

The Reality of Health Promotion: The Perspective of Clinical Nurse Leader Students

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Abstract

This pilot project examined the value of health promotion activities in clinical practice and the personal lives of 28 master's entry Clinical Nurse Leader (CNL) students in their last semester of education. Data collection involved an open-ended questionnaire and focus group discussion. Students expressed concern about finding time for health promotion and noted that patients were often too sick to be appropriate for health promotion. Participants believed that health promotion was better situated in community-based care. Of great concern to students was the lack of role models for health promotion among faculty and staff. Students also noted a decreased ability to attend to their own health while enrolled in the nursing program.

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Nursing is a complex profession that has undergone tremendous change, from the provision of mere kindness and support to work that is based in science but focuses on care and nurturing. To reflect this change and allow for future change, contemporary definitions of nursing broadly define nursing practice as the promotion of health, prevention of illness, and the care of ill, disabled and dying people (ICN, 2003).

Contemporary ad campaigns to attract men and women into nursing depict action scenes of nurses racing through hospital halls with patients on gurneys or stationed at the bedside amidst an array of technology (Wilkinson & Van Leuven, 2007). These images reflect the increasing role of technology in nursing care. In addition, nursing faculty face ever-growing lists of "must cover" topics in nursing curricula. These topics are often driven by the growing knowledge base, and commonly centered on skills and technology. This high-tech fast-paced image cannot be dismissed as it does reflect what is commonly seen in today's hospitals; but these images largely reflect care of the ill, disabled, and dying rather than health promotion and disease prevention activities. If technology and

sick care are advertised and emphasized in nursing programs, what role does health promotion play in clinical practice and in the lives of members of the nursing profession?

This pilot project seeks to address these questions. It is part of a program of research examining attitudes, beliefs, and clinical practice surrounding health promotion among nursing students, practicing nurses, and advance practice nurses. In this phase, data were collected from students enrolled in their final semester of a master's entry Clinical Nurse Leader (CNL) program.

Methods

Students were approached for participation via announcement during a regularly scheduled class. Students were invited to participate in a pilot study on health promotion by reporting to school one hour prior to a required course the following week. Participation was voluntary and unrelated to any curriculum requirements. One hundred percent of the class returned for participation in this project.

Twenty-eight CNL students participated in this pilot project. Their CNL curriculum is an

accelerated 15-month program for students with non-nursing baccalaureate degrees that prepares students to function as nurse generalists. The goal of the CNL program is to create nurses who can function as change agents in clinical practice. The curriculum includes all traditional pre-licensure areas as well as course work focused on leadership, financial management, outcomes-based practice, health systems, and quality improvement strategies (AACN, 2004).

Each student had successfully completed a health promotion class as their first clinical course. The health promotion course examined theories of health promotion as well as key health promotion topics and had an accompanying clinical experience in community and hospital agencies. These topics included: Health promotion theories; levels of prevention; health, illness, and wellness continuum; Healthy People 2010; family health; reproductive health; safer sex; nutrition; tobacco abuse & cessation; prenatal care; exercise & physical activity; immunizations; safety; stress management; violence & abuse; and end-of-life concerns.

In this course, health promotion was defined as activities to encourage optimum physical, spiritual and mental function and appropriate for all individuals, whether well or sick. This group was selected to participate in the pilot project because of their prior enrollment in a health promotion course. It was felt that this experience was unique as health promotion is typically integrated into other courses, and therefore might lead to increased understanding and sensitivity about health promotion. At the time of this study, participating students had completed clinical rotations in maternity, medical-surgical nursing, and pediatrics, and were concurrently enrolled, but near-completion of their community and mental health rotations. They had been enrolled in the health promotion class one year prior to data gathering.

Students anonymously completed a written questionnaire consisting of five questions. The questions were open-ended or completion style:

- 1) What is the role of health promotion in actual clinical practice?

- 2) As a nurse I can promote health by....
- 3) The biggest obstacles to health promotion in nursing practice are...
- 4) I engage in the following activities to promote my own health.
- 5) What affect has this nursing program had on your own health promotion behaviors?

When all students had finished the questionnaire, a focus group discussion began. Students were asked to discuss their views on health promotion and any concerns about the questionnaire. All concerns and themes expressed in writing were also discussed in the group setting.

Findings

The Reality of Health Promotion

Students described hospital clinical rotations as busy, hectic experiences focused on “getting things done.” The volume of tasks required — medications, wound care, IVs, getting patients out of bed, and managing equipment and technology — is complicated by the need to care for multiple patients. As a result, health promotion has a limited presence. Students acknowledged the importance of health promotion but felt that “it’s a great idea but no one has time for it.” Numerous students felt that health care worked in a backward manner by “spending all this money after people are sick rather than less money trying to keep them well.”

In writing and in discussion, students stated that bedside health teaching is the most commonly used form of health promotion as it can be fit into the constraints of inpatient care. One student summarized the discussion clearly:

When I give my meds I tell the patient what they are for and usually a little information about the problem. Or I explain why the patient is on a low sodium diet and that he’ll need to follow that at home. If I have time I give examples or tips. I try to give out pamphlets or handouts too so the patient can refer to it later. Over the course of the day or even over the course of the hospital stay the information is given in little bits. All together that amounts to health promotion. It may not

be ideal, and it really isn't the best way to get the patient the information, but it is the way it really gets done.

Students noted that there is a greater emphasis on health promotion in community-based care. However, students felt that health promotion was usually not the "most pressing" topic as the patients are often "too sick." As a result, community care involves "putting out fires." Problems that prevent focusing on health promotion included substance abuse, poverty, noncompliance, chronic illness, fatigue, and hopelessness. When pressed for details about how health promotion is accomplished in the community, students noted that community care is less task-oriented than hospital care, and that neighborhood settings allow health providers an opportunity to see what clients "face each day." CNL students felt this helped make their teaching more realistic as it forced them to offer practical examples that have greater likelihood of being enacted.

Lack of Role Models

A key concern of all students was unhealthy behaviors of nurses, other health care providers, and nursing faculty. Students noted that nurses were "busy and stressed" and as a result often ate in a manner contrary to what they asked of patients; Junk food, concentrated sweets, and high fat diets were prevalent. One student engaged the group by telling a story of an interaction in a community setting.

A nurse, who is obviously above her ideal body weight, was educating an obese client with Type 2 diabetes. In her teaching the nurse talked about the importance of avoiding fast food. The client laughed and then he pointed to the trashcan that contained wrappers from a local fast food. He said, "You mean I should eat like you folks, huh?" I felt embarrassed but the staff nurse didn't seem bothered. She just said, "I'm too busy taking care of people to be able to get anything else to eat."

Students extended this discussion to include the disparity between what faculty teach versus what they do. Twenty-five percent of students (N=7) commented on this disparity in writing

but 100% (N=28) of students engaged in this portion of the discussion. They approached this topic tentatively by asking for reassurance of confidentiality. Students commented that many topics taught in school are not seen in the "real world." Examples cited included formal care plans and standardized language (NANDA, NIC, NOC). Students noted that there is merit to learning these skills and processes; care plans allow you to practice your thinking process and research supports the use of standardized language. The fact that the students do not see these in wide use at their clinical rotations did not create much tension because faculty "really believe that it is best for the students to learn these things." In contrast, students felt very different about health promotion. One student succinctly described the difference:

With care plans we know that we are learning something. In school it's a process and the faculty need to be able to see that we learned it. So we write it down, all the way to the minutia. I know that the nurses on the floors do care planning, but it really is in their heads. They've internalized it. So it doesn't bother me that we have to do it. Sure I complain about the time, but I get it. With health promotion it's different. Faculty talk about it; staff talk about it. But they don't buy into it. If they did, they would live differently.

This disparity between what nurses ask of others versus how they conduct their own lives was very troubling for students and occupied the greatest amount of time in the group discussion. Some students expressed concern that these observed behaviors were hypocritical - a form of "selling out." Still others questioned whether these were signs of burn out. Many wanted to discuss how to avoid acting like this. Others were troubled because they felt that they had already begun acting this way as they had neglected their own health while engaged in this program.

Affect of Program on Health Behaviors

Students discussed their concerns about the demands of the program and it's affect on their own health promotion behaviors. More than one-

third (N=10) stated that school had a negative influence on their health. Concerns were focused on the increased stress and time demands associated with a nursing program. Students admitted to mental and physical stress that was frequently managed by unhealthy behaviors such as drinking and overeating. A number of students admitted to seeing a health provider about their stress. Four students stated that they had begun medications for anxiety or depression during the program.

More than half (N=15) noted that their experience in clinical had motivated them to be healthy in order to avoid hospitalization or illness. Yet, most felt that this goal could not be achieved while in school. One student clearly summarized this opinion: "Clinical experience has inspired me to try to be as healthy as I can (after graduation) so I don't end up like the patient's I care for."

One-fourth of students (N=7) stated they expected to be stressed by this program. In discussion, these students noted they anticipated the fast pace and stress of the program. This subgroup appeared surprised that others were unprepared for the stress:

They told us from the start that it would be a demanding program. I came in prepared for a tough time and that's what it is. But it's over in 15 months. I can put up with the problems because I know it will end.

Discussion

Although this is a small pilot study, these findings raise concern about the state of health promotion in the clinical arena and in the profession of nursing. This group was selected to participate in the pilot project because of recent participation in a health promotion course that stressed that health promotion activities were appropriate for all individuals. In spite of this background, students approached health promotion as a non-essential aspect of care that was appropriate when clients are stable or well. Time and the number of competing tasks were the key obstacles to incorporation of health promotion into clinical practice. This focus on tasks and time may be a reflection on their

novice status. Novices focus on learning the rules and completing tasks (Benner, 1984). Future projects in this research program will compare the responses of novices with those from nurses with greater clinical skill and judgment to determine if these areas are factors that influence health promotion.

CNL students valued the community experience as an opportunity to learn more about the client's world and individualize their approach to clients in a way not possible in inpatient care. Their concerns raise the question about whether health promotion is site dependent. Inpatient care is characterized by short lengths of stay and high intensity service. Students noted that brief health teaching associated with other aspects of care is the predominant mode of health promotion in inpatient care. If this is the case, do community health nurses provide more health promotion services? Students stated they were often "putting out fires" in their community rotations and that health promotion was not the most pressing concern. Certainly health trends have moved sicker patients into the community, but if community health nurses are also pressed for time due to the intensity and quantity of services, who is providing health promotion services? Are primary care and ambulatory settings the principal venue for health promotion? Future projects in this research program will compare responses of nurses working in inpatient care, community care, and ambulatory care practices.

Furthermore, students value role models and are dismayed when they do not find them among staff or faculty. Role models teach by example, demonstrating the behaviors and/or attitudes to be learned. Models provide inspiration and strategies for health promotion behavior. It is difficult to advocate for healthy behavior if you do not follow the behavior you recommend to clients. Efforts to improve the health of individual nurses may be needed so that nurses can truly promote health in others. In fact, the health system may need repair before health promotion can truly be accomplished. Perhaps it is not novice status that makes students focus on tasks. Is health care simply so busy that nurses can only deal with the most immediate

problems? A key strategy in managed care and current health reform efforts is controlling utilization and types of services patients may access. As a result, patients have brief interactions with providers at all levels of service (Bodenheimer & Grumbach, 2005). With limited interaction it is difficult for health providers to truly promote optimum health, therefore the responsibility for health promotion returns to the individual. As a result, future research needs to assess patients' perspectives of health promotion.

Students see nurses as stressed and busy and admit when they feel pressured they often resort to unhealthy behaviors such as overeating and

drinking. A small sub-group was able to continue to engage in healthy behaviors by preparing for the stress and planning for its end. Locus of control may explain some of these differences. The multidimensional health locus of control scale (MHLC) developed by Wallston, Wallston, and DeVellis (1978), measures the perception of control over health. MHLC data reveals that individuals who feel in charge of their own health are the easiest to motivate toward positive change, while those who feel powerless are least likely to engage in health promotion behaviors. Future research must examine the relationship between locus of control and health promoting behaviors.

References

- American Association of Colleges of Nursing. (2004). Working paper on the role of the clinical nurse leader. Retrieved October 1, 2006, from <http://www.aacn.nche.edu/Publications/WhitePapers/ClinicalNurseLeader.htm>
- Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, CA: Addison-Wesley.
- Bodenheimer, T.S. & Grumbach, K. (2005). Understanding health policy: A clinical approach (4th Edition). New York: Lange.
- International Council of Nurses. (2003). ICN definition of nursing. Retrieved September 25, 2006, from <http://www.icn.ch/definition.htm>
- Myers, J., Sweeney, T., & Witmer, J. (2000). The wheel of wellness counseling for wellness: A holistic model for treatment planning. *Journal of Counseling & Development*, 78(3), 251-267.
- Wallston, K. A., Wallston, B. S. & DeVellis, R. (1978). Development of the multidimensional health locus of control (MHLC) scales. *Health Education Monographs*, 6, 160-170.
- Wilkinson, J. M., & Van Leuven, K. (2007). *Fundamentals of nursing: Theory, concepts, and applications*. Philadelphia: F. A. Davis.

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