

Hospital Nurses and Health Promotion

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La présente étude porte sur le rôle des infirmières en soins de courte durée dans la promotion de la santé. On a pour cela utilisé un sondage ayant pour but de mesurer la connaissance, les comportements et la pratique des infirmières par rapport à la promotion de la santé. En 1992, on a sondé les infirmières soignantes de huit hôpitaux en Colombie-Britannique. Selon les répondants, la promotion de la santé fait partie intégrante des soins infirmiers. Néanmoins, plusieurs barrières dans le milieu hospitalier limitent leurs efforts. Ces barrières ont pour nom : manque de temps, ressources insuffisantes pour enseigner aux malades et manque de continuité dans les soins. Les répondants ont établi les différents types de soutien, à savoir, l'attitude positive des malades et de leur famille, ainsi que celle des collègues, et le soutien de l'hôpital pour les activités liées à la promotion de la santé. L'étude conclut que les infirmières en soins de courte durée sont une ressource sous-utilisée pour la promotion de la santé. Il faut donc utiliser plus efficacement la connaissance, les comportements et les compétences des infirmières pour promouvoir la santé en milieu hospitalier.

This study examined the role of acute-care nurses in health promotion (HP), using a survey designed to measure the knowledge, attitudes, and practices of nurses in relation to HP. Staff nurses in eight British Columbia hospitals surveyed in 1992 responded that HP is an integral part of nursing care, yet several barriers in the hospital environment inhibit their efforts in this domain. The perceived barriers are lack of time, insufficient resources for patient teaching, and lack of continuity of care. Respondents identified positive features as the attitudes of patients and families, supportive colleagues, and hospital support for HP activities. The study concludes that acute-care nurses are an under-utilized resource for HP. The challenge is to make more effective use of nurses' knowledge, attitudes, and skills in promoting health in the hospital setting.

In Canada, the nursing profession advocates a strong role for nurses in health promotion (HP) (Canadian Nurses Association, 1988, 1992; Ritchie, 1988), yet little is known about how nurses in hospitals actually incorporate HP into their practice. The study's purpose was to describe

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the current HP role of nurses in acute-care settings: it examined the HP-related activities, knowledge, and attitudes of registered nurses in both urban and rural hospitals in British Columbia; it explored barriers and supports for hospital-based HP. The study used the World Health Organization (1986) definition of HP – “the process of enabling people to increase control over and improve their health.”

Literature Review

To date few descriptions of the practice of hospital nurses in relation to HP have been published. A British study (Gott & O'Brien, 1990) that examined the attitudes and activities of nurses working in community and hospital settings found that nurses' HP activities were individualistic and lifestyle-focused, and that nurses had few opportunities to contribute to HP at the community or societal level. Gott and O'Brien concluded that there should be greater emphasis on national policies for health and more interdisciplinary collaboration.

In another British study, Latter et al. (1992) examined health education as a component of nursing practice in acute-care hospitals. Reported activities included counselling about healthful lifestyles, encouraging self-care, dispensing information, and encouraging family participation in care. Information-giving was cited as the most frequent health-education activity, facilitating patient or family involvement in care being less common. Although nurses view their role as an information-giving one, difficulties in fulfilling this role were noted in While's 1992 study of children's hospital experiences. Parents considered lack of information from hospital staff a major shortcoming, particularly lack of preparation of parents and child for discharge.

Several authors suggest that nurses should pay greater attention to HP and disease-prevention in all settings, including acute care (Aiken, 1990; Noble, 1991; Pender, Barkauskas, Hayman, Rice, & Anderson, 1992; Spellbring, 1991). Spellbring identifies several components of nurses' HP role: consultant, case manager, health educator, advocate. Jenny (1993) notes that patient education is becoming increasingly important as health care in Canada is redefined; she advocates the use of innovative strategies such as computer-assisted instruction, telephone hot lines, and community outreach programs. Lack of evaluation of the effectiveness of nurses' roles in HP is a major weakness in the literature. A study by Wyness (1990) on the outcomes of a structured education program for hospital patients taking warfarin is an example of the kind of research that is needed.

An examination of current nursing theory reveals that HP is viewed as fundamental to nursing and is a common thread in definitions of the profession (Gottlieb & Rowat, 1987; Parse, 1987; Registered Nurses Association of British Columbia [RNABC], 1990). However, actual descriptions of how to put an HP philosophy into practice in hospital nursing are rare.

The issue of whether nursing education prepares practitioners for roles in HP has been discussed by Noble (1991) and Tilley, Gregor, and Thiessen (1987). The nurse's role in teaching has often been oriented to disease rather than health. Several authors recommend increasing HP content (Clarke, 1991; Gott & O'Brien, 1990; Henderson, 1989). Pender and her colleagues (1992) advocate that HP content be incorporated into all undergraduate and graduate nursing programs. Furthermore, educators must prepare future practitioners with the competence to contribute to policy development at all levels in the health-care system (Tenn & Niskala, 1994).

The gaps in the literature reinforce the timeliness of exploring the knowledge, attitudes, and practices of acute-care nurses in the emerging HP field. The authors' earlier study (Berland & Whyte, 1991) used a focus-group approach: a small group of hospital nurses examined HP topics during three two-hour sessions.

In this first phase of our study, volunteers from the nursing staff of a metropolitan hospital formed the focus group. The sessions included carefully planned questions about the topic (Basch, 1987; Krueger, 1988). Content analysis, later validated with the participants, yielded descriptive data about facilitators, barriers, and daily HP practice.

Featured in the examples of daily HP practice were fostering mutual aid, planning for discharge, empowering patients, caring for families, exhibiting healthy behaviour, and normalizing life for hospitalized patients. Key facilitating influences were positive attitudes, informal learning opportunities, and administrative support. The principal barriers were seen as lack of time and continuity.

The most striking outcome of the focus-group sessions was the participants' recognition of features in their own practice. They had stated that HP is implicit in the nurse's role as seen from the patient's perspective: *It is sort of an everyday thing; You can't get away from it* (italicized, unattributed comments are from focus-group participants or survey respondents). HP had become taken for granted to such an extent, however, that it was invisible to the nurses; once this was recognized, HP was matter-of-factly reclaimed. Due to the potency of the

participants' responses, and the enthusiasm that greeted publication of the findings, we conceived of a follow-up study.

The research objective of the current study was to validate those earlier focus-group findings. The sample chosen also permitted comparison of HP activities in an urban teaching hospital with small, community hospitals.

Conceptual Framework

The PRECEDE-PROCEED planning model is used to assess factors influencing the HP practice of health professionals. It was chosen because it has broad applicability and has been widely tested. This model is specifically intended to "identify targets for intervention... generate specific objectives and criteria for evaluation.... [and provide] additional steps for developing policy and initiating the implementation and evaluation process" (Green & Kreuter, 1991, p. 22).

The PRECEDE-PROCEED model provides a convenient method of classification because it groups specific influences on HP practice under three broad rubrics. Knowledge, attitudes, beliefs, skills, incentives, and rewards can be grouped under predisposing, reinforcing, and enabling factors, the organizing categories of the PRECEDE-PROCEED model. According to Green and Kreuter (1991), predisposing factors arise from the knowledge and attitudes that underlie the motivation and confidence of health professionals. Enabling factors include resources, time, and the practice environment. Reinforcing factors include visible results, feedback from patients, and support from colleagues. All three broad categories may contain both positive and negative characteristics.

Purpose

The purpose of the study was to describe the current knowledge, attitudes, and practice of hospital nurses concerning HP. The research question was: what are hospital nurses' perceptions of their knowledge, attitudes, and practice regarding HP? Five general questions shaped the data analysis:

1. What HP activities do nurses say they carry out in acute-care settings?
2. What is the effect on stated practice and attitudes of demographic variables such as age, basic and continuing education, and experience?
3. What are the sources of nurses' knowledge about HP?

4. What do hospital nurses say about their attitudes towards HP?
5. What factors do nurses perceive as enhancing or inhibiting their HP efforts?

Method

This study evolved from an earlier exploration of nurses' knowledge, attitudes, and practices regarding HP, using a focus-group approach (Berland & Whyte, 1991). The focus-group technique originated in market research. Using a moderator to interview a group can elicit insights and comments unlikely to surface without the stimulating effects of group interaction. Given the scarcity of research, the technique helped us generate hypotheses and obtain detailed answers to novel questions. We also learned about the vocabulary the nurses' used to describe their practice. The insights formed the basis for the subsequent questionnaire survey.

Sample

The study used a comparative survey design, with an unintentional convenience sample as described below. Questionnaires were sent to a total of 300 registered nurses; this sample size was judged sufficient for study purposes, given the expected rate of return and the questionnaire design. One half of the sample ($n = 150$) worked in a metropolitan teaching hospital with about 1,800 nurses on staff. The other half of the sample ($n = 150$) were nurses working in eight community hospitals throughout B.C. (the total nurse population of these hospitals is not known).

The response rate overall was 57% ($n = 171$). Nurses from the teaching hospital made up 45% of respondents ($n = 77$). Overall, 65% of all respondents worked full time. Respondents worked in critical care ($n = 20$), medicine ($n = 35$), surgery ($n = 25$), operating rooms ($n = 3$), palliative care ($n = 8$), psychiatry ($n = 9$), long-term care ($n = 12$), obstetrics ($n = 8$), pediatrics ($n = 5$), cardiac sciences ($n = 10$), ambulatory care ($n = 4$), emergency ($n = 8$), and other areas ($n = 24$).

Most respondents had been nursing 10 years or more ($n = 104$). Compared to the overall population of registered nurses in B.C., the study respondents were young (unpublished RNABC 1990 registration data). Of the community hospital respondents, 14.6% had a B.S.N. ($n = 13$) and 35.4% had post-R.N. certification ($n = 32$), which closely resembled the educational level of all B.C. nurses (14.4% and 34.1%). The teaching hospital respondents, in contrast, were more likely than

B.C. nurses overall to have completed a B.S.N. (30.7%; $n = 25$), although fewer than the B.C. average had post-R.N. certificates in specialty areas (2.7%; $n = 2$).

Instrument

For Phase 2, we developed a "Healthy Practice Questionnaire" containing 53 core questions rated on a five-point Likert scale ("strongly agree" to "strongly disagree"). The questions were concentrated on the more uniformly supported statements of the original focus group, and a conscious effort had been made to use the words of the focus-group participants.

Two open-ended questions in the questionnaire elicited written comments: "What do you think are the most important factors influencing the hospital nurse's role in HP?" and "Additional comments." Also, demographic data were collected on a brief questionnaire designed for the study.

The 53 items were classified for analysis into four subscales based on the PRECEDE-PROCEED model as the underlying framework: Perceived Self-Efficacy – e.g., "I am comfortable teaching patients about self-care" ($n = 5$); Predisposing Factors – e.g., "A nurse must assume the role of patient advocate" ($n = 33$); Enabling Factors – e.g., "My hospital is supportive of health-promotion activities" ($n = 16$); and Reinforcing Factors – e.g., "If the family/caregiver supports a patient's lifestyle change, a nurse's health-promotion efforts are more effective" ($n = 4$).

Two additional subscales rated respondents' HP knowledge ($n = 4$) and promotion activities ($n = 10$). The subscale Actual Knowledge asked respondents how they had learned about HP. The subscale Promotion Activities examined their actual practice. This subscale included items about the respondents themselves and their own knowledge, activities, or practice. One item, for example, stated, "I change hospital rules or routines to accommodate patients' control." This subscale was scored by assigning a unit value of 1 to each item to which the nurse responded either "Agree" or "Strongly Agree" on the five-point Likert scale.

All other subscales, except Promotion Activities, were scored by summing responses to those items using the Likert scale. In this way the responses "Disagree" and "Strongly Disagree" were included in the average value for each item.

Three external nurse researchers reviewed the questionnaire for inappropriate jargon, value-laden words, leading or double-barrelled questions, and general content. To test face validity, a pilot test of the survey instrument was administered in advance to a group of hospital nurses. Feedback indicated that the questions and length of time allotted to complete them were acceptable.

Cronbach's coefficient alpha was used to assess the internal-consistency reliability of the subscales. Cronbach's alpha indicated that the reliability for all 53 items on the survey was .87, an acceptable level. Among the subscales, however, reliability varied (Table 1). Reliability was deemed adequate for Predisposing Factors, Enabling Factors, Actual Knowledge, and Perceived Self-Efficacy, but not for Reinforcing Factors. This subscale was not used in any later analyses.

Table 1

Means, Standard Deviations, and Cronbach's alpha for Subscales

Subscale	n Items	Theoretical	X	SD	α
		Range			
Predisposing Factors	33	1-5	3.98	.35	.88
Enabling Factors	16	1-5	3.06	.37	.69
Reinforcing Factors	4	1-5	3.61	.46	.04
Actual Knowledge	4	1-5	3.76	.62	.52
Perceived Self-efficacy	5	1-5	3.72	.55	.73
Promotion Activities	10	1-10	7.37	.16	

Procedure and Recruitment

For this Phase 2 study, the survey approach was used to validate the focus-group findings. The research proposal was reviewed and approved by the ethics committees of the teaching hospital and the university. Teaching and community hospital participation were secured in advance.

In the teaching hospital sample, surveys were sent to individual nurses selected at random by the personnel department. Nurses at the eight community hospitals made up an unintentional convenience sample. The surveys were distributed to staff through nursing administrators at each hospital. Although a covering letter to the senior nurse at each hospital requested randomization, it is not certain that randomization was carried out in all cases. The questionnaires may have been distributed only to nurses on selected units, only to nurses who were available, or randomly.

The survey included a covering letter assuring confidentiality and anonymity, as well as a return-addressed envelope. Respondents were instructed to answer the questions from their experience as hospital nurses. A follow-up reminder card encouraged them to complete the questionnaire.

Data Analysis

Because the objective of the current study was to validate earlier focus-group findings, the analysis was descriptive and comparative. Data from the completed surveys were analyzed using SPSS-X Data Analysis System Release 3.0. Most of the demographic variables were categorical (for example, age, level of education, length of time practising, participation in continuing-education programs, hospital size). Data were analyzed using descriptive statistics, correlations, and one-way analysis of variance, followed by multiple comparisons using the Student-Newman-Keuls procedure if the *F* ratio for the latter analysis was significant. The independent variables of education, age, participation in continuing-education programs, practice setting, whether community hospital or teaching hospital, and length of time in practice were compared consistently for all subscales. All statistical tests were non-directional, with an alpha level of .05 used as the criterion of statistical significance.

Responses to the two open-ended questions were transcribed and coded into thematic categories. To compare quantitative and qualitative analyses, each category was then identified as enabling, reinforcing, or predisposing. Responses in each category were summarized into a brief narrative, to supplement the findings from the survey items.

Limitations

The response rate, of 57%, is acceptable for a mail survey. However, the sampling method was a limiting factor in that the study inadvertently used a convenience sample of hospitals; the possible non-random distribution in some of the community hospitals weakens the generalizability of the findings. The age of the respondents and the nature of the topic raise the question of self-selection bias in returning the survey. An alternative model for analysis could also be considered. The survey instrument itself warrants further testing and refinement, particularly regarding reinforcing factors. Adaptation of the instrument for use in different settings, such as long-term care facilities, would provide information on HP practice by nurses in non-acute-care settings.

Table 2
HP Activities in Nursing Practice

Survey Item	Those Responding "Agree" or "Strongly Agree"
There are potential health benefits for patients when I teach them about their medications.	100 %
Healthful lifestyles is an important topic for patient teaching.	98.3
Nursing practice includes comforting patients and their families/caregivers.	98.3
Teaching patients how to care for themselves is an important part of a nurse's role.	98.2
Ensuring a healthful work environment is important to me.	97.6
It is important that hospital nurses be involved in discharge planning.	97.1
I involve patients' families/caregivers in HP when appropriate.	96.5
HP activities include enhancing patients' coping skills.	95.3
I encourage patients facing discharge to carry on with healthful behaviours learned in the hospital.	93.6
Teaching patients about disease processes is an important part of a nurse's role in HP.	91.3
A nurse must assume the role of patient advocate.	91.2
Family members/caregivers are included in a hospital nurse's HP.	91.2
Encouraging patients to advocate for themselves is part of a nurse's role in HP.	88.8
HP is an "everyday thing" for nurses.	81.2
HP principles apply in caring for terminally ill patients.	78.9
Sometimes nurses plan activities that "normalize" the hospital environment.	78.3
Encouraging patients to share experience about procedures is part of my role in HP.	76.6
I can refer patients to community agencies.	76.0
There are health benefits for depressed patients that result from a nurse's counselling efforts.	75.5
Counselling patients following physical abuse is part of a nurse's role.	57.9
HP group work with patients is sometimes part of a hospital nurse's practice.	57.3
I change hospital rules or routines to accommodate patients' control.	52.1
I direct my HP activities to my nursing colleagues.	48.6

Results

Health Promotion Activities in Nursing Practice

The survey included questions designed to elicit information to answer the research question "What HP activities do nurses carry out in acute-care settings?" As shown in Table 2, the respondents recognized a wide variety of HP activities as carried out by nurses.

The highest-rated HP role for nurses is in patient teaching directed toward self-care. Respondents also cited involvement with the patient's family and caregivers as an important aspect of HP. Less common HP tasks are group work with patients and changing hospital routines to facilitate control by patients.

In answer to the question "How often do you carry out health promotion activities, including health teaching?," respondents reported that they engaged in some form of HP daily (61%) or weekly (28%). In answer to another question, more than 80% characterized HP as an "everyday thing" for nurses.

The subscale Promotion Activities determined the extent to which respondents themselves practised specific activities. The mean value of responses to these 10 questions was 7.37 (range 1-10; *SD* 1.66), suggesting that the respondents are in fact involved in a range of HP activities. Furthermore, this subscale had a moderate correlation ($r = .37, p = .01$) with their reported frequency of general HP activity.

Given the emphasis, in the literature, on education for HP, we were interested in the impact of education on the practice of our respondents. Using one-way ANOVA, nurses with post-R.N. certification reported engaging in more HP activities than did diploma nurses ($M: 8.25$ vs. $7.08, p < .002$). General continuing education was examined in responses to the statement "I have attended continuing-education programs that include content on health promotion." Those who responded positively, 47% of respondents, scored significantly higher on Promotion Activities ($p < .05$). There were no other apparent effects arising from the demographic variables.

Knowledge, Attitudes, and Beliefs about Health Promotion

This part of the survey explored two questions: "What are the sources of nurses' knowledge about HP?" and "What are hospital nurses' attitudes about HP?" Knowledge, attitudes, beliefs, values, perceived needs, and abilities can help motivate and contribute to feelings of con-

fidence about engaging in HP (Green & Kreuter, 1991). This component was assessed using two subscales, the Predisposing Factors subscale and the Perceived Self-Efficacy subscale.

Firstly, the Predisposing Factors subscale explored nurses' familiarity with the scope, concepts, and application of HP. The mean response to all questions in this subscale was "Agree" (3.96), indicating that the respondents were familiar with these HP concepts and practices. Several questions explored nurses' attitudes to HP. At the most basic level, 93% of the respondents agreed with the statement "Health promotion is an important part of my role." More than 81% agreed with the statement "Health promotion in the community is part of a nurse's role as a member of the community."

There was a moderate correlation ($r = .40, p < .001$) between overall score on the Predisposing Factors subscale and reported frequency of carrying out HP tasks. A high correlation was seen between an individual's score on this subscale and the number of HP activities they actually engaged in ($r = .70, p < .001$).

An interesting discrepancy emerged from the second approach to analyzing nurses' knowledge, Perceived Self-Efficacy, meaning a nurse's comfort level with his or her knowledge and ability to counsel patients about HP (Green & Kreuter, 1991). Perceived Self-Efficacy was measured in the questionnaire by a subscale of five questions. More than 76% of respondents felt that their knowledge about self-care was adequate; 83% stated that they were comfortable teaching patients about self-care; 72% felt they could advocate for a healthy hospital; and 70% felt they could advocate for a healthy community. However, only 42% of the respondents agreed that they were satisfied with their skills in HP. Overall score on this scale was moderately correlated with the number of HP tasks they actually undertook ($r = .39, p < .001$).

A significant difference was seen in responses to the Predisposing Factors scale, according to level of education: 60% of respondents stated that their basic nursing program included HP; 39% had taken courses in HP since graduation. Nurses who had post-R.N. certification scored significantly higher on the Predisposing Factors scale than diploma nurses ($M: 135.16$ vs. $129.54, p < .05$). There was no difference among baccalaureate nurses and the other two groups. Again, nurses who had taken continuing-education courses scored significantly higher on the Predisposing Factors ($p < .001$) and Perceived Self-Efficacy ($p < .05$) subscales.

The content analysis of responses to open-ended questions adds to the findings about knowledge for HP. Many respondents wrote that lack of HP knowledge and skills was a significant barrier to nurses engaging in HP activities. They proposed that greater attention be given to HP in both basic and continuing-education programs, including specific content on teaching methods, assessment of clients' learning needs, and knowledge of community resources.

Barriers and Facilitators

Factors external to the nurse can help or hinder HP. The survey included questions designed to elicit information to answer the research question "What factors enhance or inhibit HP by nurses?" At the top line, a moderate correlation ($r = .30, p < .001$) was seen between the respondents' stated frequency of engaging in HP activities and their score on the subscale Enabling Factors. There was no other significant difference, based on age, highest level of education, length of time in practice, or hospital size. The predominant enabling factors identified by the nurses were teamwork, time, written records, continuity of care, and consistency of patient teaching (Table 3).

Responses to the open-ended questions provided more detail. The most critical factor for these nurses was time. Although they acknowledged the importance of HP, more than 100 respondents cited time as a barrier. HP may be an "everyday thing," but it is not always a priority. Specifically, lack of time because of heavy workloads was seen as preventing nurses from performing HP tasks that are time-intensive, such as teaching, locating resources, making referrals, and communicating with family members. One respondent explained: *Nurses are the perfect people to have advocating, promoting, and teaching health and self-care. However, the reality is that there is very little time (high acuity, short staffed) to spend more than minutes at a bedside.*

As barriers, respondents identified inadequate care planning, lack of authority in decision-making about patient care, and nurses' task orientation. But for one nurse, the delivery model was conducive to HP: *Primary nursing facilitates health promotion as you know the patient so well.* Continuity of care within the hospital was seen as facilitating HP. Several respondents noted that having different patient assignments on each shift interfered with continuity. Consistency in health teaching was also viewed as an important factor. Continuity between the hospital and the community was identified as crucial; respondents expressed a desire for improved communication between hospital nurses and community-based nurses. One nurse identified the lack of follow-up oppor-

Table 3
Enabling Factors

Survey Item	"Strongly Agree" or "Agree"	Neither	"Strongly Disagree" or "Disagree"
There is easy access to up-dated resources on health-related topics that help me in my HP efforts.	40.3%	17.0%	42.1%
There are adequate resources for teaching chronically ill patients coping skills.	26.3	21.1	52.1
Hospital activities on HP topics support a nurse's ability to carry out HP activities.	48.0	25.7	25.2
The team approach to patient care strengthens a nurse's HP efforts.	92.4	7.0	0
My hospital is supportive of HP activities.	66.1	24.0	9.4
Lack of continuity of care between different hospital departments interferes with a nurse's HP efforts.	71.3	17.0	11.7
Time constraints are a barrier to nurses undertaking HP activities.	94.7	3.5	1.8
HP efforts would improve if there were more time for patient conferences, in-services, and bedside teaching.	95.3	3.5	1.2
Hospital nurses' HP efforts would be strengthened by consistent patient teaching.	98.9	0.6	0
Incomplete written records hinder a nurse's HP efforts.	4.7	17.5	77.2
I can refer patients to community agencies.	76.0	11.1	12.3
Knowing about cultural values helps nurses in their HP efforts.	97.1	2.3	0
Learning more about HP will help me provide better patient care.	93.5	4.7	1.2
My experience as a nurse has taught me about HP.	84.2	11.1	4.1
In my basic nursing program, HP was included in the course work.	60.2	14.6	24.5
Since graduation I have taken courses on HP.	39.2	14.6	45.0

tunities as a problem: *It is difficult to find out if health promotion efforts are effective, as you may never see the patient again.*

Respondents frequently identified a lack of adequate resources for health teaching. They suggested user-friendly audio and video resources, as well as up-to-date written material to give to patients and families, and would like to see teaching plans, group sessions for patients, and information on community resources. Several respondents stated that culturally appropriate teaching materials and access to interpreter services would improve their cross-cultural HP efforts, and several saw the need for nurses to develop the skills to use the mass media in educating the public about health. A few mentioned measuring outcomes of HP: *We need tools to help evaluate our health teaching.*

Incentives and Rewards

As we have seen, the subscale on Reinforcing Factors lacked reliability and was not used in the quantitative analysis. However, analysis of the qualitative data revealed common concerns. Nurses in both the teaching hospital and the community hospitals noted that support from colleagues is not only rewarding but essential to successful HP: it is difficult to carry out health-promoting activities in isolation.

Patient-related factors identified as disincentives were unwillingness to learn, acuity of illness, and emotional problems. Supportive families and motivation to change health attitudes were identified as positive factors. Relationships among health-care providers are a factor: common disincentives include communication difficulties, professional territoriality, and conflict over the care plan; incentives include shared goal-setting through ward conferences, learning from the expertise of other disciplines, and support from the team.

Nurses' Advocacy Role

The advocacy role of the nurse as a health promoter in creating fundamental improvements deserves further study. Advocacy is one of the "invisible" aspects of nursing that often go unrecognized. One respondent stated, *Present uncertainty regarding hospital budgets and staff due to budget restraints might hinder ongoing expansion of health teaching.* With the increasing complexity of the health-care system and limited funds for some services, advocacy is becoming even more important. How will nurses find ways to inform policy-makers about the problems they see in their everyday practice?

Discussion

How is HP relevant to the nurse who says, *I am a strong believer in health promotion... It's a shame that people in high places can't get their priorities straight?* Much of the international literature on HP speaks at the level of ideology, and therefore may not provide direction to practitioners (O'Neill & Pederson, 1994). Data from this survey may provide a foundation for giving direction in the setting where most nurses work.

The results indicate that acute-care nurses perceive HP as an essential, independent, attractive, and indeed integral part of nursing. They define HP as encouraging healthy lifestyles, coping skills and self-care, family cooperation, and mutual aid.

These findings are consistent with those of our earlier study, in which we also noted that HP was invisible to the participants. The nurses did not recognize components of their own practice as health promoting until the moderator held up the mirror. Once they acknowledged the work, the respondents enthusiastically depicted themselves as teachers, counsellors, comforters, patient advocates, role models, lobbyists, and mediators in the hospital environment. They revealed that their HP role included much more than teaching about medication side-effects.

This aggregate viewpoint is both richer and more focused than the World Health Organization definition used for our study. It is perhaps more consistent with the perspective of Loomis: "Nursing is the appraisal and enhancement of the health status, health assets, and health potentials of human beings" (Loomis, 1990, p. 83). The hospital nurse's HP perspective is grounded in a unique episode in the patient's life experience. Hospitalization usually represents a personal crisis, or at least a landmark event. Thus the interventions of our respondents reflect a concern with individual and family coping responses that may be broader than the concerns of the mainstream HP movement (Gottlieb, 1992).

Generally, the respondents expressed a positive attitude toward HP concepts; they believed that HP is highly relevant for today's acute-care environments. Without prompting, they also explored issues surrounding appropriate roles in HP. While some felt that all hospital staff should be involved in HP, others saw nurses as the ideal health promoters, and yet others saw HP as a component of specialist nursing. This confusion reflects a lack of direction in applying a health-promoting philosophy in hospital nursing.

The respondents identified numerous factors that affect HP in the hospital setting. Unfortunately, most of these were negative, indicating why it is difficult for staff nurses to incorporate HP into their work. According to Green and Kreuter (1991, p. 408), the "working circumstances of nurses often conspire against implementation of their preventive practices." Based on our findings, it would be easy to glibly say, "Greater emphasis on HP in hospitals is necessary, to improve patients' abilities to gain control over their health." But how will this move hospitals beyond ideology? How can we redirect practice?

At the level of hospital policy, the survey respondents expressed strong support for the notions of interdisciplinary teamwork, continuity of care, and consistency. Some also felt that time constraints indicate that their values regarding HP are not shared by hospital managers. Responsibility for planning and supporting a variety of health-promoting activities must be shared. Green and Kreuter (1991) and Labonte and Little (1992) offer many strategies. Nurses and managers could work together to identify barriers and facilitators, then select strategies and act to overcome barriers. The clear frustration in the respondents' subjective comments indicates that the "low-hanging fruit" of the relevant and the achievable should be a priority. Further, organizing HP into "tasks" could perpetuate its invisibility. An integrated plan for HP should be based in an organizing framework.

The findings regarding education were most interesting. Based on the respondents' self-identified need, and the measurable impact on practice, continuing education on HP topics can be concluded to be of vital importance. Indeed, education aimed at practitioners may have a greater effect than education of student nurses. More short-term courses and workshops on hospital-based strategies, as well as formal credit courses, should be made available. Basic and graduate nursing programs should also place greater emphasis on HP in the hospital setting.

HP practice, as described by our respondents, tends to focus on individual patients, their families, and their caregivers. The nurses in our study reported few activities directed at promoting policies at the agency or health-system level. To fulfil the mandate of HP, more nurses must acquire competency as patient advocates at the system level. Spellbring (1991) points out that advocacy requires an understanding of the health-care system and available resources. Hospital nurses state that they lack knowledge about community resources. This is becoming an increasingly serious drawback, considering the shift to community-based care. The communication gap between hospital nurses and

community-based nurses should be addressed. Practical examples would be inter-agency continuing education programs and nursing councils representing all agencies in a community.

Research programs are critical if the role of nursing in HP is to develop. Gottlieb (1992) points out that nursing must become more explicit about its HP models, frameworks, and research. The deficiencies in this exploratory study suggest the need for hypothesis-driven quantitative research. Some questions arising from this study are: What type of nursing education has the greatest impact? What are patients' perspectives of nurses' HP activities? What are the outcomes for patients of HP by nurses? What strategies foster consistency of health teaching in hospitals? Do these strategies make a difference to patient outcomes? Do specific strategies to strengthen communication and collaboration between hospital and community nurses make a difference? What socio-political factors affect nursing's ability to contribute to HP initiatives?

Conclusion

This study assessed knowledge, attitudes, and practice related to HP, taking into consideration positive and negative predisposing, enabling, and reinforcing factors. The actual practices of the respondents were consistent with the World Health Organization definition of HP. As expected, activities focus on individual patients and their families or their caregivers. Hospital nurses' support was summed up this way: *Health promotion is important. However, I do not believe we utilize the time that patients are in the hospital to effect teaching and behaviour change to its potential.*

References

- Aiken, L.H. (1990). Charting the future of hospital nursing. *IMAGE*, 22(2), 72-77.
- Basch, C.E. (1987). Focus group interview: An under-utilized research technique for improving theory and practice. *Health Education Quarterly*, 14(4), 411-448.
- Berland, A., & Whyte, N. (1991). *The Role of the hospital nurse in health promotion: A focus group approach*. Vancouver: Registered Nurses Association of B.C.
- Canadian Nurses Association (1988). *Health care for all Canadians: A call for health care reform*. Ottawa: Author.
- Canadian Nurses Association (1992). *Position statement: Health promotion*. Ottawa: Author.

- Clarke, A.C. (1991). Nurses as role models and health educators. *Journal of Advanced Nursing*, 16, 1178-1184.
- Gott, M., & O'Brien, M. (1990). *The role of the nurse in health promotion*. London: Department of Health.
- Gottlieb, L. (1992). Nurses not heard in the health promotion movement. *Canadian Journal of Nursing Research*, 24(4), 1-2.
- Gottlieb, L., & Rowat, K. (1987). The McGill model of nursing: A practice-derived model. *Advances in Nursing Science*, 9(4), 51-61.
- Green, L.W., & Kreuter, M.W. (1991). *Health promotion planning: An educational and environmental approach* (2nd ed.). Toronto: Mayfield.
- Henderson, V.A. (1989). Countdown to 2000: A major international conference for the primary health care team, 21-23 September 1987, London. *Journal of Advanced Nursing*, 14, 81-85.
- Jenny, J. (1993). A future perspective on patient/health education in Canada. *Journal of Advanced Nursing*, 18, 1408-1414.
- Kreuger, R.A. (1988). *Focus groups: A practical guide for applied research*. Newbury Park, CA: Sage.
- Labonte, R., & Little, S. (1992). *Determinants of health: Empowering strategies for nursing practice*. Vancouver: Registered Nurses Association of B.C.
- Latter, S., Clark, J.M., Wilson-Barnett, J., & Maben, J. (1992). Health education in nursing: Perceptions of practice in acute settings. *Journal of Advanced Nursing*, 17, 164-172.
- Loomis, M. (1990). The organization of nursing knowledge. In J.C. Mcloskey & H.K. Grace (Eds.), *Current issues in nursing* (3rd ed.). Toronto: Mosby.
- Noble, C. (1991). Are nurses good patient educators? *Journal of Advanced Nursing*, 16, 1185-1189.
- O'Neill, M., & Pederson, A. (1994). Two analytic paths for understanding Canadian developments in health promotion. In A. Pederson, M. O'Neill, & I. Rootman, *Health promotion in Canada*. Toronto: Saunders.
- Parse, R.R. (1987). *Nursing science: Major paradigms, theories and critiques*. Philadelphia: Saunders.
- Pender, N.J., Barkauskas, V.H., Hayman, L., Rice, V.H., & Anderson, E.T. (1992). Health promotion and disease prevention: Toward excellence in nursing practice and education. *Nursing Outlook*, 40(3), 106-112.
- Registered Nurses Association of British Columbia. (1990). *The special contribution of nurses*. Vancouver: Author.
- Ritchie, J. (1988). Nursing accepting the challenge. *Canadian Nurse*, 85 (9), 30-35.
- Spellbring, A.M. (1991). Nursing's role in health promotion—an overview. *Nursing Clinics of North America*, 26(4), 805-814.
- Tenn, L., & Niskala, H. (1994). *Primary health care in the curricula of Canadian university schools of nursing*. Report to the Canadian Nurses Foundation.

- Tilley, J.D., Gregor, F.M., & Thiessen, V. (1987). The nurse's role in patient education: Incongruent perceptions among nurses and patients. *Journal of Advanced Nursing*, 12, 291-301.
- While, A.E. (1992). Consumer views of health care: A comparison of hospital and home care. *Child: Care, Health and Development*, 18, 107-116.
- World Health Organization. (1986, November). *Ottawa Charter for Health Promotion*. Paper presented at the International Conference on Health Promotion, Ottawa.
- Wyness, M.A. (1990). Evaluation of an education programme for patients taking warfarin. *Journal of Advanced Nursing*, 15, 1052-1063.

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