SATELLITE HAEMODIALYSIS NURSES' PERCEPTIONS OF QUALITY NURSING CARE: A CRITICAL ETHNOGRAPHY

Paul Norman BENNETT

For the degree of Doctor of Philosophy
in the School of Nursing and Midwifery
Faculty of Health Sciences
Flinders University, Adelaide, Australia

August 2009

TABLE OF CONTENTS

CHAPTER 5 FINDINGS 1: NURSES' PERCEPTIONS OF QUALITY

CHAPTER 6 FINDINGS 2: INFLUENCES ON QUALITY NURSING CARE

CHAPTER 8 DISCUSSION 2: POWER AND OPPRESSION IN THE SATELLITE DIALYSIS CONTEXT

CHAPTER 9 CONCLUSION AND RECOMMENDATIONS

DECLARATION

I, Paul Norman Bennett, declare that this thesis is my own work and has not been submitted in any form for another degree or diploma at any university or other institution of tertiary education. Information derived from the published or unpublished work of others has been acknowledged in the text and a list of references provided.

_____ _____

Signature Date

ACKNOWLEDGEMENTS

Thank you to my two principal supervisors Dr Jane Neill (2005 to 2009) and Professor Judith Clare (2003 to 2005). Without your wisdom and guidance I would not have completed this thesis. You both gave me the confidence when I needed it most. Thank you to Professor Charlotte de Crespigny (2006 to 2009) and Dr Jacqueline Jones (2003 to 2006) who provided me with valuable critique in their role as second supervisors. In addition, I would like to thank my colleagues, students and staff at Flinders University for their support. In particular Dr Ann Hoffmeyer and Dr Alison Hutton, who gave me support and guidance at vital times during my candidature.

Thank you to nephrology nursing colleagues from Australia and around the world who have patiently listened to my theories, nodding at the right times.

Thank you to the participants and management of the satellite dialysis unit where I undertook the ethnography. You know who you are even though I can not identify you. You took a risk and allowed me to interview and observe you going about your day in the unit. Your honesty and openness were vital components of this study.

Thank you to my sister Vicki, mother Val and father Norm, for their support before and during this study. You have played a significant role in shaping my critical questioning ethic.

Finally, and most importantly, thank you for the support of my long suffering family: Denise, Sam and Finlay. Now you can have the study back.

LIST OF TABLES

LIST OF FIGURES

LIST OF PUBLICATIONS AND PRESENTATIONS (RELEVANT TO THE THESIS BUT NOT FORMING PART OF IT)

Publications

Bennett, PN. & Neill J. 2008 Nephrology Nursing Care: Beyond Kt/V *Nephrology Nursing Journal* 35:1 33- 37

Bennett, PN., Simmonds, R, & Buttimore, A. 2008 A Change in Adequacy Standards: Is it Necessary? *Renal Society of Australasia Journal* 4:1 4-5

Bennett, PN. & Simmonds, R. 2008 Letter: Response to Cahill, M. A Change in Adequacy Standards Could Create a Nightmare: Is it Necessary? *Nephrology Nursing Journal*, 35:2 205-206

Dermody, K. & **Bennett PN.** 2008 Nurse stress in hospital and satellite haemodialysis units *Journal of Renal Care* 34:1 1-5

Bennett PN., Torpey DK. & Bannister, K. 2008 Dialysis residential care: A novel dialysis service model *Asia Pacific Journal of Health Management* 3:2 47-52

Bennett, PN. & Glover, P. 2008 Video Streaming: Implementation and Evaluation in an Undergraduate Nursing Program. *Nursing Education Today*. 28:3 253-258

Presentations

July 2006 Renal Society of Australasia 34th National Conference "Quality Haemodialysis Nursing Care: More than Kt/V" Melbourne, VIC

June 2008 Renal Society of Australasia 36th National Conference "In-centre dialysis nurse stress is different to satellite dialysis nurse stress" Sydney, NSW

Sept 2008 European Dialysis and Transplant Nurses Association/ European Renal Care Association 37th International Conference "Bad bridge building: a critical examination of Kt/V and nephrology nursing" Prague, Czech Republic

Sept 2008 1st Thinking Synergies Conference "Satellite haemodialysis nurses' perceptions of quality: a critical ethnography" Adelaide, SA.

August 2009 4th Health in Transition International Conference on Community Health Nursing Research Community dialysis nursing: A critical ethnography. Adelaide, SA. (Accepted abstract)

KEY TO TRANSCRIPTS AND FIELD NOTES

The following fonts and abbreviations styles have been used to present the excerpts from the participants. This also includes excerpts from my own field notes.

Quotes from data

All names in this thesis are pseudonyms. Quotes are indented. Pseudonym name, date and transcript line identifier are provided and identify the excerpts from the participant interviews or observation.

For example:

> *You tell em time and time again. You know, don't drink so much coz if you drink your little heart blows up and it can only do that for so long (Lesley28/04 #1655).*

Field notes

Field notes are identified and structured in the same manner. FN is used to identify field notes. Regular font refers to my own comment, italics refers to the original field note.

For example:

> *If a nurse has two misses then another more experienced nurse should be asked to cannulate (FN 29/3 #35)*

ABSTRACT

People living with end stage kidney disease require dialysis or kidney transplantation to maintain life. Of those receiving dialysis in Australia, most people receive this treatment in satellite haemodialysis centres that are nurse-run, community-based clinics. Nurses provide the majority of care in these clinics with little or no on-site medical support, yet there has been minimal research exploring nursing care, or perceptions of nurses, in the satellite haemodialysis context. The major aim of this study was to explore satellite dialysis nurses' perceptions of quality care. Fundamental to this aim was the premise that to improve nursing care, nurses need to understand the factors influencing satellite dialysis nursing care.

A critical ethnography exploring the culture of one satellite haemodialysis clinic, focusing on the nurse's perception of quality was undertaken, with a focus on issues of power that influenced satellite dialysis nursing care. Over a period of twelve months, interviews with nurses, non-participant observation and document analysis were conducted. Of particular concern was the satellite dialysis nurses' struggle with the dominant medical discourse of quantitative measurement of quality. Bourdieu's notions of habitus, field and practice provided a vehicle to explore nurses' dispositions that operated within the institutional conditions of the medicalised discourse and physical structure of the satellite dialysis environment.

Findings about nurses' perceptions of quality dialysis care were categorised into three broad themes: what is quality; what is not quality; and what affects quality. Nurses considered technical knowledge, technical skills and personal respect as characteristics of quality. Long-term blood pressure management and arranging transport for people receiving dialysis treatment were not seen to be quality priorities. The person receiving dialysis treatment, management, nurse and

environment were considered major factors influencing and determining quality dialysis nursing care. Acceptance by nurses about their position and their reluctance to challenge medical power was revealed.

Aspects of power and oppression operated for nurses and people receiving dialysis treatment within the satellite dialysis context, and this environment was perceived by the nurses as very different from hospital dialysis units. Bourdieu's notions of habitus and subconscious reproduced practices were embedded in the satellite dialysis nurses' behaviour and were conveyed to other nurses. In order to improve nursing care in this context, ten recommendations were proposed: 1) implementing a concordance nursing care model; 2) using a goal-setting framework; 3) increasing staff rotation between dialysis units; 4) improving satellite dialysis unit design; 5) educating satellite dialysis nurses in internet and database skills; 6) using new technologies in staff education programmes; 7) recognising increased patient acuity; 8) research exploring residential dialysis facilities; 9) introducing advanced practice nurses in a satellite collaborative model of care; and 10) requiring a structured programme of reflective practice.

Facilitating change in dialysis nursing practice was fundamental to this study and consistent with a critical approach. New understandings for the nurses may not result in practice change however, unless there is a collective review and uptake of these practices. This study offers new knowledge about quality nursing in satellite haemodialysis units, enabling nurses to critically reflect on, and improve, the quality of care they provide.

CHAPTER 1

SETTING THE SCENE: WHY EXPLORE SATELLITE DIALYSIS NURSES PERCEPTIONS OF QUALITY NURSING CARE?

1.1 Introducing the study

This study explores satellite haemodialysis nurses' perceptions of quality nursing care. Satellite haemodialysis nurses provide nursing care for people living with end stage kidney disease receiving long term dialysis. These people spend up to twenty hours per week on dialysis. Nurses are the predominant clinical care givers who greatly influence the quality of the dialysis treatment. Nurses working in satellite haemodialysis units are frequently remotely located, and distant from on-site medical or nephrology support.

The term 'quality nursing care' has been commonly used but often poorly defined in the satellite haemodialysis environment. Satellite haemodialysis nurses use this term when describing many different aspects of nursing care. In this study a critical ethnographic approach was used where satellite dialysis nurses were observed in their everyday nursing roles, interviewed, and the documents they used analysed. In addition, field notes, critical reflection and participant feedback were used to understand quality satellite dialysis nursing care.

Using a critical ethnographic framework this study was concerned with notions of power and oppression, and how these were manifested in the satellite dialysis unit. This encouraged frequent assessment of areas of power, including my own position as researcher. The study was informed by the methodological approach of Thomas (1993) and critical theorists, especially Bourdieu (1990), whose theories around

habitus, capital and practice were applied to the study's findings. Bourdieu's constructs assisted the explanation of power relations in the satellite haemodialysis unit and provided new insights to power and oppression in order to inform nursing practice, policy, education and research.

1.2 Chronic kidney disease: A global health issue

Chronic kidney disease (CKD) refers to a group of diseases that contribute to the progressive decline of kidney function (Terrill 2002) and is the result of pathological processes that cause irreversible damage to kidney tissue (Meldrum 2000). Worldwide, diabetes, glomerulonephritis and hypertension are the main causes of CKD and in all countries both incidence and prevalence of these diseases is increasing (Levey et al. 2003) and thus is a worldwide public health issue.

CKD progresses from minimal kidney disease (stage 1) through to chronic kidney disease stage 5 (CKD5), also known as end stage kidney disease (ESKD), where kidney function is equivalent to a glomerular filtration rate (GFR) of less than 15ml/min compared to a normal GFR of 115-125 ml/min. (Kidney Health Australia 2007; Levey et al. 2005). At end stage, renal replacement therapy in the form of dialysis or transplantation is required to maintain life. Those on dialysis are committed to spending at least four hours, three times per week on dialysis which keeps them alive but has major effects on their quality of life.

The term CKD5 has recently been promoted as the more favourable term for this group of people because CKD is a process, with CKD5 being the final stage, rather than a separate disease (Agar, MacGregor, and Blagg 2007). Other terms used to describe CKD5 are end stage renal disease (ESRD), end stage kidney disease (ESKD), end stage renal failure (ESRF) or established renal failure (ERF). Not all

those who reach CKD5 receive renal replacement therapy (dialysis or transplantation). As this thesis is concerned with people on dialysis, end stage kidney disease will be the term used to describe kidney disease requiring dialysis.

Medical treatment for ESKD is dialysis, transplant or a less invasive form referred to as conservative treatment (Joly et al. 2003). The most prevalent treatment, dialysis, has been available since the 1960s (Haviland 1965; Nosé 1965). In the late 1960s advances in immunosupression contributed to kidney transplantation. Conservative treatment which is defined by no, or limited dialysis and no transplantation, continues to be an option for people who do want to undergo, or who are not suitable, to receive dialysis or transplantation.

Kidney transplantation is now the preferred treatment of choice for ESKD because it is associated with lower mortality rates, improvements in quality of life and lower costs (Davis and Delmonico 2005). For these reasons most people choose to undergo kidney transplantation, unless medically contraindicated, rather than receive dialysis for the rest of their lives. Nevertheless, the number of people receiving dialysis in all countries has been increasing yearly with estimates that by 2020 one million people worldwide will be receiving dialysis (Terrill 2002). This increase in has also been caused by a decrease in the capacity for countries to provide the number of kidney donations needed to match those needing a transplant.

Therefore, prevalence and cost of dialysis treatment, has continued to increase and Australia has been no exception to this rising demand for dialysis services.

1.3 End stage kidney disease and dialysis: The Australian context

In Australia, dialysis and transplantation have been available since the early 1960s. The most recent registry data shows that, in Australia at the end of 2007, there were 9642 people receiving dialysis and 7109 people living with a kidney transplant (McDonald and Excell 2008). Since 1990, Australia has followed the worldwide trend and has seen an approximate increase of 6% of people receiving dialysis treatment each year and a decrease in the proportion of all people receiving a kidney transplant (McDonald, Chang, and Excell 2008). Because Australia's organ donation rates are relatively low (Sanz et al. 2006), by 2010, Australia will have 2700 new people starting dialysis each year (Cass et al. 2006). Therefore, in Australia, dialysis as a treatment, is increasing in numbers and there is no evidence to suggest that this will change. Therefore the burden in terms of quality of life and the costs to Australians is significant and increasing.

The most recent health cost data reveals that in Australia in 2006 there were 780,000 hospital separations related to dialysis costing $484 million, equivalent to 1.0% of Australia's total health care expenditure (Australian Institute of Health and Welfare 2006; Harris 2007). The majority of these costs are met by state and federal governments with a small proportion funded through private health funds. Thus, the cost of ESKD treatment is significant and considerable to the Australian community.

In Australia, dialysis is provided through various modalities and in various contexts. These range from haemodialysis provided in hospitals, haemodialysis provided in community-based limited care centres known as satellite units, haemodialysis performed at home and peritoneal dialysis performed at home. Since the introduction to Australia of satellite dialysis units in the 1970s (Bilinsky, Morris, and Klein 1971),

satellite haemodialysis has been steadily increasing at the expense of peritoneal and home haemodialysis resulting in satellite dialysis units providing 43% of all treatments compared with hospital-based haemodialysis (26%), home-based peritoneal dialysis (22%) and home haemodialysis (9%) (McDonald, Chang, and Excell 2008). This increase in satellite dialysis popularity has been attributed to lower costs and greater geographic locations which decrease the distance for people to travel for their treatment (Roderick et al. 2005).

Health care professionals concerned with ESKD, are mainly nephrologists and dialysis nurses. Their roles have changed considerably as a result of the increase in satellite dialysis units. Although these roles vary somewhat from unit to unit, nephrologists rarely visit satellite units even though they are generally responsible for prescribing elements of care such as medications, target ideal weight and target Kt/V (Agar, MacGregor, and Blagg 2007). Nurses are the predominant caregivers in satellite dialysis units delivering the dialysis prescription and associated nursing care which may include cannulation, management of dialysis side effects such as hypotension, setting up machines, commencing and completing dialysis treatments (Flett 1997; Lehoux et al. 2007; Price and Paganini 1999).

Nurses liaise with nephrologists in designated care meetings, and on an *ad hoc* basis, frequently undertaken through remote technologies such as emailing, videoconferencing or teleconferencing (Bevan 2007). The absence of on-site medical staff results in the satellite haemodialysis nurses being relatively autonomous in their role of providing the majority of healthcare. Therefore, their perspectives and beliefs related to quality care and how this is measured influences the care that is provided to people receiving dialysis treatment.

1.4 Current debates about haemodialysis quality measures

Measures of haemodialysis quality have traditionally been developed through quantitative studies such as randomised controlled trials and historical epidemiological methods. Quantitative measures such as Kt/V, urea reduction ratios (URRs), mortality rates, hospitalisation rates (morbidity), infection rates, serum albumin, serum phosphate, and blood pressure have been used to measure haemodialysis quality (Carvalho et al. 2003; Scribner and Oreopolous 2002). The most commonly used measure of haemodialysis quality today is that of urea clearance using the formula Kt/V. Significant literature relating to the development of Kt/V as a measure of dialysis quality is detailed in Chapter 2 (see Section 2.4.2), however, given its importance to this study of quality in satellite dialysis units Kt/V will be summarised below.

In the early 1980s the National Cooperative Dialysis Study (NCDS) in the United States established Kt/V as a quantitative measure for the adequate dose of haemodialysis (Sargent 1983). This measure of haemodialysis dose consisted of the amount of urea clearance (K) multiplied by time (t) and divided by urea distribution volume (V) (Figure 1.1).

Kt/V

K= clearance of urea in (mmol/l)

t = time on dialysis (minutes)

V = Volume of water in person*

*Approximately 60% of normal body weight

Figure 1.1: Kt/V

Since the NCDS report there has been much debate around Kt/V as a predictor of important clinical outcomes (Blake 2003). Many observational studies have associated Kt/V with increased survival (Henning 2007). However in this epistemological framework, association is not causation and there have been limits to Kt/V's predictive value for morbidity and mortality (Henderson 2004). Although the debate has been considerable, nephrologists, nurses, administrators and people receiving dialysis treatment alike have continued to embrace Kt/V as the most frequently used measure of dialysis quality.

The importance of only using one measure, Kt/V, in measuring the quality of the dialysis treatment has been problematic (Bennett and Neill 2008) and was one of the catalysts for this study. The problem of Kt/V has been demonstrated where the Kt/V formula has been used to define adequate verses optimal dialysis. Adequate dialysis suggests a minimum standard and once this minimum standard has been reached no more is required (Scribner and Oreopolous 2002). This minimum standard has been frequently proposed as a Kt/V of 1.2 (Henning 2007). Conversely, optimal haemodialysis suggests striving for a higher quality standard that is an improvement on adequate (Twardowski 2003). Optimal dialysis equates to dialysis treatment quality that achieves a Kt/V of greater than 1.2 and also achieves benchmarks for other measures, in particular mortality, morbidity and quality of life.

In Australia, nephrologists and dialysis nurses have had the opportunity, the resources and the technology to provide optimal or high quality haemodialysis. Unfortunately, complexity has arisen because measures of haemodialysis quality have not been agreed upon, particularly when favouring the questionable reliance on Kt/V. An example of the complexity of measuring quality in dialysis is that of measuring mortality or death rates. Mortality rates appear to be a simple measure and, historically, have been the ultimate endpoint measure when comparing one form

of treatment to another (Prentice 1989). Furthermore, health administrators, managers and governments have used mortality rates to measure the quality performance of haemodialysis units (National Institutes of Health 2007). This influences clinicians and managers to aim for low mortality in their units which on the surface appears to be an appropriate aim (Fleming and DeMets 1996).

For the majority of people on dialysis low mortality rates are a good outcome of quality care. However, this focus on mortality rates may have encouraged dialysis health care providers to aim for quantity rather than quality of life. Thus, for people with end stage kidney disease, mortality rates as a measure of quality haemodialysis has placed an emphasis on keeping a person alive at all costs when death may be the preferred outcome of care for the individual person. Consequently, in the satellite dialysis context, where nurses are the main health care providers, the nurses' perceptions about quality versus quantity of life and keeping people alive at all costs may influence the quality of nursing care.

1.5 Quality nursing care in the satellite haemodialysis context

Although the term quality, when relating to nursing care, has been frequently used in the dialysis context it has been infrequently defined. In this context, the term quality has been commonly associated with the processes of quality improvement and quality assurance. However, the term quality has developed many different meanings and different applications when used in the context of quality nursing care. These meanings have been elucidated through previous concept analyses of quality and nursing (see Section 2.3).

The focus of this study was to understand quality and the nursing culture that influenced quality nursing care as perceived by the satellite dialysis nurses. This

approach is in line with recommendations for the study of quality nursing care which required "examination in context" (Attree 1993 p.367). Clearly, people who use satellite dialysis units greatly depend on the nurses providing haemodialysis care (Bevan 2000). It follows then that new insights into quality satellite dialysis nursing care may improve the care that people receive (Bevan 2007).

A culturally focused exploration of satellite dialysis nursing exploring nurses' perceptions of quality could inform satellite nurses and contribute to nursing practice. This exploration of quality nursing care required a study that focused on the nurses practicing in their own culture with an understanding of aspects of power relations that may influence this nursing culture. Therefore a focus on aspects of power relations, that maybe unique to the satellite dialysis nursing culture, was considered important to this study.

1.6 Power relations

Power relations are relevant to the exploration of quality nursing care in the satellite dialysis unit as there are significant differences in the way power relations are manifested between health providers, in particular nurses and nephrologists (Bevan 2000; Liberati 1997; Ochocka, Janzen, and Nelson 2002). Power relations are further influenced by the two additional characteristics unique to satellite units, firstly, being located remotely from their parent hospital and secondly, being without the on-site presence of a nephrologist. Subsequently, in satellite units, the dialysis nurses spend the most amount of time with people receiving dialysis treatment who are rarely visited by nephrologists. This context has unique power relation aspects that required exploration in this study.

Power relations are ubiquitous and have been linked to knowledge in the epistemology of critical, feminist and post-modern paradigms. Critical approaches consider that 'superior' scientific knowledge can be used to increase one's power (Fay 1984) and that this power may be used to dominate the oppressed. A feature of this knowledgeable oppressor is the use of academic capital to "construct the world" (Kincheloe and MacLaren 2000 p. 284). Applied to the dialysis context the development, interpretation and application of the measure of Kt/V is an example of the use of academic capital to enforce a prescribed treatment. Nephrologists, scientists, administrators and nephrology nurses have used the complex notion of Kt/V to construct quality in the dialysis context.

The critical approach that has informed this study has viewed satellite dialysis nursing quality care as a concept influenced by what information is accepted and rejected as truth. This is line with previous nursing research using the critical approach to explore health care discourses (Cheek and Porter 1997; Flaming 2006; Gastaldo and Holmes 1999) to the point of consciousness raising and political activism (Street 1995). Information perceived as truth by nurses is significant to quality because it becomes the knowledge that guides practice. Furthermore, historical aspects, such as the development of Kt/V in the dialysis context, have been influenced by power relations, which in turn, have influenced the production of knowledge. A critical approach is appropriate to explore nurses' perceptions of knowledge and practice related to satellite dialysis quality care influenced by power relations.

1.7 Positioning the critical researcher

The privileging of self-reflection and the ensuing possibility that people are willing to change are two pillars of critical approaches that have been used to explore the inequalities of power that feature in the western medical system (Heslop 1997). Thus, demonstrating self-reflection in order to position the researcher in relation to the study is fundamental to this study's critical approach.

As a haemodialysis nurse with many years experience in the specialist technical skills associated with haemodialysis I have increasingly observed and listened to interactions between people receiving dialysis treatment, doctors and nurses and concluded that nurses have a major influence on the quality of haemodialysis care provided. Nurses are particularly influential in the delivery of care in a community based satellite haemodialysis unit because of their remote location and lack of nephrologist prescence. Nurses' perceptions of quality care in the community based satellite haemodialysis unit have not been examined, and thus, there was a major gap in the literature which needed to be explored.

Satellite haemodialysis nurses do not work in an isolated context and this study set out to explore any internal and external factors influencing quality care. During my clinical practice I had observed varying levels of knowledge and understanding that led to varying practices and was concerned with the range of practices that nurses were providing and how this affected the quality of nursing care. Nurses have a major influence over the delivery of quality of haemodialysis for the patient and subsequently the experience of the patient.

1.7.1 Variations in practice: An example from my own experience

An example of variations in practice as perceived by nurses occurred in a dilemma that I experienced in practice which will be used to illustrate the stimulus for this study. I was the nurse manager of a satellite haemodialysis unit when one of the nurses entered my office and closed the door. She reported to me that she was concerned with the nurse she was working with who was not following the dialysis therapy orders by turning the dialysis machine blood flow rates up from 300 ml/min to 400 ml/min. I thanked the nurse and told her that I would deal with this situation. However, I was left with a dilemma.

My dilemma was that, although increasing the blood flow rate was not in the patient's regimen, it was unlikely to harm the people receiving dialysis treatment. On the contrary, with the limited evidence on this issue and my own clinical expertise, I concluded that the increased blood flow rate could actually benefit the people receiving dialysis treatment because this leads to greater waste clearance. This then raised a dilemma for me as the manager of the dialysis unit responsible for ensuring dialysis prescriptions were followed but being unsure of the best therapeutic prescription. One option I had was to follow the regimen and ensure all blood flow rates were adhered to by nursing staff and reprimand the nurse for not following protocol. Alternately I could challenge the therapeutic prescription with various nephrologists and argue for the need to change the therapeutic guidelines.

Unfortunately, there were no evidence based guidelines supporting and little available empirical evidence regarding what was best practice. More specifically there was no agreement about the optimal blood flow rate or the optimal prescription for a patient receiving dialysis. In fact, there was no clinical agreement to what

quality dialysis nursing care consisted of, which I found unacceptable. I needed to explore what nurses in satellite units perceived as quality nursing care.

1.8 The significance of satellite haemodialysis nurses' perceptions of quality nursing care

Nurses are major care providers in the satellite haemodialysis context and they have been acknowledged as acting in the role of major decision makers for people receiving dialysis treatment (Price and Paganini 1999; Stewart and Bonner 2000;). It follows that the decisions nurses make are likely to be influenced by their perceptions regarding quality haemodialysis nursing care.

This exploration of nurses' perceptions of quality nursing care in the satellite haemodialysis context has been stimulated by my own observations of varying haemodialysis satellite practices. Importantly, different practices may be necessary to suit the situation and this study was not inherently concerned with these. What was of concern were the varying practices related to nurses' perceptions of quality nursing care that may negatively effect patient outcomes. An example was the different ways nurses used and applied information such as Kt/V and the ways nurses perceived patient non-compliance (Woodcock 1999). Therefore, my concerns were focused on nurses' perceptions of quality nursing care and nursing practice in the satellite haemodialysis context.

Complexity arises when exploring the perceptions of any group of people in relation to their practice. The exploration of which practices that are reproduced and become accepted practice is important (Bourdieu 1990). Hence, the emphasis of this study is to explore nurses' perceptions of quality that influence their reproduced practice and determine accepted practice.

1.9 Study objectives

This study involved exploring satellite dialysis nursing culture to understand nurses' perceptions of satellite dialysis quality nursing care and order to shed new light on, and provide stakeholders with, more information for people, particularly nurses, to use in their everyday practice. Critical ethnography was used to guide a systematic exploration of nurses in one satellite haemodialysis unit. The objectives of the study were to:

1. Explore and uncover the perceptions of satellite haemodialysis nurses related to quality nursing care in the satellite haemodialysis context.
2. Explore aspects of power relations that may have influenced perceptions and practice related to quality nursing care in the satellite haemodialysis context.
3. Provide recommendations for future practice, education and research nurses, managers, researchers and educators.

Data from semi-structured interviews, non-participant observation and document analysis were used to achieve these objectives. These findings were combined with a thorough review of previous research and analysis of power relations to provide new knowledge in order to enhance nursing practice.

1.10 Thesis outline

Chapter 1: The introduction provided an entry point detailing relevant aspects of chronic kidney disease and contextualizing these to the Australian environment. An overview of the current debates around the measurement of dialysis quality, in particular the misuse of Kt/V as the defining measure of dialysis quality, was provided and its significance applied to the satellite haemodialysis context. An

introduction to aspects of power relations and an overview of the critical approach, including the researcher's own position in relation to this study was provided. Finally, chapter one concluded with the significance and justification for this study leading to the study's objectives.

Chapter 2: Study justification: The complexities of quality in the satellite dialysis context provides a review of the literature associated with quality and healthcare, quality nursing care, quality and haemodialysis leading to what is known about quality in satellite haemodialysis nursing care. It demonstrates the gap in the literature and current knowledge and justifies this research study exploring satellite dialysis nurses' perceptions of quality care.

Chapter 3: Methodology: Justifying and using a critical approach provides a background of critical social theory and justifies the use of critical ethnography as the methodology guiding this study. Methodological justification is based on the work of Jim Thomas (1993), and uses the concepts of critical theorist and sociologist, Pierre Bourdieu (1977, 1986, 1993, 1996), to inform alternative understandings of dialysis nurses' perceptions of quality dialysis care.

Chapter 4: Methods: Critical ethnography approaches to data collection, analysis and interpretation describes the techniques for data collection and analysis and justifies privileging the semi-structured nurse participant interviews as the major source of data. Aspects regarding the data collection, analysis, the setting, participants' characteristics, sampling techniques, recruitment processes, ethics and rigour are described.

Chapter 5: Findings 1: Nurses' perceptions of quality satellite dialysis nursing care is the first results chapter presenting a description of the nurses' perceptions of what was and what wasn't quality dialysis nursing care. To provide quality care

nurses needed specialised technical knowledge and clinical skills. Awareness of nuances such as intimacy and humour relevant to the satellite context are described. Finally, nurses provided their perceptions of what quality care did not involve, namely long blood pressure management and patient transport.

Chapter 6: Findings 2: Influences on quality satellite dialysis nursing care, the second results chapter, presents the nurses' perceptions of influences on quality satellite dialysis nursing care. People receiving dialysis treatment, management, nurses themselves and the satellite dialysis environment are presented as influences.

Chapter 7: Discussion 1: Satellite dialysis culture is the first of two discussion chapters. This chapter interprets findings from Chapter 5 and uncovers new knowledge that nurses perceived a clear distinction between the culture of the satellite dialysis unit compared to the culture of the hospital dialysis unit. These new findings are integrated with the published literature in order to explore and understand quality aspects related to technology, personal aspects, education, blood pressure management and patient transport.

Chapter 8: Discussion 2: Power and oppression in the satellite dialysis context provides new understandings about the influences on quality through a framework that negotiates the nurse (agent), their own dispositions (agency) and the institution (physical and social structures). Bourdieu's notion of field, habitus and capital related to agency and institution is used, for the first time, to assist in understanding of nurses' perceptions, power and practice related to quality in the satellite dialysis context.

Chapter 9: Conclusion and recommendations addresses the objectives of this study exploring satellite nurses' perceptions of quality nursing care. It provides recommendations for practice, policy, education and research. This chapter provides the necessary knowledge for recommendations on new and alternate approaches to the provision of quality care in satellite dialysis units. These recommendations have resulted from the findings of this study.

CHAPTER 2

STUDY JUSTIFICATION: THE COMPLEXITIES OF QUALITY IN THE SATELLITE DIALYSIS CONTEXT

2.1 Introduction

This chapter provides a review and critique of the literature regarding quality nursing care and nurses' perceptions of quality nursing care in satellite haemodialysis units, so as to identify gaps in the literature and justify this study. In order to justify this study, the complexities of quality in healthcare related to the Australian health care environment are presented, including a focus on quality care in outpatient departments where dialysis units are mainly situated. Literature regarding nursing and quality care in the context of the broader healthcare system is presented, featuring the complex issue of relating the patient's perspective to the quality of nursing care.

Literature around dialysis quality care has been dominated by medical scientific research rather than nursing research. Therefore, the literature from studies quantifying haemodialysis quality have been reviewed and critiqued and arguments against Kt/V's use as the dominating measure of quality is argued against. The review will consider the broader notions of quality, measurement, technology, and nursing in the haemodialysis context. Pertinent haemodialysis nursing literature is contextualised to the satellite dialysis nursing perspective including the issues around power relations. Finally, a justification for research exploring nurses' perceptions of satellite dialysis quality nursing care is proposed.

Throughout the exploration of the literature I expected to find relevant sources predominantly in nephrology texts and journals. Although this was generally the case

there was also important information from non-nephrology sources such as those focusing on quality, communication, technology, nursing practice, management and leadership, social science and health care economics. Therefore, this literature is integrated with that of nephrology nursing and medicine.

2.2 Quality and healthcare

Although the term quality has been commonly used in relation to the provision of healthcare, the acknowledgement of the complexities of quality has been less evident. Quality is complex in healthcare because it is forever evolving, is context and value dependant and can be viewed from multiple perspectives (Gunther and Alligood 2002; Jorgensen Huston 2003). Therefore, the literature around such a commonly used term in such a complex environment requires analysis before using the term 'quality' in relation to perceptions of quality nursing care by nurses in the satellite dialysis context.

In healthcare, quality has most commonly been related to the terms quality improvement and quality assurance (and various derivations of these). These terms were derived from the 1960s where quality measurement using structure, process and outcome frameworks were first applied to health care (Donabedian 1966). Over time measuring quality improvement has become an expectation for all healthcare providers to integrate it into their organisations both globally and in the Australian context (Australian Council on Healthcare Standards 2004; Kurtzman and Corrigan 2007). Quality measurement, in the forms of quality assurance and quality improvement, has become embedded into the Australian healthcare system.

The vital component of quality improvement is the component that defines quality. To put it another way, it is only possible to improve quality if we can actually

understand what quality is. To understand the complexities has required more than a set of numbers that can be placed in a league table to compare organisations' quality of service (McKee 1997). Quality does not just result from improved information systems and systematic performance monitoring (Asch et al. 2004). Rather, quality is an ever-evolving, complex phenomenon that requires more than a simplistic numerical approach.

The complexities of quality have led researchers to explore the complex elements and influences relating to quality. Both quantitative and qualitative approaches have been used in a variety of contexts (Brown et al. 2008). The application of these approaches has resulted in various quality measurement approaches and systems such as quality measurement and coordination of healthcare.

2.2.1 In context: Healthcare quality in Australia

In Australia, over the past 20 years, there has been increased emphasis on quality and the measurement of quality in healthcare. The Australian Government's department responsible for quality in healthcare is the Australian Commission on Safety and Quality in Healthcare (ACSQH). The commission's role has included coordinating quality and safety in healthcare, disseminating knowledge and advocating for healthcare quality and safety (Australian Commission on Safety and Quality in Healthcare 2008). Other organisations such as Australian Council on Healthcare Standards (ACHS) work with the ACSQH to maintain and improve healthcare quality standards in Australia.

Organisations such as ACSQH and ACHS can only be effective if they have the best information to inform their promotion and coordination of quality healthcare. Similarly healthcare service organisations require this best information to provide

quality healthcare based on the best evidence (Silagy 2001). Australian organisations have shown commitment to evidenced based healthcare forming Australian groups such as the National Institute of Clinical Studies (NICS) and Cochrane Collaboration's Effective Practice and Organisation of Care (EPOC) (Gruen et al. 2006). Although these groups have been committed to evidence based practice there are still many areas where more evidence for the Australian context is required. One of the areas where there has been a paucity of studies is in the quality of outpatient care which incorporates areas such as satellite haemodialysis units.

2.2.2 Quality and outpatient services

There has been an emphasis placed on measuring the quality of acute hospital care and far less focus on outpatient quality measurement (Curtright, Stolp-Smith, and Edell 2000). This has been a significant oversight given that, in Australia, outpatient care accounts for 25% of hospital expenditure and is increasing in its proportion of care (Healthcare Services and Financing Department 2007). Furthermore, high standards in outpatient care can eliminate the need for costly inpatient admissions (Martin, Balding, and Sohal 2003). Thus there is a need to ensure quality outpatient care in Australia.

The lack of evidence for outpatient services is relevant to this study because the satellite dialysis context is considered an outpatient service (Australian Council on Healthcare Standards 2004). Therefore, given the satellite dialysis' outpatient status, measures of outpatient quality such as waiting times, preventative care, patient satisfaction, patient satisfaction with information, patient satisfaction with respect and caring, cost per visit, attendances and productivity (Martin, Balding, and Sohal 2003) should be considered in the quality of care in the satellite unit rather than traditional inpatient haemodialysis quality measures. Researchers have not addressed

these measures in any depth in the satellite dialysis context, and none have been from the perspective of the satellite dialysis nurses.

2.3 Quality and nursing care

The relationship between the concept of quality and the concepts around quality nursing care is crucial to this study. As described above, quality has been embraced by healthcare stakeholders as an important concept. Given that nurses make up the largest group of healthcare professionals, quality healthcare requires quality nursing care (Australian Institute of Health and Welfare 2008; Naylor 2007). Thus what is known about the relationship between quality and quality nursing care is explored here.

Through various approaches nurse researchers have provided a greater understanding of the relationship of quality and quality nursing care. The two major approaches have been through concept analysis (Attree 1993, 1996; Chance 1980; Chin and Muramatsu 2003; Harteloh 2003; Sarvimaki and Sandelin Benko 2001) and grounded theory (Attree 2001; Hogston 1995, 1995; Williams 1997). Findings from these studies acknowledged the complexities of quality nursing care and the nurses' role in two areas. Firstly, these studies acknowledged the interpersonal quality aspects and secondly they acknowledged the nurses' requirement to understand the values and beliefs of people receiving dialysis treatment (Irvine Doran et al. 2001; Koch 1992; Meyer and Massaglia 2001; Young et al. 1998). Both of these aspects were proposed as important differences between quality healthcare and quality nursing care.

Nurse researchers have been critical of traditional quality measures in relation to the quality of nursing care, particularly the use of quantitative tools to describe quality in

nursing care (Attree 1996; Redfern and Norman 1990; Stichler and Weiss 2001). Attree (1996 p.17) has gone so far as to state that "pre-determined, quantitative tools are at best blunt instruments". Nurses may have moved too far down the technical path and outcomesacknowledging less technical measures should be placed at the forefront of quality (Donabedian 1988). Even though there has been critique of quantitative tools they have continued to dominate quality measures.

Nurses have a great influence in the way healthcare is provided and should be highly visible in the measures of quality in health care. Measures of nursing quality need to be nurse-sensitive, or in other words, have outcomes that are influenced by nursing care. However, not all nurses agree on how nurse-sensitive indicators of quality should be measured (Naylor 2007). Various comprehensive measures of nurse sensitive quality indicators have been proposed including the National Quality Forum Health Care Outcomes (NQF15) in the United States (Kurtzman and Corrigan 2007). The development of these measures has resulted in an attempt to replicate broader healthcare quality indicators and apply them to nursing care.

Criticism of the NQF15 have been that they measure adverse events and encourage fragmentation of care rather than measuring improved quality of life or measuring patients' experiences of care (Naylor 2007). Naylor provided examples that addressed the fragmentation of care, however, her examples were lacking in measuring the patient's experience. She suggested that considerable resources are required to build on previous nurse-sensitive measures to provide nursing with empirically sound clinical indicators of quality nursing (Naylor 2007). Clearly, even though there have been efforts to address the complexities of measuring quality nursing care, it is still an under-researched area.

Nurses are the largest group of healthcare providers and have great influence over the application of evidence and the delivery of healthcare (Bolton et al. 2007). It follows that nurses' perceptions of quality nursing care influence the care that they provide. Little research has been undertaken to explore nurses' perceptions in the satellite dialysis context. This critical ethnographic study adds to the understanding of nurses' perceptions in the satellite haemodialysis context. Moreover, this study focuses on the nurses perceptions' while still acknowledging other perspectives that influence nursing care quality.

2.3.1 Quality nursing care: Nurse or patient perspective?

As previously acknowledged there are various perspectives to consider when exploring quality nursing care. Studies have shown differences in what nurses perceive and what patients perceive as quality nursing care (Hagren et al. 2001). In saying this, the approach of this study was that nurses' perceptions of quality nursing care influence their delivery of nursing care which in turn influenced the quality of the patients' experience. This approach is consistent with the recommendations from Bolton et al. (2007) who explored nursing interventions, measures and outcomes. Nurses in satellite haemodialysis units, without daily medical specialist involvement, have possibly more influence than in the acute setting. Therefore, it is appropriate to explore the nurses' perceptions given that they have such an influence over the provision of care in the satellite haemodialysis setting.

In non-dialysis contexts there has been literature with opposing views on whether nurses have been able to embrace patients' perspectives in determining quality of their nursing care. Gunther and Alligood (2002) proposed that nurses have been unable to define nursing quality due to the complexities of involving the patient's perspective. Radwin and Ulster (2002) disagreed and provided a patient-centred

outcome measurement that enhanced nurses' understanding of the patients' experiences. Similarly, Sidani, Doran and Mitchell (2004) and Chin and Muramatsu (2003) proposed that incorporating individual patient characteristics into structured nursing measures can result in improved nursing care quality. Importantly none of these studies were undertaken in the satellite dialysis context and thus, nurses' perceptions of people receiving treatment in the satellite dialysis units has not been fully explored.

The perceptions of people receiving dialysis treatment around the quality of nursing care are fundamental to the care provided. However, given that this has been explored in other studies (Gill, Campbell, and Taylor 2002; Gregory et al. 1998; Hart 1996; Hiidenhovi, Laippala, and Nojonen 2001; Martin, Balding, and Sohal 2003; Rubin et al. 1997) and that the nurses are highly influential in the care provided in the satellite haemodialysis context the focus of this study is on the nurses' perceptions. In addition, given that a critical approach to the question of quality is about politics, power and change, a change in nursing perceptions, empowerment of nurses, leading to changes in nursing practice may result. Therefore, this study does not focus on the patient's perceptions of quality nursing care. That is another study and for future research. However, this study does explore whether the nurses perceive that they understand the experience of the dialysis patient.

2.4 Quality and haemodialysis

The literature defining quality of haemodialysis care is vast, with several aspects that dominate: quality improvement and quality assurance (McClellan et al. 2004; Patwardhan et al. 2008; Sehgal et al. 2002). With only a few exceptions, most quality improvement studies have focused on biochemical measures rather than dialysis

patient-centred quality measures. The most frequent biochemical measure of quality in haemodialysis has been the measurement of the waste product urea expressed by the formula Kt/V (see Section 1.4).

Although biochemical measures of quality have dominated the medical literature there have been notable exceptions where nephrologists have recommended less biochemical and more patient-centred measures. Fishbane and Goldman (2002) argued that quality dialysis involved caring for people receiving dialysis treatment to ensure desired outcomes related to their life quality. They proposed a process measure termed patient-centredness, which measured the patients' and family members' involvement in a decision-making partnership with their health care provider (Fishbane and Goldman 2002). Sadler concurs by contending that "the highest quality care is individualised care appropriate to the person treated" (Sadler 2007 p.537). Although the above authors overtly considered patient focused outcomes they were the minority, significantly outnumbered by dominant reports of quality concerned with quantifiable measures, particularly urea.

2.4.1 Biochemical quality measures of haemodialysis treatment

Ever since the first successful dialysis programs were established attempts were made to quantify and measure the removal of uraemic wastes (Michaels 1966). Following these early attempts nephrologists joined with chemists, physicists, engineers, mathematicians and other scientists in their quest to measure uraemic waste removal (Shinaberger 2001). This led to the numerical measurement of the removal of wastes becoming a multidisciplinary area of scientific endeavour.

The challenge to those who have attempted to quantify dialysis treatments has been the choice of toxin that should be measured. During the seventies the search for the

illusive uraemic molecule concentrated on molecules in the range of 5000 to 15000 Daltons (Kjellstrand et al. 1972). Following the National Cooperative Dialysis Study (NCDS) in 1983 there was a movement towards the smaller molecule, urea, being the best marker for dialysis adequacy. Analysis of this data reported the association of adequate urea clearance and adequate protein intake with clinical outcomes (Gotch and Sargent 1985). The formula Kt/V was devised and has since developed into the major measurement of quality in the haemodialysis context.

2.4.2 Kt/V as a quality indicator: Worldwide and Australian perspectives

Kt/V has been used worldwide as a measure of dialysis quality. It has been used by the USA Department of Health and Human Services (DHHS), the funder of all USA healthcare, as one of three clinical performance measure of dialysis quality care (Centers for Medicare & Medicaid Services 2007). The other two measures have been anaemia management and vascular access performance measures. The DHHS has required USA dialysis clinics to report the percentage of people receiving dialysis treatment who have received a single pool Kt/V (spKt/V) of greater than 1.2 using the Daugirdas II formula (Daugirdas 1993). They determine remuneration on the basis of these reports. Thus, urea, in the form of Kt/V, is the only solute-based clinical performance measurement used by the USA's DHHS and is fundamental in determining funding for dialysis providers.

Historically, European dialysis trends have differed from the USA. Although the Europeans are not immune from the dominance of Kt/V as a measure of dialysis quality, they have considered other measures and approaches. The European Uremic Toxin Work Group reported over 90 uraemic toxins that the kidneys play a role in regulating and suggested that many uraemic compounds remain unknown (Vanholder et al. 2006). Thus the quantification of the removal of solutes is complex

and we may be only at the beginning of being able to meaningfully quantify uraemic toxins.

In Australia, Kt/V has been used to measure adequacy (Kerr et al. 2005), however Kt/V has not been specifically tied to funding as is the case in the USA. Accredited Australian dialysis providers have not been formally asked to provide urea based measures such as Kt/V in their quality assurance measures (The Australian Council on Healthcare Standards 2004). However, urea as a measure of dialysis adequacy, has been identified in the Australian renal guidelines (CARI 2005) and is used widely as a measure of dialysis quality in Australian dialysis units.

2.4.3 The case against Kt/V as a measure of dialysis quality

Although there has always been debate on which toxin's clearance was most related to patient health outcomes, there has been an increased number of authors questioning the significance of Kt/V (Bennett and Neill 2008; Blake 2003; Bommer 2001; Henderson 2004; Henning 2007; Mees 2004; Morton and Singer 2007; Scribner and Oreopolous 2002; Twardowski 2003; Vanholder, Desmet, and Lesaffer 2002). The sentinel NCDS study showed that a Kt/V of less than 1.2 resulted in poorer clinical outcomes for people on dialysis (Gotch and Sargent 1985). However, critics noted that the study was performed using a very different cohort of people receiving dialysis treatment than we care for in today's dialysis units (Vanholder, Desmet, and Lesaffer 2002). The NCDS participants had few co-morbidities and were in an environment of short, intermittent dialysis, using low-flux relatively bioincompatible membranes. Therefore critics have argued this research was flawed and that Kt/V is limited as a marker of dialysis quality when applied in the current dialysis environment (Fishbane and Goldman 2002; Vanholder, Desmet, and Lesaffer 2002).

The increased success of frequent and longer dialysis has moved critics of Kt/V to suggesting that time and frequency on dialysis are more important than dose as measured by Kt/V (Charra, Calemard, and Ruffet 1992; Lindsay, Heidenham, and Leitch 2001; Pierratos 1999). An alternative proposal, related to frequency and time on dialysis, has been proposed as a valid measure (Scribner and Oreopolous 2002). Others argue that Kt/V be abandoned altogether as a measure of dialysis quality and replaced with measures such as cardiovascular stability (Twardowski 2003) and patient-centredness (Fishbane and Goldman 2002).

Although there has been recent increase in criticism of Kt/V it has continued to dominate the published quality measures in dialysis and in practice. Notably there has been very little critique from the group who deliver this Kt/V, dialysis nurses (Bennett and Neill 2008). This thesis has attempted to redress this somewhat by critically questioning the role of Kt/V as the predominant measure of dialysis quality from the nurses' perspective by exploring the perceptions of nurses.

2.5 Nursing and haemodialysis

Previous research exploring haemodialysis nursing is important in order to situate this study within the context of current nephrology nursing literature, and to establish the gap in the literature that this study has addressed.

The haemodialysis nurse is a sub-category of the specialised nephrology nurse (Bonner 2003). The nephrology nurse's role can vary widely from pre-dialysis care, renal transplant care, peritoneal dialysis care or the care of people receiving haemodialysis treatment (Stewart 1997; Stewart and Bonner 2000). Other specialist roles in anaemia (Benton 2008; Suranyi and Bannister 2002), vascular access (Allon and Robbin 2002; Lok and Oliver 2003) and bone/vascular syndrome coordinator

(Beavis 2007) have emerged as nephrology nursing roles over the past 5 years. These roles have developed in response to the increasing clinically specialised expertise being required in the care of people with impaired kidney function (Parker 1998).

The volume of literature reflecting research into the perceptions of nephrology nurses is scarce (Molzahn 1998; Bonner 2003). The major scholar exploring the related issue of the 'essence' of nephrology nursing has been Ann Bonner whose research explored the concept of recognition of expertise in the nephrology setting (Bonner 2003). Her qualitative study used grounded theory to explore the characteristics of expert nephrology nurses as seen through the eyes of nurses working in the nephrology setting.

A major contribution of Bonner's work was her recognition of the expert specialist nephrology nurse. She argued that expert nephrology nurses used nephrology specific knowledge and that this knowledge was crucial in their every day practice (Bonner 2007, 2007, 2003). Other characteristics that contributed to the acquisition of expert status were experience, skill and focus (Bonner and Greenwood 2006). In addition, Bonner found that expert nephrology nurses were frequently challenged to define the boundaries of their practice (Bonner 2001). Bonner built on earlier work by Schardin (1995) who described the nephrology nurse expanding the boundaries (Bonner 2004). Bonner's contributions to understanding nephrology nursing practice have informed this study however, Bonner did not concentrate on satellite dialysis nurses, which was the focus of this critical ethnographic study.

Australian nurse researcher Marianne Hardcastle (2004) undertook a critical ethnography focusing on nurses' decision making in the regional dialysis setting. She discovered that these so-called autonomous and expert nurses unknowingly followed established routines and practices. Thus their autonomy was not particularly

autonomous (Hardcastle 2004). She confirmed Bonner's and Schardin's findings that haemodialysis nurses' boundaries of practice were often extended.

Hardcastle (2004), Bonner (2001) and Schardin (1995) did not specifically explore haemodialysis nurses in the satellite haemodialysis context, although some of the participants from Bonner's and Hardcastle's studies rotated through satellite and in-centre dialysis units. Moreover, none of these studies focused on the perceptions of quality nursing care which is the focus of this ethnographic study in satellite haemodialysis units.

2.5.1 Quality nursing care in haemodialysis

Research exploring concepts related to quality nursing care is very often associated with the values, beliefs and attitudes of those involved in healthcare interactions (Gunther and Alligood 2002). In the haemodialysis context, these aspects, added to the complexities of chronic disease and high levels of technology, create a challenge for researchers.

The majority of nephrology nursing literature addressing quality in this context has focused on the nurse's role in outcome-based quality improvement programs. In particular, nurses have utilised mortality and morbidity as important outcome measures (Basham and Agar 1997; Dwight et al. 2002). Thus, the inference is that decreased mortality and morbidity equals 'high quality' care. This is far too simplistic, particularly in a context where a good death can be a good outcome for people who are on haemodialysis and whose quality of life is poor.

The use of urea clearance in the form of Kt/V as a measure of quality dialysis nursing care has also been evident in the nursing literature. This has been a relatively recent phenomenon as the earliest published article that deals solely with Kt/V and

nursing was reported by Fulcomer (1981). Most of the literature addresses the technical role nurses play in the process of measuring and applying Kt/V (Terrill 1990; Threlkeld 1992). Again, this has reflected the use of measures that have not fully captured the complexities of quality haemodialysis nursing care.

Other processes have been used to assess quality haemodialysis nursing. Denning's total quality improvement (TQI) model, using the plan, do, check and act cycle (PDCA), has been applied by nephrology nursing in quality improvement programs (Manfredi et al. 2003; Perras and Mattern 1994). Unfortunately, Perras and Mattern's (1994) approach lacked empirical evidence as their major 'measures of quality' were both structure and outcome. They concluded that people receiving dialysis treatment received a better product following their quality interventions. Their example was the use of the hospital's intravenous (IV) team to remove patient IV lines instead of haemodialysis staff removing central lines immediately post dialysis. However, no actual data on the outcomes (e.g. bleeding rates, infection rates, patient comfort/distress) of these changes was provided.

Continuous quality improvement (CQI) has been reported in dialysis nursing literature as improving 'process and outcomes'. Measured processes included Kt/V and frequency of dialysis symptoms such as hypotension. Outcomes reported were survival (mortality), serum albumin and hospitalization (morbidity) (Bednar in Levin et al. 1991; Parker 1990; Wright et al. 1996; Zabetakis et al. 2000). In these studies poor quality haemodialysis was measured by the failure of haemodialysis centres to meet benchmark targets for Kt/V and anemia management (Zabetakis et al. 2000). In all studies the measures could not reflect the complexities of quality haemodialysis nursing care.

In addition to the complexities of quality haemodialysis nursing care not being sufficiently addressed, research focusing on the perceptions of dialysis nurses has also been scarce. In the only study of its type, the American Nephrology Nurses Association (ANNA) reported that nurses' perceptions of components of quality in haemodialysis nursing care was an area that required nursing research (Lewis et al. 1999). Understanding the nurses' perspective is important given the amount of time they spend with the patient (Perumal and Sehgal 2003). Unfortunately, research exploring nurses' perceptions of quality haemodialysis nursing care acknowledging contextual complexities, has not been published. This study has attempted to contribute to this gap.

2.5.2 The nurse/patient relationship in the haemodialysis context

The relationship between nurses and patients in the satellite haemodialysis context may affect nurses' perceptions of quality care and, therefore, the care that nurses provide. Relationships between nurses and patients with chronic illness can range from paternalistic to equal partnerships (Van Biesen et al. 2004). It follows that these relationships influence the nurses' perceptions of quality in the haemodialysis context.

Nurse researchers have reported some of the complexities of nurse/patient relationships in the dialysis setting. A qualitative study using a social cognitive approach set out to explore the patient-provider relationship by examining the beliefs and experiences of 22 dialysis nurses in the USA (Morehouse, Colvin, and Maykut 2001). In this study the nurses spoke about their learning as "ongoing, in-depth and often shared between nurses and nurses, and nurses and patients" (p.298). Given that nurses' learning is ongoing, their perception of quality is likely to be an ongoing and changing concept.

A further finding by Morehouse et al. (2001) was that the relationship between dialysis nurses and people receiving dialysis treatment can be described as a therapist/patient relationship. The authors explain that the skills of dialysis nurses were not unlike behavioural therapists, but as the setting was often in a public space, the dialysis unit was more like a long-term group therapy environment. They found that nurses believed they had special relationships with people receiving dialysis treatment, characterised by "depth, reciprocity and compassion" (Morehouse, Colvin, and Maykut 2001 p.299). Although their research has been used to inform this study there was no focus on quality and the Morehouse et al. study was limited to a hospital dialysis setting and not a satellite dialysis setting.

Another perspective of the nurse/patient relationship has been provided in an ethnography focusing on the nurse/patient communication in the dialysis context (Ellingson 2007). This study uncovered the contradictory complexities of these communications where, on one hand, routinisation of care caused nurse complacency, while in contrast, the habitual routines of dialysis allowed "health care providers to devote more of their attention to patients' verbal and non-verbal communication" (Ellingson 2007 p.112). As this study was performed in the USA most of the participants were non-nurse patient care technicians (PCTs) and the findings may be difficult to apply to the Australian context where satellite dialysis units are staffed mainly by registered and enrolled nurses.

Researchers have recognised there are unique relationships formed between dialysis nurses and people receiving dialysis treatment, given their therapeutic relationship and the time they spend together. It is likely that nurses' perceptions of quality influences patient care, but also likely, that people receiving dialysis treatment, can influence the nurses' perceptions. Thus there is a complex interrelationship in the

care processes in the haemodialysis context which are further complicated by the presence of a high level of technology.

2.5.3 Technology and haemodialysis nursing care

Technology has been described as the broad application of knowledge and skills rather than only relating to the application of the sophisticated machinery such as dialysis machines (Barnard and Ward 2008). This interpretation of technology embraces the notion that it is the application of the technology rather than the technology itself that is fundamental to nursing care. Furthermore, it has been established that "technologies do not exist independent of interaction" (Ballard and Seibold 2004 p.9).

The most influential writer exploring technology and dialysis has been British nurse academic Mark Bevan. Bevan's (1998) analysis of the technological 'enframing' of haemodialysis nurses drew on the work of Patricia Benner (1984), to make a distinction between the nurse who achieves technique expertise and the nurse who understands technology. He proposed that by focusing upon techniques the novice does not master the technology but rather "the novice learns superficial survival skills that limits and enslaves the nurse within technological essence" (Bevan 1998 p. 735). He called this the 'technological enframing' of the nurse and patient, and contrasted it with the nurse who assists the patient to live well by supporting them through their experience of ESKD. Bevan's contribution was to provide a greater understanding of the complexities of technology when they are such an everyday part of nursing practice.

Bevan also reaffirmed the proposition that the 'technology' of quantitatively measuring quality, such as the use of Kt/V, may cloud the humanistic reason for

actually providing haemodialysis nursing care (Bevan 2000). This was consistent with Peplau's essence of nursing theory where she proposed a dualist interpersonal/technical construct (Peplau 1962). Peplau suggested that although technology can be used to free up nurses for interpersonal acts, nurses should develop practices that minimised the depersonalisation and distancing effects that automation potentially has. Although Bevan and Peplau's positions are well argued there is an underlying inference of a technology/nursing care dualism. In contrast, this ethnographic study aimed to explore the complexities of the perceived dualism to provide an alternate understanding of technology and nursing care in the satellite dialysis environment.

In the haemodialysis context the preference for technical measures such as Kt/V are examples of the broader definition of technology which can depersonalise the nurse/patient relationship. The excessive attention to this technology (ie. the mathematics of Kt/V) has distracted the clinician's attention away from other important aspects of dialysis quality nursing care (Lowrie 1996; Lowrie, Ofsthun, and Lazarus 2002). In addition, this technology of information has contributed to increased power and resources of the nephrologists and to a lesser extent the power of nurses (Bennett and Neill 2008). Acknowledging the role of technology influencing power relations within the dialysis unit, and exploring them in order to understand their influences on the satellite dialysis nurses' perceptions of quality nursing care, is fundamental to this study.

2.6 Satellite haemodialysis nursing practice

There is limited literature exploring satellite haemodialysis nursing practice (Bevan 2007). The lack of literature is surprising given that there is a growing worldwide

increase in satellite haemodialysis units (Ansell et al. 2007; Finelli et al. 2005; Manns, Mendelssohn, and Taub 2007; McDonald, Chang, and Excell 2007; National Institutes of Health 2007). In saying this, some authors have explored aspects of satellite haemodialysis nursing such as stress (Dermody and Bennett 2008), learning issues (Wellard and Bethune 2000), patient quality of life (Malmstrom et al. 2008), staff communication (Ellingson 2007) and models of care (Flett 1997). Apart from Bevan's (2007) recent work there has been little research focused on the unique issues that influence satellite haemodialysis nursing care.

Reasons why there has been limited research in the area of satellite dialysis nursing care may be because the increase in satellite dialysis units is a relatively recent phenomenon in many countries. Thus, the research in satellite dialysis may simply be lagging behind research into hospital dialysis service.

I suggest, however, that there are two interrelated factors that have led to the lack of research exploring satellite dialysis: firstly, the geographical distance of satellite dialysis units from the major hospital research hubs and secondly, the absence of recognition that satellite dialysis care is different to hospital provided care. Although many of the technical skills and processes are similar in both contexts, the location, support structures and influences are different resulting in a different nursing culture. There is very little published research exploring these factors related to satellite dialysis nursing care. Furthermore, there is very little research exploring power relations that shape accepted practices in the satellite haemodialysis setting.

2.6.1 Power relations in the satellite haemodialysis setting

Power relations in healthcare are complex and have been the focus of vast amounts of nursing literature. Nursing scholars have drawn from critical and feminist

literature to develop an understanding of power relations in nursing and healthcare. Among this literature is a consensus that nurses lack power, in comparison with physicians, in the delivery of healthcare. Influences such as gender, education and race, that are reflective of dominant characteristics of western society, have contributed to a sense of disempowerment for nurses in general (Maslin-Prothero and Masterson 2002). Given that nurses in satellite units fit with these attributes (female, no qualification in medicine) they too have significantly less power resources than their nephrology colleagues.

Nurses in satellite haemodialysis units are influenced by power relations, however these are not well understood. The specific characteristics of satellite units being nurse-run and not having on-site nephrology support may complicate aspects of power (Agar, MacGregor, and Blagg 2007; Roderick et al. 2005). In the satellite haemodialysis context nurses are expected to act relatively autonomously due to the limited on-site medical decision making (Lehoux et al. 2007) and work with decreased hierarchical structures compared to large hospital units where "physicians dominate the disciplinary power structure" (Ellingson 2007 p.113). However, the level of actual clinical decisions that nurses make may well be influenced by their feelings of power or powerlessness.

Even though nurses have greater potential for autonomy in the satellite dialysis context they may have lacked the resources to support this increased autonomy. Therefore, nurses' potential for greater power in this relationship (Montemuro et al. 1994) may be a positive or negative factor in patient care (Palviainen et al. 2003). For example, nurses in satellite dialysis units had limited access to ongoing education (Wellard and Bethune 2000). This may have led to the potential for poorly informed nurses making decisions with major influence over patient care. However, there is no research exploring power and power relations in this context.

2.7 A critical ethnography of satellite haemodialysis nurses' perceptions of quality nursing care: Justification for this study

Quality in satellite dialysis nursing care is a frequently used term however, it is less frequently defined. Notions such as quality improvement, quality assurance and best practice are all commonly used terms related to haemodialysis quality. Not only are these rarely defined, their complexities are rarely acknowledged. The concept of quality satellite dialysis nursing care is further influenced by context, power, technology and clinician's desire to quantify and measure quality. Unfortunately, the first two influences are often overlooked and dominated by the last two, resulting in an emphasis on quantifiable and technical measures of quality. This emphasis leads to numerical measures of healthcare services that cannot capture or acknowledge contextual and power relations resulting in simplistic, numerical measures of quality nursing care.

This study uses a critical approach to explore the complexities of quality satellite dialysis nursing care, and provide new understandings for study participants and the wider dialysis community. The use of a critical ethnographic approach acknowledges the nursing culture that exists, influencing and influenced by the history and context of the satellite dialysis unit.

To facilitate new understandings this research focused on the numerically predominant discipline, nursing, in the environment where most people are dialysed in Australia, satellite haemodialysis units. The study observed nurses' practice to inform satellite dialysis nurses' perceptions of quality nursing care, while acknowledging the complexities that influenced these perceptions. As has been

alluded to in this chapter such research has not yet been undertaken and therefore demonstrates justification for this study.

2.8 Chapter summary

Relevant extant literature related to satellite haemodialysis nurses' practices and perceptions of quality nursing care has been critiqued and reviewed. The consensus in the literature is that providing quality nursing care is vital for positive patient experiences and outcomes. What is not clear is evidence that quality nursing care, in particular in satellite haemodialysis units, has been fully understood and that quality nursing care has not been comprehensively researched in satellite haemodialysis. Furthermore, the perceptions of nurses who provide the majority of care in these units have not been studied. Therefore, the absence of this information clearly highlights a gap in the extant literature and thus offers a justification for this study. The methodological approach used in this study to contribute to this gap in the literature will be detailed in the next chapter.

CHAPTER 3

METHODOLOGY: JUSTIFYING AND USING A CRITICAL APPROACH

3.1 Introduction

Exploring and understanding quality care related to people receiving satellite dialysis is the focus of this study. As demonstrated in the previous chapter, dialysis quality has predominantly been investigated through using quantitative methods, such as randomised controlled trials and observational studies. Quantitative methods are used for measuring, for example, biochemical elements of dialysis quality, however, such research lacks the capacity to investigate and understand the human and social aspects of quality dialysis care.

Quality dialysis care involves people receiving dialysis treatment, nurses and doctors as social groups who have their own experience and perceptions of quality. These perceptions have been shaped by historical, personal and social influences and power relations. This study explores these (often hidden) influences to provide satellite dialysis nurses and other concerned stakeholders with a deeper understanding of quality dialysis nursing care. Previously unexplored influences from the nursing perspective were investigated, given that nurses are the predominant dialysis care providers in satellite dialysis units. Uncovering power differences, in order to give accurate insight into the satellite dialysis nursing culture, were fundamental to new understandings. To accomplish this, a critical approach was used to explore nurses' perceptions of quality dialysis care in the satellite dialysis context.

This chapter provides a background of critical social theory as the methodology guiding this study and provides recommendations on the use of critical methodology

in this context. The concepts of critical theorist and sociologist, Pierre Bourdieu (1977, 1986, 1993, 1996), used in later chapters, are discussed to inform alternative understandings of dialysis nurses' perceptions of quality dialysis care. Overall, this chapter justifies the decision to use critical ethnography methodology.

3.2 Critical theory

Critical theory and critical social theory can be traced back to the 18th and 19th century works of Kant (1781), Hegel (1821) and Marx (Marx and Engels 1848). These origins espoused critical social theory as enabling philosophies to

> …look beneath the surface of knowledge and reason (Kant 1781), in order to see how they are distorted in an exploitative society (Marx and Engels 1848), and thus show the possibility of less distorted forms of knowledge (Hegel 1821). (Miller and Brewer 2003 p.58).

All three had common emancipation and power concerns, even though Kant and Hegel's use of critical theory was epistemological, while Marx's use was more sociological in intent (Fay 1984).

Critical schools and theorists have emerged in historical periods where oppression was at its greatest. The Frankfurt School, often referred to as the major school of early critical theory, emerged in the post first world war Nazi German State following the failure in Europe of Marxist socialism and communist regimes (Held 1980). Following the original leadership of the Frankfurt School's Grunberg and Horkheimer (1937), critical theorists have maintained their overt emancipatory goals underpinning the construction of knowledge. The approach of early critical theorists, notably Max Horkheimer (1937), Theodor Adorno (1931) Erich Fromm (1945), Otto

Kirchheimer (1933) and Herbert Marcuse (1932), was overtly political, reflecting the emancipatory goals in times of state oppression.

A second wave of critical theorists led by Jurgen Habermas (1972, 1974, 1984, 1987, 1989) brought the epistemology of critical theory to a new level (Outhwaite 1994). Habermas proposed that critical knowledge was knowledge developed through empiric/analytic and historical/hermeneutic approaches (Habermas 1972). Critical or "emancipatory science [was able] to draw on both the other two forms of knowledge" (Blaikie 1993 p.55) in order to achieve the emancipatory goals of the critical researcher. From the Frankfurt school through to Habermas, critical knowledge privileged the exploration of differential power relations over uncritical philosophical approaches which had failed to recognise that oppression led to fundamental distortions of truth (Held 1980). More recent critical theorists propose a consensus that critical theory is concerned with revealing new understanding and employing ways of bringing about "enlightenment, emancipation, the rejection of economic determinism, the critique of technical rationality, power and domination" (Kincheloe and MacLaren 2000 p. 281). To reveal new understandings related to power relations, critical theory has embraced qualitative approaches to research.

3.2.1 Qualitative approaches

Qualitative approaches are fundamental to studies of people in their social world. "Social facts are different from the facts of nature because they are created and re-created by our own actions as human beings" (Morrow & Brown 1994 p.9). Thus qualitative methods explore the human aspects and provide rich understanding that can underpin and offer further explanation to the conditions affecting those being studied.

Critical theorists, such as Habermas (1984), Foucault (1977) and Bourdieu (1982), emphasised that traditional scientific research contributed to further invisibility of power relations and thus entrenched these further into what was regarded as truth and knowledge. The following summarises this position:

> …as a result of their [natural sciences] dependence on technical rationality (or instrumental reason), and their success in the domination of nature, they and technology have become a new source of authority and power in society. (Blaikie 1993 p.56).

It follows then that critical theory's strength is its capacity to uncover inequalities in power relations in context and within the population being studied at the micro-level where power is exercised (Miller and Brewer 2003; Rosenberg 1988).

Critical theory does not totally reject positivist knowledge claims. Both Habermas (1972) and Bourdieu (1996) acknowledged positivist methods to understand naturalistic science, but opposed these methods in social science, as emancipatory aims of critical theory could accommodate positivist claims of truth through rational consensus (Habermas 1987). This pragmatism has been identified as a strength of both Habermas and Bourdieu's approaches in increasing the potential for enlightenment and was influential in further developing critical theory and critical social theory (Morrow & Brown 1994).

3.2.2 Critical social theory

Critical social theory and critical theory are closely interrelated with literature relating to critical theory often interchanged (and at times confused) with the term critical social theory. An important distinction between the two is provided.

Critical social theory refers to exploring and explaining the broader society with an acknowledged direction towards historical aspects (Rosenberg 1988). In contrast, critical theory is the construction of truth or knowledge: an approach to epistemology (Porter 2003). Thus one could conclude that critical social theory is a sociological approach (explaining society) and critical theory is more a philosophical approach (explaining knowledge and truth). Although this is somewhat of a simplification of the complexities of the critical literature, this thesis has used the term critical theory to denote the use in explaining society and critical theory to refer to the epistemological usage.

3.3 Critical methodology

Methodology refers to the philosophy behind a set of principles that guide assumptions of knowledge (Minichiello et al. 2004). The researcher/participant relationship, including the influence of values and beliefs, is fundamental to the methodology (Harding 1987; Berman, Ford-Gilboe, and Campbell 1998). Nurse scholar Helene Berman and colleagues (1998) proposed five methodological features of the critical approach. These were:

> …that the issue addressed is of concern to [1] an oppressed or marginilised group; [2] the research could potentially benefit the group; [3] the researcher's motivation, biases and values are explicitly examined; [4] a critique of the reasons why biases have distorted existing knowledge and [5] finally, that respect for the expertise of the research participants is conveyed (Berman, Ford-Gilboe, and Campbell 1998 p.2).

The five methodological features of the critical approach identified by Berman et al. (1998), will be used to apply critical theory to this ethnography of satellite dialysis nurses.

3.3.1 Oppressed and marginalised?

The majority of the people in satellite dialysis units belong to two groups: nurses and patients, both of whom have been described as disadvantaged, disempowered, oppressed and marginilised (Bevan 1998; Roberts 2000) with nurses being oppressed because they work in the dominant medical environment (Roberts, 2000). Although nurses and patients have been labeled as such, the complex interrelationship of oppression is not linear, where doctors oppress nurses who oppress patients (Fletcher 2006; Faber 2000). The complexities of these oppressive features determined the decision to focus on nurses in order to uncover aspects of power related to nurses in the satellite dialysis context.

The continually changing satellite dialysis culture has unique features that may have influenced the oppression of, and the oppression by, nurses. These features include distance from centralised hospital nephrologist services, the long periods of time that nurses and people receiving dialysis treatment spend together and that satellite units are nurse-managed (Agar, MacGregor, and Blagg 2007). These features have not previously been reported as factors of oppression in this context which encouraged me to explore oppressive and marginilised aspects of the satellite dialysis context and therefore meet the goals of this critical ethnography.

3.3.2 Research beneficiaries

This study was undertaken in order to benefit those with lesser voices in the satellite haemodialysis field: nurses and people receiving dialysis treatment. As previously noted the focus on the satellite dialysis nurses was taken because understanding of the complexities of delivering quality dialysis nursing care could reap change and bring about improved patient care.

As described in Chapters 1 and 2 there has been an oversimplification in the literature of the concept of quality care for people receiving dialysis treatment, particularly the overuse of the dialysis quality measure, Kt/V. Nurses and people receiving dialysis treatment have uncritically privileged Kt/V as the dominant quality measure, to the detriment of other elements of care. Therefore, I propose that a critical approach, uncovering the complex nature of quality care delivered by haemodialysis nurses, could provide nurses and people receiving dialysis treatment with the motivation and confidence to challenge the use of Kt/V as the dominant quality measure. Nurses may feel more empowered to privilege other important elements, such as patient-centred care, in providing quality satellite haemodialysis nursing care.

3.3.3 Researcher's motivation, biases and values

Berman's third methodological criteria for critical research encouraged critical researchers to examine "the researcher's motivation, biases and values" (Berman, Ford-Gilboe, and Campbell 1998 p.2). In order to be critical of the status quo one must first reflexively examine one's own biases (Comstock 1982; Fay 1984; Habermas 1972), and biases of one's own discipline (Bourdieu and Wacquant 1992; Carspecken 1996). This epistemological foundation of critical theory underpins

critical researchers' theories of knowledge construction (Bourdieu 1996; Smith 2001). In other words the researcher brings to the research inherent strengths and biases and is thus required to disclose their own social, cultural and scientific interests and beliefs.

My biases emerge from my role as a nurse clinician and researcher in academia. I am a male who has moved from an oppressed/oppressor role of nurse manager to the role of critical researcher who is in the perceived privileged role of researcher. I have moved from the role of managing other clinicians to the research role of exploration, knowledge development and creating change. In my past nursing management role, I prioritised logistical management issues over the patient's experience. My subsequent clinical role enabled reflection contributing to new, unanswered questions. Influences during this time raised contradictions in my own nursing practice and research role.

A critical approach has compelled me to reflect on the position of power that I hold, the discipline in which I hold it, and the effect this may have on the research. As researcher I have maintained my position of Renal Society of Australasia (RSA) Research Coordinator and Journal Editor as well as being a university lecturer. In addition I have frequently spoken at national, state and local haemodialysis nurse meetings. It is likely that I have been perceived by the haemodialysis nurses, who were the focus of this study, as a leader in nephrology nursing. I therefore chose to be explicit in my strategies to minimise the effect of my professional position, which are addressed in detail in the methods chapter (see Section 4.6).

3.3.4 Biases that may have distorted existing knowledge

Recognising biases that may have distorted accepted knowledge is a fundamental component of critical research (Berman, Ford-Gilboe, and Campbell 1998; Bourdieu 1996). Although critical theorists may disagree over various knowledge claims, they retain consensus in their acknowledgement of historically biased knowledge distorting contextual truths (Habermas 1972). "[Critical theorists] share a radically historical theory of knowledge, and a conflict theory of society in which the domination of the social subject is the central theme" (Mill, Allen, and Morrow 2001 p. 111). Individuals are dominated by historically developed knowledge and controlled by those with dominant power relations (Foucault 1977).

The problem of distorted accepted knowledge in the satellite dialysis context is exemplified by the prominence of the measure of urea, using the formula Kt/V, over other important elements of quality dialysis care. As argued in Chapters 1 and 2, Kt/V has been used to determine quality care in satellite dialysis units because it is scientific, mathematical and measurable. This use has not been overwhelmingly questioned because of an implicit notion that a complex formula is scientific and must reflect the truth. Furthermore, the history and development of Kt/V has not been deeply questioned by those identified as having most academic capital: nephrologists, engineers and mathematicians.

The development of Kt/V as a measure of dialysis quality derived from quantitative empirical methods where Kt/V was found to be inversely associated with morbidity. Given medicines' historical privileging of quantitative methods to explain human phenomena (Bevan 1998), and its cultural capital and dominance over the health disciplines, measures such as Kt/V have been used to the detriment of including other more humanistic elements that are unable to be quantified.

Critical theory recognises that quantitative empirical methods can offer new knowledge under certain contextual conditions. The requirement for these methods to be embraced within the critical approach is that they have emancipatory features (Bourdieu 1996; Habermas 1987; Morrow & Brown 1994; Rosenberg 1988). Clearly, the application of Kt/V has not contributed to emancipation because it has not undergone sufficient scrutiny by clinicians who have used it as their major measure of quality care. Kt/V results have been used to control by the dominant group, nephrologists, and therefore, to control those with lesser power: nurses and people receiving dialysis treatment.

3.3.5 Respect for the expertise of the research participants

The principal research participants in this study were satellite dialysis nurses and people receiving satellite dialysis treatment. Respect for research participants "supersedes the goal of knowledge, completion of project and obligation to funders or sponsors" (Soyini Madison 2005 p.111). In other words, the researcher has fundamental ethical obligations to protect the safety, dignity and privacy of all participants. Although these ethical issues are addressed in the ethical section of methods in Chapter 4 (see Section 4.5) the issue of respecting participants' expertise is addressed here, given the respectful and emancipatory features of the critical approach.

Critical researchers endeavour to uncover hidden power relations with the ultimate goal of enlightenment (Habermas 1984). This has potential to challenge the status quo, which in turn, may result in detrimental rather than emancipatory effects. For example, nurse participants may become defensive and unwilling to participate in the research if their notion of knowledge is challenged (for example, that Kt/V is not the best measure of quality). Satellite dialysis nurses may feel that they are expert in the

area of satellite dialysis nursing, and have difficulty accepting alternate ways of viewing quality. It also follows that patient participants may become defensive if they consider a researcher who is observing their dialysis treatment may change their treatment (for example they may fear being prescribed a longer dialysis treatment as a goal or recommendation of the research).

To decrease the possibility of negative effects of the research on participants, I undertook formal group education sessions, individual information sessions, participant feedback following each fieldwork event and formal post-study feedback to both management and nurse participants (see Section 4.4). In addition, I chose to be reflexive following each period of fieldwork and encourage reflection by the nurse and patient participants following each observation and interview session. I was acutely aware of the need to show sensitivity and gain the confidence of research participants, which leads this discussion to the importance of reflexivity as a feature of the critical approach.

3.3.6 Reflexivity

Reflexivity of the researcher is fundamental to the critical approach (Bourdieu and Wacquant 1992) and contributes to the trustworthiness of qualitative research (Coffey and Atkinson 1996). There have been varied definitions and uses of the term reflexivity and the term needs to be defined prior to discussing its importance in this study. Reflexivity is defined here as "examining how the researcher and intersubjective elements impact on and transform [the research]" (Finlay 2002 p.4).

Reflexivity goes beyond self-reflection, although it does incorporate it. Researcher reflexivity relies on a commitment to make subjective, often hidden features of the researcher's own perspective overt (Bourdieu 1990). This relates to critical theory's

ethical or "moral dimension" (Rosenberg 1988 p.97) where the explicit position of the researcher in the academic and sociological field is recognised. Secondly, encouragement for participants to reflect by exploring any power-related restraints in their own practice contributes to the emancipatory goals of the critical approach. "…it obeys an emancipatory cognitive interest, which aims at the pursuit of reflection" (Habermas 1972 p.197).

Reflexivity within this study involved consciousness raising of nurses as well as the researcher. I was neither a detached, objective researcher or a participatory native with a "native point of view" (Reed-Danahay 2005 p.153). This required me to frequently reflect on my researcher role. Both Habermas and Bourdieu espoused critical methods privileging reflexivity to achieve as previously hidden understanding of social group practices (Bourdieu 1996).

Self-reflection as a component of reflexivity has been criticised by some as fundamentally subjective (Fay 1984), however, critical theorists argue that, in all research, there are subjective forces. "[Self-reflection] leads to insight due to the fact that what has previously been unconscious is made conscious in a manner rich in consequences" (Habermas 1974 p.22). This notion of subjective forces is fundamental to both the methodological and epistemological uses of critical theory, and using the methods of ethnography has encouraged reflexivity in this study.

It follows then that reflexivity is an important epistemological element fundamental to critical theorys overarching goal of finding covert meanings, resulting in the researcher enlightening research participants (including the researcher) by showing them "the world [as] it ought to be" (Rosenberg 1988 p.97). This implores the critical researcher to be reflexive of their own values, beliefs, biases, prejudices and

presumed knowledge which includes knowledge that has been developed in the male dominated (gendered) scientific world.

3.3.7 A gendered world

Critical theorists propose that gender, class and racial features influence complex forms of power (Kincheloe and Maclaren 2000). According to Kincheloe and MacLaren (2000 p. 284)

> …the key to successful counterhegemonic cultural research involves (a) the ability to link the production of representations, images, and signs of hyperreality to power in the political economy; and (b) the capacity, once this linkage is expose and described, to delineate the highly complex effects of the reception of these images and signs on individuals located at various race, class, gender and sexual coordinates in the web of reality.

Therefore it was important for my reflexive research to privilege the potential historical and political influences, particularly those relating to gender.

According to feminist theorists, gender has played a major role in the development of male-influenced knowledge. Importantly, feminist approaches not only critique gender relations but other systems that sustain, for example, racism, homophobia and ethnocentrism (Code 1995; Tuana 1989). The common feature of such oppressed groups is that they occupy positions of "minimal epistemic authority" (Code 1995), unlike the epistemologies of "a small, privileged group of educated, usually prosperous, white men" (Code 1995). Applied to this study, the exploration of quality nursing care through the perceptions of predominantly female satellite dialysis nurses had the potential to contribute to an alternate, female-gendered

understanding while working in a world of male-influenced knowledge. However, this alternate understanding has still been developed in this male-dominated world.

I am a male nurse researcher, exploring a professional culture (nursing) that has been historically female, and therefore, I bring a 'male perspective on female perceptions'. This area has been addressed well in the literature and is not the focus of this particular study. The question of being male in a female-dominated profession remains intriguing, but the fact that I am a male researcher may contribute to a new, unique knowledge synthesis and understanding. Although a feminist approach is not privileged in this study, my awareness of the influences of constructed gendered knowledge and my role as a male nurse researcher in this ethnographic study is acknowledged throughout this study.

3.4 Critical ethnography

This study is ethnography in the critical theorists' tradition, and thus termed a critical ethnography. The term ethnography has been used to describe and understand the "social meanings and activities of people in a given field or setting" (Brewer 2003 p.100). Originally used for anthropological studies of groups from various ethnic and tribal origins, ethnography is now frequently used to research groups in defined social contexts.

There has been debate on whether ethnography pertains to a set of research methods or epistemology, or both (de Laine 1997). In this study I have used it to define the set of research methods consistent with my epistemological approach. Therefore, when the term ethnography is used it refers to traditional ethnographic research methods of interview, observation, document analysis and reflexivity. In saying this, there is no one way to do ethnography (Bourdieu 1996; Willis and Trondman 2002) and

traditions of using a particular set of methods have developed from various theoretical approaches (Soyini Madison 2005).

Ethnographic methods have been used extensively to explore cultures related to healthcare, medicine, nursing and patients (de Laine 1997; Russell 2004). Exploring and further understanding specialist nursing cultures are particularly amenable to the ethnographic approach (Leininger 1985). Previous ethnographies have uncovered power differences between health care professionals (Mishler 1984) and raised the potential for patient-centred, holistic care (Porter 1997).

Critical ethnography is the study of culture from the critical paradigm, with critical ethnographers attempting not only to describe a culture but change that culture. "Critical ethnography is conventional ethnography with a political purpose" (Thomas 1993 p.4) where critical ethnographers are not content with studying culture to describe it, they want to change that culture so that the oppressed are emancipated (Soyini Madison 2005; Thomas 1993; Thompson 1987). This change has occurred through identifying hidden unequal power relations and enabling or advocating for providing alternate understanding and empowerment for research participants (Carspecken 1996; Kincheloe and Maclaren 2000).

3.4.1 Critical ethnographic methods

Various ethnographic methods have been proposed by critical theorists when addressing methodological issues related to the critical ethnographic paradigm (Carspecken 1996; LeCompte and Priessle 1993; Soyini Madison 2005; Spradley 1979, 1980; Thomas 1993). Carspecken's five stage approach to conducting critical ethnography has been used by nurse researchers in critical ethnographies (Hardcastle 2004; Gonda 2008). Carspecken has integrated these five stages so as to guide

research methods while allowing a certain cyclical flexibility (Carspecken 1996; Hardcastle 2004).

Critical ethnography is a methodology that allows various methods to be used (Bourdieu 1996; Thomas 1993) to answer the research question and "ultimately provides meaning that shape[s] the analysis" (Thomas 1993 p.37). In this study, nurses' perceptions, actions and experiences were the focus, and so it follows that the most relevant and the most appropriate method to investigate and understand nurses' perceptions of quality nursing care was through one to one semi-structured in depth interviews. Interviewing nurses was consistent with Thomas' (1993) recommendations and those of other critical ethnographers who emphasise the usefulness of the interview process (Bourdieu 1996; Soyini Madison 2005). I therefore followed the ethnographic methods of: 1) observation to inform the interview; 2) interview; and 3) document analysis. I have placed particular emphasis on the interview as the major source of data because I was focussing on the nurses' perceptions.

The methods used in this study were guided by Thomas (1993). Thomas resisted being overly prescriptive in the use of one particular set of methods, continually reinforcing the flexibility required to maintain the critical approach. He proposed that methods involved data sources, evidence of accuracy, data collection and conceptualization and while undertaking these methods awareness of interpretation, analysis, discourses and reflexivity was necessary. Accordingly, Thomas emphasised the need to inform the participants of the study's findings in order to reach the goal of their enlightenment (Thomas 1993). He linked these methodological guidelines with the requirement to look for issues of power relations and domination, which I have used in this critical ethnography privileging nurses' perceptions of quality dialysis nursing care.

3.4.2 Critical ethnography privileging nurses' perceptions of quality dialysis nursing care

Using critical ethnography to privilege the nurses' self-reported perceptions of quality dialysis nursing care in the satellite dialysis context has provided a new approach to this area. Accordingly, other groups involved in the dialysis treatment, particularly people receiving dialysis treatment and family carers remain silent, which situates this issue as a possible limitation in relation to the methodology used.

I specifically focused on the nurses' perceptions of quality dialysis nursing care. As such satellite dialysis nurses' views and experiences has provided perceptions of the most abundant caregivers in the satellite dialysis context. By focusing on this predominant group we could uncover a new understanding about quality nursing care. As a dialysis nurse, I could relate to them, and therefore, could explore their perceptions and identify aspects of power.

Nurses are the most abundant professional group in the satellite dialysis unit context. However, this did not automatically equate to the nurses being dominant and powerful. While the nephrologists were not physically present in the satellite dialysis unit, they could still influence the accepted knowledge and nursing practice in the unit. To understand who held the resources of power, a critical exploration of what the nurses' perceived in relation to their role and experience was crucial, in order to facilitate change. Although interviewing people receiving dialysis treatment, carers and nephrologists would have uncovered other power related issues, the focus of this study was to explore satellite dialysis nurses as potential change agents

A major aim of this study was to explore oppressive aspects of the satellite dialysis context. Oppression is not linear; it is not doctor over nurse over patient, but more complex and contextual. Medical doctors possess power resources and therefore

influence healthcare delivery (Mishler 1984). Bourdieu describes this capacity to influence knowledge within a field as cultural or informational capital (Bourdieu 1986; Bourdieu and Wacquant 1992) exemplified by the cultural capital the nephrologists used in prescribing and designating quality dialysis care. Kt/V defining quality of care is another example of the nephrologists' cultural capital dominating accepted knowledge amongst dialysis stakeholders.

To provide an alternate understanding of satellite dialysis quality this study has used Bourdieu's theories of habitus, field and capital (Bourdieu 1977). An introduction to these concepts is provided in the following section and discussed with the findings in Chapters 7, 8 and 9.

3.5 Bourdieu and practice: An alternative understanding

Pierre Bourdieu, Jurgen Habermas, Michel Foucault and Anthony Giddens, have been the most influential critical theorists over the latter part of the 20th century (Morrow & Brown 1994). Most notably, Bourdieu, has been instrumental in bringing a wider audience to critical ethnographic traditions with his theoretical concepts of capital, practice, habitus and field (Blommaert 2005).

The notion that nursing culture in a satellite haemodialysis unit is static and easily defined is problematic. Practices that continue within a specific culture, such as this, are dynamic and become reproduced practices (Bourdieu 1977). To assist in explaining this Bourdieu (1977) introduced the concepts of habitus, field and capital developed from his anthropological work with Kabyle marriage rituals (Bourdieu 1965). His work has assisted others in exploring and understanding both macro-cultures (for example ethnic groups) (Blommaert 2005) and micro-cultures, such as health care cultures (Huppatz 2006; Lauzon Clabo 2008; Rhynas 2005).

Bourdieu's work has been increasingly attractive to nursing and the study of nursing practice (Rischel, Larsen, and Jackson 2007) associated with his critical approach (Lynam et al. 2007). Bourdieu's concepts of field, capital and habitus have contributed to conceptualization of the culture and practice of nursing work (Rhynas 2005) and his ideas on the reproduction of culture, cultural methodology, reflexivity has appealed to researchers conceptualizing health care practice (Angus, Hodnett, and O'Brien-Pallas 2003; Hall 2004; Lumme-Sandt and Virtanen 2002). Overall, his concepts have been increasingly used by researchers to provide an alternate understanding of nursing culture and practice (Aléx and Hammarström 2008; Anderson et al. 2007; Angus et al. 2005; Hall 2004; Huppatz 2006).

The ethnographic study of satellite dialysis nurses' perceptions is the study of their culture and this culture is not immune to broader societal influences. The satellite dialysis nursing culture is a micro culture within a macro world (Bourdieu 1993). Bourdieu attempted to bridge the macro with micro cultures (Bourdieu 1977) and his notion of habitus was his attempt to bring the social into a micro field. He theorised that capital from the social field can influence habitus, which in turn can contribute to the reproduction of practice (Bourdieu and Johnson 1993). These concepts are explored in greater detail here.

3.5.1 Habitus and field

Bourdieu's habitus was developed in his attempt to "bridge the gap between agency (individual's dispositions) and structure (institutional conditions)" (Bourdieu 1990 p.63). Habitus referred to people's embodied behaviours or tendencies (motivations, preferences, tastes and emotions) which reproduce practices by a particular group (Bourdieu 1977). When a person without experience in a particular field enters that

field, habitus describes how the "novice insensibly and unconsciously acquires the principles of the 'art' and the "art of living in the field" (Bourdieu 1977 p.88).

Field and habitus are two related concepts. Bourdieu's field describes domains of social life such as arts, industry, law, medicine and politics (Bourdieu 1993). The field has an influence on habitus and habitus cannot be present without the field. The complexity of habitus that Bourdieu offers is that it is linked to system inequalities i.e. power and class (Bourdieu 1977), and such inequalities reproduce practice and reinforce the subordinate or dominant positions in the field.

Bourdieu's notion of field is a "series of structures, institutions, authorities and activities, all of which relate to people acting within the field" (Rhynas 2005 p.181). Thus the field can take the form of "partially independent regions of social activity" (Prior 2000 p.142). It can be explained by what happens within the field, which is made up of forces and influences (Harker 1990). Bourdieu uses the examples of an investment banker who has investment sense or the sportsman who has a feel for the game. The field is the feel and habitus is the game (Bourdieu 1990). Members in the field perform "sensible practices, linked intelligibly to the conditions of their enactment, and also among themselves, and therefore immediately filled with sense and rationality for every individual who has the feel for the game" (Bourdieu 1990 p.66). However, not all members or agents are equal in the field and this is where Bourdieu incorporates the concepts of capital.

3.5.2 Capital

Bourdieu's concept of capital is crucial in informing the concepts of field and habitus. Bourdieu and Wacquant (1992) stressed that capital only exists in relation to a field. Field in this sense is a "structured system of social positions…a structured

system of force or power relations" (Williams 1995 p.587). This definition of field is useful to explore Bourdieu's four forms of capital: economic, cultural, social and symbolic capital (Bourdieu 1986). He has furthered Marx's notion of economic capital proposing the concepts of cultural and social capital in order to understand power relations in a field (Swartz 1997).

3.5.3 Economic capital

Bourdieu acknowledged the importance of economic capital compared to other forms of capital. He commented that intellectuals "are dominated by those who hold political and economic power" (Bourdieu 1990 p.145). In addition, he proposed that economic capital is more stable and universal than cultural capital (Bourdieu 1986, 1987). His notion of economic capital was based around the Marxist notion that those who had more economic and material capital ruled in their own interests (Bourdieu and Boltanski 1976; Marx and Engels 1848).

Although Bourdieu's contribution had Marxist origins, Bourdieu attempted to further understand capital by explaining the relationship between cultural capital and economic capital. Examples of how they were related involved citing the great cathedrals and university buildings as obvious traces of the cultural and economic capital power matrix (Bourdieu, Chamboredon, and Passeron 1991; Bourdieu 1993). He argued that individuals can easily convert cultural capital into economic capital, and thus those who are culturally rich may not be critical and encourage change despite possibly coming from a poor economic background (Bourdieu 1998). In addition, he argued that business bourgeoisie maintain their power through the conversion of economic capital back to cultural capital in academe (Bourdieu and Passeron 1979).

3.5.3.1 Cultural capital

The notion of cultural capital, more recently described as "informational capital" (Bourdieu and Wacquant 1992 p.19), was Bourdieu's attempt to challenge the notion that academic success was simply "intelligence or giftedness" (Swartz 1997 p.76). Cultural capital "developed in childhood through the social milieu, the family and household, rather than formal teaching and learning" (Reed-Danahay 2005 p.46). It can include dimensions such as knowledge of art and culture, cultural tastes, formal qualifications, cultural know how and discriminating taste between good and bad (Smith 2001 p.137). Thus each employee brings their own individual cultural capital to their workplace. The more cultural capital they possess the more dominant they may be.

Bourdieu proposed that cultural capital exists in three different states: cultivated dispositions, objectified forms and institutionalised forms (Bourdieu 1986, 1984). Firstly, cultivated dispositions related to the Marxist notion of class where a child from a privileged family has a high level of cultural capital. This was demonstrated by the way they speak and write which in turn are rewarded in school (Bourdieu 1989). This cultural capital was viewed in a broader sense through the choice of spouse, friends or company's hiring practices (Bourdieu 1984) thus reinforcing the individual's cultural capital. Elias (1978) argued that these cultivated dispositions (in the form of manners) have changed through history with notions such as self-control and self restraint are appealing characteristics. Related to nursing, a nurse with higher levels of cultivated dispositions may be more likely to be in an influential position in the habitus of their workplace.

Secondly, objectified forms are those objects that take certain cultural abilities to use such as high level art, books and technology (to a point) (Swartz 1997). The third

form of cultural capital, institutionalised capital, has the potential to inform the understanding of some changes in the wider healthcare and nursing profession that have an impact on practice in the satellite nursing environment. The institutions have "create[d] the person" (Bourdieu 1990 p.185) by giving them a title, "they (the institution) summon him to become what he is, or rather, what he has to be; they order him to fulfill his function" (Bourdieu p.185). The title given provides high institutionalised capital.

3.5.3.2 Symbolic and social capital

Social capital is Bourdieu's attempt to incorporate the notion of capital related to acquaintances and networks (family, friends, peer groups, school, community organisations) (Bourdieu 1986 p.243; Swartz 1997 p.74). Social capital can "provide actual or potential support and access to valued resources" and can be a tool to reproduce practices to maintain the dominant class (Bourdieu 1993 p.143). The support and valued resources may be in the form of a safe place to live, a job or entry into university (Allard 2005).

Importantly, clarification of the term social capital is required here as it has been used to denote alternate meanings to Bourdieu's social capital and can be traced from its theoretical origins in the nineteenth century (Hofmeyer 2002). The term social capital has been used to denote the family's positive social control to advance children's prospects using notions such as trust, norms, reciprocity and civic responsibility (Coleman 1988; Dika and Singh 2002). This has been developed with a community focus rather than individual application by Putnam (2000) who differs from Bourdieu's individual application of social capital. Bourdieu's notion of social capital commits to individual agency rather than community concept of social capital. Bourdieu has suggested that social capital is influenced by "the logic of

knowledge and acknowledgement that it always functions as symbolic capital" (Bourdieu 1986p.257). Thus, when the term symbolic capital is used in this thesis it will be incorporating social capital.

Bourdieu's concept of symbolic capital was originally developed to explain the cultural recognition of an artist in contrast to an artist who simply does it for the money (Fowler 2000 p.7). Importantly for this study, this notion of symbolic capital can be applied to any practice. Bourdieu has suggested that other macro fields influence the micro culture discourse through cultural capital (Bourdieu 1986). Therefore, there is the potential for capital (economic, cultural and symbolic) to influence any culture including the satellite haemodialysis culture.

3.6 Chapter summary

This chapter has demonstrated the critical theoretical approach underpinning this study. It has described the methodology used to explore and understand satellite dialysis nurses' perceptions of quality, and the critical approach required to achieve the aim of this study. The critical theory section of this chapter has addressed five principles of using the critical approach (Berman, Ford-Gilboe, and Campbell 1998). These principles aim to address the disempowerment of an oppressed group and emancipate this group; examined the researcher's biases; critiqued why bias can distort existing knowledge, and respected the expertise of the research participants (Berman, Ford-Gilboe, and Campbell 1998). The critical ethnographic approach used in this study focused on interviewing, listening and sensitively challenging participants' perceptions. This enabled direct and appropriate feedback to encourage an alternate participant view and hence, encourage enlightenment of the nurse participants.

Theories and ideas of Pierre Bourdieu, habitus, field, practice and capital have been introduced to assist in providing an alternate understanding of how to reveal the perceptions of nurses in relation to quality nursing care in the satellite dialysis context.

Quality in the satellite dialysis culture is a concept that is dynamic and influenced by people in and out of the immediate context. Therefore, my approach to this study was to use critical ethnographic methods of observation to inform interview, semi-structured interview, document analysis and reflexivity. These methods will be described in detail in the next chapter.

CHAPTER 4

METHODS: CRITICAL ETHNOGRAPHIC APPROACHES TO DATA COLLECTION, ANALYSIS AND INTERPRETATION

4.1 Introduction

The previous chapter provided the methodological approach to this study. It argued that the study required a critical ethnographic methodology to achieve the study's goals: to better understand the culture of this group and explore issues of power to create the conditions for change.

Methods, as opposed to methodology, describe the techniques for data collection and analysis (Daly 2003). Although there have been various techniques, or methods, used in critical ethnography, there are traditions in methods that critical ethnographies follow (Thomas 1993; Soyini Madison 2005). These methods are observation, interview, reflexivity and document analysis.

In this study, privilege was given to nurse participant interviews because the focus was on the nurses' perceptions and perceptions are difficult to observe. Therefore, the majority of this chapter is focused on aspects regarding the data collection and analysis of the nurse interviews. Data collection aspects consist of the setting, the participants' characteristics, sampling techniques, and recruitment processes. Interview techniques, including the use of observation and document analysis to inform the interviews, are presented.

Ethical considerations for this study, based on the National Statement on Ethical Conduct in Human Research (National Health and Medical Council and Australian Research Council 2007) are presented detailing aspects of research merit, integrity,

justice, beneficence and respect. Ethical issues that guided data storage are detailed followed by analysis of power and political ethical considerations related to my role as nurse and nurse researcher.

Data collection methods detailing the preparation for entering the field, data collection methods through to leaving the field are described followed by a description and justification of data analysis framework and methods used in this study. Aspects of rigour: auditability, participant and colleague review, study replication, reflection and reflexive consistent with the critical ethnographic approach are presented.

4.2 The setting

The setting was a satellite haemodialysis unit attached to an outer suburban metropolitan hospital. The unit was physically located in the grounds of the hospital (Figure 4.1) however, medical services were provided by a different hospital where specialist nephrology services were provided. Therefore, this unit met the criteria of a satellite haemodialysis unit as defined by Agar et al. (2007). The term satellite applies to a lower acuity type of service where cost efficiencies are achieved through having less staff, and in some satellite units, increased patient self-care. The general premise is that patients who are not medically stable are dialysed in hospital dialysis units and medically stable patients are dialysed in a satellite dialysis unit. Therefore, a further defining difference between satellite and hospital dialysis is the level of support (medical, nephrology, nursing, allied health) immediately available to the patient (Agar, MacGregor, and Blagg 2007; Wellard and Bethune 2000).

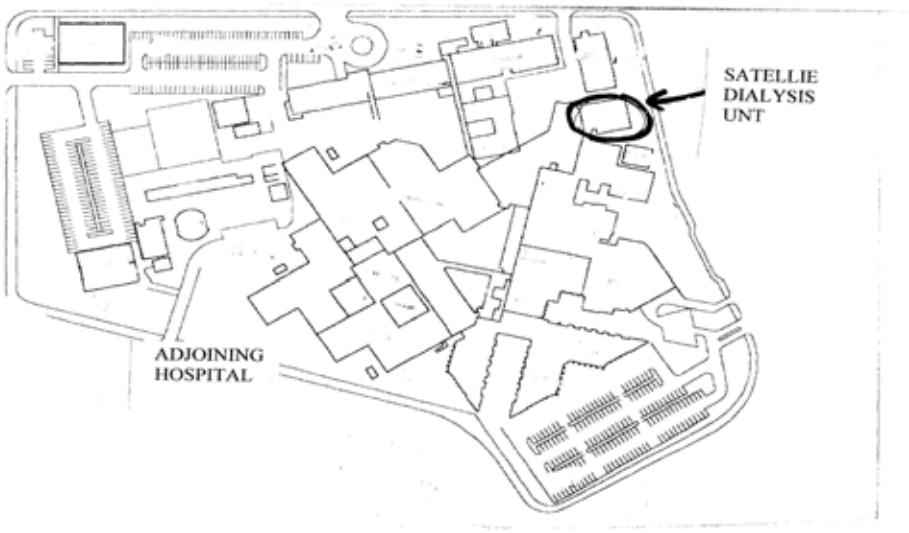

Figure 4.1: Location of Renal Dialysis Unit within Hospital

(From Field Notes # 1.1.3)

The satellite haemodialysis unit was physically separated from the main section of the hospital, equivalent to an annex of the hospital. The unit comprised a large treatment room (25m x 10m) containing 10 haemodialysis stations. Each station was approximately 3m x 3m made up of one haemodialysis machine, one treatment chair, one garbage bin and one small chair. Above each chair was one television. Within the main dialysis treatment room there was an open console area, used as the nurses' office, a patient waiting room, a Nurse Unit Manager's office, a staff tea room (which doubled as a meeting room), a store room, a machine maintenance room (which doubled as the interview room for this study) and a water treatment plant room (Figures 4.2 and 4.3).

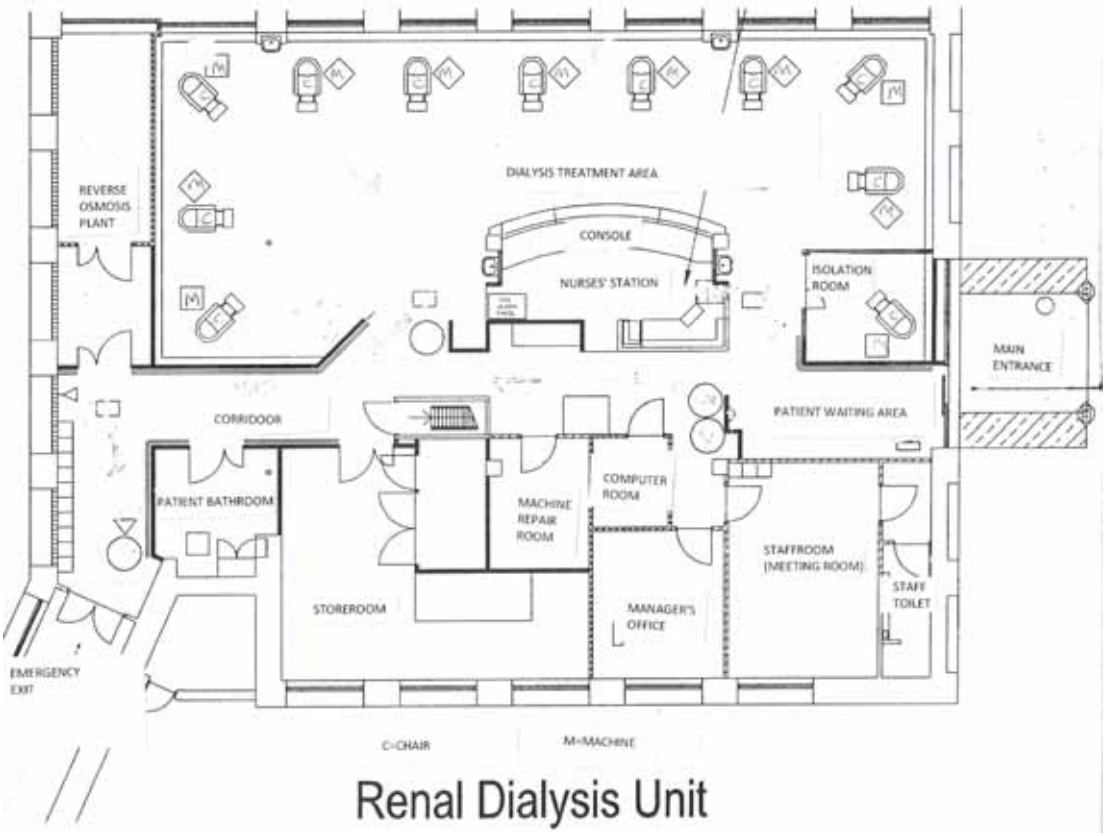

Figure 4.2: Satellite Dialysis Unit (From Field Notes #1.1.2)

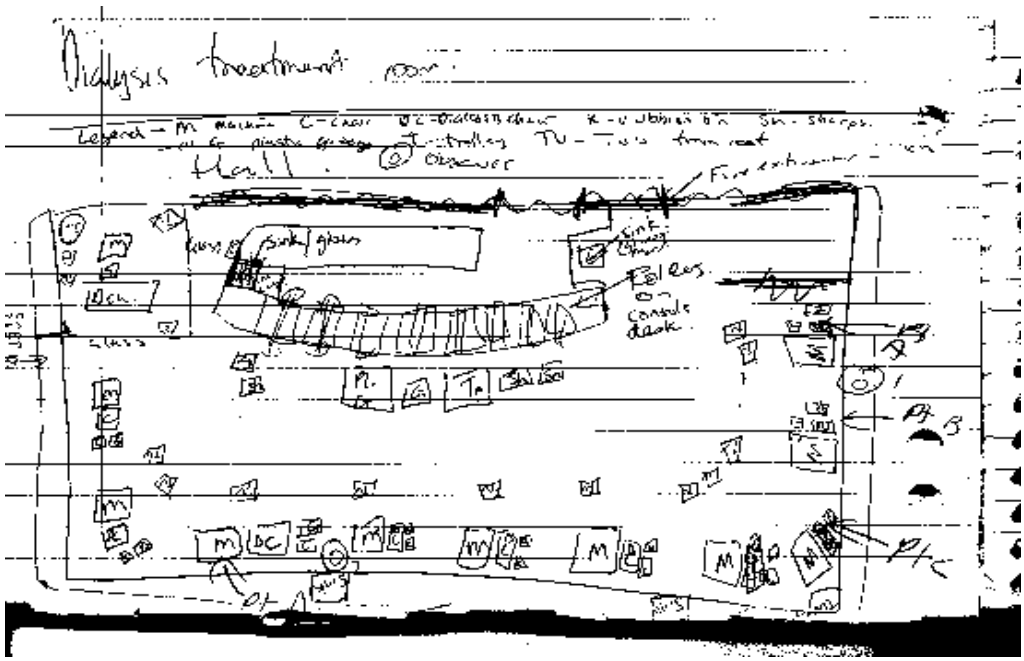

Figure 4.3: Satellite Dialysis Treatment Room (From Field Notes #1.1.1.)

The satellite haemodialysis unit was a publicly-funded dialysis unit. The core activity of the satellite unit in this study was to provide haemodialysis for people who did not require dialysis in a tertiary hospital: ie they were medically stable and did not require significant nephrologist involvement in their day to day medical care. At the commencement of fieldwork for this study the unit had been operating for two years.

4.3 Participants

The participants in this study were satellite haemodialysis nurses and the people receiving haemodialysis treatment. The satellite haemodialysis nurses were the main focus of the study. Eight out of a possible twelve haemodialysis nurses consented to participate in both observation and interviews. These nurses varied from having less than one year experience to fifteen years experience in haemodialysis nursing. Five of the participant nurses had worked in acute hospital haemodialysis units, two nurses had worked in other satellite units prior to working in the unit and one nurse had not worked in another dialysis unit. There were six registered nurses, who had received three years nurse education, one of whom was the nurse unit manager and there were two were enrolled nurses, who received one year hospital-based education. Four registered nurses had university baccalaureate degrees, one had a master's degree and the other two had diplomas. There were seven females and one male nurse. Ages ranged from twenty seven to forty six years of age.

The focus of the study was on the nurses' perceptions and thus the focus of the observation and interviews were on the eight dialysis nurses. However, in addition to the eight nurses, people receiving dialysis treatment, relatives and friends were also observed. Health professionals (one podiatrist, one counselor and one nephrologist) were also observed in this fieldwork.

4.3.1 Sampling

Purposive sampling of the nurse participants was fundamental to the critical approach of this study. The purposive sampling was undertaken through a two step process which involved the researcher selecting participants who would be able to provide the desired information (Minichiello et al. 2004; National Health and Medical Council and Australian Research Council 2007).

The first step involved choosing a satellite dialysis unit that met the Agar et al. (2007) criteria for defining a satellite haemodialysis unit. The satellite unit chosen was one that met these criteria and was situated within the metropolitan area of an Australian city. The second involved choosing the nurse participants who were the focus of the study. Purposive sampling was justified because the satellite dialysis nurses were the "informants who are most likely to possess an insider's knowledge of the research domain" (Thomas 1993 p.37). The satellite dialysis nurses have the most influence on the care provided in the satellite dialysis context and were the pivotal participants and the focus of the observations and interviews in this study.

The aforementioned incidental participants (people receiving dialysis treatment, allied health workers, nephrologist) who were not the focus of this study (Minichiello et al. 2004) were observed during observation periods. Incidental participation refers to those who contributed to the study but were not the focus of this study.

4.3.2 Recruitment

Once the satellite haemodialysis unit had been chosen, formal approval was requested and received from the nursing department head (Appendix A). This was followed with an information session to staff and people receiving dialysis treatment who were potential participants. Following this, information sheets (Appendix B),

letters of introduction (Appendix C, D) and consent forms (Appendix E, F, G) were left on site for those who wished to participate. This process, known as third party recruitment (Peel et al. 2006) was coordinated by the nurse unit manager of the satellite dialysis unit.

In addition to formal recruitment procedures for the nurse participants, recruitment procedures for the patient participants were undertaken. Although previously described as incidental, and not the focus of the study, the patient participants were prominent during periods of observation of the nurses. Therefore, the patients who attended dialysis on the days that the observation fieldwork was undertaken were formally invited to participate, which involved the same consent processes as the nurse participants.

4.4 Methods

Critical ethnographic methods were used to source the data that held the most relevance to the topic, which "ultimately provides meaning that shape [s] the analysis" (Thomas 1993 p.37). The aim to explore and understand satellite dialysis nurses' perceptions of quality highlighted the importance of the data sourced from nurse interviews as the most relevant data. This is consistent with Thomas' recommendations where he placed great emphases on the interviews and interview processes (Thomas 1993). As a consequence non-participant observation to inform interviews, semi-structured interviews, document analysis and reflexivity were data sources, with an emphasis on the interviews as the major data sources.

4.4.1 Observation to inform interviews

Ethnographic observation can be undertaken using structured, semi-structured, unstructured, participatory or non-participatory methods (Taylor, Kermode, and Roberts 2006). In this study each observation period was used to gather data to inform and stimulate discussion for the interviews that followed, and thus, I chose to be semi-structured and non-participatory in my observation technique (Kellehear 1993). Semi-structured observation involved structured periods, focusing on one nurse's activities. Although these were structured periods, the field notes were unstructured and consisted of focusing on the nurses, writing all that I could write about the activities that the nurse performed, including what the nurse said, what they did, and the context in which these activities occurred.

Non-participatory observation was chosen because if participatory and conducting my own nursing practice while also attempting to observe nurses, I would not have been able to focus on each nurse, thus making it difficult to identify quality-related aspects that could be further explored in the interviews. For example, during the observation periods I chose not to address or question the nurses' practice in front of other nurses or in front of people receiving dialysis treatment. Thus, the intention was to reduce what Kellehear describes as "participant reactivity" (Kellehear 1993 p.135). If I had questioned the nurses' practice, it may have caused a negative reaction from the nurses who may have resented me observing them, decreasing the rapport that was vital for the interviews that were to follow. By taking a non-participatory approach, where the goal was for the nurse to forget that I was present, enabled observation of nurse participants in their every day practice.

The observations took place over a period of five months from March to July, 2005. The observation periods lasted 60 to 120 minutes each. Each nurse participant was

observed on three separate occasions during both busy and quiet times. The busy periods were when the nurses were 'putting on' or 'taking off' people who required dialysis. These were the peak activity times in a satellite dialysis unit where most nurse/patient interaction occurred. Quiet times were all other times. The choice of various observation times was consistent with other qualitative studies of dialysis units (Ashwanden 2003; Bonner 2001; Ellingson 2007).

In addition to the observation of satellite dialysis nurses to inform the interviews, observation of the nurses during frequently held meetings was undertaken. These meetings were nursing handover and patient progress teleconference meetings with the nephrologists from the parent hospital. In addition, permission was granted to be present at one staff support meeting, which was held following a patient complaint. Overall there were twenty seven periods of observation culminating in forty eight hours of observation. All observations took place in the one satellite dialysis unit.

Observations were hand-written in all twenty seven observation periods. Following the observation periods I transcribed the notes and expanded them to typed field notes usually on the day of, or the day after, observation. The transcribed field notes totalled 41,064 words in 177 double-spaced, typed pages. During transcription of my hand-written field-notes attempts were made to identify aspects related to quality, nursing practice and power relations.

During the observation periods, interactions with others, particularly people receiving dialysis treatment, were observed and recorded. The ten people who were observed received dialysis three times per week on Tuesdays, Thursdays and Saturdays. There were five males and five females, all of whom spoke English and all did not identify themselves as Aboriginal or Torres Strait Islanders (ATSI). It is important to note that ATSI Australians have a 21 times age adjusted higher rate of

CKD than ATSI Australians (Hoy et al. 1998) and make up 10% of the total ESKD population in Australia (McDonald and Excell 2008). Thus, the people receiving dialysis treatment participating in this study may not reflect the composition of other Australian dialysis units who may have higher proportions of ATSI people.

Although not the focus of the study, patient/nurse interactions during these observations were stimuli for questions relating to perceptions of quality that were asked during the interviews. An example of this was observing the nursing care provided for a patient whose blood pressure had dropped (*FN 24/5 #15*).This episode was used to stimulate discussion in the interviews that followed regarding aspects of quality care during patient hypotensive episodes.

In addition to aspects of quality and nursing care aspects of power relations were documented and acted as catalysts for questions in the interviews. For example, each morning the nurses' pressed a button that opened the doors of the unit. There were usually approximately five people waiting at the door, unable to enter until the nurse had given them permission (*FN 22/3 #3*). This was then discussed in nurse interviews where the nurses justified their control over the entrance of patients even though the nurses were aware that the patients may have been uncomfortably hot or cold out in the elements (*Drew 22/3 #1815).* Thus, observation periods immediately before the interviews were particularly valuable to inform the interviews as they provided rich and very recent examples of care on which to draw on during the interviews.

4.4.2 Interview

The interviews consisted of two interviews with each of the eight nurses with each interview lasting approximately one hour. Thus a total of sixteen interviews lasting a

total of approximately sixteen hours were undertaken. Interviews were audio-taped with the transcription of the interviews yielding 129,408 words equal to 557 double-spaced pages. Prior to each interview I emphasised that the interview data was confidential and would not be able to identify the participant. I stated that the participant could stop the audiotape at any stage if they felt they wanted to. In addition, at the commencement of each interview, I repeated that at any time during the interview or study process they could withdraw from the research study. No participants withdrew from the study. Following each interview, I transcribed the data word for word using a modified version of Waitzkin's (1990) transcription process. , The modification involving transcription by the researcher rather than external and/or multiple transcribers, enhanced analysis of the content and identification of aspects related to and influencing quality.

The method of interviewing was semi-structured. Bourdieu's (1996) and Thomas' (1993) approaches that privileged the identification of power relations between the researcher and research participants was influential. This placed a priority on the interviewer to be mindful of the perceived power relations between interviewer and interviewee. In addition, following interview transcription, notes were entered about my own experience of interviewing and reflected on how the interviewer and nurse participant related to each other. For example:

> *This nurse called me a researcher and therapist. (She) saw me as someone with the answers and someone who will find out the answers and report back with some information. (FN 5/4 #204)*

This was an example of my reflections of one interview where the nurse participant had described my role and her expectations of my responsibilities as a researcher.

This process was undertaken to ensure power issues related to the interview process were identified and acknowledged.

The interview questions were based on those found in Appendix H even though my aim was to achieve a "conversational partnership" (Rubin and Rubin 1995 p.30). This included what Bourdieu calls 'active and methodological listening' (Bourdieu 1996 p.19). Bourdieu related his recommendations on interviewing with his epistemology:

> …this craft is a real 'disposition to pursue truth' (*hexis tou aletheuein*, as Aristotle says in his *Metaphysics*), which enables one to improvise on the spot, in the pressing situation of the interview, strategies of self-presentation and adaptive responses, encouragement and opportune questions, etc., in such a manner as to help the research respondent give up her truth or, rather, to be delivered to her truth. (Bourdieu 1996 p.30)

Thus, my goal was to encourage each nurse to affirm their own perceptions of what their own truth was related to satellite dialysis quality. Prompts, paraphrasing and repeated questioning encouraged nurses to affirm or challenge their own perceptions. Subsequently, the interview approach was flexible and improvisational in order to increase my chances of encouraging the participants to clarify their own perceptions of aspects related to quality dialysis nursing care.

The first interview with each nurse was undertaken within four hours after the nurse was observed. The closeness of the observation and interview was to encourage clear recall of any events that may have occurred that day. Each first interview was transcribed within two days of interview and returned to the participants who confirmed in writing the accuracy of the transcript. Following the transcription of each first interview a series of questions were developed for each nurse for the subsequent second interview to further explore aspects of quality and power that

were identified from each nurses' individual first interview. These questions contributed to a relaxed conversational second interview which enabled us to engage in discussions relating to aspects of satellite dialysis quality. This was highly successful given the honesty and candid comments of the nurses.

4.4.3 Document analysis

Document analysis has been used in ethnographies exploring micro-cultures (such as a satellite haemodialysis setting) however research has mainly been focused on data emanating from the spoken interview and the ethnographic observation (de Laine 1997). The critical ethnographer explores the production of the documents (procedures, policies) and the use of these documents by practitioners (Hammersley and Atkinson 1995) and ethnographic data sources "…can include a person, a group, documents or any other artifact that embodies cultural meanings" (Thomas 1993 p. 38). Thus document analysis was undertaken in order to explore quality aspects of the satellite dialysis nursing culture.

In this study documents were analysed and tabulated using Miller's (1997) criteria of understanding how and why the documents were produced and how they linked to other sources of data: interview and observation. In addition the documents relevance to quality satellite dialysis nursing care were analysed. For example, the daily diary was used on a regular basis to facilitate communication from one shift to the next. Nurses were observed frequently checking the diary throughout the shift and, during the interviews, nurses stated that communication was an important part of quality care and that the daily diary was used to write patient care information, such as when blood tests were required. The daily diary was produced by the nurse unit manager, with communication entries most frequently being documented by senior nurses. It was used in the wielding of power when communications to facilitate the following

of orders. Thus, the daily diary and its use was an example of a document related to quality care in practice (from the interviews with the nurses) and was an example of how quality was practiced and who influenced these practices. Therefore, although document analysis was not the major source of data in this study it did contribute when analysed in relation to interviews and observations in exploring quality satellite dialysis nursing care (Appendix I).

4.5 Ethical standards guiding this study

This study was guided by the National Statement on Ethical Conduct in Human Research (National Health and Medical Council and Australian Research Council 2007) because it comes under the definition of human research as described in the National Statement (p.8). Approval was granted for by the Flinders University's Social and Behavioural Ethics Committee (SBREC) (Appendix J) and the health care facility's institutional ethics committee (Appendix K). The guiding principles of research merit, integrity, justice, beneficence and respect (National Health and Medical Council and Australian Research Council 2007 pp.12-13) were adhered to throughout the study.

4.5.1 Research merit and integrity

The study has research merit because it contributes to new and alternate understandings of nurses' perceptions of quality in the satellite dialysis context using methods appropriate to the goals and aims of the research study, is based on a thorough examination of current literature, has been supervised by four academically qualified supervisors and has been supported by peer review through the production of peer-reviewed publications and conference presentations (see Page xiv). Thus it

has been consistent with the guidelines addressing research merit (National Health and Medical Council and Australian Research Council 2007).

This study has been performed with integrity in its search for new knowledge and understanding. The study has followed recognised principles of critical ethnography in an honest and transparent manner and has provided results that facilitate scrutiny of the methods used as indicated by the guidelines for research integrity (National Health and Medical Council and Australian Research Council 2007).

4.5.2 Justice

The ethical principle of justice is interpreted in this study as fairness (Kerridge, Lowe, and McPhee 2006). Justice as fairness in research promotes just selection and exclusion processes, ensures no unfair burden on, or exploitation of, the research participants and supports the fair distribution of benefits of the research (National Health and Medical Council and Australian Research Council 2007). This study has previously detailed the sampling selection processes undertaken and, although the process was purposive, all nursing staff in the satellite haemodialysis unit were invited to be participants in the study. The eight participants provided sufficient data for new knowledge and understanding, and provided results for a broader audience. In particular results in this study may be valuable in, and transferable to, other satellite dialysis contexts.

This study has not knowingly unfairly burdened or exploited any participant in the study. At no time in the study were participants required to undertake any work out of their normal hours. All processes including pre-entry (education, information and consent), fieldwork (observation and interview) and post-fieldwork (transcription

accuracy checks, informal and formal feedback sessions, results presentation) were all undertaken in the participants' normal working hours.

4.5.3 Beneficence

Beneficence, defined as "doing good to others", is a fundamental ethical priority of human research (National Health and Medical Council and Australian Research Council 2007 p.99). This principle was addressed in the methodological considerations of this study when describing the absolute requirement for beneficent outcomes for those participants in this study with perceived powerlessness (see Section 3.3.2). Although nurses may feel powerless at times, this study aimed to identify hidden power aspects. By identifying these aspects participants may feel empowered to improve practice in order to benefit patient outcomes. Therefore, the study can be beneficial for both nurses and people receiving dialysis treatment.

To ensure beneficence and the associated ethical principle of non-maleficence, or avoiding harm, were upheld, processes to ensure dialysis unit and participant anonymity was adhered to. To ensure anonymity no identifying the name of the satellite dialysis unit, its location or major characteristics are stated. To ensure anonymity of nurse and patient participants all names have been changed and no identifying characteristics of individuals have been included in this thesis. All electronic and written data storage requirements (National Health and Medical Council and Australian Research Council 2007) have been adhered to ensure anonymity of participants and unit.

4.5.4 Respect

Respect for participants is an overarching research principle that recognises integrity, justice and beneficence "with regard for the welfare, beliefs and perceptions" of

participants involved in the research (National Health and Medical Council and Australian Research Council 2007 p.13). As applied to the methods in this research study the principal of respect was upheld ensuring informed consent was achieved.

Individual consent was received from each nurse who participated and each patient who had the potential to be observed during fieldwork. The consent process for the nurse participants commenced before the study with two group education sessions with an accompanying information sheet (Appendix B) that was distributed to all potential participants, followed by an invitation to participate. If a nurse volunteered to participate they replied to the nurse unit manager who passed on their name and contact details to me. I then organised an appointment with the participant within one week of receiving this message where I explained the research process and the consent process. This appointment included advising the participant that they were able to withdraw at any time and gave details of professional support in the event that the participant became distressed or requested to withdraw. The participant was provided with two consent forms: one to consent for observation and one for interview (Appendix F,G). The consent forms were given to the nurse participants to consider for two days. If they were still willing to consent to participate the nurse signed each consent form and sent them to me by mail.

The consent process for the patient participants was equivalent to the nurse participant process except that they only consented to observation and not interview (Appendix E). Therefore, they were provided with only one information sheet and one consent form. The patient participants were given two days to evaluate their participation and returned the consent form to me by mail. Each patient participant was encouraged to discuss the information provided with their families or significant friends to ensure they felt comfortable to participate. All ten people receiving dialysis treatment, who were dialysed at the times of nurse observation, agreed to be

participants and returned the signed consent forms. As with the nurse participants it was reaffirmed that people receiving dialysis treatment could ask the observation to be stopped at any time and that they could withdraw at any time from the session or the research without prejudice.

4.5.5 Data storage

Respect for the research participants included issues of anonymity and confidentiality related to data storage. Data consisted of observation transcripts and associated field notes, journal notes, digital audio tape files and computer files. Observation transcripts, field notes and journal notes were kept both in original hand-written copy in three folders and transcribed into word files onto a secure workplace computer. These folders were kept in locked cupboards in a locked office during the study period. The interviews were audio taped using a digital voice recorder. Either the day of each interview or the following day each interview was downloaded to my work computer, which was in a locked room and password protected. The interview would then be deleted from the digital audiotape recorder. Following completion of the study, each interview was downloaded from this computer to external storage discs as transcribed interview word files.

Following completion of the study all data, associated files was transferred to external storage discs. Folders and discs are stored in the Confidential Data Storage Facility at the School of Nursing and Midwifery, Flinders University of South Australia and will remain there for five years.

4.6 Power and political considerations

Philosophical and methodological aspects of power relations are addressed in other sections of this thesis (Chapter 3), however, it is also important to address these under ethical considerations related to methods. Ethical considerations are related to power relation aspects such as capital (see Section 3.5)and gender (see Section 3.3.7) that influence ethnographic methods (Aléx and Hammarström 2008). Therefore, an examination of power that may influence the fieldwork was an important undertaking. In saying this, the study did not allow unequal power relations to misrepresent the nurses' perceptions of quality as the overall aim was to provide new understandings and an alternate view of quality in this context.

My past relationship with each nurse was examined. Three of the nurse participants had been dialysis nurses in a dialysis unit that I had managed over ten years ago. Two other nurse participants I had worked with as a colleague in the past five years, one was equal in the hierarchical structure and one was an Enrolled Nurse whom I assisted when she was new to haemodialysis nursing. One other nurse I knew through being at meetings and conferences together. Two remaining nurse participants I had not met before. Therefore I had past working relationships with six out of eight participants.

In addition to my previous working relationships, I held two professional positions throughout the duration of this study. I was the Research Coordinator of the Renal Society of Australasia and the Editor of the peer reviewed journal for this group. In addition I was also a nurse lecturer who had provided lectures to a majority of the nurse participants. For these reasons I was aware that I may be seen as a nurse who had the resources (academic, institutional) to hold significant cultural capital

(Bourdieu 1986) in relation to the nurse participants, which may have resulted in influencing their responses both during observation and interviews.

Given the above history minimisation of perceived power relation differences was a priority, even though it was difficult to deny my accumulated cultural capital. Therefore, when undertaking fieldwork I would dress in casual clothes, usually jeans and shirt in an attempt to relax the participants and encourage them to treat me as a researcher rather than a previous manager. In addition, I chose to be a non-participant observer. This was because I needed to gain the rapport and trust of the nurses in the data collection fieldwork stage rather than critique their practice, which may have led to hostility towards me as a researcher which, may have led to participants withdrawing from the study.

4.7 Data collection

One satellite haemodialysis unit was required to undertake the study. In critical ethnography it can be important to "focus tightly much sooner" (Thomas 1993 p.38) in order to understand, explore and critique perceptions that may or may not be "pre-patterned rhetoric that reflect[s] learned accounts" (Thomas 1993 p.38). Critical ethnographers explore beneath this pre-patterned rhetoric searching for political interests that uphold this knowledge. Thus, only one satellite unit was chosen in order to narrow down these features of culture enabling a greater depth of analysis in one unit rather than a more superficial study of many.

The challenge to choose the satellite dialysis unit for the study was problematic because of my past and current roles in nephrology nursing in South Australian and Australia. Ultimately, the unit chosen, was the unit that I had the least contact with

over the previous ten years. Once the unit had been chosen requested formal approval from head of department was achieved (Appendix A).

4.7.1 Observation

The observation process was informed by Kellehear (1993) and Soyini Madison (2005). While Soyini Madison (2005) has provided direction on bracketing observed populations, Kellehear (1993) recommended three major considerations that need to be acknowledged when deciding on ethnographers' observation techniques. The three considerations were: the researcher's role (passive, active, in-between); what and who were the focus of the observations, and what were the ways to collect the data.

The first consideration was the role of the researcher during observational periods. I chose not to actively participate during the observation period because it was the phase of establishing trust and rapport with the participants with the major aim of information-gathering to inform the interviews. Bourdieu furthers this notion of information gathering:

> …through the careful and considerate intentions which gave the respondent confidence in the research and help her enter the game, or by exclusion of inappropriate or misplaced questions, this preliminary process of information-gathering is what enables one to improvise pertinent questions, thus amounting effectively, to genuine hypothesis, based on a provisional and intuitive representation of the generative formula specific to the interviewee… (Bourdieu 1996 p.23).

The above quote provides guidance in the importance of gathering information from observation to inform the interview. The observation periods provided valuable contextual information that contributed to interview questions, which each participant could easily relate to. This process enabled me to elicit valuable perceptions of quality from the nurses and also contributed to building rapport with the nurse participants.

The choice to be a non-participant observer was an attempt to avoid major effects on the nurses' everyday practice. During observation I sat still, often behind the dialysis machines, wore dull coloured clothing, refrained from wearing cologne, and if people attempted to engage me in conversation I replied in mono-syllabic answers. Thus, I played a passive role as an observer in periods of observation attempting to allow the nurses to act in their most natural way.

The second consideration was what and who were the focus of my observation. This was linked to my initial study aim, which was to focus on the nurses' perception of quality. Thomas (1993) proposed that it is "crucial to identify the informants who are most likely to possess an insider's knowledge of the research domain" (p.37). Thus the focus was on the nurses' actions and responses during the observation period. In saying this I was cognisant of other incidental participants: people receiving dialysis treatment, carers, family, nephrologists and associated health professionals, who all had their own insider perspective.

The third consideration was the way the observation data was collected. I chose the focal method as described by Kellehear (1993) and observed the nurses at busy times, quiet times, handover and staff meetings. Thus, for each observation period I followed one nurse and recorded by hand, notes on all activities, conversations, actions and interactions. These strategies, modelled on those employed by

haemodialysis nurse researchers Bonner (2003) and Ashwanden (2003), were designed to maximise the full range of nursing activities, actions and interactions in a haemodialysis unit. The choice of these periods was also designed to explore the actions to an extent that may not be entirely possible through interview. For example, observation can uncover taken for granted routines or taken for granted power relations that may not be seen and thus may not be noticed if only using interview (Thomas 1993; Patton 2002).

I chose to write all I could regarding what I was observing throughout these periods: what people said, and my interpretations of their actions and behaviours. Kellehear's (1993) recommendations of focusing on the location's characteristics, the actors (participants), the duration and frequency of acts, language behaviour and relations between participants were followed. Following each observation period I re-read the hand-written notes and inserted my own comments related to quality and power relations. In addition, I added follow up questions that could used to probe the nurse during the interviews that followed the observations.

4.7.2 Interview

Early stages of observation and interview developed a mindful rapport (Soyini Madison 2005) through sustained encounters (Manias and Street 2001) with the participants. The early part of each interview was used to seek clarification of any issues related to the observation period. Following this, semi-structured questioning was used, commencing with demographic questions such as 'How long have you been working here?' and sensory questions such as 'How would you describe your experience in this unit?' Following these opening questions I attempted to include further focused questions such as 'What measures, and why they are important to quality care in satellite dialysis?'

Throughout the interviews, the list of questions (Appendix H) were turned face down so I could not read them. This was to encourage more of a conversation rather than a question and answer type interrogation. At the end of each interview (approximately one hour) the participant and I checked the list of questions together to see if they had all been addressed.

Following each interview a preliminary analysis was undertaken where I searched for data related to quality and related to power. I asked questions of the data such as: 'What is the relationship between nurses and nurses, and nurses and people receiving dialysis treatment? Who uses resources of power in these relationships? What is the language that the nurses are using? What is the relationship between nurse and quality?' These analyses contributed to my second interview where I could explore these aspects further. This process was informed by Thomas who stated "…one of the greatest skills of an ethnographic interviewer is the ability to identify and pursue follow-up questions" (Thomas 1993 p.40). Therefore, in each second interview I attempted to encourage a relaxed conversation style of interview to encourage open and honest responses from the nurse participants.

Following both first and second interviews I explained to each participant that if there was any further information that the nurse wanted to share they could contact me to discuss this, however, no participant took up this offer. Furthermore, following my manual transcription from audio tape to word document verbatim interview transcripts were given to each nurse participant to verify the accuracy of each transcript. Each nurse verified that the transcripts were accurate and signed the final part of the consent form to acknowledge the accuracy of the interview transcription.

There were strengths and weaknesses of the interview techniques used in this study. One weakness was that the interviewees had less informational capital, which may

have led to the nurse participants saying what they thought the interviewer wanted them to say. Thus the perceptions may not really be the perceptions of the nurse, but the perceptions of what the nurses believed the researcher wanted to hear. Interview strategies were put in place to minimise this by: relating much of the interview to the context of their own practice; using prompts and paraphrasing to reinforce or question the nurses' responses, and undertaking a review of each interview searching for examples of power relations that may have influenced the nurses' responses (Spradley 1979). By undertaking these strategies I was able to identify possible occasions where the nurse participants may have been only trying to tell me what they thought I wanted them to say.

The major strength of the interview method used in this study was the success in being able to penetrate the "deeper layers" (Manias and Street 2001 p.236) that influenced the nurses' perceptions. I was not simply exploring what the nurses perceived but what historical and cultural influences may have affected these perceptions. Using my clinical experience, which contributed somewhat to me being an 'accepted haemodialysis nurse insider', I could speak the dialysis nurses' language while at the same time explore the unrecognised power relation aspects. Therefore, I was able to explore what mattered to the nurses in relation to quality (Manias and Street 2000).

A further strength of the interview method used was that, in the second interview, I was able to return to some of the previous perceptions of the nurses and provide an alternate view. For example, on several occasions I was able to provide an alternate view of Kt/V or adequacy in relation to dialysis quality. In addition, I was in a position to provide the nurses with a further understanding of how their perceptions had been influenced. Nurses would consider these alternate views and respond

accordingly enabling the potential for them to change or influence outdated reproduced practices.

4.7.3 Document analysis

Following consent from the nurse unit manager who agreed that I could "…look at anything you want, excluding employee files" (*FN 24/4 #14)* I read all documents and reviewed commonly used databases that were relevant to exploring dimensions of quality. The documents and databases included those located in the patient treatment room such as patient medical records, daily treatment records, daily diary, communication book and the memo folder. Documents were also found in the nurse unit managers' office which included human resources policy folder, key performance indicator folder, hospital orientation folder, infection control folder and the clinical practice manual (Appendix I).

The source, production and use of each of the documents were tabulated. For example the 'Quality Management and Performance Improvement' policy document was written by the Clinical Governance Committee and provided a framework for quality improvement activities. On questioning the nurses about this document it was not used by either nurses in the clinical setting or by the nurse unit manager. A second example was the computer-based Clinical Information System (OACIS), developed by industry, doctors and nurses to provide efficient data management across all Adelaide dialysis units. This system was used frequently during the observation period by nurses to extract data and to input data. Although not at the forefront of my data I have provided elements of the document analysis where applicable to themes developed from the interviews.

4.7.4 Closing and leaving the field

The notion of 'closing and leaving the field' was interpreted in three different ways. Firstly, the end of the fieldwork, secondly, the end of the study (time to thesis submission), and finally, the notion that this will be a never ending study and this is only the beginning of a lifelong study.

Firstly, on completion of the twelve months of fieldwork, I organised a thank you afternoon tea for all participants. Only six of the nurses could attend but I felt it was important to acknowledge their important contribution to the study. Although data analysis had not been completed I presented some preliminary findings. Positive findings, for example, the high value that nurses placed on friendships and good interpersonal relationships were the focus of this presentation. It was not a time to be critical or negative in any way at this point of the study.

The second closure was at the completion of the study. In the final twelve months of the study I arranged two separate sessions with the nurse participants to present the major findings of my study. The first session was with the nurse unit manager and the second was with the nurse participants where my principal supervisor attended and wrote notes with the participants' consent. Both sessions were used to gain further feedback and confirm the findings of the study which contributed to the rigour of the initial findings.

Following these sessions I produced a one page summary and distributed this to the nurse participants. For both summaries I wrote in language that the nurses were able to understand which contributed to their synthesis of the study findings (Appendix L, M). It was a necessary part of my critical approach to inform the participants of the findings and clinical implications.

The third interpretation of leaving the field is that I will only ever leave the field when I retire, or pursue another career. However, I plan to be working in the dialysis field for the next twenty five years. Given my critical aims of producing an alternate view of quality and enhancing change in nursing practice, even if I were to leave the field, I hope to have provided a legacy that has resulted from this research including fieldwork, presentations and publications. This final interpretation of leaving the field suggests that it will occur in physical sense but not a critical sense, summed up by Thomas (1993 p.61) who stated "Critical thinking does not stop when a single research project ends, because it is a way of life".

4.8 Data analysis

The overriding contextual feature influencing data analysis was the focus on nurses' perceptions of technological measures of dialysis quality, such as Kt/V. For example, analysis of the nurses' perspectives informed by the view on imperfect measures such as Kt/V, required analysis of historical and cultural features of the nurses' perceptions. For example, how were these developed, what were the influences and who possessed the dominating cultural capital (Bourdieu 1986). Thus analysis was informed by a critical approach that the development of the perceptions of the nurses' regarding quality was influenced by power relations that were unequal in the satellite dialysis unit.

It was fundamental to this study to choose a method of analysis that would enhance the potential for power relations to become central to my analysis. Thus, qualitative coding methods proposed by Auerbach and Silverstein (2003) were used to analyse raw text, relevant text, repeating ideas, themes, through to theoretical constructs. N-Vivo software (QSR International 2005) was used in an initial effort to code for

power relation themes such as control, exploitation, technology and coercion. However, using this method I was overwhelmed by masses of data and unable to find meaningful ways of organizing and describing the power relations. Consequently, I chose to re-read the data (observation, interview and document analysis) and repeat the data analysis using a bottom-up coding method (Auerbach and Silverstein 2003) using N-Vivo software (QSR International 2005).

The bottom-up coding method consisted of identifying repeating ideas which were then developed into themes and then theoretical constructs (Auerbach and Silverstein 2003). Repeating ideas were defined as free nodes (QSR International 2005). In this study free nodes, or repeating ideas, are defined as a collection of references about a specific area of interest from interviews, observation or document sources (QSR International 2005). The full list of free nodes is found in Appendix N and an example of a node is shown in Table 4.1.

Table 4.1: 'Abusing the system'. Example of free node.

Free Node	Memo Link	Sources	References	Created By	Created On
Abusing the system	Yes	10	17	PNB	7/4/2006 11:25 AM

Table 4.1 lists the first node by alphabetical order, 'abusing the system', which was a repeating idea found in the interview transcripts. The first column 'free node' names the node. The second column 'memo link' identifies and links journal entry or entries entered that are related to the node. The third column 'sources' counts and links the amount of separate sources from the original transcripts that have contributed to this node, i e. one source is one distinct interview. The fourth column 'references' counts and links the total amount of times the node has been identified in the data which

means there can be more than one reference from a source. The final two columns identify the creator (PNB = Paul N Bennett) and the date and time the node was created. Therefore these nodes were a container for all data relating to repeating ideas. A de-identified example of all text contained in the free node 'abusing the system' is added as Appendix O.

The second step in data analysis was to categorise the free nodes into themes. These themes were used to organise related nodes to bring clarification to each node, or repeating idea. For example, 'abusing the system' was categorised under the theme of 'patient', and analysed with the related nodes of 'us and them', 'compliance' and 'difficult patient'. These themes are used as subheadings in chapters 5 and 6 to give the findings chapter's structure.

The third process of data analysis was to relate all themes that had been produced by the above analysis to the original objective of the fieldwork, which was to explore and understand the nurses' perceptions of quality. An example of fieldnotes using the 'abusing the system' node under the theme of patient was:

> *There is a sense that the nurse trying to give quality care is frustrated because of the behaviour of the patients on dialysis. Therefore, if the nurse observes the patient 'abusing the system' then the nurse questions their own practice. The nurse is frustrated that the quality care is wasted on the patient. Also refer to nodes: Compliance, Difficult Patient (NVivo <Memos\Relevance to Quality - Abusing the System>#19-10-06)*

The notes from this process demonstrate an interpretation of the relationship between the nurses' perceptions of the patient abusing the system and quality nursing care. This process was applied to all free nodes within all themes.

Three theoretical constructs developed from this process of relating nodes within themes to quality. The constructs were named ‘what is quality’, ‘what is not quality’ and ‘what influences quality’. This provided some organisation of the original free nodes and themes and a logical way to present the data findings in Chapters 5 and 6 resulting in a three level coding tree (Appendix P).

4.8.1 Coding in critical ethnography

The coding process needed to be consistent with a critical ethnographic approach. Subsequently, the coding process was also guided by Thomas’ traps to avoid and tricks to overcome while undertaking data analysis in critical ethnography (Thomas 1993 pp.61-70). Tricks and traps are summarised in Table 4.2.

Table 4.2: Tricks and Traps in Critical Ethnography. Adapted from Thomas, J. (1993). Doing Critical Ethnography pp.61-70

	Trap	**Trick**
1	Seeing only what serves our purpose	Avoid imposing meanings on data
2	Using conceptual clichés	Avoid buzzwords [buzzphrases]
3	Placing passion before science	Avoid ax grinding
4	Making claims beyond demonstrable evidence	Avoid overgeneralizing
5	Replacing reason with stridency	Avoid sledgehammers
6	Writing to the already committed	Remember the audience
7	Forgetting the ethnographic project	Appreciate difference
8	Taking ourselves as given	Discover reflexively who we are

An example of a trap that I fell into was my view that nurses in the dialysis context were heavily focused on the technological, which was the trap of "seeing only what served my purpose" (Thomas 1993 p.62). What I found was that the nurses did focus on some technology (dialysis machines, knowledge technology) but not on other technology (computer skills, literature search technology). Furthermore, there was a relative focus on both interpersonal and technical aspects of satellite dialysis nursing care. The 'trick' that I used to overcome this 'trap' was to focus on the opposite of my initial biases. Using the above example, my initial beliefs were that satellite nurses focused on the technological. To counter this I identified in the data non-technical aspects of care that the nurses' perceived was related to quality. This ensured that my own self-recognised bias was countered by my active consideration of other related aspects of each theme. Thus, this is an example of how the Thomas' framework guided my data analysis.

Overall, the methods of analysis that I used in this study (Auerbach and Silverstein 2003; Thomas 1993) contributed to the goal of critical ethnographical interpretation which was to "translate it into something new" (Thomas 1993 p.43). My interpretations attempted to reframe the mundane of satellite nursing quality care to provide something new, an alternate view.

4.9 Rigour

In qualitative research rigour has been defined as "fidelity to the spirit of qualitative work" (Sandelowski 1993 p.2) and can be applied to both the application of method and of interpretation in a qualitative study (Lincoln and Guba 2000). Classical qualitative criteria for rigour of credibility, transferability, applicability and dependability (Koch 1994) are taken into account in four criteria for consideration in

critical ethnography (Thomas 1993). The four criteria are: "auditability; participant and colleague review; study replication, and self-reflection" (Thomas 1993 p.39).

4.9.1 Auditability

In ethnographic research, auditability is a means of demonstrating trustworthiness by enabling another researcher to follow a decision trail that the researcher has used (de Laine 1997). However, complexities arise when this is applied to critical ethnography because the researcher is immersed in the research aiming for change. Therefore, although a decision trail can be followed, it is likely that a second researcher will provide a new interpretation because of their own critical point of view. In saying this, a detailed discussion of the interpretation is provided along with a model summarising the decision trail (Appendix Q). The decision trail starts at the beginning of the study, through to the final thesis write up.

In critical ethnography the importance of what is described as "accuracy of evidence" (Thomas 1993 p.39) is relevant to the audit trail. Accuracy of evidence is defined as the "accuracy of observing, recording and analyzing data" (Thomas 1993 p.39). Details of all decisions related to observations, recording and analyzing are provided. For example, the transcription of interview process involved a first listen, followed by digital download to my computer, followed by word for word transcription using the participants own words. Following this comparison with field notes taken throughout the interview (eg laughs hysterically, appeared very nervous) was undertaken. This was followed by my initial analysis looking for power relations, followed by analysis of repeating ideas (free nodes) where themes and theoretical constructs were identified related to satellite dialysis nurses' perceptions of quality. Meticulous accuracy has been followed in accurately reporting all data, and my own interpretations of the data, in an attempt to remain true to the aims of

critical research for the benefit of the research participants and the wider satellite dialysis community.

4.9.2 Participant and colleague review

Reading of drafts by participant and colleagues can contribute to the rigour of the study as it provides an opportunity to identify factual or conceptual errors (Thomas 1993). Therefore, I was active in receiving feedback from participants (nurses, patients, carers and nephrologist), through public presentations to peers and scholars, editorials, response letters and peer-reviewed publications (see Page xiv), and throughout the study from experienced renal professionals. Examples of feedback from presentations and publications in my field notes are:

> "Yeh, quality is more than Kt/V" *(FN 19/7/06 #10)*

> "What is the point of a Kt/V of over 1.7 when a patient is looking really sick?" *(FN 19/3/08 #105)*

These comments from senior dialysis nurse colleagues were recorded in my field notes. They reflected an emerging and alternate view related to power and quality in the satellite dialysis setting that confirmed the findings from my study.

4.9.3 Study replication

Thomas (1993 p.40) proposes that the "…replication of our studies by others illuminates the degree to which our evidence was accurate and our concepts fruitful". This proposition allows for replicating researchers to contribute their own critical perspective while still maintaining the replication of the study. Therefore, although a replication study will not be the same, the same processes using the audit trail can

provide illumination regarding the accuracy of the study and the critical concepts that have been presented. While no replication could be performed the audit trail in this study has been clearly presented to facilitate a second researcher repeating the study in a similar satellite dialysis environment.

4.9.4 Reflection and self-reflection

Reflection and self reflection are processes the critical ethnographer undertakes. Throughout this study the term *reflection* describes a fieldwork process where reflection on each observation, interview and document analysis was undertaken. In contrast the term *self-reflection*, which I have also termed *reflexivity*, is used to describe my own personal involvement and how the biases that I and my own disciplines (academic and nursing) influence the research. Thus the notion of reflexivity is that it "…refers to the act of rigorously examining how this involvement affects our data gathering, analysis and subsequent display of data to an audience" (Thomas 1993 p.46). Presentation of my own biases has been introduced in Chapter 1 with further analysis in Chapters 3 (Methodology) and 7 (Discussion).

Bourdieu, Wacquant (1992) and Thomas' (1993) approach to reflexivity was used to guide the reflexivity process in this study. Bourdieu's approach assists 'consciousness raising' using reflexivity to uncover the epistemological unconsciousness of the discipline as well as the researcher (Bourdieu and Wacquant 1992; Bourdieu 1990). Therefore, Bourdieu proposes a three step analysis to ensure reflexivity is achieved. Firstly, the exposure of determining relations where the participants are unaware, secondly, a focus on the active making of collective groups such as classes, and thirdly, a historical construction from which perceptions and perspectives arise (Bourdieu 1990; Fowler 2000). An example of this critical

reflexivity in my study is the examination of the power relations; class driven and historicism of the construct of technical language such as Kt/V (see Section 8.3)

Thomas (1993) interchanges the two terms, reflection and reflexivity and terms this *critical reflexivity* (p.47). He proposes that the two crucial components of critical reflexivity are our achievement to question how our own values influence our research and the social implications of our research. Thomas argues that "…we are demythologizing the knowledge-production processes by challenging our own authority…[and]…we are asking of our study 'so what'" (Thomas 1993 p.47). By challenging my own knowledge-production process I have acknowledged my own biases, both personal and discipline-related. This has contributed to the transparency, and subsequently, the rigour of this study by overtly acknowledging perceived researcher influence and bias.

Although rigour is a much debated aspect of qualitative research, this study has adhered to the critical ethnographic principles of auditability, peer review, replication, reflection and reflexivity. Adherence to these criteria ensures the integrity and findings are defensible and contribute to the body of knowledge in this area. Furthermore this study has provided evidence applicable to change in practice which is fundamental to the critical paradigm.

4.10 Chapter summary

There is no one way to do critical ethnography and methods vary depending on the study. This chapter has described the methods that were chosen, justifying the choice of methods in line with critical ethnographic traditions, the researcher's own views and beliefs in relation to the proposed context and aims of the study.

Details of recruitment, observation, interview, document analysis, ethical considerations, data collection, data analysis and rigour have been provided. Step by step descriptions of the processes used in this study have been presented to inform the reader of methods used to explore nurses' perceptions.

Chapter 5, the first of two results chapters, will provide descriptions of satellite dialysis nurses' perceptions of quality dialysis nursing care.

CHAPTER 5

FINDINGS 1: NURSES' PERCEPTIONS OF QUALITY

5.1 Introduction

The findings of this study were uncovered predominantly through unstructured interviews over a period of five months with eight specialist dialysis nurses caring for people receiving dialysis treatment in a metropolitan satellite dialysis unit. The themes identified were classified into three broad headings in relation to their nursing care:

1. What is quality?
2. What is not quality?
3. What affects quality?

What is and what is not quality will be discussed in this chapter. What affects quality will be discussed in the following chapter, Chapter 6.

5.2 Quality dialysis nursing

This section will describe the findings related to the nurse's perceptions of what quality dialysis nursing is. The findings were both overt and covert. Some of the findings were uncovered through repeatedly re-reading and analysing the interview transcripts and identifying and exploring every instance of overt or covert discussion of each participant's views on what quality nursing care is. Analysis of the data, described in Chapter 4, was undertaken resulting in the following findings.

5.2.1 The technical

This theme related to the nurses' perceptions of the technical aspects of their nursing care in the satellite dialysis unit in which they worked. The data showed that these nurses had an understanding of their technical knowledge and skills, and that these were interrelated. The nurses regarded their knowledge and skills highly and related these to the provision of quality nursing care. Although this was anticipated there were also some unexpected findings.

Analysis of the technical has been influenced by my clinical experience and beliefs about nursing care. I have been a dialysis nurse in an environment in which I have seen nurses (including myself) view their technical skills as the most important aspect of their practice. The highly regarded measures of their skills include the speed in which the nurse can set the machine up, their success in needling the patient's arterio-venous fistula in order to provide blood access, whether they can unblock a central venous dialysis catheter, or how many patients they can put on in one day. Bevan (2000) makes a distinction between the nurse who achieves 'technique' expertise and the nurse who understands 'technology'. He proposes that:

> …by focusing upon techniques the novice does not 'master' technological but rather the novice learns superficial survival skills that limits and enslaves the nurse within technological essence. (Bevan 2000 p.732)

He called this the 'technological enframing' of the nurse and patient, and contrasted it with the 'enabling nurse' who assists in enabling the client to live by supporting them through their experience of end stage renal failure.

5.2.1.1 Technical knowledge

There was a recurring theme in which the nurses considered themselves to be very knowledgeable in their particular specialty of dialysis. Contradicting this were the times they reflected on and questioned their lack of knowledge. Nurses rarely questioned their knowledge when observed providing patient care but while in the confidential interview they questioned their own knowledge. The specific technical knowledge that dominated the interviews was related to blood tests (Kt/V, potassium, phosphate, calcium, haemoglobin, albumin, iron) and machine technology.

The interviews explored the nurses' understanding of Kt/V, which revealed that the nurses were not confident in their knowledge and understanding of Kt/V. They did not understand why it is so important and said this led to them to sometimes not applying the full Kt/V prescription in their daily practice. The following quote illustrated how one nurse struggled with understanding Kt/V while still knowing it was important.

> *You know like your Kt/Vs etc. I mean I still find that a lot of it I struggle with in that I guess it is just practice. Going over and over and that. (Jackie 7/4 #1806)*

> *Well you're always looking at their clearances, their Kt/V (Leslie 7/7 #1752)*

> *…show data about their clearances will increase and that they will feel better I think it's much easier to get around those sorts of barriers (Sandy 16/6 #1018)*

None of the nurses explained this concept well, even when pushed, giving the impression that perhaps they only partially understood its importance or even that it

was not important. There was no evidence in the data that the nurses questioned the importance of Kt/V, and it seemed that they simply accepted the apparent requirement of a patient's Kt/V to be at least 1.2, and preferably greater than 1.4 (CARI 2002).

One nurse said she knew about Kt/V, wanted to know more, but there was not any literature on it. This is of interest as there is a great amount of literature on Kt/V (Diaz-Buxo and Loredo 2006). This finding suggests that this comment was more a reflection of the nurse's capacity to research the literature rather than a lack in the extant literature.

Three nurses stated that Kt/V is measurable and that is why we use it, but they did not relate it to the overall well being of the patient. In fact it was clearly described as not being important by several nurses.

> *I mean we've got an 87 year old with an access that's not really fantastic that's just, I mean she has got reasonable clearances and she's only on 3 and a half hours, I mean look at quality of life as opposed to high efficiency dialysis I think you need to take these things into account. (Kobe 7/7 #1721)*

> *You've always got your grey areas so if someone hasn't got a great Kt/V but they're achieving what they want to out of life then I won't bump their hours up to 4 and a half because I think their Kt/V should be 1.4. (Leslie 7/7 #1902)*

The previous two quotes are examples of nurses not following published Australian guidelines (CARI 2002). These guidelines were not always followed because these nurses believed that the patient was achieving what they wanted in life and that this is good even if they were not obtaining a Kt/V of 1.2. One nurse asserted that it was more important for the patient to have a job than a good Kt/V. These findings

perhaps suggest that the nurses have determined that a patient's quality of life is more important than a numerical formula such as Kt/V.

That nurses in this satellite unit prioritised the patient's quality of life over Kt/V which was surprising to me as my recent clinical experience in an acute hospital dialysis setting led me to conclude that Kt/V was the most important aspect of the treatment. It may be that this finding is linked to the satellite environment and its nursing culture and that these nurses have a more holistic approach to their patient care than the nurses in the acute renal care setting.

Other blood test knowledge dominated both the interview's discussion of technical quality and was frequently observed during observation. The nursing culture was dominated by it. For example, the nurses would be discussing what the patient's potassium was last week. Has the patient's phosphate improved? What is the patient's haemoglobin? Do they need more EPO or Iron? Has the patient's albumin improved?

In practice each nurse takes the technical blood result information, analyses and interprets them and then imparts this information to their patient. They do this even though the patient may have heard this many times as the nurses feel it is their duty as the nurse.

> *…you have a discussion with a patient about phosphate control and about taking phosphate binders properly you can look at their next monthly bloods and they're certainly better off. Um, but you could have done the same thing with the next patient and they could be just as badly off the next time around. (Sandy 30/6 #1505)*

…with monthly bloods and education and conversing with doctors, um, yeh I suppose that's what dialysis is isn't it. (Erin 7/6 #0053)

The quotes above illustrate that although nurses felt a duty to educate people receiving dialysis treatment they were cognisant that education may have no effect on patient behaviour. However, there was no evidence that nurses questioned why education does not influence the patient's behaviour. Notwithstanding this insight, nurses reported patient education about blood tests as being an important component of providing quality dialysis nursing care.

5.2.1.2 Skills

Skills related to cannulation, or needling, which are required at the beginning of dialysis to access a blood supply, were associated with quality care by the nurses. Skills related to the management of complications were also valued. Both skills had aspects of power and powerlessness that influenced who performed these skills.

Nurses placed a high priority on needling. A skilful nurse was one who did not 'blow' fistulas and was able to find new needling sites in a patient's arterio-venous fistula (AVF).

…it takes confidence to try new spots and I think you need to be a good needler. (Hunter29/3 0330)

This related to their belief that needling in the same site caused aneurysms in the fistula. Although this is a well known belief, there is no strong empirical evidence to support this. Cannulation was a high priority for these nurses and a common concern

for people receiving dialysis treatment, and such priorities were reflected in the nurse's practice.

The documentation (policy manual) available to the nurses supported the need for strict guidelines on needling practice and the priority that it is performed according to these guidelines. There was a policy that stated:

> *If a nurse has two misses then another more experienced nurse should be asked to cannulate. (FN 29/3 #35)*

In addition there were five people receiving dialysis treatment with nursing care plans that stated e*xperienced needler only (FN 29/3 #36).*

There was no statement in the documents defining 'experienced needler' criteria and no list of which nurse was an experienced needler. The concept of experienced needler in this culture appeared to be 'unwritten' knowledge with all staff being aware who the experienced needlers were.

Management of fluid removal was described frequently by the nurses in this study as an important part of their role. Assessment of patients' fluid status, including intradialytic blood pressure, was seen as important to reduce the potential for hypotension and cramps. Participants stated that it was an important part of their assessment.

> *…to just assess patients for their ideal weight by their blood pressures and whether they were cramping or not (Drew 22/3 # 1016)*

> *I tend to take a little bit longer than other people in assessing them before I put them on to work out exactly what I'm going for with fluid removal (Hunter 29/3 #3040)*

However, during observation, blood pressure monitoring of people receiving dialysis was performed pre and post dialysis and hourly during each treatment. Although patients' blood pressures were measured frequently at no time were the results acted upon. It was only when patient suffered a severe hypotensive episode that they actioned a low blood pressure. Therefore, although blood pressure was frequently measured, it was not overtly used to assess the overall condition of the patient or promote active nursing intervention.

Management of intradialytic hypotension was observed, and reported as an important role in the satellite unit. Most people receiving dialysis treatment have little residual renal function and thus need fluid to be removed through ultrafiltration during dialysis (Wang and Lai 2006). Hypotension is a result of decreased plasma volume related to the removal of fluid through ultrafiltration (Sherman 1988). If the hypotension is not treated the patient will die. Treating a patient's hypotension by stopping fluid removal, and often administering intravenous fluids, is one of the primary specialised activities that is undertaken autonomously by a dialysis nurse.

Different nurses have different approaches to fluid removal management. The more experienced nurses may be confident to push the boundaries of their accepted scope of practice and use their experience, knowledge and the technical equipment to achieve the desired fluid loss for the patients. In other words they will try to use various advanced methods such as isolated ultrafiltration and ultrafiltration profiles to remove fluid from the dialysis patient. These advanced methods often require extra knowledge and skill.

> *I mean they all have their crashes [rapid hypotension] they do I mean I remember when I worked in-centre the satellite units would only take off so much fluid. They'd never do UF but we do UF here. And the machines have*

changed as well. …now you've got so many profiles you can do amazing things to get their weight off.

(Leslie 23/4 # 1342)

This is an example of an experienced nurse who takes responsibility for fluid removal from the patient using different technical strategies to achieve the desired fluid loss. The more experienced nurses were seen as promoting these advanced strategies more than the less experienced nurses.

During the observation period several episodes of patients experiencing cramp and/or hypotension were documented. The frequency (10-30%) of these intradialytic complications were consistent with reports in the literature (Perazella 1999). There was an expectation that an experienced nurse was able to manage a hypotensive patient episode as during one episode the experienced nurse did not ask for help.

Yeh, my concern earlier in the day was that we were taking a fair bit of fluid off of her and she quite often does not cope with that amount of fluid and although the argument was we were increasing her hours it was the same UF rate per hour as it normally is, I was still concerned that we were taking that amount off. So when I saw that she was lying flat and Di looked like she was in a bit of distress I wondered, yeh (Drew 22/3 #2918)

One nurse who was aware that a hypotensive episode was occurring had been reluctant to assist the more senior nurse. When I questioned her about this she reported that she thought the more senior nurse needed assistance but was reluctant to assist unless she was invited. This finding was an example of how the periods of observation were used to inform the interview and reveal powerful hierarchical structures amongst the satellite dialysis nurses, discussed further in Chapter 7.

One interview was interrupted and delayed because another nurse called on the nurse unit manager, who was being interviewed at the time, to come and assist with a patient who was experiencing a hypotensive episode. When I asked the nurse unit manager why she needed to be called she stated that

> *They just wanted an extra pair of hands. So I felt obliged to go out there. (Kobe 7/7 #0019)*

It may be that because she was the most senior nurse in the unit, the satellite unit culture determined that this person needed to be involved because of their seniority. Although the nurses could have handled this clinical situation without the nurse unit manager's assistance in her absence they still felt compelled to involve the nurse unit manager.

5.2.1.3 Both knowledge and skills

Categorising themes into separate skill and knowledge categories is problematic because they are interrelated. Evans and Donnelly (2006 p.153) propose that "the performance of a skill cannot stand alone: it is always supported by this knowledge and judgment". For example, knowledge of a person's arterio-venous fistula (AVF) is important if there have been past complications. Knowledge related to access flows and blood temperature monitoring (required for AVF blood recirculation assessment) would also contribute to quality needling skills.

Knowledge and skills related to machine technology contributes to quality care. The knowledge around blood volume monitoring informs the skill of fluid assessment, haemodiafiltration knowledge contributes to improved patient care and dialysis

machine trouble shooting. Knowledge also informs day to day use of the dialysis machine. Furthermore, nurses' knowledge can affect patient care:

> *You sort of decide well if their clearances aren't good well let's change the dialyser let's increase the dialysate flow. Let's increase their time. In what order you do that is up to the primary nurse. So you know you've got that in the back of your head so you know you do things like that. (Leslie 23/4 #1615)*

The above quote illustrates how an experienced nurse identified her knowledge and applied it in a systematic way to increase the patient's Kt/V. This was performed by this nurse autonomously, and was then reported to the nephrologist. This experienced nurse believed that she was best placed to use her knowledge and skills to improve the quality of the patient's dialysis treatment.

Although these nurses stated they possessed certain technical skills they also felt that more technical education was needed by them.

> *… if they want us to continually grasp new technology and new information and they want us to keep up to speed in what's happening in nursing um, then why don't they provide study days to do that (Chris 10/5 #4011)*

> *I would like to have a more ongoing level of education, just to keep your training up to date because you do become a bit stale (Hunter 30/6 #4946)*

Chris's quote reflects the nurses' perceived need for more education through designated study days. There were also nurses who requested that other forms of education be offered to them at the right time, the right length and in the right location. The need for 'appropriate' education is a particular concern for nurses

working in satellite dialysis units because they are in more remote settings than the nurses working in hospital based units.

Satellite dialysis nurses, technical knowledge and skills were perceived by the nurse participants as very important in the delivery of quality dialysis nursing care in a satellite dialysis unit. Highly prized knowledge was related to Kt/V and blood tests. The technical skills emphasised were needling and management of intradialytic complications. The complex interaction between technical knowledge and technical scene was perceived to be highly relevant to the quality of nursing care delivered in a satellite unit.

5.2.2 The interpersonal

Themes of 'what is quality care' was categorised under 'the interpersonal' aspects of dialysis nursing care. Four major themes were 'intimacy', 'the little things', 'humour' and 'educating patients'.

5.2.2.1 Intimacy

The theme of intimacy was found in both interview and observation. In the interviews, participants identified intimacy between nurse and patient as a component of quality nursing care. Intimacy was described as a 'close bond and relationship', 'pushing past the screen' which included self-disclosure from nurses and people receiving dialysis treatment. The intimacy involved non-touching (personal conversation) or touching intimacy (touching, hugging). The connection between intimacy and quality nursing care was noted in the participants' comments that connected the importance of intimacy between nurse and patient as an important feature of quality dialysis nursing care:

I know there is Toni who will quite often come a little close to give a hug and I will just yeh. I am just breaking the line (Drew22/3 # 0425)

…having people that they can interact with and you know a two way thing, a bit of self disclosure, feel like we're friends everybody's happy. (Erin 7/6 # 0809)

During participant observation I observed frequent physical touching (FN 22/3 #1208) between some nurses and patients which is called breaking the line by Drew. Hugging, massage, hand holding and patting on the arm and leg of patients by nurses were all observed. Touching was most frequently initiated by the nurse but I noted two occasions of the patients initiating the touching which were arm touching and hugging. This seemed an accepted form of intimacy between those nurses and the people receiving dialysis treatment as there were no external signs of discomfort from either patient or nurse.

Documents analysed did not refer to intimacy. Both written and computer entered data was devoid of any mention of expressions of nurse/patient intimacy. The two relevant standards, The Nursing Board of South Australia (NBSA) Standards for Therapeutic Relationships and Professional Boundaries (Nurses Board of South Australia 2002), and the Competency Standards for the Australian Advanced Practice Nephrology Nurse (Renal Society of Australasia 1999) were stored in the nurse manager's office. The Standards for Therapeutic Relationships and Professional Boundaries state "the nurse recognises the potential risks with intimate interpersonal contact and acts to minimise these risks" and (Nurses Board of South Australia 2002 p.3) "the nurse recognises self-disclosure is only appropriate where it can assist to achieve therapeutic goals" (Nurses Board of South Australia 2002 p.3). This does recognise the potential risk of intimate personal contact and guides the nurse to only

self-disclose when it contributes to therapeutic goals. However, the therapeutic goal in chronic illness requiring long term nursing care can be very different and involve a different type of therapeutic alliance both from the nurse's and the patient's perspective, and thus the NBSA guideline may only be of limited use to the satellite dialysis nurse.

The document specific to renal nursing standards, Competency Standards for the Australian Advanced Practice Nephrology Nurse (Renal Society of Australasia 1999), was also stored in the nurse unit manager's office. This document states "[the nurse] Ensures that verbal and non-verbal interactions with individual/significant others reflect respect for differing values and beliefs e.g. uses appropriate physical contact with individual/ significant other" (Renal Society of Australasia 1999 p.30). This statement suggests that a nurse is required to assess the values and beliefs of the patient so as to respect their views on the appropriate use of physical contact when providing nursing care. This competency suggests nurses can offer intimacy when it is accepted by the patient as a part of their values and beliefs. Further discussion of this will be offered in Chapter 7.

Although the study found that intimacy was important there was still a 'them' and 'us' culture amongst nurses. The people receiving dialysis treatment were seen as 'different', however, there was still a respect for them. Interestingly, if the people receiving dialysis treatment showed respect to the nurse then the nurse reciprocated. The patient was considered respectful if listening, helping and doing what the nurse asked of them. The nurse identified this as respect and reciprocated with respect.

> *I guess I probably see them as people more so than patients but I don't know where the line begins and ends sort of. I know that I've got a job to do for their health and you take that on board as well (Jackie 7/4 # 0211)*

Jackie conveyed her uneasiness about what the dialysis patient versus dialysis nurse relationship should be and was uneasy about the distinction between 'person' and 'patient'.

Not all nurses perceived intimacy and getting close to the patient as a characteristic of their quality nursing care. Some believed that their role did not incorporate getting close to people receiving dialysis treatment:

> *…when they talk I listen, but I don't go out there going how's your daughter going coz I don't wanna get too close. (Leslie 23/4 # 2131)*

Leslie was an experienced nurse who chose not to get too close to the people receiving dialysis treatment. Leslie's approach was to listen and act but not encourage openness between the patients and nurses. Leslie believed the service was a nursing and technical service and therefore the nurse was there to provide the technical care and not get involved too much in patients' personal lives.

Renal nurses have recognised the role intimacy plays in dialysis nursing care. The Renal Society of Australasia advanced practice competencies (Renal Society of Australasia 1999) provides a statement that we need to be aware of the respect for different values and beliefs such as differing values in physical contact. The competencies do not address the subjective nature and the importance of the therapeutic role of intimacy which is clearly a feature identified in this ethnography. This provides further evidence of the hidden, unwritten and unrecognised feature of dialysis nursing care that is intimacy.

In summary, intimacy seems an undervalued feature of dialysis nursing. It is present but silent in the technical dialysis culture and literature. However, it has been frequently observed and discussed in interviews. Nurses have described the

importance of getting close to the dialysis patient in order to assist them. However, the concept of intimacy does not appear in accreditation documents, policy or procedure manuals, and was not documented by participant nurses. Furthermore NBSA Standards (Nurses Board of South Australia 2002) advise of the risks and requirements for nurses when intimacy is involved. I have found that intimacy is a recognised feature of quality dialysis nursing care and this may contradict the NBSA Standard.

5.2.2.2 The little things

'The little things' were observed and discussed in interviews and related to those nursing activities that included providing good food and DVDs to the people receiving dialysis treatment. These activities were often not viewed as 'legitimate' clinical dialysis nursing duties. The 'nurse friend' gets to know the patient better, is aware of their likes and dislikes, hopes and fears, and places an emphasis on ensuring that 'the little things' are provided for them.

Two nurses expressed that it was providing the extra 'little things' such as sandwiches and DVDs that improved the patient's experience as much as the 'clinical' care they received.

> *…regularly watch the DVDs you know and if their TV doesn't work oh my god there's hell to pay. (Hunter 30/6 #1150)*

> *…you know like we have the footy tipping here, you know we've got DVDs we've got nice things here and all the patients love coming here, so it's not so much just the dialysis it's all the other little things (Leslie 7/7 #4136)*

The little things (TV, DVDs, footy tipping competitions and sandwiches) related to meeting the patient's immediate needs and increasing their comfort and satisfaction (entertainment, hunger) of their non-clinical needs in the dialysis unit. This then contributed to the quality of their overall care. The nurses, in turn, received immediate thanks from the patient which confirmed to them the importance of providing the little things. This reciprocation might result in the little things being as important a marker of quality care as ongoing term clinical nursing care.

The ongoing clinical care may be less emphasised as an element of quality nursing care as it was not seen by the nurses as immediately beneficial to the people receiving dialysis treatment. Examples of the less emphasised clinical care were encouragement of people receiving dialysis treatment to spend longer hours on dialysis, having nocturnal dialysis or discussing nutritionally valuable diets.

> *Increasing hours? Absolutely not. If they could dialyse for 5 minutes they would (Leslie 23/4 #1655).*

Furthermore, nurses suggested that people receiving dialysis treatment were not interested or did not understand the importance of various aspects that were required when receiving long term care.

> *…from a clinical perspective here, a lot of them don't understand it, you can explain it to them and some of it goes over their head and a lot of them aren't even really interested (Hunter 30/6 #0701)*

Again, the nurses' perceptions of what was important in providing quality care may have reflected what the people receiving dialysis treatment expressed as important in their care.

Providing 'the little things' related to the intimate care discussed in the previous theme. This may vary from one nurse/patient relationship to another. This was expressed by one nurse who suggested that there were nurses who worked their eight hours and there were some who would be *pushing past the screen (Chris 10/5/05 # 0432)* and really getting to know the patient. This nurse was proud of the way she tried to get to know her patients as people, which in turn enabled her to be aware of patients' nursing and personal needs. Thus, this nurse believed she was able to provide people receiving dialysis treatment with better quality nursing care.

In summary, the satellite dialysis nurses in this study believed that providing 'the little things' was a very important part of their nursing role. This theme is linked with intimacy between the nurse and patient in the satellite environment and contributed to the nurse wanting to provide perceived non-clinical as well as clinical care.

5.2.2.3 Humour

The use of humour was seen to be positive by the dialysis nurses in this study and was valued in this satellite dialysis unit. Humour involved the notion that the dialysis unit reflected other spaces of social activity where close relationships formed between people and encouraged the use of humour in everyday activities. This may signify familiarity and trust between nurses and people receiving dialysis treatment, as well as a coping mechanism for what is ultimately an unnatural and uncomfortable experience that is dialysis.

Three nurses emphasised that they felt it was important to laugh when working in the unit. This also reflected their beliefs that humour was important in general life.

> *They tell me that they love it when I'm on because we have a laugh and we have a joke (Chris 10/5 # 0235).*

This example of how one nurse viewed her role in encouraging humour amongst staff and people receiving dialysis treatment in the unit. This example encapsulated other nurses' views although some nurses did not see themselves as particularly humorous but related that having fun and encouraging the patient to have fun was an important part of their care.

> *They love to joke around. They love to chat and joke and get to know you as a nurse on a personal level. (Hunter 30/6 #1010)*

The various applications of humour may have reflected each nurse's own personality and use of humour in everyday life.

Nurses felt that the strong relationships formed between nurses and people receiving dialysis treatment in the unit encouraged people to have a joke with each other.

> *You can joke, you see these people three times per week so you form quite a strong relationship with them (Drew 22/3 #0116)*

They compared this to the role of humour in their own lives where the more one got to know someone, the more comfortable one was in making a joke with them.

> *…and people get jokes from the internet and we stick all them in there. And some are really funny actually so that's good when you're having a bad hair day you read that for a laugh. (Leslie 23/4 #0738)*

Thus humour also had a strong relationship with intimacy and was used as a strategy for understanding the patient better.

Humour was frequently observed when the nurses were interacting with the people receiving dialysis treatment with various behaviours signifying humour, including laughing and giggling. As observer at times I did not know why the various people were laughing, as non-participant observer I had not been party to the joke. Thus, although I have been a dialysis nurse for 15 years some of the humour was only seen to be funny by the people receiving dialysis and nurses themselves. This suggests the finding that each satellite unit is unique in its culture, and one expression of this is its own brand of humour.

Humour appeared to be an important aspect of satellite dialysis patient care. It was both frequently observed, and stated in the nurses' interviews. Although not recognised in formal documents, humour, was a feature of satellite dialysis nursing care. Similarly, humour is another example of an important but unrecognised feature of satellite dialysis nursing care.

5.2.2.4 Educating people receiving dialysis

Patient education was seen as a very important role for satellite dialysis nurses, and was frequently referred to as a particular satellite dialysis nursing activity. Throughout the participant observations and interviews I encountered many examples of patient education. I found that the nurses referred to themselves as the educated people who were educating the non-educated people (the people receiving dialysis).

> *…educating them on appropriate diets and ways to live their lives and things that they can do better… (Erin 7/6 # 0222)*

You tell em time and time again. You know, don't drink so much coz if you drink your little heart blows up and it can only do that for so long. (Leslie28/04 # 1655).

These quotes from the nurses' interviews reflected the 'educated' nurse telling the patients what to eat, how much to drink and even how to live their lives. It illustrated a one way process of information transfer. Thus, much of the education observed and reflected upon by the nurses consisted of a didactic style of informing patients rather than an interactive information sharing session.

The nurses rarely questioned their own knowledge related to the content that they were using during patient education sessions. This was particularly evident when observing nurses interacting with people receiving dialysis.

I quite enjoy teaching the patients what that alarm means and taking some of the fear or ignorance I guess away from the patients and making them a bit more aware of what it is doing and why it is doing it (Hunter 29/3 #1840)

It was evident that this was related to the notion that the nurse expected to be seen as the expert in their field. My presence may have added to their desire to appear knowledgeable however, in interviews, they confirmed their belief in being knowledgeable in their specialty field, which was important to them. Interestingly, the nurses expressed their need and desire to find out more information relating to various aspects of dialysis nursing care which illustrated the nurses' thirst for more knowledge.

…people here are more geared up towards education. (Sandi 30/6 #2405)

The nurses' perception of their own knowledgeable status may have been a contributing factor to their frustrations expressed when their patients did not appear to take their advice. Several nurses expressed their need to educate but questioned whether it had any impact on the behaviour of people receiving dialysis treatment. The following are examples of this.

> *You have a discussion with a patient about phosphate control and about taking phosphate binders properly you can look at their next monthly bloods and they're certainly better off. Um but you could have done the same thing with the next patient and they could be just as badly off the next time around. (Sandy 30/6 #1505)*

> *Some will take what you say on board and some won't. (Hunter 29/3 # 2547)*

These are examples of nurses acknowledging that they do not always see their education as being taken on board by people receiving dialysis. Some patients will and some will not. There was no evidence that nurses questioned why some patients took the information on board and some did not. Thus this was not explored further by these nurses and seemed to be accepted by them as nothing they could do.

At no stage in the interviews did the nurses discuss in any depth why their efforts in providing education did not make any difference. There was very little acknowledgement that if their education was not relevant, or did not make any difference to the patient, it probably would not influence the patient. Like any adult, the dialysis patient will only really believe that information is valid if it means something to them. Thus, the principles of adult learning, such as previous experience and motivation for learning (Knox 2000), were not followed.

One nurse related a story from a patient about his experience with a nurse from another dialysis unit who had a very authoritative style.

> *…his nurse told him what he must do and put down strict guidelines and he wasn't happy with that. Rather than negotiation. He thought it was a lot of crap. (Erin 30/6 #0435)*

This nurse who described the other nurse's authoritative behaviour exhibited authoritative behaviour, herself, towards their patients in the observation period. That is, the behaviour observed in another nurse was not acknowledged to be their own behaviour. This suggests that some dialysis nurses may judge other nurse's behaviour, without reflecting on their own behaviour.

Didactic education styles by nurses may decrease the potential for truly negotiated care between nurses and people receiving dialysis which has been suggested as a way forward to improve the quality of care of people receiving dialysis (Polaschek 2003). There was little evidence of negotiation in this study and only one example of an expectation of negotiation which was related to a nurse expecting a negotiated plan between a nephrologist and a patient, not a nurse and a patient.

> *That that person [nephrologist], paid to make those decisions, comes back and says here's a plan and then they have the choice in what to do about it (Erin 30/6 # 0541).*

Erin was explaining her expectation of a doctor's negotiating style with a dialysis patient. No nurse, including Erin, discussed the importance of a negotiated care model that consisted of a nurse/patient negotiated goal.

Nurses reported that there was feedback from their patients that they appreciated information they were given. However, this was the nurse's perception and was not observed by me. The question of patient selective behaviour and reciprocity arises: Is the patient just trying to boost the dialysis nurse's ego because they may get better care if they are nicer to the nurses? This implies various levels of power and powerlessness and how different aspects are manifested in the satellite dialysis context.

Patient education was as high priority satellite dialysis nurses, was an important component of quality nursing care and the nurses aimed to ensure the patient was as educated as possible. However, in this dialysis unit patient education was perceived by nurses as a one-way delivery of information from the nurse to the patient. There was little recognition of the patient's knowledge and expertise in relation to their kidney disease and treatment, and thus, limited negotiation between the nurse and the patient in regards to patient care. There was little evidence that nurses used adult learning strategies to educate people receiving dialysis. The implication here is that the nurses use their perceived greater knowledge and pay less attention to the 'expert patient' knowledge, which may lead to feelings of power and powerlessness among the nurses and people receiving dialysis.

5.3 What is not quality dialysis nursing care

There were some themes found in the data that were unexpected because, while identified as important aspects in the dialysis literature, they were not perceived by these nurses to be important in quality dialysis nursing care. This section describes the themes of blood pressure management and transport, which were perceived by the nurses not to be important in the delivery of quality dialysis nursing care.

5.3.1 Blood pressure management

The technical side of satellite dialysis nursing involves the management of patients' blood pressure. Blood pressure management involves long term and short term (intradialytic) intervention and management.

I was expecting both the short and long term management of blood pressure to be a nursing care priority. However, discussion of blood pressure management was almost entirely related to short term intradialytic management and was only related to long term management by one nurse. In field notes following several interviews, I reflected that:

> *There was a lack of comment from nurses on blood pressure as being important when it comes to quality care. The dominance of Kt/V rather than blood pressure supports my thesis that Kt/V is overemphasised to the detriment of other aspects of quality (FN 26/6/05 #37).*

Thus, the management of blood pressure seemed to be perceived as not significant as a measure of quality care for these satellite nurses. This was an important area related to quality care that was worth exploring further.

5.3.1.1 Long term blood pressure management

The kidneys play a major role in the control of blood pressure, both through the renin-angiotensin-aldosterone system, and the management of salt and water (Terrill 2002). People on dialysis with end stage kidney disease have limited kidney function and are unable to control their blood pressure. Blood pressure abnormalities can be volume-related (Daugirdis and Ing 1988), but can also be related to the patient's medication regimen. Given that polypharmacy is ubiquitous for people receiving

dialysis (Cook et al. 2006) it can be challenging for the dialysis patient to adhere to a complex medication regimen (Loughman-Adham 2003). Within this polypharmacy there are unique challenges to antihypertensive medication adherence (Caro et al. 1999), so the dialysis nurse could potentially play a vital role in the management of their blood pressure.

There was very little discussion or observation of long term blood pressure or antihypertensive medication management, as an important component of quality dialysis nursing care. When discussing quality care measures during interviews no participants talked about the long term management of blood pressure as being important in quality nursing care. The following excerpt from an interview is an example of when I had to prompt a participant to consider long term blood pressure management as important.

PB: What else do we measure?

Leslie: Oh yeh blood pressure

PB: People have died from high blood pressures

Leslie: Coz of stroke yeh

(Leslie 7/7 # 1617)

When the above excerpt was further analysed it was an example where Kt/V was placed far higher on the quality measurement scale than blood pressure. After I pointed out to some participants that no one has ever died from a low Kt/V, and that cardiovascular mortality is the highest killer of dialysis patients (ANZDATA 2008), they appeared surprised that they had not placed more emphasis on long term blood pressure management as the following excerpt from the interview with Kobe suggests.

Kobe: Well you're always looking at their clearances, their Kt/V.

Paul: So the one definable thing that you're looking at is their urea clearance

Kobe: Yeh, that's right

Paul: Yet it's never killed anyone

Kobe: No that's right (laughs). No it hasn't killed anyone. Not like high blood pressure.

(Kobe 12/4 # 1655)

The above exchange between Kobe and I was an example of placing urea measurement in perspective with blood pressure management. It was clear that Kobe was rethinking her quality priorities as the interview was proceeding.

The above was also evidence of the critical ethnographic process affecting new understanding by challenging previously held views. This example demonstrated that in the interview an alternate view could be provided. However, the interviewer needs great care in introducing an alternate view to ensure that the nurse participant is able to cope with this. This alternate view, which challenged the emphasis of Kt/V over long term blood pressure management as a measure of quality care, may give the nurse the confidence to challenge the status quo.

This section has presented the findings related to blood pressure and fluid management and the nurses' perceptions role in assessment, long term management and intradialytic care. Nurses placed higher importance on immediate blood pressure management of hypotension than long term blood pressure assessment. This is in the era where we know that cardiovascular factors including hypertension are the major cause of death in dialysis patient in Australia (ANZDATA 2008).

5.3.2 Patient transport

Transport to and from dialysis is an issue for the quality of service that a dialysis unit provides. The burden of travel is significant for people receiving dialysis treatment in satellite units given that they have to travel twice a day (to and from dialysis), three times per week. Although the average distance travelled is only between 5 to 20 km (Kidney Health Australia 2006) it can be either early in the morning or late at night when there is limited public transport. A 2001 survey of South Australian dialysis patients' perceptions chose transport as one of the six areas of concern (Gill, Campbell, and Taylor 2002). They found that 43% of people receiving dialysis drove themselves to their dialysis unit with 57% requiring volunteers, ambulance services, taxis, public transport or friends and family to transport to and from dialysis (Gill, Campbell, and Taylor 2002). Findings from this study suggest that there is significant debate in the professional dialysis community as to who is responsible for providing transport.

The perspective of every nurse that I interviewed was clear. Every nurse stated that they thought it was the patient's responsibility to travel to and from dialysis:

> *Transport's another issue. They get their knickers in a knot. (Hunter 30/6 #1215)*

This statement reflects the nurses' view that patient's complained greatly about transport. Most of the nurses believed that it was not the unit's responsibility to transport patients to and from dialysis. This was clear from the following quote

> *And it really annoys me that they don't take more responsibility getting themselves in and out of their own dialysis. (Hunter 3/6 #1232)*

…when they are asking and asking for different types of transport (Kobe 12/4 #2630)

Hunter and Kobe exemplified the nurses' views that some patients expected different types of transport, such as taxis and personal drivers to be provided by the dialysis unit. The nurses referred to this practice as an 'abuse' of the system and believed that these patients should be more independent and take responsibility for their own transport. The nurses viewed this as the dialysis patients taking on the sick role and 'abusing' the health system. This view somewhat contradicts other aspects of the holistic care that nurses provide, such as the previously described 'little things'

5.4 Chapter summary

Analysis of interviews and observation revealed that technical skills and knowledge, related to the dialysis procedure, were highly valued by the nurses. The skill of needling and knowledge around management of fluid removal dominated the nurses' responses.

Measurement of Kt/V was found to be the dominating measure of dialysis quality care. When this view was challenged some nurses reflected on the possible misuse of this measure and the non-use of other measures such as blood pressure management and aspects of interpersonal care that were difficult to measure.

An unexpected finding of this study was that the nurses' perceptions of satellite dialysis nursing care were 'different' to hospital dialysis nursing care. Although most nurses still perceived measures such as Kt/V as indicators of quality dialysis, some identified more interpersonal aspects of intimacy and humour as important in the satellite context. In addition, providing extra services, not always considered in the

nurses' role, were described by the nurses as being significant to the people receiving dialysis in the satellite unit.

Evidence of power and powerlessness were revealed through observation and interview. In particular the nurses' perception that the nurses were the 'knowledgeable experts' who educated the 'less knowledgeable' patients featured frequently. Nurses expected people receiving dialysis to comply with the nurses' advice and did not expect negotiation with compliance, increasing the patient's powerlessness. Complicating this were the nurses' feelings of powerlessness in relation to seniority and experience and powerlessness over their ability to influence patient behaviour.

Chapter 6, the second findings chapter, will present findings related to the influences affecting quality nursing care in the satellite dialysis context.

CHAPTER 6

FINDINGS 2: INFLUENCES ON QUALITY NURSING CARE

6.1 Introduction

Satellite dialysis nurses' perceptions of quality nursing care are dynamic and affected by various influences. The unique characteristics of the satellite dialysis unit, being nurse-managed, without immediate nephrologist support and being located remotely from nephrology services, may influence the satellite nurses' perceptions. Patient, management, nurse and environment were all found as influences on quality nursing care as perceived by the satellite dialysis nurses.

6.2 People receiving dialysis treatment

Satellite dialysis nurses perceived that people receiving dialysis treatment influenced the quality of nursing care. Although this appears to be a logical finding, the complexities of how the patients influenced nursing care, was evident and even conflicting at times. There are very few health care contexts like the dialysis unit where nurses and patients can spend so much time together year after year. It is in this unique environment that the themes 'abusing the system' and 'us and them' were found, describing the influences patients have on satellite dialysis nursing care, through the perceptions of the satellite dialysis nurses.

6.2.1 Abusing the system

Throughout the interviews the nurses referred to the actions of some people receiving dialysis who were perceived as 'abusing the system'. The theme of 'abusing the system' describes perceptions of patient behaviour such as non-adherence and

playing the sick role, and highlights how nurses blamed the 'patient victim', making assumptions about patients' capabilities. In saying this, the nurses were consistently professional and kind while delivering their nursing care. It was in the interviews, away from the people receiving dialysis, where these other alternative perceptions were provided by the nurses.

Nurses commented on the people receiving dialysis who took on the sick role when they perceived the patients to be not that sick. The nurses saw some of these patients as not being sick enough to justify the support they were receiving from the health care system, and thus saw these patients as 'abusing the system'. An example of this was that certain patients expected to be transported to and from dialysis three times per week. Nurses did not feel that this was justified as many of these people receiving dialysis had the capacity to independently travel.

> *…um, a lot of our time and energy is involved with organizing their transport but yeh, a lot of our time and energy and XXXX's time and energy is spent organizing their transport. And it really annoys me that they don't take more responsibility getting themselves in and out of their own dialysis. (Hunter 30/6 # 1232)*

> *…they slip into that sick role (Kobe 12/4 #2615)*

These were examples of the nurses' perceptions of people receiving dialysis who had stopped work and went on a pension as soon as they commenced dialysis. Many nurses were frustrated by the patients who were 'slipping' in to the sick role, and thus, unnecessarily abusing the system.

They've wasted our time, they don't care about themselves and they don't care about the effect that has on us. That's why I dislike them. And they're taking the place of somebody who does care (Chris 10/5 # 5126)

…but probably when they are asking and asking for different types of transport and abusing the system a bit and whining about how bad they are treated or how bad their life is and we know that they are given quite a lot (Drew 22/3 #2630)

The above quotes exemplify that the nurses making assumptions about patients' capacities to work, travel, and are defining who is sick and who is not. These assumptions are interesting given that most nurses have not had the experience of what it is like to live with kidney disease and have to receive dialysis to survive.

Nurses in the unit frequently expressed their frustration about the behaviour of the people receiving dialysis, while trying to provide quality care. If nurses observed the patients abusing the system then they questioned the amount of effort invested in their own practice.

We've got a couple of patients that abuse, their abuse of fluid is ridiculous. I still, that's one thing I still find hard to conceive that someone can knowingly do that to themselves (Chris 10/5 #1520)

Nurses were frustrated that quality care was 'wasted' on the patient. Examples of abusing the system included patients not taking their prescribed medications, not adhering to diet and fluid regimens, expecting transport to and from dialysis and stopping work once they have started dialysis. The following comment illustrates the nurses' frustration:

> *…who bring on a lot of their conditions themselves through their lifestyle and behaviour but that doesn't mean you don't look after them. You might think and I do I think, god, you know, some patients you think 'you're a bloody idiot' (Hunter 29/3 #3943)*

Hunter's comment showed that the nurses in this unit were inclined to blame the victim. Hunter stated that the patients brought their conditions on themselves. However, the original reason why the people were on dialysis, end stage kidney disease, is unlikely to have been self inflicted. This regimen was not self inflicted. It has been inflicted on them by nurses and doctors. Thus the nurses may not be applying empathy to the extent that they could possibly be expected to by the people receiving dialysis.

Although the nurses blamed patients somewhat for their lack of adherence to the desired regimen the nurses took it upon themselves to be responsible for patients' adherence to their regimen.

> *…you sort of think why so much importance or why so much time is spent educating these people on anything, not just phosphate but their fluid control, their potassium (Kobe 7/7 #0327)*

The nurses who took responsibility for their patient's adherence or lack of adherence voiced success when a patient adhered to the medical regimen. Similarly, they interpreted non-adherence as a lack of success of their patient education. This point is further discussed further in Section 7.3.

The notion that patient adherence is the responsibility of the nurse is reinforced by the accreditation process that the satellite unit was going through at the time of this

study's fieldwork. The accreditation process encourages the use of key performance indicators (KPIs) which were used by the dialysis unit to report measurable quality improvement through a formal external accreditation process. One of the KPIs measures interdialytic fluid gains, which is directly related to the fluid input and output of each patient. Nurses may have some effect on patients' fluid input but other associated factors such as gender (Everett et al. 1993), age (Bame, Petersen, and Wray 1993; Leggat et al. 1998), social support (Oka and Chaboyer 1999), length of time on dialysis (Safdar 1995), education status (Morduchowitz et al. 1993), smoking (Kugler et al. 2005), alcoholism (Hedge et al. 2000) stress (Everett et al. 1995) and psychiatric disorders (Taskapan et al. 2005) have also been reported. Thus the nurse may have only limited influence on patient adherence to fluid regimen but may take an inappropriate responsibility for this.

The significance of the accreditation process is that it emphasises the significance on a measure over which the nurse and dialysis unit have limited control.

> *Um, there are things that can be improved, um, but generally, considering the types of patients we have got here I think we're all pretty much aware of the KPIs that we are trying to meet as far as their clinical outcomes go. We don't always meet them, that's not always the fault of the nursing care that they're getting. (Hunter 30/6 #4946)*

The above quote lends support to why nurses took on responsibility for patients' adherence. Nurses were aware of the KPIs and encouraged, by management, to measure their nursing care through the accreditation process. This led to nurses applying the fluid adherence KPI inappropriately. This was an example of a KPI that was not a nurse-sensitive outcome. Like Kt/V this measure does not account for the

complexities of what it is actually measuring and is a poor indicator of the quality dialysis nursing care.

The relationship between patients 'abusing the system' and the nurse's perception of quality care is clear. Nurses who do not respect the patient who abuses the system are unlikely to go the extra mile to contribute to the patient's dialysis quality. If the patient isn't motivated to self care why should the nurse care?

6.2.2 Us and them

The theme of 'us and them' refers to nurses (us) perceiving themselves as very different from people who were receiving dialysis (them). Although appearing to be contradictory to the theme of intimacy, 'us and them' helps explain this apparent contradiction, where nurses have an intimate relationship with people receiving dialysis treatment, yet they still see the need to refer the patients as them or 'others'.

Nurses did not label patients as 'people receiving dialysis', but as 'dialysis patients'. Some nurses generalised and stated that people receiving dialysis were different to the nurses. Comments in the interviews such as:

> *…what's normal to them and what's normal to me might be two different things (Leslie 7/7 #4330)*
>
> *…. dialysis patients are odd (Hunter 30/6 #2909)*
>
> *…the worst offenders (Kobe 7/7 #1249)*

Leslie points out differences, Hunter describes the patients as odd and Kobe describes some of the patients as the worst offenders. These comments were examples of nurses 'othering' the dialysis patients. These statements reflect the

nurses dealing with this 'othering', and contradicted the times nurses treated the patients as people with lives but had difficulty in respecting them as an individual person like themselves.

Contradicting the notion of other was the nurses' perception that the patients were people (albeit different from the nurse) and were expected to contribute to their own care. Even so, the nurses perceived the patients as 'dialysis patients' and not 'people' with kidney disease who received the treatment called dialysis. Thus there was a certain amount of depersonalisation occurring. In saying this, the term patient is a commonly used term in the dialysis context, however one may argue that simply by using the term automatically creates power differences. It is noted that the term 'dialysis patient' has not been used in this thesis, however, the term 'patient' has been used. Where possible in this thesis the term 'person' or 'people receiving dialysis' has been preferred to patient.

Related to the 'us and them' theme is the proposition that nurses subconsciously apply their own values to the people they are caring for. This application of values is demonstrated through comments made by nurses in interviews. Each dialysis nurse, as an individual person, has a unique value system. However, there are values that may be homogenous. These values are reflected in the nurse's actions and words. For example if patients show respect for what the nurse is saying then the nurses may respect patients more.

One characteristic that is highly valued is hard work (both nurses and people receiving dialysis).

> *And a lot of our patients work and that's fantastic so I think if they're out there working then I've gotta make their life better in what I can do through a dialysis treatment. (Leslie 23/4 #2131)*

We've got a guy out here who is just over 40 and he arranged all his work prior to coming on dialysis. He was doing night duty, his nephrologist contacted his employer, we get his dialysis hours all in place so he could fit his work in around dialysis and within a month he is now on a disability pension. He is young he is fit he is able to go to the gym because he is not working. And we said why cant you continue work? Oh because I am sick I am on dialysis (Kobe 12/4 #2416)

Those patients who maintain paid employment while still requiring dialysis are highly valued by the satellite nurses. If a patient gives up work this is frowned upon. Similarly, if a nurse is seen to be hard working this is also a characteristic that is admired. The (hidden) comfort of consistent values, such as the value of hard work, may contribute to a different level of care to hard working people receiving dialysis. These values almost contradict the 'us and them' notion. However, it appears that if patients display values and behaviour that are consistent with the nurses' values then the patients are perceived as less 'them' and more 'us'.

'Othering' of patients by nurses has been reported previously (Canales 2000). The findings here acknowledge othering in the satellite dialysis context. Othering has aspects related to power and powerlessness and is incorporated in the Chapter 8 discussion of power in the satellite dialysis unit.

6.3 Management

Management was identified both as influencing and not influencing the quality satellite dialysis nursing care. When it was identified as a theme there were three distinct components of management identified by the nurses. These were the nurse

unit manager (charge nurse), management of the associated co-located hospital (not the parent nephrology hospital) and the specialist doctors (nephrologists) at the parent hospital. Sometimes these were combined, particularly the nurse manager and the hospital management. However, for clarity of discussion of findings they will be discussed separately.

6.3.1 Nurse unit manager

Throughout the observation and interview period it was clear that the nurse unit manager (NUM) played the pivotal role in decision making in the unit.

> *There are stronger personalities than others but ultimately [name of nurse manager] is the senior and everything goes straight to her if you have got any questions (Drew 22/3 #0736)*

There were frequent responses that linked the NUM with the decision-making, communication processes and overall nursing satisfaction in the unit. Many issues from important decisions to trivial aspects were brought to the NUM's attention. If there was an emergency and the manager was there then the nurses made the NUM aware.

> *... ultimately Kobe is the senior and everything goes straight to her if you have got any questions. (Drew 22/3 #0736)*

> *... and Kobe's time and energy is spent organising their transport (Hunter 30/6 #0235)*

However when Kobe, the NUM, was not in the unit the nurses handled all decisions, including emergencies, without notifying the NUM. Staff and the NUM had high

expectations with the characteristics of a 'good' dialysis manager being knowledgeable, using evidence in practice, approachable, having high professional standards, showing respect for all staff, not showing favouritism, managing timely staff meetings, being a good communicator, being a people person and being aware of the problems or spending time on the floor.

> *They need to be educated about dialysis as you'd expect. And um, approachable, willing to listen to your needs and help you problem solve that. I don't think that is always successful. (Erin 7/6 #1922)*

> *And I think it is because of our leader you know she's a people person and I think that's great and if you've got people on your side all the sheep will follow (Leslie 23/4 #4330)*

> *I think that she's the sort of leader that I would like to be if I was a leader and I am a leader but you know if I was a CNM I'd model myself just on her (Sandy 30/6 #2552)*

When there was a complaint or negative feedback from patients it was difficult for the NUM to accept. An example of this was when there was a patient complaint and the NUM took it very hard.

> *I suppose it has affected me so much because I try to have a perfect unit (Kobe 12/4 #0331).*

This was a reaction from the nurse unit manager following a patient complaint about a nurse. The NUM took full responsibility for this complaint and it affected her personally.

The nurse manager was seen to function mainly as a manager rather than a leader. This included managing operational processes such as transport, patient selection, delegating medical orders and running meetings. Common leadership traits such as motivating, engaging and visionary (Keogh 2004) were not frequently reported by the nursing staff.

6.3.2 Hospital management

The satellite unit in this study was situated in the grounds of a large outer metropolitan hospital (Figure 4.1). The nurse unit manager reported to a nursing director on administrative matters (including human and material resources). The nurses' perception of the function of hospital management was to support the nurse unit manager, provide a safe working environment and ensure administrative functions, most importantly accreditation, were performed.

Accreditation was seen as a major responsibility of both hospital management and the nurse unit manager. This may have been influenced by timing of the fieldwork which was undertaken during the time the hospital was undergoing external evaluation as part of the accreditation process. When questioned in the interviews some nurses found it difficult to associate accreditation with quality care.

> *Oh (laughs) they don't have anything to do with individual patient care I don't think. But if we as a unit can strive to better our phosphates and to have all of our patients above or below a certain marker then that does relate down to individual care (Sandy 30/6/08 #4554)*

Sandy, above, was able to link accreditation with patient care, although Drew's logic below was rather interesting.

It is important. Because we need to keep doing it. Because otherwise we might not do it (Drew 22/3 #1807)

Access flows, exercise program, patient education were seen as what the nurse unit manager presented to the accreditors. These were measurable, quality improvement programs that had been implemented by the unit. There was no evidence that the interpersonal was assessed. In fact, one nurse, referring to recent personal clashes in the unit, expressed her concern that the accreditors did not measure the interpersonal relationships in a unit stating:

We're not being judged on interpersonal relationships are we (Erin 7/6 #0301).

Erin's statement implied that this nurse was unhappy with the interpersonal communication performance of staff and questioned the accreditation's ability to assess this.

6.3.3 Nephrologists

Nephrologists referred patients to the satellite dialysis unit in this study. At the satellite unit nurses performed the dialysis procedures and coordinated the nursing care. Patients attended appointments with their nephrologist on a three monthly basis. The nephrologists did not visit the patients at the dialysis unit so patients had to attend their parent hospital. Medical prescription, consisting of ideal weight, length of treatment and medications were ordered by the nephrologist. Part of the role of the nurse was to implement these orders.

Nephrologists were seen as the members of the health team charged with prescribing the treatment that the patients received. However, there were frequent examples where the nephrologists' orders were 'stretched' or changed to what nurses perceived would benefit the patient at that time (see Section 6.4.2).

> *I wouldn't say that someone should cut their time every treatment or anything like that but if they said that my son is flying in from the UK and I need to leave half an hour early so I can pick him up I'm not gonna say no you've got to do your full hours (Sandy 30/6 #0850)*

This was an example of one nurse attempting to be flexible with the treatment schedule, ordered by the nephrologist, to suit the patient's social needs.

In the satellite dialysis context, management (NUM, hospital management and nephrologists) have both overt and subtle influences on quality dialysis nursing care in the satellite unit. This complex hierarchical structure of reporting to both hospital management and parent hospital nephrologists both enabled and disabled the decision making capacities of the NUM and the dialysis nurses. The power to make clinical decisions varied whether the NUM was present and whether a nephrologist was immediately available.

6.4 Nurses

In the interviews nurses reported they had a significant influence on the quality of nursing care through the information that they obtained and the knowledge that they applied. Nurses described frustration with barriers to education and their struggle to consistently apply clinical guidelines in the satellite haemodialysis context. This

struggle led to the nurses bending the rules or, not always keeping to medical guidelines, hospital policy or unit policy.

6.4.1 Information, knowledge and influence

Information, knowledge and influence' were elements of expertise for the satellite dialysis nurse. Information is defined as tangible and represented outside of the human mind while knowledge is far more complex, being an objective or subjective entity, constantly changing and being re-negotiated (Stenmark 2001). During interviews the nurses did not distinguish between the two terms, information and knowledge, and used them interchangeably. The knowledge referred to in this passage is the explicit and particularly relevant knowledge that the nurses expressed.

The knowledge most frequently referred to by the nurses was related to the technical aspects of dialysis. Nurses reported that there were vast amounts of technical information to be learnt in a dialysis unit. The information, referred to as 'technical knowledge', was related to blood result interpretation (including Kt/V), blood volume monitoring (BVM), haemodiafiltration (HDF) vascular access flow management, blood temperature monitoring (BTM) and ultrafiltration (UF) profiling.

> *What I know about Kt/Vs and BVMs BTMs and all that sort of stuff I've learnt while I've been out here. (Chris 10/5 #2038)*

'Knowledgeable' nurses were those who had sound understanding of this information and could explain how these technologies could be interpreted in practice.

Much of the influential technical information was referred to as 'acute' knowledge. This knowledge was attained by nurses through their acute hospital clinical

experience. These nurses were considered as having a greater influence over other nurses in the unit who did not have acute hospital experience.

> *… I'm far down in the pecking order. Just the vibes I pick up. You have to do your service you have to [have] time in critical care otherwise you are not valued and you haven't nursed and you haven't done it. (Erin 7/6 #1705)*

> *… you've got that acute experience. (Leslie 23/4 #1246)*

The influence of the nurses with acute experience was greater if they explained the rationales for their practice. When rationales were not presented, nurses questioned the validity of this knowledge. They viewed it as only information that may not have been valuable. Erin gave an example of this by stating:

> *I think there's one person here who is quite educated and perhaps knows more than me but I tend not to listen to this person very much because they are very um, it's my way or no way. (Erin 7/6 #1351)*

The nurses believed they were knowledgeable (they had information) however, some perceived that they were not recognised for this knowledge, and thus limited in their influence on others' practice. They saw themselves as autonomous but believed they were not recognised as such.

> *I haven't been studying my butt off for years to just wash and feed people…perhaps we're frustrated. We're educated people and we're not recognised by society. (Erin 7/6 #0016)*

I guess that is what is hard is that he [patient] thinks that we are not competent, that we are negligent we don't know what we are doing. (Kobe 12/4 #0359).

These two comments, one from an experienced and one from a less experienced nurse reflected the perception that the nurses were relatively autonomous, compared to other nurses, however, they were not recognised for their level of responsibility.

Each nurse identified themselves as a nurse with the particular specialty in haemodialysis nursing. Many dialysis technological skills are unknown to other nurses and therefore these skills were highly valued by others. These specialised skills could be used to make the dialysis environment a comfortable working area because when these nurses were seen as the experts in their area it was difficult for others to challenge the quality of their practice without the same specialist dialysis knowledge and skill. This contributed to the view that in a satellite unit some nurses felt others were too comfortable at times.

They um, definitely don't want to have anything to do with general nursing any more. And ah, I do see a reluctance by quite a few of them to move out of their comfort zone. (Hunter 30/6 #2415)

Hunter was referring to the specialist satellite dialysis nurses who used their unique knowledge to stay in the comfort zone of the dialysis unit and not be rostered to other areas of the organisation. This occurrence was particularly the case in this unit because it had only been operating for two years. Most of those in management of the attached hospital had not had experience with managing dialysis units and thus were most likely to allow the specialist dialysis nurses to run the unit with little management interference.

6.4.1.1 Education barriers

Even though nurses believed that they had highly regarded specialist knowledge and skills they also believed there were barriers in obtaining further knowledge. These included lack of education updates provided by the unit, inability to access educational material through the internet, inconsistent messages from medical staff, and clinical guidelines that did not match what was happening at the 'coal face'. Some nurses were provided with technical training prior to working in dialysis and would have preferred to put their technical training into practice immediately.

It was recognised as challenging to provide education updates in this area. The in-service education was mainly provided by external 'experts' from other professions (dieticians, physiotherapists, doctors), universities, other hospitals (nurses, doctors) and from industry. The nurses perceived that the success of the in-service education was dependant on many factors. These included the source, timing and venue.

Nurses were suspicious of industry educators who were representatives of dialysis product companies. They felt these people were only acting in their own interests and staff did not trust them, as the following quote illustrates.

> *Um, here we get a lot of reps that come out here and promote their own thing. Aranesp, EPO and all those sorts of things you know. And that's fine it always seems to be an ongoing war as to which one is best. Who gives you most stuff when they come. To me it's just like a bribe (laughs) …(Chris 10/5 #3015).*

The notion that the companies were trying to bribe the nurses suggested to the nurses that such companies were giving biased information, and subsequently, they questioned the veracity of this information. This is contrary to my recent acute

experience where nurses quoted industry representatives as being the experts in some technical areas. Thus, I concluded that some industry representatives were trusted, and some were not.

Throughout observation and interview the nurses did not frequently use databases through the internet to access information which they found challenging.

> *… articles that come out, and actually there's been not a lot on urea, let me tell you coz I've tried to investigate this because that was my little study I was going to do was looking not so much urea but more albumin and I tried to get articles on that and couldn't find jack shit you know it was more like on um, it was more like on body-building sort of stuff nothing on haemodialysis…I wanted to look into and research but you know you go on the internet to find any articles and there's nothing really out there. (Leslie 7/7 #0645)*

The above quote reflected the inability of the nurse to find research information on relationships between urea, albumin, nutrition and haemodialysis although there have been many publications in this area. She did not know how to access these publications, which may be related to the nurse's own abilities and/or lack of training in accessing the literature.

The inability of nurses to access evidenced-based information in this dialysis unit was a particular concern for me. The satellite unit is situated remotely from its parent renal unit, which limits access to the libraries, journals and text books that the units in the parent hospital accumulate. If these nurses are not trained to use this technology their capacity to explore evidence-based information is seriously limited.

6.4.1.2 Clinical guidelines

The nurses were aware of Australian evidence-based practice guidelines, known as Caring for Renal Impairment (CARI) guidelines, formal organisational practice guidelines and informal guidelines. There was not always consistency across these guidelines and this was frustrating for the nurses attempting to put them in to practice.

> *If they're over 2.0 [phosphate] they [doctors] are even looking at this in outpatient's clinic and they're [doctors] saying oh we're not that concerned about it don't worry about it. Yet CARI and we all know that we've set the indicator target ranges at less than 1.8. Why are some people more focused on it and other people aren't? (Kobe 7/7 #0327)*

The above example was referring to the serum phosphate levels of people receiving dialysis. Serum phosphate is tested monthly on each patient to assist in the management of bone disease, which can be a secondary complication of ESKD. USA guidelines state an upper limit of 1.78 mmol/l (National Kidney Foundation 2003) while Australian guidelines have recommended an upper limit of 1.6mmol/l (Hawley 2005). Some nephrologists have strongly encouraged an upper limit of 1.8mmol/l and some 2 mmol/l for phosphate. The nurses found it difficult to accept these variations, and consequently, the perception was that nephrologists were presenting inconsistent treatment orders.

In addition to the inconsistent phosphate guidelines, satellite dialysis nurses perceived that medical guidelines and medical decisions were not always in the best interest of the patient. For example, Kobe referred to one nephrologist who requested

that dialysate baths contain a potassium level of 1.5 mmol/L. This request resulted in nurses adding a potassium supplement to the dialysate.

> *I mean I've challenged him on why put people on a 1.5. I mean one it's like a pain in the arse making it up but point 5 is it really going to make that much difference? And like I was saying to him I've actually refused to make them. (Kobe7/7 #1235)*

Kobe questioned the benefit of the 1.5 bath and thus refused to make them most of the time. There were two patients who still received 1.5 potassium baths because:

> …*they are on Digoxin.* (Kobe7/7 #1239)

In the interview, when I asked what the evidence was for 1.5, Kobe could not state evidence to support or refute the need for a potassium bath level of 1.5 mmol/l. This is an example of an experienced nurse questioning, and then refusing to follow medical orders because of the perceived nursing workload and questionable patient benefit even though the evidence was unclear.

In a satellite dialysis unit the nurses' access to evidence-based information contributed to their knowledge and influence. This knowledge is important because of the varied orders from the nephrologists and nephrology nurses from the different teaching hospitals. This is a complex issue for this satellite unit and requires an evidence-base for optimal quality dialysis nursing care. Satellite dialysis nurses who have access to up to date evidenced-based information can inform their knowledge and, in turn, inform their practice and the practice of others.

6.4.2 Bending the rules

Bending the rules by nurses is a theme that was frequently discovered throughout the data. It refers to the care nurses provided that was not always within the accepted evidence, medical guidelines, hospital policy or unit policy. Examples include fluid removal practices, treatment shortening and reappropriation of nutritional supplements.

In satellite dialysis unit there are expert, intermediate and novice nurses (see Section 2.5.3). In hospital dialysis units these have been named expert, experienced non-expert and inexperienced non-expert (Bonner 2007). Bending of the rules was mostly undertaken by expert nurses, although, in this satellite unit, there were novice (experienced and in-experienced) nurses who also claimed they were rule benders.

The major justification for bending the rules by the nurses in this study was that it was in the patient's interest. The nurses believed that they knew the patients better than any medical guidelines and they believed they benefitted the patient by bending the rules a little. An example of this was nurses removing fluid from the patient. Prior to each dialysis treatment nurses, with some negotiation with the patient, calculated the total fluid removal from the patient. The usual goal was to remove enough fluid in order to achieve the patient's ideal weight (also known as dry weight). Nurses were also aware that chronic hypervolaemia in people receiving dialysis contributes to left ventricular hypertrophy, myocardial infarction, congestive heart disease and higher mortality (Jaeger and Mehta 1999). However, as the following example suggests, some nurses did not aim for the dry weight citing some patients' discomfort when very dry.

Well I don't leave em that wet but you just leave em a little bit wet coz if they're not eating or drinking very much I don't want to dry them right out so they'll feel crap (Leslie7/7 #3617).

Leslie, an experienced nurse, exemplified nurses who understood the importance of the concept of the ideal weight yet overrode it because of her belief that patients 'felt better' if they remain hydrated slightly above their ideal weight. This belief was based on her twenty years of experiential knowledge mainly gained from listening to people receiving dialysis. This was an example of nurses deciding between medical guidelines and what they believed was best for the patient.

A further example of nurses bending the rules was the shortening of these hours during the dialysis treatment. The shortening of hours is a frequent occurrence in haemodialysis units (Kimmel et al. 1995). Shortening hours decreases the dialysis time and therefore decreases the waste removed in the dialysis treatment. This type of rule-bending was reported in the interviews by most nurses in this study.

So you might cut a treatment short so that all areas of their lives are fulfilled (Sandy 30/6 #0650)

This nurse was prepared to shorten hours, usually in the short term interests of the patient. Her actions were not viewed by her as rule-bending, but rather meeting the patient's individual life needs.

A more obvious example of bending the rules was a nurse who actual stole nutritional supplements, called Ensure (trade name for a protein supplement) for those people receiving dialysis who they thought needed the protein.

I steal him 'Ensure' (Leslie7/7 #0356).

If there was an excess supply of supplements, or patients had not used their supply, then the nurse gave away the supplements to a patient who may have benefitted from the additional protein. Although Leslie admits that this is 'stealing' it also could be viewed as a reallocation of resources.

Throughout the period of data collection there was no documented evidence of the nurses 'bending the rules'. In the two examples cited above neither were documented, suggesting that there is a form of silence that accompanies bending the rules. All staff interviewed bent the rules but nowhere is there documented evidence of this admission. It further suggests a form of hidden autonomy where the nurses, often in collaboration with patients, will bend the rules in order to benefit the patients. Not only does this benefit patients but it may benefit the nurses who do not follow normal procedure and, for example, need to order new stock for a patient.

Findings in this study have shown that the satellite nurses bent the rules somewhat. They believed that they knew the patient best and were willing to take risks and bend rules as long as they believed it was in the interests of the patients.

6.5 Satellite environment

Throughout the interviews nurses described their working environment compared to the hospital environment was unique and that this unique environment influenced the quality of nursing care in the satellite unit. The satellite environment themes included: 'not just four walls', 'more personal time', 'patient features' and 'nursing team'.

6.5.1 Not just four walls

'Not four walls' described the perception that the satellite unit was not simply a clinic bounded by its geography. Although the physical environment, composed of one large dialysis room, was one view of a satellite dialysis unit, there were complex community, social and health care relationships related to the dialysis unit. Nurses were also involved with what occurred outside the four walls.

> *…we've got one that's just returned to work so that's really great and we really fit in with what he's doing which is really important because coming here three times a week is a huge impact on somebody's day (Leslie 23/4 #2332)*

> *…that whole thing of listening to the other issues in their life and maybe someone's deliberately abusing something or an aspect of their treatment because their kids have been taken away by an ex wife and so people get on downers for all sorts of reasons. If we can listen to what the real reasons are and why they are happening then that's certainly important (Sandy 30/6 #1745)*

There was a high level of personal involvement in the satellite unit as exemplified by the above quotes. These two quotes were examples of the nurses describing the satellite dialysis nursing care that impacted on patients and contributed to a patient returning to work and for a patient's treatment non-adherence. Thus the nurse's perceived their work in the satellite dialysis unit extended beyond the service provided within the four walls.

6.5.2 More personal time

Having more personal involvement with people receiving dialysis was particularly apparent when the nurses compared the satellite unit with the hospital unit. It was not just a technical role but highly influenced by the interpersonal relationships between nurses and people receiving dialysis.

> *I think we are quite close to our patients yet the bigger ones, the [parent hospital], they are not. You do not have the same rapport because they are more acute (Drew 22/3 #0036)*

> *When I came out here I realised it was a lot more personal involvement, personal time, personal liberties, um, more of you required than do your hours and just go home (Chris 10/5 #3148)*

Drew's quote described the difference between the patient/nurse relationship in the hospital and the satellite unit. Chris concurred by describing the more personal time that is spent with people receiving dialysis in the satellite unit. These findings reflect the difference between hospital and satellite dialysis nursing. There was more emphasis on the interpersonal than the technical in the satellite dialysis unit. Therefore, quality nursing care was perceived by the nurses to involve more personal time with those on dialysis.

6.5.3 Features of people receiving dialysis treatment

The satellite dialysis concept was originally developed to allow people who required dialysis to receive treatment closer to their home and in a less 'hospitalised' setting. Thus it was originally conceived that the healthier people receiving dialysis with fewer co-morbidities would be treated in the satellite units. The sicker patients would

be dialysed in a tertiary hospital that provided acute services (x-ray, blood diagnostics, specialist medical officers and intensive care support).

There is still the notion that the satellite unit has fitter patients, however patient acuity is changing. This is the result of people who commenced dialysis relatively fit whose condition has deteriorated, and a perception that hospitals are sending sicker people to satellite units because there are not enough beds or chairs in the hospital units. Whatever the reason, the satellite patients are requiring more and more intensive nursing care.

There were times when a patient required considerable nursing care. The patient may have chest pain, a hypotensive episode or have difficulty with activities of daily living. Thus a patient who was getting sicker received more nursing time than the fitter patients. Other patients were aware of this and aware of the health status of most other patients. There was sometimes tension when patients became sicker.

> *And on Saturday I arrived for a late shift which starts at 12 and there was a patient in there who had chest pain that morning. She was sitting there with oxygen on and was still scoring chest pain at 4 out of 10. It had been 8 out of 10. It was 3 o'clock before that woman finally left our dialysis unit. So for 3 hours she had been sitting in that chair with chest pain and all she was given was some oxygen and some anginine and it was just disgraceful (Hunter 30/6 #3654)*

This is an example from the satellite dialysis unit that is occurring more frequently in these units and illustrates the difficulties that arise when sicker patients remain in satellite units. It also is an example of the nurse's frustration that the sicker patients

were not being cared for well enough because the satellite unit, with limited medical support, was not the best place for someone with chest pain.

The acuity of people receiving dialysis in satellite units may have changed somewhat however, the nurses felt that it was important for all patients to get along with each other. Even when the patients are acutely sick, the physical environment of one large room, required each patient to spend four hours sitting with ten other people who they may or may not get along with. There was minimal privacy in the room so everyone knew what each other is up to.

> *I mean obviously they're on their own shifts so they get to know the other clients so they have their chit chats amongst themselves, so it's just building up that friendship in dialysis and I mean one patient well he's incentre at the moment and another patient on that shift went in to see him (Leslie 7/7 #4225)*

Getting along with each other is not just in the unit but when patients are being transported to and from dialysis. There were examples of patients spending over six hours with other people receiving dialysis. This can develop close friendships but it can also cause conflict between patients.

> *I've probably underestimated what effect it has had on the other patients. There are a couple with him and they say "he's just so bad in the car and he is constantly having digs" and I've gone just "try and ignore it and it's not personal la la la" without really realising that that is their cry, and it's horrible to be in the car with him, and I don't want to be in the car with him and all of that.*
>
> *(Kobe 12/4 #0540)*

The above quote described an event where one patient had been registering complaints with the nursing staff and had also been complaining to other patients. It was an acknowledgement from a senior nurse that there was conflict between the patients that was not recognised by nursing staff but affected patients. Thus, the lack of recognition by nurses, of the unique features of people receiving dialysis in a satellite unit, may influence the quality of care.

6.5.4 Nursing team

The nursing staff in the satellite unit perceived that satellite dialysis nursing was unique and that they contributed to this. The unit in this study had a low turnover of staff and a great sense of teamwork. However when critical events occurred, the small satellite nursing team was challenged to remain a cohesive team. There was a sense that the team was vitally important and it was a priority to maintain this teamwork. In saying this there were conflicting views on how well this was achieved.

> *Um and although it can have its stressful times and lately with the few critical incidents it has been stressful um it's nowhere near as stressful as ward work. Nowhere near. I think we work well enough as a team despite certain personality differences. (Hunter 30/6 #2107)*

> *If there was something needed to be done it wasn't that that's their patient or that's their thing to do people just got in and helped out people and there was a lot of support and a lot of friendship and I think there's that undercurrent now it sort of seems to have divided staff a little bit (Kobe 12/4 #0739)*

> *If you can all work together as a team then you're laughin'. There's your good unit. (Leslie 23/4 #0139)*

That because there is not a high changeover and we get bored and the people we attack when we're frustrated are each other. (Erin 7/6 #2847)

The above quotes demonstrate opposing perspectives on teamwork in the unit. However, the importance of being a team was clear even though recent events in the unit had tested the team. Although this sense of team had been challenged it was seen as a vital element of satellite dialysis nursing.

6.6 Chapter summary

Through the perceptions of nurses in this study there were various influences that affected the nature of satellite dialysis nursing care which, in turn, influenced the quality of satellite dialysis nursing care. These influences, both external and internal to the dialysis unit, were perceived by the nurses as unique to satellite dialysis and contrasted with hospital dialysis nursing care.

The finding of unique satellite dialysis influences implies that there were unique cultural and power aspects affecting satellite dialysis nursing care. The following discussion in, Chapters 7 and 8, will interpret these findings, combine previous research with the findings of this study, and reveal previously unreported cultural and power-related aspects of satellite dialysis nursing.

CHAPTER 7

DISCUSSION 1: SATELLITE DIALYSIS NURSING CULTURE

7.1 Introduction

The aim of this study was to explore haemodialysis nurses' perception of quality nursing care in one Australian satellite haemodialysis unit. The two previous chapters presented findings related to the nurses' perceptions of: what is quality; what is not quality, and what affects quality in a satellite dialysis nursing unit. Findings from Chapter 5, what is and what is not quality, showed that that the nurses perceived a clear distinction between the culture of the satellite dialysis unit and the culture of the hospital dialysis unit. Aspects of this satellite dialysis culture will be discussed in this chapter under the headings satellite culture, technology, caring, the personal and education, blood pressure management and patient transport. I will integrate these aspects with the published literature in order to contribute to understandings of satellite dialysis nursing care.

7.2 Researcher's position revisited

At this beginning discussion stage the need to revisit and confirm my own position as part of the process of my critical approach is necessary. I entered this study in 2003 with the idea that quality nursing care in haemodialysis units could be defined, and ultimately measured, in order to monitor and improve standards of quality nursing care in satellite dialysis units. I emerged from the fieldwork in 2007 realising that quality nursing care can not be measured using a simple tool. A satellite dialysis unit is complex and is very different from quality care in a hospital haemodialysis unit.

This has been discovered through exploring the perceptions of the satellite nurses in this study who, mostly, have had experience in both acute and satellite settings.

The major goal of this research was to provide the potential to improve satellite dialysis nursing care. This goal encouraged me to ensure my findings and recommendations were disseminated in a language that could be readily accessible to renal nurses. Even though the study's theoretical underpinnings may be drawn from critical theorists such as Habermas, Foucault, Bordieu and Giddens, I was committed to applying theories in ways clinicians could use to inform practice. This did not mean a dumbing down of the often complex theoretical constructs of critical theorists but more a use of their language that could be understood and applied by clinicians.

7.3 The satellite dialysis unit nursing culture is different

The previously unreported finding of this study was that the nurses' perceptions of satellite dialysis nursing culture differred from the in-centre dialysis unit culture. Given that satellite dialysis units were originally developed for a different purpose than the hospital units it is surprising that this difference has gone unreported for so long. This discussion highlights the complexities and differences in the satellite culture compared to the hospital dialysis culture.

Satellite dialysis units were initially intended for medically stable people with low acuity and higher self care capabilities (Agar, MacGregor, and Blagg 2007; Lam et al. 1994). They were often built in areas geographically distant from hospital dialysis centres but closer to where patients lived (Feest et al. 2005; Lehoux et al. 2007). These satellite units were most commonly run by nurses and did not offer daily medical or nephrology staff attendance (Agar et al. 2005; Lehoux et al. 2007).

Findings from this study confirm the nurses' perceptions that people receiving dialysis are getting sicker resulting in challenges for nurses in the satellite dialysis environment. This is related to the patients becoming older and with more co-morbidities, particularly diabetes, resulting in higher acuity levels of nursing care (Soroka, Kiberd, and Jacobs 2005; Elseviers et al. 2006). Given the relative autonomy of satellite dialysis nurses compared to hospital dialysis nurses, the perception that the people receiving dialysis are getting sicker complicates the already complex challenge of incorporating technology with the nurses' caring role.

7.4 Technology and caring

The tension between caring and technology in satellite dialysis nursing was evident in this study. This tension has already been acknowledged in the literature (Bevan 1998; Hoffart 1989) in the context of the highly technical focus of nurses in hospital haemodialysis units (Ashwanden 2003; Hardcastle 2004; Wellard 1992). In the satellite dialysis setting technology and caring are complex with further analysis required to understand the relationship.

The hospital's highly technical focus has coincided with the claim by nurses in this study who valued the acute hospital dialysis nurse's knowledge and experience. Technical knowledge had a more measurable and numbered approach (Kt/V, urea clearance, haemoglobin, phosphate levels) emphasising the importance of technical knowledge and skill. The technically skilled nurse has been described as claiming a higher status than the non-technical nurse in the medical hierarchy (Fairman and D'Antonio 1999) and has been viewed as prestigious and powerful (Barnard and Gerber 1999). This was clearly a perception of nurses in the satellite dialysis unit in this study. Those who had been nurses in satellite units described that they felt lower

in status than those who had acute hospital experience. Therefore, technical aspects assumed changing importance depending on the context: the hospital dialysis unit or the community based satellite dialysis unit.

The importance of the nurse in this technology/caring relationship relates to the nurses having claimed this 'space' (Barnard and Gerber 1999) where the highly technical treatment meets the chronically ill satellite dialysis patient (Bevan 1998). The personal needs of the satellite dialysis patient, as perceived by the nurses, were intimacy, humour and 'the little things'. The nurses also saw their role as encouraging employment and supporting the emotional and social aspects of the patient. These personal needs are vastly different to the technical priorities of dialysis in this environment.

The satellite dialysis nurses required confidence with their ability to combine both the interpersonal and technical in their nursing care to provide quality nursing care. While some authors support the argument that technology opposes caring (Cooper 1994; Locsin 1998), more recently nurse scholars have argued that it is not a simple dualist technology verses personal caring (Barnard and Sandelowski 2001). Therefore an examination of how satellite dialysis nurses have applied the technology can assist further understanding of this complex relationship.

7.4.1 The application of technology

The emphasis on technology may not lie with the technology per se but rather the nurse's application of technology. The application of technology in nursing has been claimed to have led to the point of dehumanising the person receiving the technology (Barnard and Sandelowski 2001). An example in the satellite dialysis unit was the dehumanisation of the patient as common practice when the nurses incorporated both

the patient and the machine in to the patient's name. When a machine alarmed the nurse would commonly ask "is that you (insert patient's name here)"? The patient and dialysis machine were seen by the nurse as one entity while the patient was attached to the machine. This contributed to a dehumanising process that may or may not have been overt and certainly wasn't recognised by the nurses.

Technology has a strong ethical foundation given that it has a strong beneficent aim (O'Mathuna 2007), consistent with ethics in nursing practice (Kerridge, Lowe, and McPhee 2006). However, the beneficence of dialysis technology (ie. keeping a person alive) may result in diminishing the highly valued principle of autonomy. In saying this, a patient who does not receive dialysis will probably die, resulting in no capacity for autonomy.

This study has shown that technology and caring are not mutually exclusive and a tension exists. In saying this, aspects of technology have sometimes been valued higher than interpersonal care. Examples of this were where the nurses attended to a dialysis machine alarm or the telephone had to be answered, rather than sitting and listening with a patient. Barnard (2002) described the humanities' philosophical perspective that technology is more than the mechanistic version of technology. Rather it was how people experience the technology that is the more important. Furthermore, human characteristics that are affected by politics, gender, culture and values in turn affect how technology is experienced (Fairman and D'Antonio 1999). Therefore, it is not always that the technology is detrimental to nursing care but it depends on how the technology is embraced as to its affect on personal care.

There were influences evident in how nurses embraced and applied technical skills and knowledge. These influences were related to the hierarchical application of technical skills and knowledge. This was consistent with the claims of previous nurse

scholars who had noted hierarchical influences on the application of technology in nursing (McFarlane 1976; Melia 1979). Examples of this hierarchical influence were the way the nurse unit manager was called out of an interview when she really was not needed, and the instruction of *experienced needlers only* (see Section 5.2.1.2). Therefore, in my study, there was evidence of the hierarchical culture that determined the application of technical skills and knowledge.

This study demonstrated that the application of the technical was determined by who you were. If you were the nurse unit manager or a nurse with acute hospital experience you were more likely to apply the skills and knowledge than if you were a less experienced. If you were less experienced you were more likely to alert a senior member of staff. Therefore, the level you were in the hierarchy had a major influence on the nurses' application of the technology.

The above analysis can be viewed as nurses constructing their practice, or constructing their reality in the satellite dialysis unit. Nurses in influential positions or with influential status construct practice norms according to their dominant position in the culture (Mantzoukas and Jasper 2004). This construction reflects the notion of disciplinary technology (Foucault 1973) where the dominant becomes the norm (Doolin 1998; Riley and Manias 2002). Thus, technology combined with the constructed hierarchy determined the use and influence of the available technical skills and knowledge.

7.4.2 Technology, caring and habitus

An alternate understanding of the technology/caring tensions is provided through Bourdieu's theory of habitus (Bourdieu 1977) where he attempted to explain practices in a socio-cultural context (Webb, Schirato, and Danaher 2002). Bourdieu's

habitus was a concept that, like the well recognised term habit, refers to systems of social practices. It assists in explaining how people develop attitudes and dispositions, and how they engage in particular practices (Webb, Schirato, and Danaher 2002). Bourdieu claimed that engagement in social practices is not based on conscious calculation but rather results from unconscious dispositions towards practice (Bourdieu and Johnson 1993) or "second nature" (Jenkins 1992 p.72).

Habitus contributes to explaining the practices of the satellite dialysis nurses. On one hand there is the cultural and historical production of individual practices, such as delivering a dialysis prescription of Kt/V greater than 1.2, which reflect the nursing context, norms and rules. The other part of habitus is the individual production of these practices that are "always act[ed] from self interest" (Webb, Schirato, and Danaher 2002 p. 15). An example of this was the need to be seen as a competent nurse who abided by the protocols and rule of the unit (see Section 5.2.1.1)

Bourdieu explained that habitus evolved from turning history into practice and the forgetting of the history, which he described as the as "the unconscious" (Bourdieu 1977 p.47). Nurses' practice around the perception of competing priorities (technical and interpersonal) was influenced by the habitus of the satellite unit, and influenced nursing practice. However, from this study, the application of the technical can be done in a way that is more personal and caring.

7.5 The satellite unit is more personal

The major finding regarding the nurses' perceptions of differences between satellite and hospital dialysis units, related to the greater personal culture that was found in the satellite unit. Intimacy, 'the little things' and humour were significant

characteristics of the satellite unit which reflected the more personal community characteristics of the satellite unit.

The proposition that nurses perceive the satellite dialysis unit as more personal than the hospital dialysis unit has not been well established in the literature. Furthermore, there is no literature, quantitative or qualitative, that has compared the interpersonal aspects of hospital and satellite dialysis nursing care. Subsequently this proposition is hard to establish, however, there is a strong theme from the perceptions of these nurses that the satellite unit was a more intimate and personal environment than the hospital unit.

Personal aspects of care have been reported in other community nursing specialties and the renal nursing literature. Personal aspects identifying the nurse-patient relationship have been reported in community mental health nursing (O'Brien 2000 p. 47), general practice (Jones, Edwards, and Lester 1997), community palliative care (Mok and Chiu 2004; Luker et al. 2000) and fertility nursing (Allan 2001). Aspects such as knowing the patient as more than a set of clinical symptoms, trust, part of the family and intimacy have been reported in these contexts (May 1992). Similarly, the satellite nurses identified these features in this study.

'Knowing' the patient was identified as being important to nurses in the satellite unit. This 'knowing' was more the "getting a sense of the patient as a person" (Tanner et al. 1993 p.275) rather than "knowing the patients as a set of patterns and responses" (Tanner et al. 1993 p.275). Tanner et al. (1993) studied critical care nurses who, like hospital dialysis nurses, are focused on the technical/clinical knowing. The satellite nurses study found that the knowing was more the 'patient as a person' knowing and contributed to the perception of the ideal nurse.

7.5.1 The ideal nurse

The personal aspects of community nursing have spurned further commentary on the notion of the 'ideal' nurse and the 'good enough' community nurse. This was introduced by Allan (2001) in her ethnography of fertility nursing. Fertility nursing had several similar elements to satellite dialysis nursing in that it is highly technical, features patients with chronic health concerns and consists of many repeat patient/nurse interactions. The ideal or 'fantasy' nurse was "giving, caring, motherly and warm and the real nurse was there if needed, emotionally aware but not intimate" (Allan 2001 p.55).

There were elements of the fantasy nurse and elements of the real nurse in the satellite haemodialysis unit. By Allan's (2001) definition elements of the fantasy nurse were demonstrated by nurses in the satellite unit feeling that the patients could discuss anything with them. Furthermore, there was evidence of the 'real' or 'good enough' nurse who didn't want to get too close. Thus, there was variance in the nurses' perception of their role given that there were some nurses who were willing to listen and talk about anything (the fantasy, ideal nurse) and some who did not want to get too close (the good enough nurse).

7.5.2 Intimacy

Although these examples suggest the varying nature of each nurse and each nurse's perceptions of the intimacy that is involved in their nursing care, overall, there was a greater emphasis on the more intimate and more personal culture than the nurses perceived was evident in the hospital units. Perceptions by the nurses that patients in the satellite unit received more personal attention and the nurses sat down and talked to them more were examples of this. Nurses in this study reflected on their

experience and compared the satellite dialysis unit to a hospital dialysis unit that they had worked in previously. They suggested that relations were more personal and that there was greater intimacy in the satellite dialysis unit.

The concept of intimacy has not been widely explored in the renal nursing literature. Nurses from other contexts have described intimacy as simply being there (Muetzel 1988) and that it involves the "self disclosure of personal information with the expectation of understanding and acceptance" (Kadner 1994 p.215). Certainly self disclosure has been a recurring theme when exploring nursing intimacy (Reis 1995) accompanied by the elements of trust, reciprocity and emotional closeness (Timmerman 1991).

The intimacy that was observed in the satellite unit and noted by satellite nurses was not only an emotional intimacy but a physical intimacy. The physicality usually was in the form of gentle touch (FN 22/3 #1208). Not only did nurses touch people receiving dialysis in the course or taking a blood pressure, or when needling a patient but there was an intimate touching described by Sims (1986) as an expressive touch. This expressive touch referred to the spontaneous touch aimed at communicating feelings and thoughts to another. Forms of expressive touch noted in the satellite unit were hugging, patting on the arm and holding a patient's hand. From the nurse's perspective this intimacy was expressive, reassuring and exemplified a personal caring.

7.5.3 Technical intimacy

The notion of providing intimate and personal care is challenging in the satellite dialysis setting because the satellite unit environment is open-spaced with very little personal privacy for the people receiving dialysis. Satellite units have been designed

to accommodate the technology. Thus, there was little evidence of the somology, or 'dirty' intimate nursing (Lawler 1991) in the satellite unit, which involves the physical touching involved in personal hygiene and is performed behind screens, doors and curtains. There was no opportunity in the satellite unit for the intimacy that Lawlor (1991) described given the open layout of the unit and time constraints before and after the dialysis treatments. Thus, the satellite unit has what I describe as a 'technical intimacy' that is intimacy undertaken in full view of the technical environment.

Connected with intimacy were the 'little things' that the nurses provided and humour that they used to contribute to the intimate and personal experience. The 'little things' and humour contributed to the personal, intimate nurse/patient relationship, which was consistent with a guarded alliance relationship originally described in the context of chronic illness by Thorne (1993) and applied to hospital haemodialysis relationships by Sloan (1999). I observed, and was told by the nurses at interview about, examples of this type of relationship, which was characterised by respect and interest for each other. Their relationships had developed to a guarded alliance that was exemplified by open disclosure at sometimes, but limited disclosure at other times.

In addition to the intimate and personal aspects, a major nursing role perceived by the nurses was educating people receiving dialysis. This was interwoven into much of the practice of satellite dialysis nurses.

7.6 Educating people receiving dialysis

Dialysis nurses in this study perceived that teaching and educating people receiving dialysis were primary aspects of their practice. This was consistent with previous

research in haemodialysis units which noted the educating role of the dialysis nurse (Bevan 2007; Bonner 2003; Perumal and Sehgal 2003; Wellard and Bethune 2000). Perceptions of nurses in this study were consistent with the notion that adherence to the dialysis regimen is improved through nurses educating people receiving dialysis (Headley and Wall 2000). In contrast there are scholars who argue there is little empirical evidence that the one way flow of information from nurse to patient has improved medical regimen adherence (McDonald, Garg, and Haynes 2002).

7.6.1 Didactic or negotiated

An example of a didactic education program in my study was where the nurses provided education aimed at decreasing the patients' phosphorous blood levels. The education program was targeted at patients' medication and diet adherence, which was known to influence blood phosphorous levels. Although the nurses did note an effect, it was only a short term effect. Unfortunately, this was an example of an education program that was successful in the short term but unsuccessful in changing patient's long-term behaviour. I propose that the didactic education process is a component of the compliance approach as described by Woodcock (1999). Woodcock suggested that this approach is used because of "stressful working environments and limited resources" (p.29). The findings from my study suggest that it is far more complex than this.

What I saw and heard in this study of satellite dialysis nurses were more embedded work practices related to the compliance approach. These embedded practices represent an example of Bourdieu's (1977) unconscious attitudes and dispositions that contribute to the habitus of nursing practice (see Section 3.5.1). Moreover, the expectation of compliance was so embedded that even when this finding was presented to the nurses in my feedback presentation following my fieldwork, it was

difficult for the nurses to identify this embedded practice (Appendix M). Thus, the more embedded the practice, the more difficult it is for the nurses to identify it in their own practice.

Didactic education processes I observed and that the nurses described in interview are unlikely to successfully change damaging health behaviour. It has been proposed that the quality of these nurse/patient relationships actually determines adherence to regimens (Kammerer et al. 2007). The strength of the dialysis nurse's role is their potential to "respond to the client's experience as a person living on dialysis" (Polaschek 2003 p.50) and not a didactic one way transfer of information from the 'expert' nurse to the 'naïve' patient. Thus the quality of the therapeutic nurse/patient relationship in the dialysis setting may depend on negotiated care planning between the nurse and the person on dialysis (White 2004; Polaschek 2003). This negotiated care has the potential to improve satellite dialysis nursing care.

There were many examples of didactic educational encounters in this study of satellite dialysis nurses. Complicating these encounters were observations that the didactic approach to educating people receiving dialysis was also combined with intimate, personal actions that were clearly mutually acceptable and had developed over long periods of time. These relationships were to the extent that nurses in the satellite unit believed that they had developed bonds with some people receiving dialysis that may have extended beyond professional nursing boundaries. The nurses perceived that the close relationships occurred more in the satellite dialysis unit than the hospital unit and were aware that negotiation was important. They recognised this when one nurse described a patient who appreciated negotiation rather than being told what to do. This nurse demonstrated an ability to recognise when negotiation was absent from a colleague's nursing practice, but she was not aware of the non-negotiated way that she framed her responses.

7.6.2 Education and behaviour change

In this study nurses vented their frustrations related to the limited effect their education had on behavioural change of people on dialysis. The nurses' frustrations with patients not adhering to weight gain, dietary or medication regimens were clearly evident. Further analysis led me to question whether their frustrations were part of the nurses' concerns for the patients' health status or a more personal frustration, where the nurses had little or no impact on the behaviour of the people receiving dialysis. Thus, when the people receiving dialysis had not changed their health-damaging behaviour following education by the nurses, the nurses felt that they had 'failed' in their education. Furthermore, this failure of the nurses' own ability to change the behaviour of another caused them to look for reasons why the education had failed. Thus, the tendency to 'blame' people on dialysis for non-adherence may not be just about these people non-adhering, but about nurses being unsuccessful change agents.

There is evidence that patient education improves outcomes for people receiving dialysis (Nicolucci, Cavalierre, and Scorpoglione 1996), however educating patients in the traditional didactic form or authoritarian approach (Bernadini 2004) that is common in dialysis units, has not been shown to improve adherence to medical regimens (Loughman-Adham 2003). There is support for strategies other than direct education to assist health regimen adherence among people receiving dialysis such as patient/health provider partnerships (Kutner 2001; Polaschek 2003), cognitive behavioural programs (Johnstone and Halshaw 2003), screening/profiling (Christensen and Smith 1995; Johnstone et al. 2004), primary healthcare approach (Sehgal et al. 2008) and self management programs (Kammerer et al. 2007). The importance of these educational approaches over the autocratic approach confirms

their need for further exploration in satellite dialysis units predominantly provided by nurses.

7.7 Omissions from considerations of quality

Findings of this study that related to the satellite nurses' perceptions of quality were around technology and caring, the personal and educating people. Unexpectedly, two aspects of the satellite dialysis nurses' role were not perceived by the nurses as being important in quality nursing care. Nurses perceived they spent a great amount of time involved in blood pressure management and patient transport but neither were perceived by them as pertaining to quality care. The lack of interest in long term blood pressure management was a particular concern and required analysis of clinical guidelines to assist in the interpretation of this finding.

7.7.1 Long term blood pressure management

The nurses' perceptions that long term blood pressure management was not a part of their role concerned me and needs further exploration. Management of blood pressure has implications for patients' health outcomes. People receiving dialysis have hypertension (BP>140/90) rates of 70 to 90% (Salem 1995) significantly contributing to increased morbidity and mortality (Mazzuchi, Carbonell, and Fernandez-Cean 2000). In Australia in 2005, 49% of all deaths of people on dialysis were due to cardiovascular related causes (ANZDATA 2007). Conversely, low blood pressure has also been associated with increased mortality (Foley, Herzog, and Collins 2002; Li et al. 2006) suggesting that blood pressure management for people receiving long-term dialysis is more complex than simply reducing high blood pressure. Although there are complexities in hypertension management, accepted

recommended practice is to aggressively treat hypertension in people receiving haemodialysis (Foley and Agarwal 2007).

Non-pharmacological interventions have been shown to reduce interdialytic blood pressure for people receiving long-term dialysis. These include decreasing salt intake, decreasing dialysate sodium, titrating ultrafiltration rates and patient education (Al-Hilali et al. 2006). Nurses can play a role in these interventions, however, nurses did not perceive that managing long term interdialytic blood pressure was relevant to quality care. This perception contrasted with other elements of quality care such as phosphate and fluid education that the nurses perceived as a major part of their role.

There are various reasons why satellite haemodialysis nurses may not perceive long term blood pressure management as a priority in quality nursing care. Although the factors involved may be complex I propose that the major influence is the lack of perceived knowledge by nurses of long term blood pressure management, lack of accessible practice guidelines and the historically-based dominance of the nephrologists in the dialysis model of care.

Lack of perceived knowledge relating to blood pressure is contrasted with the nurse's role in improving long term blood pressure management. The lack of knowledge can be related back to the previous findings around access to knowledge. Limited recent hospital in-service education had been provided relating to long term blood pressure management and there was no evidence that nurses applied research findings in their practice. Although research around blood pressure management was mainly from medical researchers and not nurses, other research findings were embraced by nurses. Research related to urea reduction, hyperkalaemia and fluid gains were all applied by nurses. Long term blood pressure management was notable by its absence and

exacerbated by the lack of guidelines for long term blood pressure management for people on long-term dialysis.

7.7.2 Complexities of practice guidelines

Although it is clear that chronic hypertension and hypotension increase morbidity and mortality in people receiving dialysis, there are no clear guidelines that guide haemodialysis nurses. Guidelines in the USA, Australia and Europe have provided little guidance for the management of blood pressure for the person receiving long-term haemodialysis. European Best Practice Guidelines (EPBG) advise that hypertension, along with other cardiovascular risk factors, should be assessed six monthly (ERA/EDTA 2002). There are no CARI hypertension guidelines for haemodialysis patients apart from an archived guideline that supports salt restriction, lowering dialysate sodium and encouraging target pre-dialysis blood pressures of 140/90mmHg (CARI 2003).

Blood pressure guidelines are available for people with chronic kidney disease (CKD) stages 1 to 4 (CARI 2005; KDOQI 2004). These stages range from 1 to the more diseased stage 4. CKD stage 5 requires dialysis or transplantation. The reason why hypertension is emphasised in the pre-dialysis population is to slow the progression of kidney disease to stage 5, which then requires renal replacement therapy. Notwithstanding this emphasis, it is curious that once a patient has reached stage 5 and is on dialysis, blood pressure guidelines are not clear.

American, Australian and European guidelines are dominated by urea related recommendations. America's Kidney Disease Outcomes Quality Initiative (KDOQI) guidelines devote their first nine haemodialysis guideline sections to the measurement of urea and not one on the management of hypertension for dialysis

patients (KDOQI 2000). In Australia, two out of six CARI haemodialysis adequacy guideline sections relate to urea removal. Although dominated by urea-related adequacy, European guidelines are the only ones that specifically advise that time and/or frequency of dialysis treatments need to be increased for the hypertensive patient (Tattersall et al. 2007). Overall there is far more emphasis on urea related adequacy than on other measures of patient related quality such as hypertension.

In the satellite unit, guidelines were identified by the nurses as being a necessary tool to guide their practice. They cited serum phosphate, serum urea clearance (Kt/V), serum albumin and interdialytic weight gains as examples of practice that have been directed by national and international guidelines. From this, I concluded that the paucity of guidelines for blood pressure management for people receiving dialysis may contribute to the laissez faire attitude of nurses towards hypertension in the dialysis patient.

7.7.3 Nephrologist dominance in model of care

In addition to the lack of guidelines, I propose that the historical development of the model of care for satellite haemodialysis patients has influenced the nurses' provision of care. More accurately, this development is an example of the perception of the influential nephrologist, often conveyed through the nurse unit manager. Knowledge related to patient's blood pressure has been an example of this.

In saying this, nephrologists are only part of a system where the choice of guidelines influences patient care priorities. Using guidelines and experience they communicate their medical orders to both the people receiving dialysis and nurses. The outcome of these communications in relation to blood pressure is the prescription of antihypertensive medication and the possible request for the patient's volume status

to be changed relative to the patient's perceived ideal weight. Although nurses are the health professionals who have the most contact with the patient, it has been the nephrologists who assess patients' fluid status and hypertensive status, and who have the dominant position in defining patients' treatment.

The lack of prioritisation of long term blood pressure management has likely contributed to the dialysis nurses' inaction when a patient's blood pressure was low or high. Although there were frequent occurrences of low and high blood pressure before, during and after dialysis treatments, not once did I observe any action taken. It was accepted that the usual practice was no action where blood pressure was low or high. This lack of action was consistent with my own clinical experience and constitutes a reproduced practice, and a sub-conscious habitus, in the satellite dialysis setting.

7.7.4 Organising transport: competing perspectives

When discussing satellite dialysis nurses' perceptions of quality there was complexity that lay in the perspectives of people receiving dialysis and nurses. Satellite dialysis patient transport was an example reflecting the complexities of satellite dialysis nurses' perceptions of quality. The provision of patient transport was complex because it questioned what the nurses' role was, where the nurse's role stops, political factors and patients' responsibilities. These questions were all raised in this study where the nurses were grappling with their transport responsibilities. It was complex because many people receiving dialysis depend on others to transport them to and from dialysis, by taxi or organised volunteer transport (Gill, Campbell, and Taylor 2002). Moreover, many people receiving dialysis treatment are physically unable to drive or catch public transport.

The findings from this study suggested that the nurses believed some patients who requested transport assistance were capable of independently transporting themselves to and from dialysis. The nurses suggested that these patients were 'abusing the system' by not providing their own transport. The nurses did not see it as their responsibility to organise transport for people receiving dialysis who were 'abusing the system'. Even though they did not see it as their responsibility, satellite dialysis nurses continued to organise transport, frequently begrudgingly. The complex aspects satellite nurses' responsibility, the promotion of patient self responsibility, and the belief that 'no-one else will do it' led the nurses to organise the patient's transport, which can be described as nursing work 'by default'.

The patient transport dilemma is an example of the struggle nurses have when they wanted to encourage patient self-management but were concerned that people receiving dialysis will not receive appropriate care if they do not attend the dialysis unit. Nurses are challenged because, as previously described, they perceive some people receiving dialysis as able to self-manage and these people should not rely on others. The nurses were frustrated when people receiving dialysis take on this sick role once they are labeled a 'dialysis patient'. There seemed a challenge for the nurses to empathise with patients' requests for transport assistance particularly when the nurses have never had to cope with the challenges of a living on dialysis. This lack of empathy reflected the different roles of nurses and people receiving dialysis in this context.

Overall, in this study, nurses did not acknowledge that organising transport and long-term blood pressure management were their responsibility and thus were not perceived as part of their nursing role. Furthermore, nurses did not perceive these aspects as relevant to quality care in satellite dialysis units.

7.8 Chapter summary

The nursing culture of the satellite dialysis is truly unique. The complex mix of technology, personal care, long-term nurse/patient relationships, nurse autonomy, education and practice aspects contribute to this uniqueness. Nurses perceive that the satellite dialysis unit is a very different place to work than a hospital dialysis unit, and thus, their perceptions of what quality nursing care is in the satellite dialysis unit is different when compared to quality nuring care in the hospital dialysis unit.

The notion that the satellite unit culture is unique implies that the power and oppressive elements that affect their culture may also be unique. The next chapter, Chapter 8, will further explore power aspects that affect and influence satellite haemodialysis quality practice. It will provide evidence that power relations do influence quality in the satellite dialysis context.

CHAPTER 8

DISCUSSION 2: POWER AND OPPRESSION IN THE SATELLITE DIALYSIS CONTEXT

8.1 Introduction

The satellite dialysis unit, characterised by healthier patients, no on-site nephrologists and remoteness of location, is a place where technology meets community. Amid this technology nurses and people receiving dialysis spend a great deal of time together contributing to a unique satellite dialysis culture. Health related cultures are influenced by aspects of power (Blackford and Street 2002). Through the perceptions of nurses this study has revealed aspects of power, powerlessness and oppression that influence nursing care in the satellite context. These aspects can be explored through a framework that interprets whose place the satellite dialysis unit is and who wields what power.

Bourdieu's (1977, 1990) notion of field, habitus and capital can inform the discussion of power and oppression to uncover oppressive aspects of satellite dialysis nursing culture and contribute to an understanding of quality care in this context. A better understanding of whose place it is and who wields the power, contributes to the critical aim of decreasing imbalances in power, and thus, providing the conditions for change.

8.2 Whose place is it?

Nursing and patient practices and characteristics, as well as location and structures, define the space that is the satellite dialysis unit. The constants for each satellite dialysis unit are nurses and people receiving dialysis, whereas the physical location

could be a converted house, a purpose built centre or a small, relocatable shipping container in a remote community. The 'place' could also be a large modern air-conditioned room in a community hospital. They are all physically different but still defined by the people in it and the practices of those people, that is, people accepting nursing care and nurses providing this care. Naming the place as a satellite unit helps define the practices to be undertaken such as, a level of patient autonomy, self care and autonomous nursing practice (Roderick et al. 2005). Complexities occur however, when nurses come to 'know' the patients holistically (May 1992) and are required to make clinical decisions regarding treatment. In this study, whose place it is, or who directs what goes on, is determined by the nurses and to a lesser extent the patients and nephrologists.

Exploring whose place the satellite dialysis unit is can be informed by Bourdieu's notion of habitus, field, lieu and location (Bourdieu 1993) (see Chapter 3). Satellite dialysis units can be viewed as health care facilities that incorporate transitory 'travelers'; people receiving dialysis and dialysis nurses. These units have unique characteristics that make them a 'satellite dialysis unit'. Bourdieu argued that "space can have no meaning apart from practice" (Bourdieu 2003 p. 135). He proposed the term habitus as "the system of generative and structural dispositions made up of actors' movement(s) through space" (Bourdieu 1977 p.214). Thus the satellite nurses' practices, influenced by the habitus of the satellite nurses, define whose place, or space, it is.

In contrast to Bourdieu's 'place', Auge (1995) introduced the notion of 'non-place' which has contributed to exploring issues such as those faced by people with dementia in the aged care facilities (Reed-Danahay 2001). An important difference between an aged care facility and a dialysis facility is that people receiving dialysis attend three times per week for five hours and go home, rather than being in a

confined in a 24 hour secure environment as experienced by dementia patients. Thus, the more constant 'actors' are the satellite dialysis nurses who dictate the practices in the satellite unit every day. That the nurse 'actors' in satellite units influence practice may not be as apparent and does not seem to have been reported in the hospital dialysis 'place'. Therefore, when asked whose place is it the answer may well be that it is mainly the nurses' place.

8.2.1 Field

The satellite dialysis is an example of Bourdieu's field (1977) that has developed from situating a previously acute hospital dialysis treatment within the community setting. The overlapping of hospital and community culture has occurred, resulting in a "transposition of logics and practices" (Angus et al. 2005 p.168). Transposition of logics and practices were seen and described as those unique nursing practices combining the technical aspects of dialysis with holistic and personal care. This combination has resulted in a new 'satellite dialysis sub-field' with its unique set of practices. Thus, the idea of field (medicine, nursing or other health care), and sub-field (satellite dialysis nursing) can increase our understanding of what might comprise the unique practices of satellite dialysis nursing, and therefore what would constitute quality nursing care in this context.

8.2.2 Surveillance and space

In satellite dialysis units there is surveillance of people receiving dialysis undertaken by medical and nursing staff. Although the nephrologists are not on-site in the satellite unit, they are responsible for each medical regimen and, in a sense, they 'remotely observe' patient care and nursing practices. They can 'see' the patient through clinical processes (Habermas 1972) by viewing the patient through clinical

signs and symptoms (Wright and Teacher 1982) and by accessing information from blood results, diagnostic results, nurse reports and case notes. The patient knows they have a nephrologist who directs their medical treatment but may be unaware that the nephrologist is undertaking surveillance. While the satellite unit is separate from the nephrologists' own clinical environment the medical 'gaze' (Foucault 1973) remains powerful in this environment and can influence the patient's health status and wellbeing.

Nephrologists' surveillance of people receiving dialysis is largely dependent on the expertise of, and communication with, satellite dialysis nurses. Although nurses have been described as subordinate technical operators in the health care system (May 1992), satellite dialysis nurses still have varying levels of expert practice (Bonner 2003, 2007; Ran and Hyde 1999). Some nurses have blurred the boundaries (Bonner 2004) of medical and nursing practice guidelines while others have adhered to the nursing role. This could be determined by the amount of patient information provided by a nurse to a nephrologist, leaving the medical gaze dependant on the communication level and type of communication and inter-professional relations (Strauss 1985) between the nephrologists and the on-site nurses, which may have implications for quality care, practice and patient outcomes.

In the satellite dialysis environment surveillance by nurses was evident whether the patient was in or out of this physical environment. Liaschenko's (1994) study of home care nurses revealed an holistic version of such a gaze. Applied to the hospital or satellite dialysis unit the nurse's surveillance is an element of nursing care of patients while in the unit, when the nurse measures a patient's diet, fluid and medication compliance. Nurses measure such levels developing their perception of what patients might have managed while at home. Thus, the dialysis nurses' gaze

(Bevan 1998) occurred both in the dialysis unit and remotely when the patient was at home.

8.2.3 Gaze and habitus

How do the notions of Foucault's (1973) medical gaze fit with Bourdieu's (1977) notion of habitus? Bourdieu has drawn on Foucault's views on culture and has, like Foucault, searched for structures of social life linked to power (Schwartz 1997). Bourdieu's actors (nurses and people receiving dialysis in the satellite unit) can be strategists in attaining control over their environment and what happens in it. The interactions of nurses and people receiving dialysis "reproduce the objective structures of which they are a product" (Bourdieu 1977 p.72).

Bourdieu (1984) argued that by being powerful, the elite members of a culture defined what was valued as cultural capital. Clearly, the elite of the satellite dialysis unit are the nephrologists, and secondly, the dialysis nurses. Lowest in the hierarchy of power relations are the people receiving dialysis. Even though the nephrologists exercise 'gaze in absentia', they remain in a position to exercise power related to their medical role and responsibility. This was evident by most satellite dialysis nurses perceiving the doctors as 'boss', and that their orders were important to follow. They regarded the doctor as intellectually superior and having more academic and medical knowledge. The nephrologists used this cultural capital to maintain the status quo to "preserve the worth of their own skills and knowledge, and thereby confirm their own status" (Smith 2001 p.138). There was no evidence that nephrologists did this knowingly as it is likely they were caught up in their own reproduction of practice.

8.2.4 They are not that sick

Although nurses advise the people receiving dialysis on their treatment, and provided nursing care, the perception of the nurses in this study, that the patients are 'not that sick', complicates these relations of power. Nurses described people receiving dialysis as different, using the terms 'them' and 'other', implying that they perceived the patients as different people, 'not people like them'. Although this objectification and dehumanisation was observed and unearthed in the interviews, the nurses also conveyed a contrasting caring personal attitude. The nurses' caring attitude was evident to the extent that they were prepared to extend the boundaries of their nursing care for the benefit of people receiving dialysis, such as leaving a patient 'wet' by removing less fluid, or by taking them off the machine early.

The complexities of the nurses' perceptions revealed important interrelated aspects; values, reciprocity and (lack of) empathy. Nursing care was, at times, determined and affected by what nurses believed was expected of people receiving dialysis. This behaviour was in the form of patients' compliance which the nurses valued and applauded. Thus, reciprocity expected between nurses and people receiving dialysis was value laden. The nurses' values, expectations of reciprocity, and empathy provided a richer understanding of these satellite dialysis nurses' perception of people receiving dialysis as 'not that sick'.

8.2.4.1 Values

People receiving dialysis who were labeled as non-compliant were perceived as not having the same values as the nurses themselves. This non-compliant behaviour frustrated the nurses who saw their role as promoting health and avoiding harm, over and above the need for patient autonomy. The balance of these two values was

complicated by the nurses' goal in applying their clinical expertise while also empathising with the people receiving dialysis. Woodward (1998) used the term "beneficent guidance" (p.1046) to describe the nurse's aim of balancing their clinical expertise with patient autonomy to promote patient beneficence.

Many people receiving dialysis treatment are disempowered by the strict routines and regimens of dialysis. Their non-compliance was perceived by nurses as patients trying to reclaim some power by using strategies such as silence and disinterest towards nurses. Bloor and McIntosh (1990) proposed that patients can resist nursing and medical influence by using non-cooperation, avoidance and concealment. In my study people receiving dialysis who used these forms of resistance were labeled non-compliant, which led to nurses' frustration when trying to enforce patients' behaviour change.

To enforce behaviour change among people receiving dialysis, nurses exemplified the knowledgeable nurse using this medical knowledge in order to enforce the regimen. This could also be considered a form of oppression of the less-resourced dialysis patient. In saying this, power and oppression can be better understood by acknowledging it as a dynamic relationship where both groups can be either oppressor or oppressed at any time (Collins 1990). Therefore, although not observed in this study, greater patient consumerism can lead to nurses perceiving that they have been oppressed by people receiving dialysis. Thus, oppression needs to be necessarily viewed as more complex than simply the nurse who holds all the power resources oppressing the disempowered patient. In saying this, this study revealed, through the perceptions of the nurses, the powerlessness of people receiving dialysis treatment.

8.2.4.2 Reciprocity

Nurses' perceptions that the people receiving dialysis were 'not that sick' were also related to their expectations that reciprocal behaviour should have been demonstrated by patients. This reciprocal behaviour was associated with evidence that people receiving dialysis could comply with medical and nursing regimens thus demonstrating they could adhere to the regimens that the nurses were trying to implement. The patient's reciprocity was therefore, in the eyes of the nurses, compliance over a long period of time in the dialysis context.

Reciprocity between the patient and the nurse, had elements of strategy and reflexivity as well as being a non-conscious set of behaviours. For example, in this study, a self-disclosing relationship appeared between a nurse and a patient whereby the nurse disclosed to the patient information related to the nurse's own ethnicity. This led the patient to disclosing sensitive information, in that he did not want to be considered for a transplant because of his fears from previous experiences. Because the nurse had self-disclosed and shown trust, reciprocal self-disclosure was then offered by the patient. The nurse reported that offering intimate information had not been immediate but developed over time and had some strategic benefit in regards to better understanding the patients' fears that involved trust and acceptance. This was an example of empowering a patient and achieving a beneficial therapeutic relationship, demonstrating that reciprocity was more than simply 'gift-giving' but the exchange of trust and respect that minimised the power differences between nurse and patient. Usually, not wanting to be placed on the transplant list was seen as non-compliant behaviour by nurses.

The above example of reciprocity can be better understood by Bourdieu's (1977, 1990) exploration of cultural reciprocity where he stressed the importance of time

and manipulation, suggesting that these factors are components of strategic behaviour. Schwartz furthered Bourdieu's notion by suggesting that reciprocity "stem(s) from practical dispositions that incorporate ambiguities and uncertainties that emerge from acting through time and space" (Schwartz 1997 p.100). The nurse in this example attempted to 'know' the patient by disclosing personal information. On the surface this disclosure may have appeared as informal chat while it had a second, more strategic aim of developing trust so as to explore the patient's resistance to receiving a kidney transplant. Strategically, the patient was reciprocating with an aim to gain the best quality of life possible, notwithstanding his beliefs about the safety of kidney transplantation.

Thus, reciprocity along with ambiguity and strategy over periods of time, conveys how quality nursing can be influenced by the dispositions and strategies taking place in routine clinical practice.

8.2.4.3 Selective symptom report

Nurses' perceptions of patient's reciprocation while receiving dialysis influenced their nursing practice. People receiving dialysis who showed interest in their own blood results were seen by nurses as reciprocating 'what the nurses wanted'. Given the long term reliance of patients on the nurses it was in the interest of the patients to behave in an interested and obedient manner, as they learnt that not to, displeased the nurses. This could be interpreted as the patients' managing their powerlessness and avoiding the nurses' disapproval.

In a study of long-term dialysis patients this adaptive behaviour has been described as selective symptom report management (Curtin and Mapes 2001). Selective symptom report management is undertaken by people receiving dialysis because if

they tell the nurse every symptom they have suffered since their last dialysis the nurses may blame the patient or further investigate the symptoms, requiring the patient to undergo more medical tests or interventions. For these people receiving dialysis selective symptom report is a way of having some control over their own lives (Curtin et al. 2002). The entrenched on Kt/V as a measure of dialysis quality distracts nurses from identifying important symptoms and side effects that people receiving dialysis may not report or may not think are important.

There were no examples of nurses in this study considering the possibility that people receiving dialysis may selectively report symptoms. Therefore, although nurses perceive they are providing what the patient wants the patients can selectively provide information that will influence the nurses' perceptions. Selective symptom report is a feature where the patient manages to retain some control during their treatment.

8.2.4.4 Empathy

Empathy is a concept that has found use in nursing (Alavi 2006; Reynolds 2006), perceived as "a human trait, a professional state, a communication process, caring, and a special relationship" (Kunyk and Olson 2001 p.317). Although there is debate around the conceptualisation and elements of empathy (Morse 2006) there is general agreement patients want nurses to attempt to "listen actively, be sensitive to their feelings and provide clarification of confused messages" (Reynolds 2000 p.40). Thus empathy can be viewed as a positive component of nursing care as long "as experiencing another person's feelings" does not "sometimes immobilise a nurse" (Reynolds 2006 p.88).

This study found that some satellite dialysis nurses found it difficult to empathise with people living with the constraints of dialysis. Nurses reported that people receiving dialysis contributed to their own poor health and they blamed patients for not adhering to the required recommended medical regimen. Attributing blame without having had to adhere to such a regimen themselves demonstrated a lack of empathy and an inability to "walk in the patient's shoes" (Tims, King, and Bennett 2007 p.52).

On the surface, nurses in this study blamed people receiving dialysis for their non-compliance. On further analysis, the nurses may have felt partly responsible for the patients' non-compliance and subsequently voiced disappointment when they perceived patients had not adhered to the medical regimen. Therefore, the nurses' lack of empathy may have been related to their own failure when trying to encourage patient compliance. The nurses' frustration may result from a combination of the patient's perceived non-compliance and their inability to influence patient non-compliance.

There is potential for a lack of empathy on the part of nurses to contribute to feelings of powerlessness among people receiving dialysis. People on dialysis are asked to restrict types of food, fluid intake and to adhere to complex and substantial medication regimens. A lack of empathy from nurses can make patients feel a lack of control over their own lives as well as feelings of 'failing to adhere'. Clearly nurses can not walk in the shoes of people receiving dialysis, however, greater reflective empathy may lessen patient's feeling of powerlessness.

8.3 Who wields power?

Throughout this study nurses appeared committed to an holistic approach, in that they promoted patient empowerment and patient influence over nursing care. However, this commitment has elements of a nursing strategy rather than a pure altruistic belief that patient empowerment would benefit the patients.

An example of this strategic behaviour was the delivery of Kt/V. Nurses told the patients they needed to be on dialysis for four to five hours with a blood flow rate of 350mls/minute to ensure their Kt/V is greater than 1.2. Nurses and patients in turn, checked monthly blood results to ensure this Kt/V was meeting target values. Using the Kt/V measure created the illusion of allowing the patients to direct their own care when, in fact, the nurses were actually dictating care. Nurses were not using qualitative human responses such as how the patient felt, were they itchy, did they have a headache, were they tired, did they sleep or did they experience cramps (Twardowski 2003). Nurses seemed to be providing care that they wanted but presenting it as 'what the patient wants', thus creating an illusion of patient empowerment.

8.3.1 Contradictions

In discussing the nurse who wields power in the satellite unit, I am drawn to explore the different and sometimes contradictory positions of individual dialysis nurses in this study. Although these differences would be expected in any group, I am reminded of Bourdieu's (1993) contribution around the cultural capital of group members and how this capital influences practice, in this case satellite dialysis nursing practice.

One interpretation of Bourdieu's (1993) notion of cultural capital is that satellite dialysis nurses need to hold status over the patients in response to their own feelings of powerlessness with the medical nephrologists. There were examples of nurses being frustrated about the lack of respect shown by people receiving dialysis and nephrologists but there was no desire to improve their own status in relation to the medical staff.

Bourdieu may suggest that these nurses were unlikely to improve their status. However, there was evidence that some nurses took on aspects of the nephrologists' more powerful role in making clinical decisions. Examples of these decisions included changing the strength of potassium in dialysate baths, leaving patients slightly over their ideal weight and shortening dialysis hours. These nurses were moving into the scope of practice of medicine, prescribing dialysis regimens and blurring their nursing practice boundaries (Bonner 2001). Some who blurred these boundaries justified it by claiming to have the needs of the patient as their primary motivation so as to assist them in their daily life. Such nurses perceived these practices to go 'under the radar' of the nephrologists. The implication from all of this is that the nephrologists' dialysis prescription did not always meet the needs of the patient as perceived by the nurses and thus required regular adjustment. This provided the nurses with a form of influence (power) in adjusting the treatment prescription.

This study revealed that the role of the satellite dialysis nurse unit manager (NUM) was seen by other nurses as equivalent to a surrogate nephrologist. Bourdieu's view may have been that this NUM was trying to improve her own cultural capital, thereby increasing her power, by exerting more influence over other nurses, thus changing her cultural, social and economic status. This was certainly reflected in the

perceptions of nurses who saw the NUM as senior management as well as one of the nursing team.

Cultural capital and seniority in the satellite dialysis context have implications relating to power and powerlessness of nurses. Even the senior nurses, who considered themselves experts in dialysis, were unwilling to make major decisions in the presence of the satellite dialysis nurse unit manager. Neverltheless, these same expert nurses were able to make daily decisions when the nurse unit manager was not present.

8.3.1.1 Novice to expert

The novice to expert notion, developed by Benner (1984) and based on Dreyfus (1980) acquisition of skills model to nursing, was recognised in this study. Benner described one of the characteristics of the expert nurse as having "local, specific knowledge" (Benner 2004 p.197) and that their knowledge was transferable. The local clinical knowledge was clearly identified by the nurses, however, knowledge transferability was less easy to identify and in fact, several nurses suggested they had lost touch with their general nursing knowledge and practice and would not return to general nursing. In saying this, their perceptions may reflect their satisfaction and comfort in the dialysis context and they may well be able to transfer back to nursing in hospital wards.

This study revealed that, although there was a strong focus on specialised dialysis technical skills and knowledge, there was also high regard for the nurse who, in addition to expert technical skills and knowledge, spent time with the patients in the unit. Bonner's (2007) study of hospital nephrology nurses reflected Benner's Model, with nurses being more patient-focused than technically focused. In addition, the

expert nephrology nurse was more inclined to "ensure that patients could be kept in the best possible health for the longest period of time" (Bonner 2007 p.12).

Some, but not all nurses in this study, valued their colleagues who made the effort to get to know their patients and who strove to address complex issues faced by people receiving dialysis. Thus holistic nursing was perceived by the nurses as a major difference between incentre and satellite dialysis nursing care, and part of what made the satellite unit special. However, this complicated power relations further, with the struggle for some nurses to be not only the patient's friend but also the powerful health decision maker.

8.3.2 Practice, capital and satellite dialysis nursing

An interpretation of findings in this study was that economic, symbolic, cultural and social capital (Bourdieu 1986) contributed to the habitus (dispositions) of nurses in the satellite dialysis unit. These forms of capital were dominant at different times, supporting Bourdieu's notion that "habitus is a dynamic construct producing enduring but not fixed orientations to action" (Bourdieu 1977 p.44). It is thus an embodied 'habit' that is not a conscious, strategic practice.

Nursing practice that was embedded in the satellite dialysis context is what Bourdieu considered the habitus of the satellite dialysis nurse. Practices, influenced by habitus, consisted of both agency (each nurse and each nurse's capital) and structure (management, policies, procedures, technology). According to the nurses, practices were different in the satellite unit than the hospital unit, and were considerably influenced by the different habitus. Furthermore, Bourdieu's (1993) proposition that the 'field' has an influence back on the habitus, and that habitus can not be present without a field was supported in this study.

8.3.2.1 Practice

Practice has been described as a "product of an encounter between a habitus and a field" (Thompson 1991 p.16). In the satellite dialysis context habitus can be viewed as the nurses' actions influenced by their dispositions in the field of the satellite dialysis unit. Dominant practices, such as the use of Kt/V to measure dialysis quality, are reproduced and embedded into dialysis nursing practice. Historically developed and implemented by those with greater symbolic capital (nephrologists) Kt/V has questionable empirical support (Twardowski 2004).

Although controversial, I contend that a second example of embeddedness is the practice of rotating cannulation sites (see Section 5.2.1). Similar to Kt/V, the practice of rotating cannulation sites has been embedded into dialysis nursing practice by those with the greatest capital (senior nurses and nephrologists). Again, this practice has been historically developed and to date has no empirical evidential base supporting rotating sites over same site needling. In fact, there has been evidence to support that same site needling (buttonhole cannulation) reduces pain and anxiety associated with cannulation (Ball 2006) contributing to improved patient quality of life (Verhallen, Kooistra, and van Jaarsveld 2007). This habitus, leading to nurses' fundamental cannulation practices is a response to an embedded clinical disposition rather than skilful action resulting from a conscious, researched intellectual operation (Bourdieu and Wacquant 1992). These embedded practices are influenced by those with the greatest capital, nephrologists and senior nurses.

8.3.2.2 Symbolic capital

Of Bourdieu's (1986) four forms of capital, symbolic capital is most influential in satellite dialysis nursing practice (and maybe all nursing practice). Symbolic capital

informs practices that are reproduced by nurses in satellite dialysis units, and was revealed though the nurse interviews. Influential symbolic capital was related to acute hospital experience, the time nurses spent with the patient, long-term follow through of nursing care, and their commitment to listening to, and empathising with, people receiving dialysis. While these practices were valued by the nurses the attitudes to their jobs varied widely from the nurse who displayed these characteristics to those who simply came to work for the salary. The symbolic capital identified in the satellite unit was related to experienced, knowledgeable and skilful nurses with a committed and caring approach.

8.3.2.3 Institutionalised capital

Satellite dialysis nurses apportioned high institutionalised capital to the nephrologists, and to a certain extent, the renal trained nurses with hospital experience. The institutions have "create[d] the person" (Bourdieu 1990 p.185) by giving them a title (nephrologist, clinical nurse specialist, nurse manager). "They (the institution) summon him to become what he is, or rather, what he has to be; they order him to fulfil his function" (p.185). The title given thus provides and supports greater institutionalised capital. This notion of institutionalised capital has the potential to inform the understanding of the wider healthcare workforce.

This study identified adherence to institutionalised capital, following the orders of the nurse unit manager and nephrologists, but may be undergoing current change. The transfer from hospital-based to university-based education in Australia (Borland 1996), has resulted in nursing graduates practising with greater professional knowledge (Lumby 1996). As the newer university-educated nurses become more experienced there may be a shift in the recognition of institutionalised capital, which may result in dialysis nurses who may question 'reproduced' practice and search for

evidence to support or oppose such practice. Thus the effect of university-educated nurses on this institutionalised capital in the satellite dialysis context is yet to be determined.

8.3.2.4 Seniority and symbolic capital

Although experience and/or institutional seniority were respected they were not always related to being committed and caring i.e. symbolic capital. The committed caring ethic could be 'owned' by an enrolled nurse or the nurse unit manager. In fact there were signs that the symbolic capital of the caring ethic decreased with dialysis unit nursing hierarchical seniority. This may be related to the decreased time senior nurses spent with the people receiving dialysis due to administrative and management responsibilities. Thus, some elements of symbolic capital were not related to institutional hierarchical seniority, but rather the nurses' quality care and proximity to the people receiving dialysis.

The notion that symbolic capital does not always coincide with nurse seniority supports findings from Bonner's (2007) study of hospital nephrology nurses. Using Conway's (1996) advanced practice typology Bonner stated "the expert nephrology nurses were simultaneously technologists, traditionalists, specialists and existentialists" (p.166). The important element is the existentialist characteristic, with Bonner further describing the humanist, existentialist nurse as viewing their patients "holistically, were passionate about nursing practice, and were able to use a combination of theoretical knowledge, values, and experience to inform their practice" (p.166). The holistic, caring nurse possesses high symbolic capital in the dialysis nursing culture, which increases their cultural 'power'. This is consistent with Bourdieu's (1986) view of symbolic capital as an element of capital contributing to the reproduction of habitus and thus the reproduction of quality

practice. Thus, symbolically capitalised nurses tend to have significant power in the satellite dialysis.

8.4 Power and oppression in the satellite dialysis unit

Critical theory espouses the epistemological assumption that "oppression that characterises contemporary societies is most forcefully reproduced when subordinates accept this as natural, necessary and inevitable" (Kincheloe and Maclaren 2000 p.291). Acceptance by nurses about their position and their reluctance to challenge medical power was revealed in this study. Similarly, through the perceptions of nurses the powerlessness of patients was revealed.

An example of patient powerlessness was how nurses' controlled patient access into and movements within the unit and furthermore, chose which patient would receive more attention and care. Nurses often perceived their care as empowering when in fact they may have been enacting their own desires and presenting these as the patient's own choice. Even when the people receiving dialysis were not in the satellite unit their drinking and eating habits were measured by the nurses when they returned for their next treatment. The nurses' frequent use of the term 'they' suggested the nurses' perception of patients as 'other' and separate from their own humanity. Illich (1977) and Ehrenreich (1978) described dehumanisation by health care workers who treated patients like biological machines through authoritarian and oppressive practices. This study revealed a complex mix of these authoritarian practices while at the same time revealing the existence of caring, holistic compassionate nursing.

Although this study highlighted authoritarian practices by the nurses it also revealed their own perceptions of oppression. The predominantly middle class, female,

professional nurses were frustrated by their under-recognised contribution, knowledge and professionalism which can manifest into general workforce concerns such as nurse burnout and absenteeism (Virtanen et al. 2000). Bourdieu may suggest that these characteristics would not be as apparent among those health care professionals with greater symbolic capital. Therefore, the gendered, class-related cultural capital that the nurse brings to the dialysis culture forms a part of the habitus that is evident in this field. This contributes to the complex grid that influences power relations and occurs in this field.

Although not the focus of this thesis, the critical approach of postcolonial feminism can inform the study of satellite dialysis nursing. The predominant aim of postcolonial feminism is "deliberate decentering of dominant culture so that 'voices', perspectives and experiences of people from diverse socio-historical locations [gendered, sexual, ethnocultural] become[s] a starting point for knowledge development" (Anderson et al. 2007 p.182) which could certainly have merit in the satellite dialysis unit. The matrix of power resources in the satellite dialysis sub-field that is dominated by the nephrologist, then the predominantly female nurse then, the (often) non-dominant, ethnocultural patient (Indigenous, Asian) could be a complementary approach to the more theoretical starting point of Bourdieu.

Findings from this study support Tims's (2006) view that dialysis patient empowerment will only be possible when dialysis nurses understand their own power and lack of power. Nurses reflecting on their own use of power will be better positioned to support patients who feel powerless in relation to their dialysis treatment. People receiving dialysis are what Friere would describe as "dispossessed of their word, their expressiveness, their culture" (Freire 1970 p.134). Nurses can help people receiving dialysis create conditions where they gain their own voice, collaborate in their own care and gain more control over their own lives. Empowered

patients would more likely feedback aspects of the nursing care they receive in order to assist nurses in providing quality nursing care.

8.5 Chapter summary

Power of the satellite dialysis nurses over people receiving dialysis is present within the satellite dialysis context. This is made more complex by the relative difference in capital among the nurses themselves, the nurses' own feelings of disempowerment towards the nephrologists, and the nurses' aim to be both a technical clinician and a caring friend. By applying critical principles to the findings of this study, differences in power and how it is wielded in the satellite dialysis context has been provided.

It may not be remarkable to discover power differences in a culture, such as a satellite dialysis nursing culture. However, it is a fundamental requirement of this critical study that identifying elements related to power contributes to breaking down power differences and improving the plight of the most disempowered, people receiving dialysis treatment. Thus, conclusions and recommendations for practice will be provided in the next and final chapter to contribute to this requirement.

CHAPTER 9

CONCLUSION AND RECOMMENDATIONS

9.1 Introduction

The life of a person with ESKD has many intrusions, including having to attend a dialysis unit at least three times a week for five hours at a time. In addition, most people receiving dialysis spend many days at medical appointments, undergoing tests and being examined by various health professionals.

Most people receiving dialysis treatment attend satellite dialysis units where nurses and patients spend great periods of time with each other. In these satellite units the nurses are the key care providers and have a great influence on the quality of health care that is provided. The views, perceptions, values and beliefs of satellite nurses influence their nursing practice and can make a vast difference to the quality of care, and ultimately, the quality of life of a person on dialysis.

The original objectives of this study were to explore the perceptions of satellite dialysis nurses of quality haemodialysis nursing care, identify aspects of power relations and to provide recommendations for nursing practice, policy, education and research. Based on three years of ethnographic fieldwork involving interview, observation, document analysis, reflexivity and participant feedback, the study has uncovered new understandings about satellite haemodialysis nurses' perceptions of quality nursing care. Observing, listening to, and questioning nurses provided qualitative data for analysis and interpretation. A critical approach uncovered unique contextual and political aspects that have not been reported before in this setting. Bourdieu's theories of capital and habitus further illuminated the political and

cultural complexities associated with quality nursing care in the satellite dialysis context.

This study found that quality nursing care as perceived by satellite dialysis nurses is far more complex than a single quantitative measure that is heavily influenced by the satellite context. Incorporating these findings with previous and current literature produced recommendations for practice, education, policy and research. These findings and recommendations were presented to the nurse participants and dialysis unit management towards the end of this study. The responses from both nurses and management (Appendix L and M) confirmed that these recommendations were relevant and potentially contributed to improvements in satellite dialysis nursing care. The findings of this thesis have shed new light on the:

- Differences in quality nursing care in satellite units
- Educational needs of satellite dialysis nurses
- Increased patient acuity and quality nursing care in satellite units
- Reflective practice and quality nursing care in satellite units
- Critical methodological concerns in nursing research
- Application of Bourdieu's concepts of habitus and capital to satellite dialysis nursing

9.2 Differences in quality nursing care in satellite units

Nurses' perceptions of quality nursing care in this study were reflected in their views that satellite dialysis nursing was very different to hospital dialysis nursing. On the surface there was evidence that quantitative measures, such as Kt/V, were priorities in the measure of quality in the satellite context. However, with further exploration

through confidential interview, nurses viewed the satellite unit as requiring different quality measurements.

Person-centred care reflecting the closeness and intimacy between staff and people receiving dialysis was regarded as an important element of quality satellite dialysis nursing care. Furthermore, the nurses perceived that the nuances associated with providing these important elements of quality satellite dialysis nursing care were undervalued by others (hospital nurses and nephrologists). They perceived that quantitative measures of quality dominated their practice but reported that these measures did not reflect what was valued by the people receiving dialysis and nurses in the satellite context.

The person-centred nursing culture in this satellite unit, where many nurses were committed to improving the patients' quality of life and not just the quality of dialysis treatment, was clearly evident. However, there was a lack of formal processes, and thus no measurable process, to contribute to the success of improving a patient's quality of life. To address this conundrum recommendations for practice include implementing a structured, concordant model of care and encouraging nursing staff rotation strategies. One strategy to facilitate a concordant model is through goal attainment scaling.

9.2.1 Concordance

Concordance suggests a nurse/patient partnership to achieve the health-related goals of the patient. It was developed to be used as an alternative to the terms compliance and adherence by Curtin et al. (2005). "Nephrology nurses can consistently strive for improved communication and can actively pursue the concordance that precedes patient adherence to prescribed regimens" (p.393). Concordance has also been

described in the nephrology nursing literature as a patient/health care provider partnership (Kammerer et al. 2007) and negotiated care (Polaschek 2003; White 2004). Concordance challenges the traditional role of the dialysis nurse to strongly encourage compliance of patients to the strict medical regimen that they are expected to adhere to (Woodcock 1999) which has been criticised as a method of forcing patients to comply with the demands of nephrology health care professionals (Loughman-Adham 2003; Vermeire et al. 2001). Although the patient-centred concordance approach seems well-suited to the satellite dialysis context, absence of guidelines or a process that can be followed and measured, affects its potential.

9.2.2 Goal attainment scaling

A process such as goal attainment scaling (GAS) may contribute to a more concordant model and can be considered in the satellite dialysis setting. Goal attainment scaling is a method which contributes to the patient/nurse partnership by systematically breaking down major goals into manageable smaller goals (Gage 1999). An example of GAS in the satellite dialysis unit would be to set manageable goals for a patient's nutritional status or exercise capacity. The goals are necessarily patient/client focused goals that are important to the patient and not to the dialysis unit or dialysis nurse.

GAS has been reported to identify patient's priorities and has assisted in achieving outcomes that were important to patients (Nieuwstraten, Dolovich, and Chase 2002). Although not used greatly in the nephrology setting it has been used for people receiving dialysis treatment resulting in a sense of accomplishment (Bare 1997). This lack of use in the nephrology context is surprising given it's application in many other long-term care contexts such as aged care (Evans et al. 1999; Stolee et al. 1992; Rockwood et al. 1996; Yip et al. 1998), community mental health (Fiester and Fort

1976; La Ferriere and Calsyn 1978; Lefley 1979), severe physical and mental health (Brown, Effgen, and Palisano 1998; Maloney et al. 1978), cardiac rehabilitation (Oldridge et al. 1998), drug and alcohol programs (Peckham 1977) and for chronic pain (Zaza, Stolee, and Prkachin 1999). GAS has a well established methodology, is quantitatively measurable, maintains the patient-centred focus, and could be used more widely in the satellite haemodialysis setting. GAS education for satellite dialysis nurses would be required to undertaken as would further research to explore the value of GAS in the satellite dialysis context.

9.2.3 Staff rotation

In addition to emphasising concordance using the GAS approach, structural changes are recommended to increase the recognition of person-centred care in the satellite units. Rotation of nursing staff through both satellite and hospital dialysis units is recommended to increase the recognition of differences in satellite dialysis nursing care. In addition, rotation of nurses, may provide a strategy to prevent the routinisation of dialysis work (Ellingson 2007).

The idea of rotating satellite dialysis staff within acute or tertiary dialysis units has been suggested in the literature (Tallis 2005; Long 1995) and has received divergent opinions from nurse unit managers (Ashwanden 2004). Clearly rotating staff from remote units may prove to be logistically challenging and it may not be possible with some satellite units. However, there is no reported research on the benefits or problems associated with rotating staff through various dialysis units. This an area that requires further research to ascertain the benefits of this strategy for satellite dialysis nursing care.

9.2.4 Satellite dialysis unit design

Findings from this study, related to the nurses' emphasis on technology, led to a review of how satellite units are designed, because there was continued evidence that the nurses returned to the nurses' office or nurses' desk when there appeared to be no reason for doing this. The unit in this study consisted of one large open space containing 10 dialysis stations, with one glassed off room, and a separate nurse work station (see Figure 4.2) and typical of satellite dialysis unit design in Australian dialysis units. The design of the dialysis unit encouraged nurses to be distant from the people receiving dialysis when they were not with them. This reinforced the 'us and them' theme referred to as 'othering' (Canales 2000).

Field notes *(FN 29/8 #73)* made a comparison of dialysis nurses could be made with 'bungee jumpers' who, traditionally, jump off bridges (or other high platforms) with an elastic bungee cord attached. The elastic cord almost brings the jumpers back to the bridge. A horizontal form of the bungee cord can be found in game parlors where people are attached to this elastic cord and aim to get to a point before the elastic cord brings them back to their original position. Similarly, dialysis nurses appear to have an 'invisible bungee cord' attached, bringing them back to the nurses' station each time they make a foray out to the dialysis patient, mainly to address a machine alarm. In follow up discussions I requested feedback from nurses about this comparison and they agreed that it was an accurate comparison *(FN 7/11 #112).*

Redesigning a satellite dialysis unit to encourage nurse/patient concordance could be a strategy for future satellite dialysis design. The incorporation of physical workstations out in the dialysis area as reported in non-dialysis settings (Korpman 1991), integrated or wireless communication systems, and a modular unit design could encourage the nurses to be closer to the patients where they would undertake

other work (documentation, data entry, quality improvement activities) in the patient care area. This redesign may encourage more frequent and more meaningful interactions with patients rather than the nurses continually returning to the distant nurses' station. This may decrease the 'othering' of people receiving dialysis treatment and ultimately decrease perceived power differences between nurses and patients. This is an area that has had little research and requires further exploration.

9.2.5 Summary of recommendations about differences in quality nursing care in satellite units

Clinical Practice

- Implement goal attainment scaling into satellite dialysis units

Education

- Greater nurse education promoting concordance and goal attainment scaling in nephrology nursing courses and hospital education programmes

Management

- Implement staff rotation between hospital and satellite dialysis units

Research

- Future research exploring the utility of goal attainment scaling in the satellite dialysis context
- Future research exploring the benefits and challenges of staff rotation through hospital and satellite dialysis units
- Future research exploring satellite dialysis unit design

9.3 Educational needs of satellite dialysis nurses

A finding revealed in this study confirmed the challenge that satellite dialysis nurses had to meet their educational needs. This was made more difficult by the nurses' lack of skills to access evidence, the varied quality of education, inconsistent messages from medical staff and clinical guidelines that were perceived as irrelevant or inappropriate. The following recommendations relating to internet and database skills, formal staff education programmes, and new technologies may provide improved access and quality of satellite dialysis nurse education.

9.3.1 Internet and database skills

Lack of access to, and confidence with, the internet was an unexpected finding of this study, although previous research has shown internet use by nurses in their workplace was low (Estabrooks et al. 2003). Low nurse internet use was related to "lack of administrative support, negative attitudes towards computer technology, lack of expertise, and time constraints within the workplace" (Estabrooks et al. 2003 p.74). These factors were all identified by nurses in this satellite dialysis study. Although in some areas web-based use is growing in nursing (Gilmour, Scott, and Huntington 2008) there is still evidence that it was more likely among nurses, a nurse with web-based skills, termed the 'information enthusiast', (Morris-Docker et al. 2004 p.162) and was the exception rather than the rule.

Low web usage by the nurses in this study appeared on face value to be surprising because these are nurses prided themselves in operating complex haemodialysis machines and the nurses have been enframed by the technology (Bevan 1998). Thus, the infrequent use of the internet reported in other clinical nursing areas (Estabrooks

et al. 2003; Gosling, Westbrook, and Spencer 2004) appears a common feature of nurses practice, albeit one that may be slowly changing.

Added to the lack of web confidence was a further finding that the satellite nurses in this study lacked database search skills which limited heir access to evidence via databases. The skills that nurses lacked were the ability to use correct search terms, key words, Boolean principles and article retrieval. Nurses require these skills to retrieve and manage evidence-based information to facilitate change (McNeil et al. 2006). However, as Gilmour (2008 p.20) suggested "a wide range of skills is required to access evidence and, more importantly, transform that information into knowledge that can be applied to personal health circumstances".

The lack of database search skills has a fundamental effect on the capacity for nurses to quickly access evidence quickly. Nurses either gave up or used old, historically based information that may not have reflected the latest research, leading to the nurses using historically based procedures and protocols that did not reflect the latest evidence based practice. This was exemplified by the experienced nurse who reported that she could not access information about phosphate clearance or anaemia flow charts when in fact there are large bodies of literature dedicated to these areas. The lack of database search skills may negatively affect nursing practice, possibly leading to poorer outcomes for people receiving dialysis.

The lack of capacity of nurses to access web and database skills education leads, not surprisingly, to a decreased motivation to access the latest evidence. This, in turn, becomes embedded or reproduced practice (Bourdieu 1993) where it is unusual for the satellite nurses to refer to these sources for evidence. Therefore, satellite dialysis nursing practice is dominated by the reproducing, or recurring, historical nursing care that limits change. Furthermore, some parent organisations of satellite units restrict

access to the internet. Clearly, there is an imperative for health care institutions and nursing education facilities to provide nurses with web-based and data base search education to assist in improving nursing practice.

9.3.2 Formal staff education programmes

Nurses in this study had wide ranging perceptions of the quality of staff education sessions and programs, with some perceiving the education as good and some as needing improvement. The unique features of satellite dialysis units that contribute to nursing staff education barriers are distance from educational institutions and parent hospital, costs and increased workforce casualisation (Wellard and Bethune 2000). No one program will fit all satellite units so each unit requires a program to fit its own context. In saying this, there are also common features to satellite units that require examining prior to developing a staff education program. These common features are similar shift times (Monday to Saturday with morning and afternoon shifts), common quiet periods and the notion that satellite units are 'less connected' geographically to their parent hospital. These common features could utilise novel education technologies.

9.3.3 New technologies

Strategies to overcome the satellite unit barriers can include the use of new technologies in association with carefully planned session times. For example, the use of web streaming technology enabling staff to view education sessions in quiet patient times can be encouraged. A commitment to this process by satellite dialysis unit managers would be required to set up and, in some cases, allow web streaming to be enabled. Given that this technology is simple and relatively cheap for the institution (Bennett and Glover 2008) web streaming could be appropriate for

education sessions. Organisations such as the American Nephrology Nurses Association (2008) and the Renal Society of Australasia (2008) already have clinically focused on-line education sessions that can be viewed through web technology. Encouragement, enabling and promotion of this technology in addition to a structured time where the nurses could view these education sessions could be valuable in the educational progression of nurses in satellite dialysis units.

A further enhancement for satellite dialysis units using web-based technology is the use of virtual classrooms. Virtual classrooms use desktop computers, web-based software, multimedia, and distance learning systems to enable nurses to "log on to distance learning and continuing education courses from the convenience of…an inpatient setting" (Simpson 2003 p.84). Virtual classrooms allow users to share documents, real-time audio to chat, real-time text chat and whiteboard facilities. This new technology has not been widely reported in nursing clinical education, but evidence of its use to assist multi-centre nurse practitioner education has been reported (Kleinpell, Perez, and McLaughlin 2005). Given the homogeneity of shift times in satellite units, the quiet periods could be used to facilitate multi-centre education sessions, which would result in efficient use of educational resources by reaching many units at once.

The virtual classroom could be used to network and encourage the sharing of knowledge and experience among satellite units that are otherwise detached from each other. In a survey of Australian satellite dialysis units nurses ranked their preferred strategies for education in the following order: regular study days; local access to dialysis expertise; short courses: specific parent hospital liaison contact, followed by use of videos (Wellard and Bethune 2000). The use of interactive virtual classrooms could facilitate all five of these highest ranked educational strategies.

The physical design of satellite dialysis units can also contribute to the lack of education of nurses. The incorporation of physical workstations and wireless communication systems out in the dialysis area, as reported in non-dialysis settings (Korpman 1991), may enable nurses to be involved in education while remaining closer to the people receiving dialysis. Future satellite dialysis units could be designed to provide units capable of facilitating access to education, research and evidence.

The lack of access to evidence was felt by the nurses in this study to be an everyday issue when discussing medical guidelines, and their application in the satellite dialysis context. There were examples of the nurses being frustrated by one doctor ordering one prescription for their patient while another requested a different prescription. Contrasting medical orders are more common in satellite units than in hospital dialysis units given that satellite dialysis units receive patients from various parent hospitals with different nephrologists (a feature that is less apparent in hospital settings). However, the nurses' frustration has more to do with the nurses' inability to understand the dynamic nature of evidence rather than the lack of consistency by the medical staff (see Section 7.7.2). So when an order for patient's dialysis prescription is conveyed, the nephrologist may not to explain to the satellite dialysis nurse the evidence behind each order, and why their order may differ from another nephrologist. This becomes a self-defeating spiral where the satellite nurse, unable to keep up with the latest evidence, will give up trying to understand the clinical reasoning supporting the medical order.

The contradiction observed in this study was that on one hand the nurses were proud of their autonomy yet they expected consistent guidance and 'sameness' of orders from medical staff. Nurses practicing with an evidenced-based approach are more informed, which may lead to better interpretation of the varied medical orders and

guidelines from the nephrologists from the different teaching hospitals. The concern here is that if the nurses' autonomous decisions are not evidence-based then the delivery of care will not be evidence-based. Therefore it is vital that strategies to implement regular, appropriate educational sessions for satellite dialysis nurses are prioritised in order to support quality evidence-based dialysis nursing care.

Epistemological concerns here relate to the prioritising of the nephrologists' knowledge over the nurses' and patients' knowledge. The nephrologists have the academic and cultural capital (Bourdieu 1986) and thus, their knowledge is privileged over the nurses' knowledge. However this raises the question: "Should we priviledge the the nephrologists' knowledge or the nurses' knowledge?" Further research, exploring what models of care in the complex satellite/hospital dialysis unit model are best for clinical decision making, is recommended.

9.3.4 Summary of recommendations about the educational needs of satellite dialysis nurses

Education

- Increased web and database skills education for satellite dialysis nurses
- Increase web and database skills education in nephrology nursing programmes
- Increased education of satellite dialysis nurses in the use of new educational technologies such as web streaming and virtual classroom

Management

- Increased access to the web for satellite nursing staff by management
- Commitment from satellite unit management to engage in new education technologies
- Incorporate wireless workstations in future designs of satellite dialysis units to facilitate nurse and patient education

Research

- Future research exploring new models of care to achieve improved clinical decision making in satellite dialysis units
- Future research to explore the value of new educational technologies in satellite dialysis units

9.4 Patient acuity and quality nursing care

Findings from this study revealed the nurses' perceptions of increased patient acuity in the satellite dialysis unit. Many people receiving dialysis were older and sicker, requiring frequent medical attention for acute exacerbations of co-morbidities such as cardiovascular and diabetic complications. These patients, described as stoic by Caress, Luker and Owens (2001), avoided complaining about their symptoms because they were comfortable in the satellite unit and were reluctant to return to the hospital dialysis unit (Bevan 2007). This resulted in the nurses caring for sicker patients without the necessary medical and allied health support they felt was needed.

In contrast to the perception of patients getting sicker there was also the apparent contradictory perception of dialysis patients who were 'not that sick', but who had taken on the 'sick and institutionalised' role. Nurses reported these people receiving dialysis as resisting self care responsibilities, preferring that the satellite dialysis nurse perform all activities for the treatment. The nurses in this study reported that both the 'stoic' and 'institutionalised' people receiving dialysis increased the satellite dialysis nurses' workload.

9.4.1 Residential dialysis facilities

Whatever the perceptions of the nurses in this study, acuity, age and co-morbidities of people receiving dialysis treatment in satellite units, are increasing, and requiring more acute nursing care. Data from the ANZDATA Registry (McDonald and Excell 2008) confirms that dialysis patients greater than 70 years of age are the most increasing demographic in the dialysis population leading to older patients in dialysis units. Satellite dialysis units are less able to provide necessary medical care when patients suffer declining health. This trend towards increasingly older people receiving dialysis in satellite dialysis units should encourage more pro-active ideas when designing dialysis services. For example, the idea of incorporating a dialysis unit into a residential aged care facility (Tong and Nissenson 2002) or a skilled nursing facility (SNF) (Haas 1999) has been suggested and preliminary results have recently been reported by Reddy et al. (2007).

Although not drawn directly from the findings of this study, Bennett, Torpey and Bannister (2008) have proposed a model that is more stratified than Reddy's (2007). This model is a four-tiered facility offering different levels of dialysis care. The levels of care are high, hostel, independent and ambulatory care, mimicking the current levels of residential aged care in Australia. Partnership structure and methods

of funding for such a model would need to be carefully considered to provide a quality facility focusing on aged dialysis patients, however, the time may have come for the aged care dialysis facility to be seriously considered. Again, further research is required in this area to determine the most effective dialysis residential care model.

Further new models of care would contribute to the increasingly complex needs of aging satellite dialysis patients. Collaborative care models incorporating advanced practice nurses have been proposed as models of care for satellite units should aim for the best possible knowledge, both generalised and contextual, in order to facilitate evidenced-based, high quality nursing care.

9.4.2 Nurse Manager model

The most common model of care in current Australian satellite dialysis units is one that functions around the nurse unit manager, who is the conduit through which all information flows. This model occurs in this study (see Section 6.3) and describes the nurse unit manager as the person to whom nurses, people receiving dialysis and nephrologists approached in order to 'get things done'. Whether it was organising transport for a patient, through to changing the dialysis prescription of a patient, the nurse unit manager was approached. This model has developed historically from the medically dominated hierarchical model but it does not suit the satellite dialysis context.

Supporting the nurse unit manager are experienced clinical nurses who manage the unit when the nurse unit manager is not present (late shifts and weekends) but they will defer decisions to the nurse unit manager when the nurse unit manager is present. The clinical nurses may be responsible for the long-term care of a number of people receiving dialysis in a type of primary nursing care model (Bevan 2003; Flett

1997; Ilumin 2003; Quirk 1998). This primary nurse model has been implemented in satellite dialysis units because of the long term nature of the treatment where people receiving dialysis are frequently cared for by the same nurses often over many years. Although this model has been reported on, in practice, this model frequently still requires frequent nurse unit manager input.

The current management model places workload demands on the satellite dialysis nurse unit manager, restricts decision making by senior nurses and can delay necessary decision-making required for patient care (Hardcastle 2004). Moreover, the nurse unit managers place great expectations upon themselves and may be reluctant to delegate or follow desirable transformational leadership principles (McGuire 2006). Alternate models of nursing care for dialysis programs are recommended to provide timely, patient-centred care for satellite dialysis patients.

9.4.3 Advanced practice nurses

The most widely reported models designed to overcome the over-reliance on the nurse unit manager describe the advanced practice nurses working in partnership with nephrologists (Agar 2008; Chmielewski et al. 1996; Easom 2000; Harwood et al. 2004; Headley and Wall 2000; Nhan and Zuidema 2007; Stanley 2005; Steele, Hamilton, and Arnaout 2007). Advanced practice nurses and nurse practitioners are defined by the Australian and Nursing Midwifery Council Nurse Practitioner Standards Project (Gardner et al. 2004 p.8) as:

> ... a level of nursing practice that utilises extended and expanded skills, experience and knowledge in assessment, planning, implementation, diagnosis and evaluation of the care required. Nurses practising at this level are educationally prepared at postgraduate level and may work in a specialist or generalist capacity. However, the basis of advanced practice is the high degree of

> knowledge, skill and experience that is applied within the nurse-patient/client relationship to achieve optimal outcomes through critical analysis, problem solving and accurate decision making.

Further they propose that:

> Advanced practice nursing forms the basis for the role of nurse practitioner. The nurse practitioner role is an expanded form of advanced practice nursing which is specifically regulated by legislation and by professional regulation. Legislation may allow prescribing and referral, in addition to admitting privileges to health care facilities. (Gardner et al. 2004 p.8)

The differences in advanced practice nurses and nurse practitioners in Australia are clearly defined above in that the advanced practice nurse role is the basis for developing the nurse practitioner role. However, in this thesis, as the proposal of an advanced practice nurse/nephrologist partnership model, the term advanced practice nurse will be used to incorporate both advanced practice nurse and nurse practitioner.

The roles and responsibilities of the advanced practice nurse in the dialysis context can take on many roles. For example, in one model the nephrologist manages areas of dialysis prescription such as ideal weight and medications, the advanced practice nurse manages patient physical assessments and coordinates chronic disease management and the nurse manager coordinates the operational management of the unit (Dwight et al. 2002). Similar models have suggested positive outcomes associated with patient and staff satisfaction (Harwood et al. 2004) and decreased morbidity and mortality (Steele, Hamilton, and Arnaout 2007). However, there are no reports of a model specifically developed for satellite dialysis units even though it

is likely that some of the studies above have been implemented in satellite units but the reports have not been explicit about naming the settings.

Findings from this study highlight perceptions by nurses regarding the demands on the nurse unit manager role and the lack of support provided. This lack of support is not a deliberate action or inaction by any one person or individual but a result of the development of the dialysis satellite concept based on the traditional hospital model. Implementation of a more supportive model consisting of the nurse unit manager, advanced practice nurse and nephrologist(s), termed the collaborative care model (Harwood et al. 2004) is recommended as a more supportive structure for staff and patients in satellite dialysis units.

9.4.4 Satellite collaborative care model

This dialysis collaborative care model, applied to the satellite dialysis unit, would consist of the care coordinator (not necessarily a nurse), an advanced practice nurse and the nephrologist. The care coordinator coordinates the logistical aspects of managing the satellite dialysis unit, leaving the advanced practice nurse to target specific clinical issues with a focus on the primary care of people with end stage kidney disease. Currently, in Australian dialysis units, the nurse unit manager is responsible for both roles. The hospital application of the coordinated care model reportedly enabled people receiving dialysis to be seen sooner and "provide[d] high quality care to a greater number of patients" (Harwood et al. 2004 p.280) which would logically have the same benefits in the satellite context.

This proposed satellite dialysis coordinated care model would contribute to improved coordination of the recent proliferation of specialist renal nurses. The past decade has seen the development in Australia of specialist renal nurses such as renal anaemia

coordinators (Johnson and Byrne 2006; Suranyi and Bannister 2002), vascular access coordinators (Allon et al. 1998; Kalman et al. 1999), diabetic renal coordinators (Marchant 2002; Youngman 2004) and bone vascular syndrome coordinators (Beavis 2007). The development of these nurse-led positions has often been funded by drug companies and they are often based in one tertiary dialysis centre, while having responsibilities for home dialysis, satellite dialysis, peritoneal dialysis and pre-dialysis patients. In the proposed model, the advanced practice satellite dialysis nurse, based in the satellite unit, would coordinate these specialties, decreasing overlap and resulting in more efficient holistic care.

9.4.5 Summary of recommendations around patient acuity and quality nursing care

Clinical Practice

- Access to acute medical services for people receiving dialysis treatment in satellite dialysis units
- Appropriate resources to support the care of the aging people in satellite units

Education

- Develop education streams to prepare advanced practice dialysis nurses

Management

- Implementation of advanced practice satellite dialysis nurses

Research

- Future research exploring the utility of residential dialysis care
- Future research exploring the satellite collaborative care dialysis model

9.5 Structured reflective practice

The recommendation that nurses in satellite dialysis units incorporate a structured process of reflective practice developed from the finding that there was a lack of reflection by the nurses reviewing their own practice. Lack of reflection was demonstrated by the desire of the nurses to change perceived health-damaging behaviours and were often related to fluid and diet restrictions that the nursing staff expected patients to adhere to. Thus, a structured process of reflective practice is recommended for satellite dialysis nursing practice.

Structured reflective practice requires a method to encourage reflective practice among nurses. Various methods of reflective practice in nursing have been proposed (Atkins and Murphy 1993; Boud, Keogh, and Walker 1985; Hancock and Durham 2007). One model consisted of a three stage reflective process consisting of: (1) an awareness of uncomfortable feelings and thoughts; (2) an examination of feelings and knowledge; and (3) practice transformation where actual learning and practice change occurs (Boud, Keogh, and Walker 1985). This model can be applied to reflective nursing practice in the satellite dialysis context.

9.5.1 Reflective stage 1

A starting point for satellite dialysis nurses in relation to the awareness of uncomfortable feelings and thoughts was their frustration and inability to change the perceived health damaging non-adherence behaviours of people receiving dialysis. These potential damaging behaviours included perceived non-compliance with dietary, medication and fluid prescriptions. The frustration found in this study was consistent with other researchers who were critical of non-reflective nursing practices related to patient compliance (Polaschek 2007, Woodcock 1999). Therefore, stage one is all about encouraging dialysis nursing staff to identify what they are uncomfortable or frustrated about the lack of behaviour change in people receiving dialysis.

9.5.2 Reflective stage 2

Stage 2 requires an examination of the feelings and knowledge of why the nurses are frustrated with their perceived lack of success when educating people receiving dialysis. Potential reasons for these feelings could be a desire to contribute to the patient's quality of life and their frustration in not being able to change the patient's behaviour. Thus, the nurses could be encouraged to reflect on their own lives and the difficulties they have in 'complying' with all health affirming behaviours. This is an example of the application of adult learning principles, or andragogy (Knowles 1970), to their teaching practices in the clinical setting.

9.5.3 Reflective stage 3

An example of Stage 3 in this reflective process would be an examination of the methods of teaching that the nurses performed following the reflective practice process. Although patient behaviour may not change, reflective practice would

encourage the nurses to approach each patient individually in order to negotiate a plan to meet the patients' life aims and goals and how the dialysis therapy can contribute to these goals. This recommendation of reflective practice fits well with the aforementioned goal attainment scaling.

Reflective practice has been addressed in post graduate nephrology nurse programmes, to improve internal and external reflection (Bridger 2007), based on the recommendation that "...reflection on practice would help nurses to become more self aware. This is important as it helps them bring themselves to the patient" (Kilcullen 2007 p.1035). The inclusion of reflective practice in nephrology nursing curricula is an encouraging step in embedding these practices into nephrology nursing and leading to increased concordance.

9.5.4 Summary of recommendations around structured reflective practice

Clinical Practice

- Incorporate structured reflective nursing practices in satellite dialysis units

Education

- Include reflective practice education for nurses in satellite dialysis unit education programmes and nephrology nursing courses.

Research

- Future research exploring reflective nursing practice in satellite dialysis units

9.6 The research approach used in this study to explore satellite dialysis nurses' perceptions of quality

This study used ethnographic methods guided by a critical approach to explore and understand satellite dialysis quality nursing care. The critical approach has been associated with past periods of social oppression and has epistemological foundations that historically-based knowledge distorts contextual truths. This approach facilitated the aim to, not only to understand, but improve nursing care by exposing truths previously distorted by elements of power. Distortions of truth exemplified by dominant quantitative measures, such as Kt/V, of quality satellite dialysis nursing care were central to the critical approach in this study.

The nurses in one satellite dialysis unit were studied because, in critical ethnography, it assists the focus on one specific contextual culture in order to explore beneath the powerful interests that uphold this knowledge (Bourdieu 1996; Thomas 1993). In saying this, the study of more than one unit may have unearthed other findings. Resistance to methodological rules on the surface may appear to be poor, unrigorous research, however, a critical approach encourages exposure of oppressive structures which may be not be found if strict methodology processes are applied (de Laine 1997). Therefore, the view of this researcher was to focus on the nurses as major change agents and explore their culture, in particular their perceptions of quality dialysis nursing care.

In this study I was overtly promoting a cause to understand, and possibly change, features of dialysis nursing care in order to influence satellite dialysis nursing care to the way "it ought to be" (Thomas 1993 p.27). I was not satisfied with unreflective satellite dialysis nurses, who were unknowingly being influenced to provide care that had historically developed, without important contextual aspects being incorporated

into the management and practice of satellite dialysis nurses. This group of largely female nurses has been historically oppressed (Bevan 1998; Roberts 2000). Unstructured, confidential interviews, underpinned by mutual researcher/participant trust, was the way to deeply explore and change nurses' understandings of what was important in quality satellite dialysis nursing care.

This study is the first to use a critical ethnographic approach focusing on satellite dialysis nurses in the satellite dialysis setting. Further critical ethnographies could focus on satellite dialysis patients' perceptions. In addition other satellite units, such as privately managed and more remote, non-metropolitan units, could be the focus of further critical ethnographies.

9.6.1 Summary of recommendations around the research process

Research

- Critical ethnographic research exploring patients' perceptions of quality nursing care
- Critical ethnographic research exploring other satellite contexts such as private satellite dialysis units and more remotely located satellite dialysis units

9.7 Bourdieu and quality satellite dialysis nursing care

No previous study has used Bourdieu's constructs to inform understandings of satellite dialysis nursing culture. In this study Bourdieu's theory of practice, incorporating the constructs of habitus, field and capital, informed this study by providing a vehicle to explore the nurses' own dispositions that operated within the

institutional conditions of the medical discourse and physical structure of the satellite dialysis environment. Bourdieu's notion of reproduction of habitus as subconscious practices embedded in the satellite dialysis nurse and passed on to other nurses (subconsciously) was clearly found in this study.

Nurses' subconscious practices were frequently identified during nurse interviews and were perceived as being different to those in the hospital dialysis context. These unique subconscious practices had developed as a result of the nurses' own dispositions operating in a high technology micro-culture placed in the context of a community macro-culture, while remaining under the gaze of the parent hospital administering the satellite dialysis unit.

This study found that the nurses were often frustrated because they believed they were not acknowledged for their satellite dialysis expertise by those with the greatest capital, the nephrologists. Furthermore, satellite nurses perceived that they were taken for granted by some of the people receiving dialysis who they perceived as quite capable of doing more for themselves.

Bourdieu proposed that individuals within each social field were forever trying to increase their cultural and symbolic culture, evidenced here by the nurses' desire for acknowledgement of their expert nursing care required in the satellite context. This expertise of the nurses was perceived as being bound by the institutionalised structure of the satellite dialysis context and the routines of the satellite dialysis unit.

9.7.1 Summary of recommendations around Bourdieu and quality satellite dialysis nursing care

Research

- Future research exploring Bourdieu's concepts of habitus, capital, field and practice in other satellite and hospital dialysis contexts.

9.8 Study limitations

This critical ethnography explored the perceptions of nurses who worked in one satellite haemodialysis unit in metropolitan Adelaide. Undertaking the same study in another unit, or by other researchers, may have resulted in alternate findings and interpretations of these findings. In saying this, the study's findings could be transferable with elements of the findings and recommendations providing valuable insights for other satellite dialysis clinicians, managers and researchers.

One limitation of this study is that the perceptions of the people receiving dialysis and nephrologists were not given greater attention, concentrating instead on perceptions of nurses. Thus, this study focused on the perceptions of a 'sub-culture', uncovering aspects of nursing culture that influence quality nursing care. This study did not place the patients' or nephrologists' perspectives at the forefront of the study for two reasons: firstly, integral to the study approach, was my own view that nurses in satellite units are the most influential group in this context (Gregory et al. 1998; Hagren et al. 2001); and secondly, because perceptions of people receiving dialysis (Ashwanden 2003; Gill, Campbell, and Taylor 2002; Kim and Suh 1999; Lam et al. 1994; Rubin et al. 1997; Rydholm and Pauling 1991; Sloan 1999; Wright et al. 1996)

and nephrologists (Holley 1997; Plantinga et al. 2002) had been studied previously. Although these were not critical ethnographies, I was able to bring previous studies into the discussion without affecting the focus of this study on nurses' perceptions of quality nursing care in the satellite dialysis context.

The decision to privilege the nurse interviews over observation, as the major data source, may be viewed as a methodological limitation. In this study, observation was used to inform the interviews rather than for confirming or triangulation purposes. Given that the study aimed at exploring nurses' perceptions the interviews reflected these perceptions in a way that was not possible through observation. Thus, each nurse was interviewed twice to ensure that their perceptions were fully explored. In saying this, observation contributed to contextual understandings of the findings while providing effective data for participants to reflect upon and further explore throughout the interviews.

A final limitation of this study is that the perceptions of a group of nurses have been explored through my own critical lens. A fundamental ontological assumption of this study is that the findings are my interpretations of the nurses' perceptions. Therefore, my own experience contributes to interpretations about nurses' perceptions of quality dialysis nursing care. Throughout the study I undertook processes to accurately check that my interpretations reflected the nurses' perceptions. This included two feedback sessions with the participants where I received confirmation of the accuracy and relevance of the study's findings and recommendations. In saying this, however, the study's findings remain my own interpretation of the nurses' perceptions, which is influenced by my own world view as a researcher, nurse, academic and change agent.

9.9 Conclusion

Chronic kidney disease is a global disease, has a complex aetiology and is increasing in incidence and prevalence. In Australia, treatment for the final stage of chronic kidney disease, end stage kidney disease, includes dialysis and transplantation, with the majority of people receiving dialysis in satellite dialysis units. These satellite dialysis units are nurse-managed and staffed with nurses who have specialised dialysis knowledge and skills and are highly influential in the care that ESKD patients receive.

This study was stimulated by my interest to improve nursing care in satellite dialysis units through exploration, improved understanding and knowledge, and to identify political aspects constraining nurses in their practice. A critical ethnographic approach was chosen to explore these aspects with the aim of identifying constraints with the view that exploring complexities of quality nursing care in the satellite dialysis unit can provide nurses with the confidence to provide high quality care. Although this care (such as personal, intimate, humorous) may not be 'quantitatively measurable' it may be far more valuable to the dialysis patient than an impersonal medical intervention or measurement.

In this study the satellite nurses' perceptions of quality nursing care involved the technical and the interpersonal. The patients, nurses, management and environment influenced quality nursing care. Furthermore, the nurses felt there were differences between satellite and hospital dialysis nursing care. In addition, this study revealed power and oppression in the satellite context. Reluctance by nurses to challenge medical power was found, even though the nurses had far greater personal knowledge of the people receiving dialysis. Similarly, through the perceptions of the nurses the powerlessness of the people receiving dialysis was revealed.

Facilitating change in dialysis nursing practice is fundamental to this study and consistent with a critical approach. New understandings for the nurses will not result in practice change unless there is a collective uptake of these practices (Bourdieu 1977). The theoretical approach has supported the proposal that change is possible and fundamental to the success of this study. Recommendations have been proposed for practice, policy, education and research which have emerged from the findings of this critical ethnography.

Finally, quality nursing care in satellite dialysis units can not just be measured by a mathematical formula. Real people with real lives require considerably more than a formula to measure their healthcare. Nurses need to recognise and challenge the power of people who use such quantitative measures for their own convenience. Nurses challenging these quantitative measures may go some way to achieving empowerment and emancipation for both satellite dialysis nurses and the people they care for.

REFERENCES

Agar, J, RJ Knight, RE Simmonds, JM Boddington, CM Waldron, and CA Somerville. 2005. Nocturnal haemodialysis: An Australian cost comparison with conventional satellite haemodialysis. *Nephrology* 10 (6):557-570.

Agar, J, M MacGregor, and C Blagg. 2007. Chronic maintenance hemodialysis: Making sense of the terminology. *Hemodialysis International* 11 (2):252-262.

Agar, JWM. 2008. Who will replace me? A renal physician's lament. *Internal Medicine Journal* 38 (3):211-215.

Agar, JWM, MS MacGregor, and CR Blagg. 2007. Chronic maintenance hemodialysis: Making sense of the terminology. *Hemodialysis International* 11:252-262.

Al-Hilali, N, H Al-Humoud, VT Ninan, MM Nampoory, and KV Johny. 2006. Blood pressure control in haemodialysis patients: An audit. *Nephrology* 11 (2): 100-104.

Alavi, C. 2006. 30th Anniversary commentary on Morse J.M., Bottorff J., Anderson G., O'Brien B. & Solberg S. (1992) Beyond empathy: expanding expressions of caring. Journal of Advanced Nursing, 17, 809-821. *Journal of Advanced Nursing* 53 (1):89-90.

Aléx, L, and A Hammarström. 2008. Shift in power during an interview situation: methodological reflections inspired by Foucault and Bourdieu. *Nursing Inquiry* 15 (2):169-176.

Allan, H. 2001. A 'good enough' nurse: supporting patients in a fertility unit. *Nursing inquiry* 8 (1):51-60.

Allard, AC. 2005. Capitalizing on Bourdieu: How useful are the concepts of 'social capital' and 'social field' for researching 'marginilized' young women? *Theory and Research in Education* 3 (1):63-79.

Allon, M, R Bailey, R Ballard, MH Deierhoi, K Hamrick, R Osser, V K Rhynes, ML Robbin, S Saddekni, and ST Zeigler. 1998. A multidisciplinary approach to hemodialysis access: Prospective evaluation. *Kidney International* 53 (2): 473-479.

Allon, M, and ML Robbin. 2002. Increasing arteriovenous fistulas in hemodialysis patients: problems and solutions. *Kidney International* 62 (4):1109-24.

American Nephrology Nurses Association. 2008. *Discover Nephrology Nursing* 2008 [viewed 16th April 2008]. Available from http://www.annanurse.org/.

Anderson, JM, S Reimer Kirkham, AJ Browne, and MJ Lynam. 2007. Continuing the dialogue: postcolonial feminist scholarship and Bourdieu - discourses of culture and points of connection. *Nursing Inquiry* 14 (3):178-188.

Angus, J, E Hodnett, and L O'Brien-Pallas. 2003. Implementing evidence-based nursing practice: a tale of two intrapartum nursing units. *Nursing Inquiry* 10 (4):218-228.

Angus, J, P Kontos, I Dyck, P McKeever, and B Poland. 2005. The personal significance of home: habitus and the experience of receiving long-term care. *Sociology of Health & Illness* 27 (2):161-187.

Ansell, D, J Feehally, TG Feest, C Tomson, AJ Williams, and G Warwick. 2007. *UK Renal Registry Report* Bristol, UK: UK Renal Registry.

ANZDATA. 2007. Australian and New Zealand Dialysis and Transplant Registry. Adelaide: The Queen Elizabeth Hospital.

ANZDATA. 2008. *Australian and New Zealand Dialysis and Transplant Registry*. Adelaide: The Queen Elizabeth Hospital.

Asch, Steven M., Elizabeth A. McGlynn, Mary M. Hogan, Rodney A. Hayward, Paul Shekelle, Lisa Rubenstein, Joan Keesey, John Adams, and Eve A. Kerr. 2004. Comparison of Quality of Care for Patients in the Veterans Health Administration and Patients in a National Sample. *Annals of Internal Medicine* 141 (12):938-945.

Ashwanden, C. 2003. Discovering the culture of haemodialysis units: an ethnography. *EDTNA ERCA J* 29 (4):192-4.

Ashwanden, C. 2004. Caring for Staff in Renal Care. In *Advanced Renal Care*, edited by N. Thomas. Oxford: Blackwell.

Atkins, S, and K Murphy. 1993. Reflection: a review of the literature. *Journal of Advanced Nursing* 18 (8):1188-92.

Attree, M. 1993. An analysis of the concept of 'quality' as it relates to contemporary nursing care. *International Journal of Nursing Studies* 30 (4):355-69.

Attree, M. 1996. Towards a conceptual model of 'Quality Care'. *International Journal of Nursing Studies* 33 (1):13-28.

Attree, M. 2001. A study of the criteria used by healthcare professionals, managers and patients to represent and evaluate quality care. *Journal of Nursing Management* 9 (2):67-78.

Auerbach, CF, and LB Silverstein. 2003. *Qualitative Data: An Introduction to Coding and Analysis*. New York: New York Press.

Auge, M. 1995. *Non-Places: Introduction to an Anthropology of Supemodernity*. Translated by J. Howe. London and New York: Verso.

Australian Commission on Safety and Quality in Healthcare. 2008. *Australian Commission on Safety and Quality in Healthcare Home Page*. Australian Federal Government 2008 [viewed 27th October 2008]. Available from http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/home.

Australian Council on Healthcare Standards. 2004. *ACHS Clinical Indicator Summary Guide: An approach to demonstrating the dimensions of quality*. Sydney: ACHS Publication Service.

Australian Institute of Health and Welfare. 2006. *Chronic Diseases and Associated Risk Factors in Australia*. Canberra: AIHW.

Australian Institute of Health and Welfare. 2008. *Nursing and midwifery labour force 2005*, *National health labour force series*. Canberra: AIHW.

Ball, LK. 2006. The Buttonhole Technique for Arteriovenous Fistula Cannulation. *Nephrology Nursing Journal* 33 (3):299-304.

Ballard, DI, and DR Seibold. 2004. Communicated-related organization structures and work group temporal experiences: The effects of coordination method, technology type, and feedback cycle on members' construals and enactments of time *Communication Monographs* 71 (1):1-27.

Bame, SI, N Petersen, and NP Wray. 1993. Variation in hemodialysis patient compliance according to demographic characteristics. *Social Sciences Medicine* 37 (8):1035-1043.

Bare, MR. 1997. Confronting Life-Threatening Disease: Renal Dialysis and Transplant Programs. In *Social Work in Health Settings: Practice in Context*, edited by T. Kerson. New York: Haworth Press.

Barnard, A 2002 Philosophy of technology and nursing *Nursing Philosophy* 3 (1): 15-26.

Barnard, A, and M Sandelowski. 2001. Technology and humane nursing care: (ir)reconcilable or invented difference? *Journal of Advanced Nursing* 34 (3): 367-375.

Barnard, A, and R Gerber. 1999. Understanding technology in contemporary surgical nursing: a phenomenographic examination. *Nursing Inquiry* 6 (3):157-170.

Barnard, A, and D Ward. 2008. Excellence in practice: technology and the registered nurse. In *Transitions in Nursing*, edited by E. Chang and J. Daly. Sydney: Elsevier.

Basham, LM, and JWM Agar. 1997. Time Spent on Dialysis: The Paramount Consideration in Dialysis Adequacy? A New Application for the BioStat 1000 On-Line Urea Monitor. *Dialysis and Transplantation* 26 (11):739-748.

Beavis, J. 2007. Bone Vascular Syndrome Coordinator. In *Renal Society of Australasia Conference*. Perth: Renal Society of Australasia.

Bednar in Levin, N, FA Gotch, B Bednar, N Gallagher, and G Peterson. 1991. Kinetics and Quality Assurance: Prescription Therapy Through Kinetic Modelling. *American Nephrology Nurses Association Journal* 18 (3):269-90.

Benner, P. 1984. *From Novice to Expert: Excellence in Power in clinical Nursing Practice*. Menlo Park, CA: Addison-Wesley.

Benner, P. 2004. Using the Dreyfus Model of Skill Acquisition to Describe and Interpret Skill Acquisition and Clinical Judgment in Nursing Practice and Education. *Bulletin of Science, Technology & Society* 24 (3):188-199.

Bennett, PN, and P Glover. 2008. Video streaming: implementation and evaluation in an undergraduate nursing program. *Nurse Educ Today* 28 (2):253-8.

Bennett, PN, and J Neill. 2008. Quality Nephrology Nursing Care: Beyond Kt/V. *Nephrology Nursing Journal* 35 (1):33-37.

Bennett, PN, DK Torpey, and KM Bannister. 2008. Dialysis residential care: a future dialysis service model. *Asia Pacific Journal of Health Management* 3 (2): 44-50.

Benton, S. 2008. A successful anaemia management algorithm that achieves and maintains optimum haemoglobin status *Journal of Renal Care* 34 (2):54-58.

Berman, H, M Ford-Gilboe, and JC Campbell. 1998. Combining stories and numbers: a methodologic approach to critical nursing science. *Advances in Nursing Science* 21 (1):1-15.

Bernadini, J. 2004. Ethical Isues of Compliance/Adherence in the Treatment of Hypertension. *Advances in Chronic Kidney Disease* 11:222-227.

Bevan, J. 2003. Bridging the "theory-practice gap" in renal nursing: establishing a renal professional practice model. Experiences of the Adam Linton Dialysis Unit. *Canadian Association of Nephrology Nurses and Technicians Journal* 13 (1):27-33.

Bevan, MT. 1998. Nursing in the dialysis unit: technological enframing and a declining art, or an imperative for caring. *Journal of Advanced Nursing* 27 (4):730-6.

Bevan, MT. 2000. Dialysis as 'deus ex machina': a critical analysis of haemodialysis. *Journal of Advanced Nursing* 31 (2):437-443.

Bevan, MT. 2007. Experiencing Dialysis: A Descriptive Phenomenological Study of Nurses and Patients in Dialysis Satellite Units. PhD, University of Huddersfield, Huddersfield.

Bevan, MT. 2007. Experiencing Dialysis: A Descriptive Phenomenological Study of Nurses and Patients in Dialysis Satellite Units, School of Human and Health Sciences, University of Huddersfield, Huddersfield.

Bilinsky, RT, AJ Morris, and HR Klein. 1971. Satellite dialysis. An economic approach to the delivery of hemodialysis care. *Journal of the American Medical Association* 218 (12):1809-13.

Blackford, J, and A Street. 2002. Cultural conflict: The impact of western feminism(s) on nurses caring for women of non-English speaking background. *Journal of Clinical Nursing* 11 (2):664-71.

Blaikie, N. 1993. *Approaches to Social Enquiry*. Cambridge: Polity Press.

Blake, PG. 2003. Adequacy of dialysis revisited. *Kidney International* 63 (8): 1587-1599.

Blommaert, J 2005. Bourdieu the Ethnographer: The Ethnographic Grounding of Habitus and Voice. *The Translator* 11 (2):219-236.

Bloor, M, and J McIntosh. 1990 Surveillance and concealment: a comparison of techniques of client resistance in therapeutic communities and Health Visiting. In *Readings in Medical Sociology*, edited by S. Cunningham-Burley and N. McKegany. London: Tavistock.

Bolton, LB, NE Donaldson, DN Rutledge, C Bennett, and DS Brown. 2007. The Impact of Nursing Interventions: Overview of Effective Interventions, Outcomes, Measures, and Priorities for Future Research. *Medical Care Research Review* 64 (2 suppl):123S-143S.

Bommer, J. 2001. If you wish to improve adequacy of dialysis, urea kinetics, such as Kt/V, may be the wrong parameter to study. *American Society of Artificial Internal Organs Journal* 47 (3):189.

Bonner, A. 2001. Nephrology nursing: blurring the boundaries: the reality of expert practice *Journal of Clinical Nursing* 13 (2):210-218.

Bonner, A. 2003. Recognition of Expertise: An important concept in the acquisition of nephrology nursing expertise. *Nursing and Health Sciences* 5 (2):123-131.

Bonner, A. 2004. Nephrology Nursing: blurring the boundaries: the reality of expert practice. *Journal of Clinical Nursing* 13 (2):210-8.

Bonner, A. 2007a. Focusing on Patients: Differences Between the Practice of Expert and Non-Expert Nephrology Nurses. *Renal Society of Australasia Journal* 3 (1):5-12.

Bonner, A. 2007b. Understanding the role of knowledge in the practice of expert nephrology nurses in Australia. *Nursing and Health Sciences* 9 (3):161-167.

Bonner, A, and J Greenwood. 2006. The acquisition and exercise of nephrology nursing expertise: a grounded theory study. *Journal of Clinical Nursing* 15 (4):480-489.

Borland, M. 1996. Australian nursing: Traditions and transitions. *Medical Journal of Australia* 164 (9):557-560.

Boud, D, R Keogh, and D Walker. 1985. *Reflection: turning experience into learning*. London: Kogan Page.

Bourdieu, P. 1965. The sentiment of honour in the Kabyle society In *Honour and Shame*, edited by J. Peristiany. London: Weidenfeld & Nicholson

Bourdieu, P. 1977. *Algierie soixante*. Translated by R. Nice. English ed. Cambridge: Cambridge University Press.

Bourdieu, P. 1977. *Outline of a Theory of Practice*. Cambridge: Cambridge University.

Bourdieu, P. 1982. *Language and Symbolic Power*. Cambridge, Massachusetts: Harvarad University Press.

Bourdieu, P. 1984. *Distinction: A Social Critique of the Judgement of Taste*. Cambridge, Massachussets: Harvard University Press.

Bourdieu, P. 1986. The Forms of Capital. In *Handbook of Theory and Research for the Sociology of Education*, edited by J. Richardson. New York: Greenwood Press.

Bourdieu, P. 1987. *Choses Dites*. Paris: Editions de Minuet.

Bourdieu, P. 1989. *La noblesse d'Etat: Grands corps et grandes ecoles*. Paris: Editions de Minuit.

Bourdieu, P. 1990. *In Other Words: Essays Towards a Reflexive Sociology*. Translated by M. Adamson. Stanford, California: Stanford Press.

Bourdieu, P. 1990. *The Logic of Practice*. Stanford: Stanford university Press.

Bourdieu, P. 1993. Effets de lieu. In *La Misere du Monde*, edited by P. Bourdieu. Paris: Editions du Seuil.

Bourdieu, P. 1993. *The Field of Cultural Production*. Cambridge: Polity Press.

Bourdieu, P. 1993. *La Misere du Monde*. Paris: Seuil.

Bourdieu, P. 1993. *Sociology in Question*. London: Sage.

Bourdieu, P. 1996. Understanding. *Theory, Culture and Society* 13 (2):17-37.

Bourdieu, P. 1998. *Practical Reason*. Cambridge: Polity.

Bourdieu, P. 2003. The Berber House. In *The Anthropology of Space and Place: Locating Culture*, edited by S. Low and D. Lawrence-Zuniga. Oxford: Blackwell.

Bourdieu, P, and R Johnson. 1993. *The Field of Cultural Production: Essays on Art and Literature*. Cambridge: Polity

Bourdieu, P, and L Boltanski. 1976. La Production de l'Ideologie Dominante. *Actes de la Recherche en Sciences Sociales* 2-3:4-73.

Bourdieu, P, J-C Chamboredon, and J-C Passeron. 1991. *The Craft of Sociology*. Berlin: de Gruyter.

Bourdieu, P, and J-C Passeron. 1979. *The Inheritors*. Chicago: University of Chicago Press.

Bourdieu, P, and L Wacquant. 1992. *An Invitation to Reflexive Sociology*. Chicago: Chicago University Press.

Brewer, JD. 2003. Ethnography. In *The A-Z of Social Research*, edited by R. Miller and J. Brewer. London: Sage.

Bridger, J. 2007. From passive to active learners: The "lived experience" of nurses in a specialist nephrology nurse education programme. *Journal of Workplace Learning* 19 (2):78-91.

Brown, C, T Hofer, A Johal, R Thomson, J Nicholl, BD Franklin, and RJ Lilford. 2008. An epistemology of patient safety research: a framework for study design and interpretation. Part 4. One size does not fit all. *Quality Safety Health Care* 17 (3):178-181.

Brown, DA, SK Effgen, and RJ Palisano. 1998. Performance following ability focused physical therapy intervention in individuals with severely limited physical and cognitive abilities. *Physical Therapy* 78 (8):934-47.

Canales, MK 2000. Othering: Toward an Understanding of Difference. *Advances in Nursing Science* 22 (4):16-31.

Caress, AL, KA Luker, and GR Owens. 2001. A descriptive study of meaning of illness in chronic renal disease. *Journal of Advanced Nursing* 33 (6):716-727.

CARI. 2004. *The CARI Guidelines. Caring for Australians with Renal Impairment* 2002 [viewed 3rd September 2004 2004]. Available from http://www.kidney.org.au/cari/drafts/da1.html

CARI. 2007. *The CARI Guidelines - Caring for Australians with Renal Impairment: Hypertension: Left Ventricular Hypertrophy* 2003 [viewed 20th November 2007]. Available from <http://www.cari.org.au/Hypertension_LVH.pdf viewed 20th November 2007>.

CARI. 2007. *Caring for Australians with Renal Impairment*. CARI 2005 [viewed 19th June 2007]. Available from http://www.cari.org.au/dose_of_hemodiallysis_jul_2005.pdf.

Caro, JJ, M Salas, JL Speckman, G Raggio, and JD Jackson. 1999. Effect on initial drug choice on persistence with antihypertensive therapy: The importance of actual practice data. *Canadian Medical Association Journal* 160 (7):631-645.

Carspecken, P. 1996. *Critical Ethnography in Educational Research: A Theoretical and Practical Guide*. New York: Routledge.

Carvalho, MS, R Henderson, S Shimakura, and IPSC Sousa. 2003. Survival of hemodialysis patients: modeling differences in risk of dialysis centers. *International Journal for Quality in Health Care* 15 (3):189-196.

Cass, A, S Chadbam, J Craig, K Howard, S McDonald, G Salkeld, and S White. 2006. *The Economic Impact of End-Stage Kidney Disease in Australia*. Melbourne: Kidney Health Australia.

Centers for Medicare & Medicaid Services. 2007. Annual Report, End Stage Renal Disease Clinical Performance measures Project. Baltimore, Maryland.

Chance, KS. 1980. The Quest for Quality: An Exploration of Attempts to Define and Measure Quality Nursing Care. *Image - The Journal of Nursing Scholarship* 128 (2):41-5.

Charra, B, D Calemard, and M Ruffet. 1992. Survival as an index of adequacy of dialysis. *Kidney International* 41 (10):1286-1291.

Cheek, J, and S Porter. 1997. Reviewing Foucault: possibilities and problems for nursing and health care. *Nursing Inquiry* 4 (2):108-119.

Chin, MH, and N Muramatsu. 2003. What is the quality of medical care measures? Rashomon-like relativism and real-world applications. *Perspectives in Biology and Medicine* 46 (1):5-20.

Chmielewski, C, MJ Holechek, D McWilliams, K Powers, and A Tu. 1996. Advanced Practice in Nephrology Nursing. *Dialysis and Transplantation* 25 (5):260-266.

Christensen, AJ, and TW Smith. 1995. Personality and patient adherence, Correlates of the five factor model in renal dialysis. *J Behv Med* 18 (305-313).

Code, L. 1995. *Rhetorical Spaces: Essays on Gendered Locations*. New York: Routledge.

Coffey, A, and P Atkinson. 1996. *Making sense of qualitative data analysis: Complementary Strategies*. Thousand Oaks, CA: Sage.

Coleman, J. 1988. Social capital and the creation of human capital. *American Journal of Sociology* 94 (Supp):95-120.

Collins, PH. 1990. *Black feminist thought: knowledge, consciousness, and the politics of empowerment*. Boston: Unwin-Hyman, Inc.

Comstock, D. 1982. A Method for Critical Research. In *Knowledge and Values in Social and Educational Research*, edited by E. Bredo and W. Feinberg. Philadelphia: Temple University Press.

Conway, JE. 1996. *Nursing Expertise and Advanced Practice*. Salisbury: Quay Books.

Cook, WL, G Tomlinson, M Donaldson, SN Markowitz, G Naglie, B Sobolev, and SV Jassal. 2006. Falls and Fall-Related Injuries in Older Dialysis Patients. *Clinical Journal of the American Society of Nephrology* 1 (S1 –S27): 1197-1204.

Cooper, MC. 1994. Care: antidote for nurses' love-hate relationship with technology. *American Journal of Critical Care* 3 (5):402-403.

Curtin, R, and DL Mapes. 2001. Health care management strategies of long term dialysis survivors. *Nephrology Nursing Journal* 28 (6):385-394.

Curtin, R, D Mapes, M Petillo, and E Oberley. 2002. Long-Term Dialysis Survivors: A Transformational Experience. *Qualitative Health Research* 12 (5):609-624.

Curtin, RB, D Mapes, D Schatell, and S Burrows-Hudson. 2005. Self-Management in Patients with End Stage Renal Disease: Exploring Domains and Dimensions. *Nephrology Nursing Journal* 32 (4):389-395.

Curtright, JW, SC Stolp-Smith, and ES Edell. 2000. Strategic Performance Management: Development of a performance management system at the Mayo Clinic. *Journal of Healthcare Management,* 45 (1):58-68.

Daly, M. 2003. Methodology. In *The A-Z of Social Research*, edited by R. Miller and J. Brewer. London: Sage.

Daugirdas, JT. 1993. Second generation logarithmic estimates of single-pool variable volume Kt/V: An analysis of error. *Journal of the American Society of Nephrology* 4 (5):1205-1213.

Daugirdis, J, and T Ing. 1988. *Handbook of Dialysis*. Boston: Little Brown.

Davis, CL, and FL Delmonico. 2005. Living donor kidney transplantation; a review of the current practices for the live donor. *American Society of Nephrology* 16:2098-2110.

de Laine, M. 1997. *Ethnography: Theory and Applications in Health Research*. Sydney: MacLennan and Petty.

Dermody, K, and P Bennett. 2008. Nurse stress in hospital and satellite haemodialysis units. *Journal of Renal Care* 34 (1):28-32.

Diaz-Buxo, J, and J Loredo. 2006. Standard Kt/V: comparison of calculation methods. *Artificial Organs* 30 (1):178-185

Dika, SL, and K Singh. 2002. Applications of social capital in educational literature: a critical synthesis. *Review of Educational Research* 72 (1):31-60.

Donabedian, A. 1966. Evaluating the Quality of Medical Care. *Milbank Quarterly* 44:166-206.

Donabedian, A. 1988. The Quality of Care. How Can It be Assessed. *Journal of the American Medical Association* 260 (12):1743-1748.

Doolin, B. 1998. Information technology as disciplinary technology: being critical in interpretive research on information systems. *Journal of Information Technology* 13 (4):301-311.

Dreyfus, SE, and HL Dreyfus. 1980. A five stage model of mental activities involved in directed skill acquisition Berkeley: University of California.

Dwight, CA, BZ Bispham, LJ Callen, K Brady, M Chonchol, and DM Spiegel. 2002. A Collaborative Practice Model for the Care of Hemodialysis Patients: Assessment of Outcomes. *Dialysis and Transplantation* 31 (5):2002.

Easom, AK. 2000. Nephrology APNs: Who Are We and What do We Do? *Nephrology Nursing Journal* 27 (2):187-191.

Ehrenreich, J. 1978. *The Cultural Crisis of Modern Medicine*. New York: Monthly Review Press.

Elias, N. 1978. *The Civilising Process Vol. 1: The History of Manners*. Oxford: Basil Blackwell.

Ellingson, Laura L. 2007. The Performance of Dialysis Care: Routinization and Adaptation on the Floor. *Health Communication* 22 (2):103-114.

Elseviers, M, J-Y De Vos, M Harrington, A Zampieron, P Ormandy, and T Kafkia. 2006. Comparison of renal care practice in Europe: centre and patient characteristics. *EDTNA ERCA J* 32 (11):8-13.

ERA/EDTA. 2002 Assessment of Cardiovascular Risk Factors *Nephrology Dialysis Transplantation* 17 (suppl 7):88-109.

Estabrooks, Carole A., Katherine A. O'Leary, Kathryn L. Ricker, and Charles K. Humphrey. 2003. The Internet and access to evidence: how are nurses positioned? *Journal of Advanced Nursing* 42 (1):73-81.

Evans, DJ, S Oakey, S Almdahl, and B Davoren. 1999. Goal attainment scaling in a geriatric day hospital: team and program benefits. *Canadian Family Physician* 45 (9):954-60.

Evans, RJ, and GW Donnelly. 2006. A Model to Describe the Relationship Between Knowledge, Skill, and Judgment in Nursing Practice. *Nursing Forum* 41 (4):150–157.

Everett, KD, PJ Brantley, C Sletten, ON Jones, and GT McKnigh. 1995. The relation of stress and depression to interdialytic weight gain in hemodialysis patients. *Behavioral Medicine* 21 (1):25–7.

Everett, KD, C Sletten, C Carmack, PJ Brantley, GN Jones, and T McKnight. 1993. Predicting noncompliance to fluid restrictions in hemodialysis patients. *Dialysis & Transplantation* 22 (10):614-620.

Faber, S. 2000. An investigation of life with end stage renal disease: sociocultural case studies analysis. *Canadian Association of Nephrology Nurses and Technicians Journal* 10 (3):24-34.

Fairman, J, and P D'Antonio. 1999. Virtual power: gendering the nurse-technology relationship. *Nursing Inquiry* 6 (3):178-186.

Fay, B. 1984. *Critical Social Science*. New York: Cornell University Press.

Feest, TG, J Rajamahesh, C Byrne, A Ahmad, D Ansell, R Burden, and PJ Roderick. 2005. Trends in adult renal replacement therapy in the UK:1982-2002. *Quarterly Journal of Medicine* 98 (1):21-28.

Fiester, AR, and DJ Fort. 1976. Implementing an automated goal attainment system for CMHC program evaluation. *Hospital Community Psychiatry* 27 (6): 625-6.

Finelli, F, JT Miller, JI Tokars, MJ Alter, and MJ Arduino. 2005. National Surveillance of Dialysis-Associated Diseases in the United States, 2002. *Seminars in Dialysis* 18 (1):52-61.

Finlay, L. 2002. The reflexive journey: mapping multiple routes. In *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences*, edited by L. Finlay and B. Gough. London: Blackwell.

Fishbane, S, and R Goldman. 2002. Quality outcomes and obstacles to their achievement in end-stage renal disease. *Seminars in Dialysis* 15 (1):30-34.

Flaming, D. 2006. The ethics of Foucault and Ricoeur: an underrepresented discussion in nursing. *Nursing Inquiry* 13 (3):220-227.

Fleming, TR, and DL DeMets. 1996. Surrogate End Points in Clinical Trials: Are We Being Misled? *Annals of Internal Medicine* 125 (7):605-613.

Fletcher, K. 2006. Beyond Dualism: Leading Out of Oppression. *Nursing Forum* 41 (2):50-59.

Flett, A. 1997. Introducing primary nursing to a satellite dialysis setting in Singapore. *EDTNA ERCA J* 23 (2):41-43.

Foley, RN, and R Agarwal. 2007. Hypertension Is Harmful to Dialysis Patients and Should Be Controlled. *Seminars in Dialysis* 20 (6):518-522.

Foley, RN, CA Herzog, and AJ Collins. 2002. Blood pressure and long-term mortality in United States hemodialysis patients: USRDS Waves 3 and 4 Study. *Kidney International* 62 (11):1784-1790.

Foucault, M. 1973. *The Birth of the Clinic: An Archeology of Medical Perception*. London: Tavistock.

Foucault, M. 1977. *Discipline and Punish*. New York: Pantheon.

Fowler, B. 2000. Introduction. In *Reading Bourdieu on Society and Culture*, edited by B. Fowler. Oxford: Blackwell Publishers.

Freire, P. 1970. *Pedagogy of the oppressed*. New York: Seabury.

Fromm, E. 1945. *Escape from freedom*. New York: Farrar and Rinehart.

Fulcomer, F. 1981. Kinetic modelling: a nursing perspective. *J Am Assoc Nephrol Nurses Tech* 8 (2):31-5.

Gage, M. 1999. Physical disabilities: meeting the challenges of client-centred practice. In *Client-Centred Practice in Occupational Therapy: A Guide to Implementation*, edited by T. Sumsion. New York: Churchill Livingstone.

Gardner, G, J Carryer, SV Dunn, and A Gardner. 2004. *The Nurse Practitioner Standards Project: Report to the Australian Nursing & Midwifery Council*. Canberra: Australian Nursing & Midwifery Council.

Gastaldo, D, and D Holmes. 1999. Foucault and nursing: a history of the present. *Nursing Inquiry* 6 (4):231-240.

Gill, T, K Campbell, and A Taylor. 2002. Perceptions of patients on renal dialysis in South Australia. Adelaide: South Australian Department of Human Services.

Gilmour, JA, SD Scott, and N Huntington. 2008. Nurses and Internet health information: a questionnaire survey. *Journal of Advanced Nursing* 61 (1): 19-28.

Gonda, J. 2008. The Impact of Politics, Systems and Culture on the Success of a Clinical Education Partnership, School of Nursing and Midwifery, University of Queensland, Brisbane.

Gosling, A. Sophie, Johanna I. Westbrook, and Rosemary Spencer. 2004. Nurses' use of online clinical evidence. *Journal of Advanced Nursing* 47 (2):201-211.

Gotch, FA, and JA Sargent. 1985. A mechanistic analysis of the National Cooperative Dialysis Study (NCDS). *Kidney International* 28 (5):526-584.

Gregory, D, C Way, T Hutchinson, B Barrett, and P Parfrey. 1998. Patient's perceptions of their experiences with ESRD and haemodialysis treatment. *Qualitative Health Research* 8 (6):764-783.

Gruen, RL, H Buchan, J Davies, A Mayhew, and JM Grimshaw. 2006. A new EPOC in Australian health research. *Medical Journal of Australia* 184 (1):4-5.

Gunther, M, and MR Alligood. 2002. A discipline-specific determination of high quality nursing care. *Journal of Advanced Nursing* 38 (4):353-9.

Haas, M. 1999. Building a dialysis facility within the confines of a skilled nursing facility. *Nephrology News and Issues* 13 (7):42-3.

Habermas, J. 1972. *Knowledge and Human Interests*. London: Heinemann.

Habermas, J. 1974. *Theory and Practice*. London: Heinemann.

Habermas, J. 1984. *The Theory of Communicative Action, Volume 1. Reason and Rationalization of Society*. London: Heinemann.

Habermas, J. 1987. *The Theory of Communicative Action, Vol. 2: Lifeworld and System*. Cambridge Polity Press.

Habermas, J. 1989. *The New Conservatism*. Cambridge: MIT Press.

Hagren, B, I Pettersen, E Severinsson, K Lutzen, and N Clyne. 2001. The haemodialysis machine as a lifeline: Experiences from end-stage renal disease. *Journal of Advanced Nursing* 34 (2):196-202.

Hall, JM. 2004. Marginalization and symbolic violence in a world of differences: war and parallels to nursing practice. *Nursing Philosophy* 5 (1):41-55.

Hammersley, M, and P Atkinson. 1995. *Ethnography: principles and practice*. London: Routledge.

Hancock, Helen C., and Lesley Durham. 2007. Critical care outreach: The need for effective decision-making in clinical practice (Part 2). *Intensive and Critical Care Nursing* 23 (2):104-114.

Hardcastle, MA. 2004. The dialectic of control: A critical ethnography of nurses' decision making. PhD, School of Nursing Sciences, James Cook University, Townsville.

Harding, S. 1987. Introduction. Is there a feminist method? In *Feminism and Methodology*, edited by S. Harding. Bloomington.: Indiana University Press.

Harker, R 1990. Bourdieu: education and reproduction. In *Introduction to the Work of Pierre Bourdieu: The Practice of Theory*, edited by R. Harker, C. Mahar and C. Wilkes. Basingstoke: Macmillan.

Harris, A. 2007. The organization and funding of the treatment of end-stage renal disease in Australia *Journal of Health Care Finance and Economics* 7 (2-3): 113-132

Hart, M. 1996. Incorporating outpatient perceptions into the definition of quality. *Journal of Advanced Nursing* 24 (6):1234 -1240.

Harteloh, PP. 2003. The meaning of quality in health care; a conceptual analysis. *Health Care Analysis* 11 (3):259-67.

Harwood, Lori, Barbara Wilson, A. Paul Heidenheim, and Robert M. Lindsay. 2004. The advanced practice nurse-nephrologist care model: Effect on patient outcomes and hemodialysis unit team satisfaction. *Hemodialysis International* 8 (3):273-282.

Haviland, J W. 1965. Experiences in establishing a community artificial kidney center. *Transactions of the American Clinical and Climatological Association* 77:125-9.

Hawley, C. 2005. Serum phosphate. *Nephrology* 11 (s1):S201-S205.

Headley, CM, and B Wall. 2000. Advanced practice nurses: roles in the haemodialysis unit. *Nephrology Nursing Journal* 27 (2):177-184.

Healthcare Services and Financing Department. 2007. State of Our Public Hospitals Report, edited by Department of Health and Aging. Canberra: Commonwealth of Australia.

Hedge, A, J Veis, A Seidman, S Khan, and J Moore. 2000. High prevalence of alcoholism in dialysis patients. *American Journal of Kidney Diseases* 35 (6):1039-1043.

Hegel, GWJ. 1821. *Elements of the philosophy of right*. Heidelberg.

Held, D. 1980. *Introduction to critical theory*. Berkely and Los Angeles: University of California Press.

Henderson, LW. 2004. The inadequacy of Kt/Vurea: A brief history of time. *Hemodialysis International* 8 (2):139-143.

Henning, MR. 2007. Affecting Kt/V: An Analysis of Staff Interventions. *Dialysis & Transplantation* 36 (11):584-601.

Heslop, L. 1997. The (im)possibilities of poststructuralist and critical social nursing inquiry. *Nursing Inquiry* 4 (1):48-56.

Hiidenhovi, H, P Laippala, and K Nojonen. 2001. Development of a patient-oriented instrument to measure service quality in outpatient departments. *Journal of Advanced Nursing* 34 (5):696-705.

Hoffart, N. 1989. Nephrology nursing 1915-1970. A historical study of the integration of technology and care. *ANNA J* 16 (3):169-78.

Hofmeyer, A 2002. Using text as data and writing as the method of inquiry and discovery. *Nursing Inquiry* 9 (3):215-217.

Hogston, R. 1995. Evaluating quality nursing care through peer review and reflection: the findings of a qualitative study. *International Journal of Nursing Studies* 32 (2):162-72.

Hogston, R. 1995. Quality nursing care: a qualitative enquiry. *Journal of Advanced Nursing* 21 (1):116-24.

Holley, JL. 1997. Nephrologists' Perception of Their Role as Primary Care Providers for Dialysis Patients. *Seminars in Dialysis* 10 (6):305-306.

Horkheimer, M. 1937. *Critical Theory: Selected Essays*. New York: Herder and Herder.

Hoy, WE, JD Mathews, Z Wang, DA McCredie, BG Hayhurst, DJ Pugsley, RJ Norman, R McFarlane, M Rees, E Kile, and K Walker. 1998. Towards an epidemiologic definition of renal disease: Rates and associations of albuminuria in a high-risk Australian Aboriginal community. *Nephrology* 4 (s2):S59-S65.

Huppatz, K. 2006. The interaction of gender and class in nursing: Appropriating Bourdieu and adding Butler. *Health Sociology Review* 15 (2):124-131.

Illich, I. 1977. *Limits of Medicine: Medical Nemesis: The Expropriation of Health*. Harmondsworth: Penguin.

Ilumin, MP. 2003. A continuous quality improvement (CQI) initiative: focusing on primary nurse accountability. *Nephrology Nursing Journal* 30 (1):33-37.

Irvine Doran, D, L McGillis Hall, S Sidani, L O'Brien-Pallas, G Donner, and GR Baker. 2001. Nursing staff mix and patient outcome achievement: The mediating role of nurse communication. *International Nursing Perspective* 1 (2-3):74-83.

Jaeger, JQ, and RL Mehta. 1999. Assessment of Dry Weight in Hemodialysis: An Overview. *Journal of American Society of Nephrology* 10 (4):392-403.

Jenkins, R. 1992. *Pierre Bourdieu*. New York: Routledge.

Johnson, S, and P Byrne. 2006. Technology in the background of the improvement of anemia treatment. *Journal of Renal Care* 32 (3):157-61.

Johnstone, S, and D Halshaw. 2003. Makng Peace with Fluid: Social Workers Lead cognitive-Behavioural Intervention to Reduce Health-Risk Behavior. *Nepphrology News & Issues* December 20-31.

Johnstone, S, LL Walrath, V Wohlwend, LD Jobe, and C Thompson. 2004. Overcoming Early Learning Barriers in Hemodialysis Patients: The Sue of Screening and educational Reinforcement to Improve Treatment Outcomes. *Advances in Chronic Kidney Disease* 11 (2):210-216.

Joly, D, D Anglicheau, C Alberti, AT Nguyen, M Touam, JP Grunfeld, and P Jungers. 2003. Octogenarians Reaching End-Stage Renal Disease: Cohort Study of Decision-Making and Clinical Outcomes. *Journal of the American Society of Nephrology* 14 (4):1012-1021.

Jones, D, J Edwards, and C Lester. 1997. The changing role of the practice nurse *Health & Social Care in the Community* 5 (2):77-83.

Jorgensen Huston, C 2003. Quality health care in an era of limited resources: Challenges and opportunities. *Journal of Nursing Care Quality* 18 (4): 295-301.

Kadner, K. 1994. Therapeutic intimacy in Nursing. *Journal of Advanced Nursing* 19 (2):215 218

Kalman, PG, M Pope, C Bhola, R Richardson, and KW Sniderman. 1999. A practical approach to vascular access for hemodialysis and predictors of success. *Journal of Vascular Surgery* 30 (4):727-33.

Kammerer, J, G Garry, M Hartigan, B Carter, and L Erlich. 2007. Adherence in Patients On Dialysis: Strategies for Success. *Nephrology Nursing Journal* 34 (5):479-486.

Kant, I. 1781. *Critique of Pure Reason*. N. Kemp-Smith (trans.), London: Macmillan, 1929.

KDOQI. *K/DOQI Clinical Practice Guidelines on Hypertension and Antihypertensive Agents in Chronic Kidney Disease* 2004 [viewed 20th November 2007. Available from http://www.kidney.org/professionals/kdoqi/guidelines_bp/index.htm.

Kellehear, A. 1993. *The unobtrusive researcher, a guide to methods*. Sydney: Allen and Unwin.

Keogh, A. 2004. Clinical Governance. In *Advanced Renal Care*, edited by N. Thomas. Oxford: Blackwell.

Kerr, P, V Perkovic, J Petrie, J Agar, and A Disney. 2005. Dose of haemodialysis. *Nephrology* 10 (s4):S61-S63.

Kerridge, I, M Lowe, and J McPhee. 2006. *Ethics and Law for Health Professionals*. Sydney: Federation Press.

Kidney Health Australia. 2006. Kidney News. October. Melbourne: Kidney Health Australia.

Kidney Health Australia. 2007. *Chronic Kidney Disease (CKD) Management in General Practice*. Melbourne: Kidney Health Australia.

Kilcullen, Nora. 2007. An analysis of the experiences of clinical supervision on Registered Nurses undertaking MSc/graduate diploma in renal and urological nursing and on their clinical supervisors. *Journal of Clinical Nursing* 16 (6):1029-1038.

Kim, EM, and MJ Suh. 1999. A Study on the Relationship Between Learned Helplessness and Self-care Agency in Dialysis Patients. *Korean Journal of Rehabilitation Nursing* 2 (1).

Kimmel, Pl, RA Peterson, KL Weihs, SJ Simmens, DH Boyle, D Verme, WO Umana, JH Veis, S Alleyne, and I Cruz. 1995. Behavioral compliance with dialysis prescription in hemodialysis patients. *Journal of the American Society of Nephrology* 5 (10):1826-1834.

Kincheloe, JL, and PM MacLaren. 2000. Rethinking Critical Theory and Qualitative Research. In *Handbook of Qualitative Research*, edited by N. Denzin and Y. Lincoln. Thousand Oaks, California: Sage.

Kincheloe, JL, and PM Maclaren. 2000. Rethinking critical theory and qualitative research. In *Handbook f Qualitative Research*, edited by N. Denzin and Y. Lincoln. Thousand Oaks, California: Sage.

Kirchheimer, O. 1933. Marxismus, Diktatur und Organisationsformen des Proletariats. *Die Gesellschaft* 10.

Kjellstrand, CM, RL Evans, RJ Peterson, LW Rust, J Shiderman, Buselmeier TJ, and LT Rozelle. 1972. Considerations of the middle molecule hypothesis. *Proceedings from the Clinical Dialysis and Transplantation Forum* 2 (s1): 127-132.

Kleinpell, RM, DF Perez, and R McLaughlin. 2005. Educational Options for Acute Care Nurse Practitioner Practice. *Journal of the American Academy of Nurse Practitioners* 17 (11):460-471.

Knowles, MS 1970. *The Modern Practice of Adult Education: Andragogy Versus Pedagogy*. New York: Association Press.

Knox, D. 2000. Learning Theories. In *Theoretical basis for learning*, edited by M. McEwan and E. Willis. Philadelphia: Lippincott, Williams and Wilkins.

Koch, T. 1992. A review of nursing quality assurance. *Journal of Advanced Nursing* 17 (7):785-794.

Koch, T. 1994. Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing* 19 (5):976-986.

Korpman, RA. 1991. Bedside terminals can improve nursing efficiency. *Healthcare Financial Management* 45 (4):48, 50, 52.

Kugler, C, H Vlaminck, A Haverich, and B Maes. 2005. Nonadherence With Diet and Fluid Restrictions Among Adults Having Hemodialysis. *Journal of Nursing Scholarship* 37 (1):25–29.

Kunyk, D, and JK Olson. 2001. Clarification of conceptualizations of empathy. *Journal of Advanced Nursing* 35 (3):317-325.

Kurtzman, Ellen T., and Janet M. Corrigan. 2007. Measuring the Contribution of Nursing to Quality, Patient Safety, and Health Care Outcomes. *Policy Politics Nursing Practice* 8 (1):20-36.

Kutner, NG. 2001. Improving compliance in dialysis patients: Does anything work? *Seminars in Dialysis* 14:324-327.

La Ferriere, L, and R Calsyn. 1978. Goal attainment scaling: an effective treatment technique in short term therapy. *American Journal of Community Psychology* 6 (2):271-82.

Lam, DTY, CM Chan, KL Tong, HWH Chan, and SCR Kapoor. 1994. Rehabilitation In Haemodialysis Patients. *Hong Kong Practitioner* 16 (6):299-306.

Lauzon Clabo, LM. 2008. An ethnography of pain assessment and the role of social context on two postoperative units. *Journal of Advanced Nursing* 61 (5): 531-539.

Lawler, J. 1991. *Behind the Screens: Nursing Somology and the Problem of the Body*. London: Churchill Livingstone.

LeCompte, MD, and J Priessle. 1993. *Ethnography and Qualitative Design in Educational Research*. San Diego: Academic.

Lefley, HP. 1979. Environmental Interventions and Therapeutic Outcome. *Hospital Community Psychiatry* 39 (3):341-4.

Leggat, JE, SM Orzol, TE Hulbert-Shearon, TA Golper, CA Jones, and PJ et al Held. 1998. Noncompliance in hemodialysis: Predictors and survival analysis. *American Journal of Kidney Diseases* 32 (1):139-145.

Lehoux, P, G Daudelin, B Poland, GJ Andrews, and D Holmes. 2007. Designing a better place for patients: professional struggles surrounding satellite and mobile dialysis units. *Social Sciences Medicine* 65:1536-1548.

Leininger, M. 1985. *Qualitative Research Methods in Nursing*. New York: Grune and Stratton.

Levey, AS, J Coresh, E Balk, A Kausz, A Levin, M Steffes, R Hogg, R Perrone, J Lau, and G Eknoyan. 2003. National Kidney Foundation Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification, and Stratification. *Annals of Internal Medicine* 139 (2):137-147.

Levey, S, KU Eckardt, Y Tsukamoto, A Levin, J Coresh, Rossert, D Zeeuw, T Hostetter, N Lameire, and G Eknoyan. 2005. Definition and classification of chronic kidney disease: A position statement from Kidney Disease: Improving Global Outcomes (KDIGO). *Journal of the American Society of Nephrology* 67 (6):2089-2100.

Lewis, SL, CL Cooper, KG Cooper, PN Bonner, K Parker, and A Frauman. 1999. Research Priorities For Nephrology Nursing: American Nephrology Nurses' Association's Delphi Study. *American Nephrology Nurses Association Journal* 26 (2):215-225.

Li, Z, E Jr Lacson, EG Lowrie, NJ Ofsthun, MK Kuhlmann, JM Lazarus, and NW Levin. 2006. The epidemiology of systolic blood pressure and death risk in hemodialysis patients. *American Journal of Kidney Diseases* 48 (6): 606-615.

Liaschenko, J. 1994. The moral geography of home care. *Advances in Nursing Science* 17 (2):16-26.

Liberati, A. 1997. Consumer participation in research and health care. *British Medical Journal* 315 (7107):499.

Lincoln, YS, and EG Guba. 2000. Paradigmatic controversies, contradictions and emerging confluences. In *Handbook of Qualitative Research*, edited by N. Denzin and Y. Lincoln. Thousand Oaks: Sage.

Lindsay, RM, AP Heidenham, and R Leitch. 2001. Short daily versus long nocturnal hemodialysis. Daily/Nocturnal Dialysis Study Group. *Journal of the American Society of Artificial Internal Organs* 47 (4):449-455.

Locsin, R. 1998. Technologic competence as caring in critical care. *Holistic Nursing Practice* 3 (1):50-56.

Loghman-Adham, M. 2003. Medication Noncompliance in Patients With Chronic Disease: Issues in Dialysis and Renal Transplantation. *Am J Manag Care* 9 (2):155-171.

Lok, CE, and MJ Oliver. 2003. Overcoming Barriers to Arteriovenous Fistula Creation and Use. *Seminars in Dialysis* 16 (3):189-196.

Long, CG. 1995. Renal care. In *Health Psychology; Processes and Applications*, edited by A. Broome and S. Llewelyn. New York: Chapman & Hall.

Loughman-Adham, M. 2003. Medication Noncompliance in Patients with Chronic Disease: Issues in Dialysis and Renal Transplantation. *American Journal of Managed Care* 9 (2):155-171.

Lowrie, EG. 1996. Thoughts about judging dialysis treatment: mathematics and measurements, mirrors in the mind. *Seminars in Nephrology* 16 (2):242-62.

Lowrie, EG, N Ofsthun, and JM Lazarus. 2002. Body size, dialysis dose and death risk relationships among hemodialysis patients. *Kidney International* 62 (12):1891-7.

Luker, KA, L Austin, A Caress, and CE Hallett. 2000. The importance of 'knowing the patient': community nurses' constructions of quality in providing palliative care. *Journal of Advanced Nursing* 31 (4):775-782.

Lumby, J. 1996. Nurses, doctors and sacred cows. *Australian Health Review* 19 (2):1-6.

Lumme-Sandt, K, and P Virtanen. 2002. Older people in the field of medication. *Sociology of Health and Illness* 24 (3):285-304.

Lynam, MJ, AJ Browne, S Reimer Kirkham, and JM Anderson. 2007. Re-thinking the complexities of 'culture': what might we learn from Bourdieu? *Nursing Inquiry* 14 (1):23-34.

Malmstrom, Raija K., Risto P. Roine, Anne Heikkila, Pirjo Rasanen, Harri Sintonen, Riitta Muroma-Karttunen, and Eero Honkanen. 2008. Cost analysis and health-related quality of life of home and self-care satellite haemodialysis. *Nephrology Dialysis Transplantation* 23 (6):1990-1996.

Maloney, FP, P Mirrett, C Brooks, and K Johannes. 1978. Use of goal attainment scaling in the treatment and ongoing evaluation of neurologically handicapped children. *American Journal of Occupational Therapy* 32 (5):505-10.

Manfredi, SR, ME Canziani, SA Draibe, MA Dalboni, MC Andreolli, R Watanabe, and M Cendoroglo. 2003. A Model for Improving Quality in Nephrology Settings. *Nephrology Nursing Journal* 30 (3):295-299.

Manias, E, and A Street. 2000. Possibilities for critical social theory and Foucault's work: a toolbox approach. *Nursing Inquiry* 7 (1):50-60.

Manias, E, and A Street. 2001. Rethinking ethnography: reconstructing nursing relationships. *Journal of Advanced Nursing* 33 (2):234-242.

Manns, BJ, DC Mendelssohn, and KJ Taub. 2007. The economics of end-stage renal disease care in Canada; incentives and impact on delivery of care. *Int J Health Care Finance Econ* 7 (2-3):149-169.

Mantzoukas, S, and MA Jasper. 2004. Reflective practice and daily ward reality: a covert power game. *J Clin Nurs* 13 (8):925-33.

Marchant, K. 2002. The renal diabetic nurse specialist...a luxury or an essential player? *EDTNA ERCA J* 28 (2):67-9.

Marcuse, H. 1932. The foundations of historical materialism. *Die Gesellschaft* 9.

Martin, K, C Balding, and A Sohal. 2003. Stakeholder perspectives on outpatient performance: what patients, clinicians and managers want to know. *Australian Health Review* 26 (2):63-72.

Marx, K, and F Engels. 1848. *The Communist Manifesto*. Translated by S. Moore. New York: Washington Square Press.

Maslin-Prothero, Sian, and Abigail Masterson. 2002. Power, Politics, and Nursing in the United Kingdom. *Policy Politics Nursing Practice* 3 (2):108-117.

May, C. 1992. Nursing work, nurses' knowledge, and the subjectification of the patient. *Sociology of Health & Illness* 14 (4):472-487.

Mazzuchi, N, E Carbonell, and J Fernandez-Cean. 2000. Importance of blood pressure control in haemodialysis patient’s survival. *Kidney Int* 38:2147-54.

McClellan, WM, E Hodgin, S Pastan, L McAdams, and M Soucie. 2004. A randomized evaluation of two health care quality improvement program (HCQIP) interventions to improve the adequacy of hemodialysis care of ESRD patients: feedback alone versus intensive intervention. *J Am Soc Nephrol* 15 (1):754-760.

McDonald, HP, AX Garg, and RB Haynes. 2002. Interventions to enhance patient adherence to medicationprescriptions: Scientific review. *Journal of the American Medical Association* 288:2868-2879.

McDonald, S, S Chang, and L Excell. 2007. Method and Location of Dialysis. In *ANZDATA Report*, edited by S. McDonald, S. Chang and L. Excell. Adelaide: Australian and New Zealand Dialysis and Transplant Registry, 288:2868-2879.

McDonald, S, S Chang, and L Excell. 2008. Method and Location of Dialysis. In *ANZDATA Registry Report*, edited by S. McDonald, S. Chang and L. Excell. Adelaide: Australian and New Zealand Dialysis and Transplant Registry.

McDonald, S, and L Excell. 2008. Stock and Flow. In *ANZDATA Registry Report*, edited by S. McDonald, S. Chang and L. Excell. Adelaide: Australian and New Zealand Dialysis and Transplant Registry.

McFarlane, JK. 1976. A Charter for Caring. *J Adv Nurs* 1 (3):187-196.

McGuire, E. 2006. Nurse managers as transformational and transactional leaders *Nursing Economics* 24 (4):179-184

McKee, Martin. 1997. Indicators of clinical performance. *BMJ* 315 (7101):142.

McNeil, Barbara J., Victoria Elfrink, Suzanne C. Beyea, Susan T. Pierce, and Carol J. Bickford. 2006. Computer Literacy Study: Report of Qualitative Findings. *Journal of Professional Nursing* 22 (1):52-59.

Mees, E. 2004. Adequacy of dialysis: An inadequately applied concept. *Dial Transplant* 33 (12):738-746.

Meldrum, E. 2000. Chronic Renal Failure. In *Renal Nursing*, edited by T. Smith. London: Harcourt.

Melia, KM. 1979. A sociological approach to the analysis of nursing work. *Journal of Advanced Nursing* 4 (1):57-67

Meyer, M, and MP Massaglia. 2001. The forgotten component of the quality triad: Can we still learn something from "structure"? *Journal on Quality Improvement* 27 (9):484-493.

Michaels, AS. 1966. Operating parameters and performance criteria for hemodialysers and other membrane-separation devices. *Trans Am Soc Artif Intern Organs* 12 (3):387-392.

Mill, JE, MN Allen, and RA Morrow. 2001. Critical Theory: Critical Methodology to Disciplinary Foundations in Nursing. *Canadian Journal of Research* 33 (2): 109-127.

Miller, G. 1997. Contextualizing Texts: Studying Organizational Texts. In *Context and Method in Qualitative Research*, edited by G. Miller and R. Dingwall. Thousand Oaks, CA: Sage.

Miller, RL, and JD Brewer. 2003. *The A-Z of Social Research*. London: Sage.

Minichiello, V, G Sullivan, K Greenwood, and R Axford. 2004. *Research and Methods for Nursing and Health Science*. Sydney: Pearson Prentice Hall.

Mishler, E. 1984. *The Discourse of Medicine: Dialectics of Medical Interviews*. Norwood, New Jersey: Ablex.

Mok, E, and PC Chiu. 2004. Nurse-patient relationships in palliative care *Journal of Advanced Nursing* 48 (5):475-483

Molzahn, AE. 1998. Research in nephrology nursing: overview, development and future directions. In *Contemporary Nephrology Nursing*, edited by J. Parker. American Nephrology Nurses' Association: Pitman.

Montemuro, M, L S Martin, S Jakobson, E A Mohide, M L Beecroft, P Porterfield, and D Ollinger. 1994. Participatory Control in Chronic Hospital-Based Hemodialysis Units. *ANNA Journal* 21 (4):429-438.

Morduchowitz, G, J Sulkes, S Aizic, U Gabbay, J Winkler, and J Boner. 1993. Compliance in hemodialysis patients: A multivariate regression analysis. *Nephron* 63 (3):365-368.

Morehouse, RE, E Colvin, and P Maykut. 2001. Nephrology Nurse-Patient Relationships in the Outpatient Dialysis Setting. *Nephrology Nursing Journal* 28 (3):295-300.

Morris-Docker, SB., A Tod, JM Harrison, D Wolstenholme, and R Black. 2004. Nurses' use of the Internet in clinical ward settings. *Journal of Advanced Nursing* 48 (2):157-166.

Morrow, RA. and DD Brown. 1994. *Critical theory and methodology*. Thousand Oaks, CA: Sage.

Morse, JM. 2006. 30th anniversary commentary on Morse J.M., Bottorff J., Anderson G., O'Brien B. & Solberg S. (1992) Beyond empathy: expanding expressions of caring. Journal of Advanced Nursing 17, 809-821. *Journal of Advanced Nursing* 53 (1):87-88.

Morton, AR, and MA Singer. 2007. The problem with Kt/V: dialysis dose should be normalized to metabolic rate not volume. *Semin Dial* 20 (1):12-15.

Muetzel, PA 1988. *Therapeutic nursing*. Edited by A. Pearson, *Primary Nursing: Nursing in the Burford and Oxford Nursing Development Units*. London: Chapman & Hall.

National Health and Medical Council, and Australian Research Council. 2007. *National Statement on Ethical Conduct in Human Research* Canberra: Australian Government.

National Institutes of Health. 2007. *United States Renal Data System, USRDS 2007, Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States*. Bethesda, MD: National Institute of Diabetes and Digestive and Kidney Diseases.

National Kidney Foundation. 2007. *NKF-KDOQI Guidelines*. NKF 2003 [viewed 13th June 2007 2007]. Available from http://www.kidney.org/professionals/KDOQI/guidelines.cfm.

Naylor, Mary D. 2007. Advancing the Science in the Measurement of Health Care Quality Influenced by Nurses. *Med Care Res Rev* 64 (suppl 2):144S-169.

Nhan, J, and S Zuidema. 2007. Nurse practitioners in the Northern Alberta Renal Program. *CANNT J* 17 (2):48-50.

Nicolucci, A, D Cavalierre, and N Scorpoglione. 1996. A comprehensive assessment of availability of long-term complications of diabetes: A case-control study. *Diabetes Care* 19:927-933.

Nieuwstraten, C, L Dolovich, and H Chase. 2002. Goal Attainment Scaling in the Provision of Pharmaceutical Care to Hospitased Patients with Cardiovascular Disease: A Pilot Study. *Can J Hosp Pharm* 55 (4):262-71.

Nosé, Y. 1965. Discussion. *Trans Am Soc Artif Intern Organs* 11:15.

Nurses Board of South Australia. 2002. NBSA Standard Therapeutic Relationships and Professional Boundaries, edited by NBSA. Adelaide: NBSA.

O'Brien, L 2000. Nurse-client relationships: The experience of community psychiatric nurses *Australian and New Zealand Journal of Mental Health Nursing* 9 (4):184-194.

O'Mathuna, DP. 2007. Bioethics and biotechnology *Cytotechnology* 53 (1):113-119.

Ochocka, J., R. Janzen, and G. Nelson. 2002. Sharing power and knowledge: Professional and mental health consumer/survivor researchers working together in a participatory action research project. *Psychiatric Rehabilitation Journal* 25 (4):379-387.

Oka, M, and W Chaboyer. 1999. Dietary behaviors and sources of support in hemodialysis patients. *Clinical Nursing Research* 8 (4):302-317.

Oldridge, N, G Guyatt, J Crowe, D Feeny, and N Jones. 1998. Goal Attainment in a randomised control trial of rehabilitation after myocardial infarction. *J Cardiopulmonary Rehabil* 19 (1):29-34.

Outhwaite, W. 1994. *Habermas: A Critical Introduction*. Cambridge: Polity Press.

Palviainen, P, M Hietala, P Routasalo, T Suominen, and M Hupli. 2003. Do Nurses Exercise Power in Basic Care Situations? *Nursing Ethics* 10 (3):269-280.

Parker, J. 1990. Reduction in ESRD Reimbursement Rate; Identifying Research Priorities and Quality Indicators. *ANNA J* 17 (2):147-150.

Parker, J. 1998. Nephrology Nursing as a speciality. In *Contemporary Nephrology Nursing*, edited by J. Parker. American Nephrology Nurses' Association: Pitman.

Patton, MQ. 2002. *Qualitative Research and Evaluation Methods*. 3rd ed. Thousand Oaks: Sage.

Patwardhan, Meenal B., David B. Matchar, Gregory P. Samsa, and William E. Haley. 2008. Opportunities for Improving Management of Advanced Chronic Kidney Disease. *American Journal of Medical Quality* 23 (3):184-192.

Peckham, RH. 1977. Uses of individualised client goals in the evaluation of dug and alcohol programs. *Am J Drug Alcohol Abuse* 4 (4):555-70.

Peel, E, O Parry, M Douglas, and J Lawton. 2006. "It's No Skin off My Nose": Why People Take Part in Qualitative Research. *Qual Health Res* 16 (10): 1335-1349.

Peplau, HE 1962. Interpersonal Techniques: The Crux of Psychiatric Nursing *The American Journal of Nursing* 62 (6):50-54.

Perazella, MA. 1999. Approach to Patients with Intradialytic Hypotension: A Focus on Therapeutic Options. *Seminars In Dialysis* 12 (3):175–181.

Perras, ST, and M Mattern. 1994. A Practical Approach to TQI. *ANNA J* 21 (2): 129-36.

Perumal, S, and AR Sehgal. 2003. Job Satisfaction and Patient Care Practices of Haemodialysis Nurses and Technicians. *Nephrology Nursing Journal* 30 (5): 523-528.

Pierratos, A. 1999. Nocturnal home haemodialysis: An update on a 5 year experience. *Nephrol Dial Transplant* 14:2835-2840.

Plantinga, L, N Fink, H Sadler, and H Rubin. 2002. The association of the frequency of patient-physician contact with mortality and patient views of nephrologists' care: The ESRD quality (EQUAL) study. Paper read at ASN Annual Meeting, Sep.

Polaschek, N. 2003. Negotiated Care: a model for nursing work in the renal setting. *Journal of Advanced Nursing* 42 (4):355-363.

Polaschek, Nick. 2007. 'Doing dialysis at home': client attitudes towards renal therapy. *Journal of Clinical Nursing* 16 (3a):51-58.

Polaschek, NR. 2003. Living on dialysis: concerns in a renal setting. *Journal of Advanced Nursing* 41 (1):44-52.

Porter, S. 1997. The patient and power: sociological perspectives on the consequences of holistic care. *Health and Social Care in the Community* 5 (1):17-20.

Porter, S. 2003. Critical Theory. In *The A-Z of Social Research*, edited by R. Miller and J. Brewer. London: Sage.

Prentice, RL. 1989. Surrogate endpoints in clinical trials: Definition and operational criteria. *Statistics in Medicine* 8 (4):431-440.

Price, C, and E Paganini. 1999. Debate: Should nurses have a larger role in the outpatient dialysis setting than they currently do? *Seminars in Dialysis* 12 (5):359-362.

Prior, N. 2000. A different field of vision: gentleman and players in Edinburgh, 1826-1851. In *Reading Bourdieu on Society and Culture*, edited by B. Fowler. Oxford: Blackwell.

Putnam, RD. 2000. *Bowling Alone. The Collapse and Revival of American Community*. New York Simon & Schuster.

NVivo 7. QSR International, Melbourne, VIC.

Quirk, BP. 1998. Primary Patient Care in a Chronic outpatient Hemodialysis Unit. *ANNA J* 25 (3):301-306, 319.

Radwin, L, and K Alster. 2002. Individualized nursing care: an empirically generated definition. *International Nursing Review* 49 (1):54-63.

Ran, KJ, and C Hyde. 1999. Nephrology nursing practice: more than technical expertise. *EDTNA/ERCA* 25 (4):4-7.

Reddy, Naveen C., Stephen M. Korbet, Julie A. Wozniak, Sheri L. Floramo, and Edmund J. Lewis. 2007. Staff-assisted nursing home haemodialysis: patient characteristics and outcomes. *Nephrol. Dial. Transplant.* 22 (5):1399-1406.

Redfern, SJ, and IJ Norman. 1990. Measuring the quality of care: a consideration of different approaches. *Journal of Advanced Nursing* 15 (11):1260-71.

Reed-Danahay, D. 2001. 'This is your home now!': conceptualizing location and dislocation in a dementia unit *Qualitative Research* 1 (1):47-63.

Reed-Danahay, D. 2005. *Locating Bourdieu*. Bloominington: Indiana University Press.

Reis, HT. 1995. Intimacy. In *The Blackwell Encyclopaedia of Social Psychology*, edited by A. Manstead and M. Hewstone. Oxford: Blackwell

Renal Society of Australasia. 1999. *Competency Standards For The Australian Advanced Practice Nephrology Nurse*. Edited by RSA. Australia: Renal Society of Australasia.

Renal Society of Australasia. 2008. *RSA*. RSA 2008 [viewed 16th April 2008]. Available from http://www.renalsociety.org/.

Reynolds, W. 2006. 30th anniversary commentary on Morse J.M., Bottorff J., Anderson G., O'Brien B. & Solberg S. (1992) Beyond empathy: expanding expressions of caring. Journal of Advanced Nursing 17, 809-821. *Journal of Advanced Nursing* 53 (1):88-89.

Reynolds, W 2000. *The measurement and development of empathy in nursing*. Aldershot: Ashgate.

Rhynas, SJ. 2005. Bourdieu's theory of practice and its potential in nursing research. *Journal of Advanced Nursing* 50 (2):179-86.

Riley, R, and E Manias. 2002. Foucault could have been an operating room nurse *Journal of Advanced Nursing* 39 (4):316-324.

Rischel, V, K Larsen, and K Jackson. 2007. Embodied dispositions or experience? Identifying new patterns of professional competence. *Journal of Advanced Nursing* 61 (5):512-521.

Roberts, SJ. 2000. Development of a positive professional identity: Liberating oneself from the oppressor within. *Advances in Nursing Science* 22 (4):71-82.

Rockwood, K, P Stolee, K Howard, and L Mallery. 1996. Use of goal attainment scaling to measure treatment effects in an anti-dementia drug trial. *Neuroepidemiology* 15 (6):330-8.

Roderick, P, T Nicholson, A Armitage, R Mehta, M Mullee, K Gerard, N Drey, T Feest, R Greenwood, D Lamping, and J Townsend. 2005. An evaluation of the costs, effectiveness and quality of renal replacement therapy provision in renal satellite units in England and Wales. *Health Technology Assessment* 9 (24):1-6.

Rosenberg, A. 1988. *Philosophy of Social Science*. Oxford: Clarendon Press.

Rubin, HJ, and IS Rubin. 1995. *Qualitative interviewing: The art of hearing data*. Thousand Oaks, California: Sage.

Rubin, HR, M Jenckes, NE Fink, K Meyer, AW Wu, Eb Bass, N Levin, and NR Powe. 1997. Patient's view of dialysis care: development of a taxonomy and rating of importance of different aspects of care. CHOICE study. Choices for healthy Outcomes in caring for ESRD. *Am J Kidney Dis* 30 (6):793-801.

Russell, C. 2004. Ethnography and participant observation In *Research Methods for Nursing and Health Sciences*, edited by V. Minichiello, G. Sullivan, K. Greenwood and R. Axford. Sydney: Pearson.

Rydholm, L, and J Pauling. 1991. Contrasting feelings of helplessness in peritoneal and hemodialysis patients: a pilot study. *American Nephrology Nurses Association Journal* 18 (2):183-186,200.

Sadler, JH. 2007. With the Pursuit of Quality Comes a Retreat From Personal Care: The Path of Medical Practice and Dialysis Care in America. *Am J Kid Dis* 50 (4):535-537.

Safdar, N. 1995. Non-compliance to diet and fluid restriction in hemodialysis patients. *Journal of Pakistan Medical Association* 45 (11):293-298.

Salem, MM 1995. Hypertension in the hemodialysis population: A survey of 649 patients. *Am J Kid Dis* 26 (4):461-8.

Sandelowski, M. 1993. Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *Advances in Nursing Science* 16 (2):1-8.

Sanz, A, R Boni, A Ghirardini, AN Costa, and M Manyalich. 2006. IRODaT: 2005 donation and transplantation preliminary figures. *Organs, tissues and cells* 1: 9-12.

Sargent, J A. 1983. Control of dialysis by a single-pool urea model: The National Cooperative Dialysis Study. *Kidney Int* 13:S19-25.

Sarvimaki, A, and S Sandelin Benko. 2001. Values and evaluation in health care. *Journal of Nursing Management* 9 (3):129-137.

Schardin, KE. 1995. Scope of practice for nephrology nursing. *American Nephrology Nurses Journal* 22 (4):413-415.

Schwartz, D. 1997. *Culture and Power; The Sociology of Pierre Bourdieu*. Chicago: University of Chicago Press.

Scribner, BH, and DG Oreopolous. 2002. The hemodialysis product (HDP): A better index of dialysis adequacy than KT/V. *Dial Transplant* 31 (1):13-15.

Sehgal, A, C Sullivan, J Leon, and K Bialostosky. 2008. Public Health Approach to Addressing Hyperphosphatemia Among Dialysis Patients. *Journal of Renal Nutrition* 18 (3):256-261.

Sehgal, AR, JB Leon, LA Siminoff, ME Singer, LM Bunosky, and RD Cebul. 2002. Improving the quality of hemodialysis treatment: a community-based randomized controlled trial to overcome patient-specific barriers. *JAMA* 287 (1):1961-1967.

Sherman, R. 1988. The pathophysiological basis for hemodialysis-related hypotension. *Seminars in Dialysis* 1 (2):136-142.

Shinaberger, JH. 2001. Quantitation of Dialysis: Historical Perspective. *Seminars in Dialysis* 14 (4):238-245.

Sidani, S, DM Doran, and PH Mitchell. 2004. A Theory-Driven Approach to Evaluating Quality of Nursing Care. *Journal of Nursing Scholarship* 36 (1):60-65.

Silagy, CA. 2001. Evidence-based healthcare 10 years on: is the National Institute of Clinical Studies the answer? *MJA* 175 (1):124-125.

Simpson, RL. 2003. Welcome to the Virtual Classroom: How Technology is Transforming Nursing Education in the 21st Century Nursing Informatics. *Nursing Administration Quarterly* 27 (1):83-86.

Sims, S. 1986. Slow stroke back massage for cancer patients. *Nursing Times* 82 (47): 47-50

Sloan, RS. 1999. Guarded alliance relationships between hemodialysis patients and their health care providers. *ANNA J* 26 (5):503-5.

Smith, P. 2001. *Cultural Theory: An Introduction*. Malden, Massachusetts: Blackwell

Soroka, SD, BA Kiberd, and P Jacobs. 2005. The marginal cost of satellite versus in-center hemodialysis. *Hemodialysis International* 9 (2):196-201.

Soyini Madison, D. 2005. *Critical Ethnography: Methods, Ethics and Performance*. Thousand Oaks, California: Sage.

Spradley, JP. 1979. *The ethnographic interview*. New York: Holt, Rinehart and Winston.

Spradley, JP. 1980. *Participant Observation*. New York: Holt Rinehart and Winston.

Stanley, MJ. 2005. A Nurse Practitioner Model of Care in Maintenance Dialysis: a Personal and Professional Reflective Journey. Discussion, Recommendations and Conclusion (Part B) *Renal Society Australasia Journal* 1 (2):40-49.

Steele, DJ R, E Hamilton, and M Arnaout. 2007. A case management model to improve hemodialysis outpatient outcomes. *Hemodialysis International* 11 (2):247-251.

Stenmark, D. 2001. The Relationship between Information and Knowledge. Paper read at Proceedings of IRIS, at Ulvik Norway.

Stewart, G. 1997. Specialisation in Nursing: implications in Australia. *Europ. Dial.Trans. Nurse Assoc./Euro Renl. Care Assoc. J. Assoc./Euro Renl. Care Assoc. J* XXIII:49.

Stewart, G, and A Bonner. 2000. Competency based standards for advanced practice in nephrology nursing. *Europ. Dial.Trans. Nurse Assoc./Euro Renl. Care Assoc. J.* XXVI:50-54.

Stichler, JF, and ME Weiss. 2001. Through the eye of the Beholder: multiple Perspectives on Quality in Women's Health Care. *Journal of Nursing Care Quality* 15 (3):59-74.

Stolee, P, K Rockwood, RA Fox, and DI Streiner. 1992. The use of goal attainment in a geriatric care setting. *J Am Geriatr Soc* 40 (4):574-8.

Strauss, A. 1985. *The Social Organisation of Medical Work*. Chicago Press: London.

Street, A. 1995. *Nursing Replay: Researching Nursing Culture Together*. Melbourne: Churchill Livingstone.

Suranyi, M., and K. M. Bannister. 2002. Practical experience with the Renal Anaemia Management Database. *Nephrology* 7 (s2):S7-S11.

Swartz, D. 1997. *Culture and Power; The Sociology of Pierre Bourdieu*. Chicago: University of Chicago Press.

Tallis, K. 2005. How to improve quality of life in patients living with end stage renal failure. *Renal Society Australasia Journal* 1 (1):18-24.

Tanner, CA, P Benner, C Chesla, and D Gordon. 1993. The Phenomenology of Knowing the Patient. *IMAGE: Journal of Nursing Scholarship* 25 (4): 273-280.

Taskapan, H, F Ates, B Kaya, M Emu, M Kaya, C Taskapan, and I Sahin. 2005. Psychiatric disorders and large interdialytic weight gain in patients on chronic haemodialysis. *Nephrology Nursing Journal* 10 (1):15–20.

Tattersall, J, A Martin-Malo, L Pedrini, B Basci, B Canaud, D Fouque, P Haage, K Konner, J Kooman, F Pizzarelli, J Tordoir, M Vennegoor, C Wanner, P ter Wee, and R Vanholder. 2007. REBPG guideline on dialysis strategies. *Nephrol Dial Transplant* 22 (suppl 2):ii5-ii21

Taylor, B, S Kermode, and K Roberts. 2006. *Research in nursing and healthcare: evidence for practice*. Melbourne: Thomson.

Terrill, B. 1990. Urea Kinetic Modelling. *Renal Educator* 10 (4):86-87.

Terrill, B. 2002. *Renal Nursing - A Practical Approach*. Melbourne: Ausmed.

The Australian Council on Healthcare Standards. 2004. *ACHS Clinical Indicator Summary*. Edited by T. A. C. o. H. Standards. Sydney: ACHS.

Thomas, J. 1993. *Doing Critical Ethnography*, *Qualitative Research Methods*. Newbury Park, California: Sage.

Thompson, J. 1991. Editor's introduction. In *Language and Symbolic Power*, edited by P. Bourdieu. Cambridge, Massachusetts: Harvard University Press.

Thompson, JL. 1987. Critical Scholarship: the critique of domination in nursing. *Adv Nurs Sci* 10 (1):27-8.

Thorne, SE. 1993. *Negotiating Health Care: The Social Context of Chronic Illness*. Newbury Park: Sage.

Threlkeld, JAS. 1992. Nursing Implications in Kinetic Modelling. *ANNA J* 19 (2): 178-181.

Timmerman, GM. 1991. A Concept Analysis of Intimacy. *Issues in Mental Health Nursing* 12 (1):19-30.

Tims, S. 2006. 'Sentenced to life on dialysis': a critical ethnography of empowerment for people with end stage renal disease undergoing haemodialysis in a hospital connected day facility, School of Nursing and Midwifery, Flinders University, Adelaide, South Australia.

Tims, S, L King, and PN Bennett. 2007. Empowerment for people with end stage renal disease: A literature review. *Ren Soc Aust J* 3 (2):52-58.

Tong, EM, and AR Nissenson. 2002. Dialysis in nursing homes. *Semin Dial* 15 (2): 103-106.

Tuana, N. 1989. The Importance of Feminist Critique in Contemporary Cell Biology. In *Feminism and Science*, edited by N. Tuana. Boomington: Indiana Press.

Twardowski, Z. 2004. Short, thrice weekly hemodialysis is inadequate regardless of small molecule clearance. *Int J Artif organs* 27 (6):452-466.

Twardowski, Z J. 2003. Fallacies of High-Speed Hemodialysis. *Hemodialysis Int.* 7 (2):109-117.

Twardowski, ZJ. 2003. Should Strive for Optimal Hemodialysis: A Criticism of the Hemodialysis Adequacy Concept. *Hemodial Int* 7 (1):5-16.

Van Biesen, W, N Lameire, N Veys, and B Vanderhaegen. 2004. From curing to caring: one character change makes a world of difference. Issues related to withholding/withdrawing renal replacement therapy (RRT) from patients with important co-morbidities. *Nephrol Dial Trans* 19 (3):536-540.

Vanholder, R, R Desmet, and G Lesaffer. 2002. Dissociation between dialysis adequacy and Kt/V. *Seminars in Dialysis* 15 (1):3-7.

Vanholder, R, E Schepers, N Meert, and N Lameire. 2006. What is uremia? Retention versus oxidation. *Blood Purif* 24 (1):33-8.

Verhallen, AM, MP Kooistra, and BC van Jaarsveld. 2007. Cannulating in haemodialysis: rope-ladder or buttonhole technique? *Nephrol. Dial. Transplant.* 48 (s1):S176-S317.

Vermeire, E, H Hearnshaw, P Van Royen, and J Denekens. 2001. Patient adherence to treatment: Three decades of research: A comprehensive review. *J Clin Pharm Ther* 26 (1):331-342.

Virtanen, P, R Nakari, H Ahonen, J Vahtera, and J Pentti. 2000. Locality and habitus: the origins of sickness abscence practices. *Social Science and Medicine* 50 (1):27-39.

Waitzkin, H. 1990. On studying the discourse of medical encounters: A critique of quantitative and qualitative methods and a proposal for reasonable comprimise. *Medical Care* 28 (6):473-487.

Wang, AYM, and KN Lai. 2006. The importance of residual renal function in dialysis patients. *Kidney International* 69 (16):1726–1732.

Webb, J, T Schirato, and G Danaher. 2002. *Understanding Bourdieu*. London: Sage.

Wellard, S. 1992. The nature of dilemmas in dialysis nurse practice. *Journal of Advanced Nursing* 17 (8):951-958.

Wellard, S, and E Bethune. 2000. Learning Issues for Nurses in Renal Satellite Centres. *Australian Journal of Rural Health* 8 (6):322-326.

White, RB. 2004. Adherence to the dialysis prescription: Partnering with the patients for improved outcomes. *Nephrology Nursing Journal* 31 (4):432-435.

Williams, A. 1997. The delivery of quality nursing care: a grounded theory study of the nurse's perspective. *J Adv Nurs* 27 (4):808-816.

Williams, S. 1995. Theorising class, health and lifestyles: can Bourdieu help us? *Sociology of Health and Illness* 17 (5):577-604.

Willis, P, and M Trondman. 2002. Manifesto for Ethnography. *Cultural Studies Critical Methodologies* 2 (3):394-402.

Woodcock, S. 1999. Why do renal nurses focus on issues of compliance when working in rehabilitative HD settings. *EDTNA ERCA J* XXV (1):28-30.

Woodward, VM. 1998. Caring, patient autonomy and the stigma of paternalism *Journal of Advanced Nursing* 28 (5):1046-1052.

Wright, LF, SM Francisco, A Warmath, B Gibbs, P Perkins, and D Turner. 1996. Improving Outcomes for Maintenance Hemodialysis Patients by Using Continuous Quality Improvement. *Dialysis and Transplantation* 25 (6):346.

Wright, P, and A Teacher. 1982. *The Problem of Medical Knowledge*. Edinburgh: Edinburgh University Press.

Yip, AM, MC Gorman, K Stadnyk, WG Mills, KM Macpherson, and K Rockwood. 1998. A standardised menu for goal attainment scaling in the care of frail elders. *Gerontologist* 38 (6):735-42.

Young, GJ, MP Charns, K Desai, SF Khuri, MG Forbes, and W Henderson. 1998. Patterns of coordination and clinical outcomes: A study of surgical services. *Health Services Research* 33 (5):1211-1236.

Youngman, S. 2004 The developing role of the renal diabetes nurse. *EDTNA ERCA J* 30 (3):169-72.

Zabetakis, PM, C Sasak, C Callahan, L Gutzmer, MJ Tozzi, P Balter, and MF Michelis. 2000. Improving Clinical Outcomes Through internal Benchmarking and Quality Targets. *Dialysis and Transplantation* 29 (3): 130-135.

Zaza, C, P Stolee, and K Prkachin. 1999. The application of goal attainment scaling in chronic pain settings. *J Pain Symptom Manage* 17 (1):55-64.

APPENDIX A

APPROVAL FROM HEAD NURSE

19/08/04.

To whoever it may concern,

RE: Research to be undertaken by Mr Paul Bennett

I am writing to advise you that Mr Paul Bennett, higher degree candidate enrolled at Flinders University, has requested the use of [redacted] Satellite Dialysis Centre to conduct fieldwork as part of his research project. He has discussed the research with myself and given appropriate approvals from appropriate ethics committees.
We would support the use of our dialysis centre for his fieldwork.

Yours sincerely,

[redacted]
Clinical Nurse Manager
[redacted]

APPENDIX B

NURSE AND PATIENT INFORMATION SHEET

FLINDERS UNIVERSITY
ADELAIDE • AUSTRALIA

School of Nursing and Midwifery
Faculty of Health Sciences

GPO Box 2100
Adelaide 5001 Australia

Telephone: (+61 8) 8201 3972
Fax: (+61 8) 8201 3456

INFORMATION RELATING TO RESEARCH PROPOSAL OF PAUL N BENNETT

HIGHER DEGREE CANDIDATE – FLINDERS UNIVERSITY

TO ALL STAFF AND PATIENTS/CLIENTS

This following is information relating to the research proposal of Paul N Bennett.

What is being researched?
The research will focus on the haemodialysis nurses' perceptions of quality dialysis.

Why is it being researched?
It is important to acknowledge that this dialysis unit has very high standards of quality dialysis care. However, for various reasons people have different views on what "Quality Dialysis Care" actually means. Because the nurse plays a significant role in the way dialysis is provided it may be significant to find out what the nurses actually believe is "Quality Dialysis Care".

As a patient/client how will this effect my daily treatment?
You may be observed by Paul and you may be asked to briefly clarify observations. This may happen at various times during your dialysis day.

As a nurse how will this effect my daily workload?
You may be observed during various times of your work day and may be asked to clarify observations. Following this you will be asked to be interviewed at a mutually agreed time. The interview will last no more than one hour and will not require any extra time commitments outside your normal working day.

Is this research being done any where else?
Yes. There is one other haemodialysis unit that Paul is using to gather data.

Will there be any the benefits of this research?
There are several potential benefits that this research may contribute to. By finding out more and possibly new information relating to nurses and quality dialysis there is the potential to improve the provision of dialysis care. This may contribute further to the quality of care that dialysis patients/clients receive.

Will I get to see the results?
Paul will provide your unit with a copy of the results and copies of any publications that arise from this research.

If I need to contact anyone regarding this research whom do I speak with?
Please contact Paul Bennett on 0438834706 if you would like any further information.

APPENDIX C

LETTER OF INTRODUCTION FOR HAEMODIALYSIS NURSE

27 September 2004

LETTER OF INTRODUCTION OF MR PAUL N BENNETT
HAEMODIALYSIS NURSE – XXXXXXXXXXXXXXXXXXXXXXXXXX

Dear ,

This letter is to introduce Mr Paul Bennett who is a Higher Degree Candidature student in the School of Nursing and Midwifery at Flinders University. He will produce his student card, which carries a photograph, as proof of identity. He is undertaking research leading to the production of a thesis or other publications on the subject of "Nurse's perceptions of quality in Australian haemodialysis units"

He would be most grateful if you would volunteer to assist in this project, by agreeing to observation and granting an interview which touches upon certain aspects of this topic. Observation will take place during your normal working day. Paul will be observing every significant action, interaction or conversation in relation to patient care during the observation period. The length of time for observation will be from 30 minutes to two hours at various times of your treatment.

Following the observation you will be interviewed at a mutually agreed time and location. The interview will not take longer than one hour. Since he intends to observe and to make a tape recording of the interview, he will seek your consent, on the attached forms, to observe and to record the interview, to use the recording or a transcription in preparing the thesis, report or other publications, on condition that your name or identity is not revealed, and the recording will not be made available to any other person.

Be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting thesis, report or other publications. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions. In addition, participation or non-participation will have no impact on your employment.

Any enquiries you may have concerning this project should be directed to Judith Clare at the address given above or by telephone on 82013972 fax 82013456 or e-mail judith.clare@flinders.edu.au.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. The Secretary of this Committee can be contacted on 8201-5466, fax 8201-2035, e-mail Lesley.Wyndram@flinders.edu.au.

Thank you for your attention and assistance.

Yours sincerely,

Professor Judith Clare (Research Supervisor)
Professor of Nursing
School of Nursing and Midwifery, Flinders University

APPENDIX D

LETTER OF INTRODUCTION FOR HAEMODIALYSIS CLIENT/PATIENT

27 September 2004

LETTER OF INTRODUCTION OF MR PAUL N BENNETT TO HAEMODIALYSIS CLIENT/PATIENT
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Dear ,

This letter is to introduce Mr Paul Bennett who is a Higher Degree Candidature student in the School of Nursing and Midwifery at Flinders University. He will produce his student card, which carries a photograph, as proof of identity. He is undertaking research leading to the production of a thesis or other publications on the subject of "Nurse's perceptions of quality in Australian haemodialysis units".

He would be most grateful if you would volunteer to assist in this project, by agreeing to observation during your dialysis treatment. The focus of the observation will be on your nurse who may be observed at various times during your dialysis treatment. Paul will be observing every significant action, interaction or conversation of your nurse during the observation period. The length of time for observation will be from 30 minutes to two hours at various times of your treatment. You may be asked questions to clarify areas of observation.

Be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting thesis, report or other publications.

You are entirely free to discontinue your participation at any time or to decline to answer particular questions. In addition, participation or non-participation in this study will have NO impact on your current haemodialysis care.

Since Paul intends to observe your nurse (and his/her interactions with you) he will seek your consent, on the attached form, to observe you (in the observing of your nurse), record these observations and use his field notes in preparing the thesis, report or other publications, on the condition that your name or identity is not revealed.

Any enquiries you may have concerning this project should be directed to Professor Judith Clare at the address given above or by telephone on 82013972 fax 82013456 or
e-mail judith.clare@flinders.edu.au.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. The Secretary of this Committee can be contacted on 8201-5466, fax 8201-2035, e-mail Lesley.Wyndram@flinders.edu.au.

Thank you for your attention and assistance.

Yours sincerely,

Professor Judith Clare (Research Supervisor)
Professor of Nursing
School of Nursing and Midwifery, Flinders University.

APPENDIX E

CONSENT FORM FOR PATIENT/CLIENT OBSERVATION

I ….....
being over the age of 16 years hereby consent to participate as requested in XXXX Haemodialysis Unit for the research project on “Nurse’s perceptions of quality in Australian haemodialysis units”

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to my information and participation being recorded on tape.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:
    - I may not directly benefit from taking part in this research.
    - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
    - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
    - Whether I participate or not, or withdraw after participating, will have no effect on any treatment or service that is being provided to me.
    - I may ask that the recording/observation be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.
6. I have had the opportunity to discuss taking part in this research with a family member or friend.

Participant’s signature……Date……...

7. I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher’s name – Paul Bennett

Researcher’s signature……..Date…….

8. I, the participant whose signature appears below, have read a transcript of my participation and agree to its use by the researcher as explained.

Participant’s signature……Date……...

9. I, the participant whose signature appears below, have read the researcher’s report and agree to the publication of my information as reported.

Participant’s signature……Date……...

APPENDIX F

CONSENT FORM FOR PARTICIPATION IN NURSE OBSERVATION

I ….....
being over the age of 16 years hereby consent to participate as requested in XXXXXXXX Haemodialysis Unit for the research project on “Nurse’s perceptions of quality in Australian haemodialysis units”

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to my information and participation recorded by transcript.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:
    - I may not directly benefit from taking part in this research.
    - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
    - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
    - Whether I participate or not, or withdraw after participating, will have no effect on my employment at XXXXXXXX Hospital. This is supported by the Nurse Unit Manager of XXXXXXXX Haemodialysis Unit.
    - I may ask that the observation be stopped at any time and that I may withdraw at any time from the session or the research without disadvantage.

Participant’s signature……Date……...

6. I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher’s name – Paul Bennett

Researcher’s signature……..Date…….

7. I, the participant whose signature appears below, have read a transcript of my participation and agree to its use by the researcher as explained.

Participant’s signature……Date……...

8. I, the participant whose signature appears below, have read the researcher’s report and agree to the publication of my information as reported.

Participant’s signature……Date……...

APPENDIX G

CONSENT FORM FOR PARTICIPATION IN NURSE INTERVIEW

I ….....
being over the age of 16 years hereby consent to participate as requested in XXXX Haemodialysis Unit for the research project on “Nurse’s perceptions of quality in Australian haemodialysis units”

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to my information and participation recorded by audiotape.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:

I may not directly benefit from taking part in this research.

- I am free to withdraw from the project at any time and am free to decline to answer particular questions.
- While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
- Whether I participate or not, or withdraw after participating, will have no effect on my employment at XXXXX Hospital. This is supported by the Nurse Unit Manager of XXXXX Haemodialysis Unit.
- I may ask that the interview be stopped at any time and that I may withdraw at any time from the session or the research without disadvantage.

Participant’s signature……Date……..

6. I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher’s name – Paul Bennett

Researcher’s signature……..Date……

7. I, the participant whose signature appears below, have read a transcript of my participation and agree to its use by the researcher as explained.

Participant’s signature……Date……..

8. I, the participant whose signature appears below, have read the researcher’s report and agree to the publication of my information as reported.

Participant’s signature……Date……..

APPENDIX H

INTERVIEW QUESTIONS

NURSE'S PERCEPTIONS OF QUALITY IN AUSTRALIAN HAEMODIALYSIS UNITS

RESEARCHER – PAUL N BENNETT

LIST OF INTERVIEW QUESTIONS

The Interview

The interview will be semi-structured commencing with broad ranging open-ended questions followed by more focussed questions. The questions will serve as an interview guide which may be revised during the research. Practice interviews with research supervisors will be performed prior to fieldwork interviews.

Before the taping commences I will talk a little about the research, explain the process of the interview and outline the interview plan so the interviewee has an understanding of what to expect.

Examples of interview questions are provided under the two categories: Introductory questions and focussed questions.

Introductory Questions

- How would you describe your experience in this unit?
- How would you describe the relationships you have with your colleagues and clients?
- How do you view your clients?
- What do you know about your clients?

Focussed Questions

- What are the important issues related to quality care in dialysis?
- What characteristics of the unit do you value?
- How do you feel when a client does not adhere to what the health care professional is advising?
- Where and from whom do you get information about dialysis?
- Why is Kt/V important in the care of dialysis clients?

Following the Interview

Following the interview (after the audiotape has been turned off) I will thank them for their involvement and allow them to ask any questions relating to the interview or study. I will explain to them how the interview may be used in the research. I will also check any points that I may not have understood. Finally, I will reassure the participant about the confidentiality of the information that they have shared.

APPENDIX I

UNIVERSITY ETHICS COMMITTEE APPROVAL

FLINDERS UNIVERSITY
ADELAIDE • AUSTRALIA

Social and Behavioural Research Ethics Committee
Office of Research

GPO Box 2100
Adelaide 5001 Australia

Telephone: (+61 8) 8201 5962
Facsimile: (+61 8) 8201 2035
Email: sandy.huxtable@flinders.edu.au

SBRE 3098

8 October 2004

Mr Paul Bennett
2 Knowles Crescent
Marino SA 5049

Dear Mr Bennett

Project 3098 Nurse's perceptions of quality in Australian haemodialysis units

Further to my letter dated 20 September I am pleased to inform you that approval of the above project has been confirmed following receipt of the additional information you submitted on 5 October 2004.

Approval is valid for the period of time requested and is given on the basis of information provided in the application, its attachments and the information subsequently provided. In accordance with the undertaking you provided in the application, please inform the Social and Behavioural Research Ethics Committee, giving reasons, if the research project is discontinued before the expected date of completion and report anything which might warrant review of ethical approval of the protocol. Such matters include

- serious or unexpected adverse effects on participants;
- proposed changes in the protocol; and
- unforeseen events that might affect continued ethical acceptability of the project.

May I draw to your attention that, in order to comply with monitoring requirements of the *National Statement on Ethical Conduct in Research Involving Humans* an annual and/or final report must be submitted in due course. If a report is not received beforehand, a reminder notice will be issued in twelve months' time. A copy of the report pro forma is available from the SBREC website http://www.flinders.edu.au/research/office/ethics/index.html.

Yours sincerely

Sandy Huxtable
Secretary
SOCIAL AND BEHAVIOURAL RESEARCH ETHICS COMMITTEE

cc: Prof Judith Clare, Nursing & Midwifery
Dr Jacqueline Jones, Nursing & Midwifery

NB: If you are a scholarship holder and you receive funding for your research through the National Health & Medical Research Council please forward a copy of this letter to the Head, Higher Degree Administration and Scholarships Office, for forwarding to the NHMRC.

(esr\letter\3098finapp)

Location: Sturt Road, Bedford Park, South Australia.

APPENDIX J

HEALTH SERVICE ETHICS APPROVAL

HEALTH SERVICE

Ethics of Human Research Committee ( )

24 December 2004

Mr Paul Bennett
School of Nursing and Midwifery
Faculty of Health Sciences
Flinders University
GPO Box 2100
Adelaide SA 5001

Dear Mr Bennett

Application Number 2004163

The Ethics of Human Research Committee (EOHRC) Chairman has considered your protocol entitled:

"Nurse's perceptions of quality in Australian haemodialysis units"

The following documentation has been reviewed and approved under expedited review:

- Application to the Ethics of Human Research Committee dated 23rd November 2004. The amendment re the minimum age of patients as being 18 is noted.
- Letter from dated 6 December 2004 indicating her support as a recruiting agent for the project.

Condition:

Researcher must ensure that the identity of patients/nurses must not be disclosed in any report (ie.' age/years of experience/level which is likely to identify a nurse as someone.

Approval status: Final

Approval period: 24 December 2004 - 23 December 2005

Please note the terms under which Ethical approval is granted:

1. Researchers are required to immediately report to the Ethics of Human Research Committee anything which might warrant review of ethical approval of the protocol, including:
   (a) serious or unexpected adverse effects on participants;
   (b) proposed changes in the protocol; and
   (c) unforseen events that might affect continued ethical acceptability of the project
2. Protocols are approved for up to twelve months only and a report is required at the end of the study or 12 month period. Extensions will not be granted without a report to the Committee.

Yours sincerely

Chairman
Ethics of Human Research Committee

APPENDIX K

DOCUMENTS ANALYSED

1. Computerised data
   a. Dialysis machine generated (FINESSE) data
   b. Open Architecture Clinical Information System (OACIS) data
2. Documents in public area (nurses' station, dialysis treatment room)
   a. Daily diary
   b. Communications book
   c. Memo folders
   d. Iron folders
   e. Erythropoietin folders
   f. Calcitriol folders
   g. Daily treatment folders
   h. Access flow folder
   i. Articles of interest folder
   j. Roster/request folder
3. Documents in Manager's Office
   a. Evaluation of Quality Improvement Performance (EQuIP) evidence folder
   b. Human resources policy folder
   c. Key performance indicator folder
   d. Caring for Australians with Renal Impairment (CARI) guidelines folder
   e. Hospital orientation folder
   f. Infection control folder
   g. Joanna Briggs Institute (JBI) best practice folder
   h. Clinical practice manual
   i. Occupational Health and Safety policy folder
   j. Nurses Board handbook
   k. General policy manual
   l. Medical administration instructions
   m. Emergency response plan
   n. Clinical resource folder
   o. Diabetes resource folder
   p. Material safety data sheets
   q. Articles of interest
   r. Clinical procedures manual

APPENDIX L

FEEDBACK SESSION TO NURSE UNIT MANAGER

Background

In line with this study's methods I chose to feedback my initial findings to the research participants. My strategy was to feedback the findings initially to the Nurse Manager (NM). Following this meeting and reflection on our discussion I will then feedback the findings to other staff.

The NM who was originally a part of the study has moved to an Acting Nursing Director position. This person was unavailable for this meeting. Therefore, I organised a meeting with the current Acting NM of the satellite dialysis unit.

Initially I summarised the research study so far under the headings background, satellite unit history and study methods. This was required to assist the NM to contextualise my study and remind her of the study methods. Following this I presented my initial findings to her and requested feedback from her. The following is a summarised record of this.

Findings

She agreed with the findings that nursing nurses perceptions of quality include the technical and the interpersonal. She agreed that the nurses were challenged in balancing the two. She agreed that the interpersonal themes of intimacy, the little things, humour, educating patients were all consistent with her understanding.

The most passionate response I received from the NM was when I suggested the findings of an "us and them" culture. She believed that there was a culture that developed over time and was led by some senior staff.

She agreed that nurses did not treat all patients consistently with favouritism for those patients who complied with staff and those patients who were polite. She explained that there was a certain tolerance for some patients but not others. An example of this is that a patient who was labelled as a "difficult" patient was kept waiting to go on the machine while other patients were free to come in to the treatment area when they wanted to. Another patient who was labelled "non-compliant" was kept on the machine for the full 4.5 hours when he was suffering

with complications (cramps, hypotension). With other patients receiving dialysis these complications were often a reason to stop dialysis but the nurses did not stop dialysis on the "non-compliant' patient.

The NM described the inconsistent practices by the nurses as *favouritism* and *borderline unprofessional.* Furthermore, the NM suggested not all nurses in the unit acted this way and this behaviour occurred more when there were *certain staff combinations* present. Therefore, the NM suggested that certain staff needed to be working together for this to happen. It was not just an individual nurse but a group of nurses. Does this lead to nurses needing to feel confident that another will support them in their practice?

The NM agreed with the findings that management, referring to the nurse manager, hospital management and the nephrologists, clearly influenced the nurses' perceptions of quality. She particularly focussed on the nephrologists as being perceived as *affecting quality.* Her major input was the *lack of consistency of medical orders* provided by the nephrologists. She was concerned that the nephrologists did not always abide by the guidelines that were developed through Caring for Renal Impairment (CARI) Guidelines. This supported a finding from the nurses' interviews.

Reflecting on the view of the NM and nurses towards the guidelines, I propose that the nurses see practice guidelines as important and that the nurses apply them in their care. They believe that it is important for the guidelines to be followed in order for good patient outcomes. In addition, I propose that they use the guidelines as a form of oppression over the patient. They are saying "you have to abide by these guidelines" and "I am here to enforce them". I do not believe that they are consciously and deliberately oppressing the patient. The nurses are doing this because it is a practice that is seen to be historically acceptable and promoted by senior staff. It has evolved as normal nursing practice or "habitus".

The above strict adherence to practice guidelines is in contrast to the nurses who are seen to be bending the rules. In offering this theme to the NM she was quite well aware of certain examples of rule-bending. These were in addition to the rule bending that I observed and heard in the nurse interviews. The NM gave the rule bending examples of *taking patients off half an hour early so the nurses can go to lunch* and *not documenting Fragmin because others didn't do it and it was given*

every dialysis anyway. These two examples are very different and have different professional, ethical and legal implications. The NM has addressed the above practices in the unit in order to improve practice and was met with some resistance. In summary the finding of rule-bending among the nurses was supported by the NM.

Implications for practice

I presented the implication for practice under the broad headings of Access to Information, Models of Care and Reflective Practice. The NM agreed with the implications for practice that I presented to her under these headings.

She conceded that there was a need for better understanding of evidence based practice and that this was a great concern in the satellite dialysis environment. She agreed that the satellite dialysis environment is fairly insular and not exposed to many of the regular updates in other hospitals and units. Coincidentally, the supervising organisation had started to develop a series of workshops to improve nurses' skills in accessing evidence such as database search skills. My findings have encouraged her to ensure all staff will attend these sessions.

Improved models of care in the satellites were discussed. She agreed that staff rotation was a worthwhile option. This may consist of nursing staff spending 1 to 2 months in another unit (satellite, private, acute) to assist with updating skills, increasing awareness of alternate practices and to improve networking of nurses. This would significantly benefit the satellite nurses who are relatively underexposed to alternate practices.

The management processes involved with patient care and patient information was discussed under this section. She believed that improvements were necessary. She cited *sending emails into voids* where there were no responses and thus no surety that the email would be acted upon. As the NM she is responsible for the coordination of information relating to the patients that come from GPs, allied health, patients and significant others. She would frequently be asking the nephrologists for information such as herbal therapies and feeling that the emails were being *sent into a void.* It was clear that the idea of new and different suggestion relating to information management was worth pursuing.

The final recommendation that I offered was to encourage practice evaluation and reflective practice. Firstly the NM agreed that evaluation of care leading to ensuring

there is a high level of continuity of care could be improved. This was raised at a recent staff meeting where ideas were suggested of ways to continue care. What were the best documentation other information processing strategies? Did they need to review their daily treatment sheets? How could they utilise OACIS better? These questions were consistent with my findings that these areas required further exploration to contribute to quality information management. Thus my findings in this area was consistent with the NM's perceptions and supported her practice interventions.

The greatest affirmation I received from the NM was my recommendation for reflective nursing practice. In particular, was the affirmation of the nurses' lack of reflective practice when their nursing care had little or no effect on patient health-damaging behaviour. The NM agreed with my findings that the nurses educated the patients in a mostly didactic way. She believed that the nurses were not addressing what was labelled as *non-compliant behaviour* with any success. She believed that the nurses should self-reflect more and respect that non-compliant behaviour is a normal human trait. The patients are no different to the nurses in this matter. The NM stated that *she smoked* yet she knew that that was unhealthy behaviour. She supported the notion that behavioural change requires more than some health professional saying *don't do it or you'll die.* She agreed that nurses should question, for each person who has perceived health-damaging behaviour such as large interdialytic fluid gains or hyperphosphataemia, why their education does not change each individual's behaviour. She believes that a more concordant model where the nurse and patient agree to an achievable goal given each patient's unique circumstances will have greater benefit for each patient. This strategy encourages respect and may improve the health outcomes of the patients.

In summary, this feedback meeting was a valuable part of the study. The feedback from the NM supported the findings that I found and recommendations for practice that I suggested. This gives me confidence for the next step which will be to feedback these findings to the staff of the participating satellite dialysis unit to encourage practice change for improved nursing care and ultimately improved patient outcomes.

APPENDIX M

FEEDBACK TO PARTICIPANTS SUMMARY

Nurses' Perceptions of Quality in a Satellite Dialysis Unit – Outline Notes
Outline of Feedback to XXXXXXXXXXXX Unit
Paul N Bennett 9-11-07

Background

Initial frustration with what I saw was being emphasised in the measure of care of people receiving dialysis. Lack of reflective practice in the use by nursing staff of a poor quality measure (Kt/V). Resulted in poor "patient" outcomes

Satellite Unit History

Originally developed in the 1970s to supplement existing hospital based renal replacement therapy services. Initially intended for medically stable patients with low acuity and higher self care capabilities. Nurse managed without daily medical or nephrology staff attendance. People getting sicker in satellites. Change to offering complete or total care reflecting the needs of the dialysis patients who are getting older and are suffering more co morbidities. In Australia more people dialyse in a satellite unit than anywhere else (ANZDATA 2006).

Study Methods

Nurses' perceptions of quality in a satellite dialysis unit has not been studied. Therefore, I needed to watch nurses, listen to nurses, observe what other influences, culture, structures and more. This is an ethnography.

Data Collection over 12 months (2005/2006). Observation of busy times, quiet times, meetings, handover. Interviews with 8 Nurses. 16 Interviews of approx 1 hour each.

Document Collation of daily notes, communication books, quality manuals, procedure manuals, meeting minutes. Reflective Journal, journaling frequent reflections of own and other's thoughts, discussions and observations.

Data Analysis involved analyzing the raw text, identifying relevant text, identify repeating ideas, develop themes, theoretical constructs and clinical implications.

Findings

Nurses Perceptions of quality include

The Technical - Knowledge, Skills, Knowledge and skills

The Interpersonal - Intimacy, The little things, Humour, Educating patients

Certain factors affect quality

The Patient - Abusing the system, Us and them

Management - Nurse Manager, Hospital management, Nephrologists

Nurse - Information, knowledge and influence, Bending the rules

Satellite Environment - Not just four walls, More personal time, Patient features, Staff

Implications for Practice

Improved access to information for Satellite Dialysis Units

- ☐ Tailored education for the units needs depending on staff mix skills knowledge background context and patient cohort.
- ☐ Potential use of the web.
- ☐ Education on use of databases to facilitate evidence based practice.

Explore best model of care

- ☐ Staff rotation,
- ☐ Management roles. Managing Satellite Units are unique and require different management models.

Reflective practice

- ☐ Nurses assessment is at a high standard. Continuous evaluation from shift to shift is a challenge. Exploration of uses of nursing informatics from other contexts to enhance information systems such as OACIS.
- ☐ Encourage the model of concordance encouraging shared goals for patients and nurses.
- ☐ Encourage reflection into the complexities of non-adherence.

APPENDIX N

FREE NODES: N-VIVO

Type	Name	Memo Link	Sources	References	Created By	Created On
Free Node	Abusing the system	Yes	8	15	PNB	7/4/2006 11:25 AM
Free Node	Access	Yes	11	28	PNB	7/4/2006 2:45 PM
Free Node	Accreditation	Yes	8	20	PNB	7/20/2006 3:57 PM
Free Node	Acute Hospital Dialysis	Yes	8	33	PNB	5/30/2006 2:55 PM
Free Node	Advocate		1	3	PNB	8/6/2006 1:57 PM
Free Node	Age		1	1	PNB	5/30/2006 3:21 PM
Free Node	Autonomy	Yes	4	8	PNB	7/6/2006 2:30 PM
Free Node	Bending the rules	Yes	8	14	PNB	5/30/2006 3:28 PM
Free Node	Blood Pressure	Yes	2	3	PNB	7/4/2006 2:49 PM
Free Node	Blood Results	Yes	12	42	PNB	7/4/2006 2:45 PM
Free Node	Bullying		4	11	PNB	7/6/2006 2:22 PM
Free Node	Compliance		3	4	PNB	8/6/2006 1:34 PM
Free Node	Death		1	4	PNB	7/13/2006 4:20 PM
Free Node	Difficult patient		4	6	PNB	7/10/2006 4:00 PM
Free Node	Enrolled Nurse	Yes	6	19	PNB	5/30/2006 1:56 PM
Free Node	Evidence	Yes	5	11	PNB	7/30/2006 8:05 PM
Free Node	Exercise	Yes	5	8	PNB	7/20/2006 4:00 PM
Free Node	Experience	Yes	12	27	PNB	7/4/2006 11:44 AM
Free Node	Family	Yes	5	10	PNB	5/30/2006 2:50 PM
Free Node	Flexibility		1	1	PNB	8/5/2006 10:03 AM
Free Node	Fluid Removal	Yes	15	39	PNB	5/30/2006 3:15 PM
Free Node	Frustration	Yes	5	14	PNB	8/5/2006 5:58 PM
Free Node	Gender	Yes	4	9	PNB	5/30/2006 2:18 PM
Free Node	Good for patients	Yes	8	27	PNB	5/30/2006 1:50 PM
Free Node	Hesitation to answer question		2	5	PNB	7/4/2006 4:54 PM
Free Node	Humour	Yes	15	24	PNB	5/30/2006 2:02 PM
Free Node	Industry	Yes	5	10	PNB	7/4/2006 10:52 AM
Free Node	Infection Control	Yes	2	10	PNB	7/4/2006 3:10 PM
Free Node	Intimacy	Yes	7	16	PNB	5/30/2006 3:04 PM
Free Node	Knowledge	Yes	16	73	PNB	5/30/2006 1:59 PM
Free Node	KTV	Yes	7	28	PNB	7/10/2006 3:23 PM
Free Node	Language	Yes	3	4	PNB	7/10/2006 3:25 PM
Free Node	Learning	Yes	6	9	PNB	7/10/2006 2:58 PM
Free Node	Making a difference	Yes	7	17	PNB	7/4/2006 3:23 PM
Free Node	Management or Manager	Yes	13	87	PNB	7/4/2006 11:15 AM
Free Node	Medical Guidelines	Yes	10	31	PNB	5/30/2006 3:33 PM
Free Node	More than a job		3	7	PNB	7/4/2006 11:07 AM
Free Node	Negotiation		1	1	PNB	8/5/2006 9:57 AM
Free Node	Nocturnal Dialysis		2	5	PNB	8/6/2006 6:40 PM
Free Node	Nurse		9	31	PNB	5/30/2006 1:46 PM

	Characteristics of Self				
Free Node	Nurse Education	12	37	PNB	7/6/2006 2:28 PM
Free Node	Nurse Nurse Relationships	13	58	PNB	7/4/2006 11:32 AM
Free Node	Nurse's Comfort Zone	6	14	PNB	5/30/2006 2:51 PM
Free Node	Nurse's Personal	13	36	PNB	5/30/2006 2:57 PM
Free Node	Nurse's taking responsibility	12	19	PNB	5/30/2006 3:16 PM
Free Node	Nurse's Work	16	61	PNB	5/30/2006 1:44 PM
Free Node	Passion	4	4	PNB	7/4/2006 11:49 AM
Free Node	Patient Assessment	10	29	PNB	5/30/2006 2:45 PM
Free Node	Patient Autonomy	6	14	PNB	7/4/2006 11:40 AM
Free Node	Patient Education	15	44	PNB	7/4/2006 3:20 PM
Free Node	Patient Respect	12	31	PNB	7/4/2006 3:12 PM
Free Node	Patient Social	12	34	PNB	5/30/2006 2:44 PM
Free Node	Patient to Patient Relationships	3	3	PNB	7/10/2006 3:46 PM
Free Node	Patient's Routine	1	1	PNB	8/6/2006 1:37 PM
Free Node	Perception of Patients	17	53	PNB	5/30/2006 2:06 PM
Free Node	Personal	11	26	PNB	5/30/2006 3:04 PM
Free Node	Person-centred	9	20	PNB	5/30/2006 2:16 PM
Free Node	Physical Environment	7	8	PNB	7/10/2006 3:13 PM
Free Node	Power	12	42	PNB	5/30/2006 1:47 PM
Free Node	Private - Public	2	19	PNB	8/5/2006 9:59 AM
Free Node	Quality	5	14	PNB	5/30/2006 1:43 PM
Free Node	Quality Improvement	11	30	PNB	7/4/2006 11:50 AM
Free Node	Researcher's role	8	21	PNB	5/30/2006 3:32 PM
Free Node	Satellite	11	49	PNB	5/30/2006 2:52 PM
Free Node	Sick Role	1	2	PNB	7/20/2006 4:02 PM
Free Node	Specialise	1	3	PNB	8/6/2006 1:25 PM
Free Node	Stress	9	15	PNB	7/4/2006 11:38 AM
Free Node	Teaching	6	27	PNB	7/4/2006 11:05 AM
Free Node	Team	5	12	PNB	7/10/2006 3:47 PM
Free Node	Technical	9	30	PNB	5/30/2006 3:09 PM
Free Node	Transport	1	4	PNB	8/6/2006 1:17 PM
Free Node	Waiting times	3	4	PNB	8/5/2006 7:41 PM
Free Node	Withholding information	4	6	PNB	5/30/2006 2:47 PM

APPENDIX O

NODE EXAMPLE: 'ABUSING THE SYSTEM' NODE (DE-IDENTIFIED)

<Internals\Interviews\XXXXI1> - § 2 references coded [1.03% Coverage]

Reference 1 - 0.55% Coverage

Yep, their abuse of the system. They've wasted our time, they don't care about themselves and they don't care about the effect that has on us. That's why I dislike them. And they're taking the place of somebody who does care

Reference 2 - 0.48% Coverage

Even though this is a free service, that's another issue, but just because it's free doesn't mean you can abuse it. It's people like that because that's why in America they don't have a free system.

<Internals\Interviews\XXXX1> - § 2 references coded [2.27% Coverage]

Reference 1 - 1.03% Coverage

but probably when they are asking and asking for different types of transport and abusing the system a bit and whining about how bad hey are treated or how bad their life is and we know that they are given quite a lot

Reference 2 - 1.24% Coverage

I guess when they complain about red cross or the volunteer service sometimes well you think you are lucky that you get it. If it really bugs em I would probably say in a diplomatic round about way we are lucky to have tehse services so I just listen and listen and

<Internals\Interviews\XXXXI1> - § 1 reference coded [1.68% Coverage]

Reference 1 - 1.68% Coverage

Mm things that annoy me, when you tell somebody or educate them about the way that's appropriate and they don't. And they're quite entitled to that but it gets very frustrating. You feel like you're saying the same thing month in month out and no changes are occurring. I find that frustrating. They're entitled to it they're people, they're adults. I find frustrating, perhaps aggressive people.

<Internals\Interviews\XXXXI2> - § 1 reference coded [1.04% Coverage]

Reference 1 - 1.04% Coverage

How do I feel about that? Oh, if we lived in a perfect world which we don't, well if people have no other way of getting there or if it's late at night or things like that I have no qualms but I'm sure if somebody came in and assessed it, it is probably a lot more help that we give than is necessary. But that's not based on any information that's based on ignorant attitude.

<Internals\Interviews\XXXX1> - § 2 references coded [3.34% Coverage]

Reference 1 - 1.77% Coverage

a lot of them, some of them, do not take the level of responsibility for their own healthcare that you would like them to or that you know would benefit them and yet they just seem not to be able to do that for lots of different reasons and sometimes you just have to step back as a nurse and think well I can not do any more about that,

Reference 2 - 1.57% Coverage

A lot of them don't seem to want to know or accept the responsibility of their own health issues and that sometimes annoys the crap out of me because I guess I am one of those people who tries to, anyway, assists to maintain their health and there are so many people it is just eye opening you know

<Internals\Interviews\XXXXI2> - § 5 references coded [2.09% Coverage]

Reference 1 - 0.34% Coverage

And it really annoys me that they don't take more responsibility getting themselves in and out of their own dialysis.

Reference 2 - 0.32% Coverage

um they're every demanding. Not all of them some of them are very demanding. They expect everything for nothing.

Reference 3 - 0.42% Coverage

Lots of crap that XXXXX has to deal with on the phone constantly from these patients that ring up and complain about stupid little things and..

Reference 4 - 0.67% Coverage

who bring on lot of their conditions themselves through their lifestyle and behaviour but that doesn't mean you don't look after them. You might think and I do I think, god, you know, some patients you think you're a bloody idiot.

Reference 5 - 0.34% Coverage

There are patients who don't take responsibility and don't comply with taking their medications and things like that.

<Memos\Relevance to Quality - Abusing the System> - § 1 reference coded [100.00% Coverage]

Reference 1 - 100.00% Coverage

PB 19-10-06

There is a sense that the nurse trying to give quality care is frustrated because of the behaviour of the patients on dialysis. Therefore, if the nurse observes the patient "abusing the system" then the nurse questions their own practice. The nurse is frustrated that the quality care is wasted on the patient.

Also refer to nodes: Compliance, Difficult Patient

<Documents\Interviews\XXXXI1> - § 2 references coded [1.03% Coverage]

Reference 1 - 0.55% Coverage

Yep, their abuse of the system. They've wasted our time, they don't care about themselves and they don't care about the effect that has on us. That's why I dislike them. And they're taking the place of somebody who does care

<Documents\Interviews\XXXXI1> - § 1 reference coded [1.68% Coverage]

Reference 1 - 1.68% Coverage

Mm things that annoy me, when you tell somebody or educate them about the way that's appropriate and they don't. And they're quite entitled to that but it gets very frustrating. You feel like you're saying the same thing month in month out and no changes are occurring. I find that frustrating. They're entitled to it they're people, they're adults. I find frustrating, perhaps aggressive people.

<Documents\Interviews\XXXX1> - § 2 references coded [3.34% Coverage]

Reference 1 - 1.77% Coverage

a lot of them, some of them, do not take the level of responsibility for their own healthcare that you would like them to or that you know would benefit them and yet they just seem not to be able to do that for lots of different reasons and sometimes you just have to step back as a nurse and think well I can not do any more about that,

Reference 2 - 1.57% Coverage

A lot of them don't seem to want to know or accept the responsibility of their own health issues and that sometimes annoys the crap out of me because I guess I am one of those people who tries to, anyway, assists to maintain their health and there are so many people it is just eye opening you know

Reference 5 - 0.34% Coverage

There are patients who don't take responsibility and don't comply with taking their medications and things like that.

<Documents\Interviews\XXXXI2> - § 2 references coded [0.90% Coverage]

Reference 1 - 0.56% Coverage

Won't cooperate or comply with their treatment properly um some of them are mentally unstable and even question the nurse's authority to make decisions about their treatment while they're here

<Documents\Interviews\XXXX1> - § 1 reference coded [0.39% Coverage]

Reference 1 - 0.39% Coverage

and so when you have got a difficult person you either like it or lump it I suppose

<Documents\Interviews\XXXX1> - § 3 references coded [4.34% Coverage]

Reference 1 - 1.06% Coverage

Oh, I feel quite angry I suppose because I feel he should have got moved a long time ago but then being nurses you take so much, you take so much and then it just you know, we all talked about it but nobody really understood the impact of what was really happening underneath.

<Memos\Relevance to Quality - Management or Manager> - § 1 reference coded [8.43% Coverage]

Reference 1 - 8.43% Coverage

Lots of crap that XXXX has to deal with on the phone constantly from these patients that ring up and complain about stupid little things and

Reference 7 - 0.25% Coverage

So it all sort of goes through XXXX? Is that how it works?3325 It generally does.

Reference 8 - 0.90% Coverage

I mean it's not as if we the other nurses don't deal with anything um we certainly try to but it gets to a point where you try as the primary nurse or the team leader that's on that shift or whatever you've tried to deal with it you're not getting anywhere you then have to go to your next point of reference

Reference 9 - 0.69% Coverage

I don't think it's fair that all the patients try to dump on XXXX as much as they do um you know some of them if she's on the floor they'll call her over for the most trivial things that any of us could have looked after or do for them.

<Memos\Relevance to Quality - Perception of Patients> - § 1 reference coded [2.10% Coverage]

Reference 1 - 2.10% Coverage

um they’re every demanding. Not all of hem some of them are very demanding

<Memos\Relevance to quality - Quality improvement> - § 1 reference coded [0.03% Coverage]

Reference 1 - 0.03% Coverage

21-2-07

Nurses struggle to associate quality assurance (accreditation) with patient quality. QA was seen as forms, KPIs, mission statement, extra paperwork, proving that you have improved, access flows, blood results

It is not judging interpersonal relationships

We need to do QA because if we didn't it wouldn't be done.

The KPIs are often perceived as not being related to nursing care. Nurses do not have power over the KPIs. If you target one thing that improves but then when you target another thing the original one returns to original level (eg phosphate).

<Documents\Interviews\XXXX1>

EPO forms and the iron forms to make sure that it was all checked and checked by two and then signed. I did the mission statement for the unit. I have collected all the KPIs and I am helping XXXX getting ready for accreditation as well.

Reference 5 - 2.72% Coverage

It is all like, I guess we all know the frustrating thing with accreditation and probably why I ended up leaving that position is because we all know we do it we do it every day but you have got to write everything down. You have got to prove it. Rather than putting every single piece of evidence in a folder for the surveyors to look at, and they don’t look at it all we can just put the refer to pieces of paper in the folders and they can look at them if they really want to. Yeh there s lots of preparation and not much review. They don’t have time to see it all they don’t.

It is important. Because we need to keep doing it. Because otherwise we might not do it. Because we have to do it we know that it is part of quality improvement it is part of continuing.

<Documents\Interviews\XXXXI2>

That the accreditors should be impressed.

0123 I think so. We’re not being judged on interpersonal relationships are we we’re being judged on the quality of care that we give.

<Documents\Interviews\XXXXI2> -

Um, there are things that can be improved, um, but generally, considering the types of patients we have got here I think we're all pretty much aware of the KPIs that we are trying to meet as far as their clinical outcomes go. We don't always meet them, that's not always the fault of the nursing care that they're getting.

<Documents\Interviews\XXXX1>

We target a blood for two months. For example from one month from our KPIs we identified phosphate as being really bad so we have a sign up next to the scales and we can slide a sign in so we did one on phosphate and in the 3 monthly newsletter we actually put the graphs from our indicators and showed them exactly where we were at and we were only 50% I think at that stage and I think the threshold for the state is 75% and I said I wanted to improve it by 10%. And we actually improved it by 20% for the first month. So it just shows that that whole approach does help. Now that we have taken the focus off phosphate and we are looking at protein our phosphates are back down to 50%

<Documents\Interviews\XXXXI1> -

Mm that's interesting um on a different tact the KPIs that you do here..do you feel they're important?

4550 As a quality assessment tool I think they're fantastic

Oh (laughs) they don't have anything to do with individual patient care I don't think. But if we as a unit can strive to better our phosphates and to have all of our patients above or below a certain marker then that does relate down to individual care

I don't think that they are a bad thing but I don't think that they are necessarily the best thing for individual patient care but they're certainly one of the numerous tools to better everybody's treatment.

APPENDIX P

CODING TREE

- Quality
  - Technical
    - Knowledge
      - Kt/V, blood tests, in-centre, evidence, experience, nocturnal dialysis, nurse education, barriers,
    - Skills
      - Needling, vascular access care, management of complications, experience, fluid removal, nurse work, patient assessment
  - Interpersonal
    - Intimacy
      - Family, negotiation, nurse personal, passion, patients social
    - The Little Things
      - Respect for patients, person centred,
    - Humour
    - Educating Patients
      - Compliance, good for patients, language, teaching styles
- Not quality
  - Blood pressure management
  - Transport
- Affects quality
  - The Patient
    - Abusing the system
      - Compliance, difficult patient, fluid removal, patient autonomy
    - Us and them
      - Frustration, nurse perceptions of patients, sick role
  - Management
    - Nurse Manager
      - Industry
    - Hospital management
      - Accreditation, infection control, looking after staff, quality assurance
    - Nephrologist
      - Medical guidelines
  - Nurse
    - Information, knowledge and influence
      - Patient advocate, enrolled nurse, experience, learning, language, making a difference, nurse competence, nurse education, comfort zone, taking responsibility, withholding information
    - Bending the rules
      - Nurse autonomy, experience,
  - Satellite Environment
    - Not just four walls
      - Flexibility, relatives, physical environment, different stresses
    - More personal time
      - Making a difference, person-centred
    - Patient features

Death, patient autonomy, patient relationships, routines, sick roleprivate/public

Staff features

Bullying, gender, more than a job, nurse/nurse relations, comfort zone, power relations, specialists, team

Researcher related

Hesitation to answer

Researcher as therapist

Researcher has the answers

APPENDIX Q

METHODS FLOW CHART

1. Frustration with measurement of dialysis quality - reflection
2. Desire to develop satellite dialysis measuring tool with an emphasis more interpersonal – reflection
3. Literature and reflection
4. Narrowed question to explore nurses' perceptions of quality
5. Literature and reflection
6. Concluded that change required culture exploration
7. Critical ethnography approach (Observation, interview, document analysis)
8. Reflected own biases and position
9. Approached NUM
10. Information session with staff
11. NUM coordinated recruitment of patients, significant (observation only) others and staff (observation and interview)
12. Completed consent forms provided to me
13. Individual consent and information sessions with patients, significant others (observation only) and staff
14. Coordinated signing of consent forms from all participants following 48 hours for their contemplation.
15. Document analysis consent from NUM.
16. Observations (nurses, meeting times, handovers)
17. Reflection of observations to inform interviews

18. Document analysis to inform interviews

19. Reflection of my own role

20. Interviews

21. Reflection of own role following each interview

22. Analysis of each first interview

23. Preparation of individualised questions for second interviews

24. Second interviews

25. Transcription of interviews

26. Coding – repeating ideas (free nodes)

27. Coding – themes

28. Generation of theoretical constructs

29. Findings discussion with NUM (management)

30. Reflection on feedback from NUM

31. Findings discussions with staff

32. Reflection on feedback from staff

33. Returned to literature and theoretical approach

34. Thesis write up

APPENDIX R

GLOSSARY OF TERMS

Arterio-venous fistula: Formed by the surgical connection of a vein and an artery, usually in the forearm, to enable access to the vascular system for haemodialysis.

Arterio-venous graft: Formed by surgical implantation of a synthetic graft joining an artery to a vein which is cannulated for dialysis.

Cannulation: The process where a nurse inserts a needle into a fistula or graft to enable haemodialysis

Chronic kidney disease stage 5: The final stage of kidney disease where dialysis or transplantation is required to maintain life.

Creatinine: A nitrogenous compound, excreted by the kidneys, formed as the irreversible end product of muscle metabolism

Cultural capital: The capital of an agent that may include knowledge of arts and culture, tastes and preferences, formal qualifications, cultural skills and the discrimination between good and bad.

Dalton: An arbitrary unit of mass, equivalent to 1.657×10^{-24} commonly used to determine whether molecules will dialyze through a semi-permeable membrane during a dialysis treatment.

Dialysate: Fluid used in dialysis to facilitate the diffusion of waste products

Dialyser: A medical device containing a semi-permeable membrane used in haemodialysis for separating substances in solution by unequal diffusion.

Dialysis: A treatment used for people with kidney disease to remove fluid and waste products from the body.

Doxa: An unquestionable orthodoxy that operates as if it were the objective truth, from the practices and perceptions of individuals to the practices and perceptions of the state and social groups. The fundamental, deep-founded, unthought beliefs that inform an agent's actions and thoughts within a particular field.

Dry weight: The weight of a patient on dialysis when there is no excess fluid.

Erythropoietin: A compound that stimulates red blood cell production. Administered to patients with CKD because of their inability to produce erythropoietin.

Field A domain of social life such as arts, industry, law, medicine and politics. Law is the dominant field. Thus it is a "structured system of social positions…a structured system of force or power relations"

Habitus Embodied behaviours or tendencies (motivations, preferences, tastes and emotions) which reproduce practices in a particular employed group. These practices are complexly influenced by agency (individual) and structure (institution).

Haemodiafiltration: A process where diffusion and convection are used to remove wastes and fluid from the body.

Haemodialysis: A process where diffusion through a semi-permeable membrane via an extra-corporeal blood circuit is used to remove wastes and fluid from the body.

Hyperkalaemia: High levels of potassium in the blood**.**

Hypertension: High blood pressure

Hypotension: Low blood pressure

Ideal weight: See dry weight

Peritoneal dialysis: Technique that uses the patient's own body tissues inside the peritoneum to act as a filter. A plastic tube (Tenckhoff catheter) is surgically inserted placed through the abdominal wall allowing the removal of waste products and excess water from the body.

Phosphate binders: Medications administered to bind phosphate in the gut for people with VKD who are unable to excrete phosphate via the kidneys.

Satellite dialysis unit: Dialysis unit that does not have on-site nephrologist support.

Urea reduction ratio: The ratio of urea removed during a dialysis treatment.

APPENDIX S

LIST OF ABBREVIATIONS

ACHS: Australian Council on Healthcare Standards

ACSQH: Australian Commission on Safety and Quality in Healthcare

AIHW: Australian Institute of Health and Welfare

ANNA: American Nephrology Nurses Association

ANZDATA: Australian New Zealand Dialysis and Transplant Registry

APD: Automated peritoneal dialysis

ATSI: Aboriginal or Torres Strait Islander

AVF: Arteriovenous fistula

AVG: Arteriovenous graft

BFR: Blood flow rate

BP: Blood pressure

BTM: Blood temperature monitoring

BVM: Blood volume monitoring

CAPD: Continuous ambulatory peritoneal dialysis

CARI: Caring for Australasians with renal impairment

CKD: Chronic kidney disease

CKD 5: Chronic kidney disease stage 5

CNM: Clinical nurse manager

CQI: Continuous quality improvement

DHHS: USA Department of Health and Human Services

EPBG: European Best Practice Guidelines

EPO: Erythropoietin

ESKD: End stage kidney disease

GAS: Goal attainment scaling

Hb: Haemoglobin

HDF: Haemodiafiltration

IV: Intravenous

K/DOQI: Kidney Disease Outcomes Quality Initiative

KPI: Key performance indicator

Kt/V: Clearance (K) times time(t) over volume (V)

NBSA: Nurse Board of South Australia

NCDS: National Cooperative Dialysis Study

NHMRC: National Health and Medical Research Council

NICS: National Institute of Clinical Studies

NUM: Nurse unit manager

nPCR: Normalised protein catabolic rate

PCT: Patient care technician

QoL: Quality of life

RSA: Renal Society of Australasia

SBREC: Social and Behavioural Ethics Committee

spKt/V: Single pool Kt/V

UF: Ultrafiltration

UKM: Urea kinetic monitoring

URR: Urea reduction ratio