

EMPIRICAL RESEARCH QUALITATIVE OPEN ACCESS

Healthcare Professionals' Descriptions of Contextual Factors Affecting Complex Aortic Surgical Care: A Secondary Analysis Using the Fundamentals of Care Framework

Linda Haakseth¹   | Caisa Öster²  | Kevin Mani³  | Anders Wanhainen^{3,4}  | Eva Jangland¹ 

¹Department of Surgical Sciences, Nursing, Uppsala University, Uppsala, Sweden | ²Department of Medical Sciences, Psychiatry, Uppsala University, Uppsala, Sweden | ³Department of Surgical Sciences, Vascular Surgery, Uppsala University, Uppsala, Sweden | ⁴Department of Surgical and Perioperative Sciences, Surgery, Umeå University, Umeå, Sweden

Correspondence: Linda Haakseth (linda.haakseth@uu.se)

Received: 5 February 2025 | **Revised:** 11 June 2025 | **Accepted:** 12 June 2025

Funding: The authors received no specific funding for this work.

Keywords: care culture | care responsibility | complex EVAR | context of care | endovascular aortic repair | fundamentals of care framework | person-centred care | postoperative recovery | reflexive thematic analysis | secondary analysis

ABSTRACT

Aim: To explore how factors in the complex aortic surgical care context can affect care provision towards patients' postoperative recovery.

Design: Secondary qualitative analysis.

Methods: Results about patients' recovery after complex aortic surgery was presented in focus groups with healthcare professionals in 2022. Reflexive thematic analysis, using the Fundamentals of Care framework, was conducted to explore contextual factors affecting care provision.

Results: Healthcare professionals' descriptions resulted in one main theme: *Care provision is challenged by discrepancies in values, goals and norms and unclear responsibilities within the context*, and two subthemes: *Values, goals and norms determine what care is provided; Taking responsibility for care requires resources, evaluation and feedback*.

Conclusion: Healthcare professionals describe care provision as affected by a dynamic integration of contextual factors. Healthcare professionals need to be made aware of their own role in this context. Care provision needs to be guided by feedback from patients and healthcare professionals, and work with patients' resources at both an individual, system and societal level.

Implications for the Profession: The results provide knowledge regarding how contextual factors in dynamic integration can affect care provision in a complex surgical context. Healthcare professionals, leaders and policy makers all have responsibility to focus on patients' values and goals, and empower adequate care through feedback loops and resource management.

Impact: The context-of-care dimension of the Fundamentals of Care framework has been scarcely described. Our results illustrate how an integration of factors affects care provision, where values, goals, and norms affect what care is provided, and responsibility for care belongs to everyone in the care system. The results can contribute to the description of the context-of-care dimension within the framework and enable professionals to understand how they, as part of the context, could affect care towards patient recovery.

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial-NoDerivs](https://creativecommons.org/licenses/by-nc-nd/4.0/) License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2025 The Author(s). *Journal of Advanced Nursing* published by John Wiley & Sons Ltd.

Reporting Method: This study adhered to the Equator research reporting checklist: Consolidated criteria for reporting qualitative research: a 32-item checklist for interviews and focus groups.

Patient or Public Contribution: No patient or public contribution.

1 | Introduction

A person-centred approach to care, where patients' individual care needs are considered and patients are involved in their care as partners, is central in many countries' national health policies and emphasised by the World Health Organization as necessary to meet the future burdens of disease (World Health Organization 2015). Nurses continue to have difficulty providing person-centred fundamental care worldwide (Chaboyer et al. 2021; Gong et al. 2025).

To mitigate the reports of missed nursing care globally, The Fundamentals of Care framework work was developed in international collaboration between clinicians, researchers and educators as a point-of-care framework, which can be used to guide how to provide person-centred fundamental care and meet the patient's individual care needs (Feo et al. 2018; Kitson 2018). The conceptual framework describes, within three dimensions, how a person's physical and psychosocial care needs are identified and integrated through the patient-practitioner relationship, while also considering contextual factors at the system and policy level affecting the practitioner's ability to do so (Figure 1) (Feo et al. 2018). However,

the framework, together with other nursing theories, have been criticised for being unclear on the concept of context, not distinguishing between contextual factors at a micro (individual), meso (organisational) and macro (societal and governmental) level, and not positioning the patient in their broader family and community setting (Mudd et al. 2020). A need to expand the description of the 'Context of care' dimension is warranted to increase the frameworks' direct use in clinical practice (Mudd et al. 2020), and in turn enable person-centred fundamental care. To do so, we conducted a secondary analysis of focus groups with healthcare professionals to explore their descriptions of care provision towards patients' postoperative recovery after complex endovascular aortic repair (EVAR), with a focus on contextual factors.

2 | Background

Undergoing surgery entails being faced with change at a psychological, social as well as physical level, and postoperative recovery can be a long and strenuous process to re-establish well-being over time (Allvin et al. 2007). This can be challenging within the highly specialised and often acute context of aortic surgical care.

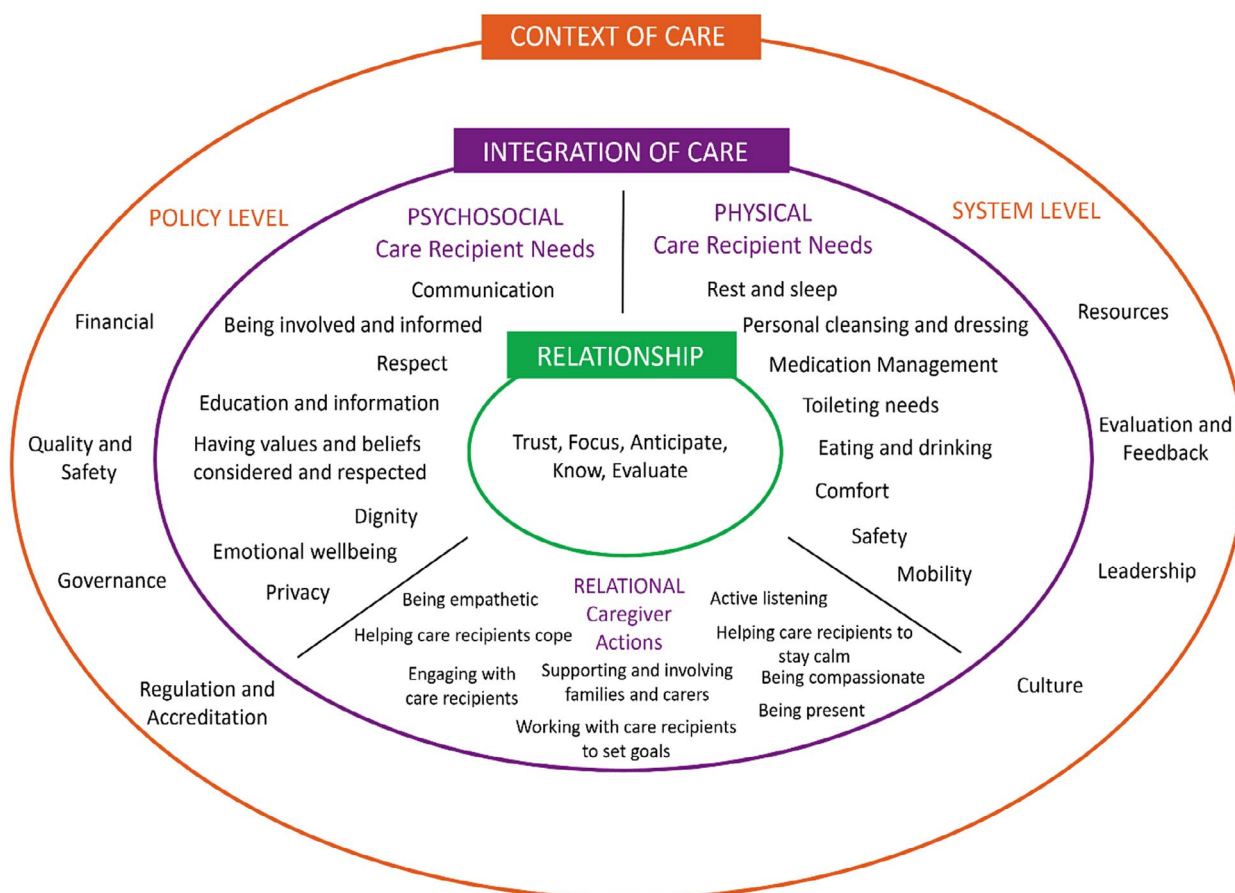


FIGURE 1 | The Fundamentals of Care framework. Image obtained from <https://ilccare.org/the-fundamentals-of-care-framework/Content> within image derived from Kitson et al. (2013) and Feo et al. (2018).

Summary

- What does this paper contribute to the wider global clinical community?
 - In this study, care provision is described as being affected by contextual factors that are dynamically integrated, which illustrates how the context of care may not be a given constant.
 - The results could enable healthcare professionals and leaders to better understand their individual role and responsibility within the organisation for developing relationships with their patients and improving the prerequisites for patient's recovery.
 - The results illustrate a need to consider expanding the concept of context within the Fundamentals of Care framework to reflect the overarching role of 'Culture', and the dynamic role of 'Responsibility'.

To the patient, having an aortic aneurysm often presents itself as an asymptomatic life threatening diagnosis, requiring preventive yet risky surgery. Aortic aneurysm is present in 2%–5% of the population above the age of 65 years globally. Endovascular repair is the predominant method for treatment in high-income countries (Png et al. 2024). Some 20% of aortic aneurysms involve branch vessels taking off from the aorta. For these aneurysms, complex EVAR with fenestrated and branched EVAR is increasingly utilised (Yu et al. 2024). Considering the low prevalence of complex EVAR, the surgical care of these patients is often centralised to high-volume centres to improve surgical outcomes (Budtz-Lilly et al. 2018). The complex EVAR procedure entails a long operative time and leaves a risk of various postoperative complications ranging from pain and neurological deficit in the surgical area to more serious complications requiring in-hospital care or reoperation (Mani and Melissano 2018). However, as in other surgical disciplines, more patients with aortic diseases, including elderly and those suffering multiple comorbidities, are surviving due to the development of such less invasive, but often more complex procedures (Mani and Melissano 2018). Complex EVAR is thus an example of modern centralised surgical care, where patients' postoperative recovery is challenged as they are referred to and treated at tertiary care hospitals, often far away from their home and usual care providers, where they later will continue their recovery after discharge (Budtz-Lilly et al. 2018).

It is especially important to minimalise negative effects of preventive surgical intervention, e.g., minimising missed nursing care, and optimise patient recovery. In a recent qualitative study from Sweden, involving both patients and healthcare professionals, patients' care needs when undergoing complex EVAR were found to revolve around fundamental care like information, patient involvement, and continuity and follow-up (Haakseth et al. 2025). While interventions, such as *individual care plan*, *team meetings*, and *contact nurse*, were found relevant to meet these needs by both patients and healthcare professionals, the healthcare professionals in the study described how implementing such interventions, providing person-centred care, into current clinical practice was not feasible due to barriers in the care context (Haakseth et al. 2025). This is in line with how information and support towards safe discharge planning and self-care are frequently reported as missed care in many countries

(Chaboyer et al. 2021). Reasons for missed care globally has been found to be factors found at the system, policy and individual level (Chaboyer et al. 2021; Gong et al. 2025). It has also been described as linked to complexity within the care environment (Gong et al. 2025; Mantovan et al. 2020).

The Fundamentals of Care framework lists contextual factors at the system and policy level that play an important role in supporting or hindering fundamental care delivery (Feo et al. 2018). While the framework places the responsibility for fundamental care on healthcare professionals, they are required to consider the context where care is delivered (Feo et al. 2018). The context of care, however, is described by clinical nurses as 'abstract' and a limitation to achieve high-quality care rather than a prerequisite (Muntlin et al. 2023). A study by Blackman and Mudd (2023) conducted in a residential care setting found a predictive relationship between missed nursing care and the factors listed in the context-of-care dimension of the framework. Further research exploring what and how contextual factors within the framework impact care provision in other settings is called for, to enable further development of the framework and make it more useful for clinical nurses (Blackman and Mudd 2023). To our knowledge, no study has explored care provision, using the Fundamentals of Care framework, to understand how factors in the complex surgical context can affect care provision towards patients' postoperative recovery.

The challenge of meeting the care needs of patients in the complex surgical context, like patients undergoing complex EVAR, calls for a person-centred approach to improve patient recovery. However, contextual factors seem to persist as barriers to implementing relevant interventions, and theories that describe the context of care in a practical manner are lacking. An exploration of healthcare professionals' descriptions of care provision in complex EVAR care with a focus on contextual factors is thus warranted to understand how contextual factors affect care provision towards patients' postoperative recovery, and enable refinement of the *Context of care* dimension within the Fundamentals of Care framework.

3 | The Study

3.1 | Aims

To explore how factors in the complex aortic surgical care context can affect care provision towards patients' postoperative recovery.

4 | Methods

4.1 | Design and Theoretical Framework

The study was a secondary analysis of qualitative data (Thorne 2013) using the Fundamentals of Care framework as the theoretical lens (Feo et al. 2018; Kitson et al. 2013). The original study, which focused on what can improve patient recovery, left unexplored data regarding the gap between what should and can be done in clinical practice (Haakseth et al. 2025). This rich data, coming from a complex surgical setting, was fit for empirical testing of the context-of-care dimension within the

Fundamentals of Care framework, which could enable further development of the framework and increase its applicability in clinical practice (Blackman and Mudd 2023). A reanalysis of data focusing on how contextual factors affect care provision was therefore called for.

4.2 | Study Setting and Recruitment

The study was conducted at a vascular surgery centre, consisting of a vascular surgery ward and an outpatient clinic at a university hospital in Sweden. The vascular surgery centre constitutes a tertiary centre for advanced aortic surgery, conducting the complex EVAR procedure on a high volume of patients, on both national and international referrals. Descriptions of complex aortic diseases and treatment, including descriptions of standard care at the present vascular surgery unit, have been presented by Haakseth et al. (2019).

All data, involving four focus groups with a total of 12 healthcare professionals, were included for reanalysis. Inclusion and exclusion criteria are described in Table 1. Possible participants were identified through the ward manager responsible for the nursing staff and the section manager responsible for the vascular surgeon staff. Sixty-seven were contacted directly through their professional email for recruitment. The study aimed for a purposive sample of healthcare professionals based on their professional characteristics, but a convenience sample was lastly recruited for the first three focus groups due to a low response rate and difficulty finding a suitable time for the focus groups. For the fourth focus group, a purposive sample of the participants from the three subsequent focus groups was selected based on individual characteristics to maximise variation in the data.

4.3 | Data Collection

The focus groups with healthcare professionals were conducted between April and September 2022. The focus groups constituted stage 2 and stage 3 of a qualitative study involving three subsequent data collection stages. Stage 1, involving individual interviews with patients, was not subject to reanalysis in this study. The data collection was accelerated by presenting the participants with existing and emerging knowledge about patients' recovery after complex EVAR. The existing knowledge presented to the participants came from two previous studies on patients' recovery after complex EVAR (Haakseth et al. 2019, 2023). Emerging knowledge came from the analysis of the

subsequent stage(s). Details on the reanalysed data is shown in Table 2.

Data was collected using semi-structured topic guides (one each for stage 2 and 3) and were audio-recorded and transcribed verbatim. The duration of each focus group was approximately 30–60 min. All focus groups were conducted by the first author (female registered nurse within geriatrics and formerly vascular surgery, and PhD student with experience in qualitative research) and assisted by the last author (female registered nurse within general surgery, and associate professor with longstanding experience in qualitative research) who took field notes of e.g., non-verbal expressions and asked additional questions. The focus groups were held in a conference room at the participants' workplace. Most of the participants had a former professional relationship with the first author but not with the last author. The reason for doing the research was introduced at the start of the focus groups, before all participants and the researchers introduced themselves. Probing questions were asked, and the focus group discussion would otherwise only be interrupted if it strayed from recovery after complex EVAR. Topic guides were piloted prior to data collection, and minor adjustments and clarifications were made. No repeat focus groups were conducted and the transcripts were not returned to the participants.

4.4 | Data Analysis

The focus group transcripts were coded and analysed thematically using a deductive reflexive approach with a constructionist perspective, as it has been described by Braun and Clarke (2021a, 2022). Factors outlined in the Fundamentals of Care framework as constituting the context of care were used as a lens through which to interpret the data (Feo et al. 2018; Kitson et al. 2013). The definitions of the predefined themes and subthemes for analysis are shown in Table 3. The analysis process consisted of five steps. The first step involved noting down possible points of significance and patterns, getting a sense of the data. Minor definition changes were subsequently made to the analysis matrix. At the second step, codes were generated for individual meaning units (semantic and latent) of the most basic elements of data that appeared related to contextual factors affecting patient recovery. The third step involved identifying recurring themes by sorting the different codes into the predefined themes (contextual factors) conceptualised by the Fundamentals of Care framework and subthemes (how they affect patient recovery). One code could be sorted into more than one theme. In step four, themes were refined based on their internal homogeneity and external

TABLE 1 | Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> • Nursing staff (registered nurses, specialist nurses in surgical care and assistant nurses) • Vascular surgeons (registrars, specialist physicians and vascular consultants) • Currently working and routinely in contact with patients undergoing complex endovascular aortic repair at the vascular surgery ward or out-patient clinic 	<ul style="list-style-type: none"> • Not involved in the care of patients undergoing complex EVAR ($n = 1$) • Being a ward manager or section manager ($n = 2$) • Being a member of the research team, or in any other way involved in the performance of the study ($n = 2$)

TABLE 2 | Details on the reanalysed data.

Aim of original study	Stage of the original study	Type of data	Participants	Acceleration	Main question(s) of the topic guide
To explore what can improve patients' recovery after complex endovascular aortic repair	2	Three focus groups	Two groups of nursing staff ($n = 4$ and $n = 5$) One group of vascular surgeons ($n = 3$)	Presenting existing summary statements, quotes and one statistical figure from two previous studies on patients' recovery after complex EVAR ^a Presenting themes, subthemes and quotes from stage 1 of the original study, which entailed individual interviews with patients who had undergone complex EVAR, ^a asking them what works well and what can be improved with current care, to improve patient recovery after undergoing complex EVAR ^a	Based on the results presented to you and your own experiences what would you say works well and what can be improved with current care, to improve patients' experience of recovery after undergoing complex EVAR ^a What do you think could affect your ability to support the patients' recovery?
	3	One focus group	Purposive sample of nursing staff and vascular surgeons from stage 2 ($n = 5$)	Presenting summary statements and quotes from stages 1 and 2, in addition to intervention suggestions developed through consensus discussion within the research team, also based on the findings in stages 1 and 2	Is there anything you would like to change or add to the results presented to you from stage 2? How do you review these suggested interventions in terms of relevance and feasibility?

^aEndovascular aortic repair.

TABLE 3 | Definition of contextual factors within the Fundamentals of Care used as predefined themes and subthemes for the deductive analysis. Content within the table derived from seminal papers; Feo et al. (2018) and Kitson et al. (2013).

Context of care		
Theme		Subtheme with clarification
System level	Resources	<i>Infrastructure</i> : routines for care (i.e., coordination of care, documentation, information, follow-up) <i>Equipment</i> : practical, technical and informatics material <i>Staff</i> : staffing levels to meet the task, staff usage <i>Skill mix/competence</i> : multiprofessional team, competence/knowledge requirements, different levels of care, involving patient/family/carers, patient health literacy <i>Environment</i> : physical environment, integrity
	Evaluation and feedback	<i>Feedback processes</i> : individual, team, organisational <i>Quality indicators</i> : patient-reported outcomes, patient experience outcomes, fundamentals of care, staff well-being <i>Availability of quality indicators</i> : to staff and patients
	Leadership	<i>Informal leadership</i> : opinion leaders, central figures with implicit power and/or responsibility <i>Formal leadership</i> : management structures, management role, explicit power and responsibility at different levels <i>Leadership style</i> : trusting and enabling or dictating leadership
	Culture	<i>Values</i> : what is considered as important or unimportant <i>Norms</i> : the way things work <i>Goals</i> : purpose, meaning, patient and staff goals <i>Respected and valued staff</i> : power, hierarchy
Policy level	Financial	<i>Correctly invested money</i> : distribution and use of financial resources <i>Financial models driving performance</i> : focus of investments, public and political attention
	Quality and safety	<i>Available safety and quality records, based on patient-centred outcomes</i> : transparency of care quality, patients' choice of care provider, informed consent
	Governance	<i>Dealing with complaints from staff and patients</i> : supervising organisation, management of complaints <i>Seeking feedback, involving patients</i> : patient and staff involvement in care development, patient committees/unions, trade unions, interest organisations
	Regulation and accreditation	<i>Comparing between organisations</i> : certification of standards <i>Work with all professions to ensure positive learning</i> : uncovering relevant intervention, positive reinforcement, role models <i>Laws or bylaws defining the conditions for practice</i> : health professionals' minimum educational requirements, entry to practice, title protection, scope of practice, professional development

heterogeneity, and how each theme and all themes affected care provision towards patients' postoperative recovery. The fifth and last step involved interpretation, further refining the themes and defining them in terms of an identified essence of how each theme and all themes affect care provision towards patients' postoperative recovery. An example of the analysis process from meaning unit (Step 2) to refined theme (Step 5) is shown in Table 4.

The first and last author conducted steps 1–4 independently, and jointly reviewed the work after each stage. The second author (a female registered nurse within psychiatry and associate professor with longstanding experience in qualitative research) read all four transcripts and participated in reviewing the themes at steps 3–4. The remaining two co-authors (male professors in

vascular surgery) read one transcript. Step 5 was conducted independently by the first author, before the entire research team participated in reviewing and refining the results. Respondent validation of the analysis results was not sought.

4.5 | Ethical Considerations

Study approval was obtained from the Swedish Ethical Review Authority (Dnr: 2021–02019), and all participants gave informed consent to the original data collection. No ethical approval was specifically obtained for the secondary analysis, as the research question was closely related to that of the original study. Both the original and present study

TABLE 4 | Example of the analytical process from step 2, involving identifying a meaning unit, to step 5, refining themes.

Step 2—Meaning unit	Step 3—Code	Step 4—Initial themes and subthemes	Step 5—Refined themes
“We got so little time [to provide care]. The second the patient has been ‘so lucky’ and has been to the toilet, then it [in-hospital care] is DONE. Now all is good! ‘Bye bye!’”— Focus group 1	Having limited time, as in-hospital care is limited to physical outcomes.	<i>Theme 1:</i> Resources, infrastructure <i>Subtheme 1:</i> Routines steering care provision. <i>Theme 2:</i> Culture, goals <i>Subtheme 2:</i> Physical goals with care leave limited time for other care needs	<i>Theme:</i> Care provision is challenged by discrepancies in values, goals and norms and unclear responsibilities within the context <i>Subtheme 1:</i> Values, goals and norms determine what care is provided <i>Subtheme 2:</i> Taking responsibility for care requires resources, evaluation and feedback

conform to the standards of the Declaration of Helsinki (World Medical Association 2013). The data were stored securely in a password-protected computer.

4.6 | Rigour and Reflexivity

To strengthen credibility throughout data collection, the interviewer asked probing questions during the focus groups and asked for the respondents' validation of a summary of the focus group discussion at the end. The interviewer also transcribed the focus group recordings immediately after conduction to make use of the rich insights of the interviewer. Throughout analysis, credibility was strengthened by the findings being continuously checked against the raw data. Dependability was strengthened through piloting of the topic guides, where only minor adjustments were later conducted for clarity. The research team, having previous experience with conducting qualitative research, further strengthened the dependability of the method. A semi-structured topic guide with open-ended questions was used to strengthen confirmability. It was further strengthened by parts of the analysis process being done independently by two researchers and them discussing their preunderstandings and preconceptions both prior to analysis and the original data collection. Confirmability may also have been strengthened as the research team consisted of members with different professional backgrounds. To strengthen transferability, the study involved different healthcare professionals to tell a rich and multifaceted story. The purposive sampling for the fourth focus group further strengthened transferability.

5 | Findings

5.1 | Characteristics of Participants

A total of 12 healthcare professionals participated across the 4 focus groups included in this study. An overview of the composition of the focus groups can be seen in Table 5.

5.2 | Care Provision Is Challenged by Discrepancies in Values, Goals and Norms and Unclear Responsibilities Within the Context

Healthcare professionals described care provision towards patient recovery after complex EVAR as affected by contextual factors at both the system and policy levels. The analysis resulted

in one main theme: *Care provision is challenged by discrepancies in values, goals, and norms and unclear responsibilities within the context*, and two subthemes: *Values, goals, and norms determine what care is provided; taking responsibility for care requires resources, evaluation, and feedback*. Descriptions of the different contextual factors and how they affect care provision towards patient recovery are presented below and illustrated by citations.

5.2.1 | Values, Goals and Norms Determine What Care Is Provided

Values, goals and norms at policy, system and individual levels were described by the healthcare professionals to determine what care is provided to the patient. These values, goals and norms were described to require unity, as they otherwise would lead to inadequate resource management, standards for evaluation and quality and safety records to meet the patients' care needs. Discrepancies in values and goals between the healthcare services and the patients were described by the healthcare professionals. While the healthcare services were explicitly described and implicitly demonstrated to focus on surgical outcome, short-term physical care needs and major complications, the healthcare professionals believed the patients focus more on long-term functioning in daily life and meaningfulness after discharge.

From a medical perspective you value other aspects than these ‘softer values’ [the need for information and support raised by the patients]. I'm happy and grateful if I manage to identify a complication and treat it early.—

Focus group 3

A reality was described where the goals of care perceived by individual healthcare professionals affected care provision, which could make it vary widely what information or support the patients were offered. During the focus groups, participants with the shortest work experience talked more focused on patient outcomes or solutions for care provision (e.g., time usage), while those with longer experience focused on practical tasks and barriers to care provision (e.g., time). Time-efficiency demands were depicted as a choice of quantity over quality. Norms within the healthcare system were described by nursing staff as based on a hierarchy with the surgeons as the leaders of the provided care. Utilising nurses' competence and bedside availability, it was said in all focus groups that it could contribute to continuity, efficient staff usage, and meet

TABLE 5 | Overview of the composition of the focus groups.

Focus group	Professional title	Work experience (time)	Work experience (location)	Gender
1	Registered nurse (<i>n</i> = 3)	< 2 years (<i>n</i> = 2)	Only ward	Men (<i>n</i> = 1)
	Assistant nurse (<i>n</i> = 1)	3–5 years (<i>n</i> = 1)	experience (<i>n</i> = 3)	Women (<i>n</i> = 4)
	Speciliast nurse (<i>n</i> = 1)	5–10 years (<i>n</i> = 1)	Both ward and out-patient clinic experience (<i>n</i> = 2)	
2	Registered nurse (<i>n</i> = 2)	3–5 years (<i>n</i> = 2)	Only ward	Women (<i>n</i> = 4)
	Assistant nurse (<i>n</i> = 1)	5–10 years (<i>n</i> = 1)	experience (<i>n</i> = 2)	
	Speciliast nurse (<i>n</i> = 1)	> 20 years (<i>n</i> = 1)	Both ward and out-patient clinic experience (<i>n</i> = 2)	
3	Registrar (<i>n</i> = 1)	< 2 years (<i>n</i> = 2)	Both ward and out-patient clinic experience (<i>n</i> = 3)	Men (<i>n</i> = 2)
	Specialist physician (<i>n</i> = 1)	3–5 years (<i>n</i> = 1)		Women (<i>n</i> = 1)
	Consultant (<i>n</i> = 1)	> 20 years (<i>n</i> = 1)		
4	Registered nurse from FG ^a 1 (<i>n</i> = 2)	< 2 years (<i>n</i> = 3)	Only ward	Men (<i>n</i> = 2)
	Assistant nurse from FG ^a 1 and 2 (<i>n</i> = 2)	5–10 years (<i>n</i> = 2)	experience (<i>n</i> = 2)	Women (<i>n</i> = 3)
	Registrar from FG ^a 3 (<i>n</i> = 1)		Both ward and out-patient clinic experience (<i>n</i> = 3)	

^aFG = focus group, indicating in which focus group the participant participated in the previous stage of the study.

the 'softer values' of the patients. The nursing staff reported that the devaluation of bedside care on the wards redirected the surgeons with the highest competence away from the patients, which also led to the nurses not being able to do nursing tasks, as they had to assist by doing the surgeons' tasks and focus on medical care.

I believe this management of resources [nurses not having time for informing the patient at admission due to other task and surgeons being unavailable at the ward] is one of the biggest obstacles we have in today's healthcare. (...) And how do we optimize that [resource management] without losing anything?—

Focus group 1

The norm of the patients' role within the healthcare system was also narrated, as the participants thought patients might see their minor complications and care needs as not important enough to 'disturb' the healthcare professionals. Such norms, not including patients in their care, and the discrepancies in the patients' and the healthcare services' values and goals were described that they could lead to unavailable or inadequate resources (e.g., staffing, knowledge and routines) and evaluation and feedback processes from both system and policy level, to uncover and meet the patients' care needs.

There we might be a bit too limited by what information we collect today [to give correct information and care]. We need information about who the person in front of us actually is. What worries and expectations that person have, and what he has set as goal for his recovery. So that we can actually give the information that is relevant and important to them.—

Focus group 1

Evaluation and feedback processes were described as linked to what was seen as important within the healthcare services. Lacking such processes for both patients and staff was implicitly expressed as linked to both the effectiveness and efficiency of care provision. Lack of routine contact with the patient or other care providers after discharge made it unclear how the patients were recovering after discharge, and whether recommendations for follow-up were being followed by the local care provider. An underreporting of minor complications was suspected, due to a focus on the surgery and major physical outcomes as quality indicators at a policy level. This made psychosocial and relational outcomes not available to the patients preoperatively so that they themselves could assess if doing the surgery is consistent with their individual goals.

Maybe we [the healthcare services] play down the complications. We try to get them to do the surgery, because they need it. But maybe they do not get comprehensive information about what can actually go wrong. You want to help them. I don't know how many would back down from the surgery if they got all the information either. Quite a lot can happen. But they have a right to information.—

Focus group 2

Contextual factors at the policy level were overall scarcely described by the participants, and primarily, it was addressed by the vascular surgeons. What was viewed as important at the policy level could be seen affecting care provision in the same way as on the system level, through direction of financial resources towards physical care goals, and evaluation and feedback processes not considering patients' psychosocial care. Time and resources were referred to as 'a cost' and 'investment' in structures, compensating for the short in-hospital care. The vascular surgeons referred

to how there were differences in care and resources for patient groups similar to patients undergoing complex EVAR, e.g., patients with cancer. They concluded that resources exist for patients who belong to society at large, and speculated whether politicians are biasedly invested based on personal values. Governance was implicitly described as a need to know what and how healthcare services should be given. Seeking feedback from staff and patients on how care is and should be provided was described as important. This was reflected in how the participants were positive about participation in the study. Knowing what patients appreciate about and need from the healthcare services was seen as important. The accreditation of a 'Centre of excellence', it was said, should include consideration for what is important to the patients. Patient organisations were described as the ones who can direct financial resources and push for change in clinical practice, exemplified by the existing role of the contact nurse within cancer care. Aortic surgery patients, being elderly and lacking this sort of network, were thought to make it harder for them to push their own agenda.

5.2.2 | Taking Responsibility for Care Requires Resources, Evaluation and Feedback

Responsibility for care provision at an individual, system and policy level was implicitly depicted as dynamic, as taking responsibility was described to require empowerment to do so. Such empowerment was described as being done through 'someone' (i.e., non-specific professional) taking responsibility for ensuring adequate resources and resource management, which in turn could be empowered by 'someone' making evaluation and feedback processes available, and 'someone' using them.

Various resources were both implicitly and explicitly described as empowering care provision towards patient recovery. The healthcare services or politicians' responsibilities for ensuring financial and material resources, infrastructure, sufficient staff and competence were highlighted and discussed. This in turn was said that it could enable the front-line healthcare professionals in taking responsibility for care provision. Equipment for systematically collecting, documenting and transferring information on the patients' individual values and goals regarding their care was also said that it could enable a person-centred care, even after discharge. Physical environment was mentioned that it could affect patients' ability to take in the often very complex information, or encourage and support patients' mobility. Other required equipment resources involved written information material specifically for complex EVAR and digital platforms, which could be individually adjusted, as it was described that they could facilitate providing information to the patient and save time for staff.

...and maybe we should draw a figure of their surgery too. That might take a minute, but I think it is manageable. I think it saves a lot of time and questions for later.—

Focus group 4

Infrastructural resources revolved around having routines in place for informing and following up the patients, including taking information from the patients. Clear routines were even seen

as ways to clarify responsibility and avoid care quality depending on the individual healthcare professional and available time. It also involved establishing routines for transferring information and coordinating care between different care providers. These routines were believed to empower healthcare professionals to provide a consistent and minimum level of care, where long-term recovery and patients' psychosocial care were considered.

Like you [other participant] say, start with routines. Start with templates. From there we sort of know 'This is minimum!', because it feels very fluid right now.—

Focus group 1

Insufficient staff resources were explicitly mentioned as a barrier to meeting the tasks required to improve patient recovery. Implicitly, it was also described as a 'lack of time', 'resources' and 'possibility' for them to meet the patients' care needs. Improved staff usage in terms of clear role descriptions, optimising staffing schedule, improved teamwork and allocation of high competence near the patient were said to clarify responsibility, promote continuity and increase care quality. Availability of a wide multi-professional skill mix (i.e., physiotherapist, nutritionist, social worker) was listed as a required resource when the participants described the patient group as complex and possibly affected in psychological, social as well as physical ways.

That is a bit what we [healthcare professionals] are after. That we can establish a better team work. That we [nurses] can fill in on information that you [vascular surgeons] are missing, and you [vascular surgeons] can fill in information we [nurses] are missing. That way we [healthcare professionals] can give the patients better care and information.—

Focus group 4

Multi-professional team work was, however, described as problematic as staff have different schedules and agendas. High staff turnover was described as making it difficult to keep routines from falling out. High competence around complex EVAR care and what it may entail for the patient, but also knowledge about the individual patient, was seen as important by the participants. Local care providers' competence about the patient group and the individual patient were something that was said could affect continuity and local care providers' ability to take responsibility for follow-up after care ended at the tertiary surgical unit where the operation was conducted. Patients' family were also described as a resource, as they often help and support the patients in their recovery. Consideration for the patients' competence about themselves, but also their health literacy, was described as important to empower patients in taking responsibility for their own care.

-We may not have reflected over that those who take over [care provision] may not possess our level of competence [for this specific patient group], and may not be as informed on what has happened, and what a threshold [for care] that make up for the patient. (...)

-Yes, there is a lot of responsibility on the patients themselves.—

Focus group 1

Feedback processes for staff were described as needed for evaluation whether current routines were working adequately and were being followed. Participants working at the outpatient clinic expressed not knowing how routines are working at the ward, and vice versa. Adequate feedback loops were also described that they could clarify responsibility by bringing forth what is not working to those who need to act upon it, and also enable more effective teamwork (resource management). The participants described how their feedback on routines was not usually sought out (within the organisation), but merely given on their own initiative, which they had no time to prioritise. The participants narrated experiencing stress and hopelessness from having responsibility for patients' recovery without actual power to do anything about it. Lack of ways for reporting insufficient staffing to meet the necessary tasks were implicitly described, as the participants expressed hopelessness regarding staffing issues. Feedback loops to uncover unmet care needs and clarify responsibility were described that they could happen with the individual patients or patient group, between members of the care team, between front-line staff and management (at the ward, department and organisational) or between care providers.

Overall, the participants did not explicitly discuss individual responsibility and blamed an unspecified external factor for their inability to provide care. Both nursing staff and vascular surgeons described situations when their patients were 'suddenly' being discharged, and they themselves had no power over it. Responsibility for undefined 'other tasks' was said to undermine staff's ability to meet psychosocial and relational care needs, as the participants narrated they 'have to do their job' before they could 'sit down and talk with the patients'. The participants vaguely, but repeatedly, described how both 'we' and 'someone' needs to ensure necessary routines are in place, followed and working.

It [the existing routines that are currently not being practiced] really has to be set back into practice. But someone needs to get a handle on it.—

Focus group 2

A need for formal leadership was implicitly expressed as the participants wanted 'someone' (i.e., a non-specific leader) to both empower and force them to provide consistent care. A norm of everyone doing their own thing was narrated in the absence of such leadership.

What is expected of me as a nurse? Or of me as a physician? What information do I have to give the patient? It is good to standardise this. Otherwise it is done differently every time.—

Focus group 4

An enabling leadership could be seen in the described need for management of resources. A dictating leadership could be seen in how the vascular surgeons discuss the effective use of negative incentives (e.g., the department being financially sanctioned for not

doing a task), and how both nursing staff and surgeons describe a need for 'someone' to ensure desirable routines were actually followed. Moreover, in the multi-professional care context of complex EVAR, a leadership making formal decisions and taking responsibility for desirable routines was described as required at 'another level' for the routines to work for all staff groups.

'That your department or clinic get quite a punishment fee for each patient that is discharged without written discharge information. That's a way to solve it'. —

Focus group 3

Participants expressed an uncertainty about their responsibility both as front-line staff and as a tertiary care unit. Lack of a fixed care contact, i.e., a general practitioner in community care, was said to make it unclear who is responsible for the often elderly and comorbid patients who undergo complex EVAR. A clear account of who is responsible for what, especially after discharge, was said that it could avoid the patients feeling unsafe due to a lack of contact with the surgeon or hospital that did the surgery. Competence and responsibility were implied to be linked, and patients were described to impose responsibility for their care upon the one(s) who the patients see as the most competent (i.e., the surgeon or surgical unit who did the operation). Responsibility sharing, and thus knowledge transfer, between different care providers and the patient was said that it could ensure support towards patient recovery. The patients' ability to take responsibility for their own care was raised as a resource. The nursing staff described their responsibility for supporting and 'pushing' patients in taking responsibility for their own care.

It is important that we do not just see a patient, but that we really see there is a person I need to take care of. It is my job to ensure this person can manage [their daily life] on his own when he comes home.—

Focus group 1

The participants described a need for national infrastructure, as patients undergoing complex EVAR are elderly and often referred from other hospitals. Resources and structures for information transfers, long-term rehabilitation, fixed care contacts, nursing contacts and coordination of care were warranted to clarify responsibility and empower care provision across multiple geographical and administrative regions and care providers. High transparency about all risks of the operation, including minor complications, similar to that of an 'informed consent', was said to transfer responsibility to the patients themselves, by empowering patients to make informed choices, weighing in their personal values and goals. The participants described how providing information to the patient is the law, yet they could not take responsibility for this. This was described to indicate a need for re-evaluation, so that adequate resources and routines could be established.

6 | Discussion

The findings show that the healthcare professionals describe care provision towards patients' postoperative recovery after

complex EVAR as affected by a dynamic integration of contextual factors, where values, goals and norms affect what care is provided. Responsibility for care was described as unclear. The healthcare professionals in this study describe all contextual factors listed in the Fundamentals of Care framework as affecting care provision. Similar factors have also been reported by other studies (Chaboyer et al. 2021; Dellenborg et al. 2019; Grossi et al. 2021; Jangland et al. 2018; Moore et al. 2017; Squires et al. 2019), indicating that the context of care is multifaceted, and that the contextual factors currently listed in the Fundamentals of Care framework are relevant. This was also concluded by Blackman and Mudd (2023). However, similar to the findings in this study, Dellenborg et al. (2019) have raised how the context of care tends to be referred to as a given constant, whereas it actually is dynamically integrated. Blackman and Mudd also found that there is a predictive relationship between the different contextual factors within the Fundamentals of Care framework (Blackman and Mudd 2023). In this study, a perception of contextual factors as separate constants could be what is reflected in the participants' passivity in relation to the context as external, where individual responsibility is unclear. This passivity to the context could be explained by how the concept of context in existing nursing theories has been described to not sufficiently address the complexity of context in a manner that is of direct use in clinical practice (Mudd et al. 2020).

6.1 | Uncovering the Goals of Care

Values, goals and norms, ranging from policy to individual level, were described by the healthcare professionals to determine what care is provided to the patient. This is also recognised in other studies, where 'culture' is described as a central contextual factor (Dellenborg et al. 2019; Jangland et al. 2018; Moore et al. 2017; Squires et al. 2019). A multi-study analysis even uncovered how 'culture' was reported across all behaviours, settings and professional roles (Squires et al. 2019), indicating that values, goals and norms may play an overarching role in the context of care. Similar to the findings of this study, Mantovan et al. (2020) found how nurses describe their rationing of nursing care as a choice between quantity over quality. The rationing was done to maintain stability on the ward alongside the complexity and acuity of the healthcare setting. Which shows how responsibility for reaching the goals of care risks ending up on front-line staff alone, and in turn causes poor staff well-being (Mantovan et al. 2020). Values, goals and norms have, to the authors' knowledge, not been empirically described as overarching and working at all levels within the care context, which might be why clinical nurses describe 'care culture' as an external and 'simply to blame' barrier for care provision (Muntlin et al. 2023). In McCormack et al.'s (2017) model for person-centred nursing, the values and goals of care are depicted as overarching through the centralisation of *Person-centred outcomes* and *Care processes*, and through *Shared decision-making systems* as part of the *Care environment*, and *Clarity of beliefs and values* as a *Prerequisite*. Meanwhile, in the Fundamentals of Care framework, *Culture* (including values, goals and norms) is depicted as a separate factor at the system level (Feo et al. 2018; Kitson et al. 2013), which suggests

a need to consider expanding the concept of context within the framework to reflect the overarching role of 'culture', and increase the framework's direct use in clinical practice.

Evaluation and feedback processes were described in this study as linked to what was seen as important within the healthcare services from both systems (*Evaluation and feedback*) and policy level (*Quality and safety, Regulation and Accreditation*). This is reflected in another study, where evaluations have been described to include both patient and organisational outcomes, in addition to audit (Squires et al. 2019). However, for service evaluation or audit, predetermined standards and goals are normally a prerequisite (Twycross and Shorten 2014). In this study, discrepancies in values and goals were depicted between the healthcare services and patients, and within the healthcare services at an individual, system, and policy level. This was described that it could lead to insufficient and unutilised evaluation and feedback processes, and thus leave uncertainty about what one was responsible for, and cause insufficient empowerment. Similarly, Blackman and Mudd (2023) found how *Resource allocation*, defined by *Culture, Leadership* and *Quality and safety*, is a central contextual factor within the Fundamentals of Care framework. Which in turn shows how it is necessary to, at all levels, uncover: 'What are the goals of care?'

Similar to the findings of this study, key steps to the development of quality indicators have been said to include taking in staff and patients' perspectives on the goals of care (Stelfox and Straus 2013). Within person-centred care, goals with care are suggested to be set at an individual level in collaboration between the healthcare professionals and the patient (McCormack et al. 2017). This was also suggested in this study, but was seen as requiring empowerment from both a system and policy level, which were inhibited by discrepancies in values, goals, and norms at these levels. McCormack et al. (2017) recommend a move from 'person-centred moments' to 'person-centred care' as an underpinning culture of whole teams and organisations. Similarly, Britten et al. (2020) raise that healthcare professionals should work more systematically for person-centred care, ensuring person-centred care for most patients most of the time, regardless of who is caring for them. It remains uncertain from where in the context of care the values, goals, and norms for care provision emerge or can be unified. However, the healthcare professionals in this study describe the importance of seeking feedback from both patients and staff at an individual, system, and policy level, and that evaluation of care quality should be available to them.

6.2 | Being Able to Take Responsibility for the Goals of Care

The participants in this study expressed an inability to take their individual responsibility for care provision if not empowered through the availability of resources, feedback processes, and directives for care at a system and policy level. Similarly, Bradbury-Jones et al. (2008) have described empowerment as not simply having or distributing power to act, but also providing support and feedback. Various resources at the system and policy level were described by the participants in this study as

something empowering the care required to meet the complex care needs of patients undergoing complex EVAR. Resources, including finances, have also been a central factor in other studies depicting the context of care from a healthcare professional perspective (Grossi et al. 2021; Squires et al. 2019). This might suggest resources being a reflection of empowerment bedside, thus a responsibility at the system or policy level to empower the individual level. In this study, healthcare professionals described resources empowering care provision as not merely about access to a quantity of staff or 'time', but also involving resource qualities, e.g., competence, routines and staff usage. This has also been identified in other studies (Grossi et al. 2021; Jangland et al. 2018; Squires et al. 2019). Showing that there might be an improvement potential, despite the effectivity demands on healthcare services. This indicates that responsibility for care provision may lie at the individual, system and policy level, and that both the necessary quantity and quality of resources have to be ensured to empower healthcare professionals to take responsibility for care provision towards improved patient recovery.

In the Fundamentals of Care framework, responsibility is described when talking about *Leadership* as a contextual factor at the system level (Feo et al. 2018; Kitson et al. 2013). The need for formal leadership described in this study, involving both enabling and dictating leadership styles, has also been identified in other studies (Dellenborg et al. 2019; Grossi et al. 2021; Jangland et al. 2018; Moore et al. 2017; Muntlin et al. 2023; Squires et al. 2019). However, the participants in this study describe a shift of responsibility within the care context, ranging from individual to policy level. Similarly, Blackman and Mudd (2023) found *Leadership* to be a central contextual factor, required to take in feedback and allocate and govern resources towards integrated fundamental care. The shift of responsibility between leaders and individual staff can also be recognised in the framework for person-centred nursing, where *Supportive organisational systems* and *Potential for innovation and risk taking* in the *Care environment* might imply empowerment that could shift responsibility to the individual healthcare professional (McCormack et al. 2017). Empowerment has also been described as dynamic, bottom-up and originating from everywhere depending on knowledge production, where individuals are being given the opportunity to critically assess the situation and take action towards a goal (Bradbury-Jones et al. 2008). Which in turn requires the individual healthcare professional to assume some responsibility. The mix of healthcare professionals participating in this study could identify problems within the care context and come up with solutions. This shows the importance of having and utilising feedback processes, so that front-line staff can empower management to address insufficient staffing or inadequate routines, which in turn empower care provision. Once again indicating a need to consider expanding the concept of context within the Fundamentals of Care framework, to capture this dynamic integration of contextual factors, where responsibility is everyone's.

6.3 | The Patient Role in the Context of Care—A Resource and Quality Indicator

The Fundamentals of Care framework has been criticised for not positioning the patients in their broader family and community

context (Mudd et al. 2020). In this study, the healthcare professionals describe patients' families, patients' competence about themselves, but also their health literacy as important resources within centralised surgical care. In addition, the norm where the patients were passive and not involved in their care within the healthcare system was described to negatively affect care provision, which could be understood as poor resource management. Patients' values and goals with care were described as a key quality indicator that should guide both resource management and evaluation. Moreover, to what degree a patient group belongs to society at large, and the presence of patient organisations, could affect financial priorities and governance of the healthcare services. This is reflected in another study, where characteristics of the patient group (e.g., patient age and illness severity) have been identified as a possible core contextual factor (Squires et al. 2019). Overall, seeing the patient as a resource and quality indicator can be seen reflected in the ethics of person-centred care, where the patient is a partner in their care (McCormack et al. 2017). This indicates that the patients' role in the context of care could simply be showing the link between the context of care and the two other dimensions of the Fundamentals of Care framework: *Relationship* and *Integration of Care*. Blackman and Mudd (2023) found relational care actions as predicted by both resource allocation and leadership, which could be showing the patient as a resource and quality indicator. However, psychosocial care showed no such link (Blackman and Mudd 2023). The need for a shift of empowerment and responsibility, also involving a shift between the context of care and the patient, may require specific awareness when interpreting the framework. Healthcare professionals and leaders should thus let care be guided by patients' values and goals, and be aware of their patients' resources at both an individual, system, and societal level to enable adequate evaluation of care and provide compensating resources for the empowerment of these often older and comorbid patients, e.g., through encouraging and taking in perspectives from patients and patient organisations.

6.4 | Strengths and Limitations of the Work

A strength of this study was that it was a secondary analysis that enabled looking at the existing data from a different perspective to examine contextual concepts that were not central in the original research (Thorne 2013).

There are limitations to this study. Due to the low participation rate, the original study was deprived of the possibility to purposively select participants based on their individual characteristics, which could contribute to maximum variation in the data. Determining saturation in reflexive thematic analysis is discouraged, but the focus group method, involving different healthcare professionals with different work experiences, is an adequate way to tell a rich multifaceted story (Braun and Clarke 2021b) and to uncover similarities and differences within a group (i.e., values and norms) (Côte-Arsenault 2013). This study, being a secondary analysis, where the original study did not explicitly explore the context of care, may have limited the findings. However, it did enable uncovering more latent contextual factors (e.g., values, goals, norms and responsibility), as the participants talked vividly about the context of care during the focus group and were thus unlikely to bias their responses

(Thorne 2013). The members of the research team all have experience with and thus preunderstanding of the care context could be seen as a limitation, but this was mitigated by several measures to strengthen confirmability (see Section 4.6).

6.5 | Recommendations for Further Research

This study was a secondary analysis from one centre, which calls for other multicentre original studies, both explicitly and implicitly exploring contextual factors affecting care provision in the complex surgical setting, and other settings. Such studies should explore the perspectives of different stakeholders, e.g., patients and professionals at an individual, system and policy level, to develop further understanding of the distribution and shift in responsibility, and where values, goals and norms emerge and can be changed within the context of care.

6.6 | Implications for Policy and Practice

This study contributes insight and knowledge regarding the dynamic integration of contextual factors affecting care provision. Healthcare professionals need to be aware of their individual responsibility for care aligned with patients' values and goals, and their responsibility needs to be clarified and empowered through leadership and resource management. Patients should be empowered as resources and considered quality indicators at the individual, system and policy level, to guide the goals of care. Policy and routines needs to enable this through feedback loops with patients and healthcare professionals, and effective resource management. Contextual factors listed in the Fundamentals of Care framework seem relevant for healthcare professionals and leaders when trying to understand what affects care provision within the complex surgical organisation. However, the central role of culture and responsibility within the context-of-care dimension of the framework require further clarification.

7 | Conclusion

The findings show that healthcare professionals describe care provision towards patients' postoperative recovery after complex aortic surgery as affected by a dynamic integration of contextual factors. There is a need for healthcare professionals to be made aware of one's own role in this context. Care provision needs to be guided by feedback from patients and healthcare professionals, and work with patients' resources at both an individual, system and societal level, e.g., through taking in perspectives from patients and patient organisations. There is a need to further explicitly explore the role and ways of both 'responsibility' and 'culture' at an individual, system and policy level of the context of care, to enable expanding the concept of context within the Fundamentals of Care framework, and increase the frameworks' direct use in clinical practice.

Author Contributions

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE; <http://www.icmje.org/>

[recommendations/](#)): (1) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content.

Acknowledgements

The authors would like to thank all the participants for their contribution with their perspectives.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Peer Review

The peer review history for this article is available at <https://www.webofscience.com/api/gateway/wos/peer-review/10.1111/jan.70040>.

References

- Allvin, R., K. Berg, E. Idvall, and U. Nilsson. 2007. "Postoperative Recovery: A Concept Analysis." *Journal of Advanced Nursing* 57, no. 5: 552–558. <https://doi.org/10.1111/j.1365-2648.2006.04156.x>.
- Blackman, I., and A. Mudd. 2023. "An Empirical Analysis of the Constructs of Fundamentals of Care Framework Using Structural Equation Modelling." *Journal of Advanced Nursing* 79, no. 3: 1139–1151. <https://doi.org/10.1111/jan.15369>.
- Bradbury-Jones, C., S. Sambrook, and F. Irvine. 2008. "Power and Empowerment in Nursing: A Fourth Theoretical Approach." *Journal of Advanced Nursing* 62, no. 2: 258–266. <https://doi.org/10.1111/j.1365-2648.2008.04598.x>.
- Braun, V., and V. Clarke. 2021a. *Thematic Analysis: A Practical Guide*, edited by A. Maher. SAGE Publications Ltd.
- Braun, V., and V. Clarke. 2021b. "To Saturate or Not to Saturate? Questioning Data Saturation as a Useful Concept for Thematic Analysis and Sample-Size Rationales." *Qualitative Research in Sport, Exercise and Health* 13, no. 2: 201–216. <https://doi.org/10.1080/2159676X.2019.1704846>.
- Braun, V., and V. Clarke. 2022. "Conceptual and Design Thinking for Thematic Analysis." *Qualitative Psychology* 9, no. 1: 3–26. <https://doi.org/10.1037/qp0000196>.
- Britten, N., I. Ekman, Ö. Naldemirci, M. Javinger, H. Hedman, and A. Wolf. 2020. "Learning From Gothenburg Model of Person Centred Healthcare." *BMJ* 370: m2738. <https://doi.org/10.1136/bmj.m2738>.
- Budtz-Lilly, J., M. Björck, M. Venermo, et al. 2018. "Editor's Choice – The Impact of Centralisation and Endovascular Aneurysm Repair on Treatment of Ruptured Abdominal Aortic Aneurysms Based on International Registries." *European Journal of Vascular and Endovascular Surgery* 56, no. 2: 181–188. <https://doi.org/10.1016/j.ejvs.2018.01.014>.
- Chaboyer, W., E. Harbeck, B.-O. Lee, and L. Grealish. 2021. "Missed Nursing Care: An Overview of Reviews." *Kaohsiung Journal of Medical Sciences* 37, no. 2: 82–91. <https://doi.org/10.1002/kjm2.12308>.
- Côte-Arsenault, D. 2013. "Focus Groups." In *Routledge International Handbook of Qualitative Nursing Research*, edited by C. T. Beck, 307–318. Routledge, Taylor & Francis Group.
- Dellenborg, L., E. Wikström, and A. Andersson Erichsen. 2019. "Factors That May Promote the Learning of Person-Centred Care: An

- Ethnographic Study of an Implementation Programme for Healthcare Professionals in a Medical Emergency Ward in Sweden." *Advances in Health Sciences Education* 24, no. 2: 353–381. <https://doi.org/10.1007/s10459-018-09869-y>.
- Feo, R., T. Conroy, E. Jangland, et al. 2018. "Towards a Standardised Definition for Fundamental Care: A Modified Delphi Study." *Journal of Clinical Nursing* 27, no. 11–12: 2285–2299. <https://doi.org/10.1111/jocn.14247>.
- Gong, F., Y. Mei, M. Wu, and C. Tang. 2025. "Global Reasons for Missed Nursing Care: A Systematic Review and Meta-Analysis." *International Nursing Review* 72, no. 1: e13096. <https://doi.org/10.1111/inr.13096>.
- Grossi, A., I. Hoxhaj, I. Gabutti, et al. 2021. "Hospital Contextual Factors Affecting the Implementation of Health Technologies: A Systematic Review." *BMC Health Services Research* 21: 407. <https://doi.org/10.1186/s12913-021-06423-2>.
- Haakseth, L., C. Öster, K. Mani, A. Wanhainen, and E. Jangland. 2025. "How to Improve Patient Recovery After Complex Endovascular Aortic Repair: The Experiences of Patients and Healthcare Professionals." *Patient Education and Counseling* 130: 108–460. <https://doi.org/10.1016/j.pec.2024.108460>.
- Haakseth, L., C. Öster, A. Wanhainen, K. Mani, and E. Jangland. 2023. "Patients' Health and Quality of Life After Complex Endovascular Aortic Repair: A Prospective Cohort Study." *Journal of Vascular Nursing* 41, no. 3: 132–143. <https://doi.org/10.1016/j.jvn.2023.05.010>.
- Haakseth, L., A. Wanhainen, M. Björck, and E. Jangland. 2019. "Understanding Patients' Experiences of Recovery After Staged Complex Aortic Repair: A Phenomenological Study." *Journal of Advanced Nursing* 75, no. 11: 2834–2844. <https://doi.org/10.1111/jan.14103>.
- Jangland, E., T. Teodorsson, K. Molander, and Å. Muntlin Athlin. 2018. "Inadequate Environment, Resources and Values Lead to Missed Nursing Care: A Focused Ethnographic Study on the Surgical Ward Using the Fundamentals of Care Framework." *Journal of Clinical Nursing* 27, no. 11–12: 2311–2321. <https://doi.org/10.1111/jocn.14095>.
- Kitson, A. 2018. "The Fundamentals of Care Framework as a Point-of-Care Nursing Theory." *Nursing Research* 67, no. 2: 99–107. <https://doi.org/10.1097/NNR.0000000000000271>.
- Kitson, A., T. Conroy, K. Kulski, L. Locoock, and R. Lyons. 2013. *Reclaiming and Redefining the Fundamentals of Care: Nursing's Response to Meeting Patients' Basic Human Needs*. School of Nursing, University of Adelaide. <https://digital.library.adelaide.edu.au/server/api/core/bitstreams/584b1213-5d1f-44c5-ae5a-f723ff819349/content>.
- Mani, K., and G. Melissano. 2018. "Complex Endovascular Aneurysm Repair: Patient Benefit or a Waste of Money?" *European Journal of Vascular and Endovascular Surgery* 56, no. 1: 1–2. <https://doi.org/10.1016/j.ejvs.2018.05.006>.
- Mantovan, F., C. Muzzana, M. Schubert, and D. Ausserhofer. 2020. "It's About How We Do It, Not if We Do It". Nurses' Experiences With Implicit Rationing of Nursing Care in Acute Care Hospitals: A Descriptive Qualitative Study." *International Journal of Nursing Studies* 109: 103688. <https://doi.org/10.1016/j.ijnurstu.2020.103688>.
- McCormack, B., T. McCance, and H. Klopfer. 2017. *Person-Centred Practice in Nursing and Health Care: Theory and Practice*, edited by B. McCormack and T. McCance, 2nd ed. John Wiley & Sons Ltd.
- Moore, L., N. Britten, D. Lydahl, Ö. Naldemirci, M. Elam, and A. Wolf. 2017. "Barriers and Facilitators to the Implementation of Person-Centred Care in Different Healthcare Contexts." *Scandinavian Journal of Caring Sciences* 31, no. 4: 662–673. <https://doi.org/10.1111/scs.12376>.
- Mudd, A., R. Feo, T. Conroy, and A. Kitson. 2020. "Where and How Does Fundamental Care Fit Within Seminal Nursing Theories: A Narrative Review and Synthesis of Key Nursing Concepts." *Journal of Clinical Nursing* 29, no. 19–20: 3652–3666. <https://doi.org/10.1111/jocn.15420>.
- Muntlin, Å., E. Jangland, B. Laugesen, et al. 2023. "Bedside Nurses' Perspective on the Fundamentals of Care Framework and Its Application in Clinical Practice: A Multi-Site Focus Group Interview Study." *International Journal of Nursing Studies* 145, no. 104: 526. <https://doi.org/10.1016/j.ijnurstu.2023.104526>.
- Png, C. Y. M., A. A. Pendleton, M. Altreuther, et al. 2024. "Effect of EVAR on International Ruptured AAA Mortality—Sex and Geographic Disparities." *Journal of Clinical Medicine* 13, no. 9: 2464. <https://doi.org/10.3390/jcm13092464>.
- Squires, J. E., L. D. Aloisio, J. M. Grimshaw, et al. 2019. "Attributes of Context Relevant to Healthcare Professionals' Use of Research Evidence in Clinical Practice: A Multi-Study Analysis." *Implementation Science* 14, no. 1: 52. <https://doi.org/10.1186/s13012-019-0900-8>.
- Stelfox, H. T., and S. E. Straus. 2013. "Measuring Quality of Care: Considering Conceptual Approaches to Quality Indicator Development and Evaluation." *Journal of Clinical Epidemiology* 66, no. 12: 1328–1337. <https://doi.org/10.1016/j.jclinepi.2013.05.017>.
- Thorne, S. 2013. "Secondary Qualitative Data Analysis." In *Routledge International Handbook of Qualitative Nursing Research*, edited by C. T. Beck, 393–404. Routledge, Taylor & Francis Group.
- Twycross, A., and A. Shorten. 2014. "Service Evaluation, Audit and Research: What Is the Difference?: Table 1." *Evidence-Based Nursing* 17, no. 3: 65–66. <https://doi.org/10.1136/eb-2014-101,871>.
- World Health Organization. 2015. "WHO Global Strategy on People-Centred and Integrated Health Services: Interim Report. WHO/HIS/SDS/2015.6."
- World Medical Association. 2013. "World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects." *JAMA* 310, no. 20: 2191–2194. <https://doi.org/10.1001/jama.2013.281053>.
- Yu, H. H. Y., G. Ascuitto, N. Dias, et al. 2024. "Outcomes of Elective Open Surgical Repair or Fenestrated Endovascular Aneurysm Repair for Juxtarenal Abdominal Aortic Aneurysms in Sweden." *British Journal of Surgery* 111, no. 11: znae279. <https://doi.org/10.1093/bjs/znae279>.

Supporting Information

Additional supporting information can be found online in the Supporting Information section.