

# Compassionate, collective or transformational nursing leadership to ensure fundamentals of care are achieved: A new challenge or *non-sequitur*?

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## Abstract

**Aims:** This discursive paper draws on three key leadership theories with the aim of outlining how styles of leadership impact the provision of fundamentals of care.

**Design:** Discussion paper.

**Data sources:** key leadership theories, leadership and fundamentals of care literature.

**Implications for Nursing:** The conceptualization of fundamentals of care is viewed through the lens of nursing leadership, and collective, compassionate and transformational leadership theory. The cognitive dissonance that nursing leaders encounter when trying to reconcile organizational, patient and nurses' needs is considered, and the pressure to deliver high-quality fundamentals of care presents a challenge to nurse leaders.

**Conclusion:** Leaders must align nursing and patient outcome data to drive forward and prioritize fundamental care. Focusing on key elements of relational leadership styles will ensure a workforce fit to provide fundamental care, which in the current climate must be an organizational and global nursing priority.

**Impact:** This discussion attempts to draw together overlapping leadership theories, emphasizes the importance of relational leadership in ensuring the provision of the fundamentals of care and acknowledged the impact of the COVID-19 pandemic on nurses and nursing care, with leadership implications outlined, such as a need for role-modelling, understanding shared values and giving nurses a voice. It will have an impact on nurse leaders, but also on those nurses providing direct care by issuing a challenge for them to confront their own nurse leaders, and to ask that they better resolve competing needs of both the nursing workforce and patients.

## KEYWORDS

fundamentals of care, nurse outcomes, nursing leadership, patient outcomes, relational leadership

The prominence and importance of leadership in fundamentals of care have never been more pertinent than in the past 2 years, with the advent of the global COVID-19 pandemic and the need to rise

to unprecedented healthcare and nursing demands. In this article, we present a discussion on three different leadership styles, namely compassionate, collective and transformational and their relationship

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with fundamental care. These are considered under the umbrella of relational leadership styles, which underpin modern nursing leadership (Campbell, 2020), and include compassionate, transformational (Cummings et al., 2018) and shared or collective approaches (Carson et al., 2007). We draw on various theoretical sources, outlining why this is of importance in the current healthcare climate. In an era where nursing leaders are pressured to provide increasing volumes of data and levels of transparency on nursing-sensitive indicators and associated patient outcomes, to both the public and executive healthcare boards, the concept of nursing leadership and how it affects fundamental care provision warrants examination.

In the UK, the fundamentals of care refer to core elements of nursing care, including hygiene care, nutrition, hydration, safe physical handling and bladder and bowel care and include facilitating and providing support to those who cannot achieve maintenance of these elements of self-care independently, such as through feeding support (Nursing and Midwifery Council, 2015). Whilst similar terms have been included in defining fundamental nursing care globally, scholars in the International Learning Collaborative (ILC) ([www.ilcra.org](http://www.ilcra.org); Kitson et al., 2019) go beyond the physical functions listed by the NMC Code of Conduct (Nursing and Midwifery Council, 2015). This collaborative comprehensively includes more than physical function-related care such as medication management, but also extends the concept to include the context of care and relationships, such as listening to patients and families, developing trust, anticipating needs, placing a focus on the person and getting to know them. The three key premises of fundamental care promoted by ILC include: (1) developing trusting and positive relationships (between nurses/care providers and patients/families) (2) attending physical, psychosocial and relational needs; (3) being aware of how context affects the ability to meet needs and develop relationships, mitigating the adverse effects of where context negatively affects those relationships where possible (Kitson et al., 2019).

Whilst the ILC outlines all the ideal attributes of fundamentals of care, we know from ethnographic evidence in practice that physical functions remain a focus, and that psycho-social and emotional needs are frequently neglected (van Belle et al., 2020). The need to value and talk about care fundamentals, for nurses to own their role in delivering care fundamentals, to carry out and 'do' these, as well as, and this needs to be system-wide, including leadership, not left solely to nurses' individual responsibility. Importantly, there should also be systematic, quality investigations to support these activities in practice and education (Kitson et al., 2019).

Patient and nurse experiences of fundamentals of care were the subject of a qualitative systematic review (Pentecost et al., 2020), which noted that nurse leadership was pivotal in driving up fundamental care standards. Feo and Kitson (2016) presented a clear argument for the conceptualization of fundamentals of care to be viewed as more than simply 'basic care', and that it is devalued by organizations, managers and the predominant biomedical model, leading to the invisibility of the fundamentals of care. The call for these fundamentals to be considered at all levels of the nursing 'system', from individuals to educators, leaders and institutions underpins the ILC's

approach to establishing care fundamentals (Kitson et al., 2019). That meso- and macro-level of cultural shift required to entrench fundamental care in nursing culture demands engagement from nursing leaders, locally and nationally. Therefore, nursing leaders are crucial to making this work not only visible but a high priority for organizations and the profession. Indeed, where nurse leadership has been shown to improve standards characterized by generating enthusiasm and subsequent buy-in through experience; facilitating nurse learning and competency; defining and enabling caring roles; alongside teamworking, the organization of essential care was placed as a priority (Pentecost et al., 2020). The prioritization of fundamental care for patients is a key aspect of leadership, in terms of the need to balance this with organizational and nursing needs. There is a tension between placing value on people relationships and how that might be superseded by organizational goals, including health and well-being of patients, such as trying to innovate or transform a service where the leaders of that service are reluctant for change as it might affect their area of interest. The emphasis then centres on fostering behaviour change, and inclusion and negotiation of broader, collective interests over that of individual nurses, avoiding any detriment to the population served and healthcare organization (Fast & Rankin, 2018; Parker & Hyrkas, 2011).

In this discursive article, we draw on our own experiences, supported by literature and theory, to describe the fundamentals of care in these terms and how nursing leadership drives attitudes and behaviours in fundamental care. We draw throughout on Northouse's (2016) well-used definition of leadership as "*a process whereby an individual influences a group of individuals to achieve a common goal*" (Northouse, 2016). Leadership is crucial to broader societal functioning and basic function in groups and can be critical in terms of the success and failure of an organization (Lewis, 1974). In-depth conceptualization of nursing leadership is beyond the scope of this article, instead, we draw on three key theories, reflecting leadership styles identified as associated with nursing (Cummings et al., 2010), applying these to fundamental care provision and examining this intersection.

## 1 | LEADERSHIP STYLES

Systematic reviews have noted that the more relational the leadership style, where the focus is on people and relationships, the greater the job satisfaction (Cummings et al., 2018; Cummings et al., 2021; McCay et al., 2018) and the better the patient outcomes (Wong et al., 2013). Relational styles included socio-emotional, consideration, authentic, inspirational, resonant and transformational leadership styles and can also encompass compassionate leadership. Other outcomes such as retention, intention to leave and recruitment were also adversely affected in the context of management by exception leadership, abusive leadership, authoritarian leadership (Cummings et al., 2018). In the context of so many leadership models, challenges are presented as to which model in the relational leadership domains is most aligned with achieving successful leadership in ensuring the provision of fundamental care; and whether that is suited to the individual leader, or the

broader needs of a healthcare organization, or indeed the patient population needs. Central to the fundamentals of care framework (Kitson et al., 2019), is the notion that leaders not only have to recognize but have to speak up about the value of fundamental care, and ensure that value filters through systems they have influence over. How this is achieved is predicated on the way that leaders achieve action, including how they relate to those they are influencing and managing responsible for care coordination and delivery.

There has been a tangible move away from task-based leadership globally, towards approaches like transformational leadership in healthcare (Sellgren et al., 2006), and nursing specifically (Papadopoulos et al., 2021), not least as task-oriented leadership is associated with diminished satisfaction (McCay et al., 2018), so there is a clear mandate for nurse leaders to adopt a relational approach. Campbell (2020) suggests nursing leaders have a duty to create organizational integrity, fostering an ethical climate and being open to being led by others, and that this can be achieved through relational leadership. The pragmatics of how this might be achieved can be considered through the implementation of fundamentals of care and how different leadership approaches might affect that implementation. Key relational approaches, namely compassionate leadership, collective and transformational leadership are considered in turn below in respect to nursing and fundamentals of care.

## 1.1 | Compassionate leadership

The notion of compassionate leadership is bandied about a lot in recent years, but what this actually means for nursing and patients arguably remains somewhat opaque. As with shared leadership, leading through shared learning and conversations, and reaching a shared decision on what needs to be done or how to move forward, is a key attribute associated with compassionate leadership and the role that compassionate leadership plays in the delivery of high-quality care has been highlighted in two recent thinktank reports (The Kings Fund, 2019, 2020). Nurses' autonomy, belonging and contribution are identified as key facets in delivering compassionate care, with compassionate leaders able to foster nurturing cultures to promote growth in these key areas (The Kings Fund, 2020). Leaders put aside ego to strive towards the collective good, creating a culture where power and hierarchy can be challenged, a key facet of transformational leadership as outlined below. However, nursing leaders may also have to address the tension between exemplifying the moral characteristics of nursing, which shape professional identity, including values like compassion and caring (van der Cingel & Brouwer, 2021), and addressing corporate institutional issues, such as trying to achieve tangible improvements in resourcing and addressing power differentials. These might include challenging the power differentials in interdisciplinary management and comparatively poorer resourcing for nursing. Simultaneously, there is a legacy of perceptions of nurses as compassionate carers, and not necessarily as leaders (Hoeve et al., 2014). Reconciling these tensions requires agile leadership, and nurses that are cognisant of

these myriad issues, and how they affect not only nurse–nurse relationship but also those within wider institutional structures, such as interdisciplinary relationships.

de Zulueta (2016) outlines how compassionate leaders are dynamic, promoting collective leadership and embracing shared and distributed power. There is a delicate balance between maintaining compassion, wishing to empower and engage others, whilst meeting the broader needs of the populations that nurse leaders serve, such as patients, and demonstrating a clear vision of what needs to be accomplished, echoing Fast and Rankin (2018). Advocacy in supporting nursing staff was suggested as key to compassionate leadership in a large global survey of nursing managers, with significant geographical variation in how compassionate leadership was adopted (Papadopoulos et al., 2021), emphasizing the need for compassionate leaders to listen, connect, feel close to others, to take perspectives and interest in staff. Cultural differences found in the research emphasized how collectivist cultures (such as in South America/Philippines, with high in-group cohesion) viewed compassion as essential to be human, whereas individualistic cultures, such as the US, placed more value on productivity and staff retention (Papadopoulos et al., 2021). In an increasingly global health care system, these values are important to understand, particularly where there are high migrant nursing populations, such as in the UK (19% of the workforce report non-UK nationality; UK Parliament, 2021). Authenticity and trust are components of compassionate leadership (de Zulueta, 2016), and authentic leadership is also regarded as a typology aligned with compassionate leadership, if not a distinct style in itself. Core attributes centre on integrity, trust, respect and being credible with colleagues by knowing one's values and being clear in one's personal vision (Northouse, 2016). There are parallels drawn between compassionate care and compassionate leadership (The Kings Fund, 2017, 2020), where a compassionate culture is fostered to enable the conditions to be right to deliver optimal, compassionate nursing care. Leaders' actions, such as consistently listening, empathizing and helping, define compassionate leadership and this resonates with compassionate care. Quinn (2017) provides the example of leaders ensuring that appropriate resources are in place for nurses to have the skills and tools required for delivering compassionate, person-centred care. How these attributes line up with the promotion of compassionate care and fundamentals of care requires further work, but, as the Kings Fund (2020) outlines, the priority focus needs to be on supporting the nursing workforce to deliver care and this, in turn, is driven from the top. Drawing lessons across compassionate care, compassionate leadership and fundamentals of care, there are commonalities between compassionate care and fundamentals of care with their focus on nurse–patient relationships, which can be considered through the adoption of adaptive, shared leadership approaches (de Zulueta, 2016) that centre on developing relationships between individuals, echoing the relational approaches of compassionate care. The intersection between compassionate care and fundamentals of care was also drawn on in a scoping review by Feo et al. (2018), suggesting that fundamentals of care include compassion.

The challenges around sustaining compassionate leadership, especially in times of crisis are noted (de Zulueta, 2021); it is hard to consistently be compassionate, and there is a risk of compassion fatigue in the face of relentless challenges, such as those posed in the early days of the COVID-19 pandemic. Myths associated with compassionate leadership include veering towards consensus at the expense of patients, or shying away from tough conversations (The Kings Fund, 2019).

Compassionate care is defined by the relational way in which care is delivered, through empathy, attending understanding and helping (The Kings Fund, 2020), however, as Feo et al. (2019) outline, only the literature on fundamentals of care addresses patients' physical care needs, and these bodies of literature rarely intersect (Feo et al., 2019). The relationship to compassionate leadership is less clear. Moreover, ethnographic evidence suggests that nurses may be able to deliver relational, compassionate care and physical fundamental care needs, but do not routinely incorporate psychosocial care or encourage participation in care whilst delivering physical care fundamentals (van Belle et al., 2020). This would imply that tasks and physical care remain the focus and that there is a need for leaders to address this lack of integration. Modelling or idealized influence, along with engagement and structural empowerment is one strategy under a transformational leadership approach; leaders working with direct care nurses to achieve engagement and empowerment, and ultimately, exemplary professional practice (García-Sierra & Fernández-Castro, 2018; Khan et al., 2018), including fundamentals of care.

## 1.2 | Collective: Shared and discursive leadership

Collective leadership as a concept is several decades old but was articulated as a distinct model, shared leadership, by Pearce and Conger (2003) who sought to emphasize the benefits of distributed leadership. Pearce (2015) subsequently applied this model to healthcare leadership and it has increasingly gained traction, underpinned by the notion that if followers are empowered by management to lead, this engenders shared leadership in followers. A key attribute of those demonstrating shared leadership skills is helping others make sense of organizational issues, and subsequently shaping followers' sense-making through sense-giving, sometimes associated with framing and re-framing of issues, particularly in complex or ambiguous situations (Fairhurst, 2011; Gioia & Chittipeddi, 1991). These authors suggest this can be achieved through a conversational analytic style and talking through issues or innovations, alongside written text. In other words, how leaders frame a complex problem can pave the way for discursive leadership to collectively reach a solution; leadership development involves the wider organizational community and decisions are shared. This notion has underpinned the drive towards collective leadership and shared decision-making seen as core to nursing credentialing programmes, such as Pathways to Excellence™ and Magnet®, with the ultimate aim of driving up quality and thereby improving outcomes. West (2014) describes

how a collective approach, and learning to work with a shared vision of striving to continuously improve care and deliver compassionate high-quality care, requiring integration of care to achieve this across all sectors, including social care. The Chief Nursing Officer for England has called for collective nursing leadership to improve the delivery of clinical care, including fundamentals of care (May, 2019). Extending this to include all members of the healthcare team and moving away from profession-specific collective leadership to shared leadership, where a sense of shared purpose, social support, trust and listening to people's voices is developed (Carson et al., 2007). In turn, this set of conditions fosters high levels of multidisciplinary team interdependency for the ultimate goal of improving patient outcomes, like safety (De Brún et al., 2019).

In a study of Magnet® leaders, Moon et al. (2019) found that most identified with a transformational leadership style, calling into question how shared leadership visions through nursing excellence programmes are actually led at the top of organizations (Moon et al., 2019). This could imply the shared leadership model overlaps with transformational leadership in terms of creating a shared vision (inspiration motivation), part of a continuum, or that these are in a juxtaposition and that there still needs to be a degree of transformation even within shared approaches. It is worth considering that leadership characterized by collective decisions may not always meet the needs of individuals, particularly in times of crisis and a need for rapid change. Research has demonstrated that collective or shared leadership can risk future problems, such as an inability to follow through, lack of engagement and acceptance with the approach, potential inefficiency, and danger of immature or usurping team members (Herbst et al., 2019). There may be a risk of different priorities and the centrality of the nurse-patient/family relationship could be threatened by these problems. Moreover, given how important context is shown to be in delivering fundamental care (Kitson et al., 2019), there is a chance of fundamental care being derailed where implementing collective leadership may delay care. For instance, the constraints of creating time and space to have shared conversations concerning all aspects of care, such as during pandemic crises, may collective leadership is not always possible, or indeed appropriate as care decisions may have to be made decisively and rapidly by leaders with the most knowledge of a situation. Questions arise as to how best balance playing to the strengths of a nursing leader, amending leadership behaviours and trying to address the needs of followers and those working in healthcare, to meet wider population needs and achieve excellence in care fundamentals.

## 1.3 | Transformational nurse leadership

Northouse (2016) views transformational leaders as those who can innovate and inspire, and there is evidence that this leadership approach is successful in achieving organizational change, and can improve staff retention in healthcare, and foster building of capacity through role-modelling of promoting collective interests above

one's own (Holly & Igwee, 2011; Weberg, 2010). Burns coined the term transformational leadership in the 1970s in reference to political leadership, where leaders interact with followers, inspiring each other to achieve collective goals (Burns, 1978), and has since been widely adopted. Role-modelling, in terms of setting the tone and expectations, by nurse leaders is important in developing and ensuring that fundamentals of care are met (Conroy, 2018), and is consistent with broader leadership notions of transformational leaders: individuals who are role models and provide idealized influence, inspirational motivation to followers who identify with those leaders, intellectual stimulation and individualized consideration (Northouse, 2016). These leaders inspire others to transcend their own self-interests for the collective good. Moon et al. (2019) identified that nurse leaders promoting care excellence in organizations tended towards transformational styles. Fast and Rankin (Fast & Rankin, 2018) have suggested transformational nurse leaders, put in place to optimize services, and meet organizational needs (such as making fiscal cuts), can find themselves at odds with what they wished to achieve in the role, outlining the concept of a bifurcated consciousness. Under this concept, managers know empirically through the experience of what is needed, but suppress this to meet organizational demands, or abstracted knowledge (Fast & Rankin, 2018).

A further complication is the lack of conceptual clarity in what is meant by transformational leadership (Northouse, 2016), and there is no way to ensure the new vision proposed by a transformational leader provides any improvement on existing visions. Moreover, this new vision may be at odds with what is needed on the ground, as Fast and Rankin (*ibid*) allude to. Fast and Rankin's (2018) bifurcation of consciousness could also be conceptualized as cognitive dissonance; nurse leaders wrestle with achieving the best quality fundamental care and high nurse satisfaction in the context of ever-increasing organizational demands, diminishing nursing numbers and real-time reducing costs. However, scholars have correlated transformational leadership with improved nurse satisfaction and patient outcomes, and leadership effectiveness (Boamah et al., 2018; Casida & Parker, 2011; Holly & Igwee, 2011), suggesting that despite these shortcomings, this approach can have a positive impact.

## 2 | DISCUSSION

### 2.1 | Application of leadership to foster fundamental care in times of crisis

As Northouse (2016) outlines, leaders rarely have the skills and knowledge to make all decisions. Involving nurses in providing direct patient care at the bedside is pivotal in ensuring standards of fundamental care are elevated. These nurses have crucial insights and can provide clarity around logistical and conceptual solutions to barriers in achieving high standards of fundamental care. The COVID-19 pandemic shone a light on the need for credible, agile, compassionate, coordinated and shared leadership to rapidly respond to the global

healthcare crisis encountered. Nurses bore the brunt of many of the healthcare decisions that at times may have felt foisted on them, with rapid ward and unit reconfiguration in hospitals, redeployment to new areas, working virtually to care for vulnerable people and a raft of new ways of working.

The opportunity for shared decision-making was severely challenged under the circumstances of the pandemic, and as Herbst et al. (2019) alluded to, the collective need to meet population health requirements overrode those of individual nurses, and the consequences of this cannot be underestimated. Frontline nurses, providing direct care to people, were, by and large, disenfranchised from the rapid decisions that needed to be made to meet the global catastrophe that COVID-19 presented. As nurse leaders outlined, they had to make gut decisions and try to be the voice of the patient (Aquila et al., 2020), but this frequently conflicted with nurses' voices and prioritizing nurse well-being. Moreover, in the challenge to deliver fundamentals of care during a crisis situation, it is unclear how nursing leaders can role model the point at which adequate person-centred fundamental care is delivered. The role of quality indicators, like nursing-sensitive indicators, is important here in determining the quality of care (Afaneh et al., 2021), or this notion of sufficient fundamental care, and can be used as a benchmark for nurses to deliver direct care, as well as nurse leaders to be reassured that fundamentals of care are being provided.

In this discursive article, the impact of three key relational leadership styles on the delivery of fundamental care has been presented, along with the need to balance competing priorities through advocacy. As we have seen transformational leadership in nursing is certainly underpinned by evidence, but whilst there is less evidence for newer styles such as compassionate leadership, which focuses on nursing advocacy, compassion might be even more important in the current climate where valuing people needs to take priority over organizational demands as we attempt to support a struggling nursing workforce. This notion of advocacy for nursing colleagues also links to the aforementioned concept of bifurcated consciousness (Fast & Rankin, 2018); leaders may be compromised personally and professionally in the drive to meet organizational demands, or interdisciplinary challenges, based on emergency population needs, such as in the COVID-19 pandemic. Newer models such as interdisciplinary leadership councils (Allen, 2021), where there is a dif-fused model of shared leadership, rather than it being professional specific, may be one approach to fostering collaboration practices across an organization. This may be appropriate at an organizational level, but there is a risk to nursing as a profession in not being able to clearly define the unique leadership contribution to delivering patient care. Retaining focus on the delivery of fundamentals of care as a specific nursing responsibility may be one way in which this can be addressed.

Nearly all the leadership theory and research presented in this discursive article, pre-dates the pandemic, with very little research available to evidence the best approaches to nursing leadership in times of unprecedented crisis; the pandemic was nothing like the seasonal pressures nursing leaders usually encounter. A plethora of

research in the area of nurse wellbeing is beginning to uncover the extent of the human cost to nurses of working during the pandemic, and by necessity, this has become a core focus of nursing leadership (The Kings Fund, 2020). The corollary of fundamental care is the wellbeing of nurses; without organizational investment in the care of staff and further development of nurturing cultures that prioritize nurses' well-being, fundamentals of care are unlikely to improve. Returning to Northouse's (2016) notion of leaders being able to inspire others to put their own interests behind the collective good, it is arguably unrealistic when the nursing workforce has prioritized others' (patients and organizational) needs for a protracted period over their own (well-being). Ultimately, over the sustained period we have seen in the pandemic, this results in an exhausted emotionally and physically depleted workforce in the long-run, and until nurse well-being is placed at the core of delivery of fundamentals of care; this is only likely to worsen. It stands to reason; a contented nurse is more likely to be able to deliver good fundamental care than a nurse who is spent, or who has compassion fatigue. Nurturing a sense of motivation across all levels of nursing, from leaders to those providing care will ensure engagement and that the voices of those delivering fundamentals of care are heard. The Kings Fund (2020) describe how those voices are needed to inform leaders about how care can best be improved.

Returning to the earlier point about how nursing indicators might be used to assess standards of care and, in turn, prioritize improvement, there are further challenges are posed to the provision of fundamental care excellence. Notably, this centres on a lack of robust evidence for care interventions, as outlined in a systematic review of care fundamentals (Richards et al., 2018): defined as in the review as care actions based on key areas of fundamentals of care: safety, comfort, communication, dignity, respiration, privacy, eating and drinking, respecting choice, elimination, mobility, personal hygiene and dressing, sexuality, temperature control, rest and sleep. The lack of focus on deriving patient outcomes in the evidence base was stark, with poor quality evidence noted overall (Richards et al., 2018), highlighting a clear need to improve the evidence base through high-quality interventional studies of nursing practice in delivering fundamentals of care. Moreover, being clear on what we mean by patient outcomes is also important. Liu et al. (2014), in their concept analysis on the topic, delineated the key attributes of patient outcomes as: patient functional status; patient safety and patient satisfaction (Liu et al., 2014). Where future nursing leadership studies should focus was explored in a systematic review by Cummings et al. (2021), who examined leadership styles in relation to key outcomes: nurse satisfaction; staff relations and relationships with work; health and well-being; organizational environment and productivity, with relational styles overwhelmingly associated with positive outcomes in these domains. The authors. Outlined how there should be further examination of mediating factors between nursing characteristics, leadership development and developing leadership programmes (Cummings et al., 2021). Difficulties remain in teasing out exactly what aspect of leadership development should be examined in more depth, how leadership programmes should develop, and which nurse

characteristics are of importance. The pandemic has exacerbated these challenges, creating a difficult environment in which to deliver high-quality care.

Reporting simplistic patient satisfaction is no longer enough; nurses need to articulate and agree what fundamental care they provide, adopting a broader view of what this encompasses beyond the physical domains of care outlined by the NMC (2015; and evidenced in practice in van Belle et al.'s [2018; 2020] research), aligning the nurse-sensitive indicators, nurse outcomes and ensuring patient-reported outcomes are synergistic. It is for nurse leaders to model this and ensure both nurses' and patients' needs remain a dual priority.

Public expectation has ratcheted up a notch, with arguably less tolerance than at the outset of the pandemic around meeting the unprecedented healthcare demands now encountered globally. This is in face of a beleaguered nursing workforce, who are exhausted and have had little opportunity for respite, and are struggling to meet fundamentals of care, despite this being a necessary focus. This context adds further complexity for nurse leaders who need to instil confidence in a diminished global nursing workforce to be able to competently and diligently deliver high-quality fundamental care. Workload and staffing remain the 'elephants in the room' in this debate and outwith the scope of this discussion, however, in the face of global nursing shortages (World Health Organization, 2020), this is a problem unlikely to improve without significant investment in the workforce alongside relational nurse leadership. Role-modelling by leaders that nurse outcomes are viewed as important as patient outcomes, using the clear evidence available that supports the association between patient perceptions and nurse outcomes like burnout, environment and workload (Aiken et al., 2012; Wong et al., 2013), is likely to drive up standards of fundamental care. Going forward, nurse leaders need to report granular patient outcome data on care fundamentals that is grounded in patient-derived data, and that considers a range of patient-centred outcomes, linking this directly to nurse outcomes and nurse-sensitive indicators so that interventions can be focused on supporting nurses to deliver the best care.

### 3 | CONCLUSION

To reconcile competing priorities requires a leader to know not only what their leadership style and vision is, but also have a clear plan to prioritize what is important to colleagues, the organization and the wider patient population. Nurse leaders, through the relational approaches outlined in this article, have a clear role in modelling and advancing the delivery of fundamentals of care, by inspiring the nurses they lead to want to drive up quality and deliver not just sufficient, but the best care. More evidence is needed on the impact of compassionate leadership and collective leadership styles on patient outcomes, and these need to be directly linked to fundamentals of care, as well as patient-derived outcomes, whilst also taking into account nurse outcomes. Leaders need to be prepared to closely examine and report these key issues at a granular level, using this data

to understand the nuances and ultimately to advance nursing care. Getting these key elements of leadership right will ensure a workforce fit to provide fundamental care, which in the current climate must be an organizational and global nursing priority.

### 3.1 | Implications for nursing

- Relational leadership is key to the effective provision of fundamental care, and leaders face challenges in reconciling organizational, patient and nursing demands.
- The impact of the COVID-19 pandemic has heightened the need for examination of nurse outcomes to be aligned with patient outcomes, the prioritization of nurse well-being and the role of leaders in driving data-gathering to improve outcomes for all.
- Relational leadership emphasizes a need for role-modelling, understanding shared values and giving nurses a voice; but nurse leaders must work to ensure competing demands are heard and addressed, as well as consider how nurses are given a voice.

#### CONFLICT OF INTEREST

The authors have no conflicts of interest to declare.

#### PEER REVIEW

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#### DATA AVAILABILITY STATEMENT

Authors do not wish to share the data.

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