Attitudinal Shifting:

A Grounded Theory of Health Promotion in Coronary Care

by
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A thesis submitted in partial fulfilment of the degree of Master of Health Science (Nursing)

2007

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signature : ……..

Date : ……

Acknowledgements

This research project has been a challenging personal journey, which I have completed with the support of many.

Firstly my thanks go to the study participants, who willingly told me of their experiences with health promotion in coronary care units.

My supervisor, Dr Antoinette McCallin, deserves special mention for all her ongoing energy, guidance, support and expertise which has been so freely given to enable me to complete this journey.

I must acknowledge my friends and colleagues in nursing and education, who have maintained a keen interest in my progress and provided much needed support, lively discussion and critical comment along the way.

Finally to my husband David, my heartfelt thanks for his never-ending support throughout this journey. He has gently nudged me along the way when I needed encouragement with his keen sense of humour and his belief in my ability to get the job done. Thank you!

Abstract

Current New Zealand health policy encourages collaborative health promotion in all sectors of health service delivery. The integrated approach to the acute management of coronary heart disease in a coronary care unit, combining medical therapy and lifestyle change, supports clinical health promotion. The aim of this study was to use the grounded theory approach to discover the main concerns of nurses' promoting health in an acute coronary care setting and to explain the processes that nurses used to integrate health promotional activities into their practice. Seventeen registered nurses from three coronary care units within a large metropolitan city in New Zealand were interviewed. Data were constantly compared and analysed using Glaser's emergent approach to grounded theory.

The main concern for nurses promoting health within coronary care was ritualistic practice. In this study, ritualistic practice concerns the medically-based protocols, routines, language and technology that drives nursing practice in coronary care. This concern was resolved via the socio-cultural process of *attitudinal shifting* that occurs over time involving three stages. The three conceptual categories, *environmental pressures*, *practice reality* and *responsive action* are the main components of the theory of *attitudinal shifting.* In *environmental pressures* nurses experience a tension between specialist medically-dominated nursing practice and the generalist nursing role of promoting health. In *practice reality,* nurses become aware that the individual needs of patients are not being met. This causes role conflict until the nurse observes colleagues who role model possibilities for practice, working with patients to promote health. *Responsive action* sees the nurse engaging in self-development, also focusing on the nurse-patient relationship, thereby enabling active patient involvement in individual health-promoting decisions.

The findings from this research have implications for nursing practice and education. With the increasing specialisation in nursing practice, these findings may be of interest to nurses working in delegated medical roles where the reality of everyday practice precludes nurses from undertaking their essential nursing role. Health care facilities also need to ensure that there are opportunities for the personal and professional development of nursing staff. The place of health promotion within nursing

undergraduate curricula needs to be examined, as many nurses found that they were ill prepared for undertaking health promotional activities.

CHAPTER ONE

Background to the Study

Introduction

As a former clinical nurse educator within a Coronary Care unit (CCU), and now a lecturer working with nursing students in a tertiary organisation, I see many nurses interacting with people during intense, critical illness situations such as suffering a life-threatening heart attack. During my fifteen years experience as a nurse in coronary care I became aware that nurses work with patients in many different ways. The nursing role included work as a technician, teacher, clinical specialist, carer or listener. Clearly nursing work in CCU is multifaceted and has changed over the years since nurses took up their specialist role in that area.

In previous years the emphasis in coronary heart disease care was primarily on the acute management of myocardial infarction[1] and preventing death. Substantial medical advances over the years have reduced mortality; people now survive heart attack and recovery and lifestyle are important. Nursing roles have developed, as cardiac rehabilitation and the promotion of lifestyle choices are very much part of the current management strategy. This is in line with New Zealand health policy encouraging collaborative health promotion in all sectors of health service delivery. Therefore, this research began with my interest in studying the health promotional role of nurses in the CCU. The focus of this research is clinical health promotion in coronary care – the nurses' perspective.

Nursing Practice In The Coronary Care Unit

Nursing practice in CCU focuses strongly on technological competence. This specific type of competence is critical for prompt skilled assessment and initiation of treatment of the patient with an acute myocardial infarction. A key role for nurses lies with resuscitation, interpretation of electrocardiographs and administration of emergency drugs. These skills, technological tasks, are fundamental to practice. They are highly visible and are encouraged and respected by other nurses and medical staff.

[1] A myocardial infarction is commonly known as a heart attack.

In contrast, many of the other contributions nurses make to patient care are not always recognised as significant because the work is not as visible as the technological tasks (Whittemore, 2000). For example, increasing evidence from clinical trials has demonstrated that lifestyle change can significantly reduce mortality and morbidity from myocardial infarction (Bunker & Goble, 2003). Nurses have a major role to play as clinical health promoters, motivating and supporting their patients to make significant lifestyle changes. This new approach presents a challenge to nurses who are required to question the assumptions and attitudes that have guided nursing practice since coronary care units were first opened in the 1960s.

Currently, the range of communication and interpersonal skills that are essential for effective performance are changing with this new emphasis on empowering and motivating patients to make behaviour changes through a patient-centred approach. While much is new about a role that places the patient central to care, nurses have always been involved in educating patients. For example, Peplau (1988) described the nurse as a resource person who provides health information and the teacher who facilitates instructional and experiential learning with patients. This aspect of nursing is even more important today when the nurse's role in health promotion is considered and the specialist communication and interpersonal skills associated with the patient-centred approach are specifically discussed in the New Zealand Cardiac Rehabilitation Guidelines (New Zealand Guidelines Group, 2002).

The nurse's role as a health promoter is further complicated by different priorities that change during the period of hospitalisation. Initially, health promotion is not a priority and the patient involvement in the process is variable. For example, at times of illness or vulnerability, either through incapacity or preoccupation, the patient's usual freedom to act as a person is diminished. This is common when a patient is hospitalised with a myocardial infarction. Consequently it is the nurse's responsibility to preserve the patient's integrity by providing information about their health status and the available options for care and to act in accordance with the patient's values, concept of health and the kind and quality of life he/she holds as worthwhile.

On admission to a coronary care unit, the patient is often in pain, frightened. As the rate of technological advances expands, the nurses' technological skills are paramount to ensure the patient receives the appropriate management. This is in keeping with

modern-day technological roles. For example, nurses commonly manage three types of technologies (Yoder-Wise, 2007): The first is biomedical technology involving the use of equipment in the clinical setting for the diagnosis, physiologic monitoring, testing or administering therapies to patients. The second is information technology that includes recording, processing and using data to deliver patient care. Thirdly is knowledge technology that shapes decision-support systems and assists expert practitioners in making decisions regarding patient care. All these technologies assist the nurse to make decisions that may save the life of a patient with an acute myocardial infarction.

The sudden and acute symptom of chest pain that is commonly associated with acute myocardial infarction elicits both physiological and psychological reactions that can affect the individual long after the chest pain is relieved. Dealing with patients' emotional responses to their illness is a crucial aspect of the nurses' role and illustrates the complexity of nursing practice in CCU. Peplau (1988), for instance, describes nursing as an interpersonal process in which a human relationship develops between an individual in need of help and a nurse who is able to identify and respond to this need.

This focus on the individual involves the recognition that patients are more than the disease or illness that urges them to seek health care. It also involves the recognition that emotional, psychosocial and spiritual elements as well as physical elements will influence patient healing and treatment. Watson (1988) illustrates this point defining nursing as a "human science of persons and human health-illness experiences that are mediated by professional, personal, scientific, aesthetic and ethical human care transactions." (p.54). Watson also views nursing as both a science and an art. The art is the transpersonal caring-healing work involved in alleviating pain, stress and suffering and promoting well-being and healing (1999).

Inherent in this promotion of well-being is the need to come to know and understand the patient. 'Knowing the patient' implies an interactive relationship whereby a nurse, through intentional engagement and involvement, gains an understanding of the complexity and depth of a particular patient (Whittemore, 2000). Care of the patient in coronary care needs more than a practical, technological skill base. It is from core aspects of caring, the art of nursing, focusing on the patient together with the technology, which differentiates nurses from technicians in these environments.

Despite the nurses' competence with advancing technology in CCU, nurses value the interpersonal aspects of the nurse-patient relationship. According to Sandberg (2000), competence relates to the nurses' understanding of their work. In CCU nurses provide physical and psychological support for their patients during intense and critical life situations. Bassett (2002, p. 9) describes nurses delivering an "individualised package of care" addressing the patients' physical, social, emotional and spiritual needs. Patients in CCU not only need confidence in the nurses' technological competence but also the nurturing quality of the nurse-patient relationship. Sheldon, Barret and Ellington (2006) suggest that the nurse-patient relationship is strengthened and enriched by good communication.

Clearly communication and patient education hold historical significance within the profession and the two become integrated in clinical health promotion. They are important to nurse theorists and are incorporated into professional standards of practice. Communication, for example, is one of the competencies contained in the domain of *Interpersonal relationship*s, one of the four domains of competencies for entry to the register for comprehensive nurses (Nursing Council of New Zealand, 2005). The Nursing Council of New Zealand governs the practice of nurses by setting and monitoring standards of registration that ensures safe and competent care for the patient. Evidence of safety to practice is demonstrated when the applicant " communicates effectively with clients and members of the health care team" (p. 9). Another competency is health promotion, where the applicant educates clients to maintain and promote health" (p. 7).

The other domains of competence are Professional responsibility, highlighting competencies that relate to professional, legal and ethical responsibilities and cultural safety. Management of nursing care contains competencies related to patient assessment and the management of nursing care, including technological competencies. Interprofessional health care and quality improvement demonstrates that nurses are able to evaluate the effectiveness of care delivery and promote the nursing perspective in the wider interprofessional healthcare team (New Zealand Nursing Council, 2005).

The Coronary Care Context

This is a study about health promotion in CCU. Nursing attitudes to health promotion are perhaps affected by historical factors. The first coronary care units were established in the 1960s and immediately reduced the in-hospital mortality due to acute myocardial infarction from approximately 30% to 15% (Braunwald, 1997). This success was due in part to the reorganisation of clinical care to place patients in a single site where the nurse was empowered to treat ventricular fibrillation[2] on an emergency basis in the absence of a physician.

The nursing role included monitoring the patient's heart rhythms, and observing for complications such as rhythm disturbances and the development of heart failure, as well as attending to their personal needs and activities of daily living. In the 1960s patients who suffered a myocardial infarction were immobilised for 6-8 weeks and encouraged to 'rest' for at least a year. Traditionally, psychological needs have not been a major focus of management with the emphasis on preserving life.

The next major development in the management of patients with acute myocardial infarction came in the early 1980s with the introduction of thrombolytic therapy[3], followed by other reperfusion techniques[4] that further reduced mortality. This management has continuously evolved over the past decade, and the nurse plays an important role in identifying patients at higher risk of death, myocardial infarction and recurrent ischaemia. Due to the nurses' skilled assessment of electrocardiographs, vital signs and monitoring of other physiological parameters patients who will benefit can undergo aggressive drug treatment and early coronary angiography[5].

The CCU has an important place in the acute care hospital because Cardiovascular disease[6] is the leading cause of death in New Zealand accounting for 40% of deaths annually (New Zealand Guidelines Group, 2003). Coronary heart disease (CHD) is the largest contributor accounting for 1:4 of all deaths. CHD usually affects people in their mid-life years, undermining the socioeconomic development, not only of affected

[2] Venticular fibrillation is a potentially fatal heart rhythm that requires prompt emergency treatment with a controlled electric shock via a technique called defibrillation.
[3] Thrombolytic therapy is a medication for the treatment of acute myocardial infarction.
[4] Reperfusion techniques help restore blood flow to the blood vessels of the heart.
[5] Coronary Angiography is an x-ray examination of the blood vessels of the heart.
[6] Cardiovascular disease is the term used to describe any disease related to the heart or blood vessels and includes all forms of heart disease and stroke.

individuals, but families and nations when people are not able to return to work due to the advancement of their disease. The New Zealand Health Strategy (Ministry of Health, 2000) supports the suggestion that lower socioeconomic groups generally have a greater prevalence of risk factors, diseases and mortality in developed countries. A similar pattern is emerging in developing countries as the CHD epidemic matures (World Health Organisation, 2004).

Increasing evidence from clinical trials has demonstrated that both pharmacological and reperfusion therapy combined with lifestyle change can significantly reduce mortality and morbidity (Bunker & Goble, 2003; Edwards, 2004; Glowacki, 2004). This integrated approach combining medical therapy and lifestyle change supports clinical health promotion. Nurses in coronary care can influence lifestyle changes as they educate and support patients and their families to assess their individual risk factors and begin to make the necessary changes.

Coronary Heart Disease

Changing lifestyle is critical as the World Health Organisation (WHO) has predicted that by 2020, coronary heart disease will be the greatest cause of death and disability throughout the world (Tunstall-Pedoe, 1999). The rise reflects a significant change in diet habits, physical activity levels, and tobacco consumption worldwide as a result of industrialisation, urbanisation, economic development and food market globalisation. In the 2006 World Health Report, the WHO cites coronary heart disease as a chronic disease and now has a goal of reducing deaths from all chronic disease by 2% per year over and above the existing trends during the next ten years.

Many factors relating to dietary habits, physical activity and tobacco consumption, all key factors in any health promotion programme, were studied in one of the largest research studies on coronary heart disease. The Framingham Heart Study (National Heart Lung and Blood Institute, 1948). has become one of the cornerstones of cardiac epidemiology. In 1961, Kammel, Dawber, Kagan, Revotskie and Stokes, reported on six years of follow-up and the concept of risk factors for coronary heart disease was clearly established. The three major risk factors found were smoking, hypertension and abnormal cholesterol levels. However, additional factors include a family history of coronary heart disease, diabetes, abdominal obesity, lack of fruit and vegetables in the

diet and lack of exercise (Yusuf et al., 2004). Current cardiovascular risk factor research is targeting genetic variations and chemical and environmental factors (Weinhold, 2004).

Many of these risk factors are common, regardless of sex, ethnic group or age and are frequently not found in isolation, thereby increasing the individual risk. Many of these risk factors are modifiable and both politicians and medical consultants believe efforts should be made to increase awareness, through education, of how to reduce the likelihood of developing coronary artery disease. The nurse within CCU can initiate this for the individual with identified risk factors when a myocardial infarction is diagnosed. He/she is also able to influence other family members and friends to make lifestyle changes. Reducing the risk among the population as a whole stems from interventions combining effective social policies and broad health promotion policies that will be discussed later in this chapter.

Cardiac Rehabilitation

Health promotion for cardiac patients originated with cardiac rehabilitation which aims to provide people experiencing a cardiac event with the opportunity to modify their cardiac risk status and to resume their social and vocational roles. It is a necessary aspect of care and should be individualised and integrated into the routine management of all patients with cardiac disease (New Zealand Guidelines Group, 2002).

A myocardial infarction is a major stressor to an individual who has to adjust to a change in health which may impact on daily life and future plans. According to the New Zealand Guidelines Group (2002) the main goals of cardiac rehabilitation are:

1. to prevent further cardiovascular events by empowering patients to initiate and maintain lifestyle changes;
2. to improve quality of life through the identification and treatment of psychological distress; and
3. to facilitate the patient's return to a full and active life by enabling the development of their own resources.

These goals of empowerment, improvement of quality of life and return to a full and active life mirror the health promotional philosophies that support patient autonomy and

empowerment. Traditionally, cardiac rehabilitation services have included the following: Medical evaluation and risk stratification, exercise, group education sessions and psychological and social support. Cardiac rehabilitation consists of three phases. Inpatient (Phase1) occurs during the hospital admission; Outpatient (Phase 2) occurs post discharge; and Maintenance (Phase 3) is a period where patients continue to practice behaviours that optimise cardiac health (New Zealand Guidelines Group, 2002).

The scope of Phase 1 rehabilitation has changed in the last decade due to the decreasing length of hospital stay and new acute interventions. Inpatient rehabilitation includes early mobilisation and education, helping the patient and family begin to develop an understanding of heart disease. It assists towards self-care, physical and psychological recovery, provides some information on how risk factors can be modified and seeks to increase a patient's sense of control (New Zealand Guidelines Group, Cardiac Rehabilitation 2002).

The programme provides the opportunity to coach and encourage the individual to more positive lifestyle behaviours and sustained healthy habits. The emphasis on the need to individualise care stems from the assertion that patients' actions are determined by their beliefs and expectations, some of which are pre-existing and others created by what is said and done during their contact with health care professionals (Wiles, 1998).

Self-efficacy expectation was recommended in the 1995 British Association for Cardiac Rehabilitation guidelines, and has been incorporated in the current New Zealand guidelines. Expectancy, as a concept, plays a central role in the social learning theory of Bandura (1977), who asserts that behaviour is the outcome of an interaction between cognitive processes and environmental events. Bandura distinguished between two types of expectations: outcome expectancy and self-efficacy. Outcome expectancy beliefs refer to the possible consequences of one's owns actions that a given behaviour will lead to a particular outcome. Self-efficacy expectation reflects the belief that one can successfully execute the behaviour required to produce the outcome.

Convincing the patient that a particular behaviour will lead to a desirable consequence (outcome expectation) will not lead to behavioural change unless the patient believes that he or she can perform the behaviour (self-efficacy) in the required situation

(Bandura, 1997). Behavioural change is a major factor in health promotion for patients within coronary care. Nurses are able to introduce these ideas to patients and provide the motivation and encouragement needed to support patients to identify their individual risk factors and make changes to their lifestyle. The psycho-educational interventions based on expectancy theory intend to respond to individual patient constructs of their illness and potential for recovery.

Health Education And Health Promotion

Clearly, there are overlaps between cardiac rehabilitation and health promotion and also with health education. According to Whitehead (2004) health education is "an activity which seeks to inform an individual on the nature/causes of health/illness and that individual's personal level of risk associated with their lifestyle-related behaviour" (p. 313). Naidoo and Wills, (2000) argue that health education is based on an 'authority' model that is derived from medical science and solely focussed on disease prevention. However, this advice-giving, the traditional biomedical approach to health education, has not always been effective in helping patients choose relevant behaviour changes. It is very different to the patient-centred approach to care.

Any approach to health education should be designed to bring about voluntary change (Ratzen, 2001). Simply telling people that they must change to improve their health will rarely provide sufficient motivation and confidence to achieve successful and sustained change. Enabling a patient to change means thinking of change from the patient's perspective, based on a joint understanding of where the patient is now, what making changes would involve and what successful change would mean for the patient and their family. The nurse has a significant role here.

Nursing has traditionally been influenced by psychosocial and cognitive theories in explaining health behaviours such as: Health Belief Model; Health Promotion Model; Interaction Model of Client Behaviour, Theory of Reasoned Action/Theory of Planned Behaviour; Locus of Control; and Self-efficacy Theory (Cox, 1982, Marston-Scott, 1988, Fleury, 1992). More recently, contemporary social cognitive behavioural models have been used to develop conceptual frameworks for nursing (Whitehead, 2001).

Research suggests that nurses, both in the primary and acute care settings, perceive that health education is an important part of their role (Cantrell 1997). Many nurses see it as a relatively straightforward exercise. In most instances the health-related encounter is based on an altered health status and the perception of contributing events by both the nurse and the patient (Shaw, 1999). Such an encounter ensures that there is an expectation on the part of both parties, that the patient's altered health status will be modified to varying degrees and extents. While providing the necessary health education information, the nurse assumes that the patient is only too willing to modify and adapt their behaviour. This assumption does not consider the individual patients' concept of health, motivation or willingness to change.

Health education, which emphasises individual responsibility for health, should not detract from the wider environment, which clearly affects the decisions which people are able to make about their health related behaviour. Lifestyle is only one of a variety of factors that determine health. For example, Calman (1990) suggests that there are at least five factors which interact to influence the health of an individual or population including biological factors, the environment, social and economic factors, use of and access to health services and lifestyle.

Whitehead (2001) argues that contextualisation is one of the main problems that nurses face in defining their health promotion role. McBride (1995) found that confusion reigns in deciphering the meaning and context of health education and health promotion and Whitehead (2001) reports that the confusion remains. This is compounded by the fact that many authors utilise the terminology interchangeably rather than establishing the differences between the two approaches. According to Mackintosh (1996) health education refers to "those activities, which raise an individual's awareness, giving the individual the health [ill-health] knowledge required to enable him to decide on a particular health action" (p. 14).

On the other hand, health promotion

involves social, economic and political change in order to ensure that the environment is conducive to health. Health promotion not only encompasses a nurse educating an individual about his health needs, but also demands that the nurse plays her part in attempting to address the wider environmental and social issues that adversely affect people's health. (Mackintosh, 1996, p. 14)

Many of these ideas have their origins in the history of health promotion. The term 'health promotion' was introduced in 1974 when Canadian Health Minister Marc Lalonde issued "A New Perspective on the Health of Canadians". This report advanced the perspective that people's health was affected by a broad range of factors including human biology, lifestyle, the organisation of health care, and the social and physical environments in which people live.

Norton (1998) describes health promotion as an umbrella term that has been used to cover the overlapping fields of health education and prevention. McMurray (2007) agrees, suggesting that promoting health involves "enabling the conditions for healthy choices and ensuring that support systems are available to help people achieve the level of health to which they aspire, to prevent ill health or injury and successfully recover from illness". (p. 39).

Similarly, the Ottawa Charter for Health Promotion (WHO, 1986) identified five action strategies for health promotion:

- Building healthy public policy
- Creating physical and social environments supportive of individual change
- Strengthening community action
- Developing personal skills such as increased self-efficacy and feelings of empowerment
- Reorienting health services to the population and partnership with patients.

The Ottawa Charter (WHO, 1986) drew attention to the fact that healthy public policy is characterised by an explicit concern for health and equity in all areas of policy. The main aim of healthy public policy is to create supportive environments to enable people to lead healthy lives. In theory such policy supposedly makes healthy choices possible or easier for citizens. It makes social and physical environments health enhancing. In this respect therefore health promotion has come to be understood as public health action which is directed towards improving people's control over all modifiable determinants of health.

Clearly, health promotion is underpinned by a strong emphasis on healthy public policy. In reality, health promotion relies on advocacy, community development and long-term, widespread social marketing to create social change. Health promotion is also

concerned with helping to raise awareness in the individual on how to prevent illness. In practice, clinical health promotion has been defined by Herbert (1995) as "health education and patient counselling aimed at behaviour change in patients at risk for lifestyle related illnesses, or who have diseases for which lifestyle modification can improve function or outcome" (p. 278).

According to Herbert's definition, health promotion is related to the provision of help and support for people to change lifestyles which are either causing them problems or are potentially harmful. Interestingly, the earliest historic influences on health promotion in nursing can be traced to Florence Nightingale who believed in creating environments conducive to the restoration and preservation of health. In later years the Budapest Declaration (WHO, 1991) identified hospitals as important sites for health promotion, to improve population health outcomes further by targeting people and families at strategically teachable moments. For instance, when a patient is hospitalised with an acute myocardial infarction, both the patient and the family are focused on the event and its serious nature. This focus provides a teachable moment. This moment can be useful for the nurse to begin the ongoing care that will continue as the patient recovers and leaves the hospital.

What happens, or when it happens are significant issues. However, despite this, the Jakarta Declaration defines health promotion as a process of enabling people to increase control over and to improve their health (World Health Organisation, 1997). This recognises the need to work with people not on people. Health promotion research has shown that even brief patient/practitioner exchanges have positive outcomes for health and significant cost benefits when undertaken in an appropriate way (Bartlett 1995, Francis 1996).

Current Issues

It is clear that developments within nursing, medicine and the health care system itself influence any health promotion practice. In the past, the health culture was largely dominated by the cure and care approach (Ashton & Seymour, 1988). Any health promotion activities were, in the main, unstructured and opportunistic.

The health sector's agenda was dominated by a biomedical paradigm that identified needs in terms of individuals' illness and proposed solutions in terms of the provision of health care services. This has meant that within the health sector, health promotion has been a marginal activity with limited capacity to influence either the goals of government investment in health or the distribution of health sector resources.

Recent health legislation in New Zealand has contributed to a change in health care delivery. The last decade has seen a substantial move towards empowering the users of health care services through the promotion of choice and shared decision making. Previously, paternalistic physicians prescribed tests and treatments for their patients without serious inquiry into what their patients wanted. Now patient choice, empowerment and autonomy have been widely adopted and are embedded within the Health and Disability Service Consumers' Rights (Health & Disability Commission, 1996).

These changes support the recommendations relevant both to social policy and the Treaty of Waitangi[7] from the Royal Commission on Social Policy (1998): partnership, participation and protection. Partnership involves working together in an open relationship, responsive to individual beliefs and practices. Protection involves being responsive to the individual needs of patients and providing a safe, supportive environment. Participation will ensure that patients are kept informed of progress and be actively involved in making decisions about their health.

At the same time, health service delivery is affected by the New Zealand Health Strategy (Ministry of Health, 2000). The strategy is based on seven underlying principles that the Government sees as fundamental one of which is to ensure collaborative health promotion and disease and injury prevention by all sectors. This principle reflects the governments desire to have a health system that promotes good health and 'wellness' as well as treating illness. Many of the illnesses affecting the New Zealand population are potentially preventable. One of the health objectives identified that is particularly relevant to the nurse in CCU is the reduction in the incidence and impact of cardiovascular disease.

District health boards now play a major role in regard to promotion of good health: assessing local health; setting targets; ensuring health promotion; leadership and liaison; monitoring and review. The strategies for practical health promotion are changing attitudes, changing behaviour and changing the environment. As a result, all health professionals must be able to provide effective patient education and counselling as part of the diagnosis, treatment and care as well as ensuring appropriate ongoing care on discharge from hospital.

Because the practice of health promotion has largely been perceived as a community endeavour, it has not always been easy to adopt a health promotion approach within the hospital setting. Working within a culture that has such a strong medical focus has not allowed nurses to see themselves as health promoters. Despite that, nurses within CCU certainly focus on the risk factors prevalent to CHD, for example smoking, nutrition and physical activity, educating and enabling patients to identify and change potentially health-damaging lifestyles. This matches Herbert's (1995) definition of clinical health promotion and is entirely consistent with the WHO's (1986) view which defines health promotion as the process of enabling people to both increase control over and to improve their health.

Aim Of The Study

The aim of this study is to use the grounded theory approach to discover the main concerns of nurses' promoting health in an acute coronary care setting and to explain the processes that nurses used to integrate health promotional activities into their practice.

Purpose Of The Study

The purpose of this study is to identify, describe and generate a theoretical explanation of the nurses' perspective of health promotional activities in an acute care setting. The Glaserian (1992; 1998; 2001) style of grounded theory was chosen in order to allow the main concerns of the participants to emerge from the data. Emergence is useful as it sets

[7] The founding document of New Zealand, signed in 1840, between the British Crown and Māori signifying the establishment of British law while guaranteeing Maori authority over their land and culture.

an environment to access understanding of the practical realities of health promotion within acute care and sets the scene to understand group behaviour in this setting.

Structure Of The Thesis

As per the abstract, this is a study about a grounded theory of *attitudinal shifting.* The main concern for nurses undertaking health promotion in an acute care setting is *ritualistic practice*. Nurses resolve their concerns through a three-stage process of *attitudinal shifting*. The three conceptual categories, *environmental pressures, practice reality* and *responsive action* are the basis of the theory.

The first chapter opened with an overview of nursing practice in coronary care, and provided a discussion of the key terms and current context to set the scene for the present study. Chapter Two reviews and critiques New Zealand and international research and other literature related to the study. Grounded theory methodology and its application to the research process are discussed in Chapter Three.

The findings of the study are presented in Chapters Four through to Six. More specifically, Chapter Four explores what is involved in *environmental pressures* while Chapter Five looks at the everyday *practice reality* that causes nurses to question their approach to health promotional nursing practice. Chapter Six discusses *responsive action.*

In Chapter Seven a summary of the grounded theory of *attitudinal shifting* is presented. The findings are discussed and the implications for nursing practice and education are considered. Limitations of the present study are reviewed and directions for future research are considered.

CHAPTER TWO
Review of the Literature

Introduction

In this chapter New Zealand and international research and other literature will be examined. A traditional review of the relevant literature shares the results of other related studies, identifies gaps in the current literature and provides a framework for establishing the importance of the study (Creswell, 1994). However, the use of literature in a Glaserian grounded theory study causes confusion for many researchers as it differs from the traditional approach where literature is examined to provide the background for the study.

The Use Of Literature In Grounded Theory

Glaser (1992) advises grounded theory researchers "not to review any of the literature in the substantive area under study", so to avoid distraction from pre-existing concepts. Glaser (1998) advises researchers to read generally in other fields to extend theoretical sensitivity. Literature was, therefore, reviewed in relation to general nursing roles in health promotion and health education, health promotion policy and cardiac rehabilitation guidelines. This general reading finished once the university research proposal and ethics application were completed. Once the research was underway, no reading took place until the theory of *attitudinal shifting* began to emerge.

Review of the relevant literature in a Glaserian grounded theory study occurs once the theory has emerged from the data (Glaser, 1978). Glaser adds, once the grounded theory is nearly completed only then can a literature search can be accomplished and "woven into the theory as more data for constant comparative analysis" (1998, p.67), clearly supporting the concept of emergence.

Glaser (1998) argues that a literature review before this time impacts on the researcher's ability to remain open to the emergence of new concepts and categories not discussed in current literature. For example, literature has been integrated across this thesis and has been part of the constant comparative data analysis to support emerging concepts in the evolving theory of *attitudinal shifting*.

Andrews (2006) agrees that the literature should not be used as a source of concepts and encourages researchers to read the methodological literature. Andrews argues that the differing methodological strategies followed by the original authors fuels concerns concerning the place of the literature review and the ongoing debate around philosophy and grounded theory further adds to the confusion.

McCallin (2003) concedes that in reality many clinicians are widely read in keeping with the concept of evidence-based practice and so are already familiar with current literature. As a nurse with over fifteen years experience in coronary care nursing, my personal knowledge and experiences became data to be integrated into the study during constant comparative analysis.

While these views on the place of literature are quite clear, in reality literature review in this study has been problematic. Because literature has been integrated right across the study during data collection and analysis it was difficult to decide which literature to review for this chapter that occurred once the theory of *attitudinal shifting* was clarified. For example, while the concept of health promotion must be reviewed, it is not reviewed in relation to nursing practice but is reviewed in relation to *attitudinal shifting* as is consistent with grounded theory methodology. While it is recognised that in a larger research project such as doctoral research much broader literature from health psychology and medical anthropology would be reviewed, the constraints of a masters project mean that broader review has not taken place.

Nevertheless, in this study, broad background literature has been introduced in Chapter One. As has been indicated, literature has been integrated right across this thesis as part of the constant comparative analysis. In this chapter, significant issues that influence the study are explored: health promotion, nursing attitudes to health promotion, health promotion strategies in New Zealand and professional cultural change in nursing.

Health Promotion

This research is a study of health promotion in coronary care. As has been seen in Chapter One, the term health promotion has many meanings. “Health promotion” was introduced in 1974 when Canadian Health Minister Marc Lalonde issued “A new

Perspective on the Health of Canadians". The report argued that people's health was affected by a broad range of factors which were not addressed in the narrow confines of the traditional biomedical model. The biomedical model is based on the assumption that each disease has a specific cause and affects each individual in a predictable way (Capra, 1982).

This model leads to diagnosis of health-related behaviours as a health problem. Models of health promotion are essentially individualistic (Richmond, 2002), concentrating on individual health risks. Nettleton (1995) states that health risks associated with health-related behaviours are considered to be "human made" (p.38). Ashton and Seymour (1988) prefer "self-imposed"(p. 22). This infers that individuals are capable of actively securing their health through their behaviours, so health promotion strategies are directed towards changing those behaviours. On the basis of the biomedical perspective, which influences nursing practice in coronary care, the preventive model of health education, also called 'conventional' health education, emphasises the need for 'patient compliance' in changing behaviours (Katz & Peberdy, 1997, p. 18).

The broad range of factors affecting health are combined in the biopsychosocial model of health promotion that considers the individual as a whole person in a social setting, who may or may not be ill at any given moment (Engel, 1977). This model involves adding psychological and social factors such as attitudes, beliefs, social support, and life experience, but is still focussing on the individual.

As a result of the Lalonde report, the Canadian government shifted the emphasis of its health policy from disease treatment to disease prevention and subsequently health promotion (McDonald & Bunton, 1992). The Lalonde perspective has been widely credited in advancing knowledge of the affect of lifestyle factors on health (Minkler, 1989). The report prompted the World Health Organisation (WHO) to issue a series of initiatives beginning with the Alma Ata declaration in 1978, which outlined the WHO commitment to health for all by the year 2000.

The biomedical and social perspective of health-related behaviours as allied to health education and health promotion should not be seen as competing but rather as complimenting each other (Ioannou, 2005). Health promotion does not abandon the

biomedical perspective on health-related behaviours but adds to it a greater concern for recognising the broader social context within which behaviours arise.

In 1986, the European office of the WHO published another influential report, promoting equity in health: Health Promotion: A discussion document on the concepts and principles (WHO, 1986). Growing calls for a global public health movement prompted the first international conference on health promotion in Ottawa, Canada. The conference concluded with the production of a charter for "Action to achieve Health for All by the year 2000 and beyond" (Dines & Cribb, 1993, p. 26). The Charter states:
"Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capabilities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well – being (WHO, 1986, p. iii).

As discussed in Chapter One, lifestyle choice is an important aspect of health promotion strategies in relation to cardiovascular disease. Lifestyle is defined by the WHO (1993) as "patterns of (behavioural) choices made from the alternatives that are available to people according to their socioeconomic circumstances and to the ease in which they are able to choose certain ones over others" (p. 230).

The Ottawa Charter (1986) comprises five key strategies that lay the foundation for a truly international framework for health promotion. Together these strategies seek to address both the individual behaviour-change approach with strategies to address the broader, social determinants of health. This is significant for health promotion in the acute care environment because it shifts the focus from the patient, a traditional medical and nursing approach, to one that considers the individual within his/her community environment. The Jakarta declaration (1997) reinforced these five strategies as necessary for long–term changes to the health of populations. These strategies, used in combination, aim to address factors that affect health and well–being both at an individual and community level.

Since then, there has been sustained progress in health promotion. The Bangkok Charter (WHO, 2005) outlined the following key commitments to make the promotion of health:

- central to the global development agenda;

- a core responsibility for all government;
- a key focus of communities and civil society; and
- a requirement for good corporate practice

World wide, government health promotion strategies and reviews have invested heavily in health promotion programmes (Catford, 2006). He suggests, despite this investment, progress has been less than successful in the political arena. Health promoters have been actively focussed on the shape or content of programmes and have not been attentive to the method of policy making. Wanless (2002) agrees that health promoters must be able to work within existing political and economic systems to influence health strategy.

The Ottawa Charter (1986) also led to the development of 'settings-based' health promotion strategies, where specific health-related settings were designated special attention. This approach acknowledged the importance of people's environments, framing health promotion in terms of people's daily lives. They initially included community, schools, workplace and the home and family. Other settings have been added including universities (Beattie, 2002) and prisons (Taylor, 1997). Hospitals were singled out for particular attention in 1988.

According to Pelikan, Lobnig and Krajic (1997), a health promoting hospital uses episodes of acute injury or illness as an opportunity to promote health through providing and organising rehabilitation. Secondly it encourages and empowers patients to make better use of primary health care services and most importantly it acts as an agent for health development of the whole community. The Vienna Recommendations for Health Promoting Hospitals (WHO, 1997) signify an organisational obligation to meet the changing and evolving needs of the local community. This creates a shift away from the disease–focussed, acute-based services to a focus on the continuum health for the community which mirrors the theory of *attitudinal shifting*. Communities are systems of dynamic, interactive relationships between people and their physical, geographic, personal and social networks (McMurray, 2007). Communities also have a strong cultural and spiritual heritage that influence health, an important consideration when planning health promotion strategies.

Defining health promotion

One of the main problems when reviewing the nursing health promotion literature lies in the use of the terms health promotion and health education. These are often used interchangeably and little attempt has been made to clarify terms (Naidoo & Wills, 1994; Whitehead, 2004). According to Whitehead (2003, 2004) many nurses are unaware that health promotion and health education are interrelated, but are not inter-dependent concepts.

Health education on its own is viewed as a limited health promotion approach, associated with behaviourally focussed medical/preventative strategies. The generic health promotion literature now emphasises the empowerment–based socio-political nature of health promotion and acknowledges the broader determinants of health such as fiscal, ecological and cultural factors (McMurray, 2007). Tones (2000) suggests there is tension between those who advocate empowerment and socio-political approaches to health promotion and those who alternatively support the medical/preventative approaches to health education. Many of those who support the wider health promotion reform agenda denounce medically-based health education approaches. Evidence-based medicine and the associated randomised controlled trials are attacked by the health promotion community (Tones, 2000).

While some health promotion practitioners argue on both epistemological and ontological grounds that the medical model has no place in health promotion, those such as Tones (2000) and Robertson (2001) see prevention and management of disease as a fundamental, worthwhile cause. Labonte (1999) suggests that health promotionalists should not abandon individual lifestyle change strategies. An effective health promoting nurse has knowledge of both approaches, acknowledging the wider socio-political determinants of community health and the individual behaviour modification approach of the medical model. Butler-Jones (2000) urges nurses to see linking health education and health promotion activities in clinical practice as "a challenge and an opportunity worth pursuing" (p. 240).

Richmond (2002) acknowledges the dilemmas associated with traditional approaches to defining health promotion, and proposes two polar categories: Individualistic health promotion (IHP), at the conservative end, supporting lifestyle education; and, at the more radical end, Structuralist-collectivist health promotion (SCHP). SCHP

"encompasses participatory health programmes at the community level, legislation, and bureaucratic interventions such as needle exchange programmes through to the creation of smoke-free environments" (Richmond, 2002, p.196).

Individualistic health promotion through lifestyle involves a wide group of professionals including nurses, doctors, allied health professionals and educators. Many of these professionals work in an acute hospital setting. The WHO (2003) state that most health professionals in the hospital setting do not readily associate health promotion as a valid part of their role. Authors such as Hancock, (1999); Johnson and Baum (2001) suggest that hospitals lag behind other health care settings in incorporating health promotion activities in their service. The literature debating the health promotional role of the nurse in the hospital setting uncovers a majority of activities that are health educational – behavioural and individualistic (Galvin, Webb & Hillier, 2000).

Nursing attitudes to health promotion

The earliest influence on health promotion in nursing was Florence Nightingale. She spoke with authority on "how nursing is to put the patient in the best condition for nature to act upon him" (Calabria & Macrae, 1994, p. xvii). Lillian Wald was remarkable for her political involvement in the late 1800s to establish health and social policies, including promotion of healthy environments. (Backer, 1993). However, these public health approaches were soon taken over by mainstream medicine, focussing on disease prevention (Novak, 1988) and nurses lost this important role promoting health. Nurses, however, are seemingly well placed to undertake health promoting activities. With the move from task-centred to client centred care and the introduction of primary nursing in the acute hospital setting, nurses were able to focus on the individual and their needs (Robinson & Hill, 1998). Many authors agree that while nurses may call themselves health promoters in reality they are nothing more than 'traditional' health educators (Norton 1998, Whitehead 1999) basing their activities on illness/disease outcomes of biomedical paradigms.

A range of literature has been developed out of a need to theorise and conceptualise the meaning and purpose of health promotion for the nursing practice context. For example: The health promoting nurse (Robinson & Hill, 1998) suggests that a) the dominance of an individualistic philosophy of nursing, b) the nurses' own perceptions of their role

and, c) the hospital:community divide are all obstacles to health promotion being well integrated into practice. Whitehead (2000) in Health promotion clinical practice and its related educational issues argues that clinical health promotion practice remains heavily focussed on the biomedical determinants of health. A theory of health promotion for pre-term infants based on Levine's conservation model of nursing (Mefford, 2004) demonstrated that consistency in nursing caregivers influenced the age at which health was attained by the pre-term infant. This has clear implications for nurses in the adult acute care setting in relation to health promotion.

A wider body of literature relates to the health promotion views, attitudes, behaviours, role and function of nurses and other health workers in practice. (Davis,1995; Norton, 1998; Whitehead, 2004; Rush, Kee & Rice, 2005 and Cross, 2005). Cross's study, for example, examined Accident and Emergency (A & E) department nurses attitudes towards health promotion using Q methodology. A & E departments are one of the most acute areas within hospital settings. In this research the participants were asked to place statements about nursing and health promotion on a continuum. A positive view of health promotion was evident from this study. Respondents believed that nurses played a large part in health promotion, using their interpersonal skills and knowledge, and that communication was paramount. Conclusions suggest that A & E nurses have positive attitudes towards promoting health in an Accident and Emergency department.

Similarly, McBride (1995) found that hospital nurses generally displayed positive attitudes to health promotion and, at that time, over a decade ago, nurses were keen to integrate health promotion activities into their practice. In a study of health promotion and hospital nurses, Thomson and Kohli (1997) report that nurses were interested in refining and developing their health promotional role and increasing knowledge to enable them to extend their work. In contrast, Smith, Masterton and Lloyd-Smth (1999) found that health promotion was quite distinct from nursing, with the main focus of nursing being treatment of disease. Benson and Latter (1998) agree, suggesting that reductionist 'sick-nursing' as opposed to humanistically-inspired 'health-nursing' is the predominant framework within which most nurses within hospitals find themselves working. As a result nurses tend to promote health according to the biomedical model of health. Lindsey and Hartrick (1996) argue that this approach is inconsistent with developing a shared-power relationship which is essential for successful health promotion in patient-centred care.

Role modelling health behaviours is an important aspect of health promotion practice. Health professionals, including nurses, act as role models for their patients and the wider community. Chalmers, Seguire and Brown (2002) report that there is a need for nurses to be good health role models. Smoking remains the leading preventative cause of morbidity and mortality in the developed world (WHO, 2006) and nurses are well place to promote health and educate patients about the dangers of smoking. McCann, Clark and Rowe (2005) examined the influence of smoking status, gender, age, stage of education and smoking duration on undergraduate nursing students' attitudes towards smoking health promotion. A total of 336 students completed the questionnaire. Non-smokers were found to have a set of beliefs that were consistent with nurses' professional role as health educators. Analysis of the undergraduates who smoked showed a dichotomy between their personal and professional beliefs about their health professional role, best illustrated by "do as I say, not as I do". The cognitive dissonance between personal and professional practises has been highlighted previously by Lazenbutt and McEwan (1991).

These misunderstandings concerning the nursing role in health promotion may originate in nursing education and curriculum design. The place of health promotion within undergraduate nursing curricula is an important consideration. More than a decade ago, Robinson and Hill (1995) called for a clear integration of health promotion and health education into nursing curricula. Literature reporting student and lecturer's perceptions and practices of health promotion as applied to nursing curricula and student placements was, therefore, reviewed.

Clark and Maben (1998) report that students are confused by the terms health promotion and health education. Students understand that health promotion should have a broader application but are emphasise the behavioural approach in their practice. McDonald (1998) agreed, finding there is little evidence of health promotional policy or political activity in their health education role. Poskiparta, Liimatainen and Sjogren (2000) found that few modules within the curriculum in Finland defined the aims of health promotion and suggested that educators were not able to conceptualise it in a meaningful way. This was similar to Barker, William and Smith (2001) in their evaluation of an audit tool to identify health promotion activities in practice. These audits report that staff perceived

there were no opportunities for students to be involved in health promotion and the students demonstrated poor understanding of the political contexts of health promotion.

Latter, Speller, Westwood and Latchem (2003) suggest that post-graduate nurses struggle in a health promotion capacity, because they do not have appropriate knowledge and skill development from their undergraduate preparation. It is also evident in the literature that nurses with poor understanding of the political contexts of health promotion disadvantage patients. Empowerment is a political concept (Kendall, 1998) and is defined as a "mechanism by which people, organisations and communities gain mastery over their affairs" (Rappaport, 1987, p. 122). Brown and Piper (1995) suggest that the term can be interpreted in so many ways that it is not clear what purpose it serves. It is possible that this confuses nurses on how to promote health. Tones (1991), on the other hand, sees empowerment as the most important feature of health promotion. Kuokkanen and Leino–Kilpi (2000) argue that it is more than the transfer of power from one individual to another. Brown and Piper (1995) suggest that the type of health educational activity that is aimed at the health determinants of patients which are deemed to be modifiable, are likely to be ineffective unless based upon empowering, client-led strategies. These authors add that the humanistically-inspired patient-empowerment approach should always be adopted (Piper & Brown, 1998). This approach, providing interventions which enhance social support, decrease barriers and increase self-efficacy are most likely to result in a positive health promotion outcome (Stuifbergen, Seraphine & Roberts, 2000).

Webster and French (2002) argue that empowerment in current health promotional terms means moving away from the individual and towards community-based action. An empowered community enables more individuals, including nurses, to achieve self-empowerment. Harrison (2002) argues that the term 'public health' can no longer be separated from health promotion, so, socio-political process is fundamental to all current health promotion activity. Rawson (2002) agrees that it is the ideal form of health promotion practice and supports the international agenda for social change.

Health promotion must address problems that are defined as important by the patient, enabling them to make choices about their health. Nurses must be open to the patient being an active participant in the process. Davies (2006) suggests that that if this is the aim of any intervention then its evaluation should be judged on outcomes that enable

personal choice and growth, for instance, increasing knowledge, decision–making skills, increasing self–esteem and personal control (Piper & Brown, 1998).

Health policy and health promotion in New Zealand

Health policy impacts upon health promotion affecting the health and well-being of people in New Zealand. For nurses to effectively engage in health promotion activities they must be aware of how they can contribute to the development of health policy (Latter et al., 2003). The five Ottawa Charter strategies, seeking to address the broader determinants of health, are embedded in the New Zealand Health Strategy (Ministry of Health, 2000) which was written at the time of the latest health reforms. This strategy affects health service delivery and, therefore, influences how coronary care nurses promote health in an acute care setting.

The principles that informed the New Zealand Health Strategy emphasised the Treaty of Waitangi and encouraged policy makers, funders and service providers to develop intersectorial linkages, especially between acute hospital and community care. This approach is consistent with Maori approaches to maintaining and improving well–being, in other words, promoting health. The Whare tape wha model of health (Durie, 1994) describes four dimensions that contribute to wellbeing: te tare wairua (spiritual aspects), te taha hinengaro (mental and emotional aspects), te taha whanau (family and community aspects) and te taha tinana (physical aspects). While good health depends on the equilibrium of these dimensions, the dimensions are foundational for any health promotion with Maori.

The New Zealand Health Strategy (Ministry of Health, 2000) recognises the importance of promoting health according to cultural values and beliefs. The strategy was followed by a series of further documents from the Ministry of Health: The New Zealand Disability Strategy (2001), The Primary Health Care Strategy (2001) were followed by the Pacific Health and Disability Action Plan (2002). The importance of Maori Health was underlined in He Korowai Oranga – Maori Health Strategy (2002). Achieving Health for All People (2003) provided a focus on public health but also extended the emphasis of the New Zealand Health Strategy on the need to reduce social inequalities in health.

The Primary Health Care Strategy (2001) is foundational to health promotion within New Zealand. Although health promotion is implicit in this document, this strategy defines primary care as essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods that are:

- Universally accessible to all people in their communities
- involves community participation
- integral to, and a central function of, New Zealand's health system
- the first level of contact with our health system

This is in keeping with the structuralist-constructivist approach to health promotion (Richmond, 2002).

This strategic approach provides a valuable framework for health promotion which accurately reflects the socioeconomic, cultural and environmental determinants of health within New Zealand (Wise & Signal, 2000). The 2002/2003 New Zealand Health Survey on physiological and lifestyle risk factors indicated major social and ethnic disparities. Coronary heart disease was identified as one the main factors with one in ten adults having been diagnosed with heart disease (Ministry of Health). Cardiovascular disease is the leading cause of death in New Zealand, accounting for 41 percent of all deaths in 1999, thus it has a large impact on the delivery of health services (New Zealand Guidelines Group, 2003). Nurses must play their part to actively address this statistic through health promotional strategies, both in the acute hospital and the community. The multi-faceted 'whole of society' approach is necessary to eliminate these risks, including behavioural, individual-based interventions, which nurses in coronary care are able to deliver through the process of *attitudinal shifting*.

One of the 13 population health objectives of the New Zealand Health Strategy is to reduce the incidence and disease impact of cardiovascular disease. In addressing this important priority an Expert Advisory Group was established to assist the Ministry of Health to identify those cardiovascular areas that would have the greatest population impact, a clear example of the structuralist-constructivist approach to health promotion. This group compiled the District Health Board (DHB) Cardiovascular Toolkit (2003) that included the following priority areas:

- cardiovascular risk screening and management
- acute coronary syndromes

- secondary prevention
- cardiac rehabilitation
- organised stroke care
- cardiovascular disease and Māori
- cardiovascular disease and Pacific peoples.

Assessment and treatment of cardiovascular risk are important part of the roles of primary and secondary healthcare providers. Interventions are directed at modifying cardiovascular risk factors to reduce the absolute risk of cardiovascular disease. Secondary prevention interventions are aimed at modifying cardiovascular risk to reduce the risk of further events or death (DHB Cardiovascular Toolkit, 2003). Patients with a previous cardiovascular event have a 5-year cardiovascular risk of greater than 20% (New Zealand Guidelines Group, 2003). Lifestyle change, the individualist approach to health promotion, is an essential treatment of that risk. The promotion of lifestyle change for these patients through individualised advice and support, using motivational interviewing techniques, combined with medication therapy is highly recommended. The initial encouragement and rehabilitative support for patients to consider the appropriate lifestyle changes that could benefit them comes during their stay in hospital.

Cardiac rehabilitation programmes, many of which are nurse-led, are an intrinsic part of the management of cardiac disease, providing the opportunity to coach and encourage individuals to more positive lifestyle behaviours (Lau-Walker, 2004). The initial phase occurs in hospital where patient education remains a critical component of successful patient outcomes. This is where the coronary care nurse is able to make a huge impact on health promotion through lifestyle behaviour assessment.

However, the current complex health environment, combined with increasing acuities of hospitalised patients, decreased length of stay, and staffing numbers are compromising the educational opportunities for nurses to pursue health promotional activities. McQueen (2000), for instance, argues that this shorter contact between nurses and patients limits time for the development of the *interpersonal relationship*, and potentially increases the patients' need for psychological and emotional support to survive the acute episode and initial recuperation back home. Nonetheless, as will be shown in this thesis, nurses are able to manage these limitations effectively through a

process of *attitudinal shifting*, moving their practice away from the predominant medical model once the patient is stable physiologically, to a patient–centred approach that encourages active participation. This movement challenges existing understandings of the professional culture of nursing.

Professional Cultural Change In Nursing

The organisation and development of professional health care work is a function both of culture and time (Colyer, 2004). Nursing has had attitudes that were medically entrenched as medical knowledge and culture has dominated nursing. The dominant biomedical model of health has lost ground recently to more holistic theories about health with the subsequent addition of new roles and responsibilities for many health professionals, including health promotion.

Professionalisation requires attitude change. While nursing has professionalised, changing attitudes has been much harder. Some would argue that the professionalisation of nursing has not yet been fully achieved, preferring to call nursing a semiprofession (Freidson, 1970). Wilensky cited in Colyer (2004) describes a dynamic process of professionalisation with five stages: the emergence of an occupational group, establishment of a training and selection programme, formation of a professional association, development of a code of ethics and political activity to establish recognition and protection of professional work. Changing attitudes is fundamental to professionalisation if nurses are to establish a unique culture that is relevant to a more modern world.

This type of deep seated cultural change challenges the knowledge base of a discipline. For example, in the sociology of professions literature, formal knowledge is regarded as the central characteristic of professionalisation (Friedson, 1986). Biomedical knowledge is based on a strong quantitative approach that is at odds with nursing theory (Street, 1992). The changing educational preparation of nurses from hospital-based training to university education has not changed the sociological view that nursing remains a semiprofession (Sullivan & Hobson, 2002).

New health care professions, such as nursing, arguably have less power than medicine. The influential, dominant medical culture places nursing as a subordinate

semiprofession, which makes it hard for nurses to change attitudes. Contemporary nursing work is characterised by multiple relationships between and among providers and individuals and organisations that have a widespread diffusion of responsibilities. (Liaschenko & Peter, 2004). The complexity of these demands are problematic when professional cultural change in nursing is considered. A major characteristic of a profession is the ability to control its own work (Rutty, 1998), that is at odds with nursing work in complex environments such as coronary care. Specialist units have unique working cultures, including hierarchies and overriding organisational structures that impact on their ability to change attitudes to practice.

Changing attitudes in a female-dominated environment is also problematic. Nurses are referred to in the literature as handmaidens (Melosh, 1982), or the eyes and ears of physicians (Sandelowski, 2000). Adding to the frustration of nurses is the difficulty of representing nursing work, which is often described as contributing to the invisibility of nursing work (Latimer, 2000), especially in a medically-dominated work environment. The day-to-day work of nurses today is still subject to medical control but Wilmot (2003) argues that medical dominance is challenged, often covertly, by a few nurses who have developed a range of skills to contain and circumvent medical power. This 'know-how' knowledge, or the art of nursing, is highly valued and is usually used directly in clinical practice, but is often unarticulated (Royal College of Nursing, 2003). This silence precludes the cultural change necessary to change attitudes. Nurses are responsible for their own acts but their actions challenge the authority and boundaries of medicine (McCallin, 2001). The science of nursing is derived from theory and research. In order to change nursing attitudes successfully, both art and science nursing knowledge are essential.

Nurses now work as part of a larger health care team. Each health care profession has a different culture including attitudes, beliefs, customs and behaviours. Schroeder, Morrison, Cavanaugh, West and Fache (1999) argue that they often remain obscure to other professions as nurses have been slow to articulate their unique role in the predominant nursing culture.

At the same time, empowerment is fundamental to changing attitudes. Recognition of the tensions created by a traditional model of professionalisation that vests power in the professional at the expense of the patient, has led Hugman (1991) to use the term

democratic professionalisation. Hugman proposes a structure that empowers both nurses and patients who experience themselves to be weak in the cultural context of the hierarchies and controls. Hugman's thinking is similar to Storch and Stinson's (1988) discussion of functional deprofessionalisation in respect of nursing. Each position seeks to establish an even distribution of power between the nurse and the patient, creating a culture of equal partnership and participation. Davies (2000) argues this demonstrates caring, reflexivity, engagement and collaboration, all of which are inherent in the patient-centred care approach essential for successful health promotion.

Education has a significant impact on culture change in nursing. Education is perceived as a strong social force in influencing the direction an occupational group may take towards professionalisation. Some nurses are ambivalent about the need for academic and professional development (Yam, 2004) but *self-development*, through education and practice development is critical to *attitudinal shifting*. Because health promotion is a profoundly political process (Bambra, Fox & Scott–Samuel, 2005) nurses must also be aware of the related socio-political health agendas. Education has the potential to help the nurse develop the political awareness and skills to engage in the political activity to change nursing culture. Many critics also point out nurses' lack of political will to initiate and lead on matters relating to political health policy that has left nurses being viewed as bystanders (Molloy & Cribb, 1999; Gebbie, Wakefield & Kerfoot, 2000; Des Jardin, 2001). As Whitehead (2006) suggests this political action should be a necessary, highly visible part of health promotional practice within professional nursing practice.

Such change does not occur in isolation though. In the current literature on continuing professional development three broad conceptualisations are readily identifiable: Knowledge for practice; knowledge in practice and knowledge of practice (Cochran-Smith & Lyttle, 1999). All three are necessary to influence cultural change in nursing. The major tendency with the first conceptualisation is to view nurses as knowledge users, rather than knowledge producers. Knowledge in practice relates to personal, practical knowledge, much of which is tacit. Cochran-Smith and Lyttle (1999) describe it as "an uncertain and spontaneous craft, situated and constructed in response to the particularities and complexities of everyday life" (p. 20). Knowledge of practice, the third conceptualisation, focuses more on individual professional development and is intended to be transformative. Here, nurses question and challenge practice assumptions and traditions. While these conceptualisations are discrete, this research will show in the

forthcoming chapters that professional learning in coronary care involves a mixed approach that evolves through the process of *attitudinal shifting*.

This is not surprising, as coronary care has been described as a community of practice with its own unique culture. In Wenger's (1998) model of communities of practice, knowledge creation occurs through complimentary processes of participation (the daily situated interactions and shared experiences of members of the community working towards common goals) and reification (the explication of versions of knowledge and rules into representations such as documentation or artefact). Again, this illustrates how new knowledge development is essential for attitude change and cultural change.

The development of new knowledge is critical for nurses to ensure their competence to practice in the complex health care setting. Knowledge, skills, attitudes, values and beliefs are inherent in professional behaviours. It is often expected that these professional behaviours will be acquired through clinical interactions (Hayes, Huber, Rogers & Sanders, 1999) but Schon (1987) argues that often the emphasis is placed more on the cognitive and psychomotor domains of learning. This emphasis neglects the affective domain which includes the development of professional behaviours and attitudes that are so important for successful patient-centred health promotion. These behaviours are not easily taught or evaluated (Tennant & Pogson, 1995).

Clearly, professional development is complex. Professional development refers to the developing attitudes, knowledge and skills of the individual nurse, while practice development concerns the creation of optimal organisational cultures and working environments for individuals to apply those skills (McCormack & Garbett, 2003). Both are inherent in *attitudinal shifting*, being associated with supporting modernisation, and organisational, service and quality improvements (Page & Hamer, 2002) but more importantly in promoting patient-centredness (McCormack, Manley, Kitson, Titchen & Harvey, 1999). Simmons (2004) argues that through collaboration and team working, practice development is a facilitative approach to promoting change and innovation. McCormack et al., (1999) contend that at the time it was introduced, nursing was shifting from a traditionalist approach based on tasks and rituals towards a patient-centred approach. Glover (2002) argues that nursing was attempting to break free from the chains of the dominant medical culture and move towards a professionalism based on providing patient-centred care. All these arguments imply cultural change in nursing,

suggesting that practice development plays a pivotal role in fostering a culture and context that nurtures nursing. Practice development is unique because it happens within the nurse's own practice setting, involving the "growth of personal, professional and/or organisational standards and quality of services by involving and focussing on patients' and clients specific needs" (McSherry & Warr, 2006, p.17). As will be shown, this approach is highly necessary for the integration of patient-centred health promotional practices in coronary care.

Summary

The literature review presented in this second chapter of this thesis has shown the broader socio-political underpinning the call for New Zealand nurses to incorporate health promotion strategies into acute care nursing. The tensions between those who advocate empowerment and socio-political approaches to health promotion and those who alternatively support the medical/preventative approaches to health education are complex and suggest a wider socio-cultural change is at work. How nurses actively manage those tensions and incorporate patient-centred health promotional activities in a medically-dominated specialist unit, that is designed to save lives, is examined in this thesis. In the next chapter, the research method will be described.

CHAPTER THREE
Method

Introduction

The purpose of this study is to identify, describe and generate a theoretical explanation of the nurses' perspective of health promotional activities in an acute care setting. The Glaserian (1992; 1998; 2001) style of grounded theory was chosen in order to allow the main concerns of the participants to emerge from the data.

In this section the research methodology will be presented. The chapter opens with the background to the qualitative research paradigm, followed by a discussion of grounded theory as a qualitative method of data collection and analysis. The application of the method in this study is presented, including a description of the study design, the selection of participants, data collection and analysis followed by a discussion of ethical concerns. The chapter closes with a discussion relating to the issues of rigour in grounded theory.

Background

Any process of research enquiry is guided by a set of 'basic beliefs'. These beliefs, that form the basis of, in this case, the qualitative research paradigm, are designed to answer three questions: 'what is the nature of reality?', 'what is the relationship between the researcher and the knowledge?' and, 'how should the researcher go about finding out knowledge? (Guba, 1990). These key questions help clarify the following terms: 'ontology', 'epistemology', 'axiology', 'rhetoric' and 'methodology'.

According to Guba and Lincoln (1994), ontology refers to the assumptions made about the form and nature of reality; it is the study of being. For the qualitative researcher, Creswell (1994) states the only reality is that constructed by the participants. Epistemology, the scientific study of knowledge, refers to claims as to how knowledge of reality may be gained or put more simply, how do you know what you know? Here the researcher is closely interacting with the participants. This close interaction has implications for axiology, the role of values in a qualitative study. Due to the close

involvement of the researcher, personal values and biases are actively reported (Creswell, 1994).

Rhetoric refers to the language of the research. Lincoln and Guba (1985) emphasised the qualitative paradigm by constructing a new language which differed from traditional research. Creswell (1994) states that is "personal, informal and based on definitions that evolved during a study" (p. 7). Methodology refers to the strategies used in the data collection and analysis processes. In a qualitative methodology, categories emerge from the participants. According to Creswell (1994) this emergence provides "context-bound" information that leads to the development of theories.

Grounded Theory As A Research Method

A grounded theory is induced from the data rather than preceding the data (Lincoln & Guba, 1985). Glaser and Strauss (1967) developed the systematic approach to the study of interactions, known as the grounded theory method, to bridge a perceived gap between theory and research and the consequent undervaluing of qualitative studies that were relatively uncommon at the time. Glaser and Strauss came from very different backgrounds. Glaser was trained in quantitative research whereas Strauss was strongly influenced by the Chicago School of Sociology and the symbolic interactionist perspective. Their goal was to produce a research method that would be of value to practitioners and to develop theory that fitted with reality. The method was developed originally to investigate interactions in social settings (Glaser, 1998). The objective in grounded theory is to develop theory from the data which is encompassed in a core category and related categories and concepts.

Glaser and Strauss (1967) provide an initial definition of grounded theory. They state that it is a theory that will fit the situation being researched through the categories being readily rather than forcibly applicable to the data. These categories will then be meaningfully relevant to, and able to explain, the behaviour under study. Since then, the methodology has been frequently used in many disciplines and professions.

In this research the grounded theory approach was chosen to discover the nurses' perspective on the practice of clinical health promotion in coronary care. McCallin (1999) explains that "the aim in grounded theory research is to explain and predict

behaviour, and discover the underlying social processes shaping interaction and human behaviour" (p.28). Grounded theory is an appropriate choice for addressing research questions about complex relationships, clinical situations or new areas of inquiry. The initial question starts out broadly and becomes progressively narrowed and more focused during the research process.

While the type of grounded theory used in this study is Glaserian, for the purposes of understanding I have read more widely. Literature from other sources is, therefore, integrated into the discussion. In recent years, Glaser and Strauss have differed over interpretation of the grounded theory method but both have continued with grounded theory research. Glaser (1978,1992, 1998, 2001, 2005) has extended the original 1967 text to detail concepts such as emergence, theoretical sampling, theoretical coding and use of theoretical memos, while Strauss, working with Juliet Corbin (1990), focused on developing the structure for the analytical techniques.

Glaser (1978, 1992) emphasises the importance of the emergence of the data and theory through the analysis of 'basic social processes'. He advocates gathering data without forcing preconceived questions, structures or frameworks on the participants. Glaser (1992) was concerned that Strauss and Corbin' s preconceptions and methodological techniques 'forced' the data. The key differences are issues relating to conceptualisation (Glaser, 2001) versus description (Strauss & Corbin, 1990, 1994).

Both Glaser (1998) and Strauss and Corbin (1990) describe coding as an essential aspect of transforming data into theoretical constructions of social processes. Glaser distinguishes two types of coding, open and selective, while Strauss and Corbin describe three: open, axial and selective. Both acknowledge that selective coding involves the systematic selection of a core category that accounts for most of the variation of the central phenomenon of concern, and around which all the other categories are integrated (Glaser, 1992; Strauss and Corbin, 1998). Glaser insists on the need for emergent conceptual analysis while Strauss and Corbin utilise axial coding via a paradigm model. The model is an organising scheme that helps the researcher to think systematically to analyse the data. This issue of conceptualization versus description is the main difference in the styles of the original authors. Glaser (1992) argues that the purpose of grounded theory is to generate theory, not to verify it.

In this study I followed the principles and method of Glaser (1998) because this method allows the main concerns of the participants to emerge from the data. Emergence is useful as it sets an environment to access understanding of the practical realities of undertaking clinical health promotion in coronary care. It also sets the scene to understand the group behaviour of nurses within coronary care. In their original text, Glaser and Strauss (1967), state that emergence remains the key throughout theory development: "integration of the theory is best when it emerges, like the concepts. The theory should never be just put together" (p. 41). According to Glaser (1998) "in grounded theory there is no need to force meaning on a participant, but rather a need to listen to his [her] genuine meanings, to grasp his [her] perspectives, to study his [her] concerns, and to study motivational drivers" (p. 32).

Philosophy And Grounded Theory

Philosophy and grounded theory is a contentious topic. There has been considerable adoption of grounded theory in disciplines such as nursing, business, education, marketing and political science (Glaser 1978, 1998). Grounded theory is an inductive research method that generates theory from data that is examined systematically during data collection and analysis (Glaser & Strauss, 1967). The aim is to explain behaviour and to discover the basic social processes shaping that behaviour. Glaser (1992) states that there are only two questions that need to be asked, "What is the main concern of the participants and what accounts for most of the variation in processing the problem? Then, what category or property of what category does this incident indicate? (p.4). Glaser (1998) states that the researcher must "trust that uncertainty, ambiguity, and confusion are a useful path to being open to emergence. He[she] must trust to emergence and trust that the social organisation of social life exists to be discovered". (p. 44). The philosophy of emergence is not attached to any specific philosophical viewpoint.

While grounded theory could be described as being aphilosophical many grounded theory researchers seem keen to attach the method to a particular philosophy. Charmaz (2000) debates the social constructivist version of grounded theory which Glaser (2002) believes is simply another version of qualitative data analysis. According to Glaser, this approach has accurate description as its main goal. Charmaz 's view of grounded theory "recognises the mutual creation of knowledge by the viewer and the viewed and aims

towards interpretive understandings of subjects' meanings" (2000, p. 510). In contrast, Glaser's (1992) emergence model of theory generation is devoid of interpretivism.

Glaser (2005) also expresses concerns regarding the symbolic interactionist takeover of grounded theory. Symbolic interactionism focuses on the meaning of events to people in natural or everyday settings (Glaser & Strauss, 1967). Strauss was trained in symbolic interactionism at the University of Chicago, and this is possibly where this perceived dominance has originated. According to Glaser (2005), this is only one theoretical perspective that may have emergent fit. The consequences of this takeover are clearly expressed by Glaser (2005) as a "remodelling and eroding" of classical grounded theory (p. 13). He singles out nursing and related health services as the perpetrators of this erosion due to the sheer numbers of studies produced.

Glaser (2005) argues that this symbolic interactionist takeover limits the "data, the substantive categories and subsequent theoretical concepts that the researcher will use or hopefully let emerge" (p. 16). By removing these limitations he asserts that symbolic interactionism will not be undermined but its use will be enriched when combined with data from different perspectives. This allows true grounded theory to emerge and the researcher can be open to all possible theoretical concepts.

Key Components

Grounded theory is one of the qualitative research approaches suited to the purpose of theory development (Glaser, 1998; Strauss & Corbin, 1990). The grounded theory method involves systematic steps of data collection, coding and analysis to develop an inductively derived theory.

An important benefit of grounded theory is its flexibility and open-endedness (Charmaz 1990). This is evident in *constant comparative analysis* which Glaser and Strauss (1967) define as a process including comparison, integration, delimiting theory and writing theory. Using this method, each piece of data is continually compared with every other piece of relevant data so as to generate theoretical concepts that encompass as much behavioural variation as possible (Glaser & Strauss, 1967). Concepts identified in the data are then compared with subsequent and prior data to generate their interrelationships and theoretical suppositions.

Theoretical sampling focuses and limits the collection and analysis of data by responding to the need for more data that is relevant to the emergence of new categories. In order for concepts and categories to emerge during the data analysis, the need for sampling of specific data sources continues until each category is saturated. At the beginning of the study there are no limits set on the number of the participants, interviewees or data sources. The researcher makes preliminary sampling decisions. Sampling within grounded theory is therefore described as theoretical rather than purposeful (Glaser & Strauss, 1967) in that it is driven by the emerging theory.

Although grounded theory is an inductive method of research, the use of theoretical sampling requires deductive thinking on the part of the researcher. As such, according to Glaser (1998) "deductive reasoning comes into play through the sampling procedures as sources of more data are looked for and the researcher is able to deduce where they may need to go to get more" (p. 43).

This sampling method allows data to be collected from informants who are best able to answer emerging analytic questions, rather than sampling a pre-determined group of participants or settings (Glaser, 1978). Sampling continues until theoretical saturation, *data saturation* is reached. This occurs when no new data emerge relevant to particular categories or subcategories, categories have conceptual density, and all variations in categories can be explained (McCann & Clark, 2003).

Coding initiates the process of theory development. Both Glaser (1978) and Strauss and Corbin (1990) described coding as an essential aspect of transforming raw data into theoretical constructions of social processes. Coding is constructed through line by line or word by word analysis. Initial, substantive (open) coding describes the process through which concepts are identified and their properties and dimensions are discovered in the data. Glaser (1978) described substantive coding as a way to "generate an emergent set of categories and their properties which fit, work and are relevant for integrating into a theory" (p. 56). Strauss and Corbin (1990) define open coding as a process of "breaking down, examining, comparing, conceptualising, and categorising data" (p. 61). Glaser (1978, 1992) describes the process of emergence as generation of codes and categories directly from the data and are often labelled from words found in the data themselves.

Using the constant comparative method of analysis, the coded concepts are refined, extended and cross-referenced with the data as a whole. The concepts are then grouped with more abstract explanatory terms called categories. These categories depict the problems, issues, concerns and matters that are important to those being studied.

Theoretical coding is more conceptual than open coding. Glaser (1998) is clear that once theoretical coding starts, it is time to stop open coding. The open codes or categories are examined in terms of their types, dimensions, properties, consequences and relationship to others. It is used to weave the fractured concepts (Glaser, 1978) so as to "conceptualise how the categories may relate to each other as hypotheses to be integrated into the theory" (p.55). These hypotheses work together to construct a theory that explains the main concern of the participants. Thus, theoretical coding brings all the data, codes and categories into a seamless, integrated grounded theory (Strauss & Corbin, 1998).

Referred to as the 'core stage', (Glaser, 1978, p. 83) in the generating of theory, *memoing* is a constant, persistent and precedent facet of the research process that begins with the initiation of data coding and continues to the very end. Memoing is the theoretical writing- up of ideas, separate from the data, that focuses on the relationships between codes and their properties as they become evident. Glaser suggests that it "captures the frontiers of the analyst's thinking" (p.83). Boychuk Duchser and Morgan (2004) state that memoing is critical to the advanced coding process, aiming at conceptualising ideas that which up to that point may have been purely descriptive.

One of the categories is consistently related to many other categories and their properties and this becomes classified as the *core category*. The writing up of a *substantive theory* which is grounded in the data is final step of the research process.

The Design And Method Of The Present Research

In this section application of the research method is presented. The study design, setting, access to the field, participant selection, researcher involvement, ethical considerations, data collection and analysis strategies and the rigorousness of the research will be discussed.

The study setting

The setting for this study was provided by three coronary care units within a large metropolitan city. The city serves a multicultural population of 1.5 million, including Maori, Pacifica and Asian peoples. The environment is varied including urban and rural populations living within a range of decile 1 (low socio-economic) to decile 10 (high socio-economic)[8]

Access to the field

Access to the field began with ethical approval from the Auckland University of Technology Ethics Committee. As a nurse with over fifteen years experience in coronary care nursing, I was able to utilise my extensive professional nursing networks to enable access to potential participants currently employed in coronary care. As a former clinical nurse educator I had contact with many other nurses via formal teaching, conference attendance and special interest groups. For reasons of time and the cost of travel, nurses in one large metropolitan city were invited to participate.

Participant selection

I used my professional nursing networks to access participants. Nursing colleagues who have contacts with registered nurses who have at least three months experience and have completed their orientation period in the coronary care setting were asked to identify registered nurses who were knowledgeable about the research topic. There were no restrictions in relation to gender, ethnicity or age, but the participants must be willing and able to articulate their experiences in English. These colleagues, acting as intermediaries, approached a nurse to informally discuss the potential interest in talking to the researcher.

The intermediaries checked that a potential nurse-participant was willing to have his or her name passed to the researcher. Once contact was made with the potential participant the researcher explained the research aims, and offered an information sheet (Appendix B). With their permission, contact was made again in two weeks to check interest in joining the study. If participation was confirmed, written consent was gained (Appendix C).

[8] The socio-economic rating system is determined by factors such as: Household income, Occupation, Household crowding and Income Support.

The participants

There were seventeen participants in total, thirteen women and four men. Ages ranged from early twenties to late fifties. Experience in coronary care ranged from nine months to twenty-four years. Six participants were New Zealand born while nine came from overseas, representative of the current nursing population within New Zealand. Of those nine, five participants had English as a second language.

All but three participants were educated to degree level. Six had completed a hospital based training or post-graduate coronary care course. At the time of the study, two participants were educated to a Masters level, while two were undergoing masterate study.

Ethical considerations

The common principles of ethical research practice emphasise four guidelines underpinning codes of ethics: Informed consent; deception; anonymity and confidentiality; and accuracy (Denzin & Lincoln, 2000). These issues will be addressed below, along with consideration of the principles of the Treaty of Waitangi.

Informed consent

Ethical issues were considered throughout the study to protect the rights of the participants. Prior to any data collection ethical approval was granted from the Auckland University of Technology Ethics Committee (Appendix A). According to Beauchamp and Childress (2000) informed consent is a person's autonomous authorisation to participate in research. After the initial contact was made through an intermediary, the researcher explained the research aims, answered any further questions and gave the information sheet (Appendix B). Participants were informed that the findings would be used in the researcher's thesis. Every effort was made to ensure that no persuasive language was used during this time. Informed written consent was gained from all participants. Participants were given the opportunity to ask questions and informed that they may withdraw from the research at any time as consent to participate was ongoing.

Although there was no perceived danger of physical risk to participants, the researcher was aware of the possibility of emotional issues relating to the research topic. If this

situation had arisen, the researcher would have terminated the interview, and, as a nurse with over twenty year's experience, the researcher would have offered support or information as required.

Anonymity and confidentiality

Codes of ethics insist on safeguards to protect people's identities and those of the research locations (Denzin & Lincoln, 2000). Anonymity and confidentiality are mutually exclusive. Anonymity refers to concealing the identity of all participants and their places of work. Confidentiality concerns access to the data.

In order to maintain anonymity and confidentiality the participants were asked to provide a pseudonym for their research identity. The interviews were conducted in private at a mutually convenient time and place away from work, outside working hours. No records contain any personal identification apart from the agreed pseudonym. Participants were reminded that the interview would be treated as confidential. Some demographic information (see "The Participants", p.24) was collected and discussed with participants. All material was stored in a secure cabinet accessible only to the researcher and her supervisor.

Deception

In emphasising informed consent, codes of ethics uniformly oppose deception (Denzin & Lincoln, 2000). The research study followed the process approved by the ethics committee. The reasons why the research was being undertaken and for whom was transparent throughout the study. Participants were reminded of this at the beginning of the interview and were free from answering any question that they did not wish to during the interviews. Participants were able to contact my supervisor for verification using the details included in the consent form (Appendix C).

Accuracy

Ensuring accuracy of data is crucial. Omissions or fabrications or the addition of fraudulent materials is non-scientific and unethical (Denzin & Lincoln, 2000). Accuracy of data must be assured. Participants were given the opportunity to review their interview field notes and confirm data had been reported accurately. Three participants wished to review the field notes and one requested an alteration to her script. Once data had been collected, the audit trail provided transparency and confirmed the decisions

and interpretations made throughout the data analysis and theory development. Any weaknesses in design or process are shared in this final report. (See Chapter 7, p.120).

Treaty of Waitangi

The Treaty of Waitangi is the founding document of New Zealand, signed in 1840, between the British Crown and Maori signifying the establishment of British law while guaranteeing Maori authority over their land and culture. Respect for the principles of participation, partnership and protection implicit in the Treaty of Waitangi were applied in the following ways: The principle of partnership reflected in the Treaty being a social contract involved working together to share information in an open relationship, responsive to individual beliefs and practices. The principle of protection grounded in the Treaty promise the same rights and privileges to all involved by being responsive to individual participants needs and providing a supportive welcoming environment. Participation emphasises the need for ongoing consultation and ensured that participants were kept informed at all stages of the study, and had the same access and opportunities to take part.

In order to research according to Treaty of Waitangi principles, I contacted the Maori Health unit at a large teaching hospital, for advice. The unit expressed an interest in the research and gave details of key contacts in the metropolitan area, ensuring ongoing consultation and co-operation. There were no Maori participants in this study.

The population for the selection of the initial sample had representatives from many cultures, including Indian, Chinese and Filipino, representing the current diversity in the nursing workforce within New Zealand. Respect of individual culture and background was shown to all participants in consideration of the time and place of interviews with the time for prayer and the sharing of food.

Researcher involvement

Qualitative research is interpretive research. As such, the biases, values and judgement of the researcher are stated in the research report (Creswell, 1994). Admitting to knowledge about health promotion literature at the outset of the study, demonstrates the researcher is aware of the potential for findings to be based on current theoretical knowledge.

Glaser (1992) warns the researcher who is familiar with the area under study to resist the tendency to force the data. As a nurse with over fifteen years experience in coronary care nursing, I appreciated the importance of putting my preconceptions to one side. Parahoo (1997) believes reflexivity to be a continuous process of reflection by the researcher regarding personal values, preconceptions, actions or presence and those of the respondents, which can affect responses. In order to acknowledge personal prejudices, my personal assumptions regarding health promotion in coronary care were listed prior to the commencement of data collection (Appendix D).

My own coronary care experiences assisted in interpreting participants' experiences and also served as a means for constant comparative analysis and checking different interpretations. A journal of personal reflections was kept in order to acknowledge any bias. For example, when issues were raised about continuing education, I had to consider whether the any emphasis in data analysis was also a reflection of my personal situation as an educator and a postgraduate student.

Data collection methods

Data were collected by personal, semi-structured interview only using the technique described by Glaser and Strauss (1967). Interviewing was chosen because of the difficulties of using other methods of data collection such as participant observation of nurses in clinical practice during a small, time-limited study. Glaser (1998) argues that the audio-taping of interviews is unnecessary, as the researcher ends up with too much data that slows down and limits the generation of concepts. He suggests that writing up the field notes after the interview allows the researcher to code and analyse the data immediately. I followed this approach. During the interview I recorded a key phrase or word and noted any non-verbal communication. As soon as possible after the interview had finished, I wrote up the field notes. I recognised that as a novice researcher this approach would provide challenges, not the least of which was the ability to make accurate field notes that were free from personal bias. This will be discussed in the section on rigour later in the chapter.

Each of the seventeen participants were interviewed from one to three times over a period of six months. Participants who were eloquent and expressed an interest in having further discussion were interviewed for a second or third time. Interviews lasted

from forty-five to sixty minutes. Initially, during the first interviews, the nurses would be asked:

What are your main concerns regarding health promotional nursing practice in coronary care?

Further questions included discussion about actions and interactions attributed to health promotion and factors identified as enhancing or inhibiting its delivery:

I want to understand more about the work you do promoting health in coronary care. What are some of the experiences you have had…..?

After the first initial interviews, further participants were questioned around the emerging concepts for comparison with their own experiences. For example technology appeared consistently in the first interviews and so further participants were asked to clarify issues regarding technology. Twenty interviews in all were completed until little new information came from the interviews, that is, data were saturated.

Data analysis

In grounded theory data analysis is both inductive and deductive (Glaser, 1978; Glaser & Strauss, 1967). Data analysis was a continuous process undertaken with various degrees of intensity throughout the entire research. Data were continuously examined for meaning, common patterns and emerging concepts from the beginning of data collection until the final draft was produced eighteen months later. All field notes were analysed for codes and categories which were simultaneously compared with other emerging data. Glaser (1978) states that coding is constructed by line by line or word by word analysis, or fracturing the data, to avoid missing important aspects that may escape during a cursory reading of the data.

All data were analysed line by line for substantive codes which, where possible, used the words of the participants. For example:

Many aspects of the care that patients require within CCU are driven by protocols, half hourly recordings, and 15-minute observations post procedures…
(Nera, Interview 12, p. 29)

In this description the original substantive code was "protocol driven" which was re - coded into the selective code of "constraints of practice" and which eventually came under the category of *work structure*s.

Likewise:

We are working within the constraints of the 'sickness' model, focussing on the disease process, which makes it very hard for nurses to discuss the concept of wellness to patients. (Nobbie, Interview 7, p. 18)

The original substantive code here was "sickness model" which was re-coded under the selective code of "constraints of practice" and eventually merged into the selective code of *work structure*s, adding density to the theory.

Another example of the coding process is:

I sometimes feel that I do not have the energy I need to make informed decisions because I feel as if I am being pulled in different directions. (Mata Hari, Interview 4, p. 10)

The substantive code of "Pulled in different directions" found a place in the selective code of "personal expectations" which then became part of the theoretical code *role conflict*.

Similarly:

I felt that I was letting my patients down, so I made a determined effort to get to the training. (Susan, Interview 5, p. 13)

"Letting patients down" was re-coded to "personal knowledge" and later placed in the category of "emotional intelligence". In the final analysis this became part of the theoretical code *self–development*.

Data from subsequent interviews were analysed, compared and contrasted with the initial set for similarities and differences. Glaser (1998) terms the unit of comparison as the 'incident', found in a phrase or sentence. These substantive codes were grouped together on large pieces of paper and labelled and colour-coded after answering three important questions: "What category does this incident indicate? Or what property of what category does this incident indicate? and lastly, what is the participant's main concern?" The subsequent search for the conceptual codes was frustrating at times, as with further thought and analysis these codes were reworked and regrouped, only to come back to the original after many months of analytical thinking.

Codes and categories were continuously refined and tried for 'fit'. For example the impact of technology in coronary care with the associated processes was clearly seen

from the first interview and was considered to be a key element. Time was also a consistent factor in interviews, appearing to encompass all aspects of nursing practice. How nurses used their time seemed to be important, along with their individual approach to nursing care. Their approach changed over time and there appeared to be three distinct time-related stages in this process. The conceptual categories "technological time" and "therapeutic time" were formed in the early stages of conceptualisation. When feedback was sought as to their accuracy, participants were able to clarify that time was a pressure of work, along with the processes such as invasive procedures, protocols and the influence of other departments. These processes were next conceptualised as "structures". Very quickly, the conceptual category of *environmental pressures* resulted from the theoretical codes *work structure*s and *technological focus*.

The theoretical code of *role modelling* was very clear from the data. *Role modelling* helped the nurse alter their approach to providing nursing care. *Role conflict* was apparent in everyday practice where the *technological focus* often prevented the nurse engaging with the patient. *Role conflict* was thought to be the catalyst for the change in approach but on closer scrutiny *practice reality* was the clear trigger and so became the conceptual category.

There appeared to be very obvious movement in the data, where nurses seemed to move away from the technology and towards their patients. Approaching, which was thought to explain the movement, was considered as a core category but this would not 'fit' all the data. The attitude of the nurse was seen to be central to all categories and is clearly evident in the data right across the study. The *environmental pressures* initially shape the nurses' practice with a focus on the processes but *practice reality* forces them to reconsider their attitude and approach to their practice. *Responsive action* sees the nurse responding not only to the needs of the individual patient but those of the coronary care unit as well. The emergent core category was finally identified as the process of *attitudinal shifting*, reflecting the movement associated with this change in thinking.

While there was an awareness of the importance of identifying a theoretical coding family, I was mindful of the potential to force the data to fit. Glaser (1978) states the grounded theorist should "know many theoretical codes in order to be sensitive to rendering explicitly the subtleties of the relationships in the data" (p. 72). In the end,

data were analysed using the cultural coding family. This is clearly a study about culture change from the medical model of health to the patient-centred approach necessary for health promotion. The social norms were the protocols and policies; values: the medical model, saving lives, caring; patient-centred care. Nurses experienced *role conflict* because of the conflicting values and beliefs found within the coronary care environment.

Memos were used throughout the whole process of data collection and analysis to record ideas, themes and questions. Every interview was analysed for possible concepts and developing theory. Glaser (1978) describes memo writing as a way of thinking so the most important thing is to get the ideas out regardless of grammar, spelling or expression. Memoing was particularly useful when moving into the more rigorous stages of conceptualization, when what seemed to make sense when I was analysing transcripts did not once I had started developing and writing up the theory. Methodological memos were useful to help clarify issues related to the research process (Appendix E). Theoretical memos were a vital part of the process of analysis (Appendix F).

Rigorousness of the Research

In relation to research, rigour means the "strictness in judgement and conduct which must be used to ensure that the successive steps in a project have been set out clearly and undertaken with scrupulous attention to detail" (Roberts & Taylor, 1998, p172). This checking process allows others to decide that the study's findings can be relied upon to reflect the "truth" of the matter.

I elected to follow Glaser's (1978) criteria for checking rigour. Glaser suggests that fit, workability, relevance and modifiability are criteria for judging the rigour of a grounded theory study.

Fit is said to occur when the categories within the theory relate directly to the data. Data should not be forced but allowed to emerge. Glaser (1978) talks of two more vital properties of fit; "refit and emergent fit" (p. 4). As the research proceeds it is important to constantly recheck the appropriateness of the categories. For example, participants' quotes in the text illustrate and confirm interpretation. Memoing and constant

comparative analysis kept the analysis open as did the emphasis on emergence. At the same time, the research supervisor audited the process, asking numerous questions throughout. During writing literature that fitted was linked to interpretation, provided support of the emerging theory. Finally, the theory was checked to see if it fitted empirical situations that were different from the research setting. These findings were presented to nursing colleagues in education who confirmed the emerging theory as being something they were familiar with in the educational setting.

Workability is said to occur when the theory explains what is going on in the area of study. The participants guided the process of theory generation through constant comparative analysis. Participant review of field notes and emerging concepts during formal data analysis ensured that the theory did indeed explain what was happening to nurses promoting health in coronary care. Participant review of the findings also allowed the participants to check on any personal bias or subjective assessment of the content of their interview in the field notes I had written.

Relevance occurs when the emergent theory focuses on the core problems and processes. In this study, information has been provided about the phenomenon studied and the research setting to enable the reader to assess whether the study findings are relevant to other populations. Participant characteristics are provided.

By modifiability, Glaser (1978) suggests that a grounded theory may go through changes when new data emerge, generating qualifications to the theory. Throughout the process of data collection and analysis, changes were made to accommodate the evolving concepts when new data presented variations in the emergent theory.

While every effort to maintain rigour was integrated into the research process, judgements of rigour are an ongoing process. For example, the rigour will be judged in the public arena through external examination of procedures and peer review.

Summary

This chapter has outlined the background to the qualitative research paradigm with a discussion of grounded theory as a qualitative method of data collection and analysis. The application of the research method to this study of health promotion in coronary

care has been presented including examples of data collection and analysis. Ethical considerations and issues related to rigour have been discussed. The next three chapters contain the findings of the study, organised around the key concepts identified in the process of grounded theory generation.

CHAPTER FOUR
Environmental Pressures

Introduction

The purpose of this research was to generate a substantive theory about clinical health promotion in an acute health care setting. The research results indicate that the main concern of nurses promoting health in coronary care is *ritualistic practice.* In order for health promotional activities to occur within coronary care, nurses manage ritualistic practice through a process of *attitudinal shifting. Attitudinal shifting* is a socio-cultural process that occurs over time involving three stages, *environmental pressures*, *practice reality* and *responsive action*.

Environmental pressures influence the delivery and practice of nursing within coronary care units. The technological focus and work structures shape nursing practice, where short-term nursing needs take precedence over the longer-term health promotional needs of patients. During the second stage of attitudinal shifting, *practice reality*, nurses become aware that patient health promoting needs are not being met and experience role conflict. Nursing role models actively incorporating health promotion in their practice motivate nurses to explore their attitudes to practice. *Responsive action* sees the nurse engaging in self-development, also focusing on the nurse-patient relationship, thereby enabling active patient involvement in individual health-promoting decisions.

In this chapter the nurses' experience of *environmental pressures* is examined. In this study *environmental pressures* is defined as the tension between specialisation and generalisation in an organisation. There was a tension between the specialist medically-dominated rituals of coronary care and the generalist nursing role of promoting health. The two categories that combine in the conceptual category of *environmental pressures* are *technological focus* and *work structure.*

Technological Focus

In this study *technological focus* is defined as the impact that specialised equipment, science, research, computers and information technology has in the acute coronary care environment. Advancing technology contributes to the structure of nursing work as the

use of instruments and machines for monitoring patients are commonplace in a coronary care unit. Technology also contributes to the rituals of nursing practice. The pressure on nurses to keep up with these advances is intense and nurses in the study talked about the impact that technology has had on their practice and attitudes:

Initially nurses are driven and ruled by the technology and the tasks they have to perform…. They can learn these and there is one right way of doing them. (Arthur, Interview 9, p.22)

Nurses in this study were very aware of the historical beginnings of coronary care with its emphasis on the technology of defibrillation:

Health promotional activities are not given a starring role in the nursing responsibilities and as such are not promoted as a necessary skill. It is well down the list of established priorities in a historically technologically based environment. (Rosie, Interview 8, p. 20)

A new nurse in coronary care concentrates on that technology, moving between patients, focussing on the particular tasks that need to be completed. Nursing attitude dictates that these tasks have a concrete structure making it easy for the nurse to be assessed as technologically competent, a major part of being a coronary care nurse:

Our attitudes and values influence the way we behave and the way we use our time to concentrate on the technological aspects of our role. (Nobbie, Interview 7, p 19)

This is in keeping with computer technology advances have been revolutionary over the past decades transforming the Industrial Age to the Information Age (Saba, 2001). The advancement of computer communication further revolutionised the Information Age. While computer technology is part of everyday professional nursing activities it contributes to the *environmental pressures*. The majority of nurses are technologically literate to differing levels and computers are found in every ward and department. Information technology that offers decision support systems can assist nurses to improve patient care but are seen as an another task that must be completed and add to the pressures the nurses experience:

The computerised system for risk assessment and secondary prevention takes up time that could be better spent with the patient. Data gathering, then in-putting that data on the limited computers is not seen as a priority, it is just another thing that has to be done during your shift. (Joy, Interview 2, p.6)

Nonetheless, a formal orientation programme helps to motivate new employees, facilitates learning and reduces anxiety (Ragsdale & Mueller, 2005). Orientation is seen as an important time for nurses in CCU, as it introduces nurses to the norms, values and attitudes of the nursing team in their new environment. Technical knowledge and

mastery of skills are traditionally seen as the key to success in coronary care and, as such, are given priority over other aspects of nursing work:

The focus during orientation is concentrated on mastery of technical tasks and skills and achieving the competencies that are needed in CCU. (Nobbie, Interview 7, p.18)

Many nurses enter coronary care with proven competency from other areas of practice on which to lay the new specialist knowledge and skills they need to practice safely. They are concerned with developing technological competence specific to CCU.

Competence in this new scope of practice develops over time. Nurses need to be confident of technical competence in this technology-rich environment before they can promote health. Nurses need time for the hands on practice using the technology that will increase their skill level. In this respect, clinical simulation is a useful teaching tool where nurses can safely learn how to use technological equipment by practising the skill on mannequins. This is usually conducted in a learning suite well away from the everyday work area. It involves no risk to the patients and is a common practice during orientation in coronary care:

We are taught how to defibrillate, and care for temporary transvenous pacemakers on dummies. We can learn those basic skills but no-one shows you how to respond to the person who is experiencing all this. There is only superficial training given to that aspect of care as the dummy cannot tell you how he feels. (Joy, Interview 10, p.24)

However, this practice can cause more tension for new staff. What may be physically safe in a technological sense for the patient impacts on the attitudes nurses develop during their orientation. Technological skill development potentially divorces the affective and psychomotor domains of learning and may compromise health promotion that relies on the ability to connect with patients. While admission to a coronary care unit is typically an unexpected life-threatening event, it is important that the *technological focus* does not undermine the human experience of acute illness. Having a heart attack may plunge the patient into an emotional and physical crisis:

Supporting a patient during his/her admission to CCU means getting to know the patient, spending time with them, talking with them, and there is no one expected outcome or response or piece of equipment that will do that for you. (Ashley, Interview 14, p.33)

In this age of high technology, the role of the nurse is constantly evolving and expanding (Ellis & Hartley, 2001). The nursing profession seems quick to accept new roles that are seen in isolation from the *environmental pressures* of practice at the expense of some of our original nursing tasks, especially in the coronary care environment. Progression or advancement in nursing is often seen alongside the

accumulation of clinical skills of varying degrees of complexity. Applying Benner's (1982) novice to expert theory adds another dimension to the interaction of nursing and technology. At novice level, a nurse will be guided by instructions and guidelines and at this level may have difficulty integrating technology with nursing care, as Ashley comments:

I find it hard to ignore the monitors and pumps which surround the patients. The alarms, warnings and equipment take all my attention (Ashley, Interview 14, p. 32)

Others agree:

Talking to the patient about general health issues and concerns while doing the tasks may potentially generate more work and this is difficult for the less experienced nurse to fit into their day and so they do not engage in these activities. (Nemo, Interview 2, p.4)

For the expert CCU nurse it is difficult to separate the elements of his/her practice, at which time nursing and technology can be seamlessly intertwined, using skill, intuition and a wealth of previous experience. Mollie described the difference in care that patients might receive from individual nurses:

The care you receive depends on who your nurse was because some nurses follow the tasks routinely and do not seem able to consider the individual who experienced the event. I can describe a super senior nurse within CCU who is human and caring and genuinely wants to help the patients recover and get back on with their life. The technology is still very much part of her practice but in the background. (Mollie, Interview 16, p.37)

Procedures guide many aspects of nursing work within the coronary care environment and ensure that the technology is incorporated correctly. Protocols, according to Manias and Street (2000), provide details of specific procedures to enable the implementation of particular policies. Health promotional activities though, are not to be found in a protocol or procedure:

The protocols that need to be followed and the technological procedures that must be completed in the shift drive the work of the nurses and other needs such as individual health promotion is dropped well down the list of priorities. (Nera, Interview 1, p. 2)

Protocols and procedures form the nurses' plan of work and bring a sense of structure, or routine, albeit at the expense of health promotion work. Routines are habituated ways of responding to occurrences in everyday life (Strauss & Corbin, 1998), and are part of our normative experience. As such, they are taken for granted unless they are disrupted in some way. This can often happen in the unstable environment of coronary care and cause tension for the nursing staff.

Protocols and procedures also provide a form of time supervision. These protocols are based on current evidence and research, ensuring that the patients receive quality care incorporating the latest technology. This technology drives the nursing care and can create a time pressure for nurses whose work is driven by these protocols:

Many aspects of the care that patients require within CCU are driven by protocols, half hourly recordings, and 15-minute observations post procedures… (Nera, Interview 12, p. 29)

While technology certainly adds to the *environmental pressures* , the nurses must also learn to manage their time with the help of technology. The inability to manage time or keep to time leads to stress and tension for the nursing staff. Attitudes and rituals persist pressuring the nurse to complete all aspects of care before handing over to the next shift.

Days are divided into hours and the nursing procedures must be completed in the expected time-frame. Nurses feel that they must complete everything before the next shift comes on…..the 24 hour service is known and talked about but the expectations are still that all tasks are completed before the start of the next shift. (Arthur, Interview 11, p. 27)

While task completion clearly improves the status of the patient with heart disease, technology can compromise caring. Nonetheless, caring continues to be a fundamental aspect of nursing but Joy suggests:

The human element is missing at times. We are caring for the person in the bed, we are not caring for the technology or the acute disease process. We are interested in you and how you will cope after this. Patients do not fit nicely into little compartments and boxes. (Joy, Interview 3, p.7)

In this environment technical tasks take precedence over caring behaviour. While nurses like Joy would prefer to focus on caring for the individual, their delegated role as CCU nurses precludes this. This is consistent with Carnevale (1991) who suggests that when there is a sense of urgency, nurses are unable to nurture and only perform technical functions. During an emergency, nurses in coronary care are expected to respond appropriately. The *technological focus* dominates their actions:

CCUs were built to prevent patients dying first and foremost. We all need to be able to defibrillate appropriately and that is our focus when someone is in VF [ventricular fibrillation]. (Susan, Interview 5, p.13)

This emphasis on technology, routine, and ritual can be seen as a protective mechanism for the nurse to avoid more anxiety and stress-provoking situations in an already pressurised environment. Chapman (1983) agrees when she talks of the ‘self-defence

mechanism' of ritualised care. This concentration on technological competence and the individual task is easier to cope with as it often has a predictable outcome. This conforms with Heiddeger's (1977) view of "empty busywork", in which the nurse may use technology as a barrier to developing relationships that may become emotionally draining:

It is much easier to be doing the recordings and technical aspects of care that must be done and which do not always make the patient feel able to talk about their worries because the nurse appears to be too busy to listen or pay attention to them. (Nera, Interview 12 p. 31)

Time spent with the patient, delivering hands on care is a time for communication and interaction that are essential for health promotional work. Making that time and commitment in a unit where the ability of the nurse to think critically is requisite to functioning safely and proficiently, can be a challenge in this structured environment. Critical thinking is challenging for all staff but especially a new nurse, whose attention is focussed on the technology. The inexperienced nurse, or one lacking confidence in their own ability, will fear making a mistake and prefer to follow standards, traditions, or institutional rules, rather than think for themselves and dare to do something different. They are focussed on the tasks within the procedure rather than the bigger picture. The same is true for health promotion in a highly technological environment:

Nurses can be caught in the middle, receiving mixed messages from their managers or more senior nursing staff. The abundance of rules and regulations and protocols found in nursing could smother the independence and confidence of staff who wish to use the opportunities that arise to discuss health issues with their individual patients and their families. (Rosie, Interview 8, p. 19)

This is consistent with Barnard (1996) who argues that technology is a pervasive reality for many nurses comprising people, processes, attitudes and systems, as well as machines. This reality modifies attitudes, practice and environments without nurses comprehending the importance and implications of these changes. Technology itself does not heal and excessive reliance on technology may cloud clinical judgement. What is the technology not telling nurses? Jones and Alexander (1993) discuss the technology of caring, where caring and technology are interrelated. Many nurses in the study agree that technology cannot be divorced from caring:

The patient in pain, appearing anxious or worried….not sleeping at 2 in the morning and pacing the floor…these times are opportunities to show caring and concern, and help with the immediate issues concerning them. That human to human communication and contact is vital at these times. The technology itself does not hold all the answers. (Nemo, Interview 2, p. 4)

This pull between the use of technology and the human-to-human aspect of nursing creates further tensions for nurses trying to promote health. Each individual nurse's attitude to the technology in coronary care can affect the way they practice. Nurses may become deskilled by reliance on the technology, and that technology can take them away from the bedside and contact with the individual patient.

It is clear that technology has a major influence on nursing practice within coronary care. It takes individual time and effort for a nurse to become proficient with this technology, very often at the expense of time spent doing health promotional work. The technology provides vital clinical information to enhance patient care. Health care technology is here to stay and it likely to become more complex. This *technological focus* forms a significant element in the *environmental pressures* that nurse's face within coronary care practice.

As we have seen, the use of technology is driven by medical policies and protocols within the coronary care environment. These policies are one aspect of the structures that contribute to the *environmental pressures* that help shape nursing practice in coronary care. *Work structure* will be discussed next.

Work Structure

The *work structure* refers to the protocols, rituals and routines that dominate coronary care units that were originally designed in the 1960s. The units were structured to gather all patients with acute myocardial infarction into a specific area. Here specially trained nurses monitored vital signs such as blood pressure and heart rate and rhythm for identification and treatment of life-threatening irregularities. These nurses treated and resuscitated patients with cardiac arrest in the absence of medical staff. This structure of nursing work was revolutionary at the time.

However, medical scientific knowledge has developed rapidly and the goals in the management of heart disease in the 21st century have changed dramatically (New Zealand Guidelines Group, 2002). For example, ongoing research, the discovery of new pharmaceutical agents and surgical revascularization techniques have altered both medical and nursing practice. The patient's length of stay in coronary care is significantly reduced because of the technological advances that have been made. Now,

patients are no longer kept in bed for 2 weeks. Advances in science have impacted on *work structure*s. Despite these changes, the medical focus remains dominant and the nurses work according to the medical structure, and the pervading attitude that all patients admitted to CCU are very sick and need special treatment:

Nurses are very good at ensuring patients are kept in the sick role for as long as possible. The notion of very sick people who cannot get out of bed and must be monitored continuously perpetuate perhaps subconsciously. The CCU culture with its associated rituals has not moved forward with the times and changing treatments. (Nobbie, Interview 7, p.18)

Patients are admitted to a highly structured coronary care unit because they have had a life-threatening health event and need specialist care. The patients can be frightened of the equipment, the procedures they have to undergo and their individual futures. They have lost control of their lives temporarily, in that they may have required resuscitation, and many patients are indeed survivors who have faced their own mortality, and so need to feel as if they are in a safe, structured environment. Patients are quick to conform with the expectations of the sick role. According to Parsons (1951) being sick evokes a set of patterned responses on the part of the participants to the event, in this case patients who have had an acute myocardial infarction. Being identified as "sick" ensures sympathy from their friends and relatives who come to visit and confirms the belief that illness is beyond their personal control. This does not make it easy for nurses to talk about the future, incorporating health promotion. The nurses in this study are very aware of this:

Patients within CCU are often in shock or denial about what has happened to them. They may well have nearly died and be scared about their future and want the staff to take control, so the processes and procedures take precedence in order to provide the specialist care they require. (Nemo, Interview 2, p. 3)

Trying to save life and promote health at the same time creates a tension between *work structure*s and working with a patient in a human-to-human relationship. The nurses manage this through an awareness of how important it is to allay patient anxiety by providing information about the staff, equipment, routines and general environment of coronary care. Health promotion often begins with correcting misinformation:

Patients are scared and have got a number of images created by the media and entertainment industry about heart attacks and their effects that are not correct in many instances. (Batman, Interview 6, p.14)

Nurses mostly work correcting patient misconceptions and talking about how the patient will be managed. Medical structures tend to drive the process. Nurses explain the

actions of prescribed medications, provide information about an impending angiogram and the post – procedural care required. Nursing attitudes focus very much on the present and ensure that the patient is well informed about their stay in hospital, the routines and the medical interventions:

That is what they are dealing with on a day to day basis, giving the patient the information they need to survive their stay in hospital. The future seems a long way off and can be attended to once these important diagnostic procedures and angios are out of the way. (Joy, Interview 3, p. 5)

At this time the patients live from hour to hour. They are often exhausted and overwhelmed by illness. Patients are trying to come to terms with being in hospital, so initially are very happy to have the nurses determining their needs and providing structure and safe routines.

The patients' length of stay in hospital has reduced markedly over the years because of the increasing use of technology and advances in medical science. Patient receptiveness and readiness for learning varies and may not even occur during hospitalisation. This makes health promotion difficult and it is unclear how much information the patient can process and how effective any intervention has been adding to the uncertainty for nurses:

The patients need time to begin to assimilate what has happened to them after what is often a life-threatening and perhaps life-changing experience. When they are coming to terms with these events, is often not the right time to start giving out information about lifestyle changes or health promotion as they are not ready to listen and comprehend what is being suggested. (Joy, Interview 3, p.6)

In the course of a day, the tasks and routines structure nursing work rather than individual patient needs and concerns. Health promotion becomes a task, another job to be done. There is no real thought of the individual patient and their unique circumstances. Structured checklists have been devised to help nurses ensure that the patient receives appropriate information. Nurses blindly follow this ritual without being able to question the appropriateness of each item for the individual they are caring for:

We do drugs, Action Plan, Access to emergency services, etc……. so here goes, same old information trotted out, same old information sheet given out. (Arthur, Interview 9, p.22)

This checklist brings the nurse a sense of predictability, a sense of time control and familiarity, and helps the nurse manage time, structuring work in this potentially unstable environment. It comprises a sequence of activities to be completed but there is

also an assumption that patients will play their part in supporting nurses' practice. This is not necessarily easy.

The patients admitted to coronary care are typical of the diverse New Zealand population with representatives of many cultures who have varying attitudes to health and health promotion. This can add to *environmental pressures*. Patients may have little understanding of the English language; communication is not easy. Interpreters or family members are not always available to help at the times when help is required, which upsets the routine and contributes to environmental tensions:

The multicultural patient population provides challenges for nurses to deal with in giving health information. Difficulties in communicating in English, lack of resources in other languages and the logistics of using interpreters are some of the blocks we come up against every day. (Rosie, Interview 8, p.19)

There are issues with the cultural mix of staff and patients that impact on nursing work and create further tensions. In some cultures it is not common or considered right for young women to give advice, such as promoting health to an elder male. Some nurses in this study felt that their patients did not understand their role:

Nurses are seen as the girls who help the doctor. There is respect for nurses as a carer or a mother figure, nurturing and attending the sick but not as someone with specialist skills and knowledge. (Arthur, Interview 9, p. 23)

Nurses and doctors work and think differently, epitomised as the cure versus care debate, and some nurses in this study found this challenging, especially when they held an alternative view of health promotion:

We are working within the constraints of the 'sickness' model, focussing on the disease process, which makes it very hard for nurses to discuss the concept of the wellness model of health to patients. (Nobbie, Interview 7, p. 18)

Different understandings are not unusual. Historically, nursing and medical education were structured differently creating differences in knowledge, status, power, attitude and gender between the disciplines (Salvage & Smith, 2000). The focus for doctors has been the biomedical model, diagnosing and treating specific diseases, while nurses provide the care, nursing patients from sickness to improved health. Because all work in this specialist environment, whether it be nursing or medical, is dominated by the biomedical focus, nursing work in CCU seems to get lost. Conventional medical language does not uniformly recognise nursing terminology. The dominance of medical *work structure*s means that nursing is therefore forced to rely on the standard medical terms that creates yet another pressure in an already busy environment:

The nursing handover is very medicalised, where issues discussed are from a medical slant not a nursing one. Medications are discussed, blood results, procedures and medical diagnoses, and the nursing role is lost. (Batman, Interview 6, p.15)

The true nursing role within CCU is perhaps not clearly understood, possibly because of its historical beginnings and links to medical *work structure*s and rituals. If this issue is laid against the notable success of the coronary care unit that occurred as a consequence of three separate endeavours related to the prevention and prompt treatment of ventricular fibrillation, tensions are evident. Nurses were specially trained to use the technology and follow the set structures and protocols to save lives. The terminology used is dominated by these medically delegated roles and routines, and perhaps does not accurately reflect the nursing contribution to patient management. Best practice guidelines, for example, which provide the rationale for patient management concentrate mainly on adherence to pharmacological or interventional therapy with a focus on medical practice issues. Similarly, nurses, during the ward round, are asked to report on their patients' blood pressure, angiogram site, or response to a new medication, all medical data. A report on the patient's emotional or spiritual needs and concerns or responses to health education or health promotion is not routinely requested. As this nursing work does not seem to be encouraged or valued, nurses are more likely to ensure those (medical) tasks are completed successfully and given priority:

There is a lack of emphasis on the [nursing] role and importance of health promotion within the CCU culture. Secondary prevention in heart disease is well discussed but only paid lip service to by management. It is talked about a lot but perhaps not followed through. It is under-resourced and underfunded, and not fully supported by the medical staff who are driven by their own medicalised goals and focus. (Arthur, Interview 9, p. 23)

Clearly, much of the nursing work within this environment is guided by professional cultural norms that affect *work structure*s. Policies and protocols provide information on the management of technical devices for example. These local policies are not isolated to an individual coronary care unit but reflect the national health policy that is government driven. Developing this health policy has required responsiveness to technological change, as well as to the demographic and social changes experienced by society. (Cheyne, O'Brien, & Belgrave, 2005). Similarly, the New Zealand Health Strategy (Ministry of Health, 2000) sets the platform for the government's action on health and provides the basis on which individual health board's decisions are made. While a major focus of the strategy is quality health services and the reduction of social

inequalities in health, implementation of health promotion strategies at the bedside, seems limited.

Nonetheless, each health board provides environmentally specific rules and regulations in the form of local policies that affect *work structure*s and how nurses and doctors work with their patients at the bedside. According to Manias and Street (2000), policies define the responsibilities of health care professionals, the rights of patients and their families, and other important considerations including legislative requirements. Nurses in coronary care work in accordance with these general and coronary care specific polices, adding to the general/specialty tensions. The adherence to these policies is also a professional responsibility for all nurses, in order to maintain their competence to practice.

The Health Practitioner's Competency Assurance Act's (2003) principle purpose is to protect the health and safety of the public by ensuring that health practitioners are fit and competent to practise. This puts further pressure on nurses to stick rigidly to the policies that are in place as their futures could be put in jeopardy if they do not:

They are scared to change any aspects of practice or to speak up and say this is not right because of fear ….fear of making mistakes, fear of looking stupid in front of others and fear of the recriminations that may follow. Rosie, Interview 8, p.20)

Knowledge of local policies is intertwined with *work structure*s and influences the nursing role. Policies and protocols are fundamental to ritualistic practice, detailing expected standards of care, attitudes and behaviour. Many nurses have extensive knowledge of these protocols and adhere closely to them to legitimise their decision-making. Thus protocols control, structure, enable and constrain nursing practice:

The policies ensure that we give the expected standard of care post angiogram and make it easy for new staff to get on board. They are able to recognise that standard and become competent very quickly. (Nera, Interview 1, p. 2)

Policies and protocols break down nursing work into simple tasks:

Nurses feel under pressure to complete one task so that they can progress to the next, and health promotion activities do not have a concrete beginning or end, and so can be seen as quite impossible…..where and how do I start? (Lalita, Interview 15, p.35)

While policies and protocols provide a certain structure, they can also limit the kinds of knowledge that nurses use. Nurses need to be able to rationalise and justify the decisions they have made in their practice, and this may undermine the interpretative

knowledge of experience. Intuition, for instance, has been particularly associated with nursing and is defined as "something that is based on an individual's opinion justified by the authority of their experience" (Offreddy, 1998, p. 991):

Protocols can be too rigid and not allow experienced nurses to base their care on their intuitive knowledge build from years of experience. Some may miss the quiet patient sitting in bed, scared to move around but others will go and sit on their bed and ask them how they are. This simple approach may well uncover the issues and problems that are worrying him/her. (Nobbie, Interview 7, p.18)

In contrast, policies and protocols focus on objective observation (Thomas, McColl, Cullum, Rousseau, & Soutter, 1999). Nurses regard the various components of their activities through observable steps. These steps form the structure and become the standard where nurses examine each other's practice to ensure that these steps are followed. Any deviation from normal is noticed and that nurse is singled out. This observation has been referred to as the nursing gaze (Cheek & Rudge, 1993) and this attitude is alive and well today. This behaviour and compliance monitoring creates more tension and puts pressure on all nursing staff:

There is pressure on the experienced RNs to perform. These RNs have high expectations of themselves plus the expectations their more junior colleagues on a shift alongside them place on them too to be able to survive the shift. I don't want to draw attention to myself, so I ensure that I follow all the steps and stick to the protocols. (Rosie, Interview 8, p.21)

Thus protocols structure work and increase *environmental pressures*. Similarly, clinical guidelines which build upon impartial analysis of evidence from well designed research studies, have become highly credible sources of information about effective care. They are intended to improve clinical care by describing a set of actions that should be considered when managing patients with specific health conditions and are used in frequently in coronary care. Most of these guidelines are structured to give some flexibility to the work of the healthcare team, which can cause anxiety and tension for new staff who lack the experience to make those decisions in the acute environment. The rigidity of structured guidelines raises anxiety for inexperienced nurses:

Many of their practices are driven by guidelines that new nurses think have to be stuck rigidly to. These are perpetuated by the attitude of senior nurses and nurses in positions of influence and leadership in some cases. They are not having their thinking challenged and the tasks drive the practice rather than individual patient needs and concerns. (Mollie, Interview 16, p.36)

These medicalised guidelines are developed by institutions such as the Cardiac Society of Australia and New Zealand and concentrate on adherence to diagnostic procedures

and medical therapy to aid physical recovery. Whilst the guidelines do include pointers for the psychological recovery, many nurses are frustrated by this apparent neglect of nursing input into current patient management and subsequent recovery after a potentially life-threatening illness:

The guidelines ask is your patient on a statin, taking aspirin? There is little mention of adherence to an exercise programme or dietary input or stress management. These do not seem to be important and as such are not discussed as often as they should be in our practice. These are issues that nurses can easily address but it is not encouraged or supported. (Arthur, Interview 9, p. 22)

Issues that nurses could address are not explicit within the guidelines which largely concentrate on the in-hospital, acute care of these patients. In complex organisations, such as a hospital, routines provide a form of time supervision to provide structure in the acute care environment. The synchronisation of routines in different departments provides much needed continuity of care, but also produce tensions for the nursing staff trying to care for individual patients and possibly promote health. There is a clear tension between the need for structure and ritualistic practice to save life and the flexibility required to care for the human person. Clinical pathways are in use in coronary care providing a time-related plan of management for patients. Nurses in this study followed a routine that outlined the timing for tasks or activities that they needed to complete during their shift, especially with regard to the current interventional focus of medical management:

Nurses are driven by time during the day in the makeup of their shifts….drugs must be administered at these times, the ward rounds are at these set times, angiogram pick ups and collects are continuous throughout the day, and so the hours on the clock and routines are the driving force of the unit…….health promotion has a low priority in the scheme of recording vital signs, administering medication and preparing patients for angiograms. (Joy, Interview 10, p.25)

Routine brings a sense of predictability. Time controls the sequence and duration of activities that need to be completed. Structure allows the nurse to become familiar with the nursing management and enables the nurse to develop a sense of belonging to coronary care.

The tasks and rituals that need to be completed in the shift drive the nurses and other more individual needs such as health promotion are dropped well down, or even off the list of priorities for the day. (Susan, Interview 5, p.12)

Work structure influences the attitudes and behaviour of the nurses within coronary care. Understanding structures allow nurses to be accepted into the team and function in this specialised environment. The usual work and expectations of the CCU nurse focus

on the technology, routines, tasks and rituals, allowing the nurse to determine the priorities of care for individual patients.

Summary

Environmental pressures influence *attitudinal shifting* and the delivery and practice of nursing care. There was a tension between the specialist medically-dominated rituals of coronary care and the generalist nursing role of promoting health. During this stage, nurses ensure that their approach to care delivery meets the needs of the unit that emphasise *work structure* and *technological focus*. The short-term daily nursing goals take precedence over the longer-term, individual, health-promotional needs of the patients. The other effects this has on *attitudinal shifting* will be discussed in the next chapter that examines *practice reality* that shows how the nurse experiences role conflict when trying to promote health but becomes active in the process by watching role models achieving health promoting behaviours with patients.

CHAPTER FIVE
Practice Reality

Introduction

As discussed in the previous chapter, technological competence is fundamental to the nurse in a coronary care unit in order to follow the routines and protocols that support specialist care for patients with a life-threatening illness. The *technological focus* and *work structure* contribute to *environmental pressures* and affect how nurses prioritise patient needs. Nursing practice is driven by medically-dominated practice that undermines nursing health promotional activities. The longer-term, patient-focussed goals do not take precedence, in this medical speciality that is designed to save lives.

Practice reality within CCU, the second stage of the process of *attitudinal shifting,* emerges as the nurse begins to look beyond the technology-driven biomedical model of care. Attitudes to nursing practice begin to change as the nurse sees the individual patient who is the real recipient of this care as a person with their own unique needs, anxieties, values, and understanding of health. The nurse becomes aware that in the everyday *practice reality*, immersion in the medical rituals of practice means that the rehabilitation needs of the patients, especially in regard to health promotion, are not being met. *Practice reality* serves as both a barrier and an enabler, between nurse and patient, in the development of the human-to-human aspect of nursing, which is fundamental to health promotion and lifestyle choice. The two categories that make up the conceptual category of *practice reality* are *role conflict* and *role modelling.*

Role Conflict

Role conflict evolves as the nurse considers the reality of everyday interactions with individual patients and observes nursing colleagues working with patients. Coupled with an increasing competence with the technology-focussed rituals of practice, the nurse reflects on her individual attitude and approach to nursing, especially with regard to meeting the unique needs of each patient.

As we have seen, the coronary care unit is a complicated and pressured environment that is constantly changing. The ability to react quickly to change is a major focus of the

directive rituals of nursing practice as the nurse manages the immediate physical needs of the patient suffering an acute life threatening illness. *Role conflict* is evident as nurses are torn between meeting medico-technological needs as well as addressing the important socio-psychological and health promotional needs that are a necessary part of the process of recovery after acute myocardial infarction.

Savage (1995) recognises the challenges inherent in the shift away from a ritualistic approach to caring *for* patients' physical needs towards a wider, more holistic approach, featuring the concepts of caring *about* patients. This distinction is particularly relevant in this research, where the transition from caring for to caring about patients is part of the *practice reality*:

Caring for patients is the completion of physical tasks in the acute stage using knowledge and skills in an acceptable time frame and caring about patients is the empowering and response to individual concerns, making time to address their individual needs. The emphasis changes during [the patient's] stay and this can cause conflict for some [nurses]. (Joy, Interview 2, p.25)

This change in emphasis causes *role conflict* as the nurse begins to question the differing roles and responsibilities. Patient needs are complex, as are the demands for professional performance and clinical efficiency. Organisational demands combine with personal and professional issues causing *role conflict*. *Work structure*, rituals of practice, patient acuity, time, advancing technology, high patient turnover and decreased length of stay in hospital all affect how the nurse sees health promotion. *Role conflict* is, perhaps, inevitable:

Staffing levels, skill mix and patient acuity influence the time that nurses are able to spend with patients. [Time] is a luxury on days when the unit is very busy with admissions and acutely ill patients requiring technical specialist care. Nurses feel under pressure to complete one task so that they can progress to the next, without really seeing the person and health promotion activities does not have a concrete beginning or end, and so can be seen as impossible. (Joy, Interview 2, p. 25)

Indeed, tasks structure nursing work but the unpredictable nature of that work causes conflict for staff that are unable to meet the physical and emotional needs of patients in the time available:

Time is very important. The work is unpredictable. If it suddenly becomes very busy then nurses focus on the physical tasks to be completed and the focus on the patient as a person with individual needs and concerns gets ignored in the meantime. (Arthur, Interview 11,p. 27)

Time pressures contribute to *role conflict*. Nurses in the study talked about 'clock' time that moved relentlessly on through the hours of the day. Time is limited by patients' physical needs, demands of other departments and other health professionals. Demands interrupt nursing work, limiting nurses' ability to manage time. The sporadic interruptions experienced in *practice reality* make it difficult for nurses to complete any aspect of care:

The number of interruptions we have to contend with when I really want to spend time with a particular patient and his family discussing aspects of their health care and future lifestyle changes can be really frustrating. (Ashley, Interview 14, p. 33)

Frustration adds to *role conflict*. In Greek, two words can be used to denote time, chronos, or 'clock time' and kairos, an 'opportunity not to be missed'. Some nurses, however, like Susan, see time as an opportunity to be used wisely:

I use the opportunities which arise in the course of a day to talk to the whole family not just the patient. The whole family needs to be aware of the changes the patient may need to make and be prepared to support them through the sometimes difficult times ahead. (Susan, Interview 5, p. 12)

Clearly, the individual attitude the nurse has towards time is important. In *practice reality*, time does not speed up or slow down but the nurse's subjective experience differs, potentially causing conflict:

Talking with patients, or engaging in health promotion or education, can be viewed 2 ways: wasting time or a good use of time. I'm running out of time or I don't have time for that may mean that the nurse has underestimated how long their work would take them, or the limits they have set themselves were unrealistic. Time is dragging is often heard when the unit is quiet……..nurses can see it quite differently. (Arthur, Interview 11, p. 27)

Different perceptions of time also affect the quality of relationships with colleagues. According to Irurita and Williams (2001), the work environment, particularly in relation to the demands of the unit, the hospital and the unpredictable nature of their everyday practice, influences nurses' attitudes, behaviour and their working relationships. This unpredictability may decrease personal coping strategies, which contribute to conflict and stress.

Workload, high patient acuity, dealing with acute illness and staff conflict, are well-documented sources of occupational stress in nursing (Maurier & Northcutt, 2000). Stress has a significant influence on each nurse. Sources of stress are both internal and external and may result from unrealistic or conflicting expectations in the *practice reality*. Ritualistic practices, an example of an external stressor, constrain practice:

I am always conscious of the ritualistic aspects of practice that seem to take precedence, admissions, discharges etc. I do not like the emphasis on physical busyness over psychological support but I know why it has to be so. It does cause me some stress that I cannot do all I want for my patient at times. (Mollie, Interview 16, p. 37)

According to Yoder-Wise (2007), internal sources of stress usually stem from unrealistic individual attitudes or self–beliefs. Combine these with the external sources found in the complex *practice reality* of coronary care and *role conflict* is not surprising. The number of available staff on each shift, their skill mix, departmental tensions, the overriding organisational philosophy, rostering practice and workloads all affect nurses' performance, levels of stress and job satisfaction (Adams & Bond, 2000). Similarly, the nurses experience *role conflict* between work and home life:

During a 12 hour shift nurses do get tired. They need some time to recuperate and reprioritise. Working long hours with a young family at home demanding your attention can lead to exhaustion….This causes a conflict for both them and other staff members. (Mata Hari, Interview 4, p. 11)

Staffing remains one of the most pivotal aspects of *practice reality* and causes *role conflict*. Staffing levels are determined by many organisational variables and are controlled by the nurse leader. Jones and Cheek (2003) remind us that nursing leadership is influenced by the culture of the work environment, the nature of the workforce and the educational background of the workers:

Staffing levels, skill mix and patient acuity influence the time that can be spent with patients. You need time and the staff to deliver good quality care, where you are able to be with the patient long enough to address any individual concerns that they may have. (Susan, Interview 5, p. 12)

The severe shortage of nurses in New Zealand means that staffing levels are reduced in many areas. Shortages are due to advances in technology, extended nursing roles and delegated medical responsibilities (Gerrish & Griffith, 2004). Nursing shortages here have been addressed by the recruitment of overseas nurses.

However, requirements for professional nursing registration vary internationally and are a potential source of *role conflict*. When comparing nursing work in New Zealand to overseas experiences, differences in patient management and nursing care are evident. Differing philosophies such as health promotion requires a major change of attitude and behaviour:

The individual culture of the nurse has an impact on their attitudes to practice. Nurses need to value knowing their patient and understanding their emotional needs. Coming into NZ where this approach is considered appropriate means that often [overseas

nurses] need help to develop the appropriate skills to enable them to do this. (Nera, Interview 1, p. 1)

Once again, leadership is critical. Mitchell (2005) comments that when the nurse in charge of a ward is open to new ideas, allows a flexible approach to routines and is supportive of staff, nurses feel able to give more attention to patients' emotional needs. While senior nursing staff within coronary care are aware of this, the demands are complex:

As the senior nurse on duty there are so many expectations set on you that there is little time to spare to sit with a patient and talk through the issues that causing concern. The acute setting, patient acuity, staffing numbers and skill mix, processes and procedures all have priority and impact on our time for individual health promotion. (Nera, Interview 1, p. 2)

Expectations however are often ritualistic. The need to stick rigidly to medical processes and procedures compromises nursing work and has detrimental effects on the quality of care patients receive. This, in turn, affects nurses' skill development and work satisfaction, adding to *role conflict*, as nurses are encouraged to appear busy in terms of observable, ritualistic, physical work. Duffield and O'Brien-Pallas, (2003) suggest that the culture of the workplace affects the learning experience:

Many nurses are scared to speak up and say I need some help here to develop skills because of a culture of fear. (Rosie, Interview 8, p.20)

A culture of fear will not empower nurses to seek help and adds to *role conflict*. While organisational culture inhibits the growth of nurses the nurse leader is well placed to develop appropriate attitudes and professional development in individual nurses. Chapman and Howkins (2001) suggest that valuing nurses and empowering them to develop health promotional skills, for instance, needs action to create a culture where learning is valued. This can, in turn, be a source of conflict for those nurses who are torn between their individual and professional responsibilities in *practice reality*:

There is pressure on the experienced senior RNs to perform to the expectations of local management. These RNs have high personal expectations plus the expectations of them from their more junior colleagues to be able to survive their shift. *(Rosie, Interview 8, p.20)*

Tensions between management, the individual nurse and the patient increase *role conflict*. For example, historically, physicians prescribed tests and treatments without serious inquiry into what patients wanted. Nurses worked under medical direction, perpetuating ritualistic practice. Now, patients are known as consumers and patient choice, empowerment and autonomy are embedded within the Health and Disability

Service Consumers' Rights (Health and Disability Commission, 1996). This causes conflict for nurses who try to do everything themselves:

Nurses also need to know when to refer the patients on to the Nurse Specialists or use other members of the multidisciplinary team who can help with addressing the concerns of the patients using their specialist skills and knowledge. (Nobbie, Interview 7, p. 17)

Interdisciplinary team-work causes *role conflict* as well. Interdisciplinary teams are part of the *practice reality* and challenge the nursing rituals of practice provoking further conflict. Interestingly, Philpin (2002) suggests that anthropologically, ritual serves to maintain social order through reinforcing cultural and social structure. In contrast, Interdisciplinary teams are essential to quality patient care, but can threaten the professional identity and social order of nursing:

Nurses must liaise regularly with members of the interdisciplinary team such as physios, social workers, and psychologists to share knowledge and skills to achieve the best outcome for the patient but they must clarify any misconceptions and assumptions to ensure there is mutual trust and respect amongst team members and that the nursing role is not lost. (Nemo, interview 2, p. 4)

Misconceptions and assumptions arise because of a lack of knowledge of the different roles and background of each discipline. Indeed it is the individual differences between health professionals that make teamwork more powerful in *practice reality*. The patient is now seen as a pivotal member of the team that is critical for health promotion. Nurses must also demonstrate a professional and positive attitude about nursing to their colleagues. Nurses within CCU do not work in isolation from each other and must work as a team to ensure the delivery of appropriate care for patients. This creates further *role conflict* for nurses who are used to organising the needs of the patient around ritualistic routines:

Team dynamics have a great impact on the ability of nurses to undertake health promotion. If some members of the team see it as an extra time consuming job that will not do any good then it is not encouraged and other staff will not want to be seen doing it and upsetting the routine. (Lalita, Interview 15, p. 35)

Nonetheless, *practice reality* in coronary care dictates that the routine will be upset. Nurses must be ready to react to the changes in the environment; priorities have to be continually reset throughout the shift when clinical parameters, patient acuity or the number of patients change. At times of illness or vulnerability, as in an admission to a coronary care unit, the patient's usual freedom to act as a person is diminished. Consequently it is the health professionals' responsibility to preserve the person's moral integrity by providing information about their options for care. Getting patients

involved in their medical decisions can be challenging but an important aspect of health promotion within CCU. Part of the nurses' role is to supply more information or listen to the patient discuss their thoughts, a cause of conflict in a technological, medically-focussed environment:

Doctors tend to tell patients what will happen and what to do….nurses help the patient decide what they can do to help themselves and how, which is more beneficial for the patient. (Mata Hari, Interview 4, p. 11)

Decision-making is complex. It is well known that hospitalised patients' anxiety, depression and hostility decreased when they were allowed to make their own decisions (Deaton & Namasivayam, 2004). Helping patients make decisions about their care and future health strategies affects recovery. This approach, though, is limited by the physical layout of coronary care, creating further conflict for some nurses:

Nurses hide behind the glass, sitting at computers, doing the routine paperwork and are not freely available for patients to chat to and ask questions about their care…curtains separate the beds so it is difficult for patients to talk openly about their concerns and worries. (Arthur, Interview 9, p. 23)

In the *practice reality* of coronary care nursing there is increasing recognition that assessment of patient well-being is as important as physical recovery (Mayou, Gill, Thompson, Day, Hicks, Volmink & Neill, 2000). Each patient's recovery, however, can be severely impeded by individual anxieties and worries regarding future health promotional activities. The tensions are complex:

The setup provides little room for interaction with patients or the involvement of their families. Technology rules. Visiting times are limited but not managed consistently amongst the staff, creating frustration and conflict. The enforced rest period helps to separate nurses from their patients even more and prevents assessment of individual patient well being. (Nobbie, Interview 7, p.17)

Visiting times within coronary care cause further frustration for all staff. The families' need for information and access has to be balanced with the nurses' need to safely manage patient care. In the everyday reality of coronary care nursing, the nurse is not always able to manage the complex, technological care the patient requires, along with the socio-psychological health promotional support, while also emotionally supporting an anxious family.

It is evident that nurses are caught in a tension between the biomedical and the human-to-human focus. The need to respond to the patient's socio-emotional and physical needs is challenging:

What is CCU nursing all about? The technical/clinical skills v the rehabilitative, nursing work that is not understood by others who are often more concerned with bed occupancy states and throughput. (Joy, Interview 10, p.25)

The manner in which nurses conceptualise their *practice reality* determines how they shape the culture and climate of their work environment (Locsin, 2002). The biomedical model of health care, which dominates nursing work within CCU can be a source of *role conflict* for many nurses who want to ensure that the patient and family needs are given the priority they deserve:

*I remember ***** sitting up in bed, looking scared stiff. He was 32 years old with a young family and had been resuscitated the day before. He made me realise that the psychological and psychosocial aspects of his care were as important, if not more important, than his physical care and I made a conscious decision to change my behaviour and attitude to health promotion and rehab from then on. I felt more satisfied in my work.* (Rosie, Interview 8, p.20)

This conscious decision, based on her response to an individual patient's circumstances, propelled Rosie to change her attitude, aspects of her professional behaviour and increase her own job dissatisfaction. In order for nurses to participate actively in this rehabilitative care, discussing lifestyle change, they need to develop good interpersonal skills, to compliment the specialist technical skills required for acute care.

The rituals of practice undermine the open communication and interaction required for health promotion work. Chant, Jenkinson, Randle and Russell (2002) argue that the social setting in which nurses' practice is a key determinant of the application of communication skills and may well inhibit the use of these skills. While clear, concise written documentation is essential, nursing depends on accurate verbal communication, since many management decisions are passed on verbally in the *practice reality*. Patients must also be able to communicate with the nurse who is caring for them. Interaction forms the basis for health promotion strategies for the individual patient. Nurses in the study were very aware of these issues and the frustration they could create for staff and patients alike:

My patient recounted how frustrated he was that he was having difficulty interacting with the varying nursing staff who were caring for him in terms of ethnicity, knowledge and ability to communicate clearly and concisely. (Nera, Interview 1, p. 2)

To succeed in practice nurses must be proficient in both the general interpersonal interactions that comprise everyday social communication, and the specialist coronary

care terminology. These combined communication skills have a huge impact on the work of coronary care nurses:

For some nurses English is their second language. They are able to communicate in English at a social level, not at the more advanced level required for the motivational interviewing and change management techniques, that are a part of health promotion. This creates real role conflict for all nurses. *(Nobbie, Interview 7, p.17)*

According to Chant et al., (2002), effective communication is a key determinant of patient compliance and recovery. When nurses have many tasks to perform, their feelings of being rushed because of a heavy workload can influence their attitude and approach to that communication:

If when the nurse does stop to talk with a patient, they are looking harassed then the patient will not ask questions or feel that their needs are attended to because the nurse appears busy and has more pressing business or priorities to attend to. The body language or image that the nurse portrays will influence the reaction of the patient, and the resulting interaction. (Arthur, Interview 11, p.26)

The urgent physical care the patients require, drives routines and take precedence over the psychological care that relies on communication in a human-to-human relationship. With the nurse forced to determine the priority of needs for the patient, patient psychological and emotional needs are not always addressed appropriately. This is a source of *role conflict* when nurses become aware of the important significance of the individualised care that can empower patients to change unhealthy behaviours and aid in their recovery. This individual awareness is raised by many factors in everyday practice including *role-modelling*.

Role-Modelling

Practice reality acts as both a barrier and an enabler to health promotion for the nurse promoting health with the patient. *Role conflict* evolves as the nurse observes nursing colleagues working with their patients. In this study *role-modelling* is defined as the demonstration in practice of the behaviours and attitudes of nurses that influence and change the practice of others. One of the features of learning in a practice context like coronary care is that experts are able to guide novices through the complexity of practice (Cope, Cuthbertson, & Stoddart, 2000). Clinical *role modelling* can lead to the expansion of particular skills and techniques and is a major influence in the development of professional attitude and socialisation.

In the *practice reality* of coronary care, *role modelling* occurs firstly during orientation where new staff are socialised into the coronary care way of being. The new staff member is a unique individual with their diversity both in terms of personality and experience and is a challenge for the existing group of staff. Mann (1992) suggests during this orientation period, the nurse is interacting with the continually changing environment as well as learning from all interactions with colleagues and patients:

Role modelling is such an important aspect of practice development and the preceptorship experience for new staff is not always appropriate. The individual preceptor and other environmental factors can influence how the new person thinks and acts. (Mollie, Interview 16, p.36)

The new nurse must learn how to access the available resources in this new environment and become a proficient coronary care practitioner. Group dynamics and communication strategies are another obstacle to be cleared and understood. Yoder-Wise (2007) likens this process of acclimatisation to the transition process facing a new immigrant in a new country. As we have already discussed, many nurses have been recruited from overseas and are able to observe the rituals, accepted practices and patterns of communication within CCU with a keen eye.

Role modelling in *practice reality* is facilitated by mentorship. Mentors can be a source of guidance and support for all staff, not just those new to an area. Mentors guide the development of health-promoting nursing practice. McKinley (2004) describes mentor as "a trusted advisor, teacher and wise person". (p. 3). Since Odysseus entrusted the education of his son to an advisor and friend named Mentor over three thousand years ago, the concept of mentoring has become firmly tied to the educational process. Dracup and Bryan-Brown (2004) indicate that mentors facilitate learning by positive modelling behaviours. In the past, the roles of preceptor, role model and coach have often been confused with mentoring. These relationships lack the freely given, intense, long-term commitment and direct interaction that characterise mentoring. Nurses within CCU are very aware of the usefulness of positive *role modelling* behaviours to their individual development:

I chose my mentor because of her particular skills and experience. She has been able to guide my practice by modelling holistic nursing care for her patients with energy and commitment. (Lalita, Interview 15, p.35)

This energy and commitment is fundamental to the mentoring relationship. Staff, though, often feel unsupported by organisational management when trying to initiate and maintain a mentoring programme in a very busy unit:

Mentorship is a useful way of fostering practice development and exchanging ideas and thinking processes with a trusted colleague but it is hard to achieve without a huge personal commitment by the parties involved and very little recognition or support from the employer. (Mollie, Interview 16, p.36)

In *practice reality*, patients expect that they will be advantaged by their care, so individual practice development must ensure that each nurse is adequately prepared during orientation. Time is necessary to practice the skills modelled and consolidate learning. Constructive feedback helps maintain the enthusiasm for ongoing learning. Balancing the safety of the patient with the learning needs of the nurse requires thoughtful intervention from the role models. Nurses in the study were concerned that new staff were not given enough assistance and support in *practice reality*:

The length of orientation is not long enough, often staffing levels and patient numbers and acuity mean that the new person must fly solo without having had the right amount of time to assimilate new ideas about practice and the expected attitudes, behaviours and knowledge needed to be developed. (Mollie, Interview 16, p.37)

Role modelling is also facilitated by nurse preceptors. Nash (2001) defines preceptorship as a structured educational programme in which nurses are prepared to facilitate the transition of newly employed nurses into their clinical roles. Coronary care nurses become preceptors for the new staff employed. Ramunda, Bullen and Patterson (2006) discuss the role of the preceptor who provides the teaching of clinical skills, and acts as a role model with the aim of developing professional skills and enhancing the clinical effectiveness of the learner. For some nurses working alongside a new staff member is energising, affecting attitudes by adding interest, variation and challenge to the usual daily routine:

Their continual questioning, energy and interest in learning is a real boost for the atmosphere in the unit. It makes us all take a fresh look at our practice and ensure our knowledge is up to date. (Nemo, Interview 2, p. 4)

Nurses within coronary care are unconsciously *role modelling* every day. They model their technical skills, and practice along with their attitude and approach to health promotional activities throughout every shift:

I act as a role model and preceptor with clinical specialist knowledge. As a role model, I not only model skills but behaviours and attitudes. It is exhausting in this acute environment. I sometimes feel that I do not have the energy I need to make informed decisions because I feel as if I am being pulled in different directions. (Mata Hari, Interview 4, p. 10)

"Being pulled in different directions" is an aspect of *practice reality*. Nurses have limited time to make informed clinical decisions due to the acute nature of their

patient's illness. This then makes it difficult to ensure that a preceptee has been given an adequate insight into the rationale behind the decision made. According to Freshwater and Stickley (2004) making informed decisions in clinical practice means re-evaluating the relevance of a particular intervention for a patient and learning from experience.

Bonner and Walker (2004) argue that some nurses possess attributes that make their practice superior. They have the ability to do more and achieve more. Such individuals are frequently referred to as 'expert' nurses. Expertise is acknowledged as being contextual (Benner, 1984). In order to develop expertise, a nurse needs to build that experience in a defined environment such as a coronary care unit.

For many patients, admission to coronary care is a critical life situation that can unleash many emotions. Individual reactions can vary from anger to meek submission. Withdrawal from cigarettes or alcohol can add to the stress and anger experienced. While managing such patients is difficult, it is made easier when the clinical nurse specialist in rehabilitation acts as an expert role model:

I saw how she acted, what she did and the way she said things. It really worked…his anger and aggression settled as he began to understand what has happened and why.
(Ashley, Interview 14, p. 33)

The social learning theory of Bandura (1977) emphasises the importance of observing and modelling the behaviours, attitudes and emotional reactions of others. Nursing in CCU requires nurses to interact with a variety of individuals including professional colleagues, clients and families in a high-stress environment. Bandura claims that most learning comes from observational learning and instruction. In this case, nurses observe and then imitate behaviour demonstrated by clinical experts.

Senior nurses within coronary care, some of whom are acknowledged as experts, are role models who are trusted with specific leadership functions. They are shift co-ordinators for example, regularly taking charge of the unit in the absence of the Charge Nurse. These nurses model what is acceptable practice from which other nurses learn. Nurse Specialists[9] also attend patients within coronary care and influence practice:

As a senior nurse specialist I am a role model. Other nurses, patients, relatives and members of the multidisciplinary team monitor my behaviour. I enjoy being able to

[9] An expert senior nurse with advanced knowledge and practice skills in a defined clinical area of nursing.

influence both the unit culture and the standard of care but it can be intimidating and frustrating at times. (Mata Hari, Interview 4, p. 11)

The frustration arises from the times when there has been a lack of skill recognition for the role of health promotion in *practice reality* that is not actively encouraged. Indeed, this human-to human interaction, that underpins health-promotional practice, is often invisible and, as such, is not valued by all nurses, especially those new to the area, or other members of the health care team. This interpersonal work can be critical to support and comfort patients and help them to express their emotional needs. Experienced nurses use it to induce trust and reduce the anxiety and distress that can be experienced by patients and their families:

The individual stories shape the interaction which follows and I never know where the discussion might end up. I am assessing anxiety levels, reacting to body language and particular behaviours…being able to interpret what is often not said due to fear of the unknown, anxiety and concerns about their future. (Nobbie, Interview 7, p. 17)

It is clear that the less experienced nurses within CCU tend to emulate and model the practice of these experienced nurses. They actively seek them out for clinical assistance or advice during the course of their shift. These experienced nurses continuously adapt their work practices and routines to meet the needs of their patients, the coronary care unit as a whole, and the needs of the general acute hospital. It involves working around the various constraints of *practice reality* to offer an appropriate, viable solution for staff and patients:

Experienced nurses use accommodation in their practice every day. They ensure that others needs are met first, alter their schedule to incorporate others, and even problem solve innovative ways of using equipment or supplies when the desired piece is not available. (Mollie, Interview 16, p. 37)

Accommodation is a clear description of the process of working in *practice reality* and is modelled by some nursing staff in coronary care. In addition to the setting, the personal characteristics of nurses, the quality of relationships with colleagues, the resources available, and the degree of collaboration with other disciplines, influence the quality of nursing care. Nurses constantly juggle these issues reacting to the needs of patients and the unit as a whole. Conway, McMillan and Solman (2006) agree that nurses must be driven by the need to respond to the actual and potential needs of the patients within the changing contexts of care inherent in an admission to a coronary care unit. This implies that nurses, in their *practice reality*, need to consider the patients' emotional and social needs:

Nurses need to respond and react to what the patient has told them or not told them. They need to be committed to getting involved with their patient, getting to know them as only then will they find the appropriate way to help the patient on his way back to managing his/her health. The cues or triggers, both verbal and non verbal, that arise are the starting point. This communication is a skill that has to be learned and nurtured through observation and develops with the practical guidance and role modelling of more experienced colleagues. (Lalita, Interview 15, p.35)

This involvement, according to Erickson, Tomlin and Swain (1983), uses skilled communication and allows experienced nurses to develop an image of the patients' unique, individual situation. Understanding the patients' reality helps the nurse to plan interventions with the patient, a vital aspect of health promotion, which is then role modelled by the nurse. The *role modelling* concept used here is the essence of nurturance in that one accepts persons as they are while encouraging and facilitating their growth (Kinney & Erickson, 1990). The more experienced nurse works with newer nurses and the patient to institute appropriate care, thereby nurturing nursing practice development.

Working closely with more skilled practitioners as role models enables nurses to build a bank of situational experiences that guide subsequent clinical judgements, actions and interactions. These learning experiences shape their future *practice reality*. Communication is pivotal to many of these learning experiences, as these role models were seen adjusting and adapting to the ever-changing professional demands during a shift in coronary care. The role models stimulate nurses and inspire them in their professional development as a nurse.

Nurses see other nurses whose care delivery has shifted from the traditional medical model to patient-focussed care. *Role modelling* possibilities alters perceptions of *practice reality*. This is consistent with practice development that seeks to transform care and outcomes in terms of changes in behaviour, values and beliefs of those involved (Garbett & McCormack, 2001). Good role models in nursing education and practice motivate nurses to engage in self-reflection and this shifts attitudes:

In my case it was something a nursing tutor said and modelled in practice that made me reflect on my own approach. I saw it applied to practice and I could see the importance and usefulness of her approach. I tried it and it worked for me, so it then became part of my practice. (Linda, Interview 18, p. 41)

Nurses within coronary care are often found encouraging patients to take responsibility for managing their own health. Promoting health by reducing the individual risks of

coronary artery disease may require modification in diet and lifestyle. While teaching is one intervention most often performed by nurses, nurses also teach themselves. *Role modelling* provides an opportunity to follow their own advice. It can be challenging but according to Underwood (1998), *role modelling* healthy lifestyle practices can make nurses potentially more effective in their *practice reality*:

Nurses do have a role to play as a role model in that they should be able to actively manage their own health, stay healthy, take action to manage their health and understand the processes involved. The age of the nurse does not matter as long as they have the right attitude. (Mata Hari, Interview 4, p.11)

Role modelling healthy lifestyles is a reflection of personal values (Borchardt, 2000). Awareness of self-care patterns and implementing strategies to maintain or change these patterns can be an important step in helping others achieve a higher level of health. Yet, nurses in this study face a number of barriers to modelling healthy behaviours in *practice reality*. Nurses are concerned with taking care of others, and are often not familiar with taking care of themselves. High stress in an acute environment, other duties and obligations to families contribute to the gulf between personal health behaviour and the behaviours that they recommend for their patients:

For some nurses 12 hour shifts allows them to have more time off but they are tired when they come to work and instead of spending their days off recuperating they have been working more shifts at another institution to make more money. They may not eat properly or get enough sleep, which makes me question their ability to model health behaviours to patients. (Susan, Interview 5, p. 11)

Being an effective role model for patients in coronary care stems from practising what nurses teach in *practice reality*. The credibility of the teacher is highly important when attempting to influence people to change their behaviour. The nurse has the credibility, knowledge and often has the trust of their patients, which Nobbie sees as highly important factors in teaching:

Nurses are models of health…patients see them as the caring profession. We have the trust of the public in many cases. We are still working from the sickness model that makes it very hard to push the wellness model, it does effect our credibility as health educators. The modelling is part of the ethos of being a nurse, making a difference for patients, being able to help them regain control, looking at their whole being, and teaching them ways of making positive behavioural changes in their life. (Nobbie, Interview 7, p. 18)

The credibility of the teacher has long been recognised in attitude theory (Festinger, 1957), as an important characteristic of the communicator promoting behavioural change. *Role modelling* healthy behaviours emphasises to patients, that as individuals,

we are agents of our own care which forms the basis of much health promotion teaching.

Summary

In *practice reality,* it is a challenge for nurses to deliver patient-focussed care. *Role conflict* arises from the difficulties providing medicalised, ritualistic care, instead of focusing on the health-promoting needs of the individual patient. Nurses see other nurses *role modelling* health promotion teaching, which is necessary to enhance patient-centred care. These role models motivate nurses to explore their attitudes to practice, leading to practice development. Nurses learn to alter their practice to react and respond to the constantly changing environment. In adapting their practice to suit the individual situation, the nurse responds to the physical and socio-psychological needs of individual patients. At the same time, the nurse must be able to respond and act immediately to manage the needs of the coronary care unit as a whole. The final conceptual category, *responsive action,* a key component of the theory of *attitudinal shifting*, is discussed in the next chapter. The nurse develops his/her nursing practice engaging in self-development, also focusing on the nurse-patient relationship, thereby enabling active patient involvement in individual health-promoting decisions.

CHAPTER SIX
Responsive Action

Introduction

This chapter examines the third and final conceptual category of the process of *attitudinal shifting*. As discussed previously, the tensions created by the medical dominance of the coronary care unit led to the nurses experiencing *environmental pressures* as they struggled to promote health, in a unit constrained by both the *technological focus* and *work structure*.

These *environmental pressures* ensured that the nurse followed protocols and policies, thus prioritising patient needs. With further experience of *practice reality,* it was also evident that nurse participants became aware of both barriers and enablers between themselves and their patient. The main barrier was due to the tension between the biomedical and patient-centred approach to care. Whilst caring for the patient, nurses are not necessarily able to respond to individual patient needs causing *role conflict*. Some, however, learned to manage the tension of the *practice reality* by observing other nurses *role modelling* the process of *attitudinal shifting*.

Clearly, the clinical context of coronary care is dynamic and uncertain. Priority setting is paramount. *Responsive action* conceptualises the way in which the nurse is able to adapt practice to suit individual situations, developing nursing care that encompasses both technical competence and the building of relationships with patients that promote health. In *responsive action* the nurse accepts responsibility to respond to both the physical and socio-psychological needs of the individual patient, incorporating health promotional activities, while at the same time, acting responsibly to meet the needs of the acute coronary care unit as a whole.

The categories that make up the conceptual category of *responsive action* are *self-development* and *interpersonal relationships.*

Self-Development

In this study, *self-development* is defined as the personal and professional influences and motivation that shape nurses' attitudes to practice development within coronary care. While people are intrinsically self-motivated for survival, they are socially motivated by the needs of others. Nurses, for instance, have different motives for their choice of profession. According to Sand (2003), the needs of dominance and confirmation may play a part, as may service-mindedness and a willingness to help and provide care. In this way, nursing has evolved from a simple vocation to a highly complex field of work and nursing roles have adapted accordingly.

It was evident that the participants are unique individuals with different backgrounds, attitudes, and beliefs working together in an acute clinical area; each nurse has varying degrees of self-motivation. Most nursing staff make an informed choice to work in coronary care and their individual job perception influences attitudes to *self-development*:

Why are nurses motivated to come to work in CCU? Do they come to CCU because of the adrenaline pumping action and technology driven environment or do they have a genuine desire to care for people; not just wanting to make them better but wanting to improve their life and future. Some nurses see the regular money and a job that suits their home lifestyle. (Linda, Interview 18, p. 41)

Motivation for *self-development* was individual. According to Webb (2000), motivation has three basic elements. First, motivation starts with a vision. Second, a person loves to learn, and continually seeks out new opportunities. Finally, a person learns from failures and is willing to start over and overcome barriers. Learning from failure impacts *self-development*:

I was frustrated at times by my own lack of specific skills and knowledge in relation to smoking cessation which is such an important area…….I felt that I was letting my patients down, so I made a determined effort to get to the training. (Susan, Interview 5, p. 13)

Many nurses see "letting patients down" as a failure that has potential to stimulate personal and professional development. In a general sense, motivation determines nearly all conscious behaviour. *Responsive action* is a clear example of a conscious behaviour, where the nurse chooses to adapt and accept action for change in any situation. Maslow (1970) suggests that motivation explains our actions, and is an expression of our needs and inner motive powers. Maslow was most interested in our highest need, the need for self-actualisation. According to Maslow (1954), self-

actualisers are primarily motivated by inner growth, the development of potentials and a personal mission in life. Ashley demonstrates this:

I want to do my best for my patients to care for themselves. I know that in order to help them I need to develop my communication skills and my knowledge of cardiac nursing. Working here is exciting and a great opportunity to learn these skills. My goal is to be a nurse specialist. (Ashley, Interview 14, p. 33)

Advancing knowledge and improving personal and professional skills are important motivational factors for nurses pursuing *self–knowledge*. The processes and skills required to facilitate health promotion are multi-faceted. Gaining more advanced skills and knowledge allow nurses to improve patient care through *responsive action.* According to Knowles (1990), adults have changing needs as they go through life. Benner (1982) agrees that the professional needs, interests and attitudes of nurses changed as they moved through their career. Readiness to learn is apparently important:

The nurses' own attitude, understanding, and perception of health, professionalism, and nursing affects their readiness to participate in ongoing education, and their approach to all aspects of nursing in coronary care including health promotion. (Nera, Interview 12, p. 29)

Nurses continually encounter increasing demands to remain professionally up-to-date and competent to deal with the changing demands of nursing (Masterton, 2002). Self – development is, therefore, essential for *responsive action*. *Self-development* and learning are intertwined. Wright and Draper (2002) argue that work-based learning allows nurses to see that their practice expresses unique and valuable knowledge and skill. During this process, attitudes to practice changed:

After I did the heart failure study day, I became much more active in supporting patients to make dietary changes because I could see the usefulness of it and believed it would benefit my patient. (Lalita, Interview 15, p. 35)

Openness, self-esteem and a willingness to try something new is a significant element of *responsive action* and fundamental to promoting health. *Self-development* gives nurses confidence to make change:

There has to be an element of confidence and knowledge to bring about change in practice and be prepared to try something new. If their knowledge of CVD [Cardiovascular disease] is superficial it is hard to make changes in their practice or answer the questions the patients may have. (Rosie, Interview 8, p.19)

Many nurses seek out new knowledge or read up to date literature sporadically. For example, when the professional portfolio is due, there is a great flurry of activity and general interest in the current literature, and new information. At other times, new terms

or information are simply accepted without stopping to work out what it might mean for either the nurses or their patients:

A nurse collected a patient after a 'kissing angioplasty'[10] . She did not ask at the time what this meant. It obviously continued to annoy the nurse as she finally asked what it was about a couple of days later but had made no effort to use the resources that are available to work it out for herself in the meantime. (Joy, Interview 17, p. 40)

Other nurses are keen to develop their skills and knowledge to ensure that that their practice is responsive to the needs of the patient. Mata Hari was able to talk about the catalyst for the development of her practice:

The cardiologist asked me what I did and I was not able to tell him, as I had not worked it out myself. I only knew that whatever I was doing was successful. With the help of my Masters study, I was able to articulate the approach I used and develop my practice. (Mata Hari, Interview 4, p. 10)

Practice development seeks to transform care and outcomes in terms of changes in behaviour, values and beliefs of those involved (Garbett & McCormack, 2001). Those, like Mata Hari, who are open to innovation and new ways of thinking, lead *responsive action*. This approach takes time, effort and energy as *attitudinal shifting* takes place.

The coronary care environment and the ability to become innovative affects engagement in *responsive action*. Innovation is not new to the nursing profession. According to Hughes (2006), nurses' involvement with innovative activities has resulted in significant improvements in the health of patients, populations and health systems. *Responsive action* calls for nurses to find creative and viable solutions for current health challenges:

To encourage the growth and development of nurses in health promotion, there should be an environment that fosters open discussion of ideas, innovation and encourages nurses to experiment in their practice. (Mata Hari, Interview 4, p. 10)

This encouragement supports nurses to look at their own attitudes and *self-development*. There are many opportunities for nurses to adopt different priorities:

You have to be able to change tack quickly at times, when your plan for the next couple of hours goes awry. Priorities can change in an instant and you respond, adjusting your thinking and plan accordingly. You have to be willing to try something new. (Lalita, Interview 15, p. 34)

[10] A new technique for performing angioplasty on a blockage at a point on the coronary artery where it divides into two. A single guidewire tipped with 2 balloons which were then inflated simultaneously.

Thinking and reasoning underpin *responsive action* and the ability to reprioritise work. This is part of cognitive development where accommodation refers to the modification of the individual's internal cognitive structures. When the learner, the nurse in this case, realises that his or her ways of thinking are contradicted by events in the environment, the prior ways of thinking are reorganised. This flexibility is crucial for attitude change and *responsive action*, especially when the nurse considers the patient's discharge:

It's about the ability to try something new and having flexibility in how you manage your time with your patients. I want to be able to send my patient home safely, having anticipated and solved some practical issues that may affect his/her ongoing recovery. (Linda, Interview 18, p 42)

Human care-giving in organised healthcare situations requires that at least some care-givers be flexible in their roles (Peter & Liaschenko, 2004); if not, patient needs would not be met. Nurses are traditionally known as flexible, responsive workers providing patient care 24 hours a day.

Responsive action sees nurses drawing on their previous knowledge and experience in order to adapt practice to suit patient-focussed care. This adaptation is vital for successful health promotion. Henderson (2001) suggests that the context of the encounter seems to encourage or impede the levels of engagement between nurse and patient. Nurses' respond to patients according to previous situations, and experience. Similar patients or situations that were particularly rewarding or difficult guide *responsive action*:

I came on to a night shift and the curtains were drawn around the bed of one of my patients. I wanted to introduce myself and assess his general condition so I put my head around the curtain. He shouted: I need to sleep why can't you all understand that? His reaction made me think, He was obviously frustrated angry and frightened. His reaction was just the same as a man I looked after the week before. (Ashley, Interview 14, p. 33)

This awareness of the patient's feelings stimulates self-reflection and can lead to *self-development* that impacts practice. Many nurses in this study were aware that coming into nursing exposed them to experiences that they would not have had otherwise:

I am a much more confident person now, and I will go and talk with patients and not shy away from the difficult subjects like smoking, where patients need a great deal of support and encouragement to contemplate stopping. (Batman, Interview 6, p. 14)

Self-awareness determines *responsive action*. Self-awareness also affects emotional intelligence, which has grown in popularity over the last two decades (Goleman, 1998):

The nurse's self-awareness is also very important. Their emotional intelligence, if you like, is crucial to detect and act on the emotional cues and hints that the patient gives out. (Nera, Interview 13, p. 32)

Emotional intelligence affects every nursing action (Freshwater & Stickley, 2004). It is not enough to attend to the practical procedure or technology without considering the human recipient of the process or the emotions engendered:

Being tuned into patients emotions; and anticipation of what it may mean to have a major health event in their life is really vital. I put myself in their shoes and think this person was well yesterday, going about their usual business and now see where they are. I know if I was in their shoes I would be very scared. (Linda, Interview 18, p. 42)

Understanding a patient's emotions is a skill that develops with experience, and is a vital consideration in health promotional activities. Self-regulation influences *self-development* as well, allowing the nurse to work in a calm, professional manner regardless of their own emotions and attitudes, especially in times of crisis or conflict. A sense of stability and reliability seems to underpin *responsive action*:

I have developed a way of ensuring I remain as calm as possible in an emergency by adapting my breathing and concentrating on administering the technical care. Once the emergency is over I can provide the emotional support and care the patient and their families require. (Nemo, Interview 2, p. 4)

Nurses experience positive and negative emotions such as joy, excitement, frustration and anger in the course of *responsive action*. Engaging with patients at a personal level is satisfying, but it is also skilled, demanding work that is stressful and exhausting (McQueen, 2004):

This kind of care takes a commitment and a giving of self that many nurses are not able to give all of the time as it is very tiring and trying at times and is often not recognised by others. (Joy, Interview 3, p. 5)

This commitment to work of this nature can potentially lead to burnout (Benner & Wrubel, 1989). If nurses are to take *responsive action* they need to develop coping strategies to ensure their own physical and mental health. As we have seen, the nurse as a role model for health is an important aspect of promoting health for patients.

Reeves (2005) argues that emotional intelligence also includes being able to accurately identify personal attitudes, strengths and weaknesses, and possibilities for development:

I would love to undertake a counselling course where I could improve my listening skills. I often do not hear what the patient wants/needs me to hear as I am only listening with one ear, while thinking about my next duty. (Lalita, Interview 15, p. 35)

Listening is an important nursing skill especially when linked to *responsive action.* Nurses are often "listening with one ear" while undertaking physical tasks or rituals that take their attention and concentration:

I know that health promotion is part of my role as an RN in CCU and I have to do it, it is my responsibility as a health professional. (Ashley, Interview 14, p.33)

Nurses have obligations and responsibilities to the patients in their charge and are individually accountable for caring for each patient. This is a major component of *responsive action*. The Nursing Council of New Zealand governs the practice of nurses by setting and monitoring standards that ensure safe and competent care for the patient. There are four domains of competence for the registered nurse scope of practice (Nursing Council of New Zealand, 2005).

These domains are the basis for much of the nurses' professional *self-development*. The competencies within each domain have been designed to be applicable to registered nurse practice in a variety of clinical contexts and take into account the contemporary role of nurses who "…advise and support people to manage their health" (p. 2). Nurses in coronary care see this as a very important role:

The support and advice we give must be relevant to the individuals' condition; and pertaining to their individual lifestyle. (Nera, Interview 1, p. 1)

Within *responsive action*, active health promotion through lifestyle change is a complex process. Welsh (2004) claims that, while many nurses' technical abilities are beyond doubt, their communication skills are lacking, which makes it difficult for them to respond appropriately to their patients' individual needs. For nurses used to working in a technological environment, the shift away from the bio-medical model to the health-oriented model requires a philosophical shift, as well as a change in thinking:

Nurses in CCU now appear to have duplicity in their role that many may not be aware of when they come to a unit. They have to develop a number of new skills and many find this difficult. (Arthur, Interview 9, p. 21)

Indeed this duplicity comes about because of the narrow view of nursing that is currently portrayed locally. In contrast, the International Council of Nurses' (2002) definition of nursing includes promotion of health, prevention of illness and care of ill, disabled and dying patients. It is these goals that should frame *responsive action*, not the tasks and rituals that continue to dominate thinking. Personal and professional *self–development* however help to alter that thinking:

Nurses need to find current knowledge and valid research information and evidence, not opinion. This will perhaps help to change the thinking about their professional role.
(Mata Hari, Interview 4, p. 10)

O'Rourke's (2001) model, cited in Daly, Speedy and Jackson (2004), is based on three professional role components: scientist, leader and practitioner. These factors function to form an integrated set of expectations and competencies for *responsive action* that are included in Professional Codes of Conduct. For example, the four principles that underpin the Nursing Council of New Zealand Code of Conduct for Nurses and Midwives (2001) ensures that the nurse:

- Complies with legislated requirements
- Acts ethically and maintains standards of practice
- Respects the rights of patients/clients
- Justifies public trust and confidence

These principles shape nurses' thinking and decision-making processes and are the basis for the *responsive action* nurses take to ensure that their patients' needs are met within the acute coronary care unit.

Self–development allows nurses to change their attitudes, values and behaviours to practice patient-focussed care. *Self-development* also helps nurses improve the information, education and support that they provide for patients and their families whilst undertaking health promotional activities. These consultation and communication skills are an intrinsic aspect of the *interpersonal relationship*, between the nurse and the patient, the second category within *responsive action*, which is discussed next.

Interpersonal Relationship

In this study, the *interpersonal relationship* describes the nurse-patient interactions that are fundamental for *responsive action*. These interactions demand good interpersonal skills that allow nurses to communicate effectively with patients and families when promoting health. This relationship has a different structure from general *interpersonal relationship*s as it is role-orientated and relates to the patients' specific needs, both physical and psychological, during a time of acute illness. People needing hospitalisation have clearly identified the need to be listened to, given respect for what

they are suffering and have their situations understood, as being important to their health, comfort and healing (Millar, 2001). All these factors affect *responsive action*.

A common theme in these factors is interpersonal skills. Peplau (1988) states that nursing is an interpersonal process and often a therapeutic one. She maintained that although many of the actions of nurses are technical, the nurse's interpersonal skills are the most important part of the nursing role. Peplau stresses that interpersonal interactions between a patient and a nurse often have more of an effect on the outcome of a patient's problem than many technical procedures. Many participants were aware of this:

Nurses need to value knowing their patient. To do this they need to spend time building a relationship. Responding to the needs of the patient is part of the caring aspect of nursing. (Arthur, Interview 9, p. 21)

Care and caring are frequently connected with nursing. Indeed Leininger (1984) argued that caring was the essence of nursing. Nurses in coronary care agree:

Assessing the individual needs of the patient and responding to these is part of being a caring nurse. (Mata Hari, Interview 4, p. 10)

Responsive action, therefore, provides a framework for caring behaviours. Basset (2002) suggests that the lay person's perception of the nurse is that of physical carer, assisting with medical treatments and interventions as well as assisting with activities of daily living. The acutely ill patient in coronary care, experiencing severe chest pain, wants a nurse to respond to those needs immediately, by following the correct routines and procedures:

Once the patients are stable, we are able to encourage patients to ask questions and talk about their concerns or fears. This allows us to get to know the individual and build a relationship. We can use this knowledge in our future teaching when the patient may be more receptive to new ideas. We may not even get that far though, as the need for them to talk about themselves in this situation is paramount. (Linda, Interview 18, p. 42)

Building the nurse-patient relationship is a crucial step in the process towards helping the patient to recover (Castledine, 2004) and incorporate health promotional activities into their future. This 'getting to know the patient' is the first of the four discernible phases of the nurse-patient relationship described by Peplau (1988) and a necessary component of *responsive action*. Nurses in this study see it as a vital part of their work:

Building the relationship with the patient is vital. The environment of the CCU can be daunting. The use of humour to build a rapport with patients is a useful strategy. I have been called a breath of fresh air by some patients and I think it is my maturity and

previous years of nursing experience that allows me to be confident enough to use humour appropriately. (Susan, Interview 5, p.12)

This positive approach and attitude towards the patient nurtures the *interpersonal relationship* between nurse and patient and has a positive impact on the patients' well-being. Tarlier, Johnson and Whyte (2003) suggest that building responsive relationships with patients may be one way in which individual nurses influence health promotion. These relationships are founded on respect, trust, and mutuality:

This interpersonal time helps build the relationship and fosters trust and respect and the notion that we work as a team. (Lalita, Interview 15, p.34)

Trust, while grounded in personal morals and attitudes, is also related in a fundamental way to professional qualifications, skills and competence (Tarlier, 2004). The nurse-patient relationship has also been viewed as the moral foundation of nursing, necessary for the professional commitments of beneficence, nonmaleficence and patient advocacy (Whittemore, 2000). The moral obligation to establish trusting relationships with patients is inherent in nursing codes of ethics and, therefore, is an expectation of the profession. In a dynamic health environment, like coronary care, trust is an important element improving individual patient care, incorporating health promotional activities into *responsive action*. Competent care most often refers to the nurse's expertise using skills and knowledge in the delivery of the hands - on physical care, but this can be seen as very advantageous when building a responsive relationship:

Patients trust you because you are able to use the equipment and technology; you have managed to make them feel physically better, so they are more likely to listen to what you have to say about other health issues and lifestyle changes. (Arthur, Interview 9, p. 24)

With trust comes respect for others, which is inherent once again in nursing standards of practice and codes of ethics. Treating others as equal, listening to their concerns and making genuine attempts to understand one another are characteristics of respect that the nurses in coronary care acknowledge as being critical to the *interpersonal relationship*:

The ability to engage and develop trust with patients comes with experience. The confidence to really listen to [the patient] and then respond to what you have seen and heard. This signals a genuine concern. (Batman, Interview 6,p. 15)

Visual signals affect the initial interaction. The nurse's appearance, attitude and manner can encourage the development of an *interpersonal relationship* that impacts on any health promotional work. In pressurised environments such as coronary care, McQueen

(2000) suggests that their feelings can easily spill over to their manner and behaviour, affecting the nursing response:

The first impressions gained at the initial nurse-patient encounter and the responses shown make a huge difference to how that relationship develops over time. If we do feel rushed and harassed, then we have to learn to manage these feelings so they do not affect our practice. (Linda, Interview 18, p.42)

Managing feelings and acting responsively calls for emotional work on the part of the nurse, which is made much easier when the entire nursing team supports each other to ensure patients get the quality care they require to meet their individual needs:

Spending time with patients is made much easier when the people in the team are well supported by colleagues. If I can trust my colleagues to support me then I will feel able to try to help with education and information, knowing that some of my other responsibilities or duties are being attended to. (Ashley, Interview 14, p.32)

Indeed if there is to be appropriate *responsive action* to meet individual patient needs, including health promotion, unit staff must work together to support colleagues and ensure the unit needs are also met. Staff must be able to function together as a team. Team members must be able to communicate with each other effectively, be able to co-operate with each other and be committed to achieving their objectives (Yoder–Wise, 2007). The diversity of the individual team members help the team to adapt to challenges and this can only be done through communication:

Team dynamics have a great impact on the ability of nurses to undertake health promotion. Nurses must have thoughtful, supportive and meaningful interpersonal relationships with their colleagues. (Lalita, Interview 15, p. 35)

*Interpersonal relationship*s with colleagues flow on to nurse-patient work. Relationship is by definition a spatial term, and there is a close proximity between the attending nurse and the patient. It is this close proximity that allows nurses to take appropriate *responsive action*:

Bed-making, showering, medication administration, preparation for procedures are all opportunities to build a relationship with the patient. (Joy, Interview 10, p. 25)

A nurse could shower a patient with little or no interaction and complete the task successfully but through the individual nurse's approach that same shower can become a vehicle for the psychological and emotional support essential for successful health promotion. Experience and interpersonal skills help give the nurse confidence to use these opportunities to get to know the patient and act responsively:

Getting to know the patient is the starting point. Patients within CCU are often in shock or denial about what has happened to them. Sometimes we just need to be there for them. (Mata Hari, Interview 4, p. 9)

"Being there for them" is a way of being present with the patient. Presence, is an interpersonal process, which according to Finfgeld-Connett (2006), requires nurses to have personal and professional maturity and base their practice on the moral principles of commitment and respect for individual differences. By acting responsively in any given situation, the nurse might take more time than is usually required, providing the patient with an opportunity to confide in the nurse. This can result in patients' reporting enhanced mental well-being, decreased stress and increased coping (Easter 2000), enabling them to consider future health promotional activities positively. In addition, patients report specific changes in physical health such as decreased pain. Nurses in coronary care have experienced this too:

In my experience the nurse's presence and use of empathy can make a difference to the patients' physical state including relief of pain, improved pulse and respiratory rates, and reports of reduced worry and anxiety. (Linda, Interview 18, p. 42)

Empathy is a term widely used and written about in nursing and, as such, its meaning and application has become blurred. Reynolds, Scott and Austin (2000) suggest that although empathy is important to the goals of clinical nursing and the achievement of favourable outcomes for the patients, nurses have been shown to show low levels of empathy. In a medically-dominated, technology-driven environment like coronary care, empathy may not be valued.

Empathy is an essential component of health-promotional nursing within coronary care. Empathy can also be risky (Boston, Towers & Barnard, 2001), requiring effort on the part of the nurse, self-confidence, an ability to listen, courage to delve into patients' distress, pain or suffering. As nurses listen to patients' experiences, nurses become vulnerable. In *responsive action*, this ability to empathise sees nurses knowing implicitly what to do for the patient. Responses could include both verbal and non-verbal interaction:

I spent time with my patient, listening to her. I held her hand, allowing her to talk quietly about how she nursed her husband before he died. He had terrible pain and she was scared that she would too. After she had finished telling me her story, she felt more comfortable and reported less pain. (Batman, Interview 6, p. 16)

Easter (2000) describes how nurses experience improved mental well-being resulting from presence, including satisfaction, revitalisation and self-confidence. This can only improve the quality of the *interpersonal relationship* nurses are able to form with their patients, and the quality of nursing care. Batman continues:

I felt really satisfied at the end of my shift and looked forward to coming back the next day to see her and help her take part in her health care. (Batman, Interview 6, p. 16)

Taking part shows that patients have an active role in their health care. The increasing interest in partnership in nurse-patient relationships is associated with recent legislation concerned with human rights and the direction of the New Zealand Health Strategy (Ministry of Health, 2000) encouraging health promotion. The process of creating this partnership involves developing an *interpersonal relationship*. The partnership is seen as a means of achieving positive health outcomes:

I like to think I am building a partnership with my patients, enabling them to decide which risk factor or health issue they are going to be able to address first. (Rosie, Interview 8, p.19)

Partnership working can be seen as an association between nurse and patient where each has something to contribute to a shared goal. *Responsive action* enables patients to participate in their care, a challenge for many nurses used to having the authority and power to make decisions for patients. The nurse patient relationship is the vehicle for the exchange of information and the transfer of power. Kennedy (2003) argues that traditional power in health care was based on the concept of expert knowledge. With the changes in approaches to health care, recognising the importance of biological, social, spiritual and cultural factors, which are so important in health promotion, the patient is now acknowledged as having expert personal knowledge:

[The patient] was given the appropriate information regarding the use of the drug, the pros and cons were discussed and the patient made her own decision based on her own experiences and knowledge which was respected. (Mata Hari, Interview 4, p. 11)

Kennedy (2003) agrees that patients can have greater knowledge of the varied symptoms and the effect of the disease processes, and medical therapy have on their health and the relative importance of each of these on their individual circumstances. Clearly, nurses are involving their patients, actively responding to their individual needs and concerns and encouraging their participation in health care. This can be only achieved through the building of the *interpersonal relationship*.

Increasing patient involvement in decision-making is the focus of empowerment and central to *responsive action* and health promotion. The character of the *interpersonal relationship* depends on the interaction that occurs. Millard, Hallett and Luker (2006) describe two dimensions of interaction: social and professional. The social dimension involves the exchange of personal information that is over and above that which is

required for polite social interaction. Professional interaction focuses on issues relating specifically to the patient's condition. Nurses in this study were aware of the function of the social dimension of their interaction:

By first talking about family or movies or books, we acknowledge the patient as a unique individual. We are equals, if you like, and this carries over into our discussion on health issues or lifestyle changes, where the patient feels able to contribute and become involved in decision making. (Lalita, Interview 15, p. 36)

This level of involvement may not always be possible during acute illness. On admission to coronary care, the patient seeks medical advice at a time when their ability to think or rationalise is clearly diminished due to the physical symptoms they experience. The nurses in this study were aware that many patients are reluctant to make their own decisions:

As nurses we are helping the patient help themselves by giving them the ideas and information to make the choices that will work for them. For many patients they have never thought about their health before, and they are scared to make their own health decisions. They want our help and advice. (Nemo, Interview 2, p. 4)

Empowerment is integral to health promotion and as a concept is a collection of facets that enables an individual to make health choices (Davies, 2006). Coronary care nurses interact with people during intense and critical life situations when patient empowerment is challenging:

Empowering patients to make their own decisions is at times difficult. They do not want to be a bother and will not ask questions, so the nurses must actively initiate the communication and show concern and interest. (Susan, Interview 5, p.13)

Christensen and Hewitt-Taylor (2006), argue that the *interpersonal relationship* is central to patient empowerment. This involves clear communication and a commitment to giving comprehensible, unbiased information:

The language and ideas are new to many of our patients, so it must be simple to understand and be relevant to that individual. (Rosie, Interview 8, p. 18)

The ability of patients to understand and process the health information is important. Nurses within coronary care are aware of the concept of health literacy and are in an ideal place to identify individual health literacy issues. Ensuring patients have the skills necessary to interact with the healthcare system, an important element of health promotion, comes from the *interpersonal relationship* between the nurse and the patient and their family:

Explanations and discussion can happen during all aspects of care, providing that the patient is pain free. I put ideas and concepts forward to them and see what response I

get. The family must be included so they understand what is happening, especially where the patient or has low health literacy levels. (Linda, Interview 18, p. 42)

The definition of health literacy has evolved over time to reflect the skills patients need to understand their health. Ratzen and Parker (2000) argue that health literacy involves more than just being able to read health information. Health literacy involves skills in listening, arithmetic, problem-solving and decision-making, which are influenced by culture and society. Cognitive abilities, social skills, emotional state and physical condition are factors that affect the interaction.

Nurses in coronary care have an obligation under *responsive action* to provide health information that their patients can understand. Discussion about the patient's illness presents nurses with the opportunity to identify and address individual risk factors. As we have seen in the background to this study, smoking has been identified as one of the three major risk factors for heart disease. Smoking cessation guidelines (New Zealand Guidelines Group, 2002) recommend that healthcare professionals should assess patients' smoking habits and give smoking cessation advice where possible. Because acute hospitalisation provides the opportunity for smoking cessation, opportunistic health education must be undertaken (Whyte, Watson & McIntosh, 2006):

Stopping smoking is a major issue. Nurses must respond to the smoking issue by discussing the benefits of stopping and raise awareness of the help that is readily available to support them. Acknowledgement that it is hard is essential. [It is important to] Encourage the patient to make their own decision once they have all the appropriate information to think over. (Mata Hari, Interview 4, p.9)

Responsive action requires an assessment of readiness to learn:

If they are not ready to accept or listen to the ideas we offer then there is little point in continuing at that time. I go back later, assess their readiness and try again, we cannot just give up. (Rosie, Interview 8, p. 20)

Readiness to learn aims to identify the patient's willingness to discuss the topic and their need for information on smoking as it relates to their immediate circumstances. At times in CCU, despite the patient's willingness to discuss smoking, nurses must concentrate on the complex physical tasks and procedures and the opportunity to promote health passes. However, health issues may have to be followed up at a more appropriate time:

Prioritisation is vitally important in the acute area. Relief of pain or the administration of life saving drugs obviously take priority over patient education and support. There will always be a time when you are able to stop, review the current situation in the unit and go back to spend time with your patient. (Nemo, Interview 2, p. 4)

Setting priorities involves making decisions about the significance of patient needs and about the actions that should be made in response (Hendry & Walker, 2004). This is not easy in an acute coronary care unit. The priorities set should take account of the patient as a whole person, which can only be achieved through the establishment of effective *interpersonal relationship*s.

Summary

Responsive action ensures that while enabling and supporting patients to make decisions regarding lifestyle changes, nurses must be able to respond appropriately to the complex coronary care environment at any time. Clinical priorities must be addressed and reset when clinical parameters, patient acuity or patient numbers change. Health promotion and the associated lifestyle factors associated with coronary heart disease is an increasingly important aspect of the nursing role in coronary care. *Self-development* allows the nurse to develop practice extending personal and professional knowledge, challenging attitudes and behaviour. The *interpersonal relationship* and the quality of the nurse-patient interaction enable the nurse to actively involve the patient in personal health care decisions. *Responsive action* sees the nurse responding to the physical and socio-psychological needs of the individual patient, while attending to the needs of coronary care unit as a whole.

CHAPTER SEVEN
Discussion and Recommendations

Introduction

In the previous three chapters the findings of this study have been presented. The aim of this study was to use the grounded theory approach to discover the main concerns of nurses promoting health in an acute coronary care setting and to explain the processes that nurses used to integrate health promotional activities into their practice. The research question was: What is the main concern for nurses undertaking health promotional activities in coronary care? The main concern for nurses promoting health within coronary care was *ritualistic practice.* This concern was resolved via the socio-cultural process of *attitudinal shifting*. The three conceptual categories, *environmental pressures*, *practice reality* and *responsive action* are the main components of the theory of *attitudinal shifting.*

This final chapter opens with a discussion of *ritualistic practice*. The core category, the process of *attitudinal shifting* is examined next. Then, the findings of the study will be discussed and three main themes: medical dominance, patient-centred care and politics and practice are critiqued. The implications of the study for nursing practice and education are considered, along with further research. Finally, the limitations of the present study are considered.

The Main Concern: Ritualistic Practice

The research results indicate that the main concern of nurses promoting health in coronary care is ritualistic practice. In this study, ritualistic practice concerns the medically-based protocols, routines, language and technology that shapes and drives nursing practice in coronary care. As has been carefully illustrated, the success of coronary care units remains highly reliant on the clinical expertise of nurses who carry out medically delegated roles that, in this study, can be described as ritualistic. This is hardly surprising as current in–hospital management of acute cardiovascular disease based on the evidence from large clinical trials, promotes technological treatments and interventions. Nursing in coronary care is dominated, therefore, by this biomedical positivist approach. This focus on health problems rather than health potential is at odds

with contemporary approaches to health promotion, thus placing the nurse, as health promoter, in an invidious position.

In an acute illness, patients admitted to CCU want and need to be cared for by nurses who have the technological knowledge and competence required to meet the contemporary management of acute coronary syndrome. However, when nursing focuses on health problems rather than health potential (Lindsey & Hartrick, 1996) medical protocols result in ritualistic nursing practice:

Much of the nursing practice is driven by ritual. For example; adherence to routine and time related activities, pre and post angiogram care, protocols for blood tests, medications to be administered. (Nobbie, Interview 7, p. 17)

Ritualistic practice, or ritual action is often associated with lack of thought and logic (Walsh & Ford, 1989), relying on tradition or the way it has always been done. Conversely, in this study, the phrase ritualistic practice supports a sense of nursing professionalism. Technological competence, coronary care rituals, are associated with quality nursing care:

The rituals within the protocols ensure patients receive the quality of care they require. They also allow nurses to learn skills and prove their competence. (Nera, Interview 1, p. 2)

The protocols, the rules that are 'driving' or guiding the nursing practice are seen as useful learning tools. This approach is supported in the literature in which protocols and guidelines are often used interchangeably in the literature as a means to guide practitioners' decision – making (Fennessy, 1998). This was true of the nurses in this study who indeed used protocols and guidelines interchangeably. Flynn and Sinclair (2005) argue that guidelines are broad statements of good practice whereas protocols offer a specific framework detailing precise steps of care, or rituals, that are particularly useful for staff who are new to the environment.

In contrast, Walsh (1991) places ritual in opposition to professional practice arguing that ritualistic nursing practice is unprofessional, as it is based on tradition and myths. The medically-based rituals of practice within coronary care do serve to restrict the options that are open to the nurse. The nurses in this study spoke about protocols limiting their choices in everyday practice. The protocols concentrated their attention on the disease process and associated technological support, restricting nurses'

opportunities to focus on the human–to–human relationship, a key aspect of patient-centred care and health promotion work.

Medical protocols ritualise nursing practice, detailing expected standards of care, attitudes and behaviour, not only of the coronary care unit, but the larger acute care hospital. In this respect, ritual maintains the status quo, potentially stifles innovation and new ways of practice. This is in keeping with an anthropological analysis of ritual, focussing on its importance for reinforcing cultural and social order, expressing the values of that society (Helman, 1994). The routine and rituals of the wider systems driving the organisation as a whole filter down to the bedside and influence the nursing practice within coronary care. The rituals of other departments were clearly impacting on the work of the nurse in coronary care, as seen in *environmental pressures*, limiting opportunities for health promotional activities.

The rituals inherent in protocols have been criticised. SmithBattle and Dietkemper (2001) liken them to cookbooks providing the recipes that nurses blindly follow, often ignoring the contextual, individual patient-related professional judgements that are an important part of quality nursing practice. This step by step, recipe-following approach affects nursing autonomy and individuality, constraining attitudes, beliefs and behaviour, and restricting the nurse's ability to pursue individualised health promotional activities. Clearly, in this study at least, the shift from the emphasis on care based on acute intervention to a rehabilitative, educative model emphasising self-care is difficult. This attitude is not particularly unusual. Conway, McMillan and Solman (2006), for example, argue that a lack of preparation for this new role can contribute to the dependence on ritualistic practices that have little to do with promotion of health or patient empowerment. That was clear in this research as many nurses spoke about the *role conflict* experienced, and it was only the highly experienced nurses that could move beyond the technology to focus on patient-centred care.

Whitehead (2001, 2002) identifies that nurses predominantly adopt the medical/preventative method of health education. This is a strong finding of this study where nurses focussed very much on the acute illness, enabling patients to be fully informed about their stay in coronary care and discussing the specific medical management and interventions. This is a further example of ritualistic practice, where the nurses spend time explaining medical, disease-based management strategies. Health

promotion, on the other hand, enables people to take action to improve their overall health (Nutbeam, 1998). It is not carried out on or to people but *with* people, emphasising partnership and participation in the nurse–patient relationship.

The rituals and routines associated with clinical nursing practice in coronary care prevent nurses from achieving a patient-centred model of care, which is necessary for health promotion. Copnell & Bruni (2006) suggest that change in clinical nursing practice is a rational process, synonymous with progress. Many of the changes in coronary care nursing are associated with the sustained progress in medical technology. Many of the rituals are associated with that technology. As we have seen, nurses actively seek technological competence, viewing technical knowledge and mastery of skills as a key to success. In this research, nurses were able to move beyond these restraints to focus on patient-centred care through the process of *attitudinal shifting.*

Resolution: The Process Of Attitudinal Shift

The opportunities for nurses within coronary care to actively incorporate health promotional activities into their practice are huge but many nurses' attitudes are limiting that practice. (Nobbie, Interview 7, p. 17)

It is clear to see from this quote that nurse's attitudes are limiting health promotional practice in coronary care. However, it was also evident that in order for health promotional activities to occur, nurses manage ritualistic practice through a process of *attitudinal shifting,* moving their practice away from the predominant medical model to a patient–centred approach.

In this research, *attitudinal shifting* is a socio-cultural process that occurs over time involving three stages. The influence of medical technology and *work structure*s within coronary care shape nursing practice, where the short-term nursing needs take precedence over the longer-term health promotional needs of patients. In the second stage, nurses become aware these needs are not being met in everyday practice and experience *role conflict*. Nursing role models motivate nurses to explore their attitudes to practice, leading to *self-development* and a change to a patient-centred approach. Nurses are able to adapt their practice to encompass both technical competence and the *interpersonal relationship*s that promote health, so meeting the needs of the acute coronary care unit.

This process is individually driven as the nurse makes a conscious decision to engage and participate. There is a choice between moving forward into *responsive action* or moving back into medically dominated care. *Attitudinal shifting* is driven by the *practice reality* that is the catalyst where the nurse experiences personal and professional *role conflict* while observing other nurses modelling care delivery which is driven by the needs of the individual patient whenever possible. Nurses observe other nurses working in partnership with patients, introducing aspects of health promotion such as lifestyle-change into their practice.

According to the Oxford Concise Dictionary, attitude is described as a settled mode of thinking. Fishbein and Ajzen, (1975) agree, arguing that attitudes are learned predispositions to respond consistently towards a given object, person or event. In this study it seems clear that the rituals of practice are both medically and nursing based. While *ritualistic practice* is an attitude or mode of thinking, in this study attitude moves as nurses swing between medically based protocols vital for the acute management of patients with myocardial infarction to medical-nursing approach to health promotion.

Attitude, however, is a choice, reflecting personal values, self-awareness, knowledge and influences. As the data indicated, many nurses in this study made an informed choice to work in coronary care. Their personal and professional needs, interests, behaviours and attitudes shifted over time because of the choice they made to change their area of work. According to traditional attitude theory, attitude development and change are influenced by four factors: exposure to new information, enforced behaviour modification, changes in group affiliations and increased self-insight (Fishbein & Ajzen, 1975) all of which influence the process of *attitudinal shifting*.

A shift concerns a change, involving movement or rearrangement from one position to another (Collins Thesaurus, 2005). Nurses in this study made an individually-driven, conscious, decision to shift away from the traditional, medically-based model of care to a patient-centred model necessary for health promotional activities.

As a result, *attitudinal shifting* is defined as the tension between medical practice and the professional nursing judgements the individual nurse makes in the course of his/her practice. Attitudinal change is cognitive, behavioural and affective.

Historically, the most prominent framework for the study of attitudes has been the three-component model: attitude is an observable psychological construct which can manifest itself in relevant beliefs, feelings and behaviour (Katz & Stotland, 1959). Breckler (1984) argues that this model provides a way of cataloguing various attitudinal responses. Newer conceptualisations of the attitude construct argue that the means of attitude formation covers thinking, emotions and behaviour. The findings in this study indicate that nurses focus on the expected behaviours. Becoming competent in the medically-dominated technical tasks and skills are their key focus during their orientation, where their attitudes to working in coronary care are first formed.

Fazio and Olsen (2003) contend that an attitude is formed on the basis of cognitions when you believe either that the attitude object possesses (un)desirable attributes, or will bring about (un)desired outcomes. Emotional reactions to the attitude object form the affective route. These reactions are either positive or negative. Attitudes can be learned when considered as a response or reaction. Attitudinal responses that lead to positive outcomes are likely to occur again in the future and those that lead to negative outcomes are less likely to reoccur. Nurses in this study viewed technological competence and the focus on the disease as a key to success in coronary care. As nursing work did not seem to be encouraged or valued, nurses ensured that the medical tasks were completed successfully.

Attitudes are often described as positive or negative, so there can be a wide range of difference in groups of individuals views on a particular topic. For example, the range of attitudes toward culturally diverse groups can be viewed along a continuum of intensity from hate » contempt » tolerance » respect » celebration/affirmation (Lenburg et al., 1995). Differences in attitudes may cause conflict in groups, arising from a feeling of incompatibility. The tension between the specialist medically-dominated rituals and the nursing role associated with promoting health is clear in this study in *environmental pressures*. Conflict arising from the differing attitudes of nurses to time and the unpredictable nature of their work can be clearly seen in *practice reality.* The individual nurse's response to a patient's unique circumstances also caused conflict. These, therefore became the catalyst for *attitudinal shifting*.

The new experiences the nurses in this study gained through *role–modelling* while working within coronary care, shaped their own *self–development*. Aspects of practice such as individual beliefs, attitudes and values were also further developed, sowing the seeds for their own *attitudinal shifting*. Attitudes can be measured quantitatively through surveys. Clearly, *self-development* was important. For example, Henderson, Berlin and Fuller (2002) studied the attitude of medical students towards general practice and general practitioners, and noted that medical students had a positive attitude towards general practice as a specialty, rating their personal experience of general practitioners as the most important factor influencing their attitudes.

Attitudinal shifting was not necessarily straightforward, however. Nurses within this study experienced *role conflict* because of their experiences of and reactions to *practice reality*. Some saw *practice reality* as a barrier and were unable to move forward, preferring to remain within the constraints of *environmental pressures*. Others, however, saw the opportunity to develop their practice. The new experiences, facilitated by role models teaching patient–centred care, contribute towards an attitude change, which propels the nurse on to *responsive action*. Through active support and teaching, the nurse receives the message that this approach to nursing care is successful and fulfilling, allowing nurses to involve the patients in personal health care decisions. This requires interpersonal communication in order to facilitate change in the patient. When we think about the processes by which attitude is changed, a persuasive message is commonly used. The message–learning approach (Hovland, Janis & Kelly, 1953), argued that the attitude change will occur by learning the content of the persuasive message. In contrast, the cognitive–response approach (Miller & Campbell, 1959), proposed that the attitude change is not driven by the message learning but by the generation and retention of the individual cognitive reactions to the message.

Attitudinal shifting was self-directed. Many nurses in this study were aware that coming into nursing exposed them to experiences that they would not have had otherwise, and were content with the changes they see in themselves. Nurses working in the dominant medical model but recognising the alternative models of care that are required to promote health in patient-centred care experienced tension. This tension, in the form of role conflict, in practice reality provides the motivation for *attitudinal shifting* in this study. The tension is caused when working within the confines of the dominant model, the nurse is unable to meet the individual needs of the patient and actively moves out to

seek a solution to reach a consistent state in responsive action. This tension can perhaps be likened to cognitive dissonance. Leon Festinger (1957), for instance, developed the cognitive dissonance theory which argues that an individual prefers and seeks consistency and will change attitudes and behaviours to reach a consistent state. Dissonance refers to the personal tension or stress experienced when an individual's actions contradict or are inconsistent with his or her values and beliefs.

The motivation for *attitudinal shifting* within nurses in coronary care is to reduce the discomfort, inherent in *role conflict*, caused by the inconsistency between the technologically-based nursing actions and the need to meet the individual health needs of the patient as a whole through skilled interaction. This change in approach to meet these needs eliminates the tension. The evidence in this study is supported in the literature. Johns and Saks (1996) report that the cognitive dissonance theory suggests that changing the behaviour will lead to a change in attitude so that the personal feeling of tension is eliminated.

Attitudinal shifting was clearly demonstrated by the nurses in this study who were open to innovation and new ways of thinking. They were able to successfully incorporate health promotional activities into their practice. Once again*, attitudinal shifting* is supported in the literature. In the June 7th 2002 editorial in the New Zealand Medical Journal on restructuring health management comment that the changes will 'strengthen linear command and control and is a structural answer to a situation that really requires an attitudinal shift to a more co-operative environment between organisational systems, managers and clinicians (p 40.). Co-operation is essential for the success of a shared goal, and essential in a patient-centred model of care.

Attitudinal shifting seems to be linked with self-actualisation. Nurses in this study found that advancing knowledge and improving personal and professional skills are important motivational factors for nurses pursuing self–actualisation. Self-actualisation, a concept borrowed from Goldstein (1939), refers to the actualisation of one's potentials, capacities and talents. Many nurses in this study were able to move freely across all three phases of *attitudinal shifting.* Their experience and specialist coronary care knowledge allowed them to respond appropriately to the complex environment, continually addressing and resetting clinical priorities. Others were just beginning to experience *role conflict* suggesting that the attitude and motivation of the individual has

a considerable effect on success in achieving individual potential. This is in keeping with Smith and Leland's (1975) work on personality and *attitudinal shift* in teachers. In a small group simulation exercise entailing personal enquiry, planning, performance, analysis of teaching and self-evaluation a significant shift toward self–actualisation can be achieved.

In this study*, attitudinal shifting* is clearly seen in responsive action, where nurses actively involve their patients in decision-making, responding to patient health needs and concerns and encouraging active participation in health care, through lifestyle change and health promotion. *Attitudinal shifting* is vital as patients are becoming more knowledgeable about their own health and treatment options available. The increasing interest in partnership in nurse-patient relationships is associated with recent legislation concerned with human rights and the direction of the New Zealand Health Strategy (Ministry of Health, 2000). This partnership is seen as a means of achieving positive health outcomes. Ford (2000) asked 'Is the Internet changing the relationship between consumers and practitioners?' Ford argues that all health practitioners require an attitudinal shift. Whereas health practitioners were previously in total control of healthcare decisions, now they must share the control and decision making in partnership with patients.

In summary, *attitudinal shifting* is the individually-driven process through which coronary care nurses make a conscious decision to manage *ritualistic practice.* By changing their approach to nursing work to incorporate health promotional activities through a patient-centred approach, nurses respond to the individual needs of each patient, while accepting responsibility for the needs of the coronary care unit as a whole.

Discussion

Medical dominance

The term medical dominance describes the power of the medical profession in terms of control over its own work, over the work of other health workers and in relation to health policy and resource allocation (Germov, 2002). As seen in Chapter One, the historical beginnings of coronary care can account for the dominance of medical *work structure*s in relation to the nursing role. The coronary care unit is a small, self-

contained, specialist environment situated within the acute general hospital. The doctor's key clinical role of diagnosis and treatment of acute myocardial infarction ensures professional dominance.

In this study, the nursing staff who come from many different backgrounds, have to work closely with medical colleagues. Wherever people are brought together in sustained interaction, a culture develops and a social system emerges, in this case the culture of coronary care. This system of informal relationships is comprised of cultural norms and values that become a significant element influencing the behaviour and attitudes of the group. While the CCU nursing role was revolutionary in the 1960s, medical and technological structures continue to control practice behaviour within the hospital nearly 50 years later (O'Rourke, 2001). On the one hand, control shapes operational policies such as medical protocols, but, on the other hand increases *environmental pressures* for nurses, potentially compromising change in the form of *attitudinal shifting*. In saying that, nurses and doctors within coronary care work together to provide patients with the best possible care, based on robust (medical) clinical research.

This technical emphasis challenges nursing work, as medical science and the biomedical framework have a very specific view of acute illness. This biomedical model is based on the assumption that each illness or disease has a specific cause and affects each individual in a predictable way. The body is viewed as a machine and the doctors are the mechanics who are able to repair the broken parts and systems (Capra, 1982). Measurement and observation are highly valued and are consistent with the modern management of heart disease.

Medical dominance in the form of the rising invasive and non-invasive interventions to treat heart disease due to new technology causes a dilemma for nurses, which becomes apparent in *practice reality*. Dingwall and Allen (2001) refer to the contemporary crisis facing nursing. The work that nurses now undertake 'caring for' patients makes it increasingly difficult to engage in the kind of work in which they can also 'care about' them. Nurses in this study had similar experiences when they attempted to take the time necessary to build a relationship with their patients. Whitehead (2001) argues that basing the nurse-patient relationship on an illness-disease outcome is fundamentally flawed as a health–related activity. The treatment of the illness, so necessary in the

acute care environment, where diagnosis symptom management are paramount, does not necessarily lead to the promotion of health.

Medical dominance is widespread and influences cardiovascular healthcare, contributing to the *environmental pressures* coronary care nurses encounter. New medical discoveries challenge the nursing profession to be well informed in their roles. Management strategies for the patient in coronary care will continue to adapt and readjust alongside the advancing technology and new knowledge gained from medical scientific research.

In this study medical dominance was especially evident in the nursing handover which the doctors did not attend. This separation can lead to an ineffective working relationship, creating an unhealthy work environment where patient needs are neglected (Larson, 1999). A strong finding of this study suggests that the nursing handover is heavily medically focussed and individual patient psychosocial needs, fundamental to health promotion, are not addressed.

Nurses in this study agreed that they strive to provide humanistic care that meets the needs of each individual patient but, due to the dominance of the medical focus, the routines and rituals associated with the medical model of care takes precedence over nursing health promotional activities. The changing roles and functions of the nurse during this time add to the *environmental pressures* on clinical practice. (Conway, McMillan & Solman, 2006). The focus of nursing activity is often misaligned to the health promotional needs of patients ready for discharge.

Medical dominance in the form of the delegated medical role was an issue in this study. The success of the CCU concept remains highly reliant on the clinical expertise of nurses who carry out medically delegated roles in the absence of doctors and who can work in close collaboration with their medical colleagues in order to save lives. Nurses did not have a clear understanding of the nursing role in coronary care due to the influence of these roles. Nurses also spoke of the aspects of delegated medical roles that often precluded them from caring for the individual patient that is such a necessary component of health promotion.

This is problematic. Nurses who undertake these new roles are adapting to the norms and values of the dominant medical profession (Street, 1992) and rejecting their own unique nursing perspective. The nursing role was often unclear in this study, as it is in the literature. Contemporary nursing is characterised by ambivalence concerning the legitimate boundaries of nursing work and thus, too, on the role of the nurse (Rushforth & Glasper, 2000). The conflicts may be due in part to the rise in technology and medical intervention. The range of new roles for nurses indicates the diverse nature of contemporary nursing activities. Herein lies the tension. Many of these activities, such as defibrillation, blood collection, endoscopic procedures, or new roles such as nurse anaesthetists have moved nurses into the traditional domains of medical practice.

The dominance of the medical model over the patient-centred approach was clear in this study and is perhaps not unreasonable. For example, nurses order blood tests or lead the resuscitation of a patient in cardiac arrest. Much of the nursing work blurs the boundaries between medicine and nursing as nurses are responsible to initiate appropriate treatment interventions and protect patient safety. These actions are highly visible and encouraged and supported by the medical staff. Nonetheless, these expectations pressure nurses. As we have seen the Nursing Council of New Zealand (2005) sets down formal boundaries of nursing practice in New Zealand. For instance, nurses do not prescribe medication; they administer the medication and note its effectiveness. Expert nurses within many specialty areas such as coronary care suggest treatment strategies. They have the experience and ability to question the medical dominance, and practice as an autonomous individual in *responsive action*.

The dominance of medicine has important implications for the nursing profession. Medical dominance allows doctors to develop the culture of health and illness through medical definitions socially acceptable medical definitions. (Street, 1992). Nurses in this study expressed concern regarding the dominating medical language used in nursing on a daily basis. In the health field medical dominance, is, according to Turner (1985, p.141) “a necessary feature of the professional power and superiority of the medical practitioner in relation to other occupations”. This power controls the work situation and establishes occupational sovereignty over other groups. Nurses are seen primarily as sources of information, as well as the means by which medical orders are carried out. In this study, many nurses were from overseas. These nurses are used to a rigid organisational hierarchy, where the medical culture clearly places nursing practice

in a subordinate position. Turner (1985) describes subordination as a situation where nurses who have their activities delegated by doctors have little scope for independence, autonomy or self-regulation. Gerrish and Griffith (2004) agree that this pervasive attitude leads to nurses being reluctant to question the practice of medical staff or speak upon their patients' behalf contributing substantially to the continuing medical dominance of nursing practice. Despite this, some nurses, usually the experienced ones, were able to accept this situation and work both for doctors and patients.

Patient-centred care

In this study, patient-centred care allows nurses and patients to work together in partnership to address individual health issues. According to Little et al., 2001) three elements are important in patient-centred care: communication, partnerships and a focus on healthy lifestyle and health promotion.

In the past, the nurses' role in health promotion has been described as authoritarian and prescriptive, handing out advice to their patients from their position of power (Benson & Latter, 1998). Nurses promote health according to the cardiac rehabilitation model. More recently the role emphasises the patient-centred approach with a focus on individual beliefs and values, health and health-influencing behaviour. The findings of this study indicate that nurses are using this approach in *responsive action*. Nurses must support patients to enable them to identify behaviours that can be changed, empower them to make the choices and plan to change lifestyle factors and provide them with the motivation to start. The opportunity may well be missed if these issues are not addressed while the patient is in CCU.

The concept of patient-centred care is not new. The effective treatment of patients in acute care calls for a holistic approach that does not view patients as the disease (Darwood, 2005). Modern developments in medicine have been attributed to the ability to understand more about the nature and cause of disease, but this focus has its limitations, ignoring the psychological and social components.

Coulter (2002) defines patient-centred care as that which responds to patients' needs and wishes and ensures that they are treated in a supportive manner. Communication is vital to patient-centred care. Smith and Sullivan (1997) in their study of nurses' perception of care found that nurses perceived the item 'listens to the patient' as the most

important caring behaviour. Many nurses in this study agreed and were often frustrated in *practice reality* when they could not listen their patient's concerns because of the constant interruptions found in the acute care environment.

In CCU patient-centred health promotion involves counselling patients to adopt lifestyle behaviours to lower their individual cardiovascular risk factors. It has long been argued that the teaching of counselling and communication skills will help nurses achieve their aim as health promoters (Whitehead, 2004). Nurses in this study agree that while communication skills are very necessary, these skills must be incorporated within the development of the *interpersonal relationship* between the nurse and patient that occurs in the complex CCU environment. This was seen in the present study where nurses were inspired to develop their interpersonal skills by their individual role models.

Advancing patient centred care in an acute unit is challenging. The dominant medical focus on diagnosis and symptom management does not address the practical realities of health and wellness that are more evident in the community. Joy (p. 56) describes how nurses seem to care for the technology more than the patient and that human- to- human contact is often missing. Curtin and Simpson (1999) similarly report that the more technological the environment the greater the need for human contact. This human contact is vital when encouraging patients to express their needs and concerns regarding their future health and encouraging them to make changes to their lifestyle behaviours. Nurses in intensive care described factors that enhanced care and identified *role modelling* as a critical factor (Bush & Barr, 1997). *Role modelling* is a strong finding of this study where the models were believed to empower patient-centred caring in other nurses.

The nurses were also aware that patient-centred care required them to involve patients in decisions about their care to begin the process of health promotion within CCU. Being able to help the patient decide what they can do to help themselves through lifestyle change and how this might be achieved, would result in a positive health promotion outcome. This approach is consistent with better health care options and encourages patients to take the responsibility of coming to appropriate individual health decisions.

Nurses in the study were well aware that they were not always able to engage in patient-centred care. West, Barron and Reeves (2005) suggest that emotional support and effective discharge planning are often missed when there are barriers to patient centred care such as time, tools or training. Time was highlighted by the nurses in this study because of the acute nature of the work, where priorities had to be constantly reassessed. Tools were considered such as numbers of staff on duty, skill mix, and the availability of resources to help encourage lifestyle and behaviour change. Support for anxious families was often lacking due to environmental constraints and traditional practices. The layout of the unit precludes the privacy that may be required for prolonged patient/family interaction.

Communication barriers impact on the nurses' ability to undertake patient-centred health promotional activities. In this study nurses talked of the importance of communication and relationship–building skills in delivering health promotional activities and initiating health behaviour change. Bottorff and Varcoe (1995) agree that communication skills are vitally important but warn that the development of the nurse-patient relationship needs to be viewed and taught with a recognition of the complex, dynamic personal, social and political context in which it occurs.

Many nurses felt unprepared to undertake patient-centred activities due to a lack of confidence in their ability to promote and support their patient to make health-related behaviour changes. A number of studies show that nurses do not deliver preventative education and counselling skills because of a lack of confidence in their skills and knowledge and the belief that they are ill prepared for the role (LaDuke, 2000; McDonald, Tilley & Havstad, 1999; Ienatsch, 1999).

While CCU nurses struggled to implement patient-centred care, the cardiac rehabilitation nurse specialist, who has a predominant patient education load, spent a significant amount of time teaching and supporting colleagues how to integrate that model of care in the practice. This teaching allows for the recognition of the skills of human interaction that are required for health promotion in coronary care.

Health literacy also affected patient-centred care. Nurses were aware of the importance of assessing their patients' health literacy skills in order to undertake health promotional activities. According to Ratzen (2001) where there are adequate levels of health literacy

people are able to stay healthy, recover from illness and live with disease or disability. A lack of health literacy is an important element in addressing health inequalities and prevents patients becoming empowered. As we have seen in this study many patients were not fluent English speakers. If patient-centred care is to be taken seriously, at the very least, patients need to be able to read consent forms, medicine labels and other health information. They also need to be able to understand written and verbal instructions.

Clearly, health literacy is a two-way process and an essential aspect of patient-centred care. Nurses must understand the scope of the problems many patients' face. Nurses must make their own knowledge understandable for their patients. According to Allen and Horowitz cited in McMurray (2007) this means ascertaining public need, using appropriate communication techniques, ensuring access and usability, identifying barriers within our systems and continuously evaluating the outcomes of our communications. The complexity of many of these issues is perhaps reflected in the politics of practice which is discussed next.

Politics and practice

Changes in government health policy have an impact on the nursing role in the acute care area. Over the past ten years the New Zealand public health system has been subject to political reforms. Politics and practice are intertwined as is seen in the twenty-one district health boards (DHBs) within New Zealand that have the following statutory objectives:

- improving, promoting and protecting the health of communities;
- promoting the integration of health services, especially primary and secondary care services; and
- promoting effective care or support of those in need of personal health services (Ministry of Health, 2001).

Other DHB objectives include promoting the inclusion and participation in society and independence of people with disabilities, reducing health disparities by improving health outcomes for Maori and other population groups, and to reduce toward elimination, health outcome disparities between various population groups.

Hospitals are in a strong position to advocate for health promotion, representing the main concentration of resources, skills and technology in any health system (Johnson & Baum, 2001). Although hospitals are dynamic institutions precisely because they move in time with the rapidly changing technology, they are also required to exert political influence in the services they deliver to patients. Indeed, the technological transformation and the ensuing innovations to health care practice heralds the arrival of the Sociotechnical Age (Beneveniste, 1994). Everyday the delivery of health care becomes more complex as new technologies for diagnosing and treating disease are developed. As we have seen, for the nurses in this study, the focus on technological competence is crucial to their nursing practice. The social responsibility inherent in the Sociotechnical Age assumes that the hospitals will redesign the structure and delivery of healthcare to meet the health promotional needs of the community it serves.

Until recently, competence was considered to be a set of skills and attitudes. Competence is now defined as related to the workers' understanding of their work (Sandberg, 2000). This is significant as politics in the form of law impacts on practice, at least in New Zealand. For example, the Health Practitioners Competency Assurance Act (2003) aims to protect public health and safety by providing mechanisms to ensure the competence of all health professionals. Nurses in coronary care must prove their competency to practice, continuously updating practice to meet this political need. Personal and professional development became crucial, therefore, to being able to achieve the *attitudinal shifting* required to ensure health promotional activities are incorporated into nursing practice. The research findings suggest that the nurses believe that individual motivation is essential as self–development is a clear expectation of the competent coronary care nurse. London and Smither (1999) agree arguing that because the nature of work is continuously changing, employees must 'prepare for tomorrow today' (p. 4) or, in other words, be politically aware.

Nurses are not necessarily accustomed to political activity. However, being prepared suggests that nurses must seek out new information to identify skill gaps, recognise areas to improve current performance, keep up with advances in the profession and anticipate how changes elsewhere may affect work demands and skill requirements. This implies that nurses must be proactive in leading their individual practice development. *Self-development* is particularly important to continuous learning in

changing work environments (London & Smither, 1999) and the acute health environment is one such area.

Taking a wider political point of view patients in CCU often have many longstanding health issues that need addressing, many of which are supported by lifestyles that are in hindsight unhealthy. This is consistent with populations who have heart disease. Patients admitted to hospital have multiple physical and psychosocial problems. Patients appear to be sicker than before, demanding more knowledgeable and skilful nurses.

At the same time New Zealand is facing a nursing shortage similar to many other areas of the world. A poor public image of the nurse is believed to contribute to nurse shortages (Seago, Spetz, Alvarado, Keane & Grumbach, 2006). Overseas nurse recruitment adds to the cultural diversity of the nursing population that helps health care facilities to become more responsive to the needs of the multicultural New Zealand population, a clear aim of the pervading political health strategy.

Another local, political concern that impacts on practice is Maori health status, which has been given an increasingly important emphasis in recent health policy due to the persisting health inequalities. This was highlighted in the report Progress Towards Closing Social and Economic Gaps between Maori and Non Maori (Te Puni Korkiri, 2000). Maori health status levels are considerably lower than those of non- Maori across a range of indicators. One of the aims of the New Zealand Health Strategy (Ministry of Health, 2000) is to ensure that health services are directed at areas that will ensure the highest benefits for the population. Nurses have a part to play here, promoting health.

Politics shapes health care delivery and the policies that impact upon the health of the population. Nurses must be prepared to take on the responsibility of ensuring the nursing voice is heard, especially in shaping future health policy. Buresh and Gordon (2000) believe that nurses struggle to describe the knowledge and skills that are part of the everyday practice of a nurse. Davies (1995) considers nursing work to be invisible to many others. Debate about the invisibility of nursing work is long-standing and nurses carry some responsibility to change public attitudes in this respect.

Davies (2004), for instance, argues that the implications of health policy and organisational change are often ignored by nurses working at the bedside. Nurses in

acute clinical practice have a blinkered approach, concentrating on the immediate acute needs of the patient. They must be prepared to articulate their true role and to develop the skills needed to operate in the political arena. These professional development opportunities must be made available to clinical nurses to allow nurses to expand their practice to meet the changing needs of their patients.

Nurses seemingly struggle to recognise the political dimensions of their work. Nurses in this study needed support to incorporate health promotional activities into their practice. While this support often came from role models who influenced their practice and enabled the nurses to achieve *attitudinal shifting*, nurses were unable to work collectively, politically to change the medically-dominated CCU culture. Failure to recognise that communities of practice hold great importance for nursing practice development was significant (Endsley, Kirkegaard & Linares, 2005). Often when nurses look to improve their practice, they are dependent on their many interactions with colleagues and this is supported by the findings of this study. Even though work-based learning allows nurses to learn in the working environment supported by theoretical input and support (Wright & Draper, 2002) learning to make political change in an organisation is just as important.

Political activity establishes a basis for ongoing and effective relationships with colleagues, patients, their families and the community. Nurses in this study were able to influence colleagues to adapt their practice through role-modelling, and used opportunities to challenge patients' health conceptions and misconceptions through an effective *interpersonal relationship*. All nurses manage this through their ability to communicate their ideas to others, gaining their support and participation (Sullivan, 2004), skills required for political influence.

The World Health Report (2006) states that in recent years the "traditional focus on acute, inpatient and sub specialty care has given way to new paradigms of care, emphasising self-management, and community-based patient-centred pre hospital care" (p. 25). As hospitals in New Zealand have struggled to cope with the burden of acute admissions, chronic disease management has become an area of interest (Tracey & Bramley, 2003). Politically, improvements in the management of patients with heart disease and heart failure will result in increased quality of life. The Department of Health initiative in the United Kingdom on 'The Expert Patient' (2001) reflects recent

trends in political philosophy, aiming to encourage patients suffering with chronic conditions to become more actively involved with in their treatment decisions. Badcott (2005) argues that patients can no longer be passive recipients of healthcare.

Similarly, the political pressure of short hospital stays has created tensions for families and many health services situated in the community (McMurray, 2007). Many nurses working in the acute health care setting continue to view their role from the medically dominated management of the disease, rather than from a health promotion perspective. Prevention and health promotion are mainstays of a quality health system and integral to the role of all health professionals. That health care system is judged on how well or how badly the services address inequalities, how they respond to people's expectations and to what extent dignity, personal rights and freedoms are respected (WHO, 2002).

Implications for practice

The findings of this study have implications for health promotion in nursing practice. The management of ritualistic practice in the coronary care setting through the process of *attitudinal shifting*, can be useful for nurses in other acute clinical areas. With the increasing specialisation in nursing practice, these findings may be of interest to nurses working in delegated medical roles where the reality of everyday practice precludes nurses from undertaking their essential nursing role. The findings from this research suggest, that while nurses in acute care areas may well be challenged by medical structures, nurses can find a place professionally whereby the nursing voice can be heard and, more importantly, make a positive contribution to health and social outcomes for patients. The move to *responsive action* allows the nurse to respond to the physical and psychological needs of the individual patient, incorporating health promotional activities, while at the same time, acting responsibly to meet the needs of the acute area as a whole. *Attitudinal shifting* encourages nurses to review and reconsider their role. The traditional view of health promotion as simple information giving is no longer appropriate in the context of current health strategies. Individual behavioural change strategies can only be initiated successfully when they have been tailored to the patients' unique needs. Here, the identification of key professional groups and stakeholders as potential collaborators within the wider community, is essential.

Health care facilities also need to ensure that there are opportunities for the personal and professional development of nursing staff. New staff must be supported and encouraged

to question practice, identify what constitutes socio-political health promotion and how that impacts on the practice setting. Nursing management and the profession as a whole need to ensure that nurses are actively encouraged to develop new skills and clearly articulate the nursing role in the current health climate by raising political awareness and identifying the political opportunities for clinical health policy development. It was clearly seen that the process of *attitudinal shifting* was initiated by the individual nurse after experiencing *role conflict*, between the traditional needs of the coronary care unit and their individual patient.

Implications for education

The findings of this study also have relevance for the world of nurse education. Nurses found that they were ill prepared for undertaking health promotional activities. The place of health promotion within nursing undergraduate curricula, therefore, needs to be examined. The strong *technological focus* of nursing work within the acute care setting emphasising health problems and perpetuating the rituals of practice must be balanced with the broader societal and political dimensions of health promotion. These aspects are integral to the role of all health professionals and clinical placements for students must be renegotiated to ensure this aspect of practice is highlighted. The findings of this research particularly emphasised communication and interpersonal skills. Knowledgeable and experienced health promotion practitioners should be involved in the delivery of education and should not be limited only to nurses. Working with partners in the clinical setting, provides an opportunity to develop further clinical and educational theories of practice.

Further Research

The conceptual framework presented in this study introduces a beginning theory of the nurses' perspective on the practice of clinical health promotion in coronary care. The conceptual framework identified as the process of *attitudinal shifting* is grounded in the data but has not yet been tested in other settings. Do nurses working in other specialist unit experience *attitudinal shifting*? With my own move to nursing education, it would be interesting to study nurse educator's experience of *attitudinal shifting*. Considering the importance of self – development and continuous learning in this study, and the small number of participants who were undertaking masterate education, it would be useful to question the characteristics of masters level clinical practice.

Limitations Of This Study

This small grounded theory study was restricted by time and resource constraints which are a challenge of graduate research study. The time limitations, compounded by full-time work, means it is questionable whether 'saturation' had indeed been reached and the further theoretical sampling to enhance the depth of constant comparative analysis and ensure that all possibilities had been explored fully was not possible. The participants were all from one city in New Zealand. It is questionable if the findings have application to other regions within New Zealand, nor the usefulness of the findings for the international setting.

The seventeen interviews were not tape recorded, with field notes being recorded after the interview and the risk of personal interpretation of the responses is acknowledged.

Concluding Statement

In this study a grounded theory approach has been used to generate a conceptual framework of nurses' perspective on the practice of clinical health promotion in coronary care. This study has shown that the main concern of nurses promoting health in coronary care is ritualistic practice with nursing dominated by the biomedical model. This focus on health problems rather than health potential is at odds with contemporary approaches to health promotion. The findings indicate that nurses manage ritualistic practice through a process of *attitudinal shifting*. Although coronary care nurses are strongly influenced by *environmental pressures*, *practice reality* acts as the catalyst for *attitudinal shifting*, where the nurse becomes aware that medicalised practice does not meet the needs of the patient and that health promotional activities must be individualised. *Responsive action* explains how the nurse adapts their practice to suit the individual situation, integrating medical care and health promotional activities, moving seamlessly between these two distinct aspects of nursing work within coronary care. The nurse is able to respond to the medical, technological, physical and psychological needs of the individual patient, incorporating health promotional activities, while at the same time, acting responsibly to meet the needs of the acute coronary care unit as a whole, the hospital and the organisation.

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Appendix A

AUCKLAND UNIVERSITY OF TECHNOLOGY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

MEMORANDUM

Academic Services

To:	Antoinette McCallin
From:	**Madeline Banda**
Date:	28 July 2005
Subject:	Ethics Application Number 05/138 **Clinical health promotion in coronary care: a grounded theory study.**

Dear Antoinette

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 11 July 2005. Your ethics application is now approved for a period of three years until 28 July 2008.

I advise that as part of the ethics approval process, you are required to submit to AUTEC the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online through *http://www.aut.ac.nz/research/ethics*, including a request for extension of the approval if the project will not be completed by the above expiry date;
- A brief report on the status of the project using form EA3, which is available online through *http://www.aut.ac.nz/research/ethics*. This report is to be submitted either when the approval expires on 28 July 2008 or on completion of the project, whichever comes sooner;

You are reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTEC for approval before that change is implemented.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee

Appendix B

Participant Information Sheet

Date Information Sheet Produced: 6th June 2005

Project Title Clinical Health Promotion in Coronary Care: A Grounded Theory Study.

What is the purpose of the study?
This research study is part of my work for a Master of Health Science (Nursing). Recent advances in the treatment of heart disease have shifted attention from rehabilitation to health promotion, focussing on lifestyle choices. It is anticipated that this study will provide insight into the health promotional role of the nurse in an acute coronary care unit. It should increase nurses' understanding about clinical health promotion in the acute care setting.

How are people chosen to join this study?
I have asked colleagues who know registered nurses working in coronary care units to ask you if you are interested in talking to me. The person who approaches you will check out your interest and, if you are agreeable, will pass on your name to me to follow up.

What happens in the study?
When I hear of your interest in the study, I will contact you to talk about the research and what will be required of you. You will be able to ask questions and, if you want to know more I will send you this participant information sheet so you can read about the study. I will contact you two weeks later to see if you want to be interviewed, and answer any of your questions. Then, if you are agreeable, we will organise a time and date that suits you to meet for the interview.

At the interview you will be asked to sign a consent form to confirm your agreement to be a research participant. The interview will be an in-depth discussion that will last about an hour. Early in the interview you will be asked:

I want to understand more about the work you do promoting health within coronary care. What are some of the experiences you have had…..?

Further questions may include the actions and interactions attributed to health promotion, and factors identified as enhancing or inhibiting its delivery.

What are the discomforts and risks?
It is unlikely that there will be any discomfort or risk. You will be talking about your experiences of promoting health in coronary care. If our discussions raise uncomfortable issues for you, and if you were to become upset or distressed, the interview will be stopped.

What would happen next?
The interview can be discontinued altogether, continued after a break, or continued at some other time. The choice is yours. As a nurse with over twenty year's experience, I am able to offer support or information as required. If you require counselling, I will encourage you to contact your work organisation's Employee Assistance Programme that offers three free counselling sessions.

What are the benefits?
There may be no benefits for you participating in this research but it does give you an opportunity to talk about and reflect on your practice promoting health in CCU. Your contribution may help other nurses to understand the practical problems of providing clinical health promotion in coronary care. Understanding practicalities goes some way to making change and hopefully improving practice and service delivery for patients.

How will my privacy be protected?
The interview will be conducted in private at a mutually convenient time and place. The information you have shared will be written up as a memo that does not identify you, your

workplace or any other third party. You will be asked to provide a pseudonym, a false name that will be your research identity. I will be the only one who knows your true identity. The information collected will be confidential. The consent form that you sign will be kept secure in a locked safe throughout the study. All the study data collected will be kept in a locked cupboard. Following the study, my supervisor is required to keep all the information in a secure place for 6 years, and then it will be destroyed. If you withdraw from the study, your information will be immediately destroyed.

What are the costs of participating in the project? (including time)
The main cost of participating is your time. I am happy to interview you at a mutually convenient time and place. Some nurses may be interested in having a second or third interview but that will be negotiated between us.

Opportunity to consider this invitation
It is important that you feel comfortable with the research process. You are not obliged to provide any information that you do not feel comfortable providing. If there are any questions that you are asked that you do not want to discuss, then you are not obliged to answer them. You may withdraw from the study at any time up until the completion of the data collection.

Opportunity to receive feedback on results of research
A summary of findings will be made available to you on request.

Participant Concerns
Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor.

Project Supervisor Contact Details:
Dr. Antoinette McCallin
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Email:scotfish@ihug.co.nz

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, madeline.banda@aut.ac.nz , 917 9999 ext 8044.

Approved by the Auckland University of Technology Ethics Committee on 28th July 2005. AUTEC Reference number 05/138

Appendix C

Consent to Participate in Research

Title of Project: **Clinical Health Promotion in Coronary Care: A Grounded Theory Study**

Project Supervisor: **Dr. Antoinette McCallin**

Researcher: **Sheona Watson**

- I have read and understood the information provided about this research project (Information Sheet dated 20th August 2005).
- I have had an opportunity to ask questions and to have them answered.
- I understand that I will be interviewed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant materials, memos, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research:
  tick one: Yes O No O

Participant signature: .....……..

Participant name: …….

Participant Contact Details (if appropriate):

……..

……..

……..

……..

Date:

Approved by the Auckland University of Technology Ethics Committee on 28th July 2005
AUTEC Reference number 05/138

Note: The Participant should retain a copy of this form.

Appendix D

19th June 2005

Personal Assumptions Re Health Promotion In CCU Prior To Commencement Of Data Collection

- Increasingly, nurses are encouraged to develop their health promotional role
- Traditionally trained nurses have not had the benefit of formal health promotion education
- Potential role/skill deficit
- Health promotion practice within CCU constitutes a wide range of potential activities
- Historically, health promotion has been unstructured
- Nurses may not be clear about what constitutes health promotion
- This role will seem daunting to some nurses
- Communication and interpersonal skills are embedded and critical
- The nurse is best placed to provide clinical health promotion
- This is invisible, emotional work that is often unrecognised and not encouraged by the "hierarchy"
- Medical staff will have certain expectations about what constitutes health promotion and what should be discussed
- Nurses will feel most able to contribute to patient education/advice regarding risk factors
- Along with income and employment status, education is critical in determining people's social and economic position, and therefore, their health
- Cultural factors can have both a positive and negative influence on health
- Health literacy is dependent on levels of fundamental literacy and associated cognitive development

- Learning from experience is a central concept in understanding how clinical nursing practice fosters professional development. These experiences shape individual nurses and the way they see and act in their professional world. All the emotions surrounding clinical practice contribute to the construction of our personal collective knowledge base.

Appendix E

Example of a methodological memo written during data analysis:

Am concerned that therapeutic relationship is not labelled accurately. Looking through that part of the chapter, I see that many participants talk of the nurse-patient relationship and the relationship with colleagues. That is very clear but I seem to be going beyond the data with my use of 'therapeutic' in the interpretation. It would seem that *interpersonal relationship* more accurately reflects their stories.

Appendix F

Example of a theoretical memo:

Interview Nine

Believes that secondary prevention through lifestyle change is only paid lip service to by management. It is talked about a lot but perhaps not followed through. Says it is under-resourced and underfunded, and not fully supported by the medical staff. The best practice guidelines which guide practice are medicalised in their focus. What about the nursing role in CCU? Is the nursing role lost or invisible because of this medical focus that is preventing nurses focussing on the patient and their needs?