Improving cultural and clinical competency and safety of renal nurse education

Janet Kelly, Cheryl Wilden, Melissa Chamney, Gay Martin, Kylie Herman & Christine Russell

Submitted: 25 August 2016, Accepted: 7 October 2016

Abstract

In South Australia, Aboriginal people make up 2.4% of the total population and experience chronic kidney disease (CKD) at disproportionately higher levels, and at younger ages, than non-Aboriginal people, linked to a complex mix of chronic conditions and lower access to social determinants of health. Nurses providing care for Aboriginal people in urban, rural and remote dialysis and renal units bring various levels of experience and knowledge. Renal educators/facilitators strive to prepare nurses to respond to the unique individual, family and cultural priorities as well as clinical needs of all patients, but are challenged by a lack of local and Aboriginal-specific resources and supportive theoretical frameworks.

This project aimed to develop a more responsive education package to increase cultural and clinical competence and safety of new, existing and future staff. It involved a renal focus group reviewing the current renal education curriculum and resources available within South Australia, and comparing the information within these to recent Aboriginal patient journey experiences. Participatory action research and concepts of symbiotic clinical education and mutually reinforcing relationships underpinned all activities.

A draft education package that included recent case studies and patient journey mapping tools developed through the Managing Two Worlds Together project was tested with students, reviewed and adapted. A supportive theoretical framework was developed that brought together Benner's five stages of clinical competence, a range of cultural models, and Aboriginal patient journey priorities. How and why the framework was developed by the renal group is discussed, with rationale given to the placement of clinical and cultural models within it.

Keywords
Renal nurses, Aboriginal, renal education, cultural safety, rural and remote.

Janet Kelly, RN, PhD, Research Fellow & Course Coordinator, Adelaide Nursing School, The University of Adelaide
Health Care Management, Flinders University & Wardliparingga Aboriginal Health Unit, South Australian Health and Medical Research Institute, SA, Australia

Cheryl Wilden, RN, Nurse Educator Facilitator (Renal), CALHN Learning and Practice Development, Royal Adelaide Hospital, SA, Australia

Melissa Chamney, RN, MN, Lecturer Academic, Adelaide Nursing School, The University of Adelaide, SA, Australia

Gay Martin, RN, Clinical Services Coordinator, SA Health, SA, Australia

Kylie Herman, RN, Clinical Services Coordinator, SA Health, SA, Australia

Christine Russell, RN, Renal Rural Clinical Practice Consultant, Country Heath SA, SA, Australia

Correspondence to: Dr Janet Kelly, Research Fellow
Adelaide Nursing School, The University of Adelaide, SA 5005, Australia
Email: Janet.kelly@adelaide.edu.au
Introduction

In Australia, the prevalence rates of Indigenous adults experiencing chronic kidney disease (CKD) are currently twice those of non-Indigenous adults, with many requiring renal dialysis care at a younger age (Australian Institute of Health and Welfare, 2015, p. 49). This higher incidence is linked to physical health conditions such as diabetes and cardiovascular disease, and to significant challenges in securing education, employment, housing and self-governance (Australian Institute of Health and Welfare, 2015). Access to health care may be further complicated by transport, financial, geographical and climatic factors, as well as competing personal, community and cultural priorities. Past experiences of racism, both individual and systemic, may also lead patients to question the level of safety they might expect when accessing care (Dwyer, Kelly, Willis, Glover, Mackean, Pekarsky, & Battersby, 2011). In South Australia, nurses play a key role in providing care for Aboriginal people with CKD. Nurses work across a range of health care and community services in urban, rural and remote settings, interacting with patients and family members who have diverse personal and cultural needs. They may have previous experience working with Aboriginal people, or this may be their first experience where they are required to focus on Aboriginal-specific health care needs (Dwyer, Kelly, Willis, Mackean, Battersby, Pekarsky, & Glover, 2011). Some metropolitan dialysis units have very few or no Aboriginal clients, whereas in rural and remote locations the majority of patients may be Aboriginal (Renal Focus Group Meeting 15 July 2016). In addition, nurses may not have received any cultural training during their undergraduate nurse education and this applies to both nurses trained in Australia and overseas. This means they may not be aware of the ongoing impact of Australia’s colonisation practices on Aboriginal people’s lives and health, and the need for strategies to actively close the health inequity gap.

We note there are very few Aboriginal nurses or health workers employed in renal wards and dialysis units in South Australia to act as mentors or support people. Aboriginal nurses make up only 1% of the Australian nursing workforce nationally (CATSINaM, 2016) and 0.8% in South Australia (Australian Institute of Health and Welfare, 2015). Therefore, it is imperative that renal training and education equips all nurses with the knowledge and skills required to provide quality clinical and cultural care.

Renal educators/facilitators strive to prepare nurses to respond to the unique individual, family and cultural priorities of Aboriginal patients as part of responsive clinical care. However, the available renal nursing reference and resource material is predominantly sourced from the United States of America and the United Kingdom and does not contain Aboriginal-specific content. There are differing opinions within health care and education about who is responsible for initiating and ensuring culturally appropriate care, with shifting emphasis on the role of Aboriginal and non-Aboriginal staff, individual health professionals, managers, educators, health services and systems (Wilson et al., 2015). There are also multiple approaches to cultural care and cultural training, with terms such as cultural safety, cultural competency, cultural awareness and cultural sensitivity at times used interchangeably, regardless of underlying intent, and with little evaluation of effectiveness (Williamson & Harrison, 2010).

This paper describes a collaborative activity undertaken by a renal nurse educator/facilitator, nurse researcher and three renal nurse managers. The aim was to redesign a renal course so that it included both clinical and cultural aspects of care, and was more responsive to the care needs of Australian Aboriginal patients and their families.

Methods

Renal focus group

A renal focus group was developed, bringing together the activities of the renal education review and the Managing Two Worlds Together (MTWT) Project, which investigated what works well and what needs improvement in the system of care for Aboriginal people, in particular those who travel to metropolitan and regional hospitals from rural and remote areas. The group focused on two activities: 1) an education package review and redevelopment; and 2) quality improvement focus: Development of patient journey mapping tools and case studies for reflective practice and improved care.

Figure 1: Project overview
improvement through the development of patient journey mapping tools and case studies, as shown in Figure 1. The renal educator reviewed the current renal nurse curriculum and identified practice and cultural safety education gaps. The renal nurse managers from urban and regional health care sites adapted and tested a set of patient journey mapping tools, and developed a set of case studies of recent patient journeys. Detailed information about these mapping tools has previously been published (Kelly, Herman, Martin, Wilden, East, Russell, & Brown, 2015; Kelly et al., 2016) The nurse researcher facilitated the focus group activities and shared a range of patient journey mapping and cultural models approaches. Together the focus group explored roles and strategies in the provision of more responsive and culturally safe renal care.

Research approach
A participatory action research approach with repeated cycles of Look and Listen, Think and Discuss, and Take Action was used to enhance all activities (Kelly, 2009; Stringer, 2007). Concepts of symbiotic clinical education and mutually reinforcing relationships (Prideaux et al., 2007) underpinned the education package review process.

Ethics
This study was based at Flinders University, with ethics approval provided by the Flinders University Social and Behavioural Research Ethics Committee, Human Research Ethics Committee TQEH, Aboriginal Health Research Ethics Committee (SA) and Central Australian Human Research Ethics Committee. Governance approvals and letters of support were given by each health site involved. Funding was provided by the Lowitja Institute Small Grants and SA Health.

Course development
This paper focuses on the three phases of education course development as shown in Figure 2. These activities took place as part of the renal transplant service in a South Australian hospital renal nursing course review and the MTWT Project. The renal focus group developed mutually beneficial relationships and shared knowledge and skills, thereby ensuring that the updated education and training package reflected contemporary contextual issues for patients, their families and staff. Details of the quality improvement activities and adaptation and testing of the mapping tools by the renal nurse managers has been published separately (Kelly et al., 2016).

Results
The results are discussed in the three phases in which they occurred.

---

**The Renal Education Package Review**

**Phase 1 – review of curriculum and recent patient journeys**
- Review existing resources
- Identify gaps in current curriculum
- Review recent Aboriginal patient journeys focusing on the experiences of patients, their families and of nursing staff
- Convert patient journey stories into de-identified case studies
- Experienced nurses share current clinical practice/cultural care priorities

**Phase 2 – test with students, reflect and adapt learning package**
- Test mapping tools and case study effectiveness with renal nursing students

**Phase 3 – Build a theoretical framework to support quality clinical and cultural care**
- Bring together education, clinical, cultural and patient journey concepts

**Ongoing**
- Develop a revised version learning package
- Test and review the theoretical framework

---

**Phase 1: review of curriculum and recent patient journeys**

A review of the renal education curriculum and resources, which were used were from the United Kingdom (Thomas, 2002, 2014) and United States (Molzahn & Butera, 2006), highlighted a lack of texts that describe or consider the Australian health care and geographic context and Aboriginal patients’ cultural needs in the nephrology nursing program. Recent patient journeys were mapped by the renal nurse managers within the focus group from the perspective of patients, their family members, and staff. These journey stories were then compared to ideal standards of care, and converted into de-identified case studies. The renal focus group critically reflected on these journeys from both a clinical practice and patient-centred/cultural care perspective. In addition, the renal focus group identified current clinical practice and cultural care dilemmas, the context in which they occurred, and the role nurses could play in ensuring improved quality care was provided.

**Phase 2: test mapping tools and case study effectiveness with renal nursing students**

The nurse educator/facilitator wrote a draft version of a new renal education package curriculum that included a set of patient journey mapping tools and ‘patient scenarios’. These scenarios consisted of representative patient journey stories that identified personal, cultural and clinical issues encountered in recent patient journeys. This draft renal education package was utilised for the next group of renal nurse students, and was reported in the MTWT Renal case studies report (Kelly, Herman, Martin, Wilden, East, Russell, & Brown, 2015). At the completion of the course, the nurse educator/facilitator reviewed whether the case studies and mapping tools were effective in introducing complex patient needs, and assisting

---

**Figure 2: Phases of the education project**
students to gain a better insight into the health journey experienced by Aboriginal patients.

The nurse educator/facilitator reported to the focus group that:

Initially I just used the mapping tools in class with a Patient Scenario and asked the group to discuss the wider aspects of how CKD may impact on a patient across the continuum of their disease. What I found was that while the students were very comfortable considering physical changes that might occur, they did not really feel confident to discuss cultural or spiritual aspects.

The students experienced difficulty grasping and engaging with the concepts of cultural and holistic care. This feedback led to further refinement of the renal education package and more detailed explanations of the tool. It also informed the structure and explanations within the MTWT journey mapping workbook regarding why and how to map patient journeys (Kelly, Dwyer, Pekarsky, Mackean, McCabe, Wiseman, de Crespigny, & O’Donnell, 2015).

The renal nurse educator also found that some students held broad assumptions about Aboriginal people that could potentially impact on care outcomes. She reported to the group;

Even more interesting was that in the discussion it was apparent that students had made a lot of assumptions — purely based on the cultural background identified in the case study.

One patient scenario introduced “an Aboriginal man in his thirties, who was married with two children and was a farmer”. He was initially at stage 3 CKD attending an appointment in Adelaide to see his nephrologist about what considerations regarding his future care needed to be made. Some of the students stopped me and said you have made a mistake. I said what do mean, and they said, “Aboriginal men are not farmers”.

This led to inclusion of discussion within the education session about how these assumptions and perceptions held by students and staff could potentially limit the range of care options provided to a patient, as well as the quality of care received. In this case, if the man himself prioritised returning to his farm, what options could be made available to enable him to do this? This discussion reinforced the need to develop an approach that could encourage both clinical and culturally safe care.

**Phase 3: Build a theoretical framework to support high-quality cultural care**

The review and comparison of the existing renal education resources to contemporary clinical and cultural care, Aboriginal patients and family experiences and nursing responses, identified the need to develop a new theoretical framework.

<table>
<thead>
<tr>
<th>Nurse trainee</th>
<th>End of renal course</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stages</strong> (Benner)</td>
<td>Novice</td>
</tr>
<tr>
<td>Levels of renal nursing clinical competence</td>
<td>Tell me what to do and I will do it</td>
</tr>
<tr>
<td>Cultural models</td>
<td>Cultural awareness</td>
</tr>
<tr>
<td>Definitions</td>
<td>Becomes aware that there are more than one culture</td>
</tr>
<tr>
<td>Use of patient journey case study and mapping tools to facilitate learning</td>
<td>Uses journey story to introduce complexity for renal patient care</td>
</tr>
<tr>
<td><strong>End of renal course</strong></td>
<td>Proficient</td>
</tr>
<tr>
<td></td>
<td>Learns from experiences what to expect in certain situations and how to modify plans</td>
</tr>
<tr>
<td></td>
<td>Cultural humility</td>
</tr>
<tr>
<td></td>
<td>Engages in self-reflection and self-criticism, recognises patient as expert</td>
</tr>
<tr>
<td></td>
<td>Development of case studies including strategies for responsive care</td>
</tr>
</tbody>
</table>

Table 1: Renal education clinical and cultural care theoretical framework
The results of trialling the mapping tools and patient journeys with the student group, and evaluating their effectiveness, highlighted the need to include both clinical and cultural aspects of care, particularly for high-needs client groups, such as Aboriginal people. A renal education clinical and cultural care theoretical framework was developed as a work in progress to underpin the next renal education package, and then be reviewed for its effectiveness. The framework consists of three aspects: levels of nursing clinical competence; cultural models; and the use of patient journey stories and patient journey mapping activates, as shown in Table 1.

**Discussion**

**Developing the education framework**

The renal educator/facilitator, nurse researcher and renal nurse managers considered a range of clinical frameworks and which would be most appropriate in both education and clinical settings, for both trainees and existing renal nurses who were participating in educational updates. Benner’s five stages of nursing clinical competence from novice to expert (Benner, 1982) was chosen as an appropriate model of clinical competence; it was considered by all members of the focus group to be highly relevant, widely used and generally well understood by nurses. A table format was developed (Table 1) outlining each stage, and the corresponding level of clinical competence that would be expected within and beyond the renal education course.

Next, the cultural aspects of care were considered, with the benefits and limitations of a variety of cultural terms and definitions (and underlying philosophies) discussed, and placed in the table. A range of cultural care approaches were considered. It was agreed that cultural safety, a New Zealand Maori and nursing council developed model (Papps & Ramsden, 1996) endorsed by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM, 2014) and Aboriginal nurses more widely (Best, 2014), was an appropriate overarching model to use for three reasons. Firstly, it incorporated the importance of care being safe if the patient themselves identified that it was so. Secondly, it included considerations of social determinants of health, power imbalances and the impact of racism, assumptions and colonisation impacts. Thirdly, it provided an understanding that nurses may move incrementally in their understanding, from cultural awareness to sensitivity, on their journey towards cultural safety (Papps & Ramsden, 1996). The group decided that cultural awareness aligned with the novice, and cultural sensitivity with advanced beginner.

The qualities of a culturally safe nurse were agreed by the group as being aware of their own culture and that of the hospital, socio-political events and the impact these have on patient perceptions of safety and quality of care (Papps & Ramsden, 1996). The educator/facilitator perceived that it was unreasonable that all trainees would reach this level of understanding within the course. Usually these qualities were found in more experienced expert nurses, often years post-training. Therefore, cultural safety was lined with the level of an expert.

What was reasonable to expect by the completion of the course was a level of competency. Therefore cultural competency (Adams, 2010; Cross et al., 1989) was positioned in line with Benner’s clinical competency. A column was added to the right to indicate that this was the end of the formal training. The vertical alignment of clinical competency with cultural competency highlighted the importance and expectation that nurses would develop both clinical and cultural care skills by the end of their training.

The group spent much time debating whether to combine Benner’s “proficiency” with competence or expert, but then decided that proficiency was the next logical step for students to achieve when completing the course. In reviewing wider literature and approaches, the group considered the merits of cultural humility (Hook, 2013; Tervalon & Murray-Garcia, 1998), which involves staff engaging in self-reflection and self-criticism, and in recognising the patient as expert in their own health care needs. This was thought to reflect a level of proficiency. A proficient nurse, however, may still not explicitly take into account the impact of social, historical, political and economic factors in the way that a nurse with cultural safety skills does. The group’s reading of cultural humility is that while it encourages nurses to be self-reflective and recognise the patient as expert, it remains within an interpretive rather than a critical social justice/equity/social determinants of health framework. The group agreed that an “expert nurse” who is culturally safe, is one that can provide both quality clinical and cultural care within a complex health system.

There was awareness within the focus group that the positioning of specific cultural approaches within the framework may be somewhat controversial or contested, particularly as there are many other interpretations of cultural approaches. For example, Adams (2010) describes cultural competence as taking a broader approach and being inclusive of cultural safety, dimensions of systems, organisations, professions and individuals. However, the group decided to remain positively influenced by concepts within cultural safety, equity and Aboriginal organisations such as the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM).

To complete the table, the group considered how to incorporate patient journey stories and mapping tools. Using the educator/facilitator’s experiences in teaching recent
trainees, the group carefully considered how best to use the case studies and mapping tools to assist students to combine both clinical and cultural care concepts. They also identified the role of experienced nurses providing contemporary and localised case studies.

**Potential responsiveness of the framework**

It was anticipated that this framework would assist the educator/facilitator to identify where each nurse was positioned along the stages, and what level of understanding and response to patients’ needs could be expected. The course outline, content, and framework would need to be appropriate for nurses who had varying levels of knowledge and experience in relation to providing quality clinical care and culturally safe care. The group considered how the framework would respond to different scenarios.

A nurse who has trained in Australia may be a novice in renal clinical skills, but has worked and lived with Aboriginal people for many years, and is very aware of cultural needs and cultural safety as per Table 2. A nurse who has trained overseas may be an expert in renal nursing, but a novice when it comes to understanding the cultural needs of Aboriginal people as shown in Table 3. Plotting this renal course participant’s trajectory into the education framework could guide the educator/facilitator in how best to adapt the training to suit this participant’s needs.

**Future aims**

The focus group continues to meet and expand their activities. They are currently applying for funding to enable a one-day workshop for renal nurses to be held in both a metropolitan and regional setting, with continuing practice development points if run in conjunction with the Renal Society of Australasia. The case studies and patient journey mapping tools have also been introduced into other nursing education courses, and are currently being used with both undergraduate and postgraduate nursing students in one Adelaide University School of Nursing online course (for 160 students in 2016).

**Limitations**

One of the limitations of this project is that some of the seminal texts we used are older, but still remain relevant to education and clinical practice today. Also, whilst Aboriginal patients and family members were involved in developing the patient journey mapping tools and case studies, they have not been directly involved in reviewing the education framework or course content. Future work will consider ways of including patients, carers and students as well as an external review from a non-renal discipline and/or multiprofessional team members.

**Conclusion**

The review of the education package for renal nurses working with Aboriginal patients in South Australia provided an opportunity to develop a more locally relevant, culturally safe and responsive nursing education approach. Combining symbiotic and participatory action enabled significant gaps in an educational program and resources to be bridged, with experienced nurses and researchers providing locally relevant contemporary resources and a reflexive approach. A new theoretical framework was developed to respond to current needs.

<table>
<thead>
<tr>
<th>Table 2: Culturally aware nurse but clinical novice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stages (Benner) levels of renal clinical competence</strong></td>
</tr>
<tr>
<td>Novice</td>
</tr>
<tr>
<td>Cultural models</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 3: Expert clinical nurse but cultural novice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stages (Benner) levels of renal clinical competence</strong></td>
</tr>
<tr>
<td>Novice</td>
</tr>
<tr>
<td>Cultural models</td>
</tr>
</tbody>
</table>
gaps in knowledge and the need for nurses to provide quality clinical and cultural care.

References


