

Recognition of expertise: An important concept in the acquisition of nephrology nursing expertise

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TITLE:**Recognition of Expertise: An Important Concept in the Acquisition of Nephrology Nursing Expertise****Author:**

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ABSTRACT

This article, which is abstracted from a larger study into the acquisition and exercise of nephrology nursing expertise, aims to explore the concept recognition of expertise. The study utilised grounded theory methodology involved 17 registered nurses who were practicing in a metropolitan renal unit in New South Wales, Australia. Concurrent data collection and analysis was undertaken incorporating participant observations and interviews. According to nurses in this study, patients, doctors and other nurses recognised that some nurses were experts while others were not. In addition, being trusted, being a role model and 'teaching others were important components of being recognised as an expert nephrology nurse. Of importance for nursing, the results of this study indicate that knowledge and experience are not sufficient to ensure expert practice; recognition of expertise by others is an important function of expertise acquisition.

KEYWORDS:

Expert practice
Expertise
Grounded theory
Nephrology nursing
Trust

INTRODUCTION

Contemporary nursing practice is a large and complex field, too large and too complex for any one person to master the full range of knowledge and skills it encompasses. Specialisation in one field has become the norm, enabling nurses 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 specialty of nephrology nursing has evolved in response to increasingly complex knowledge, technology, and clinical expertise required in the care of people with impaired renal function (Parker 1998). Nephrology nurses practice in primary, secondary and tertiary care settings and in the home (Schardin 1995). They are both practical and versatile and practice within and across a broad range of subspecialties such as general nephrology, haemodialysis, peritoneal dialysis and renal transplantation units, including paediatrics (Stewart 1997; Stewart & Bonner 2000). Nephrology nursing focuses on the health needs of individuals and their families who are experiencing a progressive decline in renal function or who have lost function completely. Nephrology nursing necessitates that the nurse focus on the provision of renal replacement therapy, teaching self-care, assisting individuals to make informed choices regarding the type and proposed location of therapy, and the prevention of related illnesses or complications associated with renal disease (Parker 1998).

Research into nephrology nursing has been influenced by many of the factors which have affected all nursing research. These include the number of nurses qualified to engage in research, trends in nursing practice and health care, and the availability of funding (Molzahn 1998). The volume of research in this specialty has increased

(Hoffart 1992; Molzahn 1993) and covers a wide range of topic areas such as quality of life, psychologic adaptation, coping, renal replacement therapies, attitudes, compliance, psychological stress and patient education (Hoffart 1995). There has, in addition, been relatively little research into the essence of nephrology nursing and the outcomes of nursing interventions (Hoffart 1995; Molzahn 1998) although the level of nursing competence and the effect on patient outcomes is considered a research priority by nephrology nurses (Lewis et al. 1999). In a practice-oriented specialty such as nephrology nursing, it is important to understand how nurses practice and, more importantly, because experts achieve the best patient outcomes (Benner 1984), how expertise is acquired.

The existence and acceptance of expert nurse practice have been evident by the increasing amount of literature that has become available over the last decade (see for example Adams, et al. 1997; Brown & Tiavale 1996; Edwards 1998; Jasper 1994). Since Benner (1982, 1984) first applied the Dreyfus and Dreyfus model to nursing, the interest in expertise has been gaining momentum. Benner (1984) identified five levels of competence in clinical nursing practice based on the Dreyfus model of skill acquisition. These levels are novice, advanced beginner, competent, proficient and expert. According to Benner, nurses move through these levels as they develop in their clinical practice, and that expert nurses possess attributes which make their practice superior.

Whilst there is general agreement within the literature that expertise is dependent upon the acquisition of a number of skills and attributes (Benner 1984; Macleod 1993; McClosekey & Grace 1990), the description of expert nursing practice is, nevertheless, incomplete (Adams et al 1997; Edwards 1998; Jasper 1994). It is not clear whether

expertise derives from personal qualities of the nurses that are made evident in practice or whether expertise is dependent on practicing within specific clinical settings.

This article will report on an important concept, namely recognition of expertise, which emerged during a grounded theory study into the acquisition of nephrology nursing expertise.

METHOD

Grounded theory methods are used to investigate social and psychological phenomena (Glaser 1978; Glaser & Strauss 1967; Strauss 1987; Strauss & Corbin 1990) in which the objective is to develop a theory, generated from a highly systematic research process, capable of explaining basic patterns of common interaction in particular contexts (Chenitz & Swanson 1986; Strauss 1987). Using this method, the researcher attempts to understand the meaning of concepts, things, events and situations as they interact in natural settings [the field] (Glaser 1992; Glaser & Strauss 1967; Strauss & Corbin 1990).

Selection and recruitment of participants

This study was conducted in a renal unit spread across an Area Health Service in New South Wales, Australia. The renal unit consisted of several in-patient and out-patient areas (i.e., clinics and satellite dialysis unit); acute and chronic renal replacement services including renal transplantation; and home training facilities for haemodialysis and peritoneal dialysis patients. Following institutional ethics approval, nurses who worked permanently in each of these areas were invited to participate in this study. Participants' selection criteria were devised from existing literature and consisted of identifying two types of nurses – experts and non-experts. The criteria included post-

graduate nephrology nursing qualifications, length of nephrology nursing experience, level of practice, personal characteristics and whether they were recognised as an expert nurse by their nursing peers. When a nurse consented to participate in the study, s/he was informed whether s/he had been classified as an expert or a non-expert. A total of 17 nurses were studied, consisting of 11 experts and 6 non-expert nurses; 16 nurses were female.

Data collection and analysis

In keeping with grounded theory methodology, concurrent data collection and analysis was employed in this study. Data was collected over a nine-month period, and consisted of a total 32 episodes (103 hours) of participant observations, 37 (24 hours) interviews, and ten episodes of nursing documentation (report writing rather than merely charting). Anonymity of data was achieved through the use of pseudonyms.

Participant observation represents an excellent source of qualitative data (Davis 1986; Morse & Field 1996; Polit & Hungler 1991) when combined with interviews, and is a typical data collection method used in grounded theory (Glaser 1992; Glaser & Strauss 1967; Strauss & Corbin 1998). Data is collected in the natural setting (Adler & Adler 1994) where the participants are located and requires the researcher to gather impressions of the participants' behaviour and involves looking, listening and asking (Lofland & Lofland 1995).

In this study observational strategies used to increase the richness of data included sampling by both time and by event. Observations occurred during morning and afternoon shifts and were spread across the entire week. Observations also occurred at strategic points during a shift. Particular events such as shift handover, initiation of

haemodialysis, and immediate post-operative care of transplant recipients were observed. Observations occurred during busy and quiet periods so that the full range of nephrology nursing activities such as time management, problem solving and patient or peer teaching could be described. Field notes were recorded during all observational episodes. A separate notebook for each episode was used and the majority of field notes were written at the time they occurred in the presence of the participant. Observational episodes ranged from 1.5 hours to 4 hours.

Although there are various types of interview which are broadly classified into structured, semi-structured and unstructured (Minichiello, et al. 1999; Morse & Field 1996; Oppenheim 1996), grounded theory studies typically utilise focused, open-ended interviewing (Glaser 1992; Strauss & Corbin 1998) for the purpose of collecting in-depth information concerning a participant's perspective about an experience. In this study, accordingly, 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. The timing of each interview was arranged to suit the participants and ward routine; they lasted for no longer than one hour and were conducted in a private office located near the ward. Interviews were also audiotaped for subsequent verbatim transcription.

The analysis of documentary sources, such as patient's health records, is a common method of data collection used by qualitative researchers (Janesick 1994; Morse & Field 1996), the purpose of which is to enhance data collected by way of observation and interviewing (Jorgensen 1989; Mason 1996). In this study, it was anticipated that nursing documentation on bed charts and progress notes would provide additional qualitative data on particular themes such as: 1) focus of nursing practice; and 2)

support for nursing actions. Patients' notes and charts were reviewed only during an observation period. Due to specific contextual factors, however, only a limited amount of data was collected by this method. This was because, in the chronic dialysis unit and home training areas, nurses undertook limited report writing.

In grounded theory research (Glaser 1978, 1992, 2001; Glaser & Strauss, 1967) data collection and analysis proceed simultaneously. Accordingly, in this study, a line by line analysis of the data was undertaken initially and this resulted in many codes, some of which were "in-vivo" codes; that is, codes that reflected the actual words or actions of the participants. 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. The preliminary categories developed during the open coding phase of the data analysis were simple clusters of several similar codes; these tended to be at the descriptive level.

Further analysis or the second stage of the analytical process was needed to identify common and conceptualised categories which were more inclusive and explained more of the data. According to Glaser (1978), several questions need to be asked of the data in order to refine categories, their properties and their linkages. Some of the questions that were of asked of the data in this study were: To what broader category does this group relate? What is actually happening in the data? What label can I give this broader category? This technique of questioning the data was consistently applied to the remaining codes and clusters until eventually all of the data was condensed into higher and higher levels of conceptualised categories that had broader explanatory power than lower level categories.

The third and final stage of the analytical process involved generating theoretical codes to integrate similar categories under one conceptual name which was mutually exclusive of other categories could be linked by explanation. At this point, four interviews remained to be coded; no new categories were identified and the remaining “free” codes were easily subsumed into categories. Theoretical saturation of categories had been achieved.

RESULTS

Recognition of expertise

The goal of this study was to gain an understanding of the acquisition and exercise of nephrology nursing expertise (Bonner 2001). The purpose of this article is not to report on the entire findings but to discuss an important concept of expert nephrology nursing practice, that is, *recognition of expertise*.

The results of this study revealed that *recognition of expertise* was a necessary for the exercise and maintenance of expert nursing skilfulness. In order to practice as an expert, nephrology nurses must be first recognised as one. They were recognised and designated by others (e.g. patients, other nurses, doctors) as having expertise in nephrology nursing. Expert nurses, by being recognised as having expertise, were trusted by others to undertake a number of functions not afforded non-expert nurses. These functions included extending the scope of normal nephrology nursing practice, being a role model, a teacher and one who was allowed to take charge of particular situations.

All nurses were asked during an interview who they believed was the “most expert” nurse within the entire renal unit in order to gauge peer evaluation of the level of

expertise of other nurses. Several nurses suggested some of the qualities necessary to be recognised as experts. These qualities included having:

- A wealth of up-to-date knowledge and experience which continues to increase;
- Extensive clinical skills;
- Capacity to deal with patients better than other nurses;
- An ability to teach other nurses (cf. teaching “master classes”);
- An ability to move into a renal area and succeed without faltering;
- An enquiring mind;
- A capacity to put more effort into their work in comparison to other nurses; and
- Ability to take on more responsibility than other nurses.

In addition, the category *recognition of expertise* consisted of three sub-categories. These were identified as *being trusted*, *role models for others* and *teaching others*. Figure 1 represents the relationship between the category recognition of expertise and its sub-categories.

Being Trusted

The first sub-category of *recognition of expertise* was *being trusted*. Being recognised as comprehensively expert meant others increasingly trusted these nurses. Expert nurses gradually developed trust in experienced non-expert nurses as their knowledge, experience and skilfulness increased. *Being trusted* not only assists in developing expert practice but is also one of the conditions under which it is maintained, that is, patients, other nurses and doctors need to trust what the expert nurse is doing, when, how and why.

Patients, for example, know that nurses who have longer experience with cannulation of arteriovenous fistulae are better at performing this task. Further, patients

have developed a rapport and trust with nurses who can demonstrate greater knowledge about their renal disease and its management.

Patients feel that it's you who has made a difference rather than any other nurse, I mean you build up a rapport and people get to trust you so that it does become your expertise that makes the difference (Prue, 1st interview).

Similarly, less experienced nurses clearly recognise expert nurses by seeking their guidance and assistance with their practice. Less experienced nurses designated some nurses as experts because these nurses knew a great deal more about nephrology nursing and could also practice it. Judy, for example, recognised Prue's expertise in cannulating a particular patient because his fistula was new and not matured enough for less skilled hands.

I'm not really sure [why I am not allowed to cannulate this fistula] cause I haven't really asked Prue but I think that he might have a very fragile fistula...it's still...not a real well developed fistula yet and I think that because she's the 'Grand Poo Bah' of cannulating she's actually taking over for a while (Judy, 2nd interview).

Doctors, in particular, trusted only those nurses who had been designated (cf. symbolic interactionism) by them as expert. According to expert nurses, doctors trust their practices and judgements. Doctors did so because they designated these nurses as experts with extensive knowledge and experience in managing patients on either haemodialysis or peritoneal dialysis treatment. Expert nurses "develop a trusting relationship with all of the consultants and some of them will let you do a little bit more than others" (Kim, 1st interview) and the doctors "realise that, that if [an expert nurse]

refers something there is a genuine problem” (Prue, 3rd interview). Sandra suggests why renal physicians trusted the expert nurses in this study.

I think we have a very good renal unit compared to a lot of other renal units, and I think our renal physicians allow us to do a lot more than renal nurses in other units. They recognise that we are the experts in our field, whereas in other units the doctors think they’re the experts and not the nurses. I’m sure there are some nurses in other units who may feel down-trodden by physicians because they’re always overridden, whereas most of the renal physicians in our unit don’t do that; they know what we’re talking about (Sandra, 2nd interview).

By being recognised as an expert and, consequently, being trusted by doctors enabled expert nurses to practice differently to other nephrology nurses in this study. *Being trusted* was a sub-category of *recognition of expertise* which gave expert nurses greater scope to practice. Although patients and other nurses trusted expert nurses, renal physicians, in particular, trusted these nurses to a larger extent to work in (informal) extended roles. Renal physicians trusted them “to change medication, to cease medications if [an expert nurse] thought it was appropriate especially when people are new to dialysis and you have to wean them off certain tablets when they start” (Sandra, 2nd interview). Being trusted by doctors, and being recognised as an expert, gave a nurse implicit permission to step over or around the traditional nursing boundaries and extend their scope of practice under particular circumstances.

Role Model for Others

The second sub-category of *recognition of expertise* was *being a role model for others*. Other nurses recognised that expert nurses were role models who were trusted with leadership functions in the renal unit. Expert nurses dictated what was acceptable

practice and set a good example from which other nurses across the entire renal unit learnt. During observations of expert nephrology nursing practice, these nurses were incidentally engaged in role modelling. That is, other nurses tended to emulate the practice of expert nurses or seek them out for clinical assistance, supervision or advice during the course of a shift. On other occasions, expert nurses were observed preceptoring new staff members to the haemodialysis unit. Expert nurses were resource people who knew what to do, why to do it, how to do it, when and how often.

Expert nurses could quickly deal with all issues and, in some instances, could simultaneously teach other nurses how to solve problems. For instance, Prue described how other nurses would come to her to learn how to improve a patient's dialysis treatment.

...they discuss [dialysis prescription changes] with me ... often they're not sure, then I give them the option to choose. Like if someone's under adequacy I might say 'what do you want to do about it?' and they might say change the dialyser to a bigger one and if I can see a reason why they shouldn't do that, like the [blood] flow rate can obviously go up before we change the dialyser, I'd suggest that... (Prue, 1st interview).

Teaching Others

The third and final sub-category of *recognition of expertise* was *teaching others*. Teaching patients, families, other nurses and medical staff is a significant component of nephrology nursing practice and, most nurses would agree, is the main focus of concern for patient care in a renal unit. During this study, it became apparent that expert nurses were performing most of the teaching compared to other nurses. In addition, expert nurses worked in areas with a pre-dominant patient teaching load; for example, teaching patients to manage either haemodialysis or peritoneal dialysis at home or to understand

about kidney transplant rejection. They used a variety of teaching strategies such as explaining, demonstrating, guiding, prompting and reinforcing to facilitate patient learning.

Expert nurses could spend a significant amount of time teaching other nurses. Most of the teaching was informal, on-the-job, practical explanations about how to do something; they taught much more frequently than other nurses. Expert nurses were also invited to conduct formal, classroom style teaching.

Finally, expert nurses also spent a considerable amount of time teaching doctors. For instance, in the haemodialysis unit, expert nurses taught medical students, interns, residents and registrars how to perform haemodialysis. Most levels of medical staff know the principles of haemodialysis (i.e., diffusion and ultrafiltration) but they do not know how to perform the actual dialysis treatment, how a haemodialysis machine works, its alarms and what they indicate and how to prepare a machine and patient. Teaching medical staff was undertaken primarily to improve their clinical abilities in the best interests of patient care.

... if you've got a medical person who's not doing it the right way then it not only impacts on the medical team but it impacts on the patient and impacts on the nurses looking after the patients cause they're delayed in their care, and it also means that the unit is delayed because you know we're cancelling things because they're not up to scratch, so it's often easier to get in and show them how to do a thing or tell them how to do a thing or give them the resources to do it, than it is to let them fumble around and make idiots of themselves and 'stuff' the patient up (Norma, 2nd interview).

DISCUSSION

The goal of the present study was to gain an understanding of the acquisition and exercise of nephrology nursing expertise; given this, *recognition of expertise* was a significant finding. In order to practice as an expert, a nurse must be first recognised as one. During this study, nursing peers were able to identify who, in their opinion, were expert nephrology nurses. Initially peer recognition occurred during the participant selection criteria. Nurses were also in the best position to judge others' practice because they frequently witnessed it in action or had to manage the consequences of that practice. In addition, peer designation of expertise was explicitly gauged during the study. All nurses were asked during an interview who they believed was the most expert nurse within the entire unit. There was consistency in their answers. Finally, less experienced nurses recognised some nurses as having expertise by seeking their guidance, advice or assistance with managing patient issues or problems.

While there is a wealth of evidence to suggest that knowledge and experience are important requisites in the development of expertise, there is very little literature which suggests that in order to practice as experts, that is, exercise their advanced nursing skills, nurses must be recognised by others as having expertise. Jasper (1994), however, in her analysis of the concept of nursing expertise, suggests that there is a need to "prove" a nurse is an expert. *Recognition of expertise* should be undertaken by people who are qualified to do so, that is by peers, or by other experts in similar or related fields (Jasper, 1994).

To date, *recognition of expertise* has been used explicitly in sampling to identify (potential) nursing experts by nursing peers in some studies (see e.g., Benner & Tanner 1987; Jenny & Logan 1994; McClement & Degner 1995). *Recognition of expertise* by

others is, however, only implied in several studies of expert nursing practice (Benner, Tanner & Chesla 1996; Conway 1996; Walker 1996).

In addition, this is the first study to identify explicitly that doctors recognised some nurses as experts. This was evident in the way these nurses interacted with all levels of medical staff, in particular, registrars and consultant renal physicians. According to expert nurses, they were recognised as having expertise and their judgements, therefore, were respected and trusted by doctors; as a consequence some doctors trusted them to extend their scope of practice.

Trust is an integral component of nursing practice which applies primarily to patient-related and work-related trust (Johns 1996). Trust, according to Delbridge et al. (1991) is a quality or attribute of a person who can be relied on for their integrity, confidence or authority. Trust is spontaneously accorded to individuals who are known to be competent, respected, trustworthy, reliable, effective communicators and negotiators (Johns 1996; Lynn-McHale & Deatrck 2000). Respect and trust between nurses and doctors have been identified as necessary antecedents to collaborative health care practices (Hanneman 1995), and as a requirement for expert practice (Ball 1999).

This study, while concurring with previous literature, has extended the concept of *being trusted* in two respects. Firstly, the findings suggest that nephrology nurses gain the trust of their nursing peers, medical staff and patients when their performance was recognised as expert. Secondly, by *being trusted*, expert nephrology nurses were given permission to move beyond traditional nursing boundaries and extend their scope of practice.

To date, there has been limited research which identifies trust as a factor in expert nursing practice; only two previous studies were found to do so. The first, by Conway

(1996), suggested that medical staff trusted some nurses' advice or input providing that the doctor knew them, their level of knowledge and experience and abilities. The second, by Snelgrove and Hughes (2000), suggested that when doctors recognise nurses as being experienced, they tended to trust the judgement and decision-making of these nurses.

Although the literature provides a variety of definitions surrounding the meaning and function of nursing preceptors, nursing mentors and role models (e.g., Andrews & Wallis 1999; Madison, et al. 1994), Kinley (1995) suggests that it is more important to examine the performance of the preceptor, mentor or role model. In the context of the present study of nephrology nursing expertise, the term "role model" was chosen to describe those functions of clinical practice which combined direct and indirect teaching (e.g., demonstration, supervision, guidance, and so on). This is consistent with Peutz's (1985) continuum where role modelling commences as preceptorship and develops into mentorship.

This study's findings are consistent with other literature concerning role models. Researchers have found that expert nurses are frequently seen as role models by less experienced nurses (Pyles & Stern 1983; Edwards 1998; Johnson, Cohen & Hull 1994); they act as teachers, advisors, counsellors and sponsors to develop skill and professional commitment during the professional socialisation of less experienced nurses (Coulon, et al. 1996; Davies 1993; Madison, et al 1994; Pyles & Stern 1983). The expert nurse as role model assists less experienced nurses to acquire specialty knowledge, professional values and confidence, as well as assessment, decision-making, problem-solving and technical skills (Ecklund 1998).

Study limitations

This study was designed to be exploratory, descriptive, and theory-generating, and to result in the development of a substantive theory of the acquisition and exercise of nephrology nursing expertise. The sample size, however, was small and the context confined to one renal unit which implies that the findings may not be fully applicable to other nephrology nurses, other renal units or more widely in other fields of nursing. Although the findings cannot be generalised, they can be verified (Corbin & Strauss 1990), and they provide a key reference point for nurses seeking to examine the practice of expert nurses.

CONCLUSIONS

Whilst the larger study sought to gain an understanding of the acquisition and exercise of nephrology nursing expertise, *recognition of expertise* was a significant finding. Using grounded theory methods, this study explicitly demonstrated that nephrology nurses must be recognised by others as having expertise in order to practice as an expert. *Recognition of expertise* was further explained by three sub-categories – *being trusted, being a role model* and *teaching others*, and it enabled expert nephrology nurses to significantly extend the scope of “normal” nursing practice. Finally *recognition of expertise* has importance for nursing practice and education as it revealed that knowledge and experience are not sufficient to ensure expert practice; being recognised by others is an important function of expertise acquisition.

Further research

Recognition of expertise warrants further investigation in several respects. Firstly, additional investigations could establish what precisely, in terms of expert practice, does *recognition of expertise* additionally allow nurses to undertake and under what sorts of conditions. Secondly, what types of socio-political, economic or other factors influence such recognition? Finally, can a relationship between *recognition of expertise* and motivation and enjoyment as a nurse be established?

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Figure 1 Relationship of Recognition of Expertise and Sub-categories

