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SCHOLARLY PAPER

Defining the fundamentals of care

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Defining the fundamentals of care

A three-stage process is being undertaken to investigate the fundamentals of care. Stage One (reported here) involves the use of a meta-narrative review methodology to undertake a thematic analysis, categorization and synthesis of selected contents extracted from seminal texts relating to nursing practice. Stage Two will involve a search for evidence to inform the fundamentals of care and a refinement of the review method. Stage Three will extend the reviews of the elements defined as fundamentals of care. This introductory paper covers the following aspects: the conceptual basis upon which nursing care is delivered; how the fundamentals of care have been defined in the literature and in practice; an argument that physiological aspects of care, self-care elements and aspects of the environment of care are central to the conceptual refinement of the term fundamentals of care; and that efforts to systematize such information will enhance overall care delivery through improvements in patient safety and quality initiatives in health systems.

Key words: evidence-based practice, fundamentals of care, meta-narrative review, nursing practice, quality.

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INTRODUCTION

Despite the innovations that have taken place in nursing clinical practice and research, there is often a gap in our understanding of what matters to patients and to the nurses and carers who deliver care in complex, challenging environments.

For these reasons, an international group was established to focus on some of the fundamental aspects of patient care and how we can develop and coordinate an integrated international research and knowledge translation agenda that will help to provide the core data needed to direct the transformation of the systems within which we work. The original idea for the collaborative emerged from work commissioned by the first Academic Health Science Centre (AHSC) to be set up in the UK.[1]

The vision of AHSCs, whether newly established or mature, is to operate on a world stage, leading and shaping the course of clinical practice, patient care and knowledge generation and transfer across the international health economy.[2] The motivation to achieve AHSC status relates to building a world-class multidisciplinary research enterprise, supported by funds from major sponsors and delivering a world-class health service to the community. However, what is less clear from the descriptions of successful AHSCs is how nursing and caring services are supported within this research culture.

Given the global trends in health care (an ageing global population, exponential increase in chronic illness and lifestyle-related illnesses such as obesity and addiction disorders), there is a growing expectation that self-care, management of chronic illness, public health and health promotion will continue to be significant challenges. These are areas of health-care interventions that flourish within a culture of clinical nursing excellence. Equally, creating the evidence base around what clinical interventions are most effective, what system designs are the safest and most effective and what configuration of the health workforce can most economically and competently deliver care are all potential questions that need to be systematically reviewed and researched. At one level therefore given the technological sophistication and advancement in health, it seems incongruous that health scientists and clinicians are engaging in discussions around the evidence base that informs the fundamentals of care. Surely, we ought to have documented and defined the essential elements of care that are required by every patient regardless of their clinical condition. And surely, such core elements ought to be standard across all health systems with clear metrics, clear processes and clear skills and competencies.

Yet, this does not seem to be the case. To understand the complex interactions between personal self-care needs when healthy and fit, and how those needs change with illness and disability requires a specific range of knowledge. How individuals maintain their optimum self-care when admitted to (any type) of health or care facility is not a matter of chance; it is part of the therapeutic plan for the individual and is complementary to the clinical treatment plan. How members of the various professions perceive their therapeutic role in terms of protecting, maintaining and promoting dignified, respectful person-centred care that is based on best available evidence is another core element of the preparation and education of health professionals to manage both the self-care potential of their clients and address the presenting clinical condition.

The safety agenda also connects with the fundamentals of care agenda. Reports such as Crossing the Quality Chasm[3] and the World Health Organization Safety Strategy[4] affirm the central importance of getting the basics of care correct to support patient safety and welfare. Equally, the growing body of evidence from patient groups[5] also confirms the need to systematically address fundamentals of care from the patient's perspective.

THE ONTOLOGICAL AND EPISTEMOLOGICAL CHALLENGES

There are many challenges when considering or viewing the fundamentals of care as a discrete group of activities. First, they are universal activities essential for life, part of our daily self-care activities and, as such, are often relegated to the unconscious or common sense level of knowledge. Few adults can remember when they learnt to control their elimination or defecation, respond to hunger and thirst or to understand the basic principles of personal hygiene, exercise and diet. But when confronted with any kind of health or lifestyle challenge, such tacit knowledge and activity are often the first to be compromised and suddenly, become very important. Informal carers often talk about the difficulties they have in accommodating the self-care needs of loved ones, such as having to manage the toileting needs of a parent or sibling or taking responsibility for another person's oral hygiene.

The research literature is replete with theorizing about the concept of self-care. According to this research base, we can argue that the way self-care activities are managed

and mediated is therefore altered according to the level of dependence of the individual, what support they have to help them, whether they have a clinical condition that has affected their ability to self-care and what sort of environment or place they find themselves in. In other words, we could argue that we would be able to predict a person's ability to manage their own activities of living (the fundamentals of care) by evaluating their level of independent living (based on knowledge, intellect, lifestyle, resources); their clinical or medical condition (whether the dependence is caused by a presenting illness or condition); and the environment in which they find themselves (at home, hospital, nursing home with the requisite support systems for activities of daily living).

To this point, our knowledge base appears well researched and debated. One might even argue that health professionals already consistently do assess patients for a set of activities of daily living, working out normal self-care, judging the impact of illness or disability and then devising a plan to manage the deficit. However, this is not the case and part of this paper is to try and understand why we are still unable to create a simple taxonomy around these fundamental elements and use it for all patients, based on the evidence we have of what works for which patients in what circumstances and why.

The challenges seem to be both ontological (concerning the essential meaning and understanding of these aspects of our existence) and epistemological (our ability to develop systematic processes around the method of finding out about fundamentals of care). If we take the first challenge—creating a common classification system or taxonomy to describe the fundamentals of care—we immediately run up against a language problem. Indeed, there is little agreement on the use of the overarching descriptor. Do we talk about self-care, patient-centred care, activities of daily living, functional ability, fundamentals of care, essentials of care or basic nursing care? All these, and no doubt many more, have been used to describe what we are discussing.

So, if there is no conceptual clarity around the 'essence' or truth of the phenomenon under study (its ontological representation), does that mean it does not exist? Does it mean that we do not need to try and construct a composite taxonomy that describes fundamentals of care? Common sense would lead us to say that we do, indeed need, to reach consensus on both the language and representation of the fundamentals of care and its conceptualization because we all know from our lived experiences that we need a collection of skills and knowledge to manage our normal activities of daily living. In fact, most of our social interactions and processes are built around such self-care activities as eating, drinking, sleeping, exercising and washing.

The challenge therefore will be to arrive at a list of terms that reflect the core philosophical concept, fundamentals of care, and then address the epistemological challenge of developing ways to find the different elements in the real world. A major challenge for this work is the implicitly held and enduring belief that caring activities (whether they are undertaken by individuals, carers or professionals) are devoid of any scientific basis. Do we, for example, consider research into the gastric emptying in elderly patients suffering from hypotension after mealtimes more 'scientific' than researching the most effective ways of encouraging elderly patients suffering from dementia to chew and swallow their meals? If we assume both of these research questions justify study, then how do we develop the body of knowledge (with its refined definitions, its classification systems, its indexes and its research journals) that relates to helping demented patients eat their food?

One has to ask the question at this stage. If there is little ontological and therefore epistemological clarity around the concept of fundamentals of care, is there any point in trying to undertake a review of the literature to see what evidence exists? Perversely, we believe that the way to tackle the more philosophical issues is to look at the existing literature in ways that take account of these bigger philosophical questions but that also begin to identify patterns of meaning and interpretation.

What we do not want to do is to get into the realm of defining concepts, undertaking a concept clarification exercise of core elements or compiling a classification index for every nursing intervention. These pieces of work have already been started.[6] Nor are we attempting to develop a new theory for nursing practice. Again there are sufficient nursing theories not to require us to add yet another one. Equally, we are not attempting primary qualitative research. Our task as we have defined it is to review how the fundamentals of care aspects have been described, researched and reported in the nursing literature. We are particularly interested to map the terminology that has been used and how it has developed over time and whether and to what degree these concepts have been researched at a level that demonstrates therapeutic effectiveness. Equally, we are not claiming that the term

fundamentals of care is the sole domain of nursing care. We are starting here because we would argue that nursing, both historically and currently, has a recognized responsibility to manage these processes with patients regardless of clinical condition and setting.

METHODS—THE METHODOLOGICAL CHALLENGE

The task we set ourselves was to try to establish what is considered to be the fundamental aspects of patient care and what research evidence there was in the literature that could inform nursing practice. We did not think a standard Cochrane type systematic review[7] would help us get started because of the lack of consensus around the major concepts, definitions and terminology. We decided early on that a more inclusive review process would be appropriate, one that acknowledged the historicity and conceptual refinement of the concepts as well as accessing the appropriate databases. For these reasons, we decided to use Greenhalgh *et al*.'s meta-narrative approach to systematic reviews.[8] Table 1 outlines the phases in such a review and how the fundamentals of care team proceeded with the different phases.

Our first meta-narrative review cycle therefore has focused on the first three stages (planning, searching and screening and mapping (see Fig. 1). As indicated in Table 1, the planning phase for the initiative commenced in 2008 with the inaugural meeting of the Oxford International Learning Collaborative (ILC). The purpose of this group has been on building research capacity in AHSCs around key areas of nursing interventions—called the fundamentals of care. The group has international membership and is diverse in its background and experience although the majority of members are from the nursing profession. We are adding to the diversity of this original group by inviting members of the Cochrane Nursing Care Field (CNCF) to be involved in the process and facilitate a joint seminar with a patient group in Oxford so they can share experiences with these aspects of care (http://www.healthtalkonline.org) and to plan further work.[13]

RESULTS

The initial search: Description of process and findings

In order to establish a common language for the fundamentals of care, the seminal texts and other documents relating to nursing practice were reviewed. Two members of the review team (AK and TC) initially searched all available nursing textbooks in the University of Adelaide library. One paper by Kitson[14,15] was used as a conceptual framework and was further extended by using information where it related to *activities of living* as described by Roper *et al*.[9] The Roper *et al*. text became the central point between the earlier historical documents and the latter texts as they began to describe fundamentals of care/activities of daily living as the core elements of self-care that might require nursing interventions.

The link between nursing care and self-care is well recognized and is consistent with Virginia Henderson's definition.[16] Two other members of the team (JP-M and YW) were asked to review the emerging list and add any international texts from their countries (Canada and Sweden, respectively). The Potter and Perry Canadian text and Swedish texts developed through consensus conferences by the Swedish Society for Nurses were found to be in the main translations of the seminal English language texts.[17–19]

Textual information was reviewed chronologically, commencing with Florence Nightingale's *Notes on Nursing*.[10] Using a data analysis procedure called Thematic Analysis Program,[20] each text was examined and data, in the form of words and related text, were extracted. The method of data extraction for each text is detailed in Table 2.

The primary descriptor terms that were selected for use by the team were those that were used most frequently in the texts. Table 3 shows the number of texts that addressed the topic area and Table 4 summarizes the variety of language used to define the aspect of care.

A first preliminary analysis of the seminal texts revealed the following patterns:

1. Marked variation in elements identified under the broad term activities of living or fundamentals of care and marked variation in the language used to describe these elements.

2. Variation in the focus or underlying conceptual framework used to describe the specific element, that is, whether it had a physiological, self-care or environmental (safety) base to it.

3. Variation in the level of synthesis of elements and how they were grouped together.

4. Variation in the level of guidance for assessment and action following the description of the particular element of care.

5. Little consistency in pattern of language and concepts.

Table 1 Phases in the meta-narrative review process and the fundamentals of care (FoC) review process

Phase	Instruction (adapted from Greenhalgh *et al.*)[8]	FoC team response
Planning	Initial scoping phase Get the right multidisciplinary team together Set out initial research question in broad way Agree potential output with sponsors Set up series of meetings	Stage One • Expert group set up • Project team identified • Thematic analysis of seminal texts • Stakeholder consultation—conferences, Cochrane Nursing Care Network (CNCN) • Multiple iterations/discussions will provide information to assist in the development of review questions and inclusion criteria
Search and screen	Initial search led by intuition, informal networking, *browsing* Aim to map the diversity of perspectives and approaches Search for seminal conceptual papers across research traditions by tracking references of references Evaluate these by generic criteria of scholarship, comprehensiveness and contribution to subsequent work within the tradition Search for empirical papers by electronic searching key databases, hand searching key journals and 'snowballing' (references of references)	The seminal texts and other documents relating to nursing practice were reviewed. Information was extracted where it related to 'activities of living' as described by Roper *et al.*[9] Textual information was reviewed chronologically, commencing with Florence Nightingale's *Notes on Nursing*.[10] Each text was examined and data, in the form of words and related text, were extracted. Team members also checked the international fit of the terms
Mapping	Identify (separately for each research tradition) The key elements of the research paradigm (conceptual, theoretical, methodological and instrumental) The key actors and events in the unfolding tradition (main findings and how they came to be discovered) The prevailing language and imagery used by scientists to *tell their story*	The mapping stage has included a thematic analysis of seminal texts from which three dimensions/elements of the fundamentals of care have been extracted (self-care, environment and physiology). These terms reflect different research paradigms and traditions and we will be exploring these in more depth in Stage Two
Appraisal	Using appropriate critical appraisal techniques: Evaluate each primary study for its validity and relevance to the review question Extract and collate the key results, grouping comparable studies together	Stage Two Searching Librarian recruited as part of team List of key search terms developed based on the thematic analysis for Stage One Commence traditional database searching Expert consultation Mapping Project team identifies key elements, concepts and descriptors for FoC Develop plan Active involvement of ILC, CNCN and other key stakeholders Agree priority themes (e.g. nutrition, elimination to run full review)

Table 1 *Continued*

Phase	Instruction (adapted from Greenhalgh *et al.*)[8]	FoC team response
		Appraisal Inclusion criteria and data extraction forms developed Pilot inclusion criteria tool Pilot data extraction form Conduct full review of the evidence Key results extracted and collated This detailed stage will commence with Stage Two of the project, when the Team has fed back their preliminary mapping of key concepts to the ILC group. The team to devise specific search terms around discrete aspects of care, e.g. nutrition and feeding
Synthesis	Identify all key dimensions of the problem that have been researched Take each dimension in turn and give a narrative account of the contribution (if any) made to it by each research tradition Treat conflicting findings as higher order data and explain in terms of contestation between the different paradigms from which data were generated	A first stage synthesis was conducted following the review of seminal texts Subsequent syntheses will take place when the discrete terms are explored in Stage Two. Part of our task is to determine which methods to use[11,12]
Recommendations	Through reflection and multidisciplinary dialogue with potential users of the review findings: Summarize the overall findings Distil and discuss recommendations for practice, policy and further research	First set of recommendations will relate to the feasibility of continuing with the search using elements that make up the fundamentals of care and how this information could be used in practice

ILC, Oxford International Learning Collaborative.

Consistency of concepts across the seminal texts and further categorization

Across the texts, there was strong agreement for the areas of care relating to safety, nutrition and elimination and moderate agreement for the areas of rest/sleep, mobility and personal hygiene (see Fig. 2). There was little consistent presentation of concepts such as comfort, pain management, privacy and dignity. These concepts seemed to have emerged as discrete elements of fundamentals of care in the last 10 years or so, and in particular, linked to government responses to patient safety or public concern.[3,28,29]

Further examination of the data illustrated the variety of descriptors and terminology for each area of care (see Table 4). For example, when considering nutrition, extracted data included terminology such as: eat and drink adequately, nutrition, eating and drinking, food and nutrition, dietary essentials, intake of food and nutrients, maintenance of a sufficient intake of food, taking food and nutrition/hydration. It was in an attempt to make sense of the variations in language, emphasis and description that we began to notice other categories emerging. We found that the diverse language describing the care elements could actually be themed according to whether the focus was around self-care activities, whether the primary descriptors were targeting physiological aspects or whether the issues being addressed looked at environmental or resource issues. For example, the *self-care* element of nutrition could be the ability to eat and drink adequately. The *environmental* elements of nutrition are

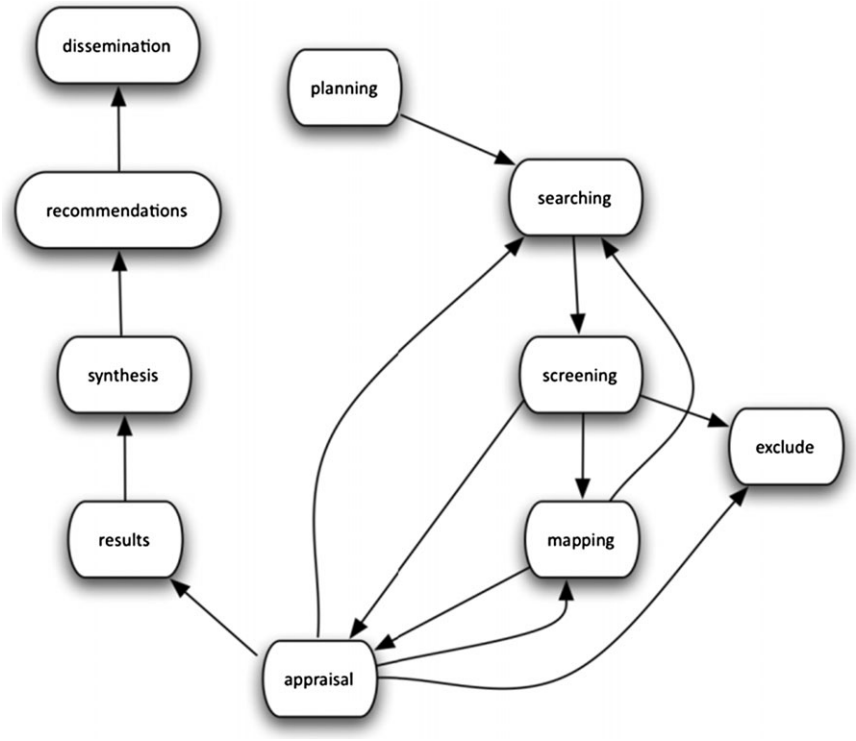

Figure 1. Steps in meta-narrative review methodology.

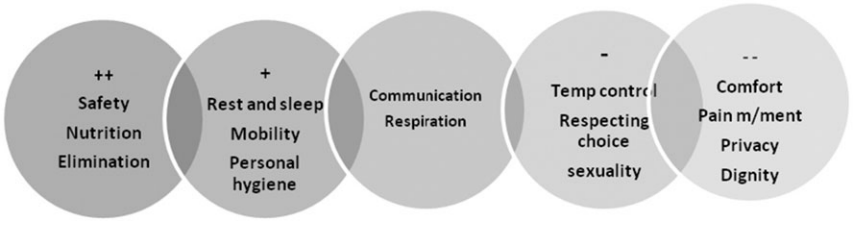

Figure 2. Level of agreement around the fundamentals of care in reviewed texts.

the choice of food and the observation of the patient eating, and the *physiological* elements are the intake and absorption of the nutrients. Similarly for elimination, the self-care elements are the ability to maintain bladder and bowel continence, the environmental elements are the physical requirements for adequate toileting and provision of privacy and the physiological elements are the excretion of waste, the genitourinary system and the gastrointestinal system. These distinctions have been drawn from this first analysis of the textual data and will require more careful interrogation.

When we re-examined the range of care descriptors across the texts to see if authors had addressed each of these dimensions in a consistent way, we found no evidence of any patterns. It seemed that some texts had adopted a strong physiological framework around which to describe fundamentals of care[17,24] whereas other authors such as Orem[27] took a consistent self-care approach, perhaps to the detriment of acknowledging or describing some of the physiological aspects of care. The issue of environmental aspects of care was most often articulated around notions of safety and particularly related to prevention of pressure ulcers and infection control. These seemed to be the main items to be made explicit, particularly in the latter publications and reflect more the patient safety agenda rather than considering the safety and environmental issues pertaining to each fundamental aspect of care.

We would argue that these dimensions/elements need to be further explored and in particular to determine whether the separation of the core aspects of care into these three dimensions would help in our second stage of work when we come to undertake systematic searches of existing databases for empirical research studies (Fig. 3).

Table 2 Data extraction approach

Texts (in chronological order)	What was extracted
Nightingale, *Notes on Nursing, What it is, and What it is Not*.[10]	Data were extracted from each chapter as information pertaining to activities of living was not presented in a single distinct section
Henderson and Nite[16]	Data were extracted from the section titled 'Fundamentals of Nursing care—Helping others provide for their basic needs'
Roper *et al*.[9]	Data were extracted from the section titled *Nursing and the Activities of Living*
Pearson and Vaughan[21]	Outlined the following models of nursing in their text. These included: Henderson's 14 activities of daily living. Each of these activities was extracted. Orem's model of self-care requisites. Each of these was extracted
NHS Modernization Agency, Essence of Care, Patient-focused benchmarks for clinical governance document[22]	Data relating to each of the nine areas of care were extracted
Welsh Assembly Government, Fundamentals of Care. Guidance for Health and Social Care[23]	Data were extracted for each of the fundamental aspects of health and social care
VK Saba, Clinical Care Classification System[24]	Data were extracted for each of the 21 care components
New South Wales Health Nursing and Midwifery Office, Essentials of Care Project[25]	Data were extracted for each of the essentials of care domains
Potter and Perry's Fundamentals of Nursing[26]	Data were extracted from the section titled 'Basic human needs'

Other preliminary findings included observations that the way fundamentals of care were described between Nightingale's seminal text and Henderson and Nite's text was driven by a conceptual framework based on medical textbooks.[10,16] Reviews of nursing textbooks that were in use in South Australia, for example between 1932 and 1973,[30–33] were usually laid out according to physiological system and presenting disease with short sections on the requisite nursing care required to care for such patients. The conceptual shift came with Henderson and Nite's seminal text where, possibly for the first time, the care nurses gave patients became the focus and then was differentiated into clinical conditions.[16]

Roper *et al*.'s[9] text followed this tradition but more recent texts[17,24,26] have begun to swing more into physiological descriptions. One other observation was that several of the most recent texts were actually government documents[22,23,25]—produced often in response to system concerns about how care was being delivered. This might explain why these documents do not take a comprehensive view of the fundamentals but focus on specific aspects (e.g. the National Health Service Wales document focused on patient dignity and respect, two elements that were perceived to be problematic within the service).[23] Although it is acceptable to focus on particular aspects, the question still remains that if there is little or no agreement around the original concept 'fundamentals of care' then how are policy-makers and practitioners going to know how to improve it across the whole system?

Our preliminary planning, searching and mapping had therefore brought us to a set of interesting observations about how nursing has described the fundamentals of care. We had extracted some common terms and had proposed a further way of categorizing specific information around these terms. Our next step was to take one or two terms, for example nutrition and elimination, and devise a search strategy.

DISCUSSION

Moving to Stage Two: Do we have sufficient clarity of terms to move into a formal appraisal phase?

We consulted an expert information scientist (Maureen Bell) to help establish a search strategy for one area of care. Discussion of the elements and how these might contribute to the development of a more comprehensive search strategy ensued. A draft logic grid was developed to map the indexing terms used in the two major electronic databases, Medline and CINAHL (see Table 5). Using Elimination as an example, the index terms have been stratified into each of the three dimensions/elements, self-care, environmental and physiological.

Table 3 Number of texts that explicitly addressed the topic area

Term/text	Nightingale[10]	Henderson and Nite[16]	Roper *et al.*[9]	Pearson and Vaughan (Orem)[21,27]	NHS Modernization Agency[22]	Welsh Assembly Government[23]	New South Wales Health[25]	Saba[24]	Crisp and Taylor[26]
Safe environment	✓	✓	✓	✓	✓	✓	✓	✓	✓
Communication	×	✓	✓	✓	✓	✓	✓	×	×
Breathing	×	✓	✓	✓	×	×	×	✓	
Eating and drinking	✓	✓	✓	✓	✓	✓	✓	✓	✓
Elimination	×	✓	✓	✓	✓	✓	✓	✓	✓
Personal cleansing and dressing	✓	✓	✓	×	✓	✓	✓	×	✓
Rest	✓	✓	×	×	×	✓	×	×	×
Controlling body temperature	×	✓	✓	×	×	×	×	✓	×
Mobilizing	×	✓	✓	✓	×	×	✓	✓	✓
Working and playing	×	✓	✓	×	×	×	×	×	×
Expressing sexuality	×	×	✓	×	×	×	×	×	×
Sleeping	×	✓	✓	✓	×	✓	×	×	✓
Dying	×	×	✓	×	×	✓	×	✓	×

Table 4 Variation in terminology used to describe fundamentals of care

Fundamental of care	Other terms used
Safe environment	Light, ventilation, clean environment, water, noise, aesthetics, cleanliness;[10] controlling the environment;[16] prevention of hazards;[27] safety, pressure ulcer management;[22] ensuring safety, risk assessment, prevention of pressure ulcers;[23,25] safety[24,26]
Communication	Spirituality and worship;[16] solitude and social intervention;[27] record keeping;[22] information;[23] documentation[25]
Breathing	Respiration;[16] air;[27] tissue perfusion and cardiac respiration;[24] oxygenation[26]
Eating and drinking	Food type;[10] nutrition;[16,22–24,26] water and food[27] (Orem); hydration;[25] bowel and gastric[24]
Elimination	Elimination;[16,25,27] elimination processes and excreta;[27] continence;[22] toilet needs;[23] urinary elimination and liquid consumption;[24] fluid and electrolyte balance and acid base balance;[26] urinary and bowel elimination[26]
Personal cleansing and dressing	Personal cleanliness;[10] keeping clean;[16] hygiene;[22] personal hygiene and oral health[23]
Rest	Rest and sleep[16]
Controlling body temp	Temperature, infection, bodily processes[24]
Mobilizing	Body mechanisms;[16] activity[27] promoting self-care/mobility;[25] activity;[24] activity and rest[26]
Working and playing	Self-efficacy respecting choice[23,25]
Expressing sexuality	
Sleeping	Rest and sleep[16]
Dying	End-of-life care;[23] life cycle[25]

Figure 3. Dimensions/elements of care.

This grid is an example of the index headings relating to Elimination in CINAHL and Pubmed/Medline.

From this preliminary check, we found that the main databases (Medline and CINAHL) do recognize the terms identified in the preliminary analysis and that the categorizations around physiology, self-care and environment also have some face validity. A list of key search terms can now be drafted and scrutinized. In addition to traditional database searching, reference and cited reference searching might be conducted of key papers and texts identified through expert consultation, reference list scanning and database search results. We will then recruit teams of volunteer reviewers who will be able to work with us on discrete areas, starting with elimination and see what the databases hold.

Synthesis phase

Using the outcomes of the appraisal stage, key elements will be identified and narrative accounts described for each of the fundamentals of care. From here, conflicting findings will be discussed based on the context of its paradigm of origin and contrasted in relation to other paradigms in the map. We will have to check with our key stakeholder groups (ILC, CNCF and Patient Experiences Group) as to whether we synthesize discrete elements as we amalgamate a set of care activities together.

Recommendations phase

Our overall objective is to map out the coordinates of the fundamentals of care and to provide evidence as to the most appropriate ways of delivering such care. We are not

Table 5 Logic grid-elimination

Database: Pubmed/MeSH		
Self-care	Environment	Physiology
Toilet training	Toilet facilities	Defecation
Continent		Elimination disorders
		Water–electrolyte balance
		Urination
		Urination disorders
		Faecal incontinence
		Urinary incontinence
		Diurnal enuresis
		Nocturnal enuresis
Database: CINAHL		
Self-care	Environment	Physiology
Toileting	Toilet facilities	Bowel and bladder management
Personal care (Omaha)	Architectural accessibility	Urination physiology
Self-care: toileting (Iowa NOC)		Defecation
Self-care assistance: toileting (Iowa NIC)		Urinary incontinence
Toileting deficit (Saba CCC)		Faecal incontinence
Toileting self-care deficit (NANDA)		Urinary elimination (Iowa NOC)
Urinary continence		Bowel elimination (Iowa NOC)
Faecal continence		

CCC, Clinical Care Classification; NANDA, North American Nursing Diagnosis Association; NIC, Nursing Interventions Classifications; NOC, Nursing Outcomes Classifications.

yet confident that such an objective can be achieved but we do believe that the exercise in trying to create some conceptual and linguistic clarity will in itself be beneficial. If we do achieve our aim, then we would hope that the work lays the foundation for the next wave of research and development work around care and how we do it effectively and humanely.

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