Abstract

Specialisation in nursing enables a nurse to focus, in much greater depth, on the requisite knowledge and skills for providing patients with the best possible care. Nephrology nursing is one such area where specialisation has evolved. The characteristic focus of practice emerged as an important feature during a study into the process of expertise acquisition in nephrology nursing practice. Using grounded theory methodology, this study involved 6 non-expert and 11 expert nurses and took place in one renal unit in New South Wales. Nephrology nursing practice was observed for 103 hours, and this was immediately followed by semi-structured interviews. The characteristic of focus was conceptualised as the nurses’ centre of attention or concentration while they were undertaking nursing activities. Focus ranged from inexperienced non-expert nurses concentrating predominantly on the immediate task at hand, experienced non-expert nurses who focussed on the medium term to expert nurses who viewed actions (and their possible consequences) more broadly and in the longer term. Of significance to nursing, is how nephrology nurses alter their focus of practice as they acquire and exercise their developing expertise in this specialty.

Introduction

In contemporary nursing practice specialisation in one field has occurred. This enables a nurse to focus, in much greater depth, on the requisite knowledge and skills for providing patients with the best possible care. Nephrology nursing is one such area where specialisation has evolved in response to increasingly complex knowledge and technology required in the care of people with impaired renal function. This specialty occurs in primary, secondary and tertiary care settings and in the home (Tamplet Ulrich, 2006), and across a range of subspecialties such as general nephrology, haemodialysis, peritoneal dialysis and renal transplantation units (Stewart, 1997; Stewart & Bonner, 2000).

One unique aspect of nephrology nursing is that these nurses have access to and provide nursing care for people over much longer periods of time than most other nurses (Scharlin, 1995; Tamplet Ulrich, 2006). For instance, haemodialysis nursing care can be provided to the same patient for four to six hours, three times per week for as long as the patient remains on haemodialysis. For some nephrology nurses and patients, this can be for many years and, in some cases, greater than twenty years. While nephrologists would also provide medical care for patients for similarly long periods, it is nephrology nurses who have much more frequent (thrice weekly versus monthly, quarterly or annually) and prolonged contact with the same patient. In comparison to all other areas where nursing care is provided to people with chronic illnesses such as psychiatric disorders, diabetes, asthma or permanently disabling conditions such as spinal cord injury; only a few other nursing specialties such as nursing the intellectually disabled or long-term residential care, has a similar amount and degree of constant contact with the same patient as does nephrology nursing. This prolonged contact with the same patient over many years (or even decades) has the advantage of enabling the establishment of long-term relationships and allows nurses to know their patients and families well.

The aims of the study were: 1) to understand the characteristics of nephrology nursing expertise and the process through which it was acquired; and, 2) to explain how expert nephrology nurse practice differed from that of non-expert nephrology nurses.

The Study

One renal unit in New South Wales, which consisted of several in-patient...
and out-patient areas; acute and chronic renal replacement services including renal transplantation; and home training facilities for haemodialysis and peritoneal dialysis patients was the site for this study. Following ethics approval by both the Area Health Service and University Human Ethics Committees, nurses who worked permanently in each of these areas were invited to participate in this study. Participants’ selection were devised from existing literature (Benner, 1984; Jasper, 1994) and included formal nephrology nursing postgraduate qualification, length of experience, personal characteristics, and level of practice (Dunn et al., 2000). The final sample consisted of six non-expert nurses and eleven expert nurses. Table one summarises the demographic information about the participants.

Data Collection and Analysis
Data collection involved participant observation and semi-structured interviews based on the observational period. Thirty-two episodes (103 hours) of participant observation occurred in all areas of the renal unit and field notes were recorded during that time. Thirty-seven (24 hours) interviews followed every observational episode and information was sought from participants to clarify the focus of their nursing actions and, more importantly, their rationales for these actions were collected. Interviews were tape recorded and transcribed verbatim. Anonymity of data was achieved through the use of pseudonyms.

In grounded theory research (Glaser, 2001) data collection and analysis proceed simultaneously using the processes of substantive and theoretical coding. Initially data was collected and a line by line analysis was undertaken. The emerging codes guided subsequent data collection. Questions about the similarities and dissimilarities between expert and non-expert nephrology nursing practice were developed and explored in subsequent data collection episodes with both groups. Eventually no new categories emerged and a sense of closure of data collection (i.e. theoretical saturation) was achieved.

Findings
The purpose of this study was to discover the structure and process of expertise acquisition and its exercise by nephrology nurses. It also sought to reveal the characteristics of expert nephrology nursing practice as well as the differences between expert practice and less expert practice. The data revealed a three stage process of expertise acquisition, namely, non-expert, experienced non-expert and expert stages (Bonner & Greenwood, 2006). Each stage consisted of four characteristics which describe how the nurse practices. These characteristics were knowledge, experience, skill and focus. This paper presents in detail the findings for the fourth characteristic of nephrology nurses’ practice – focus - which was conceptualised as the nurses’ centre of attention or concentration while they were undertaking nursing activities.

Narrow Focus of Practice
Non-expert nursing practice was characterised by a focus on performing the task at hand, that is, non-experts were focused on getting the job done rather than on the person at the receiving end of the task (i.e., the patient with a renal disorder).

Well here [in the haemodialysis unit] it’s more, interacting more with machines as well you’ve got that interaction with the patient but its a minimum, you know a minimum, putting the patient on, taking the patient off, you know it’s more with the machine and things like that (Alexis, 1st interview).

Getting the Job Done
In order to get the work of a shift completed, the non-expert nurse is focused on completing each individual task which a nurse ought to do for the patient. These tasks included performing the dialysis treatment (e.g., setting up the machine, cannulation), administering medications, assessing and recording observations, performing wound dressings and completing fluid balance...
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charts. All nurses in this study were questioned about the focus of nursing care which they had provided during an observation episode. Non-expert nurses typically described their focus of attention as being devoted to completing tasks and managing their workload (i.e., time management).

My focus was basically to try and get the medications done and maintain all the proper charts and, you know, do fistula observations, also BSL’s [blood sugar levels] and giving insulin, and complete the fluid balances (Helen, 1st interview).

In nephrology nursing, the majority of patients a nurse will come into contact with will have end-stage renal failure, an irreversible condition, which necessitates life-sustaining renal replacement therapy for the rest of a patient's life. As a consequence, it is not uncommon for a nephrology nurse to provide nursing care to a patient for many years, for possibly as much as twenty years. By having a narrow focus of practice, the non-expert nurse’s view of the concept of continuity of care was different from that of both experienced non-expert nurses and expert nurses. When questioned about their understanding about continuity of care, and what it meant for their nursing practice, they invariably suggested that continuity of care lasted for a few days or for that admission to the renal unit. Even when prompted to consider that patients have a chronic illness requiring life-long treatment, non-expert nurses consistently described their focus of attention in terms of the present rather than the future.

With dialysis you can’t look too far, you know, and it’s day by day but with some of them that are a little bit more difficult to dialyse you probably look at them in the future, well okay say today’s Tuesday and then you think…will I leave his weight till [his next dialysis on] Thursday. But the focus is mainly a day to day basis (Alexis, 1st interview).

Changing Focus of Practice

By comparison with non-expert nurses, the focus of experienced non-expert nephrology nurses had gradually changed. Their nursing practice had shifted from predominantly focusing on the task and getting the job done to an increased patient-focus (i.e., developing a patient focus). While the patient's well being was a focus of attention, experienced non-expert nurses were observed to be only briefly patient-focused in comparison to expert nurses. Generally, experienced non-expert nurses described their actions during interviews as being directed towards the patient but, during observation episodes, the observer’s impressions were that the primary focus was on making the job easier for themselves.

I suppose [I make things easier as] I’ve got a bad back and I use the stool for cannulating rather than stooping over patients. I find it a lot easier. What else? I don’t know I must do things that I don’t even realise that make it easier easy for me to do… (Stacey, 1st interview).

Cannulation was a common task performed by most participants in this study, and participants were asked about their focus of attention when cannulating. Non-experts were clearly concentrating on performing the task and getting the cannula in successfully, that is, they could not converse with patients during cannulation or when connecting up to the haemodialysis machine. It was only when these tasks were completed did non-expert nurses acknowledge the patient or respond to their requests. Experienced non-experts still needed to concentrate on performing the task of cannulation but could also consider how it was affecting the patient. These nurses had acquired sufficient procedural knowledge to enable them, albeit briefly, to engage in conversations with patients or respond to their requests. This is in contrast to expert nurses who did not need to concentrate on performing the cannulation and could devote their attention elsewhere (e.g., talking to the patient to calm them down) while cannulating.

The view taken by experienced non-expert nurses regarding the concept of continuity of care also explains the characteristic changing focus of practice. Continuity of care is a particularly important aspect of nephrology nursing practice. In the second stage of expertise acquisition, experienced non-expert nurses have broadened their previously narrow concept of continuity of care. This focus, although not as broad as that of expert nurses, was certainly wider than, for example, a patient's dialysis treatment session over one to two days. For experienced non-expert nurses, the concept of continuity of care spans a period of a few weeks to a few months. Once again, when reminded during an interview that they had provided nursing care for some patients over several years, experienced non-expert nurses described continuity of care as being over a much shorter time frame (i.e., months rather than years).

If you know they’re having an operation soon, or in a few weeks, you know they need to [be] prepared for that. So mainly I focus on the day to day but I [also]... think ahead (Leonie, 2nd interview).

Being Patient-Focused

Expert nurses’ focus, by comparison with other nurses in this study, was consistently on the patient as the recipient of nursing activities. Patients, according to expert nurses, were the raison d’etre of a renal unit. In order to be patient-focused, to consider their well-being, comfort and safety, expert nurses also believed that they needed to pay attention to other staff, particularly nursing staff, in order that they too could provide quality nursing care. Being patient-focused for expert nurses also included regarding the needs of the unit as a whole, as well
**EPREX**

**eoepitnin alfa**

**ABRIDGED PRODUCT INFORMATION**

**THERAPEUTIC INDICATIONS**

EPREX is indicated for the treatment of patients with symptomatic or transfusion requiring anaemia associated with chronic renal failure due to impaired erythropoietin production, fatigue and poor sleep patterns and by reducing the need for blood transfusions.

EPREX is indicated in adult patients with moderate anaemia (haemoglobin > 10 to 12 g/dL) scheduled for elective surgery with an expected moderate blood loss (2-4 units or 900 to 1800 mL) to reduce exposure to allogeneic blood transfusion and to facilitate erythropoietic recovery.

EPREX is not indicated for the treatment of anaemia in adult patients with nonmalignant maladies, where anaemia is anticipated to develop or develop as a result of concomitantly administered chemotherapy. Eprex is indicated to decrease the need for transfusions in patients who will continue to receive concomitant chemotherapy for a minimum of 6 months.

EPREX is also indicated to augment autologous blood collection and to limit the decline in haemoglobin in anaemic adult patients who are scheduled for major elective surgery and who are not expected to pacinate their complete perinatal blood needs.

**CONTRAINdications**

EPREX is contraindicated in patients with:

1. Uncontrolled hypertension;
2. Known sensitivity to mammalian cell derived products;
3. Patients scheduled for elective surgery, who are not participating in an autologous blood donor programme and who have severe coronary arterial, peripheral arterial, or cerebrovascular disease;
4. *Patients who develop Pure Red Cell Aplasia (PRCA) following treatment with any erythropoietin should not receive Eprex or any other erythropoietic agent.*

**Warnings**

Hypertension develops or is aggravated in about 30% of patients with chronic renal failure (CRF) treated with Eprex while the haemoglobin is rising during the first 3 months.

The incidence of hypertension is not dose related. Patients should be closely monitored for changes in haemoglobin and blood pressure. Eprex can produce serious and life-threatening hypertension, but especially during this period when such hypertensive episodes (or some cases with encephalopathy and seizure) are most likely to occur. Particular attention should be paid to sudden, stabbing, migratory-like head pain, pallor, dyspnoea and neurological phenomena. Patients should be cautioned to avoid potentially hazardous activities such as driving or operating heavy machinery during this period.

**Adverse Events**

During clinical trials, patients treated with Eprex may require an increase in diuresis regimen to prevent clotting the dialysate. In patients receiving Eprex, clotting of the vascular access has occurred in 13% of patients in some series. Short frommation may occur, especially in patients who have a tendency to hypertension or whose arteriovenous fistulae exhibit stenosis.

Early short version and thrombosis prophylaxis by administration of prophylactic acidic, for example, is recommended in these patients.

Thrombolytic/vascular events such as myocardial ischaemia, myocardial infarction, cerebrovascular accidents, peripheral vascular disease, limb amputations, or non-cerebrovascular vascular events may occur in cancer patients as a consequence of their disease, comorbidities, and treatment itself.

An increased incidence of such events has been observed in patients receiving erythropoietic agents, including patients receiving EPREX.

**PRECAUTIONS**

EPREX should be used with caution in those patients with preexisting hypertension, cardiovascular disease, history of seizures, or suspected allergic reactions to any component of the product. Some patients with chronic renal failure, pure red cell aplasia (erythroblastopenia) has been rarely reported after 3-4 months to years of treatment with erythropoietins. In most of these FICA patients antibodies to erythropoietins have been reported. In patients receiving Eprex, it was not possible to distinguish between those cases of neutropenia that were caused by aplasia and those where neutropenia was more than 2 g/dL per month. If in case is identified, a bone marrow examination should be performed. Red blood cell aplasia (PRCA) is diagnosed, Eprex should be immediately discontinued and testing for antibody to erythropoietin antibodies should be performed. Antibodies to erythropoietins are detectable in patients with pure red cell aplasia and have been attributed to another erythropoietin product as antiepoietin antibodies cross-react with other erythropoietins. Other causes of pure red cell aplasia should be excluded, and appropriate therapy initiated.

In patients with chronic renal failure and clinically evident ischaemic heart disease or congestive heart failure, maintenance haematocrit levels are recommended to be limited to the upper limit of the target haemoglobin concentration as recommended under Dosage and Administration (i.e. 11.5 g/dL).

In patients with anaemia scheduled for surgery, potentially concomitant anaemia should be investigated and appropriately treated.

The possibility of potential pregnancy should be discussed and the need for contraception evaluated.

There may be a moderate or discontinue rise in the platelet count within the normal range during treatment with Eprex. This rise is present during the course of treatment. Development of thrombocythaemia is very rare. It is recommended that the platelet count is regularly monitored during the first 8 weeks of therapy.

**DOSAGE AND ADMINISTRATION**

**Parenteral administration**

EPREX can be administered either intravenously or subcutaneously, according to indication. For patients who are converted to the intravenous route or who have renal failure of any origin or who have renal failure of any origin, the recommended dose is 600 IU/kg EPREX given weekly for three weeks (Days -21, -14, and -7) prior to surgery, on the day of surgery, and for four days immediately thereafter. The administration of EPREX should be stopped as soon as the haemoglobin level reaches 11.5 g/dL in the perioperative period, even if not all the planned EPREX doses have been given.

All patients being treated with Eprex should receive adequate iron supplementation (e.g. 200 mg oral elemental iron daily) throughout the course of Eprex therapy. If possible, iron supplementation should be started prior to Eprex therapy, to achieve adequate stores.

**In Anemic Adjutant Surgery Patients in An Autologous Donor Programme**

The iron stores should be used. The recommended dose is 300-600 IU/kg twice weekly for three weeks, together with at least 200 mg oral elemental iron daily.

**Use in Pre-surgical Anaemia**

If the required haemoglobin increase is 2-4 units (1.2 to 2.5 g/dL) per month or the reticulocyte count has increased 300,000 cells/µL per month, the recommended dose is 600 IU/kg EPREX given weekly for three weeks (Days -21, -14, and -7) prior to surgery, and then 600 IU/kg on the day of surgery and for four days thereafter. The administration of EPREX should be stopped after the third week of therapy, even if not all the planned EPREX doses have been given.

**Use of EPREX for the prevention and treatment of anaemia in adult patients with non-myeloid malignancies, for autologous blood predeposit programme and elective surgery with an expected moderate blood loss (2-4 units or 900 to 1800 mL) to reduce exposure to allogeneic blood transfusion and to facilitate erythropoietic recovery.**

**Use in Children**

If the required haemoglobin increase is <2 units (1.2 g/dL) per month or haemoglobin levels of <11.5 g/dL are to be achieved. If the haemoglobin is rising by more than 2 g/dL per month, the EPREX dose may be increased by about 25-50% depending upon the rate of rise of haemoglobin. If the haemoglobin increases 12 g/dL (0.7 mmol/L), terminal therapy will be efficient 12 g/dL (0.7 mmol/L) and the terminal therapy will be efficient.

**Use in Pre-surgical Anaemia**

If the required haemoglobin increase is <2 units (1.2 g/dL) per month or haemoglobin levels of <11.5 g/dL are to be achieved. If the haemoglobin is rising by more than 2 g/dL per month, the EPREX dose may be increased by about 25-50% depending upon the rate of rise of haemoglobin. If the haemoglobin increases 12 g/dL (0.7 mmol/L), terminal therapy will be efficient 12 g/dL (0.7 mmol/L) and the terminal therapy will be efficient. If the haemoglobin increases 12 g/dL (0.7 mmol/L) and the terminal therapy will be efficient 12 g/dL (0.7 mmol/L) and the terminal therapy will be efficient.

**Use in Pre-surgical Anaemia**

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**Use in Pre-surgical Anaemia**

If the required haemoglobin increase is <2 units (1.2 g/dL) per month or haemoglobin levels of <11.5 g/dL are to be achieved. If the haemoglobin is rising by more than 2 g/dL per month, the EPREX dose may be increased by about 25-50% depending upon the rate of rise of haemoglobin. If the haemoglobin increases 12 g/dL (0.7 mmol/L), terminal therapy will be efficient 12 g/dL (0.7 mmol/L) and the terminal therapy will be efficient.

**Use in Pre-surgical Anaemia**

If the required haemoglobin increase is <2 units (1.2 g/dL) per month or haemoglobin levels of <11.5 g/dL are to be achieved. If the haemoglobin is rising by more than 2 g/dL per month, the EPREX dose may be increased by about 25-50% depending upon the rate of rise of haemoglobin. If the haemoglobin increases 12 g/dL (0.7 mmol/L), terminal therapy will be efficient 12 g/dL (0.7 mmol/L) and the terminal therapy will be efficient.
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EPREX® subcutaneous administration is available again. So now you have the choice of administering EPREX – the erythropoietin that revolutionised the treatment of anaemia in renal failure, cancer and surgery14 – through SC or IV injection. With over 3 million patient years of experience, EPREX has more than proven its ability to provide a better quality of life.5

PBS Information: S100 Private Hospital Authority Required. Treatment of anaemia requiring transfusion, defined as a haemoglobin level of less than 100 g per L, where intrinsic renal disease, as assessed by a nephrologist, is the primary cause of anaemia.

Before prescribing, please note changes to Approved Product Information found elsewhere in this publication.

TGA Approved Product Information June 2005: ‘Where IV access is not readily available (haemodialysis patients), administration via the IV route is preferable. Where IV access is not readily available (patients not yet on dialysis and peritoneal dialysis patients), EPREX may be administered subcutaneously.’
as considering the needs for individual patients.

I mean basically it all centres around the patient, without the patient you’ve got no unit, no staff, no anything, so yes, it is I mean, central to your nursing has to be the patient and everything you do for in terms of planning and staffing and managing, everything basically in the end comes back to patient centred practice and some things are less direct than others, I mean you do things for your staff but in the end you do things for your staff to keep them happy, educated and whatever so they’re still there to look after the patients (Prue, 3rd interview).

Expert nurses did not need to devote considerable cognitive attention to performing tasks, and this allowed them to focus on patients. Their practice was solely directed towards providing quality nursing care to people with renal dysfunction. Being patient-focused consisted of three dimensions. These were being there, keeping a close eye on, and protecting the patient.

Being There

Being there was a strategy employed by expert nurses which demonstrated just how focused they were on patients and the unit:

I suppose my example has to be of some use somewhere along the line in that I work hard and I try to work so that things are better for the patients and I'd rather make them good for the staff as well…I don’t know but I suppose there’s strengths in being reliable and being there which are awfully important for both staff and patients (Prue, 3rd interview).

Expert nurses also see themselves as being there for patients over protracted periods of time. In contrast to either non-expert or experienced non-expert nurses, expert nurses viewed continuity of care over a much longer period (i.e., years rather than months or weeks); for some nurses, they could provide nursing care for the same patient for many years.

With these patients, I think it is because they are chronic patients and they are part of our unit for however long they live in the area or live themselves and I think we have a responsibility for their care right throughout that time (Fran, 2nd interview).

Continuity of care can be provided for “some of the patients [because] I’ve known them for 25 years and you’re still caring for them” (Sandra, 2nd interview). While a person is receiving dialysis therapy, they need on-going medical and nursing care. One expert nurse described it as pointless to put a person on dialysis and then forget about them “…so the care doesn’t stop when the patient goes home, the care must continue for the long term, years” (Fran, 2nd interview).

Keeping a Close Eye On

Non-expert nurses revealed during interviews that they needed to concentrate on performing the task rather than on the patient’s response to that task. Expert nurses, by comparison, described their practice as keeping a close eye on the patient as a strategy for preventing problems during dialysis treatment sessions. For instance, Theresa, an expert nurse, described how she monitored a patient’s response to an altered dialysis prescription.

I tend to do turn the [dialysate] temperature down and the [dialysate] sodium up a little bit and just keep an eye on them…so they don’t drop their blood pressure while I’m taking fluid off (Theresa, 1st interview).

Protecting the Patient

With patients as the central focus of practice, expert nurses initiated several strategies to protect vulnerable patients from receiving nursing care from inexperienced nurses. All nurses in the haemodialysis units in the study repeatedly identified particular patients who they were, or were not, permitted to cannulate. Similarly, in the transplant unit, inexperienced nurses were not permitted to provide immediate post-renal transplant nursing care (i.e., for the first 24 hours) without direct supervision from a more experienced nurse. In both situations, expert nurses allocated inexperienced nurses to patients who were “at the appropriate level” for their clinical abilities. This, clearly, was a strategy used to protect patients to ensure that they received the best available nursing care.

DISCUSSION

This study has increased understanding of what a nurse, at various stages of expertise acquisition, focuses on when giving nursing care. Specifically, it provided evidence of a nurse’s focus of attention and how this changed as the nurse acquired expertise in nephrology nursing. Non-expert nurses were task-focused because they had not yet learnt or developed adequate procedural knowledge to assist them to perform new tasks, or similar tasks in a new environment. Non-expert nurses were task-focused because they had not yet learnt or developed adequate procedural knowledge to assist them to perform new tasks, or similar tasks (i.e. general, common routine nursing task) in a new environment. Experienced non-expert nurses had proceduralised much of the general routine practice required of a nephrology nurse and this had freed up some of their attention for deployment to other, less familiar task situations. This provided them with additional time to think about and plan their actions; typically, their planning focused on making things easier for themselves. Expert nurses, by comparison, were entirely focused on the provision of optimal nursing care to people with renal disorders. Their focus of attention was the patient but this did not exclude
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attention to other nurses. Expert nurses simultaneously devoted attention to the ways other nurses practiced in order to guide and support them to ensure that all nurses in the renal unit provided optimal nursing care. This finding is consistent with Ashwanden (2004) who suggests that care of renal nursing staff is important and conducive to quality patient care.

There is considerable literature which suggests that novice nurses are predominantly task-focused. For instance, Coulon et al. (1996) identified that a characteristic of undergraduate (i.e., pre-registration) nursing students is task-oriented nursing care. Little (2000) also found that nurses with one to three years experience in nursing who were undertaking a critical care course were task-focused, that is, they were not expert nurses, and they all needed to focus on the equipment which they were required to use (Little, 2000). Nurses with less experience in critical care nursing directed their attention to the performance of tasks or on equipment, rather than the patient. This study’s findings on non-expert nephrology nursing practice concur with Little’s study. Non-expert nurses, when specifically asked about their focus of nursing, invariably indicated that completing the tasks and interacting with the dialysis machinery were central to their practice. This is in contrast to expert critical care nurses who seamlessly integrate technology into everyday practice (Cooper, 1993; Walters, 1995). Similarly, Radwin (1998) found that expert cardiology nurses are more likely to focus on the patient in a given situation rather than on equipment, technical factors or tasks.

Being patient-focused required the nurse to move beyond a limited concept of individualised care, where the nurse provides choices concerning, for example, hygiene and wake-up times. Being patient-focused means the nurse strives to provide nursing care and services which are compatible with a patient’s needs, values and beliefs (Ford & McCormack, 2000). The essential elements of patient-focused care, according to Kitson (1999) are essential care, technological care, psychosocial/emotional care, information and education, continuity and coordination.

Although the nursing literature contains evidence of the concept of patient-focused or patient-centred nursing care (see for example Bradshaw, 1996; Ford & McCormack, 2000; Lutz & Bower, 2000), only three previous articles were found which either implicitly or explicitly suggested that expert nurses delivered patient-focused nursing care to individual patients (Benner, 1984; Brown, 1992; Brown & Tiavale, 1996; Edwards, 1998). In addition, Kitwood and Bredin (1992) suggest that patient-focused practice can be achieved if the nurse places at the centre of all decisions/actions the desire to maintain/improve patient wellbeing. Expert nephrology nurses, in the present study, did exactly that. The concept of being patient-focused meant that expert nurses viewed the person with renal failure as central to their practice in a desire to provide quality, continuing nursing. Non-expert nurses, by comparison, were more focused on getting the job done and completing all necessary tasks.

The present study describes an alternate construct of continuity of care with respect to recent literature. Nephrology nurses variously construed continuity of care as the short, intermediate and long-term goals or needs of people with renal failure. At best, the present literature suggests that the concept of continuity of care could be described as a process over time which requires coordination and transfer of information between numerous people and across several settings (Sparbel & Anderson, 2000a, b).

Nephrology nurses viewed continuity of care differently during this study. Depending on their stage of expertise acquisition, non-expert nurses viewed it as the immediate needs of the patient, spanning a few days. Experienced non-expert nurses considered continuity of care in terms of a few weeks to months. Expert nurses, in contrast, viewed it over many years. Expert nurses had acquired more knowledge and experience in nursing people with renal disorders; they recognised that not only that these people required long-term renal replacement therapy (RRT) but also that RRT has long-term consequences. Expert nurses, because they had developed a patient-focused approach to their nursing care, were able previously described (Cohen, Hausner & Johnson, 1994; Gilje, 1992). In a phenomenological study of the patient’s experience of nursing, Wallace and Appleton (1995) found that being there was attributed by patients when the nurse had a willingness to connect and become involved with them. Strategies nurses used to demonstrate being there were commitment, compassion and competent practice. Wallace and Appleton further suggest that by being there, nurses came to know their patients, respected and valued them as individuals in order to assist patients to restore or manage their well-being. Bevan (1998), in an analysis of caring in dialysis units, suggests that dialysis nurses identify being there as an element of caring.

The present study elaborates our understanding of the concept being there as an important component in the provision of quality nursing care. Being there was a strategy expert nephrology nurses employed to be patient-focused. By having a reliable presence in the renal unit, these nurses believed that, through their expertise, events, issues or situations would be managed so that patients received quality nursing care. Being there, in addition, was related to expert nurses’ provision of continuity of care to patients.

The concept of being there, as a feature of expert nursing practice, has been
to assess for and institute management strategies to reduce the effects of long-term RRT complications. One strategy these nurses used in the provision of continuity of care was to act as a conduit of information between the patient, other nurses, medical staff and other healthcare workers (e.g., dietician, social worker) in an attempt to ensure that issues were managed appropriately and in a timely way for the patient. The aim of expert nurses was to ensure that patients could be kept in the best possible health for the longest period of time. It is important, therefore, that strategies are put in place in renal units to ensure that expert nurses are kept in clinical positions which have direct patient contact and responsibility.

**Study limitations**

This study was designed to be exploratory, descriptive, and theory-generating. Consistent with qualitative research, the sample size was small and the context confined to one renal unit; data collection, however, was extensive and, according to grounded theory research, reached theoretical saturation. However, the findings may be applicable to other nephrology nurses, other renal units or more widely in other fields of nursing.

**CONCLUSION**

Whilst the larger study sought to gain an understanding of the acquisition and exercise of nephrology nursing expertise, the characteristic of focus in the practice of these nurses was a significant finding. Non-expert nurses had a narrow focus of practice which was related to getting the job done, and experienced-non experts’ focus was changing towards the patient and for the medium term. Only expert nurses were actually patient focussed, and this was evidenced by the way, in which they were actively being there in the unit, keeping a close eye on, and protecting the patient. The findings of this study explicitly reveal that focus is important to quality renal care.

**REFERENCES**


