FACTORS INFLUENCING THE PROVISION OF HEALTH EDUCATION PROGRAMS FOR PATIENTS DURING HOSPITALIZATION

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ABSTRACT

Health education has been an essential part of health care for many years. Some acute care hospitals provide health education programs for patients during hospitalization. These programs are offered only in certain patient care areas; therefore, all patients do not have access to this service. The purpose of this study was to identify and describe factors that influence the provision of health education programs for patients during hospitalization on medical surgical patient care areas. Nurses make up approximately 70% of the health care professionals in acute care hospitals; therefore, a nursing perspective on this issue was sought. Using a descriptive, qualitative approach and the PRECEDE model for health promotion planning and evaluation, 14 registered nurses in various positions in an acute care community-based hospital were interviewed. Data from this study were classified as direct or indirect influences on the provision of health education programs for patients. Six main conclusions were drawn: (a) no Type 2 , "planned" health education program was provided for patients during hospitalization, (b) a Type 3, "comprehensive" health education program was provided for specific patients - namely those recovering from a heart attack, (c) the influence of the medical model on the provision of health education programs for patients during hospitalization was significant and pervasive, (d) nurses and other health care professionals were unaware of the impact the medical model had on their approach to health education programs for patients, (e) factors, in addition to time and resources, were identified as important in influencing the provision of health education programs, and (f) more exploration is needed to identify additional factors in the PRECEDE model, in order to understand the phenomenon regarding the provision of health education programs for patients during hospitalization in an acute care facility. Previous studies have fallen short in grasping the basis for the disparity in the provision of health education programs for patients during hospitalization. Therefore, more studies are required in this area to fully understand the factors and challenges involved.

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CHAPTER ONE

INTRODUCTION

Chapter One introduces the research problem, articulates the research question, and identifies a number of underlying assumptions regarding the interrelationship between health education and the acute care hospital. The limitations and significance of this study are discussed and the organization of the thesis outlined.

* Whenever "patient" is discussed in relation to educational needs, "family" is also inferred.
* Whenever the term "program" is used, activity or intervention is implied.

Background to the Problem

Many contemporary illnesses are due to lifestyle and/or environmentally based factors. Up to 70% of the deaths in the United States are due to heart disease, cancer and stroke (Orlandi, 1987). Other chronic diseases such as diabetes and AIDS are prevalent as well (Hoffmaster, 1992). Health experts agree that the incidence of these diseases could be reduced by making healthier choices about how we live.

Health promotion is concerned with giving people choices regarding their lifestyle and health education prepares individuals to make those choices. During the past two decades, Canadian and American health officials, as well as the World Health Organization, have endorsed health promotion as a major focus for improving individual and community health (World Health Organization [WHO], 1987). Consumers also value this concept and are demanding more information about their options to achieve a higher level of health (Innes, 1987; Nelson, 1989).

Health education is a key component of health promotion and fast becoming a specialized field of adult education. Health education provides planned educational experiences that enable individuals to have control over their health by more readily adopting and maintaining health promoting practices in their everyday life. Presently, health care professionals in acute care hospitals have recognized their role in this aspect of health care provision, and many agree that

they are in a unique position to offer health education programs to their patients during hospitalization. Patient education is provided in all patient care areas of the hospital, but the focus is primarily on the diagnostic tests and treatment of the patients' presenting condition and not on health education (Bartlett, 1985). A 1987 survey "Health Promotion in Canadian Hospitals" revealed that health education was offered mainly to patients on maternity and cardiac rehabilitation units (Canadian Hospital Association [CHA], 1987).

A number of factors may be responsible for the disparities that presently exist in the provision of health education programs for patients. For example, there is a lack of a systematic approach to the provision of health education for patients during hospitalization unless they have delivered a baby or have had a heart attack. This suggests that many patients may not have the appropriate information to help them improve their health while recovering from their illness during hospitalization. Nurses have not adequately responded to this problem, even though they are aware that one of their fundamental roles as nurses is to assist in promoting and maintaining the health of their patients. Since nurses make up the largest number of health care providers in an acute care setting (70%), they are central to the function of the hospital organization and have a certain degree of influence and power (Hoelzel, 1989). Because of this fact, it was determined that the nursing perspective would be a valuable source of information; and the roles, experiences, and perceptions of nurses in relation to the provision of health education programsfor patients in a hospital setting would be the focus of this study (Jenny, 1990).

Research Question

What factors influence the provision of health education programs for patients during hospitalization in an acute care hospital?

Review of the Study

In order to identify and describe what factors may influence the provision of health education programs, a community-based acute care hospital providing at least one health education program for patients during hospitalization was involved. Fourteen registered nurses in various positions in the hospital were the main source of data. A qualitative descriptive approach was chosen as the most appropriate methodology for this study. The PRECEDE PROCEED model for health promotion planning and evaluation was used as a framework to develop the items for the interview guide and to collect, organize, and analyze the data. The study was conducted over a four month period during which one-on-one interviews with the registered nurses were conducted and audio taped. Official documents were obtained and personal on-site observations were carried out as well.

Assumptions

The following assumptions formed the basis for this study:

1. Health education is beneficial and therefore valued. It provides individuals with the information, skills, and reinforcement to make positive decisions about their health
2. Patients value health education and seek information.
3. Hospitals value their role in the diagnosis and treatment of disease (medical model). This approach describes most aspects of health education that is provided in hospitals at present.
4. Health care professionals in acute care hospitals have an important role to play in the treatment of disease, but more so in the prevention of disease.
5. There are many factors that influence the provision of health education programs in acute care settings.
6. When health education for patients during hospitalization is a priority, support and resources are readily available.

Limitations of the Study

This study acknowledges limitations in the sample size, perspective, scope of health education, and the selective role taken in acute care hospitals in the provision of health education programs. First, the findings of this study were obtained by interviewing 14 registered nurses selected from various positions in one acute care hospital. The sample size was small and consequently, not representative of all of the nurses in this hospital. Second, the results cannot be generalized to other hospitals because only one hospital was involved. Third, this descriptive study only represented the perspective of nurses, even though many other health care professionals are involved in the provision of health education programs for patients. Fourth, the focus of health education programs was limited to the individual's responsibility for his/her own health and to four of the many positive lifestyle practices that may affect one's health - nutrition, exercise, stress management, and smoke cessation. Fifth, the questioning was directed and focused on factors that influence the provision of health education programs, thus excluding a review of the implementation and effectiveness of the programs.

Significance of the Study

The results of this study have the potential to:

1. develop the research base for the study of health education programs.
2. expand the role of health care professionals in health education in acute care settings.
3. develop the research base for nursing practice by emphasizing the health educator role of the nurse.
4. provide information on factors that influence the provision of health education programs.
5. develop instruments (survey questionnaire) for hypothesis testing.
6. provide data that may be used to develop a model for health education programs for patients during hospitalization.
7. initiate discussions among nurses and other health care professionals regarding their role in providing and expanding health education programs for patients.

Organization of the Thesis

This thesis is presented in seven chapters. Chapter One provides an introduction to the problem, identifies the research question, and discusses the significance of the study. Chapter Two reviews the literature relevant to the problem, including health education in the acute care hospital system and factors influencing the provision of health education programs. Chapter Three describes the study, including design, methodological approach, selection of a framework, selection of subjects, method of data collection and content analysis. In this chapter, underlying assumptions and limitations of this study are identified. Chapters Four and Five present the findings and the influences which impact on these findings. They are identified and classified as direct and indirect influences. Chapter Six provides an in-depth discussion of the five major findings. Chapter Seven presents six conclusions that were drawn, and addresses implications for health promotion and health education, health care and nursing practice as well as suggestions for future research. A list of references and a four-part appendices conclude this thesis.

CHAPTER TWO

REVIEW OF THE LITERATURE

Chapter Two provides a review of the literature regarding the evolving role of health education in the field of health care, specifically in relation to nurses and acute care hospitals. It also explores influences that may affect the provision of health education programs for patients during hospitalization.

Shifting Paradigms of Health Care

Over the last two centuries, major health problems in Canada have shifted from major epidemics of acute infectious diseases in the early 1800's, to individual infections and accidents in the early 1900's, to present day health problems of trauma and chronic disease (Starr, 1984; Stryock, 1959). The response of the medical community to these major health problems has shifted over time as well - from a focus on maintaining cleanliness and easing suffering to a focus on modern science and medical technology (Berger & Williams, 1992). Now, diagnostic procedures and high technology treatments have become the main emphasis in responding to chronic illness and disease. These procedures and treatments are expensive and in great demand and, consume almost one third of the overall provincial budget for British Columbia (British Columbia Royal, 1991).

However, the advances in science and technology have had little impact on chronic health problems such as heart disease, cancer, diabetes, or AIDS. These health problems are mainly influenced by lifestyle choices made by individuals rather than by technological decisions made by physicians (Hoffmaster, 1992). For example, cardiovascular disease is still a major cause of mortality and morbidity and the number of adults with cardiovascular problems may be increasing (Joffres,1992; Stachenko, 1992). In addition, the major risk factors associated with heart disease have consistently been identified as smoking, high blood pressure, and increased levels of cholesterol. Heart health surveys conducted by the public health system in a number of Canadian

provinces indicated that two out of three adults have one or more of these risk factors (O'Connor & Petrasovits, 1992). Studies have also shown that by reducing these risk factors in individual lifestyles, the risk for heart disease can also be lowered (O'Connor & Petrasovits).

Many of the other illnesses and health problems are also the consequence of unhealthy lifestyles and can be prevented with simple, inexpensive, and effective strategies that encourage lifestyle change through health promotion and health education activities (Hoffmaster, 1992; O'Connor & Petrasovits, 1992; Orlandi, 1987). There is a general consensus among experts in the field, that health promotion is an effective strategy for the control and prevention of disease (U.S. Department, 1979, 1980, 1984). Health promotion is a process that fosters awareness, influences ideas, and identifies alternatives that individuals can choose from in order to make informed decisions regarding a healthier lifestyle (American Hospital Association [AHA], 1979). Health education, a specific component of the larger concept of health promotion, is considered to be a mechanism that bridges the gap between the need for health information and the adoption of healthy behaviors (Preventive Medicine U.S.A., 1976). The Stanford Three Community Study clearly indicated that health education has an influence on behavior change (Stern, Farquhar, Maccoby & Russell, 1976).

Unfortunately, there has been a slow response from the medical community in recognizing and accepting health promotion and health education strategies, despite years of research supporting the importance of these strategies in health care (Hoffmaster, 1992; Last, 1987; Mitchell, 1983). While efforts have been made to include health promotion and health education in the health care system, it has been limited owing to the rigid implementation of the medical model approach to patient care, and therefore has not been very effective. Often, where preventive measures have been initiated, the medical model approach has even determined what constitutes a health issue and which health issues will receive priority attention. Consider for example, the efforts in striving to improve the health of infants; the health care system has determined that screening every newborn infant for phenylketonuria (a condition that is found in 1:1500 births) is a high priority (Reeder, Martin & Koniak, 1992). Yet, efforts to provide health education that can assist women to stop smoking and/or using alcohol during pregnancy and

protect the health of the unborn child, have been minimal. According to Manciaux and Sand (1987), the benefits of health education far outweigh the benefits of screening in relation to the impact each has on the health of these infants.

Some hospitals do offer health education programs relating to lifestyle factors. However, it is usually provided as a treatment for patients who have already developed heart disease and/or have experienced a heart attack (CHA, 1987). One explanation for this medicalization of health education may be due to the value that society places on science and technology which then translates into a highly valued science-based, technological approach (medical model) to health care.

The Historical Evolution of Health Policy in Canada

The health care system in Canada has served society well since its inception in the 1920s. However, since that time major changes have occurred in its policies. In 1974, Marc Lalonde, then Minister for Health and Welfare Canada, produced a revolutionary document entitled "A New Perspective on the Health of Canadians" that identified health promotion as the major focus for federal health care planning and signaled Canada's entry into a decade of new health policy (Lalonde, 1974). Health promotion, at this level, was concerned with education and environmental supports for actions and conditions of living conducive to health and was directed at individuals, groups, communities, policy makers, employers etc. (Green & Kreuter, 1991).

In 1978, the Alma Ata Declaration underscored this emphasis on preventive services versus curative care with the declaration of the "Achieving Health for All" Movement (WHO, 1978). In 1986, Jake Epp, then Minister for Health and Welfare Canada, proposed a framework for health promotion -- "Achieving Health for All" and endorsed the vital roles of health education and patient education (Epp, 1986). Since that time, many changes have occurred in health policies across the country. For example, in 1987 a National Heart Health Policy was developed, and by 1992 all ten provinces were involved in some way in an initiative called "The Canadian Heart Health Initiative" (O'Connor & Petrasovits, 1992).

In 1991, The Royal Commission on Health Care and Costs in British Columbia endorsed recommendations that would increase the emphasis on health promotion and disease prevention (Bruce, 1992). In fact, one statement made in the "Closer to Home Report" from The Royal Commission on Health Care and Costs was that it "is better to educate than operate" (British Columbia Royal, 1991).

The Historical Evolution of Health Education in Canada

A historical review of the literature on health education in Canada has revealed that the field has evolved over time in its scope and approach. Initially, it began as a need for basic survival skills e.g. sanitation, immunization, and nutrition (Redman, 1984). From the 1960s to mid 1980s, a traditional education approach was incorporated to educate the general population about other issues, such as pre and post natal care and lifestyle change. This approach reflects Verner's definition of adult education -- "a relationship between an educational agent and a learner in which the agent selects, arranges, and continuously directs a sequence of progressive tasks that provide systematic experiences..." and is still prevalent in many areas of health education today (Verner, 1964, p. 32).

Health education has evolved from a focus of changing lifestyle behavior in the individual, to a new perspective that health issues and problems are a social, economic and environmental concern and that health is determined by many factors that are often beyond the individual's control (Stachenko, 1992). Therefore, health is the responsibility of individuals, families, the health care system, community, and society. One of the most recent changes is the notion that the empowerment of individuals, groups, and communities will be more effective in helping people improve their health than just the transfer of knowledge (Fahlberg, Girdano & Dusek, 1991). Health educators across Canada and the United States are emphasizing this approach in their practice, because it promotes a collaborative process between the client, the community, and the health educator, and focuses on health issues involving individuals, their environment and the greater society (Wallerstein & Bernstein, 1988).

It was evident from a review of the literature that society also places a high priority on health (Innes, 1987). Over the past 30 years, Canadians have come to recognize that there are many factors that affect their health, including the choices they make in everyday life. Risk factors such as smoking, high blood pressure, and increased levels of cholesterol have consistently been associated with chronic disease. These risk factors can be prevented or reduced by individuals, thus reducing their risk for chronic disease. It has also been identified that a healthier lifestyle can reduce the effects of existing chronic disease (Jenny, 1990; O'Connor & Petrasovits, 1992; Orlandi, 1987). Canadians are also changing their views regarding how health care should be provided, and are more willing to learn about and engage in activities that may help them to become healthier (Nelson, 1989). Studies have shown that individuals are more interested now in participating in screening tests that may lead to the early detection of disease than they previously had been (Wilson, 1992). They are also seeking more health information and access a variety of resources for this information (Freimuth & Marron, 1978).

The Role of Hospitals in Health Education

Among other areas of health care delivery, the hospital is considered a unique and important setting for health education and health promotion activities. During hospitalization, patients are an available "captive audience" (Mitchell, 1983; Vickery, 1979). Removed from the distractions of daily life, patients have time to reflect on their health status. Many patients are more motivated to request health information and are more receptive to making changes in their lifestyle to improve their state of health because an illness has made them feel more vulnerable to disease (Runions, 1988). Usually, health is more valued at this time rather than taken for granted (Orr, 1990; Pender, 1987; Stott & Davis, 1979).

The public generally views the hospital as the center for health and health professionals are considered a credible resource for health information (Vickery, 1979). According to a U.S. study of 659 adults in 1978, health professionals were the most trusted and most frequently used source

of health information (Freimuth & Marron, 1978). Because of the multidisciplinary nature of the hospital, a variety of resources is readily available for information and consultation (Vickery, 1979).

In 1976, the American Hospital Association reported that only a handful of hospitals offered health education programs (Preventive Medicine, 1976). As a result, in 1978, the notion that hospitals share the responsibility for health promotion emerged from a convention of the American Hospital Association (AHA, 1979). Since that time however, only a few studies have documented health education activities in hospitals. One recent survey, conducted by the Canadian Hospital Association, indicated that 75% of all hospitals in Canada were engaged in some health promotional, educational, preventive activities. These activities ranged from restricting smoking in the facility to teaching patients about risks associated with lifestyle behaviors that may or may not be related to their reason for hospitalization (CHA, 1987). It is not clear what percentage of these activities was educational and what percentage involved health risks that did not relate to the patients' presenting problems.

Fyke (1989) suggests that hospitals adopt a much broader role in the promotion of health. However, the scope of that expanded role is under much debate. Regardless of the opposition, support for the health education role of the hospital is increasing. For example, the British Columbia Health Association has endorsed the notion that health promotion activities could be provided in the hospital setting (British Columbia Health Association [BCHA], 1989). And in "A guide for health promotion by health care facilities", it is the view of the national Ministry of Health that health promotion and health education "fit logically within the goals for health care facilities" (Health and Welfare, 1990, p. 7). One of the approaches suggested in this guide is "taking action through education and positive health counseling that will enable individuals and their families to influence their lifestyle in order to increase control over and improve their health" (pp. 9-10). The 1986 Ottawa Charter on Health Promotion also states that "the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services (WHO et al, 1986).

Thousands of individuals spend at least a few days in hospital each month. The opportunity to reach individuals who would not normally access health information services in their community, is a rich one. Hospitalization provides an excellent mechanism to reach the "unconverted" or "unreachable" as well. This differs from populations in the community, where programs offered generally "preach to the converted" (Fletcher, 1991).

Patient Education in Acute Care Hospitals

There is a definite distinction in the literature between patient education and health education. Patient education is generally provided routinely as part of patient care and is defined as "a planned learning experience using teaching and counseling to influence knowledge and health behavior. It is provided by health care professionals and is intended to assist patients to (a) be informed about their illness, including diagnostic tests, treatments, and care, and (b) participate actively in the management of their own care" (Bartlett, 1985, p. 323). Some examples of patient education are preparation for tests and x-rays, pre and postoperative teaching, ostomy care, and medication regime. In addition, an essential component of patient education is to attain and maintain optimal health and quality of life. Therefore, patient education as defined here, is considered one type of health education. Patient education provides opportunities for patients to use their natural ability to learn in order to cope with, minimize, or prevent further illness, to improve their health, and reduce the need for rehospitalization. Patients want to be informed about their care and frequently indicate that they do not receive adequate information (Orr, 1990).

Although patient education is considered one type of health education as Rovers (1987) suggests, in a hospital setting patient education is mainly associated with the primary function of the hospital -- that of diagnosing and treating illness. Patient education has always been considered an integral part of patient care and generally occurs throughout all the patient care areas of the hospital. For example, inpatient and outpatient clinics provide information to patients with diabetes or pacemakers; medical and surgical daycare services and diagnostic areas offer instruction about procedures and tests that patients are undergoing; and treatment areas provide patients with information about their chemotherapy or physiotherapy treatments.

The Nutrition Department is involved with teaching patients and families about special diets. Nursing units such as rehabilitation and long term care focus on teaching patients how to be more independent through self care. Medical/surgical areas, including Orthopedics, Cardiology, and Gynecology provide information on preoperative teaching, ostomy care, and the patient's illness, treatment or medical regime. Specialty areas, such as Maternity, Pediatrics, Psychiatry, and the Emergency Department etc. are also involved in the education of patients and their families providing information about their hospitalization, as well as planning for their care when they return home.

All the nursing care areas focus mainly on information that is related to the patients' illness, medications and/or treatments. The only exceptions to this, for some hospitals, are Maternity and Cardiology Units and Diabetic Clinics. In these three areas patients receive information about their present condition, and in addition, receive information and learn strategies on how to improve their general health by making changes in their lifestyle. Strategies often included are smoke cessation, dietary habits, exercise and stress management.

The benefits of patient education during hospitalization have been clearly documented in the literature (Greenberg, 1991; Orr, 1990). For example, providing adequate instruction for patients undergoing surgery can (a) reduce post-operative pain, thus reducing the requirement for analgesia, (b) reduce the incidence of post-operative complications, (c) reduce the length of hospitalization, (d) shorten the patients' recovery time, and (e) reduce the number of readmissions to hospital (Goldstein, 1991; O'Connor et al, 1990).

Health Education in Acute Care Hospitals

Health education is broader than patient education and is defined as any combination of learning experiences designed to assist individuals and their families in the pursuit of a healthy lifestyle in order to reduce their personal risk for disease and to maintain or improve their health (see Appendix A). Health education prepares individuals to make healthy choices about their lifestyle.

Health education that focuses on healthy practices can increase the benefits of patient education fourfold by (a) reducing the requirement for medication at times, (b) reducing the need for subsequent hospitalizations and visits to the physician, (c) reducing the risk of relapse or other illness; and (d) improving patients' general health status, sense of well being and ability to cope with recovery (Jenny, 1990; Levine et al, 1979; O'Connor & Petrasovits, 1992; Orlandi, 1987; Rosenberg, 1979; Vickery, 1979).

Unfortunately, despite all these benefits, very few hospitals and very few units in hospitals provide health education programs for patients. In a 1987 survey of Canadian hospitals, "Health Promotion in Canadian Hospitals", conducted by the Canadian Hospital Association, (n = 732), 49% identified inpatients as high priority for these activities. Yet, when asked what health promotion programs (lifestyle) they offered their inpatients, the results were disappointing. Fifty-seven percent offered health promotion programs related to the patients' diseases and only 23% offered programs related to lifestyle. It is important to note that the majority of these programs relating to lifestyle were provided on the Maternity Unit (46.5%) and the Cardiac Unit (58.6%). In addition, when reporting the results, the number of programs provided in the medical and surgical areas were combined indicating that programs were offered in 51.3% of the instances. However, when reported as individual areas, approximately 25% of the medical units and 25% of the surgical units were involved in the provision of health education programs (CHA, 1987).

Another survey conducted in 1989 by the British Columbia Health Association involved 38 acute care hospitals. The results were similar. Only 10 of these hospitals (26.3%) provided one lifestyle program and only three of the hospitals (8%) provided two lifestyle programs. Not one hospital provided more than two programs (BCHA, 1990).

It is interesting to note that hospitals have quickly responded to the Non-smoker's Health Act passed in Canada in January, 1990, by severely restricting or eliminating smoking on-site. Patients who smoke will, at times, tell their nurse that they wish they could stop smoking. In fact, many times patients make a genuine commitment to stop smoking using their illness or upcoming

surgery as a reason for beginning the process of smoke cessation. However, the results from these studies demonstrate that there are very few smoke cessation programs provided to assist and support these patients in their efforts to stop smoking, thereby improving their health and reducing their risk for disease.

In both of these surveys, follow-up was not carried out on the non-responding facilities to determine the reasons for not participating in the survey. Sometimes information regarding the non-respondents is more valuable than the results gathered from the respondents. In the British Columbia survey, 61% of health care facilities did not respond (BCHA, 1990). This represents a large number of the health care facilities in the province and may indicate that they do not see their role as one of health promoter and/or have no interest in this issue.

The Role of Acute Care Nurses in Health Education

Traditionally nurses have been responsible for most of the educational interventions for patients and one of the fundamental roles of the nurse is to promote health (Durbach, 1987; International Council for Nurses, 1973). In addition, nurses are guided by an underlying assumption of the Registered Standards for Nursing Practice that nurses encourage a wellness philosophy in their daily practice (Registered Nurses of British Columbia [RNABC], 1992). Nurses recognize their role in health promotion and health education and consider it vital when providing patient care (Pender, 1987). A recent study of 59 hospital-based nurses conducted by the Registered Nurses' Association of British Columbia supported these facts, demonstrating that nurses have increased their awareness of their role in health promotion over time (RNABC, 1991).

In addition to providing care and information to their patients, nurses also act as role models (Hoskin, 1988; Pender, 1987). This is a powerful reinforcer of healthy attitudes, as well as an effective strategy for teaching and for influencing lifestyle change in their patients (Fletcher, 1991; Milsum, 1980). Because nurses have the most frequent contact with patients during hospitalization and because they develop close relationships with their patients, they are in the best position to influence the health of those in their care.

Nurses have been providing health education for their patients since the mid 19th century, but in the last few decades, the information most often focused on is the individual's illness and treatment (Bartlett, 1985). A review of the published literature catalogued in the 1986 American Journal of Nursing International Nursing Index identified only 98 articles on patient teaching and patient education. Seventy-percent of those articles focused on the disease process, and the preparation for procedures, diagnostic tests, and surgery. Only 18% of those articles were concerned with health promotion (Runions, 1988). Presently, some nurses do provide education on lifestyle issues for patients, but most often it is specifically focused on patients recovering from a heart attack. Lifestyle information is not offered to patients during hospitalization even though they may be at risk for heart disease.

Values regarding health strongly influence the choices and decisions individuals make (MacLean, 1989). The values of health and illness held by the nurse, the patient, and the hospital, converge during hospitalization, and interact and influence each other (Pender, 1987). Values affect decisions that nurses make at the bedside and on their unit in relation to patient care and patient education (Berger & Williams, 1992). Commitment to a value of health education is evident in the innovative ways nurses ensure that health education programs are supported, maintained, and protected. However, because social norms of the hospital bias the expression of values, a contradiction in values between those of nurses and those of the organization may occur, causing nurses in an acute care setting to focus their patient care and patient education mainly on the diagnosis and treatment of illness (Wywialowski, 1993).

Influences on the Provision of Health Education Programs

Since the mid 1980s, hospitals have increased their awareness of the importance of health promotion and have responded by initiating certain activities that promote health. As noted, the most widespread and successful activity has been the provision of a smoke-free environment in each facility. But generally, response in other areas has been slow and inadequate in comparison to the changes called for by theorists and experts in the field of health promotion (Blum, 1982; Hoffmaster, 1992). Why might this be?

This section explores a number of factors identified in the literature that influence the provision of health education programs in the hospital setting. They are as follows: (a) the nurses' definition of health and health education, (b) the philosophical orientation of hospitals and nurses, (c) hospital priorities, and (d) the position of the nurse in an acute care setting.

Nurses' Definition of Health and Health Education

The World Health Organization (1986) defines health as "a resource for every day living to the extent that an individual or group is able to realize aspirations, satisfy needs, and change or cope with their environment, emphasizing social and personal resources as well as physical capabilities" (p. 2). But individual definitions of health can vary from simply the absence of disease to self-actualization. In the hospital, there may be as many definitions as there are individuals. Here, the definitions of health by patients, the hospital and the health professional interact in a very intense and personal way (Steele & Harmon, 1983). For the patients, health may have been redefined now that they are ill. For the hospital, health may have been thoughtfully incorporated into the hospital philosophy, or it may be considered as an extension of the medical model. For healthcare professionals, the scope of their definition may also be restricted to the medical model or it may encompass social, economic, and environmental aspects as well.

The important point to note is that, whatever the definition of health may be, the provision of patient care and health education programs will be affected. Services provided by the hospital and the manner in which health professionals carry out their practice will reflect the definition they hold (Steele & Harmon, 1983). What nurses believe health to be, will influence the focus they have when providing health education programs for patients, such as, the illness and treatment alone, the illness in relation to the patients' health status and lifestyle, or general health practices over their life span. Those who define health as the absence of disease, will use their resources, time, and energy to combat disease. They will be satisfied with alleviating the symptoms of illness as their way of promoting health. Those with a broad definition will respond to the social and personal roots of the illness and concentrate on many other factors.

It is possible that a disease focus is used in the definition of health when referring to patient care, because inherent in this definition lies the fact that health is something that is tangible, present-oriented and results-oriented (medical model). Alleviating symptoms of distress and disease can be dramatic and are often noticeable within a short period of time - generally within the period of hospitalization. When this occurs, both the patient and the health professional feel a sense of satisfaction and accomplishment. For the patients and those who care for them, there seems to be a tendency to focus on the urgency of the present situation and the presenting problem. Once acute symptoms subside and the patient improves, attention and care are proportionately diminished for that patient and redirected toward the next urgent situation or problem (Greenberg, 1991). In this situation, health is defined only in terms of the health problem. Therefore, patients most often will receive information needed to help them comply with their treatment and recover from or adapt to their illness. However, the benefits of health promotion and health education may not be realized during hospitalization. Because changes are more subtle and may not be readily observed, the importance of health education may be overlooked or ignored.

Philosophical Orientation of Hospitals and Nurses

The philosophy or value system of an organization is a determinant of education program decisions, objectives and content, and often defines and limits the scope of activities (Peters & Boshier, 1976). Therefore, the philosophy or value system of a hospital may determine whether health education programs are provided or not, especially since health education is not the primary function of acute patient care.

The hospital system is influenced by a medical model approach focusing on illness and the reason for admission rather than by a health model approach that focuses on the total well-being of each patient over the long term . Presently, attempts are being made to adopt a health model, but physicians, as leaders of the health team and experts in the field of cure have been slow to respond (Steele & Harmon, 1983). The medical model approach is often the only priority and this perspective on health care leaves health as a subordinate philosophy (Elzinga, 1990; Hoffmaster,

1992). Medical care is managed mainly through high-technology and results can often be seen during the period of hospitalization (Bruhn, 1974). This is perceived as a glamorous, prestigious and dramatic way to "save lives" (Orlandi, 1987; Steckel, 1984). However, preventive and promotive-oriented care is simplistic, often invisible and less prestigious, and therefore, does not command the same attention from physicians and other health professionals (Orlandi).

Nurses tend to support the predominant philosophy and focus their nursing care on medical services (Jenny, 1993). Nursing students are educated with this philosophy and are attracted to the high technology approach as well. Therefore, even if individuals enter a nursing education program with a broad perspective on health and health promotion, they are socialized into the medical model approach to patient care over the course of their education. In fact, a three year study of 590 students in a university nursing program indicated that the students were more aware of their health promotion functions in first and second year than they were in their fourth year (Donoghue, Duffield, Pelletier & Adams, 1990).

Priorities of the Organization

Some theorists believe that professional practice is more often determined by the demands of the workplace than by professional or philosophical orientation (Guy, 1985). Therefore, it is important to explore the influences of the organization or hospital structure on the promotion of health and the provision of health education for patients. The bureaucracy of a hospital, as with any other organization, demands adherence to its policies and procedures and therefore, health professionals are expected to support them (Guy). Priorities in health care are determined more by the availability of resources than by a particular philosophy (Walker & Norby, 1987). However, priorities are identified by decision makers in the system who act as gatekeepers in the allocation of these resources - including what resources will be used and what services will be supported (Orlandi, 1987). Their philosophy guides the decisions they make.

Hospital priorities mainly support medical services that involve patient care. Therefore, health education may not be readily accepted when it must compete with these medical services for time, funds or space (Orlandi, 1987). A 1991 study conducted by the Registered Nurses

Association of British Columbia, reported that nurses feel they do not have enough time to teach their patients about health and lifestyle choices because they are engaged in supporting medical services (RNABC, 1991).

Socialization is "a process by which values are instilled in individuals, groups, and professions" (Steele & Harmon, 1983, p.2). It is one way to ensure that organizational priorities are supported and maintained. Because socialization to the hospital organization supersedes the social norms of a profession, health professionals including nurses, support the present hospital system of health care (Guy, 1985; Jenny, 1993). If the present structure of the hospital is threatened by adopting a new role in health promotion, maintaining the status quo may become its highest priority in order to ensure survival of the present system.

The Position of Nurses in Acute Care Hospitals

Nurses are the largest professional group practicing in the hospital setting. A vast majority of them care for patients at the bedside. They are at the center of all activities that involve service to patients (Berger & Williams, 1992). Because of this, they can influence the delivery of health care and make independent decisions regarding the care of their patients. Nurses have the most frequent contact with patients during hospitalization and because of the unique relationship they develop with their patients, they have the best opportunity to initiate discussions relating to general health issues, or to the patients' health status and lifestyle habits. They are also an excellent resource for health information and health counseling (Dalton, 1990; Hoelzel, 1989; Pender, 1987).

When nurses practice in an area such as acute care, where health education is subservient to the primary function of the hospital, they experience confusion and uncertainty regarding the goals of nursing practice and the goals of the hospital organization. This is similar to what many individuals experience when education is secondary to the main function of their organization (Peters & Boshier, 1976). For example, the nurse as an agent, acts on behalf of the hospital and is charged with the responsibility for providing patient care and education. However, today,

nurses are influenced more by the bureaucracy of the hospital than by the medical profession and often find themselves caught between the financial and scientific goals of the hospital administration and the goals of nursing and health care (McSwain, 1991).

Nurses, as part of the hospital system, are the ones most affected by the policies and procedures, and must always maintain a balance between their responsibility to the patient, to the physician, and to the hospital (Newman, 1986). In their responsibility to patients, nurses must balance between the patients' right to live at risk and their right to be informed. In their responsibility to physicians, nurses must balance the medical model approach to patient care with their nursing roles -- to care, comfort, and promote health. They must also balance their responsibility to the organization to provide patient care in an efficient, cost-effective way with their responsibility to introduce changes in the hospital system in order to provide quality patient care. Balancing these responsibilities is often difficult. The nurses' response to this balancing act will affect the opportunities, the resources, and the focus of patient education at the bedside and will influence whether patients, who are interested, will receive the information and assistance they need to improve their health or reduce their risk for disease.

Summary of the Literature Review

The medical model is often viewed as the only means of achieving health. A review of the literature has indicated that this is no longer the case. Diseases today are chronic and do not respond to the medical model approach. For the most part, many are preventable. This shift from the treatment of communicable diseases to the prevention of the chronic illnesses of today, calls for a new approach to health care. The morbidity and premature mortality caused by many illnesses can be reduced when people adopt healthier lifestyles. Health education can play an integral role in this process. The role of the hospital in health promotion through health education is an important one, because the public views hospitals as health centers. In addition, the hospital has many credible resources to use in promoting health as well as in diagnosing and treating disease. The goals of health education and health care are very similar in that they both include

the concept of self responsibility in their philosophy. Both of these areas focus on assisting the patients to gain control of their lives or illness in order to improve the status of their health and quality of life.

Patient education and health education are strategies used to achieve this goal. Patient education is considered part of basic patient care and is provided in most areas of the hospital. However, health education is considered an entity separate from patient care and therefore, is provided for only a few specific groups of patients. Because of this, a clear distinction has been made between patient education and health education, even though both are generally considered as part of the same whole - health education. This distinction exists because in a hospital setting, patient education is mainly associated with the primary function of the hospital - that of diagnosis and treatment of illness and disease. Health education, has a broader focus that goes beyond the patient's current illness. It focuses on the general health of the patient and how it can be maintained or improved, even in the presence of illness.

Recently, acute care hospitals have been rethinking their role in the health care system and are initiating health promotion strategies and health education activities for their employees and the community they serve. Several Canadian studies have also indicated that hospitals are beginning to engage in some health promotion, education, and preventive activities for their patients as well, but they are still very few.

Nurses, who make up 70% of the health care team in a hospital setting, have the most frequent, continuous contact with patients and provide much of the patient education. Therefore, they are also in the best position to provide health education for the patients. At the same time, it is important to take into account that health education does not happen on its own. The definition of health that guides patient care, the philosophy and priorities of the hospital and the position of nurses in the hierarchy of decision making, all have a direct or indirect influence on the provision of health education for patients -- influences that can either encourage or discourage the provision of programs in acute care areas. In addition, the values held by those in the hospital may influence health education programs, but it is unclear from the literature what the influences might be.

CHAPTER THREE

METHODOLOGY

Chapter Three identifies and defines the parameters of the education program in general and more specifically, health education activities/programs that are provided in an acute hospital setting. It describes the methodology used in this study to identify influences on the provision of health education programs. It explores three health promotion models that were considered for this study. It explains the design, selection of the site and sample, as well as issues of validity, reliability, and ethics. The chapter concludes with a detailed review of the methods of data collection and data analysis that were used.

Parameters of Health Education Programs

According to Verner (1964), the term "program" can be applied to three levels of activity: (a) all educational opportunities that may exist for adults in a community, (b) the variety and extent of educational activity carried out by an institution, and (c) the design of an educational activity. This study uses the second level of activity - the extent that health education programs are provided for patients in an acute care hospital.

For the purposes of this study, health education program will refer to a learning experience for patients that is provided by a health care professional on a one-on-one or small group basis on the patient care units. It is designed to achieve certain specific outcomes and may consist of a single meeting or a series of sessions (Verner, 1964). Using this definition, a health education program does not include formal programs that are provided in outpatient clinics and other patient areas of the hospital.

The data in Table 1 shows the parameters of health education activities or programs that are provided for patients during hospitalization. The three types of activities or programs were identified as (a) incidental discussions, (b) planned sessions, and (c) comprehensive series of sessions. The first format may be a spontaneous, incidental discussion between a patient and the nurse at any time. It can be a mutual exchange of health information, and at times the patient may

be the educator. The second format may be planned for any patient following the identification of a learning need. The third format may be routinely scheduled, and involve a multidisciplinary team that is provided for a specific group of patients with predetermined learning needs. It has links to the community and is one component of a larger program.

This study will focus attention on the second format of "planned" programs. These health education programs focus on health and well-being, are generally initiated and implemented by the nurse after an assessment of health needs, may be formal or casual, and use single and/or multiple methods of instruction that follow guidelines and/or teaching plans.

Table 1: Parameters of Health Education Activities for Patients During Hospitalization

TYPE 1	TYPE 2	TYPE 3
Incidental	Planned	Comprehensive
General patient population	General patient population	Specific patient population
Patient or nurse may be educator	Nurse is educator	Nurse is educator
Patient or nurse initiated	Patient or nurse initiated	Nurse initiated
Discussion	Intervention	Intervention
At bedside/nurses station	At bedside	Classroom/bedside
No assessment of health needs	Assessment of health needs	Preassessment of health needs
Implemented on cue or trigger	Implemented as indicated	Implemented routinely
Spontaneous 1:1	Casual 1:1	Formal 1:1 or group
General health information	Focus on health and wellbeing	Focus on specific risk factors
Intended outcome	Intended outcome	Fixed outcome
No presentation	Simple presentation	Multimethod presentation
No specific guidelines/plans	Specific guidelines/plans	Specific guidelines/plans
		Links with community program
		Involves a multidisciplinary team

Profile of the Hospital Programs

Education programs offered for patients in the study followed the traditional pattern of hospital programs as discussed in Chapter Two (BCHA, 1990; CHA, 1987). For the most part, patient education and health education programs were provided by nurses at the bedside for cardiac, diabetic, and pre and post operative patients. In addition, a program for ostomy care was provided for patients on one of the surgical patient care units. The cardiac, diabetic, and ostomy programs contained a lifestyle component because it was considered a part of the treatment for

those illnesses. Because these programs focused primarily on how lifestyle impacted on the specific illness, they were not readily adaptable to the general patient population. The program for diabetes was provided for patients on all the units throughout the hospital. The others were specific to the units that provided care for those particular patients.

The three main programs, cardiac, ostomy, and diabetes included nutrition, stress management, exercise, and smoke cessation. The cardiac and ostomy programs had a link with the community as well and therefore, were only one component of a larger patient education program. Both programs had been available at this hospital for ten years. All of the programs were developed, coordinated, implemented, evaluated, and updated by nurses with the assistance of a multidisciplinary team. This study confirmed that there were no Type 2 "planned" health education programs for patients in the general patient population in this hospital. However, it did provide a Type 3 "comprehensive" health education program for specific patients.

Research Design

The purpose of this study was to identify and describe influences on the provision of health education programs for patients during hospitalization. Studying the influences that affect the provision of health education programs within the complexity of an acute hospital setting required a detailed description of what was happening regarding the provision of health education programs rather than describing the content, process, or outcomes of the programs.

As discussed in Chapter Two, nurses form the largest number of health care providers in an acute care setting. They are central to the function of the hospital organization and therefore, have a certain degree of influence and power (Hoelzel, 1989). In order to gain an understanding of the nurses and the programs in context, it was required that (a) the study be carried out in the practice setting, (b) there be a close interaction with those involved in the study, and (c) the context and relevant forces outside this issue would be taken into account. These criteria suggested that a qualitative approach was the most appropriate one to choose. Although the

qualitative approach reduces the generalizability of the research findings, it produces a wealth of detailed information about a small number of people in a particular situation that increases understanding of that situation (Bogdan & Biklen, 1992: Patton,1990).

According to Patton (1990) and others, qualitative inquiry "can stand on its own as reasonable ways to find out what is happening in programs and other human settings" (p. 90). Although a variety of qualitative frameworks can be used, valid, reliable quality studies can be conducted without them. Patton also states that each time a method or framework is added to a research design, certain constraints are imposed on the depth and openness of the data, resulting in the exclusion of some aspects of the phenomenon.

The research question was not theory-based. It was a concrete, practical question that had emerged from an observation in the clinical setting. Patton (1990) suggests that when studying concrete practical questions, it is not necessary to place the study in any framework. However, in order to organize and focus the data collection, analysis and interpretation, a conceptual model was considered. Although it would exclude some information, a conceptual model would select particular information that would help collect, organize, and report the findings on this complex issue.

Conceptual Framework

Three models of health promotion were reviewed to identify the most appropriate framework to guide this study. The Health Belief Model, one of the most widely used models, explains and predicts health-related behaviors in individuals based on certain beliefs (Hardy & Conway, 1988; Rosenstock, 1974). Pender's Health Promotion Model is similar, in that it deals with individuals' abilities to make changes in their behavior in order to improve their health (Pender, 1987). However, both of these models are narrow in focus and do not address the issue of the provision of health promotion activities or health education programs.

Another framework considered for this study was the PRECEDE-PROCEED model for health promotion planning and evaluation. It is a conceptual framework that takes into account not only individual characteristics, but the interaction of health education with multiple

environmental characteristics as well. The PRECEDE component of the model looks at predisposing, enabling, and reinforcing factors and environmental supports that influence health practices. It deals with educational and organizational diagnoses and the planning phase of health education programs. The PROCEED component of the model focuses on the analysis and diagnosis of factors relating to administrative issues and policy development for the implementation and evaluation of health education programs. Both PRECEDE and PROCEED frameworks work in tandem in a continuous process of planning, implementation, and evaluation (Green & Kreuter, 1991).

The strengths of this model rest in the fact that it is highly adaptable and has wide utility for a variety of diverse settings and applications. A recent review of the adult education literature suggests that the PRECEDE-PROCEED framework "would have broad application for many forms of adult education" (Houle, 1992, p. 275). For example, it can be used to focus on improving the health of individuals or the community, or it can focus on increasing the efficiency and effectiveness of health education programs. It has, in some instances, focused on the influences on the program planner as well. Various adaptations of this model in the community, workplace, school, and health care settings have been documented (Green & Kreuter, 1991). In addition, this model provides a framework similar to that of the nursing process model of patient care. Both are problem solving models based on assessment, planning, implementation, and evaluation. Both models rely on continual feedback and make revisions accordingly.

However, the PRECEDE framework deals specifically with educational needs, while the nursing process may deal with physical, psychological and educational needs - and are generally in that order of priority (Green, Kreuter, Deeds, & Partridge, 1980). Therefore, the PRECEDE model has utility for investigating the influences on health education programs for patients receiving care during hospitalization and was selected as the most appropriate framework for this study (see Figure 1). Only the PRECEDE framework was used, because the implementation and evaluation phase of the PROCEED framework was not the focus of this study.

Factors that influence the provision of health education programs were categorized according to predisposing, enabling, and reinforcing factors (Green & Kreuter, 1991). Environmental supports and conditions were included in enabling factors for this study.

Predisposing factors address the knowledge, attitudes, values, beliefs and perceptions that facilitate or compromise decisions to provide health education programs. Individuals who value the health model approach to patient care and believe that health education is important for patients would be motivated to provide health education programs.

Enabling factors relate to the skills and resources that are available or shared when making these decisions regarding health education programs. Adequate time, money and experienced personnel would facilitate the provision of health education programs for patients.

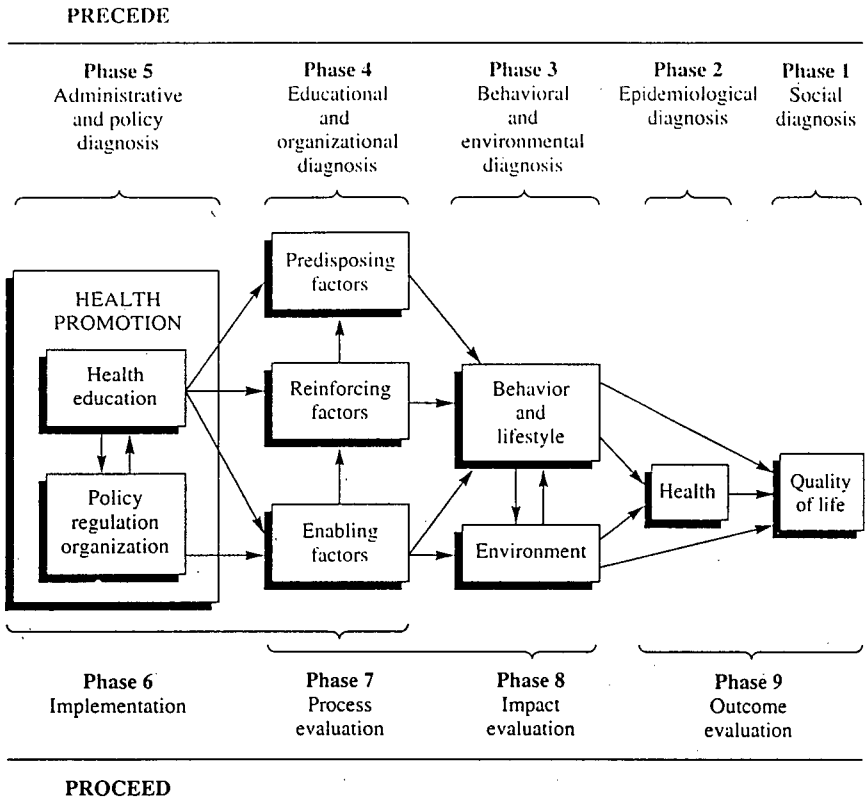
Reinforcing factors are the recognition, rewards and feedback given and received that may encourage or discourage the provision of health education programs. Recognition and positive feedback for providing health education programs for patients encourages the continuation of health education programs provided on a regular basis.

Environmental supports are factors that are external to the individual providing the health education program and often beyond their control. They refer to the policies, regulations, guidelines, organizational arrangements, and the behavior of those who control the resources/rewards. These factors create a condition or atmosphere that either impedes or supports the provision of health education programs for patients (Green & Kreuter, 1991). As previously indicated, these factors were included with the enabling factors.

However, several limitations have been identified when considering the PRECEDE-PROCEED model and need to be addressed. In all previous accounts this model has been used to study the influences on programmers, programs, and individuals with the intent of changing or improving a certain situation. Some applications of this model have been based on the assumption that program planners are the main decision makers regarding the health education programs they provide and that program planning is their primary function.

When investigating influences on the provision of health education programs for patients during hospitalization, it is necessary to point out several key factors regarding the role of acute care nurses in relation to the provision of health education programs for patients. They are: (a) the programmer (nurse) has a primary role in the hospital other than the provision of health education programs, e.g. providing physical and emotional care, (b) there are no formal expectations that health education will be provided for patients during hospitalization, and (c) there are competing demands for the time and resources of the "programmer" (nurse) because of other roles and responsibilities.

Figure 1:



The PRECEDE–PROCEED model for health promotion planning and evaluation.

Note. From Health Promotion Planning: An Educational and Environmental Approach 2nd ed. (p. 24) by L.W. Green and M.W. Kreuter, 1991, Toronto: Mayfield. Copyright 1991 by Mayfield Publishing Company. Reprinted with permission.

Selection of the Site

The selection of a site for this study was based on three criteria: (a) that it be a community-based acute care hospital, (b) that the hospital provide at least one routine health education program for patients on an acute medical or surgical unit, and (c) that the program be provided by nurses at the bedside.

Procedure

Four community-based acute care hospitals were contacted by telephone, through their Nursing Departments, to determine which one was most appropriate. Of the four sites that responded, only one fit the criteria. Consequently, it became the site selected for the study.

Profile of the Selected Site

The hospital selected was a 350 bed acute care community-based hospital serving a rapidly growing community that has a significantly high incidence of acute heart disease. It had eight acute medical/surgical patient care units, one of which, a cardiac rehabilitation unit, provided a routine health education program for patients during hospitalization. As the literature suggests, there was a wealth of resources for health education programs available in this hospital for patients during hospitalization. For example, there was a department of educational services that consisted of a registered nurse, a librarian and an up to date library. There were nurse clinicians, nutritionists, physiotherapists, a nursing education committee, and an active cardiac team of cardiologists and cardiac nurses. The hospital provided one routine health education program that focused on four lifestyle factors, in particular, nutrition, stress management, exercise, and smoke cessation. Nurses at the bedside provided the health education program for patients recovering from a myocardial infarction (heart attack) on a cardiac rehabilitation or stepdown unit.

Selection of the Patient Care Units

The criteria for selecting the patient care units were that they be acute medical or surgical units. As previously mentioned, only one of the units provided a routine health education program for patients during hospitalization. This unit was automatically selected, and because it was a single-focus unit (cardiac only) a second single-focus unit was included to balance the study. The other two units were selected on the basis that one provided medical care and one provided surgical care.

Procedure

There were eight medical/surgical patient care units in this hospital. The identification of the four units was made by the Co-chair of the Nursing Research Committee of the hospital. Initial contact of the manager (head nurse) on each unit was made by telephone. Once consent was given, arrangements were made to select the informants.

Profile of the Selected Units

The patient care areas selected were (a) a cardiac rehabilitation unit, (b) a surgical orthopedic unit, (c) a general medical unit, and (c) a general surgical unit. The patient population in each area was determined by the type of illness or disease for which the patient was hospitalized. This resulted in variations in the requirements for patient care from unit to unit. For example, patients on the cardiac rehabilitation unit were on average, 50 years of age and fairly independent in meeting their daily physical needs. Whereas, the patients on the other medical unit ranged in age from 60-65 years, and were being treated for chronic illnesses. They required a great deal of assistance with their physical care and in meeting their daily needs. The general surgical unit patients were somewhere in between in terms of the age and needs. However, regardless of the variation in the requirements for patient care, the ratio of patient to nurse was basically the same on all four units (six patients for each registered nurse or eight to ten patients for a registered nurse and a practical nurse).

Selection of the Informants

Informants were nurses selected from various positions in the hospital. They were registered nurses involved with the (a) provision of day to day nursing care, (b) educational needs of the patient, (c) administration of the unit, and (d) administration of the nursing department/patient care services. The Director of Nursing is primarily responsible for the Nursing Department and is the direct link of authority between organizational priorities and the actual provision of quality patient care (Hoelzel, 1989). The nurse appointed to plan and implement health education programs, the manager of educational services, is aware of organizational priorities that are specifically related to patient education and health education programs. The unit manager or head nurse implements the priorities for the unit. S/he oversees and directs all patient care on the unit.

Nurses believe that one of their fundamental roles in health education; and because their are at the bedside, with frequent patient contact, have the best opportunity to provide health education programs for patients. The criteria for the selection of informants were as follows: (a) one nursing administrator Director of Nursing - who was responsible for patient care on the units selected, (b) the manager of education services for the hospital, (c) the head nurse from each of the four selected units, and (d) two staff nurses from each of the four units. In addition, the staff nurses would be advocates of patient and health education, knowledgeable about health education, and reflect the philosophy of the unit and the hospital. They would be in full time positions and have held those positions for at least two years.

Procedure

Initial verbal consent for the participation of the Director of Nursing, manager of educational services and head nurse of the selected units was obtained by the Co-Chair of the Nursing Research Committee. Following all the criteria, five staff nurses were identified on each unit by the head nurse. Their names were placed in a paper bag and two names were drawn at random from each unit. Each name was returned to the bag before the next draw. Two names

were drawn twice and each time the names were returned to the bag and a redraw was conducted. Of the fourteen nurses invited to participate, three declined because of other commitments. With each refusal, the names of the five nurses from that unit were placed in a paper bag and a redraw was conducted once again. Each informant indicated her willingness to participate in the study through a signed consent form (see Appendix D).

Profile of the Informants

All of the fourteen consenting informants who participated in the study were registered nurses and were in full time positions. All but the manager of educational services, were responsible to the Nursing Department. The Director of Nursing, the manager of educational services, and the four head nurses had between seven and 25 years experience in the nursing profession. Their educational preparation was at a bachelor or masters level. The staff nurses had from two to ten years experience in the nursing profession and most of their educational preparation was at the diploma level. All of the informants had been prepared in their basic nursing program to practice in acute care settings.

Only one informant had a background in community health and none had a formal background in health promotion or health education. Only one informant had taken a formal health education course and that was provided during her basic nursing education program. In addition, the informants' experience with patient and health education programs in their nursing education was varied. Those who were educated in the last 10 years or who had post diploma preparation identified receiving some instruction in relation to patient education in their nursing programs. However, most of the informants, regardless of educational background, had not been taught how to incorporate education programs into a busy schedule of patient care. Most had learned this on the job, through trial and error and with minimal assistance. Consequently, nurses with ten years experience were able to fit their specific program into a busy schedule, whereas, nurses with two years experience were not as able to use their skills and provide education programs because they were not as experienced in fitting patient education into a busy schedule.

Data Collection and Recording

Methods

The methods used to collect data to identify and describe factors that influence the provision of health education programs for patients during hospitalization were in-depth interviews, integrated with a document review and personal observation of the patient care areas involved in the study (Patton, 1990).

Demographic data were gathered at the outset of each interview that included information regarding the informants' basic training in health education and patient education. An interview guide was developed - one for each of the groups of informants - staff nurses, head nurses, the manager of educational services, and the Director of Nursing. To facilitate a comprehensive data base, items on the interview guide were categorized according to factors that might predispose, enable, and reinforce nurses in the provision of health education programs for patients. The guide also included questions concerning environmental supports and conditions that may influence health education programs.

Charts of the questions with sources of data and lists of the questions by factor and interviewee are set out in Appendix B and C. The sequence of questions in the interview guide was adapted for the interviews in order to facilitate the flow of the conversation. In order to help focus each nurse on the scope of the study, a "lead in" to the interview (including the definitions of health education, patient education, health education programs and the four lifestyle factors) was carried out at the beginning of each interview (see Appendix D).

Pilot Test of the Interview Guide

The items on the interview guide and the interview process itself were tested with seven nurses in various areas of acute care hospitals other than the one used in this study. Personal face to face audio taped interviews lasting 30-45 minutes were conducted using semi-structured, open-ended questions (Bauman & Adair, 1992). The interview guide developed for the Director of Nursing was reviewed by a nurse administrator to assess for appropriateness and accuracy of the items for the interview.

Revisions were made according to the feedback received from the pilot test of the interview guide and input received from the Nursing Research Committee. Suggestions were as follows: (a) include patient education as well as health education, (b) add a question regarding the priority given to each, (c) include a question on how each informant was trained to fit patient education into a busy schedule of patient care, (d) provide a definition of health education and health education program with some examples before the beginning of each interview, (e) ask the bedside nurses how they feel when they provide patient and health education for their patients, and (f) some questions for the director of nursing were too specific and required open ended statements. These items were the basis for the structure of the interview guide.

Procedure

The interviews, which followed telephone contact with participants, were set at a time and location preferred by each participant. The interviews lasted from 30-45 minutes and were completed over a four month period. Codes were used to protect the identity and guarantee the confidentiality of each participant. Each participant was identified by a code that indicated her title, area of work, and whether or not a routine health education program was provided for patients in the area. In situations where an informant may not have been able to identify an example of a health education activity that she had provided, a scenario was presented to assist with recall or to identify how it might have been handled by the informant. Because the hospital has a no smoking policy, and patients, at times, express a desire to quit smoking during hospitalization, it was used as an example to explore how the nurses may have or would assist patients with smoke cessation. The data from each interview were then transcribed verbatim and carefully entered into an interview log containing a column beside each transcription for the researcher's comments. A number between one and fourteen was assigned to each coded interview. This number was placed in brackets at the end of each response.

Selection of Official Documents

The official documents that were considered to contain important data for this study were (a) the mission statement of the hospital, (b) the philosophy statements of the hospital and the selected patient care units, (c) the philosophy statement of the Nursing Department, and (d) the philosophy statement of the educational services.

Procedure

Permission was obtained and copies of each document were received from the person in charge of each department. A document containing the goals or strategic plan for the hospital for a five year period was provided by the Director of Nursing as well. In addition, patient teaching checklists were obtained from each unit that was using one as part of patient care. A review of the official documents obtained from the hospital was conducted and data relating to health education for patients were identified and summarized.

Personal On-site Observations

Although not identified in the design of the study, personal observations of the patient care units proved to be a rich source of data. They were conducted following the interviews on each patient care unit. Descriptions of the on-site observations were documented at the time of the site visit.

Data Processing and Content Analysis

The PRECEDE model was used to guide data analysis. The data were analyzed throughout the collection phase. Analyses were carried out at several levels following completion of the data collection from informants, document reviews, and on-site observations. The purpose of the analysis of the data was to answer the research question which was to illuminate factors that may facilitate or compromise the provision of health education programs for patients during hospitalization. Each transcription was carefully reviewed. Each response was placed under one of three categories: (a) predisposing factors, (b) enabling factors, (c) reinforcing factors.

Environmental supports were included with the enabling factors. Each category represented a neutral position, one that could be considered either a facilitating factor or a barrier depending on the supporting data. Each category was followed by subcategories as well. Data obtained from official documents and personal on-site observations were also categorized in a similar manner.

As the themes, categories, and subcategories emerged from the analyses, the data were grouped accordingly. Those reorganized under predisposing, enabling, and reinforcing factors were considered *direct* influences on the provision of health education programs for patients during hospitalization, because they had a personal effect on the nurses who were the providers of health education programs in this study.

Other categories identified were entered under the following headings: (a) medical model, (b) hospital culture, (c) government policies, (d) community impact, (e) hospital priorities, (f) hospital philosophy, and (g) nursing factors. These were considered *indirect* influences on the provision of health education programs for patients during hospitalization, because they had a secondary effect on both the nurses and the provision of health education programs in this study. These categories were not included in the PRECEDE model, and therefore, the model was adapted to reflect these findings (see Figure 2). The adaptations were a descriptive representation of the factors that influence all levels of health care professionals within a hospital setting. However, in this study, the data provided more information regarding how those factors ultimately influence the staff nurse. It was recognized that the factors identified and represented in the adapted PRECEDE model are not exclusive.

Issues of Validity and Reliability

According to Patton (1990), the validity and reliability of data in qualitative research depend on the methodological skill, sensitivity, and integrity of the researcher. They also depend on the appropriateness of the instrumentation used to collect and analyze the data.

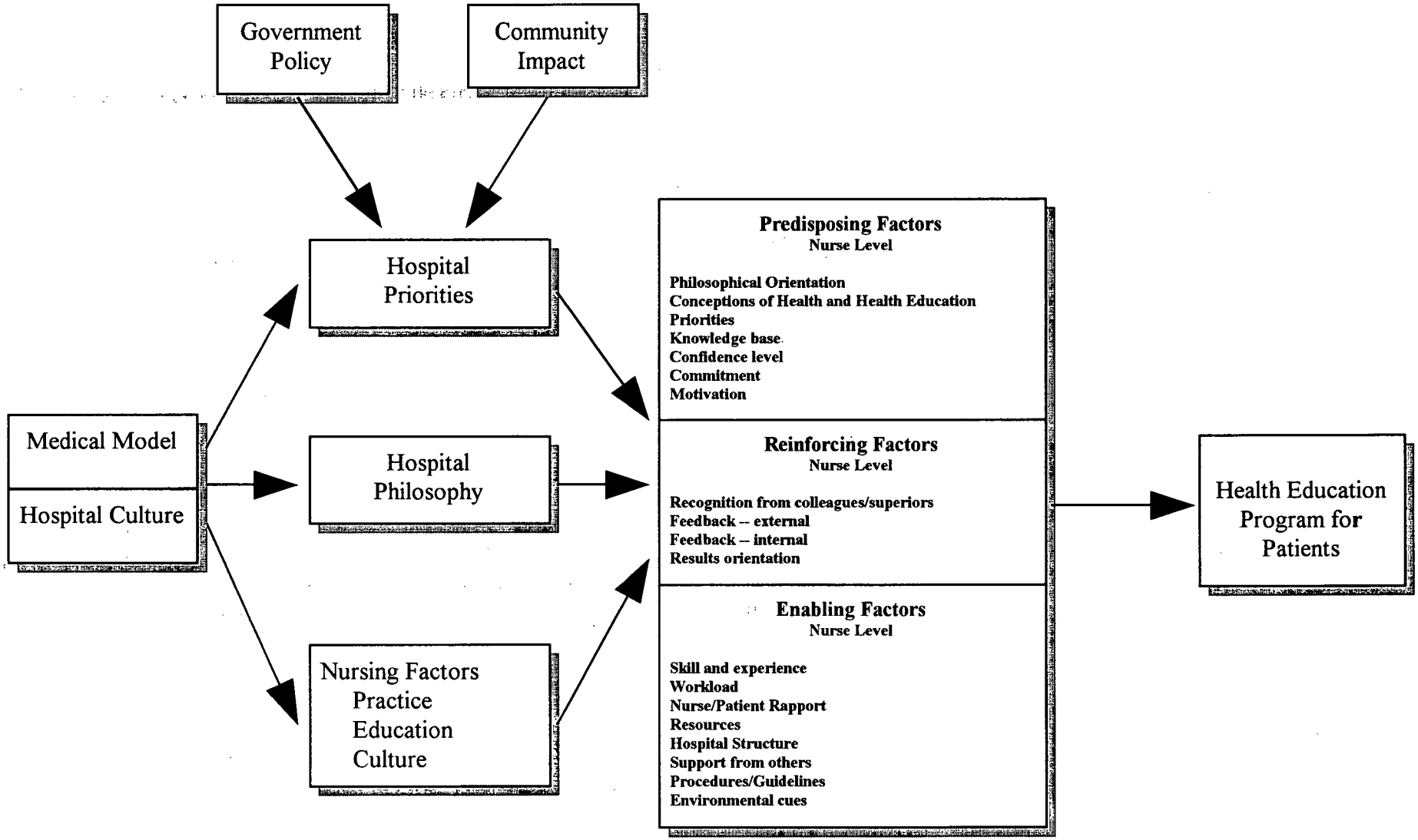


Figure 2:
Adapted PRECEDE-PROCEED model for health promotion planning and evaluation within a hospital setting

External Validity

Validity indicates that the design, method of inquiry, and instruments used were appropriate for the research question, measures what it proposes to measure and appraises the content accurately (Patton, 1990). The descriptive qualitative method as described in the previous section required that certain methods of data collection and analysis be employed. The identification and description of influences on the provision of health education programs for patients during hospitalization were based on these methods: (a) face to face, one on one, in-depth, semi-structured interviews with nurses, (b) personal observations of the selected patient care areas, and (c) a review of official documents from various areas involved in this study. The results were based on themes or issues that emerged repeatedly from the data analysis.

Criteria set out for the selection of staff nurses may have created a bias in the data, particularly in the selection of nurses who were identified by their head nurse as being advocates of health education. This was recognized, but considered necessary in order to aim for nurses who could respond to questions relating to health education for patients. It was felt that informants who were not advocates of health education programs may not be able to provide information that was related to the focus of this study. As it was, several of the selected staff nurses indicated that they may not be able to provide adequate information on the subject of health education for patients during hospitalization.

Internal Validity

Because the methods used in developing the interview guide and analyzing the data were subjective, it was important to discuss the influence of the researcher and the biases s/he may bring to the study. Inherent in every researcher is a certain unique perspective of the world which is formed by values, culture, and gender. Denzin and Lincoln (1994) suggest that every researcher speaks from that distinct point of view. The research process is influenced by this, particularly in the way individuals in the study are viewed. Therefore, it is important for researchers to indicate their personal perspective or bias as well as the "bias" of the methodological approaches selected for the study.

The researcher of this study has a background in health education as well as the health care field, and has had experience working with nurses who provide educational programs for patients in medical/surgical areas in an acute hospital setting. This background and experience brought both a subjective and an objective perspective to the study. However, having been closely aligned with nurses in acute care hospitals for over 20 years, a number of strong inherent biases may exist

that the researcher is unaware of, in particular the subtle, yet powerful influences of the medical model. This may have influenced the design of the study as well as the collection, analysis and interpretation of the data.

Reliability

Reliability indicates the degree to which a study will yield similar results with the same subjects at a different time or under different conditions (Borg & Gall, 1989). This study clearly describes the process of events, so that others may follow the thinking of the researcher. Methods of data collection and analysis are reported in detail, so that other researchers may restructure this study in a similar way and arrive at similar conclusions.

Ethical Considerations

Initially, the study received approval from three review procedures:

1. A written proposal submitted to The Behavioral Sciences Screening Committee for Research and Other Studies Involving Human Rights Subjects, University of British Columbia.
2. A written proposal submitted to the Nursing Research Committee as a routine procedure for approving research projects at the selected hospital.
3. A formal review of the study by members of the Nursing Research Committee with the researcher in attendance to respond to questions and challenges.

Consent was obtained from each informant by a signed consent form prior to the interviews. The consent form included: (a) the purpose of the study, (b) the interview protocol including the confidentiality of the information given, (c) the informant's right to refuse to participate in the study, or (d) the informant's right to refuse to answer any question or withdraw from the study at any time without recrimination (see Appendix D). Procedures were in place to protect the identity of the hospital and the informants, not only in the collection of the data, but also, in the presentation of the findings and the writing of the summary report.

This study was based on a descriptive, qualitative method of inquiry, using the PRECEDE model as a guiding framework for data collection, data analysis, and presentation of the findings. Chapter Three discussed the appropriateness of the research methodology used and described the study in detail. Issues of validity and reliability, as well as ethical considerations for this study were outlined. Procedures implemented to protect the identity of the hospital and informants were identified as well.

Chapter Four will present the findings by identifying and describing factors that may *directly* influence nurses in the provision of health education programs for patients during hospitalization to acute medical surgical units.

CHAPTER FOUR

PRESENTATION OF FINDINGS

Direct Influences on the Provision of Health Education Programs for Patients

This chapter identifies and describes predisposing, reinforcing, and enabling factors that are considered to have a *direct* influence on the provision of health education programs for patients during hospitalization. Unless otherwise indicated, informant data were used to develop each section in this chapter.

Analyses of the data revealed several recurrent themes that were categorized under predisposing, enabling and reinforcing factors. Predisposing factors are described as values, beliefs or perceptions that nurses hold which are likely to motivate them to provide health education programs for patients. In a hospital setting, it was evident that these factors were complex and had a significant influence on the provision of health education programs in this study.

Enabling factors are described as skills, experience, organizational arrangements and a supportive environment that may assist nurses in providing health education programs. Factors such as workload and resources have been identified by nurses in previous studies as having an influence the provision of health education programs for patients which, in addition to other factors, were identified in this study as well.

Reinforcing factors are those which encourage or discourage nurses to continue providing health education programs by rewards received, a sense of satisfaction and feedback from others. Although these factors have not been identified in the literature as frequently as the enabling factors, they were clearly evident as significant factors in this study.

Predisposing Factors

This study identified seven categories that may predispose nurses to provide health education programs for patients. They were as follows: (a) nurses' philosophical orientation to health and health education, (b) conceptions of health and health education for patients, (c) priorities of the nurses, (d) knowledge base, (e) confidence level, (f) commitment, and (g) motivation.

Nurses' Philosophical Orientation to Health and Health Education

For the purposes of this study philosophical orientation to health and health education relates to the beliefs and philosophy nurses hold about lifestyle and illness and the benefits that can be gained from health education programs. What nurses believe about the link between lifestyle and illness and the effect health education may have on the patients' health status is a critical factor in the provision of health education programs during hospitalization. In addition, how they see their role and the role of an acute care hospital is of prime importance to the provision of these programs as well.

Individual philosophy. Nurses bring their own unique philosophy and perspective to their nursing practice. Some of this comes from their basic and professional education, some from the area in which they practice and some by a variety of personal experiences. In an acute care setting, the focus is predominantly on illness and disease and many nurses who were trained for and practice in hospitals view health from an illness perspective. This was true for the nurses who were interviewed as well. However, six informants reported that certain personal life experiences had influenced their perspective and philosophy of health and health education. When asked what guided their practice in relation to health education, several responded:

> *It's [health education] a combination of training and how you perceive it and your own philosophy of health.(10)* *

***

* The bracketed number indicates the participant's code number.

It's a philosophy about my own personal health.(3)

***

I exercise and try to eat properly most of the time, keep the stress down, and I don't smoke.(8)

***

.... if you have a positive attitude and you eat right and get lots of exercise, you really can look after your own health. You don't have to depend on going to the doctor or depend on all kinds of things.... I am an aerobics teacher - and that involves a lot of diet.... (11)

Other informants indicated that their philosophy came from a personal experience with illness - themselves or their families.

I had a gestational diabetes with both my pregnancies and I sort of have a little bit more insight into it I think.(14)

***

There's also a personal side. I was in an MVA [motor vehicle accident] and I realize how important any education is. My family background - my dad died of a heart attack, my mother has a pacemaker and I have a brother who's a high risk cardiac patient.(5)

***

.... like my parents they're elderly and their lives are in the hands of the medical profession and they don't even know what the names of their pills are that they are taking. It really has to change.(14)

Individual beliefs about the role of nurses and the role of the acute care hospital.

When patients are in hospital, they feel vulnerable and have time to reflect on their life and their health. As a result, they may be more open to health education. What nurses believe about their role and that of the hospital in relation to health education will influence the provision of health education programs for patients. When discussing their beliefs about the role of an acute care hospital in providing health education programs, all of the informants indicated that it had a significant role to play in this area. Because of the readiness of the patient to make a lifestyle change, several informants indicated that hospitalization was a good time for health education.

It [health education] should be [provided] as soon as the patient walks in that door. We are a health care center. People tend not to think about their health until they are sick and so you've got them at prime time.(3)

***

Patients are going through a crisis in a hospital, so it could scare them enough to want to make changes.(13)

***

This is the time. We would be so wrong if we didn't at least make the effort.... so often their readiness is now.... (2)

And another informant stated that it is a good time because of the positive influence the hospital may have on the patients and their families.

I don't know that they would go home and quit smoking and start eating properly, but it certainly plants a seed and they'd start thinking more about what they are eating, and what they are doing to their bodies, how they are exercising, a little bit more.(10)

***

.... we are looking at their children too. Like maybe we're seeing our future looking health.(12)

When asked about the role of nurses in providing health education, all of the informants stated that nurses were the best advocates for health education in the hospital and that they do have an important role to play in providing health education programs for patients.

.... they [nurses] are the ones that definitely have the longest contact with the patient.(2)

***

.... they [nurses] are in the best position to do the teaching.(5)

***

It's got to be our role, because if we don't, you are going to see that patient again and again and the patient will be in a deteriorated condition.(7)

***

.... because you spend more time there [the bedside] and you have more opportunity than somebody else.(8)

***

.... my job isn't complete unless I give them at least the information, the choices, the alternatives. I feel that's my job as a nurse.(4)

Individual beliefs about the benefits of health education. Health education, provided at a time when people are receptive does influence healthier lifestyles. Therefore, health education provided during hospitalization may have benefits for individuals and subsequently, for the hospital and health care system (Jenny, 1990). All of the informants were convinced that unhealthy lifestyles are linked to illness and disease. In addition, they also believed that health education influences lifestyle and health and therefore, has benefits in general.

> *I really think that about 80% of the patients that are in here is a result of lack of knowledge of how to keep themselves healthy.... Basically it's about diet and exercise. There would be a lot less people getting sick. I really believe that.(11)*
>
> ***
>
> *.... [without] education, a lot of people don't know about - that lifestyle has such a big effect on their health....(4)*
>
> ***
>
> *I have worked overseas - in Asia - they have no cardiac problems at all. If they had any cardiac problems, it was congenital. So I do know it's lifestyle.(13)*

The nurses also indicated that they believed health education programs have benefits for patients, namely improved well-being and quality of life, reduced recurrence of illness and subsequent reduction in hospitalization.

> *Preventive is better than treatment, so I felt it was quite important.... I think it's a good thing for the patient. It's a good thing for every patient in the room to hear this information as well, because, even though they are not actively seeking, they are still aware of this teaching.... that somebody is concerned and values this. And it's good for the nurse to reinforce information that you're not thinking about. It can fade away in the back of your mind. It's keeping everybody up.(7)*

Beliefs in benefits to the hospital and health care system were clear and consistent among the informants as well. Bed utilization through fewer admissions and shorter hospital stays would result in reducing the demand for services and health care costs. One informant added that health education would also improve the image of the hospital within the community.

> *.... It helps people understand what the hospital does and can do and they see it as a place that isn't just for sick people, but it can also help people stay well. I think the more we can help people see the hospital as a small part in their continuum of health care, the better we will set ourselves up to be received by the patients and the family.(1)*

This discussion suggests that the philosophical orientation nurses have in relation to health education is important to consider in how it may influence the provision of health education programs for patients. Many nurses believed that there was a link between lifestyle and illness and that health education programs do have an effect on patients' health status. In addition, they believed that providing health education programs for patients during hospitalization would lead to benefits for patients, the hospital and the health care system.

Conceptions of Health and Health Education for Patients

For the purposes of this study, conceptions of health and health education refer to how nurses define health and health education for their patients. The operational definition of health and health education varies depending on whether one is coming from a health care perspective (medical model) or a health promotion perspective (health model). It is possible that when the medical model is the predominant model in a health care setting, nurses define health and health education in terms of disease. Consequently, this may influence the programs they provide for their patients.

How nurses define health for patients. Health defined in terms of the health model refers to well-being, health status, and health practices whereas, health defined in terms of the medical model refers to the absence of disease. In an acute care setting, the predominant use of the medical model means that nurses may view patient health as it relates to the illness/disease for which the patient has been hospitalized.

When asked to define health in general, some nurses in this study identified health on a continuum of well-being through the life span and a balance between physical, mental, and spiritual needs. However, when asked to define health for their patients, informants at all levels of nursing shifted the discussion to the patients' illnesses and on the "here and now", rather than on well-being through the life span. For example, phrases like "coping with illness" and "comfort" were used to define health for patients with chronic debilitating conditions.

Health is whatever is the optimum that a patient can achieve for themselves - because health for me and health for someone who is 85 years is quite different.(2)

***

Health is how they perceive what they are going through and their attitude toward getting better.(10)

***

I would say that anyone has stopped to say what does healthy mean for the people who come through the hospital.(1)

How nurses define health education for patients. Generally, how one defines health will determine one's definition of health education as well. In other words, if using the health model, health education may be defined as instruction that is provided in order to assist individuals in improving their general health and lifestyle, thus reducing their risk for disease. If using the medical model, it may be defined as instruction that is regarded as part of a treatment for disease. In a hospital setting, nurses mainly provide patient education - instruction that deals with the diagnosis and treatment of their illness (Bartlett, 1985).

The nurses in this study for the most part defined health education for their patients in relation to the patients' presenting condition with recuperation, restoration, or rehabilitation as the main objective.

.... we tend to focus more on disease when we are in a hospital and therefore, our teaching focuses more on disease. If lifestyle is part of the disease process, it comes into play - but if it's not, it doesn't.(6)

***

Education for patients' health is focused on what they are here for and how to help them get home. Generally, we don't go into other issues that aren't related to their stay.(10)

***

.... it would be more how to cope with their condition than preventive. It's not carried on to all patients.(2)

***

.... when you work in a hospital you don't think of preventive - you're not worried about anybody outside until they come in.(9)

***

.... [not preventive because] people didn't see those patients until they came in with the problem.(1)

This was also true for the routine health education program that the cardiac nurses provided.

> *It's [health education] part of his treatment.(5)*
>
> ***
>
> *.... this health education program has stayed very much focused on treatment for an MI [heart attack].(1)*

It was considered preventive only in terms of preventing a recurrence of the illness and/or readmission to the hospital.

> *.... that's probably one of the biggest preventive measures, not wanting the same cardiac patient coming back.(14)*

Even when specifically asked to give examples of health education using the health model perspective, most of the informants continued to relate to the reason for admission, instead of the patients' health status and health practices in general. The following statements clearly demonstrate this observation.

> *On an orthopedic ward it's difficult to teach preventatively for breaking a hip. Sometimes things just happen.... If I have a patient with a cardiac history, I will involve some cardiac teaching ie, post-op pain management. Pain increases your cardiac demand and the supply is not too great after surgery because of blood loss, etc. I do a little bit in terms of post [operative] care.... I had one patient who had a cardiac history and I did talk about his smoking and how important it is not to smoke. I usually draw from the example that often it's recommended that you stop smoking from 12-8 hours before surgery, because it really improves your chances of recovery - the 12 hours. It's really important because there are fewer respiratory problems after surgery (lower secretions, fewer problems with deep breathing and coughing) and especially with a cardiac patient.(7)*
>
> ***
>
> *Smoking would be considered lifestyle and the effects it has on your chance with anesthetic and your recovery.(9)*
>
> ***
>
> *We do the smoking one a lot and tell them it's not too wise to smoke before their surgery, that they should probably stop for 12 hours to help the breathing.(8)*

One informant gave the following explanation why she did not provide health education for her patients, even though cardiac nurses provided it for their patients.

> *You don't know you are prone to a gallbladder attack until you get one..... I can't teach the patient about how to eat right when he has gallbladder problems. If he is not having surgery, then I can deal with further preventive measures/teaching. Whereas, they [cardiac nurses] are trying to decrease the risk of heart attack and nobody thinks in terms of surgery of decreasing the risk of having to have surgery - cutting out fats may stop you having your gallbladder out. But that is sort of a post procedure teaching or preparing for the procedure - it's not lifestyle.(9)*

Only two informants demonstrated that they provide health education for their patients using the health model.

> *Health education is pretty basic.... I usually tell them it's important to exercise anyway.(10)*
>
> ***
>
> *Generally [I do] quite a bit [of health education]. You can do patient teaching every day when it comes to diet. There's so much - most patients don't realize that they have to drink a lot of fluid. That is so basic. I find with diet and fluids and eating the right things - just simple, basic - would make them feel a lot better and getting up and exercising and moving around more.(11)*

All other informants shifted to individuals in the community when asked to discuss health education in a preventive way. In addition, they identified the physician or the community health nurse as the ones responsible for this role.

> *I can't teach a patient how to eat right when he has gallbladder problems.... I would assume that when he's going to his physician, his physician would give him the diet and teach him that aspect. But the community doesn't set up preventive teaching.(9)*
>
> ***
>
> *We explain what we know about the patches [nicotine] and that they could talk to their doctor and maybe get more information on that. It's sort of directing them in the right direction, I would say.(14)*

It is evident from these findings that the nurses defined health for their patients in terms of the presenting illness and health education as a treatment for the disease. Furthermore, they viewed patients' health and health education needs as different from their own and the rest of the individuals in the community. As a result, how nurses define health and health education for patients may have a direct influence on the provision of health education programs for patients during hospitalization.

Priorities of the Nurses

In general, nurses share the same priorities, such as, meeting patients needs, providing daily care, and completing their work assignment by the end of the shift.. Included in their list of priorities is patient education and health education (Berger & Williams, 1992).

However, these data suggest that the priority nurses place on health education can vary from "amazingly high" to "it's a frill".(4, 7) As a result, the priority nurses place on health education may have a direct effect on whether or not nurses provide health education for their patients. One informant thought that the priority placed on health education was very dependent on the individual nurse.

> *.... it depends on what you consider is a priority. It just depends on how you view it - your perspective of how important is this.... Preventive is better than treatment, so I felt it was quite important - I have a few minutes - other nurses are very busy and I don't have time.(7)*

The data supported this view in the wide range informants gave to the priority of health education for patients.

> *It's something that you have to make it your primary objective. Patient teaching is the most important thing we do on this unit...(5)*
>
> ***
>
> *We feel it has to happen because it is something that is important.... and it can be important for any unit. It's not just important specific to cardiology or anything like that.(3)*
>
> ***

.... It's really quite high - amazingly high. It's part of their basic care.... It's so important that it gets done because it's on a higher priority, so that other things may go if you have to.... Because of their short stay you really have an obligation to begin your teaching as soon as possible.(4)

***

Getting our work done is number one. There are definite benefits [to health education] and we definitely have a role, but we don't do it, because of those other factors [time and money]. That's why it hasn't come to be an issue or a priority.... It's here and now that you are dealing with and you're mainly dealing with 'Is this person safe to go home and when he goes home? Will he function?' Those are your priorities. The other (health education) is a third or fourth priority. It's unfortunate, but that's the reality.(6)

***

Ostomy teaching is a high priority on this unit. Other teaching isn't quite as important.(10)

***

We are very task-oriented. We have to get our tasks done.(13)

One other factor that sets the order of priorities for nurses is patient need. One of the ultimate goals in nursing is meeting the needs of the patients. Therefore, when a need is identified, as advocates for the patients, nurses make it a top priority (Berger & Williams, 1992). And so, when health education is identified as a patient need, it becomes a high priority and nurses will endeavor to meet that need.

Several nurses in this study demonstrated that this was true in their experience. For example, one informant explained the reason why the health education program is provided on the cardiac rehabilitation unit and not on other units.

My understanding of the program is that it was set up purely for post MI [heart attack] patients.... [because of] the recognized need and identified group of patients was sitting there.... One of the biggest things is patient need - if there is a need for information by patients, professional staff will find some way of getting it for them.(1)

***

We may have a patient here for several weeks before its identified that they are lacking in some area... Then, that's brought forward usually to the charge nurse who says, "oh, this lady really needs this kind of education", and if we couldn't provide it, we would certainly find someone who could.(12)

***

[Patient education] is high up there. It's usually the preops [preoperative patients] and the postops [postoperative patients] that get the teaching, because they're the ones that need it. We try and fit it into the day.(8)

Another informant indicated that the development of future programs was dependent on identified patients' needs as well.

.... there will be more and more community education, because there is such a strong need for it.... a lot of it [health education] is by patient need.(1)

The development of a health education program for patients in the hospital was also deemed realistic by several other informants as long as there was a need.

These statements suggest that although the priority of health education varied from nurse to nurse, when health education was identified as a patient need, it became a high priority. In those instances, the nurses found some way to meet that need, regardless of barriers that were present.

Knowledge Base

The knowledge base of college and hospital educated nurses is mainly focused on illness and disease (Berger & Williams, 1992). Although most of the informants acquired some knowledge in patient education, their knowledge of health education was very limited. For example, only one informant had taken a course on healthy living in her basic program. The continuing or professional education of nurses was illness-focused as well, because of the need for nurses to keep current with the constant rapid changes occurring in their field of nursing practice. Informants who were knowledgeable about health education acquired it because of a personal - not a professional interest, nor because it was an expectation in the area where they worked. The extent of the informants' basic education in health education - the level of their knowledge base and how they kept current was evident in the following statements:

.... at school [nursing]- we were taught proper nutrition, calories - how to eat properly.(8)

***

Some of it [knowledge in health education] I came with. You have bits and pieces of it and I think it's just pulling it together. Part of it came from my personal experience before and part of it's been developed professionally, and the other part of it was when I very first came to the floor, I watched the videos - I need to know what kind of information I'm giving my patients - if it's going to be appropriate for them.(4)

***

I don't know about my colleagues, but I have been to workshops like soothing touch and relaxation techniques for stress management. A lot of nurses haven't been to these and probably wouldn't feel comfortable. These courses were taken out of personal interest.(13)

***

Speaking from past experience with other nursing colleagues that are heavy smokers, they've used patches (nicotine). So we introduced our idea to them (patients) and say have you ever thought of going on these patches - they're expensive, but in the long run, you'll be better off.(14)

***

New resources come on the unit. There's a lot of conversation among the nurses on the floor about different programs, different things that are available. There are workshops available.(5)

***

I try to read as much as I can. I clip out what I read on medicine in the newspaper.(4)

Because smoking is the single most serious, yet preventable risk factor for heart disease, the nurses were asked specifically about smoke cessation programs. Most of the informants indicated that patients had expressed a desire to quit smoking during their hospitalization. However, when specifically asked how they would respond to this, many nurses demonstrated that they did not have adequate knowledge or resources to assist their patients.

Well, we try to support them in that way, because here, they've got incentive to quit smoking and it's a step in the right direction. So we really encourage it and say, 'if you have to smoke, you have to go all the way downstairs and it's cold, it's dark, it's violent and you know what can happen'. We really discourage it. And we reinforce the positive feedback when they respond like - 'I think I'll just stay in the room and not have a smoke' and say 'that's great. I'll make you a cup of coffee or a cup of tea or you can watch TV for a while' - just encourage a healthy behavior, also.(14)

***

I would validate the patient's decision and the rationale for cessation of smoking and reinforce the decision as a positive thing. And when the doctor came in, I would certainly discuss this with him and try and seek resources to facilitate this undertaking. I'm not aware of the channeling involved in the resources that I could tap into. I would expect the doctor to have some idea of what the resources are, give me some direction and facilities even outside the community - some recommendations to the patient and perhaps facilitate this by some type of sedation to help the patient along with everything.(7)

***

We had those programs on the cardiac unit when I first came here and that was more the focus. I certainly would respond to it with positive encouragement. I'm not exactly sure how you would go about teaching someone not to smoke - it's more an emotional crutch than a physical one. There's no support here e.g. smokers anonymous.(10)

These findings indicate that for the majority of nurses in this study, unless health education was considered part of the patients' treatment or the nurse had a personal interest, their knowledge base of health education was limited. Therefore, they were not able to provide programs or readily adapt existing programs for patients who were expressing an interest in stopping smoking.

Confidence Level

The nurses' level of confidence may directly influence the provision of health education programs for patients. In this study, nurses were confident in their knowledge and skill when they had experience and frequent opportunity to provide health education. Consequently, they were likely to engage in educational activities for their patients. When nurses did not have the opportunity or experience, they lacked confidence in their ability and tended to avoid opportune situations for health education and offered encouragement and emotional support instead. Several informants indicated that they felt confident in providing health education.

Exercise and dietary issues we feel comfortable teaching. If we feel overwhelmed with the dietary, we will make referrals and get them to talk to the dietitian for more specific issues. But we would give them guidance about the variety of foods.(4)

***

I think many [nurses] have been here as long as I have and they really feel good about it [providing health education]. About 80% of them.(11)

***

It just depends on the experience of the nurse. If she's an experienced nurse she probably would [provide patient or health education]. If she's a fairly new nurse, she may not know.(12)

***

Nurses gain confidence after being here for a period of time. Some newer ones - I don't think they feel confident. They gain confidence by watching the video with the patients. If they can be part of the readings or watch the video and then talk about it afterwards with the patients. That's when they feel best and that's how they gain confidence.(3)

***

I felt confident, because we did have the course [health promotion] when I was in training. And we did practise some of the things we preached as part of a project.(7)

However, several other informants disclosed that they did not feel confident providing health education and indicated why.

I do have a lot of knowledge from teaching and nursing and I do get the point across.... We are no longer current with our teaching, so you don't feel confident and lose your touch at teaching.... You're much more comfortable when you know exactly where you are going from point A, where B, C and D are. I'd feel somewhat uncomfortable because, at this minute I do not know what the resources are.... (7)

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A lot of nurses don't think they can teach - that they are not teachers and they sort of back off a lot - saying that's not part of my job. I don't know how to do that - I couldn't do that. They are doing it and don't realize they are doing it - you just have to formalize it and that's the program.(9)

These findings suggest that experience and opportunity are two areas that determine how confident nurses are about their ability to provide health education programs and the more confident they are, the more likely they will provide programs for patients.

Commitment

The nurses in this study frequently identified commitment as a major component in both the development and implementation of health education programs. When asked what would be required to develop a health education program for patients, several informants seemed convinced that commitment was a key ingredient.

If you were really committed to that and had the energy to do that - there are ways of doing that [developing a health education program]. You could definitely do it.... It has to take one person that's really committed to it though, and then you might get 2 or 3 people together including the assistant head and just figure out ways you were going to get this thing going.(11)

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It's just a matter of being committed to that one thing that you want to do.(13)

***

I don't think it would take very much. Time is the biggest factor. Somebody that will organize it and is committed and then get commitment from the people involved.(12)

Commitment also seemed to be key elements for the two routine programs (ostomy and cardiac) currently being provided by nurses in specific areas of the hospital.

We've come to realize how important it [education] is. Nursing is certainly the drive in this program (ostomy).(11)

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One of the nursing instructors that used to work here was very much an advocate of cardiac teaching and that was her 'baby' and she spearheaded a lot of it - outpatient and on the unit.(6)

***

They did it [the cardiac program] with no money and on volunteer time. They set up a program which is now funded.(1)

Despite major cutbacks in funding and resources throughout the hospital, these two programs (Ostomy and Cardiac) have been successfully maintained. In fact, some of the nurses have been raising funds to pay for educational materials that are no longer free of charge.

The above statements provide support for the notion that when there is a strong commitment for the development and implementation of health education programs for patients, it does happen. Nurses who were committed to certain programs have managed to initiate and maintain them successfully over a long period of time despite cutbacks in hospital resources.

Motivation

Nurses enjoy educating patients and generally want to do more. Those who provide health education routinely are highly motivated and stimulate others around them.. However, nurses who engage in educational activities for their patients as infrequently as once a year or as "a very incidental type of thing" are not motivated and therefore, less apt to provide health education programs for their patients. Several informants offered a variety of examples that demonstrated that when nurses have the opportunity to provide education they want to do more.

> *It's the teaching that all of us want to do and there was talk about one nurse just doing the teaching and we all said 'no, we want to do that'.... we had an extra nurse a couple of weeks ago and it was so nice because we spent so much time teaching - and everybody gets hooked....The more teaching they [nurses] do, the more they want to teach.(5)*

***

> *Nurses mainly have time to do physical care only. Being able to teach would give them incentive to go on and learn more too.(14)*

One informant however, indicated how the lack of opportunity to provide health education had affected her practice.

> *.... the less you do [health education], the less you want to do.(7)*

These findings suggest that when nurses were involved in health education programs on a regular basis, they were more likely to engage in educational activities than when opportunities occurred on an infrequent or incidental basis.

The evidence in this section on predisposing factors suggests that the most significant factors that may stimulate nurses to provide health education programs for patients during hospitalization were the philosophical orientation and conceptions of the nurses to the health and health education of their patients. The priority nurses placed on the provision of programs in their area of work were also an important factor. The informants identified confidence level, commitment, and motivation as additional positive influences.

Enabling Factors

Enabling factors assist and support nurses in their efforts to provide health education programs for patients during hospitalization. Eight categories emerged from the data analysis. They were as follows: (a) skill and experience in providing health education, (b) workload, (c) nurse/patient rapport, (d) resources, (e) hospital structure, (f) support from others, (g) protocols, and (h) environmental cues.

Skill and Experience in Providing Health Education

The skill and experience nurses have in educating patients may influence whether or not they provide health education programs for their patients. Nurses who were skilled and had some experience in providing a particular education program wanted to educate their patients and felt confident in their ability to fit it into their daily plan for patient care. Therefore, they were likely to engage in educational activities for their patients.

> *.... I think really it's working with it for a long time - like years - and feeling good with it. And having the confidence of doing it.(11)*
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> ***
>
> *I think I do more teaching than the average nurse.... I think I tend to be a "teachy" sort of person. I enjoy teaching the patient.(7)*
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> ***
>
> *The more you do, the more you want to do.(5)*

Having experience with the specific content makes it easier for nurses to adapt the current program to each unique patient situation as well.

> *If they [patients] came in, they were anxious and their blood pressure was up and they have a busy lifestyle and they smoke and so on, we usually incorporate that easily into this scenario, I think. It's interchangeable.(14)*

Nurses who have a limited opportunity to provide health education, do not gain experience and generally tend not to engage in health education activities for their patients.

> *When you don't get a chance to teach anything very much because we are doing many non nursing functions.(8)*

***

> *I haven't had much chance to use it [knowledge and experience in health education] except when I worked on the cardiac unit and in my personal life.... I don't focus on lifestyle affecting the health on an orthopedic ward. I did focus on that in the coronary care ward.(7)*

These quotations lend support for the observation that when the nurses had skill and experience in program implementation and fitting health education into their daily plan for care, they were able to provide health education programs for their patients.

Workload

Workload for the nurse at the bedside setting is determined by the number of patients each nurse is assigned to take care of in an eight or twelve hour shift. All of the informants indicated that workload had a major impact on the provision of any patient education program. This study identified that the nurse patient ratio was six patients per registered nurse. Whenever eight to ten patients were assigned to a registered nurse, a practical nurse was also assigned to assist her. Generally this was the same for all the nurses who were interviewed. However, some nurses were assigned to patients who were independent in meeting their physical needs. Other nurses had patients who required frequent attention and a great deal of assistance. These differences in workload varied from unit to unit rather than from nurse to nurse. For the most part, the informants reported that when their work assignment was manageable, they had time and energy to provide some health education for their patients.

> *.... we had an extra nurse a couple of weeks ago and it was so nice because we spent so much time teaching....(5)*

However, when the workload increased and the same number of nurses were expected to provide all the care, health education and other programs were compromised.

> *I find patients do ask me a lot of things and it slows you down and I'm always late.... I enjoy teaching the patients but I usually feel stressed.... I feel uncomfortable, because I know I'm taking time that I don't have.(7)*
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> ***
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> *The load is very heavy. If it would be straight cardiacs [cardiac patients] that would be all right, because most of the cardiac patients when they are on stepdown, they are mobile. They can do all the care for themselves. But if you have medical patients that you have to toilet them, you've got to feed them - that is a lot of very good time that you could use for teaching.(5)*
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> ***
>
> *You are also looking at the level of care of the patient - a lot of those people (patients on the cardiac unit) are independent - they're up walking around. They have a little bit of a mix right now of medical patients which can take away time - teaching time and upstairs its quite often that I will have six patients - four totals [total care], so you are looking at the level of care.(13)*

One informant explained how workload in her area had restricted her in providing health education:

> *This unit requires heavy physical work and you get burned out.... The ward I'm on, is quite busy, unlike a general surgery ward, where the patients can do quite a bit of their AM [morning] care. On [our] ward, that's not the case, we're very busy and consequently have X number of minutes. You are not going to get X+10 number of minutes, so teaching is out.*

She went on to say:

> *I have left the ward very often very dissatisfied emotionally. All I can think of on the way home is - what did I forget to do. When you are thinking about these things you obviously haven't had time to do the teaching.(7)*

Even nurses who had experience and confidence in providing health education for patients in one area were unable to continue to do so when they moved to another patient care area where the workload was very heavy.

> *The nurses get burned out from the great amount of physical care that is required and get frustrated when they can't teach.... Many of the nurses who went there [medical unit] are good cardiac nurses and never have the chance to teach anymore.(5)*

I don't focus on lifestyle affecting the health on an my ward. I did focus on that in the coronary care ward.(7)

The manager of educational services had a workload issue as well, when considering hospitalwide health education programs for patients such as the possibility of providing a smoke cessation program. The department did not have any educators, only a manager and a librarian. They were responsible for staff education hospitalwide and served as a resource to those who provide education in all areas of the hospital. Recently, they had become involved in providing health education programs for the community as well.

It is evident from the above explanations that workload significantly influences the provision of health education programs. It is also clear that there are differences in the workload among nurses which may give some explanation why some nurses provide health education programs for their patients on a daily basis and others do as infrequently as once a year. All of the nurses at the bedside identified "heavy" workloads as a major barrier to the provision of health education programs during hospitalization.

Nurse/Patient Rapport

For the purposes of this study, nurse/patient rapport was defined as the relationship that nurses develop with their patients. It also includes how receptive nurses believe their patients are to health education during hospitalization. It is possible that the rapport that exists between patient and nurse may directly influence the provision of health education programs. Examples of the influences the nurse/patient rapport may have on health education was evident in the following statements.

I think it's [health education] an approach that you learn.(4)

***

.... because they [nurses] have a rapport with them [patients] - they've been looking after them - actually they [patients] would trust them a little more instead of someone that just came in and said I'm so and so and I'm here to teach you.... you just get little bits of information [about them] and then they sort of trust you and they tell you a little bit about themselves and their lifestyle and their attitudes that they want to change/don't want to change.(14)

***

.... Sometimes just the rapport that that individual strikes can make all the difference in the world, too.(2)

***

.... you're the one that has the rapport with the patient and things come up all the time.(11)

On the issue of how receptive patients are to health education during hospitalization, varying opinions were identified among the informants. Although many of the nurses stated that they develop a rapport with their patients that facilitates health education, they were less convinced that patients were receptive to health education in general. The following statements indicate that many nurses think that patients are not receptive to health education in a preventive way.

Patient resistance is incredible at times.(3)

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I don't think anyone thinks they are prone to a heart attack. The attitude of society is that it will never happen to me. Once it happens - then they, take steps to prevent it further.(9)

***

Don't you find that people generally not receptive unless they are in the crisis or unless it has some kind of an impact on them personally. The people on the cardiac unit believe that health education works.(13)

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Sometimes, a lot of them say they are going to [stop smoking], yet when they get up, its the first thing they want to do - sort of bargaining before surgery - but it's OK after.... I don't think people focus on health a lot. They're looking at getting better and getting back to the way they were.(8)

***

I don't like to tell them what to do because it's like kids - they don't want to hear it.... Well, they look at the doctor first before us. And usually they don't get it from him - they get a prescription.(11)

***

.... I think to some extent we have an uninformed public - who, if they knew what they should be knowing, would be asking a lot of questions. I think part of it is just the general state of the public's knowledge of health care - it's pretty limited.(1)

Two informants shared a similar belief that indicated only certain patients were receptive to health education.

> *.... our cardiac patients, they actually initiate a lot of it [discussions about health].(3)*
>
> ***
>
> *On the cardiac unit, yes, definitely - on other units that I have worked on - some [are receptive]- but few.(13)*

Only one informant gave a clear explanation of how her rapport and belief in patients' receptivity facilitated the educational process.

> *My experience has been that patients are quite anxious to learn. And the patients often ask me for information. If they feel you are an open person - sort of extroverted approachable - they tend to ask you.... Even now in nursing, I will speak to the patient about this or that and they didn't have any idea, and they say 'why wasn't I told that before?' I have a few minutes now - and often nurses are very busy and don't have time.... I get on very well, the patients are very comfortable with me....I find patients do ask me a lot of questions.(7)*

These statements indicate that the nurse/patient rapport and the nurses' perception of patient receptivity to health education both may directly influence the provision of health education programs. It was evident that when the patients trusted the nurse, they were likely to initiate discussions regarding their lifestyle. However, the nurses' perception that patients were not receptive meant that the nurses did not initiate discussions in this area and were therefore, unaware of the health education needs of their patients in many cases.

Resources

The availability of resources in order to provide adequate health education programs was important to nurses. In an acute care setting this may be especially important, because the audience, although "captive", is not self-selecting. Therefore, nurses are challenged to provide health education programs that are relevant to each patient's needs, in addition to blending educational activities with physical care activities. The main resources that were identified as essential in this study were: (a) personnel, (b) educational materials, and (c) overall funding.

Personnel. Many informants identified their Head Nurse and especially the Assistant Head Nurse as the best resource for obtaining health information materials. Several informants identified the cardiac nurses as an excellent resource and although they had not used them in the past, they would feel comfortable asking them for assistance.

> *I think they [cardiac nurses] would be a good resource, because they have such a good contact with it [health education] and because all their patients are cardiac patients and that's their main focus with their problems. So I think they would be excellent resource people to talk to.(14)*

In addition, the cardiologists, nutritionists, and librarian were other resources identified by the nurses, although it was evident that the cardiac nurses were mainly the ones who accessed them for information and educational materials.

Educational materials. Because of the complexity of their "educational" setting, nurses require a variety of educational materials to draw from and yet they identified a lack of education materials in their areas. Audiovisual and print materials containing lifestyle information were available mainly in one area of the hospital - the cardiac rehabilitation unit. In addition, because of a shortage, some of the nurses on the cardiac unit were developing their own educational pamphlets and raising funds to pay for other educational resource needs. Only isolated resources, such as relaxation tapes, were available on other units.

Overall funding. Funding was also frequently mentioned as a necessary resource for all health education programs and since the hospital did not receive government funding for health promotion or health education programs, resources were limited and available mainly according to hospital priorities. The cardiac program was funded by the hospital because it fit the criteria for funding - any program that was developed on a volunteer basis and was considered to meet the needs of the specific patient group. It had been identified as a successful program for the past 10 years. Some nurses had also been involved in fund raising activities in order to pay for educational materials that were no longer available free of charge.

The above discussion suggests that although there was a wealth of resources throughout the hospital, nurses generally used only those that were readily available in their worksite. The cardiac unit was the main resource for health information materials. While funding for health education from external sources was non-existent and very limited from within the hospital, some nurses received funding for health education activities from the physicians and their own fund raising activities. All of the nurses at the bedside repeatedly identified resources and funding as a major barrier to the provision of health education programs.

Hospital Structure

The manner in which an organization arranges its services has a direct influence on individuals who work in that organization (Wywialowski, 1993). In an acute care hospital, patient services are divided up according to specialty departments staffed by doctors who specialize in diagnosing and treating certain disease. Areas such as medicine, surgery, cardiology, etc. are some of the common divisions in most hospitals. The physicians head these departments and are the main decision makers regarding the medical care and treatment in each department (Berger & Williams, 1992).

In addition to the above, other services that were directly or indirectly involved with nurses and patients that may influence the provision of health education programs in this hospital were identified as: (a) administrative service, (b) educational services, and (c) a link with a community program.

Division of the patient population and patient care services. The hospital in this study had three major departments; general practice, internal medicine, and surgery, that served the needs of its medical and surgical patients. There were many subdivisions in these departments as well. The patient population was divided according to the reason for admission - the disease or condition, e.g. medical, surgical, cardiology. This division of the patient population by disease may fragment the perspective and practice of those involved with patient care, and therefore, may influence whether or not health education is identified as a need for patients.

The services required for the delivery of patient care were very structured and highly specialized in this hospital. For example, the four units involved in this study were organized according to medical or surgical conditions and then, further by area of specialty such as: (a) cardiac, particularly post myocardial infarction [heart attack] patients, (b) general medical, particularly patients who have had a cardiovascular accident [stroke], (c) abdominal surgery, particularly patients with ostomies and (d) orthopedic surgery, particularly patients having a hip repair or hip replacement.

Each unit operated separately and independently with its own specific focus and role. In this respect, the division of patients and patient care by specific condition facilitated the provision of health education for some nurses and compromised it for others. Because the cardiac rehabilitation unit contained mostly patients who were recovering from a heart attack, generally their patients were independent and required minimal assistance for their physical care. As a result, the cardiac nurses were able to engage in educational activities on a routine basis.

> *.... there is a tremendous amount of teaching on the cardiac unit.(2)*
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> ***
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> *We spend most of our time teaching the family, especially of the cardiac patients - right from the time of admission. The family gets a lot of teaching.... Our whole education is health education - it is what we deal with. It will change - but it will never go away.(3)*

However, when the "mix" of patients changed, these nurses had less time and energy to provide their routine program because of the increased dependency of their patients.

> *We have had a lot of medical patients with the closure of medical beds on another floor. That's one of the dissatisfactions by the nursing staff. Because when you have stroke patients or DVT [deep vein thrombosis] patients, those patients need your help and you are meeting their physical needs. Whereas, you have a heart patient that's going to be discharged and you can't meet those needs [for health education].*

This nurse went on to say:

> *So if we don't teach them, how they can prevent the next MI or how you can prevent that angina, then you get frustrated and angry with the system, because of the fact that you have these other patients that really shouldn't be on your floor. But where can they go when there are no other beds in the hospital?(5)*

Patients on the other medical surgical areas required more physical care because of the conditions they had and that affected the provision of health education programs.

> *.... on our floor there's a difference - like liver failure, respiratory infections - so it's more scattered, more of a mixed bag. The focus [on health education] is not as strong here.(14)*
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> ***
>
> *Health teaching is not done. Patient teaching - we have pre op teaching and discharge teaching (pamphlets). It's mainly condition - related. Lifestyle really doesn't [relate to a condition] - it's considered a bit of a frill on our unit.(7)*

Administrative services. Administrative services in this acute care hospital consisted of two departments - hospital administration and nursing administration. Hospital administration was provided by a senior administrator and the heads of all of the patient care divisions in the hospital, generally physicians. They made decisions regarding the priorities of the hospital as well as the overall budget and expenditures.

Nursing administration consisted of a Director of Nursing and a Vice President of Patient Services and a nursing services department. Although they were not involved in directing patient care, nursing administrators made decisions regarding the staffing and funding of all patient care units. They determined the nurse/patient ratio and were responsible for the differences in workloads from unit to unit. This impacted significantly on the time and energy nurses have to provide health education programs for their patients. Nursing administration, although not responsible for the division or "mix" of patients on each unit, was responsible for the overall staffing of these units, including the lack of relief nurses for staff nurses to attend educational activities. As a result, they were responsible for the differences in the workloads and inadequate time that the nurses repeatedly reported. As previously indicated, the nurses' workload was a major consideration in the provision of health education programs.

Funding and staffing decisions impacted on nurses and the provision and development of health education programs as well. One informant explained:

> *The senior administration [hospital] allocates an annual sum of money to all the divisions, including the education division and the nursing division. Nursing administration, in turn, decides how it will be divided between the patient care units. It is then up to each unit how much money to allocate for health education.(1)*

Some of the nursing budget was identified for education, but at the time this study was conducted, the funds were being used to keep the nurses current in the numerous changes occurring in their area of clinical practice, not health education for patients.

Included in the structure of nursing administration, is Nursing Services, a department that provides assistance to staff nurses in their day to day provision of patient care. Part of their responsibility is to assist nurses in meeting their educational needs, which are usually identified as a need to update their clinical skills (Wywialowski, 1993).

In this hospital, the Nursing Services Department included clinicians who responded to the day to day clinical needs of the staff nurses, and a Nursing Education Committee that arranged inservice education for the nurses, again focusing on clinical issues. Occasionally, the inservice education sessions included lifestyle information for the nurses with the assumption that the nurses would pass the information on to their patients.

It became evident as the data unfolded that no one had the responsibility for hospitalwide health education programs for patients. This may explain why nursing inservice presentations did not assist nurses to become more knowledgeable or current with health education information or programs.

Educational services. Although there was a department for educational services in this hospital, hospitalwide education services for patients were described as being few in number and very fragmented. This department, consisting of a librarian and a manager, was mainly

responsible for staff education and community education, not patient education per se. As a result, health education programs occurred only sporadically throughout the hospital and were for specific patients rather than for the general patient population.

Hospital/community link. A link with the community was a factor that may have influenced the health education program for cardiac patients. Nurses in Coronary Care, the cardiac rehabilitation unit, Home Care, and the Outpatient Clinic started this program with a multidisciplinary team. Coordination of the program occurred through a Cardiology Committee based in the community. One informant indicated that this link with the community and the fact that it was part of a larger educational program, gave the program on the cardiac rehabilitation unit a high priority over time, facilitating the nurses in their provision of health education.

> *It always makes education of the patient a higher priority when there are other people that also are involved in teaching.(4)*

It is possible then, that a link with a program in the community may facilitate the provision of health education programs for patients in the hospital.

These findings suggest that the hospital structure, through its administrative decisions, the division of its patient care services, the mandate of the educational services, and a link with a program in the community may have a significant, direct influence in the provision of health education programs for patients.

Support from Others

Receiving support from other members of the healthcare team in the hospital was essential for the nurses in order to be able to provide health education programs. Areas that had the greatest influence on whether or not health education programs were provided were identified as: (a) hospital and nursing administration, (b) nursing colleagues, and (c) physicians and other disciplines. The discussion that follows will demonstrate how all of these areas may have influenced the nurses in this study in the provision of health education programs for patients.

Hospital and nursing administrative support. While the hospital and nursing administration indicated that they philosophically supported the nurses in providing health education programs for their patients, one informant did not agree.

> *People in higher administration actually may not see the value that we would see - maybe in nursing, but not in other parts.(3)*
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> ***
>
> *I wonder if we come from different perspectives. Those who are not bedside nurses may have an unrealistic perception that sounds good in theory and would be nice to implement - but do they realize take time and resources.(13)*

Practical support for nurses was even less evident. For example, programs that were considered a success were allocated funding. In other words, nurses had to develop and implement new programs on their own time. In addition, paid educational leave and paid tuition for conferences were not available and replacement staff was not provided in order that nurses could attend hospital inservices.

> *.... of course the drawback is the acuteness and the busyness of the nurses - whether you can get someone off to the inservice. Replacement [of nurses] is near impossible.(12)*
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> ***
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> *All the inservices that the hospital is providing are an inconvenience, because I have to find the time out of my day to go and it's an imposition. We have to skip coffee breaks or half of our lunch breaks.(13)*
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> ***
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> *The courses they offer us are wonderful, but when you are pressured and rushing to get your work done at the bedside so you can go and when you get back you have double the work .... it's very difficult to get off the ward and go when you don't have the time. It's so much work for someone else. I haven't been lately. I try to go on my days off, because then I don't have to worry about trying to get off the ward or loading someone else up with your load [work].(7)*

Although one informant felt that nurses would get time off from the unit in order to design a new health education program, the majority of informants stated that they would have to do it all on their own time and were reluctant to do so.

Time would be an issue if they are expecting to do it on working time.... The nurses would have to initiate it and do it on their own (time).(3)

***

Time will be a problem. They will have to do a lot of it on their own time.(5)

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Good luck - there would be a lot of 'do it yourself'.(10)

***

Probably no time off. We usually do it on work time - like have an inservice or get together and talk about it. I guess it would have to be on a day off.... that makes it even more difficult.(8)

***

We put in an incredible amount of time into committees on our own time - staff meetings. So I feel we give enough time.... if we wanted this program, we'd have to [develop it] on our own time - there's no other way.(13)

Nursing colleagues. Generally nurses are supportive of each other in the delivery of patient care. They often work together and share ideas with each other. However, the support that nurses received from their colleagues for providing health education was not always positive. For example, one informant explained the difficulty she has experienced when engaged in an educational activity with her patients.

I never hear anyone say anything critical in terms of patient teaching, but if you do this you know in your mind that you are going to get behind and the patient is talking and talking. It's viewed as 'not getting your work done'. When you get behind, it's not a popular situation, because it is a very busy ward and there's a lot to get done.

She went on to explain:

I think they're anxious to get things done, because you're supposed to be ready for your break and if you're late, then you make someone else late. I learned to curtail it [educating patients], because I think they [colleagues] feel it's not necessary.... so I've been quite quiet about that.(7)

When discussing collegial support to attend hospital inservices she described a similar scenario.

People don't appreciate it when you are saying 'good-bye, take my load - I'm off to this program'.... and someone may not be happy with you besides, because they've had their workload doubled (when you were away). Basically, to benefit, you have to take time off or go on a day off.(7)

Another informant admitted that some nurses may even be unsupportive of their colleagues developing future health education programs and gave this example:

> *Sure they might have trouble. I know even with diabetes education, there is one nurse who.... was fairly concerned that all of a sudden we were teaching the inpatients.... so part of it was - if you give all those people the knowledge - am I still valued? (1)*

Generally, the informants identified that their Head Nurse and Assistant Head Nurse were supportive. In addition, one informant was very positive about the collegial support she received in her area.

> *I think it's nurtured here and another thing - everyone gets on the bandwagon - 'can I have the video machine'; 'as soon as you're finished I want to use it'; or 'by the way, I'm going to show an MI [heart attack] film - do you have a couple of MI's [patients recovering from a heart attack] that want to watch it'.... It's so satisfying. It's that appreciation of it.(5)*

It is evident from the above statements that collegial support for nurses to provide health education programs varies. However, when nurses were supported in educational activities they were likely to engage in them and when they were not, they did not engage in health education activities for themselves or for their patients.

Physicians and other disciplines. The support of the physicians, as well as other disciplines had an effect on the nurses in providing health education programs for patients. Some informants reported that the doctors they worked with were very supportive of any education that involved their patients, and others were not. When they felt supported in their efforts, the nurses were better able to reduce or resolve some of the barriers that compromised their health education program. Unfortunately, most of the support from physicians seemed to be evident on one unit only -- the cardiac rehabilitation unit.

> *.... they [physicians] are very supportive. They usually say discharge once teaching is complete.... Some of the cardiologists care - we have some new cardiologists that are doing some teaching with us as well.(4)*

***

A doctor will say to you, 'Can you do some teaching on angios before tomorrow? 'How do I get my patient into the cardiac program?' Things like that. So yes, there is recognition there. I think this encourages us to do more (teaching) and we feel more valued working so closely with the cardiologists on the program.(5)

***

The physicians have recently offered to support some of our nurses to attend some conferences in the spring - a major part of these conferences is health education. And they have volunteered through their organization to give us some money to pay for the educational materials.(3)

Several informants reported that physician support would influence the development of new health education programs as well.

The doctors [would be supportive] - depending on what it was - if it involved their patients.(13)

***

I think they would probably think that was a positive thing.(8)

***

The doctors would certainly support them. Without a doubt.(3)

***

It would depend on what it is whether the doctors would be supportive.... or let him know what our program is here and what we are going to do. And most of them would be.(11)

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If it was something that appealed to them, I'm sure they would.(10)

However, several informants were less convinced about physician involvement and support. They felt that some physicians were not involved and "don't care" about health education for their patients or do not view it as a priority

I would really like to see more doctors involved with patient teaching and communicating what they are teaching. We really don't know about it.(10)

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The doctors really could care less. It's just - 'he [patient] can go home' - it's out of his [surgeon's] hands, once he's done the surgery.(11)

***

They may encounter a doctor that says this is all a bunch of malarkey.(3)

Several informants felt that some physicians disapprove of nurses providing health education programs for their patients.

> *You really have to be careful. I remember there was an incident up here once - a patient once came up and she had so many things wrong with her and she was on twenty medications and one nurse said to her 'you know your biggest problem is all these medications - just throw them away and try some of this stress management' - and the doctor found out about it - and boy!(11)*
>
> ***
>
> *.... the physicians may resist if they feel you are stepping into their field.(3)*
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> ***
>
> *.... there certainly is some reservation on the part of the physicians to nurses gaining or teaching certain knowledge that they perceive as only their right to teach.(1)*
>
> ***
>
> *You might get some resistance from the doctors. That they may not feel that that's our priority to do - our domain.(12)*

Several informants also indicated that individuals in other disciplines in the hospital may not be supportive of nurses developing health education programs for patients as well. The following exerpts below further illustrate the complexity of the role of the nurse in providing health education programs for patients in an acute care setting.

> *I think some of the other disciplines [might resist], if they felt it was in their area of expertise.(1)*
>
> ***
>
> *You might find difficulty from other disciplines depending on whether nursing is trying to give more than nursing information. Nursing generally gives all the information. Sometimes other disciplines do feel a little threatened. If a nurse starts counseling someone about their diet, the dietitian may not be very supportive - you are treading on their territory..... I have seen it happening - people are trying to define their role and they are territorial.(3)*

These findings suggest that some nurses felt supported by physicians for their efforts in providing health education, while other did not. Some informants suggested that they may get resistance from some physicians and other disciplines if they decided to develop new health education programs for patients. As a result, when support was positive, the nurses wanted to do more health education and when it was not, they became cautious.

The overall findings in this section on the support of others, suggest that philosophical support for nurses providing health education programs for patients was strong throughout the hospital. However, practical support, particularly from the hospital and nursing administration, were inconsistent and inadequate. Areas that were problematic for the nurses were an inconsistent allocation of funding and, like the workload issue, inadequate time allocated to update their knowledge or to develop new programs. Physician support, though varied and sporadic, had a definite influence on nurses and the provision of health education as well.

Protocols

There are certain protocols within a hospital that give direction to nurses when providing nursing care for patients (Wywialowski, 1993). Certain protocols may influence whether or not nurses are able to provide health education programs for patients during hospitalization.

Some of the protocols identified in this study did not specifically relate to health education, but an assumption was made that in most cases where patient education was indicated, health education would be involved in a similar way. Five protocols were identified that may have a direct effect on the provision of health education programs for patients during hospitalization. They were: (a) the orientation of new staff nurses, (b) the documentation requirements for educational activities, (c) the protocol for developing education programs, (d) the organization of nursing care, and (e) the decision making authority of staff nurses.

Orientation of new staff nurses. For the most part, experience in health education was not a requirement of work for nurses in this study, nor was it part of their job description. However, an orientation to the major routine education programs for patients was provided for all new staff nurses who would be involved in providing the programs, giving new nurses knowledge and skill in order to feel comfortable and confident in providing these programs to their patients.

Documentation protocol for educational activities. A documentation protocol for education programs was required of some nurses, but not of others. In this instance, documentation included a teaching checklist for the patient, doctor, and nurse to complete, and two other checklists in the patients' recording system (Nurses' Notes and Kardex). One informant who was required to document all educational activities for the routine education program available for certain patients, described how this influenced the provision of the health education program in her area.

> *This has made us all aware that our teaching is important on a daily basis. There's a little spot there and you just can't just leave it blank. You have to write something in there.(4)*

One other informant, not involved in a routine education program, described very few protocols for documentation of patient education, health or otherwise in their area. In fact, educational activities were included not as an entity, but as a part of the category identified as emotional support.

> *Actually we don't document it [patient/health education] a lot - I guess with our pre ops [preoperative patients], we document on the checklist - the pre op teaching part. Sometimes, I write it in the chart [Nurses Notes], 'pre op teaching done or video watched'. We don't chart anything else. We do systems charting and we have a checklist - it says, 'do you need teaching or emotional support' - you just check it off. You don't actually say what you have done. Just teaching and emotional support - [all in one].(8)*
>
> ***
>
> *Teaching is on the checklist.... We chart as little as possible, because we don't have a lot of time to chart.(7)*

Protocol for developing health education programs. A third protocol was evident in the comments from all informants. It was a protocol within the nursing department that provided assistance for individual nurses to develop health education and other education programs for patients. However, there was no protocol in place to assist with the development of health education programs for patients on a hospitalwide basis.

Organization of nursing care. A fourth protocol was the way the nurses organized their nursing care on each unit. This may have a direct influence on the provision of health education programs for patients. Some nurses reported that their patient care was generally managed by the primary care approach where one nurse provides all the care for a specified number of patients, in this case, six patients (Berger & Williams, 1992). Other nurses reported that they managed their patient care using the team approach. In this method, several nurses provide care as a team for many patients (Berger & Williams, 1992).

The team approach may have some significance for the provision of health education programs. One informant implied that working in a team may impede nurses from engaging in educational activities with their patients, because nurses talk to each other rather than the patient when they work together, or tend to socialize more with the patient than educate him/her when there is a threesome.

> *No [education].... when you do the AM [morning] care you work together. But often when you're alone, I may give a medication or something and I will discuss the med [medication].(7)*

The decision-making authority of staff nurses. One final protocol that facilitated nurses providing health education programs was the protocol that gave some nurses the freedom (authority) to delay the patient's discharge by several hours in order to complete the patient's education. This gave nurses the message that their program was valued and considered important for the patient. In addition, the nurses were able to complete the program before the patient went home.

This discussion suggests that the absence of these protocols in some areas may influence why health education programs were not provided, rather than why they were. However, a documentation protocol seemed to have a facilitating influence on the provision of health education programs. Other protocols discussed may have had a subtle, yet significant influence on whether or not health education programs were provided for patients during hospitalization as well.

Environmental Cues

Findings from personal on-site observations as well as informant interviews were used to develop the next section on environmental cues.

Environmental cues for the purposes of this study were identified as artifacts in one's environment that may trigger some type of response in an individual. In this case, the environmental cues were educational artifacts, such as posters and pamphlets, that were in the patient care areas that may trigger an awareness or an educational need in the patient. These cues were intended to serve not only as a resource for information, but more importantly, to set the stage for initiating health education, to increase patient receptivity or to act as a trigger and assist nurses in identifying the patients' need for health education as well as implementing the program.

It was noted at the time of the interviews and document review that some nurses created an environment for their patients that was rich in health education cues while others did not. For example, the nurses in one area had placed clever, catchy posters on the walls all around their unit, so that patients, families, and nurses would come in contact with them many times a day. There were pamphlets on lifestyle issues and risk factors in the family room and by the nurses station. There was also a bulletin board advertising the fundraising nurses were doing for educational materials. The nurses in this area routinely provided health education for their patients.

However, it was evident in other medical surgical areas that the nurses had not provided health education cues in their environments, leaving a limited choice of options in which open discussions regarding health education between patient and nurse. There were no posters or pamphlets relating to general health practices as were available in the area previously discussed. Generally, these nurses were engaged in educational activities on an incidental and very occasional basis.

This discussion demonstrates that environments rich with health education cues may facilitate nurses in their provision of health education programs for their patients.

The evidence in this section on enabling factors suggests that the most significant factors that may assist in the provision of health education programs for patients during hospitalization were fourfold. First, and foremost, that nurses have a manageable workload; second, that there be positive rapport between the nurse and the patient; third, adequate funding and resources that translate into "manpower" and educational materials be readily available; and fourth, that nurses receive strong support from nursing administration, their nursing colleagues, physicians and other disciplines in the acute care setting.

Reinforcing Factors

Reinforcing factors encourage nurses to continue providing health education programs for patients during hospitalization. This study identified three categories that may reinforce the nurses' practice in this area. They were as follows: (a) recognition from colleagues and superiors, and (b) feedback - external and internal.

Recognition from Colleagues and Superiors

Recognition from colleagues and superiors was important to the nurses. Some nurses received recognition for providing health education and some did not. Those who provided some type of health education on a routine basis reported that they were recognized by their colleagues, both from inside and outside the hospital. The following examples illustrate the effect this had.

.... the rest of the hospital all knows that we do the ostomy program and we do a good job at that - because if they have an ostomy patient that they are having problems with - they always call us and they totally trust your judgment.... it feels good.... And also, the home care nurses, because they really know how well their patient has been taught, because they see them the next day and after that. They're really great - you get positive feedback from them.(11)

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One of the casuals [nurse] who works at another hospital wrote in our communication book that she has met some of our patients in the other hospital and they had nothing but praise for our nurses. They feel they have been prepared well and that we are doing a good job. It is good for nurses to hear from another nurse.(3)

Nurses also received recognition from their superiors through informal praise and their annual performance appraisal, and when something "really big" had been accomplished.

I just assume that its a part of their day. I don't recognize them and say you did do well with that teaching, unless I know specifically that there was a concern and there was a really big issue with that. Then, I will verbally say something to them. I will write in the communication book 'Congratulations - so & so did this. Isn't that wonderful'. So they get a bit of recognition that way - from everybody on the ward.(12)

However, recognition for health education programs was the exception rather than the norm as one informant indicated.

You can't depend on praise from other people. You really can't.(11)

The above accounts demonstrate that although a rarity, when nurses receive recognition for providing any educational program for patients they feel good about themselves and their work, and as a result, are encouraged to continue providing education programs.

Feedback

As previously discussed, nurses generally do not receive much recognition for the work they do unless it is something outstanding. However, they do experience feedback in a variety of ways, both externally and internally. In fact, the feedback they experience from within is often quite intense. Whether it is positive or negative, the feelings that nurses experience have an impact on the provision of health education programs for patients.

External feedback. The informants reported that feedback from others was important to them when they engaged in educational activities. They indicated that it came mainly from patients and their families.

> *.... the patient going home with a smile on his face.... It's very rewarding. That's one of the few rewards that there are.(11)*
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> ***
>
> *.... a smile from the patient [is rewarding]. They usually thank you and you can tell they've taken it in.(8)*

Internal feedback. Internal feedback, such as positive or negative feelings, will influence nurses and the provision of health education programs. The nurses in this study indicated that they enjoy their role in educating patients and find it very rewarding. They expressed positive feelings when they were able to provide any education for their patients and indicated that the satisfaction they derived from this encouraged them "to do more." Positive feelings were identified as "feeling good" and "rewarding" and came from personal satisfaction in doing what they were "trained to do" and in knowing that they had made a difference in the patient's life.

> *I feel good and this is another thing.... often we don't get very much positive feedback - really nurses don't. And that does really give you a good feeling when you can help a family and the patient and the patient feels good about it....I've been here long enough. And when you do it, you feel good - so you get that reinforcement.(11)*
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> ***
>
> *When you have time it feels good - you're maybe helping them to make the change.(8)*
>
> ***

[I feel] just great.... on cloud 9. [It gives me] a great deal of satisfaction. (This nurse agreed that this is the part of nursing that always gives nurses as real lift).... It feels good because I know when these people leave, or not even when they leave, but they have more information on what caused their condition, or how to prevent it than they started out with.(4)

***

I think a lot of it comes from their own sense of - I'm doing a good job and this is helping patients from coming back.(1)

***

If nurses had time to teach they would go home feeling good about what they do - that they had gone that one step beyond just providing physical care.(14)

However, most of the informants expressed negative feelings when they were unable to provide health education and therefore, as with their level of confidence, they tended not to seek out opportunities to provide education for their patients. Feelings of inadequacy, frustration, anger, and dissatisfaction were expressed, which came from a sense that they had not done a "good job". Some of those feelings emerged in the following statements. Three informants spoke about feelings of frustration:

It's frustrating in that part, because you want to do it [patient education].(14)

***

I feel frustrated because I am a very high achiever, and I find when I go home, I think Mr. So and So should have been taught this and he wasn't. One of the things we have noticed, we've had a lot of repeat patients coming in within a 10-day period, because we have not done angina teaching.... It's very disheartening, because you realize if we would have only spent 1/2 hour of teaching, this patient would have known.... not having the necessary knowledge brought him back in the hospital.(5)

***

Oh, that's aggravating - especially when you know that the reason they are here is to be taught and the reason why they are staying longer is to be taught. You can't get to them and it's really frustrating. They stay (in hospital) until they are taught - very rarely are people pushed out.... maybe with other issues, they go home without.(10)

While another nurse clarified her feelings with this example:

Nurses' frustration doesn't act as a barrier, because all of us want to teach - when we were having these heavy medical patients, a lot of the nurses said 'I feel like a workhorse - I want to teach my cardiac patients and I can't'.(5)

For several informants negative feelings stemmed from not being able to meet their patients' needs and described their feelings in the following way:

> *You try to say I'll try and get back to you on that - if you can't, you don't feel good about it. You like to be able to answer their questions and everything.(8)*
>
> ***
>
> *It would feel like just leaving someone hanging. I wouldn't feel very good about it, that's for sure.(14)*
>
> ***
>
> *I really felt like I had let my patients down. I don't think they realized that they are missing something. But I know that they're missing something.(4)*
>
> ***
>
> *I didn't feel very helpful or adequate. You feel like you should - being a health care person, that you should have the answers for him.(11)*

Yet, another informant agreed that nurses "turn off". If time does not allow them the opportunity to teach, they do not seek out patients' learning needs by asking their patients questions,0 and respond only to patients' requests as best they can.(5)

Job satisfaction was mentioned frequently when the nurses described their feelings. When they were able to provide health education programs, nurses derived a great deal of satisfaction from their work.

> *The more teaching they do, the more they want to teach and that leads to a lot of job satisfaction.(5)*
>
> ***
>
> *It also makes everybody feel better too, your having a certain amount of control over the situation - your job. Because you're not just doing what you are told to do. You're planning some programs and thinking out and making more decisions about your day. I guess that's what it is - making more decisions about your day. And that adds to job satisfaction.... It's basically the teaching part of it. You can decide how you are going to do it and what way is best for you, what works best for you. And there's more job satisfaction in that.(11)*

When the nurses were unable to provide health education for their patients, their sense of job satisfaction declined.

> *The morale is low, even though this is a very good happy ward. Nurses can't do what they've been trained to do.... I find that the way we were trained is not what we do. You learn things properly on one hand, and not able to do them properly on the other and it's not very satisfying. And I'm sure that many [nurses] feel this way.(7)*
>
> ***
>
> *When you don't have the time, you don't have the job satisfaction - you feel that your work is incomplete.(13)*

These findings suggest that external and internal feedback associated with providing health education that had an impact on the provision of health education programs for patients. External feedback came from the appreciation of patients and families which made nurses "feel good", because they were meeting the patients needs. Internal feedback was positive when they were able to provide health education programs, which resulted in job satisfaction and a desire to continue providing health education programs for patients.

The evidence in this section on reinforcing factors suggests that the most significant factors encouraging nurses to continue providing health education programs for patients during hospitalization were feedback from patients, colleagues and physicians, and the nurses' own sense of satisfaction.

Chapter Four identified and described factors that may have a *direct* influence on nurses in providing health education programs for patients during hospitalization. Recurrent themes that emerged through analysis of the data were categorized under predisposing, reinforcing and enabling factors of the PRECEDE-PROCEED model. The findings indicated that predisposing factors such as philosophical orientation and conceptions of health and health education for patients, reinforcing factors such as recognition and feedback, and enabling factors such as

hospital structure, workload, resources and support all may have a significant direct influence on nurses in the provision of health education programs for patients. To a lesser degree, factors such as the priorities, skill and experience of the nurses, and the presence of obvious patient outcomes and worksite procedures were also considered important in this study.

Chapter Five will identify and describe factors that may *indirectly* influence the provision of health education programs for patients during hospitalization on acute medical surgical units.

CHAPTER FIVE

PRESENTATION OF FINDINGS

Indirect Influences on the Provision of Health Education Programs for Patients

This chapter identifies and describes factors that may have an *indirect*, yet significant influence on the provision of health education programs for patients during hospitalization. It presents seven recurrent themes that emerged from the analysis and were categorized under the following headings: (a) medical model, (b) hospital culture, (c) government policies, (d) community impact, (e) philosophy and goals of the hospital, patient care units, and nursing department, (f) priorities of the hospital, patient care units and the nursing department, and (g) nursing factors. Unless otherwise indicated, informant data were used to develop each section in this chapter.

The Medical Model

The medical model is a traditional approach to the health of individuals by identifying disease that interrupts the biological structure and function of organs and provides some type of intervention or treatment in order to restore the function of the affected system (Bulger, 1990). The predominant influence in health care planning in an acute care setting is the medical model approach to patient care (Green & Kreuter, 1991).

The influence of the medical model was evident in the hospital in this study in many ways. For example, patients were cared for on specialized units that related to the type of disease and treatment for which the patients were hospitalized. Consequently, the primary focus of the hospital and the patient care units was restorative rather than preventive, its purpose was condition-specific treatment, the practice was results-oriented, and the approach to patient care was reactive rather than proactive.

This approach (medical model) to patient care influences the provision of health education in a similar way. For example, similar elements such as, a fragmented view of the patient, conceptions of health and health education, a condition-specific focus, results-oriented practice, a reactive versus proactive approach, a complex versus simple needs focus, and a health/illness dichotomy. These elements are reflected in the informants' responses from all levels of nursing.

Fragmented View of Patients

The practice of acute care nurses is influenced by the medical model approach which may lead to a fragmented view of the patient. This was evident in several comments made by the nurses who referred to patients mainly by the specifics of their illness, for example, "pre ops, cardiacs, alcoholics, diabetics, DVT patients, stroke patients, ostomy patients". One informant's description of her holistic view of a patient was a clear example of this.

> *Because we are a cardiac unit, the priority would be cardiac, but I would look at the whole system, not only cardiac. I am looking at respiratory, digestive, mental especially - that's a very high priority. I would look at it as a whole picture - we can control someone's atrial fibrillation [heart fluttering], but what is causing it - could it be anxiety producing situations at home? Because when a patient goes home to a stressful situation, the medication isn't going to be effective.(5)*

Conceptions of Health and Health Education

The medical model also had an influence on the nurses' conceptions of health and health education for their patients. For example, when nurses described their view of health for patients, in most cases, they described it in relation to the presenting condition of the patient.

> *I would say that anyone has stopped to say what does healthy mean for the people who come through the hospital.(1)*
>
> ***
>
> *Health is the best a person could be - based on their lifestyle, their previous experience, their previous state - to the point where there are as independent of capable of taking care of themselves as when they came in.(6)*
>
> ***

.... helping the patient to be the best that they can be - and helping them to be at the same level they were at before they came in.(9)

***

To bring them up to the point where they were before [hospitalization] or as best you can.(13)

And when discussing health education for patients, the nurses demonstrated the same focus on the patients' disease rather than the patient as a whole. This perspective would influence the focus of health education programs that nurses provide for their patients.

.... it's difficult to teach preventatively for breaking a hip. Sometimes things just happen.(7)

***

I can't teach the patient about how to eat right when he has gallbladder problems. If he is not having surgery, then I can deal with further preventive measures/teaching. But - communities don't set up preventive teaching for people that are prone - you don't know if you are prone to a gallbladder attack until you get one.(9)

***

We do the smoking one a lot and tell them it's not too wise to smoke before their surgery, that they should probably stop for 12 hours to help the breathing.... I don't think people focus on health a lot. They're looking at getting better and getting back to the way they were.(8)

All of the informants suggested that health education was considered a treatment rather than a preventive measure and that it was a priority only if it was considered part of the patient's illness. The following quotations provide support for this notion.

We teach exactly to the condition, if it's [lifestyle] part of the illness.(7)

***

Just because they tend to focus more on disease when we are in the hospital and therefore, our teaching focuses more on disease. If lifestyle is a part of the disease process, it comes into play, but if it's not - it doesn't.(6)

***

It is related to the condition we are dealing with - cardiac conditions relate mostly to lifestyle issues.(3)

***

I think the focus right now is on our patients that are actually ill with a cardiac diagnosis.(4)

Condition-specific Focus

A condition-specific focus was evident in the informants' statements regarding the health education program that was currently provided for patients.

That's how it is on the [cardiac rehab} unit, too. They are only identifying patients who have come in with post MI or may be with an angina attack, so they're really not preventing anything. They are preventing a decline. I would say it's a form of treatment.(12)

***

The program (cardiac) was set up purely for post MI [heart attack] patients and the cardiac [rehabilitation] unit had.... the identified group of patients.(1)

Consequently, the health education programs as they exist, are not readily adapted to the general patient population. This may explain why former cardiac nurses no longer provided health education for patients on their new unit, even though they had the knowledge and skill and recent experience. One informant indicated that the health education program from the cardiac rehabilitation unit "came to the new unit", (12) but other informants have indicated it was not being provided for the patients at the time of this study.(13) Other informants admitted that they had not continued the program when they worked in areas other than cardiac.

I don't focus on lifestyle affecting the health [of patients] on our ward. I did focus on that in the coronary care ward.(7)

***

Many of the nurses who went there [new medical unit] are good cardiac nurses and never have the chance to teach anymore.(5)

Results-oriented Practice

Several informants suggested that seeing the results of health education had an impact on the nurses as well.

The nurses need to see results. And maybe nurses on the other units think patients don't come back again. Our patients do tend to come back - to outpatients. We do have a chance to see them afterward.(3)

It [providing health education] felt good because it felt right and it was quite obvious too. Because it helped relieve his anxiety for one, and you could see the response right away, that he was more relaxed and he listened to you and he was more responsive. So I think he would apply that the next time he was anxious. (This nurse agreed that it was sort of like a little treatment for a condition and she was able to see some results).(14)

***

Seeing a change in the patients that you've actually seen the effects of teaching and seeing that change in the patient certainly helps guide you into knowing that teaching does benefit - maybe you don't see it all the time.(11)

One informant suggested that nurses may not value health education for prevention because they do not see results.

Maybe other nurses may not get the value of it - be able to see how they have helped their patients - other than medically.(3)

Reactive versus Proactive Approach

In addition to being result-oriented, nurses have been conditioned, by the nature of their practice in an acute care setting, to respond to their patients' needs in a reactive mode, by responding to signs and symptoms with a treatment intervention that will produce results in the patient. It is possible, then that nurses may be reactive in meeting patients' needs for health education as well - responding only when signs and symptoms are present. The following quotations provide support for this notion.

.... it was set up purely for post MI [heart attack] patients - those that go through the coronary care and the stepdown unit and the recognized need and identified group of patients was sitting there. So it was a reactive response to what happened - It wasn't a preventive program - Perhaps a prevention of future problems.... (1)

When asked to explain how they usually respond to patients' needs for health education, the nurses gave the following examples.

I'm not really sure. I know of an alcoholic patient who identified that he needed some assistance with his care. So we referred him to a social worker, who did some counseling and got him involved in[to] a rehab program.(12)

***

I think we had an alcoholic that was in here who was very anxious and a very high blood pressure, so we sort of incorporated that with him. Breathing techniques - when you know that you are becoming very stressful, instead of having a cigarette - doing breathing and helping relax and counting back. That seems to help I think.(14)

Another informant recalled this event:

.... a newly diagnosed diabetic who is quite eager to change his lifestyle. In this particular case, it was obesity-related, he was determined - 'that's it, I'm going to get rid of this'. I reinforced what I knew in getting him to see the dietitian and arranging for that support or reinforcement was done by the dietitian.(10)

Complex versus Simple Needs Focus

Even in its most simple form, health education for patients was applied to complex situations rather than with a simple, preventive/ promotive approach.

.... That is an opportunity to teach good lifestyles at that time [hospitalization]. If you had a patient who you knew was nutritionally deprived, then it would be an opportunity for nurses to order a clinical dietition to teach healthy eating.(2)

***

You know, the thing is - on a surgical unit, patients are here for 5 or 6 days and if we have patients that come in that have a drug problem - that want their shots - and don't really have anything wrong with them.... (11)

Health/Illness Dichotomy

Another finding that reflects the influence of the medical model on the provision of health education was, that whenever they spoke about prevention, the informants immediately shifted their focus to the community - not to their patients. This influenced the decisions that are made regarding the provision of patient and health education programs for patients during hospitalization.

Now, if that [health education need] was identified somewhere in the community beforehand....(12)

***

.... when you work in a hospital you don't think of preventive - you're not worried about anybody outside until they come in.... With cardiac patients - if you have a familial history of cardiac problems then you would assume that some sort of

prevention would be taught as far as nutrition etc. But I think noting a history would depend on the physicians to look after before they get to the hospital. We are the other step when they get here.(9)

***

Most of things are related to the community and lifestyle, because the patients are in hospital a fairly short time.... I would think they [doctors] would go to the community health nurse and say, 'This person is going to need this type of care at home or this type of education at home'. Then it would probably be more the community health nurse that would put them in contact with these resources.(6)

***

.... sometimes, I often think maybe I should start a business in community and start prevention and don't even let these MI patients ever have an MI [heart attack].(5)

This discussion suggests that the medical model does influence the provision of health education programs for patients. The focus on disease that is prominent in the perspective and practice of nurses in relation to health and health education of patients may lead nurses to unintentionally attend to complex problems rather than simple basic ones. These findings also suggest that seeing the results of the health education programs that nurses provide for their patients is a powerful reinforcer. When outcomes are obvious, nurses are able to see the effectiveness of what they are doing and are encouraged to provide health education again. In addition, the application of health education is mainly intended for the condition for which the patient is receiving treatment, rather than for the patients' health practices in general.

Hospital Culture

Each organization has its own unique culture, a factor that may have a direct influence on the individuals who work there (Holland, 1993). An acute care hospital has a culture of its own and may have an influence on the provision of health education programs for patients (Wywialowski, 1993). The hospital in this study had a culture of its own which emerged in the data in a variety of ways. For example, acuity of patient conditions and territoriality of health care professionals were identified in this study as aspects of hospital culture that would be important to consider.

Acuity of Patient Conditions

Because of the nature of the acute care hospital, health care professionals frequently engage in the diagnosis and treatment of patients with complex, life-threatening conditions (Berger & Williams, 1992). Often doctors and nurses are required to react quickly and effectively in these situations by using life-saving measures. They must respond to signs and symptoms with high technological procedures and must produce results. These situations are dramatic and health care professionals are often drawn to the dramatics of acute care practice. This may explain the strong support all the informants gave for the routine health education program for post MI [heart attack] patients. In their view, health education may prevent another heart attack for these patients and is therefore considered one of the life-saving measures in the treatment of acute cardiac disease. Other examples of the nurses' "dramatic" application of health education lies in the following comments:

> *.... you definitely see it [a change] dramatically with your ostomy patients.(11)*
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> ***
>
> *I think we had an alcoholic that was in here who was very anxious and had a very high blood pressure, so we sort of incorporated that [stress management] with him.(14)*

It is even possible that basic health education may be seen by nurses and other health care professionals as "primitive" or "too simple" in comparison to the allure of the work they generally do. Consequently, they may not attend to basic health education needs or ascribe much importance to it in the acute setting.

Territoriality of Health Care Professionals

There can be many different perspectives regarding the role of nurses and the provision of health education programs because each group of professionals may ascribe a greater role to itself than to other professional groups (Redman, 1984). This may result in signs of territoriality within and between some health care professionals who generally work together as a health care team.

Territoriality for this study referred to situations in which individuals may feel that their positions or status in the workplace were threatened by any changes that might occur. Consequently, these individuals may be resistant to new ideas that, in their view, encroach on their area of expertise.

Several informants indicated that this may be a problem in their hospital, if the nurses decided to develop a health education program for patients during hospitalization.

> *I think some of the other disciplines [might resist] if they felt it was in their area of expertise.(1)*
>
> ***
>
> *You might find difficulty from other disciplines depending on whether nursing is trying to give more than nursing information. Nursing generally gives all the information. Sometimes, other disciplines do feel a little threatened. If a nurse starts counseling someone about their diet, the dietitian may not be very supportive - you are treading on their territory.... I have seen it happening - people are trying to define their role and they are territorial.... the physicians may resist if they feel you are stepping into their field.(3)*
>
> ***
>
> *.... there certainly is some reservation on the part of the physicians to nurses gaining or teaching certain knowledge that they perceive as only their right to teach.(1)*
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> ***
>
> *You might get some resistance from the doctors. That they may not feel that that's our priority to do - our domain.(12)*

These findings demonstrate the complexity of the nurses' role in health education in an acute hospital setting. The findings also suggest that unique aspects such as, acuity of patient conditions and territoriality of health care professionals that exist in a hospital culture may influence the provision of health education programs for patients during hospitalization.

Government Policies

Data from the document review and informant interviews were used to develop the next four sections: government policies, community impact, hospital priorities and hospital philosophy, goals and policies.

In the Canadian health care system, where universal health care is funded by both the federal and provincial government, policies developed by their Ministries of Health direct all areas of health care service. It has been a difficult task over the last decade, because costs for health care have been spiraling at the same time that the country was going through two recessions (British Columbia Royal, 1991). Serious deficits in government budgets resulted from these two recessions. In order to reduce these deficits, expenditures in health care have been restrained since 1990/91. Statistics between 1988-91 indicate that 31.5% of the overall provincial budget went to the Ministry of Health, 97% of which was spent on curing illness through institutional care, medical services, and Pharmacare (British Columbia Royal, 1991).

Hospitals received 49.6% of the funds allocated for health care and were therefore a main target for restraint. The British Columbia Royal Commission on Health Care and Costs formed in 1990 to explore the expenses and services of the health care system in the province, recommended sweeping reform to all health care services. The Ministry of Health embraced the recommendations which resulted in major cutbacks to all acute care facilities. This meant funding and resources were greatly reduced in the areas of personnel, patient education, and support (British Columbia Royal, 1991).

The hospital involved in this study had been subjected to funding shortages even prior to this process, which left the hospital faced with the challenge of balancing quality patient care with a constant demand for services and very limited resources. Statements in the hospital's strategic plan identified "inconsistency of the Ministry of Health in matching funding to the hospital's changing role" as a threat to the hospital's success in meeting the objectives of its 5 year strategic plan (p.13).

Another influence that government policy has on health education is the funding formula that is used to allocate health care dollars. Currently, only 1.5% of the provincial health care budget has been ear-marked for health promotion. Furthermore, it was allocated for health promotion in the community, not in the hospital. This would imply that the government ministries do not expect health promotion initiatives to be provided in acute care facilities and has left hospitals without an external source of funding for health education programs for patients.

All of the informants validated the fact that there was no expectation or specific funding from the government for health education for patients. It was evident that government policies that constrain funding and offer little incentive or support for health promotion initiatives in an acute care hospital, have an influence on whether or not health education programs are provided for patients in general. This may be one reason why many informants have consistently identified a lack of resources and a lack of funding as a major barrier to the provision of health education programs for patients during hospitalization.

Community Impact

An acute care hospital has a mandate to respond to the needs of the community it serves. Therefore, the community has a major impact on services a hospital provides. In addition to the usual demands for health care services, the hospital in this study was required to respond to two other major forces in the community it served. One was the constant rapid growth in the community (double the B.C. average) that resulted in a need for expansion of services and an increase in the number of hospital beds. The other was the fact that this community's need for cardiac care was greater than surrounding communities, because of the high incidence of myocardial infarctions [heart attacks] in its population. The hospital responded to the increased need for cardiac care by improving the health education program on the cardiac rehabilitation unit believing it would reduce the length of the patients' hospital stay and reduce the need for readmission. The hospital also responded to the high incidence of acute cardiac disease in its community by initiating a heart health education program for individuals in the community. It was developed as a result of the goal for "preventive cardiology in the community" set forth in the

strategic plan. One informant described the community response and the effect this had on future plans for health education programs.

> *It was a brainchild of the whole group - Dr. X and I are doing a " _____ Heart " program. We thought it was a good idea and it turned out really well. The response was overwhelming. We ran it a few months ago and now we think we should go on the road with it, because the requests have been enormous - different agencies want us to come into their facility. We have been terribly booked until February.... [We do] cholesterol, diet, stress management, we suggest no smoking, exercise - all those things that would encompass that "happy heart" concept. Certainly we're going to do the community one on menopause.(2)*

The magnitude of community interest in the heart health education program was a positive influence on the hospital, both in its role and its commitment to health education. Future plans included more health education programs for the community. However, while this energy in providing health education programs was of benefit to some patients and the community, it did not benefit the majority of patients who were in hospital for reasons other than acute cardiac disease.

Informants indicated that the community placed tremendous demands on the services of the hospital. Rapid growth and an increased incidence of heart attacks facilitated the development and implementation of a community health education program. However, it did not facilitate the development of a similar program for the general patient population. It was evident that the exclusion of the general patient population would continue for programs in the future as well.

Hospital Priorities

Although the primary function of acute care hospitals is the treatment of illness and disease, a number of factors can influence the priorities that each individual hospital may address (Berger & Williams, 1992). This ultimately affects patient care services and health education programs. As previously mentioned, financial constraints, a rapid growth in the population of the surrounding community and a high incidence of acute heart disease influenced the priorities of the hospital in this study. Consequently, bed utilization was identified as the number one priority. This meant that the hospital was focused on reducing the length of the patients' hospital stay and

reducing the number of readmissions for the same illness. They were not, however, as interested in preventing or reducing the number of first time admissions. One informant disclosed how this may have influenced preventive initiatives in the hospital including health education:

> *My guess is that it [hospital priority] would not involve prevention at this point, because we are almost drowning in the utilization perspective - how to get them in and how to get them out.(1)*

Another informant questioned the priority of health education programs in hospitals, given the current circumstances in the health care system and the inadequate amount of personnel and resources.

> *.... with the busyness, lack of resources, it would probably be one of the things that you would really have to look at if it really is our priority in a hospital situation being that people who are sick come in to hospital.... So from that perspective, I would look at it and see is it really our role in terms of priorities in a hospital.(6)*

Another priority for the hospital was meeting the growing demand for acute cardiac treatment and care without increasing costs. In response to this, the strategic plan for 1991-96 for the hospital indicated that one of their goals was "to enhance services to people with heart disease" (p. 3). The influence this priority had on the provision of health education programs for patients was discussed in the previous section on community impact.

Priorities of the Patient Care Units

Hospital priorities in turn influence the priorities of the patient care units and subsequently the priorities of nursing care. For example, the priority of the cardiac rehabilitation unit became focused on the early discharge of patients and the reduction of readmissions for the post MI [heart attack] patients. Several informants discussed how this priority influenced the priority of the health education program in their area. According to the nurses on this unit, both of these strategies required that patient education and health education become a high priority. Several informants discussed how the priority of the unit influenced the priority of their health education program.

We feel it [health education] has to happen, because it is something that is important.... We set them up for the post discharge program - patients are going home so early.(3)

***

Patient teaching is the most important thing we do on this unit.... (5)

***

[The priority is] really quite high - amazingly high. It's part of their basic care.... it's so important that it gets done because it's on a higher priority. so that other things may go if you have to.(4)

However, nurses from other areas identified health education as a high priority for the cardiac rehabilitation unit, but not for their units. Several informants gave the following explanations for the differing priorities from unit to unit:

I guess for their specialty being cardiac, that's probably one of the biggest preventive measures, not wanting the same cardiac patient coming back. Whereas, on our floor there's a difference, like liver failure, respiratory infections. So it's more scattered, more of a mixed bag. The focus is not as strong here.(14)

***

We are very task-oriented. We have to get our tasks done.(13)

***

Getting their [nurses] work done is number one. There are definite benefits and we definitely have a role, but we don't do it [health education] because of those other factors or why it hasn't come to be an issue or a priority.... it's here and now that you are dealing with and you're mainly dealing with 'Is this person safe to go home and when he goes home will he function?' Those are your priorities. The other (health education) is a third or fourth priority - it's unfortunate, but that's the reality.(6)

***

Ostomy teaching is a high priority on this unit. Other teaching isn't quite as important.(10)

***

Lifestyle [education].... is considered a bit of a frill on our unit.(7)

The priority of the hospital and the units was determined by the immediate needs of the community. In this hospital, the priorities were identified as bed utilization and reducing the incidence of acute cardiac disease. This translated into using health education as a way to shorten

the time of hospital stay and to reduce the number of patients being readmitted for the same problem again. However, it was evident that the priority was identified for cardiac patients only - not patients in general.

Hospital Philosophy

The philosophy, goals, and policies of any organization are closely linked and therefore, will be dealt with together in this section. The philosophy of an organization is a particular set or system of beliefs and values that serves as guiding principles for individuals in the organization to follow. The goals and policies are developed to carry out the philosophy of the hospital. Goals generally indicate what the organization is trying to achieve and policies give direction and provide guidelines, standards, or expectations of how the goals can be met (Wywialowski, 1993). The philosophy, goals, and policies of a hospital, its patient care units, and the nursing department are a major part of its function and therefore, may influence the provision of health education programs for patients in the same way that the philosophical orientation of nurses as previously discussed in Chapter Four. The philosophy, goals, and policies may differ from hospital to hospital.

Philosophy and Goals of the Hospital

Most hospitals develop a philosophy and mission statement that indicate the overall focus of the service they provide (Wywialowski, 1993). Acute care hospitals are closely aligned with the beliefs and values of the medical model, and this is usually reflected in their philosophy and goals, and policies (Jenny, 1993).

A document review in this hospital revealed that it was aligned with the medical model, but had also embraced its role in health education. The philosophy contained a global statement with "quality patient care" as the vision. However, this was the only reference made to patients. The 1987 mission statement included "educating patients in the areas of self care and health

promotion." It was unclear though, how health promotion was defined in this hospital setting. One informant reported that the hospital had not provided direction for this, because it had not developed definition of health in its documents.

> *The hospital doesn't have a definition of health. The nursing group does and I suspect that the other professional groups do, but I have not seen a definition of health for the hospital.(1)*
>
> ***
>
> *.... to some degree in an acute care hospital, that's what the patient is here for, because they are ill, and so you are focusing on their illness and then how you can make them better.(12)*

Goals for this hospital were developed for a five year period and were articulated in an official document. Throughout the interviews, informants referred to this document as the "strategic plan". In order to avoid confusion throughout this discussion, the term "strategic plan" will be used whenever referring to the document. It was in this document that patient education was more clearly stated. For example, "a plan for health programs for different cultures" and "innovative programs that concentrate on wellness" were identified as part of the vision in the strategic plan (pp. 37-38).

Although these terms were not specifically defined, the hospital had focused on wellness programs for the community and its employees, but not for its patients. Statements made by one informant regarding the role of the hospital in health education for the community were as follows:

> *Within the strategic plan, the hospital has a commitment to education for the community - in that sense - for the patients that come in here. The manager of educational services has some responsibility for community education.... there is a stronger sense that we need to have a better link with the community as far as providing information about health matters.... the hospital as a whole has done some wellness days, and health days and health fairs.... There is [also] a recognized need to do more, but within the resources available. We have really targeted some things and not others at this point. But they are in the plans and within the strategic plan.(1)*

The same informant made statements indicating that although the community benefits from these health education programs, the patients do not.

> *I would say that anyone has stopped to say what does healthy mean for people who come through the hospital.... the hospital is not dealing well with formal patient education programs at this point....(1)*
>
> ***
>
> *There's no one [responsible] at the patient level [for health education].(2)*

The Cardiology Department of the hospital outlined its goals in the strategic plan as well, and indicated an intention to increase the emphasis on health promotion and preventive cardiology in the community. At the time of this study, action was being taken on this goal with the development and implementation of the community heart health education program.

The philosophy and goals of this hospital indicated a commitment and plan to increase community education and patient health promotion. Unfortunately, it did not define health promotion for patients and as a result, the programs for patients continued to be driven by the medical model.

Philosophy and Goals of the Patient Care Units

Each patient care unit has its own unique philosophy to guide the provision of patient care. However, the philosophy of a hospital influences the philosophy of its patient care units as well (Wywialowski, 1993). The philosophy of the selected units reflected the nurses' role in patient education more than in health education. Phrases such as "promote self-care through education", "assist the patient through periods of lifestyle change", and "teach the patient and family about his illness including health habits" were the only references that relate to health education per se. The unit philosophy of the cardiac rehabilitation unit was vague about its commitment to health education as were the other units, however, it did include health habits in the statement regarding "teaching the patient and family about his/her specific illness."

Of the four patient care units involved in this study, only the philosophy and goals of the cardiac rehabilitation unit identified health habits and lifestyle as part of patient education. This meant that the only unit that provided a health education program for patients, focused the program on cardiac conditions.

Philosophy and Goals of the Nursing Department

The nursing department generally has its own philosophy (Wywialowski, 1993). The philosophy of the nursing department in this study contained the terms "health" and "wellness", but did not define the terms. However, the influence of the medical model, not a health model, was evident in the following statements contained in nursing documents.

> *Health occurs on a continuum that fluctuates between wellness and illness.*
>
> *Health is influenced by the patient's age related biological status, developmental tasks, and the presence or absence of pathology.*
>
> *The hospital environment should be.... conducive to the recovery and restoration of patient well-being.*

One informant's comment reflects the effect this had on the provision of education programs for patients throughout the hospital.

> *Nursing specifically has not focused on patient education - other than teaching diabetics how to deal with their illness.(1)*

Goals for education programs for patients during hospitalization centered only around improving programs already in existence, such as was evident in the following comment.

> *Steri TV is in the works. There will be that educational component for patients. Certainly, there will be care of the babies [newborn].... a lot of diabetic teaching. There we go again - the usual areas [of patient education programs provided by hospitals in the past].(2)*

This discussion, as in previous discussions, reflects the influence of the medical model approach to the philosophy of and goals of the nursing department and the effect this has on the provision of health education programs for patients during hospitalization.

Hospital Policies/Guidelines

Hospital policies and guidelines define the organization's approach to achieving its goals (Wywialowski,1993). Guidelines for health education programs generally give direction to nurses regarding content and format and indicate an expectation that when patient needs are identified, health education is provided.

Although the hospital, patient care unit, and nursing care documents reviewed for this study contained a multitude of specific policies, guidelines and procedures for physical and medical care and for education for patients, there was no evidence of formal policies, or guidelines regarding the provision of health education programs - for the community or for in-hospital initiatives. This left nurses with very little direction for content or format that would assist them when an opportunity to provide a health education program arose. However, in several areas, there were very specific and detailed guidelines for health education that was an essential component of the "illness" education program. One nurse indicated that there was an expectation that these programs would be provided for specific patients.

> *I was on the Coronary Care Unit [cardiac rehabilitation unit] in this hospital for a few days and I did realize it was an expectation on that ward.(7)*

However, many informants indicated that they did not and were not expected to follow any specific guidelines regarding any type of health education program, discussion of health issues, or health promoting strategies.

It was evident from the data that policies and guidelines in this hospital provided specific direction regarding patients' diagnosis, treatment and education in relation to their illness. However, there were no expectations, policies or guidelines for the provision of health education programs for patients during hospitalization.

The philosophies and goals developed at three different levels, the hospital, the patient-care units, and the nursing department all had some indication of health education or health promotion for the community and the patients. However, because these terms were not defined, the health model was used to define programs for the community and the medical model was used to define programs for the patients. Why this division in the focus of programs occurred is unclear, but it is suggested that because the medical model was applied to everything else regarding patient services, it was also applied to health education programs for patients. Policies did not provide any clear direction that might focus health education programs for patients in the direction of health promotion rather than as a treatment for disease.

Nursing Factors

As previously discussed in Chapter Two, nurses have an important role to play in health education and because they make up seventy percent of the health care team in an acute care setting, they have a significant impact on the provision of patient care. Therefore, factors unique to nursing may be important to consider. This study identified three nursing factors that may influence the provision of health education programs for patients during hospitalization: (a) nursing practice, (b) nursing education, and (c) nursing culture.

Nursing Practice

Nursing practice occurs in a variety of settings. However, several aspects of nursing practice in acute care settings may influence the provision of health education programs for patients. In this study, two have been identified as (a) the nature of the acute care setting, and (b) nursing traditions.

The nature of acute care. In an acute care setting, nurses who practice at the bedside (staff nurses), are responsible for providing direct care to patients (Wywialowski, 1993). Unlike other areas of nursing practice, acute care nursing is often focused on intervening in dramatic, sometimes, life-threatening patient situations. This requires a certain set of skills involving tasks

and procedures that are intended to quickly reduce or relieve the acuity of the patients' condition. Generally this involves physical, emotional, or medical interventions -- ones that can be seen, measured, and produce obvious results. Therefore, nurses in acute care, unlike their colleagues in other areas of nursing, have been conditioned, by the nature of their practice, to respond to the dramatic and to expect results (Jenny, 1993). However, health education requires the use of a different set of skills - ones that are often basic, intellectual or attitudinal in nature, and do not produce immediate, obvious results.

Because nurses function independently in planning nursing care and education programs for their patients, this focus of nursing practice at the bedside is particularly important and may indirectly affect whether health education programs are provided for patients. For example, current patient education programs in this hospital were nurse-driven and had been maintained for five to ten years. Two informants described the role nurses have in relation to education programs for patients in this hospital.

> *It is a shared partnership. It should be equal, but nursing tends to take the initiative, the lead. Nursing is certainly open to any information the physicians may have.(3)*
>
> ***
>
> *It is a 'nursing' program. Doctors order it -- but the nurses are totally in charge of it.(10)*

Nurses had the freedom to choose what health information to include in a program, because at present there were no guidelines for health education, as indicated in the previous section.

> *Every nurse does her own [health education] - whatever she wants to do.(11)*
>
> ***
>
> *[Nurses are] very free. There's a wide gamut of information to draw from.... but no guidelines.(9)*
>
> ***
>
> *No specified standards. People manage stress in very individualistic ways and nurses have to understand that.(5)*
>
> ***

The nurse is not limited - she could impart any kind of information she felt was valuable.(12)

***

There are no written guidelines so I don't really know. I think I'd OK anything first though. Just to make sure.... I think I would run it by the head nurse maybe first.(8)

Nurses in this hospital also had the freedom to design and develop any program they wanted, as long as there was a patient need for it and the nurses did not profit from it.

One nurse agreed that she was free to teach whatever she wanted - no limits - (as long as it is within the standards of nursing practice), and if I wasn't going to make a profit.(5)

***

I think nurses can do any kind of program they want.(1)

As the literature suggests, nursing practice in this acute care setting focused on dramatic diagnosis and intervention of acute patient conditions. Because the skills required for this approach (medical model) to nursing practice are the opposite of those required in providing health education programs, the skills required to provide health education were left in the background, only to be used on an incidental or occasional basis.

Nursing traditions. Nurses have been practicing in acute care settings since the early 1900s. Over the years, there have been many changes in the way nurses provide care for patients (Berger & Williams, 1992). However, there are certain traditional roles and practices that endure. One area is patient education.

For the past 20 years or more, the main programs that nurses on medical surgical units have provided for patients during hospitalization have focused on diabetes, cardiac rehabilitation and pre and post operative instruction. The focus remains the same today and when changes do occur in patient education, they continue to involve the same three areas (Berger & Williams, 1992). One informant validated this and remarked that the hospital in this study did not provide education programs that dealt with present day health concerns. When asked why health education programs were not provided for all patients, only certain ones, she replied:

That's a good question, I haven't even thought of it. AIDS is a good example. Now that we have full blown AIDS.... So why don't we do it?(2)

Another tradition can be found in the daily nursing routine. The routine is centered around the delivery of patient care - what nurses do during the course of their day or night shift (Wywialowski, 1993). Although the demands of the clinical area have changed dramatically in the past 30 years, the overall nursing routine has not changed significantly during that time (Holland, 1993; Brown, 1993). It is oftentimes at this point, that some nurses seem to have difficulty making adjustments in order to have time in their daily plan of care to provide health education programs.

Nurses in some areas in the study were unable to alter their routine even though they viewed health education as important for patients and believed it was their responsibility to provide it. Comments such as the following demonstrate this:

The nurses would have to rearrange their schedule and give up something.(9)

***

Another informant agreed that she' would have to give up something that was a higher priority in order to do all the teaching necessary.(5)

A third, long time tradition of nursing practice is found in the staffing practices for the patient care units. Although nursing administration is not directly involved in providing patient care, it makes the decisions regarding the staffing and funding for all patient care units. It determines the nurse/patient ratio and is responsible for variations in the workload (Wywialowski, 1993).

This was true for the nurses in this study, and it was evident that the variation in workloads from unit to unit resulted in the subsequent variation in the provision of health education programs from unit to unit as well. Two informants explained how the decisions in their hospital impacted on the nurses and the provision of health education programs for patients.

People in higher administration actually may not see the value that we would see - maybe in nursing but not in other parts.(3)

***

.... right now, I really feel that administration has no idea what is happening on our floor. I don't think administration is aware that we need another pair of hands.... Nurses' frustration doesn't act as a barrier, because all of us want to teach.... when we are having a lot of heavy medical [patients] a lot of nurses said 'I feel like a workhorse - I want to teach my cardiac patients and I can't'.... The nurses get burned out from the great amount of physical care the is required and get frustrated when they can't teach.(5)

These discussions suggest that some nursing traditions in acute care settings may have an indirect influence on the provision of health education programs for patients. Traditions involving the development of patient and health education programs, the daily routine for the delivery of nursing care and the staffing practices, have been identified as significant traditions to consider.

Nursing Education

The basic education a nurse receives can vary from two to four years. For most of the first two years of their education, most nurses are prepared to work in acute care settings. Their academic studies and clinical experience focus on understanding and providing care for individuals who are acutely ill and require hospitalization. The professional continuing education for nurses who practice in acute care settings generally continues in the same vein (Berger & Williams, 1992). Consequently, most nurses have been conditioned to respond to symptoms and problems and therefore, may not identify the more subtle basic health education needs of patients.

All of the nurses who provided direct patient care in this study were educated in a two to three year diploma program that did not address health education to any significant degree. The majority of informants recalled having had very little health education in their basic nursing program. One informant had taken a health education course in her basic program, but for many of the reasons previously discussed, was not able to provide health education for her patients in the area where she worked now, even though she wanted to. She stated that actually she was doing far less than she was trained to do because of heavy workloads.

Nurses can't do what they are trained to do.... you learn things properly on one hand and you are not able to do them properly on the other.(7)

While most nurses indicated they had some basic preparation in educating patients, they were not taught how to alter their nursing routine in order to "fit" patient education or health education in to a busy schedule of tasks and procedures. In the hospital in this study, the informants reported that they had to learn how to deliver each program on their own - by trial and error. This method of learning was time-consuming and initially the informants described feeling overwhelmed and scared, and lacked confidence in being able to complete all the tasks required for their shift in addition to educating their patients. As a result, there was a tendency to leave the educational component out and only complete the physical care.

I think you just learn by trial and error. You watch what everybody else is doing.(4)

***

I think it's because I've been here all those years and I've learned to put it in there.... I know at first it was scary for me to do that [education]. And you are getting your nursing care done - and you are really so busy and that does tend to be left. It doesn't for me anymore.... I feel good about it....(11)

Several informants had attended hospital inservices on stress management for nurses, but had not incorporated the skills into their plans for patient care. The only nurses who had attended workshops to learn relaxation techniques for their patients had done so on their own and out of a personal interest.

There were also competing demands on the nurses time for other educational needs in the clinical area, such as keeping current with the constant changes in the delivery of health care, preparing for changes in governance in the nursing department, and learning how to take care of their own health and safety needs. Consequently, there had not been time for lifestyle programs for patients and how to provide them. The following excerpts indicate the focus of the educational programs for the nurses at the bedside:

I doubt that there are any of those programs (lifestyle). Most are management oriented - trying to prepare them [nurses] for the charge role.(9)

***

.... we have a fair number dealing with clinical conditions, skills, procedures, health issues for nurses. We are doing nursing rounds every Friday afternoon - a nurse can speak for 10-15 minutes on a topic of their choice and that was quite interesting - we take a different disease or a different skill [each week]. (10)

***

.... we usually don't do chest tubes - so recently we had some chest tubes, so we wanted inservices on chest tubes. It's when we ask for them.... our clinician's probably not involved in health education.(11)

***

There are an awful lot of inservices that are provided by the nursing instructors - like the diabetic modules.... and they [nurses] become certified as a diabetic teacher.(12)

***

On the committee [Nursing Education] we used to discuss inservices we want to come in and what topics and I would get input from my unit such as a cancer video - or the problems with MS Contin. We purchased a couple of videos on pain control. As a rep I've been very involved in setting up a 12 lead EKG course. It's just identifying what the needs of the nurses are. I think what happens most of the time is a lot of the nurses feel they need upgrading. That's the way I feel. (9)

One informant's comments indicated that the textbooks and other resources on each patient care unit related mainly to the specialty focus of that unit e.g. surgery, medicine, orthopedics.

.... we've got all kinds of books on the floor that are pretty up to date. They are more to the particulars (of the unit) than lifestyle.(8)

This disease-specific focus may explain why the nurses have not been able to keep current and confident in their knowledge and skill in relation to providing health education programs for their patients. Because acute care nurses are prepared for and must remain current in a system with a prominent medical model approach to patient care, they may often view the patients needs only from that perspective. Therefore, any health education programs they develop or implement may likely be from that perspective as well, as this study has demonstrated.

Nursing Culture

Although not completely understood, it was evident that, like hospitals, nursing has a culture of its own (Holland, 1993). Several aspects of nursing culture emerged from the analysis of the data that may have an influence on the provision of health education programs for patients. Three aspects will be discussed in this section as. They were (a) conflict resolution, (b) dedication to patients, and (c) decision making authority.

Conflict resolution. Nurses consider each other colleagues and generally work together as a group or team on one specific patient care unit. They tend to be isolated from the nurses on other units and as a result, a health education program that is provided on one unit will not necessarily be provided on other units. Nurses are generally supportive of one another if they are in agreement about an issue or concern. However, when they are not in agreement, they withdraw their support from each other.

This was evident in this study regarding the issue of patient education. When nurses agreed with each other that health education was their number one priority, they supported each other in producing it.

> *I think it's nurtured here and another thing - everyone gets on the bandwagon - 'Can I have the video machine?', 'As soon as you're finished I want to use it', or 'By the way, I'm going to show an MI film - do you have a couple of MI's that want to watch it?' It's so satisfying. It's that appreciation of it.(5)*

However, when educational activities (for patients or nurses) were in conflict with completing the work assignment and nurses did not agree that education was a high priority, those who engaged in activities to educate themselves or their patients lost the support of the colleagues who did not agree.

> *I never hear anyone say anything critical in terms of patient teaching, but if you do this [teaching], you know in your mind that you are going to get behind and the patient is talking and talking. It's viewed as 'not getting your work done'. When you get behind - it's not a popular situation, because it is a very busy ward and there's a lot to get done....I think they're anxious to get things done.... so I learned to curtail it [educating patients], because I think they feel it is not necessary. So I've been*

quiet about that.... [Also] people don't appreciate it when you are saying 'good-bye, take my load [patient assignment] I'm off to this program' [hospital inservice].... and someone may not be happy with you besides, because they've had their workload doubled.(7)

Dedication to patients. Another aspect of the nursing culture that may influence the provision of health education programs is nurses' dedication to their patients. The ultimate goal of nurses as a patient advocate is to meet their patients' needs (Berger & Williams,1992). Therefore, any patient need, as indicated in Chapter Four, is a priority for the nurse. When health education was identified as a patient need in this study, it became a priority and the health education need was met in some way. This was evident in the following informant's comment:

One of the biggest things is patient need - if there is a need for information by patients - professional staff will find some way of getting it for them.(1)

Decision making authority. One final and significant aspect of nursing culture identified in this study was the decision making authority of staff nurses. Nurses at the bedside are given the responsibility and authority to make life and death decisions regarding their patients and are expected to resolve ethical dilemmas on their own (Berger & Williams, 1992).

However, in this hospital, as in many other hospitals, the nurses were not given the responsibility and authority to decide their own patient assignments, workload or staffing needs for relief. They were also not involved in decisions that determined what the nurse/patient ratio would be on their unit or what resources they might need in order to practice nursing the way they wanted to and the way for which they were prepared. They stated that, as the literature suggests, they wanted to engage in nursing functions, like patient and health education programs rather than non nursing functions (Berger & Williams, 1992; Thomas, 1993; Wywialowski, 1993). Three informants reported:

.... right now, I really feel that administration has no idea what is happening on our floor. I don't think administration is aware that we need another pair of hands [to teach my patients](5).

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Nurses can't do what they are trained to do.... you learn things properly on one hand and you are not able to do them properly on the other.(7)

.... you don't get a chance to teach anything very much, because we are doing many non nursing functions.(8)

It was evident from these findings that the three aspects of nursing culture in an acute care setting may have an indirect influence on the provision of health education programs for patients. Lack of agreement on the priority of health education resulted in conflict and a withdrawal of collegial support for efforts to provide health education for patients. The nurses' dedication to meet the patients' needs was a powerful influence. However, patients' basic needs for health education were not identified because the nurses did not ask their patients questions or discuss health issues with them. Therefore, the patients' needs in that respect were not met. A lack of decision making power by staff nurses made it impossible for them to determine the staffing and resource needs in their area in order to provide health education programs for their patients. It was evident that the nurses' dedication in meeting their patients' needs could be a positive influence if the nurses identified basic needs for health education.

The discussions in this section on nursing factors have indicated that certain aspects of nursing practice, nursing education, and nursing culture may have an indirect influence on the provision of health education programs for patients during hospitalization. These factors may have influenced (a) whether or not health education programs were provided, (b) what the focus or issue for the health education programs would be, and (c) who the program would be provided for. Although the influences of these nursing factors were considered indirect, they are significant. Nurses, because of their numbers and their role in providing patient care and patient and health education, have a significant influence in the acute care setting on the development and implementation of health education programs.

Chapter Five identified and described factors that may have an *indirect* influence on the provision of health education programs for patients during hospitalization. Six recurrent themes emerged through analysis of the data and were categorized under the following headings: medical model, hospital culture, government policies, community impact, hospital priorities, hospital philosophy, and nursing factors. The PRECEDE model was adapted in order to reflect the unique

and complex factors that may indirectly influence nurses in the provision of health education programs in an acute care setting. The findings indicated that the medical model had the most significant indirect influence and impacted on all the other factors. The effects of community issues and government policy were also of great importance.

Chapter Six will provide a discussion and interpretation of five major findings presented in Chapters Four and Five.

CHAPTER SIX

DISCUSSION AND INTERPRETATION OF FINDINGS

Chapter Six discusses and interprets five major findings presented in chapter four and five that directly and indirectly influenced the provision of health education programs for patients during hospitalization in the acute care hospital in this study. The findings are: (a) the prominent influence of the medical model approach on the delivery of patient care, (b) the impact of certain nursing factors, (c) the variation in the nurses' workload, (d) the degree of collegial and physician support, and (e) the pivotal role of job satisfaction.

Major Findings

The Medical Model Approach

The first major finding is the powerful, insidious influence of the medical model approach to the provision of health education programs in an acute care hospital. All members of the health care team, not just nurses, are influenced by this approach. The medical model, as previously discussed in Chapter Two, is an approach to the health of individuals by identifying and treating illness and disease (Bulger, 1990). Aspects of the medical model that influence the provision of health education programs for patients are (a) the contrasting goals of the medical model and health education, (b) the illness focus of patient care, (c) the acuity factor in a hospital setting, and (d) the specialty focus of the patient care units.

Contrasting goals of the medical model and health education. The medical model requires observable, measurable outcomes as evidence of success for any intervention. Nurses and doctors alike have come to evaluate the care they provide on the basis of such outcomes. Short term goals are often the priority in an acute care setting and have observable, measurable outcomes. In contrast, the goals of health education are often long term, abstract and intangible. Consequently, health education does not readily fit the principles of the medical model.

The illness focus of patient care. The illness focus of patient care that accompanies the medical model results in a fragmented view of the patient. For example, patients are referred to by their illness or disease, as diabetics, MI's, alcoholics, or stroke patients rather than as individuals. In addition, health education programs were provided only if lifestyle was considered a factor in the patients' illness. In those instances, health education was a priority, because it was considered a treatment for their disease. This was true for the three main education programs for patients in this hospital. Programs for diabetes, ostomy care, and acute cardiac conditions contained a lifestyle component and had been provided for at least ten years. There were no health education programs for patients who were in hospital for other reasons. Only patients with acute cardiac conditions were provided with knowledge and skill regarding a healthier lifestyle.

The cardiac team which consists of cardiac nurses, a cardiologist, a nutritionist, and a physiotherapist, was committed to the provision of health education for patients during hospitalization, but failed to recognize the opportunity to provide health education preventatively for all patients during hospitalization. This may be because patients were viewed differently from members in the community. Patients were seen as in need of "illness" education, whereas, individuals in the community were seen as needing health education. Hospital nurses did not recognize their role in providing health education for patients. They believed that physicians and community health nurses were the ones to provide health education, because they had the contact with individuals in the community. Health education programs provided for the community reflected the same fragmented view of individuals as in the hospital. The main community program focused on only one part of the individual, the heart rather than the whole person.

The acuity factor in the hospital setting. The acuity factor in the hospital setting conditions health care professionals to react to dramatic, life threatening patient situations with high technology interventions that produce rapid results. This conditioning may influence the provision of health education programs. For example, a patient's need for health education may be identified or responded to only when it is complex and even dramatic. In these instances, health education may require a great deal of time and resources. This may be the reason for

nurses' comments from every study reported - that they do not provide health education, because they do not have the time or resources. In addition, it was evident that education programs that were provided for acute or "dramatic", observable conditions such as cardiac rehabilitation and ostomy care had a high profile and were very successful. However, education programs for patients with a chronic, invisible illness such as diabetes, were not high profile. Another issue this raises for the provision of health education programs is that generally, health education needs are simple and basic. In an acute care setting, patients' health education needs may be overlooked, or considered "primitive" in a health care field that is in awe of advanced technology, and therefore, may not be considered important or a priority.

The specialty focus of the patient care units. The specialty focus of each patient care unit, as previously indicated, is determined by disease or condition. This ultimately influences the priorities of each unit. In turn, this determines what education programs are provided for patients - health or otherwise - and the amount of time nurses would have to provide them. The specialty focus facilitates the provision of health education programs for some patients, such as those with acute cardiac conditions, but compromises the provision of health education programs for most other patients. It also encourages health care professionals to view the patient only in relation to the specific illness that s/he is in hospital for, rather than as an individual. This was evident in the reports of nurses who had provided health education programs for patients on the cardiac unit, but did not continue to do so when they were transferred to another unit.

The Impact of Nursing Factors

The second major finding is that there are two factors, unique to the culture and practice of nursing in an acute care hospital, that influenced the provision of health education programs for patients. They are (a) the nurse/patient relationship, and (b) the position of the staff nurse.

The nurse/patient relationship. In a hospital setting, unlike physicians, the relationship between the nurse and the patient begins and ends with the hospital experience. As a result, the relationship is focused on the reason for admission, the "here and now". This short term relationship influenced the provision of health education programs for patients in the hospital in this study. For example, when the potential for health education programs for the general patient population was explored with the staff nurses, the informants were unable to identify patient health education needs, because they related patients' health education needs to the reason for admission. In some instances, some informants could not identify a health education need for patients having their gallbladder removed or their hip replaced. The problem was not because of a lack of knowledge or skill on the part of the nurses, but because they focused on prevention for a gallbladder or hip problem rather than on the patients' general well-being or the high risk for heart disease that was prevalent in the community. In addition, the data illustrated that many of these hospital-based nurses provided care and education based on the following assumptions: (a) patients are different from the rest of the community because they are ill and have different educational needs, (b) nurses have the responsibility and authority to educate patients about their illness and treatment, and (c) nurses do not have the responsibility to address issues regarding the patients' lifestyle, unless it is linked to their illness. Lifestyle concerns and education rest with the family physician and community health nurse.

All of these assumptions have a significant influence on the provision of health education programs for patients during hospitalization and require further research to understand and explain - why they exist and what impact they have on health education programs.

The position of the staff nurse. The position of the staff nurse in an acute care hospital influenced the provision of health education programs for patients. The staff nurses from previous studies as well as this one, all reported a lack of time and resources to provide health education programs. Although nurses stated that they enjoyed teaching their patients and believed it was a priority for them to provide health education programs for their patients, they were unable to adjust their workloads to allow time for them to do so. This was because staff

nurses do not make the decisions that determine their patient assignments or their workload. Although staff nurses made major decisions regarding patients and patient care, they did not make decisions regarding their workload and the amount of time they needed to provide health and other education programs for their patients. Therefore, the nurses in most areas did not have time to provide education programs nor were they able to get relief staff to replace them in order to be current in health education or other clinical skills.

It has been suggested that certain areas of nursing in an acute care hospital have a higher status than others (Dalton, 1990). For example, nurses who work in critical care units are involved with the dramatic interventions of acute care. Because of this, they are regarded as having a higher status than nurses who work in other more stable areas. Nurses who work in a cardiac rehabilitation unit share in some of this high status. It was evident from this study that there was a difference in status between the staff nurses. For example, the cardiac nurses received support for providing health education programs from the nurses in all the areas involved in this study. These nurses felt valued and an important part of the cardiac team. The cardiac nurses did not have their workloads adjusted even though the patients on this unit were more independent for their physical care than patients in other areas. They had the time and authority to make some decisions about setting their own priorities regarding their patient care, whereas, nurses in other areas did not. Other nurses reported that they felt like "workhorses", and were unsupported by those who supported the cardiac nurses. Also, they were cautious about providing health education programs, because they felt their colleagues, the physicians and other disciplines may not approve.

Variations in the Nurses' Workload

The third major finding indicated, as previous studies have, that the nurses' workload was a significant factor in the provision of health education programs for patients. As this study and many others have indicated, the amount of work nurses had to complete by the end of their shift, either facilitated or compromised the provision of health education programs for patients. Variations in the staff nurses' workloads in this study clearly demonstrated this fact. For example,

patient education programs were provided on a routine basis in areas where patients were fairly independent for their physical care. Whereas, patient and health education programs were not provided and considered a "frill" in areas where patients were very dependent on the nurses for their physical care, because the nurses did not have the time or energy to engage in educational activities for their patients. It was noted, that when the workload increased for the cardiac nurses, their time and energy for providing health education programs diminished as well and they experienced the same frustration and feelings of inadequacy as the other nurses experienced. The workload for the educational services department influenced the provision of health education programs as well. It had only one nurse to provide education programs and support for both hospital staff and the patients alike, hospitalwide.

The Degree of Collegial and Physician Support

Collegial and physician support was the fourth major finding that influenced the provision of health education programs for patient during hospitalization. It is evident from the data in this study that there were variations in the degree of support that nurses received for providing health education programs as well as variations in their workloads. For example, nurses in one area received support from their colleagues on their unit as well as from colleagues throughout the hospital. They also received support from the physicians and cardiologists. This support was provided in the form of team work, inservices by the physicians, and financial assistance to attend conferences to update their knowledge and skills in lifestyle issues and cardiac care. These nurses provided health education programs on a routine basis and reported that the support they received encouraged them to provide health education programs in their area.

However, some nurses did not receive support for their efforts in providing health education programs, in fact they were chastised by their colleagues when they engaged in educational activities. They also felt cautious about the support they would receive from physicians. These nurses did not engage in educational activities for their patients, except in

isolated situations. This occurred despite opportunities that had been presented by patients during the course of delivering care, particularly in relation to patients expressing a desire to stop smoking during the course of their hospitalization.

The Pivotal Role of Job Satisfaction

The fifth major finding was the strong link that existed between the nurses' job satisfaction and the provision of health education and patient education programs for patients. When nurses provided health or patient education programs for their patients they felt satisfied with themselves and with their practice. This was mainly because they felt they were fulfilling their role as a nurse and they enjoyed seeing the results of their education programs - seeing that they had made a difference in their patients' lives. They reported that this encouraged them to continue to provide health education programs for their patients. However, nurses who were unable to provide education programs for their patients felt inadequate about the care they provided - that they had somehow failed their patients, expressed a sense of anger and frustration with the situation, and experienced little satisfaction from their practice. These nurses did not engage in educational activities for their patients even though they believed that providing education programs for their patients was important and that it was their role to do so.

These findings demonstrated that not only do time and money influence the provision of health education programs for patients as previous studies have indicated, but also the interrelationship of many other factors may either facilitate or compromise the provision of health education programs as well.

The five major findings identified in this study support the significant factors that influence health education programs for patients set forth in the literature review in Chapter Two. In addition, others were identified as well. Chapter Six discussed and interpreted five major findings presented in Chapters Four and Five that *directly* and *indirectly* influenced the provision of health education programs for patients during hospitalization in the acute care hospital in this study.

These findings were: (a) the prominent influence of the medical model approach on the delivery of patient care, (b) the impact of certain nursing factors, (c) the variation in the nurses' workload, (d) the degree of collegial and physician support, and (e) the pivotal role of job satisfaction.

Chapter Seven will address the conclusions drawn from the results of this study. It also discusses implications for the relevant fields and proposes suggestions for future research.

CHAPTER SEVEN

CONCLUSIONS AND IMPLICATIONS

Chapter Seven addresses six conclusions drawn from the results of this study. It also discusses implications for the fields of health education and health promotion, health care and nursing practice. It also proposes a number of suggestions for future research.

Conclusions

The six conclusions drawn as a result of this study are:

1. There is no Type 2 "planned" health education program provided for patients during hospitalization.
2. There is a Type 3 "comprehensive" health education program provided for some specific patients - specifically those who were recovering from a heart attack.
3. The influence of the medical model approach on the provision of health education programs for patients during hospitalization is significant and pervasive.
4. The nurses and other health care professionals are unaware of the impact the medical model has on their approach to health education programs for patients.
5. There are many factors in addition to time and resources, that influence the provision of health education programs. These include the medical model, hospital culture, government policy, community impact, hospital priorities, hospital philosophy, and nursing factors.
6. Further exploration is needed to identify additional factors in the PRECEDE model in order to understand the phenomenon regarding the provision of health education programs for patients during hospitalization in an acute care facility.

These conclusions require some further discussion. First, the study confirms that there is no Type 2 "planned" health education program for all patients during hospitalization in this hospital. This finding exists despite the fact that the nurses participating in this study believed that: health education provides benefits for both patients and the health care system, acute care hospitals have a significant role in providing health education programs for patients, and nurses at the bedside were the best ones to provide health education for patients.

Second, nurses, as part of a cardiac team, provide a Type 3 "comprehensive" health education program, only for specific patients, namely those in hospital recovering from a heart attack. In this instance, health education is a priority because it is considered a treatment for an acute cardiac condition and is provided in order to possibly prevent a recurrence of acute cardiac problems and subsequent readmissions. In addition, the hospital had instituted a no smoking policy, and many of the nurses reported several requests by patients for assistance to stop smoking. Even though smoking is considered one of the greatest preventable causes of heart disease and death, there are no resources or supports in the hospital for a smoke cessation program for patients in general during hospitalization.

Third, the influence of the medical model is evident in every aspect of patient health and health education investigated in this study, but most important was the influence it had on the perspective of health care professionals who practice in an acute care setting. The most significant aspect was the fact that the learning needs of patients in hospital were identified only in terms of their presenting illness or condition. This occurred to the exclusion of learning needs regarding the patients' general well-being. In the hospital in this study, only individuals in the community were identified as needing health education to prevent heart disease. In fact, at the time of this study, there were plans to expand health education programs for individuals in the community, but no plans to provide the same programs for patients in the hospital.

Fourth, it was evident throughout the analysis of the data that the nurses and other health care professionals in this hospital were unaware of the powerful influence of the medical model on their delivery of patient care and patient and health education. It was also evident that they were unaware of the impact the medical model had on their perspective as well as on their decisions.

Fifth, although previous studies have indicated that nurses consistently identify a lack of time and resources as the main factors that compromise the provision of health education programs for patients, this study concluded that there are many additional factors in an acute care setting that can either facilitate or hinder the provision of these programs for patients. These factors include the medical model, hospital culture, government policy, community impact, hospital priorities, hospital philosophy, and nursing factors.

Sixth, some of the additional factors were identified in this study, but more research is needed in this area to identify other factors and to explore and understand the phenomenon that exists between acute care and the provision of health education programs.

Relevance of the Study

Findings of the study demonstrate that one of the major influences on the provision of health education programs is the medical model. This is relevant and may raise the awareness of acute care health professionals to the fact that the medical model approach to patient care impacts on all aspects of patient care and patient education. From the way the hospital structures its patient care units, to the way nurses perceive the health education needs of patients, to the way patients are selected to receive health education programs, the influence of the medical model approach to patient care compromises the provision of health education programs for the general patient population. Numerous factors in addition to time, energy, and resources, previously identified, reinforce the fact that previous studies on this issue have fallen short in identifying many of the factors that influence the provision of health education programs for patients during hospitalization in acute care settings. Future studies can continue to explore this area and will, it is hoped, come closer to resolving some of these and other issues that influence the provision of health education programs in acute care hospitals.

Although the results generated from this study cannot be generalized, nurses who provide health education programs in other settings may face similar influences. It is evident from the findings that health care professionals will benefit from an increased awareness of the issues that surround them.

Following this study, acute care nurses and other health care professionals may be able to gain a broader perspective regarding the health education of patients. They may be better able to bridge the gap between the application of the health model and the medical model in order to provide more comprehensive health care services for the individuals and communities they serve. In addition, nursing administrators may recognize the significant contribution they can make by supporting and giving direction to staff nurses in order that health education programs are provided for patients during hospitalization.

Implications of the Study

The results of this study have implications for health education and health promotion, health care, nursing practice, and future research. The implications are as follows:

1. That a broader perspective is needed regarding the health and health education of patients during hospitalization in acute care facilities.
2. That it is necessary to bridge the gap between the field of health care and the field of health promotion for this to occur.
3. That research continue in this area using the adaptable PRECEDE-PROCEED model in order to deepen our understanding of this phenomenon and ways to reduce the barriers to the provision of health education programs for patients during hospitalization. .

Implications for Health Education and Health Promotion

The results of this study reiterate the significant role acute care hospitals can play in promoting the health of their patients through health education programs. The results also demonstrate the complexities of incorporating the health model with the medical model. Those in the field of health promotion and health education may consider this as an opportunity to expand their experience, by assisting hospital-based health care professionals with the integration of the health model and the medical model. Cardiac teams who already provide health education

programs for patients during hospitalization, can be encouraged to expand their notion of health education from treatment only to prevention/promotion and treatment. Providing health education programs that include all patients in the hospital, not just cardiac patients, would provide another setting for health promotion and health education to reach individuals

Implications for Health Care

Health promotion and health education fit with the goals of acute care hospitals. Whether hospitals act on these goals or not, they play a pivotal role in the health and well-being of the community they serve. Their silence on health matters gives patients the message that in hospitals, only illness and its treatment are valued entities. Because acute care hospitals have the expertise, the resources, and the "captive audience", it is very important that hospitals are included in the list of places that provide health education programs, along with the workplace, community, and schools. If health education programs were provided in hospitals, then health care for individuals would be enhanced by concentrating on the health of the whole person as s/he recovers from and illness or an accident rather than concentrating on the illness or accident alone. Improving health and reducing the risk of cardiac disease by reducing smoking behaviors in the general patient population, would decrease the costs of health care and the need for hospitalization as well.

Implications for Nursing Practice

Nurses in this study indicate a desire to provide health education programs for patients. The results also illustrate the complexity of providing health education programs for patients in general during hospitalization. While nurses have continued their tradition of promoting patient self-care in illness, they have not been as successful in maintaining the tradition of promoting patient self-responsibility for health (Green & Kreuter, 1991).

This study has a message for nurse administrators. It indicates that nurses who are supported in providing health education programs for patients during hospitalization, receive a great deal of satisfaction from doing so, and tend to continue to support each other in engaging in

health promoting educational activities for patients as long as they have time, energy, and resources to do so. It also suggests that by including the role of the nurse in health education in the philosophy of the Nursing Department, more emphasis may be placed on the provision of health education programs for all patients during hospitalization.

This study also has a message for nurse educators. It indicates that nurses' basic and continuing professional education has mainly focused on the medical model approach to patient care. While it is important for nurses to remain updated in medical knowledge and skill, this emphasis has resulted in nurses who feel inadequately prepared to provide health education programs for their patients. It suggests that by responding to this learning need, nurse educators can assist student and professional nurses gain knowledge and skill in incorporating health education programs in their care for all patients during hospitalization..

All levels of nursing value health and their role in health education, but there is a need for nurses to support each other in creating, within the acute care setting, an environment for valuing health (Dalton, 1990). An increased awareness of the influences identified in this study may help make this a reality. By understanding how much the medical model misdirects nursing practice in an acute care setting, and by realizing that the health model has all but disappeared from their practice, nurses can work to recapture their tradition - that of promoting self-responsibility for health in the patients under their care.

Implications for Further Research

The suggestions made in this section refer to all three fields - health education and health promotion, health care, nursing practice. Research in this area has provided valuable information for some of the influences that facilitate or compromise the provision of health education programs for patients during hospitalization. However, more research is needed in order to determine whether the factors identified in the study exist in other acute care hospitals as well. The development of a survey tool from the data produced in this study will accommodate larger

samples and a variety of hospitals to be used in future research. In addition, important information may be obtained by repeating this study using a nursing model instead of a health promotion model and comparing the results of both studies.

It was recognized that a wide variety of factors may influence the provision of health education. However, from this study emerged several factors that have not been accounted for in the original or previously adapted models used in other studies. These factors have been referred to as indirect influences rather than direct influences and were placed under categories such as medical model, hospital culture, government policy, community impact, hospital priorities and philosophy, and nursing factors.

The PRECEDE model, in its current form, could not accommodate these new factors. In order to present these factors and to reflect the nurses' experience in providing health education programs for patients in an acute care setting, the PRECEDE framework was revised and the seven additional components added. The adapted model allowed for the inclusion of both direct and indirect influences. It described interrelationships between some factors and not others. Data from this study indicated that some factors were clearly linked, but the data did not demonstrate how other factors were linked. In the schema of the adapted PRECEDE model, the influential nature of each factor in relation to health education programs and the interrelationships between each factor were accounted for (see Figure 2).

In previous studies, results have focused more on the barriers to health education programs mainly because, as this study demonstrated, very few facilitators exist in acute care settings at present. A more beneficial approach might be to investigate several acute care hospitals that are actively involved in hospitalwide health education programs for patients in order to identify factors that have promoted and facilitated the provision of health education programs for patients. Other directions could include (a) cross-case comparisons between several hospitals, (b) in-depth studies on each of the major findings revealed in this study, and (c) the degree to which the medical model has impacted on the thinking and practice of health professionals in acute care settings and how this subsequently may be changed to facilitate the provision of health education programs for patients during hospitalization.

This final chapter has addressed six conclusions drawn from the results of this study, in hopes of enhancing the factors that facilitate the provision of health education programs for patients during hospitalization. It has also discussed implications for health care, nursing practice, and the field of health promotion and health education as well as implications for further research.

Summary

In summary, this descriptive, qualitative study of factors that influence the provision of health education programs for patients during hospitalization, has identified and described six major findings that may either facilitate or compromise the provision of these programs in the complexities of medical surgical areas in an acute care hospital. These findings add to the results of previous studies on this issue and offer a beginning in the search for ways to enhance the health and health education of a community, by using hospitalization as another forum in addition to the workplace, school, and community settings. It is hoped that research will continue in this area (a) in order to increase the awareness of health care professionals regarding the pivotal role they play in the health of those they serve, (b) to bridge the gap between patients in hospital and individuals in the community, and (c) by partnering the health model with the medical model approach in acute care settings, in order that all patients will be provided with health education programs during their hospitalization. In doing so, we may come one small step closer to the realization of the goal of the 1986 Ottawa Charter on Health Promotion, "the role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services" (WHO et al, 1986).

Nurses, physicians, and especially the cardiovascular team in acute care hospitals, have a responsibility to assist in reducing the risk of heart disease in all patients, not just in those who have already had a heart attack. They have knowledge, expertise and commitment that needs only to be expanded to programs for all individuals that acute care hospitals are intended to serve.

Present-day health problems call for new paradigms, new methods, and new definitions of health - ones that include the medical model and the health model and recognize that health promotion and health education are equal partners in the health and health care of all. It is time for all health professionals, wherever they practice, to focus on health promotion by providing health education programs for their patients/clients.

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Appendices

Appendix A

Glossary of terms

Glossary of Terms

Health: A resource for every day living to the extent that an individual or group is able to realize aspirations, satisfy needs, and change or cope with their environment emphasizing social and personal resources, and physical capabilities (WHO, 1986, p.2).

Health Model: A biopsychosocial aspect of wellness that includes practices that assist in the promotion of health and the prevention of disease (Hoffmaster, 1992, p. 232).

Health Promotion: A process of enabling people to increase control over and improve their health and the factors that influence their health -including physical, social, economic, and political environment (WHO, 1984).

A process of fostering awareness, influencing attitudes and identifying alternatives so that individuals can make informed choices and change their behavior in order to achieve an optimum level of physical and mental health and improve their physical and social environment (American Hospital Association, 1979).

It is also the combination of educational and environmental supports for actions and conditions of living conducive to health -- the action or behaviors may be those of individuals, groups, communities, policy makers, employers, teachers, etc. (Green & Kreuter, 1991, p. 4).

Health Education: A process that bridges the gap between the need for health information and the adoption of health practices and attempts to directly influence behavioral factors relevant to health (Preventive Medicine USA 1976).

Any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health (Green et al, 1980, p. 7).

A teaching and learning process focussed on assisting individuals and families in their pursuit of a healthy lifestyle in order to reduce their personal risk for disease and to maintain or improve their health (Author).

Program: A learning experience designed to achieve certain specific outcomes for an individual or a group consisting of a single meeting or a series of sessions (Verner, 1964, p. 34).

Is provided on a one to one, or small group basis, and may be, 1) routine for certain patients on their care unit ie cardiac patients, 2) planned for an individual patient with a specific learning need, or 3) an incidental general discussion with any patient (Author).

Health Education Program: A learning experience designed to achieve specific health enhancing outcomes for patients and their families. The focus is on assisting them in their pursuit of a healthy lifestyle by reducing their risk for disease and improving or maintaining their health. Issues such as stress management, dietary habits , exercise and smoke cessation etc. are frequently addressed (Author).

Patient Education Program: A planned learning experience using teaching and counselling to influence knowledge and health behavior. It involves an interactive process which assists patients to participate actively in their health care (Bartlett, 1985, p. 323).

A learning experience for patients and their families that addresses only the presenting problem or illness for which the patient has been hospitalized. It deals with information about the patients' illness, including diagnostic tests, procedures and treatments and assists them to participate actively in their health care and recovery. Examples of this are preparation for tests and procedures, preop teaching, ostomy care and medication regime (Author).

Adult Education: A process by which men and women (alone, in groups, or in institutional settings) seek to improve themselves or their society by increasing their skill, their knowledge or their sensitiveness (Houle, 1982, p. 229).

Self Care: Iincludes independent decisions and actions directed toward minimizing threats to personal health, self-nurturance, self-improvement, and personal growth (Pender, 1987, pp. 185, 192).

Lifestyle: A complex of related practices and behavioral patterns, in a person or group, that are maintained with some consistency over time (Green & Kreuter, 1991, p. 12-13).

Medical Model: Measuring one's health status by focussing on biological and physiological structure and function of organs seeking to identify disease and find treatments (Bulger, 1990, p. 7).

Values: Are characterized subjectively by the individual and reflect personal preferences, commitments, and patterns of using resources. The person considers beliefs, events, objects, people, places, or goals to have special meaning. An individual's values influence his/her choices, decisions, behaviors and actions (Wywialowski, 1993, p. 204).

Value System: (of a culture, ie. hospital culture) A hierarchy of values reflecting the culture's conception of how people should behave in various situations as well as which goals they should pursue and how . They determine the cultural norms which presribe expected behaviors and provide guidelines for judging acceptability. They strongly influence the person's actions and behaviors (Wywialowski, 1993, p. 204).

Appendix B

Chart for questions by factor and sources of data

PREDISPOSING FACTORS (values, beliefs, attitudes, knowledge, perceptions)
That May Influence Nurses' Provision of Health Education Programs
for Their Patients During Hospitalization

QUESTIONS	SOURCES OF DATA						
	Unit w/RN	Unit wo/RN	Unit w/HN	Unit wo/HN	Manager Ed. Srv.	D.O.N.	Document Review
1) Definition of health of patients	x	x	x	x	x	x	x
2) Definition of health education of patients	x	x	x	x	x	x	
3) Health education indicated in philosophy	x	x	x	x	x		x
4) Priority of health education in patient care	x	x					
5) Confidence in providing health education to patients	x	x	x	x			
6) Qualifications/experience in health education	x	x	x	x			
7) Training in incorporating health education into schedule	x	x					
8) Perception of committment to health education of patients	x	x			x		
9) Discussion of lifestyle issues for self and family	x	x					
10) Discussion of health education programs for patients	x	x			x	x	
11) What guides practice in providing health education for patients	x	x					
12) What guides decisions to provide health education for patients						x	
13) Belief in benefits of health education	x	x	x	x	x	x	
14) Belief in role of hospital in providing health education for patients	x	x	x	x	x	x	
15) Belief in role of nurse as health educator	x	x	x	x	x	x	
16) Belief that providing health education for patients increases hospital image/public relations						x	

ENABLING FACTORS (skills, resources, system/societal barriers)
That May Influence Nurses' Provision of Health Education Programs
for Their Patients During Hospitalization

QUESTIONS	SOURCES OF DATA						
	Unit w/RN	Unit wo/RN	Unit w/HN	Unit wo/HN	Manager Ed. Srv.	D.O.N.	Document Review
1) Health education as a routine	x	x					
2) Amount of time allotted to provide health education program	x	x	x	x			
3) Skill in incorporating health education into schedule	x	x					
4) Previous experience in health education	x	x	x	x			
5) Health education resources	x	x	x	x	x		
6) Currency of nurses' knowlege and resources	x	x	x	x			
7) Process for developing health education program	x	x	x	x	x	x	
8) Barriers to developing health education program	x	x	x	x	x	x	
9) Availability of assistance/ support	x	x	x	x	x	x	
10) Availability of funding			x	x		x	

REINFORCING FACTORS (incentives, rewards, feedback, recognition)
That May Influence Nurses' Provision of Health Education Programs
for Their Patients During Hospitalization

QUESTIONS	SOURCES OF DATA						
	Unit w/RN	Unit wo/RN	Unit w/HN	Unit wo/HN	Manager Ed. Srv.	D.O.N.	Document Review
1) Personal feelings about providing health education for patients	x	x					
2) Outcomes of attempts to start health education program				x	x		
3) Recognition/incentives for providing health education program							x
- patients	x	x	x	x	x	x	
- nurses	x	x	x	x			
- head nurse	x	x					
- manager of ed. srvcs.	x	x	x	x			
- D.O.N.	x	x	x	x	x		
- physicians						x	
- hospital					x	x	
- administration						x	
- community						x	
- RNABC						x	x
- BCHA						x	x
- Ministry of health						x	

ENVIRONMENTAL SUPPORTS (conditions, policies, organizational arrangements)
That May Influence Nurses' Provision of Health Education Programs
for Their Patients During Hospitalization

QUESTIONS	SOURCES OF DATA						
	Unit w/RN	Unit wo/RN	Unit w/HN	Unit wo/HN	Manager Ed. Srv.	D.O.N.	Document Review
1) Presence of policies/stds./ guidlines for nurses	x	x	x	x			x
2) Accountability for providing health education program	x	x	x	x	x		
3) Changes in health education program	x						
4) Sharing of resources	x						
5) Barriers to providing health education programs		x					
6) Expectations re: provision of health education programs	x	x	x	x		x	x
7) Experience/involment in health education as a requirement							
- pre-employment	x	x	x	x			x
- annual appraisal	x	x					x
8) Perceived advocates of health education			x	x	x	x	
9) Reasons for health education program on cardiac unit			x		x	x	
10) Organization of patient care	x	x					
11) Funding alotted for health education programs			x			x	
12) How competence is insured			x	x			
13) Role in health education program			x	x	x	x	
14) Decisions made to initiate present health education program			x				
15) Physician involvement in present health education program			x				
16) Rapport with manager of educational services					x		
17) Involvement in decisions re: health education program					x	x	

QUESTIONS	SOURCES OF DATA						
	Unit w/RN	Unit wo/RN	Unit w/HN	Unit wo/HN	Manager Ed. Srv.	D.O.N.	Document Review
19) Influence of recommendations of Royal Commission						x	x
20) Future plans/goals to provide health education programs for patients					x	x	
18) Person responsible to oversee health education program					x	x	

Appendix C

Questions for interviews by factor and type of interviewee

Questions for Predisposing Factors

(values, beliefs, attitudes, knowledge and perceptions)

Unit with Health Education Program
R. Nurse

1) How do you/your unit define health for your patients?

2) How do you/your unit define health education for your patients?

3) There are many competing demands on your time in the course of your day. Where does patient education fit on your list of priorities? Where does health education fit on this list?

4) Does your head nurse expect you to provide this health education program for all the identified patients?

5) What health information do you provide for the other patients when a need is identified?

6) What were you taught about incorporating patient education into your busy work day? How else did you learn to do this?

7) What previous experience do you have in relation to health education for patients?

8) How did you acquire your knowledge and skill in lifestyle issues / and in teaching this program?

9) How do you keep current in your knowledge and skill?

10) How confident do you feel in your knowledge and skills in providing health education i.e. smoke cessation, exercise, dietary habits, and stress management? How confident do you think your colleagues on this unit feel with their knowledge and skill in these areas?

11) Is health education identified in your unit philosophy? Nursing philosophy? Hospital philosophy?

12) Do you and your colleagues/head nurse discuss lifestyle issues that relate to yourselves and/or your families?

13) What do you think the benefits of health education during hospitalization are -- for the patient? the health care system

14) What guides your practice in providing health education for patients?

15) Do you believe that providing health education for patients during hospitalization is something acute care hospitals should be doing? unit? med/surg? bedside? clinician?

Predisposing factors

Unit without a health education program
R. Nurse

1) How do you/your unit define health for your patients?

2) How do you/your unit define health education for your patients?

3) There are many competing demands on your time in the course of your day. Where does patient education fit on your list of priorities?

4) Where does health education fit on this list? An example of a situation that might occur - one of your patients who is a smoker might express a wish to be able to stop smoking or may indicate that s/he intends to quit smoking, using their illness/surgery/hospitalization as a motivation or opportunity to quit. How would you respond to this?

5) Would you feel comfortable handling this type of situation?

6) How confident do you feel in your knowledge and skill in relation to health education issues i.e. smoke cessation, dietary habits, exercise and stress management?

7)What previous experience do you have in relation to health education for patients?

8) How confident do you think your colleagues on this unit feel in their knowledge and skill in these areas?

9) How did you acquire your knowledge and skill in these lifestyle issues?

10) How do you keep current in your knowledge and skills in health education?

11) Have there been any inservice sessions/displays on health issues, or any health fairs offered in the hospital in the last 1-2 years?

12) What were you taught in your nurses training about incorporating patient education into a busy work schedule?

13) Do you and your colleagues discuss lifestyle issues for yourselves/families?

14) Do you/your colleagues/Head nurse discuss the possibility of providing a health education program for the patients on your unit? Would you be interested in providing a health education program for your patients? Explain.

Predisposing (cont'd)

15) Is health education identified in your unit philosophy?

16) What guides your practice in providing health education for your patients?

17) Do you believe there are benefits for the patient/health care system when health education is provided for patients during hospitalization? Can you tell me what some of those benefits might be?

18) Do you believe that providing health education for patients is something acute care hospitals should be doing?

- on your unit
- on other med/surg units
- by the nurse at the bedside
- by a clinician for patient/health education
- other

Predisposing factors

Unit with Health Education Program
Head Nurse

1) How do you/your unit define health for your patients?

2) How do you/your unit define health education for your patients?

3) What is the philosophy of your unit/Department in relation to health education for patients?

4) Is health education incorporated into the mission statement of this hospital?

5) Do you believe that your nurses feel confident in their knowledge and skill in relation to lifestyle issues?

6) How qualified are your nurses to provide health education for their patients?

7) How do you ensure that they keep current in their knowledge and skill in health education?

8) How do you ensure that your health education program stays current?

9) What has your previous experience been in providing health education programs for patients?

10) Do you believe that there are benefits for the patients/health care system when health education is provided for patients during hospitalization? What do you think some of them might be?

11) Do you think those same benefits might apply to the patients in other acute med/surg areas of this hospital? Explain.

12) Do you believe that providing health education programs for patients during hospitalization is something an acute care hospital should be doing?

- on your unit
- on other med/surg units
- by nurses at the bedside
- by a clinician for patient/health education
- other

Predisposing factors

Unit without Health Education Program
Head Nurse

1) How do you/your unit define health for your patients?

2) How do you/your unit define health education for your patients?

3) How confident do you/ your nurses feel in your/their knowledge and skill in providing health education for patients?

4) What previous experience do you/they have in providing health education for patients?

5) Do you believe there are benefits for the patients/health care system when health education is provided for patients during hospitalization? What might some of those benefits might be?

6) Do you believe that providing health education programs for patients during hospitalization is something acute care hospitals should be doing?

- on your unit
- on all med/surg units
- by nurses at the bedside
- by a clinician for patient/health education
- other

Predisposing factors

Manager of educational services

1) How do you define health for patients?

2) How do you define health education for patients?

3) In your view is senior management/hospital/physicians committed to the idea of health education for patients on all med/surg units? on some units?

4) Have there been discussions about providing health education programs for patients during hospitalization within the past year?

5) What previous experience do you have in health education programs for patients?

6) Do you believe that there are benefits for patients/the health care system when health education is provided for patients during hospitalization? What might some of those benefits might be?

7) Do you believe that providing health education programs for patients is something an acute care hospital should be doing?

- on all/some med/surg units
- by nurses at the bedside
- by a clinician for patient/health education
- other

Predisposing factors

Director of Nursing

1) How do you define health for patients?

2) How do you define health education for patients?

3) How are health/health education defined in the daily operating of this hospital?

4) In the competing demand for resources, what guides the decisions regarding health education when allocating

- funding
- personnel
- other resources

5) Have there been any discussions about providing health education programs for patients in the last year?

6) Do you believe that there are benefits for the patients/health care system when health education programs are provided for patients during hospitalization?

7) Do you believe that acute care hospitals should be providing health education programs for patients

- on cardiac rehab units
- on all med/surg units
- by nurses at the bedside
- by a clinician for patient/health education
- other

8) Do you believe that providing health education programs for patients raises the image of the hospital within the community it serves? Does the provision of health education programs enhance public relations with the community?

Questions for Enabling Factors

(Experience, skills, resources, and barriers created by systems/societal forces)

Unit With Health Education Program
R. Nurse

1) Is health education provided on a routine basis for all patients on your unit? Certain patients?

2) Nurses often say they don't have enough time to teach their patients.
   a) Is this true for you and the other nurses on this unit?
   b) How are you able to incorporate health education into your daily nursing care on a busy day?

3) Explain how you are involved in patient education on your unit.

4) Explain how you are involved in health education for patients on your unit.

5) Describe the health education program that you are presently providing on your unit. Does it include smoke cessation, dietary habits, exercise, and stress management?

6) Who usually initiates or identifies the need for this program -- the patient? the nurse? the doctor? standing orders?

7) What resources are available for health education?

8) How are these useful to you in providing health education for patients?

9) Have there been any inservice presentations on health education in the last 1-2 years? Were you able to attend any of them?

10) Have you been able to attend any workshops outside the hospital in relation to health education?

11) How is the patient's involvement in this program recorded?

12) When some of the areas in the program have not been covered, are they passed on to another nurse to complete or follow up on?

13) How is this communicated to the next nurse responsible?

Enabling (cont'd)

14) What kind of support and assistance do you receive in order to provide health education for your patients? From whom?

15) Do you consult with the manager of educational services? In what ways is she helpful?

16) If several nurses on another med/surg unit wanted to develop a health education program for their patients

a) what would you tell them?
b) how would they get started?
c) where might they find support/assistance?
d) what roadblocks might they encounter?
e) how might they overcome them?

Enabling factors

Unit Without Health Education Program
R. Nurse

1) Is health education provided on a routine basis for all patients on your unit? Certain patients?

2) Nurses often say they don't have enough time to teach their patients.
   a) Is this true for you and the other nurses on this unit?
   b) How are you able to incorporate health education into your daily nursing care on a busy day?

3) Explain how you are involved in patient education on your unit.

4) Explain how you are involved in health education for the patients on your unit.

5) Have there been situations relating to lifestyle issues that have come up with your patients, i.e. exercise, dietary habits, smoke cessation, or stress management? Tell me about one of them.

6) Who usually initiates or identifies the need for health education? the patient? the nurse? the head nurse? other?

7) What access do you and your colleagues on this unit have to health education materials -- pamphlets, videos, manager of educational services? How helpful are they?

8) What kind of support/assistance do you and your colleagues receive in order to provide health education for your patients?
From whom?

9) If you and your colleagues wanted to develop a health education program for patients
   a) what steps would you take?
   b) how would you get started?
   c) where might you find support/assistance?
   d) what roadblocks might you encounter?
   e) how might you overcome them?

10) Nurses on the cardiac step-down unit are involved in providing a health education program for their patients. Would you and your colleagues approach some of these nurses for assistance and to share their resources?

Enabling factors

Unit With Health Education Program
Head Nurse

1) Several studies have shown that nurses often feel they lack the knowledge and skill -- is this true for your nurses as well?

2) How do you ensure that your nurses have adequate skills and knowledge to provide health education for their patients?

3) How do you ensure that your nurses stay current in their knowledge and skills in health education?

4) Nurses value health education for their patients, but they say that they don't have enough time to do it because of their a) patient load, b) paperwork, c) limited resources. How is this different for your nurses?

5) Have you/your nurses experienced any roadblocks when providing or updating your health education program?

6) How did you overcome these roadblocks?

7) Where does most of your support for this program come from?

8) Are the physicians supportive/in charge of/have standing orders for this program?

9) In your view, what would be the greatest barriers for you to develop and implement another health education program?

10) If several nurses on another medical/surgical unit wanted to develop a health education program for their patients

- what would you tell them?
- what steps should they take to initiate the process?
- what roadblocks might they encounter?
- how might they overcome them?
- would your unit be able to share expertise/time/resources etc.?

11) Describe the assistance/support they could expect.

Who (by position) would provide the greatest support?
Who (by position) might resist?

Enabling factors

Unit Without Health Education Program
Head Nurse

1) Is health education provided on a routine basis for your patients on this unit?

2) Nurses value health education for their patients, but they say they don't have enough time to do it because of a) their patient load, b) paperwork, c) limited resources. Explain how this is similar/different for the nurses on your unit.

3) What support/assistance do you and your nurses receive in order to provide health education for your patients?

4) If given the necessary time and resources, would you and your nurses consider offering a health education program for the patients on your unit?

5) If your nurses wanted to develop a health education program for the patients on this unit,
   a) what steps would they take to begin the process?
   b) describe the support they could expect.
   c) who (by position) would provide the greatest support?
   d) who (by position) might resist?
   e) what roadblocks might they experience?
   f) how might they overcome them?

Enabling factors

Manager of educational services

1) What kinds of situations do the nurses on the cardiac unit consult with you as a resource for health education? Nurses on other med/surg units?

2) What support services are available for health education for patients?
- library
- A/V's such as videos, models, pamphlets
- teaching modules

3) In your opinion, are these services adequate?

4) If nurses wanted to develop a health education program for the patients on their unit,
a) what steps would they take to begin the process?
b) describe the support they could expect.
c) who (by position) would provide the greatest support?
d) who (by position) might resist?
e) what roadblocks might they experience?
f) how might they overcome them?

Enabling factors

Director of Nursing

1) Is there funding allotted to the hospital for health education for patients
   - for all patient care areas
   - for specific care areas?

   Explain.

2) If the nurses on one of the units wanted to develop a health education program for their patients (such as a program to support patients indicating a desire to quit smoking during their hospitalization),

   a) would this be a possibility they could consider?
   b) what steps would they need to take to initiate the process?
   c) describe the support they would receive.
      - who would provide the greatest support?
      - who would provide the least support?
      - who might resist?
   d) what roadblocks might they encounter?
   e) how might they overcome them?

Questions for Reinforcing Factors

(Incentives, Rewards, Recognition, and Feedback)

Unit With Health Education Program
R. Nurse

1) How do you feel when you provide health education for your patients?

2) Are there times when you are unable to provide your patients with health information they need/want? How do you feel then?

3) What recognition/rewards do you receive for providing health education for your patients?

- from your patients
- from your colleagues
- from your head nurse
- from the physicians
- from the manager of educational services
- from the D.O.N.
- other

Reinforcing factors

Unit Without Health Education Program
R. Nurse

1) How do you feel when you provide health education for your patients?

2) Are there times when you are unable to provide your patients with health information they need/want? How do you feel then?

3) What recognition/rewards do you receive for providing health education for your patients?

- from your patients
- from your colleagues
- from your head nurse
- from the physicians
- from the manager of educational services
- from the D.O.N.
- other

Reinforcing factors

Unit With Health Education Program
Head Nurse

1) How do you recognize/reward your nurses for their efforts in providing health education programs for their patients?

2) What recognition/rewards do you/your unit receive for providing this health education program for patients?

- from your patients
- from your colleagues
- from the physicians
- from the manager of educational services
- from the D.O.N.
- other

3) What incentives are provided by this hospital for you/your unit/your nurses for health education programs for patients?

Reinforcing factors

Unit Without Health Education Program
Head Nurse

1) How do you recognize/reward your nurses for their efforts in providing health education programs for their patients?

2) What incentives do you give your nurses to provide health education for patients?

3) What recognition/rewards do you/your unit receive for providing health education for patients?
- from your patients
- from your colleagues
- from the physicians
- from the manager of educational services
- from the D.O.N.
- other

4) What incentives are provided by this hospital for you/your unit/your nurses for health education programs for patients?

5) Have you or your nurses ever made an attempt to start some type of health education program? What was the outcome?

Reinforcing factors

Manager of educational services

1) What recognition do you give nurses/units for providing health education for patients?

2) What incentives do you give nurses/units to provide health education programs for patients?

3) What incentives/recognition do you receive for health education?
- from administration
- from the nursing department
- other

Reinforcing factors

Director of Nursing

1) What recognition do you give nurses/units for providing health education for patients?

2) What incentives do you give nurses/units to provide health education programs for patients?

3) What incentives/recognition/rewards do you/your department/hospital receive for providing health education programs for patients?

- from the patients
- from the physicians
- from the hospital administration/board
- from the BCHA
- from the RNABC
- from the Ministry of Health

Environmental Supports/Conditions

(policies, regulations, guidelines, organizational arrangements,
and the behavior of those who control the resources/rewards)

Unit with Health Education Program
R. Nurse

1) Are there guidelines/policies or standards, teaching plans for you to follow when providing this program? ie.when/who/how/what you teach your patients about lifestyle issues.

2) Is there an expectation on this ward /by the physicians/by the hospital that the nurses on this unit provide health education for your patients?

3) Are you/your colleagues held accountable in any way when you are not able to provide your patients with this program? In what way? By whom?

4) Is your head nurse held accountable for this program in the same way?

5) What would happen if a patient did not receive the information or was given different information than the guidelines suggest ie a nurse believes that reflexology or some other strategy would be useful -- does s/he have the freedom to include these as one of the components of the program?

6) Have there been any changes to this health education program over the past few months/years? In what way?

7) Who made the decision to change? For what reasons?

8) Would you and your colleagues be available to assist nurses on other units in getting started on a health education program for their patients? Would you be able to share your resources with them?

Environmental supports

Unit without Health Education Program
R.Nurse

1) Does your head nurse expect you to provide health education for your patients when a need is identified?

2) In what way are you and your colleagues held accountable for providing health education that your patients may need?

3) Is your head nurse held accountable in the same way?

4) What usually gets in the way of your unit ability to provide a health education program?

5) Do you document the times when you provide information for your patients? Where do you document it - on the kardex? nurses notes?
other?

6) Are there guidelines or standards for you to follow in relation to health education on your unit?

7) If you and your colleagues were to start a health education program what roadblocks might you encounter? How would you overcome them?

Environmental supports

Unit with Health Education Program
Head Nurse

1) Is there an expectation that your unit will provide health education for your patients during hospitalization?

2) Is health education provided for all patients on this unit or certain ones? Explain?

3) Who is responsible for
- delivery
- resources
- updating
- funding

4) What kind of funding do you receive for the health education program?

5) Describe your role in this program?

6) What written policies/procedures guide this program?

7) Is health education part of the prerequisites for your position as Head Nurse?

8) Is health education considered part of the knowledge and skills required for new staff nurses or is it part of their orientation to this unit?

9) Do you hold your nurses accountable in any way for providing health education for their patients?

10) Are you held accountable in any way for this program?

11) Is your nurses' involvement in this health education program part of their annual performance appraisal?

12) In what ways are the nurses' knowledge and skill regarding health education assessed?

13) How do you ensure that your nurses feel confident and competent in their knowledge and skill in providing health education?

14) Who (by position) are the advocates in this hospital for health education?

Environmental supports (cont'd)

15) When this program began
- who initiated the idea
- who planned the program
- who trained the nurses
- who provided the resources
- who funded the initiative

16) In what way were the physicians involved in this process?

17) Are they involved in this program in any way now?

18) Do you believe that the commitment to health education is the same in all parts of the hospital?
- on other med/surg units
- other patient care units
- in the Nursing department
- other departments

19) Is there a reason for this program being offered on your unit and not on other acute med/surg units in this hospital?

Environmental supports

Unit without Health Program
Head nurse

1) Is there an expectation that your unit will provide health education for your patients?

2) Do you expect the nurses on your unit to be able to respond to patients' need for health information?

3) Are there guidelines or policies for health education to indicate what information can and can not be given to patients?

4) Is health education considered part of the knowledge and skills required for new staff nurse or is it included in their orientation to the unit?

5) In what way is the nurses' knowledge and skills regarding health education assessed?

6) Is their involvement in health education part of the nurses annual performance appraisal?

7) Describe your role in health education .

8) Who (by position) are the strongest advocates of health education for patients in this hospital?

9) Is there a reason for a health education program being offered on a cardiac step-down unit and not on your unit?

Environmental supports

Manager of educational services

1) Describe your role in the health education of patients in this hospital.

2) Is this role indicated in your job description?

3) Are you the person responsible for coordinating and managing health education for patients in this hospital?

4) Describe the rapport that you have and how you connect with
- nurses on the cardiac step-down unit
- nurses on other med/surg units
- head nurses on all these units
- nursing administration
- hospital administration
- physicians

5) Are you responsible to the Nursing Department or to some other Department?

6) Is there a process for implementing health education programs in this hospital?

7) Is this process the same for all units and all departments?

8) In what ways does it differ from unit to unit?

9) What might the reasons for this difference be?

10) Several studies have indicated that acute care hospitals provide health education programs on cardiac, diabetic, and maternity units more frequently than on other med/surg units. Is this true for your hospital as well?

11) What might the reason for this be?

12) Are you involved in the decisions this hospital makes regarding health education programs for patients?

13) In your view, who should be responsible for making health education available for all patient care units?

14) Who (by position) are the advocates for health education for patients in this hospital?

15) Have you initiated a health education program for patients in this hospital in the last 1-2 years? What was the outcome?

Environmental supports

Director of Nursing

1) Describe how you are involved in health education in this hospital.

2) Tell me about the health education programs that are provided by Nursing for patients in this hospital?

3) Who (by position) are the decision makers for health education for patients in this hospital?
- nurses
- physicians
- head nurses
- manager of educational services
- Nursing administration
- Hospital administration

4) Who (by position) is responsible to oversee, coordinate and manage health education in this hospital?

5) The cardiac step-down unit provides a health education program for the patients on that unit. It includes lifestyle information such as exercise, dietary habits, stress management, and smoke cessation. Which other units provide this type of information for their patients? Which units do not? Can you explain this?

6) How are funding decisions made regarding which units receive funding for health education for patients and which ones do not?

7) Who is included in making those decisions?

8) In your view who should be responsible for making health education available for patients in this hospital?

9) Do you have a sense of what influence the recommendations of the Royal Commission on Health Care and Costs may have on the priority of health education for patients in this hospital?

10) Are there expectations by the BCHA or the RNABC that this hospital will provide health education for its patients?

11) What future plans/goals are there for health education programs for patients during hospitalization?

Appendix D

Letter to informants
Subject consent form
"Lead in" to the interview

SUBJECT CONSENT FORM

PROJECT TITLE: Factors Influencing the Provision of Health Education by Nurses for Patients During Hospitalization: A Nursing Perspective.

UBC FACULTY ADVISOR: Judith M. Ottoson, M.P.H., Ed.D.

UBC STUDENT: Denise L. Hawthorne R.N. B.S.N.

PURPOSE/PROCEDURES: The purpose of this study is to identify and describe factors that may facilitate or compromise the provision of health education for patients during their hospitalization in an acute care facility. It will focus on the nursing perspective of this issue. Results of this study will be useful to all aspects of nursing and patient education in relation to health issues.

The research project will be conducted during December, 1992 and January, 1993 and will involve approximately one hour of your time. One 30-45 minute audio taped interview will be required during which you will be asked about your experience and perception regarding the provision of health education interventions in the acute medical/surgical patient care area(s) of your hospital.

For the purposes of this study, health education program will be referred to as a learning experience for patients that is provided by nurses on a one to one or small group basis that focuses on healthy lifestyle issues. Health education activities may range from 1) an incidental discussion of a health issue with any patient on the unit, to 2) a planned routinely offered intervention for a target group of patients (i.e. post MI), to 3) a regularly scheduled, multidisciplinary program that has links with the community.

All of these activities are designed to achieve specific outcomes and can be a single meeting or a series of sessions. The focus will be on smoke cessation, dietary habits, stress management and exercise. The intent of these activities is to assist patients to cope with and stabilize their illness, reduce their risk for other illnesses and disease and to maintain or improve their present level of health. Patient education program will be referred to as a learning experience provided for patients by nurses on a one to one or small group basis. It focuses on the presenting problem or condition and assists patients to understand and cope with the diagnosis, treatment, and recovery from their illness. Examples of this might be pre-op teaching, medication regime, ostomy care, and diabetic protocol.

"Lead in" for Interview

Hello, I'm Denise Hawthorne. Thank you for coming today. Is this time still convenient for you, _____? As I mentioned in the letter to you, I am a nurse -- a nurse educator and in this study I will be looking at health education programs that are available for patients during their hospitalization at Surrey Memorial Hospital. I am especially interested in the factors that encourage or discourage the provision of these programs ie. -- whether they are made available for patients or not. This interview will last about 30-45 minutes and will be recorded on this audiocassette. A code will be the only identification of the information from this interview. I'd like to remind you again that there are no right or wrong answers, just what you have experienced. At no time are your experiences or your responses being judged. You are free to ask and/or refuse to answer any question that I ask. You have a right to ask that any information given be erased from the tape and therefore be excluded from this study. If any of the questions are not clear, please ask me to clarify them for you.

Some of the terms I will be using have a specific meaning. I will go over them with you to be sure that we are both talking about the same thing.

Program means -- a planned learning experience for the patients that is provided by nurses on a one to one or small group basis. It may be offered routinely for certain patients on your unit, it may be planned for a specific individual patient, or it may be a general discussion of a health issue with any patient.

Patient education means -- a planned learning experience for patients provided by nurses on a one to one or small group basis that assists patients, 1) to be informed about their illness including diagnostic tests and treatments, and 2) to participate actively in their health care. Examples of this might be pre-op teaching, ostomy care, and medication regime.

Health education means -- a planned learning experience that focuses on assisting patients/families in their pursuit of a healthy lifestyle in order to reduce their risk for disease and to maintain or improve their health. Examples of this might be smoke cessation, dietary habits, exercise, and/or stress management.

Is health education considered a part of patient education or is it separate?

Do you have any questions about these three definitions? Any questions about the interview? Give copy of Program Parameters.

First, I'd like to know a little bit about you

1) What is your position on your unit/in the hospital?
2) How long have you been in this position on this unit?
3) How many years have you been a nurse in this hospital?
4) How many years have you been in nursing?
5) What is your nursing education background?
6) During you nurses' training, how were you taught to integrate patient teaching into a demanding work schedule? How was it incorporated throughout your training?

Thank you.

PROGRAM PARAMETERS

A Health Education Program is:

- a learning experience for patients
- designed to achieve certain specific outcomes
- provided by nurses
- one to one or in small groups
- focuses on healthy lifestyle issues
- assists patients in their pursuit of health and wellbeing
- examples exercise, nutrition, stress management and smoke cessation

A Patient Education Program is:

- a learning experience for patients
- designed to achieve certain specific outcomes
- provided by nurses
- one to one or in small groups
- focuses on the presenting problem or condition
- assists patients to understand and cope with the diagnosis, treatment and recovery from their illness
- examples are preop teaching, medication regime and ostomy care

The difference between the two is that patient education deals specifically with the patient's illness and health education deals with lifestyle issues and has a health focus.

The type of health education program under study is

- planned
- provided routinely
- for a target group of patients (post MI, MVA,s etc)
- deals with healthy lifestyles
- initiated and implemented by the nurses
- follows an assessment of health needs
- may be offered on a casual basis or a formal setting
- may use simple or multiple methods of instruction
- follows guidelines and/or a teaching plan

This type of program does not include casual discussions of a health issues nor does it include instruction in a diabetic clinic.