideration of nursing education is necessary, offering students opportunities to understand the meaning of the fundamentals of care and their relevance for clinical outcomes: '*university preparation is centered on techniques and methodologies, rather than on the ill person's needs*.' (I17).

## Discussion

We used grounded theory [19, 26] as an analytical approach to qualitative data combined with an inductive process whereby theoretical insights are generated from data to develop a psycho-social understanding of the progressive detachment of nurses with regard to FNs as a phenomenon. We sought a purposeful sample of nurses, who had been recognized in the community as 'exemplary nurses', and who were thus in a position to act as role models and clinical leaders [27]. They were all convinced of the value of patients' FNs and the dedication they deserve, not only because of the significance they have in the discipline and nursing profession, but also because while meeting the patients' needs they reach a sense of utility and gratification both from individuals (the patients) and society (e.g., the family). Moreover, being close to patients, nurses also perceive an expansion of their knowledge [28]. In other words, they are capable of contributing to the patient's clinical pathway and understanding of his/her health problem. The professional profile of participant nurses reflects that, as documented at the national level [29], their position regarding the FNs has emerged as substantially homogenous and of high value, with this as a positive deviant approach—which is thus different to the anecdotical, and scientific literature reported at the national and international level (e.g., [5]).

Finding first suggests that nurses are in deep personally and professionally convinced on the relevance of FNs, suggesting that they fully embody the concept of nursing care as focused on FNs that also trigger professional satisfaction. Findings also indicate that nurses are not focused on fundamental needs because they are influenced by two main processes: (a) the first leads to a progressive distance mainly due to personal and professional factors; and (b) the second where external forces keep nurses away from patients' needs. Concerning the latter, the dramatic experience of the COVID-19 pandemic, during which several strategies have been enacted at hospital levels (e.g., preventing family

members from visiting, limiting face-to-face contacts), has introduced a further distance between nurses and FNs further shaping their attitudes. These will be difficult to change given that years have been spent valuing, for example, the presence of family at the bedside, and there is a key need to facilitate this [30, 31].

The first process involved in the nurses' detachment from the patients' FNs seems to be internal for the nurses, whereby they lose motivation, perceive that they are wasting knowledge acquired during the academic education when devoting time to basic needs, think they are not being understood by others (e.g., colleagues), and are not aligned with the professionalisation process of nursing; all these reasons play the main role. These factors may be considered in two different ways: first, they express the consequence of the complexity of staying close to patients and their suffering, triggering compassionate fatigue (e.g., [32]). On the other hand, all factors seem to rely on some misunderstandings of the professionalisation process: with the progressive growth of nursing education, both in duration and level (from diploma to academic settings), nurses expect to apply knowledge learnt. When dealing with basic needs (e.g., eating, walking), these needs do not appear relevant to nursing care, because they are not taught, based on a strong body of research-based knowledge, and not recognized as relevant by both the educational and organizational system. Previous authors have emphasized the difference between basic needs (those where patients require only simple support) and fundamental needs (where academic, clinically based knowledge should be applied, to integrate all dimensions) and how the latter deserves greater consideration in education, research, and practice. Therefore, the force starting the process of distancing nurses from the FNs seems to also rely on hidden messages coming from the undergraduate and continuing education curriculum and workplaces [33].

The second force is that which establishes the nurse's detachment from patients' FNs', by fixing it over time. These are factors external to the profession and associated with the organization and work environments, in which the limited resources devoted to nursing care, the number of tasks required to be performed during shifts, the time required for bureaucracy issues, as well as the performance indicators of the organizations which express the need to proceed rapidly, on essential issues, impose a definitive distance between nurses and FNs. Emerging values in the organization appear to force nurses into some limited priorities, by determining practices, rules, protocols, and procedures for acting, in a substantially homogeneous manner. These factors can be attributed to the system which acts in an interrelated way on the frailty of nurses in a sort of looming hierarchy. Such factors that do not only pertain to the unit but belong to the system (including how the patient and his/her needs are considered, thus triggering nurses to consider only some aspects), ultimately leave patients vulnerable to unmet educational, emotional, and psychological needs. In other words, the values that influence systems create social structures that influence human action, and individual motivations for action related to resource allocation and to how individuals rationalize actions to resist or comply with social structures [34]. Technocracy in healthcare has already been underlined as threatening the concept of humanity, where the patient's needs are subordinated to the priorities of the organization; technology is overvalued, little moral debate is possible, there is mainly attention on controlling performance and not the drive for values, by the forcing of homogeneity [35].

Strategies suggested by nurses are substantially in line with their perceptions: they suggested spaces for reflection on care delivered, more attention to resources that should be available at the unit level and better distributed across departments to ensure a social justice in the workloads. They also require more attention devoted to their needs as people involved in the care, and more emphasis should be placed on the value given to FNs within nursing education and on the unit. Above all, strategies emerged that suggest a multidimensional approach, also including the systems where the educational and the work of nurses take place, both locally, regionally, and nationally.

The present study has several limitations. First, the study was conducted by interviewing nurses who were members of a single Provincial Nursing Board, and this may affect the results' transferability. Second, we used a positive deviant approach [36] by investigating the perception of 'exemplary nurses'; involving nurses detached from FNs as contrary cases may increase the understanding of the phenomenon on a broader level. Third, interviews were performed at the beginning of coronavirus pandemic in Italy, and this may have affected the perception of nurses of the Fundamentals of Care [37]. Thus, continuing to investigate the phenomenon by including other perspectives (e.g., that of physicians and patients) might also increase the transferability [38].

Nurses are personally and professionally convinced about the relevance of the care for Fundamental Needs: however, they distance themselves due to the emotional fatigue that daily work entails but also because they expect to apply knowledge in the care of these needs, a knowledge that should be developed, offered in the academic path, and continuously increased with the research. When the relevance of fundamental needs of patients is neglected or hindered both in the education and in the work environments or considered implicitly as not important by the entire system, nurses' detachment from them increases reaching a definitive fixed stage. To prevent this detrimental process that may result in relevant negative outcomes on patients and their relatives, several strategies at the individual, organizational, and educational levels should be implemented. Basing on the

findings of this study, organizations need to rethink models of care delivery, promoting teamwork and thinking about alternative strategies to reduce the bureaucratic workload on nurses. Finally, university education should place the FNs of patients at the center of its educational aims to grow health professionals who care about FNs. Further studies are needed to identify which organizational model should be recommended to promote nursing care close to the FNs of patients.

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## Declarations

**Ethical approval** All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

**Human and animal rights** This article does not contain any studies with human participants or animals performed by any of the authors.

**Informed consent** Informed consent was obtained as part of the questionnaire for all participants in the currect study.

**Conflict of interest** The authors declare that they have no conflict of interest.

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