The Unrecognized Role:

Hospital-based Nurses' Experiences of Health Promotion

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Thesis presented in fulfilment
of the requirement of the degree of
Doctor of Philosophy

The University of Edinburgh

2013

Abstract

The interest of this thesis lies in examining hospital-based nurses' experiences of health promotion by enquiring into what they understand by the term and what their practice of it is. The research begins with a questionnaire survey in order to describe the nurses' attitudes, the health promotion activities they took part in and the influencing factors. The sample for the survey, all from one NHS hospital in Scotland, was a group of 244 nurses (47% response rate) from both medical and surgical wards in the hospital. Semi-structured interviews with 16 nurses were recorded to gather further data on the nurses' insights into their role in health promotion in the hospital. Role theory was employed to orient this study to analyse the nurses' role expectations, their behavioural patterns, and the environment of hospital nursing relevant to health promotion. The data were analysed using quantitative and qualitative methods as appropriate.

The study finds that there is a distinct discrepancy between the nurses' role expectations and the actual experiences described in the nurses' accounts. The health promotion role as understood by the nurses appeared to be too theoretical and rhetorical to fit with their current practice of it. The finding also reveals that the health promotion role was composed of divergent patterns within nursing practice although the nurses were not aware of this. The discussion of this phenomenon focuses on three issues: the nurses' experiences of the discrepancy between the expected role and the actual practice, the relation between health promotion and nursing, and the duality of the health promotion role. These analyses are, in varying degrees, all concerned with the idealized and the actual of the health promotion role and what and how each of them impacts on nurses' experiences of health promotion in hospital. It suggests that health promotion is much more sophisticatedly interconnected with nursing in hospital than has been recognized. Ignoring the existence of the actual health promotion role, a radical shift in ideology and policy of health promotion may never be a good solution for expanding the nursing role since this may result in a distorted role expectation and in unnecessary emotional cost to nurses in hospital.

Declaration

I composed this thesis, the work is my own. No part of this thesis has been submitted for any other degree or qualification.

Name:

Date: 29 NOV 2013

Declaration of Originality

This thesis was written entirely by myself, and I made a substantial contribution to its conduct.

The work presented in this thesis has not been submitted for any other degree or professional qualification.

Juan Du /杜娟

Acknowledgements

I would like to thank many people whose contributions and support have made the completion of this thesis possible. First of all, I must thank the nurses and the managers who were supportive and participated in the study. I thank them for allowing me to go into their world and for openly accepting me to understand their work. Without their contributions, it would never have been possible for this thesis to take form and succeed.

I am fortunate to have Professor Kath Melia and Dr Sheila Rodgers as my supervisors. From the very beginning of my study in Edinburgh, they have given me professional and pastoral guidance, and have been a source of true inspiration for this research. I thank them for their great patience with my progress through the difficulty and pain I experienced recently in my life. Without your faith and support in this work, as well as in me, I would not have been able to finish this work.

I owe thanks to the University of Edinburgh for providing a friendly studying and working environment. I also would like to thank the sponsors who contributed to the College Postgraduate Scholarship for my study here. Without your generosity, I would not have been able to study here, and would not have fulfilled my dream. Also, I thank them for giving me a chance to appreciate being helped and to understand the value of helping others.

I also want to thank my family and my friends who have supported me continuously all the way through. Because of them, I have been able to enjoy my work on this PhD. I just wish my father could be alive to enjoy this moment with us.

Dedication

In memory of my father Du Yutian 1/5/1943 - 12/3/2011

纪念我的父亲杜玉田 长眠 安息

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Chapter One – Introduction

In this chapter the thesis is first presented in summary form, aiming to tell why and how the research came to the researcher's attention and what the significance of the research is. The structure of the thesis is also introduced. In the second section, the researcher explains how the research started and how the project was conducted and written.

1.1 About this thesis: topic, justification and structure

The study of nurses' health promotion role is vital to identify their role and practice since health promotion is regarded as an important aspect of nursing. The literature reviewed in this study place considerably weight on the value of health promotion in nursing and on nurses' role in health promotion. However, it is also frequently reported that nurses were having difficulties in understanding health promotion as it is taught, and are being widely criticized for not actively incorporating health promotion into their current nursing practice in the literature. There is a concern that nurses' role in health promotion has not been fully recognized. It is therefore necessary to study what is actually going on when nurses engage in health promotion and identify their role in it. This is where this study found its interest.

The problem, noted by this study, with current theories of nurses' health promotion role is that health promotion in nursing has not paid much attention to the difference between it as a general concept and as a special one in particular nursing contexts. This study argues that ignorance of nurses' health promotion role as a special concept indicates a lack of understanding of what the health promotion role means to nurses and to their nursing life in particular contexts. There could be two ways of conceptualizing nurses' health promotion role in the nursing literature. Whitehead (2005), one of the leading authors in the field of health promotion for nursing, insists that nurses are ready to claim a role in health promotion alongside other health professionals. From this perspective, health promotion seems to be a concept separate from nursing, and the "health promotion role" refers to the nurses' experiences of that concept. A very different perspective considers health promotion to be a part of nursing, so the "health promotion role" is what nurses have already experienced within the context of nursing. The difference between the two perspectives is perhaps subtle but very significant in defining what nurses' health

promotion role ought to be, and then how to address the relationship between health promotion and nursing. This study argues that it is significant to put aside preconceived ideas about the health promotion role and set out to look at the field itself for evidence of what exactly health promotion means to nurses in practice and how it is constructed or related to nursing.

To capture the nature of the health promotion role in a nursing context is complex and difficult, especially when there is no adequate definition of what a health promotion role is for nurses. The health promotion role is understood in this study to simply refer to the part of health promotion that is relevant to nurses and nursing. "Nurses' health promotion role" is thus the research topic and the heading under which the facts relevant to it are brought together. In this sense, the term has the function to name the phenomenon being studied. Nurses' health promotion role is also the concept that in this study is expected to be comprehensively examined via accessing hospital-based nurses' accounts. The hospital setting is supposed to be one of the special contexts for the health promotion role in nursing, and it has its special qualities because of its particular location and structure. The hospital-based nurses' health promotion role and its actual practice have been investigated in several previous studies with different emphases, and by different methods in the literature. A mixed-methods design is important in order to understand nurses' health promotion role objectively and subjectively, especially when the perspectives are inconsistent. The survey has its objectivity in understanding nurses' health promotion practice, but the qualitative interviewing is also important to gather nurses' additional comment and insight. Nevertheless, the researcher was always mindful of the need to be aware of the nurses' perspectives since these might be influenced by the political tone of health promotion. By analysing the nurses' accounts of their health promotion role, the chief concern of this study was able to be met, i.e. to find out what health promotion means to nurses and how it affects their experiences in practice.

The study finds that the health promotion role comprises the actual practice in the hospital and what is expected of nurses in this role, which we may consider its "ideological" content. Awareness of this interesting duality of the health promotion role is essential to understanding nurses' experiences of health promotion in the hospital. The study revealed that only accounting for the expected health promotion role would result in stress for nurses. The thesis provides an opportunity to

reconsider our understanding of the relation between health promotion and nursing. This study is also important for an understanding of the nursing role in hospital, and as health promotion is one part of nursing, no matter what shape it takes and what the actual practice of nursing, a study such as this has its contribution to make to understanding the gap between theory and practice of health promotion as well as nursing. This will have implications for policy and education as well as the practice of nursing.

The thesis is organized into eight chapters. Chapter One introduces the thesis and the study in general. Chapter Two reviews the main theme of "what is the health promotion role" as described and analysed in the literature. It examines health promotion in a nursing context, and the background knowledge required for the health promotion role that underlies this study. The nurses' attitudes to the health promotion role are examined, particularly in terms of what this role is as well as how it has been researched in previous studies. Health promotion practice is reviewed to give a picture of what nurses could do and what the influencing factors are in hospital. Finally, an account of the Precede-Proceed model is presented. This is based on the researcher's experiences of working on this model in preparing the questionnaire used in this study, and both the strengths and problems of this model when researching health promotion practitioners are reviewed.

A variety of terms exist to refer to nurses' work with health promotion. The phrase "health promotion role" is used in the current study, capturing the characteristic world of health promotion for nurses in hospital. In Chapter Three, role theory is employed as a theoretical framework to operationalize the health promotion role. The essential concepts of role theory, to the extent that they are relevant to this study, are introduced and discussed in the chapter. According to the concept of role, in one sense, "health promotion role" refers to a characteristic type of practice, task and even behavioural pattern/s, which is somehow different from other nursing activities. In another sense, "health promotion role" is the world of health promotion experienced by hospital-based nurses.

Chapter Four presents the what, where and how of conducting this study in the field. The methods used are presented and the choices made justified. Both quantitative and qualitative research methods are employed to examine nurses' accounts of

health promotion. The questionnaire and interview schedule used are presented in this chapter.

Chapter Five analyses the data gathered in the survey. It provides a descriptive analysis of nurses' role expectations and their actual experiences. The possible correlations of variables are tested and explained. The interview findings presented in Chapter Six concern nurses' insights and their experiences of the health promotion role. The analysis confirms the necessity and efficiency of combining the questionnaire survey and the interviews to study the conceptual complexity of the nurses' health promotion role. In this way, the study is able to research the dual aspects of the health promotion role as it has been experienced by nurses in hospital.

The discussion in Chapter Seven analyses the findings from the survey and the interviews. The main feature of the nurses' accounts of the health promotion role is illustrated by a metaphorical "golden key" representing their experiences in an unattainable ideal role. With a brief discussion of the "golden key", three issues emerging from the findings are examined in detail: "nurses' experiences", "health promotion and nursing", and "the duality of the health promotion role". Chapter Eight provides a brief summary of the study. The contribution to knowledge is addressed. The limitations and strengths of the thesis are set out.

1.2 Researching the health promotion role

As I come to the end of writing this thesis, I have an inclination as a novice sociological researcher to write down an account of how this study came to be formed. The need to provide such an account has become stronger, especially considering how this study has been through many challenges and difficulties. On the one hand there is the study's complexity, and on the other, I must admit, there have been moments when I realised that I was not fully prepared and armed with the necessary sociological knowledge since I am a novice social researcher – and a convert from medical science – and importantly, a learner of Western culture. For both reasons, it does little harm to pause a moment to reflect on the stages of this research, about where it started and where it ended. The description of the process includes important decisions made and may also provide an understanding and appreciation of the style and ethos of the thesis. It may thus be helpful if I briefly

outline how I began this study in order to provide some context for how I approach the topic of the role of health promotion in nursing.

It seems, somehow, that the main idea underlying this study from the beginning to the end never fades; an idea drawn not only from nurses' accounts, but also from my experiences as a nurse and then a teacher. When I was a nurse in a hospital in China in the late 1990s, health promotion became an important new subject for nursing practice in hospital. I perhaps caught the first moment of health education to be taught at the university. The brief chapter in a nursing book from America was translated through the efforts of teachers who were pioneers in teaching and learning health education, and soon after it was updated into health promotion. I was still pondering what health promotion was when I started nursing in hospitals. What helped me understand it was perhaps observing the leaflets and posters on the walls for patients and the atmosphere around it. We as nurses in hospital were really encouraged to spend time with patients and talk with them more than ever before, although we really knew little about "health promotion" and how to talk about it. The question of what health promotion was remained a constant puzzle to me, even when I became a nurse teacher. What I could deliver was what the books described as heath promotion, and how health promotion would be helpful for the health of the population, in theoretical concepts more than in operational terms. I could imagine that health promotion might not go far beyond the classrooms. My experiences taught me that I wanted to know what health promotion was and how it was relevant to nursing. Interestingly, I have never questioned what nursing is. Maybe nursing is just there, and health promotion is something I had difficulty referring to. It was from this background that I decided to enquire into hospital-based nurses' experiences of health promotion when I started this PhD programme.

It was not surprising to find similar situations here in the UK as far as this topic was concerned. Health promotion has a global influence on nursing. Health promotion has become an important part of a nurse's life nowadays. It is found in health policies and nursing professional documents, in the nursing curriculum and in practice nationally as well as internationally. According to the literature of the UK, first of all, it is very important to understand the role of the hospital-based nurse in health promotion to provide holistic nursing within acute care services (Latter, 2001). In previous studies, nurses in hospital are expected to take more action regards health promotion; however, the environment in hospital is not supportive of it, but

frustrating for both nurses and authors (e.g. McBride, 1994; Twinn & Lee, 1997; Casey, 2007a, 2007b). It is on the basis of this scenario, which has been frequently reported in the literature, that the thesis seeks to take a realistic attitude in looking at what nurses can do regarding health promotion in hospital.

Probably the most difficult part of this study was finding suitable theories in the literature on nurses' role in health promotion. Previous studies focusing on nurses in hospital tended to present concepts of health promotion too broad to be useful. There is a common perspective on the health promotion role that, in a manner of speaking, has the political tone of health promotion. Against this backdrop, the current study focuses on the concept of "role" in health promotion. Role theory has been employed to provide the connotations and meanings of role in the concept of health promotion role. Role theory contributes to operationalizing the concept of health promotion role by focusing on the essential concepts related to role, which orientates the study in terms of where to look and how to analyse the data. Particularly, the study emphasizes examining and analysing nurses' role expectations and behavioural patterns, and the structural factors of the health promotion role in hospital.

The field work was conducted in one NHS hospital in the UK, both in medical and in surgical wards, which partially was a function of the limited time and budget available to this PhD project. A related reason for sitting the study in an NHS hospital is perhaps heavily influenced by Levinson's (1973) perspective that "the organization provides a singularly useful arena for the development and application of role theory. It is small enough to be amenable to empirical study. Its structure is complex enough, a wide variety of social positions and role standardizing forces" (p. 223).

The combination of quantitative and qualitative methods, i.e. survey and interview, is particularly interesting in this study. It had been predicted that the interviews would help to collect the nurses' insights, thus going beyond the survey results, at the design stage. However, it was during the analysis of the data from two different sources that I had direct experience of how the data were differently organized, and, moreover, how nurses responded to these two methods. Then I realised that survey and interviews seemed to be very suitable to the study of the health promotion role when it is hypothesized that nurses' role expectations can be divorced from their practice. The survey in which nurses responded to questions thus provided a

structure for the information to be gathered. The interviews, on the other hand, provided much space for nurses to express themselves. I found that the nurses in my study were more conscious of some parts of health promotion than of others. It may not be surprising that in the interviews nurses wanted to talk about the prestigious parts, and these were usually the parts they were not good at in practice but desired to master. The survey questionnaire, on the other hand, gathered information on what their daily practice was, especially the routine parts. It is psychologically normal for humans to be attracted to what they are interested in and ignore what they are used to, especially when they have been used to it for a long time. The study took note of how research methods and respondents interacted in the field.

Constantly engaging with the data and, importantly, thinking of the data in different ways is very necessary for this kind of study. Perhaps, at certain points, I wanted to lead the story with preoccupied ideas, but in the end, the story led in its own way. At the point of interpretation, I had to let the nurses' voices express themselves. A metaphor may be useful, citing Lamoureux' (2005) interpretation:

> Sometimes we just can't find the right words to articulate what we want to say. This is not necessarily due to linguistic inadequacy or cognitive deficiency. It may be the result of trying to express literally some experience that is riddled with emotion or that has a depth dimension that cannot be captured in a word. (p. 71)

The "golden key" as an analytic conceptual device to be used in the study came from the darkest days of the research, and was perhaps the only idea that I held on to for quite a while. In social research, metaphor is not unusual to be utilized, known as a starting point to providing a way of understanding the world. A metaphor could provide a quick illustration and shape a theory's standpoint and perspective (Hart, 1998). Plummer (2010) summarizes the function of metaphor in sociology as follows: "Generally, behind every major social theory, there is an imaginary (a trope, a metaphor) or way of explaining just how the social works – they are ways to open your eyes for seeing the social world in new ways" (p. 29).

Metaphor is a way of starting a journey of sociological imagination to make sense of what it is being studied. In the case of the current study, three metaphors, "golden key", "Russian doll" and "role", evidently contributed a way to understanding the nurses' world of the health promotion role. Just like "role" itself as a metaphor is applied from the theatre context to the study of human society, so role in this study is

indeed a helpful analytical tool to arrive at a comprehensive analysis of the health promotion role. "Golden key" has its mysterious moment as an intuition that came to me; interestingly, it works well in this study for providing an image of what it is going on in the nurses' accounts. The metaphor of "golden key" creates a vivid image of nurses' desire for and pursuit of an ideal health promotion role, without knowing what it is and how to use it. It hints at nurses possibly forgetting the ordinary key in their hands for illustrating their lack of understanding and appreciating their own practice. The metaphor certainly facilitates a starting point for unveiling the nature of the health promotion role, which is difficult to observe directly from the data. This is to say that this study has benefited from the use of the "golden key" in finding the hidden structure of nurses' accounts of the health promotion role. Additionally, the notion of the "Russian doll", borrowed from Laverack's (2004) description of different approaches to health promotion, also inspires the concept of "levels of health promotion practice" in this study. Perhaps it can be said that the metaphors in this study are indeed providing "new" ways of understanding the health promotion role.

Chapter Two – Literature Review

That this review is divided into six sections perhaps reflects the breadth and complexity of the task of reviewing nurses' health promotion role in the literature. A very important feature of the knowledge of the topic is noted: health promotion has not yet been defined for nursing or for nurses. Rather, health promotion in the nursing literature is general and diverse. Little difference could be identified from health promotion in general and health promotion in the nursing context in the literature (Delaney, 1994; Maben & Clark, 1995). This means that nurses' health promotion role has been discussed within the knowledge of health promotion rather than how it is for nurses or how it is in nursing practice. This probably gives a hint that there is a lack of understanding of nurses' health promotion role from a nursing perspective. Thus, the challenge for reviewing and discussing hospital-based nurses' health promotion role is evident. It would be hardly possible to think of nurses' health promotion role within the hospital nursing context only when health promotion is discussed in general. More importantly, it would be insufficient and problematic to narrow the review of the topic to the hospital nursing context if the mainstream literature considers health promotion in a wider sense.

This chapter reviews the health promotion role by critically surveying and reviewing the nursing literature. In the first section, it begins with an exploration of the conceptualization of the health promotion role, providing concepts and terms of the health promotion role by reviewing it in different contexts. The second section of the chapter discusses the concept of health promotion in the nursing literature, aiming to identify key issues in defining the health promotion role. Also, the different approaches to study the health promotion role in previous studies will be reviewed and discussed.

In the following sections, the focus of the review is the hospital-based nurses' understanding and practice of health promotion. The third section reviews what nurses' attitudes to health promotion are and how nurses' attitudes have been explored in the literature. The fourth section of the chapter reviews health promotion practice in hospital and discusses its essential aspects. This will include factors relating to health promoting hospitals (HPH), the scope and content, the practical models, and the extent of the health promotion practice in hospital. In the fifth section, a review of the Precede-Proceed model (P-P model) will examine the

advantages and the limitations of the model as a device by which to examine health promotion practitioners' behaviours. This discussion is beneficial for considering the choice of the theoretical framework for this study. In the last section, this chapter will conclude with a perspective of the nurses' health promotion role for this study in order to clarify the gaps in knowledge concerning that role.

2.1 Health promotion role in context

This section begins with a review of the health promotion role by exploring the different ways of looking at it. In the mainstream of the literature, nurses' health promotion role is enriched by political and professional contexts (Gallagher & Burden, 1993), and health promotion seems to be viewed as a new approach and as a new function of nursing. The literature emphasizes how and how much nurses could apply this new idea in their nursing practice. A further examination of the philosophical and historical contexts of the relation between nursing and health promotion in this section finds that they have shared the same or very similar values and concepts. The opposing ways of understanding the health promotion role are influencing the definition of what the health promotion role is for nurses. Each way will bring its particular contexts and the meanings associated with them. Thus, this section explores how the health promotion role could be enriched in various contexts, before reviewing what the health promotion role is in the following sections.

2.1.1 Health promotion as a new frontier in nursing

In the nursing literature, usually, health promotion is viewed as a new idea and movement for nursing and nurses. There was a universal call for health promotion to become part of nursing (Whitehead, 1999) when the term health promotion started to be used in the 1970s. In the UK, the role of health promotion in nursing has been continuously emphasized in national directives and declarations. For example, the Department of Health's (DoH) (2002) *Liberating the Talents* clearly identifies the involvement of nurses in public health, health protection and health promotion as one of the three core functions for nurses. Even as recently as 2012, health promotion is still a hot topic in nursing documents. The RCN's (2012) *Going*

Upstream: Nursing's Contribution to Public Health calls for nurses in all locations to identify opportunities for health promotion.

At the international level, the World Health Organization (WHO)'s (2000) *Munich Declaration* has officially encouraged nurses to increase their role in public health, health promotion and community development. The importance of nurses engaging in health promotion has also been strongly emphasized in WHO's *World Health Report* (WHO, 2003). As a result, the call for health promotion has led to nursing formally expanding in its functions and the scope of its practice. This is shown in the changing definition of nursing, which singles out health promotion as one of the aims of nursing practice:

> Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups, and communities, sick or well, and in all settings. Nursing includes the promotion of health, prevention of illness, the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management and education are also key nursing roles. (ICN, 2002, http://www.icn.ch/about-icn/icn-definition-of-nursing/ (accessed 23 Mar 2012))

In the UK nursing context, following the spirit of the double mandate for health services initiated by the WHO (1986), the Royal College of Nursing (RCN, 1992) advocates a health promotion approach in nursing practice which combines promoting health and caring for the sick at the same time, and it highlighted the need for nurses to develop skills in health education and health promotion. In the Scottish nursing context, the document *Nursing for Health* (HMSO, 2001) reviews the distinctive efforts by nurses, midwives and health visitors in improving public health in Scotland. It suggests that nurses have responsibility for promoting health and health care. *Caring for Scotland* (HMSO, 2001) further emphasizes nurses' unique caring role in public health policy, and advocates that nurses be prepared for a changing health culture.

Interestingly, nursing professionals have responded very quickly to demands for health promotion being included in the nursing agenda. Indeed, health promotion is now an important contributor to an ever-expanding nursing role. The emergence of the "new public health" concept and health promotion is regarded as an important opportunity for the nursing profession to seek further improvement of nursing

(Robinson & Hill. 1999). Robinson and Hill (1999) argue that the movements of health promotion policies are a "golden opportunity" for nurses to "have appropriate education in health promotion and then become catalysts for change, nursing with their acquired knowledge and skill" (p. 14). Chamber and Narayanasamy (2008) argued, for example, that if nurses would not learn to keep up with contemporary health promotion movements, they would lag behind in the field of health promotion.

In meeting the challenge of taking on health promotion role, nurses are seeking to redefine and re-evaluate their role, recognizing the need to develop their expertise in health promotion in the NHS (Gallagher & Burden, 1993). Nursing education plays an active role in preparing nurses for health promotion by adjusting the nursing curriculum accordingly. The *Project 2000: a new preparation for practice* (UKCC, 1986) had a great impact on the nursing curriculum. This project is regarded as the one that most effectively addresses the needs of nursing studies relevant to their health promotion role (Delaney, 1994; Gott & O'Brien, 1990). As a result, the themes of health and health promotion have been a priority in pre-registration of phase of nursing curricula (Robinson & Hill, 1999). According to McDonald's (1998) study, nurses have usually been prepared for such a role.

Due to this changing perspective on the role of nursing, it is believed that as the largest group of providers of health services, nursing has the great advantage of being able to deliver health promotion to clients in different settings (King, 1994). Compared with other health professionals, nurses are a cheaper human resource to provide health promotion services (Gallagher & Burden, 1993). However, the extent to which nurses could contribute to health promotion and whether nurses' function in health promotion really could save resources is not clear yet. Importantly, nurses' role in health promotion, and the resources and support for nurses to perform health promotion, are neglected or downplayed. This implies that there are political and professional concerns regarding the relation between nursing and health promotion. Health promotion may be an opportunity for nurses to improve their professional status in many aspects, but the magnitude of the task of delivering health promotion and the capacity of nurses to carry out this task have been little discussed in the context of encouraging nurses to take on a health promotion role.

2.1.2 Health promotion as a part of nursing

Early nursing literature emphasized health promotion as a central philosophy of nursing (Tones, 1993), exploring the feasibility of nursing as a site for health promotion. The philosophical reasoning in support of a health promotion role for nurses provides important evidence that health promotion and nursing have been joined together historically. It also reminds us of what we have lost in a rapid and radical change of the fields of both health promotion and nursing.

Historically, health promotion has been a primary goal of nursing since the days of Florence Nightingale, who dedicated herself to establishing a systematically organized nursing profession. Her ideas for promoting health have been recorded in her books. In *Notes on Nursing*, Nightingale (1859) indicated that nursing the well was even more important than nursing the sick. In addition to her insistence on a hygienic environment for people, respect for a person's dignity was also emphasized in her nursing practice. Nightingale's environmental theory of nursing provided the ideas for a holistic view of health, not merely being concerned with a person's physical condition but also with a person's psychological and social aspects. As the initiator of public health nursing, Nightingale (1894) noticed that promoting health can be cheaper than maintaining people in sickness, and suggested that a country should care for people from infancy and childhood throughout their lives. This idea was the basis of Nightingale's importance in the development of public health. Perhaps her most significant contribution to public health was to encourage nurses to teach people how to keep healthy (Nightingale, 1897). In contributing these elementary ideas, Nightingale recognized the essence of health prevention and health promotion and made these notions part of nursing. Her humanistic and holistic perspectives contributed not only to the nursing profession but also to many other health disciplines, especially benefit public health and health promotion. Her thinking hints at nursing contributing to health promotion by shifting the health ethos from a medical model even before health promotion had become an important subject. In this sense nurses could be seen as the pioneers of the health promotion movement.

Health promotion and nursing have since developed into two disciplines, yet sharing core values and concepts among which are health and empowerment. One important tradition of nursing is wanting to help people keep well (Whitaker, 1962), which is consistent with the goal of health promotion, which is to gain health. The WHO's

(1946) definition of health is the most frequently cited in both the health promotion and the nursing literature. In particular the holistic view of health is solidly embraced in nursing, with individuals and families viewed as functioning units, interacting freely and holistically with their surrounding environments (Baranowski, 1981). Nurses make great efforts working towards illness prevention and health maintenance to bring about health and well-being of the whole population. The most often cited definition of nursing, by Henderson (1966), gives a nursing perspective on health and the dynamics between patient and nurse:

> The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would be unaided if he had the necessary strength, will, or knowledge, and to do this in such a way as to help him gain independence as rapidly as possible. (p. 15)

This definition explains nursing as being to "assist" and "help" people to achieve their own potential of being independent in the context of health. Both the health and the patient-centred approach in nursing have close ties with the notion of health promotion for the population.

Particularly the concept of empowerment as a core value of health promotion (Tones & Green, 2004) is consistent with the notion of self-care in nursing in many senses. Dorothea Orem (1985), who primarily coined the term self-care, defined it as "the practice of activities that individuals personally initiate and perform on their own behalf in maintaining life, health and well-being" (p. 13). The notion of self-care identifies the role of patients in staying healthy. In this, it reflects the idea of empowering patients by which they gain control of their own health. Self-care also encourages the process of educating patients, aiming to increase their caring abilities after discharge from hospital. In the nursing literature, the importance of how the notion of self-care and empowerment are logically consistent has not been fully recognized.

Perhaps health promotion as a discipline by that name is relatively new to nursing but the shared historical and philosophical roots of health promotion and nursing can not be ignored. Health promotion and nursing are closely connected, overlap, and even contribute to each other. This is also to say that health promotion can be considered an inherent part of nursing. This is very different from viewing health

promotion as new to nursing. In other words, this understanding challenges the view of health promotion as a new approach and function of nursing as it is understood in the mainstream of the literature. Significantly, discovering health promotion as a part of nursing leads to a perspective that treasures nursing for how it has already contributed to health promotion. This is contrary to the attitude of either encouraging nurses to take more action in health promotion or criticizing nursing for not yet being close to the field of health promotion as currently conceptualized. Rather, nurses have already done health promotion in a historical and philosophical sense. Furthermore, it can be said that nurses do health promotion in the name of nursing since it is a part of nursing. The question is whether it is necessary to call it health promotion when nurses do things which are the equivalent of health promotion, such as practising holism and empowerment. Then the question of what a health promotion role is for nurses is how to demarcate the boundary between health promotion and nursing.

2.1.3 A discussion

The review of the health promotion role in the above provides two different ways of looking at nurses' health promotion role and how they are relevant in different contexts. Perhaps, a "contemporary" view and a "traditional" view of the health promotion role need to be introduced. Health promotion as a new approach and function for nursing is very much taken-for-granted knowledge in the literature. This is related to a politically and professionally contextualized view of health promotion as well as of nursing, as discussed above. Health promotion as a new frontier focuses on the difference between health promotion and nursing, and the changing value of health promotion for nursing role is emphasized accordingly. In contrast, the historical and philosophical examination of the relation between health promotion and nursing suggests that they not only share the same or similar values and concepts but also have developed to become part of each other. It shows that health promotion is already part of nursing but not yet recognized as health promotion. It is in their nursing that nurses contribute to health promotion in their daily practice. Health promotion in this sense is a fundamental value of nursing.

The different views of the relation between health promotion and nursing certainly lead to different attitudes and understandings of the health promotion role. Therefore,

the significance of the discussion "contemporary" versus "traditional" view of the health promotion role is evident. It suggests that nurses' health promotion role is conceptualized in more than one context. In fact, the health promotion role can be defined in many different contexts: in political and professional contexts as well as in historical and philosophical contexts. Thus, there are meanings and understandings to be attributed to the health promotion role from each context. Importantly, these differ in the contemporary view of the health promotion role and the traditional view of it. This reminds us that it is inevitable to begin from within a particular stream of meanings and understandings when starting to study the health promotion role.

Delaney (1994) made an attempt to consider the relation between health promotion and nursing:

> Nursing, despite healthy debate as to its nature, has adopted a number of core values; these might include caring, respect for persons, client-centeredness, and a commitment to empowerment. There is clear overlap in some issues of concern and interventions adopted between nursing and health promotion. This does not mean that nursing and health promotion are synonymous nor that one might subsume the other. (p. 833)

Delaney (1994) recognized that there is overlap between nursing and health promotion in terms of values. However, she pointed out that health education is the clearest aspect of health promotion that can be distinguished from nursing. This seems to be a contradictory view of the relation between health promotion and nursing, an example of being trapped in various understandings of health promotion and nursing. In Delaney's view health promotion is a set of values and approaches of which health education is one. She did not see health education as a part of nursing but instead saw it as a method or approach to health promotion. This is an example of the complexity of defining a health promotion role for nurses, which becomes confusing when applying different understandings of health promotion, as a value or as an approach, and its relation with nursing.

There are at least two questions which should be considered: how do we want to define the health promotion role and, perhaps more subtly, what should our attitude towards the health promotion role be. This question probably should be answered in a concrete and specific sense, to see the extent to which health promotion and

nursing are connected in particular contexts. This sets up the particular contexts for understanding the health promotion role. The contemporary view of the health promotion role is emphasized in the literature for its political and professional tone. This attitude is found in the upper levels of nursing professionals. Usually, nurses' voices, especially from the grassroots and the frontline of practice, are muted (Norton, 1998). Empirical studies are even less concerned with the question of how current nursing practice is relevant to health promotion and, according to nurses' accounts, how the concept of health promotion has been applied in practice. So far, it is noted that there are multiple possible contexts in which the health promotion role can be conceptualized. Probably, it is better to define the health promotion role possibly on the basis of the evidence gathered in future studies. Indeed, little effort is made to discuss the nature of the health promotion role, or how nurses' health promotion role should be defined, in either a contemporary or a traditional view.

2.2 Background knowledge of health promotion role

As discussed above, the health promotion role can be conceptualized differently according to the context. It may be argued that as yet there is a lack of definition of the health promotion role. This section begins with conceptual concerns about health promotion in the nursing literature. First, the key issues in defining the health promotion role for nurses will be examined. Then, the confused but essential components, health promotion and health education, which have a great influence on the view of the nurses' health promotion role will be reviewed. Finally, the empirical studies on the topic will be reviewed and evaluated for the purpose of identifying a suitable way to approach the health promotion role.

2.2.1 Conceptual analysis of health promotion

Maben and Clark (1995) make an important attempt to examine the concept of health promotion in the nursing literature. Their systematic examination of "health promotion" in nursing may provide a framework for understanding how it is used and how it is communicated in the nursing literature. It finds that health promotion could have six different understandings in the literature (Maben & Clark, 1995, pp. 1160-1162):

- health promotion is an umbrella term;
- health education and health promotion are synonymous and interchangeable;
- health promotion is the marketing or selling of health;
- health promotion is concerned with lifestyle behaviour change;
- health promotion is "health education plus"; and
- health promotion is an approach which encompasses a set of values.

Maben and Clark's (1995) analysis shows that health promotion is understood in diverse ways in the nursing literature. Health promotion could be used and understood as an "all-encompassing term" or "umbrella term" that takes account of any issue concerned with promoting health. Some of the understandings more specifically refer to lifestyle behavioural change or to the marketing of health. The understandings is also confused about whether health promotion is health education or has a wider sense than health education.

The understandings of health promotion are not mutually exclusive (Maben & Clark, 1995). Maben and Clark (1995) went further in concluding what are the dimensions of health promotion in the nursing literature:

> At its broadest level it is concerned with the wider influences on health and therefore with the policy and legislative implications of these. Health education is through information-giving, advice, support and skills training is a part of, and necessary prerequisite to, health promotion, attempts to raise awareness of the issues in question and fosters an ability to cope with illness or disease. More radically, health promotion is in itself an approach to care through empowerment, equity, collaboration, and participation, and may involve social and environmental change. (p. 1163)

The striking feature of Maben and Clark's (1995) summary is that health promotion in the nursing literature is little different from its understanding in the general literature, which implies that nursing might either adopt the concept of health promotion uncritically or that health promotion is being applied widely in nursing.

Based on their analysis of health promotion, Maben and Clark (1995) support the idea that health promotion could be extremely widely applied if it were viewed as an approach to or a method applied in any activity. Cribb and Dines (1993) argued that it is hard to limit the boundaries of health promotion. They argued that "health promotion does not belong to any institutional setting or professional role", and that "health promotion has no obvious boundaries and hence discussions which attempt to delimit its domain are liable to run into trouble" (Cribb & Dines, 1993, pp. 21-30).

Delaney (1994) noted the diversity of interpretations of health promotion in the nursing literature, ranging from "inclusive" to "umbrella" or "eclectic", since "the term of health promotion encompasses a range of component activities contributing to health" (Delaney, 1994, p. 828). She also noted that there is "no single authoritative voice and many commentators and agencies are about to pronounce on health promotion" (p. 829). However, Delaney (1994) argued that, "in translating such inclusive definitions into practice, substantial variations exist such that very different practices might claim to be health promotion" (p. 830).

Thus, she preferred the notion of "exclusion criteria or principles" which is an important constraint in defining health promotion. Delaney did not fully elaborate this notion. Perhaps, the exclusion criteria or principles are supposed to be held by different stakeholders or parties. However, Delaney (1994) provides an insight into this, arguing that both inclusive and exclusive definitions are "ideal" types:

> Confusion arises where health promotion is seen as a combination of activities but practice of any single one (especially health education) is denied the label. Such logic would hold that no one could practice health promotion unless they operated at all levels, in all contexts. (p. 830)

Delaney (1994) proposed a solution, i.e. to consider the contributions of different professional roles, which reclaims health promotion as multi-disciplinary and multi-sectoral in nature.

Arguing in a different way, Gott and O'Brien (1990) claimed that the meaning and the range of health promotion are inseparable concepts both of which reflect the agenda of the defining parties. Gott and O'Brien (1990) suggested that the types and scales of health promotion activities are likely to be different for different branches of nurses, and that it is necessary to delineate roles according to the contexts and

levels of operation in nursing practice. Therefore, nurses working in different institutions have different kinds of health promotion roles.

Laverack's (2004) notion of "situated practice" in health promotion has a similarity with Delaney's (1994) and Gott and O'Brien's (1990) arguments:

> ...health promotion is best thought of as a "situated practice" rather than as some universal theory or approach to health. By this, I mean that people, largely employed by (situated in) state agencies or state-funded non-governmental organizations (NGOs), engage in activities or programmes that are intended to improve or maintain the health of individuals and groups. Increasingly, such activities are undertaken with persons working in other sectors, both public and private. To a lesser extent, activities have broadened to include changing public polities that condition individual or group choices and behaviours. (Laverack, 2004, p. 6)

Laverack (2004) clearly argued that it is ellusive to have a shared and unified definition for everyone, and that people working in different disciplines and fields may have different perspectives and approaches. Their emphases and views could be different from each other, although all health-related disciplines are working for the promotion of the health of populations. Tannahill (1985) noted even earlier that the current vibrant situation, with so many perspectives on and approaches to health promotion, has risked making a one-for-all definition meaningless. Because of its breadth, health promotion has been vividly accused of being a "magpie profession" that has accumulated a stockpile of adopted techniques, models and goals (Seedhouse, 2004). It could be very problematic to communicate efficiently within groups of people working on health promotion when there is a lack of shared understanding of health promotion among its practitioners.

Maben and Clark (1995) noted that the core of health promotion is "the notion of improving health and the prevention of disease, and/or the promotion of positive health" (Maben & Clark, 1995, p. 1160). They proposed the following general definition of health promotion:

> Health promotion is an attempt to improve the health status of an individual or community, and is also concerned with the prevention of disease, though this is not its only purpose, as health is not merely the absence of disease. (p. 1162)

This has great similarities with the definition of health promotion by WHO (1986). Maben and Clark (1995) were aware of the fact that this definition is too broad and idealised, but they argued that it could be helpful to have an ideological definition of health promotion for understanding the idea of health promotion. However, these broad-ranging concepts of health promotion are not likely to be useful and helpful in practice, as pointed out by Downie et al. (1996).

It is significant to note that both Maben and Clark (1995) and Delaney (1994) found that nurses' contribution to health promotion and the concept of health promotion as used in the nursing literature are different. This leads to a division between the meanings of health promotion given by nurses in empirical studies and that which is communicated in the nursing literature. Maben and Clark (1995) found that nurses' understanding of the concept implies a more traditional approach rather than the more modern or new paradigm approach to health promotion. Maben and Clark (1995) argued that this is the result of the lack of an up-to-date education of health promotion. However, in recent studies it is still being frequently reported that nurses' understandings of health promotion are more traditional (e.g. Casey, 2007a, 2007b; Irvine, 2007), despite constant educational efforts regarding health promotion. The attitudes found in empirical studies are interesting. Nurses have been criticized for not being able to move beyond the traditional understanding of health promotion to a new paradigm of it (e.g. Chambers & Narayanasamy, 2008; Piper, 2007).

Delaney (1994) recognized this fact as a theory-practice gap regarding health promotion. Theoretically, there are various interpretations of health promotion subscribed to by different stakeholders. These interpretations, differing between theory and practice, may have different implications for interpreting and defining nurses' contributions to health promotion, and the allegation of an inadequacy in nurses' role in health promotion is misplaced (Delaney, 1994):

> If this is the case for nursing in general, perhaps an even wider gap should be expected between "positive" health theory (and rhetoric) and practice, which with few exceptions remains largely concerned with acute and chronic illness, pain and suffering? (p. 833)

It has been noted above that there are different interpretations of health promotion found in the nursing literature. It is certainly very difficult to answer the question of

what is health promotion according to the nursing literature, let alone the question what is the health promotion role for hospital-based nurses. In different ways, many authors contribute their ideas of what health promotion should be, such as Delaney's (1994) "exclusive criteria", Gott and O'Brien's (1990) "contexts and levels" of health promotion, and Laverack's (2004) "situated practice", all of which provide possible ways of defining health promotion in a concrete way. This is different from either the idealised or the general way of understanding health promotion. The implications of health promotion in the ideal, theoretical or even rhetorical sense, and health promotion in a constrained context, are different for nurses. This suggests that when examining nurses in the hospital context, it is necessary to look at what health promotion is in hospital settings and how it is practised.

Gott and O'Brien (1990), as the first investigators of nurses' health promotion role in actual practice in the UK, strongly recommend an empirical study of nurses' voices on the topic. They argue that it is not good enough to impose predefined categories of a health promotion role before "seeing" what nurses actually do in their practice. The virtue of starting with nurses is that their perceptions and experiences could help an understanding of the political and structural contexts of the role since they have an impact on nurses' orientation to and beliefs about health promotion practice (Gott & O'Brien, 1990).

2.2.2 Health promotion versus health education?

Any discussion of the theory and practice of health promotion as found in the nursing literature unavoidably has to deal with the question of the relation between health promotion and health education. These are the subject of the continuous debate in the health promotion and nursing literature:

> Traditionally, health education activity is associated with behaviourally focused medical/preventative approaches to practice. Health education strategies are usually firmly rooted within biomedically positivist frameworks that advocate the use of reductionist, mechanistic, individualistic and allopathic activities in health interventions. Health promotion strategies, on the contrary, are usually associated with broader empowerment-based and socio-political approaches that concern themselves with community-based social, environmental, economic and political determinants of health care. (Whitehead, 2003a, pp. 796-797)

Nurses' understanding as well as practice of health promotion usually remains within the area of health education. Health promotion for nurses is situated at the biomedically defined individual level of behavioural change rather than at any social-political level.

The centrality of the tension remains between individual and collective responsibility for health, or between voluntarism and control of health promotion (Tones & Green, 2004). Health education provides an educational approach to enhancing the awareness of disease prevention and behavioural or lifestyle changes. However, this traditional and individual health education approach has been criticized as being isolated from the broader social and environmental factors determining health and as having little of a new paradigm approach (Benson & Latter, 1998). It also has a potential problem of victim blaming (Whitehead, 2004). However, Smith and Cusack (2006) pointed out that the language used around health promotion sometimes conveys the impression that it has nothing to do with ill-health or acute care. There is an over-emphasis on well-being and positive health in the understanding of health promotion. As a result, the value of health education has not been recognized (Smith & Cusack, 2006).

Delaney (1994) strongly supported health education as "a legitimate and valid part of nursing work" (p. 833). She argued that a simple distinction between health promotion and health education is not valid and not logical either for three reasons. Firstly, since there are different models of health education reflecting a range of values, goals and approaches, the narrow, victim-blaming approach is challenged. Secondly, the division between health education and health promotion as discrete activities "is health damaging, [i.e.] it is not logical to exclude it [health education] from health promotion" (p. 829). This implies that health education and health promotion are allies when they share the goal of improving health. Thirdly, health promotion is more an umbrella term so that health education is a composite of activities carried out under the topic of health promotion. This suggests that the view of health promotion versus health education is not healthy for an understanding of nurses' role in health promotion.

The opposing views of health promotion and health education have an impact on evaluating nurses' role in health promotion (Whitehead, 2004). Robinson and Hill (1999) argued that nurses would not reach to be "health promoting nurses" because

of a fundamental individualism in nursing practice in hospital, and health promotion is viewed as the new paradigm focusing on holism of health. Nurses' role in and practice of health promotion are constantly compared with this conceptualization of health promotion. Rush (1997) argued that from an ideological viewpoint, nursing failed to identify the individualism of health promotion in its own profession. Norton (1998) recognized a political correctness in the constant paradigmatic debates around health promotion. He argues that nurses should balance the idealism of health promotion and government policy in nursing practice.

However, empirical studies show that nurses are not interested in being involved in the paradigm debates. In many reports, nurses are quoted as saying that they could not distinguish between health promotion and health education. The terms health promotion and health education might be used equally without distinguishing between them in the practice of nurses (Gott & O'Brien, 1990; Latter et al., 1992; Maben & Clark, 1995). Health promotion has been referred to by nurses as likely representing the traditional preventative health education practice (Norton, 1998; Whitehead, 2001a, 2003a, 2003b). There are also reports showing that nurses have noticed the difference between health promotion and health education. Maben and Clark (1995) noted that health promotion could be understood as "health promotion is health education plus". It seems that nurses have recognized health promotion as the developed and advanced version of health education. Still, although nurses were found to be good at speaking the language of health promotion, health education is still a strong traditional foundation in the nurses' knowledge of health promotion (Irvine, 2007).

Nurses, as suggested in the literature, may have little understanding of what health promotion and health education should be. There is little research conducted on what are health promotion and health education in the context of nursing and how they are related in nursing practice. To increase nurses' knowledge of health promotion, they should be studying the relation between health promotion and health education; this would also increase their knowledge of nurses' health promotion role.

Tones (2001) offered a sound understanding of health promotion and health education via an "operational" definition of health promotion. It does not focus on the conflicting paradigms but provides a synthetic model of health promotion in one formula. The essential components are twofold and give rise to the following

formula: "*Health Promotion = Health Public Policy X Health Education*" (p. 4). Tones' definition of health public policy follows the Ottawa Charter's definition: "its major purpose being to create legislation, economic and fiscal measures and various forms of social and environmental engineering in order to make the healthy choice the easy choice" (p. 4). Tones thus emphasized the importance of policy in health promotion. On the other hand, Tones emphasizes that without health education it will be impossible for health promotion to develop into the implementation of healthy public policy. He further clarifies that "health education is any intentional activity which is designed to achieve heath or illness related learning" (p. 4). Health education is the prerequisite of health promotion (Tones & Green, 2004). In the nursing context, Whitehead (2003a) supports health promotion and health education as "symbiotic paradigms", regarded as being complementary to each other.

Green and Kreuter (1991, 1999) considered the idea of an educational and ecological approach to combining health education and health promotion in their single conceptual framework presented by the Proceed-Precede model (see below). Essentially, this model suggests that it is not necessary to view health promotion and health education as conflicting paradigms. In its operational sphere, two approaches are associated in one network for practitioners. The model puts emphasis on multiple-disciplinary approaches to achieve cooperation in health promotion rather than singling out any one approach.

More sophisticated categories or approaches in the literature concern the operational sphere of health promotion. Naidoo and Wills (1998) discuss five different approaches to health promotion: medical or preventive, behavioural change, educational, empowerment, and social change. Taking a different approach, Ewles and Simnett's (1999) interpretation of health promotion outlines medical, behavioural change, educational, client-centred, and societal change approaches. Each approach has a different discourse, influencing the design, implementation and evaluation of programmes, and separate ways of thinking and shaping the behaviours. Laverack (2004), based on the above authors, reviewed and categorised health promotion as three approaches: medical approach, lifestyle/behavioural change, and social-political approach. Significantly, Laverack (2004) modelled these three approaches to health promotion under the metaphor of the "Russian Doll". This views the characteristic relations of the approaches as one inside another.

The medical approach is the smallest doll, with lifestyle/behavioural change in the middle, and the social-political approach is the largest one. This metaphor suggests that each approach has a certain "space". Only the inside approach is fulfilled and then health promotion practice reaches to the outside one. However, Laverack (2004) only proposed this metaphor to imagine how different health promotion approaches are related to each other. He did not utilize this "Russian Doll" metaphor to explain how practitioners work with any of the approaches or what factors influence the choice of a particular health promotion approach. However, the Russian Doll metaphor is certainly worth looking at in the nursing context.

It is also worth noting that the medical model and the educational model of health promotion are inconsistent with the ideological thrust of health promotion (Tones, 2001). This suggests that there might be an ideological form of health promotion, beyond the above approaches. An ideological sphere is assumed to be separate from the operational sphere of health promotion. The paradigm of health promotion may still exist but in the forms of its ideology and its operational sphere. Health promotion, in this sense, is truly a concept complex enough to cause confusion and debate if not clearly defined.

So far, the knowledge of health promotion and health education, and how these concepts impact on evaluating nurses' health promotion role, has been reviewed and discussed. However, how the paradigms of health promotion influence nurses has not yet been made clear, particularly, what approaches to health promotion have been taken by nurses and how health promotion and health education are associated in practice in hospital-based nursing are still insufficiently studied. These questions are essential to an understanding of what is the health promotion role of nurses.

2.2.3 Approaching the health promotion role

A few attempts, from different approaches, are made in the literature to look at nurses' health promotion role in hospital.

Attempts are made to reach a consensus of what the health promotion role for nurses is by using the Delphi technique. This technique requires experts in the field to assess and evaluate what health promotion is or what the health promotion role is. Davis (1995) applied this technique to designing a questionnaire that asked a group

of experts to answer the questions and try to arrive at a consensus on the basis of the experts' answers. Davis (1995) stated that the experts' position of seniority in the field may be considered a limitation of the study in that it could have affected getting honest responses from the nurses to the questionnaire. Whitehead's (2008) study, at an international scale, attempted to reach the expert-based consensus about health promotion and health education in nursing practice, education and policy. The participants in his study were the experts active in the field of health promotion. The study found that the experts shared an understanding of health promotion and health education consistent with "mainstream" knowledge. The experts also criticised nurses for not fulfilling the role if following their view of health promotion.

The studies by Davies (1995) and Whitehead (2008) obviously value the experts' view of nurses' health promotion role. It could be said that the health promotion role of nurses is conceptualized as seen from the top, with the experts defining it. The findings are not surprising in that the experts' opinion is close to the general conception of health promotion. This is to say that the experts' view of nurses' health promotion role is an idealized one. There is little consideration of the reality of health promotion for nurses, how it is actually practised in their working lives. Nor do the experts seem to notice how health promotion differs from nursing in terms of how it is talked and thought about.

Studies based on nurses' accounts of the health promotion role take two different approaches, according to which conceptual framework is applied. Casey's (2007a) study approaches hospital-based nurses' health promotion role via the Ottawa Charter's (WHO 1986) conceptual framework, which is used to identify nurses' use of health promotion methods. The Ottawa Charter (1986) itself emphasizes the principles and methods of health promotion, as summarised by Casey (2007a):

> Within the charter, five key principles which underpin health promotion are described: building healthy public policy, creating supportive environments, strengthening community action, development of personal skills and the reorientation of the health service. It also outlines three methods by which health can be promoted: advocacy, enablement and medication. (p. 581)

Casey (2007a) employed its concepts to identify and categorize hospital-based nurses' activities which are thought to be relevant to health promotion. Casey's study emphasizes how nursing practice could be labelled as health promotion in the

way it is defined in the Ottawa Charter. However, this depends not only on the wording of the Ottawa Charter itself, but also on the author's understanding of the WHO concepts since nurses' activities are interpreted in the language and thinking of health promotion rather than of nursing.

It is necessary to state that health promotion *practice* particularly refers to the activities relevant to health promotion. Health promotion practice is different from health promotion; the latter is a broad and inclusive concept with many different aspects while the former indicates behaviours engaged in as part of health promotion. As discussed above, the health promotion role may be viewed from two perspectives, from that of health promotion or from that of nursing. The different perspectives can lead to a very different understanding of nurses' health promotion role.

Regarding the language used, Hravnak (1998) states that it is difficult to determine from documents whether their concern is health promotion or not, due to the use of terms in the documents, although health promotion can be a foundation for nursing practice. Hravnak noted differences in language in the communications of health promotion and of nursing, specifically how nursing jobs were described. Although the literature has nothing to say about this, it may be hypothesized that these language differences involve differences in how nurses think about health promotion and nursing, and in the perspectives they take on these. The differences concern not merely the speaking of the language of health promotion but also the way of thinking about it. The difficulties concern the strategies of health promotion as well as their varied application, related to "patient needs, prioritization of needs during acute and critical illness, organization of the health care delivery system or agency, and the team approach to health care that is inherent to the inpatient settings" (Hravnak, 1998, p. 285). In all of this, there is a lack of consistency which accounts for the variation found in studies of nurses' health promotion role.

Berland et al.'s (1995) study takes a very different approach to the hospital-based nurses' world of health promotion. The study explores nurses' health promotion practice by compiling a list of concrete activities that nurses are carrying out in hospital nursing via group interviews. It is grounded in nurses' actual practice rather than starting from an existing concept of health promotion. It focuses on how nurses themselves construct their health promotion practice in the context of hospitals. Berland et al.'s (1995) study shed light on how health promotion is conducted in

nursing practice in hospital. The study's questionnaire explored nurses' health promotion practice by using the language nurses use in their work. This is a valuable attempt to explore this topic when there is generally little effort made to value the language of health promotion nurses use and the nurses' actual daily activities. Compared with Casey's (2007a) study, Berland et al.'s (1995) study is more specific and concrete being rooted in nursing activities and nurses' language. Casey's study on the other hand focuses on how nursing activities could be framed by the knowledge of health promotion.

Regarding research strategies, there are examples of both qualitative and quantitative studies on health promotion role to be found in the literature. A review of these studies shows how divergent the research strategies are in reporting what health promotion role is in hospital. Both Casey's and Berland's studies are good examples of this. Casey's study employs a qualitative strategy to approach the topic, while Berland's employs a questionnaire in a quantitative survey. Although having employed different strategies, the findings from both studies are similar in that they report what nurses could do for health promotion in hospital.

However, the analysis of why and how the health promotion role varies is due to the perspectives taken by the two studies. Casey's study is more critical of nurses since she judges the nurses' practice against the WHO standard, while Berland et al.'s study has sympathy for why and how nurses' practice in hospital is the way it is. However, even Berland et al. suggest that improvements in health promotion can be made by nurses employing the P-P model (discussed below). The value of Berland's contribution lies in their study speaking the language of nurses as well as speaking for nurses in terms of health promotion. Their attitude to the nurses' work matters more than their research strategies, let alone their conceptual or theoretical choices, since it orientates and defines their understanding of nurses' health promotion role.

The most important issue in approaching nurses' health promotion role is how a specific and concrete role is defined in the nursing context and in the hospital context. It must define how nurses understand, communicate and conduct health promotion in hospital. Berland et al.'s questionnaire approach has provided an effective and efficient tool to gain access to the world of nurses' health promotion role. The information gleaned should not be wasted; future studies should take note and use it as much as possible. However, there is a place for interviews, for tapping nurses'

insights qualitatively in order to serve local needs. Research methods are further discussed in Chapter Four.

2.3 Nurses' attitudes to health promotion

The investigation of nurses' attitudes towards health promotion is an important indicator for health promotion practice according to the literature. That how nurses have been prepared for a role in health promotion is reflected in their attitudes, beliefs, values and motivations (e.g. Berland et al., 1995; Casey, 2007b). Nurses' attitudes are perceived as the internal force responsible for nurses taking on a health promotion role. The concept of attitude, in this context, is used to measure how much nurses have accepted health promotion as a part of nursing.

Previous investigations show that the vast majority of nurses working within hospital or other institutional settings strongly believed health promotion to be one of the important roles in nursing nationally and internationally (e.g. Berland, 1995; Casey, 2007a, 2007b; McBride, 1994; Twinn & Lee, 1997; Whitehead, 2005). In fact, nurses were passionate about being involved in health promotion. The majority of nurses thought that they were ideally placed to deliver health education and health promotion to patients (McBride, 1994; Twinn & Lee, 1997). Further, Thomson and Kohli's (1997) study shows that nurses were not only interested in learning about health promotion but also willing to expand their practice in order to deliver health promotion. This suggests that nurses have acknowledged the importance and relevance of health promotion for nursing. Nurses also have expressed enthusiasm for supporting health promotion in their job.

However, interestingly, nurses actually could not tell the difference between health promotion and health education (Casey 2007a; Davis, 1995; Twinn & Lee, 1997). Frequently nurses could not even explain what health promotion is (Casey 2007a; Chamber & Narayanasamy, 2008). Thus, the question must be asked whether nurses actually understood the question, and what the health promotion role means for them. The concept of nurses' attitudes as explored in previous studies is vague as an indicator of the health promotion role. This calls into question the validity of previous studies investigating nurses' attitudes towards the health promotion role.

Generally speaking, attitude is a vague concept when used in behavioural science (Green & Kreuter, 1999), and it is difficult to measure (Cross, 2005). Findings of a positive attitude may only show that nurses have either potential and/or motivation for a health promotion role (Thomson & Kohli, 1997), rather than that a positive attitude leads to nurses carrying out a health promotion role. The problem of investigating nurses' attitudes has been recognized in several studies. Berland et al. (1995) made attempts to utilize the Precede-Proceed model to examine how nurses had been ready for health promotion. The Precede-Proceed model, designed by Green and Kreuter (1999), seeks to identify values, beliefs and knowledge, considered factors that predispose xyz to engage in particular behaviours of change of people regarding health promotion. Berland et al. (1995) noticed that the predisposing factors had multiple directions so that nurses' actual knowledge and their self-efficacy were defined as a solution to further specify the predisposing factors. Thomson and Kohli (1997) concurred that the nurses' attitudes to health promotion could have its motivational, cognitive and nominative dimensions, measurable by a Health Action Model (Tones et al., 1990):

> However, in the study the ways in which "cognitive factors" (knowledge and beliefs) and "motivational factors" (considering values, attitudes and drives) and pressures from social norms and significant others assisted in the understanding of the nurses' orientation to and beliefs about health promotion practice. (p. 507)

Therefore, it is important to further divide "nurses' attitudes" into sub-concepts to clarify this complex concept. This is an important step in increasing its validity and the trustworthiness of any findings concerning attitudes.

Clarifying the concept of attitudes is particularly important for studying nurses' health promotion role. In the literature it is noted that there are two ways of looking at nurses' attitudes to the health promotion role. In McBride's (1994) study, the "majority of hospital nurses felt *they should* take a leading role in the prevention of diseases in the community even though they are working in the hospital rather than primary settings" (p. 94). Nurses making such a statement suggests that a health promotion role is something they desire rather than a statement of what they do in their current job. This means that nurses' attitudes to health promotion are not necessarily highly related to their practice of health promotion. It more likely shows that nurses are interested in health promotion rather than that they actually are putting their interest into practice. However, Berland et al.'s (1995) study has been

designed to investigate nurses' actual involvement in health promotion by framing "health promotion is important for my role" in the questionnaire. This clear presentation in the questionnaire gives nurses a choice to face their current practice in hospital. It intends to clarify what nurses respond to: an objective expectation or a subjective one. Although the two studies examined nurses' attitudes to health promotion, having different emphases, their findings are not comparable.

The question to be asked is why do nurses not perceive their current practice as health promotion. It is hypothesized that nurses' understanding of the health promotion role might be ethical rather than practical, i.e. stating what is desirable rather than what is actually happening. A role incongruity related to nurses' perception of health promotion has been identified by Chamber and Narayanasamy's (2008) study. They questioned newly registered nurses in hospital about their health beliefs. Two opposing sets of health beliefs were recognised. The authors, using Mead's role theory (Mead, 1934), interpreted their responses as conflicting between "Me" and "I". When nurses described health and health promotion within a humanistic and holistic framework, they were the public "Me" as an object. Nurses delivered a "social script" which they had learned in their nursing education. However, nurses also maintained an individualistic account of health and health promotion, realized as private "I". Chambers and Narayanasamy (2008) argued that the private "I" account came from nurses' direct experiences of daily practice. This finding represents an important phenomenon: a division between what they felt nurses should do, and what they actually did do.

Chambers and Narayanasamy (2008) have argued that current nursing education has modified nurses' attitudes and values by artificially synthesising holistic health, from which nurses learned values and expected behaviours while they only experienced an individualistic view of health. Consequently, the authors argued that nursing education should help nurses to learn holistic health and translate it into practice. Irvine (2007) also found that nurses could speak the language of health promotion but might not understand what it is and how it applies to them in practice. That nurses have difficulty in describing what health promotion or the health promotion role is has been found by many studies in the literature (Casey, 2007b; Davis, 1999; Gott & O'Brien, 1990; Later, 1994; McBride, 1994; Treacy et al., 1996; Twinn & Lee, 1997; Whitehead, 2004). This implies that nurses have a conceptual

image of health promotion and their role in it but have scarcely thought this through in relation to their daily practice.

The external pressures on nurses' attitudes to the health promotion role could arise from multiple sources. McBride (1994) found that other professionals are encouraging nurses to take on a health promotion role in hospital. Compared with other health professionals in hospital, nurses appeared to be more motivated to incorporate health promotion into their practice (McBride, 1994). Thomson & Kohli (1997) also established that more than 90% of patients would like to have health promotion services in hospital. Perhaps such positive feedback from patients and other health professionals contributes to nurses expressing the view that they should be more active in health promotion. However, it is a very complicated task to devise a role for nurses in health promotion. Defining the normative health promotion role is not only relevant to patients and other health professionals but is also related to the discipline of nursing itself. For instance, if patients need health promotion related services, all health professionals ought to be responsible for it rather than singling out nurses as the ideal type of provider. A definition of nurses' health promotion role should, first of all, take into account nurses' views of the health promotion role.

2.4 Health promotion practice in hospital

In the literature, nurses' health promotion practice seems to be situated in two kinds of contexts. One context is provided by the Health-Promoting Hospitals (HPH) programme, where nurses are working as part of a team of cooperative professionals. HPH develops a systematic and coordinated approach to health promotion (Kemm & Close, 1995). The HPH programme aims to take every opportunity, no matter formal (planned) and informal, but also a whole environment to support and reinforce health promotion practice (Kemm & Close, 1995). The other context is one in which nurses practise health promotion without a significant framework, in other words, nurses provide a health promotion service in hospital guided by its nursing discipline. Without the HPH's support, nurses' health promotion practice is limited to the nursing arena. A significant difference between these two kinds of context, and thus two kinds of health promotion practice, is the degree to which nurses are involved in health promotion.

The HPH programme has been little emphasized in the NHS system, although there are authors with a UK background who encourage a move to HPH. Thus, the most relevant of the literature for this study is the review of nurses' health promotion practice with little HPH support. In this section, I will first provide a picture of what nurses' health promotion practice could be if set in a particular health promotion programme, i.e. one by HPH. This review also provides a backdrop against which to show how much nurses could contribute to health promotion when there is little structural and cultural support for it in hospital. The review and discussion focuses on the scope and content of nurses' health promotion practice in hospital. This is followed by a discussion of the important concept of empowerment and how this is currently approached in hospital. Finally, the extent of health promotion practice by nurses is examined, looking at how much nurses could do for health promotion in hospital, and what are the factors influencing their practice.

2.4.1 Health-promoting hospitals for nurses or vice versa?

Whitehead (2004), one of the most active writers on health promotion, provides a blueprint of the nurses' function and role in Health-promoting hospitals (HPH). He criticizes current hospitals for being conservative and reluctant to adapt to current HPH programme. His central thesis is that nurses should take the leadership roles in health promotion reform in hospital. In his view, nurses' traditional health education approach in hospital is not adequate for a new development of health promotion, a view that is the consequence of Whitehead radically interpreting health promotion as an inherently political activity which ignores the value of health education.

Smith and Cusack (2006), coming from a nursing perspective, strongly disagree with Whitehead. They argue that although nurses are in hospital in large numbers, their power base and capacity to make such a change to health promotion is very limited: "For nurses to be in a position to implement significant change within the hospital, they need to be both competent and confident in the areas of health promotion" (p. 23).

It is no surprise that Smith and Cusack (2006) argue that a new approach to health promotion is a radical health reform, and that the shift to health promotion in hospital needs "...organizational policy support that provides for adequate funding,

education and initiative development, staff support and assistance are require to realize the legitimize the nurses role in proactively undertaking health promotion" (p. 23). According to Smith & Cusack (2006), change in health promotion will not occur in hospital without support at every level of nursing management.

Although further development in health promotion seems to be ruled out, the above authors do raise the awareness of what has been neglected if nurses are to be required to carry out health promotion at a higher level in hospital. Also, they warn us to be realistic in thinking about what the health promotion role should be in the current hospital context, where there is little support of the HPH kind.

The idea of HPH directly follows from the Ottawa Charter's (WHO, 1986) definition of health promotion and its principles. One development strategy in health promotion is based on settings. Hospitals have been singled out for particular attention among four other settings in the Ottawa Charter: workplace, community, schools and home and family. Although hospitals may not play the major role in health promotion compared with communities, it is believed that hospitals fulfil an important role in initiating, evaluating and transferring health promotion projects (Mavor, 2001).

After years of development, HPH is now considered a connective, plausible, acceptable and feasible development concept (Pelikan et al., 2001). Based on continuous practice and experience internationally, the models and strategies of HPH have been transferred from pilot hospitals to other hospitals to find wider application. The standards used in HPH are based on the practice of nine European countries (Groene et al., 2005). Further details concerning the development of HPH are available in a numbers of publications. For example, Cummings et al. (2006) started a feasibility study in a Canadian tertiary hospital. The findings map out the opportunities for health promotion in hospital. The study suggests that emergency departments should use waiting time to screen patients for further health risks, especially common local health problems, such as drinking, substance abuse and smoking, as well as for cervical cancer, and carry out immunizations. The study demonstrates that there is great potential for health promotion in hospital being explored.

HPH redefines the function and role of hospitals, in fact, it reforms and changes hospitals fundamentally. Pelikan et al. (2001) and Aujoulat et al. (2001) further

detailed HPH as a process of interventions, which focus on several functions and settings of the hospital: a physical and social setting; a workplace; a provider of health care services; a setting for training, education and research; the development of a strategy for "healthy hospital organizations"; and an advocate and change agent for health promotion in its community. Apart from providing a general framework, HPH addresses specific local, regional and national needs, especially where management support and political support vary (Bakx, 2001). The HPH programme is systematic and holistic in its approach to health promotion practice at different levels of reform in hospital, and it is meant to change the traditional hospital services fundamentally.

Johnson and Baum (2001) emphasized that the essential component for successful HPH is strong organizational support at multiple levels. They argued that health policy and health promotion movements are influencing people who are interested in health promotion. An effective and efficient health promotion practice must have necessary aspects such as depending on social or organisational policy supports, health professionals' perceptions of it, a practical framework or model for practice, cooperation and resources. Therefore, an HPH programme actually needs strategic management to keep it well.

Regarding personnel, Pelikan et al. (2001) mentioned that HPH could involve any group of health professionals in the field:

> Health promoting hospitals is a concept for hospital development that was jointly developed by representatives of hospital professionals (owners, management, clinicians, nursing personnel and other professional groups), health promotion and organizational development experts, as well as national and international European health policy players. (p. 239)

The cooperation of multiple disciplines in health promotion is highly valued in the HPH programme. On the one hand this clearly shows that HPH is not a nurses' mission alone, but on the other, it shows that it would be very difficult if not impossible for nurses to put forward the idea of HPH from their current power base and with current capacity, as argued by Smith and Cusack (2006).

The potential problems of nurses engaging in health promotion has been identified in Robinson and Hill's (1998) work which discussed the idea of creating a "health promoting nurse" in the UK. They confirmed the necessity of adopting "a truly

holistic approach to promoting health" and recognizing the "wider socio-economic determinates of the health of the individual whilst valuing and maintaining the individual autonomy at the core of practice" in promoting health (p. 237). However, the authors identified three obstacles to creating a health promoting nurse: the dominance of an individualistic philosophy of nursing, nurses' own perspectives of their role, and the hospital and community division. Ultimately they conceded that there are fundamental problems with the idea of "health promoting nurses" in hospital.

The largest contribution of the HPH programme is to provide an essential concept of health promotion in practice. A significant characteristic of HPH is that it is highly dependent on systematic reform and transformation from the traditional model of hospitals at every level. HPH is about creating a culture of health promotion in hospital and beyond, which is essential to enable health professionals, including nurses in hospital, to promote health. This implies that something is missing in the nursing literature in which nurses are encouraged to move forward to engage in health promotion with little awareness of the breadth and depth of health promotion.

2.4.2 Health promotion practice: scope and content

Nurses' health promotion practice is widely criticized for its scope and content. Thompson & Kohli (1997) express a commonly held view of nurses' health promotion practice in hospital:

> Fulfilling this role for professionals in hospital may seem a somewhat daunting prospect, despite the view that health promotion in hospital is not a new concept. (p. 509)

The perspective of health promotion follows the contemporary view of health promotion in the literature. It is this contemporary view of health promotion that nurses found difficult to fulfil. It is not the case that nurses have little to contribute to health promotion; it is merely assumed by researchers that their practice has not reached the level of what they consider constitutes proper health promotion.

Nurses' actual health promotion practice is usually carried out at an individual level. Davis (1995, p. 955) states that nurses could "identify their role in health promotion

as covering the same area as health education, with the addition of raising awareness, promoting self-esteem and being an effective role model". However, nurses rarely conducted health promotion activities such as policy making and increasing environmental awareness (Davis, 1995) and community involvement (Berland et al., 1995). There is little sign of empowerment and client-centredness in nursing practice so far in hospital (Casey, 2007a). Usually, nurses' health promotion practices take place at an individualistic level and follow a health education approach.

This is the opposite of functioning at a social-political level or taking up a new paradigm approach to health promotion. The impacts of the two paradigm debates on conceptualizing nurses' role in health promotion have been reviewed above. Here, it is necessary to restate that the social-political view of health promotion could devalue nurses' current health education approach which may be narrower but is nevertheless important in terms of the scope and content of nursing practice.

The focus of health promotion practice in hospital is on taking care of patients and dealing with their illness. Studies frequently report that health promotion practice in hospital is related to illness or constituted of disease-oriented activities (Davis, 1995; Gott & O'Brien, 1990; Clark et al., 1992; Jones, 1993; Twinn & Lee, 1997). It has been characterized as individualistic and concerned with the prescriptive delivery of knowledge and information about illness and lifestyle factors that are detrimental to health (Casey, 2007a; Latter, et al., 1992; Thomson & Kohli, 1997; Twinn & Lee, 1997). Casey (2007a) also claims that information delivered by nurses is related to patients' present conditions. The topics of health promotion practice could be much more specific and local in hospital. Health promotion includes advice to patients about post-myocardial infarction, asthma, diabetes, infection risk and the topic of breast awareness (Thompson & Kohli, 1997). This range gives the impression that although the topics of health promotion practice are diverse, they are strongly related to the needs in particular nursing contexts.

More frequently, health promotion practice in hospital refers to risk factors that are part of individual lifestyle. Berland et al. (1995) found that the vast majority of nurses supported the idea that adopting a healthy lifestyle is an important topic for patient education activities. Healthy lifestyle issues could be subcategorised into specific topics. Johnston (1988) lists alcohol and tobacco consumption, diet and weight issues as topics for health education. In a study carried out in Scotland,

nurses can provide a range of answers to questions concerning issues of healthy lifestyle (Thompson & Kohli, 1997). Thompson and Kohli (1997) found that most nurses include nutrition/diet, smoking, physical activity/mobilization of patients among topics for promoting healthy lifestyle.

The content of health promotion practice may be constituted by two main topics in hospital: illness-related care and promotion of a healthy lifestyle. However, the specific topics are diverse and various, subject to particular contexts or cases. This suggests that listing all specific health promotion activities occurring in nursing practice will be difficult. The solution adopted by previous studies is to list categories of health promotion practice. Casey (2007a) identified the emerging strategies used by nurses as "the giving of information and explanation, telling the patients, mediating for the patient and allocating responsibility for health promotion to others by referring patients to the dressing nurse specialist and the diabetic nurse specialist" (p. 585). Casey's findings are oriented towards WHO's (1986) classifications of health promotion methods to see how they match with "enabling" and "mediation". Casey condensed these strategies into "encouragement, giving explanations/information and instructing or telling patients" (p. 587). Grounded in nurses' experiences, Berland et al.'s (1995) study listed health promotion activities as they are communicated in practice: comforting patients and their families or caregivers, teaching patients self-care, discharge planning, teaching about disease processes, encouraging patients to be involved in their own care and advocating for themselves. The listed strategies imply that the attempts to categorize health promotion activities are very likely related to the ways of conceptualizing nurses' health promotion role.

There are two themes constantly repeated in previous studies: information delivery and patient education in hospital (Casey, 2007a; Clark et al., 1992; Davis, 1995; Gott & O'Brien 1990; Thomson & Kohli, 1997; Twinn & Lee, 1997). Tones (2004) regards information delivery and patient education as "two broad paths" in health education practice. Information delivery is the preventative approach of health education which seeks to achieve behavioural change by means of applying psychological theories/models, e.g. health belief model, social cognitive theory (Tones & Green, 2004). Patient education as the educational approach is "in tune with progressive educational philosophy to enable people to make informed choices" (Tones & Green, 2004, p. 14). Information delivery and patient education

are both important and essential components of nurses' health promotion practice in hospital.

Interestingly, the two themes of or approaches to health education, namely information delivery and patient education, are identified to be correlated in nursing practice (Casey, 2007a). Latter et al. (1992) found that although health education practice had been categorized as falling into five areas, i.e., patient education, information-giving, healthy lifestyle advice, encouraging patient and family participation, they are all positively correlated. However, the first two categories are significantly correlated and the activities are conducted in hospital more frequently than others. Piper (2007) identified nurses as "informers" when analysing the nurses' accounts of health promotion. He finds that while nurses may follow different approaches or methods, even have different aims and produce different outcomes under each of these categories, finally it is informing that is the most essential practice carried out by nurses in hospital. This is to say that although there may be different approaches followed in the delivery of health promotion and health promotion may even have different goals, in hospital nurses are fundamentally informers. While this may imply an important division in approaches between information delivery and patient education, these are not mutually exclusive. However, the complexity of the relation between patient education and information delivery in nursing practice has not been further pursued in the above studies.

The discussion of information delivery in some studies suggests that information delivery is a matter of degree. Twinn and Lee (1997) found that nurses in their study delivered "preparatory information" only to patients, such as before surgery. Davis (1995), however, described nurses' practice as having a sense of patient education by providing knowledge and information or teaching in hospital. Similarly, Casey (2007a) found that nurses sometimes made a specific time to provide detailed information to patients but without setting goals and/or conducting an evaluation of patients' learning. Casey (2007a) argues that this is not patient education, since the latter is part of a formal process of health education yet nurses rarely follow a planned education process in hospital. Information delivery, in nursing practice, can vary in degree, from mere "preparatory information" to a simple version of patient education. This implies that there is continuity between information delivery and patient education in the implementation of the health education approach. Perhaps both information delivery and patient education are concerned with providing

information to patients in order to raise awareness and for patients to learn to gain control of their health. In other words, information delivery and patient education have the same goal, achieved by informing patients.

2.4.3 Issues of empowerment

The concept of empowerment has been the central component of health promotion since the inception of WHO's (1986) "emphasis on individuals gaining control over their lives and health and on the importance of active participating communities" (Green & Tones, 2010, p. 38). Empowerment is the essence of nurses' health promotion practice. Empowerment can be defined as being of terminal value and/or of instrumental value. As an instrumental value, it is a means to achieve (positive) health (Green & Tones, 2010); as a terminal value, empowerment is synonymous with positive health and that "to be healthy is to be empowered!", as argued by Tones (2004, p. 10). Empowerment represents the value and the goal of health promotion. The conceptualization of empowerment leads to an important concern for this study, namely, what is meant by empowerment in nursing practice and how is it contextualised in nursing practice.

In the hospital nursing context, McBride (1994) has noted an inconsistency in nurses' health promotion practice in terms of empowering or controlling patients. The source of inconsistency has been identified as two different models which lead to various practice formats and relationships between nurse and patient. On the one hand, nurses have acknowledged patients' right to make choices or decisions concerning their health. On the other hand, nurses have tended to ban unhealthy behaviours without considering patients' choices. Importantly, McBride also observed that nurses do not appear to operate exclusively within one model but tend to move from one to another. However, McBride viewed this inconsistency as a potential problem for nursing practice, and she believed that if there is no unified approach, health promotion may never be consistent and will cause confusion for the patients. In this view, empowerment is perceived as a model of health promotion, and the two co-existent models of health promotion in nursing practice, empowerment or control, are not supported by the author. With this perspective, McBride actually missed the chance to explain the complexity of the issue of empowerment in nursing practice.

Casey's (2007a) study, a non-participatory observational study, examined the concept of empowerment in nursing practice by looking at patient participation. She found that nurses understood the notion of empowerment; however, nurses' practice has not shown the intention to empower patients. Casey (2007a) observed the exclusion of the patient as:

> ...nurses were observed "doing to" the patient, without engaging the patient in any verbal interaction, or chatting among themselves, ignoring the patient, while simultaneously carrying out a nursing task. (p. 588)

Casey identified a "top-down" approach in nurses' health promotion practice, including a kind of information giving that does not allow patients' participation in the plan of nursing activities. In practice, nurses quite often ignore patients' choices. Casey's finding confirms Twinn and Lee's (1997) study which also found that patients' involvement in health promotion in hospital has been "passive".

The concepts of empowerment have been examined by looking at patients' choices (e.g. McBride, 1994) or patients' participation (e.g. Casey, 2007a). Both concepts pertain to the relationship between nurse and patient, i.e. how they interact in terms of health promotion. A more detailed investigation of the interaction in health promotion practice was conducted by Piper (2007). By analysing nurses' accounts, two sub-themes of health promotion practice were identified in an acute NHS hospital setting in the UK: "behavioural change" and "empowerment". Piper perceived them as two approaches underlined by deviant paradigms, involving different aims, methods, relations between nurses and patients, and outcomes. Behavioural change is "top-down" and "expert directed"; it derives power from biomedical research highlighting the relationship between disease, risk factors and lifestyle and control of the latter. Empowerment emphasises patient control and choice, which takes a "bottom-up" approach, unlike "behavioural change". Piper located empowerment at both the individual and the community level. Empowerment can be further divided into strategic practice and advocacy, the former being concerned with operational issues at a hospital and departmental level, and the latter with the patient population at a community level.

Piper's study makes a real contribution to the understanding of empowerment in nursing practice since the category in the study is much more sophisticated than it is in previous studies. However, it is worth noting that Piper analysed nurses' accounts

for their relevance with regard to theory, language and practice. Piper's study does not make it clear whether the category of empowerment is from the author's theoretical sensitivities or nurses' own awareness of different approaches and sub-approaches. Piper did mention that the theory of empowerment was not much applied in nursing practice. It seems that the category of empowerment very likely occurs in nurses' language which appears to be theoretically oriented. However, the finding from Casey's non-participatory observational study focuses on the practice of empowerment by nurses. Thus, Piper's finding is inconsistent with Casey's finding that nurses usually subscribed to the notion of empowerment in theory rather than in practice.

One consensual character of the above studies is that empowerment is equated with health promotion. Empowerment is thus recognized for its instrumental value rather than for its terminal value. Only the empowerment model has been recognized as the proper one for health promotion practice. This perspective of empowerment ignores the existence of other approaches or models in health promotion. As a result, Brown and Piper (1997) argue that nurses should abandon the medical integration of health and narrow individualistic lifestyle advice. While different models exist, health promotion aims to follow an empowerment model (Green & Tones, 2010). The findings of previous studies have led to the concern that there are degrees of empowerment found among the approaches to health promotion in hospital. This has not been fully recognised in the literature.

In terms of gaining health, Piper's (2007) notion of a power continuum is helpful to explain the relationship between empowerment and control in different models or approaches. In Piper's (2007) study, behavioural change with its top-down approach involves a lesser degree of empowerment, while the bottom-up approach of empowerment involves a higher degree of empowerment. This resonates with the idea of degrees of empowerment in health promotion; the empowerment model is at the highest level of the empowerment spectrum (Green & Tones, 2010). However, behavioural change is more popular and formal in hospital. In nurses' accounts empowerment is used opportunistically and is less commonly applied in hospital as it is not always relevant to patients in hospital. This suggests that empowerment and its model are relatively less commonly applied in the hospital context. Nurses tend to be more controlling than empowering of patients, which suggests that there is an unequal power relationship between nurse and patient in hospital.

Thompson and Kohli (1997) argue that in the hospital environment it is difficult for nurses to empower patients. To do this would require hospitals to move from disease to health, and nurses would have to strive for a creative environment in which to develop a different kind of nurse-patient relationship. This would lead to a "dual role" for nurses, handling disease prevention and health promotion separately. This issue seems to have already been recognized as a problem in nurses' philosophy of health by Smith et al. (1999). They found that there are multiple philosophies or values of nursing: disease, care and health promotion. In following these different values and approaches, nurses fail to be clear as to what nursing is and how it is related to health promotion in hospital (Smith et al., 1999).

According to the publications reviewed, the scope of nurses' health promotion practice covers both secondary and primary levels of preventive interventions. The latter is concerned with prevention of disease by reducing exposure to risk factors, behaviourally and environmentally (Green & Tones, 2010). But, both levels of preventive interventions fit in with the general philosophy of care underpinning nursing practice in hospital, which is based on the medical model (Robinson & Hill, 1998). It is logically consistent that nurses in hospital seem to have the power to control their practice under the medical approach. Casey (2007a) supports the view that the tradition of nursing, based in a medical model, hinders the development of health promotion. Besides, the fact that current nursing is task-oriented, where nurses focus on complete tasks, carried out in a highly routine manner, is not designed to advance the development of health promotion. As Casey states, while nursing routine perhaps guarantees the smooth running of a ward, ensuring compliance and order, it hinders empowerment and autonomy in health promotion. In the current context of nursing, the practice of health promotion is unfair, and it challenges current power structures.

Structural factors are important for empowerment (Green & Tones, 2010). McBride (1994) noted that empowering people gives them important choices, and a facilitative environment and enabling framework are essential for change. Laverack (2004) suggests the concept of community empowerment in health promotion include community and empowerment as two conceptual components of health promotion. This suggests the importance of recognizing the community of health promotion, in which community refers to area, relationship ties and the interaction within community. The establishment of community organizations is a crucial step

in the process of community empowerment and it is at this point that "individuals can develop the necessary skills in resource mobilization, leadership, problem assessment and critical awareness" (Laverack, 2004, pp. 47-48).

Chambers and Thompson (2009), writing about how to think and use the concept of empowerment, identified two types of nurses in hospital: Type I being the divergent thinker and Type II the convergent thinker. It is a very interesting finding that the Type II nurses are not conscious of their power-over patients; their nursing is medically-oriented nursing. Further, Chamber and Thompson (2008) argued that the medical model has symbolic power, which hinders the use of the holistic approach as well as empowering. Medical concepts and the medical way of thinking are deeply rooted in the medical model; nurses' understanding of choice and empowerment has been corrupted by the clinical environment and the medical concepts to which they are exposed, and clinical practice thus has a powerful influence on nurses' understanding of empowerment. It is assumed that the success of empowering depends on healthcare education programmers, and nurses' continuous practical training beyond initial registration.

Fulton (1997) conducted a study exploring nurses' views on empowerment, finding that nurses showed sensitivity and insight into the empowerment of others. Empowerment was identified as both a process and an outcome, which includes decision-making, choice and authority. Fulton found that the nurses were oppressed and striving for their own empowerment. Fulton's study was not intended to answer the question whether nurses had not been adequately empowered; however, if there were not, then empowering their patients as part of health promotion would be a problem. However, Chamber and Thompson (2009) argue that empowerment is an enabling process in which empowering a nurse gives power to patient; however, the danger is that the nurse remains in control and defines the terms of the interaction between nurse and patient. Empowering nurses may be viewed as a danger that nurses gain power over patients, thus disempowering patients. The empowerment of nurses and patients in the context of health promotion, and perhaps the wider context of nursing, is a complex concept awaiting further study.

The above review of the nursing literature on the topic of empowerment leads to a number of conclusions. First of all, it is very necessary to clarify whether the concept of empowerment is of terminal or instrumental value. This would help to identify the

latter as a model for health promotion in specific contexts, and the former as its final goal. The medical model, although it is unlike the empower model, is worthy to be recognized of being one of ways reaching the terminal value of empowerment. In this sense, empowerment indeed has two kinds of meanings and understandings which should be clarified in this present study in order to avoid the confusion surrounding health promotion practice. Finally, based on the review of the literature, the relation between the medical model and the empowerment model is a significant aspect of nursing practice, worthy of study.

2.4.4 Extent of health promotion practice in hospital

What nurses can and can not do as part of health promotion in hospital, based on the findings of the empirical studies discussed above, suggests that there is a limit to how much health promotion practice could be conducted within the context of hospital nursing. It is necessary to discover what restrains its range and to discuss the possibility of extending health promotion practice in hospital.

The literature review revealed that the factors influencing health promotion practice can be presented in various ways due to the diversity and complexity of the conceptualization of health promotion. It seems that the three main themes that have been consistently and frequently discussed relate to the extent of health promotion practice: the nurses' competency in health promotion practice, the opportunity in hospital for health promotion and the working environment for health promotion. These three themes are not mutually exclusive; rather, they are connected, more or less. Which factors influence each of the three themes and how they work together to influence health promotion practice is discussed below.

Regarding nurses' competency, research found that hospital-based nurses do not feel confident enough to be working in health promotion. Thompson and Kohli (1997) found that nurses in hospital expressed needs for training in health promotion, demanding it in fact, since they felt a lack of knowledge and skills related to it. It was also found that the lack in knowledge and skills inhibited nurses' morale, and willingness and ability to carry out a health promotion role (Casey, 2007b; Thomson & Kohli, 1997). However, only a few studies actually specified what knowledge and skills were required to carry out this role. Nobel (1991) and Jones (1993) argued that

communication skills and interpersonal skills are essential for nurses' health promotion practice. In most cases, nurses' lack of knowledge and skills is attributed to inadequate nursing education. Nursing education is emphasized for its potential role in improving nurses' capacity and confidence to conduct health promotion (Casey, 2007b; Gott & O'Brien, 1990; Latter, et al., 1992; McBride, 1994; Thompson & Kohli, 1997).

However, Berland et al. (1995) reported that nurses' actual knowledge and their self-efficacy were adequate for their current health promotion practice. This raises an important question, namely what competency refers to in the literature. It is very possible that nurses' competency is sufficient for the current practice but it is difficult for nurses to go any further in terms of health promotion in hospital. This means that the evaluation of nurses' competency in delivering health promotion is relevant to how health promotion is interpreted. It is likely that nurses' self-evaluation of their knowledge and skills might be related to their own perception of health promotion. If so, then nurses' awareness of their competency can be related to the important question of what health promotion is or should be. If nurses have a higher expectation of their practice than what they can do currently, their self-evaluation of their competency and efficacy in delivering health promotion could be lower than is warranted, and nurses' demands for training in health promotion could accordingly be greater.

Whitehead (2009) found that nurses certainly regarded health promotion as their role but were unsure how to carry it out. This is particularly obvious in the case of newly graduated nurses who had good knowledge of theory but had had little chance to develop their skills in health promotion. Benson and Latter (1998) suggested that the teaching of interpersonal skills in health promotion within the nursing curriculum was crucial in enabling the transfer of theoretical concepts into practice. In other words, work experiences, especially clinical ones, are reported to be important for developing understanding and skills for health promotion practice. Latter et al. (1992) found that senior nurses were good at understanding health education and its meaning in practice. It is interesting to see that junior nurses are prepared with advanced concepts but senior nurses with their clinical background experiences are better at practising health promotion in hospital. In Berland et al.'s (1995) study, nurses also emphasize that training in clinics is essential for improving health promotion practice in hospital. Thompson and Kohli (1997) confirm that being more

involved in health promotion practice would make nurses more aware of it in hospital. However, training and learning in the clinical context may be difficult, if there is a lack of opportunity to learn how to integrate health promotion into nursing, as reported in the literature.

Opportunities for health promotion could be identified as arising when nurses are about to undertake, or are in the process of undertaking, a nursing task with a patient (Casey, 2007a; Twinn & Lee, 1997). Twinn and Lee (1997) also recognized that the opportunities for health education are varied in the wards, ranging in terms of occasion and length of time. The admission procedure is believed to be the most frequent opportunity for health promotion delivery (Casey 2007a; McBride, 1994; Twinn & Lee, 1997). Activities around surgery (Twinn & Lee, 1997) and discharge planning (Berland et al., 1995; Twinn & Lee, 1997) are recognized as good opportunities for health promotion.

However, in practice, it is reported that nurses seem to have missed opportunities for health education and health promotion practice (Casey, 2007a; Jones, 1993; Twinn & Lee, 1997). Both Jones (1993) and Casey (2007a) found that nurses seemed to be more interested in filling in forms than in helping patients solve health problems so that many golden opportunities were missed. Patients' needs were frequently overlooked because nurses did not properly use the available opportunities for health promotion (Jones, 1993). Casey (2007a) found that nurses collected a lot of information but had not used this information for improving health promotion. Casey (2007a) argued that it is the current standardized admission forms that stimulate nurses' habit of "ticking the boxes". This makes nurses only focus on the tasks required on the forms but not on health promotion. This result supports an early study by Noble (1991) which stated that nurses were locked into routine practice, and that it was difficult for ideas about health education to find their way onto the nurses' agenda. Noble (1991) argued that it is vital that nurses can identify the moment for teaching.

For nurses, health promotion, compared with other nursing activities, is not a priority, something frequently reported in the literature. It is a fact that the priority in hospital is still disease prevention and medical treatment. Berland et al. (1995) quote nurses' complaint that health promotion is the "low-hanging fruit" which has not been noticed. Casey (2007a) describes the current health promotion practice by nurses in

hospital as a sporadic activity. Health promotion practice is an optional extra "added on" when nurses have time for it (Casey, 2007b). This is the opposite of other nursing activities which are routinely and reliably conducted by nurses in hospital. By being opportunistic, health promotion practice indeed depends on when nurses have time for it. Health promotion in this manner is casually conducted, and with a lack of considering its effectiveness and efficiency.

There is also a view put that there could be benefits from opportunistic health promotion because it is cheap and chances could be found for it in busy hospitals (Naidoo & Will, 1998). Health promotion and health education are not necessarily formal procedures. Maben and Clark (1995) believe that any event between client and health professional has the potential to be health promotion, either by information giving or educating. Gott and O'Brien (1990) have a sophisticated view: there is some health promotion in the traditional areas of nursing but others carry it out amid developing and changing frameworks and contexts for health promotion practice. This implies that there are different ways of looking at how health promotion should be conducted. It is also possible that there is more than one way of health promotion being conducted by nurses in hospital.

The desire for a better health promotion practice has frequently run into the criticism that the current working environment is not up to it. The findings from previous studies suggest that there are many barriers to further advancing health promotion practice in hospital. Lack of time is the main barrier reported by many studies, correlated with a lack of staff and a lack of resources. Casey (2007a) presumed that the hospital structure, focused on the geography of the ward, or the duty roster, with patients transferring to different wards, would be a barrier to health promotion. This feature of the hospital working environment seems to break the continuity of health promotion considered to be important for an effective and realistic health promotion practice. In addition, the lack of feedback leads to no or less effectiveness of practice (Casey, 2007a). However, before criticizing the current working environment, two important questions should be asked: whether health promotion, in a form expected by either researchers or nurses, is suitable for hospitals or not.

McBride (1994) calls for a facilitative environment and an enabling framework as essential components for change. A ward philosophy or management supportive of health promotion plays a crucial role in facilitating nurses' involvement in health

promotion practice, as argued by Casey (2007a). It is hard to have a cultural ethos of health promotion in hospital (Clark et al., 1992; Latter et al., 1993; Thompson & Kohli, 1997). Thompson and Kohli (1997) find that the ethos of health promotion in the working environment appears to be associated with nurses' belief in health promotion. The ethos of health promotion also seems to increase nurses' awareness of health promotion practice in hospital (Thompson & Kohli, 1997). In terms of philosophy or cultural ethos for health promotion there is never easy an answer. Laverack (2004, p. 55) suggests that a "flattering organizational hierarchy is a prerequisite to an organization culturally supportive of an empowering health promotion practice, since hierarchy brings with it the greater exercise of power-over". The possibility of changing the structure of the nursing context of hospitals exists via a movement such as HPH. However, the effort to be made and the costs this entails are not for nurses alone to bear, and the change necessary for a wider sense of health promotion practice is not limited to the nursing context.

2.5 Reflections on Precede-Proceed model

It was argued above that Berland et al.'s (1995) study makes an important contribution to an understanding of hospital-based nurses' role in health promotion. Its research approach, using a survey questionnaire, is appreciated for its way of examining the health promotion role, as is the Precede-Proceed model (P-P model) used, which has framed the data collection and analysis of Berland et al.'s (1995) study. This section discusses the advantages and disadvantages of the P-P model for studying nurses' behaviours in health promotion. It aims to provide a justification for using the P-P model in the present study. The discussion is also necessary to provide a reference point for the use of Berland et al.'s (1995) questionnaire in this study.

According to the studies reviewed, nurses generally do not "consciously" use a model in health promotion practice in hospital; they usually practise health promotion casually and spontaneously. Consequently there is no clear picture of how to implement health promotion guided by particular models. Perhaps, introducing a health promotion model helps us to understand how health promotion practice could be structured under a planned framework. In particular, this section examines the P-P model for the following aspects: what it is about and how it helps

to organize a plan for health promotion practice; and more importantly, how to apply the P-P model to study nurses' health promotion practice.

2.5.1 Introduction to Precede-Proceed model

Health promotion can involve wide-ranging strategies and activities as it responds to the multiple and interwoven determinants of health (Tones & Green, 2004). A well-planned intervention is more likely to be effective in health promotion (Green & Tones, 2010), and the Precede-Proceed model is one of the best known models for planning health promotion.

The P-P model is composed of two components or sub-models. "Precede" stands for "predisposing, reinforcing, and enabling constructs in educational/ecological diagnosis and evaluation" (Green & Kreuter, 1999). The process of "Precede" is designed to diagnose the factors influencing health-related behaviours:

> Predisposing factors are antecedents to behavior that provide the rationale or motivation for the behavior. Enabling factors are antecedents to behavior that allow a motivation to be realized. Reinforcing factors are factors following a behavior that provide the continuing reward or incentive for the persistence or repetition of the behavior. (p. 153)

"Proceed" refers to a process of planning and implementing the interventions representing the "policy, regulatory, and organisational constructs in educational and environmental development" (Green & Kreuter, 1999). Thus, the P-P model is composed of both environmental and behavioural risk factors of health. In practice, "Precede" and "Proceed" work in tandem from assessment to implementation (Green & Kreuter, 1999). First of all, the factors influencing health and health behaviours are assessed and diagnosed via the process of the "Precede". Then, this is followed up by "Proceed", with implementation and evaluation in response to the results of the assessment. This means that the priorities identified in "Precede" are also the goals in the process of "Proceed". In simpler terms, "Precede" and "Proceed" consider the same conceptual elements but work in different directions as well as serving different purposes in health promotion practice.

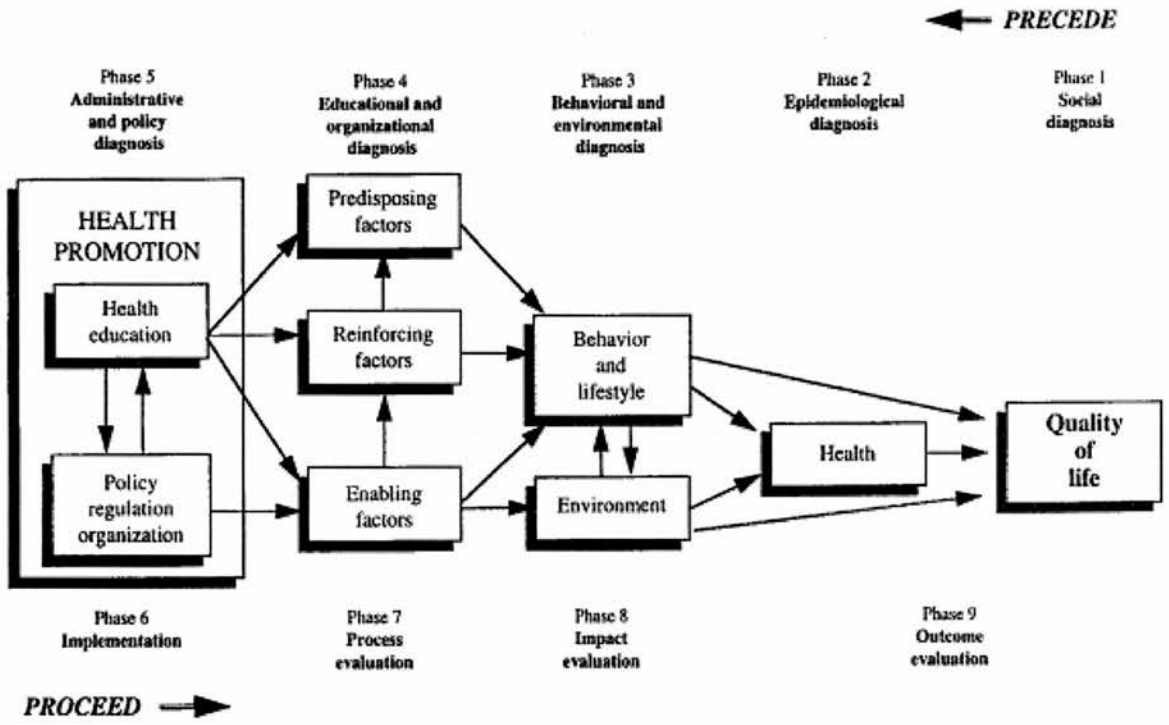

Figure 2.1 Precede-Proceed Model of Health Promotion Planning (adopted from Shakeshaft & Frankish, 2003, p. 71)

"Precede" - the first five phases **Phase 1** – Social Assessment **Phase 2** – Epidemiological Assessment **Phase 3** – Behavioural and Environmental Assessment **Phase 4** – Educational and Ecological Assessment **Phase 5** – Administrative and Policy Assessment	**"Proceed"** - the second four phases **Phase 6** – Implementation **Phase 7** – Process Evaluation **Phase 8** – Impact Evaluation **Phase 9** – Outcome Evaluation

The P-P model attempts to include any relevant activity or intervention of health promotion under its two broad titles: the educational and ecological supports. The "educational supports" refer to the health education approach, which is "any combination of learning experiences designed to facilitate voluntary actions conducive to health" (Green & Kreuter, 1999, p.27). The "ecological supports" have been defined as "the social, political, economic, organisational, policy, regulatory and other environmental circumstances interaction with behaviour in affecting health" (Green & Kreuter, 1999, p.27). The adequate ecological and educational supports empower individuals, groups or communities so that they can continue to exercise their own control over the determinants of their health. Health promotion in this perspective is a strategy of intervention and support to promote better health for the population (Green & Kreuter, 1999), which could be summarized as:

> ...the combination of educational and ecological supports for actions and conditions of living conducive to health. Combination refers to the necessity of matching the multiple determinants of health with multiple interventions or sources of support." (p. 27)

The combination of educational and ecological factors in one conceptual framework is a central feature of the P-P model. Rather than singling out one aspect, it values both approaches of health promotion, the health educational approach and the socio-political approach in evaluating and improving the quality of health. Neither holism nor individualism is over-emphasised in the P-P model since it focuses on being useful in the practice of health promotion, more than the debates in the paradigms of health promotion. In the P-P model individual behaviours and social-political impacts are not in conflict but are both factors influencing health and quality of life in different contexts. It is by combination of educational and ecological supports for heath promotion that the P-P model has managed to avoid the paradigm conflicts of health promotion, conceptually and theoretically. In the P-P model, the two approaches are part of one conceptual framework, but at different levels of the management of health issues. This highlights the individual risk factors of health and behavioural changes, and the notion of empowerment is also well presented in the P-P model in which the task of health promotion is to intervene and give support to individuals, groups or communities to achieve health gains.

In application, the P-P model is indeed a very flexible model, compatible with many fields. According to a survey in Australia, the P-P model is the most frequently used health promotion model (Jones & Donovan, 2004). It is a highly practical and easily used model, capable of framing both problems and solutions. The P-P model has been applied in effectively solving health problems, for example, fat intake behaviours of low-income mothers (Chang et al., 2004) and in carrying out macro-level, environmental health promotion interventions (Kegler & Miner, 2004).

2.5.2 Precede-Proceed model for analysing practitioners' behaviours?

There is another kind of application of the P-P model, which is to examine practitioners' behaviour. Berland et al. (1995) used the P-P model to design a questionnaire to study nurses' health promotion practice. The model provided a convenient classification for grouping specific influences on health promotion practice under broader rubrics: predisposing factors, enabling factors and reinforcing factors, under which headings nurses' values and beliefs, knowledge and practice of health promotion were collected and analysed. Green and Kreuter, the authors of the P-P model, confirmed the eligibility of the model for assessing nurses' practice of health promotion to Berland. Since the P-P model is based on theories from the cognitive and behavioural sciences, it is likely to find application beyond health promotion practitioners' behaviours (Green & Kreuter, 1999). For example, Bian and Smith (2006) used the P-P model to study particular dental procedures associated with obstructive sleep apnoea care. The model was used to measure dentists' knowledge, opinions, educational resources, physician cooperation and clinical practice.

Perhaps, the potentially wide of application of the P-P model is the result of having a generic conceptual framework rather than a specific one. Information is input from the assessment of particular situations in which the specific issues are addressed determined by local needs. It is thus not necessary for the P-P model to be limited to health and health promotion related behaviours.

> The classification of predisposing, enabling and reinforcing determinants of behaviours offers a broad framework within which one can organize more specific theories and research. (Green & Kreuter, 1999, p. 154)

As a generic model, different meanings may be attributed to the factors of the model (Green & Tones, 2010). This is its strength, allowing for the idea of health and/or health promotion meaning different things to different people, including for the health promotion role of nurses. For example, Berland et al.'s (1995) study categorises enabling factors of health promotion practice as teamwork, time, written records, continuity of care and consistency of patient teaching, based on the analysis of the interview data from hospital-based nurses. This means that the enabling factors can be specified by looking at the local contexts.

However, being generic, the P-P model also seems to have its problems in the application. Berland et al. (1995) found that the reinforcing factors in their study were not consistent across a whole unit in the analysis. However, they failed to explain the cause of this lack of consistency; rather, they carefully interpreted their findings as a solution to the inconsistency problem. Bian and Smith (2006) had met a similar problem; they argued that the reinforcing factors blur boundaries between predisposing and enabling factors because they not only strengthen present behaviours but reinforce the search for future resources and motivation to improve the performance of the behaviour. This implies that the contents of reinforcing factors could be specific and varied in different situations. For instance, the priority of reinforcement for individuals' behaviours would be ranked differently, with some factors assigning great importance to one issue while others ignore it. According to their study, it seems to be a better solution to define and evaluate each of the reinforcing factors separately, rather than as a whole group. This means that the subcategories or constructs of reinforcing factors need to be explored by evidence-based research that is specific to particular context.

It is worth noting that the P-P model aims to pursue the "perfection" of behavioural outcomes (Green & Kreuter, 1999). The model begins with a desired goal and then seeks to identify the influencing factors to achieve it. This means that the behavioural outcomes are the emphasis in the process of the P-P model but not the inputs of health promotion interventions. The model mainly helps planners to begin the planning process with the desired outcomes and work backwards to determine what causes them, and what precedes the outcome. When the P-P model

is applied in examining practitioners' behaviours, the model would assess and then set up a desired goal and the changes necessary to achieve it.

In its application, MacDonald and Green (2001) experienced the P-P model's dilemma in balancing the goal demanded by the model and the institutes to respond to the problems identified by the model. Mirand et al. (2003) investigated and explained the de-prioritisation of primary prevention in physicians' perceptions of their role in the delivery of primary care; see Figure 2.2.

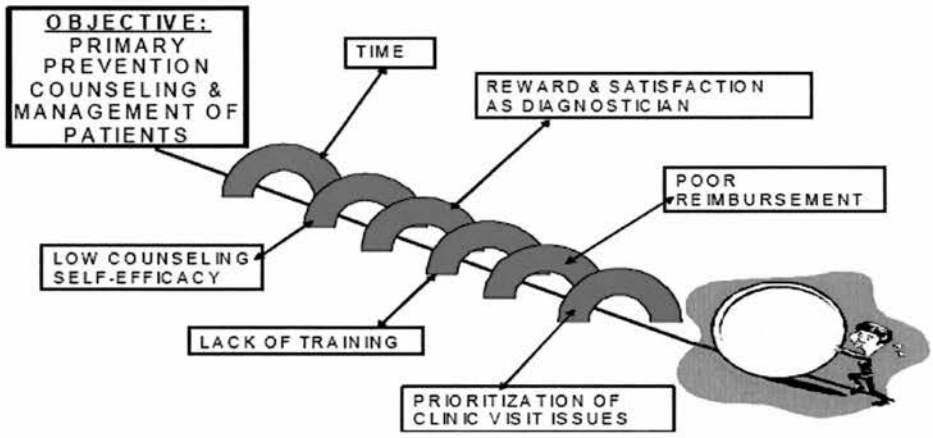

Figure 2.2 Physician-Reported Barriers to Delivery of Primary Prevention (adopted from Mirand et al., 2003, p. 4)

The figure was originally used to explain how physicians were not being supported in delivering health promotion. However, with these factors listed in the above figure waiting to be improved, the figure gives the impression that perhaps every aspect of influence on the service should be improved in order to reach the higher standard set up by the model. Two questions are raised: one, to what extent can structural changes be possible? and two, to what extent could the physician achieve change seeing the model has so many structural problems? It is possible that the requirement for a desired or expected outcome might be unreasonable, at least in the current situation. It is perhaps better to think of the possibility of change within the capacity of institutions. A realistic perspective may need to be adopted when using the P-P model to analyse practitioners' behaviours in terms of health promotion.

The studies by Berland et al. (1995) and Bian and Smith (2006) argued/aimed for a change in current practice and complained of a lack of resources and support. Based on the P-P model, the authors discussed a very broad coverage of the issues being considered to be improved for supporting a better practice. This shows that because practitioners desired to seek improvement, current practice would necessarily be challenged, and even practitioners would be criticized for doing an "imperfect" job. Meanwhile, local needs and organizational contexts of practice have been downplayed since the P-P model focuses on cognitive and behavioural changes due to their origins in the relevant theories behind them. The supporting systems, such as funding and resources, have not been emphasized in the search for a change of practice. It is in this sense that the P-P model proves weak in understanding the conditions of organizational and social contexts of behaviours.

The discussion, so far, has focusing on a critical analysis of the P-P model's limitations and even presents a potential fallacy for analysing practitioners' behaviours. It should be clarified that the problems addressed above do not necessarily deny the quality of the P-P model itself. It is more a case of a likely misuse of the model, using it for inappropriate purposes. As a generic conceptual framework, the P-P model is evidently good at organizing a vast amount of information into groups of factors in a sensible and logical way. It is also evident that this model is a convenient tool for assessing and identifying the factors influencing behaviours. It is this feature of the model that attracted Berland et al. and so many other researchers to its application. Berland's questionnaire, framed by the model, is partially successful in exploring the nurses' attitudes, values, knowledge, health promotion activities and the factors influencing behaviours. The problem of applying it also to the analysis of practitioners' behaviours lies in its outcomes; or rather, it relies on the way in which it looks at them. The perspectives held by the researchers are essential for the interpretation of the data, even when these perspectives are not necessarily linked with the P-P model itself. It is necessary to restate that a precede-proceed analysis should incorporate a range of theoretical perspectives into the various stages (Green & Kreuter, 1999) as well as its application in specific contexts. Therefore, the misuse of the P-P model is the problem.

The critical analysis of the P-P model and how Berland et al.'s questionnaire and study have experienced it have implications for conducting this study. It is argued

that the P-P model is a valuable tool for the exploration of the health promotion practice in hospital nursing contexts. The limitations of the P-P model and Berland et al.'s questionnaire could be complemented by an interview which opens up the understanding of local needs and specific contexts for nurses' health promotion role. It is most important to carefully choose a theoretical perspective in analysing the complicated contexts of the health promotion role. For certain reasons, this study uses role theory as a theoretical framework for studying the health promotion role in its organizational as well as behavioural aspects. The details will be discussed in the next chapter.

2.6 A conclusion and its implications for this study

The interest in hospital-based nurses' health promotion role has shaped the review of the relevant literature in this chapter. The review has explored the interactive and complex relationship between contexts, conception and perception (including nurses' attitudes) of health promotion practice in the nursing literature. Due to the breadth and complexity of the topic, the review of the health promotion role has been revisited and organized in several parts of this chapter, thus at times interrupting the continuity of considering the health promotion role. For this reason it is necessary to state the conclusions drawn from the arguments put and to point out their implications for the present study. This section aims to restate the main points discussed in this chapter, including making brief references to key authors and their studies.

The literature review maps out the knowledge we have of the topic so far, and how it is gained, such as what strategies and methods are applied in published studies. A striking impression of the nursing literature is that there is a lack of understanding of the health promotion role, especially from nursing perspectives. The health promotion role, discussed at the beginning of the chapter, could be enriched by different contexts, i.e. political and professional, or philosophical and historical ones. These should be acknowledged at the outset of developing our understanding of the nature of the health promotion role. Although published authors, such as Gott and O'Brien (1990) and Delaney (1994), showed their concerns about defining a health promotion role for nurses via recognizing nurses' role in health promotion, and differentiated between health promotion in nursing from its more

general meanings, their thoughts seem to be neglected in the fast growing literature of health promotion when there is even a radical shift in the concept of health promotion.

The review finds a need to question the existing contemporary conception and perception of the health promotion role, and to pay attention to the actual health promotion practice of hospital-based nurses. An understanding attitude towards studying the health promotion role therefore requires the evaluation of the data from different perspectives, unconstrained by the analysis of an understanding of the health promotion role according to the literature. This means keeping an open mind about what is the health promotion role. Without taking for granted the existing concepts and conceptions of the health promotion role, this study seeks to ask the questions what is nurses' understanding of the health promotion role, what is the current health promotion practice, and how are the two interwoven in nurses' accounts? With this consideration, the aim of this study is to understand what is the health promotion role understood to be in current hospital practice and then how is it in actual practice. The aim is to unveil the "hidden structure" of the health promotion role in the nursing field.

Maben and Clark's (1995) conceptual analysis of health promotion reminds us that the meanings and understandings of health promotion in the nursing literature are diverse. They involve a shift in concepts from traditionally defined health education to a contemporary concept of health promotion, as well as two paradigms undermining them, which impact the structure of the knowledge of the health promotion role suggested by the literature. Further, the different aspects and focuses of previous empirical studies make it even more complicated in considering what the health promotion role is. The review of this chapter resembles some of Delaney's (1994) conceptual concerns about nursing and health promotion.

> ...confusion is inevitable and results at least in part from the differential focus and emphasis in nursing literature and "mainstream" literature and in the conceptual variation and confusion within those two areas. This also confounds attempts to operationally define the notions for empirical research. Methodologically, it is extremely difficult to assess the extent and quality of nurses['] health education, let alone other health promotion work. (p. 832)

Both qualitative and quantitative studies on the topic of hospital-based nurses' health promotion role and practice have been discussed. Such studies have not always been characterised by a logical coherence and continuity in researching health promotion, due to the diversity and complexity of the topic. Many studies displayed a range of different understandings of and approaches to their topic. Two empirical studies are interestingly divergent in terms of approach and conduct. Berland et al.'s (1995) study is a questionnaire survey, the virtue of which is how its data are grounded in nurses' current activities in hospital. Casey's (2007a, 2007b) studies are very different in their qualitative approaches, being concerned with the adoption of WHO's conceptual framework of health promotion, with its limited consideration of nursing and hospital contexts. Unsurprisingly, Casey's studies show that the WHO standard of health promotion is too high for nurses in hospital, while Berland's study, grounded in nurses' actual practice, is more commendable for its exploration of nurses' health promotion role.

However, it is interesting to note that both studies have a similar tendency of wanting further improvement in health promotion. It has been noted above that the attitudes of the authors, and the application of WHO's conceptual framework by Casey and the Precede-Proceed model in Berland's study, are contributing to guiding the way to interpretations of nurses' health promotion role. Both studies have shortcomings in their uses of WHO's conceptual framework and Green and Kreuter (1999) Precede-Proceed model respectively. Being aware of this fact, the current study uses role theory for good reasons (see Chapter Three). Meanwhile, the current study appreciates the efforts of Berland et al.'s study and Casey's study for different reasons. Berland et al.'s survey questionnaire is rigorously devised to explore health promotion activities in hospital, although its lack of space for nurses' accounts is a serious shortcoming. Casey's qualitative studies provide a detailed description of diverse aspects of the health promotion role. Thus, the current study has adopted a combination of questionnaire survey with a follow-up interview study. Justifications for using Berland's questionnaire along with interviews, as part of focusing on research methods, will be discussed in Chapter Four.

2.7 Summary

This chapter has reviewed the literature on nurses' health promotion role. It has argued that the taken-for-granted knowledge of the topic should be questioned and re-examined in the light of evidence-based empirical studies. The review concludes that the conceptualization and contextualization of hospital-based nurses' health promotion role in the literature is problematic. Particularly, it has pointed out the significance of looking at what nurses mean by health promotion and what is the health promotion practice in hospital according to nurses' accounts. The review also noted that the inconsistency of nurses' attitudes and health promotion practice should be taken into account when researching the health promotion as this could be due to the nurses being influenced by different sources or different contexts. Thus, it finds that there is a need to make attempts to understand the health promotion role by investigating both nurses' attitudes and practice, and then by exploring the relation between them. The critiques of research approaches of previous studies reviewed in this chapter have implications for the choice of theoretical framework and research design for the present study, an issue that will be discussed in the following chapters.

Chapter Three – Role Theory for this Study

Chapter Two reviewed the health promotion literature and the health promotion role. It showed that the existing theories either focus on an all-inclusive definition of the health promotion role or are not grounded in empirical investigations. This implies that theory development related to the health promotion role or the theorizing of the health promotion role is still in its early stages, with little effort at further specifying the concepts related to this topic. The relations between the essential concepts of the health promotion role are also loose. Research of this kind has its flaws, some of which are discussed with the example of applying the Precede-Proceed model to study the health promotion role in the final part of Chapter Two. It is noted that whether the health promotion role is carried out or not is usually considered a matter for the practitioner; the organizational impacts on health promotion practice are either downplayed or neglected. Against this backdrop, this study is aware of the deficiency in the concepts and theories related to the health promotion role. This chapter therefore discusses the selection of role theory as theoretical framework for this study, and its usefulness for orientating and organizing research into the health promotion role.

Role theory includes a collection of concepts and hypotheses to account for the relationships between self and society (Biddle, 1979, 1986; Hilbert, 1981; Morris, 1971). Conway (1978) provides a further explanation:

> Role theory represents a collection of concepts and a variety of hypothetical formulations that predict how actors will perform in a given role, or under what circumstances certain types of behaviors can be expected. (p. 17)

Role as a concept refers both to an individual matrix (thoughts and actions) and a collective one (socially patterned demands and standardizing forces) (Levinson, 1959). This means that the concept of role is useful for analysing cognitive and behavioural characteristics of individuals within the context of the collective (Gioscia, 1961; Gordon, 1966; Morris, 1971; Schuler et al., 1977). This feature of role theory is useful for examining how nurses perceive the health promotion role and how they practise it, and how the context impacts on nurses' perceptions of the health promotion role and their behaviours related to it. It is in this sense that role theory solves the problem that individuals' efforts with regards to the health

promotion role have been over-emphasized while its social context has been ignored in the past.

Role theory could be a general title for collections of studies of role, or any theory related to role could be called role theory (Biddle, 1979). Hardy (1978a) suggests the term *theory* here is "used loosely to refer to a specific orientation toward social structure and social behaviour, and to a selected body of concepts and research" (p. 9). This understanding of role theory means that in its application, the specific concepts and theories of role theory are selected and their usefulness for this study can be discussed. Therefore, this chapter firstly introduces basic but essential concepts of role theory in order to conceptualize the health promotion role. Secondly, the perspectives of role theory, which are helpful to understanding the health promotion role, are presented and discussed. Thirdly, the concepts of role expectation, role conception and role performance are introduced, which are important to define the specific role. Finally, based on the literature review, role stress is assumed to be the problem underlying nurses' accounts of the health promotion role, so its relevance to this study is discussed.

3.1 Operationalizing the health promotion role

The health promotion role is little defined in the literature, but it is called "role" in a conventional sense in the literature and by relevant practitioners. Health promotion could belong to anyone who has a claim to it (Tones & Green, 2004). Following this logic, "health promotion role" then refers to a title anyone, both professional and non-professional, may have who accepts health promotion as part of their life. Nurses indeed actively respond to health promotion as shown in Chapter Two. It could be said that nurses have a role in health promotion or have a health promotion role. Health promotion role in this sense refers to the part of health promotion that is relevant to nurses or that nurses respond to. However, the health promotion role, if it is not clearly defined, could be very vague. To conceptualize the nurses' part of health promotion or the nurses' health promotion role for this study, we should probably start by understanding the basics of hospital-based nurses' health promotion role: what role is, what is meant by role, and how role organizes the nurses' world of health promotion.

The term role is used in daily language yet it can be also elusive and difficult to define. It has its theatrical or dramatic roots in referring to a part which is assigned in a drama and played by an actor. When role is introduced into social science, it works as a metaphor emphasizing the selection and performance of parts in social systems (Banton, 1965). Role occupants are required to perform its scripts. In essence, role does refer to a pattern of characteristic behaviours (Biddle, 1979). Hardy (1978b) adds that "the term (role) is commonly used in the literature to refer to both the expected and the actual behaviours associated with a position" (p. 75). Both of the above definitions of role could be traced back to its dramatic sense.

However, while it is understandable that roles in the theatre context are constrained to "scripts", in a social contexts roles are associated with the actual "interpretations" of the expected scripts by the individuals who carry out the role (Biddle, 1986). This means that role in a social context is more complicated than a rigorous "script". This is because, as Biddle (1986) states, role in a social context is not an isolated concept but is closely related to other important concepts. Biddle (1979, 1986) proposes that role is "a collective concept" that is associated with four essential elements: persons, position (or status), behaviours and social structure. This indicates how role could be related to other concepts in sociology.

Instead of listing role and its related concepts in a social context, Levinson (1973) focuses on role in three specific senses: "the structural demands associated with a given social position", "as the member's orientation or conception of the part he is to play", and "as the actions of the individual members" (p. 226). This definition of role focuses on the relation between role and person, simply translated as: role expectation and position, conception and performance. Biddle focuses on role and its social context, what role means in the social context, and what social context means to role. In a different focus, Levinson emphasizes what role means to person, and how person connects to role.

Due to the meanings of role, conceptualizing a health promotion role should examine the health promotion role not only as a type of featured behaviours related to health promotion but also, more importantly, as related to its associated elements: nurses, nursing position, health promotion practice and the social structure (hospital or beyond) of the health promotion role. It is indeed a social context of role that is required to understand nurses' health promotion role. By Levinson's

definition of role, the health promotion role would be defined by different dimensions, such as, what role expectation of the health promotion role is, what nurses' perceived role expectation or conception of the health promotion role is, and what nurses' practice is in the health promotion role. The two ways of conceptualizing role have similarities, or rather they interpret role from different angles and with different emphases.

Arditi (1987) argues that role is no longer a purely analytical construct but a cultural concept, which "represent[s] a concrete constituent of social reality" (p. 567). This notion is different from role as a sociological concept as proposed by the above authors; it sees role itself as a phenomenon that can be studied and lived within. This notion is consistent with Popitz's (1972) and Gerhardt's (1980) "role as a phenomenon". The main thesis of "role as a phenomenon" is that role should not be limited to an element of the social structure in a sociological discourse (Arditi, 1987). Popitz (1972) indicates that role is not an invention of sociology but an invention of society. It is in this sense that role refers to "some concrete, observable empirical construct" (Arditi, 1987, p. 567). The contribution of the notion of "role as a phenomenon" avoids the perspectives of role theory (which are introduced below), while "role as a phenomenon" is beyond the sociological context of role theory. Role as a phenomenon is a world of experiential reality that is continuously being experienced rather than a conceptualized concept of sociology (Gerhardt, 1980).

Hilbert (1981) argues that despite the diversity in perspectives of role, they share a basic similarity: they view role behaviour as a consequence of actors following rules, whether culturally given or situationally negotiated. Thus, Hilbert (1981) suggests that role should be viewed as:

> an organizing concept used on occasion by actors in social settings, and to view its utility for actors in terms of what they can do with it; i.e., the work they require it to do, in sustaining the perceived stability of social behavior, whatever their immediate purposes. Viewed this way, roles are not behavioral matrices to be described and explained but are conceptual resources actors use to clear up confusion, sanction troublemakers, instruct others in the ways of the world, and so forth. (pp. 216-217)

Therefore, "role" is used as a conceptual resource, and role actors constantly reference it and decide what to do with it. Role as an organizing concept has similarities to role as a cultural object, both of which can be used to make sense of the world experienced by role actors.

Fundamentally, the notions of "role as a sociological concept", "role as an organizing concept" and "role as a phenomenon" are not conflicting notions but are simply viewing "role" differently. The former is rigid in sociological concepts and languages and focuses on conceptual analysis. The latter is focused on abstraction of the phenomenon rather than insisting on the existing sociological concepts. "Role as an organizing concept" is more focused on the analysis of social problems. The difference is that role is either an element concept of the social structure, which means a tight connection with position, or that role itself is a cultural object and a social phenomenon, which has a loose coupling relation with the social structure (Callero, 1994).

Levy (1952) indicates that role is a "position differentiated in terms of a given social structure" (p. 159). In this sense, social structure is built up by a network of differentiated roles. Role as position seems to be too simple to interpret the complex social world until we take into account Linton's (1936) contributing "rights and duties" to describing social status in social structure. It is proposed that social status is "a position in a particular pattern which is a collection of rights and duties" while role is the "dynamic aspect of a status (that) puts the rights and duties which constitute the status into effect" (pp. 113-114). In this way, the individuals are linked to the position in social structure via the rights and duties of the role. This functionalist view of position leads to the argument that social order is explained as sets of interlocking social positions in society. Therefore, certain rights and duties are attributed to the position, and also to those who occupy the positions toward each other (Parson, 1968; Hilbert, 1981). However, the social world has never been simple enough to be classified into a mutually exclusive system of clearly identified positions (Biddle, 1979). Biddle (1979) contributes to distinguishing the concepts: "positions are classifications of human beings; roles are classifications of behaviours" (p. 93). He also separates task role and status role. The former represents a type of behaviours without necessarily referring to a position, while the latter is tightly associated with a position as well as with status. Baker & Faulkner (1991) add that role and position are only connected by

enactment of persons. In this sense, position (or status) is a location in a particular social structure while role can be a classification across social structures (Winship & Mandel, 1983). There is an important concept of role-set, proposed by Merton (1971), to interpret the relation between a bundle of roles in one position. Merton (1971) divides concepts of status/position and role:

> By status Linton meant a position in a social system occupied by designated individuals; by role, the behavioral enacting of the patterned expectations attributed to that position. Status and role, in these terms, are concepts serving to connect the culturally defined expectations with the patterned behavior and relationship which comprise social structure. (p. 209)

In other words, when a particular social status involves an array of associated roles rather than one single role, it is a role-set. The significance of role-set is its contribution to analysing the substantive problems of social structure. The above authors contribute within their own disciplines and interests to the concepts of role and position. The perspectives of viewing the relation between role and position are indeed diverse in role theory, which demonstrates the dynamics and complexity of society itself.

In this study, it is very important to identify that the health promotion role is different from the nursing role. The nursing role seems to be synonymous with the classification of nurses while, according to the literature, the health promotion role is synonymous with the classification of a characteristic pattern of behaviours. Only when nurses perform health promotion in the context of the nursing role could the health promotion role be connected with the nursing role which may be in a form of a role-set. This means that the health promotion role is one of many roles nurses have, as shown in status and position. It also means that a nurse is a nurse even if they do health promotion. The health promotion role in this sense is not a status and position but a task or task role, in Biddle's wording, while the nursing role is a status role. There is also another meaning to the health promotion role, that of a cultural object or abstraction, which might not be directly relevant to the nursing position. The hypothesis put forward in the literature that there is a relation between the health promotion role and the nursing role needs to be further confirmed in empirical studies.

The main interest of this study remains in how nurses respond to the health promotion role, cognitively and behaviourally. The health promotion role in this sense is an organizing concept. Based on the review of the literature, the health promotion role, in this study, is hypothesised to be open to both views of role. On the one hand, the health promotion role can be constructed within the structure. In this sense, the health promotion role refers to behavioural patterns and structural demands. In this, the health promotion role is a sociological concept. On the other hand, the health promotion role could be a cultural and conceptual object that nurses perceive and respond to. The health promotion role then, on a certain level, could be role as phenomenon. This implies that the health promotion role has a conceptual complexity, with multiple meanings found expressed in the nurses' accounts, which need to be explored in the study.

3.2 Perspectives on role theory

Traditionally, there are two perspectives on role theory, functionalist and interactionist. Each perspective understands role and its social context differently. The functionalist presumes that role is constructed by social facts which include institutions, culture and norms (Conway, 1978). Thus, social factors as a powerful force are supposed to be dominant in the given society at any point in time (Bandura & Walters, 1963). Under this presumption, individuals have little choice but learn to conform to the social facts through the process of socialization (Banton, 1965; Conway, 1978), in which the individuals are supposed to learn to understand the rights and duties of their role and then perform the functions of that role (Linton, 1936). Accordingly, roles are generally conceived of as the shared, normative expectations that prescribe and explain the behaviours that should be enacted by individuals (Biddle, 1986). In this functionalist perspective, role and social structure are assumed to be relatively fixed and stable unless society is changing. As a result, the concept of role becomes a vocabulary for describing the differentiated parts of a stable social system as well as a vehicle for explaining participants' role-playing in it (Conway, 1978).

The interactionist perspective of role theory is characterized by the idea that social structures are less deterministic of individual action (Callero, 1994). In other words, role is the behavioural expectations that are associated with, and emerge from,

identifiable positions in social structure rather than normative expectations in the functionalist perspective (Callero, 1994). The behavioural role expectations are assumed to guide the actions of the role occupants of those positions and determine interaction within the social structure. This view makes it possible for us to draw insights into the interactions between individual actors and the surrounding social structures. It seeks to recognize the "meanings which the acts and symbols of actors in the process of interaction have for each other" (Conway, 1978 p. 20). Hurley (1978) also addresses the interactionist perspective as a socialization of roles, which emphasizes the need for role actors to learn how to behave in the role.

Derived from a social psychological orientation, the interactionist perspective on role theory focuses on the meanings of significant symbols for the role actors, rather than shared and normative expectations attributed to the social structure (Conway, 1978). This interactionist perspective on role theory disagrees that the power of social structure is the only force for roles. Rather, it recognizes role occupants' creations in specified circumstances via the process of role-making (Conway, 1978). Role in the interactionist perspective, then, is perceived as a device for organizing and structuring social context (Halkowski, 1990).

Recently the development of role theory has moved to merge the functionalist and interactionist perspectives. This means that neither of the two traditional perspectives on role theory is right or wrong, but both are eligible for interpreting social phenomena in specific contexts. It is interesting to find that in empirical studies, it is difficult for these perspectives to exclude each other completely. In fact, studies usually encounter both perspectives but may emphasise one or the other in their research orientation. Handel (1979) argues that the functionalist and interactionist perspectives are neither what they have commonly been characterized to be nor are they very different from one another. Rather, the two perspectives are compatible and complementary (Handel, 1979).

Role occupants face conflicting expectations, one a normative one and the other derived from interaction in the workplace; conceptual analysis does not solve the problem of conflicting expectations. But, Handel (1979) argues that:

> Negotiated meanings do not replace conflicting expectations, but coexist with them as a working consensus among actors concerning how conflicts are to be solved in particular situations, despite their several preferences. (p. 855)

Daily work experiences seldom exactly follow the normalized prescription and procedure. Role distance (Goffman, 1961), the standardized identity implications of incumbency in a position, may constitute a complete characterization of the incumbent, an important but limited aspect of a single organizationally situated identity (Handel, 1979).

Goffman (1961) introduced the term "situated role" to describe the situationally determined as opposed to the formally prescribed occupational role performance. In bureaucratic settings discrepancies occur between formal and informal levels of organization. With regard to the roles, the discrepancy is replicated in the divergence between the general scheme (formal level) and the positional interpretations (information level). The discrepancy between levels is evidence of constraints and contradictions encountered in a bureaucratic setting (Gerhardt, 1975). Recognizing the situated activity system as a locus of social organization serves to show how social organization can be shaped and maintained without corresponding minute normative expectation. In this perspective, actors orient to concrete, situated, pragmatic concerns (Goffman, 1961; Handel, 1979). But the variety in particular social organizations may not get rid of the essence of normative expectations. There is some connection between normative expectation and behavioural expectation. Unless role expectation is too abstract, too rigid and unreasonable, it is varied and not recognizable from the norm of social structure; this is then less a sociological perspective on role theory.

3.3 Role expectation, conception and performance

The perspectives on role theory outlined above are helpful to understand role and its social context where individuals play out their role. In this section, Levinson's (1959) three specific senses of role introduced above could be translated into three factors: role expectations, role conception and role performance, which are used to define a specific role (Rheiner, 1982).

Role expectation has been briefly mentioned in discussing the perspectives on role theory. In the functionalist perspective, role expectation has its normative sense, while in the interactionist perspective it has its behavioural sense. Role and role expectation are correlated concepts in role theory. Levinson (1959) states that role

expectation can be defined as the structurally demands given to a position, and also possibly as the role actor's orientation or conception of the part he is to play in the social structure. Also, Biddle (1986) argues that role expectation is perceived as a major generator of role, since the meaning of role expectation leads to a different understanding of role, which results in the different perspectives on role theory. Therefore, different forms of behaviours are likely to result when persons share or do not share role expectations (Biddle, 1979). Role expectation, in this sense, is a key concept of role theory, influencing what role is and how it is.

Hardy (1978b) provides an essential meaning of role expectation:

> Role expectations are position-specific norms that identify the attitudes, behaviors, and cognitions that are required and anticipated for a role occupant. (p. 76)

Because of this attributed link to position, role expectation seems to be equalized to the definition of the role itself (McCall & Simmons, 1978). In other words, role expectation appears to be the real bond of mutual communication between macro-level structure and micro-level individuals in the social structure. This important feature of role expectation contributes to connecting social structure with individual role actors through a shared consensus of what is the role (Biddle, 1986). These hypothetically cognitive constructions help role actors to account for and predict their behaviours (Biddle, 1979), which refers to the prescription of role, and the role occupants are required to conform to this prescribed or normative expectation. Role expectation thus could be a reference to a set of role behaviours in terms of what role actors should play for the role (Biddle, 1979; Topham, 1987). This definition of role expectation is favoured by functionalists.

It is worth noting that it is through defining the tasks and social structure of role that role expectation is created as internalized pressure influencing role behaviours (Heller & Quatraro, 1977). This means that role expectation needs a process of cognitive construction by role actors before it can be translated into role performance or a pattern of behaviours. The term "expectation" in this context connotes awareness, thus suggesting that persons are phenomenally alive and rational in their orientation to events (Biddle, 1979). It presumes a "thoughtful and socially aware human actor" by utilizing the concept of role expectation (Biddle, 1986 p. 69). Levinson (1973) argues:

> Role may be defined as the members' orientation or conception of the part he is to play in the organisation. It is, so to say, his inner definition of what someone in his social position is supposed to think and do about it.... (p. 226)

As long as role actors are able to verbalize their expectations of the role, it is assumed that they are aware of it (Biddle, 1979). This is especially important from the perspective of interactionists, because of the way that role actors are encouraged to generate their individual understanding of role based on their experiences in particular circumstances. The value and function of role expectation in this sense contributes to building up role actors' predisposition to respond to particular events in structure and then helps to understand their performance (Buchanan & Huczynski, 1997).

In some empirical research, high expectations could facilitate performance due to expectations being involved in the cognitive perceptions of role actors (Feather, 1966; Kovenklioglu & Greenhaus, 1978). However, the results of studies on the relationship between expectations and performances are also noticeably conflicting. Role expectation may have motivational properties through the propositions of role (Biddle, 1979). Biddle (1979) indicates that an individual's personal attitudes and socialization experiences will influence their role expectations. Personal attributes that affect role expectations include personality, knowledge level, communication skills, interpersonal skills and prior experiences (Topham, 1987). As a result, the relation between role expectation and performance is not consistent.

Biddle (1979) makes efforts to separate the subjective role expectation from the positional one. The former is when role actors' comments on role are based on their own practice; while the objective role expectation is a stated expectation for the role. Role expectation is a weak measure of a person's motivation (Bardwell, 1984; Biddle, 1979). A positive link between role expectation and role performance may possibly be created in certain highly motivated persons rather than as an indicator of the whole community (Biddle, 1979). That is to say, it is inadequate to merely consider the mutual relations between role expectation and role performance. There are complications when both inner and outer factors have impacts on role expectations and/or role performances.

Rheiner (1982) emphasizes that an individual's own picture of his/her role is the role conception of this person rather than role expectation. This means that the conception of a role could be different from the shared role expectation. However, Biddle (1979) insists that the value of role expectation is that people in one group share a common definition of an object. No matter what individual role actors prefer, role expectation is an agreeable meaning shared by the group of members in the society (Biddle, 1979). This important feature of role expectation contributes to connecting social structure with individual role actors through a shared consensus about the role. Thus, the main function of role expectation is to link individual and organization rather than merely personal conception and motivational force. This echoes Levinson (1959) in that role expectation is internalized by members and thus is mirrored in their role conceptions.

In the view of a symbolic interactionist, Newcome (1950) distinguishes role expectation as beliefs and cognitions held by certain personas in regard to what are considered appropriate behaviours for a given status, and the actual behaviour of the status of incumbents. He terms the two conceptual units "prescribed role" and "role behaviours"; "social concept" and "psychological concept"; "social prescription" and "individual behaviours". Psychologically, Mead (1934) interprets the dual accounts of role that person holds a "social script" for a public "Me", and a private self for "I". "'Me' represents the person as an object, as a physical body or locus of social properties, a recipient of behaviours from others and one to whom standards apply" (Chamber & Narayanasamy, 2008). In opposition, "I" as a private account is more concerned with the private self who thinks, and values and wants. It is the subjective sense of understanding role, self and behaviour (Chamber & Narayanasamy, 2008; Mead, 1934).

In sociology, role environment either facilitates or forms a barrier to role performing (Biddle, 1979). If there exist barriers in the social context, persons' role expectation might not lead to the behaviours expected. Therefore, the conflict between role expectation and role performance is significant to identify structural problems. However, role expectations might lead to changes in role environment for preferred role behaviours as well. Role expectation would cause the emotional appeal of individuals. Role conflict, in which persons are unhappy if their expectations are not met, and thus are willing to influence surrounding factors toward the conformity of behaviours, commonly happens (Biddle, 1979; Khan, et

al., 1964). An alternative possibility is that expectations are adjusted to suit the performance level (Dinitz et al., 1962).

3.4 Role stress

According to Biddle (1979), role behaviour is controlled and predicted by expectations; persons are not happy when their expectations are not met. The inadequate conception of role expectation causes role problems, such as role conflict and role ambiguity, a lack of clarity in roles and many others, because there are many concepts involved in role problems, and these concepts constantly develop. Therefore, it is very difficult to locate specific concepts, or specific phenomena. This is also because it is not unusual that role problems are associated with each other. Each role problem has its special features in its social context; while each role problem may have a similar definition to every other, its interpretation needs to be located in its own study. In this section, the concept of the commonly occurring role stress is introduced, based on the needs of this study.

If there is a problem with role expectation, role occupants might not be comfortable with it, and suffer role stress eventually. In this sense, role stress may refer to role problems related to role expectation. In other words, role stress here is to bracket role problems related to role expectation in the social structure:

> When a social structure creates very difficult, conflicting, or impossible demands for occupants of positions within the structure, the general condition can be identified as one of role stress. (Hardy, 1978b, p. 73)

The rationale for role stress is that the social structure forms a vital part of the individual's environment; it is a major determinant of social behaviours (Hardy 1978b). The attention of role stress in this study focuses on looking at the kind of problem resulting from social structure, involving concepts such as norms, sanctions, position or status. A further precise definition of role stress provided by Hardy (1978b):

> Role stress is a social structural condition in which role obligations are vague, irritating, difficult, conflicting, or impossible to meet. (p. 76)

Stress can be a wide research field for any consideration that causes stress and ends with a stress response (Hardy, 1978b). A highly relevant concept, but different from role stress, is role strain. Role strain focuses on the subjective feelings of frustration, tension or anxiety. Role stress, however, is located in the social structure, and is primarily external to the individual. Hardy (1978b) discussed role stress in terms of the assumptions of structural conditions which will bring role stress: socialization deficits, increased role of social change in organizations, and advances in technology.

Role stress usually includes role ambiguity, role conflict, role incongruity, role overload, role incompetence and role over-qualification (Hardy, 1978b). Because of the interest of this study, the first four of these role problems will be briefly introduced for the purpose of clarifying the concepts and as a reference of this study. In a brief review Hardy (1978b, pp. 81-83) defined these as follows:

> *Role ambiguity* is usually about vagueness, uncertainty, and lack of actor agreement on role expectations. Role ambiguity is associated with one position from the perspective of the occupant of a focal position in interaction with members of his role set.
>
> *Role conflict* is a condition in which existing role expectations are contradictory or mutually exclusive. It usually involves clear but conflicting or competing role expectations.
>
> *Role incongruity* happens when a role occupant finds that expectations for his role performance run counter to his self-perception, disposition, attitudes, and values. It commonly occurs when role actors undergo role transitions involving a significant modification in attitudes and values.
>
> *Role overload* is a difficulty in fulfilling role demands when a role actor is confronted with excessive demands. Lack of time is a distinct impediment to complete fulfilment of role demands in empirical studies.

Fundamentally, this is all related to problematic role expectation in social structure, which role occupants would experience. Based on the nurses' attitudes to the health promotion role as set out in the literature review, it could be hypothesised that role problems do more or less exist.

3.5 Summary

The chapter introduced role theory for the purpose of researching nurses' health promotion role. The essential concepts of role were introduced and discussed to orientate the conceptualizing of the health promotion role. It was suggested that the health promotion role is very complicated in its meanings and varied in its contexts according to the different perspectives on role theory. The details of different perspectives on role and role theory were discussed in order to increase our understanding of role and its related social contexts, and to enable us to think about the health promotion role from different angles. A specific role was shown to be usually concerned with three concepts: role expectations, role conception and role performance; the chapter unfolded these for the study into rich meanings. Lastly, the chapter introduced the concept of role stress, along with its related role problems, as these may be the problems nurses experience in the process of engaging in health promotion.

Chapter Four – The Study

Previous chapters have discussed the problems of the existing theories of the "health promotion role" and explained how role theory is useful to orient this study. This chapter is concerned with presenting what this study is about, how it develops its research interests, how it is conducted in the field.

The chapter starts by defining the aim of the study and the research questions, followed by an account of methods, beginning with the survey questionnaire and the interviewing schedule and the conduct of a pilot study. This is followed by the details of the main study: how the population was defined, how the participants were sampled, and how the data were collected and analysed.

4.1 Introduction to study

4.1.1 Aim of study

The study aims to understand the health promotion role in hospital settings from the nurses' accounts by studying hospital-based nurses' expectations of their role and their experiences of health promotion. The analysis focuses on the latent relations between nurses' role expectations and experiences to find out whether their role expectations are consistent with their performance in hospital or not.

4.1.2 Research questions

The research aim is translated into three specified research questions:

1 What are nurses' role expectations regarding the health promotion role in hospital?

2 What are nurses' experiences of undertaking health promotion practice in current hospital settings?

3 How are nurses' role expectations and experiences associated with each other in the context of health promotion?

4.1.3 Research process

The research process is modelled in a flow chart in Figure 4.1. The study is designed as a mixed-method project, combining a self-completed questionnaire survey with follow-up interviews. The process began with specifying the aims and the research questions, followed by adapting a questionnaire adopted from a previous study to the current study. A pilot study was carried out, followed by the study itself in a general NHS hospital in Scotland.

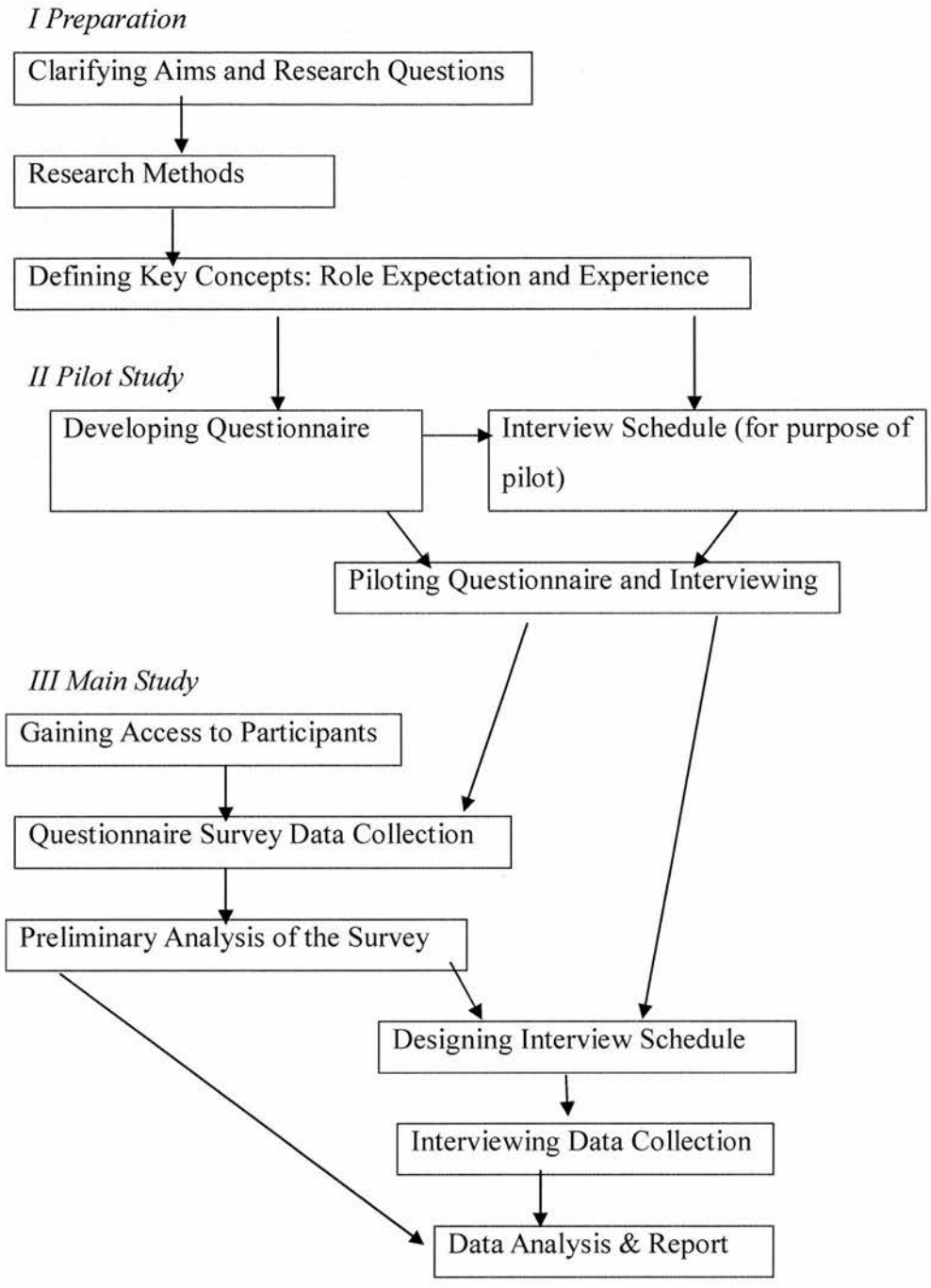

Figure 4.1 Flow Chart of Study Process

4.2 Methodological issues

A brief introduction to the research has been provided above by outlining the aims, research questions and the study process, showing that the study is designed as a

mixed-methods one. This section focuses on methodological issues, including the choice of methodological approaches, the assumptions underlying the research design, the strategy of combining quantitative and qualitative research methods, and finally its ethical considerations. Methodology differs from research methods as the latter are concerned with the techniques used for collecting data and for analysing them (6 & Bellamy, 2012). The technical aspects of the research methods will be discussed in the following sections.

4.2.1 Designing a mixed-methods study

The study is a two-stage mixed-methods study, beginning with a quantitative survey and followed up with qualitative interviews. The main concern for designing a mixed-methods study is to make it relevant to the research questions of the study. As stated above, the study aims to examine nurses' health promotion role in hospital by looking at two important and complex concepts, "role expectations" and "experiences", as well as the relation between them in nurses' accounts. There are many aspects to nurses' health promotion role, and a mixed-methods study is particularly suitable to investigating it (Bryman, 2004). For example, there are two different kinds of role expectation: personal role expectation and positional role expectation (Biddle, 1979). The former reflects nurses' understanding of the health promotion role, based on their current experiences, while the latter reflects nurses' ideas of what the health promotion role should be without referring to their current experiences. It is of great interest to this study whether nurses' role expectations, based on their experiences vs. their reflections, cohere with their actual experiences or not. Following the literature review, it is hypothesized that nurses' role expectations will be interwoven with their experiences in a complex manner. There is then a need to examine nurses' accounts, both their subjective insights and their actual objective practice. This is one reason for combining quantitative and qualitative research methods. For example, the interview survey contributes data to the information collected about the actual health promotion activities of nurses in hospital. Conducting interviews allows the researcher to gather nurses' insights regarding health promotion that go beyond the information collected via the survey. The interviews accord nurses an opportunity to provide their subjective insights, thus adding to the diversity of the meanings about health promotion gathered.

This leads to another reason for selecting a mixed-methods study.

> "Sometimes, researchers want to gather two kinds of data: qualitative data that will allow them to gain access to the perspectives of the people they are studying; and quantitative data that will allow them to explore specific issues in which they are interested. When this occurs, they are seeking to explore an area in both ways, so that they can both adopt an unstructured approach to data collection in which participants' meanings are focus of attention and investigate a specific set of issues through the more structured approach of quantitative research." (Bryman, 2004, p. 459)

The literature provides examples of studies using both qualitative and quantitative methods to explore nurses' experiences of health promotion in hospital. As discussed in the literature review chapter, the different perspectives as well as different emphases adopted may be responsible for the variety of theories of nurses' health promotion role found. Particularly the contemporary view vs. the traditional view of health promotion role identified in the literature review could lead to very different views of "what happens to nurses" and "what nurses feel or think of what happens" regarding the health promotion role. There being different standpoints of looking at the health promotion role makes it difficult for a researcher to choose the "right" methods since any particular method might be giving too much weight to the nurses' voices or give too much weight to preconceived notions of health promotion and the nurses' role.

Importantly, mixed-methods research is designed to be conducted in sequence: the quantitative survey in the first stage and the semi-structured interview in the second stage. The survey provides a descriptive analysis of nurses' experiences of health promotion as well as associations of variables. However, how to explain relationships between variables is a frequent problem for quantitative researchers (Bryman, 2004). One strategy is to find the "intervening variable":

> "which is influenced by the independent variable but which in turn has an effect on the dependent variable" (Bryman, 2004, p. 460)

The literature review chapter discussed the evident lack of an adequate understanding of nurses' health promotion role in hospital, with one of the problem being that the conceptual frameworks used by researchers are very problematic. Either the Ottawa Charter or the P-P model has deficiencies to

explain nurses' experiences of health promotion in hospital (see Chapter Two). Thus, this study, after carrying out the questionnaire survey, conducted interviews to further examine nurses' accounts of health promotion. This means that the follow-up interviews not only provided nurses' insights into the health promotion role but a detailed analysis was able to identify the intervening variables to explain the relations between the variables of interest to this study. This is an important contribution of the qualitative research to this study as it answers the "why" of the findings and helps develop an explanatory theory of nurses' experiences of health promotion in hospital. Ways in which the intervening variables are in this study will be identified and utilized in theory building will be discussed in Chapter Seven.

The research methods selected and how they are expected to contribute to this mixed-methods study is now discussed in some detail. The questionnaire survey is carried out in the first stage of the data collection process for the purpose of exploring what it is going on in the nurses' world of health promotion. The survey is a systematic and standardized quantitative research methodology which combines sampling, question design and data collection into a whole project (Fowler, 2002), of which the questionnaire is the "centre-piece" (Punch, 1998). The questionnaire is a predetermined, standardized and structured quantitative approach (Parahoo, 2006); it is good for collecting the facts (Parahoo, 2006), and useful for describing nurses' attitudes, beliefs and knowledge, as well as their practice and experiences. Additionally, the self-administered questionnaire has the capability of generating a large amount of information with a wide coverage during a relatively short time (Buckingham & Saunders, 2004). Thus, it is considered a relatively cheap and quick way to conduct an investigation, compared with other data collection methods (Wilson, 1996).

The data collected via the questionnaire survey can be analysed statistically. The survey is good for generalizing the individual data into group characteristics using statistical methods (Bryman, 1988). In other words, the findings from the survey carried out in this study become information about the characteristics of the nurses being investigated, allowing us to describe their attitudes on the basis of their answers, and of testing and interpreting the patterns of relationships between specified groups and variables derived from previous theories. Statistical methods

allows examination of the comparisons made, identifying any associations between the variables in this study.

The self-administered questionnaire also has the advantage of being anonymous and confidential, which helps to avoid any uncomfortable situations. There is a concern that asking questions about health promotion practice may be controversial or sensitive for nurses since they, according to the literature, have been criticized for their inadequacy in performing health promotion. The questionnaire, confidential and anonymous, may avoid uncomfortable moments and perhaps help to gain a measure of the "true feelings" of nurses with regard to health promotion issues.

As discussed above, the questionnaire survey, conducted in the first stage of the research, allows us to explore the field and setting up a descriptive analysis of it. However, it is important to note that the questionnaire also has its weakness:

> The main disadvantage with the self-administered questionnaire is that there is no opportunity to ask respondents to elaborate, expand, clarify or illustrate their answers. (Parahoo 2006, p. 299)

Because of its tightly standardized and structured form, the responses are, to a certain extent, limited to the questions provided by the questionnaire. Both role expectation and experience are complex concepts, and it is difficult to formulate these ideas precisely in the structured questionnaire. Although the questionnaire has left a place open for nurses to write down their opinions, going beyond the questions, this is not sufficient to cover most of the nurses' insights into the health promotion role. More importantly, if any of the nurses' perceptions of the health promotion role which go beyond the questions in the questionnaire is missed, this increases the bias of the results. As mentioned above, nurses may have their own perspectives on health promotion, health promotion for hospital nursing, and their role in health promotion, as well as on any related experiences in hospital.

In order to limit any shortcomings, at the second stage, the study employs a semi-structured interview method to gain nurses' insights into the health promotion role. Compared with the tightly structured questionnaire, interviews are good for collecting data about what the health promotion role based on the nurses' attitudes and understandings. The qualitative interview has the advantage of being

flexible and having the potential to yield more information on a given topic (Tim, 1997). In this study, the semi-structured interviews provide an opportunity to meet the nurses and examine their perceptions of their role and insights into health promotion, based directly on their field of activity. Interviewer and informants being able to talk face-to-face helps to create a good understanding of the context of the topic. This is especially significant for the researcher who is from a different country and working in a second language. Since the interview provides room for the researcher to improvise questions to have answers clarified or extended, it may uncover meaningful information beyond the prepared schedule (Robin, 1995). In other words, the interviews probably provide a better account of what nurses mean by health promotion and nurses' role in it.

Foss (2002) notes that the qualitative findings may be viewed as adding "spice" to the results. The interviews in this study contributed towards echoing and confirming the results of the survey. The findings of the survey questionnaires, after being analysed, provided directions for asking nurses questions or about their insights. Thus, the interview aimed to gather more explanations from nurses about how they perceive the situation and how they construct the health promotion role. In this sense, the survey carried out in this study was effective for investigating attitudes, while the interviews strengthened the explanations of the survey findings. It is in this way that the interview, as a research method, overcomes any disadvantages of the survey questionnaire. De Vaus (1996) argues that the post-coding of qualitative data is a valuable source of survey data. Furthermore, because the survey questionnaire administered in this study was adopted from a survey conducted in another country, it is essential to bear in mind inherent differences between the study settings. The interviews play an important part in grounding some of the unanticipated themes straight from the respondents, rather than the responses being only from the items chosen by the researcher (Arksey & Knight, 1999).

Briefly, the researcher is aware of the advantages of both quantitative and qualitative methods for gaining an understanding of nurses' health promotion role in hospital. They are, in a way, used for different purposes as they are complementary to each other. This is done to avoid the limits of each approach. It is necessary to take note of the fact that the different methods have been carefully

arranged in sequence, with each having its own task. The main concern of this study is how to get the most comprehensive picture of the health promotion role.

> Its central premise is that the use of quantitative and qualitative approaches, in combination, provides a better understanding of research problems than either approach alone. (Creswell & Clark 2012 p. 5)

Both methods contribute to the study, thus avoiding the limitations of using a single method. The questionnaire survey aims at an exploration of the field and the follow-up semi-structured interview, due to its great flexibility, is designed to add nurses' insights and/or to provide explanations of the findings of the survey. Further details of the research methods used, such as the choice of questionnaire and the process followed in the interview, are discussed below.

4.2.2 Combining quantitative and qualitative methods

Mixed-methods studies may have the problem of integrating the data gathered in the different approaches. Quantitative and qualitative methods are based on different paradigms. For example, the survey has its tradition in positivism, while the interview is of a more subjective and interpretive nature, with a variety of methodological approaches (Parahoo, 1997). However, debating different philosophical positions is not useful to answering the research questions regarding nurses' health promotion role. Mixed-methods research has its pragmatic foundations, suggesting perspectives on what works better to address a given research problem and research questions (Creswell & Clark, 2012). Therefore, this discussion focuses on the strategies used to combine the quantitative and qualitative methods in this study.

It is very important to recognize that this study has been designed as a sequential mixed-methods research and follows an explanatory mode. In both data collection and data analysis, the questionnaire survey and the semi-structured interview were sequenced as they have different purposes and functions. In other words, the quantitative and the qualitative research are separate stages, contributing differently to the study. The questionnaire survey in the first stage has the purpose of seeking to discover what is going on in the nurses' world of health promotion. It has the function of providing an initial description of the characteristics of the

population and the associated variables. The analysis of the survey results helped to identify the significant questions for the follow-up interviews. This means that the interview schedule for the semi-structured interview in the second stage was developed from the findings of the survey. The follow-up interviews go further to examine and interpret nurses' insights and experiences in detail. The findings of the interviews allowed the researcher to go back to confirm the survey results as well as to add to the understanding of the nurses' world of health promotion. Importantly, as discussed above, the interview accounts provided in-depth explanations for the variables identified in the survey. Therefore, this sequential process of data collection and analysis meant that they connected to each other and was an important strategy in integrating two methods in this study.

The strength of the sequential design lies in its straightforward nature (Creswell, 2003). It is easy to implement since the stages follow one another (Creswell, 2003). In this study, as the first stage, the conduct of the quantitative research prepared the ground for the follow-up interviews. Firstly, the data collection instruments could be used to guide purposeful sampling (Sandelowski, 2000). In this study, the survey provided a convenient way of recruiting the participants for the interviews. Secondly, answering the questions in the survey possibly helped the nurses to become engaged with the investigation and interested in participating in an interview. Thirdly, the sequential arrangement also suited the purposes of the interview, i.e. to confirm and explain the findings from the survey. Because of its sequential and explanatory mode, the data from different methods were analysed separately. Additionally, the quantitative and qualitative results are also reported separately in two chapters, i.e. Chapter Five and Chapter Six.

In this study, the choice of the format of the questionnaire and the interview schedule has also been considered for the purpose of keeping the consistency between two methods. The questionnaire provides space designed for nurses to state their opinions beyond the tightly structured questions. The data gathered in response to the open-ended question were analysed together with the interview data. The questionnaire data therefore make a small contribution to the qualitative data collected in the follow-up interview. The semi-structured interview has both the features of a quantitative interview (survey interview) and a qualitative one (in-depth interview) (Corbetta 2003, May 1993). It lies between a tightly structured interviewing and an unstructured, in-depth one. Thus, it could be said

that the semi-structured interview itself has continuity in form and data with the questionnaire survey.

Regarding the choice of analysis strategies, content analysis is used for the interview data, which has a varied continuum from traditional statistical analysis to thematic analysis (Grbich 2007). This has the advantage of connecting the data from the questionnaires to those from the interviews. When new themes emerge in the interview data, they could either be coded into categories similar to the survey variables or into new categories. Also, any additional information provided by the nurses at the end of the questionnaire could be treated as qualitative data together with the interview data. Therefore, the questionnaire survey and the interviews could be compared and integrated in the interpretation stage, presented in the discussion chapter.

It should not come as a surprise that the study might yield conflicting or contradictory findings since both the survey and the interviews have their own purpose. As a result, the findings from the survey questions and the interviews are differently focused on certain topics. For example, in the interviews the nurses expressed individual preferences regarding the role of health promotion and provided their explanations of current health promotion practice. The survey, on the other hand, focused on the shared, consensual meaning of both role expectations and actual experiences. It is in this sense that the study values differences in findings resulting from each method rather than considers this a failing.

4.2.3 Ethical considerations

The study involved nurses working in one hospital. Since the nurses were recruited in a hospital, a certain amount of time needed to be set aside for them to fill in the questionnaires and to participate in the interviews, which demanded a time commitment from the nurses as well as from the hospital. The guarantee given by the researcher that the study would promote the interests and benefits of the nurses in the area was delivered on through the careful design of the questionnaires, the authorities' supervision and the researcher's efforts. Ethical considerations demanded that any interruption of their work be kept to a minimum, that their

benefits be considered, and that their identities be kept confidential in order to expose them to as little harm as circumstances permitted. A series of specific actions were carried out which are discussed below to demonstrate how ethical considerations were implemented.

The study followed the regulations and procedures of the local ethics committee. The study gained the approval and permission from both the hospital's Research and Development Office (R&D Office) and the local NHS Research Ethics Committee before going into the hospital. Thus, all of the potential ethical issues had been reported and considered before the collection of data in the hospital.

Before distributing the questionnaires to the nurses, senior nurses and clinical managers were informed about the study and permission for the study sought and granted. The clinical managers helped distribute the questionnaires to the Charge Nurses on the wards. The questionnaires were given to the nurses only after achieving agreement to administer the survey questionnaires on the wards from all managerial levels. It was essential to protect the nurses' right to decide whether to be involved in the study or not. In order to guarantee the voluntary basis of participation, every questionnaire package included an invitation letter, an information sheet and instructions about the questionnaire. The nurses were completely free to decide whether or not to return the completed questionnaire. The package also contained an invitation letter and a consent form for the following interview. A brief report of the findings was promised to be available to everyone who was interested in the study.

As the interviews were to take place in the workplace, it was necessary to withdraw the nurses from the patients, whose safety and quality of care were considered. An appointment was made before each interview would take place. The interviews were conducted only after the nurses had informed the Charge Nurses and arranged their own work properly.

As the nurses were effectively asked to self-report on their clinics in health promotion, the study adopted a confidential and anonymous process. No one could identify an individual taking part from the reports. The Charge Nurses helped the researcher to distribute the questionnaires, and then the nurses were asked to seal the envelopes and return them to a designated area. No names were printed on the envelope of the questionnaire package. The questionnaire itself did not record the

names, but instead used post-registered reference numbers. The process guaranteed that the researcher would not contact the nurse directly, and the Charge Nurse would not know who had participated in the study. Only the volunteers who had signed the consent form were contacted by the researcher personally.

According to the literature review, previous studies had suggested that health promotion was practised poorly in hospital settings, despite the majority of hospital-based nurses appeared to have a strong commitment to the value of the role in hospital (see Chapter Two). The tension between preconceived values and performance in reality might lead to nurses' "cognitive dissonance", involving feelings of being unhappy, worried, upset and even guilty about themselves. With this in mind, some background information regarding current health promotion practice in general was provided after the interviews, which helped the nurses see the problem in a wider context rather than blaming themselves for any perceived shortcomings.

Interviews are dependent on person-to-person interaction, making it all the more important to respect the confidentiality and anonymity of the participants. According to the UK Data Protection Act, any recorded documents, including participants' voices and any notes taken in interviews, must be locked away at all times, and can only be accessible to the researcher. These are to be destroyed once the research has been finished.

4.3 Tools for data collection

A survey questionnaire and a semi-structured interview schedule were designed to facilitate the collection of data.

4.3.1 Developing the survey questionnaire

The survey questionnaire is a tool for gaining information from the sample of nurses to whom the survey questionnaire is administered. Berland et al.'s (1995) questionnaire was adapted for the purpose of examining the nurses' role expectations and experiences in hospital nursing in Scotland. The details of the

process of adaptation and development are discussed after introducing the original questionnaire.

4.3.1.1 Survey questionnaire by Berland et al. (1995)

According to the literature, several studies have constructed survey questionnaires to investigate nurses' health promotion role, and these were considered as the basis of a questionnaire for the current study. Selecting an existing questionnaire from previous studies requires consideration of the similarity of interests and the quality of the questionnaire's construction. Four studies reported in the literature had similar interests to the current study, two of which had been carried out in the UK. The other two took place in Canada and Hong Kong respectively (Berland et al., 1995; McBride, 1994; Thomson & Kohli, 1997; Twinn & Lee, 1997). Only Berland et al.'s (1995) questionnaire has a wide coverage of nurses' attitudes, beliefs, values, knowledge and practice of health promotion in hospital, while the other three studies only covered some aspects of the subject.

Berland et al.'s questionnaire certainly is well constructed because it has been systematically and rigorously formed via a focus group exploring nurses' views on the health promotion role. Given the lack of support in the literature in the 1990s, the focus group interviews helped the author to arrive at a number of hypotheses and obtain detailed answers directly from nurses. The questionnaire was designed on the basis of the analysis of the focus group from which the item-pool was formed. After piloting the questionnaire with 20 nurses, Berland et al.'s questionnaire was further tested in a survey of 300 nurses in both general and community hospitals. This standardized process applied to developing the questionnaire resulted in a quality questionnaire in terms of validity and reliability of the scale construction.

Another important feature of this questionnaire is that it has a strong theoretical framework as its foundation of scale construction. Berland et al.'s study presumes that the nurse's role in health promotion is the leading concept, which is underpinned by a set of items in the questionnaire. The subscales emerging from the item-pool are organized by a well-known health promotion planning model: the Precede-Proceed model (see Chapter Two). A total of 53 items has been clustered

into three grouping subscales: "Predisposing Factors" (n=33); "Enabling Factors" (n=16); and "Reinforcing Factors" (n=4). Another three subscales are identified in the process of analysing the data from the field: "Actual Knowledge" (n=4), "Perceived Self-efficacy" (n=5) and "Promotion Activities" (n=10). The high validity of the questionnaire was arrived during the process of framing a "theoretically informed design", followed by testing it in the field. Berland et al.'s questionnaire applies a popular scaling model, a 5-point agreement Likert scale. A Likert scale is regarded as an easy construction, with precise information about a respondent's degree of agreement or disagreement (Oppenheim, 1992). In the questionnaire, the Likert scale measures the degree to which nurses agree with a proposition on an attitude continuum, from "strongly agree" to "strongly disagree".

In general, Berland et al.'s questionnaire has an acceptable consistency regarding its internal reliability since its Cronbach's coefficient alpha of the overall 53 items is 0.87 (Table 4.1), which is acceptable for statistics (Polit, 1999). However, it is also noticeable that "Reinforcing Factors" and "Actual Knowledge" seem to have a fairly poor performance on the internal reliability measure, while "Promotion Activities" lacked a reliability test in the original study. A possible reason might be related to the fact that the scale is only used to explore the frequency of health promotion activities without further intention to explore the associations with other subscales. The scaling from 1-10 rather than 1-5 as normal on a Likert scale suggests that the original questionnaire needs to be carefully examined and further adapted for the present study.

Table 4.1 Subscales and Means, Standard Deviations, Cronbach's alpha (α)

Subscales	Items	Theoretical Range	X	SD	α
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	--

(Berland, Whyte and Maxwell (1995) Hospital Nurses and Health Promotion *Canadian Journal of Nursing Research* **27** (4) 13-31)

In summary, Berland et al.'s (1995) questionnaire is a well-developed and user-friendly instrument on the topic of nurses' health promotion role in hospital. Its inductive process of scale construction and its theoretical framework improve the validity of the questionnaire while further field testing guarantees the quality

and practicality of the questionnaire. Although it needs still further testing in the setting of the current study, the questionnaire is considered suitable for use in the exploration of nurses' health promotion role in hospital. After gaining Berland et al.'s agreement, the questionnaire was employed in this study.

4.3.1.2 Development of survey questionnaire

The original questionnaire had to be adjusted for use in the UK context, and it might not have retained the same value when applied to a different country and hospital setting, especially a decade after its formulation. Other factors, such as language and cultural differences, were also taken into account in adapting the questionnaire for this study. The changed context could be an issue influencing the findings.

The questionnaire needs to meet the interests of this study which emphasizes the nurses' role expectations and experiences. The variable "Role Expectation" is the one variable that is significantly different from the original questionnaire. Since the original questionnaire is guided by the Precede-Proceed model, the nurses' attitudes, beliefs and values are clustered together as "Predisposing Factors". However, the current study, on the one hand, has a further interest in nurses' role expectations, while on the other hand, it considers the "Predisposing Factors" too condensed a notion, with the potential to conceal the complexity of nurses' opinion of health promotion role. A reorganization of the items in the original item-pool was carried out to form the variable "Role Expectation". Therefore, the questionnaire as adapted for the current study includes two fundamental parts: the demographic variables and the Likert scale items. Apart from the main body of the questionnaire, there is a brief instruction at the beginning and a blank space for any additional information at the end. A sample questionnaire is provided in Appendix 4.

Demographic Variables

The demographic questions are in the first part of the questionnaire (Section A). Referencing the relevant literature, the questionnaire has a list of demographic

variables, including "Practice Area", "Qualified Years" of RN (Registered Nurse), "Education Level", "Grade", "Age", "Gender", "Work Time" and "Current Position". Table 4.2 shows the demographic variables and the categories in each variable.

Table 4.2 Demographic Variables in Survey

Variables	Categories
Practice Area	Medical Care/Surgical Care
Specified Ward	Open Question (left blank)
Gender	Female/Male
Work Time	Full-time/Part-time
Education Level	RN/RN-Diploma/RN-Bachelor's Degree/RN-Honour's Degree/ RN-Master' Degree
Grade	Grade C/Grade D/Grade E/Grade F/Grade G/Grade H/Grade I
Qualified Years	1-4 years/5-9 years/10-14 years/15-19 years/20-24 years/25-29 years/30+ years
Age	20-29 years/30-39 years/40-49 years/50+ years
Current Position	Staff Nurse/Specialist Nurse/Charge Nurse/Other

The answers to demographic questions are helpful to gain a general profile of the nurse respondents and the population they represent. The information provides a general context of the study, such as nursing resources, education background and hospital management. Another significant function of demographic variables is to group nurses under several categories. The demographic variables might account for different nurses' attitudes and opinions on the health promotion role. The assumptions and hypotheses about the influence of demographic factors were established drawing on common sense and the literature. For example, the analysis tells whether the nurses' health promotion role is the same on the medical wards and the surgical wards. The same interests are also concerned around work-time patterns and nurses' education levels.

A special consideration of the variables "Age" and "Qualified Years" is to protect nurses' privacy and avoid offence which could cause resistance to continuing to answer the questions. Therefore, these questions are designed as categories or ranks, rather than requiring an exact number as response.

Usually, it is recommended that demographic questions should be asked in the final part of the questionnaire, in order to avoid respondents becoming reluctant about being asked personal details (Oppenheim, 1992). In the current study, the demographic questions are considered to be easier questions than others, and by asking them early, it is hoped that they will encourage the nurses to become more

participative and involved in the study. Besides, the questions are designed in a friendly way to avoid putting nurses off.

Constructing the Scales

Concepts in social science are usually complex and cannot be adequately captured with a single question (De Vaus, 2002). A concept needs to be operationalized as several related items, which could then be aggregated and constructed as a subscale. De Vaus (1996) also suggests that, if a well-constructed scale exists, one should use it, because a scaling needs many years of testing. By carefully considering these conditions, Berland et al.'s five subscales with a total of 49 items are adopted for this study: "Predisposing Factors" (n=33), "Enabling Factors" (n=16), "Actual Knowledge" (n=4), "Perceived Self-efficacy" (n=5) and "Promotion Activities" (n=10). Only "Reinforce Factors" (n=4) has been abandoned because of its far less reliable performance (see Table 4.1). The adopted subscales have also kept their form as a Likert scale and the exact wording of the majority of items is as used in Berland et al.'s study. The small adjustment in the wording is based on language and cultural differences between Canada and Scotland (see Appendix 10 for Berland et al.'s scaling and items, and Appendix 4 for the questionnaire used in the current study).

The big adjustment is the dividing of the scale "Predisposing Factors" and re-grouping it into two subscales. As discussed above, "Predisposing Factors" is supposed to be a group of factors clustering attitudes, beliefs and values due to the Precede-Proceed Model. Berland et al.'s questionnaire follows the rationale of the P-P model without acknowledging that "Predisposing Factors" could include more than one dimension. In other words, "Predisposing Factors" as a scale in the original questionnaire probably suffers from a deficit in blending multi-dimensioned concepts together. The current study thus specifies a subscale of "Role Expectation" created from the existing items of "Predisposing Factors" of the original questionnaire.

The process of regrouping "Role Expectation" starts to clarify the difference between the concepts "role expectation" and "actual practice". The items from "Predisposing Factors" are identified and separated into two groups which refer to

role expectation and actual practice respectively. The process of grouping the subscales is based on the analysis of the meaning of each item under the criteria of content validity. The items which state the beliefs and values of the health promotion role usually go into the "Role Expectation" section (Section C) in the questionnaire, while the questions exploring the actual practice of the health promotion role are clustered into the "Experience" section (Section B) in the questionnaire. It is significant that when nurses are like "outsiders" they perceive the health promotion role in an idealised form, which is different from their actual practice as "insiders". In brief, "Role Expectation" seeks to examine nurses' perceptions of the health promotion role, while "Experience" is related to what nurses practise when carrying out the role in hospital.

One important factor is the strong emphasis on statements with a self-identifying word, such as "I", "my" or "me", which acts as indicator of the actual performance of the health promotion role. For example, the item "I changed the hospital rules or routines to accommodate patients' control" obviously represents the personal experience of health promotion practice, whereas the item "Teaching patients about disease processes is an important aspect of a nurse's role in health promotion" represents the role expectation as perceived objectively by nurses. Other items describe factual aspects of nurses' experience, such as items 2, 8, 19, etc. (see Table 4.3).

Items (items 34, 35) relevant to smoking and alcohol issues have been added to the "Section B" of the questionnaire. This was done on the advice of experts from the Local Research Ethical Committee (LREC). Both issues are considered problems on an epidemic scale in Scotland. The literature also supports that nurses be involved in the smoking and alcohol programs in nursing practice in Scotland.

The "Enabling Factors" lists the designed influencing factors that influence the extent of health promotion practice in hospital, in "Section B" of the questionnaire. Nurses are asked questions about external influencing factors, such as the hospital environment, resources, ward level routines and personal actual knowledge. These factors, external to the nurses, either help or hinder the health promotion practice (see Table 4.4).

Table 4.3 Items of Experiences in Health Promotion (Questionnaire Section B)

1. There are potential health benefits for patients when I teach them about their medications.
2. Patients expect nurses to encourage them to adopt healthy lifestyles.
3. I encourage patients facing discharge to carry on with healthy behaviours learned in the hospital.
4. I generally model healthy lifestyles for my patients.
5. Encouraging patients to share experiences about procedures is part of my role in health promotion.
6. Ensuring a healthy work environment is important to me.
7. Health promotion is an important part of my role.
8. The hospital nurse's health promotion activities are incidental rather than planned.
9. I changed hospital rules or routines to accommodate patients' control.
10. I involve patients' families/caregivers in health promotion when appropriate.
11. I direct my health promotion activities to my nursing colleagues.
12. I am satisfied with my skills in health promotion.
13. My knowledge on self-care is adequate.
14. I am comfortable in teaching patients about self-care.
15. I have the ability to advocate for a healthy hospital.
16. I have the ability to advocate for a healthy community.
17. I am involved in health promotion activities in my community.
18. There is easy access to up-dated resources on health-related topics that help me in my health promotion efforts.
19. There are adequate resources for teaching chronically ill patients coping skills.
20. Hospital activities on health promotion topics support a nurse's ability to carry out health promotion activities.
21. The team approach to patient care strengthens a nurse's health promotion efforts.
22. My hospital is supportive of health promotion activities.
23. Lack of continuing of care between different hospital departments interferes with a nurse's health promotion efforts.
24. Time constraints are a barrier to nurses undertaking health promotion activities.
25. Health promotion efforts would improve if there were more time for case conferences, in-service education and bedside teaching.
26. Hospital nurses' health promotion efforts would be strengthened by consistent patient teaching.

27. Incomplete written records hinder a nurse's health promotion efforts.
28. I can refer patients to community agencies.
29. Knowing about cultural values helps nurses in their health promotion efforts.
30. If I learn more about health promotion, it will help me provide better patient care.
31. My experience as a nurse has taught me about health promotion.
32. In my basic nursing programme, health promotion was included in the course work.
33. Since graduation I have taken courses on health promotion.
34. Educating patients to give up smoking is part of my job.
35. I am confident in teaching patients to change their alcohol abuse habits.

Table 4.4 Items of Role Expectation (Questionnaire Section C)

36. A healthy lifestyle is an important topic for patient teaching.
37. Teaching patients how to care for themselves is an important part of a nurse's role
38. Teaching patients about disease processes is an important part of a nurse's role in health promotion.
39. There are health benefits for depressed patients that result from a nurse's counselling efforts.
40. Nursing practice includes comforting patients and their families/caregivers.
41. Counselling patients following physical abuse is part of a nurse's role.
42. Health promotion activities include enhancing patients coping skills.
43. Sometimes nurses plan and deliver care to make the lives of patients as normal as possible during their stay in hospital by encouraging them to be independent and to live as much like a "normal" person as possible.
44. Health promotion group work with patients is sometimes part of a hospital nurse's practice.
45. Encouraging patients to advocate for themselves is part of a nurse's role in health promotion.
46. Health promotion in the community is part of a nurse's role as a member of the community.
47. A nurse must assume the role of patient advocate.
48. It is important that hospital nurses are involved in discharge planning.
49. Family members/caregivers are included in a hospital nurse's health promotion efforts.
50. Health promotion principles apply in caring for terminally-ill patients.
51. Health promotion is an "everyday thing" for nurses.

It needs to be restated that the questions in the survey are based on the study by Berland et al. during the early 1990s. The health promotion activities fall mostly under the strategy of health education (see Chapter Two). In the original questionnaire, these activities are common ones for nurses, carried out on a daily basis in acute hospital settings in Canada. The demographic variables in the questionnaire help with presenting the diversity of groups of nurses in different countries. The consideration of any special aspect of the health promotion role in the country where this study is located would be completed by the follow-up semi-structured interviews.

In the questionnaire, the "Section B" is arranged before the "Section C" for considering that the nurses might be more comfortable with answering the questions in the "Section B" which comprises the feelings and activities that nurses' experience every day. In addition, the "Section B" is designed to generate "awareness" of health promotion, i.e. to help the respondents engage in the questionnaire (Oppenheim, 1992). The questions in the "Section B" are meant be a "warm-up" for the "Section C". In this way, the order of the sections helps the participants to think about their own experiences.

Validity and Reliability Reconsiderations

Validity and reliability are two technical criteria by which to judge the quality of a survey questionnaire (Punch, 1998). Validity indicates how well a questionnaire measures a given topic under certain circumstances and with a given group (Burns, 2000), while reliability indicates how stable and consistent it is. Therefore, the issue of the questionnaire's validity and reliability should be considered again after any adaptations have been made.

The original questionnaire makes many efforts on both scaling and its construction, as discussed above. After adapting the items and patterns of the subscales of the questionnaire for the current study they should have similar validity in the construction of the scaling. The subscale "Role Expectation", newly developed for the current study, is based on the definition of role expectation and the meanings of the items constituting the subscale, which in turn is required to meet the criteria validity. The questionnaire was checked by experts from LREC.

4.3.2 Schedule for semi-structured interview

The semi-structured interview aims to discover information that goes beyond the questionnaire survey, and to seek explanations for at least some of the survey findings. The interview schedule covers three topics, following the variables of the questionnaire: "health promotion in hospital", "nurses' health promotion role" and "nurses' experiences in health promotion". Accordingly, the scaffolding questions are organized into three sections. The questions on the schedule are in the form of either open-ended or closed questions. In the current study some questions are designed to have follow-up questions, seeking elaborations of the context of the answers (Rubin & Rubin, 1995); see Appendix 6 for the full interview schedule.

In the first section of the interview schedule, the nurses are asked their opinions of health promotion in hospital. Answers provide the general views held by nurses of health promotion in the context of hospital settings. In the second section, the interviewees are asked their attitudes, values and beliefs about the health promotion role. They are asked their reasons for taking on the role, which helps to see the factors influencing nurses' health promotion role in a wider context, such as any educational and political factors. The third section of the interview schedule emphasizes the nurses' experiences in performing health promotion. A description of the content of the health promotion role is required of the nurses which is supposed to outline how nurses perceive the role as well as the extent of the practice in the current hospital nursing situation. During the interviewing, the nurses' response may be varied to their daily practice and encounters. They may also display feelings and emotions about things that have happened in practice so the researcher needs to be prepared for that kind of response as well. In particular, the support or the barriers perceived or experienced by the nurses in health promotion practice are examined in detail by follow-up questions.

Extra questions are designed and asked of the specialist nurses at the end of the interview schedule (see Appendix 6). Based on an understanding of the divisions in hospital practice, specialist nurses may be more involved in health promotion practice than staff nurses with regard to the volume and quality of health promotion. The interviews with Charge Nurses also present a special case. As Charge Nurses work at the management level, their views are very important since they are likely

to influence other nurses' attitudes and behaviour. Thus, the interview questions were designed to relate to the management of the health promotion role and its practice (see Appendix 7).

4.4 Pilot study

Before the main data collection, both the survey questionnaire and the interview schedule were piloted in the field.

4.4.1 Piloting the survey questionnaire

The survey questionnaire was tested to see how long it would take the nurses to fill in the questionnaire by trying them out on two volunteer student nurses involved in clinical training. The researcher recorded how long it took by each participant to fill in the questionnaire, keeping them unaware of the fact that their speed was monitored. After they had completed the questionnaires, the student nurses had briefly commented on the questionnaire. In addition, the following questions were asked: "What do you think about the questionnaire?", "How difficult did you find the questionnaire?", "Can you give me some advice on improving the questionnaire?", etc.

Though the survey questionnaire had been used and tested in a previous study in Canada, differences in language and working circumstances were taken into considerations. This has been addressed in the above section of developing the questionnaire. The survey questionnaire was tested in the hospital for the purpose of further refining the wording, order and layout (Hoinville & Jowell, 1978). The main piloting was then conducted in the hospital with the emphasis on improving face validity. The Charge Nurse in one cardiology ward agreed to participate in the pilot study and five questionnaires were distributed to nurses on that ward. The nurses were made aware that the study was for piloting purposes. They not only gave their responses in the questionnaire, but also provided written comments for improving the wording and appearance of the questionnaire in the margins.

The piloting of the questionnaire gave clues as to what the likely responses to the questions would be. Especially in a cardiology ward, it was expected that the nurses perform a relatively good job with regard to health promotion. The nurses in the pilot study had many experiences of promoting health. The piloting and its results helped the researcher to begin to be familiar with the field. Further, the pilot study helped me to improve the wording of the questionnaire. Face validity of a questionnaire is improved when pilot testing shows whether its items are understandable or not. For instance, the word "healthful" has been changed to the British English term "healthy", and item 43 in the original questionnaire, which states that "sometimes nurses plan activities that "normalize" the hospital environment", has been changed into what would be understandable by nurses in Scotland, while keeping the meaning of the original question. Instances of working language which differed from Canada were also changed. Some phrases in Item 25 caused confusion for the nurses in the pilot study. After confirmation with the author by emails, Berland et al. give her explanations of "patient conferences" and "in-services" in Canada. With the help of the researcher's supervisors, the phrases were translated into "case conferences" and "in-service education", which better suit the UK context.

4.4.2 Piloting the interview

One of the purposes of piloting the interviews was to test the interview questions. The interview questions had been developed from the research questions. It was essential to test the questions in the field to see how they would work in the real world, and to find out how interviewees might respond. The other aim of piloting the interviewing was to increase the researcher's interview technique.

An interview with one student nurse was conducted in the office of the university. Another two nurses participated in the pilot interview in the cardiology ward. The piloting completely imitated the real environment of interviewing, such as the room and the time of the interviews. The pilot interviews were also recorded by a digital voice recorder for further analysis. Recording the interview during the piloting helped the researcher to improve her interviewing techniques, and to manage the questions more skilfully when doing the main study.

4.5 Main study

This section discusses how main study has been conducted. It includes the definition of the population and the participations, the recruitment of the participants for the study, the process of data collection, and the discussion of the strategies for data analysis.

4.5.1 Population and participants

This section provides a definition of the population of the study and the method used for sampling the participants. This is followed by an account of the management of the study.

4.5.1.1 Definition of population

The population of this study intends to cover general qualified nurses who are working for health promotion in hospital settings in Scotland. This excludes nurses from specialist wards. The criterion used to exclude specialist areas is relatively narrow nursing practice that deals with particular diseases, such as in rheumatology, dermatology and neurology. It is presumed that health promotion on such wards is treated differently from other wards. For example, Berland et al. (1995) found that health promotion was a controversial topic with terminally ill patients in some wards, such as oncology and haematology. Moreover, the special characteristics of such working areas may mean that there are unpredictable external factors influencing the findings, even resulting in deviation from this study's principles.

The other consideration for excluding the specialist areas comes from the patients for whom the nurses care. Health promotion is supposed to be more for people who are able to make decisions and changes for healthy behaviour. This requirement is different if realized in high dependency wards where the patients are very ill and dependent on intensive care. The priority of medical treatment is probably be far more important than health promotion practice. Therefore this study will only look

at nurses' health promotion role in general medical and surgical wards, without involving the any specialist wards.

The questionnaire survey only takes into account qualified nurses in either full-time or part-time employment. Thus, trainee nurses or care assistants are excluded from the study. The reason for choosing qualified nurses is that they are the ones who can make independent clinical decisions on the wards, so qualified nurses are believed to perform the more complete role in health promotion.

Night staff are also excluded from the study population, since they are considered the group least likely to be assigned the role of health promotion. Night nurses usually do maintenance routines at night on the wards. Seldom do they have opportunities for doing health promotion with patients because patients like to rest at night. Health promotion happens more often in the daytime when patients are ready to consider the efforts they can make towards achieving better health. Nurses doing night shift exclusively make up only a very small number of nurses in the hospital. Nurses doing shift work, however, meet the criteria for participation since they have experience of promoting health on their day shifts.

The position of a nurse is likely to have an impact on her responses about the nurses' role in health promotion. The survey participants included Charge Nurses and specialist nurses, as they are presumed to be more active in health promotion practice. The study explores their valuable perspectives on nurses' health promotion role in hospital.

4.5.1.2 Sampling for the study

Sampling is the technique of selecting a group of people to represent the population in order to save effort and costs (Schofield, 1996). After the population has been defined, a method of random sampling should be considered which is ultimately supposed to represent the characteristics of the population. It needs a reasonable sample size and also appropriate sampling techniques to meet the criteria for a random sample.

Seeking a larger sample to cover more locations would be ideal, but it is not what the researcher could manage. Availability of resources was one of the most

important factors in making decisions about sample size in the study. As an unfunded doctoral project, time and budget constraints are unavoidable but realistic issues. As a compromise, the study was undertaken in only one local hospital. It is believed that "a small study, well-designed and executed is superior to a large study that has been messed up" (Sudman, 1983, p. 149).

It seems a questionable decision to have only one hospital representing the nurses in hospital in Scotland. Yet, Sudman (1983) suggests that "the quality of sampling depends entirely on the stage of the research and how the information will be used" (p. 146). In this study, information gathering is not focused on generating statistical representativeness about the population; instead, the priority is to comprehensively describe and interpret the role of nurses in health promotion, via measuring the range of nurses' perceptions rather than pursuing numerical precision. In this sense, the nurses in one hospital convey a broad and insightful picture of nurses' health promotion role in hospital settings. Although the current study only sampled one hospital in Scotland, its findings certainly reflect the situation of the health promotion role of nurses beyond this hospital and throughout the country.

All of the nurses in the hospital who met the study criteria were selected for the survey. In principle, a study involving all wards in the hospital, with each ward a sampling unit, would present the best chance of representing the characteristics of nurses' health promotion role in a hospital setting, and also be the most accurate. However, the sampling carried out is a case of probability sampling, as all the wards in the sample frame have an equal chance of being involved in the study (Fowler, 2002). The hospital selected for the study has about 400 nurses, while the number of nurses belonging to the defined population is estimated to be 200-300. In practice, a sample size of 150-300 is quite common for doctoral research (Kent, 2001; Sudman, 1983). More confidence was gained after reviewing previous studies which were conducted with a similar number of 150-300 nurses (Berland et al., 1995; McBride, 1994; Thomson & Kohli, 1997). In the current study, the participant nurses were necessarily divided into two groups: medical wards and surgical wards. For considerations of statistical analysis, each group had to have at least 50-100 cases after excluding the non-responses, which is sufficient for the required statistics (De Vaus, 1996).

A further estimation of an appropriate sample size aimed to avoid a Type II error when analysing the associations between subscales. In the current study, the sample size was estimated by using the technique of power analysis (Power=0.8 and alpha=0.05), mainly based on Berland et al.'s (1995) study, which shares a similar survey questionnaire. The co-efficient between subscales found in Berland et al.'s study varied from 0.30 to 0.70. Accordingly, the sample size in the current study required from 17-88 per group (Polit & Hungler, 1995).

For the interviews, convenience sampling is employed. The recruitment of interviewees was based on volunteering. Any nurse who completed the questionnaire was welcome to sign up for an interview. Other nurses who had not completed the questionnaire were also considered for the study.

4.5.1.3 Setting and gaining access to participants

The hospital where the participations were located is one of the hospitals in Scotland which provides a broad service in both acute medical and surgical areas. According to the definition of the study population, as discussed above, only nurses from the general medical and surgical wards were recruited while nurses from the specialist areas were excluded. The definition of general medical and surgical wards is based on the nature of nursing practice because some wards are not easily identified by only looking at the name of the wards. For example, nurses from the acute receiving unit and the medical assessment ward deal with any patient before being diagnosed. The nature of nursing practice is still that general nursing is delivered to the patients although they may be patients with a mixture of medical and surgical health problems. Therefore, the above two wards are included as general medical wards in the current study. The Charge Nurses and other nurses helped to confirm the nature of the wards by reporting what type of nursing practice they conduct daily on the wards. In order to protect the anonymity of the hospital serving as the study site and the participant nurses, the list of wards that participated in this study is not provided here.

The process of gaining access to the participants was a top-down process. First of all, permission for the study was given by the R&D Office in the hospital and then by the local NHS Research Ethics Committee. The Director of Nursing was

contacted in order to seek permission and cooperation for this study. An opportunity was given to the researcher to meet with a Senior Nurse who was in charge of the research practice in the hospital. After agreement about the study procedure, including the questionnaire and its related documents, was reached, the Senior Nurse helped the researcher to go on the wards by sending emails to the Clinical Managers of each division of the medical and surgical wards. The questionnaire packages, which included the information sheet, were read through by the Clinical Managers. Once they were satisfied with the conduct of the study, the Clinical Managers helped to circulate the questionnaire package to the Charge Nurses on each ward. Meanwhile, email addresses were given to the researcher in order to enable direct contact with the Charge Nurses on each ward. At the ward level, the Charge Nurses were the first persons who read the questionnaire and information sheet about the study. After they had examined all of the documents and the study procedure, the questionnaires were allowed to be distributed on the wards. According to the guidance of security and privacy policies by the local NHS Research Ethics Committee, the nurses' names remained inaccessible to the researcher.

4.5.2 Data collection

This section presents a complete account of the data collecting process followed in the current study. First the questionnaire survey is described, as it does in the conduct of the data collection, followed by a description of the interviews.

4.5.2.1 Questionnaire survey

A questionnaire package contained an invitation letter, an information letter, the questionnaire and an envelope for returning the completed questionnaire. The invitation letter and the consent form for recruiting volunteers for the follow-up interviews were included with the questionnaire package.

The distribution of the questionnaire packages was dependent on the Charge Nurse on each ward. Once the Charge Nurses had agreed to the study, the researcher made contact by email to arrange appointments for visiting the wards. The Charge

Nurses were given information about the study, including the selection criteria for the participants. The Charge Nurses provided information about the number of qualified nurses on their wards. Once they had received the questionnaires, the researcher and the Charge Nurse worked out the best way to distribute them to the nurses.

The Charge Nurses helped the distribution of the questionnaires to each nurse. The wards had different cultures and working styles. The questionnaires were put in each nurse's mail box on some wards, or given by the Charge Nurse to each nurse in person when they were on duty. On other wards, the questionnaires were displayed in an obvious place with an eye-catching poster. No matter what methods were used, the most important point was that the Charge Nurse acknowledged the importance of having every qualified nurse access to the questionnaire package.

The completed questionnaires were returned to the Charge Nurses. Posters advertising a spot where the nurses could return the completed questionnaires were put up in each ward when the study began. The purpose of the posters was to maintain the nurses' anonymity and to encourage them to participate freely in the research, rather than being influenced one way or the other by the Charge Nurses. This process was designed to encourage the nurses to fill in the questionnaire and to provide the most honest answers.

Clear instructions and a deadline printed on the questionnaire told nurses that they had two weeks to complete the questionnaires. Another week was allowed for tracing non-responses. Rather than having the questionnaires returned by the postal system, the researcher collected the completed questionnaires, ward by ward. This procedure was implemented in order to save the nurses' energy and time associated with posting material and also to avoid the cost of postage and the potential loss of questionnaires in the post. This proved to be a practical way for the researcher to trace the information on non-responses on each ward.

4.5.2.2 Interviews

The follow-up interviews were conducted shortly after the questionnaire survey. The participants were those had voluntarily signed the content forms after

completing the questionnaire survey. However, it is not necessary to consider the interviewees as a sub-sample of the survey participants. In this study, the questionnaire survey at the first stage indeed provided a convenient way of recruiting nurses, contributing to covering a wide range of work areas, as the recruiting letter was part of the questionnaire package. The weakness of volunteer recruitment is self-selection (Parahoo, 2006). As a result, the nurses on the medical wards were more involved than those on the surgical wards. Some of the possible reasons for this are discussed in the analysis chapters, i.e. Chapters 5 and 6.

A total of 16 interviewees from the medical and surgical wards participated in the interviews. Table 4.6 lists the interviewees with their demographic characteristics, including 11 staff nurses, two specialist nurses and three Charge Nurses.

Table 4.5 Distribution of Interviewees

Interviewees and Area	Specialty	Position
11 Nurses in Medical Areas	Cardiology	Staff Nurse
	Cardiology	Staff Nurse
8 Staff Nurses	Respiratory	Staff Nurse
	Respiratory	Staff Nurse
	Gastro-intestinal	Staff Nurse
	Medical Assessment	Staff Nurse
	Acute Medicine	Staff Nurse
1 Specialist	Acute Medicine	Staff Nurse
	Infectious Diseases	Specialist
2 Charge Nurses	Acute medicine	Charge Nurse
	Geriatrics	Charge Nurse
5 Nurses in Surgical Areas	Urology	Staff Nurse
3 Staff Nurses	Colorectal &Urology	Staff Nurse
	Colorectal	Staff Nurse
1 Specialist	Urology Clinic	Specialist
1 Charge Nurse	Colorectal & Acute Admission	Charge Nurse

Each interview normally took about 20-30 minutes but a few of the nurses had more to talk about so that their interview lasted about 40 minutes. All of the interviews were conducted in the ward offices, quiet rooms, without any interruptions. The nurses were guaranteed that all of the information they provided would be treated confidentially.

The interview started with an introduction to clarify the aims of the study and to address any anxiety about the interview topics. The nurses had been informed that

the interview was not an attempt to judge whether they worked well or not, and it was reiterated at the beginning of the interview that its purpose was to gather nurses' opinions and experiences regarding the health promotion role. Field notes were made immediately after the interviews which recorded any comments on the interviews. The interviews were recorded and the audio transferred onto computer for storage. Then all of the recordings were transcribed verbatim. Although the researcher did most of the transcribing, for the transcription of three interviews professional editors were brought in because of the challenge posed by fast talkers. All of the transcripts were checked by professional editors.

4.5.3 Data analysis strategies

This section discusses the data analysis strategies employed for the survey data and the interview data, and the justification for the choices made. A more detailed discussion is presented in the chapter 5 and chapter 6.

The survey questionnaire was designed in such a way as to facilitate the statistical analysis of the data gathered. Therefore, the data gathered via the questionnaires were coded into numeric variables, with the exception of extra comments made by the nurses on the last page of the questionnaire. The coded data were entered into the Statistical Package for Social Scientists (SPSS) Version 11.5. The statistical methods included descriptive statistics and the analysis of the correlations between the variables or groups for the purpose of providing a statistical description of what was recorded in the nurses' accounts regarding the health promotion role (see Chapter Five).

The interview data were analysed according to two stages of analysis: the preliminary data analysis stage and the final analysis stage. The preliminary data analysis was carried out immediately after the first interview. This preliminary analysis aimed to "highlight emerging issues, to allow all relevant data to be identified and to provide directions for the seeking of further data" (Grbich, 2007, p. 25). At this stage, the initial analysis of the data was used to adjust the interview schedule until it was settled. This was an on-going process of engaging with the text, recognizing the significant issues. In achieving this purpose, the open coding technique suggested by Strauss (1987) was selected; it provided the guidelines to

examining the interview data by "breaking down, examining, comparing, conceptualizing and categorizing data" (Strauss & Corbin, 1990, p. 61).

The follow-up interview was designed to fulfil not only the task of explaining the survey results, but also to open up to nurses' insights into the health promotion role and to see what had shaped their experiences of health promotion in the hospital. For these reasons, open coding was used as a way of examining the data in depth, and to stimulate the generation of ideas. Open coding is designed to find themes by thoroughly scrutinizing the data and constantly comparing them among the interviews. This helped to generate concepts and allowed them to be grouped and turned into categories (Bryman 2012, p.569). This process provided key issues and words to feed into the final analysis.

When all of the data had been gathered, a final analysis was initiated. The analysis at this stage focused on key concepts and issues in the data by systematic and thorough exanimation. Firstly, when all the transcripts had been gathered, there were many texts to be analysed but content analysis has the merit of allowing the processing of large amounts of information (Grbich, 2007). Secondly, the qualitative data collected were from a follow-up semi-structured interview which had been designed to complete and explain the survey results. It means that the researcher already had key ideas of what to look at in the analysis. The content analysis was particularly good at examining how the ideas had been shaped in nurses' accounts (Grbich, 2007).

Thirdly, content analysis is a good method for combining the findings from the quantitative method and the qualitative one. Moreover, it is sufficiently flexible to combine enumerative and thematic content (Grbich, 2007):

> This combination of quantitative and qualitative methods allows for a more reflective approach to the analysis of documents and enables contextualisation and the development of theoretical interpretations which can link to the structural organizations producing the events. (p. 120)

This reflexive combined approach includes both enumerative and narrative descriptive tools which can serve "to illuminate critical questions and issues beyond what it presented" (Grbich, 2007, p. 121). This was the ideal design for the mixed-methods research conducted in this study. Fourthly, the content analysis

provided a sense of "objectivity" (Grbich, 2007). This characteristic is important for the study since the nurses' accounts focus on role expectations and their experiences, and it was important to keep their perspectives and emotions at a distance. In light of these four considerations, the thematic content analysis was able to serve the goals of the study. A detailed account of the process of qualitative analysis will be presented in Chapter Six.

4.6 Summary

This chapter has presented the whole study process in great detail, from specifying the aims and research questions to data collection and analysis. This chapter restates its concern with building up the concept of a social phenomenon, namely of the health promotion role. The central idea driving the study is not scale or broad coverage, but to collect sophisticated data that allow us to provide an in-depth understanding of what is going on in the nurses' world of health promotion in hospital. Thus, the study combines a questionnaire survey with interviews of the nurse participants, thereby being able to examine the health promotion role from different angles. The questionnaire survey seeks to achieve validity and reliability, while the semi-structured interviews seek a balance between flexibility and structure while engaging participant nurses in providing their insights. The conduct of the data collection and analysis follows the research plan in attempting to achieve results that will answer the research questions of the study.

Chapter Five – Survey Results

In this chapter, the analysis of the quantitative data and the findings will be presented. First, the processing of the survey questionnaire will be outlined, including the response rates and techniques of analysis. Second, the respondents' characteristics will be described in order to obtain a profile of those sampled as well as the population from which they were drawn. Third, the statistical analysis of the data will be described and interpreted in order to present the nurses' role expectations and their experiences in health promotion practice in hospital nursing. Finally, the associations between the subscales will be identified and discussed with the objective being to explore the influencing factors of current health promotion practice. During the presentation of the findings, a number of graphics and tabulations will be displayed to strengthen the understanding of the survey results.

5.1 Analysis of survey data

The quantitative data from the survey is analysed using the *Statistical Package for Social Science Version 11.5* (SPSS 11.5). The online interactive statistical analysis, *Simple Interactive Statistical Analysis* (SISA), has also been used when SPSS was either inapplicable or inappropriate.

The data have been coded then input to an SPSS dataset. As all the data have been input by the researcher alone, the entries have been subsequently verified. A further systematic check has been conducted to guarantee the accuracy of the data: all of the demographic questions are re-examined and certain distance spread items (Items 5, 18, 30, 39, 47), which occupied 10% of the questionnaire, have been checked in every case.

The non-responses to some questions are left blank in the dataset, which could be recognized by SPSS as system-missing values. These system-missing values are excluded from any calculation during the analysis, so that they do not influence the analysis results. The implementation of missing value analysis shows that the demographic variables have no missing responses. The number of missing values for other questions is less than 4% of the total count. As this proportion would not

influence the results the non-responses have not been included in the analysis (Kent 2001).

5.2 Response rates

The survey questionnaires were distributed to 244 nurses from 13 wards in one hospital. In total, 115 nurses completed and returned the questionnaires. The total response rate was 47%. However, two questionnaires were less than half completed, and so were excluded from the analysis. The final number of respondents was 113, with a 46% survey response rate. This response rate is acknowledged as acceptable in the empirical field (Wilson, 1996).

The questionnaires were distributed in 13 wards, defined as covering two practice areas: medical wards and surgical wards. Although the distribution in the medical wards (n=68) is larger than in the surgical wards (n=45), the response rates from both wards are similar with the surgical wards (48%) having a 3% higher response rate than the medical wards (45%). The details of the response rates in different practice areas are displayed in Table 5.1.

Table 5.1 Response Rates from Medical and Surgical Wards

Practice Area	Distribution N	Original Response N (%)	Valid Response N (%)
Medical Wards	151	75 (50)	74 (49)
Surgical Wards	93	40 (43)	39 (42)
Cumulative n (%)	244	115 (47)	113 (46)

5.3 Characteristics of respondents

A list of nine demographic variables has been designed to elicit information about the characteristics of the nurses being investigated. These are either nominal or ordinal data, including the variables of Practice Area, Specified Ward, Work Time, Gender, Age, Education Level, Qualified Years, Grade and Current Position (see detailed categories of each variable in Chapter Four). The demographic profiles of the respondents in the survey are described here, and a further analysis is presented in order to test for differences between the subgroups of the nurses segmented by demographic variables.

5.3.1 Demographic profiles of respondents

The demographic variables are described and analysed in order to construct a picture of the sample of respondents being studied.

5.3.1.1 Practice Area

The hospital investigated in the study employs around 400 nurses in total, and the survey has been conducted across 13 wards, involving 244 nurses. This number includes the defined sample nurses but excludes a few wards which were unwilling to take part in the survey (for details of the sampling method, see Chapter Four). The respondents from the 13 wards belong to two general practice areas: "Medical Wards" and "Surgical Wards". Among the 113 respondents, there are 74 nurses (65%) from the medical wards and 39 (35%) from the surgical wards, as shown in Figure 5.1, so there are almost twice as many nurses from the medical wards as from the surgical wards participating in the survey. It seems to be a proportional result since the number of the original participants from the surgical wards is less than that from the medical wards.

Figure 5.1 Distribution of Respondents by Practice Area

The wards are also defined by the field of specialisation. The findings show that the nurses come from nine specialist areas, which cover most of the general medical and surgical wards in the hospital setting. Table 5.2 and Figure 5.2 show the distribution of nurses in the working areas and their specialties.

Table 5.2 Distribution of Respondents by Practice Area and Specified Area

Practice Area	Specified Area	N (%)
Medical Ward	Medical Assessment	20 (18)
	Respiratory	5 (4)
	Cardiology	17 (15)
	Gastroenterology	7 (6)
	Infectious Diseases	20 (18)
	Geriatric Assessment	5 (4)
Surgical Ward	Urology	17 (15)
	Colorectal Diseases	16 (14)
	Colorectal & Urology	6 (5)

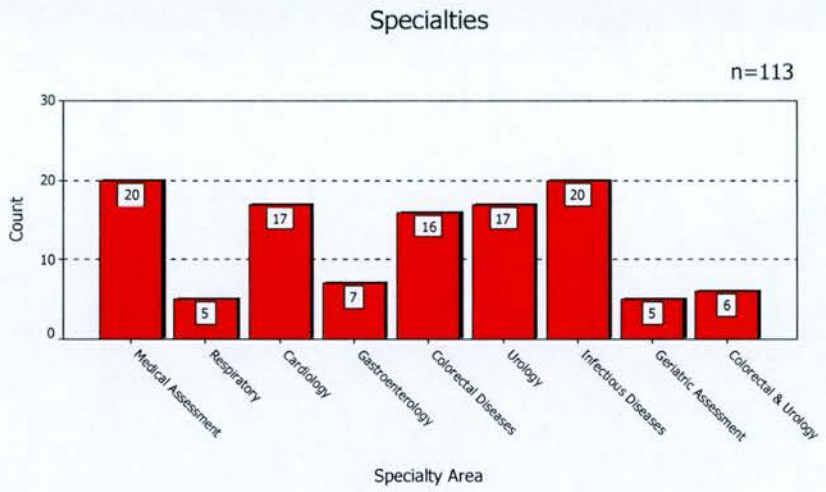

Figure 5.2 Distribution of Respondents by Specialty Area

With regard to the medical wards, the nurses are more likely to come from the medical assessment and infectious diseases areas, with 18% of the respondents coming from each area. Another 15% of the nurses work on the cardiology wards. The nurses from respiratory, gastroenterology and geriatric assessment, combined, occupy about 14% of the total. In the surgical areas, the nurses from the urology or colorectal disease wards constituted around 15% and 14% of the total respectively, and one group (5%) of nurses' practice covers both urology and colorectal disease. The wards with a higher response rate might imply a higher level of interest in the survey than the wards with lower response rates.

5.3.1.2 Work Time

The respondent nurses work either full-time or part-time, according to their employment conditions, as shown in Figure 5.3. Most of the respondents (101/89%) worked as full-time nurses and only a very small number (12/11%) worked part-time.

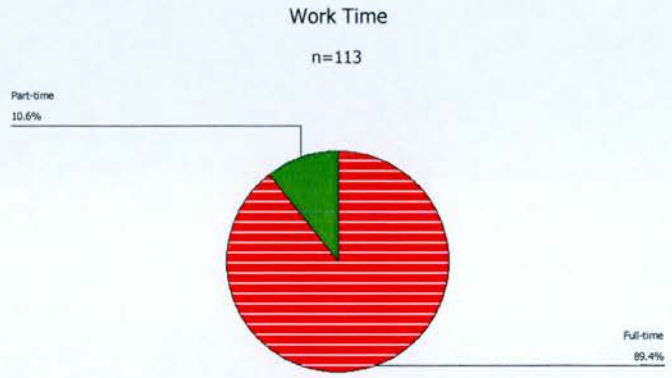

Figure 5.3 Distribution of Respondents by Work Time

5.3.1.3 Gender and Age

In the aspect of gender, Figure 5.4 shows there are far more female nurses than males, recording 95 female respondents (84%) compared with 18 males (16%).

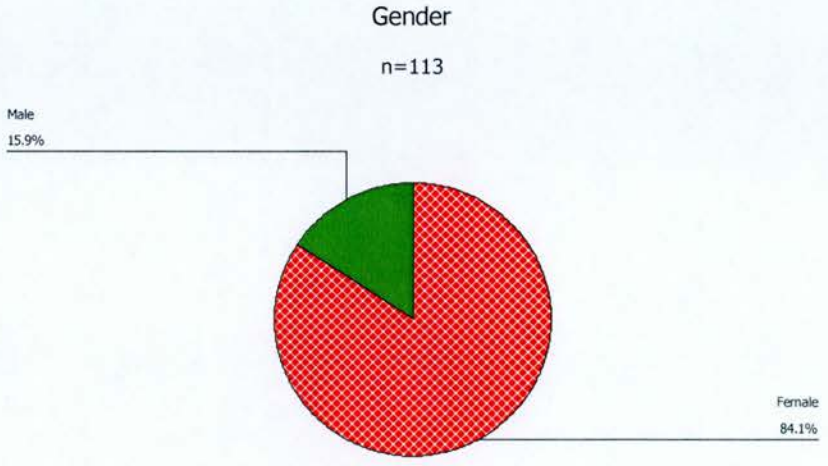

Figure 5.4 Distribution of Respondents by Gender

The nurses' age was also elicited in the questionnaire, within four age-band categories. Apart from nurses in the over 50 year age group, the respondents are

evenly spread across the other three younger age groups, as shown in Figure 5.5. There is an equal spread of nurses in the 20-29 year and the 30-39 year age groups, with 37 (33%) in each. The 40-49 year age group contains 31 nurses (27%), but only 8 of the nurses (7%) in the survey are over 50 years old.

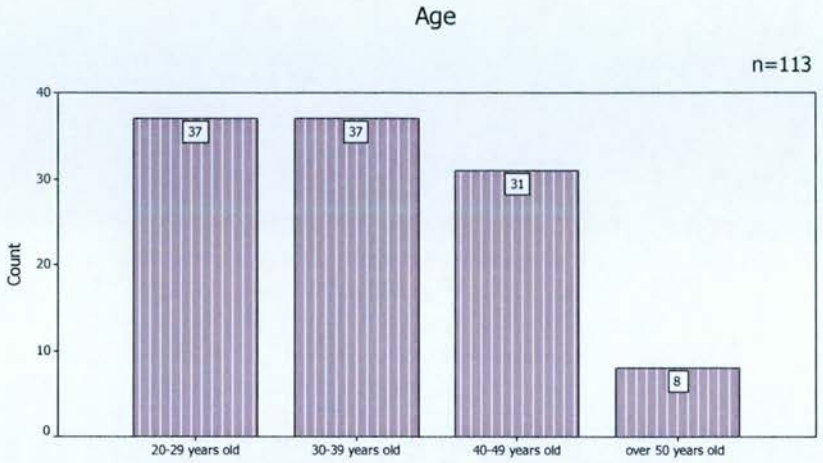

Figure 5.5 Distribution of Respondents by Age

5.3.1.4 Education Level

The education attainment of nurses who participated in the survey is shown in Figure 5.6. Registered nurses and nurses with a diploma are dominant among the respondents with thirty two (28%) being "Registered Nurses" and 38 (34%) being "Registered Nurses with Diploma". The remaining 38% of nurses had a university degree with 23 (20%) having a Bachelor's degree, 16 (14%) having an Honour's degree, and four nurses (4%) having a Master's degree.

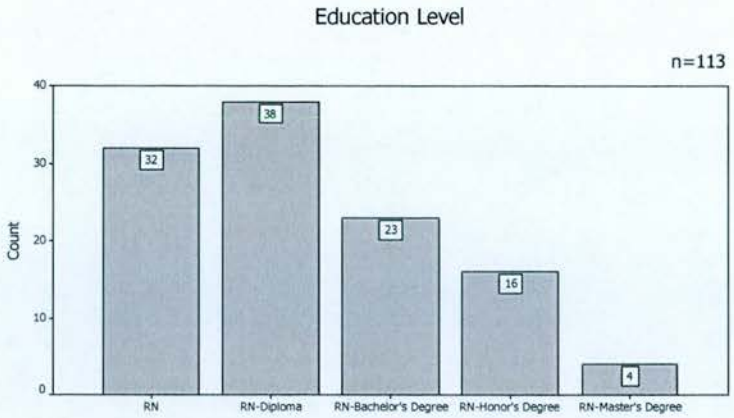

Figure 5.6 Distribution of Respondents by Education Level

5.3.1.5 Qualified Years

The length of time during which the respondents had been qualified as a nurse was termed "Qualified Years" in the survey. There were vastly more junior nurses than seniors among the respondents. Nearly half of the nurses (53/47%) had worked for less than four years. At the other end of the spectrum only two nurses (2%) had been qualified for more than 30 years. In the middle of this span of years, the remaining 51% of respondent nurses were evenly spread across the qualified year groups, with the 5–9 year qualified group including 17 respondents (15%), 10–14 years (11/10%), 15–19 years (12/11%), 20–24 years (8/7%) and 25–29 years (10/9%). Figure 5.7 portrays the distribution graphically.

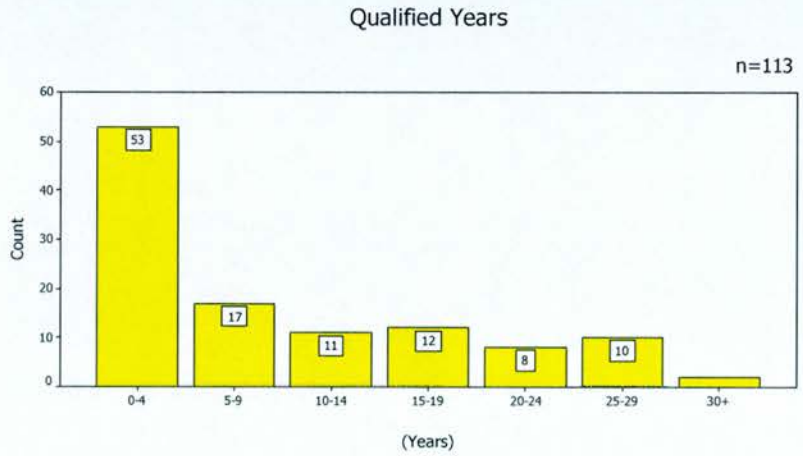

Figure 5.7 Distribution of Respondents by Qualified Years

5.3.1.6 Grade

The nurses are identified by their professional titles and accompanying grades. As Figure 5.8 shows, there were no respondents from the lowest nursing grade level, Grade C. The majority of nurses were from Grade D and Grade E, with 47 (42%) and 44 (39%) respectively, which constitutes 81% the nurses involved in the survey. The higher graded nurses were Grades F and G, with 9 (8%) and 13 nurses (12%) respectively.

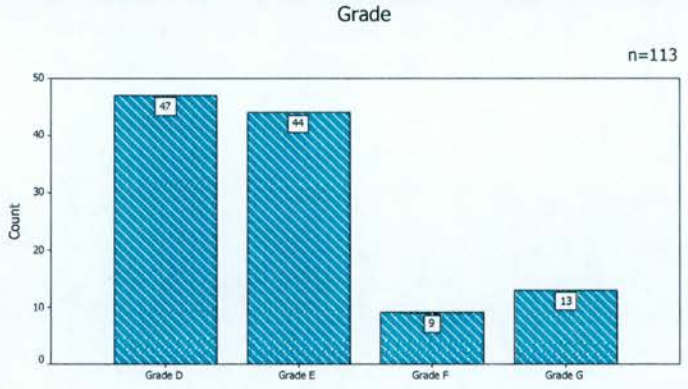

Figure 5.8 Distribution of Respondents by Grade

5.3.1.7 Current Position

The respondents are uniquely categorised in terms of their employment status within the hospital. The majority of the respondents (92/81%) were the staff nurses (see Figure 5.9). The other 21 nurses (19%) in this study, included charge nurses (14/12%), specialist nurses (4/4%), and a small uncategorised group (3/3%).

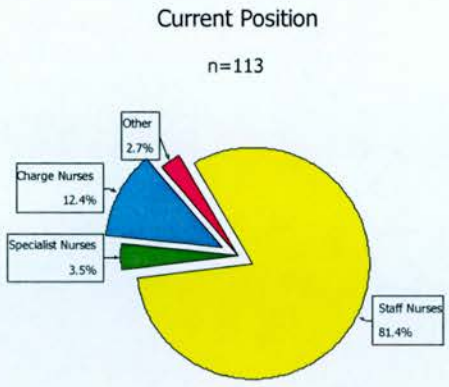

Figure 5.9 Distribution of Respondents by Current Position

5.3.2 Analysis of respondents' characteristics

This study assumes that the variables in the demographic profile of respondents are influential factors in the nurses' perceptions of the health promotion role and practice. In this section, the analysis tests whether there are differences between the subgroups of nurses characterised by demographic variables, especially given that the respondents are not evenly distributed across sub-categories within "Practice Area", "Gender", "Work Time" and "Current Position". As shown in the demographic profile, each variable obviously has a dominant clustering of respondents and less prominent clusters. In these circumstances, it is essential to examine further the differences within the variables, and also their relationships with the other variables such as "Education Level", "Grade", "Qualified Years" and "Age", in order to examine whether or not the unevenly distributed data affect the ensuing analysis. For example, it should be assessed whether the nurses on the medical wards and those on the surgical wards represent two discrete populations possessing meaningfully different characteristics in terms of education level, grade, years qualified and age. The same concern is equally applicable to the factors of gender, work time and current position. The following analysis is designed to answer these questions.

The analysis techniques used to test the significant associations are the Chi-square test, Fisher's exact test, the Mann-Whitney test and the Kruskal-Wallis test. The specific techniques are chosen depending on the type of data, the number of

categories of variables, and the sample size of the subgroups. For example, the Chi-square is applied to examine if there are any relationships between two or more nominal categorized groups by calculating the frequency of occurrence of the cases in the contingency table, such as the significant association test between "Practice Area" and "Gender". However, the Chi-square test relies on a large sample approximation and assumes that each cell has an expected frequency of five or more (Kinnear, 2006).

In this study, the cases in the subgroups are distributed in a very uneven way across the variables of "Work Time" and "Current Position". Some subgroups contain so few cases that this leads to a very small number or even zero in the cells in the contingency tables. In this kind of situation, Fisher's exact test seems to be more appropriate for the highly uneven tables because it computes the exact probabilities from a specific distribution (Anthony, 1999). In particular, Fisher's exact test is more appropriate for this study when analysing 2*4 contingency tables in which "Current Position" had four categories, with a sample size under 150 (Quantitative Skills at Consultancy for Research and Statistics, http://home.clara.net/sisa/five2hlp.htm, accessed April 12, 2007). A Fisher's exact test only performs in a 2x2 table in SPSS (UCLA: Academic Technology Services, Statistical Consulting Group, http://www.ats.ucla.edu/STAT/SPSS/whatstat/whatstat.htm, accessed April 12, 2007). Thus, an online statistical analysis, Simple Interactive Statistical Analysis (SISA) (provided by Quantitative Skills at Consultancy for Research and Statistics, http://www.quantitativeskills.com/sisa/index.htm, accessed April 12, 2007), has been used to calculate the Fisher's p value in the relationship tests on any variable divided across the four categories of "Current Position".

Mann-Whitney tests and Kruskal-Wallis tests are employed for testing the associations between nominal and ordinal variables, regardless of their distributions. Mann-Whitney tests are applied in any tests that involve comparing the variables of "Gender" and "Work Time", which have two subgroups with dependent ordinal variables. When calculating the associations in "Current Position", Kruskal-Wallis tests are selected to test the statistical significances with ordinal variables; namely, "Educational Level", "Grade", "Qualified Years" and "Age".

5.3.2.1 Tests on Practice Area

The nurses from different "Practice Areas", namely the medical wards or surgical wards, were tested for statistical differences relating to other variables, as shown in Table 5.3.

Table 5.3 Tests on Practice Area by Demographic Subgroups

Chi-Square Tests (n=113)					
Dependent Variables	**df**	**Chi-square χ2**		**P (2-tailed)**	
Gender	1	3.02		**0.082**	
Fisher's Exact Tests (n=113)					
Dependent Variables	**df**	**Chi-square χ2 (P value)**		**Fisher's Exact Test P (2-tailed)**	
Work Time	1	0.01 (p=0.928)		**1.000**	
Current Position	3	2.11 (p=0.550)		**0.554***	
Mann-Whitney Tests (n=113)					
Dependent Variables	**Categories**	**Cases (n)**	**Mean Rank**	**Mann-Whitney U**	**P**
Education Level	Medical Area	74	56.68	1419.00	**0.880**
	Surgical Area	39	57.62		
Qualified Years	Medical Area	74	57.14	1433.00	**0.949**
	Surgical Area	39	56.74		
Grade	Medical Area	74	58.24	1351.50	**0.553**
	Surgical Area	39	54.65		
Age	Medical Area	74	56.32	1392.50	**0.749**
	Surgical Area	39	58.29		

NB: Use of * (starred) statistical value has been achieved from online statistical analysis via *Simple Interactive Statistical Analysis* (SISA) http://home.clara.net/sisa/.

The Chi-square test shows that there are no statistically significant differences between the nurses from the medical and surgical wards with regard to "Gender". There are no statistically significant differences found for "Work Time" and "Current Position" either, when using Fisher's exact tests. It appears that the nurses from medical and surgical wards statistically share similar characteristics in terms of gender, work time, or current position.

The Mann-Whitney tests reported no statistically significant differences between the nurses from the medical wards and from the surgical wards when they were considered in terms of their "Education Level", "Qualified Years", "Grade", and "Age", respectively.

Therefore, the respondents from the medical and surgical wards can be treated as one homogenous population as they statistically share similar characteristics. Furthermore, the response rates are not too dissimilar from both the medical wards (49%) and the surgical wards (42%), as shown in Table 5.1. It could be concluded that the nurses in this study are representative of the population from which they were drawn.

5.3.2.2 Tests on Gender

Female nurses constitute the majority of the respondents in this survey. However, there are no statistically significant differences between the females and males in terms of "Work Time", "Education Level", "Grade", "Qualified Years" and "Age", according to the results of Fisher's exact tests and the Mann-Whitney tests, as shown in Table 5.4. Statistically, the female and male nurses share similar characteristics in the survey, although the male nurses seemed to have a slighter advantage in the years qualified as well as grade than the female nurses on these aspects.

Table 5.4 Tests on Gender by Demographic Subgroups

Fisher's Exact Tests (n=113)					
Dependent Variables	**df**	**Chi-square χ2 (P value)**		**Fisher's Exact Test P (2-tailed)**	
Work Time	1	2.54 (p=0.111)		**0.209**	
Current Position	3	2.71 (p=0.550)		**0.336***	
Mann-Whitney Tests (n=113)					
Dependent Variables	**Categories**	**Cases (n)**	**Mean Rank**	**Mann-Whitney U**	**P**
Education Level	Female	95	58.03	757.00	**0.425**
	Male	18	51.56		
Qualified Years	Female	95	55.29	692.50	**0.177**
	Male	18	66.03		
Grade	Female	95	54.81	646.50	**0.079**
	Male	18	68.58		
Age	Female	95	56.60	817.00	**0.754**
	Male	18	59.11		

NB: Use of * (starred) statistical value has been achieved from online statistical analysis via *Simple Interactive Statistical Analysis* (SISA) http://home.clara.net/sisa/.

5.3.2.3 Tests on Working Time

In terms of the nurses' working time, there are no statistically significant differences at any education level. However, there are statistically significant differences between the nurses working full-time and part-time in terms of other variables, as shown in Table 5.5. From the results of Fisher's exact test, it is clear that full-time and part-time nurses have markedly different profiles with regard to employment positions (p=0.011).

The Mann-Whitney tests reveal that there are statistically significant differences between "Work Time" categories and the dependent variables "Qualified Years", "Grade" and "Age". Table 5.5 shows that nurses who have full-time jobs have a different grade profile to those of part-time workers ($p<0.05$) and a different profile of years qualified in comparison to part-time workers ($p<0.01$). That is, observing the mean ranks for each variable, reveals that the nurses who work part-time were generally more highly graded and had more qualified years than the full-time nurses. Statistically, the part-time nurses do not have the same age profile as those with full-time jobs ($p<0.05$), with the part-time nurses being generally older than the full-time nurses in the study.

Table 5.5 Tests on Work Time by Demographic Subgroups

Fisher's Exact Tests (n=113)					
Dependent Variables	**df**	**Chi-square $\chi 2$ (P value)**		**Fisher's Exact Test P (2-tailed)**	
Current Position	3	18.36 (p=0.000)		**0.011***	
Mann-Whitney Tests (n=113)					
Dependent Variables	**Categories**	**Cases (n)**	**Mean Rank**	**Mann-Whitney U**	**P**
Education Level	Full-time	101	57.74	531.50	**0.471**
	Part-Time	12	50.79		
Qualified Years	Full-time	101	54.36	339.00	**0.008**
	Part-Time	12	79.25		
Grade	Full-time	101	54.78	381.50	**0.025**
	Part-Time	12	75.71		
Age	Full-time	101	54.94	397.50	**0.042**
	Part-Time	12	74.38		

NB: Use of * (starred) statistical value has been achieved from online statistical analysis via *Simple Interactive Statistical Analysis* (SISA) http://home.clara.net/sisa/.

5.3.2.4 Tests on Current Position

The nurses in different employment positions had many different characteristics, based on the Kruskal-Wallis tests, when considered in terms of the variables of "Grade", "Qualified Years", "Age" and "Education Level", as shown in Table 5.6. It is revealed that the respondents in different positions (Staff Nurse, Specialist, Charge Nurse or Other category) do not share similarities of grade, years qualified, age or education. Unsurprisingly, strong statistical associations are identified between the nurses' grades and their employment position ($p<0.01$), with the mean ranks showing that Charge Nurses had were graded highest, followed by Specialists, and then Staff Nurses on the lowest grade.

Strong statistical significances also exists in the relationship between the nurses' years qualified as a Registered Nurse (RN) and their employment position ($p<0.01$). The "Others" category of nurses had the longest years qualified as a RN, But as no further information is recorded, this could be caused by chance given the small number of "Others" in the sample. The charge nurses and specialists have similar length of years qualified as registered nurses, whilst staff nurses are relative novices, as expected.

With respect to age, the charge nurses, specialists and the "Others" were generally older than the staff nurses according to the mean ranks ($p<0.01$). In terms of educational level, the specialists tended to have a higher level of education than the other categories ($p<0.05$). Interestingly, the charge nurses have a slightly lower educational level than the staff nurses.

Table 5.6 Tests on Current Position by Demographic Subgroups

Kruskal-Wallis Tests (n=113)					
Dependent Variables	**Categories**	**Cases (n)**	**Mean Rank**	**Mann-Whitney U**	**P**
Grade	Staff Nurse	92	47.33	51.91	**0.000**
	Specialist	4	101.50		
	Charge Nurse	14	103.86		
	Other	3	75.67		
Qualified Years	Staff Nurse	92	49.37	30.78	**0.000**
	Specialist	4	88.00		
	Charge Nurse	14	88.32		
	Other	3	103.50		
Age	Staff Nurse	92	51.61	16.03	**0.001**
	Specialist	4	86.38		
	Charge Nurse	14	75.57		
	Other	3	96.50		
Education Level	Staff Nurse	92	57.30	8.38	**0.039**
	Specialist	4	94.25		
	Charge Nurse	14	52.36		
	Other	3	28.17		

5.3.2.5 Summary of nurses' characteristics

The analysis of demographic variables provides a general picture of the characteristics of the nurses participating in the survey. The sample is predominantly made up of full-time staff nurses aged between 20 and 50 years of age. Female nurses still constitute the majority in the field of hospital nursing. Nurses with an RN-Diploma, especially those who have been qualified for 0-4 years, form the majority of hospital nurses. Considering the education level and years qualified, it is understandable that Grades D and E occur more frequently than other grades. The characteristics of the sample appear to be close to the findings of previous British reports (McBride, 1994; Thompson & Kohli, 1997).

Further analysis shows that the nurses from the medical and surgical areas comprise a homogenous population, as they reflect similar demographic characteristics. Female and male nurses also have similar demographic characteristics. However, the principal distinction among the nurses occurs in terms of their working time and position. The survey reveals that part-time nurses appear to be older, with a higher grade and are more qualified in years. Specialist nurses have a higher education, higher grade and are longer qualified in years, while the charge nurses have a high grade and longer working years but a slightly lower education level than the staff nurses. The findings of the demographic profile

of the sample could be comparable with a general view of the population of hospital nurses in the UK.

5.4 Nurses' perceptions of health promotion role

The survey's account of the nurses' perceptions of the health promotion role is outlined in this section. It begins by assessing the validity and reliability of the subscales and introduce the statistical techniques employed in the analysis. Then, the nurses' role expectations and health promotion activities are described and explained based on the findings of the survey. The statistically significant associations among the subscales will be explored in order to identify the influencing factors for the health promotion practice in current hospital nursing.

5.4.1 Assessing the subscales

As discussed in the survey design, the nurses' health promotion role is presumed to be a single dimension scale, which includes several correlated substrata of domains. The data from the questionnaires are then grouped and summed into six subscales for statistical analysis, based on the questionnaire design: "Predisposing Factors", "Role Expectation", "Perceived Self-Efficacy", "Promotion Activities", "Enabling Factors" and "Actual Knowledge" (see Chapter Four). Because of the use of the Likert scale, the data for each subscale are combined and summed for the purpose of data reduction. The validity and reliability of the subscales are assessed in order to test the reliability of, and confidence in, the questionnaire for this study.

5.4.1.1 Validity

Validity is the most important index of the quality of the survey, but it is complex and controversial (Burns, 2000). The issue of validity actually goes through the study from the very beginning to the end of the survey. The process of reviewing the literature and building the theoretical framework have explicitly defined the key concepts of this study, such as the role expectations and experiences of the health promotion role, which is the rationale for the construct validity (details in

Chapters 2 and 3). The process of developing a questionnaire and conducting a pilot study involved the incorporation of content validity and face validity for the survey (see Chapter Four). After gathering the data, the concurrent criterion validity and construct validity are considered here.

However, concurrent criterion validity is very difficult to measure, because of the lack of appropriate criteria:

> Many of the constructs of interest to survey researchers do not have criteria against which the validity of a measure can be easily ascertained. When they do, the criteria may themselves be so poorly measured that the validity coefficients are badly attenuated due to measurement error (Bohrnstedt, 1983 p. 98).

The very limited empirical research concerning the nurses' health promotion role makes assessment of the criterion validity almost impossible. Moreover, the existing questionnaires in the literature contained little information on how the questions have been constructed so far. Although Berland et al.'s (1995) study and the current research share a similarly structured questionnaire, people's perceptions may change in different surveys especially when they are conducted a decade apart. Therefore, concurrent validity cannot be measured through the standardized calculations in this study. However, the results of this study will be further compared with the findings of other studies in the concluding discussion chapter (see Chapter Seven).

Construct validity demands that the questions should have relationships with the underlying concepts and also that the subscales should be correlated with each other (Bohrnstedt, 1983). The scale validity comes from the solid theoretical framework applied in the scale building, which has been considered in previous chapters. Here, the dimensions of the subscales have been considered.

Theoretically, a valid Likert scale should unidimensionally measure only one concept. The correlation method could initially provide evidence for the unidimensionality of the scales which focus on how strongly the item is related to the total subscale score (De Vaus, 2002; McIver, 1981). The corrected item-total correlation coefficients, shown in Table 5.7, report that the subscales of "Predisposing Factors", "Promotion Activities" and "Actual Knowledge" have less than 50% of the items above 0.30, the value that De Vaus (2002) suggests.

Table 5.7 Item-Total Correlation of the Subscales

Subscale	Total n Items	n items of Corrected Item-Total Correlation Coefficient >0.30	%
Predisposing Factors	33	14	**42**
Role Expectation	16	15	94
Promotion Activities	10	3	**30**
Perceived Self-Efficacy	6	5	83
Enabling Factors	16	11	69
Actual Knowledge	4	1	**25**

This indicates that the "Predisposing Factors" category probably has more than one dimension in the scale. This has actually been expected from the stage of developing the questionnaire based on the understanding of the Precede-Proceed model. As has been mentioned in Chapter Four, the "Predisposing Factors" category has clustered all attitudes, beliefs, values, and motivations together as one group of factors. The fairly high Cronbach's alpha of 0.85 in Berland et al.'s study probably explains the similarity of meanings shared by the above concepts. However, based on external item analysis, with a visual inspection of the meanings, the "Predisposing Factors" include three subscales in this study: "Role Expectation", "Promotion Activities", and "Perceived Self-Efficacy".

The situation in the subscales of "Promotion Activities" and "Actual Knowledge", are different from the "Predisposing Factors". It shows that "Promotion Activities" and "Actual Knowledge" cover a range of relevant issues. This study argued that the reality of the health promotion role is varied in activities and then in nurses' knowledge and skills. Therefore, this study would not delete the few uncorrelated items in these two subscales based on the item-total correlation coefficient alone, especially the two subscales originally sourced from Berland et al.'s rigorously developed questionnaire. The following interviews were expected to confirm the assumption. However, it triggered a need to consider the remit of the item-total correlation coefficient testing the validity of scaling. Spector (1992) indicates that the correlation method might be controversial to use in determining the direction of the scale. Bohrnstedt (1983) suggests a more appropriate way to evaluate and screen items from various content domains is to use confirmatory factor analysis. However, this is not employed here, as it is a time-consuming process and requires a high level of ability in analysing experiences and techniques. With a sample size of 100, the effect of factor analysis would be poor and would be inadequate for recreating a valid scale (Comrey & Lee, 1992). Another important reason is that using factor analysis to validate scale construction is also controversial. The ideal

way to increase the validity of the scaling is to employ an inductive procedure based on the meaning of the concepts rather than depending on the statistics to uncover the constructs within the items (Spector, 1992). Thus, defining the constructs in the earlier research and in the theoretical framework employed in the study is the most important conceptual task in building the construct validation of the scaling in the survey.

For these substantive reasons, the above three subscales are grouped in accord with the description of the items. the consequent function of applying the item-total correlation tests in this study is mainly in the confirmation that the subscales of "Perceived Self-Efficacy", "Enabling Factors" and "Role Expectation" all have an acceptable level of correlated items. It means that these three subscales have appropriate validity in the survey. In particular, "Role Expectation" has a high item-total correlation of 94% which suggests that this newly-created subscale for the study could prove successful in defining and constructing the design.

5.4.1.2 Reliability

As for the multi-item measures, the internal consistency index is the best method among other tests, of which Cronbach's alpha is the most widely used (De Vaus, 2002). Cronbach's alpha test shows that 51 items overall have an alpha of 0.88, giving an acceptable level of reliability. Table 5.8 reports the means, standard deviations and Cronbach's alpha for the subscales. Except for two subscales, the majority of Cronbach's alphas for the subscales ranged from 0.71–0.85. The subscales which have an alpha above 0.70 are normally considered an adequate indication of a reliable set of items (De Vaus, 2002). The "Promotion Activities" factor has an alpha of 0.62, so it may be acceptable in the analysis, although a typically high coefficient is above 0.70 (Anthony, 1999). There are no deleted items from the "Promotion Activities" factor, because 10 questions covered the scope of the health promotion role.

However, the Actual Knowledge factor containing four items has an alpha of only 0.42. The low value of internal consistency could be caused by the small number of items in the factor (De Vaus, 2002). Compared with Berland et al.'s survey, where the questionnaire is used, the reliability of the subscales in the two studies is very

similar (see Table 4.4). The Actual Knowledge factor in Berland et al.'s survey also has the lowest alpha value. As the actual knowledge factor tends to be unreliable, it has been simply described in this study, rather than analysed.

Table 5.8 Means, Standard Deviations and Cronbach's alpha (α) for Subscales (n=113)

Classified Topic	Subscale	Items (n)	Range	X	SD	α
Nurses' Perception of HP Activities	Predisposing Factors	33	1-5	3.79	0.33	0.85
	Role Expectation	16	1-5	3.98	0.39	0.81
	Promotion Activities	10	1-5	3.60	0.37	0.62
	Perceived Self-Efficacy	6	1-5	3.77	0.48	0.71
Influential Factors on HP	Enabling Factors	16	1-5	3.63	0.39	0.74
	Actual Knowledge	4	1-5	3.52	0.57	0.42

5.4.1.3 Statistical analysis of subscales

In the analysis, both descriptive and inferential analyses are used to obtain full details of the nurses' health promotion role in the hospital. The descriptions are constructed through the calculation of the proportions of nurses' answers, in which the basic unit is the individual nurse. Furthermore, the inferential statistics are employed to collect the relevant answers in the form of scale scores. The demographic independent variables are tested among the subscales in order to explore whether they influenced nurses' attitudes, beliefs and practice regarding health promotion. The relationships between the subscales are analysed via their summed scores.

In terms of statistical techniques, strictly speaking, the five-point Likert scale belongs to ordinal data which would be limited in the application of advanced statistical techniques. However, because of its summarizing character, the Likert scale could be upgraded to the interval level of data in the statistical analysis (Kent, 2001). Therefore, the sophisticated analysis techniques which are designed for the interval data could be applied in order to analyse the subscales in this study. For example, the t-tests and one-way analyses of variance (ANOVA) are used to compare the means of the subscales by different demographic subgroups of nurses; the Pearson correlation analysis is also used to test the relationships between the subscales of interests.

It needs to be stated that only the mean scores of the subscales are analysed in this study for several reasons. First, the scores on the Likert scale are not precise

measurements, since they require a context in order to interpret the meanings (McIver, 1981). The scores could only be meaningful after the individual nurse's answer has been compared with the mean of the group, which is seen as a typical or average attitude of the group. Second, the number of items held by each subscale factor differs in this study, from a minimum of 4 to a maximum of 33, meaning that the sum score for each subscale could be varied, and be less meaningful for comparison when small numbers are concerned. In contrast, the application of the averages makes the subscales comparable to each other without weighting the data. The use of averages also makes it simpler to explain the individual answers. Third, the application of the mean of the subscales also avoids the disadvantage arising from the sums of the subscales in coping with missing values. Any empty blocks would limit the value of the analysis when the sum is calculated. In this study, the analysis shows that the highest missing value is 10% of the sum of one subscale. The average scores for the variables with missing data would be automatically adjusted in the analysis (De Vaus, 2002). In light of these considerations, only the means were applied in the further analysis of the subscales rather than their summed score.

The correlation between the subscales is tested by different methods of analysis based on "goodness-of-fit". The Kolmogorov-Smirnov tests are applied to determine whether the data are normally distributed or in technical terms, satisfy a goodness-of-fit criterion (Kinnear & Gray, 2006). The results for the subscales in this study are presented in Table 5.9. An alpha level of 0.05 is used as the criterion for statistical significance in all of the tests. As shown, the distributions of the subscales for "Actual Knowledge" and "Perceived Self-Efficacy" are not normally distributed ($p<0.05$), while the others are. Thus "Actual Knowledge" and "Perceived Self-Efficacy" are analysed using nonparametric or distribution-free tests, but when analysing subscales with normal distributions, parametric tests, such as the t-test and Pearson's r correlation test, are applied.

Table 5.9 Kolmogorov-Smirnov Tests for Goodness-of-fit of Subscales (n=113)

Subscale (Mean)	Kolmogorov-Smirnov Z Asymp. Sig. (2-tailed)	D Value (greatest discrepancy)
Predisposing Factors	0.980	0.04
Role Expectation	0.648	0.07
Promotion Activities	0.361	0.09
Perceived Self-efficacy	**0.020**	**0.15**
Enabling Factors	0.334	0.08
Actual Knowledge	**0.009**	**0.16**

5.4.2 Nurses' perceptions of health promotion role

The findings related to the nurses' perceived role expectation and their perceived health promotion practice, and their influencing factors for practice, are presented here. As discussed before, the "Predisposing Factors" in this survey includes three subscales so that they are analysed in sequence: the nurses' role expectations, health promotion activities and perceived self-efficacy. Then, the "Enabling Factors" on the health promotion role are displayed, which includes nurses' actual knowledge of it. Finally, the associations of the subscales are explored to look at the factors influencing health promotion practice.

5.4.2.1 Nurses' role expectations

Nurses were required to provide their opinions about a list of 16 topics relevant to "what nurses' health promotion role should be", namely their expectation of the health promotion role for a nurse in hospital, by using the five-point Likert scale questions, from "strongly agree" to "strongly disagree". It should be restated that the nurses in the survey were supposed to answer the questions as "outsiders" in an objective sense. The answers could be based on their knowledge and experiences, but this is focused on what the nurses have expected of their health promotion role hospital settings.

Table 5.10 reveals the nurses' answers to the 16 questions which are identified as statements about the nurse's role regarding health promotion. The mean value of the responses to all 16 questions is 3.98 (range 1–5; SD 0.39), indicating that the main responses by the nurses are distributed toward the "agree" end of the scale. This suggests that the nurses are likely to accept the image of the health promotion role which was depicted in the questionnaire. For a better understanding of the

agreement among the nurses, the responses of "strongly agree" and "agree" are combined in the analysis, and the same process is followed with disagreement as well. Table 5.11 shows the nurses' answers in descending order of agreement, and Table 5.12 displays the mean scores for every item, indicating the trends in responses and their dispersions

The findings illustrate that the nurses tends to accept a health promotion role for nurses in hospital settings, with 89% of them agreeing that it should be an important part of nursing. Nurses also strongly perceive that the health promotion role should include health teaching and patient empowerment in the survey. For example, the vast majority of nurses believe that a hospital-based nurse's health promotion role should include discharge planning (98%), health teaching about lifestyle (96%), teaching self-care (96%), teaching disease processes (94%), and empowering patients to be independent (92%). In the above responses, there exists a relatively high proportion (35%–70%) of replies claiming to "strongly agree" with the above-mentioned aspects, as shown in Table 5.10. The majority of nurses (79%) also believe that enhancing the coping skills of patients should be included in the nursing role. The nurses appear to have a solid perception that the health promotion role should consist of health teaching and patient empowerment for the purpose of increasing the patients' self-care and independence. It shows that the nurses could grasp the essential notion of health education. In other words, the notion of health education is deeply embedded in the hospital-based nurses' understanding of the health promotion role, as indicated by the survey.

In the survey, some of the nurses (39%) agreed that nurses should help patients to improve their health by establishing group work in a hospital. This implies that nurses have less notion of cultivating the atmosphere for patients' actively participating in health services in terms of health promotion. Probably, the nurses in the survey are more familiar with helping patients on a person to person basis in practice, rather than through group work. It shows that the nurses' understanding of health promotion role tends to be limited in scope to individualistic health education.

A majority of the nurses considered that enhancing the patients' ability to be advocates for themselves should be included in the health promotion role as well (89%), while a slightly smaller proportion of nurses (79%) believed that the nurse

him/herself should act as an advocate for the patients. The findings also show that 97% of the nurses (with 54% stating "strongly agree") perceived that the scope of health promotion practice should include caring for the patients' family or caregivers in the hospital, and should make efforts to promote their health as well (89%). However, only 56% of the nurses think that it should be beneficial to extend the nurse's health promotion role into community practice. This shows that the half of nurses perceive the health promotion role as residing in the hospital and the other half would consider nursing practice as being extended into communities. Comparably, the nurses consider the health promotion role in hospital to be the kind of practice involving patients and their families, rather than in community practice.

Promoting health for special groups of patients appeared to be the most controversial topic in the nurses' perceptions. Although more than half of the respondents considered the role of counselling terminally-ill (66%) and depressed patients (62%) as integral to their role, there was an increasing uncertainty and disagreement in the answers to some special areas. For example, only a small proportion of the nurses (37%) thought that health promotion should include physically abused patients, and this was reinforced by the lower mean score attributed to this factor as well as a higher standard deviation indicating significant dispersion about the mean. In terms of the specific topics in the health promotion role, the nurses in the survey appear to have different understandings of what types of patients should be involved in health promotion services in hospital. This is to say, that the nurses' perceptions of the health promotion role are inconsistent in the specific and detailed content of health promotion role, although they reach a general consensus of the health promotion role overall.

Table 5.10 Nurses' Perceptions of Health Promotion Role

Item No.	Questions	Strongly Agree (N/%)	Agree (N/%)	Uncertain (N/%)	Disagree (N/%)	Strongly Disagree (N/%)	Total (N/%)
48	It is important that hospital nurses are involved in discharge planning.	78/70	32/28	2/2	0/0	0/0	112/100
40	Nursing practice includes comforting patients and their families/caregivers.	61/54	49/43	3/3	0/0	0/0	113/100
36	A healthy lifestyle is an important topic for patient teaching.	34/30	75/66	3/3	1/1	0/0	113/100
37	Teaching patients how to care for themselves is an important part of a nurse's role.	40/36	68/60	2/2	2/2	0/0	112/100
38	Teaching patients about disease processes is an important part of a nurse's role in health promotion.	39/35	67/59	5/4	2/2	0/0	113/100
43	Sometimes nurses plan and deliver care to make the lives of patients as normal as possible during their stay in hospital by encouraging them to be independent and to live as much like a "normal" person as possible.	51/46	52/46	6/5	3/3	0/0	112/100
51	Health promotion is an "everyday thing" for nurses.	34/30	66/59	9/8	2/2	1/1	112/100
49	Family members/caregivers are included in a hospital nurse's health promotion efforts.	30/27	70/62	11/10	1/1	0/0	112/100
45	Encouraging patients to advocate for themselves is part of a nurse's role in health promotion.	21/19	78/71	10/9	1/1	0/0	110/100
42	Health promotion activities include enhancing patients coping skills.	19/17	70/62	20/18	2/2	1/1	112/100
47	A nurse must assume the role of patient advocate.	35/31	53/48	13/11	10/9	1/1	112/100
50	Health promotion principles apply in caring for terminally-ill patients.	27/24	46/42	27/24	6/5	5/5	111/100
39	There are health benefits for depressed patients that result from a nurse's counselling efforts.	19/17	51/45	37/33	6/5	0/0	113/100
46	Health promotion in the community is part of a nurse's role as a member of the community.	14/13	48/43	26/23	19/17	5/4	112/100
44	Health promotion group work with patients is sometimes part of a hospital nurse's practice.	5/5	37/34	32/29	22/20	13/12	109/100
41	Counselling patients following physical abuse is part of a nurse's role.	10/9	31/28	40/36	25/23	5/4	111/100

Table 5.11 Nurses' Perceptions of Health Promotion Role (in 3 Categories)

Item No.	Questions	Agree (N/%)	Uncertain (N/%)	Disagree (N/%)	Total (N/%)
48	It is important that hospital nurses are involved in discharge planning.	110/98	2/2	0/0	112/100
40	Nursing practice includes comforting patients and their families/caregivers.	110/97	3/3	0/0	113/100
36	A healthy lifestyle is an important topic for patient teaching.	109/96	3/3	1/1	113/100
37	Teaching patients how to care for themselves is an important part of a nurse's role.	108/96	2/2	2/2	112/100
38	Teaching patients about disease processes is an important part of a nurse's role in health promotion.	106/94	5/4	2/2	113/100
43	Sometimes nurses plan and deliver care to make the lives of patients as normal as possible during their stay in hospital by encouraging them to be independent and to live as much like a "normal" person as possible.	103/92	6/5	3/3	112/100
51	Health promotion is an "everyday thing" for nurses.	100/89	9/8	3/3	112/100
49	Family members/caregivers are included in a hospital nurse's health promotion efforts.	100/89	11/10	1/1	112/100
45	Encouraging patients to advocate for themselves is part of a nurse's role in health promotion.	99/89	10/9	1/1	110/100
42	Health promotion activities include enhancing patients coping skills.	89/79	20/18	3/3	112/100
47	A nurse must assume the role of patient advocate.	88/79	13/11	11/10	112/100
50	Health promotion principles apply in caring for terminally-ill patients.	73/66	27/24	11/10	111/100
39	There are health benefits for depressed patients that result from a nurse's counselling efforts.	70/62	37/33	6/5	113/100
46	Health promotion in the community is part of a nurse's role as a member of the community.	62/56	26/23	24/21	112/100
44	Health promotion group work with patients is sometimes part of a hospital nurse's practice.	42/39	32/29	35/32	109/100
41	Counselling patients following physical abuse is part of a nurse's role.	41/37	40/36	30/27	111/100

Table 5.12 Nurses' Perceptions of Health Promotion Role (Mean Scores)

Item No.	Questions	Cases (N)	Mean	SD
48	It is important that hospital nurses are involved in discharge planning.	112	4.68	0.51
40	Nursing practice includes comforting patients and their families/caregivers.	113	4.51	0.55
36	A healthy lifestyle is an important topic for patient teaching.	113	4.26	0.55
37	Teaching patients how to care for themselves is an important part of a nurse's role.	112	4.30	0.60
38	Teaching patients about disease processes is an important part of a nurse's role in health promotion.	113	4.27	0.63
43	Sometimes nurses plan and deliver care to make the lives of patients as normal as possible during their stay in hospital by encouraging them to be independent and to live as much like a "normal" person as possible.	112	4.35	0.71
51	Health promotion is an "everyday thing" for nurses.	112	4.16	0.72
49	Family members/caregivers are included in a hospital nurse's health promotion efforts.	112	4.15	0.62
45	Encouraging patients to advocate for themselves is part of a nurse's role in health promotion.	110	4.08	0.56
42	Health promotion activities include enhancing patients coping skills.	112	3.93	0.71
47	A nurse must assume the role of patient advocate.	112	3.99	0.94
50	Health promotion principles apply in caring for terminally-ill patients.	111	3.76	1.03
39	There are health benefits for depressed patients that result from a nurse's counselling efforts.	113	3.76	0.82
46	Health promotion in the community is part of a nurse's role as a member of the community.	112	3.42	1.05
44	Health promotion group work with patients is sometimes part of a hospital nurse's practice.	109	2.99	1.10
41	Counselling patients following physical abuse is part of a nurse's role.	111	3.14	1.02

In terms of the analysis of the subscale "Role Expectation", there are no statistically significant differences between any demographic subgroups with regard to "Role Expectation" according to the t-tests and one-way ANOVA, as shown in Table 5.13. The nurses appear to have very similar role expectations of the health promotion role in all subgroups within the variables of "Practice Area", "Work time", "Gender", "Education Level", "Grade", "Qualified Years", "Age" and "Current Position". In a sense, this is a surprising finding because the nurses' perceptions of the health promotion role have not been influenced by levels of education and grade, and years qualified, and the like. This is to say that there is a consensual role expectation of the health promotion role among the nurses in this study.

Table 5.13 Nurses' Perceptions of Role Expectation by Demographic Subgroup

Compare Mean (T-test)						
Dependent Variables	**Categories**	**Cases (n)**	**Mean**	**SD**	**P (2-tailed)**	**Total (n)**
Practice Area	Medical	74	3.96	0.40	0.420	113
	Surgical	39	4.03	0.38		
Work Time	Full-time	101	3.98	0.40	0.673	113
	Part-time	12	4.03	0.30		
Gender	Female	95	3.98	0.40	0.937	113
	Male	18	3.99	0.39		
One-way ANOVA						
Dependent Variables	**Categories**	**Cases (n)**	**Mean**	**SD**	**Test Result**	**Total (n)**
Education Level	RN	32	3.99	0.36	F=0.890 (p=0.472) P=0.756 η^2=0.017	113
	RN-Diploma	38	3.94	0.38		
	RN-Bachelor's	23	3.97	0.41		
	RN-Honour's	16	4.07	0.51		
	RN-Master's	4	4.13	0.10		
Grade	Grade D	47	4.00	0.35	F=1.010 (p=0.391) P=0.964 η^2=0.003	113
	Grade E	44	3.98	0.38		
	Grade F	9	4.01	0.45		
	Grade G	13	3.94	0.57		
Qualified Years	0-4 years	53	3.96	0.38	F=1.225 (p=0.299) P=0.344 η^2=0.061	113
	5-9 years	17	4.01	0.33		
	10-14 years	11	4.03	0.35		
	15-19 years	12	4.09	0.41		
	20-24 years	8	3.93	0.31		
	25-29 years	10	3.81	0.61		
	30+ years	2	4.50	0.18		
Age	20-29 years	37	3.98	0.36	F=0.114 (p=0.952) P=0.373 η^2=0.028	113
	30-39 years	37	3.95	0.38		
	40-49 years	31	3.96	0.45		
	50+ years	8	4.22	0.39		
Current Position	Staff Nurse	92	3.98	0.36	F=1.351 (p=0.262) P=0.844 η^2=0.007	113
	Specialist Nurse	4	4.16	0.61		
	Charge Nurse	14	3.97	0.54		
	Other	3	3.94	0.60		

To sum up, the subscale "Role Expectation" in the survey represents the nurses' role perceptions of the health promotion role which represents what nurses expect of the health promotion role based on their understanding of it. The findings show that nurses have reached a consensual perception of the health education role in the sense of what it should be for nurses in a hospital. However, in terms of specific topics, the nurses appear to have different opinions as to whether certain of those topics should be a health promotion role or not. It suggests that the detailed content of the health promotion role is not what the nurses are familiar with. In other words, the nurses have not fully thought through the contents of what the health promotion role should be, despite teaching and encouraging self-care as familiar themes in the health promotion role. The nurses' perceptions of health promotion tend to be more

relevant for patients and their family when in a hospital, but with less affinity for the health promotion role if extended into community practice.

5.4.2.2 Promotion Activities

The nurses responded to a group of 14 questions on the subscale of "Promotion Activities", which is related to the health promotion practices that they perform, and could perform, in current nursing practice. The nurses were supposed to answer these questions based on their daily experiences on the job in the hospital. Table 5.14 shows the original answers given by the nurses, while Table 5.15 presents the combined agreement and disagreement answers with the midpoint responses. Table 5.16 displays the mean scores for the items, indicating the trends and dispersion of the nurses' responses.

The findings show that the majority of nurses (85%) agree that the health promotion practice was an important part of their role in the nursing practice. It implies that the health promotion role could be performed on a daily basis in the course of nursing practices in the hospital. As well, 93% of the nurses agree there are potential benefits to be had when they inform patients about medication. Based on the nurses' experiences in their roles, 74% of the nurses felt that the patients expected to receive health promotion related care in the hospital, but 16% of the respondents were uncertain about this, and 10% disagreed.

In health promotion practice, the nurses believe that they are effective in encouraging patients to adopt healthy behaviours. For example, 90% of the nurses answered that they had encouraged patients to adopt and continue healthy behaviours that patients learnt about in the hospital. However, only 67% of the nurses considered that they would be effective in modelling the lifestyle of patients, and 25% remained uncertain about this activity. This finding that the nurses would deliver the information to the patients and encourage behavioural changes without further seeking to model the patients' lifestyle is worth pursuing further to ascertain the scope of what the nurses could, and could not, accomplish. Only 63% of the nurses acknowledged the importance of patients' sharing their experiences during health promotion activities. This finding confirms that patients' active participation is the priority in current health promotion practice. The details about

the approach to nursing health promotion are further explained in the interview results (see Chapter Six).

Table 5.14 Nurses' Perceived Health Promotion Practice in the Hospital

Item No.	Questions	Strongly Agree (N/%)	Agree (N/%)	Uncertain (N/%)	Disagree (N/%)	Strongly Disagree (N/%)	Total (N/%)
6	Ensuring a healthy work environment is important to me.	58/51	52/46	3/3	3/3	0/0	113/100
10	I involve patients' families/caregivers in health promotion when appropriate.	23/20	83/74	5/4	2/2	0/0	113/100
1	There are potential health benefits for patients when I teach them about their medications.	47/42	58/51	7/6	1/1	0/0	113/100
3	I encourage patients facing discharge to carry on with healthy behaviours learned in the hospital.	26/23	76/67	9/8	2/2	0/0	113/100
7	Health promotion is an important part of my role.	31/27	65/58	13/12	4/3	0/0	113/100
2	Patients expect nurses to encourage them to adopt healthy lifestyles.	15/13	69/61	18/16	8/7	3/3	113/100
28	I can refer patients to community agencies.	18/16	62/56	23/21	6/5	2/2	111/100
4	I generally model healthy lifestyles for my patients.	13/11	63/56	28/25	7/6	2/2	113/100
34	Educating patients to give up smoking is part of my job.	27/24	44/40	10/9	22/20	8/7	111/100
5	Encouraging patients to share experiences about procedures is part of my role in health promotion.	18/16	53/47	29/26	11/10	1/1	112/100
11	I direct my health promotion activities to my nursing colleagues.	9/8	36/32	27/24	35/31	5/5	112/100
8	The hospital nurse's health promotion activities are incidental rather than planned.	4/3	29/26	24/21	46/41	10/9	113/100
9	I changed hospital rules or routines to accommodate patients' control.	1/1	24/22	46/41	35/32	5/4	111/100
17	I am involved in health promotion activities in my community.	1/1	10/9	8/7	63/56	31/28	113/100

Table 5.15 Nurses' Perceived Health Promotion Practice in the Hospital (in 3 Categories)

Item No.	Questions	Agree (N/%)	Uncertain (N/%)	Disagree (N/%)	Total (N/%)
6	Ensuring a healthy work environment is important to me.	110/97	3/3	0/0	113/100
10	I involve patients' families/caregivers in health promotion when appropriate.	106/94	5/4	2/2	113/100
1	There are potential health benefits for patients when I teach them about their medications.	105/93	7/6	1/1	113/100
3	I encourage patients facing discharge to carry on with healthy behaviours learned in the hospital.	102/90	9/8	2/2	113/100
7	Health promotion is an important part of my role.	96/85	13/12	4/3	113/100
2	Patients expect nurses to encourage them to adopt healthy lifestyles.	84/74	18/16	11/10	113/100
28	I can refer patients to community agencies.	80/72	23/21	8/7	111/100
4	I generally model healthy lifestyles for my patients.	76/67	28/25	9/8	113/100
34	Educating patients to give up smoking is part of my job.	71/64	10/9	30/27	111/100
5	Encouraging patients to share experiences about procedures is part of my role in health promotion.	71/63	29/26	12/11	112/100
11	I direct my health promotion activities to my nursing colleagues.	45/40	27/24	40/36	112/100
8	The hospital nurse's health promotion activities are incidental rather than planned.	33/29	24/21	56/50	113/100
9	I changed hospital rules or routines to accommodate patients' control.	25/23	46/41	40/36	111/100
17	I am involved in health promotion activities in my community.	11/10	8/7	94/83	113/100

Table 5.16 Nurses' Perceived Health Promotion Practice (Mean Scores)

Item No.	Questions	Cases (N)	Mean	SD
6	Ensuring a healthy work environment is important to me.	113	4.49	0.55
10	I involve patients' families/caregivers in health promotion when appropriate.	113	4.12	0.55
1	There are potential health benefits for patients when I teach them about their medications.	113	4.33	0.67
3	I encourage patients facing discharge to carry on with healthy behaviours learned in the hospital.	113	4.12	0.61
7	Health promotion is an important part of my role.	113	4.09	0.73
2	Patients expect nurses to encourage them to adopt healthy lifestyles.	113	3.75	0.87
28	I can refer patients to community agencies.	111	3.79	0.84
4	I generally model healthy lifestyles for my patients.	113	3.69	0.89
34	Educating patients to give up smoking is part of my job.	111	3.54	1.26
5	Encouraging patients to share experiences about procedures is part of my role in health promotion.	112	3.68	0.89
11	I direct my health promotion activities to my nursing colleagues.	112	3.08	1.07
8	The hospital nurse's health promotion activities are incidental rather than planned.	113	2.74	1.05
9	I changed hospital rules or routines to accommodate patients' control.	111	2.83	0.85
17	I am involved in health promotion activities in my community.	113	2.00	0.89

The data show a variety of responses across the spectrum of health promotion practices by the nurses. For example, whilst most practices recorded a strong agreement, for some practices, such as educating patients to give up smoking, only 64% of the nurses considered it as their role to advise about this, while 27% disagreed, and 9% were uncertain. Together with other practices, this finding implies that the nurses lack a consensus with regards to some particular issues of health promotion activities in nursing, even though the activities are usually considered important activities in health promotion. This indicates the different understandings amongst nurses about some particular activities in health promotion and suggests the possibility of individualistic approaches. Another possibility is that the health promotion practice itself requires a varied and individual approach, which could be discovered in the interviews.

In terms of working style, an individually conducted health promotion practice seemed to be more popular than a cooperative one, as only 40% of the nurses had experienced colleague cooperation in the survey. When asked whether the health promotion practice had been planned or incidental, 50% of the nurses responded to the former, 29% to the latter and 21% were uncertain in their response to the question. This reflects the varied current health promotion practice in the hospital. For example, the smoking programme is strongly associated with the practice area ($p=0.001$ by t-test). Smoking-relevant health promotion activities were more supported by nurses from the medical wards than the surgical areas, as indicated by the respective response means (the mean for the medical area=3.82; the mean for the surgical area=3.00). This case implies that wards with different specialties have different attitudes and perform different activities regarding the health promotion practice. In this sense, the health promotion practice on the wards has a degree of variety or flexibility across the wards.

As expected, that families and caregivers are involved in the health promotion practice, is supported by most of the nurses (94%) who consider the patients' family-based support systems to be an important issue in promoting health. In connecting with the communities, 72% of the nurses could refer patients to the community, although only 10% of the nurses admitted that they were involved in promoting health in the community, while 83% are not. The hospital nurses have seldom been involved in community care but merely referred patients during health promotion. In this, the nurses' perceived the health promotion practice

consistent with their expectations of the health promotion role in the hospital. In this sense, what nurses understand of the health promotion role is very likely related to what they practice in the hospital. Indeed, the association between nurses' role expectations and actual practice is significantly correlated, as evident in the following presentation, reflecting the nurses' understandings of the health promotion role.

Almost all nurses (97%) agreed that a healthy working environment is important for them to engage in health promotion practice. This high rate of agreement suggests on the one hand that nurses believe in the importance of the working environment on their health promotion practice. On the other hand, it may suggest that the working environment itself fundamentally influences the nurses' health promotion practice for some reason. Why the working environment has an influence on the nurses' awareness of the importance of health promotion practice is a question that should be answered. However, very few nurses (23%) think that they actually have the capability to change the rules in order to facilitate better working conditions; more were uncertain (41%) in this regard or else disagreed with the proposition (36%). The varied and significant spread in the answers to this question will need to be probed in the interviews, to find out whether the nurses are not concerned with changing their working environment, or are unwilling or perhaps unable to do so.

The subscale of "Promotion Activities" includes 10 items to determine the extent to which the respondents themselves practice in matters relating to health promotion (see Tables 5.17 and 5.18). The list of the health promotion activities include most of the items in the foregoing description of the nurses' performance but focuses more on representing the frequency of health promotion activities among nurses. The mean value is 3.60 (range 1–5; SD 0.37), which suggests that the nurses engage in a moderate degree of health promotion practice. However, there is a wide spread in frequency of occurrence of the health promotion activities. Some activities appear to be more frequently conducted than others in the hospital. Therefore, the different frequencies have been converted to an average level of practice. Table 5.18 shows the items relating to "Promotion Activities" that attracted the greatest agreement included patients encouragement and family involvement. This shows that the patients were the centre of the health promotion service in the hospital. The less frequent practices appeared to be related to

community practice, the modelling of a healthy lifestyle for patients, and the patients' participation in health promotion. Briefly, the current health promotion practice seems to focus on encouraging patients individually through lifestyle advice in the hospital and focusing much less on team work or cooperation, and the community service.

Table 5.17 Nurses' "Promoting Activities" in the Hospital (Mean Scores)

Item No.	Questions	Strongly Agree (N/%)	Agree (N/%)	Uncertain (N/%)	Disagree (N/%)	Strongly Disagree (N/%)	Total (N/%)	Mean	SD
6	Ensuring a healthy work environment is important to me.	58/51	52/46	3/3	3/3	0/0	113/100	4.49	0.55
10	I involve patients' families/caregivers in health promotion when appropriate.	23/20	83/74	5/4	2/2	0/0	113/100	4.12	0.55
3	I encourage patients facing discharge to carry on with healthy behaviours learned in the hospital.	26/23	76/67	9/8	2/2	0/0	113/100	4.12	0.61
49	Family members/caregivers are included in a hospital nurse's health promotion efforts.	30/27	70/62	11/10	1/1	0/0	112/100	4.15	0.62
28	I can refer patients to community agencies.	18/16	62/56	23/21	6/5	2/2	111/100	3.79	0.84
4	I generally model healthy lifestyles for my patients.	13/11	63/56	28/25	7/6	2/2	113/100	3.69	0.89
5	Encouraging patients to share experiences about procedures is part of my role in health promotion.	18/16	53/47	29/26	11/10	1/1	112/100	3.68	0.89
11	I direct my health promotion activities to my nursing colleagues.	9/8	36/32	27/24	35/31	5/5	112/100	3.08	1.07
9	I changed hospital rules or routines to accommodate patients' control.	1/1	24/22	46/41	35/32	5/4	111/100	2.83	0.85
17	I am involved in health promotion activities in my community.	1/1	10/9	8/7	63/56	31/28	113/100	2.00	0.89

Table 5.18 Nurses' "Promoting Activities" in the Hospital (in 3 Categories)

Item No.	Questions	Agree (N/%)	Uncertain (N/%)	Disagree (N/%)	Total (N/%)
6	Ensuring a healthy work environment is important to me.	110/97	3/3	0/0	113/100
10	I involve patients' families/caregivers in health promotion when appropriate.	106/94	5/4	2/2	113/100
3	I encourage patients facing discharge to carry on with healthy behaviours learned in the hospital.	102/90	9/8	2/2	113/100
49	Family members/caregivers are included in a hospital nurse's health promotion efforts.	100/89	11/10	1/1	112/100
28	I can refer patients to community agencies.	80/72	23/21	8/7	111/100
4	I generally model healthy lifestyles for my patients.	76/67	28/25	9/8	113/100
5	Encouraging patients to share experiences about procedures is part of my role in health promotion.	71/63	29/26	12/11	112/100
11	I direct my health promotion activities to my nursing colleagues.	45/40	27/24	40/36	112/100
9	I changed hospital rules or routines to accommodate patients' control.	25/23	46/41	40/36	111/100
17	I am involved in health promotion activities in my community.	11/10	8/7	94/83	113/100

The analysis also compared the "Promotion Activities" by different demographic subgroups. Table 5.19 reports that there are no statistically significant differences between any of the demographic variables. It suggests that the nurses engage in a uniform practice of health promotion, regardless which defined subgroup in the survey they belonged. It is surprising that there are no significant differences between the groups of nurses having a higher education level or those with more qualified years, and other groups. This means that all of the nurses, no matter what their educational level and qualified years, would perform a similar level of health promotion practice. The other surprising result is that there were no significant differences between the wards with regard to the frequency of delivery of health promotion activities. It suggests that on each ward, no matter what its specialization, the extent of the health promotion practice would be similar, despite the traditional division that exists between medical and surgical wards. In this context, it is probable that the frequency of health promotion activities is probably similar across all wards in the hospital. It is noted that the specialists in each ward representing different types of diseases, do not have an impact on the extent of the health promotion practice in the hospital.

In summary, a wide variety of health promotion practice as reported by the nurses has been presented here, from the particular activities to the overall working style. The encouragement of, and information-giving to, the patients appear to be dominant activities in hospital nursing. A further involvement of the patients' participation and healthy behavioural changes are less frequently conducted in nursing practice. The patients and their family are the priority in the nurses' health promotion practice. Interestingly, the extent of the health promotion practice is shown to be similar across the demographic groups. More information is required from the interview data to explain the causes of this finding.

Table 5.19 Promotion Activities Divided by Demographic Subgroup

Compare Mean (T-test)						
Dependent Variables	**Categories**	**Cases (n)**	**Mean**	**SD**	**P (2-tailed)**	**Total (n)**
Practice Area	Medical	74	3.59	0.38	0.885	113
	Surgical	39	3.60	0.36		
Work Time	Full-time	101	3.58	0.37	0.169	113
	Part-time	12	3.74	0.34		
Gender	Female	95	3.58	0.37	0.283	113
	Male	18	3.68	0.36		
One-way ANOVA						
Dependent Variables	**Categories**	**Cases (n)**	**Mean**	**SD**	**Test Result**	**Total (n)**
Education Level	RN	32	3.59	0.37	F=0.901 (p=0.466) P=0.847 η^2=0.013	113
	RN-Diploma	38	3.56	0.35		
	RN-Bachelor's	23	3.64	0.39		
	RN-Honour's	16	3.65	0.34		
	RN-Master's	4	3.47	0.66		
Grade	Grade D	47	3.58	0.34	F=0.150 (p=0.930) P=0.946 η^2=0.003	113
	Grade E	44	3.59	0.39		
	Grade F	9	3.66	0.44		
	Grade G	13	3.62	0.42		
Qualified Years	0-4 years	53	3.54	0.36	F=0.836 (p=0.545) P=0.062 η^2=0.105	113
	5-9 years	17	3.61	0.32		
	10-14 years	11	3.80	0.42		
	15-19 years	12	3.60	0.37		
	20-24 years	8	3.73	0.18		
	25-29 years	10	3.44	0.43		
	30+ years	2	4.15	0.50		
Age	20-29 years	37	3.54	0.35	F=0.259 (p=0.854) P=0.067 η^2=0.063	113
	30-39 years	37	3.53	0.37		
	40-49 years	31	3.68	0.38		
	50+ years	8	3.84	0.37		
Current Position	Staff Nurse	92	3.58	0.36	F=0.601 (p=0.615) P=0.278 η^2=0.035	113
	Specialist Nurse	4	3.95	0.38		
	Charge Nurse	14	3.60	0.41		
	Other	3	3.53	0.57		

5.4.2.3 Nurses' Perceived Self-Efficacy

The subscale of "Perceived Self-Efficacy" examines the nurses' perceptions of their own knowledge and capabilities with regard to delivering health promotion practice, by asking six questions. Table 5.20 presents the nurses' responses in terms of percentages and mean scores, while Table 5.21 displays the combined agreement and disagreement answers. The mean value of the subscales is 3.77 (range 1–5; SD 0.48), which suggests that the nurses have a moderate degree of comfort regarding their knowledge and skills when promoting nursing health, but this may not be at an acceptable level of confidence. The detailed questions identify that, although most of the nurses (89%) perceive that they engage in health

promotion on a daily basis, only 52% of them feel satisfied with their own skills in promoting health, with 31% feeling uncertain. It is surprising to find that the nurses are able to engage in health promotion on a daily basis but only half of them felt satisfied with their skills in this area, and this is especially so given the high proportion of uncertainty answers. Further findings show that the nurses (86%) feel relatively satisfied with their teaching of self-care in particular, and the same proportion of respondents feel that their knowledge of self-care is adequate. However, with regard to advocacy, 70% of the nurses believe that they have the ability to advocate for a healthy hospital, but only 47% for a healthy community.

Table 5.20 Nurses' Perceived Self-efficacy in Health Promotion Practice (Mean Scores)

Item No.	Questions	Strongly Agree (N/%)	Agree (N/%)	Uncertain (N/%)	Disagree (N/%)	Strongly Disagree (N/%)	Total (N/%)	Mean	SD
51	Health promotion is an "everyday thing" for nurses.	34/30	66/59	9/8	2/2	1/1	112/100	4.16	0.72
14	I am comfortable in teaching patients about self-care.	22/20	74/66	13/11	3/3	0/0	112/100	4.03	0.65
13	My knowledge on self-care is adequate.	14/13	82/73	11/10	11/10	5/5	112/100	3.94	0.63
15	I have the ability to advocate for a healthy hospital.	13/12	65/58	26/23	7/6	1/1	112/100	3.73	0.78
12	I am satisfied with my skills in health promotion.	3/3	56/50	35/31	18/16	1/1	113/100	3.73	0.82
16	I have the ability to advocate for a healthy community.	9/8	43/39	45/40	8/7	6/5	111/100	3.73	0.93

Table 5.21 Nurses' Perceived Self-efficacy in Health Promotion Practice (in 3 Categories)

Item No.	Questions	Agree (N/%)	Uncertain (N/%)	Disagree (N/%)	Total (N/%)
51	Health promotion is an "everyday thing" for nurses.	100/89	9/8	3/3	112/100
14	I am comfortable in teaching patients about self-care.	96/86	13/11	3/3	112/100
13	My knowledge on self-care is adequate.	96/86	11/10	5/4	112/100
15	I have the ability to advocate for a healthy hospital.	78/70	26/23	8/7	112/100
12	I am satisfied with my skills in health promotion.	59/52	35/31	19/17	113/100
16	I have the ability to advocate for a healthy community.	52/47	45/40	14/13	111/100

As the subscale is not a normal distribution, it is analysed using non-parametric techniques. Table 5.22 shows that there is little or no statistical significance attached to "Perceived Self-Efficacy" when segmented by the demographic variables. It was surprising to find that the nurses' education level, grade and years qualified had not influenced their perceived self-efficacy. In other words, the nurses' confidence about their ability to engage in health promotion remains at a uniform level. The ensuing interviews will focus on exploring and explaining this finding.

Table 5.22 Nurses' Perceptions of Perceived Self-Efficacy Divided by Demographic Subgroups

Mann-Whitney Test (n=113)

Dependent Variables	Categories	Cases (n)	Mean Rank	Mann-Whitney U	P (2-tailed)
Practice Area	Medical	74	58.83	1307.50	0.409
	Surgical	39	53.53		
Work Time	Full-time	101	56.52	525.00	0.447
	Part-time	12	63.75		
Gender	Female	98	55.74	735.00	0.342
	Male	18	63.67		

Kruskal-Wallis Test (n=113)

Dependent Variables	Categories	Case (n)	Mean Rank	Chi-square χ^2	P
Education level	RN	32	57.42	2.94	0.567
	RN-Diploma	38	56.22		
	RN-Bachelor's	23	56.67		
	RN-Honour's	16	52.00		
	RN-Master's	4	82.88		
Grade	Grade D	47	57.67	0.26	0.967
	Grade E	44	56.10		
	Grade F	9	53.61		
	Grade G	13	59.96		
Qualified Years	0-4 years	53	54.62	12.30	0.056
	5-9 years	17	46.03		
	10-14 years	11	66.68		
	15-19 years	12	61.92		
	20-24 years	8	81.44		
	25-29 years	10	44.45		
	30+ years	2	95.50		
Age	20-29 years	37	54.35	2.96	0.398
	30-39 years	37	52.28		
	40-49 years	31	63.03		
	50+ years	8	67.69		
Current position	Staff Nurse	92	56.39	2.72	0.438
	Specialist Nurse	4	76.88		
	Charge Nurse	13	59.57		
	Other	3	37.33		

In summary, the findings show that although the nurses are able to carry out health promotion on a daily basis, half of nurses are not satisfied with their self- efficacy

in this task. The majority of nurses only felt satisfied with teaching self-care in health promotion practice. The nurses' perceived self-efficacy appears to be related to their practice; it is not, however, significantly different across the demographic groups of the education level and qualified years.

5.4.2.4 Factors influencing health promotion practice

As part of their health promotion experiences, the nurses responded to 16 questions that were designed to examine the influential factors on health promotion practice. These questions constituted the subscale of "Enabling Factors" in the analysis. Another four items were extracted from the "Enabling Factors" to form a further subscale of "Actual Knowledge", which was used to evaluate the nurses' actual knowledge of health promotion practice. These external factors could facilitate or hinder the nurses' health promotion practice, so the items in the survey are classified into facilitators or barriers based on the statements to which responses were sought and which included the hospital environment, the ward level management, resources, and the actual knowledge background.

Tables 5.23 and 5.24 present the responses of the nurses in terms of percentages, mean scores, and combined agreement and disagreement frequencies. The mean value of the "Enabling Factor" is 3.63 (range 1–5, SD 0.39). This suggests that the nurses experience more facilitators than barriers in current health promotion practice. For instance, ten questions achieved over 70% agreement, as shown in Table 5.23. However, the other six questions achieved rather less agreement, showing that barriers still exist in the hospital environment, in terms of resources, training and the consistency of health promotion activities (see Table 5.25).

In terms of the hospital environment, only 65% of the nurses believed that the hospital is supportive of their health promotion practice, and over a quarter are uncertain about this (28%). Only 42% of the respondents agreed that the current hospital activities with regard to health promotion support their ability to carry out health promotion practice, while many nurses are uncertain (30%) or disagree with this question (28%). The findings are unable to show consistent agreement here. This high proportion of uncertainty is also valuable information but could only be further explored in the following interviews.

Table 5.23 Nurses' Perceived Facilities or Barriers in Health Promotion Practice

Item No.	Questions	Strongly Agree (N/%)	Agree (N/%)	Uncertain (N/%)	Disagree (N/%)	Strongly Disagree (N/%)	Total (N/%)
29	Knowing about cultural values helps nurses in their health promotion efforts.	41/36	65/58	4/4	2/2	0/0	112/100
25	Health promotion efforts would improve if there were more time for case conferences, in-service education and bedside teaching.	52/47	53/47	6/5	1/1	0/0	112/100
24	Time constraints are a barrier to nurses undertaking health promotion activities.	55/49	49/43	4/4	5/4	0/0	113/100
26	Hospital nurses' health promotion efforts would be strengthened by consistent patient teaching.	31/28	68/61	12/11	0/0	0/0	111/100
30	If I learn more about health promotion, it will help me provide better patient care.	38/34	60/53	10/9	3/3	1/1	112/100
31	My experience as a nurse has taught me about health promotion.	20/18	74/66	9/8	6/5	3/3	112/100
21	The team approach to patient care strengthens a nurse's health promotion efforts.	15/14	71/64	16/14	8/7	1/1	111/100
27	Incomplete written records hinder a nurse's health promotion efforts.	28/25	56/51	20/18	6/6	0/0	110/100
32	In my basic nursing program, health promotion was included in the course work.	30/27	53/47	12/11	10/9	7/6	112/100
28	I can refer patients to community agencies.	18/16	62/56	23/21	6/5	2/2	111/100
22	My hospital is supportive of health promotion activities.	10/9	63/56	32/28	4/4	4/3	113/100
18	There is easy access to up-dated resources on health-related topics that help me in my health promotion efforts.	11/10	47/41	29/26	19/17	7/6	113/100
20	Hospital activities on health promotion topics support a nurse's ability to carry out health promotion activities.	2/2	45/40	34/30	24/21	8/7	113/100
19	There are adequate resources for teaching chronically ill patients coping skills.	3/3	27/24	41/36	29/26	12/11	112/100
33	Since graduation I have taken courses on health promotion.	3/3	14/12	7/6	67/60	21/19	112/100
23	Lack of continuing of care between different hospital departments interferes with a nurse's health promotion efforts.	1/1	10/9	31/27	64/57	7/6	113/100

Table 5.24 Nurses' Perceived Facilities or Barriers in Health Promotion Practice (Mean Scores)

Item No.	Questions	Cases (N)	Mean	SD
29	Knowing about cultural values helps nurses in their health promotion efforts.	112	4.29	0.62
25	Health promotion efforts would improve if there were more time for case conferences, in-service education and bedside teaching.	112	4.39	4.64
24	Time constraints are a barrier to nurses undertaking health promotion activities.	113	4.36	0.76
26	Hospital nurses' health promotion efforts would be strengthened by consistent patient teaching.	111	4.17	0.60
30	If I learn more about health promotion, it will help me provide better patient care.	112	4.17	0.77
31	My experience as a nurse has taught me about health promotion.	112	3.91	0.84
21	The team approach to patient care strengthens a nurse's health promotion efforts.	111	3.82	0.79
27	Incomplete written records hinder a nurse's health promotion efforts.	110	3.96	0.82
32	In my basic nursing program, health promotion was included in the course work.	112	3.79	1.12
28	I can refer patients to community agencies.	111	3.79	0.84
22	My hospital is supportive of health promotion activities.	113	3.63	0.84
18	There is easy access to up-dated resources on health-related topics that help me in my health promotion efforts.	113	3.32	1.07
20	Hospital activities on health promotion topics support a nurse's ability to carry out health promotion activities.	113	3.08	0.98
19	There are adequate resources for teaching chronically ill patients coping skills.	112	2.82	1.01
33	Since graduation I have taken courses on health promotion.	112	2.21	0.98
23	Lack of continuing of care between different hospital departments interferes with a nurse's health promotion efforts.	113	2.42	0.78

Table 5.25 Facilities or Barriers of Health Promotion Practice (in 3 Categories)

Categories	Item No.	Questions	Agree (N/%)	Uncertain (N/%)	Disagree (N/%)	Total (N/%)
Hospital Environments	22	My hospital is supportive of health promotion activities.	73/65	32/28	8/7	113/100
	20	Hospital activities on health promotion topics support a nurse's ability to carry out health promotion activities.	47/42	34/30	32/28	113/100
Resources	25	Health promotion efforts would improve if there were more time for case conferences, in-service education and bedside teaching.	105/94	6/5	1/1	112/100
	24	Time constraints are a barrier to nurses undertaking health promotion activities.	104/92	4/4	5/4	113/100
	18	There is easy access to up-dated resources on health-related topics that help me in my health promotion efforts.	58/51	29/26	26/23	113/100
	19	There are adequate resources for teaching chronically ill patients coping skills.	30/27	41/36	41/37	112/100
Ward Level Routines	29	Knowing about cultural values helps nurses in their health promotion efforts.	106/94	4/4	2/2	112/100
	26	Hospital nurses' health promotion efforts would be strengthened by consistent patient teaching.	99/89	12/11	0/0	111/100
	21	The team approach to patient care strengthens a nurse's health promotion efforts.	86/78	16/14	9/8	111/100
	27	Incomplete written records hinder a nurse's health promotion efforts.	84/76	20/18	6/6	110/100
	28	I can refer patients to community agencies.	80/72	23/21	8/7	111/100
	23	Lack of continuing of care between different hospital departments interferes with a nurse's health promotion efforts.	11/10	31/27	71/63	113/100

The influential factors with regard to ward management were examined in the survey. A high proportion of the nurses (94%) believed that cultural values are important in health promotion practice. The nurses also considered that the recording system is an influential factor, as 76% of the nurses believe that current incomplete records of promotion activities have hindered their efforts regarding health promotion practice. The majority of nurses (89%) agreed that the consistency in health teaching could strengthen their health promotion efforts. Teamwork is also viewed by 78% of the nurses as an important factor in improving the practice. However, over half the nurses (63%) did not think that the lack of consistency of care between different departments or wards would interfere with their efforts towards health promotion, while 27% of the nurses are uncertain about this, and 10% disagreed. It is significant to find that many of the nurses do not view the lack of consistency of care as an influencing factor on their health promotion practice. Probably, those nurses have acknowledged their own function in health promotion, no matter what the other health professionals or wards are doing in this respect.

Regarding resources, the data show that the nurses desire more resources for health promotion. In particular, the majority of the nurses (92%) believe that the time constrain is a barrier to promoting health. In terms of training resources, 94% of the nurses expect to have more learning opportunities in practice through case conferences, in-service education and bedside teaching. In terms of up-dating the resources, only 51% of the nurses reported that there are up-to-date resources that they could use for practising, while 26% are uncertain and 23% disagree. A mere 27% of the nurses felt that they have observed adequate resources for chronically ill patients, while most are uncertain about this (36%) or disagreed (37%). The resources available for nurses' health promotion practice appeared to be limited or even absent. The high rate of uncertainty implies that the nurses might be unsure about whether the resources existed or not.

The tests are used to identify the differences between the "Enabling Factors", segmented by demographic group. The results in Table 5.26 show that there are no statistically significant differences between the "Enabling Factors" for the various demographic subgroups. Therefore, the responses from the whole sample appear to suggest a similar perspective on the issue of the facilitators or barriers provided in the survey questionnaire.

Table 5.26 Nurses' Perceptions of Enabling Factors x Demographic Subgroups

Compare Mean (T-test)						
Dependent Variables	**Categories**	**Cases (n)**	**Mean**	**SD**	**P (2-tailed)**	**Total n**
Practice Area	Medical	74	3.62	0.42	0.711	113
	Surgical	39	3.65	0.33		
Work Time	Full-time	101	3.65	0.40	0.209	113
	Part-time	12	3.50	0.20		
Gender	Female	95	3.98	0.40	0.937	113
	Male	18	3.99	0.39		
One-way ANOVA						
Dependent Variables	**Categories**	**Cases (n)**	**Mean**	**SD**	**Test Result**	**Total (n)**
Education Level	RN	32	3.60	0.31	F=1.738 (p=0.147) P=0.791 η^2=0.015	113
	RN-Diploma	38	3.65	0.38		
	RN-Bachelor's	23	3.71	0.39		
	RN-Honour's	16	3.56	0.46		
	RN-Master's	4	3.57	0.79		
Grade	Grade D	47	3.69	0.33	F=0.971 (p=0.409) P=0.309 η^2=0.032	113
	Grade E	44	3.63	0.42		
	Grade F	9	3.57	0.29		
	Grade G	13	3.47	0.53		
Qualified Years	0-4 years	53	3.63	0.38	F=0.797 (p=0.574) P=0.284 η^2=0.066	113
	5-9 years	17	3.70	0.38		
	10-14 years	11	3.75	0.32		
	15-19 years	12	3.69	0.33		
	20-24 years	8	3.63	0.41		
	25-29 years	10	3.34	0.55		
	30+ years	2	3.56	0.09		
Age	20-29 years	37	3.62	0.38	F=0.831 (p=0.480) P=0.924 η^2=0.004	113
	30-39 years	37	3.65	0.34		
	40-49 years	31	3.61	0.47		
	50+ years	8	3.70	0.43		
Current Position	Staff Nurse	92	3.65	0.37	F=1.781 (p=0.155) P=0.593 η2=0.017	113
	Specialist Nurse	4	3.63	0.22		
	Charge Nurse	14	3.51	0.48		
	Other	3	3.52	0.72		

The influential factors related to the nurses' individual actual knowledge are grouped into the subscale "Actual Knowledge". The mean value of "Actual Knowledge" is 3.52 (range 1–5, SD 0.57), which indicates that the nurses have a moderate level of agreement about the issues raised in the questionnaire. Tables 5.27 and 5.28 show that the nurses expect to have more training after graduation with regard to the health promotion role. In fact, the survey results suggest there are very limited opportunities for nurses to engage in further learning after graduation. For example, the majority of the nurses (87%) expressed a desire to acquire more health promotion knowledge in order to improve their performance in this area, with 34% strongly agreeing with this view. Although 74% of the nurses admitted

that they had gained a basic knowledge of health promotion in their nursing training, only 15% reported that they had any further training after graduation, while a high proportion (79%) believed that they had not. Meanwhile, most of the nurses (84%) believed that their working experiences contributed to the better practice of health promotion. The findings suggest that the nurses received very limited training in health promotion during either their nursing training or working experience, but such training as they did receive they considered very important in improving their knowledge and skills regarding the health promotion role.

Table 5.27 Nurses' Perceived Actual Knowledge of Health Promotion Practice (Mean Scores)

Item No.	Questions	Strongly Agree (N/%)	Agree (N/%)	Uncertain (N/%)	Disagree (N/%)	Strongly Disagree (N/%)	Total (N/%)	Mean	SD
30	If I learn more about health promotion, it will help me provide better patient care.	38/34	60/53	10/9	3/3	1/1	112/100	4.17	0.77
31	My experience as a nurse has taught me about health promotion.	20/18	74/66	9/8	6/5	3/3	112/100	3.91	0.84
32	In my basic nursing program, health promotion was included in the course work.	30/27	53/47	12/11	10/9	7/6	112/100	3.79	1.12
33	Since graduation I have taken courses on health promotion.	3/3	14/12	7/6	67/60	21/19	112/100	2.21	0.98

Table 5.28 Nurses' Perceived Actual Knowledge of Health Promotion Practice (in 3 Categories)

Item No.	Questions	Agree (N/%)	Uncertain (N/%)	Disagree (N/%)	Total (N/%)
30	If I learn more about health promotion, it will help me provide better patient care.	98/87	10/10	4/3	112/100
31	My experience as a nurse has taught me about health promotion.	94/84	9/8	9/8	112/100
32	In my basic nursing program, health promotion was included in the course work.	83/74	12/11	17/15	112/100
33	Since graduation I have taken courses on health promotion.	17/15	7/6	88/79	112/100

A comparative analysis of the "Actual Knowledge" by demographic variables is shown in Table 5.29, revealing that there are statistically significant differences when Actual Knowledge is segment into Work Time (P=0.031) and Gender (P=0.016) using the Mann-Whitney tests. The detail of the mean ranks indicate that full-time nurses and male nurses have a much better knowledge of health promotion than the others. However, unusually, there are no statistically significant differences when Actual Knowledge is segment by Education Level, Grade, Qualified Years, Age and Current Position. The unsatisfactory reliability of the subscale could be a possible reason for this.

Table 5.29 Actual Knowledge by Demographic Subgroups

Mann-Whitney Test (n=112)

Dependent Variables	Categories	Cases (n)	Mean Rank	Mann-Whitney U	P (2-tailed)
Practice Area	Medical	74	55.37	1322.50	0.602
	Surgical	38	58.70		
Work Time	Full-time	100	58.75	375.00	**0.031**
	Part-time	12	37.75		
Gender	Female	94	53.32	547.00	**0.016**
	Male	18	73.11		

Kruskal-Wallis Test (n=112)

Dependent Variables	Categories	Cases (n)	Mean Rank	Chi-square χ^2	P
Education level	RN	31	53.39	1.05	0.902
	RN-Diploma	38	57.05		
	RN-Bachelor's	23	60.80		
	RN-Honour's	16	57.28		
	RN-Master's	4	47.50		
Grade	Grade D	47	64.32	7.51	0.057
	Grade E	44	54.50		
	Grade F	8	51.50		
	Grade G	13	38.08		
Qualified Years	0-4 years	53	59.55	5.62	0.467
	5-9 years	17	58.56		
	10-14 years	11	60.18		
	15-19 years	12	58.96		
	20-24 years	8	49.06		
	25-29 years	9	34.17		
	30+ years	2	53.50		
Age	20-29 years	37	57.73	1.81	0.612
	30-39 years	37	60.72		
	40-49 years	31	50.56		
	50+ years	7	54.00		
Current position	Staff Nurse	91	58.80	2.80	0.423
	Specialist Nurse	4	50.38		
	Charge Nurse	13	43.96		
	Other	3	53.50		

In summary, the lack of adequate support from the hospital is the main barrier that the nurses believe significantly influences health promotion practice. In particular,

the barriers at the management level include cultural values, the recording system, inconsistency in teaching patients and teamwork. Interestingly, the nurses do not consider the inconsistent care caused by transferring across wards as a barrier to health promotion practice. This opinion is surprisingly different from the current notion of the importance of "cooperation" in health promotion. The lack of resource supports mainly refers to the issue of time constraints and the lack of up-dating resources. Further, the nurses feel tension about the necessity to improve their knowledge and skills regarding health promotion practice. Unfortunately, the survey results suggest that there is little opportunity to meet the nurses' demands for knowledge and skills. A large degree of uncertainty in the nurses' responses may be a very important clue in attempts to identify whether the nurses have acknowledged and/or applied the support from the hospital and the management level or not, and this could be explained by the interview accounts.

5.4.2.5 Correlations among subscales

The subscales in the survey are further explored for the associations between each other when appropriate. However, "Actual Knowledge" has not been involved with the correlation tests because of its unreliability. Also, "Actual Knowledge" is regrouped from the items of the "Enabling Factors" so that the former is one of the external influencing factors which will be represented by the latter. It is also noted that the analysis does not consider the correlation between "Role Expectation" and "Perceived Self-efficacy" because these two have not established a theoretical relation. The "Perceived Self-efficacy" refers to the nurses' feelings about their capability in performing health promotion so it is coexistent with the "Promotion Activities".

The findings of the correlations are shown in the Table 5.30. The "Role Expectations" and the "Perceived Self-efficacy" are significantly related to the "Promotion Activities" respectively, while the "Role expectation", "Perceived Self-efficacy", and "Promotion Activities" are all significantly associated with the "Enabling Factors" in the survey.

Table 5.30 Correlation Tests of the Subscales (n=113) – Pearson's r (R) and Significance (P)

Subscale	Role Expectation	Perceived Self-efficacy	Promotion Activities	Enabling Factors
Role Expectation	--			
Perceived Self-efficacy	--	--		
Promotion Activities	R=0.52 P=0.000 G-power= 1.0000*	R=0.525 P=0.000 G-power= 1.0000*	--	
Enabling Factors	R=0.547 P=0.000 G-power=1.0000*	R=0.287 P=0.002 G-power=0.9358*	R=0.544 P=0.000 G-power=.0000*	--

*Computed by power analysis program *G*Power 2* (http://www.psycho.uni-duesseldorf.de/aap/projects/gpower/)

Statistically, Pearson's correlation test shows that these two subscales have a high coefficient of 0.52 (p=0.000). This means that the nurses' role expectation is related to the extent of current practice. This finding is not surprising since the above descriptive analysis has suggested that the nurses' understanding of the health promotion role as it is expected and as it is in practice are consistent in some respects. For example, the nurses in the survey both expected and practiced health promotion within the scope of their patients and their family, but hardly extended such effort to community area. Health promotion for self-care as the main theme is shared in both the results from the "Role Expectation" and the "Promotion Activities". What is confused in the "Role Expectation" also occurred in the "Promotion Activities", such as the view of whether certain activities belonged to health promotion at all. One important explanation is that both sections, although they are separated in the questionnaire, are based on the nurses' understanding of health promotion; the cognitive processes would be difficult to exclude from each other. Another important reason is that the survey questionnaire has limited its conceptualization of the "health promotion role" to the scope of what nurses usually do in hospital, as reflected in the original questionnaire design. It means that the respondents to the survey, if they had more ideas about the health promotion role, could not exceed the fixed structure of the questionnaire items. Thus, the "Role Expectation" in the survey is expected to be consistent with the "Promotion Activities". Further, in the interviews, the participants would have an opportunity to talk through their personal opinions and preferences for the health promotion role beyond the scope of the questionnaire. Significantly, the comparison between the mean scores of two subscales shows that the nurses have a

higher expectation of the health promotion role than the actual performance. It means that even though the two subscales are based on the same conceptualization of the "health promotion role", there is a gap between the nurses' expectation and the actual practice. The nurses expect more than what they do in the hospital regarding health promotion role.

The "Perceived Self-Efficacy" has a statistically significant association with the "Promotion Activities", according to Pearson's correlation test. As expected, the nurses' perceived self-efficacy is linked with their experiences in health promotion practice. Presumably, the more experience nurses have the more self-confidence with their capability and efficacy in health promotion practice. But, this needs to be confirmed with the interview results.

It has been hypothesised that the "Enabling Factors", as external factors, influence the other subscales. Then, the "Enabling Factors" are tested for statistical associations using the subscales of "Role Expectation", "Perceived Self-Efficacy", and "Promotion Activities" using the Pearson's correlation tests. Initially, scatterplot graphs were used to identify the visible trends in the positive and essentially linear associations. The findings showed that there were strong statistical relationships between the "Enabling Factors" and the other three subscales ($P<0.01$). The correlation coefficients between "Enabling Factor" and "Role Expectation", "Promotion Activities" and "Perceived Self-Efficacy" were 0.54, indicating substantial to very strong relationships, while there was a low to moderate strength for the subscale "Perceived Self-Efficacy" ($R=0.29$) (De Vaus 2002). The power analysis is used to test the power of the correlation analysis among the subscales. The results suggest that there exists a strong power in the statistical tests within the sample size of the study. Statistically, the issues of the external facilitators or barriers have externally affected the nurses' role expectations of the health promotion role, nurses' perceived self-efficacy and the health promotion practice. It could be concluded that the external factors have a heavy impact on many aspects of the health promotion role in the hospital.

5.5 Summary

This chapter has displayed and discussed the findings of the survey. According to the statistical analysis, the participants in the survey have a representative quality similar to hospital-based nurses in the UK. The findings of this survey are thus eligible to be referenced to other studies. The main finding is that the participants in the survey strongly believe that nurses should have a health promotion role; it is beneficial for patients. It also finds that the nurses' expectations exceed their actual efforts towards health promotion in the hospital. Health promotion practice is reported at its modest level, and the nurses' perceived self-efficacy is coherent with it at its average level. Interestingly, both health promotion practice and nurses' self-efficacy have not been influenced by nurses' educational level and qualified years. It suggests that all nurses from different categories share a similar view, practice, and confidence in the hospital. This might not be an overly optimistic result because the higher educated and/or senior nurses could not improve further with regard to health promotion in the hospital unless, as the nurses have indicated, the working environment, management support and resources are applicable and available for health promotion practice in the hospital. The external influencing factors were explored as enabling factors having an impact on the nurses' perceptions, and the practice within the health promotion role. As for nurses themselves, they would prefer further training for knowledge and skills, up-dated information, and a strong desire for clinically-based training for health promotion. The findings of the survey are mainly strong in statistically describing the health promotion role from the perception of nurses and in exploring significant correlations between variables. It is necessary that these findings are confirmed and explained by the ensuing interview results.

Chapter Six – Interview Results

The second stage of data collection in this study is the semi-structured interview, in which a total of 16 interviews were conducted. The interviews aimed to gain the participant nurses' insights into the health promotion role and their experiences of it. Four topics were discussed with the participant nurses during the interviews: attitudes to health promotion in hospital, meaning of health promotion for nurses, health promotion activities and any related experiences regarding health promotion.

The process of data collection and management was discussed in Chapter Four. This chapter presents the analysis of the interview data. Firstly, the process and techniques used in analysing the interview data are explained in detail to demonstrate the validity of the findings. Secondly, the findings are presented as a series of 12 interlinked themes that emerged from the nurses' accounts, which are grouped into four categories. These are examined and discussed one by one, supported with quotations from the interviews.

6.1 Qualitative analysis process

Qualitative analysis in this study refers to the whole process from collecting the data to writing up the interview results, which could be divided into two stages: the preliminary analysis and the final analysis.

The preliminary analysis took place soon after the first interview. It aimed to scrutinize the transcripts, to engage with the data in depth and to identify the significant issues in the nurses' accounts. This task was carried out by utilizing the open coding technique (Strauss, 1987). The temporary themes or categories thus developed helped to adjust and improve the interview schedule for the following interviews. After all interview data had been collected, the thematic content analysis was begun. The final analysis focused on systematically and comprehensively examining the transcripts to see to what extent and how the nurses' insights of the health promotion role and practice had been shaped by their experiences. By employing thematic content analysis, the final analysis was able to develop a frame of themes and categories. While the strategies employed in the

qualitative analysis, and the reasons for them, were discussed in Chapter Four, this chapter explains in detail how the data were analysed.

6.1.1 Preliminary analysis

All the interviews were recorded and transcribed verbatim, followed by the preliminary analysis of the transcripts. Occasionally, the field notes were referred to when the participants' facial expressions, tones of voice and gestures were significant in helping to understand the meanings given to the health promotion role and its practice, i.e., the field notes were employed to clarify what nurses exactly meant by their non-language expressions during the interview.

Under the principles of the open coding technique suggested by Strauss (1987), the interview data were scrutinized line-by-line and word-by-word. The analysis mainly focused on constantly enquiring into the what, why and how of the nurses' understanding of the health promotion role and its practice. Analytically, the coding process involved tracking the nurses' accounts to see what was going on, what was emerging from the data, and what special circumstances had impacted on the nurses' views of the health promotion role. When analysing the interviews with the specialist nurses and the charge nurses, further efforts were made to examine how their positions had influenced their attitudes and what the differences were between people in different positions at the ward level. By following this procedure, the data were examined in depth, and reconstructed nurses' insights in a logical way from which their understandings of the health promotion role in hospital nursing was able to be achieved.

In the process, the significant and interesting issues were highlighted and notes were recorded in the margins of the transcripts. Meanwhile, the interview data were constantly compared with the findings from previously conducted interviews in order to identify the significance and potential themes or categories of the interviews. These temporary themes and/or categories were tried out in subsequent interviews to further adjust the picture of the nurses' experiences of health promotion role in the hospital.

The preliminary data analysis helped the researcher to engage with the data and the context in order to prepare to fill in the gaps in the information during the next

interview. The themes and categories provided a focused list in order to follow the conversations with the nurses. Whenever a new theme or category was emerged or recognized, the interview schedule was amended before the next interview. Therefore, the interview schedule was adjusted each time, before the next interview.

After eight nurses had been interviewed, the picture of nurses' health promotion role in the hospital had become clearer. The transcribed data were scrutinized and synthesized via a cross-case analysis, and a comprehensive understanding achieved, which led to a primary coding scheme. The analysis showed that the themes and categories appeared to be relatively stable. This marked the midpoint of the interview process by which point the interview schedule had been settled. The next eight interviews were conducted with the same interview schedule. This made both the interviewing and the subsequent analysis more efficient and effective compared with the first eight interviews. After all the interviews and the transcripts had been completed, the final analysis of the qualitative data was carried out.

6.1.2 Final analysis

The final analysis was conducted following the principles of thematic content analysis. According to a general definition, content analysis aims to conceptualize data via systematically scrutinizing it, particularly looking for repeated words or phrases, or evidence of answers to the research questions (Grbich 2007). The final analysis in this study examined nurses' wordings related to health promotion, identified the key words, and then looked at these words in their contexts.

The content analysis built on an existing conceptual framework of health promotion role and practice, based on the literature review, with both open to reinterpretation in line with nurses' perspectives on them, mainly in the preliminary analysis. The content analysis was aided by the temporary themes and categories for explaining nurses' insights into the health promotion role identified in the preliminary analysis. These aspects of the health promotion role and practice provided direction to the final analysis so that its role and practice were able to be examined in a systematic manner. The content analysis maintained its objectivity

in the comparison of health promotion role and practice with their preconceived images by valuing nurses' insights, including by observing objectively what nurses ignored and missed. Nurses' emotions were also identified and valued in the analysis, thus the data were recognized and analysed in both their objective and subjective senses. This is particularly important for nurses' health promotion role, given the problematic and confusing conception of health promotion in the nursing literature. In this sense, the content analysis in the final stage not only re-examined the key issues or themes identified in the preliminary analysis but also recognized how these had been shaped in the nurses' accounts.

The content analysis process stipulated that the words selected as significant had been counted for frequency and rank ordering, and examined in their contexts. This process was helped by exploring the texts of the transcripts using the computer software package *Concordance* (http://www.concordancesoftware.co.uk/). The Concordance programme contributed towards establishing a database of all interview transcripts.

A brief description of the *Concordance* programme might be useful here. Firstly, it has a function for listing the identified key words and for counting their frequencies, which are the quantitative features of content analysis. Secondly, *Concordance* also provides a function for highlighting selected words in the sentences on screen, which makes comparison far easier than when using methods involving manual coding. Relying on advanced computer techniques, *Concordance* provides visualization of the data. Although use of computer concordancing is not a method of automated content analysis (Lowe, 2006), it can be a very fruitful way of examining the data in the process of designing content analysis. It makes it possible to discover data quickly and lightens the reading burden of the researcher, especially where a large volume of text is concerned. However, it could be overly focused on language details. As a result, it may be inappropriate for the analysis of complicated conversations. For example, the nurses could say one thing but mean another in different discourses, which is difficult to discover by scanning a brief context. Thus, this study employed the *Concordance* programme for content analysis mainly to explore data in order to verify the findings in all of the essential categories and to count the frequency of the significant key words.

Thirdly, *Concordance* helped to examine quickly "what it says" and "how it says" it in a fashion of "key-word-in-context" (Weber, 1990). For example, when analysing interview IRN007 (see Appendix 8 for full transcription), there was a need to find the keyword "lifestyle" to see how many times it had been mentioned and how it had been described in the discourse. In *Concordance*, the computer screen showed all three sentences which included the highlighted keyword "lifestyle": 36-N, 47-N, 55-N (see the coding index in the Appendix 8). It also made it possible to discover sets of words that co-occurred reliably with the keyword (Lowe, 2006). In this case, "lifestyle" co-occurred with the words "sit-down and read", "talk" and "give information", which identified the way in which it was performed in hospital nursing. Briefly, the *Concordance* content analysis was good for searching the data and making cross-comparisons in the analysis of the interview data.

The *Concordance* programme was used in two ways in this study. It helped to identify the words that the nurses had used to describe the health promotion role and its practice. The emphasis was on the language related to health promotion activities. *Concordance* was then used to compare the frequency and variety of health promotion activities between the interviews The process generated an account of the key words that the nurses used in their descriptions. In this way, the exploration carried out with *Concordance* helped to create a quick overview of the nurses' perceptions through their wording. Beyond the preconceptions of the themes, it helped the researcher to reread and rethink the data with a "fresh eye" in the highlighted analysis units. Since human eyes would be attracted by outstanding minorities or expected preconceptions, *Concordance* instead helped to focus on the most frequently used words in the transcripts. This is of practical benefit to the researcher who is a second language user. The researcher's lower sensitivity to the words (at the analysis stage) was counterbalanced by the highlighting and counting function of *Concordance*. Therefore, an exclusive summary of each interview with the key words was created from the raw data in one step, while in the other step, the programme helped the researcher quickly find the identified words in the transcription. With the preliminary categories in mind, the process proved efficient in interpreting the meanings of words and comparing them within the interviews in a convenient way. Briefly, the *Concordance* programme is useful for finding what was missed or difficult to spot by the naked eye, and also provides a backup to confirm the themes found through human endeavour.

It is necessary to clarify that the criteria for the categories and themes in this study were typical and meaningful conceptual phrases. The themes were mainly drawn directly from the interview data and represent the features of nurses' experiences of health promotion. The linked themes were clustered into categories which were supported by the data and also organized with the aim of answering the research questions. The qualitative analyses were further developed by comprehensively editing for categories and themes through reading and rereading the data. Category refinement was applied during the whole journey of writing up the interview results. The credibility of the qualitative analysis rested on the efforts made to follow the rationale of the methods, continuously clarifying the purpose of the analysis, and non-stop reflection on the link between the thematic patterns and the data. Thus, the final analysis focused on developing a series of categories and themes to enable the development of a theory explaining the nurses' accounts of the health promotion role.

6.2 Interview findings

In the interviews, the participants provided detailed accounts of what meaning the nurses have given to the health promotion role and how nurses have constructed the health promotion practice and then how they interpreted their experiences. In this section the unedited interview transcripts are examined. The analysis identified 12 themes, clustered in four main categories:

Taking on the role

"It should be my role"

Benefits for all

In a good position

"What is the health promotion role?"

Something, everything, and "in the same pot"

Knowing the doing

Informing, advising, educating...

"The simple talk"

The general and the specific

The casual vs. the formal

Three patterns of health promotion practice

Feeling powerless

"Not good enough"

Lack of confidence

"Trying as much as possible"

The first two categories are related to the nurses' predispositions to the health promotion role in the hospital. They contribute to understanding how nurses' attitudes, beliefs, preferences and knowledge basis could impact on their responses to being given a health promotion role. The third category is relevant to the nurses' experiences of practising health promotion in the hospital, i.e., how the health promotion practice was conducted in the hospital. The last category is how the nurses have interpreted their experiences in current nursing and/or hospital contexts.

The detailed results are presented under each category and its themes. Quotations from the interviews with the nurses are used to illustrate the interpretations and support the results. The quotations are labelled with an IRN (Interview Reference Number) rather than participants' names to maintain their anonymity. A full interview transcript is provided in Appendix 8 as an example of how the semi-structured interviews were conducted. The profiles of the 16 interview participants are presented in Appendix 9. The information helps us to understand how the social background of the nurses might influence the interpretations of the health promotion role.

6.2.1 Taking on the role

The questionnaire survey found that the nurses strongly believed that health promotion should be an important part of the nursing role. The interviews further confirm the results and, more importantly, to reveal why the nurses were enthusiastic about taking on the health promotion role. The interrelated themes that emerged from the nurses' accounts form the substance of this category, namely, "it should be my role", "benefits for all" and being "in a good position". The category comprises the nurses' orientations to health promotion or the health promotion role,

from nurses' knowledge and perception to their preferences, and to their evaluation and choice of taking on a health promotion role.

6.2.1.1 "It should be my role"

When asked their attitudes to the health promotion role in the interviews, the nurses were usually quick to answer that the health promotion role was part of the nursing role without further thinking about it:

> *"I just think it's part of our job, really." (IRN004:15-N)*

> *"Yes, definitely. I think it should definitely come from us." (IRN011:15-N)*

This manner of making quick responses seems to show that the health promotion role had been well constructed in the nurses' perceptions as a part of the nursing role. This kind of perception was popular among all types of participant nurses, namely staff nurses, specialist nurses and charge nurses, who all gave very similar responses regarding the health promotion role. The data give the impression that nurses shared the view that health promotion was a part of nursing. One nurse pointed out that health promotion was a part of the documented package of nursing and went on to say:

> *"Yeah. I think it's part of the job description, to be honest. If you're going to be a nurse, you have to be a health promoter as well. It's part of the job." (IRN014:12-N)*

The idea that "to be a nurse means to be health promoter" suggests a strong link between health promotion and nursing in the nurse's perception of the health promotion role.

However, it is important to note that many nurses showed uncertainty about the role, by using "isn't it?" at the end of the statement. By using this phrase, the participants in the interviews show their desire to seek confirmation from the researcher. One charge nurse (IRN012) interpreted his conflicting attitudes to the health promotion role:

> *"Yes. Without doubt, yes. I think that's one of our responsibilities, isn't it? As I said, I don't think it's something that they [nurses] do particularly well." (IRN012:19-N)*

The charge nurse (IRN012) probably provided a very important opinion on nurses' health promotion role, stating that, on the one hand, the health promotion role should be the nurses' responsibility, while, on the other hand, he pointed out that nurses might not be good at the role. That is to say, that the nurses believed that they had a role in health promotion but were still not completely certain that they really were qualified to take on the health promotion role in practice.

The findings suggest that in the interviews the nurses may have been answering the question "do you think nurses have a health promotion role?" as applying to two different contexts. The nurses would say, without thinking, that health promotion was an important part of the nursing role. This shows that they have sound knowledge and a clear perception of the health promotion role of nurses. However, when they considered their own practice, their hesitation regarding the health promotion role was significant. In other words, their answers seemed to focus on what "should be" rather than on "what is" when referring to their current practice. This uncertainty might be the result of having second thoughts, but they nevertheless believed that the health promotion role belongs to nurses in the first place. This implies that the nurses' current health promotion practice in the hospital might not really support their view that "nurses should have a health promotion role". Although nurses had doubts, they did not show much sign of being ready to justify the current situation of the health promotion role in nursing practice. It is probably the case that the view "it should be my role" is more dominant in nurses' perception of the health promotion role currently. This would be consistent with the finding by the questionnaire survey that the nurses' role expectation is much higher than their experience, and thus that there is a gap between "what it should be" and "what it is" in terms of the health promotion role. In the interviews, nurses felt that their current health promotion practice was not as good as they expected, which is further discussed in the following analysis.

6.2.1.2 Benefits for all

The nurses expressed values and beliefs concerning health promotion based on their understanding of it. In the interviews they stated their perceptions of the many benefits of health promotion and, more importantly, their strongly held beliefs in

health promotion, which seemed to motivate nurses to take on the health promotion role.

In the interviews, the nurses generally expressed the opinion that health promotion activities provide an important opportunity for patients to acquire information about maintaining their health:

> *"It's important so that the patients can go home and maybe take control of their own health, and most of them wouldn't have been able to without the information, the health promotion opportunity we give them." (IRN008:6-N)*

Understood in this way, the health promotion role provides an opportunity for patients to acquire knowledge and learn skills for taking control of health. One nurse emphasized how important and unique was the opportunity of health promotion for helping patients:

> *"...I think we should interfere with it, yeah, because it might be their one chance. They don't really get out and about much at home, and they probably don't go to the GP that often. Then, if they suddenly become ill, there is a chance to speak to them about it. It's an important chance. It'd be a shame to miss it, if they go back home and don't get the help that they need. They might have been thinking about maybe going to get help for their alcoholism, and just never make that step, and nobody's spoken to them about that before." (IRN002: 13-N)*

This nurse believed that health promotion would be an important means for enhancing the patients' awareness of how to take care of their health, and more importantly, to provide necessary information to them. Raising awareness and encouraging self-care in patients is what the nurses understood the health promotion opportunity to mean for patients. One nurse interpreted this as a "wake-up call" for patients:

> *"It's important, because some people are unaware of how they should be taking care of themselves. They just need pointing in the right direction and I think they go from that. Other people arrive thinking, 'I really should be doing something', and they don't until they've actually been. It's like a wake-up call. For example, one patient who came in last week was a smoker and they swore they're not going to smoke again after the surgery. There is no previous history and they took all the books and the pamphlets that we suggested, you know, that stuff they're going to do, and yeah, we are geared towards health promotion here. But I'm not sure what the other wards are like, but here it is important, because you know, to go home with new ideas of how to look after themselves. They are concerned, you know, because of the attack that they've had, they would think, 'So I need to look after myself a bit more'." (IRN006:1-N)*

It is noted that the nurses' understanding of health promotion as opportunity might be limited to giving information and issuing wake-up calls for patients. This means that the nurses did not go further and state why and how health promotion could be beneficial besides providing an opportunity for patients to gain access to information. Some understanding of health promotion is even vague. The nurses would simply state that health promotion could help patients in gaining health but seldom went further to answer questions of how it could do so:

> *"...I think you want people to be better, and you want people to feel better, so you just do it [health promotion], because you feel that it's good." (IRN004:37-N)*

Belief in the benefits of health promotion seems to be attractive to nurses, which in turn may motivate them to take on the health promotion role. In the interviews the nurses frequently stated their willingness to help patients by engaging in health promotion:

> *"...they're suffering a lot, you know, they will be confused, getting confused, and, you know, sometimes fearful, you know. So, in that case, you know, it [their illness] makes me want to help them, you know. I don't want them to come back again with the same problems." (IRN001:17-N)*

In the above quotations, the nurses showed empathy with and sympathy for their patients, simply wanting to help them to be healthy. This may be based in the nurses' strong beliefs that health promotion would help patients overcome unpleasant illness and improve their health.

Given the nurses' perception that health promotion would help patients to achieve health, they further acknowledged that not only patients but also they and health services would benefit from health promotion by "keeping patients away" from hospitals:

> *"Well, educating patients, if they can have as much knowledge as you can give them to maintain themselves at an optimum condition, then they may be less likely to have to come back to hospital, whether the patients are, you know, a hospital admission, so you have to try to get them as much knowledge as you can to empower them, so they can keep themselves in good condition and avoid them having to come back again. And it wastes resources as well...to improve their quality of life." (IRN005:7-N)*

> *"I think if we can help them to keep well, then the patients have a better quality of life, which makes our job a little bit easier as well. So I think it's very important." (IRN007:7-N)*

The above quotations show that the nurses tended to believe that, if the patients could maintain a healthy or adequate self-care capability, then they would need less access to the hospital services, which could save health resources and also reduce the nurses' workload in the hospital. There is a train of logic in nurses' understanding of health promotion in terms of its benefits for patients, practitioners and health services. The belief in the benefits of health promotion seemed to make the nurses in the interviews appear to be incredibly passionate about taking on the health promotion role.

However, the nurses' perception of health promotion and its function is questionable. The nurses' accounts only provide the positive and beneficial part of health promotion, such as saving resources and reducing the workload of nurses. Webster and French (2003) argued that it would be impossible for health promotion to prove valuable in saving resources. It is interesting that the nurses actually complained that the current hospital environment was lacking in resources for health promotion in some interviews. It seems that when the nurses considered taking on the health promotion role, they only thought of how beneficial health promotion would be. The nurses failed to perceive that providing the health promotion service could itself be a heavy workload and complicated task, and cost hospital resources. It was only when they considered the conduct of health promotion in the hospital that the nurses demanded further resources and support for it. This implies an inconsistency between the nurses' perception of health promotion in theory and practice in terms of its benefits.

6.2.1.3 In a good position

The nurses in this study usually thought that the nurse is the ideal person to deliver health promotion services for patients in hospital, although they acknowledged that health promotion should be everyone's responsibility. In the following quotation, the nurses described themselves as "in a good position" to conduct health promotion with patients:

> *"Well, you're [the nurses] in a good position to [pause] things like, you know, diet [pause] and our patients are often very frightened when they stop smoking, and you can ask them about it, talk about it, so [pause] you spend a long time with the patient and there're always opportunities to talk about things like that." (IRN003:3-N)*

The "good position" refers to nurses being around patients and having opportunities to give advice to patients on the wards. It is important to note that health promotion is perceived as a process of "talk[ing] about things" by the nurse in the above quotation. Nurses believed that they were in a good position to talk with patients about issues related to health. In this sense, nurses being around patients is valued as a very important advantage when it comes to performing health promotion practice. This is further explained by one charge nurse:

> *"Well, because they [the nurses] are looking after a patient's care all the time, so they can see what somebody is or isn't doing. And they are caring for the patient the whole time they're in hospital, so they know [the patients], they give advice and promote." (IRN014:9-N)*

It was believed that being around patients' bedsides provided opportunities for recognizing the patients' health problems and for offering advice to them. In general, the nurses seemed to focus on the value of being around patients as an advantage in performing health promotion. Only some nurses directly stated that health promotion fitted well with nursing in terms of its nature:

> *"Because our job is to look after people and to care for them, and if we support them to look after themselves, then that's helping them and that's caring for them. But if we do not, if we're just saying a lot, 'OK, you smoke, it's all right', then that's really not doing our job." (IRN004:16-N)*

> *"Well. Yes, we're here to help people get better. We're also here to help them stop being ill in the first place." (IRN007:7-N)*

In the above quotations, the nurses noticed that nursing shares a similarity with health promotion in terms of taking care of and giving advice to patients. This suggests that health is the shared goal of both health promotion and nursing, which is probably the reason that nurses are fundamentally prepared to take on the health promotion role. One nurse even pointed out that all aspects of nursing might be health promotion:

> *"...I suppose, in some ways, everything that you do as a nurse is health promotion because you're showing a patient that you can give out drugs and you're showing them to take that education at the right time, so that's health promotion. And telling them to wash and eat properly, and drink properly. So I suppose everything is health promotion, yeah. Is that okay?" (IRN004:69-N)*

Perhaps, it is from this kind of perspective that nurses sensed that some elements of nursing could be health promotion as well. Therefore, being "in a good position"

for health promotion could refer to either "being around" patients all the time, or caring and helping as nurses usually do in hospital. However, there is a sense that the nurses interviewed had focused on valuing the former as the main reason for taking on the health promotion role; they appear to have taken less notice of the latter.

More often, the notion of nurses being "in a good position" for conducting health promotion results from the continual comparisons between the positions of nurses and doctors in the nurses' accounts. In the interviews, the nurses frequently indicated that they would be more appropriate to undertake the health promotion role than the doctors:

> *"I think it's very important but I think we're also in an ideal position, the nurse patient relationship has always been good and I think there's a great deal of respect between the nurses and patients and I also think that in an ideal position the patients are going to take it on board and listen to what they're saying, as opposed to the doctor preaching over them, type of thing, and I think that's different. So I think we're in an ideal position to try and present the information that's required, I think, in...it's all down to time, I think, isn't it?" (IRN012:18-N)*

The nurses described that doctors usually preached at patients and provided little constant care for them due to less time being spent on wards, while nurses were continuously around for patients to ask them questions. It should be noted again that health promotion is viewed as information giving by the nurses in the interviews. Doctors and nurses indeed had different working approaches, something observed by the nurses in the interviews. One nurse described how doctors and nurses would differ on health promotion:

> *"Sometimes, the patient just feels that the doctor is lecturing them about what they should be doing, whereas a nurse can just have a general chat, can be a bit more informal, a bit more relaxed about it. Sometimes, that's better for the patients you take it on-board sometimes, and, at other times, it's better if the doctor says, because some patients say, 'Oh, the doctor said, so I have to do, and you're just a little nurse, what do you know?' kind of attitude sometimes. They don't really take on-board what the nurse is saying. It really depends on the patient. Sometimes, it's good for the nurse to do it; sometimes, it's good for the doctors to do it." (IRN007:10-N)*

The different approaches of doctors and nurses to giving information to patients were viewed as complementary in terms of health promotion by the above nurse. The doctors would focus on delivering information on patients' disease and

medication. The nurses, on the contrary, would provide general advice to patients. The different approaches reflect the fact that doctors and nurses have different emphases in working with patients. The nurses also mentioned that doctors were perceived as better at supplying trustworthy information than nurses.

However, not being able to be around patients on wards was perceived as doctors' disadvantage in health promotion:

> *"Doctors don't spend as much time with the patients as the nurses do. They'll come and do the ward round, and then they will say, they will do a certain amount of health promotion on the ward round, or when they're dealing with patients. But they're not caring for them all the time." (IRN014:10-N)*

Apparently, doctors did not spend as much time on wards as nurses did. It is reasonable to argue that doctors probably prescribed "health promotion" to patients, telling them what should be done and left the doing to the patients. Conversely, constantly being around patients seemed to give nurses opportunities to keep a close watch on patients' health and check how patients dealt with health problems, just as nurses usually do on wards. It is in this sense that nurses appeared to have a very important advantage in providing health promotion. In the following quotations, the nurses explained how the special nature of the relationship between patients and nurses would encourage health promotion:

> *"I think it's important because nurses tend to be viewed by the patients as somebody they trust. Quite often, the patients will look for a nurse and ask questions of a nurse before they would go for a doctor, just because they always have this vision that doctors are busy people and, you know, they don't have time to sit and talk to the patients. And, the nurses supposedly, I mean obviously we are busy, but we do have a bit more time to sit down with the patients, and try and sort of educate them a bit better, or perhaps how they could be promoting their health, or stopping smoking, giving them advice and things like that. But, more importantly, I think the nurses are very good at being able to help." (IRN013:6-N)*

> *"Over other health professionals, or...I think nurses are generally able to be relate to patients without using such a high level of terminology that maybe the medical staff would. But they're constantly in contact with the patient, they're always there, they're not moving away and seeing the patients on other wards and departments, and that's who the patient's first important call would be for, to enter into that sort of conversation. So this seems like an ideal person to be doing health promotion." (IRN008:9-N)*

The participants in the interviews mentioned that nurses being more casual in style, making less use of medical terminology and being around and available to the patients was significant with regard to talking with the patients in the hospital. In the nursing context, the relationship between nurses and patients seemed to be close and relaxed, enabling talk about personal health issues on a daily basis. When patients had any problem with their health, they would first go to nurses and it would be discussed by nurses. In other words, communication between nurses and patients seems to happen as needed, so there might be many opportunities for discussing health promotion. This suggests that the nursing practice itself involves a lot of information giving activity, which was usually perceived as health promotion by the nurses in the interviews. In this sense, nursing and health promotion might be naturally linked on the basis of information giving or communication. This is why nurses viewed being around and talking with patients in hospital as important for health promotion.

One nurse also provided a very insightful thought on nurses taking on the health promotion role. He explained that doctors relied on nurses to take responsibility for health promotion:

> *"You know, we are doing this kind of job more than the officials, even the doctors, they don't do it, because there are nurses, they depend on nurses to do the occupational therapy job, you know, in organizing the occupational therapy or social workers, so." (IRN001:21-N)*

Health promotion might be one of the tasks which has not been given priority by doctors and other health professionals in hospital. On the wards, the nurses might be in a place to meet the expectations of the doctors and other health professionals. This might be an important external condition to be met if nurses are to take on more responsibility for health promotion in hospital. In a sense, it seems that health promotion in hospital has perhaps been left to nurses to take on.

According to the analysis so far, the nurses' views are that nurses would be "in a good position" to provide health promotion services in hospital, which notion seems to be based on the fact that nurses are around and talking with patients about their health issues. It is important to note that health promotion was viewed as a talking and information giving activity. The nurses valued the importance of the opportunities to talk with patients. Especially when comparing this with doctors' work and approaches, they believed that nurses are "in a good position" for

delivering health promotion on wards. In other words, health promotion is viewed as a suitable activity for nurses. It is also interesting to note nurses' perceptions of what it means to be "in a good position" as they seldom said that health promotion was just one part of nursing work and one aspect of what nurses do in hospital.

In summary, under the category "taking on the health promotion role", an account provided by the nurses that how enthusiastically they valued the importance of the health promotion role for nurses. A significant feature of the nurses' accounts is that their perceptions of the health promotion role lacked consistency. When the nurses regarded the health promotion role as one part of the nursing role, they hesitated between "it is" and "it should be". When the nurses thought of the benefits of health promotion, they overlooked that the delivery of health promotion in hospital would actually cost resources. They rather held to the belief that health promotion would save resources if patients were to get healthier and ceased visiting hospitals. This implies that the nurses' discordant perceptions of the health promotion role are somehow not reconciled. Interestingly, the nurses' notion of being "in a good position" valued nurses being around and talking with patients rather than emphasizing that health promotion might actually be one of the elements of nursing.

6.2.2 "What is the health promotion role?"

One of the interests of this study was to look at how the nurses defined their role in health promotion, i.e., their health promotion role. It is surprising to find that the nurses initially showed enthusiasm for taking on the health promotion role, while then having difficulties in explaining "what is the health promotion role". The nurses seemed to be quite anxious to seek answers to this question in the interviews. Health promotion is variously described in the nurses' accounts, which suggests that a consensus definition of either the health promotion role or health promotion is not to be found there. Further analysis will examine how the nurses developed their understanding of health promotion based on their experiences and what this means for the nurses' health promotion role.

6.2.2.1 Something, everything and "in the same pot"

The significant finding is that the nurses had difficulties in providing a definition of the health promotion role. They appeared to feel uncomfortable with the question "what is the health promotion role?"

> *"I know, I know, I try to think. What have I worked with this one [pause] promoting health [pause] it needs to be done. I think it's something that needs to be done. What else [long pause]..." (IRN006: 28-N)*

> *"To me, I think, on a personal level, I think it's something that we do, it's just something to do with, in general, about lifestyle. About...it's difficult to say what, apart from having, like, media, and papers, television, NHS 24, it's just something pops up in the news and you'll hear...just now, it's like immunization for under-twos for pneumococcal vaccinations. So that's sort of all in the press just now. Children, obese children, you know, children that are not active enough, and their diet, that's all that's in the press just now. Bird flu, you know...so I think health promotion is geared to the general public to say, 'You've got to think about what you're doing, what you're eating, what lifestyle you lead', and that's something in their power to change. It's not all just down to nurses. It's information that we give the public." (IRN011: 44-N)*

The above examples show their difficulties and uncertainties in answering the question. Judging not only from the answers but also from their facial expressions, the nurses tried hard to recall what they had known about health promotion. One nurse (IRN011) seemed to make everything she had experienced part of her answer.

It is probably the case that the nurses have seldom been expected to define health promotion. Signs of uncertainty are to be found in their language, for instance, words such as "suppose", "maybe" and "probably", or more directly stated "I'm not sure".

> *"I suppose it's about stating the best way to live your life, I suppose, how to feel healthy, how to keep yourself healthy. And I suppose health promotion, mostly from the perspective of working here, is more about helping people to develop their own systems for dealing with the condition that they have. So I think that would probably be..." (IRN012: 37-N)*

When nurses experienced difficulty and uncertainty about the question, they tended to modalize the definition by using "I think". It is interesting that the newly graduated nurses and specialist nurses could give a "standard" definition of health promotion. However, they also seemed to recite the clichés which they had learned

from textbooks rather than explaining health promotion in detail. Whether this indicates a lack of understanding or a lack of experience of it in their practice is difficult to tell, as these may be related. It seems to say that nurses' knowledge of health promotion is possibly derived from their prior nursing education, in which case the structure of nursing education may be one of the factors influencing nurses' conception of health promotion. However, if so it seems not to help nurses transfer the concept into practice, since this is missing in the nurses' accounts.

Rather, nurses tried to make the definition meaningful around their understanding of "health". It has been indicated that health promotion is a way of "keeping healthy" (IRN012), which seems to be used in a self-explanatory manner simply by drawing on the words constituting the phrase "health promotion". The nurses would consider health promotion to be anything and everything related to health. That "everything" has been stamped on health promotion seems originally to come from nurses' focus on the meaning of health. Nurses tended to include any practice which aimed at health, so that health promotion was to promote health for all and by all means in nurses' accounts.

> *"Basically, improving their [people's] health activities, including the in patients and all [people/public], you know, to bring them to work, activities to leave people should living all their life in the society basically, it covers everything, all the diseases, particular from the disease. I think." (IRN001: 30-N)*

By "health" nurses meant the notion of holistic health and wellbeing, which is probably the origin of the "everything" perspective in health promotion. Still, nurses seemed to improvise the common sense meaning of health into a definition of health promotion:

> *"It's [health promotion] like holistic, thing [pause] usually, you know, for people [Pause] it's just like mental, spiritual, everything, everything connected with your surroundings, that's why everything, everything that's important, everything. You know, just for [pause] to be healthy." (IRN009:61-N)*

In light of the way the nurses outlined the concepts of health promotion, they seemed to be comfortable explaining it in terms of "what health promotion is aiming for" or "what health promotion is important for". In other words, the nurses were well-informed about the goal and end-value of health promotion. Also, it

seems that the nurses noticed that their way of defining health promotion was too ideal, as a "hopefully" shows here:

> *"I think it's an important part of [pause] trying to improve the patients' quality of life, and to hopefully extend, prolong their life [pause]. I think also to help them psychologically as well, make them happier themselves. Hopefully." (IRN013: 32-N)*

> *"Health promotion means to enhance well-being and lifestyle, to prolong life, and it's for the benefit of the patient. Any advice on health promotion we can give is for the general health and well-being of the patient. It's very important." (IRN014: 38-N)*

However, it is not helpful to understand health promotion at a semantic level as nurses could not go further to explain the "what it is" and "how it is" questions in defining health promotion.

The definition of health promotion given by nurses is vague, with terms such as "something" or "everything" being used. The vagueness has implications for defining the boundaries of health promotion vis-à-vis nursing. If health promotion is "something" then it has a scope, while it does not when health promotion is "everything". However, the nurses had little notion of these implications, probably because they really did not have a clear understanding of health promotion. Nurses' definitions being vague extended to them confusing two important concepts of health promotion, health education and health promotion, with most considering the two concepts to be similar if not the same.

> *"Much the same, the same thing. I sort of put them in the same pot, really." (IRN007: 35-N)*

> *"I just think it's the same thing, really. If you're educating someone to be healthy...you know, I suppose health promotion...maybe health promotion, I don't know, maybe you're trying to get them a bit more involved, maybe health promotion is more clubs, you know, you're doing health promotion, and then more campaigns, trying to get people all together in a group, and health education is a bit more talking like I do, really." (IRN010: 7-N)*

The vagueness surrounding the concept of health promotion appears to range from something or everything to being "in the same pot" in nurses' accounts. Some nurses tended to exemplify some activities which they regarded as health promotion. The most common issues were topics related to lifestyle. It appears that many nurses' immediate reaction when asked to define health promotion is to

discuss how to improve one's lifestyle, raising topics such as diet and smoking, which they believed to be the basic lifestyle issues.

> *"Um, I don't know. Help people; give a definition of what health is; the kind of lifestyle you need to [pause] achieve?" (IRN 003: 33-N)*

In the above analysis, the goal of health promotion seems to be too ideal to be meaningful and practical as well. No matter how health promotion is idealised, the only illustration by nurses used lifestyle-related activities; possibly this is what the nurses truly experienced in practice (discussed below). This suggests that nurses might know little about what exactly health promotion is in nursing practice. A missing link seems to be between the operational means and ultimate health end-value thereof. Unfortunately, the missing link is how nurses define health promotion and its role in nursing, which is the most important piece of knowledge.

6.2.2.2 Knowing the doing

Even though nurses were vague when defining health promotion, they seemed to be able to describe what they had done in current health promotion practice. But this is not an easier effort for the nurses; usually, it is encouraged by the researcher by the questions, such as "have you done ...?". The nurses appeared to lack awareness of what they had done in practice, especially the activities most frequently conducted as part of their nursing routine. This means that the nurses knew what they were doing but were not always conscious of the fact that their activity might constitute health promotion or how that is might function as health promotion.

Once the nurses knew that their practice could be health promotion, they were intrigued to realise that they could give detailed examples of health promotion. This was more like an exhibition of health promotion activities that they had carried out in daily nursing than a demonstration of their understanding of how health promotion is constructed in nursing practice.

> *"Means to me [pause] is how to explain [pause] giving information about how to keep healthy, how to, you know [pause] sort of diet, in diet things, in exercise things, alcohol, smoking, and everything to try to keep the person healthy, which relation to this disease. Obviously, if somebody has no legs, you wouldn't go and ask them to run a marathon or something, but you kind*

of relate the information that you're giving to the patient, their illness and their knowledge, just to try to give them as much as information you can to keep them well without confusing them, get them then to think, 'Oh, I'm not listening to any of that. That's a load of rubbish.' That's what it is, passing on the good information to them." (IRN007: 34-N)

The nurse quoted above (IRN007) had given a series of examples of health promotion based on her experiences. She felt comfortable using concrete activities or tasks to describe the health promotion role. She also indicated the flexibility of health promotion in nursing practice, illustrating this with the various situations she had encountered. This contextual variation is responsible for the conditions and reactions of patients or clients having influence on the meaning of health promotion practice as well, which suggests that health promotion in practice could be opportunistic and individualistic according to specific situations. Health promotion practice seems to be shaped by patients' interests and the extent to which they accept it.

In the following quotation, nurses' responsibility in health promotion is identified as involving four elements: "identification", "information-giving", "support" and "patients' empowerment":

"In hospital...Well, I mean, I think health promotion is all about people taking an active interest in what they do health-wise, lifestyles etc., how they look after themselves and I think health promotion is about us supporting people and I think widely identifying the changes, sort of identifying your lifestyle and identifying the changes that they might need to make and I think the only way to actually do that is to give them the information and once they've had time to kind of sort of assimilate that information then have a follow up discussion with them and ask them what they think they could do to make things better for them, whether it's related to wound care, skin conditions and diet, alcohol intake or whatever but in essence we need to support them, to get them to make the decision of what they want to do and then you can support them and ask them their decision." (IRN015: 35-N)

Health promotion being regarded as to "support", "help" and "assist" patients to gain health is a consensual view of health promotion. It aims to increase patients' self-care or self-responsibility for their own health, which is what has been shaped into nurses' notions of empowerment of health promotion. It tends to be an individualistic approach to health promotion, contrasted with a holistic approach to it. As the former approach, the information-giving appeared to be the most common strategy being used in health promotion practice:

"...there's lots of different things you can try and help support them and give them as much backup in the community in order that they can have a better standard of health, you know, educate them, give them information, see, you give them tools, that they can help themselves." (IRN005: 28-N)

"Assisting the patients to take control of their own health and improve it to the best of their ability." (IRN008: 37-N)

These descriptions by the nurses suggest that what they understood by health promotion is equivalent to their actual experiences of it. This means that nurses found it difficult to understand health promotion going beyond their experiences. Therefore, it is understandable that nurses in different positions usually have their own views of health promotion. Charge nurses and senior nurses seemed to have a broader view while staff nurses were more likely to take pieces of what they could manage or think of to explain health promotion. However, the strength of charge nurses seemed to be the ability to gather the most information together, whilst newly graduated nurses could interpret health promotion in textbook wording – especially those who had been working for just one year. In terms of terminology, the specialists seemed to be able to use some fashionable words in defining health promotion. The specialists with master's degrees were the only nurses who could apply a socio-political dimension to the interpretation of health promotion.

It is significant that a nursing education may help nurses to construct a conception of health promotion, as mentioned above, while a meaningful definition and a deep understanding of health promotion came from nurses' own experiences. In brief, nurses could probably only truly understand the meaning of health promotion from their experiences of "doing" it. Although newly graduated nurses could recite the concept from textbooks, they seemed not really able to make sense of it, especially at a practical level. Charge nurses and specialist nurses seemed to have a broad view of health promotion, which implies they may be benefiting from their work experiences as well. In brief, the practice and direct experience that came with each nurse's position was essential to their understanding of health promotion. This diversity of understanding of health promotion may be also reflected in their experiences of it.

In summary, the category "what is the health promotion role?" groups the themes of nurses' understanding of health promotion, while finding diverse and fragmented conceptions of health promotion in the interviewing data. On the one

hand, health promotion could be something that nurses felt an understanding of but were not able to illustrate what it is; on the other hand, nurses would pick up the words "health" and "promotion" to interpret health promotion. However, the meaningful definitions are from the nurses' descriptions of what they were actually doing as health promotion in their current practice. The analysis suggests that the nurses could understand what they have experiences of in practice, and nurses from different working contexts may have different capability in interpreting health promotion. This finding above echoes Maben and Clark's (1995) conceptual analysis of health promotion, as discussed in the literature review, since five of six of their categories could be found in the nurses' understanding in this study: health promotion as promoting health, health education and health promotion as mixed or interchangeable terms, health promotion as lifestyle behavioural change, and health promotion as a set of values. There might also be a meaning of "health promotion as health education plus" held some nurses, but this is not obvious in the data. The nurses in this study were rather vague as to the meaning of heath promotion and the health promotion role. It is significant that the nurses' accounts covered a broad range of meanings of health promotion since this suggests that there is indeed an absence of a consensus as to what is health promotion. Most importantly, the nurses have difficulty defining their own role in health promotion. This is more problematic in the performance of health promotion in hospital if there is more than one meaning underlying it and the nurses can not form an appropriate perception of the health promotion role. The following analysis explores the above concerns further.

6.2.3 Informing, advising, educating...

The category "informing, advising, educating" generated from the data concerned with the health promotion practice in current nursing reported and interpreted by the participant nurses in this study. During the interviews, there were opportunities for the nurses to discuss their experiences in performing the health promotion role in hospital. The discussion by nurses focused on what activities they usually practised as health promotion and related circumstances on the wards. One important feature of the nurses' health promotion practice is that it is underlined by an individualistic approach to health promotion, specifically in the scope and content of health education. This is consistent with the findings of the survey. It

also confirms that the survey questionnaire, which focuses on topics in health education, is suitable to examining the health promotion practice of nurses in hospital. This brings confidence to combining the data at certain levels of the analysis in this study. The interviews add the fact that the main strategy employed by nurses in health promotion is informing or information delivery in hospital, supported by advising, educating and others. The category is concerned with three interrelated themes which allows us to analyse the health promotion practice from different angles: "the simple talk", "the general and the specific" and "the health education programme". Finally, the category "three patterns of health promotion practice" allows further analysis of the health promotion practice by presenting three featured patterns each of which has its own way of being constructed in nursing practice.

6.2.3.1 "The simple talk"

Health promotion, as discussed above, is a difficult concept for the nurses to illustrate in the context of current nursing practice. Indeed, there is little sign of a consensus as to what exactly the health promotion role was in their nursing practice. For this reason, the analysis starts with examining the language used by the nurses to describe their health promotion practice in daily practice. The language contains information on how the nurses conducted, as well as interpreted, their practice of health promotion. In this sense, it shows the discourse in which the health promotion practice had usually had been conducted.

The *Concordance* programme was used to count the frequencies of the words used for describing health promotion practice in the transcripts. The most frequent words used by the nurses in this study may be those most automatically chosen in describing health promotion as they present the nurses' individual understanding of current health promotion practice in the hospital. Table 6.1 lists the words used, thereby showing a diverse range of health promotion activities by the nurses.

Table 6.1 Words Used by the Nurses to Describe Health Promotion Practice

Rank Verb*	Frequency (N)
Talk	70
Tell	63
Advise	62
Educate	56
Teach	46
Speak	32
Discuss	24
Encourage	22
Chat	20
Suggest	14
Conversation	10
Read	10
Explain	9
Communicate	7
Inform	4
Advertise	3
Advocate	2
Introduce	2
Address	1

*The figures include any tense form of the verb and the derived nouns.

The verbs seem to embed the notion of health education to different degrees. For example, among the most frequent verbs used for indicating the health promotion practice, "talk", "tell", "advise", "educate" and "teach" show different emphases in practice. In terms of meaning, these five words can probably be divided into two groups. "Talk", "tell" and "advise" may form one group, with an emphasis on informing patients, while "educate" and "teach", as the other group, show a strong sense of educating more than merely informing.

The relative frequency of words used by the nurses shows that they had a comfort zone of understanding. For example, "talk" was used 70 times in total by 16 nurses during the interviews. The nurses were comfortable using "talk" to describe current health promotion practice. In this sense, "talk" possibly frames the nurses' general action and meaning of the health promotion role along with other similar words, such as "chat", "speak" and "address". Most of the verbs suggest that the health promotion practice is a conversation and a communication between patients and nurses. It gives a clue that current health promotion practice seems to be an information service that the nurses offered to inform and advise patients about health-related issues. The most frequently used words, such as "inform", "tell", "read", "introduce" and "explain", provide further evidence that nurses are information deliverers. It is in this sense that *information delivering* might be an

adequate concept to describe the current health promotion practice in nursing in a general and broad sense. The following quotation provides a typical example of a general "talk":

> *"Sometimes, you can give them advice about, you know, getting them to think about what smoking cigarettes is, like, for example, if they're going to the pub for a pint of beer, obviously now they can't smoke because of the ban, but getting them to think, 'When do I get smoke, when is the time I have a cigarette, what can I do instead of sitting down with a coffee and a cigarette, could I be doing something else?' Just to get them to think about it, really. That's about as far as we go. We never suggest a daily programme for them or anything. I wouldn't do that. No." (IRN007:14-N)*

This quotation shows how giving up smoking was working on the ward. It is more like a small amount of information delivery. This nurse tried to stimulate the patients' thinking with a series of questions and a supply of certain techniques which were seen as being unrecognized and ignored by the patients. This follows the nurses' perceptions of health promotion as a "wake-up call" for patients, as shown in the analysis of the theme: "knowing the doing". The nurse's attempts usually did not go into further detail by teaching the patients the knowledge and skills to deal with their behaviour. A senior nurse on the respiratory ward, who seemed to have a level of clear thinking and details about promoting smoking cessation, was still unable to provide a proper health education programme.

Another example of the general talk really could be a "baseline" of information to patients as described by the nurse in the following quotation:

> *"...We do give them an idea, you know. I think that a lot of people have got their own mechanism. You just have to give them the baseline and then they'll deal with things in their own way. It's not always...No one is ever the same. Some people want to know, some people don't want to know so much. It just depends on how much they want to really know." (IRN006:33-N)*

It seems that the nurses only conveyed "baseline" information to patients. The above quotation actually mirrors the reality of current health promotion practice in the hospital, whereby the hospital nurses usually try to provide basic knowledge to help the patients recognize their personal responsibility and take action to protect their health.

The nurses' accounts show that it might be common for health promotion practice to be conducted casually in the hospital. The following quotation from the

interview with a specialist nurse (IRN010) from the Infectious Diseases Ward probably serves to illustrate a typical account of current health promotion practice on the wards:

> *"It's all just talk. It's all just chatting with patients. I don't, haven't run any clinics or anything like that. It's just generally on a one-to-one basis, you know, because, as part of my daily visit with them [the patients], anyway. So it's just simple, things like, you know, to try to get them to stop smoking if they're smoking, get them onto patches, nicotine patches, do a lot about diet, we've got a dietician as well who kind of works with that...exercise. You know, it's all kind of basic ones, but it's also kind of...I do quite a bit of HIV prevention, so it's safer sex, safe injecting, all that, and so in a way that is health promotion in that you're keeping yourself free, you know. But it's generally kind of talking rather than doing any clinics or anything." (IRN010:3-N)*

The specialist nurses seemed to be in a better position for performing the health promotion role than nurses and charge nurses. Their higher education and expertise in taking care of patients seems to gain them a reputation for being efficient at health promotion practice among nurses. However, the interview accounts show that there is little difference between the specialists and other nurses in terms of their accounts of current information delivery practice. This might suggest that their health promotion practice had probably been structured in a similar way to that of other nurses, which was "talk" in general.

It is worth noting that the nurses seemed to be dominant in delivering information rather than exchanging information during conversation with patients. This may confirm the survey findings that patients' participation is not popular in health promotion practice. It is a fact that, relatively speaking, the words "educate" and "teach" were less frequently applied to describe health promotion practice in the interviews, along with "encourage" and "advocate".

The variety of words that nurses used to describe their health promotion practice indicates a certain confusion. From another perspective, the words could be connected and cover the diversity of health promotion itself. The following quotation illustrates how one specialist nurse perceived health promotion and health education, and finally rendered them as "talk".

> *"I just think it's the same thing, really. If you're educating someone to be healthy...you know, I suppose health promotion...maybe health promotion, I don't know, maybe you're trying to get them a bit more involved, maybe health promotion is more clubs, you know, you're doing health promotion,*

and then more campaigns, trying to get people all together in a group, and health education is a bit more talking, like I do, really." (IRN010: 7-N)

"Talk", in the nurses' accounts, usually means information delivery. It seems that the nurses have sensed that health promotion is something more than a talk. However, many of the nurses in the interviews, like the specialist nurse above, were able to take a wider view of health promotion when it extended into the operational sphere or practice. Only a very few nurses could mention sophisticated strategies such as lobbying, campaigning and media advertisement, but they still could not provide a further explanation beyond "talk". Another example of the talk could be as simple and brief as this:

"Yeah. We can say, you know, 'You need to get your diabetes under control'; 'You...don't eat these sorts of food'. But, at the end of day, it's down to the patient." (IRN011:31-N)

"You give them just an idea, 'you are smoking too much', 'you should control yourself', or 'you are drinking too much', and all sorts of this type, and also whenever you have got free time." (IRN001:11-N)

The health promotion practice under this approach sounds shallow and ineffective. In this approach, it is difficult to avoid, at its worst, a tone of blaming the patients. It may be unethical to blame patients for their diseases, but the nurses had little notion that the simple talk could be troublesome. Probably, this fits with the nurses' understanding of health promotion as a "wake-up call" in the sense of lecturing and pointing out health problems. However, it is noted that there are health education programmes that are identified from the nurses' accounts but limited in occurrence, which is analysed later.

6.2.3.2 The general and the specific

When discussing health promotion in the hospital, the nurses in the interviews would instantly refer to the activities of giving advice on personal lifestyle. By unhealthy lifestyle, the nurses referred to the risk factors for diseases. This means that the nurses tended to promote a healthy lifestyle for patients. The following quotation provides a good example of why the nurses advise their patients to adopt a healthy lifestyle:

"Well, I think, you can see the results, the health issues that it has. I think that they are aware that, you know, that smoking...The cost itself to the health service, you know, they're aware of the complications to health...abilities, and that's its own issue. Cost to the health service, things like that. You won't only be healthier if you stop smoking, you might live longer, if you're not a smoker." (IRN011:35-N)

Unhealthy lifestyle habits, such as smoking and drinking alcohol, are believed to be one of the important health risk factors. Lifestyle advice was widely mentioned in the nurses' accounts, in fact, it was the most frequently mentioned topic that the nurses referred to when they thought about health promotion. The *Concordance* programme provided a list of the topics that the nurses considered health promotion, together with their frequency; see Table 6.2.

Table 6.2 General Health Promotion Topics and their Frequency (n=16)

General Health Promotion Topic	Exemplified by Nurse (n)
Diet	15
Smoking	15
Alcohol	13
Exercise	12
Hygiene	5
Entertaining/Travel/Relaxation	2

Table 6.2 lists most of the topics of lifestyle advice that the nurses discussed in the interviews, and also what they could practise in the hospital. Diet, smoking, alcohol and exercise were the most commonly mentioned health promotion topics. For example, 15 of the 16 interviewees reported that healthy diet promotion and smoking cessation were particular topics of health promotion in the hospital. Only a few nurses considered topics beyond the popular spectrum, such as entertaining and travel.

It is important to note that the nurses on different wards appeared to have very similar views on health promotion practice insofar as it is interpreted as lifestyle advice. The specialty of each ward did not seem to influence the nurses' perception of this. In other words, health promotion practice as lifestyle advice is alike on different wards in the hospital. A possible explanation is that lifestyle could be related to the causes of any disease and thus its information would be relevant to any patient on each ward in the hospital, making it "general". It is in this sense that lifestyle advice is a general practice of health promotion.

Not only did lifestyle advice appear to be relevant to any ward but the nurses also had a general approach towards promoting a healthy lifestyle among patients, according to the nurses' accounts. The following quotation provides an example of how the nurses delivered "general" information on personal lifestyle:

> *"Just general information about the kind of, sort of...you know, the fact that you should be exercising two, three times a week, or you should be eating more fruit and veg than you perhaps are, or, you know, smoking really isn't very good for you because it does X, Y, and Z, and the effects of smoking can also lead you to a lot of [pause] smoking illnesses. We've learned about the effects of smoking and alcohol, and that sort of just general health issues, but I wouldn't tell somebody to, you know, go to the gym every other day and do 20 reps on the treadmaster, or anything, you know, that level of information I couldn't give, but generally information, I'm quite happy to..." (IRN007:51-N)*

The health promotion practice discussed in this quotation only involved general issues of a healthy lifestyle. The information delivered by the nurse seemed to be too general and simple. It is therefore not surprising that the nurses on any ward, no matter that the forms of disease prevention would vary, could apply the general practice to any patient on the wards. The general practice implies a general protocol for advising on a healthy lifestyle among patients across the wards in hospital.

Apart from the lifestyle advice, in the interviews some nurses would mention activities that focused on information on disease prevention. This information is specific, in that it is strongly related to a particular disease or particular patients with that type of disease. Although the strategy is still to inform patients, the disease information has to be specially targeted to particular types of patients and/or wards. It is in this sense that the provision of disease information is named a specific practice in this study, compared with the general practice of giving lifestyle advice. Another speciality of disease information is that the nurses usually could not identify it as health promotion but rather as nursing. It was only when the researcher asked that the nurses would agree that they actually did that on the wards. The following quotation provides an example of a nurse informing patients on the ward about avoiding dehydration:

> *"Yeah, I think the one I always push is to tell patients to drink more, what target they need to meet on a daily basis because you see so many dehydrated patients come in. That's the big one (on this ward). I always*

worry about it. Always feel like telling them, you know, a litre and a half minimum a day, you know." (IRN002:22-N)

Although the advice on drinking water seems to be related to the patients' diet, it is actually aimed at the treatment or prevention of dehydration. Another example of disease prevention is "catheter care":

"Health promotion again is to do with eating and drinking, and getting dieticians in. And if we feel that somebody's not eating and drinking, and, as I said, mobilizing and moving around more...catheter care in urology is a big thing...sitting up in a chair, all things like that, diet and everything, yeah, and it's all...everything to do with the activities of getting you moving." (IRN014:14-N)

The information delivered by the above nurse, for the purpose of increasing the capability of patients to take care of themselves regarding catheter care, has a notion of informing and educating patients to increase their ability for self-care and for taking control of their health. It is designed by nurses on the wards to empower patients to cope with their illness. It is in this sense that the above activities are identified as health promotion. Therefore, the same or similar activity could have different meanings for the nurses, being either health promotion or nursing, in fact, quite objectively, the same activity can be both health promotion and nursing. In the other words, health promotion and nursing in practice could overlap, one being concerned with disease prevention and the other with disease cure. In practice, this depends on whether, and in what circumstances, it is necessary to separate nursing and health promotion. Significantly, most nurses did not view a specific practice, such as providing information about disease, as health promotion. Yet it was clearly "invisible" health promotion. Conversely, the general practice of health promotion, the giving of lifestyle advice, was "visible" health promotion to the nurses in this study. It is notable that the nurses usually only mentioned lifestyle advice as health promotion. This means that although both lifestyle advice and disease prevention belong to secondary prevention and follow the notion of health education, the nurses do not perceive the specific practice as health promotion. There is no confusion or blurring for the nurses on this matter because they did not even think of it. For the nurses, giving lifestyle advice was the only practice of health promotion they did in the hospital.

However, some nurses recognized the problem of how health promotion and nursing could overlap in practice:

"I do think they [health promotion and nursing] interlink. As I say, I think possibly sometimes we may not think that we are health promoters, but we probably are without being conscious of it, in certain circumstances. I think there is definitely an overlap, I would say." (IRN016:23-N)

"Well, I think it's [health promotion] very important. I mean, you're always doing health promotion anyway, whether you're actually thinking about it or not. So, unconsciously, the thing that you do, because obviously even if you're telling a patient not to drink beforehand, you don't want to separate that from health promotion." (IRN013:4-N)

Some nurses stated that they regarded the relationship between health promotion and nursing as one of integration:

"I think we integrate it [health promotion] without giving it that name." (IRN011:22-N)

"I think it [health promotion] has to be integrated [with nursing]. I said that I don't think I do separate things, I don't have health promotion clinics. I kind of just have a general chat with the patients, and it's all kind of muddled up together, really." (IRN010:18-N)

The nurses indicated that health promotion might have been integrated into current nursing. The nurses conducted health promotion automatically and spontaneously in their daily nursing without recognizing it as such. This shows that it was difficult for the nurses to separate health promotion practice from nursing. Possibly, nurses in similar circumstances would just feel it was a part of nursing that needed to be done. The notions of nursing and health promotion might not be able to be distinguished here. This implies that health promotion might have a varied, complicated definition in nursing practice. The majority of nurses perceived health promotion to be the giving of lifestyle advice, but some nurses regarded "drinking for dehydration", "washing hands" and "hospital induction" as health promotion, and some might even include any informing action in nursing as health promotion practice. In these examples, health promotion appeared to be difficult to define in nursing practice in the hospital. This seems to echo the survey findings that the nurses' understanding of health promotion appeared to vary with specific circumstances.

It is interesting that the nurses who recognized the connection between health promotion and nursing were including the senior nurses (IRN011), the charge nurses (IRN016), the specialist nurses (IRN010) and a newly graduated nurse (IRN013). A possible explanation could be that the senior nurses, specialist nurses

and charge nurses, because of their experience, might understand more than the staff nurses. They were good at identifying the elements of health promotion and separating them from nursing. The above newly graduated nurse (IRN013) who, unusually, had insight into this issue, is a single case, perhaps an individual with unfathomable reasons for her insight, so it is difficult to analyse this further.

6.2.3.3 The casual vs. the formal

As it is analysed above, health promotion practice in the hospital could be categorized as general practice and specific practice, both under the strategy of information-giving. The difference between them is that the former is general lifestyle advice while the latter is disease information, which is identified as nursing rather than health promotion. Thus, for the nurses, health promotion practice usually refers to lifestyle advice.

Another health promotion practice that is likewise considered different from nursing is the health education programme. It was only conducted on some wards in the hospital. The health education programme is a project targeting particular patients, according to the nurses' accounts, while the giving of lifestyle advice is casually and opportunistically practised by the nurses in the hospital. In the following analysis, the lifestyle advice and the health education programme are compared. The analysis, in this part, focuses on how the casually conducted practice of lifestyle advice giving and the formally structured practice of health promotion are differently constructed on the wards.

Regarding health promotion in the hospital, the nurses interpreted what health promotion practice was supposed to be and what it was not:

> *"We don't do a sit-down and have a booklet that we go through or anything...To be honest, I don't think it's appropriate for us, for any nurse to do teaching for certain things, unless you've been given a training day, because I think it's very difficult to advise patients on what the best thing to do is for certain things that...you've not been on a training day for them." (IRN013:23-N)*

A "sit-down and have a booklet" seemed to be the nurses' understanding of a proper health education practice in the context of hospital nursing. Compared with the casual "talk" with patients, this represents a gesture of formally conducted

health promotion as part of nursing in the nurses' view. However, as the nurse above stated, this kind of formally conducted health education seemed to be difficult for them to perform in practice since they had not been trained for this.

A different picture comes from the nurses from the Cardiology Wards in the interviews, who were presenting a relatively complete health education programme based on the Heart Manual for patients who had had a heart attack. One nurse described it as follows:

> *"...a big book...it's a six-week exercise programme...to get them [the patients] back to being as active, or even more active than they were before." (IRN003:13-N).*

As described by the nurse, the Heart Manual is a well-designed for the health education programme with teach-and-learn materials, such as reading materials and an accompanying DVD. The manual-guided practice was formally structured into a nursing routine on the wards, according to the nurses' accounts. The importance of the Heart Manual could be sensed by the nurses' description of it as their "bread and butter":

> *"What I do is I give the patients a chance to watch a video, of other patients who've had a heart attack, and...I think, patients...sometimes you knew who used the video. But I think, for the patient, it's very good because it is going to be half an hour dedicated to them, and most of them identify with the people in it, at the end it's kind of...it's a positive end, and positive message. I think that's good. And then our main bread and butter is the Heart Manual." (IRN003:9-N)*

The Heart Manual guaranteed patients who had had a heart attack the opportunity to be educated to acknowledge the disease and improve their skills in self-care. The significance for nurses seems to be that it provided a scheduled task for them to carry out in their nursing practice. The vivid expression "bread and butter" implies the importance to nurses of relying on the manual for teaching materials and as guidance for their practice. With the help of the manual, health promotion practice can probably be much more solidly performed in the hospital. The manual had two functions: on the one hand, its reader-friendly booklet provided guidelines for patients to follow and learn how to take care of themselves, while, on the other hand, the nurses could also follow the guidelines for giving appropriate instruction and supervision. With a function like this, the manual seemed to work as a medium

that enabled both nurses and patients to work together towards the common goal of the patient becoming healthier, as part of health education.

The significance of the manual and the information sheet also resided in the concrete procedures and/or information content offered to patients. One nurse expressed how the Heart Manual relieved him of the burden of understanding the theoretical concept of health promotion:

> *"I've been working here for six years now, and I feel a little bit...kind of tired of being very theoretical. The Heart Manual is health promotion for people who already have damaged hearts, and then we try and prevent that damage going any further, and get them back to...We have lots of confidence in the Heart Manual. It seems that they all [the designers] tell us that they're doing well, and they want to spread it to other countries and their hospitals...I mean things like, I do mention things like five pieces of fruit and vegetables to everyone. But, apart from the Heart Manual, there isn't really any...health promotion goes on and everything." (IRN003:12-N)*

The existence of booklets and information sheets seems to help the nurses to make sense of the concept of health promotion. The analysis in the section 6.2.2 provides a context, since the definition of the health promotion role by nurses was found to be vague so that they commonly experienced problems about what to do in detail. However, in this case, the nurses appeared confident about health promotion practice, assisted by the Heart Manual. Especially the junior nurses, as suggested by the nurse in the following quotation, needed the assistance of the manual or information sheet:

> *"The junior nurses need guidance, I think, on how to do health promotion, but people get used to it very quickly, know about what's best. And on a urology ward, people need to do the same things, drink more, and look after their catheters and...Everyone, after a while, gets more experienced and then they know what to advise the patients to do." (IRN014:46-N)*

Therefore, with the manual and the information sheet as visual guides, the health promotion service could be formally structured in the process of nursing.

There existed other examples of health promotion practice in the hospital which had been guided by the teaching materials. The nurse working in the urology area mentioned how they taught catheter care to the patients:

> *"It's an information sheet, and we go over it and let them [the patients] practise how to look after their catheter." (IRN014: 24-N)*

By comparison, the information sheet applied by the nurses seemed to be simpler and less systematically designed than the Heart Manual. It seemed to focus on the knowledge and skills of catheter care with less sense of a structured process in practice, but the existence of an information sheet might constantly serve to remind the nurses about the service. However, it is noted that the casually delivered pamphlets and the posted bulletins on the wall might not be structured into nurses' practice. In these cases, the responsibility for using the services seemed to rest with the patients, who would be required to examine the material by themselves, while the nurses were just the deliverers of the teaching materials:

> *"We have posters on the walls in the corridors and things that they can look at as well, so..." (IRN007:40-N)*

> *"We've got leaflets for individuals...once they've had a particular operation, we've got leaflets that we can give out for each particular operation that say, you know, when you go home, you'd expect to blah-blah-blah, you shouldn't be doing this, blah-blah-blah. We give them to the patients on discharge to make sure that they've got the right information...They should, but not every patient does go home with them." (IRN013:30-N)*

The nurses seemed to welcome the teaching materials and they would send them out when they were available. However, the formal procedure of teach-and-learn for patients on an individual basis was missing here. Probably the worst example might be the bulletin on the wall, which totally relies on the patients' own motivation to change healthy behaviours. Little responsibility from the nurses was expected with this means of health promotion. Although the teaching materials might provide an atmosphere of health promotion on the wards, the effectiveness of this strategy might never be known. Basically, this kind of information delivery would not be different from the casually conducted conversations. Therefore, what is important is how the nurses had been involved in helping the patients in practice, which seemed to be guaranteed by the formal structured manual or the information sheet according to the nurses' accounts.

Conversely, casual information delivery is not structured or guided by booklets and information sheets. The information delivery seemed to be highly influenced by the nurses' own decision-making. This might imply that there were few normative requirements regarding health promotion on the wards. In this sense, health promotion practice might be said to completely rely on the nurses' initiative. There was much evidence that the information delivery seemed to be fostered

individualistically by the nurses. So, when the nurses' understanding of health promotion varied, the practice could be unstable. In the following quotation, one nurse seemed to have confused health promotion with independence, which misconception led to incorrect judgments, so that "independent patients" might miss the opportunity to access health promotion services:

> *"Not to every patient, because you might have an independent patient who does everything for themselves, who doesn't need health promotion. Very independent people and very young people, who leave hospital, they don't need it. Just the people who need encouragement and need help and promotion for when they go home or, you know, go to other hospitals." (IRN014:20-N)*

Another nurse described how her personal beliefs motivated her to promote smoking cessation among patients:

> *"I usually nag people about smoking, actually, because I am very anti-smoking..." (IRN006:13-N)*

This nurse, who was strongly anti-smoking, was very active in advocating smoking cessation because of her own attitudes about it. This case might show that the nurses' attitudes and beliefs could be very important in promoting health, but only in the sense of them taking individual action. It is reasonable to assume that, if the nurses have less strong attitudes about health promotion, they may be less active in practice. Even the fact of nurses possessing different attitudes and beliefs may lead to different actions. In this way, if the nurses had incorrect perceptions about health promotion or varied attitudes about it, then the quality of the practice could probably not be guaranteed.

In other situations, it seems to be difficult for the nurses to make decisions when the patients' conditions were flexible:

> *"A very personal view. But I kind of feel, if you've got a patient who's terminally ill, and you know, the cancer's spread all through their body, and they're still smoking like a chimney, that wouldn't be appropriate, I don't think, to walk in and say, 'Right, what can we do to stop you from smoking, because it's not good for your health?' because, you know, they've already got cancer spread all through their body, they've only got a month left to live, and, in that sense, I don't think health promotion's so important. I think it's better that the patient's happier in their last bit of life, I think." (IRN013:12-N)*

The nurse above decided whether to engage in health promotion with patients based on her understanding of terminal illness and the concept of health promotion. She might merely view health promotion as promoting health among patients, so that health issues, in this logic, would not be considered the priority for terminally ill patients. Health promotion, in this case, might even be controversial. However, health promotion may not be undertaken to promote a healthy body only, although it might be controversial and difficult to recognize the demands of terminally ill patients. This implies that the nurses' predispositions regarding health promotion could directly influence health promotion practice. If the nurses had ambiguous, inadequate or even incorrect conceptions about health promotion, this might obstruct the nurse-initiated health promotion practice in the hospital. It should be mentioned that this study focuses on discussing how the nurses' predispositions would influence health promotion when the practice had been allowed to be casually performed on the wards, rather than intending to dig into the composites of these predispositions. This implies that health promotion could be very complicated in reality and that nurses might be less capable of initiating it appropriately on the wards.

The time factor is a major issue in the nurses' accounts. All of the nurses interviewed believed that a lack of time was the most important barrier standing in the way of them undertaking health promotion. Some of the nurses eagerly admitted at the beginning of the interviews that the practice was unsatisfactory and that there was no time for it:

> *"Time. [No hesitation.] Yeah, time, yeah, we just don't have enough time to sit with patients to do anything. You know, I never mind sitting down to have a chat about health promotion. It would be just something, if I were making the bed, I'd have a quick chat with the patient about, you know, 'Don't you think you should give up smoking? It's not good for you', that sort of thing. So it's very kind of casual, on a casual basis, and it is just trying when you've got a quick five minutes with the patient, you've not really the time to do a proper, kind of, improvement of the patient, really." (IRN010:11-N)*

The quick response in this quotation probably was the nurse's prepared answer for this interview. This might indicate how important the time factor was in current health promotion practice. The nurse seemed to feel a heavy burden due to the little time for health promotion. This nurse again mentioned the "proper" health promotion practice as a "sit-down", an informal expression of health education in this study, which was supposed to need a certain amount of time for health

promotion. It seemed that the nurses were too busy to have the time for a "sit-down" to conduct proper health promotion. A lack of time might lead to a quick and casual conversation with patients in current hospital nursing. Another nurse also reported that time was a major problem for health promotion:

> *"In hospital...oh, I don't know. I'd have to think about that one. It's a big question. (Laugh) All I can think about is the time factor, when would we fit it in? It's really such a major issue. That's a major issue, that's the quality of care. I feel guilty a lot of the days I go away. There's a lot of things I haven't managed to do and I know the next shift won't be able to come on and do it either, we're desperately trying to make time to do a little bit extra, need that little bit extra. I don't think you could fit it into the ward, as much as we want to." (IRN002:65-N)*

The above nurse described the very important working context in the hospital, in which the nurses seemed to have a heavy workload. It seems that the nurses already had a long list of nursing tasks, while health promotion appeared to be at risk of disappearing in this busy work atmosphere. This was reflected in the way in which the nurses tried to find "extra" time for health promotion, showing that it seemed to be an extra task for them. In fact, health promotion seemed to rely on whether there was time available after the nursing routine had been completed. Health promotion might not be such a priority in nursing as other practices in the hospital. The lack of time seems to represent the fact that it is a challenge to structure health promotion practice within current nursing practice.

Significantly, the nurses' accounts suggested that health promotion was not a priority in hospital nursing practice. The nurses explained that health promotion was considered less crucial than medicine-related nursing in the hospital:

> *"I would say, probably, it's not a priority, no, not on the general wards, no. No, I don't think it's a priority for a lot of nurses." (IRN010:13-N)*

> *"There's no [pause] in this ward, there's no way that...that medication is the main thing, they will go home on tablets or whatever, new ones, and if they do the Heart Manual, they do it or they don't. I'd be interested in things like Tai Chi for exercise for these people, but we'd never suggest that they don't take their tablets, because I had two friends who just...who died, even though they were doing exercise." (IRN003:24-N)*

Even with the formal practice of the Heart Manual, health promotion would not be a priority in the hospital, one nurse suggested (IRN003). Instead, medical treatment appeared to be the central feature of nursing practice in the hospital. Thus, if the

nurses had time, medicine-related nursing practice would be the priority rather than health promotion practice, so health promotion seemed to be a lesser consideration on the wards.

It is important to question whether health promotion is on the agenda of hospital nursing. It implies that nurses might engage in the specific practice of health promotion as part of their nursing routine. Therefore, the health promotion practice mentioned here, which suffered from a lack of time, might be closely related to health rather than the medical treatment of disease. In the prevailing medical environment it would therefore be difficult for the nurses to find time for the health-focused health promotion practice in current nursing. This further confirms the possibility of integrating health promotion into current hospital nursing, from a disease-related practice to a health-related one in descending order of importance. Thus, the general practice of health promotion, which involved the giving of healthy lifestyle advice, might be the lowest priority, since it was usually casually conducted on the wards, as discussed above.

Health promotion seemed to be one of the nurses' many roles or tasks in the hospital. The nurses' experience of a lack of time revealed that the current management had problems regarding the strategy of nurses undertaking so many roles or tasks at once and, most importantly, were leaving it up to them to prioritize these. Without efficient management support, the health promotion role might be one of the roles competing for the nurses' limited time in the hospital. So, time seemed to be the most conflicting aspect for the nurses in managing the health promotion role among their other roles in practice.

Only one senior nurse questioned whether health promotion would be suitable for hospital nursing:

> *"I think we should be aware of the individual patient's lifestyle as much as possible, and then...sort of thinking, 'What information can I give them to make their life easier, more comfortable, longer?', which can be quite difficult sometimes. If the patient's only in for a short time, you don't get to know them very well. If the patient's in for a longer time, you do get to know them well, and you know what their lifestyle's like at home, and you can then give them information and advice, so..." (IRN007:55-N)*

It is understandable that, when patients are in a critical condition on the wards, the opportunities for health promotion seem rare for the nurses in a medicine-focused

hospital. Especially when there is a high turnover of patients, it even seemed difficult for the nurses to find an opportunity to deliver disease-related health promotion to the patients. In the next category, the nurses' experiences of this aspect will be discussed. Although the majority of nurses did not make attempts to challenge the idea of health promotion role put forward in the study, they felt the difficulties and dilemmas of the gap between idea and practice.

6.2.3.4 Three patterns of health promotion practice

The above analysis provided an account of how health promotion practice has been constructed in nurses' daily nursing practice, based on nurses' accounts of their experiences of health promotion in the hospital. It suggests there is variety in the health promotion practice, which is recognized as the category "informing, advising, educating...", representing the variety of strategies in health promotion practice. Regarding content, health promotion practice is identified as being divided into general practice and specific practice. The significant difference between two types of practice is how it could be made general protocol and applied across the wards. The former has an advantage because the giving of lifestyle advice can be applicable to any disease, while the latter has its specific aim in caring for patients with certain diseases. Most importantly, the nurses' perceptions of the two types of practice were distinguished between the visible and the invisible; in the one context health promotion and nursing overlap, and in the other health promotion has different relations with nursing, since the nurses gave different meanings to health promotion and ordered each in terms of importance based on their perceptions and experiences.

There is a third type of practice that has emerged when comparing the casual and the formal aspects of health promotion practice. It is noticeable that a health education programme is well-structured on some wards. This is a unique way in which the health education programme has been introduced and supported in particular circumstances. As a result, the nurses who conduct the health education programme regarded its meaning and place in an order of importance as different from those of both general and specific practice in the hospital.

The analysis of the data suggests that there are three patterns shaped within the different circumstances or structural conditions of hospital nursing. These could be named as disease information, lifestyle advice and health educational programme. These three patterns, as discussed, not only have different strategies as well as discourses, but also, more importantly for this study, have distinct structural behaviours. The nurses conducted the conveying of disease information as a specific practice focused on disease prevention as part of their nursing routine. The majority of nurses did not recognize it as health promotion, but as nursing. Perhaps disease information has features of nursing and also is so soundly embedded in the nursing routine that nurses were too comfortable to notice it.

The giving of lifestyle advice is what nurses believed to be health promotion in practice. In many ways, the giving of lifestyle advice is very different from conveying disease information. It was usually conducted by the nurses when they had time left, and when other opportunities presented themselves. This means that the giving of lifestyle advice is not part of the nursing routine and seldom is a priority of nursing work. The data reveal that the giving of lifestyle advice is what the nurses believe to constitute health promotion and that they want to contribute to by themselves, rather than regarding it as a structural demand since it has minimal structural support. On some wards, the health educational programme has been devised in by an organizational source beyond wards and hospitals. The systematically designed programme and support make it a successful case of health promotion in hospital. However, it is noted that this health education programme is limited to one type of patients only. Possibly, this pattern of health promotion practice is very expensive to maintain in hospital.

In a way, it is not surprising to have three patterns in health promotion. Health promotion itself covers a broad area; even the nurses in this study considered health promotion to be "anything and everything relating to health". Health promotion has many models, strategies and discourses in the literature. Laverack's (2004) category of health promotion is closest to the needs of this study for analytical purposes. Laverack analyses health promotion as a set of approaches which includes the medical approach, the behavioural/lifestyle approach and the social-environmental approach. Each approach has a different discourse and strategy shaping the method of design, implementation and evaluation of health promotion practice (Laverack 2004). The findings of this study only showed the

discourses and strategies of the medical approach and the behavioural/lifestyle approach in the three patterns. There is little evidence for the social-environmental approach in the nurses' accounts, which implies that hospital-based nurses probably could apply only two approaches in their health promotion practice.

The pattern of disease information identified in this study is the practice of delivering disease-specific information to patients with the purpose of informing them and acknowledging strategies for prevention. This pattern follows the medical approach in which nurses are in the dominant position to deliver disease-specific information to patients, rather than considering patients' choices and participations. The both patterns of giving lifestyle advice and of the health education programme are concerned with healthy lifestyle and behavioural changes. In their discourse and strategy, they lean towards the behavioural/ lifestyle approach. In its particular approach, the pattern of the health education programme is closer to that of the behavioural/lifestyle approach.

The giving of lifestyle advice is an interesting pattern in the nursing practice found in this study in many senses. Giving lifestyle advice, technically, does not fall into any of Laverack's (2004) categories of health promotion but has features of two of them. On the one hand, the giving of lifestyle advice follows the medical approach of delivering information to patients. On the other hand, it focuses on the risk factors of an unhealthy lifestyle which is the theme of the behavioural/lifestyle approach. However, it is problematic to combine these two, not only different but also conflicting, approaches. The medical approach and the behavioural/lifestyle approach have conflicting interests. Laverack (2004) recognizes the difference on the issue of empowerment. In the medical approach, the role of health practitioners historically has been assumed to be that of the elite experts who know best; thus the top-down approach is unavoidable when health promotion practitioners have modelled themselves on the medical approach to gain legitimacy. In contrast, the behavioural/lifestyle approach as part of the new public health movement has recognized the value of individuals' lifestyle choices and behaviours that could directly influence their health and the health of others (Laverack 2004). This approach shows signs of bottom-up empowerment. In terms of health promotion, the behavioural/lifestyle approach is more sophisticated and more difficult for hospital nursing. It is reasonable to argue that the giving of lifestyle advice might be the simple and convenient version of the behavioural/lifestyle approach which

has been adapted for hospital nursing. It is what nurses believed to be a kind of health promotion, which although it is not exactly what they hoped for, it is at least what they could do in the hospital. However, the giving of lifestyle advice is never an important and frequently conducted practice in the nursing role. Seldom has it found its way onto the nursing schedule.

So far, the analysis of the three patterns has focused on their features in the nursing practice and how they are distinguished from each other by employing Laverack's categories of health promotion approaches. The implications of the three patterns identified in this study should be looked at again in a wider context, which is further discussed in the next chapter.

6.2.4 Feeling powerless

It has been claimed that the nurses in this study had experienced complex and various working patterns in health promotion. The nurses themselves, however, did not fully acknowledge the nature of their practice, as discussed above. In the interviews, nurses had frankly expressed their perception that they wanted to do more than what they actually practised but that the current conditions of the hospital environment seemed to restrain them. More important, the nurses felt that they could do little to alter the working environment, which was also revealed in the survey. The nurses felt that they had experienced many difficulties and restrictions in the hospital regarding the health promotion role. "Feeling powerless" was one of the main categories to emerge from the nurses' accounts of how they had shown certain reactions affectively and behaviourally in facing the difficulties or dilemmas of their passion for health promotion yet which could not be realised in the hospital. In the next section, the nurses' insights are further explored under three themes: "not good enough", "lack of confidence" and "trying as much as possible".

6.2.4.1 "Not good enough"

During the interviews, negative feelings were identified by the nurses. Although these varied in degree, nurses usually had feelings of dissatisfaction, self-reproach

and guilt regarding current health promotion performance. Nurses did not perceive they had good enough practice in the health promotion role. Many nurses being interviewed viewed their current health promotion practice as simple and inadequate:

> *"I suppose you [the nurses] kind of do, because you say, you tell them what tablets to take, and you tell them, sort of...other little bits and bobs, I suppose you kind of do, but not...I don't think we do enough."(IRN004:36-N)*

> *"I think it's probably...we should be doing more over it, I don't think we do enough of it...Say, in my role, I'm a clinical nurse specialist, and I look after the HIV patients, so I tend to go around every morning, just make sure they're ok, they're managing all right with their therapy." (IRN010:2-N)*

It could perhaps be argued that this was associated with the distance between nurses' role expectations and the current performance of health promotion in the hospital. As presented in the discussion of the survey results, nurses usually held a higher standard of role expectation but the actual practice itself had not been conducted in the way they wished. Nurses' dissatisfaction with current practice confirmed that they probably have a perception of the health promotion role that is not only different but also higher than the actual performance.

It is interesting to review the finding that nurses seemed not to have a clear definition of the health promotion role, as argued above. The nurses could still not provide details about what had been missed. The ambiguity of the health promotion role may make their situation worse. The nurses were just not happy with the current practice, without being able to give further reasons. Instead, a nurse might comment on "something missed out" (IRN002). There were many things they wanted to do but they just could not do them because of the conditions, such as lack of time (IRN013).

> *"You don't feel like you're doing your job properly, because there are something missed out."(IRN002:54-N)*

> *"It's generally quite nice to let the patients know that you're not...that there's something you possibly and potentially could do to benefit the patient. But you just don't have time to actually do it, and that's when you feel, like, low job satisfaction at the end of day. You feel like you've let a patient down. You generally just go home, have a laugh with your friends, then come in the next day." (IRN013:44-N)*

The nurses possibly have an image of the health promotion role which is not matched with the image of their practice in the hospital. In other words, the nurses hold a role expectation which is not relevant to the current practice. Clearly, the actual practice was not considered as health promotion by the nurses, while the vague image in their perception of the health promotion role is believed to be the role and its expectation. Perhaps, the nurses felt they did not do a good job and did not fulfil the role expectation because of this.

In the interviews, junior nurses especially who had just commenced clinical work seemed to have more frustrations than senior nurses. Negative feelings appeared to be experienced strongly by the junior nurses. Senior nurses appeared to be good at accepting the fact that this was the situation of the hospital, although they still had feelings of not having fulfilled their job expectations. It could be argued that the new graduates probably had an expectation of the health promotion role in a theoretical context, and the situation of both the actual practice and the hospital environment might feel overwhelmingly different, so that they were struggling with the different images of perception and practice. Possibly, the new graduate was likely to be at the stage of forming a role identity of what it was like to be a nurse in hospital. In brief, this finding confirms that both junior and senior nurses' perception of the health promotion role impacted on their satisfaction with their current practice as well as on their identity of being a nurse. The junior nurses suffered more than the senior nurses because they were at the special stage of developing a professional identity of being a nurse in hospital. It is significant to note that both junior and senior nurses committed to the image of the health promotion role when they experienced difficulties in their current practice in the hospital.

Nurses pointed out some of the reasons for this situation, which they considered causes by their experiences with unavailable resources.

> *"In hospital...oh, I don't know. I'd have to think about that one. It's a big question. (Laugh) All I can think about is the time factor, when would we fit it in. It's really such a major issue. That's a major issue, that's the quality of care. I feel guilty a lot of the days I go away. There's a lot of things I haven't managed to do and I know the next staff won't be able to come on and do it either, we're desperately trying to make time to do a little bit extra, need that little bit extra. I don't think you could fit it into the ward, as much as we want to." (IRN002:65-N)*

Junior nurses might not think that far. Unfortunately, senior nurses usually viewed it as a problem impossible to conquer. The unavailability of resources, consistent with the findings in the survey, such as being short of staff and time, a busy ward and heavy workload, were continually suffered by nurses. The nurses stated that there was little they could do in changing this unsatisfying situation. It was likely that nurses would continually suffer the difference between perception and practice aspects of health promotion.

> *"I don't think much can change within this ward." (IRN013:40-N)*

> *"I sometimes think that there's...theory I was told about 10 years ago when I was a student nurse, and I don't see that it's really happened." (IRN003:42-N)*

These feelings very likely represent the weakness of nurses' power in current hospital health promotion because of their desire for a health promotion role, ideally as they perceived it. The nurse quoted below further expressed her wish to "escape" the hospital to working in the community.

> *"I thought there would be more health promotion. I don't think there is [in the hospital]. I feel like there's almost none. So, disappointed that way, because I'm not involved in any, but I am looking into being a community nurse, hopefully. So, get involved in that side of things."(IRN002:53-N)*

This case might be a little dramatic but it suggests nurses' suffering in struggling with the discrepancy between perception and practice. It should be time to rethink whether the nurses' perception of the health promotion role is a problem itself. The nurses seemed to struggle with the actual situation of the practice and the hospital environment, but remained committed to the perception. This means that the nurses feeling "not good enough" is related to the perception, which does not match actual practice.

6.2.4.2 Lack of confidence

A lack of confidence is another big problem for the nurses when they considered implementing health promotion for patients in the hospital. One nurse, like many others, was concerned about her lack of knowledge and skills to conduct health promotion:

"I would say no, but I would...If I had the right tools and information, I will definitely try, but not off my own back, because I'd be a bit worried about what's out there, what's new, what developments are going on, and am I giving the patient the right information. So I would say, if I had the right information, I would, but it's just sort of like personal knowledge, just general knowledge of what's going on around us, a bit of what's happening." (IRN011:59-N)

This nurse expressed her willingness to deliver information to patients but seemed unsure about the kind of information she could offer them. Obviously, health promotion here had been understood as information delivery. As information delivery, the nurse revealed her lack of confidence about delivering up-to-date information. However, it seems that the nurse felt competent to advise patients about personal lifestyle issues and provide disease-related information. Another nurse confirmed that she was better at disease prevention than health promotion:

"I think if I knew a lot more about diseases and stuff, then I would maybe...and I write their progress as you say, and about things that you could...I suppose it's just experience, isn't it? And I would, sort of, maybe feel a bit more confident then...But I do feel confident about, sort of, smoking cessation. I'd like to know a lot more about it, but I feel I can at least make a start, and maybe start somebody off in the right direction."(IRN004:30-N)

The experience that the nurse talked about seems to be essential for the nurses' confidence in engaging in health promotion. For instance, smoking cessation seems to be widely acknowledged and implemented in the hospital reported by the nurses in the interviews. This nurse also mentioned that she felt good about doing smoking cessation, since she had confidence due to her experience of this. Currently, health promotion seemed to be "basic" and most importantly, the nurses experienced it, as interpreted by the following nurse, so that she felt confident about it:

"Yes, on basic health promotion, yes. And, obviously, perhaps more detailed information about the specific help that can be given to the person might not...I'd have to go and find it out, but basic health promotion I'm quite confident about." (IRN007:50-N)

If the nurses were confident with what they had experienced, namely what they currently practised in health promotion, them feeling a lack of confidence is related to their perception of what the health promotion role should be. In the analysis of the survey, the nurses had a higher role expectation than health promotion was in actual practice. The nurses seemed to lack confidence about what to expect from

health promotion while they felt good about their current "basic" practice. This also suggests that the nurses' lack of confidence correlates with their dissatisfaction with the current health promotion, while they felt unqualified to improve it. This might be the nurses' reactions to their current lack of confidence to improve health promotion in the hospital, which also seemed to be linked to the nurses' approach to health promotion called "trying as much as possible", discussed below.

Further analysis finds that the junior and senior nurses appeared to share a lack of confidence with regard to the health promotion role, but the junior nurses had relatively much less confidence, especially those who had worked for less than two years. The nurse quoted below seemed to be suffering from serious self-doubt and to have a lower capability of recognizing the patients' needs for health promotion:

> *"Sometimes, you think, well, they're not going to listen to me, so why am I bothering, or they're just going to think I'm really stupid, because they already know this. But they don't always, so I think it's just, yeah...sometimes it's a bit, yeah, difficult." (IRN004:50-N)*

This case suggests that health promotion practice might be more complicated for junior nurses to manage and so they feel less confident about it. On the contrary, the senior nurses appeared more confident about promoting health among the patients. One senior nurse (IRN006) described how she got her experiences from practice:

> *"...Just. I've been in different areas. Picked up enough, and if you don't know, there's enough materials out there for me to go and find it. It's nice to go on refresher courses, to be reminded about something. That's to say, once I've been...I think I'm down to go on a Heart Manual course eventually...I'll be thinking, 'Oh, I didn't know that, I didn't know that'. There will be things I don't know, but I think, in general, I think I've got a fairly sound base, but I could always learn more." (IRN006:47-N)*

The senior nurses might have more work experience and more ability to manage complicated situations. Especially the senior nurses might be more sophisticated in applying the available resources than the junior nurses. All of these abilities that the senior nurses possessed might help in enhancing their confidence about performing health promotion.

It is significant to note that the senior nurses' work experiences might not necessarily be relevant to health promotion. On the contrary, one senior nurse felt

that she was "the old" one (IRN011) in health promotion since she had missed the training for it:

> *"I think we're all, sort of, we are in the profession, we are, we're all sort of there to do the best we can for the patients. And I think, you know, if we're...Maybe it's a new generation of nursing coming up, you know, that health promotion will have a big impact on the health service. We're just...I'm the old." (IRN011:50-N)*

"The old" suggests that the senior nurses felt they lagged behind in terms of health promotion. The senior nurses might have less training in health promotion because it was probably a new frontier for nursing. The lack of confidence among the senior nurses seems to be related to their lack of special training in health promotion. The above nurse (IRN006) also wished to take a training course on the Heart Manual which suggests that her work experience might not be sufficient for the health education programme. Therefore, the senior nurses' work experiences might be merely adequate for current "basic" health promotion practice. In other words, their nursing practice/experiences could contribute to their health promotion practice. This might imply that the knowledge and skills had probably been shared between nursing and health promotion in terms of current "basic" health promotion. This is not a surprising finding since it has already been discussed above that health promotion and nursing overlap at certain points in the category of "informing, advising, educating, ...".

The junior nurses seemed to have been trained under the new curriculum of nursing education which has health promotion as one of its subjects. However, current nursing education for health promotion seems to focus on primary care or rather a theoretical approach, so that the nurses seem to find it difficult to fit it into the "busy" hospital environment:

> *"In terms of what I was taught at university, there's much more prolonged care, then community-based...Here, it's fast, it has to happen. So the rapid...the patient turnover here is very high. So I don't have the opportunity to plan health promotion in the way that I would have been encouraged to at university. I've got to do it on the spot, to a certain extent, it's got to be done on the day." (IRN008:32-N)*

It seems that the strategies for health promotion that the nurses had learnt might be unsuitable for practice in hospital. This might be an important reason why some nurses thought that field experience was more important than education at

university. One junior nurse (IRN013) expressed a desire for more specific knowledge and techniques for health promotion in practice:

> *"I think we need more specialized, like specialized days, you know, how to get specialized in, you know, what's a question that needs to be raised to engage with a patient, on how to, I don't know, how to..., you know, how to make their dietary intake improve, or whatever, and then another day for smoking. You can't lump them all into one day, because they're all quite specialized. They have very different patient needs." (IRN013:26-N)*

However, the nurses merely expressed their lack of confidence about health promotion, failing to describe in the interviews what kind of training and capability they demanded. It seems that the nurses' lack of confidence was closely related to their vague perception of the health promotion role. The nurses seemed to have a concept of health promotion but to lack the knowledge and skills of how to put the concept into practice, namely, "what to deliver" and/or "how to do it", beyond the current "basic" level of health promotion. This confirms that the nurses' lack of confidence seems to be related to what they had never encountered in the field. The nurses might not know exactly what health promotion should be in practice, while believing that it should be much better than what they could do currently. The nurses' lack of confidence might be related to the ideal but vague concept of health promotion. This might lead to the very important suggestion that the clarification of the definition of the health promotion role might be vital in relieving the nurses' tension about their lack of confidence.

In the interviews, the nurses complained that they had very limited support in the hospital regarding their learning and training. In the interviews, the nurses usually expressed the wish to seek help personally:

> *"I'd probably ask somebody more senior than me. And then, if they didn't know, I'd look it up in a book. Or I suppose there's always the Internet as well. And I would try to find out as much information as I could, to tell them." (IRN004:59-N)*

> *"Just look at the* Nursing Times. *Different books, magazines, whatever, different nursing magazines." (IRN002:61-N)*

This could be seen as how the nurses chose to cope with their lack of confidence. When facing difficulties, the nurses showed that they liked to ask the senior nurses and doctors for help and to consult books, journals and the internet. The *Nursing Times* seemed to be the most popular resource, probably because it was commonly

provided on the wards. The help-seeking behaviour showed the limited degree to which the nurses were capable of improving themselves in terms of health promotion. Probably, these are the real available recourses to which the nurses could gain access in hospital. The expectation for training for health promotion in hospital may be also vague and their chance of obtaining it limited, besides being a question of necessity.

6.2.4.3 "Trying as much as possible"

"Trying as much as possible" is a very frequently used expression by the nurses in the interviews on facing the current situation regarding health promotion role. This is how the nurses themselves frequently described their endeavours towards performing health promotion in their nursing practice. This expression seems to deliver important information about how the nurses had reacted to the current context regarding health promotion practice. In this section, the analysis examines how far the nurses were comfortable about the "trying as much as possible" approach in current practice, and then analyse what facilitated the nurses' "trying as much as possible" approach in practice.

"Trying as much as possible" could be understood in at least two contexts in this study. First of all, "trying as much as possible" seems to express the nurses' enthusiasm as well as describe their performance in current health promotion practice:

> *"As much as possible. Anything...just to prevent somebody from becoming ill again, it's got to be an advantage." (IRN008:34-N)*

> *"We just try to manage the time, make it as effective as you can, and try to give patients as much information as possible, because it will help to keep them in that optimum condition, not to have to come back into hospital." (IRN005:45-N)*

"Trying as much as possible" probably reflects the nurses' attitudes and efforts regarding health promotion in the context of hospital nursing. It seems to echo the above discussion about the nurses' strong beliefs and values regarding health promotion in the quotation by the nurse IRN008. It further confirms the nurses' commitment to the health promotion role. In the second quotation by the nurse

IRN005, the nurse described their efforts to commit to their beliefs and values in order to conduct health promotion in the hospital.

In a way, "trying as much as possible" appeared to be a positive sign in nursing practice. However, it might also imply that the nurses tried hard to push their idea of health promotion into their current nursing practice. It should be remembered that the nurses seemed to be dissatisfied with their current health promotion practice. For example, one nurse, like many others, defined the current health promotion practice as simple and inadequate:

> *"I suppose you [the nurses] kind of do, because you say, you tell them what tablets to take, and you tell them, sort of...other little bits and bobs, I suppose you kind of do, but not...I don't think we do enough." (IRN004:36-N)*

> *"It's generally quite nice to let the patients know that you're not...that there's something you possibly and potentially could do to benefit the patient. But you just don't have time to actually do it, and that's when you feel, like, low job satisfaction at the end of the day. You feel like you've let a patient down. You generally just go home, have a laugh with your friends, then come in the next day." (IRN013:44-N)*

This suggests that the nurses were dissatisfied with the health promotion practice, although they tried as hard as they could to perform it. On the one hand, the nurses might have much higher standards for health promotion than exists in their current practice. On the other hand, the nurses might have been restricted by their current working conditions. When the nurses could not perform the health promotion role as they perceived it, it is possible that "trying as much as possible" might be an appropriate reaction to this, especially when they had enthusiasm about and commitment towards the health promotion role. In this sense, "trying as much as possible" is associated with the gap between the nurses' role expectations and the current situation of health promotion in hospital nursing. The analysis further finds that the nurses in the study seemed to have suffered from a tension between the expected role and the actual practice. In this situation, perceiving current practice in the "trying" sense could help the nurses to relieve the tension caused by the gap between their expected role and their actual practice.

In the other sense, some nurses were able to analyse and rationalize the situation by considering the work environment, so that they believed that the nurses had already done what they could do in the current hospital nursing setting:

> *"I think it may be not great, but I think it's as good as we can make it, given the type of ward it is. On another type of ward, there are more opportunities to promote health, I think." (IRN013:35-N)*

In general, "trying as much as possible" represents the nurses' attitude. Their efforts had been restricted by certain working conditions and in response, the nurses applied this approach for coping with the tension between the expected role and the actual practice.

There is another context linked with the above analysis. "Trying as much as possible" implies that the nurses felt a lack of control over the current situation. This is interlinked with "I can't change anything of the hospital environment" attitudes. It sounds like pessimism; however, it is a fact that there are many situations that the nurses could not change but must adapt to in order to survive.

Under the approach of "trying as much as possible", it had been left for nurses to initiate health promotion "on an informal basis". It could be assumed that it probably was less possible for nurses to properly check on patients in the current busy work context, although nurses sometimes would "chat" to show their concerns.

> *"Not on a formal basis, no. But, informally, although...the patients we have do come back, that have stopped smoking, they have just commented to us that since they've stopped smoking, this, that, and the other has happened to them, they describe the effects of it to us, but it is very informal. It's not a formal audit or anything." (IRN007:16-N)*

"Trying as much as possible" is interlinked with the theme "the casual vs. the formal" practice in the hospital. It also reminds us that there is a formal practice in the hospital which is not following the "trying as much as possible" approach. However, the health education programme is applied on very few wards. For the majority of nurses, this approach is important in the practice in the hospital.

According to nurses' accounts, the situations were not under their control. There were fewer opportunities for nurses to have feedback on whether patients had taken up the knowledge and skills being offered. One of the reasons for the lack of feedback was supposed to be the short stay of patients, especially in the Acute Receive Unit.

"It's difficult though to do your health promotion and things because you can't follow up. You can't follow the patients up, check them in the ward because they're only here for such a short time. You've not got that long. Actually, if you educate them and make sure they understand, and then..." (IRN013:4-N)

The short stay in hospital probably is a big problem for feedback and evaluation. Nurses normally seldom met the patients again after they had been discharged. Since the changes in healthy behaviours might need a period of time before manifesting themselves, it may be rare for nurses to witness patients' behavioural changes in the hospital.

"I would say it's difficult to say, because we don't see patients putting their...the information that they've got into practice, so because we don't see the far end of the process, it's difficult to evaluate it when you can't see the end product...But because we can't see the far end of it...Generally, if the patient doesn't come back, then I would hope they're well enough to be living on their own outside of hospital." (IRN008:46,47,48-N)

"You can't know how effective your own contributions have been if you get nothing back from the patients. I think in that sense it's better if you're sending them [health promotion roles] on to the community, so when they [patients] go home, they can follow up at home, and that's, can happen more regularly, I think." (IRN013:34-N)

The lack of feedback appeared to frustrate nurses' initiative in performing further health promotion. However, feedback on the outcomes of health promotion would not be limited to patients' behavioural changes. The patients' immediate reaction, namely willingness to have the service or not, also is found to be one form of feedback in nurses' accounts.

This kind of patients' reaction seemed to be one of the critical reinforcing factors to start health promotion in nurses' accounts. As discussed above, when health promotion had been left for nurses' individual decision, they usually identified the needs or demands before initiating an action for it:

"I think it really depends on the feedback that we get from the patients. When the patient is admitted and we ask them if they're smoking...It depends on what kind of feedback that we get from the patients whether we feel that we can pursue that any deeper. Patients will say, 'Yes, I smoke, I'm going to carry on, thank you', then we don't push it. But if they say, 'Oh, yes, I've been trying to give up', or 'I've been struggling', or whatever, then we might give them more information or more support and things, it really just depends on the feedback we get from the patients as to how far we go." (IRN007:17-N)

Patients' face-to-face reaction as one form of feedback appeared to be important for nurses' performance of health promotion activities. However, probably based on their experiences, quite a few nurses felt that the patients were not following their suggestions. There were no clear sign of the reasons for this situation given in this study. However, it could be assumed that probably the patients would not follow the health promotion advice given by nurses either for their own reasons, or because the promotion was delivered in an inappropriate way:

> *"You know, unless it's just blatantly obvious that the patient's just not going to, you know, because some people are...they're not rude, but they're quite, not listening, but percentage-wise it's a tiny, tiny per cent. But most of the patients, I give them information because then they have the choice, and if they choose to listen to it, and they choose to follow it, and that's fine, but I've given them that choice, so it's up to them what they do, yeah." (IRN005:38-N)*

This probably leads to another problem, where nurses seemed unable to control patients' reactions to health promotion activities. In fact, it seemed to be typical that the nurses would totally respect patients' own choice on health issues. The nurses felt they had the responsibility to "give information" while patients on the other hand had completely dominant power to accept or reject it. It was also typical that most nurses believed that they were weak in resolving those dilemmas. As a result, nurses tended to abandon the situation:

> *"Well, we can say we have advised the patient, that this is not appropriate for their diet or not appropriate, but...if they still continue to do it, there's nothing else we can really do." (IRN011:32-N)*

> *"Well I could say that (stopping smoking), but it's a choice. If people who, I can oblige to people who...yeah, I would say yeah. I mean I'm not responsible for their...I am in a way though, I may be here and you know, but can't do that, I can't oblige them." (IRN009:42-N)*

It seems that nurses as information deliverers look to be less concerned with whether what they had delivered had an effect or not. Probably, the nurses' own lack of control over the outcomes of health promotion activities might be a major factor in explaining this situation. There are always questions of responsibility for the approach of "trying as much as possible".

In summary, the category "feeling powerless" is concerned with the analysis of the nurses' emotional and behavioural responses in their accounts of the health promotion role. This category has been found to have many interlinks with the

themes discussed above in this chapter. It is supposed that this is so because the nurses' attitudes, beliefs and knowledge basis, and the behavioural patterns of health promotion practice, are not connected, in the sense that the former does not help interpret the latter. Possibly, the nurses' emotional and behavioural reactions in this category interpret most of the previous three categories of the nurses' accounts, about how the nurses reacted to the situation as it was. A baseline of the category is about facing and coping with the gap between expected role and actual practice. It is argued that the expected role is beyond what the nurses could reach. Since the nurses had the perception of the health promotion role at a higher level, they would always feel that the actual practice was "not good enough". The theme "lack of confidence", as was argued above, may not relate to nurses' problems with their knowledge and skills for their current practice. The nurses' confidence is relevant to how much of the necessary experiences they could obtain and how much access they could gain to necessary resources to implement the health promotion role as they expected it to be. This ideal role is truly very difficult to reach, if not unattainable. "Trying as much as possible" is considered a survival response by the nurses when they live with an irreconcilable gap between perception and practice. The nurses' accounts show how nurses felt powerless to perform health promotion in real contexts. This shows that the nurses were very limited in what they could do in practice but were trying to do what they could, psychologically as well as behaviourally.

6.3 Summary

This chapter has presented and discussed the interview findings. The interview participants offered their insights into what health promotion is, how it is related to their work, and how it is in nursing practice in the hospital. By thoroughly scrutinizing the data via thematic content analysis, four main categories and 12 themes were discussed, supported by selected quotations from the nurses' accounts.

The analysis shows that the nurses were keen to offer health promotion to patients as they perceived it was beneficial for both patients and hospital services. The nurses believed that they were in "a good position" in the hospital for practising health promotion. However, nurses appeared to have difficulties in supplying a

definition of health promotion. The nurses responded with various vague answers, ranging from "something" to everything related to health. The nurses felt it was easier to just describe the activities as they saw them as health promotion. This suggests that nurses might only instil meaning into health promotion by "doing" it.

By way of the content analysis, the actual practice of health promotion in the hospital could be identified in the nurses' accounts. It found that health promotion has been conducted by the nurses in various ways, which could be categorized as general vs. specific practice. Health promotion practice was also conducted either casually or formally. Accordingly, the nurses behaved differently in health promotion practice. Three patterns were able be identified from the analysis of how the health promotion practice had been shaped by their contexts.

Finally, the chapter focused on the nurses' emotional reactions to health promotion. This produced some important findings that added to the survey findings because the survey had little chance to expand on the nurses' feelings about health promotion. Significantly, the nurses felt they had less power to improve the current health promotion practice in the hospital due to the lack of support and resources. On the one hand, the nurses appeared to be lacking in confidence to practise health promotion; however, on the other hand, they had strong beliefs in their responsibility to carry out health promotion. The nurses were "trying as much as possible" to do what they could for the cause of health promotion in the hospital. The interview data suggests that the gap between the perceptional and behavioural aspects had psychologically damaged nurses such that they were likely to engage in self-blame, be dissatisfied, feel hopeless and guilty on account of their current health promotion activities.

Chapter Seven – Discussions

The previous chapters have described and, to a limited extent, explained and discussed the findings concerning the nurses' experiences of health promotion in the hospital. The overriding impression given by the data in this study is how passionate the nurses were about health promotion, but, for some reasons, they actually could not reach the level they expected of themselves. The study shows that the nurses' role expectations and their actual experiences of health promotion are truly different. The study draws on two accounts of the health promotion role: one of nurses' role expectations, referring to the role they expect to play, and one of their actual practice of it. This chapter will discuss this phenomenon further by examining the nurses' experiences of health promotion and by interpreting the relation between health promotion and nursing. Finally, a concept of "the duality of health promotion role" is proposed, based on the nurses' accounts of the health promotion role.

First of all, it may be helpful to briefly review the findings of the study. The study was a mixed-methods one, with the data from the questionnaire survey and the interviews gathered in sequence and reported separately. The findings reported in the results chapters will now be put together to provide a relatively complete picture of the nurses' experiences of health promotion in hospital. This is followed by the introduction of the metaphor "golden key", an analytic concept developed in the data analysis process and used to unfold the nurses' health promotion role in the hospital.

Summary of findings

Both the survey and the interview data describe a discrepancy between what the nurses expected of the health promotion role and what they actually practised in the hospital. The survey suggests that the nurses' role expectations were significantly higher than their actual health promotion practice. The data from both sources show that the vast majority of nurses were passionately committed to health promotion. The nurses explained in the interviews that "it should be my role", and they believed that health promotion provides "benefits for all". The nurses also viewed themselves as being "in a good position" to offer this service. Nevertheless,

the nurses admitted that they were not good at health promotion in practice. They described the practice they could engage in in the hospital as just "simple talk". The nurses pointed out that the hospital environment was not supportive of health promotion practice, which confirms the survey results. Lack of time, support and resources were the main barriers to health promotion practice in hospital, according to the findings from both the survey and the interviews. According to the interview accounts, the nurses were not satisfied with their current health promotion practice nor with the environment in which to do health promotion. They strongly argued for further support and resources for health promotion.

However, the nurses' understanding of the health promotion role seemed to have limitations. Their perceptions were rather fragmented as shown by the category "something, everything, or in the same pot". In the interviews they found it very difficult to explain what health promotion was. However, a positive finding by both the survey and the interview is that their work experiences could improve nurses' understanding of health promotion and its practice. The interview accounts confirm that the nurses tended to be "knowing the doing" of health promotion in the hospital. Experienced senior nurses and specialists whose work involved more health promotion practice usually had a better understanding of health promotion and its practice than the staff nurses.

The intensive analysis of the interview accounts was rewarded with identifying the existence of patterns of health promotion practice of which the nurses had little awareness. Three patterns of health promoting practice could be identified: disease information, lifestyle advice and health education programme. The survey found that the providing of disease-related information was the most frequently conducted health promotion practice in the hospital while lifestyle advice was less commonly given. The interview data showed that the nurses on the cardiological wards and the specialists were able to carry out health education programme. It is particularly interesting to find that in the interviews the nurses usually did not recognize that providing disease information is a health promotion practice but instead saw it as part of nursing. This is quite problematic since the nursing practice in the hospital was mainly constituted of disease-related activities, as suggested by the survey data.

Golden Key: an analytic concept

The concept or metaphor "golden key" is based on the researcher's understanding of the nurses' accounts of the heath promotion role. The metaphor seems to illustrate the nurses' experiences of health promotion: they enthusiastically embraced an ideal image of their health promotion role but in reality could not carry out this role in the hospital. The usefulness of this metaphor in unfolding nurses' experiences of health promotion is discussed below.

It is noted that the nurses in this study had been struggling with the issue of their actual experiences of health promotion not matching their role expectations. Throughout the data shows that the nurses were not satisfied with their current practice and felt frustrated at not being able to "take on a health promotion role", as they expected. The nurses considered that their current practice was "not good enough" to satisfy the health promotion role, although they were "trying as much as possible" to improve their practice. Considering changes to the situation, they provided a long list of difficulties they had suffered when conducting health promotion, including lack of time, resources, support and training. This raises the question whether their expectation of the health promotion role is too ideal to be conducted in practice, or whether it might be unrealistic for the current nursing practice in hospital.

The findings show that the nurses' understanding of health promotion was quite simple – it is about "promoting health". By health, the nurses meant the holistic health and wellbeing of patients, but they were never able to give further explanations of what the concept of health promotion was and how it was relevant to their practice. The health promotion role, if understood in this way, was not only vague but also extremely inclusive. The nurses themselves actually noticed that it could mean "anything and everything" to do with health. But, the findings showed that their current health promotion practice was mainly concerned with disease-related nursing activities. It seems just not possible, logically and practically, to carry out what the nurses' expected of a health promotion role in the hospital. The difficulties of conducting health promotion as defined by the nurses are due to their expectations being too high, too idealized, to fit into the current working conditions in the hospital rather than vice versa.

It is evident that the ideal image of the health promotion role was important for the nurses. Even with difficulties experienced in reality, the nurses were passionate about health promotion being a good thing that brought "benefits for all". They welcomed the health promotion role simply because they wanted to help patients to regain their health. They were committed to an ideal health promotion role and thought that if the hospital environment could be more supportive, and if they had further training and up-to-date information, it was possible to achieve what they expected of it. They believed that every nurse should have a health promotion role, since otherwise, they would not be doing a good job. It seems that an ideal image of the health promotion role was part of their identity of being a nurse in hospital.

The "golden key" has resembled the nurses' perception of the health promotion role which is too idealized and thus unattainable to be helpful in practice in hospital. The data show that the nurses actually did not know what the expected role exactly is and how they could get to fill the role. Further, the nurses might not realize that the ideal image of the health promotion role could be blinding them to see the reality of current practice. The nurses in this study were aware of the discrepancy between what they expected and what they practised. Certainly, they did not feel a need to reconcile these since they strongly believed that their expectation of the health promotion role was supposed to be the role. In contrast, the nurses only considered the actual practice as some casually conducted health promotion activities, rather than their role in health promotion. The "golden key" simply portrays the nurses' problematic perception of the health promotion role and leads nurses to a misunderstanding of their actual practice in the hospital. This is what makes the nurses' experiences of health promotion difficult and stressful, and leaves them "feeling powerless" in the face of being unable to fulfil their perceived role expectations. Briefly, the "golden key" is being used here to stand for holding an ideal and vague notion of the health promotion role without considering the reality of health promotion practice in hospital.

A brief introduction to the concept of a "golden key" is necessary. The concept "golden key" is not directly mentioned by the study participants, which means that it has not been derived from the data but is instead the result of the data analysis. The use of "golden key" is essential for this kind of study since its aim is to listen to nurses' voices and to value their opinions; however, the findings of the study show that the nurses seemed to be living in a certain culture of health promotion. It is

very difficult for the nurses to realise that their accounts of the health promotion role could be very problematic for its practice in hospital. It is for this reason that the "golden key" is postulated to interpret the nurses' experiences of health promotion in the hospital. The following discussions will further test this tentative concept, "golden key", to explain why the nurses' role expectations do not cohere with their actual experiences, and what had been missed by the nurses in their actual practice. Additionally, the metaphor reminds us that there is an "ordinary key" in the nurses' hand; this is perhaps the actual practice ignored by the nurses in this study. Thus, the discussion of the "golden key" provides an overall impression of the nurses' experiences of the health promotion role, which helps to quickly grasp the essence of the findings. In this sense, the "golden key" could be the core theme of the findings of the study at a higher level of its interpretations; it serves as a backdrop for the following discussions in this chapter.

7.1 Nurses' experiences

The discussion of the "golden key" above portrays an unpleasant experience of the nurses in the hospital when they believed that the health promotion role should be one way, but in practice it was another. It seems that the nurses could not reconcile the two images of the health promotion role. As a result, they constantly faced a gap between what they expected and what they actually did as part of health promotion in the hospital. It is really important now to ask what it is about the nurses' experiences, and why they expected an ideal health promotion role if they had never encountered it in practice, and how this experience impacted them.

7.1.1 Role-person misfit

The study finds that the nurses' attitudes, beliefs and knowledge of the health promotion role were at a very much higher level than their current practice. As discussed above, the health promotion role expected by the nurses was like a "golden key" which is too ideal to be possible in hospital. The nurses' actual practice was not sufficiently valued by them nurses because they thought it was "not good enough" for a health promotion role. According to Ralph Turner's (1978, 1990) concept, such findings indicate a situation of role-person misfit. The role

actors have a certain conception of the role while their conception of actual experience is different. Turner (1990) argues that the role-person misfit is an instance of an incomplete or unsuccessful case of role change since the changed conception of the role stops before reaching a complete role change, and the person's experience cannot be identified with the conception of the role. Reasons for the role-person misfit could be dynamically initiated by role actors or by role definers (Turner, 1990). Whether what is causing this role-person misfit is the nurses or the definition of the health promotion role should be further examined, although the nurses in this study apparently had passion for the health promotion role.

In the health promotion literature Chambers and Narayanasamy (2008) report a role incongruity when investigating nurses' health beliefs. They identified two opposing sets of health beliefs in newly registered hospital-based nurses' accounts: a holistic view of health and an individual view of it. Chambers and Narayanasamy (2008) found this difficult to explain until they applied Mead's (1934) ideas of "Me" and "I". The authors interpreted that nurses expressed a public self when they professed a holistic view of health, while a private self when they professed an individual view of health based on their own personal experiences. When nurses expressed a public self, the "Me" is object, while the "I" is concerned with the private self and personal experiences. Interestingly, the authors believe that the individualistic view of health is newly registered nurses' lay view, while the holistic view expresses a "social script" or "role expectation". Thereby, the authors argued that it is nursing education with its holistic view of health that may simply overlay nurses' lay view as well as their individualistic view of health which leads to the dual set of health beliefs. They conclude that this is the cause of ineffective health promotion practice. Thus, the authors suggest that nursing education should take note of nurses' role incongruity[1] and change the curriculum to improve nurses' understanding of health as well as health promotion.

The nurses in this study had similar experiences with two accounts of the health promotion role. They considered that health promotion and the health promotion role be related to holistic health and wellbeing while simultaneously they had

[1] "Role incongruity happens when a role occupant finds that expectations for his role performance run counter to his self-perception, disposition, attitudes, and values. It commonly occurs when role actors undergo role transitions involving a significant modification in attitudes and values" (Hardy 1978b, pp. 81-83).

different experiences in their practice, identified as an individualistic approach to health promotion. The nurses actually had little notion of holistic and individualistic approaches to health promotion, as suggested by the data from both the survey and the interviews. However, the nurses sensed the differences between the expected role and the actual practice in the relevance they saw in holistic health and disease prevention. As discussed above, the study argues that what the nurses expected of the health promotion role is a "golden key" which is too ideal to be possible for a hospital. This means that the nurses' understanding of the health promotion role is impossible for practice in a hospital or possibly for practice in any context. Thus, the study argues that the practice of an individualistic approach is relevant to the actual practice of the health promotion role in hospital rather than the holistic one. In this, the study disagrees with and departs from Chambers and Narayanasamy's (2008) thesis.

It is important to note that there is a consistency between the above authors' attitude and understanding of the health promotion role and the contemporary knowledge of health promotion. In the literature, it is not unusual to find that the individualistic approach to health promotion is regarded as a traditional strategy, while the holistic approach to health promotion is regarded as a new paradigm as well as an advanced one. Evidence for how the contemporary view of health promotion has impacted the understanding of nurses' health promotion role can be found in previous studies. Piper (2007) comments that hospital-based nurses' understanding of health promotion is still quite "traditional", referring to the notion of health education. He encourages nurses to embrace a wider sense of health promotion, by which he means a holistic approach to health promotion. In this, Piper's attitude to health promotion is consistent with Chambers and Narayanasamy's (2008) conclusion. Both studies set a holistic approach to health promotion against an individualistic approach.

However, previous studies frequently reported that nurses fail in explaining health promotion in nursing (e.g. Casey, 2007b; Gott & O'Brien, 1990; Latter et al., 1992; McBride, 1994; Thomson & Kohli, 1997). Usually, nurses could only "speak the language" but not understand health promotion (Irvine, 2007). The findings of this study echo the view that it was very difficult for the nurses in the hospital to further explain health promotion and the health promotion role that they expected to carry out. The role expectations held by the nurses were rather a vague image of what

they wanted from the health promotion role. More often, the nurses could only tell that their current practice did not yet match their vague image of holistic health promotion. This suggests that they were very likely to adopt a holistic image of health promotion role, based on contemporary knowledge of health promotion, without critical thinking of what it is and how it is related to their practice in the hospital.

The nurses in this study complained that the knowledge of health promotion they had been taught was very theoretical and that they actually did not know how to use it in practice. With this, they also acknowledged the value and the importance of work experience to learning health promotion. Especially clinically-based training and practice was regarded by the nurses as an important way to help them improve their knowledge and skills of health promotion, as suggested by the survey. It seems that nurses' understanding of the health promotion role is very possibly formed via nursing education. Interestingly, it never occurred to them to question the feasibility of putting into practice their expectations of the health promotion role in hospital, even though they felt it was very difficult to live up to them in the hospital. By contrast, the nurses disrespect the actual practice of it which they experienced every day and which they were familiar with. How the nurses' role expectations could be firmly modified by an ideal and never-experienced notion of the health promotion role comes with complexity within and beyond the context of nursing in hospital that is worth examining further in the nurses' accounts; the question needs to be asked what forces and factors had an impact on their expectations of the health promotion role. This will be discussed in the following section.

7.1.2 Expected role and actual practice

The study finds that there is a gap between what the nurses expected of the health promotion role and how they practised it. While their accounts refer to a single health promotion role they make a distinction between expected role and actual practice.

The discrepancy between the expected role and the actual practice may not be unusual. Goffman (1961) discussed, in a more general sense, that there could be

divergence between a general scheme (formal level) and positional interpretations (informal level) in bureaucratic settings. It is the discrepancy between these levels that provides evidence of how a role may be constrained and contradictory in a bureaucratic setting. Based on Goffman's theory, Gerhardt (1975), in an examination of semi-professional career advisors' role in bureaucratic settings, further argued that a role could be defined at different levels. She found that the semi-professional needs to be loyal to the positional orientation, while at the same time maintaining the high standards of expertise and efficiency that are part of the professional thinking. Therefore, the career advisors engaged in professional thinking and held a positional orientation towards the role. This means that they experienced both levels of role interpretations. The participants in Gerhardt's (1975) study reconciled the two levels of role representation by forming a perception of identity via rationalizing the conditions of the particular settings in coping with the discrepancy of two different role interpretations. Gerhardt (1975) observed that "...the prospects of a professional interpretation of the job are relatively weak compared with those of the more bureaucratic one" (p. 279).

However, rather than being relatively weak, the professional thinking in the nurses' understanding of the health promotion role in this study seemed to be dominant. It is argued that the nurses' understanding of the health promotion role had very possibly been influenced by the contemporary knowledge of health promotion. The study showed that the nurses were committed to what they expected of the health promotion role. Although the professional thinking was powerfully dominant in the hospital-based nurses' understanding of the health promotion role, the positional orientation of the heath promotion role never left the nurses. In fact, the nurses in the hospital experienced it in their current practice. The difficulties that the nurses suffered due to their desire to further take on the expected role possibly duplicated the hospital's constraints on the health promotion role. Although the nurses, perceptually, ignored and even disrespected their current practice, their current practice was highly relevant to the nursing role and practice in the hospital. Thus, the positional orientation is also very powerful since it is the one to actually define what the nurses could practise as health promotion in the hospital. Therefore, a finding like this suggests that both professional thinking and positional orientation of the health promotion role are powerful at defining the health promotion role in this study: one is in the form of the expected role while the other is its actual practice.

It is truly the case that nurses' professional thinking and positional orientation of the health promotion role co-exist in the nurses' minds. The nurses' role expectations and their actual experiences have never been reconciled in the nurses' accounts in this study. The data show that the nurses appeared to have kept two pathways in their minds to think of and practise health promotion differently. The nurses were strongly committed to the expected role, but they were also painfully aware of the constraints imposed by one on the other. The nurses had to constantly struggle with the conflicting images of the expected role and the actual practice. When the nurses were working routinely, they seemed to forget the expectations of the health promotion role, but when they began to think of what they should do as a nurse, the actual practice became "not good enough" for them. It seems that the nurses could be functioning well in their practice as long as they had not started to think of the health promotion role.

It is very noticeable that the nurses in this study were passionately welcoming the idea of health promotion. By health promotion the nurses meant holistic health and wellbeing. The nurses eagerly wanted patients to regain and maintain their health, and they saw health promotion was the way to achieve it. For the nurses, the health promotion role represented the "benefits for all" suggested by the interview data. Health promotion, the nurses believed, was not only beneficial to patients' health, but also saved health resources when patients took control of and regained their health. A health promotion role with these attributes was certainly very attractive to the nurses in the hospital. However, they confessed that they seldom really experienced the benefits of health promotion as they thought it should. It seems that the nurses' understanding of health promotion, in terms of how it is beneficial to patients and to themselves, is not evidence-based, especially not on their own experiences in the hospital.

Interestingly, the nurses' preference as regards health promotion is based on the comparison of health promotion and nursing. The nurses saw their current nursing practice as "basic nursing" in the interviews, by which they meant that nursing was boring and a dull job. It should be noted that when the nurses referred to basic nursing, health promotion was distinguished from current nursing practice as regards values. Health promotion was something the nurses regarded as interesting and advanced. It is for this reason that the nurses wanted to welcome and follow

professional thinking about the health promotion role and to improve and change their current nursing practice by taking the health promotion role on further.

In the study of semi-professionals in welfare bureaucracies, Gerhardt (1975) interpreted the causes of the professional and positional definitions of a role as related to the political fate of Western welfare, with its dual aims of change and order:

> As for positional interpretation, actual definitions of the job (collective images) as well as individuals' ideas about their jobs (individual images) represent distortions of varying degree of the legal scheme. Such distortions may be conceived as occurring along the lines of the two general aims of welfare bureaucracies: order and change....It is within the scope of these contradictory forces of order and change that actual positional interpretations are to be located. (p. 261)

Although the nurses in this study desired to take on the health promotion role according to their expectations of the role, they admitted that health promotion was not their priority in practice and they would conduct it only when they had some time left. In fact, the nurses needed to carry out the nursing routine according to their current position in the hospital. Although they were not conscious of the importance of positional orientation, they actually experienced it in everyday practice. The nurses experienced their own limited knowledge and skills to perform health promotion according to their expectations of the role, and complained in both the survey and the interviews that there was a lack of support and resources in the hospital working environment. Also, they emphasized that the work environment was very important in enabling them to do health promotion. In this sense, positional orientation is very powerful in shaping the actual practice of health promotion, either because of limited resources or by being busy with their nursing routine. In other words, positional orientation shapes the nurses' actual experiences of health promotion in the hospital due to the hospital routine.

One might say that the health promotion role had been doubly defined for the nurses in the hospital, by professional thinking and by positional orientation. The nurses had to meet the requirements from both sources. In other words, both professional thinking and positional orientation of the health promotion role are forces acting on the nurses, making theirs a difficult situation. The nurses were struggling between passionately taking on the health promotion role and being

tightly engaged with the daily hospital routine. However, the nurses had no doubt that their role expectations were correct, even while experiencing so many difficulties in trying to take on a health promotion role. The nurses' commitment to their role expectation was very impressive. This suggests how powerful the contemporary knowledge of health promotion is in modifying the nurses' attitudes to, beliefs in and knowledge of the health promotion role. It also suggests that the nurses in the hospital had little understanding of their own practice of health promotion. In this sense, they really did not know what the health promotion role is exactly for hospital-based nurses. Perhaps, because the nurses did not know that their role expectations were very problematic, they would never rationalize the conditions of the hospital for health promotion either. As a result, with the passion to take on the health promotion role, rather than defending themselves by referring to the facts of the hospital constraints, according to the nurses' accounts, they chose to demand more resources and more training for health promotion. Meantime, the nurses were still struggling with the clash between expected role and actual practice. These will be discussed in detail below.

7.1.3 Golden Key Syndrome

The nurses did not realise that what they already practised could actually be the health promotion role. It seems that by holding a professional view of the health promotion role, they had imposed a higher standard of the health promotion role on themselves. The metaphor "golden key" vividly illustrates that the nurses' role expectations were not only little relevant to their actual experiences in the hospital but they were also too idealized to be able to be fulfilled in practice.

Other findings are also interesting. For example, the nurses functioned well in daily practice in the hospital. However, stressful moments came when they started to think about health promotion and their role in its delivery. This suggests that if the nurses did not think about health promotion or if they did not hold an idealized view of the health promotion role, they seemed to be fine, carrying out the current practice. We may therefore conclude that the nurses' role expectations had little influence on their daily practice but that they were a source of perceptual and emotional suffering.

The findings of the study show that the nurses had to cope with the tension between these two rather divergent role interpretations: professional thinking and positional orientation. In the nurses' accounts, they justified the situation by stating that they would be "trying as much as possible". Meanwhile, they made efforts to improve their current practice by applying a "trying as much as possible" strategy. However, the strategy of "trying as much as possible" could not take them further in delivering on the health promotion role since their role expectations were just too idealized to be a possible practice in hospital. The nurses were frustrated when they considered their current practice was "not good enough". The nurses' intensive emotional reactions to being constantly unable to carry out the ideal health promotion role could be identified in the interview accounts, grouped under the theme "feeling powerless". The nurses' reactions to their experiences of health promotion in the hospital are expressed in the interview data. The term Golden Key Syndrome (GKS) is proposed to capture the nurses' stressful reactions when thinking about the ideal health promotion role as well as their initial attempts to do more than they could about health promotion in the hospital. Vividly speaking, the GKS is what the nurses had experienced when they were undertaking nursing in the hospital, a "golden key"-like role expectation regarding health promotion. The GKS represents a cluster of nurses' thoughts and reactions to the clash between their idealized role expectations and their actual experiences.

Adding health promotion to the nursing curriculum is not meant be a criticism of nurses' current practice in hospital. It would also not be fair to say that nursing in hospital is getting worse because of the introduction of the idea of health promotion. However, as observed in this study, the nurses indeed had been heavily influenced by the ideology of health promotion in contemporary culture. The nurses were truly passionate about having an idealized view of their health promotion role while they disrespected their current practice in the hospital. It is not too late to ask why the nurses had little notion of the actual health promotion role, which is supposed to be position-oriented, while they thought the idealized one was the right image of the health promotion role.

The nurses indeed saw health promotion as a professionally higher and advanced expertise than their current disease-related nursing practice in the hospital. The data suggested that if they could not be involved in health promotion, they would feel that they are lagging behind other health professionals. This is a feeling of a

lack of being privileged, it seems. The nurses felt that not being trained properly for health promotion, and the working conditions in the hospital not being supportive of their passion for health promotion, they could not carry out the health promotion role as they expected. The nurses thought that they were not cared about by the hospital as there was little chance of being trained for health promotion. The nurses responded to the health promotion role, but they also expressed their concerns about current nursing practice as well as being a nurse in hospital. Perhaps they already considered their nursing practice in hospital to be at the bottom of the hierarchy of the nursing profession when they discussed nursing in hospital as "basic nursing".

If the nurses did not appreciate their current practice, the quality of nursing and its development would be suffering in the long run or maybe was already suffering. The data show the nurses' lack of confidence in prompting patients to focus on regaining and maintaining their health. This possibly results in poor staff morale and low interest in current work, leading to poor performance in hospital. Thomson and Kohli's (1997) study found that nurses who could practise health promotion had more confidence and higher morale. The current study also finds a relation between nurses' confidence and their practice of health promotion. This study reported that nurses' actual knowledge and skill were relatively adequate to current health promotion practice. However, the current study also found that when the nurses considered taking on further duties associated with what they expected of the health promotion role, the felt a lack of confidence, knowledge and skill to do so. This implies that the nurses' lack of confidence is a response to the idealized role expectation rather than to their current practice. The interview data show that because of the idealized health promotion role, nurses were not satisfied with their job, and expressed a willingness to quit being a nurse in hospital. As suggested by this study, it is very possibly the case that the way in which health promotion has been introduced politically and/or professionally could have had a negative impact on the nurses' sense of fulfilment and commitment to their current nursing practice in hospital.

The GKS proposed depicts a problem related to the idealized health promotion role, something that has frequently happened to nurses in hospital. It particularly refers to an idealized role expectation which can not match actual experiences. The analysis of the nurses' accounts suggests that it is not necessary to keep nurses

experiencing a dual role interpretation, one being merely perceptual and the other one truly functional but unknown to nurses. It is time to drop the "golden key" as a fancy idea of health promotion and the health promotion role which has been shown to damage the nurses' welfare and causing them emotional stress in hospital. A heavy cost was identified when the nurses could not recognize their actual health promotion role in hospital. At a time when nursing has a critical need for quality and efficiency in hospital care, as well as stable staff support and a recognition of the importance of hospital nursing care, it has become urgent to define a health promotion role for all nursing positions in hospital.

Thus, it is suggested that the solution to the nurses' GKS dilemma in nursing rests with rethinking the topic of health promotion in nursing or the health promotion role for nurses, and starting to initiate a realistic attitude to understanding how nursing and health promotion are connected. This would require a careful analysis of their current practice, revalue disease prevention, and even rethink the importance of hospital nursing for the nursing profession and the health service. Rather than posing a role-person misfit for the nurses in hospital, it would be better to establish a connection between health promotion and nursing in hospital if the nurses can not do so themselves. An understanding of how health promotion is carried out in hospital is very necessary and helpful for nurses. The following discussions will be looking at this issue based on the data collected in this study.

7.2 Health promotion and nursing

There were different views identified by the current study of how much health promotion is relevant to nursing in hospital. In the nurses' view, the relation between health promotion and nursing could be best presented by their own wording in the interviews: "it [health promotion] should be a part of the nursing role". The health promotion role, as the nurses saw it, had not yet been made integral to the nursing role. This confirms that health promotion and nursing still remain as different entities in the nurses' minds, as discussed above. However, further analysis of the nurses' accounts did not always support the nurses' understanding of the health promotion role, but instead suggested a very different picture of the health promotion role in current practice. There were three different patterns of health promotion practice identified in the data: disease information,

lifestyle advice, and a health education programme. These three patterns suggest that the health promotion role had already been shaped within the nursing role to various degrees, whether the nurses were conscious of it or not.

It is also important to state that the health promotion role is by no means equal to the nursing role although both were sometimes called "role" in the nurses' accounts. This could simply be evidence of the fact that the nurses in this study seldom saw themselves either as health educators or as health promoters. For the nurses, they were always being a nurse in the hospital and a nurse who practised health promotion as part of her nursing practice. This means that the nursing role has more meanings for the nurses than the health promotion role, including being a profession and an identify, a position and/or having status. Similarly, the health promotion role is more likely to be a characteristic type of task or practice within nursing or the nursing role. The role-set proposed by Merton (1957) as an analytic device in role analysis (see Chapter Three) is probably helpful to imagining the relation between the health promotion role and the nursing role. Clearly, the health promotion role is a part of the arena of the nursing role-set. In other words, the health promotion role is one of the roles associated with the nursing position or status. This section will further discuss how the patterns of health promotion practice have been presented in the nursing role-set in hospital.

7.2.1 Health promotion as extra task

The nurses in the current study reported that health promotion had just been casually practised rather than properly planned in the hospital. They clearly explained in the interviews that health promotion was not a priority of their work since they were busy with the daily routine and it was this which was regarded as nursing in the hospital. This means that the nurses were usually busy with nursing practice and could only practise health promotion when they had some time left. The lack of time for health promotion was complained by the nurses in both the survey and the interviews. Health promotion was rather a formal practice but as an extra task imposed on the nursing routine in hospital. This study suggests that health promotion is really treated differently by nurses in hospital.

The nurses' accounts of the health promotion practice in the hospital have great similarities with findings from previous studies. In the literature, nurses' health promotion practice is frequently reported to be spontaneously and opportunistically conducted rather than organized as nursing routine (e.g. Casey, 2007a, 2007b; Twinn & Lee, 1997). Casey (2007b) describes nurses' health promotion practice as "sporadic activity" in hospital because of its being optional "added on" nursing practice (p. 1044). Casey (2007b) explains that nurses need to be busy getting tasks done as quickly as possible in hospital while health promotion consumes more time. Being busy with nursing practice and lacking time for health promotion are frequently reported in previous studies to be associated factors that hinder health promotion practice in hospital (e.g. Berland et al., 1995; McBride, 1994; Thomson & Kohli, 1997; Twinn & Lee, 1997).

It seems that the nurses in the current study and the studies listed above report a similar story of health promotion in hospital. However, the current study notes that health promotion is hardly one unified concept. Instead, health promotion was further identified as three patterns in a further analysis of the nurses' accounts, as discussed above. By health promotion, the nurses usually meant lifestyle advice and the health education programme. Interestingly, the disease information pattern, which happened to be main health promotion practice by the nurses in the hospital, had not been considered as health promotion but nursing practice. This means that the nurses in this study had not recognized all the health promotion practices in the hospital. It seems that disease information had been so integral to the nursing routine that the nurses had not even recognized it as health promotion. It also suggests that health promotion was not always an "extra" task in the hospital. The nurses might only pick up what they considered as health promotion but ignored other important activities. Thus, the current study suggests that health promotion, as reported by the nurses, could not represent the actual health promotion practice in the hospital. This is to say that talking about health promotion without further defining it could be problematic, possibly challenging the findings from previous studies, such as whether health promotion has been carefully defined.

Health promotion in the nurses' understanding was "the extra", which may have had its reasons. It seems that both lifestyle advice and the health education programme were difficult to practise for the majority of the nurses in the hospital. In the current study, the health education programme was a special case in the

hospital since only specialist nurses and the nurses on some wards could conduct it. Importantly, the health education programme usually involved other organizations beyond the hospital. Therefore, the nurses would be better prepared for and supported in health promotion. One could say that the health education programme was an advanced health promotion project in hospital. Without special support, it would have been hardly possible for the nurses to initiate a rather complex programme such as this. However, the health education programme was very limited in application perhaps because it is very expensive to maintain; it was usually focused on particular patients. The case of the health education programme does provide a good example of how much or under what conditions nurses in hospital could contribute to health promotion. It suggests that adding a health education programme means having to give it structural support.

More often, health promotion referred by the nurses is the lifestyle advice in this study. This is what the majority of the nurses in the hospital could practise in an opportunistic and casual way. The lifestyle advice was featured as "simple talk" by the nurses in this study aiming to inform patients about their risk factors of healthy lifestyle. The nurses explained that their health promotion practice was the "wake-up call" to patients only. Usually, the nurses would not go further to model patients' lifestyle behaviours or encouraged patients' participation suggested by this study. As discussed in the interview analysis chapter, lifestyle advice could be considered very simplified health education since it follows the notion of a behavioural/lifestyle approach but actually adopted a medical approach in practice. As discussed in the analysis of the interviews, both disease information and lifestyle advice could be considered as informing patients, one on disease and the other on lifestyle-related topics. The informing seems to be the feature of the medical approach of the nurses in the hospital. It seems that the nurses in the hospital tried to reach a proper behavioural/lifestyle approach but ultimately they could not reach that level. The medical approach was what the nurses were familiar with in current nursing practice.

Piper (2007) also identifies nurses as "informer" of health promotion in hospitals. He depicts the salient feature of nurses' health promotion practice in hospitals as being a patient consultant to deliver information on the topic of health. However, Piper (2007) further categorises the informing into two categories, i.e., "behaviour change" and "empowerment", identified as "top-down" model for the former and

"bottom-up" model for the latter. He finds that nurses in hospital usually practice the "top-down" or "expert directed" model rather than empowering patients. Casey's (2007a) study echoes the view that patient empowerment or participation is rare in nursing practice in hospital. Both Casey (2007a) and Piper (2007) noted that a change to an empowerment "bottom-up" model would require resources as well as a modification of relations between patient and nurse. This hints at the importance of structural support or changes to adapt a more sophisticated health promotion practice beyond the current nursing approach.

In investigating how the career advisors performed their role, Gerhardt (1975) found that, in a bureaucratic structure, the work content tends to be narrowed to an office location and a personal consultancy. If the task needs to go beyond the office, it would either not be conducted or ignored by career advisors. She argues that this is because of the shortcomings of the position, such as manpower shortage and lack of time. Gerhardt further argued that the size and composition of the role-set depend on the power structure and size of the agency to which the position belongs (Gerhardt, 1975; Khan et al., 1964; Merton, 1957). Gerhardt (1975) explains that role occupants have "difficulties in choosing an occupation or finding an open apprentice position" (p. 278) to go beyond their practice.

Gerhardt's (1975) analysis provides a good way to understanding what the nurses could do for health promotion in the hospital. It seems that the nurses' health promotion practice was highly relevant to their current nursing position or role-set. The analysis of the survey conducted as part of the current study, which focused on the frequency of health promotion activities, found that the scope of the nurses' practice was limited to disease prevention and the individual patients in the hospital. There were very limited chances for the nurses to emphasize the patients' families. Even more rarely did the nurses in this hospital participate in community affairs. The interview data confirm that disease information for patients was the main practice that the nurses could contribute to health promotion in the hospital. They could not go further to institute a sophisticated health education programme in the current hospital environment unless adequate support was available for their nursing positions.

Similarly, lifestyle advice was opportunistic and showed a lack of consistency in practice so that it is difficult to see it as a stable service by the nurses in hospital.

Based on the data in the current study, lifestyle advice was not a priority or a must-do nursing routine. The question is raised as to whether lifestyle advice was within the scope of responsibility of nurses. It is noted that lifestyle advice is an attempt by nurses to do health promotion under the limiting conditions of hospitals, which the nurses interpreted as "trying as much as possible" for health promotion. In this sense, lifestyle advice is nurse-initiated practice, an extra task rather than a positional task. There would also be moments when patients asked for lifestyle advice, having then a sense of problem solving or dealing practically with the everyday life of nursing. Problem solving is not unusual in nurses' work; it could be said that it is positionally related. However, the real problem is the boundary of responsibility for lifestyle advice. The nurses giving lifestyle advice would encourage patients' self-care and let patients take responsibility for their own health. As discussed above, the nurses were aware that they were just delivering information to raise patients' awareness of lifestyle-related health issues for patients; seldom did they check on its effectiveness, to see whether it had led to behavioural changes in patients. However, the nurses could not afford to let patients take full responsibility for disease prevention in the hospital – lifestyle advice and disease information are truly different patterns in the nursing role.

Briefly, health promotion as the nurses saw it is indeed the extra task for the nurses, since it is difficult for the majority of nurses in the hospital. The scope of the nurses' health promotion practice is defined by their current nursing position or role-set in the hospital. By contrast, the nurses had not recognised the part that was "invisible" to them as they had not regarded it as health promotion. This is a dilemma because if health promotion is "invisible" to nurses then they can do it well as part of their current practice; however, if they can identify it as health promotion, then it is usually difficult for them to conduct it, either as extra support for patients or as a personal endeavour. Therefore, it is necessary to look at the problem of the "integration" of health promotion in nursing practice, which is done in the next section.

7.2.2 Problem of integration

The integration of health promotion with nursing is frequently discussed in the literature. However, the results from previous studies are not consistent. It is very

noticeable that the date of the study is important. The earlier studies reported that health promotion or the health promotion role was an integral part of the nursing role (e.g. Berland et al., 1995; McBride, 1994), while recent studies concluded it was not (e.g. Piper, 2007). A tendency to "becoming integral to nursing" could be found in the middle of this ten year period (e.g. Thomson & Kohli, 1997). Casey's (2007a, 2007b) studies also produced conflicting findings in that some health promotion is found to be invisible in nursing yet they still conclude that health promotion was not integral to nursing. According to the literature review, health promotion seems to have become less and less integral to nursing in hospital.

It is worth noting that the "invisibility" of health promotion in nursing practice is used as a sign of the integration of health promotion with nursing in previous studies. By the criterion of invisibility, health promotion and nursing ought to be completely merged in practice. This means that health promotion might not be allowed to keep its identity once integrated with the nursing role. This might be understandable because the concepts or the conceptualization of health promotion has developed enormously in recent decades. In the early studies, health education is dominant in understanding nursing practice, which suggests that health education is closely connected to nursing. It is very likely that when the meaning of health promotion expanded, the health promotion role became more complex. The current study suggests that it is very difficult to use one criterion to understand the integration of health promotion and nursing. Apparently, the disease information pattern is "invisible" to the nurses in this study, while lifestyle advice and the health education programme are visible to them. The current study suggests that judged by the three patterns found, the integration of health promotion and nursing could be diverse and dynamic.

Smith et al. (1999) investigated the interpretation and implementation of a philosophy of health in nursing among teachers, students and nurses in the UK, finding that there might be different values informing disease prevention, care and health promotion. Interestingly, the nurses in their study were moving from one area to the other without awareness of their movement.

> As our paper demonstrates, that set of values is not agreed. Disease fighting makes obvious sense. Health promotion makes sense as an intervention on 'lifestyles.' Emotional support for people in pain and fear makes most sense under a philosophy of care. (p. 237)

The authors criticized British nurse education and practice for failing to achieve "blissful clarity", resulting in the absence of a "value-consensus", and instead in discord and an anxious "would-be profession" (p. 237).

The nurses in the current study had not formed a clear view of what health promotion role is either. In fact, the nurses were not aware that there were these patterns of health promotion practice in the hospital. The interview accounts show that health promotion practice in the nurses' eyes was fragmented: "informing, advising, educating...". This means that the nurses themselves were indeed not able to recognize the patterns of health promotion practice. In this sense, the current study confirms Smith et al.'s (1999) findings that the nurses probably unconsciously moved from one practice to the other without understanding their conduct of health promotion.

The requirement of a "value-consensus" could be problematic; it might simply be part of the authors' obsession with nursing and health promotion as a unified concept. The overarching conception of health promotion seems to cover the diversity of health promotion as well as its relation with nursing. The health promotion role with its three patterns, based on the analysis in the current study, is a very dynamic and integral part of the nursing role. Such integration could never be simple and clean-cut. This is different from Berland et al.'s (1995) view in which health promotion is an independent, attractive, essential and integral part of nursing. The current study suggests that health promotion is multi-dimensional and dynamic, interacting with other parts of the nursing role. Not only does health promotion have many different values, with different approaches to it, but its integration with nursing may permeate many parts of the nursing role-set.

However, this study shows that, rather than being marked by discord as described in Smith et al.'s (1999) study, health promotion was actually organized into three patterns which involved different thinking and approaches. Although the nurses had not fully recognized and understood health promotion practices, the three patterns were the result of health promotion's organization within certain structures of nursing in the hospital.

There is a relation between health promotion and nursing in hospital. The nurses might not be clear about what and how health promotion and nursing had been related with each other; however, this does not mean that health promotion

practice itself has little order. Considering the patterns of health promotion, health promotion could be argued to be integral to nursing in many different ways in hospital. Thus, the current study argues that the problem of the integration of health promotion and nursing is very possibly a problem of how to understand health promotion practice rather than a nurses' problem with the practice itself. In other words, it is the perceptual and conceptual problem rather than one of the relation between health promotion and nursing. This implies that there is still a lack of adequate knowledge of health promotion as well as of nursing practice.

The study suggests that the three patterns represent what the nurses had practised in the hospital. In other words, the existing three patterns in the nurses' accounts are highly relevant to the actual health promotion role in the hospital. The three patterns are what the nurses had experienced in reality. Therefore, when the patterns of health promotion are formed, health promotion is already associated with nursing in some ways. In one sense, health promotion, when it is relevant to nursing, is already a part of the nursing role and the question of the integration of health promotion and nursing becomes meaningless. Further, the requirement of either "invisibility" or "value-consensus" of health promotion in nursing is actually a question of how the patterns of health promotion practice have been formed in the nursing role and what is the significance of the patterns in the health promotion role. It is noted that possibly not all of the nurses had a similar role in health promotion. The study shows that the nurses in the hospital could contribute to health promotion differently, from disease information to the health education programme. This will be discussed in the next section.

7.2.3 Structural analysis of health promotion role

The patterns of health promotion practice in nursing practice have so far not been discussed in the literature. However, the finding of this study shares a certain similarity with Laverack's (2004) observations about health promotion. According to Laverack's analysis, health promotion could be categorized into three different approaches in practice: medical approach, behavioural/lifestyle approach and socio-environmental approach. Laverack (2004) argues that health promotion itself is multiply approached in practice, and these approaches have very different discourses. He further explains that the health promotion approach is "relevant to

shaping the way in which we design, implement and evaluate programmes" (p. 20). Significantly, Laverack (2004) identified the relations among health promotion approaches. He utilizes the Russian doll as a tool to explain the fractal relations between the health promotion approaches, arguing that each has its different ways of thinking and different approaches, but importantly they overlap each other. The medical approach is on the inside, i.e. the smallest doll, and the socio-environmental approach is on the outside, i.e. the smallest doll, with the behavioural/lifestyle approach situated between them (Laverack, 2004). An important notion of "space" is posited by Laverack (2004), which varies across the health promotion approaches.

> Russian doll one inside the other, than wholly separate ways of thinking...The socio-environmental approach incorporates both the behavioural and the medical in the largest doll, whose new 'space' is clustered with all of the social, economic and political structures that shape not only individual lifestyles but also people's risks of disease or opportunities for wellbeing. (p. 23)

Although Laverack does not further specify the notion of "space" in health promotion approaches, it is important to recognize the relation between health promotion approaches and the structures of nursing role in the hospital.

The three patterns of health promotion practice identified in this study are to some extent consistent with Laverack's health promotion approaches (see Chapter Six). This suggests that the health promotion practice in the nursing context has the essentials of health promotion embedded within it. However, it is also important to note that the patterns of health promotion practice identified in this study are different from Laverack's health promotion approaches. The three patterns identified in the current study emerged from the nurses' accounts in this study. This is to say that the patterns of health promotion practice formed in the nursing context represent not only the discourses in nursing but also have the information about how nurses practised health promotion embedded within them. The study suggests that the patterns of health promotion practice have information about the structures of nursing in hospital embedded in them rather than information about health promotion in general. In other words, the patterns of health promotion practices in this study are the result of how health promotion or health approaches have been adapted in the nursing practice in hospital.

In this study, each of three patterns has its own discourse and strategy in practice, carved out from different circumscribed structures of nursing in the hospital, as discussed above. The data show that (1) disease information follows the medical approach, which is what the majority of nursing staff do in their daily routines; (2) the health education programme represents the behavioural/lifestyle approach, which comes with additional hospital and/or organizational support; and (3) lifestyle advice, which has features of both approaches, is what the nurses in the hospital would try hard to do as part of health promotion if there were more support from the hospital. The staff nurses in the hospital generally take the medical approach, and this is disease prevention which is a traditional health education approach by nurses in hospital. Obviously, cardiology nurses and specialist nurses have many discourses and approaches in practice, and presumably their role-sets are very different from those of staff nurses. Lastly, the socio-environmental approach has not been identified in the nurses' accounts in this study, which may suggest that it is very difficult for nurses in hospital to "go outside" simply because they have little in the way of social, economic and political structures for that health promotion approach.

Staff nurses' role-set is more focused on their current nursing routine. It is difficult for staff nurses to exceed its capacity regarding health promotion, simply because of the limitations of scope and opportunity as discussed above. Similarly, the role-set of cardiology and specialist nurses, with plenty of space to expand their health promotion role, contains different levels of practice, communicating at many levels of work and with many role-partners. This is indeed so in the case of cardiology nurses; for instance, the health education programme is created and distributed by a third organization rather than the hospital itself. The cardiology nurses must have a way of thinking about the programme while busy with other nursing tasks. It is evident that cardiology nurses have to constantly manage relations with particular patients who are the targeted population for the programmes. Specialist nurses' strategies and approaches appeared to be more sophisticated in dealing with the different work contexts in hospitals and beyond. Also, their nursing position is not focused on "basic nursing" any more, which is to say that specialist nurses could bring about a wider scope of practice, and with more partners within and even beyond the hospital. Specialist nurses' role as well as role expectations are multiply defined for their position, possibly due to recognition of being highly educated and having opportunities for improving their

professional expertise. These are important for reaching higher levels of health promotion in practice. Therefore, the features of their nursing position and role-set, which is where the strategies and discourses are based, determine the levels of the nurses' contribution to health promotion.

Based on this analysis, a concept of "levels of health promotion practice" is proposed for recognizing that there are different types of nurses working on health promotion in hospital: staff nurses, cardiology nurses and specialist nurses. In general, staff nurses can only do disease information and a little lifestyle advice, which means that they have a relatively low level of health promotion practice. Conversely, cardiology and specialist nurses' practice could involve the more sophisticated health education programme besides disease information and lifestyle advice, so that they would have a higher level of health promotion practice.

The concept of "levels of health promotion practice" is consistent with the notion of "space" in the Russian doll model by Laverack (2004). In hospitals, cardiology and specialist nurses may have the space to reach higher levels of health promotion, while staff nurses' health promotion role is at a relatively low level in the delivery of health promotion, thus occupying the smallest space. The implication of "space" is that cardiology and specialist nurses can apply many different ways of thinking and approaches. In other words, their health promotion role comprises thinking about both health promotion and nursing. On the other hand, staff nurses' thinking is largely constrained to one main pattern, disease information, and a little lifestyle advice, so that it is more focused on nursing than both nursing and health promotion.

The identification of "levels of health promotion practice" as well as different types of nurses working on health promotion is significant for understanding the health promotion role in hospital, which involves many different ways of thinking and approaches, as well as levels of health promotion practice. This further demonstrates that the unified conception of the health promotion role is very problematic for understanding nurses' health promotion role in hospital. With a unified conception of the health promotion role, the nurses did not know that they were able to play just a part of it. Especially staff nurses had a low level of health promotion practice in hospital. Although they had other functions of nursing in

hospital, the nurses thought their health promotion practice was not adequate for being a nurse in hospital. The study provides evidence that the hospital nurses seemed to have an illusive understanding that their role in health promotion should be the same or similar, no matter what their positions, wards or specialization. When the staff nurses saw that the specialists could do more health promotion, they felt threatened by them since the specialists are at a higher level; however, the specialists did not feel threatened by the staff nurses' health promotion activities. The nurses complained of pressure that the specialists might grasp their chances of having a role in health promotion while they did not have one. The nurses easily understood that they had a very different job from the specialists but they seemed not to be not tolerant of the specialists doing health promotion. The problem is that the nurses did not understand that there are different levels of health promotion practice due to the division of work in the hospital. This implies that staff nurses did not see the specialists as cooperating partners but as competitors in terms of health promotion.

In the literature nurses have been accused of only understanding and conducting health education, rather than contemporary health promotion (e.g. Piper, 2007) and/or encouraged to move radically to health promotion (e.g. Whitehead, 2004). According to the current study, the social/political aspects of health promotion are impossible for nurses to gain access to at any level: knowledge, information, practice or resources. Usually, nurses in hospital, due to the location and structure of their work, were able to contribute to three patterns or levels of health promotion practice, while health promotion practice in the wider sense, for instance, taking the socio-environmental approach, is probably very difficult for them. This suggests that the hospital as an organization has its arena and scope in terms of discourses and approaches. The socio-environmental approach, embracing policy, media and campaign in terms of health promotion, has too broad a structure, exceeding nurses' capacity. This could be the top level of health promotion practice. It may be too broad to be contributed to by hospital-based nurses alone but in practice, it could be contributed to by different types of nurses as well as other health professionals in hospitals. Health promotion indeed needs multiple levels of discipline and cooperation to mobilize it. This suggests that nurses' health promotion role should be defined specifically by their positions in hospital.

7.3 Duality of health promotion role

In this study, the health promotion role seems not to be clearly defined. The analysis shows that there are two accounts related to the health promotion role, the expected role and the actual practice, which the nurses themselves could not reconcile. The striking finding of this study is that theses two accounts are not connected in the nurses' experiences of health promotion. One could say that the health promotion role refers to two different entities in this study: the expected health promotion role and the actual one. It is in this sense that a duality of the health promotion role could be recognized in the hospital-based nurses' accounts of their experiences of health promotion. The concept of the duality of health promotion role is related to what the health promotion role means to nurses in hospital and under what conditions the nurses experienced the dualism of health promotion role. Finally, it needs to be asked what is the significance of identifying the duality of the health promotion role in nurses' experiences of health promotion. Theses questions are the concern of the last section of the chapter.

7.3.1 Ideal vs. reality

Gerhardt (1980) made significant contributions to interpreting the dualism of role. Role as a phenomenon could have an abstract image as well as actual ones from particular contexts, according to Gerhardt (1980). She further theorizes that:

> In organizational contexts, roles are divergent behaviour patterns and, at the same time, unified formal images....In spite of the measured diversity, the unity of the role was maintained by a perception of identity between formal and actual levels. (p. 564)

In this study, both the ideal and the actual health promotion role have been identified in the nurses' accounts. Significantly, the nurses' view of the ideal health promotion role was expressed in their role expectation but ignored the actual health promotion role, which is actually the role to be practised in hospital. It is argued in this study that the nurses' perception of the professional view of the health promotion role overrode the positional view. That is to say, the nurses were heavily influenced by external forces, namely, professional and political contexts, rather than the current nursing context in the hospital in terms of the health promotion

role. As a result, the nurses in the hospital did not form "a perception of identity" between ideal role expectation and actual practice. On the contrary, the nurses in the hospital regarded the actual practice as "not good enough" to be the health promotion role. However, this study shows that the existence of the actual practice never relied on the nurses' role expectations. The actual practice had never faded away in spite of the nurses' neglect of it. In fact, it is the reality that the nurses experienced in everyday practice in the hospital. This becomes a perplexing situation in that the nurses' role expectations had little connection with their actual experiences. This study shows that the nurses constantly struggled with clashes in their mind-set: the ideal health promotion role versus the actual practice.

Surprisingly, the study finds the nurses' commitment to the ideal health promotion role even after they had experienced many difficulties in the hospital with the idea. One might ask that what good the ideal health promotion role did for the nurses in the hospital if it was not relevant to their actual experiences at all. The nurses in this study provided an account of how health promotion would be beneficial for patients' gaining holistic health and wellbeing. In the interviews, the nurses rather selflessly appeared more worried about patients' health and welfare rather than about how much they could contribute to health promotion and how their life would be impacted by choosing to passionately pursue holistic health and wellbeing. It seems there is a misconception of health promotion and health promotion role for nurses. The promotion of holistic health and wellbeing seems to have become a unified image of health promotion role for nurses in hospital. Holistic health and wellbeing may be the ultimate goal of health promotion as well as nurses' health promotion role. However, once needs to consider the capacity of nurses in hospital to promote health, and this study demonstrates that the nursing positions are important for defining nurses' health promotion role. Particularly for hospital-based nurses whose work is dominated by disease treatment and care, the goal of holistic health and wellbeing could be very unrealistic. Actually, the nurses in this study did notice that there was a lack of support and resources for health promotion. However, the nurses' values, beliefs and knowledge of health promotion were too strongly modified by this ultimate image of health promotion for them to develop a sense of being one of the contributors to health promotion rather than taking on the whole responsibility of health promotion for patients.

This study provides evidence for the contention that only introducing the idea of health promotion without further defining it is unlikely to establish the connection between the idea of health promotion and the nursing practice in hospital. In other words, health promotion has become either very theoretical or even rhetorical for nurses in hospital – the ideology of health promotion is truly a "golden key" that nurses desire in their minds but which is unattainable in reality. The problem is that health promotion becomes a rallying call for nurses in the hospital, since they passionately speak its language without understanding and implementing it, and this is likely to bring real harm to nurses and the quality of nursing in hospital. This suggests that the general and ideological image of the health promotion role is of little use when nurses can not understand and implement it in practice suggested. Nevertheless, the study recognizes that the ideology of health promotion is a powerful influence on nurses' perception of health promotion role in hospital, i.e. it diverts nurses from focusing on their current practice in hospital. The power dimension of the ideology of health promotion will be specifically discussed below.

While the abstract or ideal image of role is usually distorted (Gerhardt), the discrepancy between the ideal and the actual levels of the health promotion role remain since this is the nature of the health promotion role itself. This is to say that the health promotion role itself has a dualism in nature. This dualism of role represents the cultural and material spheres of role (Calleo, 1994). Gerhardt (1980) explains that it is "a dialectical relationship between material production and cultural life includes the assumption that the two spheres are relatively independent from each other" (p. 567). It is between these spheres that Gerhardt (1980) posits levels of positional interpretations. Gerhardt's notion is coherent with the concept of "levels of health promotion practice" in hospital in this study which argues that interpretations of the health promotion role could vary between idealized and actual practice. It is significant to acknowledge that there are many types of nurses in hospital doing health promotion at different levels, rather than imposing a health promotion role on staff nurses alone. However, this study show that the nurses hardly noticed the dualism of the health promotion role, and perhaps it is indeed difficult for them to comprehensively understand how this works. The nurses were very much engaged with what they had been taught about health promotion. The findings of this study further confirm that the idealized and actual levels of the health promotion role were two independent entities in the nurses'

mind-set and that they were not able to reconcile them. Therefore, this study argues that it is not reasonable to overemphasize political and professional thinking about health promotion without taking notice of how the nurses do health promotion.

Based on the above analysis, the study emphasizes the importance for nurses in hospital to value their own actual experiences. This is to recognize the actual health promotion role in hospital which allowed nurses to rationalize their practice within a particular nursing context in hospital. As long as ideal image and real experience are reconciled, nurses in hospital will be content to recognize their levels of health promotion practice as a way of contributing to health promotion. The findings of the study remind us that current health promotion policy and the nursing profession have failed to acknowledge the dualism of the health promotion role, and the discrepancy experienced by nurses in hospital due to inappropriately merely delivering the ideology of health promotion with little effort made to address the particular approaches of health promotion to its practitioners.

7.3.2 Issue of power

It is argued that the nurses' role expectations of health promotion were fuelled by the ideology of health promotion rather than the interests of their own position in the hospital. Particularly, nurses are required to empower patients to take control of their own health. Empowerment is the core value of health promotion as well as one of models of or approaches to health promotion (Tones & Green, 2004). In the literature, the main interest is the evaluation of nurses' approaches to empowering patients in health promotion (see Chapter Two). However, nurses in this study were "feeling powerless" when conducting health promotion. The current study thus asks how, and how much, the nurses "feeling powerless" might be able to empower patients to take control of their health.

That the nurses in this study were "feeling powerless" when they did health promotion has similarities in Fulton's (1997) study of how nurses understand the concept of empowerment. Fulton (1997) made an interesting finding, namely that nurses were disempowered when facing up to the concept of empowerment. She concluded that nurses were asked to empower others but they actually were a oppressed group striving for liberation. The nurses in her study were constantly

describing "a dialectical situation, simply the existence and action of opposing social forces, but they were not aware of it as such, which was thus disempowering" (p. 534). However, she did not provide any further detail of the "opposing social forces" and how they impact on nurses in terms of empowerment. She found that the nurses seemed to be in "impossible situations" without the insight that something might be done about it (p. 534). The nurses in Fulton's (1997) study felt uncomfortable with the situation but knew they were lacking something and wanted to do something about it; above all, they wanted to get their voices heard.

Echoing Fulton's "impossible situations", the nurses in this study also faced a perplexing situation with the health promotion role. The nurses in the hospital were very stressed when they considered the ideal image of the health promotion role. The detailed emotional and behavioural reactions that the nurses suffered are a kind of Golden Key Syndrome, as discussed above. The nurses were actually aware that there was little they could do to improve both health promotion practice and the environment of the hospital. Even if the nurses were willingly "trying as much as possible" to do health promotion, the staff nurses could only do lifestyle advice casually and opportunistically alongside their current nursing routine according to the data in this study. In this context, the nurses "feeling powerless" seems to be reasonable since they were looking for something beyond what they could understand and do.

Gerhardt (1975) argues that it is the political fate of welfare in Western capitalist societies that policy always targets the powerless groups in societies.

> Vocational guidance is concerned with groups of relatively low status people. Clients have little bargaining power, and they often come from poor families and have comparatively little education. Vocational guidance works with powerless clients in a political climate where enhancing these clients' rights interferes with the interests of more powerful groups in the community. (p. 280)

Gerhardt (1975) draws a political context from the career advisors' story. So does this study in that, being affected by professional thinking, the nurses in the hospital had been influenced by the political cultural atmosphere of health promotion. Health promotion was believed by the nurses to deliver "benefits for all". The nurses were truly passionate about helping patients regain their health as well as

contributing to saving health recourses, yet they had very limited power over what they could do and what they could aspire to in terms of health promotion. This finding seems to contradict nurses' understanding of their being "in a good position" to carry out health promotion. In fact, the nurses in the hospital were more involved in disease prevention than any high level health promotion practice. The nurses could only think about how they were closely working with patients and being there for patients. However, health promotion itself has a much wider sense than they knew.

The study shows that the notion of empowerment seemed only to be found in the health education programme, whereas disease information and lifestyle advice practice by the nurses in the hospital scarcely involved the concept of empowerment. Empowerment seems to belong to the higher levels of health promotion practice. The medical approach has little notion of empowerment by which the nurses delivered information for disease prevention or lifestyle advice in the hospital. It seems to be very difficult for the nurses to empower patients when modelling lifestyle behaviours and taking control of health. As discussed above, the nurses only could practise health promotion within the scope of their current nursing position or the role-set in the hospital. The data show that the nurses' health promotion activities were usually narrowly located on the wards. It is noted that the three patterns disease information, lifestyle advice and health education programme are all individualistic approaches to health promotion. The hospital-based nurses barely promoted health in a social-political holistic approach due to insufficient resources and support. The nurses in this study could deliver information and give advice to patients, but they could not touch further areas, such as managing healthy food supplies to patients outside of hospital. The nurses could possibly address the economical, social and political factors of health but they did not have the position and power to affect those factors. It is simply not what nurses in hospital could do, not only because of lack of time, but also because of their limited position and power. However, patients with whom nurses work in hospital really need help in many aspects; they may also be limited in the power to control their own health. How could nurses and patients in hospital, both powerless, aspire to a socially, politically and economically dimensioned holistic approach to health promotion?

Even within the individualised health promotion approach, it is very difficult for the staff nurses in the hospital to apply more than one type of thinking and approach to health promotion from their current position, when there were no structural resources and support available. Especially the staff nurses' thinking and approach in the hospital was more focused on a medical approach to disease prevention and a simplified version of the behavioural/lifestyle approach. In other words, the scope and content of the nurses' work is highly constraining of what nurses can think and what they can achieve regarding health promotion in hospital. The study suggests that the majority of nurses in hospital are actually very limited in their power regarding thinking about and practising health promotion beyond what they can in current practice.

Briefly, the study suggests that for nurses in hospital the ideology of health promotion makes it impossible to fulfil the task. The nurses would indeed be in the "impossible situations" discussed by Fulton (1997). The current study further describes how the ideology of health promotion would lead to the Golden Key Syndrome, includes nurses feeling powerless, disrespecting their work and lacking in confidence regards current practice. This is what nurses are suffering in hospital because of the ideology of health promotion. Nurses might also be sensitive about the issue of power, expecting a change in their current role and practice to result in greater prestige.

7.3.3 Role change?

The study finds that introducing the ideology of health promotion to the nurses in the hospital might not be useful if it is meant to change their current health promotion role. As discussed above, the nursing position or role-set has great influence in shaping the actual health promotion role in hospital. Rather than following the nurses' understanding of health promotion as an extra task, health promotion is actually integrated into nursing with different patterns. This is the actual health promotion role that could be identified from the nurses' accounts in this study. It is argued that there are different levels of health promotion practice as well as different types of nurses in hospital doing health promotion. Each level of health promotion practice seems to be closely responding to its structure in hospital. This finding suggests that nurses' health promotion practice has hardly improved

or changed as a result of stressing the ideology of health promotion without consulting the structural factors. It is in this sense that the modification of nurses' role expectations could not be expected to lead to improvements of the health promotion role in practice although the nurses in this study were passionate about it.

Findings like this seem to emphasize the dominance of structures in interpreting the relation between health promotion and nursing. The study values the actual health promotion role in its attempt to discover exactly what is the health promotion role of nurses in hospital. The study finds that the patterns of health promotion practice have been formed without the nurses' awareness. The nurses more or less automatically followed one of the patterns when it fitted equivalent circumstances. Even lifestyle advice appeared to be conducted opportunistically and casually despite finding its own place in practice with its patterned thinking and approach in the hospital. This reminds us that we should not ignore the process of shaping and forming of the health promotion role historically and philosophically. Perhaps health promotion and the health promotion role have been overemphasized in their political and cultural contexts in the literature. The current study finds a need to address the importance of the structures of nursing in hospital when interpreting the actual health promotion role in hospital.

The current study finds that the different types of nursing positions respond to health promotion differently in hospital. The staff nurses in hospital might not aspire to higher levels of health promotion practice but their work focuses on what they are doing. Other types of nurses might apply multiple ways of thinking and approaches to health promotion, especially at higher levels of health promotion practice. This means that advanced health promotion practice is already a part of some nursing roles in hospital. In this sense, a change of nursing role is a broad term including many types of nurses in hospital. Thus, a role change in health promotion could be stratified to different types of nurses in hospital, resulting in different levels of health promotion practice. The development of health promotion is not necessary for every type of nurse in hospital to reach higher levels of health promotion practice. Each type of nurse should have their own focus. It is inappropriate to criticize nurses in hospital for not improving health promotion practice without acknowledging different health promotion roles for different types of nurses.

The staff nurses in this study evidently had little space for improving health promotion practice despite having trying hard. Whether there is a chance for individual nurses to initiate an improvement of their role activities and how much staff nurses could contribute is an interesting question. It has been noted that the actual knowledge of health promotion needs an opportunity to "know the doing". According to the nurses' accounts, the staff nurses needed chance and opportunity to know and practise health promotion. The study finds that the staff nurses only could casually conduct lifestyle advice to patients, which is identified as an activity done on individual nurses' initiative, and whether it has the potential to be included in current nursing routine needs further observation. Currently, lifestyle advice does have an unstable character; perhaps it could be viewed as a "leeway" of nursing practice. The staff nurses' main work was still disease prevention in the hospital.

This thesis concludes that it is better to avoid a radical shift in the ideology of health promotion unless the current structures of the health promotion role in hospital are considered. The desire for an improvement in the nursing role in hospital via health promotion is understandable since health promotion is understood by nurses as a valuable and beneficial service for patients. However, the current study has shown how solid the nursing positions in hospital are and that this has a powerful impact on shaping the actual health promotion role, something which is goes beyond the nurses' passion for health promotion.

The study suggests that the topic of role change in nurses' health promotion role could be looked at differently when considering its historical and philosophical contexts. It is rewarding to recognize that there are types of nurses in hospital who contribute to health promotion. It is also important to recognize that staff nurses who are working on disease prevention in hospital have an essential function in health promotion as well. Although contemporary knowledge and the culture of health promotion may not favour it, it is never acceptable to devalue disease prevention in hospital in the face of health promotion. In fact, according to the levels of health promotion practices, the pattern of disease information is the first and fundamental base for health promotion practice. Every type of nurse in the hospital, no matter at what level they could perform and contribute to health promotion, needs to include the basic level of health promotion and then go further to contribute to other levels; this is the disease prevention or disease information

pattern in this study. The contribution of hospital-based nurses to health promotion should not be ignored, in fact, it at least deserves being accorded the same value of other patterns of health promotion.

Chapter Eight – Conclusions

Through several chapters the data have been analysed and interpreted, gaining a comprehensive understanding of nurses' health promotion role in hospital. The task of this chapter is to summarize the study and to conclude its contribution to knowledge as well as to a professional perspective. Finally, the limitations and strengths of the study will be discussed.

8.1 Summary of study

The purpose of this study was to examine nurses' experiences of health promotion in hospital in order to look at "what is the health promotion role" for hospital nursing. Due to the lack of an adequate conceptual framework of the "health promotion role", role theory was employed to operationalize the health promotion role. By taking a role theory approach, the study was able to look at nurses' role expectations and experiences according to the nurses' interview accounts. The study sample was a group of 244 nurses from the general medical and surgical wards at an NHS hospital in Scotland. Semi-structured interviews (n=16) were conducted to look at how nurses constructed the health promotion role in nursing practice. A quantitative survey, using a questionnaire, contributed to exploring nurses' values, beliefs and knowledge of the health promotion role. The statistical analysis of the findings explored the associations between various factors, including role expectations, health promoting activities, predisposing factors, enabling factors, actual knowledge factor and self-efficacy factor. In the interviews the nurses' insights into the health promotion role and their experiences of health promotion were further examined. Thematic content analysis was employed to identify and categorize a number of themes in the interviews accounts.

One central feature of the nurses' accounts is the discrepancy between the nurses' role expectations and their actual experiences regarding the health promotion role. The health promotion role expected by the nurses was not only too ideal to be put into practice but also had little connection with their actual experiences in the hospital. Further analysis of the nurses' accounts constituted the following aspects: discrepancy between expected role and actual practice of health promotion in hospital; relationship between health promotion and nursing; and duality of the

health promotion role. Firstly, the discrepancy between expected role and actual practice of health promotion was explored by focusing on the nurses' experience of this discrepancy. Secondly, the relationship between health promotion and nursing, and thus nurses' capacity for delivering health promotion in hospital, was explored via the concept of "levels of health promotion practice", itself based on the nurses' accounts of the health promotion role. Thirdly, the duality of the health promotion role was analysed via asking why and how the dualism of the health promotion role bothered the nurses in their perception of the health promotion role, causing emotional reactions in them. The thesis ended discussing how the ideology of health promotion had little contribution to make to improving the role of nursing and its practice in hospital.

8.2 Contribution to knowledge

The contribution of this study to knowledge can be grouped under five headings: nurses' experiences of health promotion, nature of actual health promotion role, concept of duality of health promotion role, implications of role change for health promotion, and researching health promotion role.

8.2.1 Nurses' experiences of health promotion: Golden Key Syndrome

The study depicts the nurses' experiences of health promotion in hospital by using the metaphor of a "golden key" to illustrate and interpret the dilemma that nurses struggled with due to the discrepancy between role expectations and the actual experiences regarding the health promotion role. The literature documents studies where nurses could speak the language of health promotion but could not explain it (Casey, 2007b; Irvine, 2007; McBride, 1994). The current study argues that the nurses' understanding of the health promotion role was too ideal to be implemented in hospital, and that they ignored the practice they actually did engage in. The study further argued that external influences, including political and professional contexts, diverted nurses' role expectations from their actual health promotion practice so that they could not recognize their actual health promotion

role in hospital. This suggests that there is little understanding of the health promotion role in nursing by nurses, and also by previous studies.

Taking a role theory approach, the study paid attention to nurses' perception of health promotion and to their experience of it. The study contributes to an understanding of how nurses are influenced by theoretical knowledge, and both the rhetoric and the ideology of health promotion. It describes the type of role stress that nurses suffer because of their distorted role expectations concerning health promotion, which it refers to as Golden Key Syndrome. This is a pattern of nurses' emotional reactions to the discrepancy between role expectations and actual experiences, including feelings of being inadequate in fulfilling their job, of being helpless and powerless in their current situation, and of being unable to understand their practice despite it having been richly described by them in this study. The current study is different from previous studies in that it understands nurses' struggle rather than criticizing them for not being good at health promotion. Future studies should be undertaken that focus on examining in detail how hospital-based nurses' role expectation and/or perception of the health promotion role have been influenced by the current political and professional culture of health promotion.

8.2.2 Actual health promotion role

Besides identifying the ideal health promotion role that the nurses imagined, the current study contributes to identifying the actual health promotion role, i.e., what the nurses actually performed as health promotion. Based on the analysis of the questionnaire survey and the interviews, the study finds that the health promotion role could be categorized as falling into three patterns within current nursing practice: disease information, lifestyle advice and health education programme. This finding is very important for a number of reasons. Firstly, it suggests that the health promotion role is not a unified concept but could be divided into three patterns in practice, each of which apparently characterized by different thinking and a different approach. While nurses in hospital may be saying that health promotion is not performed well by them or that the literature says so, the current study argues instead that not all patterns are ill performed. Secondly, the identification of three patterns of health promotion practice challenges the notion of "integration" of health promotion and nursing in the literature. The study

reveals that the nature of actual health promotion practice in hospital nursing is more complex and dynamic than shown in the literature. The current study argues that each pattern of health promotion practice finds its place in a suitable nursing position or role-set. In this study, the staff nurses were found to be mainly engaged with disease information, plus giving a little lifestyle advice. Only specialist nurses and nurses on certain wards, being specially trained and supported by either the hospital or other organizations, could go beyond disease information and lifestyle advice. The concept of "levels of health promotion practice" was proposed to explain how different types of nurses could contribute to health promotion from their own positions, suggesting that the health promotion role be defined according to nurses' particular nursing positions or work contexts in hospital.

8.2.3 Duality of health promotion role

The study contributes to theory by recognizing the duality of the health promotion role in the nurses' accounts since they experienced both the ideal and the actual health promotion role. It is theorized that nurses' stress is related to the impact of the ideology of health promotion on their perception of the health promotion role. The study argues that the ideology of health promotion has powerfully modified nurses' role expectations and prevented them from realising their actual health promotion role. The study, by utilizing Gerhardt's (1975) concept of professional thinking and positional orientation, details how powerful both these impact on nurses' experiences of health promotion and make a difficult situation worse by making them "feeling powerless". The study explains Fulton's (1997) concept of nurses' "impossible situation" in terms of empowerment. It is in this sense that the study contributes a main thesis to the literature, i.e., that health promotion is actually integral to nursing in many different ways. It is only the ideology of health promotion that distorts nurses' perception and makes them believe that they have not performed a proper health promotion role yet.

8.2.4 Implications of role change

The study could be extended to look at the issue of role change in terms of health promotion role in hospital. According to the findings of the study, role change in

health promotion is not likely to be influenced by the ideology of health promotion although it has changed nurses' role expectations. The study contributes to identifying the relation between health promotion and nursing, which has formed into patterns in the structure of nursing in hospital. This implies that the nursing role in hospital is relatively settled as part of nurses' current roles. This supports the view that the health promotion role in hospital has historical and philosophical foundations. Change or improvements of the health promotion role is little likely to be initiated by simply changing nurses' perception or role expectation of the role. Perhaps a few energetic nurses could initiate some health promotion activities but this kind of casual conduct is of questionable value on account of it being due to the interests of individual nurses. The study concludes that the fundamental structures of the nursing role in hospital determine the form of a health promotion role rather than individual nurses' passions for health promotion.

8.2.5 Knowing how to research health promotion role

Delaney (1994) argued that researching the health promotion role is extremely difficult. To some extent the current study agrees with Delaney's observation. Nevertheless, as an example of empirical social research it can be confident of contributing to how to research the health promotion role by taking a role theory approach as well as a mixed-methods research approach. The study suggests that it is important to acknowledge that the structural contexts of health promotion role in hospital. The previous studies have argued that given adequate time, staff, resources and support, the contemporary view of health promotion is possible for nursing practice in hospital. However, by examining the structures of the health promotion role, this study goes back to question the feasibility of nurses' role expectations as well as the contemporary knowledge of health promotion and health promotion role in the literature. The mixed-methods research design adopted for the current study revealed the features of the health promotion role, which is particularly significant in light of there being different ways of defining the health promotion role, and finding that what nurses perceived as the health promotion role is not what they actually performed, the combination of quantitative and qualitative methods was necessary to avoid the limits of either of method.

In summary, this study contributes to establishing that nurses had not identified many health promotion activities they were undertaking in practice in hospital. The main explanation for this phenomenon is that nurses' perception of the health promotion role has been influenced by external factors, namely political and professional contexts of health promotion, rather than being related to the actual practice within the hospital nursing context. It suggests that nurses should make efforts in recognizing what they already performed for health promotion in hospitals although it may not always be recognised as being part of the nursing role. This leads to a critical question of how to define the health promotion role for nurses in hospital. Through the analysis of nurses' accounts, this study has achieved a model of 'the level of health promotion practice' which could be a useful device to define what nurses could do in particular positions. This study has also pointed out the importance of understanding the duality of the health promotion role and how it has implications in the role change of health promotion in nursing.

8.3 Contribution to professional perspective

The study contributes to developing a professional perspective on the following six aspects. Firstly, the study takes a realistic attitude to enquiring what is exactly the health promotion role in the nurses' accounts. This is different from the contemporary knowledge of health promotion role as found in the literature. Secondly, role theory as employed in the study contributes to unfolding the nature of the health promotion role via looking at role expectation, behavioural patterns of health promotion practice, and its relations with surrounding contexts. Thirdly, the use of a mixed-methods research approach contributes to gaining a relatively complete picture of nurses' experiences of health promotion in hospital. Fourthly, the study was able to recognize the dualism of health promotion role in the nurses' accounts: the ideal and the actual levels of the health promotion role. This is essential for understanding nurses' experiences of health promotion in hospital when they struggle with the dual accounts of the health promotion role created by certain circumstances. Fifthly, the study proposes the important concept of "levels of health promotion practice" to understand the fact that health promotion has been contributed to by many different types of nurses with different capacities in health promotion in hospital. This confirms the importance of defining a health promotion role for nurses in practice. Finally, the study contributes to the theory of how the

ideology of health promotion impacts on hospital-based nurses' role expectation (and/or perception) and how their distorted role expectation causes their emotional reactions, and finally, how the findings of the study imply a concern with role change regarding hospital-base nurses' health promotion role. Thus this thesis presents a cogent contribution to a professional perspective concerning nurses' health promotion role in hospital.

8.4 Limitations and strengths

The limitations and the strengths of the study define what the study achieved and what it did not.

8.4.1 Limitations

The clarification of the boundaries of this study is important to understand what the findings of the study could represent of the topic. If the study had focused on what are the health promotion activities in hospital, it would have an obvious weakness in that the findings are from one hospital only and could not be generalized. In other words, the study is not good at knowing what is the health promotion role in terms of naming every detailed activity carried out by nurses in the hospital. In this way, the study might be limited in researching and defining one particular health promotion role for nurses in hospital. In fact, the study argues that the health promotion role is carried out at "levels of health promotion practice", i.e., that it should be defined according to particular positions in hospital. This means that different nurses are expected to carry out different specific activities. Similarly, it is assumed that the specialization of a hospital as well as, in a wider sense, the health service system would have an impact on defining a health promotion role for nurses. However, the study was not designed for that purpose and the content and scope of nurses' health promotion role should not be used as a complete guideline for nurses in other hospitals. Instead, the study focused on examining the nature of nurses' health promotion role in hospital, making an effort to interpret nurses' experiences of health promotion, and to analyse nurses' health promotion practice and its influencing factors in hospital. Therefore, the findings of this study are

better used to understand how nurses' health promotion role is carried out in hospital.

Secondly, the study aimed to examine the health promotion role on general wards in hospital. By general wards is meant that the participants were recruited from general medical and general surgical wards in the hospital. The wards supported specific areas of medicine in hospital, such as dermatology, and high dependency units were not selected for participation in the study. Thus, the health promotion role examined by the study pertains to the majority of nurses including staff nurses and specialist nurses who work in general medical and surgical areas. This should be taken into account when applying the findings of the study to nurses' health promotion role in hospital.

Thirdly, the study only focused on examining the health promotion role from the nurses' perspective. It did not include any reference groups of the health promotion role in hospital, such as nurses' working partners, patients or clients and other health professionals, who would be an influence on the health promotion role and its nursing role-set. A comparison of reference groups may help us to further understand the health promotion role and how it is influenced by reference groups. More dynamic aspects of nurses' health promotion role might have been discovered; however, the scale of investigating the health promotion role from the perspective of both nurses and reference groups would have involved a very large amount of work, which is impossible for a small-scale PhD project. The interests of other dimensions of nurses' health promotion role in hospital must be left for future research.

The research methods chosen in this study have the following shortcomings. The survey questionnaire presented some difficulty in having two completely separate main concepts: role expectations and role experiences. Role expectations and experiences may overlap to a certain extent in nurses' thinking. In this study, the nurses were expected to answer questions on role expectations in order to demonstrate their expectations of the health promotion role, while they were also expected to answer questions on their experiences based on the actual practice in the hospital. However, both concepts, role expectations and experiences, were categorized as having similarities in terms of health promotion activities in the questionnaire. Although the overlap of concepts was predicted and measures were

taken to address this, for instance, by arranging role expectation and experience in separate sections of the questionnaire (see Chapter Four), the nurses might cross-reference role expectations and experiences when answering the questions in the survey questionnaire. These shortcomings of the questionnaire were intended to be made up by the interviews carried out subsequently.

The problem of non-responses in the survey questionnaire could have caused some bias. The reasons why some nurses chose not to participate in the study are not able to be known. If the study attracted nurses who were more interested in the topic of health promotion and the health promotion role than the nurses who failed to respond to an invitation to participate, then a non-response was likely to cause a certain bias. However, the reason could also be that the nurses who did not respond to this study were not interested to the survey or a study of any kind. It is also possible that the study missed out on some valuable information from the nurses who did not respond. On the other hand, the nurses who were interested in the study might have brought more insights to the study than the nurses who did not respond. Whatever the reasons for the non-responses, the statistical analysis of the survey was able to limit the bias caused by non-responses to some degree (Kent 2001).

The researcher being a non-native speaker of English caused some difficulties in understanding the nurses, both linguistically and culturally. This mainly happened in the first couple of years which involved the conduct of interviews. There were moments when the researcher thought she might lose opportunities for further follow-up, important questions in the interviews. However, this might also have been due to being a novice researcher. These kinds of limitations should be allowed for in the process of researching a PhD. Importantly, the researcher was well aware of the problem so that the use of a voice recorder and calling on professional help with the transcripts to some extent overcame these weakness. Constantly referring back to the voice recorder and the transcripts, and over and over again consulting the data helped with understanding the interviews.

8.4.2 Strengths

The strengths of the study are to be found in its contributions to knowledge as well as professional perspectives. Here, two issues are briefly highlighted again. The application of role theory strengthened the study of the health promotion role in recognizing both its cognitive and structural aspects as a way of comprehensively understanding its nature. The mixed-methods research approach is another strength of the study which allowed it to capture the health promotion role from different angles. The questionnaire survey mainly explored the scope and content of the health promotion role and its influencing factors, while the follow-up interviews provided the details of how the nurses perceived the health promotion role and how the health promotion practice had been constructed in the hospital nursing. As a benefit from this interview process, the pattern of the nurses' emotional reactions, named the Golden Key Syndrome, and the patterns of the health promotion practice could be identified in the nurses' accounts. The above patterns are very important to explain the findings from the survey. Thus, both methods employed in the study contributed to completing the picture of the health promotion role as presented in the nurses' accounts.

There are some advantages in being a non-native speaker in sociological research, based on the experiences of conducting this study. As a second language user, the researcher had difficulties in the early years of conducting this study in understanding the topic in Western culture. There are language barriers, of course, but fortunately, understanding did not totally rely on language forms. There are "feelings", "intuitions" and "simple honesty attitudes" which were valued in conducting sociological research. The clash of the researcher's native culture with Western culture had its benefits when writing up the study. The researcher was sensitive to matters and issues that are taken for granted in Western culture but are fresh to a person from a different culture. This was very evident in analysing the literature and the data collected during the course of the study. Bauman (2000) talked about the importance of "being alien" when doing sociological research. The capacity of making the "invisible" become "visible" is the essential task of sociological research. It was not totally by accident that the researcher's experience of "being alien" has some coherence with the nurses finding health promotion both "visible" and "invisible". Indeed, it was important for this study to adopt a different

perspective when examining the nurses' accounts for the actual health promotion role.

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Appendices

Appendix 1: Cover Letter of Questionnaire Package

Office Tel: 0131 651 3931
Mobile: 0771 661 3966
Email: s0454212@sms.ed.ac.uk

30/05/2006

Dear Sir or Madam

I would like to invite you to complete a questionnaire for a research study that I am undertaking as part of my PhD at the University of Edinburgh. This study aims at understanding the hospital-based nurses' opinion on health promotion in hospitals. I would like to find out about your attitude and your own experience of practicing health promotion in the hospital. *The questionnaire has been designed so that you can complete it very quickly and easily. It takes only 10 minutes, and you need only tick a box or circle a number.*

There is an information sheet about the research study attached. Please take some time to read it, and if you are happy to be involved, please return your completed questionnaire in the envelope attached *before June 20th 2006.*

I would also like to interview some nurses and would be grateful if you could take part in a short interview (about 15 minutes) at a later stage. *If you agree to be interviewed, could you please sign the consent form and provide your contact details at the end of the questionnaire, and keep the green copy for yourself.* After receiving your agreement to participate in the interview, I will contact you to negotiate a convenient interview time and place for the interview.

Thank you very much for your time and effort on the study. I am looking forward to hearing from you in the near future.

Yours sincerely,

Juan Du
PhD Student in Nursing Studies
School of Health in Social Science
The University of Edinburgh

Appendix 2: Information Sheet for Nurse

Information Sheet for Nurse

You are invited to take part in a research study. Before you make your decision, it is important to understand why the research is being done and what it will involve. Please take some time to read the following information carefully and discuss it with others if you wish. Ask me if anything is not clear or if you would like more information.

1. What is the study title?

The title of the study is ***"Hospital-based Nurses' Role Expectations and Experiences in Health Promotion'***. I am looking at what your opinions are on health promotion and your experiences in practising health promotion.

2. What is the purpose of the study?

I would like to know what your expectation for the nurse role in health promotion is, namely what nurses should do and what the nurses' role should be in promoting health in hospitals. Also, I would like to know what your experiences are in health promotion in your hospital. The study will be conducted during April to August 2006.

3. Why have I been chosen?

The study has two stages, which are especially intended to examine health promotion in medical and surgical wards. The first stage is a self-completed questionnaire survey. With the management approval, these questionnaires have been sent to all the nurses in the medical and surgical wards via the clinical nurse managers. The second stage is a 15-minute interview. If you are willing to participate in the interview, I will contact you after you have completed and returned the consent form back to me.

4. Do I have to take part?

It is up to you to decide whether or not to return the questionnaire. If you decide additionally to take part in the interview, you will be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

5. What will happen to me if I take part?

Taking part would involve your completing the questionnaire by yourself and then sending it back in the envelope attached. If you could attend the second stage, a 15-minute interview, I will make an arrangement to see you at a time and place to suit you in the hospital. You will be encouraged to speak freely at all times. The interview will be recorded only for the purposes of this study. All the activities are on a voluntary basis. So you also could decide not to attend the interview.

6. What is the procedure?

The initial contact with you will be made through the letter and the questionnaire. Only after you send back the signed consent form, will the researcher get in touch with you for the interview. That means only if you are willing to take part in this study and also sign the consent form, will I make an appointment with you for the interview. As a matter of routine, I will let your ward manager know that you are taking part in the study.

7. What are the possible disadvantages and risks of taking part?

There are NO possible disadvantages and risks of taking part.

8. Will my taking part in this study be kept confidential?

Your name will not be recorded; it will be replaced with a code. The description of your opinions and your experiences will not be stored with any identifying labels. No one will be able to identify you from any report published about the study. The data will be used as quotes for the purposes of this research study only.

9. What will the results be used for?

The result will be only used to develop this study on health promotion service. The result will be reported in a PhD thesis form. All nurses who take part will be sent a summary of the result in a format that is easy to understand. You are welcome to request a copy of the full report as well.

10. Who is organising and funding the research?

The study is sponsored and funded by the University of Edinburgh. The researcher is a research student who is carrying out a PhD programme in Nursing Studies of the University of Edinburgh.

11. Who has reviewed the study?

The study has been reviewed by the Lothian Local Research Ethics Committee in February 2006.

12. Contact for Further Information:

If you have any queries, please do not hesitate to contact the researcher, Ms Juan Du at the following number:
Office line: 0131 651 3931
Home line: 0131 667 6000 ext 77407
Mobile: 0771 661 3966

Thank you very much for taking the time to read this information.

Juan Du
Nursing Studies
School of Health in Social Science
University of Edinburgh

Appendix 3: Consent Form for Nurse

Centre Number:

Study Number:

Interviewee Identification Number for this trial:

Consent Form

Title of Project:

Hospital-based nurses' role expectations and experiences in health promotion

Name of Researcher: Juan Du

Please initial box

1. I confirm that I have read and understand the information sheet dated March 1st 2006 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. ☐

3. I agree to take part in the above study. ☐

Name of Nurse_____
Date_____
Signature_____

Name of Researcher_____
Date_____
Signature_____
1 copy (green one) for nurse, 1 copy for researcher

Appendix 4: Questionnaire for Nurse

Case No:

Nursing Studies

School of Health in Social Science

The University of Edinburgh

Questionnaire

Hospital-based Nurses' Role Expectations and Experiences in Health Promotion

I would be grateful if you could take 10 minutes to fill in this straightforward questionnaire. **Thank you**. Please **return** it in the same envelope **before 20 June 2006**.

Hospital-based Nurses' Role Expectations and Experiences in Health Promotion

Instructions

1. This questionnaire aims to know your views on health promotion activities in hospitals and your experience when promoting health.
2. I would like to know your expectation of the nurse's role in health promotion, namely what nurses should do to promote health in hospitals. Also, I would like to know what your experience is in health promotion in your hospital.
3. There are no right or wrong answers. I would greatly appreciate your personal opinion.
4. Everything you provide will be treated in complete confidence and anonymity. Your name is not recorded.
5. There are three sections for you to complete: Section A, B and C.
6. Please indicate your answers on the questionnaire by putting a tick in the appropriate box or circling a number.
7. If you have any queries or questions when completing the questionnaire, please do not hesitate to contact me:

Juan Du
Nursing Studies
School of Health in Social Science
University of Edinburgh
Email: s0454212@sms.ed.ac.uk

Thank you very much for your help.

Section A

This section asks for your general information which is related to this study. Please *give a tick* ' √ ' for each question.

Question 1: Which is your current area of practice?

Tick One Box

- ☐ Medical Care
- ☐ Surgical Care
- ☐ High Dependency (Level 2)
- ☐ Care of the Elderly

Please state any specialty of your ward,_____

Question 2: How many years have you been a registered nurse or been qualified?

Tick One Box

- ☐ 0-4 years
- ☐ 5-9 years
- ☐ 10-14 years
- ☐ 15-19 years
- ☐ 20-24 years
- ☐ 25-29 years
- ☐ Over 30 years

Question 3: Education Level and Degree

Tick One Box

- ☐ Registered Nurse
- ☐ Registered Nurse—Diploma
- ☐ Registered Nurse—Bachelor's Degree
- ☐ Registered Nurse—Honour's Degree
- ☐ Registered Nurse—Master's Degree

Question 4: What is your grade?

Tick One Box

- ☐ Grade C
- ☐ Grade D
- ☐ Grade E
- ☐ Grade F
- ☐ Grade G
- ☐ Grade H
- ☐ Grade I

Question 5: Are you a full-time nurse or a part-time nurse?

Tick One Box

- ☐ Full-time
- ☐ Part-time

Question 6: What is your gender?

Tick One Box

- ☐ Female
- ☐ Male

Question 7: What is your age?

Tick One Box

- ☐ 20-29 years old
- ☐ 30-39 years old
- ☐ 40-49 years old
- ☐ Over 50 years old

Question 8: Which one is your current position?

Tick One Box

- ☐ Staff Nurse
- ☐ Specialist Nurse
- ☐ Consultant Nurse
- ☐ Charge Nurse
- ☐ Other:_____

Section B

This section is about **your activities and experiences** in promoting health in your hospital. Please circle 'O' a number to show how much you agree or disagree on each statement.

Strongly Agree -- **Agree** -- **Uncertain** -- **Disagree** -- **Strongly disagree**				
5	**4**	**3**	**2**	**1**

1. There are potential health benefits for patients when I teach them about their medications.	**5**	**4**	**3**	**2**	**1**
2. Patients expect nurses to encourage them to adopt healthy lifestyles.	**5**	**4**	**3**	**2**	**1**
3. I encourage patients facing discharge to carry on with healthy behaviours learned in the hospital.	**5**	**4**	**3**	**2**	**1**
4. I generally model healthy lifestyles for my patients.	**5**	**4**	**3**	**2**	**1**
5. Encouraging patients to share experiences about procedures is part of my role in health promotion.	**5**	**4**	**3**	**2**	**1**
6. Ensuring a healthy work environment is important to me.	**5**	**4**	**3**	**2**	**1**
7. Health promotion is an important part of my role.	**5**	**4**	**3**	**2**	**1**
8. The hospital nurse's health promotion activities are incidental rather than planned.	**5**	**4**	**3**	**2**	**1**
9. I changed hospital rules or routines to accommodate patients' control.	**5**	**4**	**3**	**2**	**1**
10. I involve patients' families/caregivers in health promotion when appropriate.	**5**	**4**	**3**	**2**	**1**
11. I direct my health promotion activities to my nursing colleagues.	**5**	**4**	**3**	**2**	**1**

12. I am satisfied with my skills in health promotion.	**5**	**4**	**3**	**2**	**1**
13. My knowledge on self-care is adequate.	**5**	**4**	**3**	**2**	**1**
14. I am comfortable in teaching patients about self-care.	**5**	**4**	**3**	**2**	**1**
15. I have the ability to advocate for a healthy hospital.	**5**	**4**	**3**	**2**	**1**
16. I have the ability to advocate for a healthy community.	**5**	**4**	**3**	**2**	**1**
17. I am involved in health promotion activities in my community.	**5**	**4**	**3**	**2**	**1**
18. There is easy access to up-dated resources on health-related topics that help me in my health promotion efforts.	**5**	**4**	**3**	**2**	**1**
19. There are adequate resources for teaching chronically ill patients coping skills.	**5**	**4**	**3**	**2**	**1**
20. Hospital activities on health promotion topics support a nurse's ability to carry out health promotion activities.	**5**	**4**	**3**	**2**	**1**
21. The team approach to patient care strengthens a nurse's health promotion efforts.	**5**	**4**	**3**	**2**	**1**
22. My hospital is supportive of health promotion activities.	**5**	**4**	**3**	**2**	**1**
23. Lack of continuing of care between different hospital departments interferes with a nurse's health promotion efforts.	**5**	**4**	**3**	**2**	**1**
24. Time constraints are a barrier to nurses undertaking health promotion activities.	**5**	**4**	**3**	**2**	**1**

25. Health promotion efforts would improve if there were more time for case conferences, in-service education and bedside teaching.	**5**	**4**	**3**	**2**	**1**
26. Hospital nurses' health promotion efforts would be strengthened by consistent patient teaching.	**5**	**4**	**3**	**2**	**1**
27. Incomplete written records hinder a nurse's health promotion efforts.	**5**	**4**	**3**	**2**	**1**
28. I can refer patients to community agencies.	**5**	**4**	**3**	**2**	**1**
29. Knowing about cultural values helps nurses in their health promotion efforts.	**5**	**4**	**3**	**2**	**1**
30. If I learn more about health promotion, it will help me provide better patient care.	**5**	**4**	**3**	**2**	**1**
31. My experience as a nurse has taught me about health promotion.	**5**	**4**	**3**	**2**	**1**
32. In my basic nursing program, health promotion was included in the course work.	**5**	**4**	**3**	**2**	**1**
33. Since graduation I have taken courses on health promotion.	**5**	**4**	**3**	**2**	**1**
34. Educating patients to give up smoking is part of my job.	**5**	**4**	**3**	**2**	**1**
35. I am confident in teaching patients to change their alcohol abuse habits.	**5**	**4**	**3**	**2**	**1**

Section C

This section is about **your views on the nurse's role in health promotion** in hospitals. What do you think the hospital-based nurse should do and should be in promoting health?

Please circle 'O' a number to show how much you agree or disagree on each statement.

Strongly Agree -- Agree -- Uncertain --- Disagree -- Strongly disagree
5 4 3 2 1

36. A healthy lifestyle is an important topic for patient teaching.	**5**	**4**	**3**	**2**	**1**
37. Teaching patients how to care for themselves is an important part of a nurse's role.	**5**	**4**	**3**	**2**	**1**
38. Teaching patients about disease processes is an important part of a nurse's role in health promotion.	**5**	**4**	**3**	**2**	**1**
39. There are health benefits for depressed patients that result from a nurse's counselling efforts.	**5**	**4**	**3**	**2**	**1**
40. Nursing practice includes comforting patients and their families/caregivers.	**5**	**4**	**3**	**2**	**1**
41. Counselling patients following physical abuse is part of a nurse's role.	**5**	**4**	**3**	**2**	**1**
42. Health promotion activities include enhancing patients coping skills.	**5**	**4**	**3**	**2**	**1**
43. Sometimes nurses plan and deliver care to make the lives of patients as normal as possible during their stay in hospital by encouraging them to be independent and to live as much like a 'normal' person as possible.	**5**	**4**	**3**	**2**	**1**

44. Health promotion group work with patients is sometimes part of a hospital nurse's practice.	**5**	**4**	**3**	**2**	**1**
45. Encouraging patients to advocate for themselves is part of a nurse's role in health promotion.	**5**	**4**	**3**	**2**	**1**
46. Health promotion in the community is part of a nurse's role as a member of the community.	**5**	**4**	**3**	**2**	**1**
47. A nurse must assume the role of patient advocate.	**5**	**4**	**3**	**2**	**1**
48. It is important that hospital nurses are involved in discharge planning.	**5**	**4**	**3**	**2**	**1**
49. Family members/caregivers are included in a hospital nurse's health promotion efforts.	**5**	**4**	**3**	**2**	**1**
50. Health promotion principles apply in caring for terminally-ill patients.	**5**	**4**	**3**	**2**	**1**
51. Health promotion is an "everyday thing" for nurses.	**5**	**4**	**3**	**2**	**1**

Please write any additional comments here:

Thank you for completing this questionnaire for the study. Your feedback is very important, as the information you provide will help nurses in hospitals to improve their services, and help current and future nurses to identify their role in health promotion.

Please sign up for the interview!

Welcome!

You are more than welcome to attend the second stage of the study, a 15-minute interview. You will be encouraged to talk about your opinions on health promotion in hospitals, and I would be pleased to hear about your experiences of it. I am hoping to speak to nurses who have a range of experiences in health promotion. I am interested in speaking to you if you have a wealth of experience but equally interested if you perhaps have very little experience of health promotion.

If you decide to participate in the interview, please sign the consent form (2 copies) attached behind the questionnaire. *Please remember to keep the green*

page for yourself, and send the questionnaire with consent form back in the envelope provided.

For the purpose of contacting you for the interview, please provide your contact details:

Your name: _____

Ward address:_____

Telephone number:_____

Mobile number (if appropriate):_____

E-mail address (if appropriate):_____

Thank you very much for your kind help and your contribution to this nursing research.

Appendix 5: Interview Face Sheet

Face Sheet and Post Interview Comment Sheet

Case No.

Computer File Name:

Time:

Place/ Ward:

Interviewee:

Field Note:

Interviewer Comments:

Background Information

Question 1: Which is your current area of practice?

Question 2: How many years have you been a registered nurse or been qualified?

Question 3: Education Level and Degree

Question 4: What is your grade?

Question 5: Are you a full-time nurse or a part-time nurse?

Question 6: What is your gender?

Question 7: What is your age?

Question 8: Which one is your current position?

APPENDIX 6: Interview Schedule for staff nurse/specialist nurse

Face Sheet and Post Interview Comment Sheet
(For Staff Nurse/Specialist Nurse)
Version 19/09/2006

Reference ID:

Case No. in Survey:

E-Voice File Name:

Interview Date:

Interviewing Time:

General Information:

Place/ Ward:

Interviewee:

Question 1: Qualified years for Registered Nurse:_____

Question 2: Education Level/Degree:_____

Question 3: Grade C D E F G H I

Question 4: Full-time / Part-time

Question 5: Age: 20s / 30s / 40s / 50s and over

Field Notes:

Interview Sheet

Introduction

Greetings:
Hello, nice to meet you.
Thank you for agreement to take part in a follow-up interview.

The Study:
I am a PhD student doing a research about hospital-based nurse and health promotion. As you know, I have done a questionnaire before. And this interview is following as part of it. There is no right or wrong answers. I understand there must be many different ideas about health promotion in hospital. I am not aiming to check and judge your work whether it is good or not. I just want to know what exactly you think about health promotion practice in hospital and what you have experienced in your work.

The Interview:
I will ask you some questions about this topic. You are free talk at any time. I will use this recorder just in order to transcribe and data analysis. Except me, no one will know and hear what you have said. Any report will not have your name, your ward number. All of it will remain confidential and anonymously. If quotes are used, they would be attributed to a staff nurse rather than your name. No one can identify you from the report. So, you are free to talk about your opinion. Whenever there is something unclear, please do not hesitate to interrupt me.

I Health Promotion (HP)

HP in Hospital

Q: About this topic, what do you think about HP in hospitals?

II Nurse Role in HP

Nurse role

Q: What do you think about relationship between nursing and HP?

Q: Do you think nurses are more appropriate than other professionals (such as doctors) to be involved in HP or not, or equally?

III Experiences

Activities

Q: Could you give some examples you have done in promoting health in your ward?

Q: In your experience, do you think HP is difficult or not to be separated from your nursing practice?

Q: Do you have a routine of promoting health or not in your work?

Q: Do you do HP to every patient or not?

Q: Do you do health education or patient teaching or not?

Q: How do you understand modelling lifestyle?

Q: Do you use some teaching methods or models in HP or health education/teaching?

Q: Do you think teaching patients stop smoking is your work or not?
Why?
How about Alcohol?

Q: Do you record what you do in HP or not?

Q: Are there any facilities particularly for HP/HE in your ward?

Q: Do you group patients together for a health education or teaching them individually?

Q: Can I just check what HP means to you? How about health education?

Nurses' Feeling

Q: Do you feel the patients happy or not with your HP practice?

Q: How do you think about your work in promoting health?

Q: From your working experiences, do you like to be involved with HP activities or not?

Q: Do you feel confident/ comfortable or not to do HP?

Supports & Barriers

Q: Do you think it is difficult or not to do HP in hospital?
If yes, what difficulties are they?

Q: What kind of supports or needs do you think nurse should have for a good HP practice?

Q: What do you think nurse should do in HP in hospital?

Q: Are you able to do some efforts to improve it?
In your opinion, how to improve?

Q: Before working in hospital, what did you expect in terms of HP?

Q: Does the hospital give the opportunity to improve HP ability to you?
If yes, can you give some examples?

Additional Questions For Specialist Nurse

Q: What do you think specialist nurse role in HP?

Q: Are there any differences from other nurse role in HP?

Could you explain it in more details?

Q: In your opinion, what specialist nurse could do to improve HP in hospital?

Q: Do you think that specialist nurse has more opportunities on HP or not?

Q: Do you think it is the reason that nurse has missed out learning HP skills or not?

Appendix 7: Interview Schedule for Charge Nurse

Face Sheet and Post Interview Comment Sheet
(For Charge Nurse)
Version 19/09/2006

Reference ID:

Case No. in Survey:

E-Voice File Name:

Interview Date:

Interviewing Time:

Place/ Ward:

Interviewee:

General Information:

Question 1: Qualified years for Registered Nurse:_____

Question 2: Education Level/Degree:_____

Question 3: Grade C D E F G H I

Question 4: Full-time / Part-time

Question 5: Age: 20s / 30s / 40s / 50s and over

Field Notes:

Interview Sheet

Introduction

Greetings:
Hello, nice to meet you.
Thank you for agreement to take part in a follow-up interview.

The Study:
I am a PhD student doing a research about hospital-based nurse and health promotion. As you know, I have done a questionnaire before. And this interview is following as part of it. There is no right or wrong answers. I understand there must be many different ideas about health promotion in hospital. I am not aiming to check and judge your work whether it is good or not. I just want to know what exactly you think about health promotion practice in hospital and what you have experienced in your work.

The Interview:
I will ask you some questions about this topic. You are free talk at any time. I will

use this recorder just in order to transcribe and data analysis. Except me, no one will know and hear what you have said. Any report will not have your name, your ward number. All of it will remain confidential and anonymously. If quotes are used, they would be attributed to a staff nurse rather than your name. No one can identify you from the report. So, you are free to talk about your opinion. Whenever there is something unclear, please do not hesitate to interrupt me.

First, could you tell me what kind of patients do you take care?

HP in Hospital

Q: About this topic, what do you think about HP in hospitals?

Nurse role

Q: What do you think about relationship between nursing and HP?

Q: Do you think nurses are more appropriate than other professionals (such as doctors) to be involved in HP or not, or equally?

HP Practice

Q: In your ward, in what aspects do nurses promote health in their work?

Q: In your opinion, do you think HP is separated from nursing practice, or integrated in nursing routines?

Q: Is there a routine of promoting health in the nursing care?

Q: Do nurses record what you do in HP?

Q: Are there any facilities particularly for HP/HE in your ward?

Q: In terms of HP, does nurses' role and specialists' role are different?

Expectation & Improvement

Q: How do you evaluate nurses' work in promoting health?

Q: In your opinion, what HP activities else should be done?

Q: In your opinion, what does a good practice mean to you?

Q: Do you think it is difficult to promote health in hospital or not?
If yes, what difficulties are they?

Q: If time is a major barrier, what are the reasons for lack of time for HP?

Q: In your opinion, how to improve HP practice? What support do nurses need to do a good HP practice?

Q: Are you able to make changes to improve HP in your ward or not?

Appendix 8: Example of Interview Transcription

IRN 007 (29 minutes)
Background Information:
Qualified for 10-14 years/RN/Grade E/Full-time/Female
/30-39Years old/Staff Nurse

IRN007
1-Q: First, could you tell me what your ward is about?
1-N: It's a respiratory medicine ward, where we have people from 16 years old upwards with a range of respiratory problems, either chronic or acute, and sometimes emergency things as well.

IRN007
2-Q: About this topic, what do you think about HP in hospitals?
2-N: Being in respiratory, you probably can do quite a lot of health promotion things, like smoking cessation and care of, treatment of asthma things, continuing treatment in the community. That's the two main things you can do quite a lot of on the ward. The other things, they tend to do not so much, potentially more chronic conditions are not curable, so there's little that we can do, or we can give them support. And obviously, these sort of acute cases that you have, like, for example, neurangiosis, that's just very spontaneous, there's no sort of obvious causes, we can't really do health promotion on that kind of thing, but for the asthmatic and COPD patients we have, you can do quite a bit of health promotion on those.

IRN007
3-Q: Are there any other activities you have done related to HP?
3-N: Not really, no. I have done a smoking cessation course, a very short course. To give me more information about what I can then tell the patients. That's really the only thing I've done with regard to health promotion.

IRN007
4-Q: Do you think it is important or not to promote health in hospital?
4-N: I think it is important.
Q: Why do you think so?
N: As long as we speak to you, give patients information about, a: what is partly causing your illness, and b: what can we do to help to prevent recurrence, or to make them physically better, give them some ideas about what they can do, rather than just fixing them for the moment then sending them home, to get them back in again in a month to see the same problem again. I think it's a good idea...trying to make them as well as possible, to make them see what they can do to help themselves.

IRN007
5-Q: In your opinion, what's the relationship between nursing and health promotion?
5-N: Variable. It's very individual. Some nurses see it as an important role. Other nurses don't see it as important at all, I think. So, it's very...how the individual nurse sees it all, as to how much they input they have in it. So, it's quite, quite variable.

IRN007
6-Q: Do you believe nurse should have a role in health promotion?
6-N: Yes. I do.

IRN007
7-Q: Why do you think so?
7-N: Well. Yes, we're here to help people get better. We're also here to help them stop being ill in the first place. I think if we can help them keep well, then the patients have a better quality of life, which makes our job a little bit easier as well. So I think it's very important.

IRN007
8-Q: Are there some advantages to promote health in hospitals?
8-N: I think it gives a bit of variety to our role as well. If we're just constantly looking after to sick people, it can get quite...not boring, very same-y, and monotonous. Doing different things with different people, it can give a bit of variety, a bit of interest into our role.

IRN007
9-Q: Do you think the nurses are more appropriate than other professionals (like doctors) to be involved in health promotion or not? Or equally, or less?
9-N: Sometimes, yes, they are, because they can have a much closer relationship with the patient.

IRN007
10-Q: Are 'they' meaning to nurses?
10-N: The nurses, yes. Sometimes the doctors can be...there can be a barrier between the doctor and the patient. Sometimes the patient just feels the doctor's lecturing them about what they should be doing, whereas a nurse can just have a general chat, can be a bit more informal, a bit more relaxed about it. Sometimes that's better for the patients you take on-board sometimes, and at other times, it's better if the doctor says, because some patients say, 'Oh, the doctor said, so I have to do, and you're just a little nurse, what do you know?' kind of attitude sometimes. They don't really take on-board what the nurse is saying. It really depends on the patient. Sometimes, it's good for the nurse to do it; sometimes, it's good for the doctors to do it.

IRN007
11-Q: Could you give me some examples you have done in promoting health in your work?
11-N: The smoking cessation is supposed to be the main one. Whenever anybody ever comes into the ward as a patient, we ask them their smoking history, if they've ever smoked, or if they haven't ever smoked, then that's fine. If they have smoked, or still do smoke, then we encourage them to, suggest that they perhaps look at ways of stopping smoking, tell them what smoking does to them, and how it would benefit them. I think that's the main one I've done. But also, I am involved with diabetes as well. So, I'm sort of to trying to get people aware of health, implications of diet and exercise, diabetes as well, that's the sort of thing I'm quite involved in personally on this ward. So.

IRN007
12-Q: Are there others?

12-N: No. Not really.

IRN007
13-Q: You said the smoking cessation is the major one?
13-N: Yes.

IRN007
14-Q: Do you help patients to model their lifestyle? Like health behaviour?
14-N: Not really. Sometimes you can give them advice about, you know, getting them to think about what the smoking cigarettes are, like, for example, if they're going to the pub for a pint of beer, obviously now they can't smoke because of the bans, but getting them to think, 'When do I get smoke, when is the time I get a cigarette, what I can do instead of sitting down with a coffee and a cigarette, could I be doing something else?' Just to get them to think about it, really. That's about as far as we go. We never suggest a daily program for them or anything. I wouldn't do that. No.

IRN007
15-Q: Do you think the patients are happy with your promoting health practice or not?
15-N: Some of them are. Some of them just don't want to know and just ignore everything you say. Most patients are quite happy.

IRN007
16-Q: Have you checked the results after you promoting health?
16-N: Not on a formal basis, no. But, informally, although... the patients we have do come back, that have stopped smoking, they have just commented to us that since they've stopped smoking, this, that, and the other has happened to them, they describe the effects of it to us, but it is very informal. It's not a formal audit or anything.

IRN007
17-Q: What make you think which patient should do health promotion?
17-N: I think it really depends on the feedback that we get from the patients. When the patient is admitted and we ask them if they're smoking... It depends on what kind of feedback that we get from the patients whether we feel that we can pursue that any deeper. Patients will say, 'Yes, I smoke, I'm going to carry on, thank you', then we don't push it. But if they say, 'Oh, yes, I've been trying to give up', or 'I've been struggling', or whatever, then we might give them more information or more support and things, it really just depends on the feedback we get from the patients as to how far we go.

IRN007
18-Q: Do you assess every patient about this?
18-N: Everybody has a questionnaire. When they are admitted, there's a questionnaire to fill about, you know, daily smoking, when and how much do you smoke, when do have your first cigarette, how do they make you feel...

IRN007
19-Q: Is this kind of manual?
19-N: It's under paperwork. There's a checklist on the back of the paperwork that we fill in it for yes and no box, and we go according to what the patient gives us

for answers to these things, and sort of carry on from the responses that we get from them.

IRN007
20-Q: Have you done things related to health promotion beyond this paperwork?
20-N: Not really. Most of work that you do is based on paperwork, the questionnaires. The questionnaires are quite new to the ward. We used to do informal questioning just by ourselves and going according to the answers we got.

IRN007
21-Q: How long it ago?
21-N: Maybe 18 months, perhaps. May be not quite as long as that. But we felt, because a lot of the staff in the ward were asking these big kind of questions of our patients anyway, that we should formalize it onto the paperwork that we have in the admission packs, um, just so that everybody would then start doing it, rather than just a few individuals that were perhaps more experienced and more senior that were doing it anyway, so...

IRN007
22-Q: Does it mean you do everything follow this paperwork?
22-N: Mostly, yes.

IRN007
23-Q: Do you do anything beyond it?
23-N: Not really, no. The paperwork is the basic...

IRN007
24-Q: How about alcohol, less alcohol or more exercises?
24-N: In this paperwork, they are asked about their alcohol intake, that's part of the general questionnaire so that we know how, perhaps...blood tests, beer, you know, how they're going to behave, how they're going to be affected while they're in. And sometimes if a person admits to drinking a litre of vodka a day, then we might suggest that they perhaps don't drink so much. The paperwork is obviously quite formal, you fill it in, but sometimes, there's sort of conversation between the staff and the patient, quite informal sometimes, and it varies depending on a: how much time we have to spend with the patient, and b: how much knowledge the staff have about these sort of things, and c: how the patient is responding to the fast as well. So there's a whole different range of things, but it mostly comes from the paperwork, and then we kind of spread out a little bit with our questions, activities and things.

IRN007
25-Q: I notice that you use a, b, c. Are they from paperwork?
25-N: No, it's just the way I organize it in my head.

IRN007
26-Q: Have you had the courses about health promotion in your education?
26-N: In my basic general nursing training, no, we didn't, these were all extra courses, things that we can do after... When I did my training, a long time ago, we don't really have health promotion stuff. Our training was based on getting an ill patient well, it wasn't based on keeping a well patient well. We didn't have an awful lot of that, this has all kind of evolved over time to try and keep patients

healthy and things. This is all separate courses and things that we go on.

IRN007
27-Q: Then, how do you get these knowledge and skills?
27-N: The wards are all given information about what courses are on when and who, you know, who would benefit from them. You can read them and go, 'Oh, that looks interesting. Could I do that, it's relevant to my work, and I think it would benefit me, and the patient and everything.' And we then apply to go on the courses.

IRN007
28-Q: Is it asked by ward sister, or by hospital, or by yourself?
28-N: Well...as a nurse, we're obliged to do training courses so many days in a year. Our ward sister is quite into education and things. So she sometimes suggests, 'Oh, I think you might be interested in this. What do you think?' And sometimes, it's just the nurse herself who spots it and thinks it'd be interesting and does it, so it's a combination of all three. We know that we have to do various training courses to keep our registration up. And then it's just depending on which one that we're interested in that we can apply to.

IRN007
29-Q: After you study it, can you apply new things into your work?
29-N: Yes. Yes. If it's appropriate and relevant, then yes, we can apply our knowledge into what we do.

IRN007
30-Q: Does that mean you do this kind of things, other nurses may not do this?
30-N: Yes, that sometimes happens.

IRN007
31-Q: So, it just depends on you?
31-N: Yeah, but what then also happens is, if I've learned a new skill, and I come back to the ward, I'm then expected to teach everybody else the skill as well, so that everybody's learning from my education as well.

IRN007
32-Q: Is it always happened or occasionally?
32-N: It's supposed to always happen, but it doesn't always happen. Some skills are for this specific person that's being taught it, and we're not then supposed to pass it on to everybody. It depends on the skill. If it's for a senior nurse's role, then we don't teach it to junior nurses. But if it's a general skill, then yes, then we pass it on everybody else.

IRN007
33-Q: Do you do this to patients individually or group them?
33-N: Individually. We have had group sessions, sort of trial sessions to see how they would work, and the one that I can think of did work very well, but we didn't have the financing to keep it going. So we just did the trial and then stopped, although it did work, so now it's just an individual patient-nurse thing.

IRN007
34-Q: Can I just check what health education means to you?
34-N: Means to me...is...how to explain...giving information about how to keep

healthy, how to, you know...sort of...diet, in diet things, in exercise things, alcohol, smoking, and everything to try to keep the person healthy, which relation to this disease. Obviously, if somebody has no legs, you wouldn't go and ask them to run a marathon or something, but you kind of relate the information that you're giving to the patient, their illness and their knowledge, just to try to give them as much as information you can to keep them well without confusing them, get them then to think, 'Oh, I'm not listening to any of that. That's a load of rubbish'. That's what it is, passing on the good information to them.

IRN007
35-Q: How about health promotion?
35-N: Much the same, the same thing. I sort of put them in the same pot, really.

IRN007
36-Q: Do you use some teaching theories, models or methods in promoting health?
36-N: Again, it's very much how the patients respond. If they're very interested, then we have a variety of written information or pictures, or sometimes we have models and things that you can show them as to how their lifestyles are affecting them. Sometimes they just want a book that they can sit and read, or...just by talking, it's very dependent on the patient.

IRN007
37-Q: Is this room for patients teaching?
37-N: No, No, this is for staff teaching. But we have pictures, and other pages as well that we can show them.

IRN007
38-Q: Do you report what you have done?
38-N: Yeah, not word for word, but we do record that we've spoken with the patient regarding their smoking, and have suggested, whatever it is, so that it's down that it's been discussed with them, yeah.

IRN007
39-Q: Are there some facilities particularly for you to promote health?
39-N: We don't have a teaching room for patients, but we have books and pictures, and we have information leaflets that we have out in the waiting area outside the front door, there are information leaflets that they can sit and read.

IRN007
40-Q: All of the staff can use?
40-N: Yes. Most of the staff use it. We have posters on the walls in the corridors and things that they can look at as well, so...

IRN007
41-Q: Can you refer patients to community?
41-N: Yes. We can refer people to...various...different kinds of people that, you know, the smoking cessation. There used to be a community association for elderly persons, and that's actually left, but there are ones, the GPs sometimes run collectively, and we can suggest or refer them to GPs or an outside authority to see if they can. I either refer them myself, or I give them the contact number for them to do it when they go home.

IRN007
42-Q: In your opinion, do nurses do a good work or not?
42-N: Yes and no. Sometimes yes, sometimes no.

IRN007
43-Q: Can you explain more about it?
43-N: Some nurses aren't interested in it. Some nurses don't have time to do it. So sometimes they do a good job, and sometimes they don't, it depends on how interested the nurses are, how interested the patient is, and how much time you have, a whole range of different things. So…I think on balance, we probably do a reasonable job.

IRN007
44-Q: Does it mean if nurses have time and interested in, they would do good job, but if not, they will not?
44-N: Mm-hmm, yeah.

IRN007
45-Q: In your opinion, what the nurse role should be in promoting health?
45-N: I think it should be just part of their role. I think it should be that, we should be able to talk with the patients about…about things that would benefit them, you know, stopping smoking or stopping drinking, or looking into a healthy diet, getting more exercise. I think that should just be part of our role, you know. When we're chatting with someone about, you know, things that they're doing over the weekend or whatever, it is part of it. Yes, you can formalize it and say, 'Oh, we've got a session on how to eat healthy next week on Monday, you coming along?' That might be ok for some people, but I think it's just sort of a general, everyday…I think it should just be part of our everyday tasks.

IRN007
46-Q: Do you feel it is difficult to promote health in hospital?
46-N: It can be, yes. Sometimes the patients are too ill to want to know the information that you're giving them. Some patients are too stubborn, and, 'I've done it this way all my life, I'm not going to change now, thank you very much,' they don't want to know anything. Oh yes, it can be difficult sometimes. But at other times, patients are more than willing to take on-board any help that you can offer them.

IRN007
47-Q: Some nurses think lack of time, lack of staff are the barriers for promoting health in hospitals. What do you think about it?
47-N: It can be, yes. If you're too, if you're…maybe you've got somebody off sick and you've having to look after twice as many patients, you haven't got time to sit down with somebody and talk about their lifestyle and what they can do to improve it. …When you have more time, then you can…it's easier for us to sit down and suggest things to them, you don't feel pressured to, 'Oh, I have to be doing this now,' and rushing off and leaving them. Time and staff, it has a big impact on it.

IRN007
48-Q: Have you noticed that there may be unequal chances for patients to have health promotion?
48-N: I don't know if there is. Probably, obviously, I'd say there shouldn't be,

but...I think it depends on the nurse, you know, if the patient, if the nurse doesn't want to know or doesn't want to help or anything, then the patient wouldn't get help. I think there should be an equal chance, but I don't think there is.

IRN007
49-Q: In you experience, do you like to be involved in health promotion practice?
49-N: Yeah, I don't always think about it as often as I perhaps should, but yes, I do, when I get the chance, I do like to talk about it with the patients.

IRN007
50-Q: Do you feel comfortable to promote health?
50-N: Yes, on basic health promotion, yes. And obviously, perhaps more detailed information about the specific help that can be given to the person might not...I'd have to go and find it out, but basic health promotion I'm quite confident in.

IRN007
51-Q: What's this basis health promotion means to you?
51-N: Just general information about the kind of, sort of...you know, the fact that you should be exercising two, three times a week, or you should be eating more fruits and vegs than you perhaps are, or, you know, smoking really isn't very good for you because it does X, Y, and Z, and the effects of smoking can also lead you to a lot of...smoking illnesses. We've learned about the effects of smoking and alcohol, and that sort of just general health issues, but I wouldn't tell somebody to, you know, go to the gym every other day and do 20 reps on the tread...master,* or anything, you know, that level of information I couldn't tell, but generally information, I'm quite happy to...
[*Ed: She seems to be trying to say something along the lines of 'Twenty minutes on the Stairmaster' or 'Twenty minutes on the treadmill,' and it all sort of ran together here.]

IRN007
52-Q: In your opinion, if nurses want to do a good health promotion, what supports and resources they need?
52-N: I think they probably need a good basic knowledge themselves on how to look after your body, and then obviously some confidence that you do know what you're talking about, and that you can tell, pass information on to other people, without thinking, 'Well, maybe I'm making a terrible mistake telling you that you shouldn't be doing...whatever it is that you're doing.' I think time and expertise, you know, experience, and a basic knowledge base, I think, are quite important. And perhaps a newly qualified staff nurse wouldn't have that knowledge or confidence to do that, but somebody who's been working for a little while, even just six months or a year, begins to build up that confidence, and the sort of realization that they can be getting that kind of information across to patients on a day-to-day basis.

IRN007
53-Q: Do you think nurses are qualified or not to promote health?
53-N: Yeah, I think mostly they are. Yeah.

IRN007
54-Q: Is your expectation before you working in hospital the same as the reality here, in terms of health promotion?

54-N: I had no expectation from health promotion before I started training, but as I did my training, then I learned what my role ought to be, yes, I think it is probably much the same. But that, the expectations only developed while I was training. Before I started at college, I had no expectations at all. I didn't know what would be involved at all, so...

IRN007
55-Q: In your opinion, what nurse should do in health promotion?
55-N: I think we should be aware of their individual patients' lifestyle as much as possible, and then...sort of thinking, 'What information can I give them to make their life easier, more comfortable, longer?' which can be quite difficult sometimes. If the patient's only in for a short time, you don't get to know them very well. If the patient's in for a longer time, you do get to know them well, and you know what their lifestyle's like at home, and you can them give them information and advice, so...

IRN007
56-Q: Does hospital give you opportunity to develop knowledge and skills in health promotion?
56-N: The hospital provides some courses, and they also give you some time to go to outside courses if it's relevant. Sometimes, there's problems with funding, if you've got to fund it, and it can be difficult to go, because obviously it can cost quite a lot of money and time as well away from work. So yes, there are courses, they do expect you to go on courses. So that's why we provide some courses, provided by the hospital you can go on. And then they are then expected to pass that information on to your patients.

IRN007
57-Q: Except these chances, how do you find other help to improve knowledge and skills?
57-N: Some outside sources, you apply to them, and you have to go and find funding from...these...sometimes the drug reps will give you money to go on a course, or, uh... The hospital...in this, we have a lottery, and the lottery funds some money towards some courses. You have to apply, the application, it can take time and a lot of effort, a lot of sweat, and it...it can be a bit of a struggle sometimes. Then again, if you go on these courses, then you're then expected to pass that information on to the relevant people as well. You are expected to, it's part of your job, but it can be difficult.

Appendix 9: Profiles of Interviewed Participants

IRN: 001 (30 minutes)
Gastro-intestinal,
Qualified for 5 years/RN-Diploma/Grade E/Full-time/30s/Male/Staff Nurse/A second language speaker

IRN: 002 (29 minutes)
Ward 26 Medical Assessment Ward
Qualified for 3.5 years/RN-Honour's/Grade D/Full-time/40s/Female/Bank Nurse/Staff Nurse

IRN: 003 (25 minutes)
Cardiology
Qualified for 5-9 years/ RN-Diploma/Grade E/Full-time/40s/Male/ Staff Nurse

IRN: 004 （26 minutes）
Respiratory
Qualified 0-4 years/RN-diploma/ Grade D/Full-time/20s/Female/Staff Nurse

IRN: 005 (41 minutes)
Urology clinic- Surgical
Qualified 15-19 years/ RN/ Grade E/ Full-time/ 40s/ Female/ just begin as specialist

IRN: 006 (37minutes)
Cardiology
Qualified for 15-19 years/RN/Grade E/Full-time/Female/40-49 years old/Staff Nurse

IRN 007 (29 minutes)
Respiratory
Qualified for 10-14 years/RN/Grade E/Full-time/Female/30-39Years old/Staff Nurse

IRN: 008 (20minutes)
Acute medicine
Qualified for 0-4 years/RN-Honour's Degree/ Grade D/Full-time/Male/20-29 years old/Staff Nurse

IRN: 009 (26 minutes)
Acute medicine
Qualified for 0-4 years/ RN-Diploma/Grade D/ Full-time/30s/Female/Staff Nurse

IRN: 010 (29 minutes)
Infection disease
Qualified 10-14 years/RN-master degree/Grade G/Part-time/40s/Female/Specialist

IRN: 011 (29 minutes)
Colorectal surgery
Qualified for 10 years/RN/Grade D/Part-time/40s/Female/Staff Nurse

IRN: 012 (23 minutes)
Acute medicine
Qualified for 15-19 years/ RN/Grade F/ Full-time/30s/Female/Deputy Charge Nurse (in charge of the general medical area)

IRN: 013 (24 minutes)
Colorectal & urology surgery
qualified 1 year/degree-honour's/Grade D/Full-time/20s/Female/Staff Nurse

IRN: 014 (20 minutes)
Urology surgery
Qualified for 3.5 years/Degree in Nursing/Grade E/ Full-time/30s /Female/Staff Nurse (senior nurse?)

IRN: 015 (36 minutes)
Colorectal & acute admission surgery
Qualified for 20-24 years/RN/Grade G/Full-time/Male/40-49 years old/Charge Nurse

IRN: 016 (34 minutes)
Geriatrics
Qualified Years: 5-9 years/Registered Nurse—Diploma/Grade G/Full-time/Male/Age: 30-39 years/Charge nurse/Male

Appendix 10: Subscales and Items used in Berland's Questionnaire

Predisposing Factors

Healthful lifestyles is an important topic for patient teaching.
There are potential health benefits for patients when I teach them about their medications.
Teaching patients how to care for themselves is an important part of a nurse's role
Teaching patients about disease processes is an important part of a nurse's role in health promotion.
Patients expect nurses to encourage them to adopt health lifestyles.
I encourage patients facing discharge to carry on with healthful behaviours learned in the hospital.
There are health benefits for depressed patients that result from a nurse's counselling efforts.
Nursing practice includes comforting patients and their families/caregivers.
Counselling patients following physical abuse is part of a nurse's role.
Health promotion activities include enhancing patients coping skills.
Sometimes nurses plan activities that 'normalize' the hospital environment.
Health promotion group work with patients is sometimes part of a hospital nurse's practice.
I generally model healthful lifestyles for my patients.
Encouraging patients to advocate for themselves is part of a nurse's role in health promotion.
Encouraging patients to share experiences about procedures is part of my role in health promotion.
Health promotion in the community is part or a nurse's role as a member of the community.
A nurse must assume the role of patient advocate.
Ensuring a healthful work environment is important to me.
Health promotion is an important part of my role.
A hospital nurse's health promotion activities are incidental rather than planned.
I changed hospital rules or routines to accommodate patients' control.
It is important that hospital nurses are involved in discharge planning.
I involve patients' families/caregivers in health promotion when appropriate.
Family members/caregivers are included in a hospital nurse's health promotion efforts.
Health promotion principles apply in caring for terminally ill patients.
I direct my health promotion activities to my nursing colleagues.
I am satisfied with my skills in health promotion.
My knowledge on self-care is adequate.
I am comfortable teaching patients about self-care.
Health promotion is an "everyday thing" for nurses.
I have the ability to advocate for a healthy hospital.
I have the ability to advocate for a healthy community.
I am involved in health promotion activities in my community.

Enabling Factors

There is easy access to up-dated resources on health-related topics that help me in my health promotion efforts.
There are adequate resources for teaching chronically ill patients coping skills.

Hospital activities on health promotion topics support a nurse's ability to carry out health promotion activities.
The team approach to patient care strengthens a nurse's health promotion efforts.
My hospital is supportive of health promotion activities.
Lack of continuing of care between different hospital departments interferes with a nurse's health promotion efforts.
Time constraints are a barrier to nurses undertaking health promotion activities.
Health promotion efforts would improve if there were more time for patient conferences, in-services and bedside teaching.
Hospital nurses' health promotion efforts would be strengthened by consistent patient teaching.
Incomplete written records hinder a nurse's health promotion efforts.
I can refer patients to community agencies.
Knowing about cultural values helps nurses in their health promotion efforts.
Learning more about health promotion will help me provide better patient care.
My experience as a nurse has taught me about health promotion.
In my basic nursing program, health promotion was included in the course work.
Since graduation I have taken courses on health promotion.

Reinforcing Factors
Feedback about the effectiveness of health teaching is lacking.
If the family/caregiver supports a patient's lifestyle change, a nurse's health promotion efforts are more effective.
Family members/caregivers who expect a nurse to give the patient total care hinder health promotion efforts.
Societal values that are in opposition to the values of health promotion are a barrier to health promotion efforts.

Actual Knowledge
Knowing about cultural values helps nurses in their health promotion efforts.
My experience has a nurse has taught me about health promotion.
In my basic nursing program, health promotion was included in the course work.
Since graduation, I have taken courses on health promotion.

Perceived Knowledge
I am satisfied with my skills in health promotion.
My knowledge on self-care is adequate.
I am comfortable teaching patients about self-care.
Health promotion is an "everyday thing" for nurses.
I have the ability to advocate for a healthy hospital.
I have the ability to advocate for a healthy community.

Promotion Activities
I encourage patients facing discharge to carry on with healthful behaviours learned in the hospital.
I generally model healthful lifestyles for my patients.
Encouraging patients to share experiences about procedures is part of my role in health promotion.
Ensuring a healthful work environment is important to me.
I change hospital rules or routines to accommodate patients' control.
I can refer patients to community agencies.
I involve patients' families/caregiver in health promotion when appropriate.

Family members/caregivers are included in a hospital nurse's health promotion efforts.
I direct my health promotion activities to my nursing colleagues.
I am involved in health promotion activities in my community.