Preparing student nurses to be healthy role models: a qualitative study

ABSTRACT

There are national and international expectations for nurses to be healthy role models. This study aimed to investigate student nurses', nurse educators' and registered nurses' experiences and perceptions about being healthy role models and to explore whether nurse education prepares students to become healthy role models. The study used an exploratory qualitative design and was based in the south of England. Participants *(n=39)* included student nurses, nurse lecturers and registered nurses. Data collection was conducted through focus groups and data were analysed using thematic analysis. The themes highlighted nurses' understanding of the key features of being a healthy role model, and perceptions that working as nurses does not support individuals to be healthy. Participants had varied views about whether they should be healthy role models or mirror society and share the same struggles with their health. Students and registered nurses reported inadequate understanding of health promotion and that there was a lack of healthy lifestyle content within undergraduate nurse education. Participants also considered that role modelling healthy behaviour would not in itself influence behaviour change. In conclusion, there needs to be preparation and support for student nurses to be healthy role models from the outset of nurse education.

Key words: Role model, health promotion, nurse, education

Highlights

- Nurses in the United Kingdom may lack awareness of professional expectations to be healthy role models
- Nurses in this study held varied views about the expectation for them to be healthy role models.
- Healthcare settings in the United Kingdom do not always support a healthy lifestyle for nurses and students.
- Nurse education may not prepare student nurses to be healthy role models.

INTRODUCTION

The International Council of Nurses (ICN) suggested that if nurses worldwide are committed to healthy lifestyles, they could act as healthy role models for their families, their patients and their communities, as well as improving their own health and well-being and lowering their risk of chronic disease (ICN, 2010). The expectation for nurses to be healthy role models is also established in English government documents (Department of Health [DH], 2009, 2010, 2011). However, these expectations for nurses to be healthy role models are not always consistent with the reality of nurses' health. For example, in the UK, many National Health Service (NHS) staff are reported to be obese or overweight, smoke, have poor nutrition or lack sufficient exercise (Blake *et* al., 2011, Blake et al., 2012, Blake and Patterson, 2015). International research suggests that this situation is not limited to the UK (Miller et al., 2008, Zapka et al., 2009, King et al., 2009, Timmins, 2011). Therefore, it is important to consider the role of nurse education in supporting healthy lifestyles and preparing students to be healthy role models in their future roles as registered nurses. This paper presents findings from a qualitative study

conducted in England that explored views of student nurses, nurse educators and registered nurses about expectations to be healthy role models and the role of nurse education in practice.

BACKGROUND

In the UK, the Nursing and Midwifery Council (NMC) Standards framework for nursing and midwifery education require that universities, practice placement and work-based learning partners must ensure that: 'Students are provided with information and support which encourages them to take responsibility for their own mental and physical health and wellbeing' (NMC, 2018, p.10). However, knowledge about health behaviours gained during education is often not transferred to nurses' lifestyles (Blake et al., 2011), despite the potential for nurturing and supporting mental health to address the stressors in nurse education and prepare students to be healthy role models (Timmins et al., 2011). In the UK, Blake et al. (2011) conducted a cross sectional questionnaire survey demonstrating the poor health of student nurses; more than half of the 325 participants did not meet physical exercise recommendations. Blake et al. (2011) provide findings that could question whether all providers of nurse education in the UK provide education of health promoting behaviours from the outset to prepare students for registration, given the expectation for registered nurses to be healthy role models:

> "nurses and midwives must acknowledge that they are seen as role models for healthy living, and take personal responsibility for their own health" (DH 2010: 6).

The study concluded that barriers to transferring knowledge gained about physical exercise to personal lifestyle included: lack of time, cost, tiredness and lack of motivation. Blake et al. (2011) argued that the poor health profile of pre-registered nurses needs to be addressed by early education, with improving and maintaining personal health and interventions targeted to raise awareness about their role as exemplars in healthy lifestyle choices.

Role modelling healthy behaviour is of national and international interest because of the implications for public health. However, the nursing literature presents conflicting views about being a healthy role model. In an early study based in Canada, Rush et al. (2005) found that for some nurses, an idealised role model seemed unrealistic while other nurses felt it represented an aspiration. Some nurses conveyed a humanistic understanding that nurses and patients struggled with the same health promoting goals and that flaws could motivate behaviour change in others. Rush et al. (2005) also found that the requirement to role model made some nurses feel threatened and highlighted inconsistency between what they teach and what they do. Rush et al.'s (2005) study had a small sample size and included no student nurses, who could have provided valuable data.

More recent studies have revealed that many nurses feel that they should be healthy role models (Sarna et al., 2016, Ordas et al., 2015, Blake and Patterson, 2015) although opinions can be influenced by their own weight or smoking status (Blake and Harrison, 2013), suggesting that cognitive dissonance may be relevant (Pericas et al., 2009, Blake and Patterson, 2015). Cognitive dissonance theory, originating from Leon Festinger's work in the 1950s, proposed that people have an inner drive

to keep all attitudes and beliefs in harmony with behaviours and to avoid disharmony (or dissonance), therefore changing their actions, beliefs, opinions or knowledge to maintain inner harmony (Festinger, 1957). A recent survey of obese nurses in England found that most agreed that nurses should be a healthy weight and should be healthy role models (Wills et al., 2018).

In a study based in the United States of America (US), healthy weight nurses were found to inspire higher levels of confidence in teaching and health promotion advice than overweight nurses (Hicks et al., 2008). Indicating varied views amongst nurses themselves, one survey found that 48% considered that the public would be less likely to trust health messages from obese nurses (Wills et al., 2018). Nursing literature emphasises that believing that one should try to influence others, and self-efficacy (i.e., belief in their own capability) to be a healthy role model, are both important in determining whether or not role modelling takes place (Chan, 2014, Blake and Patterson, 2015). A wider literature review of 47 international papers revealed a link between role modelling and patients' behaviours and an association between health care professionals' (HCPs) personal physical exercise habits and counselling practices (Lobelo and De Quevedo, 2016). Physically active HCPs were more likely to provide counselling on physical activity to patients and were considered to be powerful role models (Lobelo and De Quevedo, 2016).

Previous research findings have challenged whether nurses being healthy role-models is a realistic expectation, recommending further research with front-line nurses (Kelly et al., 2016). The evidence suggesting most nurses are not living up to professional expectations, offers little exploration of nurses' own views about the requirement to be healthy role models, nor the role of nurse education. The aims of this study were therefore to investigate student nurses', nurse educators' and

registered nurses' (RNs) experiences and perceptions about being healthy role models and to explore whether nurse education prepares students to become healthy role models. The study findings also contributed to a concept analysis which clarified the meaning of role-modelling health promoting behaviour (Authors, 2017).

METHODS

Design

The approach of this study was grounded in social constructivism (Bryman, 2012), which enabled a critical stance of taken for granted approaches of understanding the world, in order to explore nurses' perceptions and experiences of being healthy role models. A qualitative exploratory design was chosen using focus groups. Thematic analysis of focus group data provides the opportunity to explore participants' attitudes, priorities, language and framework of understanding (Kitzinger, 1994). Focus groups with participants who have common characteristics can provide a better understanding of how they feel or think about an issue (Krueger and Casey, 2009). Therefore, two focus groups (SN1, SN2) involved third year student nurses, a further two focus groups (RN3, RN4) were conducted with registered nurses (RNs) working in practice, and two focus groups involved participants who were nurse lecturers (NL5, NL6). Due to fewer nurse lecturers volunteering, a further focus group was organised; as only one nurse lecturer attended on that occasion, an individual interview (Int7) took place.

Participants

Recruitment of participants was via a gatekeeper at a university where the lead researcher did not teach. The gatekeeper, who was head of pre-registration nursing programmes at the university, provided access for recruitment but was unaware of

the identity of the participants. Participants worked as nurse lecturers or studied (pre-registered students or RNs on a mentorship course) at a university in London. Recruitment was through email and a researcher presentation to a third year student cohort. There were 39 participants in total (Table 2). The RNs were from a range of primary and secondary care clinical environments across London and South East England. Only 8% were male; only 10% of nurses in the UK are male (Vere-Jones, 2008).

Data collection

One researcher conducted all focus groups using a semi-structured topic guide (Table 1), with questions about views and experiences of role modelling healthy behaviours in practice and the role of nurse education. . The topic guide was used flexibly to encourage discussion between focus group participants, offering an opportunity to understand meanings and interpretations (Morgan, 2002). All focus groups were audio recorded, uploaded to a password protected laptop and transcribed verbatim.

Ethical issues

Ethical approval was obtained from the relevant university approval committees (University of Bath Research Ethics Approval Committee for Health (REACH) reference number EP 14/15 118), and the research was conducted within the guidelines of the Research Governance Framework for Health and Social Care (DH, 2005). Volunteers were emailed two weeks prior to the focus groups with participant information sheets, so they had time to decide whether to participate. Written consent and demographic forms were completed prior to commencing the focus groups and participants were assured of anonymity.

Data analysis

Thematic analysis was used to identify and analyse patterns in data through familiarisation, coding, searching for themes, reviewing themes, defining and naming themes and writing up (Clarke and Braun, 2013). Reading, familiarisation and noting items of interest in the data took place before initial coding, which was approached in a cyclical way, linking data to ideas and ideas to data (Saldana, 2013). Line-by-line manual coding was conducted and incorporated both *in vivo* (using participants' actual words) and process coding, which identifies gerunds or "ing" words as codes. Broad patterns were searched for amongst codes leading to provisional themes, which were reviewed and revisited by the research team, while regularly returning to the dataset to ensure codes accurately reflected original meaning.

To enhance trustworthiness of the analysis and interpretation of the data, an audit trail was maintained (Scwandt et al. 2007). The codes, themes and thematic map were scrutinised, revisited and revised by the authors, which contributed to the dependability of the findings (Lincoln and Guba, 1985). This data analysis approach aligned with a constructivist (Bryman, 2012) view of the world by developing an understanding of nurses as healthy role models, through the experiences and perceptions of RNs, students and nurse educators. Knowledge and meaning is constructed by social action and interaction, it is historically and culturally specific and often bound with power relations (Burr, 2003).

FINDINGS

The six themes are presented next, supported by data extracts, identified by the focus group codes: SN1 and SN2 (student nurses), RN3 and RN4 (RNs), and NL5, NL6 and Int7 (nurse lecturers).

Theme 1: Features of being a role model in health promoting behaviour

Participants discussed that being a healthy role model requires nurses to listen, guide, communicate and empathise. Connecting with people, working 'with' patients, and developing a therapeutic relationship rather than just providing advice, were all considered important:

> (SN2) "It's kind of steering away from telling the person what to do and saying, 'what you are doing is wrong and you should be doing this'. It's more of a guiding process".

Most nurses described healthy role models as inspiring and leading by example or being exemplars, with a starting point of being fit and healthy oneself:

> (RN3) "Well very simply it's about doing what you are telling others to do. Showing that you actually live the behaviours that you are expecting your patients to adopt".

Participants considered that nurses should be honest about their own behaviours, while respecting boundaries, for example, discussing and sharing personal behaviours and health struggles appropriately, and showing integrity:

> (SN1) "Just not seem as if you are reading from a script, that you believe in what you are saying […] integrity, having some authenticity".

Participants described the attributes of being a healthy role model as: being self-aware, resilient, passionate, enthusiastic, inspirational, charismatic, positive, sensitive, caring, gentle and approachable, open, knowledgeable, innovative, creative and flexible.

Theme 2: Unhealthy behaviour resulting from being a nurse

Many participants considered that working as a nurse does not support them to be healthy:

> (RN4) “The work itself does not support our own health sometimes. So how are we supposed to promote it? The work we believe in, going past our duties, giving our all of ourselves but then the work in return makes us ill.” (Everyone nods)

Factors impinging on their own health and wellbeing included: shift work, lack of breaks, the stressful nature of nursing, and not feeling valued by their organisations:

> (NL6) “You can’t have a water fountain because it’s too much money and the vending machine is only available at some trusts at weekends because they’ve had to close them, so you have to go to the petrol station for a sandwich for dinner. They don’t look after their staff; they don’t have this culture that we’re looking after you.”

Further barriers to being a healthy role model included lack of time, high workload, workplace responsibilities and the higher perceived financial cost of being healthy. Participants suggested that work-related stress leads to unhealthy coping mechanisms, such as comfort eating, smoking and alcohol consumption, which can start during nurse education. Lecturers observed that many students gained weight after qualifying. The constant supply of unhealthy gifts from patients was also considered unhelpful (SN1&RN3). Student participants discussed feeling more able to be healthy outside work:

> (SN1) “The ward environment is a stressful place and it’s not the place to be focusing on your health because you can go a whole shift without

drinking water, without eating properly, you come home and you're ravenous and you eat junk food but then if you're not working the next day you'll probably eat better".

Every group discussed that nurses' lack of sufficient breaks to drink, urinate or eat within a twelve-hour shift affected personal health and ability to act as role models. Having a break was not always considered the norm within the organisational culture and many participants considered that the organisation was not looking after staff. The RNs in particular perceived that not being valued by their organisations undermined their ability to be healthy role models.

Theme 3: Nursing is more than a job

Some participants considered nursing as more than a job, as professional behaviour extended beyond the time spent at work. They perceived that being a healthy role model had the potential to bring about behaviour change in others and affect the wider community of friends, colleagues and family. Visible behaviour in uniform was described as portraying a particular image in public:

(SN1) "I often feel I am playing a role in a way, when I put on my uniform I am like 'I am nurse [name] now I am going to be health promoting, no one is going to see me smoking, my behaviours and this kind of thing. I'm not going to use bad language all these sorts of things.' I am going to model a sort of image".

Some participants considered themselves as representatives of the NHS and to be in a powerful position to be role models:

*(*SN2) "Nurses are the face of the NHS, and in a hospital environment they are the patients' first point of call to have role modelling. If you've

got a nurse looking after you that you don't see as a role model in anyone's eyes then I don't think it's going to be a positive environment".

However, some participants reported feeling powerless, not having a voice or questioned the power they have to bring about change, particularly from a political perspective and reported organisational resistance to suggestions for change:

(NL6) "I think sometimes well often as nurses working across the board you feel quite powerless....the system is broken, it isn't working as well as it could do so nurses become, they feel quite disempowered"

Some participants perceived that a "certain sort of person" is attracted to nursing and described such individuals as nurturing 'givers', which impacted on their ability to be healthy role models. Some participants discussed that people attracted to nursing often bring 'baggage', such as previous experience of illness or loss of a loved one. Such individuals were perceived to inherently not prioritise personal self-care. Caring for themselves by "giving in" rather than constantly "giving out" (NL5) was considered important to being a role model.

Theme 4: The requirement to be a role model for health-promoting behaviour: the divide in opinions

There were varied views about the professional expectation to be healthy role models. However, while many participants were previously unaware of this expectation, most considered that they should be healthy role models and aspired to be so. Some participants felt that a professional expectation to be a healthy role model provided direction for those entering the profession. There were suggestions

that health-promoting advice was more effective if the person giving advice was 'practising what they preach':

> (SN2) "Health promotion would be more effective if people were acting as role models […]. I think that there is more chance that the person will try and make a change if they can actually see that person as a role model rather than not".

Some participants considered that unhealthy behaviours such as smoking portrayed nurses as 'imperfect role models', which could reduce patients' trust:

> (RN4) "We are saying to the patient you should give up smoking because your lungs are in danger of having cancer or COPD but then nurses are doing it, so patients are losing trust in us."

Participants used expressions such as 'being a hypocrite' about nurses smoking, being seen smoking or smelling of smoke. Being overweight or obese was considered detrimental to both nurses and patients: impacting on the nurses' physical ability to perform their role, and the visual impact on patients and the general public.

In contrast, others opposed the expectation for nurses to be healthy role models, considering it a personal choice rather than a professional requirement:

> (NL5) "How dare you tell me how to live my life, it feels like that".

There was also some ambivalence about being healthy role models, particularly with the workplace pressures:

> (RN4) "I think some people just think, do you know what I'm just not interested, whether I'm role modelling health behaviours, I either don't

care or it's my choice to not. So long as I do my job well and I'm safe […]. Role modelling health promoting behaviours is the least of my worries".

Others considered that some patients would not find the perfect image of a healthy nurse helpful:

(NL5) "You could put certain patients off because someone [who] looks very lithe and fit and thin […]. It could make the patient more defensive and have the opposite effect".

Some participants felt nurses mirror society and share the same problems and health issues as everyone else, which helps them relate to their patients:

(NL6) "The NHS is the biggest employer therefore it must be representative of normal people and I think that's what makes us empathise with people."

Most discussions about nurses mirroring society focused on smoking and weight issues, and some nurses felt struggling with these issues provided personal insight and empathy, which patients appreciated:

(SN1) "I've had experience with people who feel perhaps being on the larger side or people who smoked or people who don't necessarily partake in what might be classed as ideal, feel that they are better able to relate to their patients."

Theme 5: The role of nurse education

Discrepancies in what is taught and what takes place in practice were identified as barriers to nurses becoming role models in health promoting behaviour:

(RN4) "What you learn in theory, it doesn't always transfer in practice".

All three groups of lecturers (NL5, NL6, Int7) considered that there is a theory practice gap surrounding health promotion generally. Some participants expressed difficulty in understanding the concept of promoting healthy behaviours:

> (SN1) "Role modelling…..health promoting behaviours…that's the thing that will have to be defined".

Lecturers had a clearer understanding but reported lack of knowledge or understanding within the profession generally:

> (Int 7) “Sometimes people don't even understand what we mean when we say health promotion; they think what are you talking about? Are you talking about health improvement or protecting yourself, protecting your health?”

The RNs in this study acknowledged their limited understanding and identified a need for education to remind them of the role they play with patients in promoting health, with particular emphasis on how to take care of themselves. Students commented on a lack of knowledge amongst RNs with whom they had worked in practice placements. They further acknowledged that they were not confident in their own knowledge and that they “just need a little bit more education” (SN1) to support them in becoming healthy role models. Students also reported feeling disempowered and unable to challenge RNs about behaviours, which hampered their aspirations to be healthy role models:

> (SN2) “When you do go into a workplace there is a certain attitude and a certain way that nurses work. […] Student nurses don’t want to stand out because they want to be accepted. If they do seem really keen to do it

> [role modelling] and the environment around them is not like that at all, they end up doing the same. […] it's like you're being stifled".

Participants recommended changes to undergraduate nurse education to improve the health of nurses, including a suggestion that the application process should consider whether candidates would be potential positive role models. Lecturers observed that first year students' knowledge of basic healthy lifestyles and behaviour change was limited. Looking after personal health was considered key but lecturers (NL5) perceived that students lacked personal resilience to complete education, which should be addressed through self-healing. A lecturer suggested that story-telling could be used to "think through self-healing" (NL5), while another argued that "sorting out your own mental health" (NL6) provides personal insights, which could support becoming a healthy role model. More reflection on practice was considered necessary with self-learning opportunities to support healthy coping mechanisms, such as yoga and mindfulness (NL5, Int7).

Both lecturers and students perceived that lecturers have a pivotal role as healthy role models. Most participants agreed that health promotion content within the curriculum was incoherent, and suggested that health promotion should be integrated throughout, rather than taught in isolation, with a greater focus on self-care. However, many lecturers considered adding more health promotion content into the curriculum would be challenging as there was already so much pressure (NL5).

Theme 6: Behaviour change requires more than role modelling

Some participants perceived that improving healthy behaviour in patients is more complex than nurses being healthy role models:

(RN4) “It’s not just as simple as that […] it’s good to try to role model healthy behaviours but there is so much more to why people make choices about their health than just because your nurse or midwife or doctor is doing something or not doing something”.

Without exception, each group considered that patients have to want to change behaviour, before nurses could even be seen as healthy role models:

(RN3) “Where a patient may want to kind of change but yeah I think the patient has got to want to change before the nurse is a role model.”

Students and lecturers considered that there is a ‘right moment’ or ‘window of opportunity’ to influence behaviour change. If patients wanted to change they may choose to identify positive role models to support decisions about their lifestyle; however if they are not ready, they may identify negative role models among nurses. Nonetheless, most participants believed that they could be a positive influence for change, but that the potential impact of being healthy role models also depended on factors such as contact time with individual patients:

(NL6) “I don’t think from the acute perspective patients are in our care long enough or we don’t have enough exposure to influence them”.

Participants discussed a snowball or ripple effect, perceiving that impacting on a few can escalate to many (RN3, NL5 &Int7). They did not underestimate the impact of each individual relationship:

(SN2) “You can’t change the whole world but you could start with one person and if they see that they are changing their lives they can do it to someone else and it could have a good impact. You can just start with one”.

DISCUSSION

Using a semi-structured approach to focus group data collection is consistent with a social constructivist approach and facilitated interactions between participants, which enabled the construction of themes outlined in the findings that are culturally specific to nursing and nurse education in the United Kingdom.

Whilst there were some varied views about role modelling health promoting behaviour, the findings showed a general agreement amongst student nurses, RNs and nurse lecturers that nurses should aspire to being healthy role models. They considered that the advice they provided has more impact if they ‘practise what they preach’, supporting arguments previously presented (Hicks et al., 2008, Blake and Patterson, 2015; Wills et al., 2018). Those participants who opposed the requirement to be healthy role models considered being healthy a matter of personal rather than professional choice, and argued that nurses should mirror society and were more empathetic with patients by being ‘imperfect role models’. Similar views have been expressed in previous studies (Rush et. al., 2005, 2010, Kelly et al., 2016, Wills et al., 2018) Participants were not asked to report on their own health behaviours in this study, so it is not possible to discern whether their attitudes to being healthy role models were affected by their own weight or smoking status, as suggested previously (Blake and Harrison, 2013, Slater et al., 2006)~~or).~~

The present study highlights nurses’ beliefs that some poor health behaviours are coping mechanisms attributable to the stresses of the job that can start from the

outset of nurse education. Many participants discussed the need for students to develop more healthy coping mechanisms during nurse education, such as: developing personal resilience, self-care and self-healing. Previous research has also highlighted that improving the personal health of students during education is important to prepare them for their role as RNs (Blake and Chambers, 2011, Blake and Harrison, 2013). Lecturers and RNs in the present study described the 'sort of people' attracted to nursing often carry 'baggage' and are not good at putting themselves first, which they felt compounded nurses' poor health behaviours and impacted on their ability to be healthy role models. Such views support previous discussions of nurses as 'wounded healers'(Conti-O'Hare, 2002). There were suggestions that self-healing may be required for some nurses and therefore necessitate teaching strategies to support self-healing and personal resilience in the curriculum, thus supporting those who care for others to care for themselves.

Participants largely considered their work environments unhealthy and many felt employers did not look after them; all these factors were considered barriers to being healthy role models. They linked their personal health to their ability to be healthy role models, which is consistent with a recent UK study (Johnston et al., 2016). Organisations would be better able to support nurses to be healthy role models if they could understood the complexities such as unhealthy coping mechanisms, which are often the result of work pressure (Timmins et al., 2011). Some participants reported feeling powerless in the current political climate to bring about change in their working environment. Feeling powerless, not having a voice or not being heard could lead to nurses feeling undervalued. Stress is a major cause for concern for much of the nursing workforce in the UK (RCN 2015). If nurses continue to be expected to act as healthy role models, understanding of the complexities identified

in this study can help inform nurses in practice, nurse educators, health care organisations and policy makers to support the profession to meet that expectation.

Participants felt that encouraging students to transfer knowledge gained about health during education to personal behaviours was important for students to become healthy role models, which supports previous findings (Blake et al., 2011, Malik et al., 2011). Students need to be empowered to challenge workplaces if what they have learned about taking care of themselves is not possible in clinical placements. However, some students in this study did not feel empowered to challenge the existing culture of a workplace. Nurses recognised a disconnect between what they learn about health promotion in their nurse education to their own lives, suggesting that they need more support to apply their learning to themselves first. The introduction of experiential teaching strategies to support self-healing and personal resilience in the curriculum could therefore be valuable. The findings indicated that health promotion would be better taught throughout the curriculum, rather than in isolation, which could include a spiral curriculum approach, thus revisiting topics with increasing complexity throughout the curriculum. There also needs to be more focus on supporting and empowering students to develop the skills to appropriately question practice areas that do not encourage a healthy working environment.

Limitations and further research

The study was based in one area of England and this limitation should be considered when applying findings more widely. Future studies could examine whether negative and positive attitudes to being a healthy role model are affected by personal factors, such as weight and smoking. A mixed methods study to examine associations between attitudes and personal measurable factors (e.g. weight, smoking, alcohol

consumption) would test the relevance of cognitive dissonance previously discussed (Blake and Patterson, 2015, Holt and Warne, 2007). Future studies should ensure a cultural and ethnic mix of nurses to include cultural variance of attitudes to what is understood by a healthy lifestyle. Further research could also consider whether the fields of nursing (adult, mental health, child, learning disability) influence nurses' views and experiences of being healthy role models.

CONCLUSION

This qualitative study explored the views of students, registered nurses and nurse lecturers in the UK towards the expectation to role model health promoting behaviour and the role of nurse education in preparing student nurses. The study provided insights into the complexities surrounding nurses being healthy role models and highlighted varied views about the requirement to be a healthy role model. However, most participants agreed that it was reasonable for them to aim to be healthy role models and so there needs to be preparation and support for student nurses from the outset of nurse education. It is also important that healthcare settings are supportive to the health and well-being of student nurses and the workforce generally and that there is greater recognition of the challenging nature of contemporary healthcare environments.

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Table 1: Topic Guide Questions
1. Can you identify any experiences/examples of observing registered or student nurses role modelling to encourage health promoting behaviour? 2. Do you have any experiences of observing registered or student nurses not role modelling to encourage health promoting behaviour? 3. Can you identify characteristics or personal qualities, which could be associated with the concept of role modelling to encourage health promoting behaviour? 4. What are your views about the requirement for nurses to encourage health promoting behaviour through role modelling? 5. Do you believe that nurses role modelling health-promoting behaviour could impact on lifestyle behaviours of others? 6. What do you think are the consequences/ impacts or potential consequences of nurses encouraging health promoting behaviour through role modelling? 7. Do you feel that nurses currently do role model health promoting behaviour? 8. What do you feel needs to be in place during nurse training for nurses to become effective role models in encouraging health promoting behaviour? 9. Can you identify any experiences/examples of observing registered or student nurses partly encouraging health promoting behaviour through role modelling? 10. Can you identify any factors that might affect the ability or desire for nurses to act as role models for health promoting behaviour? 11. Do you feel there is any way in which the education of nurses could be

improved to meet this requirement to encourage health promoting behaviour through role modelling?

12. Do you feel that your workplace supports nurses to become effective role models in encouraging health promoting behaviour?

Any other comments about the topic of role modelling to encourage health promoting behaviour?

Table 2: Participant Profile

Focus Group	Participant	Registration status/branch/ dept.	Sex	Age **(mean 33.range 21-58)**	Self-Reported Ethnicity
SN1	1	Student nurse (Adult)	F	48	Black British
	2	Student nurse (Adult)	F	34	Caucasian British (CB)
	3	Student nurse (Adult)	F	27	Caucasian
	4	Student nurse (Adult)	F	30	Caucasian
	5	Student nurse (Adult)	F	22	CB
	6	Student nurse (Adult)	F	21	Black African
	7	Student nurse (Adult)	F	38	CB
	8	Student nurse (Adult)	F	39	Caucasian
SN2	9	Student nurse (Adult)	F	29	Mixed. White/Asian
	10	Student nurse (Adult)	F	22	CB
	11	Student nurse (Adult)	F	31	Caucasian
	12	Student nurse (Adult)	M	25	CB
	13	Student nurse (Adult)	F	29	Mixed. Black Caribbean/Polish
	14	Student nurse (Adult)	F	24	CB
	15	Student nurse (Adult)	F	21	Caucasian British/French
	16	Student nurse (Adult)	F	28	CB
	17	Student nurse (Adult)	F	33	CB
	18	Student nurse (Adult)	F	21	CB

RN3	19	Registered. Child. A&E	M	29	CB
	20	Registered. Adult. Primary Care.	F	48	Caucasian
	21	Registered. Adult. Acute Medicine	F	23	Black
RN4	22	Registered. Midwifery	F	34	Caucasian
	23	Registered. Adult. Accident & Emergency	F	37	Caucasian
	24	Registered. Child. Day surgery	F	33	Black
	25	Registered. Adult. Day surgery	F	52	Caucasian
	26	Registered. Mental Health	M	36	Caucasian
	27	Registered. Midwifery	F	34	CB
	28	Registered. Adult. Theatres	F	Not provided	Asian
	29	Registered. Midwifery	F	39	Black British
	30	Registered. Midwifery	F	32	Caucasian
	31	Registered. Adult	F	58	Black
NL5	32	Lecturer-palliative care	F	58	CB
	33	Lecturer-community	F	43	CB
	34	Lecturer-Primary care	F	53	British (Irish)
NL6	35	Lecturer-Adult. Intensive Therapy Unit.	F	57	Caucasian Irish
	36	Lecturer-Learning Disability	F	57	Caucasian

	37	Lecturer- Child	F	54	Caucasian
	38	Lecturer-Adult Acute Care	F	40	Caucasian
Int 7	39	Registered. Advanced Nurse Practitioner. Primary Care. Lecturer Practitioner	F	55	CB