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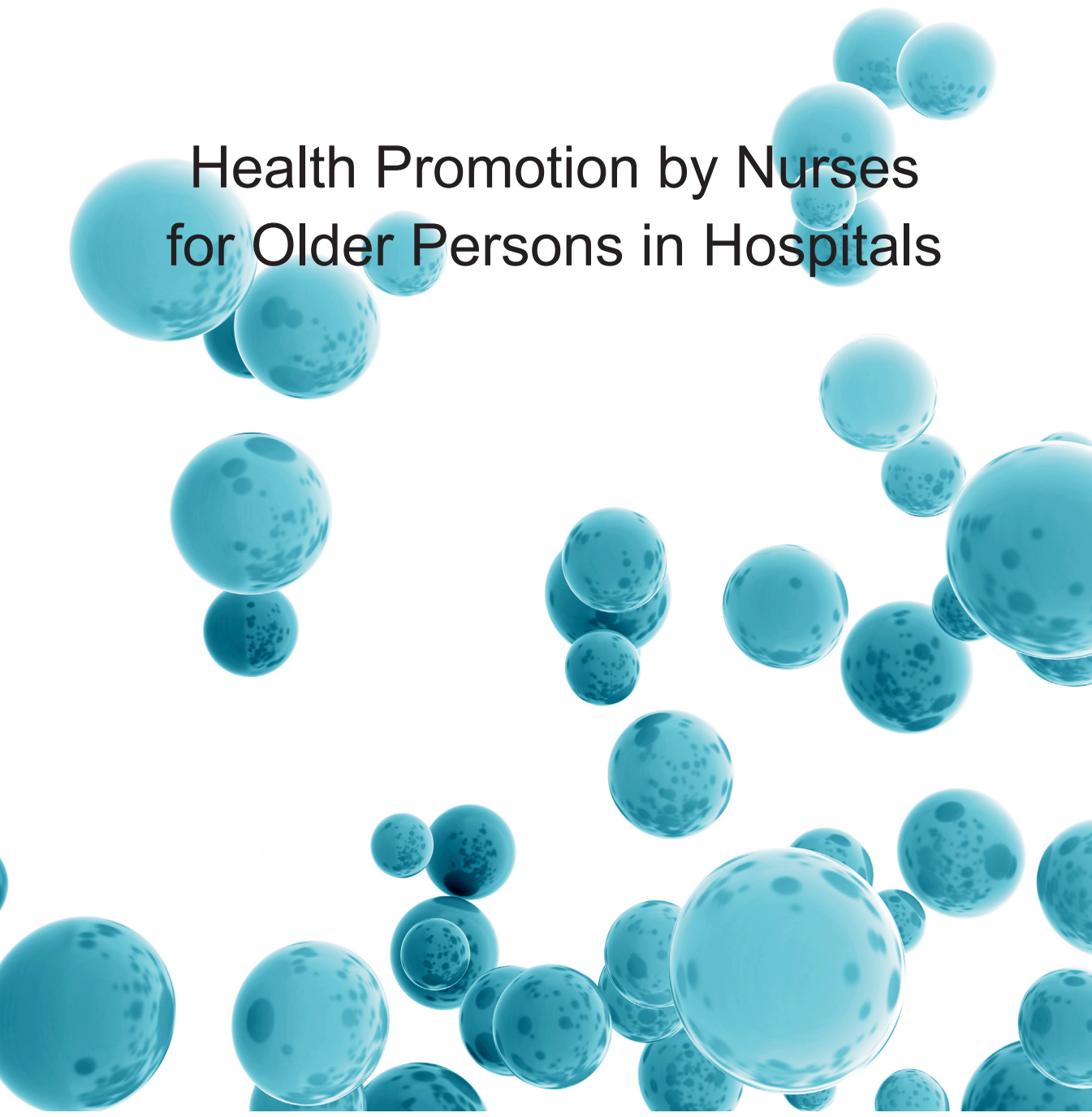
SIBYLLE MAJA FREY

Health Promotion by Nurses for Older Persons in Hospitals



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Health Promotion by Nurses for Older Persons in Hospitals

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ACADEMIC DISSERTATION
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University of Tampere, Faculty of Social Sciences

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ABSTRACT

Introduction: For many years, health promotion and its aim to enable people to control and improve their health situation, has been a recommended task throughout the different health professions. This dissertation describes the actual situation with regards to health promotion (HP) by nurses of older persons' aged 65+ in acute hospitals in Switzerland. Described are the theoretical and practical expectations of health care experts with regards to nurses' HP for older persons in acute hospitals. Furthermore, the clinical nurses' experiences and the hospitalised older persons' perceptions of the performed HP activities in the daily clinical life have been recorded. Additionally, older persons were asked to explain their needs and requirements concerning HP performed by nurses at the hospital.

Aims: The objective of this study is to answer the question: do the competences of nurses' HP, which are required by health care experts', meet the older persons' needs and do they correlate to the actual situation of the daily clinical work of nurses at the acute hospital setting.

Material and Methods: For this dissertation, the mixed method research (MMR) design was selected. The multiphase design consisted of two phases; phase 1 was guided by the explanatory sequential design and phase 2 by the convergent parallel design. Each new approach was developed on the results of the previous phase of the study. Phase 1 included two separate interactive strands. The first strand consisted of a Delphi survey, identifying the opinion of health care experts on the HP by nurses for older persons 65+ in an acute hospital setting. The data collected from round one was analysed and adapted using a qualitative content analysis. The results from the questionnaires in the following two rounds were analysed using descriptive statistics. The second strand included two focus group discussions with bedside nurses working in an acute hospital setting. In this strand, the data collected was qualitatively analysed using the documentary method by Ralf Bohnsack. Phase 2 included face-to-face interviews with older persons, during their hospitalisation and after discharge. In strand 3 the open-ended interviews were evaluated using the concept of qualitative content analysis developed by Mayring. In strand 4, the interviews conducted using a structured questionnaire were analysed separately again using descriptive statistics. The overall analysis was

performed deductively, using a part of the PRECEDE- PROCEED model as defined by Green & Kreuter.

Findings: The nurses' studies described the 'expected' and the 'experienced' nurses' role in HP of older persons in an acute hospital. The summary of the findings from both studies defined that; health promoting nurses support older patients by assessing their needs and resources, they further enable the patients through counselling and health education, thus improving their autonomy and ability to cope with the changing circumstances associated with their ill-health and daily life situation. The healthcare experts participating in the Delphi survey described the knowledge, skills and attitudes required by a HP nurse in more detail. Although the health care experts declared HP was an integral part of nursing for all patients at any age, the findings from the bedside nurses' study clearly indicated the minor relevance of nurses' HP in daily clinical life. Furthermore, the bedside nurses identified the additional challenge of integrating HP interventions with the patient and their relatives. The bedside nurses stated that nurses act as an intermediary and delegate the responsibility of identified HP problems to experts. The findings from the older persons study show that the patients appreciated the HP advice given by the nurses, but their relatives did not receive the joint HP counselling as expected. The findings of the study confirm that HP by nurses in acute hospitals was important and meant a lot to the participating older persons. The majority of the elderly acted upon the HP advice given and added that further counselling by nurses' would have been appreciated.

Discussion: The actual situation of nurses' HP for older persons at the hospital has to be considered in relation to the commitment given to, and by, the nurses practising HP. This includes the defined competences of nurses' HP, the shared decision making and the integration of the older persons' family, the interprofessional collaboration, including the hospital management, nursing education and further research. Due to methodological limitations of this study, the findings have not been generalised but do indicate further directions to follow up on.

Conclusions: The findings clearly indicated that there is a gap between the theory and the practice of nurses' HP. If HP is to be an integrated part of professional nursing, as expected by the older persons and as required by the health care experts, the commitment to HP has to be improved and reinforced by all of the concerned parties. This is of upmost importance as the findings of this study clearly indicated that the daily clinical practice does not fulfil expectations. Specifically, there needs to be a clearly defined and agreed upon framework of

nursing HP so that all the engaged parties, involved in the interprofessional collaboration know and understand what their objectives are; that they are able to discuss any issues or challenges and can be rewarded appropriately. Finally, it is essential that the nurses and older persons along with their families make shared decisions during the planning, performing and analysing of health promotion activities. This is an absolute requirement to improve the quality of health promotion and quality of health in general.

TIIVISTELMÄ

Johdanto: Jo pitkään terveyden edistämistä ja sen tavoitetta auttaa iäkkäitä ihmisiä hallitsemaan ja parantamaan terveyttään on pidetty terveyden ammattilaisten tärkeänä tehtävänä. Tämä väitöskirja käsittelee sairaanhoitajien toteuttamaa terveyden edistämistä joka kohdistuu yli 65-vuotiaisiin henkilöihin akuuttisairaalassa. Työssä kuvataan terveyden asiantuntijoiden tähän terveyden edistämistoimintaan kohdistamia teoreettisia ja käytännöllisiä odotuksia. Lisäksi kartoitetaan kliinisen alan sairaanhoitajien ja sairaalassa olevien iäkkäiden ihmisten kokemuksia päivittäisen kliinisen työn osana harjoitetusta terveyden edistämisestä. Iäkkäitä ihmisiä pyydettiin myös selostamaan omia hoitajien sairaalassa toteuttamaan terveyden edistämiseen kohdistuvia tarpeitaan ja vaatimuksiaan.

Tavoitteet: Tutkimuksen tavoitteena oli selvittää, vastaavatko terveydenhuollon asiantuntijoiden vaatimat sairaanhoitajien terveydenedistämispätevyydet vanhusten tarpeita ja todellista tilannetta akuuttisairaaloissa työskentelevien sairaanhoitajien päivittäisessä kliinisessä työssä.

Materiaalit ja menetelmät: Väitöskirjatutkimuksen asetelmaksi valittiin mixed method research (MMR), eli monimenetelmätutkimus. Monivaiheinen asetelma rakentui kahdesta vaiheesta: ensimmäisessä vaiheessa noudatettiin selittävän sekvenssitutkimuksen mallia (explanatory sequential design) ja toisessa vaiheessa rinnakkaismuotojen yhdistämismallia (convergent parallel design). Jokaista uutta lähestymistapaa kehitettiin tutkimuksen edellisen vaiheen tulosten pohjalta. Ensimmäinen vaihe koostui kahdesta erillisestä ja vuorovaikutteisesta tutkimushaarasta. Ensimmäinen haara koostui Delfoi-menetelmään perustuvasta kyselystä, jolla selvitettiin terveydenhuollon asiantuntijoiden näkemys sairaanhoitajien akuuttisairaaloissa toteuttamasta yli 65-vuotiaiden potilaiden terveyden edistämisestä. Ensimmäisellä kierroksella kerätyt tiedot analysoitiin ja niitä muokattiin laadullisen sisältöanalyysin keinoin. Seuraavien kahden kierroksen kyselytuloksille suoritettiin kuvaileva tilastollinen analyysi. Toinen tutkimushaara koostui kahdesta kohderyhmäkeskustelusta, joihin osallistui akuuttisairaaloissa työskenteleviä sairaanhoitajia. Tässä tutkimushaarassa kootut tiedot analysoitiin kvalitatiivisesti Ralf Bohnsackin dokumentoivalla menetelmällä. Tutkimuksen toisessa vaiheessa suoritettiin kahdenkeskisiä haastatteluja ikääntyneiden kanssa

sairaalahoidon aikana sekä kotiutuksen jälkeen. Kolmannessa tutkimushaarassa vapaamuotoisia haastatteluja arvoitiin Mayringin kehittämän kvalitatiivisen sisältöanalyysin käsitteen pohjalta. Neljännessä tutkimushaarassa strukturoituun kyselyyn perustuvat haastattelut analysoitiin erikseen uudelleen kuvailevan tilastoinnin keinoin. Kokonaisanalyysi suoritettiin deduktiivisesti osittain Greenin ja Kreuterin määrittämään PRECEDE-PROCEED-malliin perustuen.

Tulokset: Sairaanhoitajiin keskittyvissä tutkimuksissa kuvattiin sairaanhoitajien "odotettua" ja "koettua" roolia ikääntyneiden terveyden edistämisessä. Molempien tutkimusten yhteenvedoissa luonnehdittiin, että terveyttä edistävät sairaanhoitajat tukevat ikääntyneitä potilaita arvioimalla heidän tarpeitaan ja voimavarojaan. Lisäksi hoitajat aktivoivat potilaita neuvomalla ja tarjoamalla terveysopetusta, mikä parantaa potilaiden itsenäisyyttä ja jaksamista heikkoon terveydentilaan liittyvien muuttuvien olosuhteiden keskellä ja arjessa. Delfoi-menetelmään perustuvaan kyselyyn osallistuneet terveydenhuollon asiantuntijat kuvasivat tarkemmin sairaanhoitajilta vaadittavia tietoja, taitoja ja asenteita terveyden edistämisessä. Vaikka terveydenhuollon asiantuntijat totesivat, että terveyden edistäminen on olennainen osa kaikkien potilaiden sairaanhoitoa ikään katsomatta, sairaanhoitajiin keskittyvän tutkimuksen tulokset osoittivat selvästi, että terveyden edistämisellä on vain hyvin pieni rooli sairaanhoitajien jokapäiväisessä kliinisessä työssä. Lisäksi sairaanhoitajat kokivat terveyden edistämiseen liittyvien interventioiden sisällyttämisen potilaiden ja näiden läheisten kanssa toteutettavaan hoitotyöhön haasteelliseksi. Sairaanhoitajat totesivat toimivansa välikäsinä ja delegoivansa tunnistettuihin terveyden edistämisen ongelmiin liittyviä vastuita asiantuntijoille. Ikääntyneisiin keskittyvän tutkimuksen tulokset osoittivat, että potilaat arvostivat sairaanhoitajilta saamiaan terveyden edistämiseen liittyviä neuvoja, mutta potilaiden läheiset eivät saaneet odotusten mukaista yhteistä terveydenedistämisneuvontaa. Tutkimuksen tulokset vahvistavat, että sairaanhoitajien sairaaloiden akuuttiosastoilla toteuttama terveyden edistäminen on tärkeää ja merkityksellistä tutkimukseen osallistuneiden ikääntyneiden näkökulmasta. Useimmat ikääntyneet noudattivat saamiaan terveyden edistämiseen liittyviä neuvoja ja totesivat lisäksi, että he olisivat mielellään ottaneet vastaan enemmänkin neuvoja sairaanhoitajilta.

Pohdinta: Sairaaloissa ikääntyneiden terveyttä edistävien sairaanhoitajien todellista tilannetta tulee tarkastella suhteessa heidän velvollisuuksiinsa ja sitoutumiseensa. Näihin sisältyvät sairaanhoitajille määritellyt terveyden edistämisen pätevyydet, ikääntyneiden perheiden yhteinen päätöksenteko ja osallistaminen, moniammatillinen yhteistyö, johon osallistuu myös sairaalan johto, sairaanhoitajakoulutus ja lisätutkimus. Tutkimuksen menetelmällisistä rajoituksista

johtuen tuloksia ei ole yleistetty, vaan niiden pohjalta on määritelty mahdollisia lisätutkimussuuntia.

Johtopäätökset: Tulokset osoittavat selvästi, että sairaanhoitajien toteuttaman terveyden edistämisen teoriat ja käytännöt eivät kohtaa. Jos terveyden edistämisen tulee sisältyä sairaanhoitajien työhön ikääntyneiden oletusten ja terveydenhuollon asiantuntijoiden vaatimusten mukaisesti, kaikkien asianosaisten tulisi parantaa ja vahvistaa sitoutumista terveyden edistämiseen. Tämä on erityisen tärkeää ottaen huomioon, että tämän tutkimuksen tulosten perusteella päivittäisen kliinisen työn käytännöt ei vastaa odotuksia. Sairaanhoidon osana toteutettavalle terveyden edistämiselle tulisi laatia selkeästi määritelty ja yhteisesti sovittu viitekehys, jotta kaikki moniammatilliseen yhteistyöhön osallistuvat tahot tiedostaisivat ja ymmärtäisivät toiminnan tavoitteet, pystyisivät keskustelemaan asioista ja haasteista sekä saisivat asiaankuuluvaa tunnustusta omasta työstään. Lisäksi olisi tärkeää varmistaa, että sairaanhoitajat ja hoidettavat ikääntyneet sekä ikääntyneiden perheenjäsenet osallistuvat yhteisesti terveyttä edistävien toimien suunnitteluun, toteutukseen ja analysointiin liittyvään päätöksentekoon. Tämä on terveyden edistämisen laadun sekä myös yleisellä tasolla terveyden parantamisen kannalta ehdoton edellytys.

(Translated from English to Finnish by multidoc translation service Tampere, www.multidoc.fi)

CONTENTS

1 INTRODUCTION

This dissertation describes the actual situation with regards to health promotion by nurses of older persons' aged 65+ in acute hospitals in Switzerland. Described are the theoretical and practical expectations of health care experts with regards to nurses' health promotion for older persons in acute hospitals. Furthermore, the clinical nurses' experiences and the hospitalised older persons' perceptions of the performed health promotion activities in the daily clinical life have been recorded.

Nurses' and health care experts were asked to identify the theory and the practice of the meaning of 'nurses' health promotion for older persons in hospitals'. Additionally, older persons were asked to explain their needs and requirements concerning health promotion performed by nurses at the hospital.

Firstly, the theoretical background information based on the review of the previous literature looking into health promotion by nurses of older people has been defined. Secondly, the empirical study has been outlined and has been divided into two parts, the nurses' study and the older persons' study. An overall picture is presented through the analysis and comparison of the findings of the nurses' study and the older persons' study. The overall analysis was performed using the educational and ecological assessment of the PRECEDE- PROCEED model (Green & Kreuter, 2005). The discussion and recommendation, the third part of the dissertation provides insightful discussions into the findings of health promotion by nurses of older persons 65+ in acute hospitals in Switzerland. The conclusions have been formed from the perspective of health care expert, nurses and the older people 65+.

For many years, and especially since the Ottawa Charter (WHO, 1986), health promotion has been a recommended task and plays a highly integrated role throughout the different health professions. The aim of Health promotion is the process of enabling people to increase control over and improve their health to reach the best state of physical, mental and social well-being (WHO, 1986). The World Health Organisation (WHO, 2006) has suggested that hospitals are

appropriate settings for health promotion. Furthermore, the Munich declaration (WHO, 2000) states that nurses' have a key and increasingly important role to play in society's efforts to tackle the public health challenges of our time. This role enhances the provision of high-quality, accessible, equitable, efficient and sensitive health services to ensure the continuity of care and addresses patients' rights and their changing needs. The declaration additionally urges the increase of action to strengthen the role of European nurses in public health, health promotion and community development (Brieskorn- Zinke, 2003; Büscher & Wagner, 2005; Fischer & Danzon, 2000).

For some time health promotion has been considered an integral part of the Swiss nursing education curriculum. As is clearly described in the 'BSc Nursing skills and competence criteria' professional nurses are responsible for motivating patients to take care of and be in charge of their own health. They are there to support the population in helping them adjust to the evident changes in their lives. According to the definition of professional nursing at the Institute of Nursing at the University of Basel, disease prevention and health promotion plays an important role in the working relationship of professional nursing, patients and relatives (Spichiger, Kesselring, Spirig & De Geest, 2006).

In Swiss hospitals, the majority of patients are older persons (Swiss statistics, 2014) and healthy ageing adults. It is for this specific reason that health promotion for people aged over 65 years is becoming increasingly important. When considering the demographics, for Switzerland from 2005-2050, the Federal Administration of Statistics show a significant change in age culture caused by an awaited increase in the elderly population. The life expectancy in Switzerland is 84.4 years for women and 80.5 years for men and is in fact amongst the highest in the world (BFS, 2010, Swiss statistics, 2014). The retirement age is 64 years for women and 65 years for men. In comparison to previous generations and on a general basis, the elderly remain healthier longer and usually discover physical, psychological and social restrictions later on in life (Höpflinger & Hugentobler, 2003). The Swiss health department (Gesundheitsziele für die Schweiz, BAG, 2002) aims to define and requires a systematic approach to deal with healthy ageing (Ackermann, Paccaud, Gutzwiller & Stutz Steiger, 2002). It has become an important part of one's life to maintain one's independence and quality of life as long as possible, for ethical and economic reasons (Weaver et al., 2008).

The current and future changes affecting us in the population and family structure are essential in this new formula and must be taken seriously. The number of older persons needing care will undoubtedly increase in the future due to the increased mobility and professional prospects of women and men, the increased divorce quotas and couples choosing not to have children. Currently, relatives play an important role in providing health care for older persons after hospital discharge in Switzerland (Perrig-Chiello, Höpflinger & Schnegg, 2010). The majority of the Swiss population is involved in professional careers and no longer has the ability to provide twenty-four hour home care duty, this has become much more limited due to their high workloads. As a consequence, the limited family/relative resources may increase the in-patient care at hospitals and will very likely reduce the support provided by family members during the patients' hospitalisation. It is important to recognise as, Groene & Jorgensen (2005) emphasized that there is evidence that patients are more receptive to advice and counselling in situations of experienced ill health. Additionally, in a survey conducted by McBride (2004), it was confirmed that there is a growing international awareness for health promotion in the hospital and the survey further states the increasing interest of receiving health promotion for the adult patient.

More recent literature indicates that Public Health Services and Ethics are becoming increasingly more important. An example of this is the ongoing discussion requiring the ban on the sale of cigarettes, which have a considerable impact on the populations' health, and threatens behaviour. This has to be acknowledged by all health care professionals (Grill & Vogt, 2015).

Health promotion addresses all health professionals at the hospitals. Nevertheless, nurses do have an extremely important role to play to ensure health promotion activities. Nurses have the most frequent contact with patients (McBride, 2004) and the "core of nursing", is the professional nurse-patient relationship that supports the opportunities for health promotion activities (Halldorsdottir, 2008).

Literature however also describes clear barriers for nurses' regarding health promotion in clinical practice. Seedhouse (2004) underlines the lack of a common understanding of health promotion among health professionals this is reinforced by Kelly & Abraham, (2007). Recent literature clearly supports the ongoing need for a clear explanation of the health promotion concept (Kemppainen, Tossavainen & Turunen, 2012; Whitehead, 2010).

There are various definitions of nurses' health promotion in the literature available (Casey, 2007a; Kelly & Abraham, 2007; Naidoo & Wills, 2009; Seedhouse, 2004; WHO, 1986). The literature shows that the nurses are unsure of their understanding of health promotion (Casey, 2007b; Latter, 2001; Whitehead, 2004, 2010). A further obstacle, which results in the missing clarity about the role of health promotion in nursing, is the unavailable practical details of health promotion activities, which need to be applied in practice (Berg, Hedelin & Sarvimäki, 2005; Caelli, Downie & Caelli, 2003). Moreover, Caelli, Downie & Caelli (2003) identified that, even nurses who were considered experts in health promotion, had difficulty in describing their health promotion practice (Whitehead, 2008). The literature approves different authors who have tried to tackle this challenge with descriptions of health promotion activities by nurses (Kemppainen et al., 2012; Piper, 2008, 2009; Whitehead, 2006).

This leads to the question of, what is the present day situation of nurses' health promotion for older persons in the acute hospital setting in Switzerland. How do nurses introduce the theory and practice of health promotion and what effect does this have on the professional daily routine of an acute hospital? What is the meaning of health promotion of the older persons by nurses in the daily routine of an acute hospital?

In this dissertation health promotion by nurses in acute hospital settings is addressed using the opinions of health care experts and the judgement of clinical nurses'. Also clearly addressed are the requirements and engagement of hospitalised older people 65+ as an essential part of the study.

2 THE THEORY OF NURSES' HEALTH PROMOTION FOR THE OLDER PERSONS

2.1 Health Promotion

The World Health Organisation (WHO) describes health as a resource for everyday life and not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities. The prevention of diseases is linked to the biomedical model, which describes health with the absence of disease or illness (Naidoo & Wills, 2009). Health promotion derives from the salutogenic concept and is defined as the process of enabling people to exert and increase control over the determinants of health as well as improving their health to live an active and productive life (Antonovsky, 1996; Erikson & Lindstrom, 2008; Nutbeam, 1998; WHO, Ottawa Charter, 1986). Advocacy, enabling and mediation are the three basic strategies for health promotion identified by the Ottawa Charter. "Advocacy for health", stands for the process to generate the essential conditions for health. Through "enabling", the people should be supported to achieve their full health potential and with the support of mediation, the different interests in health should be recognized among the society. Health promotion not only supports the increase of individual health knowledge, it aims to avoid illness and to raise the awareness and capability of using the available health services (Naidoo & Wills, 2009). A quick reference guide for comprehension of the full screening of health promotion is the WHO Health Promotion Glossaries (Smith, Tank & Nutbeam, 2006).

Nutbeam (2000, 1996) increases the understanding of health promotion using his model "outcome for health promotion" (figure 1) to distinguish the different levels of outcome. The coupling of modifiable determinants of health (healthy lifestyles, effective health services and healthy environments) and intervention impact measures (health literacy, social action and influence, public health and organisational practice) together with health promotion actions (education, social mobilization and advocacy) strongly determine the health and social outcomes.

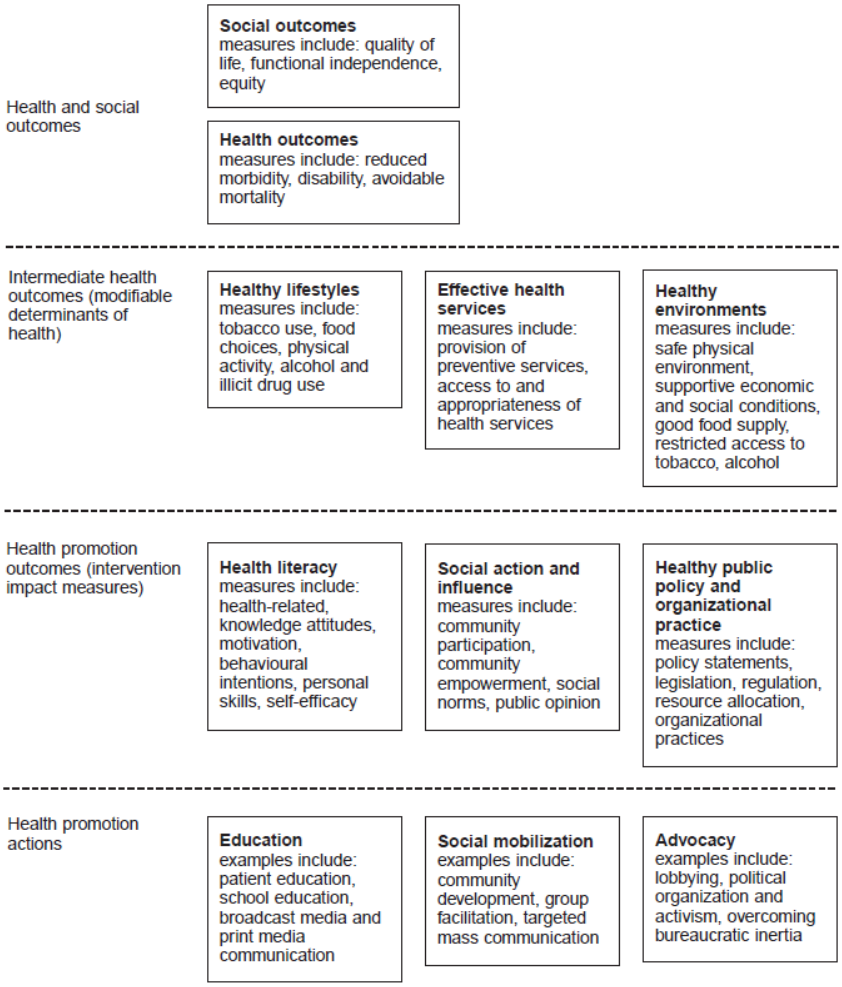

Figure 1. An outcome model for health promotion, Nutbeam, 2000, p. 262

Health promotion is defined in different terms and concepts, throughout the currently available literature (Maben & Macleod Clark, 1995; Piper, 2008; Whitehead, 2004). Saylor (2004) describes health promotion as life style coaching for good health, quality of life and well-being. Irvine (2007) refers to the concepts analysis of Maben et al. (1995) and Whitehead (2004). Her approach is to differentiate between the health promotion activities along with the top-down focus on health education, life style coaching and behaviour change and the new paradigm of health promotion with the bottom-up focus on empowerment and

social change (Irvine, 2007). Alternately, Naidoo & Wills (2009) describe the five approaches of health promotion, medical, behavioural, educational, empowerment and social change in detail. This medical or preventive approach keeps the focus on the reduction of morbidity and mortality. The behavioural change approach encourages individuals to lead a healthier lifestyle. The aim of the educational approach is to provide the necessary knowledge, information and skills to enable the individual to make a voluntary and informed choice about their health behaviour.

By following the empowerment approach people are able to gain control over their lives (WHO, 1986). They are encouraged to make their own choices and facilitate their activities autonomously. The fifth approach is social change, which refers to the socio-economic environment and public health policies (Naidoo & Wills, 2009).

Literature portrays different models of health promotion, in addition to those from Nutbeam (2000), (for example, Beattie, 1991; Caplan & Holland, 1990; Ewles & Simnett, 2003; Naidoo & Wills, 2009; Tones & Tilford, 2001) and other various theories on health behaviour and health behaviour change with regards to individual characteristics. Examples of this are, the health belief model (Janz & Becker, 1984), the theory of planned behaviour (Ajzen, 1991), the transtheoretical model (Prochaska & DiClimente, 1984) and the social cognitive theory (Bandura, 1986). Furthermore, there are theories on changes in community health, such as the diffusion of innovation theory (Rogers, 1983).

Due to the volume of models present, a precise definition of what health promotion means and entails can be confusing (Piper, 2009; Rawson, 2002). Also Piper (2008) states that an agreement on a common model for conceptualising theory and practice in general is still undetermined. Mcdonald & Bunton (2002) argue that the health promotion definition might be inconsistent in the near future as health promotion is strongly linked to social and political influences, they emphasise the much-needed increase of interdisciplinary co-operation in health promotion development (Mcdonald & Bunton, 2002). This is confirmed by Naidoo & Wills (2009), they argue "if health promotion is to progress as a discipline and an activity in its own right, a strong theoretical framework is needed" (Naidoo & Wills, 2009, p.81). Furthermore, in order to make a meaningful impact

to health promotion in the different disciplines the mainstream terminology must be recognized by all the stakeholders (Piper, 2009).

The current literature identifies a further point of discussion with regards to health promotion. A decade ago, Green (2000) requested an editorial evidence base for health promotion and strongly expressed the core importance for an appropriate theory regarding the implementation of a health promotion program and an evaluation. Her requirements are due to the strong link between the accumulation of empirical evidence and the development of theory. This is supported by Whitehead (2003), who offers a process model for evaluating nursing health promotion. Subsequently, the nurses' health promotion profile should be improved by engaging in concerted evaluation research strategies and the publication of the findings.

Moreover the PRECEDE-PROCEED model (figure 2) introduced by Green & Kreuter (2005, 1980) is widely used as a framework. The model has been evaluated and presented in the literature (Phillips, Rolley & Davidson, 2012; Tramm, McCarthy &Yates, 2012; Yamada et al., 2015). The acronym PRECEDE stands for Predisposing, Reinforcing, and Enabling Constructs in Educational Diagnosis and Evaluation. The acronym PROCEED stands for Policy, Regulatory and Organisational Constructs in Educational and Environmental Development. The PROCEED- PRECEDE model with its educational and ecological approach contains eight phases and is a framework for health program planning, practice and evaluation. It allows for the identification of health behavioural and environmental factors and predictors for intervention with the focus on participation at the multilevel context. The process behind this model gives a deeper insight into the relationship of the predisposing factors such as the knowledge, attitudes, practice and their sociocultural and psychological backgrounds. In addition the enabling factors referred to skills, resources and barriers and the reinforcing factors as reward and feedback (Green & Kreuter, 2005).

Green & Kreuter (2005) explain that the model integrates the epidemiological, economic, psychological and sociological theories used to guide these complex ideas. Particularly, the concepts of Participation (Levasseur, Richard, Gauvin & Raymond, 2010), the Health Belief Model (Janz & Becker, 1984), the theory of planned behaviour (Ajzen, 1991) and the Social Cognitive Theory including the concept of self-efficacy (Bandura, 1986) have been included.

Tramm et al. (2012) describe the model as a mutual approach that tackles the complexity of the interrelations between people and their environment. This is imperative influencing health behaviour change.

Recent literature (Tramm et al., 2012) continues to support and approve of the PRECEDE-PROCEED model stating that the model offers a competent theoretical framework for the development of nursing health promotion interventions.

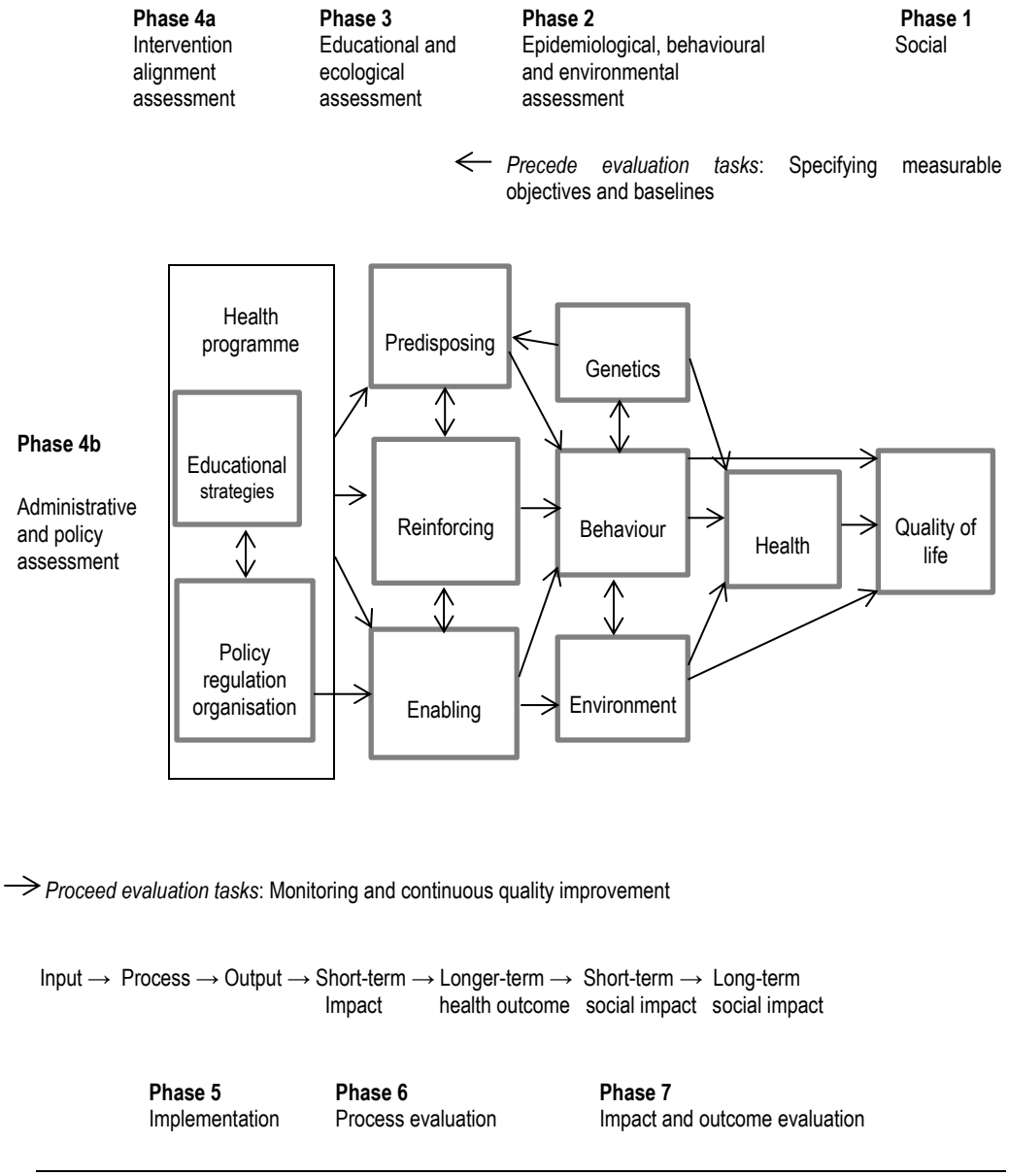

Figure 2. PRECEDE- PROCEED Model, Green & Kreuter, 2005

2.2 Health Promotion at Hospitals

The WHO (2006) has suggested that hospitals and health services are appropriate settings for health promotion. This is confirmed in the literature and has been testified to by patients and their families as being more sensitive to advice or contemplating behavioural change intervention during the hospitalisation phase (Groene, Alonso & Klazinga, 2010; Groene & Jorgensen, 2005; McBride, 2004). The survey conducted by McBride (2004) affirms the growing international awareness of health promotion in hospitals and the results clearly show the interest of the adult patient receiving health promotion. Nevertheless, she suggests the need for some improvement, the joint support of policies and the practice of an increased integration of health promotion into the culture of the hospital should be considered (Aujoulat et al., 2001; McBride, 2004). Moreover the positive outcomes of the investment into Health Promotion activities at the hospital have to be approved (Groene & Jorgensen, 2005). Furthermore standards and assessment tools to improve the quality of health promotion at the hospital have been requested (Groene & Jorgensen, 2005).

The aim of the international network of Health Promoting Hospitals (HPH) which is a World Health Organisation (WHO) concept is to encourage hospitals to actively work towards being a model healthy organisation. The Network of Health Promoting Hospitals and Health Services have developed a health promotion standard and a self- assessment tool to facilitate the implementation of health promotion in hospitals (Groene et al., 2010; WHO, 2006, 2004). The standard addresses the topics of patient assessment, patient information and intervention, healthy workplace environment and the improvement of continuity and cooperation (WHO, 2004).

In the international Network of Health Promoting Hospitals 40 member states are currently registered, this includes more than 700 hospitals and health services (HPH, 2016). Groene & Jorgensen (2005) argue that despite the missing legislative support in many European countries the network of members has continuously increased. However the Swiss HPH Network was discontinued in 2013/2014 and none of the participating hospitals chose to stay on as individual members.

Interestingly enough the Network of Health Promoting Hospitals believes that the increase in costs of health care while improving quality of life can be counteracted

through health promotion. A matter of concern in the current situation of health promotion is that there is no pre- approval of intervention costs. This is in relation to, the introduction of Diagnosis Related Groups (DRG) in January 2012 into Swiss hospitals. As the length of hospital stays become shorter and curative medicine determines the everyday care, alternative solutions are being looked in order to support the quality of life of older patients and avoid rehospitalisation (Busato & von Below, 2010; Fourie, Biller-Andorno & Wild, 2014).

2.3 The Nurses Role in Health Promotion

The Munich declaration states that nurses have a key and increasingly important role to play in society's efforts to tackle the public health challenges of our time. This role enhances the provision of high- quality, accessible, equitable, efficient and sensitive health services, which ensures the continuity of care and addresses patients' rights and changing needs. The declaration additionally urges the increase of action to strengthen the role of European nurses in public health, health promotion and community development (Brieskorn- Zinke, 2003; Fischer & Danzon, 2000). Recent literature supports this even though the public debate, research activities and health policies have little impact on nursing practice (Irvine 2007; Kemppainen, et al., 2012; Whitehead, 2010; Whitehead & Irvine, 2011).

Nevertheless, the healthcare provided, plays an important role in the promotion and maintenance of health. Professional nurses motivate patients to take care and take charge of their own health. They support the population in helping them adjust to the evident changes in their lives. According to the definition of professional nursing at the Institute of Nursing, University of Basel, disease prevention and health promotion play an important role in the working relationship of professional nurses, patients and relatives (Spichiger et al., 2006). The main goal is to convey the basic knowledge and necessary information to enable the patient to realise and motivate his own responsibility (Bosch-Capblanch, Abba, Prictor & Garner, 2007; Kempainenet al., 2012).

Supporting this, Brieskorn-Zinke (2006) formulated interventions and strategies for health behaviour change in regards to the patients' competences improvement. The strategies of Brieskorn-Zinke (2006) are considered in the curricula of the Nursing Diploma program at the College of Nursing in Bern (Höhere Fachschule, HF). Furthermore, the Bachelor in Nursing Studies at the Bern University of Applied Sciences (BFH) includes health promotion in several modules and it is integrated into each of the semesters. This is proof that public health, health promotion and disease prevention are an integrated part of the Swiss nursing educational system.

Additionally, there are various, more specific advanced trainings in health promotion for nurses and different universities offer a master's degree in the advanced studies in disease prevention and health promotion program.

Indeed, nurses' competences in health promotion are required as health promotion is among the categories of the NANDA-International system of nursing diagnosis. NANDA-I, the North American Nursing Diagnosis Association is the organisation working on the development and the integration of standardized nursing diagnoses worldwide (Ackley & Ladwig, 2008). Likewise health promotion is an integrated part of the nursing process which includes five steps to ensure the quality of care (Doenges, Moorhouse & Murr, 2008). The approach comprises of the assessment and the identification of the nursing diagnosis in addition to the planning and the implementation of required interventions and finally the evaluation to determine the effectiveness of the nursing interventions. Examples of nursing diagnosis in regards to health promotion are "ineffective Health Maintenance", "impaired Home Maintenance" or "Health- seeking Behaviours" (Doenges et al., 2008).

Nevertheless, there are various definitions of nurses' health promotion in the literature (Casey, 2007a; Kelly & Abraham, 2007; McBride, 1994; Naidoo & Wills, 2009; Seedhouse, 2004; WHO, 1986). Furthermore, authors underline the lack of a common understanding of health promotion among health professionals (Kelly & Abraham, 2007; Seedhouse, 2004). Maben & Macleod Clark (1995) and Whitehead (2004) published a concept analyses on this specific topic. Recent literature clearly supports the on going need for a clearer, more succinct explanation of the health promotion concept (Kemppainen et al., 2012; Whitehead, 2010). The results of the integrative review of Kemppainen et al., (2012) describe two main approaches concerning the theoretical basis of nurses' health promotion. In the review, the authors identify the health promotion orientation with a holistic and patient-orientated attitude, the public health orientation that includes chronic diseases, and the medical orientated approach (Kemppainen et al., 2012).

The traditional health promotion concept focuses on health education, lifestyle and behaviour change and the new health promotion paradigm emphasises empowerment and community development (Irvine, 2007).

Also discussed in the literature are the legitimacy and the role of the professional nurse and a conceptual framework is requested for effective nursing- related health promotion (Gott & O'Brien, 1990; Whitehead, 2004). Such a framework has been developed by Piper (2009). He identified three key approaches, "the nurse as a behaviour change agent", "the nurse as an empowerment facilitator" and "the

nurse as a strategic practitioner". This is confirmed in the framework of Kemppainen et al., (2012) which classifies the nurses as "general health promoters", "patient- focused health promoters" and "managers of health promotion projects".

The literature describes various health promotion activities undertaken by nurses with Kemppainen et al., (2012) classifying the nurses' health promotion competencies in multidisciplinary knowledge, skill related knowledge, competences with respect to attitudes and personal characteristics (Kemppainen et al., 2012).

The literature however shows that the nurses are unsure of their understanding of health promotion (Casey, 2007b; Gott & O'Brien, 1990; Latter, 2001; McBride, 1994; Twinn & Diana, 1997; Whitehead, 2010, 2004). An obstacle, which results in the missing clarity about the role of health promotion in nursing, is the unavailability of practical details regarding health promotion activities that need to be applied in practice (Berg et al., 2005; Caelli et al., 2003). Furthermore Caelli et al. (2003) identify that, even nurses who were considered experts in health promotion, had difficulty in describing their health promotion practice (Whitehead, 2008). As nurses' work in inter-professional teams, in cooperation between physicians, health therapeutic professionals and social workers this obscurity presents many challenges in their daily clinical work.

Consequently "nurses must recognize that health promotion is a broad concept that does not exclusively focus on the individual or specific lifestyle factors. Nurses must be educated to recognize health – promoting opportunities in the acute setting, as well as know how to plan for and conduct health promotion so that it becomes integral to practice" (Casey, 2007b, pp1039).

This is confirmed by Piper (2008) who clarified the need for a common education strategy and curriculum for health promotion in nursing. Pender, Murdaugh & Parsons (2006) also supports the missing theory-based health promotion education for nurses. Priority and importance should be given to the common health promotion terminology and to increasing the nurses' health promotion knowledge, skills and attitude. The adaption of a consensus view, which contributes to the interdisciplinary health promotion debate among the associated policy and practice issues, is highly recommended (Casey, 2007b; Piper, 2009; Whitehead, 2010, 2008). Whitehead (2005) urges health care professionals in hospitals to take an active role in health promotion. He argues that instead of dealing with health education issues

that are limited to localised ward-based practices, nurses should be actively engaged in a much broader health-related role and should have more responsibility in health-related affairs management (Whitehead, 2008).

2.4 Health Promotion of Older Persons

In general, global life expectancy has increased and in Europe, people of retirement age can expect to live, on average, twenty two years longer, due to medical innovation, new technology and socio-economic improvements (WHO, 2014).

There is no United Nations standard numerical criterion with regards to the older population, but it was agreed that the cut-off age would be 60+ years of age (WHO, 2014). Chronological age however does not follow systematically with the changes inherent in ageing, one is as old as one feels and the environment play a role. The World Health Organisation (WHO, 2014) supports the differences in the health status, by showing different levels of participation and independence among older persons of the same age. The literature available today refers to three subgroups of older persons, as it is known that the older persons' age group extends three to four decades. First the "younger old" with the ages of 65- 74years, second the "older old" including the ages from 75-85years and subsequently the third "oldest old" with the age of 85 years and above (Crews & Zavotka, 2006).

Despite the increase in the worldwide older population, health promotion for older persons of all age groups has been of minor importance for many years. The health care burden changed during the 20th century and infectious diseases were replaced by chronic health problems, which are strongly linked to ageing (Marengoni et al., 2011). Effectively, during the last few years the awareness of the ageing phenomenon has been progressively considered more important in social science and humanities research.

Recent literature topics on the various health promoting interventions for older persons include, among others, smoking cessation, physical activities, nutrition, hypertension, falls prevention, poor oral health, osteoporosis, medication safety and patient involvement and safety (Besdine & Wetle, 2010; Gschwind, Wolf, Bridgenbaugh & Kressig, 2011; Hall et al., 2010; Neidrick, Fick & Loeb, 2012; Shariff-Ghazali, Browning & Shajahan, 2013; Simek, McPathe & Haines, 2012). Additional foci include preventive home visits (Behm et al., 2013; Gustafsson et al., 2012) and health literacy among older people (Zamora & Clingermann, 2011). More recently additional topics have emerged such as the meaningful social role (Heaven et al., 2013) as well as loneliness and social isolation (Aartsen & Jylhä, 2011; Nyqvist, Cattan, Andersson, Forsman, & Gustafson, 2013). Social

participation is an important factor for life quality and healthy aging for older persons (Levasseur et al., 2010).

Further studies explain mental health and health promotion such as the study of Price & Keady (2010), which describes health promotion in vascular dementia.

The majority of studies are adapted to the medical or preventive approach of health promotion (Naidoo, & Wills, 2009) and refer to age related-chronic diseases or to specific illnesses such as cardiovascular diseases (Moher et al, 2001; Murchi, Campbell, Ritchie, Simpson & Thain, 2003). Several studies have focused on the educational approach for example the fall prevention study or the diabetes education program study (Dykes et al., 2010; Heinrich et al., 2012). Additionally part of the literature includes studies which address behaviour change approaches encouraging life style interventions such as physical activities and improved diet to cancer survivors (Meraviglia, Stuifbergen, Parsons & Morgan, 2013; Morey et al., 2009). Examples for an empowerment approach are the preventive home visit studies and the diabetes self-management study (Behm, Ivanoff & Zidén, 2013; Gustafsson et al., 2012; Rygg, Rise, Gronning & Steinsbekk, 2011). The study of Perna et al. (2012) is closely allied to social change approach by Naidoo & Wills (2009).

A point of concern is the limited methodological quality of the studies available (Gschwind et al., 2011; Price & Keady, 2010; Shariff- Ghazali et al., 2013; Simek et al., 2012). The missing focus for the assessment of patient involvement (Hall et al., 2014) is a critical point, which also needs to be addressed.

Moreover, Wilson & Palha (2007) state the importance of health promotion for retired persons and require further research on the topic of health promotion and retirement. The majority of the health promotion intervention programs have been designed for the adult population in general and the older population was addressed only as a homogenous group (Dykes et al., 2010).

2.5 Health Promotion for Older Persons in Hospitals

The percentage of older persons affected by one or multiple chronically diseases due to natural aging is increasing. The prevalence of multi-morbidity is increasing in very old persons, women and people from lower social classes (Marengoni et al., 2011). Ageing progressively goes along with functional impairment and poorer quality of life and the population affected is harassed by high health care utilization alongside financial consequences due to their health situation (Marengoni et al., 2011).

Since the number of older people living in their own houses is increasing and the majority are capable of living independently, despite the consequences of ageing (Crews & Zavotka, 2006), the role of the family care giver has become increasingly important. Living at home, for older people goes along with being autonomous and the capability of taking care of oneself (Berg et al., 2006). In Switzerland, family members and their family doctors mainly support this and only a minority requires in-home care-giving (Perrig-Chiello et al., 2010). The family care-givers subsequently play an important role in preventing unnecessary hospitalisations and re-hospitalisation. Support for these caregivers in their role is required. (Tao, Ellenbecker, Chen, Zhan & Dalton, 2012).

Due to environmental changes, acute hospital admission can be stressful for older patients and their families. It can lead to the loss of the older persons' sense of identity and autonomy. The literature describes the older patients' difficulties when they have to consider their own health related decisions (Berg et al., 2010; Resnick, 2003). In addition, this might be complicated by low health literacy, which is highly prevalent among older peoples (Baker et al., 2007; Sequeira et al., 2013). In Switzerland low health literacy is an important challenge and the results of a recent representative survey (BAG, 2015) showed that low general health literacy lies just in access of the European average. The figures show about half of the elderly surveyed participants 65+ presented problematic or insufficient health literacy (BAG, 2015).

The older patient may not consider their own health expertise and the understanding of health promotion might be confusing (Berg et al., 2010, 2006; Cavanagh et al., 2007). Studies show that especially frail older persons have limited engagement in health promotion participation with restricted interest to gain

control over their own health (Berg et al., 2010; Janlöv, Hallberg & Peterson, 2006). Arguments like this might lead to a conflict with the ethical principal of respect for the individual autonomy. In a study conducted by Berg et al. (2010) the ethical dilemma was described by nurses dealing with older patients. They reported that their patients were not capable or willing to be empowered or act autonomously. Hughes, Poole & Louw (2013) also discuss the difficulty of balancing between respect for autonomy and the need for beneficence. They argue that autonomy goes along with dependency and is interrelated with other persons. If autonomy is enjoyed it can be beneficial and therefore nudging older persons into semi-supervised care might be considered (Hughes et al., 2013).

In the study of Berg et al. (2006) the requirements for health promotion of the older hospitalised persons is information, knowledge, hope and motivation, as well as the nurses' appreciation of the person they are. Though Breitholz, Snellmann & Fagergerg (2013) argue that nurses might not respect the older patients as individuals especially under stressful, time restricted situations.

Considering the nurses' view, the literature shows that nurses were supportive to health promotion for older persons but stated their concerns about effectiveness in changing behaviour (Kelley & Abraham, 2007).

As mentioned in the previous chapter there is definitely a need for further research in health promotion for older persons, especially regarding health promotion for elderly patients in the routine practice of the acute hospital setting. Currently, there are only a small number of research projects on this matter being undertaken (Berg et al., 2010, 2006; Kelley, & Abraham 2007; Markle-Reid, Browne & Gafni, 2011). Health promotion by nurses, which consider the multifaceted needs of older hospitalised persons, is required (Berg et al. 2006). Health care treatment needs to be adapted for older persons due to the changes in social structure, increasing health care costs and shorter hospitalisation periods. The major question is, do the competences of the nurses' health promotion, which are required by health care experts', meet the older persons needs and do they correlate to the actual situation of the daily clinical work of nurses at the acute hospital setting.

2.6 Summary

There is no clear concept for health promotion despite the WHO's definition in the Ottawa Charter (1986) and the many models evident in the literature to date. Health promotion for older persons of all age groups has been of minor importance for many years and it is only in the last decade that increased importance has been given to this topic. Nurses are unsure of the definition of health promotion, what it entails and how this can be adapted for the older patients in an acute hospital setting. Several scientific studies have concluded the following: health promotion should be part of nursing but there is a lack of relevant knowledge. Skills and training are urgently needed but not necessarily provided (Casey, 2007b; Kelley & Abraham, 2007; Whitehead, 2005). Despite the fact Public health, disease prevention and health promotion are an integrated part of the nursing education, the value of health promotion by nurses should be encouraged further and be supported by institutional health-care managers (Casey, 2007a; Kempainen, Tossavainen & Turunen, 2012). Furthermore, the requirements for health promotion of the older hospitalised persons are information, knowledge, hope and motivation, as well as the nurses' appreciation of the individual they are (Berg et al., 2006). This goes along with the statement of Breitholz, Snellmann & Fagergerg (2013) who argue that nurses might not respect the older patients as individuals especially under stressful, time restricted situations.

As mentioned above there is a definite need for further research in nurses' health promotion for the elderly and patient involvement in health promotion during routine practice in the acute hospital setting.

3 AIMS OF THE STUDY AND RESEARCH QUESTION

Health promotion is defined as the process of enabling people to exert and increase control over the determinants of health as well as improving their health to live an active and productive life (Erikson & Lindstrom, 2008; Nutbeam, 1998; WHO, Ottawa Charter, 1986). Health promotion strategies such as advocacy, enabling and mediation are becoming increasingly important to health professionals. Professional nurses motivate people to take care and to be in charge of their own health. Empowerment and health education are a central part in the working relationship of professional nursing, patients and relatives. An obstacle, which results in the missing clarity about the nurses' role in health promotion for older persons at the hospital, is the unavailability of practical details for health promotion activities that need to be applied in daily clinical practice (Berg et al., 2010, 2005; Kemppainen et al., 2012).

The main question is about the present day situation of nurses' health promotion for older persons in the acute hospital setting in Switzerland. Do the competences of nurses' in health promotion, which are required by health care experts', meet the nurses' health promotion activities in daily clinical practice and do they correlate to the expectations and needs of the older persons?

The purpose of this dissertation is the analysis of health promotion by nurses of older persons 65+ in acute hospitals from the perspective of nurses and older patients. This challenge requires attention on multiple levels and across different dimensions. The central aim is to firstly identify the requirements for the role of nurses in health promotion for older persons in an acute hospital setting in Switzerland, and secondly, to identify the needs and requirements of hospitalized older patients 65+ with regards to health promotion by nurses in an acute hospital.

The study was divided into sub-aims and the research questions were as follows:

- What are the general expectations and requirements for the role of nurses in health promotion for older persons in an acute hospital setting?

- What are the required knowledge, skills and attitudes needed to fulfil the role of a health-promoting nurse?

- How do the health care experts' general expectations and requirements for nurses' health promotion for the elderly patients in an acute hospital setting correspond to the daily clinical situation?

- What is the actual meaning of health promotion by nurses for older persons in acute hospital from the professional nurses' perspectives?

- What is the meaning of health promotion by nurses for older persons in an acute hospital setting from the older patients 65+ perspective?

- Which expectations and requirements do older persons 65+ have in an acute hospital setting, with reference to health promotion?

- What are the barriers and resources necessary regarding health promotion for older persons 65+ in hospitals, taking into account the gender, age and environmental factors involved?

4 STUDY DESIGN

For this dissertation, the mixed method multiphase design (figure 3) was selected as this design offers the flexibility needed to address the layered research questions and interconnected samples. It was assigned as the central methodological framework (Creswell & Plano Clark, 2011) and was conducted with single mixed methods that combined sequential and concurrent phases. The multiple study questions were addressed by the repetition of connected quantitative and qualitative studies sequentially aligned. Each new approach was developed on the results of the previous phase of the study.

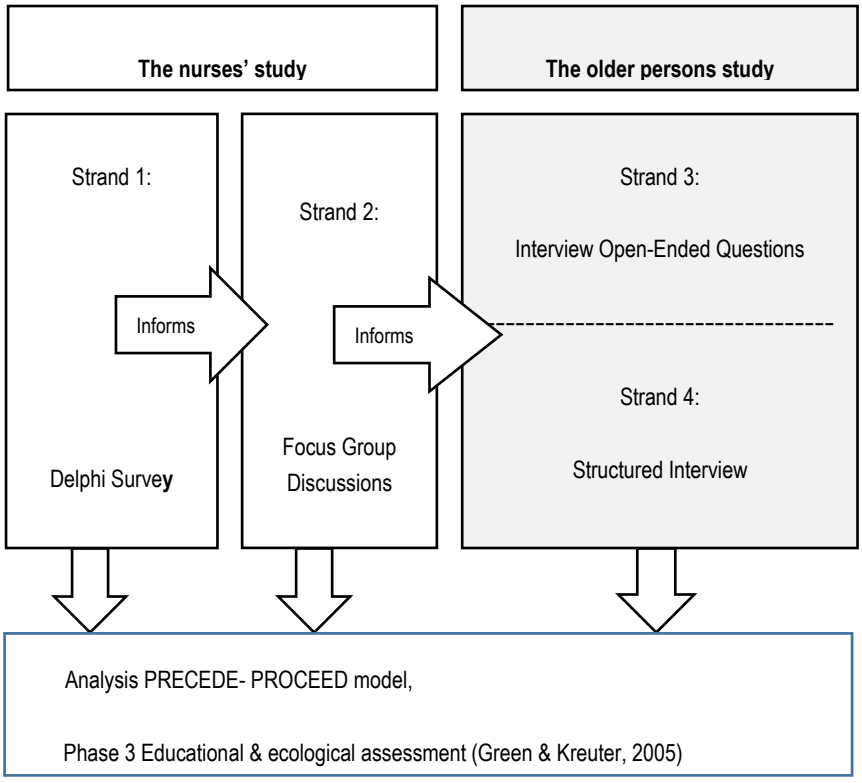

Figure 3. Design of the study

The philosophical paradigm as the foundation of this multiphases design is pragmatism (Creswell & Plano Clark, 2011; Johnson & Onwuegbuzie, 2007). This philosophical assumption is related to the mixed methods approach and supports the overarching research question as the focus lies on the usefulness or the consequences of accepting an ideology or proposition from a practical point of view; unpractical ideas are to be rejected (Creswell & Plano Clark, 2011; Lavelle, Vuk & Barber, 2013). The purpose of using the mixed methods design is to gain a more holistic understanding of the nurses' and older persons' needs and requirements in health promotion. The study is further supported by higher evidence through the breadth and depth view, rather than the use of a quantitative or qualitative approach alone (Creswell & Plano Clark, 2011; Ivankova, Creswell & Stick, 2006; Mayoh, Bond & Todres, 2012).

The nurses' study is guided by the explanatory sequential design. The qualitative method supports the interpretation of the quantitative results (Creswell & Plano Clark, 2011; Pluye & Hong, 2014). The explanatory sequential design includes two parts. Firstly, a Delphi survey, which identifies the opinion of health care experts about health promotion by nurses for older persons 65+ in an acute hospital setting, was conducted. Secondly, two focus group discussions with bedside nurses in an acute hospital setting were organized. The themes of the focus groups were based on the findings from the Deplhi survey. The main purpose was to analyse whether, and to what extent, the results of the discussions of the bedside nurses' support and confirm the opinions expressed by the health care experts in the Delphi surveys.

The older persons study was conducted using the convergent parallel design (Creswell & Plano Clark, 2011; Pluye & Hong, 2014). It included face- to-face interviews with older persons, during the hospitalisation and two weeks after discharge. Both interviews were conducted with the same participants, included open-ended questions and a structured interview questionnaire.

The overall analysis was performed deductively using a part of the PRECEDE-PROCEED model (Green & Kreuter, 2005), similar to that described in the literature (Bakken, Lantigua, Busacca & Bigger, 2009). The data collected from the Nurses' study and the older persons study was analysed with the help of the Predisposing, Reinforcing, and Enabling constructs of the PRECEDE-PROCEED model. Of particular interest were the perceived barriers that hamper the nurses'

health promotion in the daily clinical work, and the perceived facilitators for nurses' health promotion for the older patients' in the acute hospital setting.

5 MATERIALS AND METHODS

5.1 The Nurses' Study

In the first part of the nurses' study, a Delphi survey with health care experts was conducted to address their expectations and understanding of nurses' health promotion for older persons in hospitals. Their judgement about the meaning of nurses' health promotion was investigated. The missing clarity about the nurses' role in health promotion and the practical details of health promotion activities were also addressed.

In the second part, the focus group discussions with bedside nurses were added to get a broader understanding of nurses' health promotion in clinical practice. The qualified nurses' were asked to analyse their experiences of the nurses' role in health promotion for older patients in their daily clinical life. Their daily resources and barriers in performing health promotion in the acute hospital setting were identified. The bedside nurses' opinion about the health care experts' consensus for the role of nurses in health promotion of older persons in acute hospitals was also analysed.

5.1.1 The Delphi Survey

The Delphi technique has a growing popularity (Keeney, Hasson & McKenna, 2011) and is well established in health and social research (Häder & Häder 2000). The literature shows a number of modifications to the Delphi technique as there is no formally agreed guideline on the use of the Delphi survey (Keeney et al., 2011). Häder (2002) describes four different Delphi approaches. Type 1 Delphi approach contains studies summarizing the collection of ideas; type 2 Delphi approach defines the accuracy of forecast for an uncertain state of affairs, whilst type 3 Delphi approach is when the experts' opinion about an uncertain state of affairs; is qualified and represented empirically. If the consensus of an expert-panel group has to be met, it is then, type 4. In Nursing and health research the Delphi is

commonly used either for the use of priority setting or to gain consensus by an expert panel (Keeney et al., 2011).

The Delphi survey has multiple advantages compared to interviews with experts. If the experts were asked to join a face-to-face meeting, substantial time and financial resources would be required. Using the Delphi approach, allows the expert to follow his/her own time schedule and not the one set for the interview meeting. The technique allows confidential expert input and interaction with controlled feedback (Keeney et al., 2011).

For this study, type 4 Delphi approach was applied to establish the most reliable consensus of opinion of the health care experts about the nurses' role in health promotion for older persons in an acute hospital setting. This was achieved through a series of three investigations referred to as round 1, 2 and 3 (figure 4). Round 1 started with an open-ended questionnaire, followed by two rounds of structured questionnaires, which were used in combination with controlled feedback (Häder, 2002).

The Participants

For this study the Delphi panel was formed and consisted of a purposeful sample (n=31) of health care experts from the German speaking part of Switzerland. The criteria governing the selection of the panel members was at least two years of knowledge, expertise and professional experience in the field of nurses' health promotion for the elderly. Additional criteria were that they had to work in Switzerland, be fluent in German and be aware of the actual and local situation of nurses' health promotion. Attention was paid to the balance between hospital-clinical nursing and district nursing, as well as nursing management, policy building, nursing research and education. This heterogenic sample of health care experts ensured the declaration of all the various opinions in different contexts and assured the validity of the results (Keeney et al., 2011). Häder (2002) and Duffield (1993) argue that the experts should have potential influence to achieve changes in their profession as required.

The participants were recruited by mail which included information regarding the aim and the content of the study. 90 persons from 27 different institutions from the German part of Switzerland were contacted by mail and selected according to the criteria listed above, to ensure a panel size of 31 health care experts. The mail

addresses were chosen from previous personal work experience and through word of mouth from colleagues. The final panel members were chosen on a first come, first serve basis and matched the requested positions shown in the table below (table 1).

The questionnaire was sent to 31 health care experts to ensure the heterogenic sample of participants for the third round with the assumption that there would be "drop-outs" (Häder, 2002). The final panel size for the first round was 29 persons as one registered nurse and one nurse director dropped out. The second round was conducted with 27 panel members (one nurse director and one nurse lecturer dropping out) and the third round with 26 health care experts with one registered nurse dropping out. Detailed information about the study sample is illustrated in table 1.

Table 1. Expert panel characteristics

Round 1 n= 29	Round 2 n= 27	Round 3 n = 26	Profession	Professional experience on their current position ≥ 2 years
8	8	7	Registered nurses (RN)	Hospital ward
3	3	3	Registered nurses with public health degree	Hospital ward
5	5	5	Nurse expert	Hospital ward
3	2	2	Nurse director	Hospital Management
3	3	3	Registered District Nurse	Community
2	2	2	Nurse Researchers with Public Health degree	University Research Department
3	2	2	Nurse Lecturers	University of Applied Sciences
2	2	2	Policy Makers	Gerontology health care management

The Process

The small-scale pilot study was conducted between August and December 2009 with a small comparable group of six panel members (round 1 n=7/ round 2 n=6/ drop-outs 1). No potential problems during the conducting of the pilot test were identified. The panel members of the pilot study were not included in the main study. The three rounds of the Delphi study were conducted between February-July 2010 using the survey software, Survey Monkey® questionnaire tool. Figure 4 gives an overview of Delphi process.

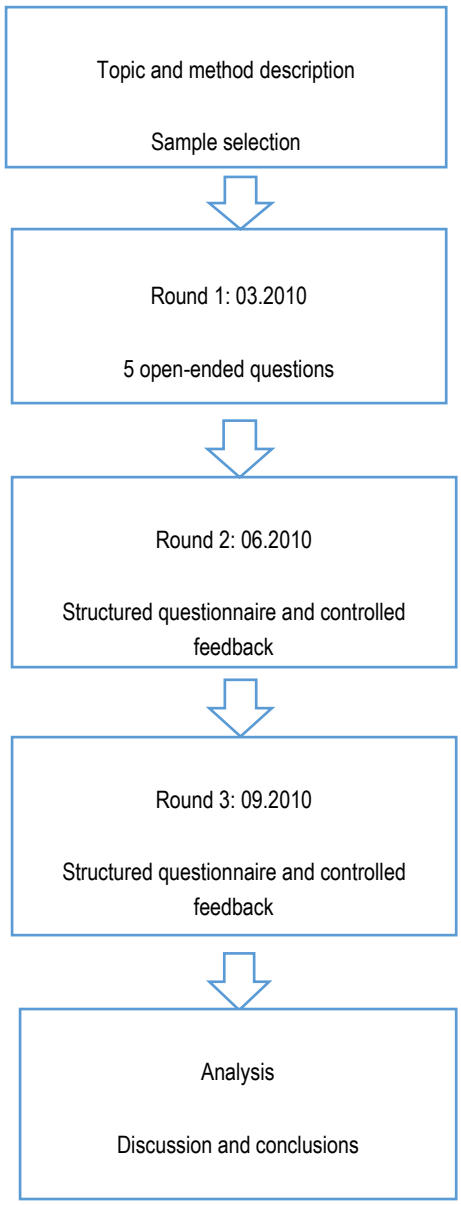

Figure 4. Delphi Survey process

The 31 health care experts received the detailed information about the process and the aim of the study, with a brief summary of the discussion and the definition of nurses' health promotion in recent literature, in advance. At the same time they received the connecting link to the web- based questionnaires in the German language. In this study, the first questionnaire, which included five open-ended questions, was aimed at drawing out responses related to the large vague undefined area of health promotion by nurses. It was also aimed at defining the role of the nurse in health promotion for the older persons in a hospital setting. The first question addressed the value of nurses' health promotion for older persons in hospitals. The second question asked the panel members to note three examples of knowledge, attitudes, skills, resources and barriers in regards to the role of the nurses' health promotion of older persons in an acute hospital setting. Questions three to five addressed the essential differences related to nurses' health promotion regarding the gender, the diversity management and in addition the differences concerning the younger patients (see table 2).

Table 2. The Delphi survey first round open questions

Question 1	What is your opinion about the meaning of the study core theme „Health promotion by nurses for the elderly in hospitals"?
Question 2	What are the knowledge, attitudes and skills, fundamental to and what are the resources needed and the barriers encountered to perform the role of a health-promoting nurse for older patients in an acute hospital setting?
Question 3	What are the essential differences related to health promotion for the elderly regarding the gender management?
Question 4	What are the essential differences related to health promotion for the elderly regarding the diversity management?
Question 5	What are the essential differences related to health promotion between the elderly and younger persons?

The second questionnaire was formulated to reach a panel consensus on the items developed from the findings of the first Delphi round. The questionnaire used in round 2 contained 25 questions with a total number of 305 items. The experts were asked to score the items, using a five- point Likert scale, ranging from 5 to 1 (strongly agree, agree, undecided, disagree, strongly disagree). The health care experts were then invited to indicate the score that best reflects their opinion about each individual item.

Additionally the panel members were asked if they recognized their responses given during the first round and were told that if they wished, they could add comments and new items to the questionnaire.

With the third round questionnaire, the experts received the second round results (frequency) and were asked to reconsider their judgement on the items, which did not reach the consensus level during the previous round.

The questionnaire used in round 3 contained the results of the second round and two new additional items to the first question "the value of Health promotion by nurses for the elderly in hospitals" and one additional item connected to "the essential differences related to health promotion between the elderly and younger persons".

After each round follow- ups were sent to enhance the response rates (Häder, 2002; Keeney et al., 2011). In this study the controlled feedback (Häder, 2002) was arranged, as a part of the interactive multi-stage process to inform the panel group of the current status of their collective opinions and to support each member in identifying missed items or items thought of as unimportant (Hasson, Keeney & McKeena, 2000). The questions of round 2 and round 3 are shown in table 3, and the questionnaire of the Delphi study is presented in appendix.

Table 3. The Delphi survey 2nd and 3rd round questions

1st round questions	Sub- questions	Items 2nd round	Items 3rd round
Q1: What is your opinion about the meaning of the study core theme „Health promotion by nurses for the elderly in hospitals"?	• What is the meaning of health promotion by nurses for the elderly in acute hospitals? • Health promotion by nurses for older persons of minor meaning due to? • Health promotion by nurses for older persons of prime meaning due to? • The decreased meaning of health promotion by nurses of hospitalized older persons is due to? • The increased meaning of health promotion by nurses of hospitalized older persons is due to?	6 17 9 6 16	6 17 9 6 16
Q2: What are the knowledge, attitudes and skills, fundamental to and what are the resources needed and the barriers encountered to perform the role of a health promoting nurse for the elderly in an acute hospital setting?	• The knowledge needed is? • The attitudes and behaviour needed are? • The needed skills are? • The resources needed are? • The barriers are?	22 19 16 17 23	21 11 13 17 23
Q3: What are the essential differences related to health promotion for the elderly regarding the gender management?	• The knowledge needed is? • The attitudes and behaviour needed are? • The needed skills are? • The resources needed are? • The barriers are?	20 10 4 11 14	20 10 4 11 14
Q4: What are the essential differences related to health promotion for the elderly regarding the diversity management?	• The knowledge needed is? • The attitudes and behaviour needed are? • The needed skills are? • The resources needed are? • The barriers are?	12 10 9 14 16	12 8 9 14 16
Q5: What are the essential differences related to health promotion between the elderly and younger persons?	• The knowledge needed is? • The attitudes and behaviour needed are? • The needed skills are? • The resources needed are? • The barriers are?	13 9 2 2 8	14 8 2 2 8

Analysis

A qualitative and quantitative data analysis was conducted in this Delphi- survey (table 4). The data collected in round one was analysed and, adapted from qualitative content analysis of Mayring (Mayring, 2002). The data in the first round was analysed and coded by theme. Following the question of round one and the research question, categories for new items were defined by the text interpretation. The entire wording of the panel of experts was respected when formulating the items (Keeney et al., 2011). A second researcher controlled the procedure and categories were revised to ensure the correct representation of the data. The questionnaire obtained from the analysis of the results of round one was used for round two and round three. For this study 80% of the panel with the item "strong agreement" or "strong disagreement" represented the consensus indicating the expert- panel agreement.

The second and the third round questionnaires were analysed using descriptive statistics (frequency and median (mode), but because of the small sample size the normal data distribution could not be assumed. The consensus level (%) and the frequency (n) are listed in order to present the collective judgement of the health care experts. In ordinal scales the median (mode) is presented as the measure of central tendency, the means and standard deviations have no validity. In this study the mean was used to rank the statements in order of importance (Keeney et al., 2011). To calculate the median the values of strongly agree=2, agree=1, undecided=0, disagree=-1 and strongly disagree=-2 were used. The analysis was supported using the survey software SurveyMonkey ® and the IBM SPSS statistics 21.

Table 4. The Delphi survey analytical approach

Round 1	Questionnaire with 5 open-ended questions	1 Content analysis of the items generated. 2 Categorised in to themes and subthemes	Control and discussion with 2nd researcher
Round 2	Structured questionnaire	Descriptive statistic frequency and median (mode)	Control and discussion with 2nd researcher
Round 3	Structured questionnaire	Descriptive statistic frequency and median (mode)	Control and discussion with 2nd researcher

5.1.2 Focus Group Discussions

The aim of the focus group discussion is to determine, from the point of view of bedside nurses, the role of nursing and the meaning of health promotion for older patients' in the hospital. By comparing it with the findings from the health care expert testimony, it should support the discussion regarding the actual situation of the nurses' health promotion for older persons in the hospital. The investigation is to find out if the requirements of the health care experts meet the bedside nurses' judgement and their view of the actual daily clinical work situation. Moreover, it should support the discussion about the lessons learned and define the future needs for daily professional practice.

The focus group discussion is a conversation held within a group on a particular topic under the guidance of a facilitator. In research, the focus group method is frequently used as an alternative to individual interviews. Focus group discussions are especially recommended for the investigation of opinions and attitudes, because they allow for group dynamics. The focus group discussions rely on the interaction within the group based on the interview guidelines (Flick, 2004). According to Bohnsack, Przyborski & Schaeffer (2010) the strength of the focus group discussions lies in the possibility to reconstruct collective orientations. It is also argued that the action-guiding orientation knowledge opens the way to practical action (Bohnsack et al., 2010). Another benefit of the focus group discussion method is that group processes are clearly established at the beginning of the session and the results of the discussion are summarised at the end of the session. Mayring, (2002) argues that rational discussions and inhibitions can be minimised in well-managed group discussions. Such discussions allow individuals to expose settings that affect their thinking, their feelings and their behaviour in everyday life. This method is therefore ideal for this type of study, since it allows the group or individuals to describe their subjective opinions about the structures in daily nursing practice. Using this method, the focus group discussion should allow for a realistic reflection on opinions and attitudes of nurses currently working in hospitals in Switzerland.

The Participants

Group participants in this study were graduate nurses enrolled for a Bachelor Degree in Nursing Studies at the Bern University of Applied Sciences and employed part-time on medical- and surgical wards in different hospitals in German-speaking Switzerland. The nurses showed their interest in remaining professionally up-to-date by their enrolment in a post-diploma educational program. The nurses that participated in the first group discussion were in the final term of the study program. The participants of the second group discussion were in their first year of the bachelor degree program.

The number of participants required for focus group discussions varies in the literature. It has been argued that the number of participants required depends on the extent of the knowledge and the description of the subject under investigation (Kean, 2000; Lamnek, 2005). In smaller groups an odd number of participants is recommended to avoid arguments and stalemate situations (Bohnsack et al., 2010). For this study, 49 nurses enrolled in the nursing study program were invited to participate in the focus group discussions. They all received initial study information by mail, they were asked to indicate their participation interest and provide their signed consent form to participate in the study. The anonymity and confidentiality was assured and all participants were informed of their right to withdraw from the study at any stage, without giving prior notice. Fifteen nurses replied and two smaller groups of 5 and 7 nurses were chosen by purposeful sampling according to the selection criteria. The participants of the group discussions had to be employed as professional nurses in an acute hospital in Switzerland with a minimum of two years professional experience. An additional selection criterion was the fluency in German. Nurses employed at paediatrics, psychiatry, or emergency departments were excluded. Three nurses dropped out on short notice and finally three (Group 1) and six (Group 2) nurses participated in the focus group discussions.

In the literature, the possibility of the choice of a natural or artificial group of participants is discussed. It is agreed that naturally formed groups hold more validity from the research point of view than the artificially formed groups, even though in some cases peer group pressure may influence group dynamics. In this study, the groups cannot be defined as "naturally formed" because the nurses were acquainted with one another, even though they were employed in different

departments and in different hospitals throughout Switzerland. The group and the participant characteristics are provided in table 5.

Table 5. Group Discussion Participants

Group 1	▪ group discussion date and duration: 23.11.2010, 40 minutes ▪ n=3 (3 female, Af, Bf, Cf) ▪ BSc nursing students in the final year of the bachelor degree program ▪ part-time hospital employment: surgical ward 1 medical (neurology) ward 1 different surgical and medical wards 1
Group 2	▪ group discussion date and duration: 25.11.2010 55 minutes ▪ n= 6 (5 female/ 1 male, Af, Bf, Cf, Df, Em, Ff) ▪ BSc nursing students in the first year of the bachelor degree program ▪ part-time hospital employment: surgical ward 3 medical ward 2 mixed surgical and medical ward 1

The Process

The group discussions took place in a seminar room at the Bern University of Applied Sciences (BFH). Attention was given to create a comfortable, pleasant and relaxed environment and refreshments were offered to the participants.

In order to understand the acoustics better and to reconstruct the process of group dynamics, the discussion was recorded using an audio- and a video recorder. The participants were informed about the purpose of the audio- and video recorder and consent of the participants was achieved. The audio recorder was placed in the center of the room and the video recorder was placed at the back, to avoid influencing to the participants' contributions to the discussion.

The participants of the discussion were informed about the group structure, but all personal data remained anonymous. To ensure this, participants were only addressed by their first name during the group discussion (Lamnek, 2005).

The group discussion was conducted in the Swiss-German language and started with a presentation of the study project and the results of the preliminary Delphi study. The review of a selection of the results was the basis for the group

discussion. To prevent participants from digressing from the discussion and in order to be able to compare the two group discussions, both focus groups were provided with the identical topic guide for discussion (table 6). In the absence of a topic guide, group discussion can become too general and prevent useful findings (Flick, 2004; Lamnek, 2005).

The facilitator (author) remained neutral in the group discussions, but provided participants with a structured and goal-oriented approach allowing visualisation of questions and answers on a flip chart (Lamnek, 2005). The main results of the discussion were noted on the flip chart and verified by the participants at the end of the discussion. The duration of the discussion was set as one hour. At the end of the discussion, the participants concluded that they had no additional important knowledge to share. Adhering to the written transcription rules, the group discussions were transcribed verbatim by a research assistant and validated by the author upon the replaying of the video.

Table 6. Focus Group discussion topic guide (Krueger, R. A. 1998, in Lamnek, S. 2005)

Focus group discussion topic guide		
Opening		**Short introduction of the study and process**
1.	Opening	You all work in an acute hospital – please describe your work setting e.g. ward
2.	Introduction	How many patients 65 + years old present to your ward on a yearly basis?
Discussion		**Presentation of selected results of preliminary study (Delphi survey)**
3.	Transition	the nurse's role in health promotion for the older persons was discussed in the preliminary study: Concerning your own professional experience, how would you describe the nurse's role in health promotion for older persons?
4.	Key	there was no consensus about the meaning of health promotion by nurses for the older persons among health care experts in the preliminary study: How to you judge the meaning of health promotion activities in your daily clinical work?
5.	Key	What are the main barriers for nurses performing HP for older persons?
6.	Key	How can these barriers be overcome?
End		**Summary of the group discussion**
7.	End	What advice would you give for the implementation of the health promotion interventions?
8.	End	What advice would you give to nurses in acute hospitals wishing to undertake health promotion in older persons? What should they consider?

Analysis

The focus group data was analysed qualitatively using the documentary method outlined by Ralf Bohnsack (Bohnsack, 2010; Bohnsack, Marotzki & Meuser, 2006; Bohnsack, Pfaff & Weller, 2010). The documentary method was used to address any divergent opinions about nurses' health promotion for older persons in acute hospitals. For this study, the aim of the documentary method was the reconstruction of the collective orientation and the experiences of bedside nurses working in acute hospitals. An important part of the analysis was the interactive process of how well the participants described their knowledge, attitude and experiences. The interview transcripts were analysed in four steps following the recommendations made by Bohnsack (Bohnsack, 2010; Bohnsack, et al., 2006; Bohnsack et al., 2010).

1. The formulating interpretation included the overview of the discussion based on the transcript of the tape-and video recorded material. The aim of formulating the interpretation was the decoding, the differentiation and the elaboration of major topics (MT) and sub-topics (ST).

2. By using the reflective interpretation, the meaning of documented content along with the aim of reconstructing the framework of orientation was described.

3. By the use of the discourse description, the presentation of the main orientations and the description of the discourse organisation were explained.

4. The different modes of discourse organisation compare behaviours and interactions among the participants.

5. Przyborski (Przyborski, 2004) divides the identical structured experiences in two different modes. If the participants are promoting each other, Przyborski (Przyborski, 2004) names it the parallelizing mode. If the participants are in a disagreement it is called the antithetical mode. Furthermore named is the oppositional mode, which describes if the participants are against each other, they disagree and they do not share the experience. The aim of the use of these different modes of discourse

organisation is to present how much the participants share a common experience and a collective orientation of the topic under discussion.

6. To this end the summary of the participant statements included a comparison of the analysis of the two focus group discussions. It also included the evaluation of the reflection of opinions and attitudes with regards to the research question and the interaction of the two groups during their discussion.

7. The findings from each of these four analytical steps were compared with each other and discussed with a second researcher in order to come to a common agreement. The transcription of the audio data from both focus group discussions was supported by the use of a software program ATLAS.ti 6. The reflective interpretation and the discourse description were supported and verified by the videotape of the focus group discussions.

5.2 The Older Persons Study

For this study face-to-face interviews with older persons during their hospital stay and two weeks after discharge, at home, were conducted. The aim of this study was to establish the needs and requirements of hospitalised older persons (65+) with regards to health promotion performed by nurses. The interviews aimed to investigate the older persons' subjective view of the actual situation during the hospitalisation and after discharge at home. The interviews after discharge at home were conducted to address the short-term sustainability of the nurses' health promotion. Potential difficulties encountered when older persons self-manage aspects of their own care were identified (Mc Keown, 2007).

5.2.1 Open-ended- and Structured Questions Interviews

The first part of the interview included open- ended questions and the second part was conducted using a structured questionnaire.

The narrative part with two open questions gave freedom to the participant to discuss their "own perspective and own behaviour". Moreover, by using the open-ended questions, the persons' own wording, the diversity and the individuality was respected and provided a more detailed picture of their experiences and subjective understanding of health promotion.

Using a structured questionnaire in the second part of the interview allowed for information on the older person's intention, knowledge, opinions and attitudes in regards to the research question. In addition to the structured questions there were four open questions asking for a specific example to the answer given. This was to reconfirm the health promotion focus but was not used for the analysis. More importantly the use of the structured interview method allowed for better comparison between older persons responses.

Using the convergent mixed-methods design in the older persons study addressed two independent components of qualitative and quantitative data and also combined the results of each in an overall interpretation (Creswell, & Plano Clark, 2011). By using the combination of the two interview methods, the personal and financial resources of face-to-face interviews and the challenge of superficial results were considered.

The Participants

The sample size of forty participants (n=40) was chosen after considering the different sampling approaches of the qualitative and quantitative research. Attention was given to the informational needs and the aim of the data saturation of the narrative part of the study. With regards to the structured interview part, the largest sample possible was considered keeping in mind the personal and financial resources. Attention was given to the sampling strategy although the generalisability could not be a guiding criterion for this study (Polit & Beck, 2012, 2006).

The purposeful sample of 40 older patients (20 female and 20 male) was recruited at surgical and medicine wards in the general county hospital of Basel (Switzerland).

The hospitalized patients were of 65 years or older and an important criteria governing the selection was that the hospital discharge allowing patients to go home followed a hospitalisation stay of more than three days. All of the participating patients were able to communicate in Swiss German (or German) and were free of cognitive disability. Details of the inclusion- and exclusion criteria for the older persons sample are presented in table 7.

Table 7. Older persons' study, recruitment criteria

The inclusion criteria governing the selection of the participants were:
▪ 65 years or older ▪ Equal participation of female and male participants. ▪ Hospital discharge to home following hospitalisation of more than three days. ▪ Understanding and communication of the German or Swiss German language. ▪ Of sane and sound mind, capable of judgement and rational act (according to Art. 16 of the Civil Code). ▪ Personally aware of time, location and capable of expressing their needs. ▪ Voluntary study participation with an informed letter of consent
The exclusion criteria governing the selection of the participants were:
▪ Palliative care patients or patients in life threatening situations ▪ Patients living in nursing homes. ▪ Patients discharged to rehabilitation clinics.

The participants consisted of 20 female persons aged 67 - 89 years old and 20 male persons aged 65 – 92 years old. The majority of female participants belonged to the age group of 75-84 years old whilst the male participants were spread across the age groups of 75-84 years old and 85-94 years old. The average age of the 40 older persons was 80.5 years old (table 8).

Three female participants could not finish the study, two due to rehospitalisation and one due to the withdrawal of consent from the spouse. Upon her request, one female participant had the second interview by phone and not in person. Five male participants could not finish the study, three due to rehospitalisation, one due to the spouse's critical health and one whose reason was not named.

All of the participants lived in the county of Basel and the majority of participants lived in suburban or rural areas. The majority of women lived in a single household (n=12), only six women were living with their husbands and two women were living in a multi-generation households. The majority of men lived with their wives

(n=14) and six men were living alone. Swiss-German was the native language for 18 women and 19 men.

The majority of the older persons interviewed were hospitalized due to illness (f n=18; m n=19), with the majority being hospitalized due to an emergency situation (f n= 18/ m n= 14).

The participants highlighted that they were supported at home mainly by their relatives. Additional support contributors mentioned were cleaning services, the district nurse service and support by friends and neighbours. There was a gender difference concerning the higher education of the men compared to the women participating in this study (table 8).

Table 8. Older persons' study: characteristics of female and male participants

	Female		Male	
	1 Interview N=20	2 Interview N=17	1 Interview N=20	2 Interview N=15
Age years 65-74	5	4	2	1
Age years 75-84	11	9	9	7
Age years 85- 94	4	4	9	7
Age years 65 – 94 Mean (Median)	75 (79)	74.5 (77)	78 (77)	76.5 (79)
Support at home by spouse/ relatives	16	15	19	14
Support at home by cleaning service	12	10	5	3
Support at home by district nurse	7	6	5	3
Support at home by friends	9	8	3	1
Support at home by neighbours	6	6	5	2
School 8 years	8		0	
Profession	7		6	
Higher education/ university degree	5		14	

The Process

The data collection started in January 2012 after the pre- test with 2 female and two male participants and was conducted under similar criteria (aged 65+, same inclusion criteria and interview questionnaire during hospitalisation and at home). The face-to-face interviews were scheduled for assigned days over a six months period but this time frame was not followed. Due to recruitment difficulties, the data collection was conducted over a period of 18 months, from January 2012 until June 2013.

The head of the surgical and the internal medicine ward received the written information regarding the aim and the content of the study personally and recruited the participants following the recruitment schedule. With regards to the risk of a sampling bias, a sampling time schedule was elaborated but was dismissed due to organisational problems. The head of the ward handed a brief written information leaflet regarding the study aim and the study process to the older persons. This information leaflet included a concise definition of health promotion. With the same information leaflet the older persons received the explanation of the voluntary nature of the participation. After the participants' agreement, the author contacted the patients for the study participation. 20 female and 20 male patients (n=40) were recruited for the two face-to-face interviews. The first interview took place at the hospital and the second interview at the participants' home 14 days after hospital discharge.

Prior to all the interviews the author informed the patients about the study in more detail and answered any questions asked. The interviews started after the participants had agreed to participate and delivered their signed informed consent form. Special attention was given to provide privacy and the author completed all of the interviews.

The interview part of the open-ended question was audiotaped and an interview protocol was completed, so as to support the quality criteria. For the structured part of the interview the author read the interview questions out loud to the participants and wrote down the answers into the questionnaire. The personal status was applicable only in the first interview.

No time limit was set for the interviews. This was to ensure that participants could speak freely with their own wording and make sure to include their own

perspective and behaviour. The duration of the interviews conducted at the hospital and at home was from 30 to 45 minutes.

This study "health promotion by nurses for older persons 65+" was approved by the Ethical Commission of Basel and Basel Country (November 2011/ Ref. EK: 336/11).

Instrument

In view of no validated questionnaire being available, the findings of the previous nurses' study were used for the development of an interview questionnaire.

For this study two open-ended questions and a structured interview questionnaire (appendix) were used.

The author asked the following main questions to start the interview, generating a conversation about the participants' experiences, health attitude and behaviour:

- What do you personally do to stay healthy?
- After discharge, will the advice, given by nurses, support your wellbeing and autonomy at home? (applicable to interview during hospitalisation)
- Did the advice given by the nurses, support your wellbeing and autonomy at home? (applicable to interview at home 14 days after hospital discharge)

Optional additional questions by the researcher were:

- Do you have further examples?
- What do you mean by this?

The questions of the structured interviews contained two main themes; the first is Health promotion by hospital nurses which includes empowerment, health education and health literacy and the second, the older persons' self-management and the support at home by relatives and external services.

In addition to the structured questions there were four open questions asking for an example to the answer given. This was to reconfirm the health promotion focus but not used for the analysis. The themes of the structured questionnaire (table 9) were sustained by the 5- point Likert scale from "strong agreement, agreement, undecided, to disagree, strong disagreement" (Polit & Beck, 2006). The second part consisted of personal topics with a scale of yes or no. These are shown below in table 9.

Table 9. The older peoples' study themes of the structured questionnaire

Themes	Questions
Health promotion by hospital nurses (empowerment, health education, health literacy)	• I have been advised well by the nurses • I do appreciate the nurses' health promotion advice • Health promotion is not only for young people • I am interested in health promotion at the hospital • At the hospital I do have time to think about Health promotion • I may actively promote my health myself I think less about my own health back home • Now, I know how to promote my health • I won't change my health behaviour • If I did not understand the information, I could ask for an explanation several times • Important information by nurses was given over several days • Information given by the nurses was at a convenient time • I understood the written information received at the hospital • It might be that I did not understand all of the information • The information given was difficult to understand • The information was not interesting /boring • Too much information was given • There was no time to read the information • More information and counselling would have been appreciated / Example • I could talk about my personal concerns to nurses • The nurses had time to listen to me • Whenever I asked for it, the hospital nurses supported me • I do have mixed feelings about going home/ being at home • I feel healthy

Table 9. Continued

Themes	Questions
The older peoples' self-management and the support at home by relatives and external services.	• I did receive good advice from the nurses about being independent at home / Example … • The nurses supported me by giving helpful advice with regards to aid materials • I will/I do follow the nurses' advice at home / Example … • I could be trained on the skills needed step by step • Too much self- commitment was asked for by the nurses • Nurses counselled my relatives and myself at the same time • Whenever I asked for it, my relatives supported me • My relatives will support me at home / Example … • I do not need any support at home, I am autonomous • Spitex (Community nurse) will support me at home • Spitex will support me with nursing care, wound care, injections • Spitex will support me with cleaning, cooking, washing
demographic topics	• age, gender, language
Reason for hospitalisation	• accident or illness • surgical or medical unit
social context	• education and hobby

Analysis

The open-ended interview was analysed using qualitative content analysis developed by Mayring (Mayring, 2010). The literature recommends the qualitative content analysis (QCA) for the evaluation of qualitative data collected through interviews (Bohnsack, Pfaff & Weller, 2010; Schreier, 2012).The purpose of this evaluation was to gain an overall understanding of the statements of each individual experience.

Under the consideration of the written transcription rules, the interviews were transcribed verbatim by the author and validated by a second researcher.

During the explorative phase all the transcribed data was carefully read and examined along with the audiotape of each interview. The next step of the evaluation was the segmentation of the material. The text was paraphrased to the most important meaningful units. The text was then generalised and a coding frame was created. The coding frame and the new short passages were tested to make sure they still represented the original data. The category system was developed through the ongoing evaluation and aligned with the research question. Four categories were elaborated "Needs required to be healthy, activities required to be healthy, situation after discharge at home and advice support at home". The author and a second member of the research team discussed and approved the category system. The protocol was checked to control there was no missing information within the summarized categories.

The structured interviews were analysed separately. The questions measured with the Likert scale were analysed using descriptive statistics that is, the use of IBM SPSS statistics 21. Due to the small sample size, the descriptive statistic was only applied with frequency, median and mode with regards to gender.

Additionally, the findings of the open ended questions (strand 3) and the results of the structured questions (strand 4) were compared and examined for common outcomes with regards to the research questions.

5.3 Overall Analysis PRECEDE-PROCEED model

The overall analysis was performed using a part of the PRECEDE- PROCEED Model (Green & Kreuter, 2005). This framework for planning and practice of health promotion activities supports an educational and ecological approach with a focus on participation at the multilevel context. In health promotion literature, the PRECEDE- PROCEED Model is widely used as a framework, evaluated and published internationally (Tramm et al., 2012).

The PRECEDE- PROCEED Model with its eight phases is described in more detail in chapter 2. In this dissertation the educational and ecological assessment (phase 3) is applied to analyse the findings of the nurses' studies and the older persons studies. To get a deeper comprehension in the nurses' health promotion, the three categories like predisposing- enabling- and reinforcing factors of the behavioural and organisational influences are used. This analysis identifies the barriers and motivators, which are classified into positive and negative predisposing- enabling- and reinforcing factors. Due to Green & Kreuter (2005) they represent a convenient classification of the "more specific Influences" to the approaches used to fulfil the role of a health promoting nurse at the acute hospital.

Firstly, the findings of the health care experts' expectations about the practice of nurses' health promotion for older persons at the acute hospital in Switzerland was analysed. Secondly, the findings of the bedside nurses perception and the performed health promotion activities for older patients at the clinical setting were looked at, and thirdly, the findings of the older persons perception and experiences regarding nurses' health promotion at the acute hospital.

Finally, the summary of the overall analysis describes the integration of the different strands. The aim of this mixed method research was to gain a holistic understanding of the nurses' health promotion for older persons at the acute hospital setting and to answer the research questions posed.

The following Figure 5: Expected and experienced nurses' health promotion for older persons' at the acute hospital in Switzerland is based on the PRECEDE-PROCEED Model and gives an overview of the analytical process.

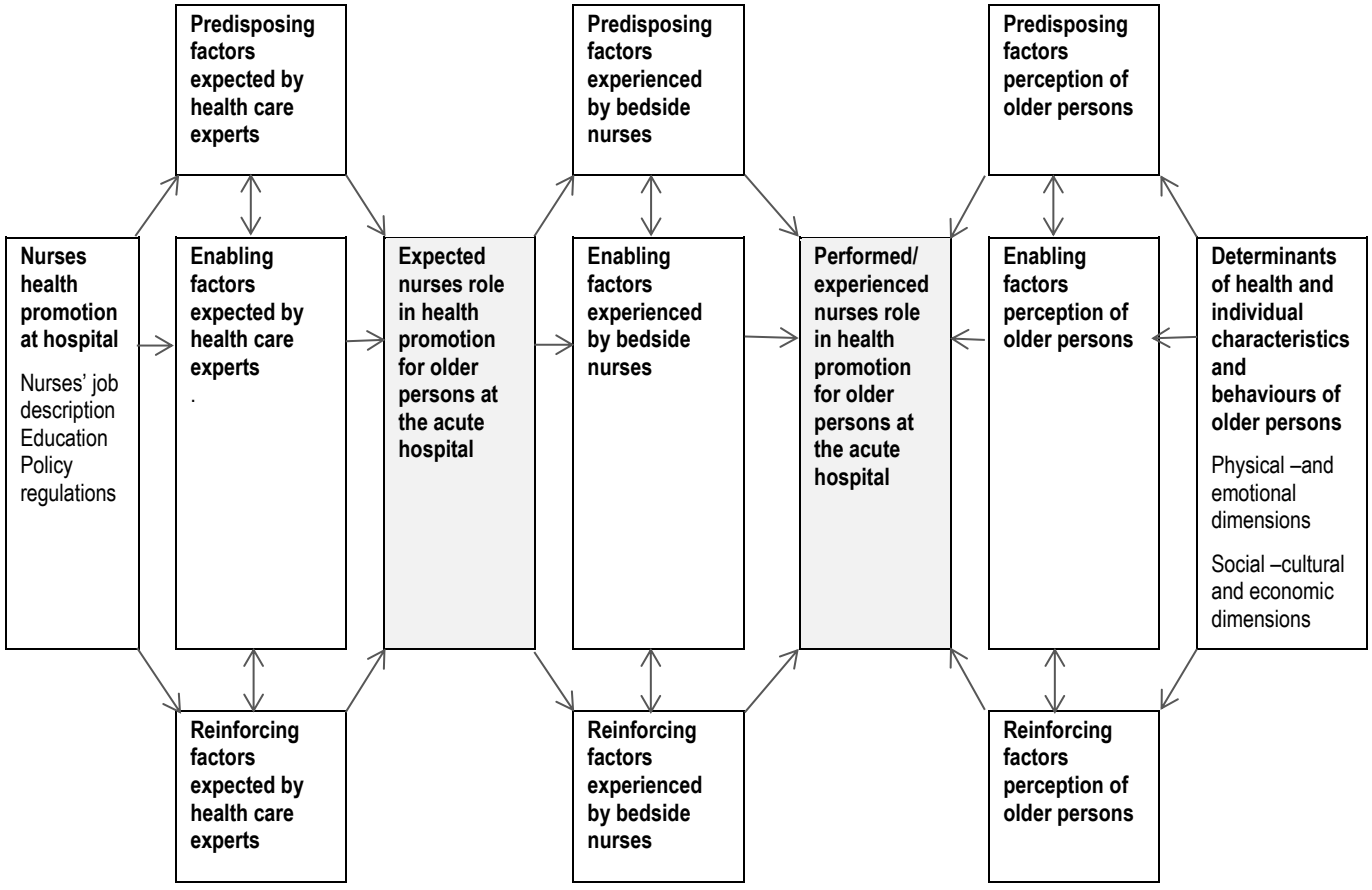

Figure 5. Expected and experienced nurses' health promotion for older persons at the acute hospital in Switzerland based on the PRECEDE- PROCEED Model

6 FINDINGS

6.1 Findings - the Nurses' Study

The findings from the nurses' study, which investigated the expectations and understanding of nurses' health promotion by health care experts and the experiences made by bedside nurses, are presented. Additionally, the expected and the actually performed situation of the role of nurses in health promotion for older persons 65+ in an acute hospital setting in Switzerland are addressed.

The findings of the nurses' studies are presented in two parts. Firstly, the findings of the Delphi survey demonstrate the most reliable consensus of opinion of the health care experts about nurses' health promotion for older persons in an acute hospital setting. The findings include their recommendations and their expectations with regards to the role of a health-promoting nurse at the hospital. In addition, the findings detail the health care experts' opinions about the meaning of nurses' health promotion for older persons in clinical practice.

Secondly, the findings of the focus group discussions provide information about the understanding of nurse's health promotion for older persons, as described by the participating bedside nurses. They provide a detailed insight into nurses' health promotion in the daily clinical practice in Swiss hospitals.

6.1.1 Health promotion by nurses for older persons: the expectations of health care experts

The Delphi survey was applied to establish the most reliable consensus of opinion given by health care experts about nurses' health promotion for older people in an acute hospital setting. In this study 80% of the panel of the item "strong agreement" or "strong disagreement" represented the consensus indicating the expert- panel agreement. The median (mode) is presented as the measure for central tendency. The mean and the standard deviation have no validity and were only used to rank the statements in order of importance (Keeney et al., 2011).

Through the three-round approach of this Delphi survey, consensus among the health care experts was reached on the most relevant items concerning the role of the nurse in health promotion of older persons (65+) in an acute hospital setting. However, no clear consensus among the 29 health care experts could be generated concerning the value of the nurses' health promotion for older persons in the daily practice.

The health care experts approved their commitment to the study, as the respond rate was 93% (n=29) in round 1, 87% (n=27) in round 2 and 83% (n=26) in round 3. Nevertheless, not all questions were answered by all the panel members in round 2 and round 3.

Findings - Round 1

The finding from the first question of round one identified the fact that from the health care experts' point of view health promotion by nurses of older persons is of relevance. This however, in the nurses' daily clinical work, is not evident. The increasing and decreasing value of health promotion performed by nurses in the near future were also declared.

The second question addressed the knowledge, attitudes and skills, fundamental to perform the role of a health promoting nurse for older patients in hospitals, in answer to this the experts listed a variety of topics. Concerning the requested knowledge the experts named pathophysiology, chronic diseases, models of health promotion and education. Listed attitudes were empathy, respect and autonomy. Amongst the named skills were communication and coaching. The needed resources mentioned were time, the nursing diagnosis and the interdisciplinary team. Among the barriers encountered to perform the role of a health-promoting nurse were the missing time resources in the daily clinical life and the missing assignment for nurses' health promotion. The findings of the second question concerning the knowledge, attitudes, skills, and resources needed for the role of a health promoting nurse and the barriers encountered, are presented below in table 10.

Table 10. Themes Delphi 1st round: the role of a health promoting nurse for older persons

Themes	Topics
Knowledge	• Physiology /pathophysiology • Chronic diseases • Gerontology • Epidemiology/ Health indicators • Models of Health promotion • Education • Interdisciplinary management • Economy
Attitudes	• Empathy • Respect • Autonomy • Participation
Skills	• Communication • Coaching/Education • Implementation of therapeutic appliances
Resources	• Closeness to patient • Nursing diagnosis • Nursing standards • Interdisciplinary Team • Education/ informative material
Barriers	• Time resources • Heavy workload • No priority, missing sustainability • No health promotion guidelines • No assignment for health promotion • Financial resources/ Diagnosis Related Groups (Swiss DRG) • Hierarchical structural management • Only medical diagnosis under consideration • Health promotion knowledge gap of nurses • Missing acceptance /interest of patient towards health promotion

The statements on the essential differences related to health promotion for older people regarding gender (question 3) included additional knowledge of gender and demographic developments in general, taking into account the growing ageing population. Furthermore, as declared by the experts were the multi-cultural traditions and the changing role of the family members. Some points were made concerning the predominance of the female ageing population versus the predominance of the female gender in nursing. The health care experts mentioned

that the nurses' role in health promotion concerning skills, attitudes, resources and barriers was the same for male and female patients.

The findings from question 4, describing the topic of diversity among the elderly included transcultural nursing, different religions and traditions of the older patients. Barriers named were language and the communication through translators or family members as well as low health literacy. In regards to the differences related to health promotion between the elderly and younger persons (question 5), the health care experts found that the understanding of one's health differed between older and younger patients. Nurses need to be aware of the increased use of website information by younger people who are more sensitised to health promotion. Even though older patients may be experts on their living conditions and diseases due to their experience, their age might lead them to be more confused by the requirements of nurses compared to that of younger patients.

The findings generated from the five open-ended questions used in the first round were converted to a structured questionnaire with five themes, 25 sub-themes and a total of 381 items.

Findings - Round 2

The second Delphi survey round was based on the same topics as the first round. The specific questions were formulated based on the feedback from the first round. The 27 panel members (drop off n= 2) who participated in the second round reviewed the items. They indicated that the questionnaire was in accordance to the information given in the first round and reported that they needed about 45 minutes to answer the questions (305 items).

In the second round the most reliable consensus results (consensus level at least 80%) were achieved for 15 items by a strong agreement of the health care experts.

Regarding the meaning of health promotion by nurses for older patients, one item reached the consensus level. The health care experts declared that nurses' health promotion can lead to the reduction of health care costs. Concerning the nurses' role in health promotion in the hospital the experts agreed that the nurses' should have knowledge of health behaviour. Furthermore the nurses' attitudes should support the older patients' autonomy and participation. Additional opinions agreed upon were the nurses' empathy, appreciation, respect and openness towards the

older patients and the nurses' conviction of the meaningfulness of health promotion. Nurses' should be aware that being old does not go along with being sick.

Results, which reached the most reliable consensus level among the recommended skills were counselling, establishing a relationship and active listening.

Concerning health promotion by nurses' for older people with regards to diversity, two items reached the consensus level. The health care experts agreed on the attitudes. Nurses should be aware that patients might have a different perception of health comprehension and a diverse perception of life and death due to their different cultural backgrounds

An additional item reached the consensus level during the second round. This was in regard to health promotion by nurses for older persons versus younger patients. There was a clear statement by the panel that health promotion is necessary and important for all ages.

The results of the second round, which reached the consensus level, are presented in table 11. The remaining items which did not reach the consensus level were forwarded to round 3.

Table 11. Delphi 2end round: consensus results identified

Theme	Sample n	Consensus level (strong agreement) % (n)	Median (Mode)	Mean (SD)
The meaning of health promotion by nurses for older persons in an acute hospital				
Reduction of health care cost by health promotion	26	81 (21)	2 (2)	1.8(0.4)
The knowledge needed to perform the role of a health promoting nurse for the elderly in an acute hospital setting				
Knowledge about health behaviour	25	80 (20)	2 (2)	1.8(0.4)
The needed attitudes and behaviour of the nurse				
Autonomy	25	92 (23)	2 (2)	1.9 (0.3)
Appreciation	25	88 (22)	2 (2)	1.9 (0.3)
Empathy	24	87 (21)	2 (2)	1.9 (0.3)
Respect	25	88 (22)	2 (2)	1.8 (0.4)
Participation	25	84 (21)	2 (2)	1.8 (0.3)
Openness	25	80 (20)	2 (2)	1.8 (0.4)
Conviction of the meaningfulness of health promotion	25	80 (20)	2 (2)	1.8 (0.4)
Being old does not go along with being sick	25	80 (20)	2 (2)	1.8 (0.4)

Table 11. Continued

Theme	Sample n	Consensus level (strong agreement) % (n)	Median (Mode)	Mean (SD)
The skills needed				
Counselling	25	80 (20)	2 (2)	1.8 (0.4)
Establishing a relationship	25	80 (20)	2 (2)	1.8 (0.4)
Active listening	25	80 (20)	2 (2)	1.8 (0.4)
Health promotion by nurses' for older persons, in regards to diversity				
Different relevance of life and death	27	85 (23)	2 (2)	1.8 (0.4)
Awareness of different health comprehension	27	81 (22)	2 (2)	1.8 (0.4)
Health promotion by nurses' for older persons, in regards to young patients.				
Important and reasonable for patients at any stage of life	27	89 (24)	2 (2)	1.9 (0.3)

(Strongly agree=2, agree=1, undecided=0, disagree=-1 and strongly disagree=-2)

Findings - Round 3

Twenty-six panel members (drop off n=1) participated in the third round. The questionnaire used in the third round contained the questions that did not achieve the consensus level in the second round (291 items). Additionally, two new items based on the panel members' feedback from round two were integrated. Two new items were listed concerning the theme and the meaning of Health promotion by nurses for the elderly in hospitals (Q1) and the theme regarding the differences related to health promotion between the older persons and young (Q5). These additional items did not however reach the consensus level during the final third round. Regarding the meaning of health promotion by nurses for older patients, one item reached the most reliable consensus level. The health care experts clearly declared that the increase of relevance or the value of health promotion by nurses in hospitals is due to the increasing number of older persons with chronic diseases.

The expert panel strongly agreed that the knowledge needed for the nurses' role in health promotion is the expertise of health promotion including the health promotion concepts. The strongest agreement on the required nurses' attitudes and behaviour was the empowerment of the older persons (n= 24, 96% consensus). Furthermore, the panel agreed that the required attitudes were, the interest of nurses to assess the older patients' health behaviour and the resources orientated behaviour of nurses. There was also agreement on the awareness of the individuality of older persons and the conviction that old age does not assume a bad quality of life. With regards to the needed skills to perform the role of a health promoting nurse the experts agreed on the professional strategy such as the expertise to implement health promotion interventions. Under competence they included professional communication and management skills. Further described were the assessment skills integrated into the nursing process. The health care experts declared that professional nurses should be capable of identifying health-promoting opportunities, analysing the situation and reacting based on their own perception.

Among the resources needed to perform the role of a health promoting nurse, the expert panel mentioned time resources. Moreover, they declared the nurses' expertise and knowledge supported by the nursing education in Switzerland were resources needed to perform the professional nurses' role in health promotion.

A barrier to health promotion activities, by consensus decision, was the missing scope of health promotion activity by nurses in general (n =23, 92% consensus). Again this was supported by the missing health promotion knowledge and the missing designated health promotion competencies of nurses. The results are shown in in table 12 below.

Table 12. Delphi 3rd round: meaning of health promotion, knowledge, attitudes, skills, resources and barriers- consensus results identified by strong agreement

Theme	Sample n	Consensus level (strong agreement) % (n)	Median (Mode)	Mean (SD)
Increased meaning of health promotion by hospital nurses				
The increasing number of older persons with chronic diseases	26	81 (21)	2 (2)	1.8 (0.4)
Knowledge needed to perform the role of a health promoting nurse for the elderly in an acute hospital setting				
Expertise of health promotion	25	88 (22)	2 (2)	1.9 (0.3)
Knowledge of health promotion concepts	25	84 (21)	2 (2)	1.9 (0.3)
The needed attitudes and behaviour of the nurse				
Empowerment	25	96 (24)	2 (2)	1.9 (0.2)
Interest to assess the patient health behaviour	25	92 (23)	2 (2)	1.9 (0.3)
Interest in health behaviour of older person	25	88 (22)	2 (2)	1.9 (0.3)

Table 12. Continued

The needed attitudes and behaviour of the nurse				
Conviction that old age does not assume bad quality of life	25	88 (22)	2 (2)	1.9 (0.3)
Resources orientated behaviour	25	88 (22)	2 (2)	1.9 (0.3)
Awareness of the individuality of the older persons	25	88 (22)	2 (2)	1.7 (0.5)
The skills needed				
Proficiency to implement the health promotion interventions	25	92 (23)	2 (2)	1.9 (0.3)
Communication skills	25	88 (22)	2 (2)	1.9 (0.3)
Management skills	25	84 (21)	2 (2)	1.8 (0.3)
Providing confidence	25	80 (20)	2 (2)	1.8 (0.4)
Skills to act guided by perceptions	25	80 (20)	2 (2)	1.8 (0.4)
Assessment skills	25	80 (20)	2 (2)	1.7 (0.7)
Resources				
Time resources	25	84 (21)	2 (2)	1.8 (0.5)
Nurses' expertise	25	80 (20)	2 (2)	1.7 (0.7)
Nursing study programs	25	80 (20)	2 (2)	1.7 (0.7)
Barriers				
Missing scope of health promotion activity by nurses	25	92 (23)	2 (2)	1.8 (0.8)
Missing definition of nurses health promotion competencies	24	83 (20)	2 (2)	1.7 (0.8)
Missing health promotion knowledge	25	80 (20)	2 (2)	1.6 (0.8)

(Strongly agree=2, agree=1, undecided=0, disagree=-1, and strongly disagree=-2)

Concerning the essential differences of the nurses' attitude with regards to gender management, the experts supported the need to respect a persons' own social role. The nurses' attitudes were related to the diversity of the older persons in hospitals and the awareness of existing learning skills by all the older persons was described. There was an agreement that a health-promoting nurse should consider and accept the different ambitions and attitudes of older patients.

In relation to the diversity of the older patients in hospitals and the requested skills the experts agreed on the nurses' expertise in verbal and nonverbal communication skills. Once more the panel experts reconfirmed the missing knowledge as an obstacle for health promotion concerning diversities.

When answering the questions on the differences essential to health promotion for the older patients versus younger patients, the experts pointed to nurses having knowledge about the pattern of the age group diseases, to the understanding of physiological development of the age group and to the comprehension of health of the older versus the younger patients (table 13).

Table 13. Delphi 3rd round: Gender, diversity, older versus younger persons- consensus results

Theme	Sample n	Consensus level (strong agreement) % (n)	Median (Mode)	Mean (SD) μ (s)
Health promotion by nurses' for older persons, in regards to gender				
Respect for a person's own attitude	25	80 (20)	2 (2)	1.8 (0.4)
Health promotion by nurses' for older persons, in regards to diversity.				
Awareness of existing learning skills by all the older persons	25	88 (22)	2 (2)	1.9 (0.3)
the acceptance of different ambitions of older patients	25	84 (21)	2 (2)	1.8 (0.3)
Missing knowledge as an obstacle for health promotion concerning diversities	25	80 (20)	2 (2)	1.8 (0.4)
Nurses expertise in verbal and nonverbal communication skills	25	80 (20)	2 (2)	1.7 (0.5)
Health promotion by nurses' for older persons, in regards to young patients.				
knowledge about the age group diseases pattern	25	84 (21)	2 (2)	1.8 (0.3)
Comprehension of health of the older versus the younger persons	25	80 (20)	2 (2)	1.8 (0.4)
Understanding of physiological development of the age group	24	87 (21)	2 (2)	1.9 (0.3)

(Strongly agree=2, agree=1, undecided=0, disagree=-1 and strongly disagree=-2)

Findings - No consensus level reached

In this Delphi study not all statements reached the consensus level. According to the literature these statements are often not reported in Delphi studies (Keeney et al., 2011). Nevertheless for this study ten statement which did not gain consensus, are presented as they expose interesting findings for the PRECEDE-PROCEED model (Green & Kreuter, 2005) analysis and further discussion.

Whilst there were clear statements that currently health promotion for older persons is considered as a part of nursing, the judgement of the value or the meaning of health promotion for older patients was diverse. Health care experts stated without consensus reached, that empowerment is of low meaning in nursing for older patients. Furthermore, few health care experts were of the opinion that nurses perform health promotion and disease prevention simultaneously. Moreover, the medical diagnoses are treated and the patients are discharged without any further investigation.

Health care experts mentioned that nurses are not consciously performing health promotion. The experts gave diverse views about the nurses' health promotion performance within the interdisciplinary team of other health professionals.

As the most reliable consensus level was not reached, health promotion was perceived as being of minor importance, especially considering the missing mandate and guidelines for health promotion by nurses.

Concerning diversity, one barrier to the non-performance of health promotion was because of the short hospitalisation stays and there being no time for the nurse to be informed about the patient adequately.

Table 14 highlights the ten results where no consensus level was reached by strong agreement despite the three Delphi rounds.

Table 14. Delphi 3rd round: results- no consensus level reached

Theme	Sample R 2 n=27 R 3 n=26	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)	Mean (SD)
The meaning of health promotion by nurses for older persons in acute hospitals								
Health promotion for older persons is a part of nursing	R2, 27	20	6	1	0	0	2 (2)	1.7 (0.5)
	R3, 26	18	6	1	1	0	2 (2)	1.6 (0.7)
Health promotion is performed through disease prevention / prophylaxis	R2, 26	7	14	3	2	0	1 (1)	1.0 (0.8)
	R3, 26	1	22	2	1	0	1 (1)	0.9 (0.5)
Empowerment is of low meaning in nursing for older patients	R2, 26	5	13	3	4	1	1 (1)	0.6 (1.0)
	R3, 26	1	20	3	2	0	1 (1()	0.7 (0.6)
Health promotion is performed interdisciplinary	R2, 26	6	11	3	6	0	1 (1)	0.6 (1.0)
	R3, 26	5	15	3	3	0	1 (1)	0.8 (0.9)
Nurses are mostly unaware of performing health promotion	R2, 26	11	10	0	4	1	1 (1)	1.0 (1.2)
	R3, 26	6	15	1	4	0	1 (1)	0.9 (0.9)

Theme	Sample R 2 n=27 R 3 n=26	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)	Mean (SD)
Health promotion by nurses for older persons is of prime importance	R2, 26	6	5	5	8	2	0 (-1)	0.2 (1.3)
	R3, 26	3	8	2	11	2	-0.5 (-1)	0.4 (1.2)
Minor meaning of health promotion								
The missing mandate for health promotion	R2, 26	17	7	1	1	0	2 (2)	1.5 (0.7)
	R3, 26	19	5	1	1	0	2 (2)	1.6 (0.7)
The missing guidelines for health promotion in the acute hospital setting	R2, 26	16	7	0	2	1	2 (2)	1.3 (1.0)
	R3, 26	19	3	2	1	1	2 (2)	1.4 (1.0)
The medical diagnoses are treated and the patient are discharged without any further investigations	R2, 26	4	11	3	6	2	1 (1)	0.3 (1.2)
	R3, 26	4	13	2	4	3	1 (1)	0.4 (1.2)
Barriers to health promotion by nurses' for older persons, in regards to diversity.								
The impossibility to know each other due to the short hospitalisation	R2, 27	12	8	3	2	2	1 (2)	0.9 (1.2)
	R3, 25	17	5	2	1	0	2 (2)	1.5 (0.8)

6.1.2 Health promotion by nurses for older persons: the experiences of bedside nurses

The findings of the focus group discussions were centred on the role of nurses' health promotion for older persons. Moreover, it assessed wether this role is actually being performed, in daily practice, in Swiss hospitals. The focus groups participants, nurses' employed at different medical and surgical wards declared their professional expertise with older patients. They confirmed that the majority of their hospitalised patients are older people (65+). The discussion was supported using the topic guide that was introduced by the moderator (author) during the focus group discussions. Through the analysis (documentary method, Bohnsack et al., 2010) the participants opinions and interactions were divided into five themes; the nurses' role in health promotion; the meaning of health promotion activities in daily clinical practice; the barriers for health promotion; the strategies or the supporting factors for health promotion and, the recommended interventions for the daily nursing practice at ward level.

The nurses' role in health promotion for older people

The moderator asked the participants about their own professional experience regarding the role of nurses' health promotion for older people in the acute hospital. Interestingly enough, the participants of the first group hesitated and asked if they should discuss the nurses' role in health promotion as it is 'supposed' to be or the authentic nurses' role in health promotion in daily clinical practice , as follows:

Excerpt 1.

Barbara: *"Well, what we do or what we are supposed to do?"*

Moderator: *"What you do."*

Barbara: *"What we do ok!"*

The following excerpt shows that after some hesitation the nurses' indicated the nurse's key role in health promotion for older persons is the assessment of needs, resources and empowerment. Nevertheless, they indicated the elementary activities of health promotion on a short-term base and mentioned the possibilities for improvement.

Excerpt 2.

Claudia: *I think there are some basics and we implement interventions, but this could be improved.*

Barbara: *The task is mainly the assessment of resources and the improvement of resources of the older patient and maybe some parts of education if there are some sorts of skills they should learn.*

Anna: *For us at the acute hospital it is mainly to avoid falls and complications on a short term; and the promotion of resources of daily activities; but these are minor activities in health promotion.*

The participants of the second group showed their more common (identical) experiences and a collective development of the nurses' role definition. As shown in excerpt 3, they explained that the nurses' role in acute hospitals is counselling and health education. In short nurses support the patients and their relatives to cope with the changing circumstances through health promotion.

Excerpt 3.

Corinne: *Nurses do counselling in regards to health.*

Daniela: *..and give information, indeed they do counselling.*

Fiona: *Advising and teaching*

Amelie: *I_ and collaborate for health promotion*

Amelie: *Collaborate actively with the patients for health promotion*

Eric: *(nodded) not only with the patients with the relatives as well.*

The participants declared that the patients' problems and risks are recognized through the nursing assessment as nurses' are close to the patient. Nevertheless the participants concluded that identified problems are then delegated to health experts and interventions are evaluated by regular interdisciplinary exchange meetings (excerpt 4).

Excerpt 4.

Bea: *Well I would say, we do the assessment but if we do have any concern and we think one should inform somebody, we inform the interdisciplinary group…..*

Fiona: *But*

Eric: *Well*

Fiona: *When the patient arrives, we do the assessment of his requirements (pause) but finally he is forwarded to a specialist*

Amelie: *l_mhm*

Fiona: *l_or if sombody of the interdisciplinary team is involved, the main activity is among them and (long pause) and we are just involved if the patient has additional questions after their external consultation. We take care of these questions or forward them to the experts.*

During their discussion they reached an internal agreement that the nurses act as an intermediary and they may include advice given by the health experts in their daily nursing care. The participants explained nurses' do not control the achievement of given interventions. Nurses delegate the responsibility for health promotion to experts and they do not have the overall picture of the outcome for enhancing the health of their patients.

The meaning of health promotion activities in daily clinical practice

The meaning of health promotion activities in daily clinical practice should give an actual insight into how health promotion is performed in daily life at the acute hospital. The focus group participants were asked about their experience and about the meaning of health promotion activities at their hospital. Thus the discussions

of the two groups showed a diverse discourse. In group one the discourse was on common (identical) experiences and a collective development, while the second group had an ambivalent discourse and more diverse argumentations.

The participants of the first group pointed to the gap in theory and practice. The speakers felt that in daily work life health promotion does not receive the "as wished" attention or work as it supposed to. By internal agreement they argued "if attainment of competencies in health promotion is officially part of a student nurses' evaluation, more importance has to be placed on health promotion in the actual ward practice". Health promotion should be considered in a broader context and not only the assessment and empowerment of resources. In general health promotion activities are regarded as less important than the treatment of the medical condition(s). The flow of the conversation ended up in arguments about how the daily activities of health promotion should be improved. In short and by a collective development they added multiple focuses. Health promotion intervention should be applied right at the beginning, at the entry assessment, to assure the older persons performance after discharge at home. Furthermore, the speakers pointed out that improvement, to the older patients participatory and collaboration needs to be made. As an example of health promotion in their daily clinical work they mentioned activities such as to fall prevention. Related to their description of the nurses' role in health promotion, they concluded that trained health experts in specific therapeutic fields perform more health promotion than they do. This discussion ended with the statement that nurses need the collaboration of older patients' relatives to implement health promotion activities in their daily clinical work.

Excerpt 5.

Moderator: *How do you judge the meaning of health promotion activities in your daily clinical work?*

Claudia: *In my opinion, at the hospital ward, health promotion is of minor meaning than nurses would wish for and health promotion is supposed to be*

Barbara: *And if you think about the students' qualification, health promotion should be of upmost importance. Health promotion is one of the "decision making and responsible competences" of the curriculum, but in reality of the daily clinical life it is the assessment and promotion of resources only*

Anna: *Well I agree, mostly the treatment of the acute medical treatment has priority and health promotion is less supported*

Claudia: *The health promotion interventions should be implemented in advance. For example, considering falls, the assessment of resources and skills should be performed on the first day of the older person's hospitalisation. Likewise one can observe their skills during the hospitalisation and may approve their performance after discharge at home.*

Anna: *Yes, at our ward this is of high priority but we could improve the patient collaboration. Many things are introduced to them without their participation*

Barbara: *Well, fall prevention is of priority but not patient advising or counselling or self- help group. Yes health promotion is more performed by health experts with special training as stoma or diabetes consultants.*

Claudia: *I was just considering, how we implement health promotion for deliria patients; we need the collaboration and support of their relatives indeed.*

The passage of the following, excerpt 6, shows the participants of the second group suggested that health promotion is given low priority on acute hospital wards in general. The nurses' stated that priority is given to treating the medical condition. All too often, it is assumed that the health promotion is undertaken once the patient is discharged from the hospital and sent to a rehabilitation centre. The participating nurses' of this group discussed on which clinical wards health promotion could be seen as more required. Health promotion for specific areas such as diabetes- and stoma counselling and advice to prevent falls was considered to be essential. More detailed information was given on the example of older patients of the cardiovascular unit. They explained the importance of detailed advice for physical activities. Also the patient should pay attention to healthy nutrition to avoid overweight. The nurses recommended the assessment and support for patients' self-care management including the support for medication adherence. Followed by this statement the speakers discussed how health promotion may be more relevant on medical wards like the cardiovascular ward and less for the surgical or orthopaedic wards.

The participants seem ambivalent and after a while the discussions turned to the relevance of age and health promotion for older patients in daily practice. The

argument that older patients who are approximately 80 years old were not receptive to health education and that health promotion was not necessary was discussed.

One participant disagreed, Corinne argued that health promotion played an essential role in the oncology ward. She stated health education and empowerment of older persons is of high relevance in preventing additional harm.

Excerpt 6.

Moderator: *How to you judge the meaning of health promotion activities in your daily clinical work?*

Daniela: *In my opinion health promotion is of low relevance. It is just happening beside the medical treatment*

Bea: *I agree at our hospital health promotion is not among the priorities one takes care about the treatment of the medical condition. (long pause) And we do not advise the older patient about health behaviour if it is not bound to the medical diagnosis.*

Fiona: *Older patients are often discharged to a rehabilitation centre and mostly we delegate health promotion and counselling to the rehabilitation institution.*

(long pause)

Fiona: *Well if you think about diabetes, of course you start right away with counselling to avoid any consequences*

Bea: *Well yes, we take care and discuss it with experts if needed- but all other …*

Amelie: *l_yes or (pause) for example with cardiovascular patient I see that we take the counselling role on a regular base for (pause) lifestyle for example or what (pause) is recommended for (pause) about the regular things or what they should do for physical activities, consider healthy nutrition (pause) avoid obesity (long pause) take the medication on a regular basis (long pause) yes.*

Eric: *I think it is depending on where you work (pause) but I work on an orthopaedic ward (pause) the patients they have mmh health promotion I hardly never do, except for counselling the*

Fraxiparin injection to do after discharge at home - health promotion (pause) this is of very low relevance (long pause)

I assume on medical wards, with this cardiovascular histories (pause) health promotion has a different relevance compared to a surgical ward as orthopaedic?

Daniela: *Yes and any way if I think about (pause) on our ward the average age of the patients is approximately 80 years, well, yes! in this case how would you do health promotion, they have dementia they forget it and*

Eric: *I_"What young Johnny did not learn, neither does John"*

Daniela: *Yes and I am happy if they get up and eat at the table and don't want to be served in bed*

Corinne: *mmh*

Daniela: *Yes there are small activities but I don't think it's about health promotion activities*

(pause)

Corinne: *But I do not agree, I work on an oncology ward and health promotion is among the priorities for cancer patients. Cancer therapy has a huge influence on health and quality of life. We do a lot of counselling and advising and prevent harm by health promotion. Health promotion is of high meaning or relevance on our ward.*

Barriers for health promotion

The focus lies on the barriers, which are hindering the nurses to perform their role in health promotion for older persons at the acute hospital. When asked by the moderator about the barriers for health promotion activities both groups indicated that, priority is given to the treatment of the medical condition and not to health promotion. Furthermore, the participants of the first focus group agreed that the lack of time resources due to the short hospitalisation of older persons impacts health promotion. They mentioned the missing support and collaboration by the relatives of the patients'. Moreover, the participants elaborated on the missing health promotion knowledge of nurses regarding health promotion

implementation. They claimed the missing collaboration with the interdisciplinary teams and their missing interest in health promotion in their daily clinical work played a role. The following excerpt 7 illustrates the discourse passage.

Excerpt 7.

Claudia: *"…time plays an important role, from the assessment of the resources and the requirements…. and the outcome is not visible during the short period"*

Anna: *"…by the time you define the health promotion intervention the older patients are discharged..."*

Barbara: *"…and sometimes…nurses don't have enough knowledge to implement health promotion in daily clinical work"*

Claudia: *In my opinion nurses need the collaboration and support of the interdisciplinary team and or with medical experts, but I feel they do not pay attention to it [health promotion].*

The second group stated the barriers for health promotion by a collective agreement and shared their identical experiences. Similar to the first group they stated the need for more collaboration with the interdisciplinary team. Again they argued nurses act as mediators and discussed, if nurses' have a lack of health promotion knowledge, which would be necessary to support older persons. The participants added the challenge of obtaining and maintaining the essential skills in 'the state of the art knowledge' of all nursing-relevant fields. Furthermore, they mentioned the difficulty in communicating or the lack of communication skills, which specifically hinders the role of the nurse as a health promoter.

Excerpt 8.

Daniela: *Well. I don't think they [Nurses] don't have enough knowledge, they are supposed to know a lot thus they do not know what they know.*

Amelie: *[laughs]*

Daniela: *It is very difficult to communicate knowledge, one knows about avoiding alcohol and that one should eat fruits- it is difficult to provide advice and it is changing all the time and one cannot be up to date all the time to advise on the newest findings.*

Amelie: *Yes … and we are in charge of so many different things, we have a lot of work during the day, and we are in charge of the medications, bandages, disease prevention and have to consider the prescriptions of the medicines there are so many things to do – we have to delegate these things [health promotion] to experts.*

The participants had difficulty explaining further barriers for health promotion performed by nurses at the acute hospital. Eric mentioned that health promotion was felt to be a long-term process to tackle a life style problem of the society in general. And Fiona confirmed and explained that health promotion should be performed by the general practitioners. Bea added that "thinking about the long-term process and the complexity of the system, health promotion cannot be applied during the short hospitalisation as the nurses' do not have any influence after hospital discharge". At this point in the discussion Corinne adds an additional "problem" and declares, "the older patients are more concerned about their medical diagnoses and are reluctant to acknowledge health promotion interventions". This was confirmed by the rest of the group participants as illustrated in Excerpt 9.

Excerpt 9.

Corinne: *And I think, there is an additional problem, if the older persons are at the hospital they are occupied by their disease.*

Amelie: *Yes*

Corinne: *They are not reluctant for anything [health promotion] like advice on avoiding alcohol or the stop smoking program, if they do have all the other problems.*

Bea: *Not to any complex health promotion program, I feel that they [older patient] are open for health promotion advice for their current medical situation….but other topics are not of importance as they are self-absorbed*

Towards the end of this discussion communication difficulties around the importance of respecting patient autonomy and self-responsibility and the large age gap between the nurses and the patients were also discussed. Bea gave a long statement, which was supported by all the group participants, shown in excerpt 10.

Excerpt 10.

Bea: *What do we do, if a patient is admitted to our ward, we ask if they are willing to participate in the non-smoking program. The physician counsels the patient and asks them to join the study. They receive a lot of information materials, but as they are preoccupied by other things only few patients are participating. They might get surgery the next day, and of course it might be a chance to stop smoking in this situation, but it is patronizing as well. It is very difficult to communicate and to respect the patient autonomy and self-responsibility. I don't think this is health promotion if you impose something on the patient. If it is not required by the patient himself – I am unconvinced if I decide to advise the patient*

Amelie: *" …and being 25 years old it is difficult to advise an 65 year old man to refrain from smoking…especially if you smoke yourself"*

The participants of the first group finalized their discussion about the barriers for nurses' health promotion by arguing about the low profile of workplace health promotion at the acute hospital. They discussed the basic lack of organisation and infrastructure as an obstacle for health promotion in clinical practice. As an example the nurses pointed to the need of assigned meeting rooms for conversations with patients and their relatives. Moreover, they argued that the general attitude of the institution may influence the nurses' attitudes towards health promotion.

Strategies or the enabling factors for health promotion

In both focus group discussions the participants showed difficulties in discussing strategies to overcome the health promotion barriers. The discussion reflected common experiences but was a collection of ideas and had fewer interactions.

The participating nurses' suggested that there is a need for increasing the visibility and the core value of health promotion in health institutions in general. Strategies discussed by the participants were the development of an institutional policy

concerning health promotion. They suggested the implementation of guidelines across the hospital aimed at increasing the relevance of health promotion.

The participants discussed the attitude of hospital management towards health promotion. They suggested that it is the duty of the hospital management to highlight the impact and economic benefit of health promotion to their staff. The participating nurses' recommended further training for all health professionals as a method for increasing awareness of health promotion.

Excerpt 11.

Claudia: *.."To change the health promotion attitude in general, it should be the aim of the hospital management…or they should be able to make health promotion more visible, "live health promotion", act as an idol [role model] and approve the relevance of health promotion…"*

Barbara: *Well, the nursing directors could consider it as a goal throughout the whole year.*

Anna: *Yes and the hospital should offer further training, having a selection of courses ready and the employees may choose among them*

Barbara: *I think people would be interested in it*

Claudia: *But I think they should present the economic advantages of health promotion*

Barbara: *This is true*

Claudia*: .. show the outcome of health promotion interventions such as less complications*

Anna: *Yes, like this more nurses could be involved, participate and be aware of health promotion interventions.*

Priority should be given to the exchange of information at both times of admission and hospital discharge. Consequently attention should be given to professional reporting systems between the various institutions. According to the participants, the development of an institutional documentation system among the different clinics and wards is mandatory to increase the importance of health promotion.

Excerpt 12.

Claudia: *The example of the transferal reporting this document including the patients' records could be newly arranged. It should be more structured including the relevant health promotion intervention and the patient resources indeed.*

Barbara: *And to do it all together [interinstitutional] in cooperation, isn't it?*

Claudia: *Yes*

Barbara: *Common development among the wards at the acute hospital and other institutions*

Health promotion implementation advices at the ward level

The discussion about advice to improve the implementation of health promotion in daily practice shed light on identical experiences among the participants however, their opinions and perspectives varied.

Suggestions on the elaboration of the wards own definition of health promotion goals was formulated. Further discussed was the enhancement of patient participation based on patient characteristics and requirements, which would support the sustainability of the patients' performance after discharge. The participants argued that in some situations it may not be possible to respect patients' wills as nurses may implement a health promoting intervention to prevent harm and patients may not know or understand the reason for this intervention. In contrast they indicated that they would nevertheless still advise the patient about the intervention, even if this was unwanted and later refused by the patient. Regarding this point, they all agreed that it is necessary to ask older persons about their need for health promotion during the admission assessment, which is not currently done in practice.

Excerpt 13.

Fiona: *.."I think every ward should elaborate their own definition [of health promotion] and decide on health promotion interventions that should be performed*

Daniela: *.."Yes- as the surgery ward does not have the same aims as a medical ward*

Fiona: *Exactly*

Corinne: *Well I think it could be as you mentioned- but one should discuss the aims in collaboration with the patient and together health promotion interventions should be elaborated- like this the patient is more motivated ( ) to do it back home as well*

Fiona: *But*

Eric: *Well it's about health education?*

Corinne: *I think it is important to consider the patient individuality and the individual quality of life when describing the patient personal aims….even having lung cancer and if he wants to smoke…knowing it is not healthy, but you cannot avoid it…I feel, this is not a matter of concern*

Fiona: *As long as you can act ethically*

Daniela: *.."yes- what do you do if you cannot agree to it?*

Fiona: *As a nurse you have to… even if the patient does not understand, he might need more information and counselling….but there are situations ……a nurse has to perform interventions to maintain the health situation of the patient ….*

Daniela: *.."but- the older patient being 80 years old they might have a different goal and as a nurse even if not agreeing, one has to respect this decision*

Corinne: *But anyway I think we should do counselling during this situation… explain the consequences … still the patient may say no to it*

Fiona: *Yes*

Eric: *We could ask the patients during the entry assessment about their requirements of health promotion activities*

Moderator: *Do you do this on your ward?*

Eric: *No, it would be required indeed*

The participants agreed upon the need for basic health promotion knowledge among all nurses in an acute hospital setting. The group declared by a collective development that knowledge of health promotion should be initially introduced through the nursing training programme but must be updated over time and it remains the responsibility of each individual nurse. Moreover experienced nurses' should also be aware of being a role model for nursing students.

Excerpt 14.

Barbara: *well, they should all have the same level of knowledge? Otherwise we cannot do anything- well some nurses could have a good impact for some patients, but it should be an aim of all the ward nurses in general to advise the patients with common health promotion knowledge.*

Moderator: *It means all nurses should have the same basic knowledge of health promotion?*

Barbara: *Exactly, as a good summary, yes*

Anna: *Well actually it would be an important topic [health promotion] in the first study year. The nursing students are trained in the second year of the nursing study program. In my opinion the nurses are well-trained in health promotion, but nurses should be aware of what they know.*

Barbara: *..activate their health promotion knowledge*

Anna: *..reactivate the knowledge- yes*

Claudia: *And I think nurses should be aware of their role model and should and should act – and take the responsibility for health promotion and healthy behaviour.*

Barbara: *.."It would be favourable if nurses would be role models for nursing students, examples of the implementation of health promotion interventions. This would give a snow ball effect. One is impressed of the professional competence performing the intra venous catheter skill thus it would be adorable to impress someone by Health promotion interventions."*

Anna: *.."yes and they [nurses] should dare to discuss topics and to advocate for something.*

The participants had difficulties to formulate the exact health promotion implementation advice at the ward level. Interesting enough at the end group two recommended that nurses reflect on the definition of health promotion and

develop a common understanding of health promotion in daily practice on the ward. More nurses' should be aware and respect the older patient participation and autonomy.

Excerpt 15.

Moderator: *Do you have further advice regarding the implementation of health promotion interventions?*

Corinne: *Maybe to consider- what belongs to health promotion. We did talk about the definition of health promotion and what nurses could do*

Bea: *I think we should have a team discussion to talk about our own attitude and comprehension of health promotion. Similar to what we have done right now. This could be discussed during lunch time; there is no need for an official meeting ( ) just to get more aware of health promotion…*

Eric: *But – my advice – nurses should be aware and respect the patient participation and autonomy*

Daniela: *Yes and if they [patient] –are not interested nurses should accept that. Nurses cannot force the patient into health promotion.*

6.2 Findings - the Older Persons Study

The findings of this study present the perceptions of the older persons on the presence of nurses' health promotion at the hospital and at home after discharge. The needs and requirements for health promotion of the participating older patients are also presented.

The findings of the interviews are divided in two parts. In the first narrative part the participants understanding of health promotion and their activities to be healthy is described. The older persons explained their experiences of their actual situation and their perception of the advice given by the nurse during their hospitalisation.

In the second part the results of the structured interviews conducted with the same older persons are presented. The results are classified under two main headings. The first is health promotion by hospital nurses which includes empowerment, health education and health literacy and the second, the older persons' self-management and the support at home by relatives and external services.

6.2.1 Health promotion performed by hospital nurses'- the view of the older persons

The interviews with the older persons were conducted twice once during the hospitalisation (women, f n=20; men, m n=20) and once at the participants' home two weeks after hospital discharge (women, f n=17; men, m n=15). The majority of the older persons had difficulties to explain their own activities to be healthy. Quite often they started the conversation with their need to be healthy and later they talked about their own activities to be healthy. Nevertheless quite often a long conversation restarted after the structured questionnaire. The topics discussed off record were similar but more explained in more detail. Thus these off record discussions could not be analysed and are not presented in this study.

The findings are presented under three main themes firstly the older persons' activities undertaken to stay healthy, including the need to be healthy. Secondly, the participants' foreseen vs. actual experience at home after discharge is described. Finally, the findings about health promotion and nurses' advice about support at home are presented. The findings provide an insight to the older persons' needs,

requirements and resources in regards to health promotion performed by hospital nurses (table 15).

Older Persons activities undertaken to stay healthy

Among the "activities undertaken to stay healthy" the participants stated short distance walks on a regular base and being active in general. Also named were physical activities like regular walking for longer distances, biking, gymnastics and aqua fit.

"And walking, walking, walking, physical activities, walking and aqua fit training, I just do it all it is so important" (participant f16).

Furthermore women and men attached importance to daily life activities namely cooking, housekeeping and to the support of the family. Especially the men leaned towards activities in the garden and other duties e.g. spending time on the computer whilst women leaned more towards hobbies like singing in a choirus or making handicrafts.

"I am walking half an hour in the morning and one hour in the afternoon and I am working in the garden, cutting the trees, otherwise I do not do much but I cook and I do the household, I cook healthy food" (participant m2).

The awareness of a healthy nutrition like vegetables and fruit as well as healthy living with no alcohol, no smoking and rest and sleep were also mentioned.

A further activity considered to stay healthy was the visits to the general practitioner or other external health services such as physiotherapy, dentist or foot care. The older person stated that they pay attention to the regular management of prescribed medicine.

During the interview the older persons tended to talk about their needs to be healthy. High importance was given to the family and to social contacts and friends.

Importance was given to having good communication and harmony among each other, being respected as a person and having role or an assignment among the

family members. A further predominant statement was the importance given by the older persons to living at home in their own house or apartment. The male participants especially pointed out the need for autonomous ability with regards to financial resources.

"It is important to me that I can support my family, that I am needed by my family, to be healthy" (participant f14)

"I could help; I was needed during my daughter's house construction, this made me feel healthy" (participant m8)

Foreseen vs. actual experience at home after discharge

This theme explains firstly the responses of the participants during the first interview concerning how they foresee the situation at home after hospital discharge and secondly the responses of the participants during the second interview concerning what they actually experienced at home after hospital discharge (table 15).

Some participants stated during their first interview at hospital, that the foreseen experience at home after hospital discharge would be problem-free (f n=10; m n=14). Although women reconfirmed the statement, only few male participants maintained this during the second interview at home (f n= 9, m n=3). Following hospital discharge during the second interview, pain was among the older persons' named problems. Furthermore men had various problems with digestion, breathing and dizziness or wound infection. The older persons concurred that they still felt weak and tired.

"It was much more difficult than I expected and I am still suffering, I think I am physically in a bad state and I was not walking at all, until now" (participant m12)

The older persons named unexpected problems arising after being at home and a few, mainly women, argued that the situation was the same or even better than expected two weeks after hospital discharge.

Nevertheless the older persons depended on the support of their spouse or family members, the assistance of their neighbours and friends and the external support by professionals.

"It will be fine I have a husband at home if anything happens" (participant f 17)

"I am autonomous and my wife is as well, we have an apartment with only two steps, no problem at all" (participant m12)

In addition problems due to the management of prescribed medicine were named by one woman and one man during the second interview at home.

Health promotion and nurses' advice support at home

This theme includes the nurses' advice given to the older persons during their hospitalisation and whether this advice supported the participants' wellbeing and autonomy at home after hospital discharge (table 15).

A clear majority of the interview participants confirmed that they did receive advice by nurses' to improve their health during the first interview at the hospital. The older persons were supported by oral counselling and/ or written information material and they admitted acting upon the advice given.

"Oh yes, and I will follow and do it all … I got this advice as I was curious" (participant m1)

"Yes I did receive the information and I will follow it, but anyway I will continue as before, I will do it my way…it is important to be free of pain" (participant m2)

"Yes, and it went better than I thought, I need the advice in any case and I did act upon it, I will do the wet packs even in the future" (participant f20)

The older persons explained different examples of advice given by hospital nurses. They mentioned an example to increase the control of their management of prescribed medicine. Furthermore, the older persons stated advice on nutrition and body weight control was given. Advice on the respiratory support included behaviour change counselling as the stopping of smoking as well as advice on breathing exercises. Other activities such as physical activities, like walking and in

bed gymnastics were mentioned. The older persons declared that they had discussed their living at home conditions with nurses. Considering the pain management the older persons stated, that nurses instructed them to do the wet pack themselves.

A small number of participants mentioned that the nurses asked them to call back if questions arose. Furthermore, the older persons mentioned that the nurses asked them to seek help and advice with external health professionals for example, the district nurse or their general practitioner.

Nevertheless during the second interview at home, the comments varied and fewer women and men stated that they received advice during the hospitalization (f n=15/ n=9; m n= 14/ n=5).

"I guess I did not ask enough and they did not tell me enough" (participant m2)

One male participant admitted that he did receive the counsel and additional written information. Then he threw them away and now at home felt he would be in need of the educational pamphlet.

"It went fine, but at home I realised that I would need the paper which I threw away." (participant m1)

Another participant stated that he did not pay attention to the nurses' advice as they thought it would be unimportant.

"Yes I did receive it but I still have many questions. Maybe I did not pay attention …or I thought it is not important when they told me. But normally I observe and do it as they show me." (participant m7)

However some participants stated that they did not act upon the advice given when at home. Older persons mentioned that they preferred to act upon the advice given by their family members.

Albeit the majority of the older persons did receive advice during the hospitalisation, five female participants and six male participants acknowledged they did not get any advice by nurses. Also after hospital discharge, two weeks later the statements remained unchanged.

Additionally, during the hospitalisation phase, women and men declared that there was no need for any advice, and during the interview at home, two women reconfirmed this.

"I don't need anything; my wife is supporting me and if needed my daughter as well" (participant m14)

Generally, participants stated during the second interview at home that they would have wished for more advice during hospitalisation (f n=0/ n=5; m n=1/ n=6).

"I did not receive any advice. We did complain about it, we always receive information but this time we did not and we did not know how to react at home" (participant m14)

The following Table 15 presents the list of the described findings.

Table 15. Older persons study: Findings open-ended interview

Themes	f hospital n=20	f home n=17	m hospital n=20	m home n=15
Older persons' activities undertaken to stay healthy				
Assignment, be active, short walks	12	11	11	6
Sports, walking, gymnastics, aquafit	8	6	8	9
Cooking, housekeeping	3	3	2	3
Gardening	3	1	7	2
Fresh air, sitting outside	3	4	2	2
Hobbies, singing, handcraft, computer	4	2	4	3
Healthy nutrition	3	6	9	5
Healthy living, no smoking, no alcohol	4	3	5	0
Rest and sleep	2	2	2	1
Meeting friends, people	2	0	4	1
Visit GP/external support/	2	2	2	3
Take prescribed medicine regularly	1	0	5	4
Needs to be healthy				
Be at home/ own house, apartment	4	6	3	1
Autonomous, financial resources	5	3	8	12
Family ,wife, husband, daughter, son grandchildren	12	4	15	7
Friends, social contacts	9	5	6	4
Good communication, harmony	6	5	8	4

Table 15. Continued

Themes	f hospital n=20	f home n=17	m hospital n=20	m home n=15
Expected/ situation after discharge at home				
As before, will be ok, no problem	10	9	14	2
Less than I expected /problems, had to look how to deal with	0	6	0	10
Difficult, loneliness	2	1	0	3
Need of support by husband/ wife	4	2	6	6
Need of support by family (daughter/ son, grandchildren)	5	4	4	1
Need of support by neighbours, friends	1	2	0	2
Need of external support (district nurse)	2	2	2	2
Pain	0	1	1	4
Difficulties with management of prescribed medicine	0	1	0	1
Slowly, tired, weak, missing motivation	0	4	0	5
Problems with digestion, vomiting, breathing, dizzy, infection	0	0	0	7
Health promotion and nurses' advice support at home I				
Yes (oral and/or written advice)	15	9	14	5
No (no oral / no written advice)	5	4	6	7
Management of prescribed medicine	3	1	2	4
Nutrition advice, body weight control	1	2	1	3

Table 15. Continued

Themes	f hospital n=20	f home n=17	m hospital n=20	m home n=15
Health promotion and nurses' advice support at home II				
Respiratory therapy	1	2	0	0
Stop smoking	1	1	0	0
Gymnastics, walking, fresh air	1	2	2	0
Fall prevention, living conditions, stairs	1	0	1	2
Pain management, wet packs	0	1	0	0
No more car driving	0	0	0	1
Offer for calls / did ask call from home	2	0	1	1
External support, referral to general practitioner, physiotherapy, district nurse service	3	2	2	3
Will/did follow the advice	4	5	8	6
Did receive all supporting material	0	0	0	1
Advice not needed, useless	4	2	3	0
Not following the advice given, follow advice of family members (spouse, daughter)	0	1	2	1
Did not get enough advice, more advice needed/ should have asked for more for advice	0	5	1	6
Did find out myself	0	0	2	1
Did not pay attention, I thought it is not important	0	0	0	1
Threw away the written information, now I would need it	0	0	0	1

6.2.2 Health promotion performed by hospital nurses'- the perception of the older persons

The findings of the structured interviews are presented under two main themes, the first is Health promotion by hospital nurses (table16) which includes empowerment, health education and health literacy and the second, the older persons' self-management and the support at home by relatives and external services (table17). In Addition to the structured questions were four open questions asking for an example to the answer given. These was to reconfirm the health promotion focus but are not presented.

In general the findings are presented by the total number of responses of women and men of the first interview during their hospitalisation and the second interview two weeks later at home (f+m, n=72). Additionally some interesting results are presented separately for men at the hospital (m, n=20), men at home (m, n=15), women at the hospital (f, n=20) and women at home (f, n=17). The figures for the study participants may vary as the older women and men dismissed some questions that they did not want to answer. Moreover, one has to consider the small sample size which does not allow for a generalization. The findings are presented in table16 and table 17.

Health promotion by hospital nurses

Taking into account the responses of all the women and men during the interview in hospital and two weeks later at home (n=72), the majority of the older people confirmed by strong agreement (n=52, Mdn 2) that they appreciate health promotion advice by nurses during their hospitalisation. Also that they are generally interested in health promotion during their hospital stay (n=53, Mdn 2).

The older persons admitted that they can actively improve their health themselves (n=41, Mdn 2). 16 older persons declared by strong agreement and 29 persons by agreement that they know now how to improve their health (n=64, Mdn =1).

The results show a diverse commitment to behaviour change by the older persons. After discharge at home four men and four women considered a behaviour change, though seven men and nine women neglected to do so, five participants were undecided and three participants did not answer the question.

The participants declared by strong agreement (n=57) or by agreement (n=9) that they had been well advised by the nurses. There were no relevant differences between gender and /or the first or the second interview with the exception of one man who declared a strong disagreement during the interview after discharge at home.

The majority, 57 out of the 72 older persons completely agreed that they felt that they could ask for clarification if they did not understand the given information fully. Again one man (out of the 15 men) and two women (out of the17 women) did not agree with the statement during the second interview at home.

Additionally, 61 out of the 72 participants agreed that information given by the nurses was given at convenient times.

During the hospitalization 10 men (out of the 19 men) and 15 women (out of the 20 women) agreed that they understood the received written information. The results of the second interview indicate 10 men (out of the 15 men) and 10 women (out of the 17 women) confirmed that they understood the written information received during the hospitalisation.

To the question that it might be the case that the older persons did not understand all the information given by nurses, 33 persons disagreed, 27 persons agreed and 12 persons were undecided. The results of the related question if the information was difficult to understand, 51 out of the 72 study participants disagreed with the results of both interviews. It should also be noted however that 18 participants agreed that the information given by nurses' was difficult to understand. In the more detailed question a further three men during the hospital stay and two men after discharge at home agreed that the information was difficult to understand. More focus should be given to the participating women, as five women during the first interview and eight women during the second interview at home declared that the information given by the nurses was difficult to understand.

The majority of the participants stated that they were satisfied with the amount of information given to them during their hospitalisation. In reply to the question for the need for more information and counselling by nurses during the hospitalisation, 53 participants disagreed (26 out of the 37 women; 27 out of the 35 men). Whilst four women at the hospital and three women after discharge agreed

that there was a need for more information and counselling, the male participants showed an increase from two men to six men from one interview to the other.

The older patients were asked if they felt they could talk about their personal concerns regarding health promotion to the nurses. Among the 72 participating elderly, 54 persons stated their agreement, six were undecided and 12 disagreed. The results show that there were more female participants who felt that they could not talk to the nurses about their personal concerns than male participants.

Additional results presented in table 16 include the answer to the question whether they felt they were well prepared or had mixed feelings about going home and being at home. Within the group of all men and women, in total 36 persons did not have mixed feelings about going home whilst 20 persons did and six remained undecided.

The older persons' self-management and support at home by relatives and external services

The responses to the question if the older people received good advice about ways to be independent at home were diverse. Altogether (n=72), 34 participants agreed, 25 participants disagreed and 13 remained undecided.

Whilst six women (out of the 20 women) at the hospital and six women (out of the 17 women) after discharge disagreed that they received good advice on being independent at home, the male participants showed an increase from six men (out of the 20 men) to seven men (out of the 15 men) in disagreement from one interview to the other.

In regards to the training of needed skills, 46 out of 68 participants, the majority, agreed their personal skills could be improved step by step with the support of the nurses during hospitalisation. Also 66 out of the 72 study participants agreed they were not overstrained as the nurses did not ask for too much self- commitment during their hospital stay.

There was no majority in response to the question if the nurses conducted joint counselling of the older people together with their relatives. Altogether, 31 participants agreed, 31 participants disagreed and 10 remained undecided. As well

as eight women at the hospital and nine women after discharge disagreed that they received joint counselling together with their relatives, the male participants showed an increase from six men to eight men in disagreement from one interview to the other. Even though the clear majority agreed that they were supported by their relatives at the hospital and at home.

As a reminder, and as described in chapter 5.2.1 material and methods of the older persons study, six women were living with their husbands, two women were living in a multi-generation household and 12 women lived in a single household. The majority of men, 14 lived with their wives and six men were living alone.

Nevertheless 49 out of 70 participants, the majority, of the older people agreed that they followed the nurses' advice at home.

Concerning autonomy and the foreseen need for support after hospitalisation, seven men and five women declared they were autonomous and would not need any support at home. The findings show clearly that some of the participants misjudged their autonomy when they were in the hospital as there was a drop in agreement from one interview to the other. Back home, two weeks after discharge from the hospital three men and two women confirmed their autonomous status. Whereas during the second interview at home, 12 out of the 32 participants confirmed the support of the Community nurses (Spitex in Switzerland) services.

Table 16. Older persons study – findings HP by hospital nurses: Frequency and Median (Mode)

Theme	n	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)
I do appreciate the nurses' health promotion advice							
all m +f n=72	72	52	15	4	1	0	2 (2)
m hospital n=20	20	13	4	3	0	0	2 (2)
m home n=15	15	10	3	1	1	0	2 (2)
f hospital n=20	20	16	4	0	0	0	2 (2)
f home n=17	17	13	4	0	0	0	2 (2)
Health promotion is not only for young people							
all m +f n=72	70	54	9	7	0	0	2 (2)
m hospital n=20	19	14	3	2	0	0	2 (2)
m home n=15	15	12	1	2	0	0	2 (2)
f hospital n=20	20	17	2	1	0	0	2 (2)
f home n=17	16	11	3	2	0	0	2 (2)

Table 16. Continued

Theme	n	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)
I am interested in health promotion at the hospital							
all m +f n=72	71	53	13	5	0	0	2 (2)
m hospital n=20	19	14	5	0	0	0	2 (2)
m home n=15	15	11	2	2	0	0	2 (2)
f hospital n=20	20	16	3	1	0	0	2 (2)
f home n=17	17	12	3	2	0	0	2 (2)
I can actively promote my health myself							
all m +f n=72	68	41	13	12	2	0	2 (2)
m hospital n=20	19	11	5	2	1	0	2 (2)
m home n=15	13	12	1	0	0	0	2 (2)
f hospital n=20	19	11	5	2	1	0	2 (2)
f home n=17	17	7	3	7	0	0	1 (0*)

*multiple modes, the lowest value is presented

Table 16. Continued

Theme	n	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)
Now, I know now how to promote my health							
all m +f n=72	64	16	29	17	2	0	1 (1)
m hospital n=20	17	5	9	3	0	0	1 (1)
m home n=15	13	5	5	3	0	0	1 (1*)
f hospital n=20	20	1	10	7	2	0	1 (1)
f home n=17	14	5	5	4	0	0	1 (1*)
I think less about my own health back home							
all m +f n=72	72	10	14	16	13	19	0 (-2)
m hospital n=20	20	4	3	5	5	3	0 (-1*)
m home n=15	15	1	2	5	3	4	0 (0)
f hospital n=20	20	4	4	4	2	6	0 (-2)
f home n=17	17	1	5	2	3	6	-1 (-2)

Table 16. Continued

Theme	n	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)
I change my health behaviour							
all m +f n=72	66	12	6	14	20	14	-0.5 (-1)
m hospital n=20	17	2	1	4	6	4	-1 (-1)
m home n=15	13	0	4	2	2	5	-1 (-2)
f hospital n=20	20	3	4	5	6	2	0 (-1)
f home n=17	16	3	1	3	6	3	-0.5 (-1)
I have been advised well by the nurses							
all m +f n=72	72	57	9	4	1	1	2 (2)
m hospital n=20	20	17	3	0	0	0	2 (2)
m home n=15	15	11	2	1	0	1	2 (2)
f hospital n=20	20	16	2	1	1	0	2 (2)
f home n=17	17	13	2	2	0	0	2 (2)

Table 16. Continued

Theme	n	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)
If I did not understand the information, I could ask for an explanation several times							
all m +f n=72	72	57	8	4	2	1	2 (2)
m hospital n=20	20	19	1	0	0	0	2 (2)
m home n=15	15	12	2	0	0	1	2 (2)
f hospital n=20	20	14	4	2	0	0	2 (2)
f home n=17	17	12	1	2	2	0	2 (2)
Information by nurses was given over several days							
all m +f n=72	72	17	26	12	10	7	1 (1)
m hospital n=20	20	6	9	1	3	1	1 (1)
m home n=15	15	4	5	4	1	1	1 (1)
f hospital n=20	20	5	5	4	4	2	1 (1)
f home n=17	17	2	7	3	2	3	1 (1)

*multiple modes, the lowest value is presented

Table 16. Continued

Theme	n	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)
Information given by nurses was at a convenient time							
all m +f n=72	72	33	28	5	3	3	1 (2)
m hospital n=20	20	10	8	0	1	1	1.5 (2)
m home n=15	15	4	7	0	2	2	1 (1)
f hospital n=20	20	12	7	0	0	1	2 (2)
f home n=17	17	7	6	3	0	1	1 (2)
I understood the written information received at the hospital							
all m +f n=72	71	29	16	9	9	8	1 (2)
m hospital n=20	19	8	2	5	2	2	1 (2)
m home n=15	15	5	5	1	1	3	1 (1*)
f hospital n=20	20	9	6	2	2	1	1 (2)
f home n=17	17	7	3	1	4	2	1 (2)

Table 16. Continued

Theme	n	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)
It might be that I did not understand all the oral information by nurses							
all m +f n=72	72	9	18	12	17	16	0 (1)
m hospital n=20	20	0	4	7	5	4	0 (0)
m home n=15	15	0	5	2	2	6	-1 (-2)
f hospital n=20	20	5	4	2	7	2	0 (-1)
f home n=17	17	4	5	1	3	4	1 (1)
The information given by nurses' was difficult to understand							
all m +f n=72	72	12	6	3	18	33	-1 (-2)
m hospital n=20	20	1	2	0	7	10	-1.5 (-2)
m home n=15	15	1	1	0	3	10	-2 (-2)
f hospital n=20	20	4	1	2	7	6	-1 (-1)
f home n=17	17	6	2	1	1	7	0 (-2)

*multiple modes, the lowest value is presented

Table 16. Continued

Theme	n	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)
Too much information was given							
all m +f n=72	71	3	1	3	8	56	-2 (-2)
m hospital n=20	19	0	0	1	5	13	-2 (-2)
m home n=15	15	0	1	1	0	13	-2 (-2)
f hospital n=20	20	0	0	1	2	17	-2 (-2)
f home n=17	17	3	0	0	1	13	-2 (-2)
More information and counselling would have been appreciated							
all m +f n=72	72	11	4	4	19	34	-1 (-2)
m hospital n=20	20	2	0	0	9	9	-1 (-2*)
m home n=15	15	6	0	0	3	6	-1 (-2*)
f hospital n=20	20	2	2	2	5	9	-1 (-2)
f home n=17	17	1	2	2	2	10	-2 (-2)

*multiple modes, the lowest value is presented

Table 16. Continued

Theme	n	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)
I could talk about my personal concerns to nurses							
all m +f n=72	72	28	26	6	3	9	1 (2)
m hospital n=20	20	9	9	1	0	1	1 (1*)
m home n=15	15	7	5	1	1	1	1 (2)
f hospital n=20	20	7	6	2	1	4	1 (2)
f home n=17	17	5	6	2	1	3	1 (1)
The nurses had time to listen to me							
all m +f n=72	72	38	20	11	3	0	2 (2)
m hospital n=20	20	10	8	2	0	0	1.5 (2)
m home n=15	15	8	3	3	1	0	2 (2)
f hospital n=20	20	10	6	3	1	0	1.5 (2)
f home n=17	17	10	3	3	1	0	2 (2)

*multiple modes, the lowest value is presented

Table 16. Continued

Theme	n	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)
Whenever asked for, the hospital nurses supported me							
all m +f n=72	72	55	13	3	0	1	2 (2)
m hospital n=20	20	16	4	0	0	0	2 (2)
m home n=15	15	11	2	1	0	1	2 (2)
f hospital n=20	20	17	3	0	0	0	2 (2)
f home n=17	17	11	4	2	0	0	2 (2)
I have mixed feelings about going home/ being home							
all m +f n=72	62	13	7	6	5	31	-1.5 (-2)
m hospital n=20	18	1	1	2	1	13	-2 (-2)
m home n=15	13	2	2	2	1	6	-1 (-2)
f hospital n=20	20	7	1	1	2	9	-1 (-2)
f home n=17	11	3	3	1	1	3	1 (-2*)

*multiple modes, the lowest value is presented

Table 17. Older person's study- findings-self-management and support at home: Frequency and Median (Mode)

Theme	n	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)
I did receive from the nurses good advice about being independent at home							
all m +f n=72	72	23	11	13	16	9	0 (2)
m hospital n=20	20	8	4	2	4	2	1 (2)
m home n=15	15	5	2	1	3	4	0 (2)
f hospital n=20	20	6	3	5	5	1	0 (2)
f home n=17	17	4	2	5	4	2	0 (0)
Nurses supported me by helpful advice in regards to aid materials							
all m +f n=72	71	17	17	7	17	13	0 (-1*)
m hospital n=20	20	5	4	2	5	4	0 (-1*)
m home n=15	15	2	2	2	3	6	-1 (-2)
f hospital n=20	19	5	6	2	4	2	1 (1)
f home n=17	17	5	5	1	5	1	1 (-1*)

Table 17. Continued

Theme	n	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)
I could be trained on the skills needed step by step							
all m +f n=72	68	19	27	11	5	6	1 (1)
m hospital n=20	19	4	9	5	0	1	1 (1)
m home n=15	15	4	6	2	0	3	1 (1)
f hospital n=20	18	6	6	3	3	0	1 (1)
f home n=17	16	5	6	1	2	2	
Too much self- commitment was asked by the nurses							
all m +f n=72	72	1	1	4	21	45	-2 (-2)
m hospital n=20	20	0	1	0	5	14	-2 (-2)
m home n=15	15	0	0	2	3	10	-2 (-2)
f hospital n=20	20	1	0	1	8	10	-1.5 (-2)
f home n=17	17	0	0	1	5	11	-2 (-2)

Table 17. Continued

Theme	n	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)
Nurses counselled my relatives and myself at the same time							
all m +f n=72	72	20	11	10	11	20	0 (-2*)
m hospital n=20	20	5	4	5	3	3	0 (0)
m home n=15	15	5	1	1	4	4	-1 (2)
f hospital n=20	20	5	3	4	2	6	0 (-2)
f home n=17	17	5	3	0	2	7	-1 (-2)
Whenever I asked for it, my relatives supported me							
all m +f n=72	72	57	10	2	0	3	2 (2)
m hospital n=20	20	15	4	0	0	1	2 (2)
m home n=15	15	13	1	1	0	0	2 (2)
f hospital n=20	20	16	1	1	0	2	2 (2)
f home n=17	17	13	4	0	0	0	2 (2)

Table 17. Continued

Theme	n	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)
My relatives (will) support me at home							
all m +f n=72	72	56	5	4	3	4	2 (2)
m hospital n=20	20	16	3	0	0	1	2 (2)
m home n=15	15	11	1	2	0	1	2 (2)
f hospital n=20	20	15	0	1	2	2	2 (2)
f home n=17	17	14	1	1	0	1	2 (2)
I will/I do follow the nurses' advice at home							
all m +f n=72	70	29	20	5	5	11	1 (2)
m hospital n=20	20	7	8	1	1	3	1 (1)
m home n=15	15	6	5	2	1	1	1 (2)
f hospital n=20	18	9	4	0	2	3	1.5 (2)
f home n=17	17	7	3	2	1	4	1 (2)

*multiple modes, the lowest value is presented

Table 17. Continued

Theme	n	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)
I do not need any support at home, I am autonomous							
all m +f n=72	72	10	7	33	7	15	0 (0)
m hospital n=20	20	6	1	10	1	2	0 (0)
m home n=15	15	1	2	8	3	1	0 (0)
f hospital n=20	20	2	3	6	1	8	0 (-2)
f home n=17	17	1	1	9	2	4	0 (0)
Community nurse (Spitex) will support me at home							
all m +f n=72	72	22	4	2	1	43	-2 (-2)
m hospital n=20	20	4	2	1	0	13	-2 (-2)
m home n=15	15	4	1	1	0	9	-2 (-2)
f hospital n=20	20	8	0	0	1	11	-2 (-2)
f home n=17	17	6	1	0	0	10	-2 (-2)

Table 17. Continued

Theme	n	2 = Strongly agree n	1 = Agree n	0 = Undecided n	-1 = Disagree n	-2 = Strongly disagree n	Median (Mode)
Community nurse (Spitex) will support me with nursing care, wound care, injections etc.							
all m +f n=72	71	16	2	3	1	49	-2 (-2)
m hospital n=20	19	2	0	1	1	15	-2 (-2)
m home n=15	15	1	2	2	0	10	-2 (-2)
f hospital n=20	20	7	0	0	0	13	-2 (-2)
f home n=17	17	6	0	0	0	11	-2 (-2)
Community nurse (Spitex) will support me with cleaning, cooking, washing household etc.							
all m +f n=72	70	21	1	1	0	47	-2 (-2)
m hospital n=20	19	4	0	0	0	15	-2 (-2)
m home n=15	15	4	1	0	0	10	-2 (-2)
f hospital n=20	19	7	0	1	0	11	-2 (-2)
f home n=17	17	6	0	0	0	11	-2 (-2)

*multiple modes, the lowest value is presented

6.3 Summary of the Findings

The nurses' studies described the expected and the experienced nurses' role in health promotion of older persons 65+ in an acute hospital. The summary of the findings of both studies define; the health promoting nurse supports the older patients by the assessment of their needs and resources and enables the patients by counselling and health education to improve their autonomy and participation to cope with the changing circumstances of their ill-health and life situation. The bed-side nurses declared that nurses' act as an intermediary and delegate the responsibility of identified health promotion problems to experts. The evaluation of the health promotion interventions is performed by interdisciplinary meetings on a regular base. The health care experts' opinion was diverse if nurses' perform health promotion activities in the interdisciplinary team.

The healthcare experts participating at the Delphi survey described the knowledge skills and attitudes required in more detail. The challenge of the integration of patient and their relatives in health promotion interventions was an additional statement of the bedside nurses during the group discussions.

In the Delphi survey time was named as a needed resource for nurses' health promotion activities. Moreover the health care experts were diverse opinion if the clinical nurses' have the time resources to get to know the elderly with different cultural background as requested for the professional nurses' health promotion performance. In the group discussion the needed time resources, due to the heavy workload and the short hospital stay of the older persons, were identified as barriers for nurses' health promotion activities. Further named in both studies are the needed nurses' expertise in health promotion, which requires further training and education on a regular base. Although the health care experts declared health promotion as a part of nursing for all patients at any age, the findings of the bedside nurses' studies show the minor relevance of nurses' health promotion in daily clinical life. In regards to the missing assignment towards the nurses' health promotion activities in daily clinical life, the common definition of nurses' health promotion competencies and the adjustment of Swiss nurses' legal role in health promotion were required. Through diverse argumentation, the healthcare experts and the bedside nurses identified the need for an increase of the commitment to nurses' health promotion at the hospital.

The findings of the older persons study indicate the understanding and requirements of the older people in reference to health promotion. The personal and active roles in health promotion described by the older people were namely mobility and physical activities, including all the daily life activities. The older persons mentioned to pay attention to healthy nutrition, rest and sleep. Also they named the interventions concerning their medical situation as fall prevention, medicine and pain management. The findings of the older persons study indicate the high importance of living at home and in harmony with their relatives. Moreover, their relatives supported the majority of older people, and additional support was mentioned for example, external community nurse services. In regards to the health promotion by nurses in an acute hospital setting, the older persons pointed to the need of patients and their relatives' integration in Health promotion activities. The findings show the older persons appreciated the health promotion advises by the nurses, but their relatives (spouses) did not get the joint health promotion counselling as expected. More the findings of the older persons study pointed to the needed improvement of written and oral information and counselling.

Nevertheless the findings of the study show that health promotion by nurses in acute hospitals is of high value or meaning for the participating older persons. Furthermore the findings indicate the majority of the elderly act upon the health promotion advises given and additional counselling by nurses' would have been appreciated.

7 ANALYSIS

7.1 Analysis - the Nurses' Study

In this chapter the findings described in the previous chapter are analysed supported by a part of the PRECEDE- PROCEED Model (Green & Kreuter, 2005). The educational and ecological assessment (phase 3) is applied to analyse the findings of the nurses' studies. To get a deeper comprehension in the nurses' health promotion, the three categories like predisposing- enabling- and reinforcing factors of the behavioural and organisational influences are used. This analysis identifies the barriers and motivators, which are classified into positive and negative predisposing- enabling- and reinforcing factors. Firstly, the health care experts' expectations about the practice of nurses' health promotion for older persons at the acute hospital in Switzerland was analysed (Chapter 7.1.1). Secondly, the bedside nurses' perception and the performed health promotion activities for older patients at the clinical setting were examined (Chapter 7.1.2).

7.1.1 Expected nurses' health promotion for older persons in acute hospitals

The heterogenic sample of health care experts of hospital clinical nursing and district nursing, as well as nursing management, policy building, nursing research and education ensured that all of all the various opinions, in different contexts, of the field of nurses' health promotion for the elderly was covered thoroughly. Nevertheless the health care experts provided a more theoretical perspective of the requirements and the meaning of to fulfil the role of nurses' health promotion for older persons in an acute hospital setting in Switzerland. It is important to keep in mind the study was applied to establish the most reliable consensus of opinion of the health care experts about nurses' health promotion for older persons.

The educational and ecological assessment (PRECEDE- PROCEED Model phase 3) including the three categories of behavioural and organisational influence predisposing, enabling and reinforcing factors provided a classification for further comprehension. As mentioned by Green & Kreuter (2005) they point to specific

influences such as knowledge, skills, attitudes, barriers and resources that might be used to fulfil the nurses' health promoting role. The findings of the health care experts, which did not reach the most reliable consensus, were taken into consideration in the following analysis. However the reason for not reaching the consensus was not examined nevertheless, they are an important point for discussion.

Figure 6 below illustrates the nurses' health promotion dimensions of influencing factors identified by the health care experts based on the Precede- Proceed Model.

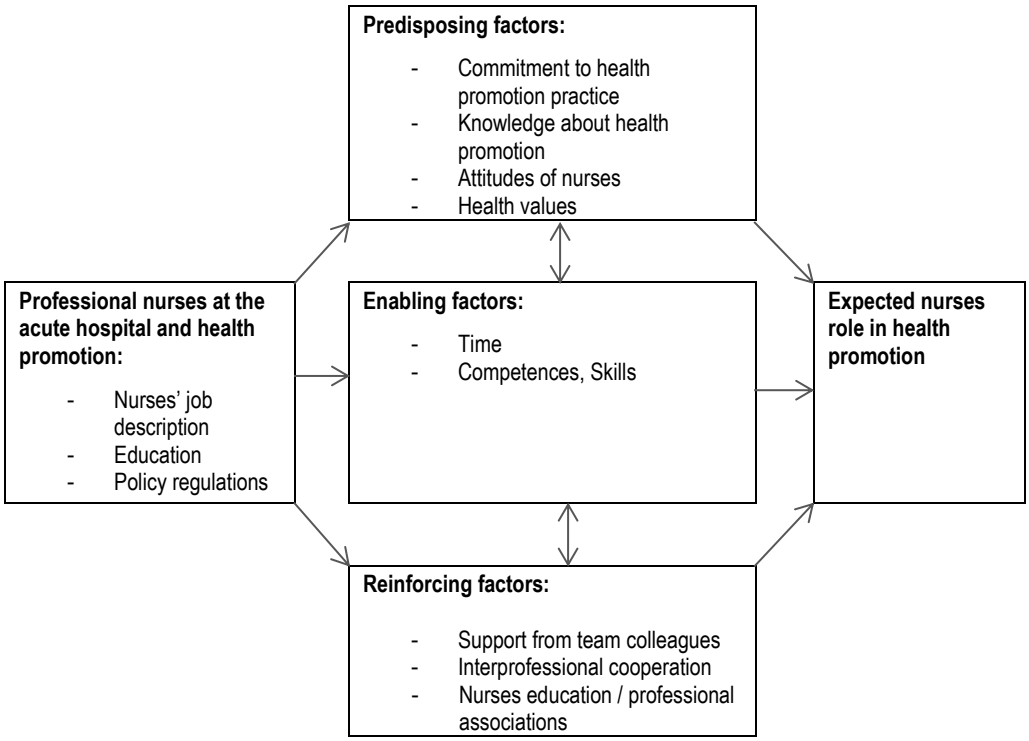

Figure 6. Nurses' Health promotion, dimensions of influencing factors identified by the health care experts based on the Precede- Proceed Model

Predisposing factors

Green & Kreuter (2005) describe the predisposing factors like precursors, the basic orientation and motivation for nurses' health promotion. Depending on the degree of self- confidence and motivation nurses' will be more predisposed to take an active role in health promotion interventions (Green & Kreuter, 2005).

Several predisposing factors for nurses' health promotion for older persons at the hospital could be named based on the findings of the health care experts study. The predisposing factors are divided in four themes, the commitment to health promotion practice, the knowledge of health promotion, the nurses' attitudes and health values in general.

Among the most important predisposing factors is surely the commitment to health promotion by nurses for older patients. The health care experts expect the nurses' commitment to health promotion and pointed to the economic benefit of health promotion. The health care expert demand is focused on the financial pressure of the health care system with its growth of the health expenditures and the exceeding economic growth in Switzerland. The economic effectiveness of health promotion and disease prevention is approved by the literature (Meier, Strähl & Szucs, 2006; WHO, 2013; Wieser et al., 2010).

However, the question still arose, to what extend does the economic benefit influence the nurses' commitment to health promotion for older patients at the hospital. This goes along with the importance and relevance of nurses' health promotion due to the ever-increasing number of older persons with chronic diseases, a further argument identified by the health care experts. Hospitalisation and medical treatments of chronic diseases are costly but they do improve the health condition and quality of life of the older persons. It is the nurses' task to support the patients, to take care and be in charge of their own health, and to consequently reduce poor health from reoccurring. Interesting enough whilst there were statements that health promotion for older persons is considered as an integral part of nursing, the opinion of the importance of health promotion for older patients was diverse. This statement should be taken further into an ethical debate. It is necessary to note, not only the economic reasons, more the combinations of factors are influencing the nurses' commitment towards health promotion activities.

A predisposing factor for health promotion is the scope of health promotion activity by nurses in general, which is missing in the daily clinical practice, according to the health care experts. Some of the experts stated that the medical diagnoses are treated and the patients are discharged without any further investigations or the nurses are mostly unaware of performing health promotion. One could argue this goes along with the missing mandate for health promotion or the missing guidelines for health promotion in the acute hospital setting. However a minority of the health care experts did not agree and had a different opinion about the minor value of nurses' health promotion for older persons.

The health care experts concluded that essential precursors for nurses' health promotion are the nurses' knowledge and, the expertise, including health promotion concepts. They agreed upon the knowledge and expertise of nurses in general, but they pointed out the missing health promotion competence of nurses. In regards to the nurses' attitudes and behaviour, the health care experts expected empathy and respect towards the older persons and the nurses' support of the patients' autonomy and participation. Moreover, the nurses' interest or awareness of the individuality of the older person's health behaviour was expected. Interesting enough there were clear statements on the expected nurses' attitude of empowerment but they demonstrated diversity in their statements about the low meaning of empowerment in nursing for older patients. This is difficult to understand and the findings do not give any further explanation. There are several topics under consideration as it might be due to different definitions of empowerment in nursing as discussed in the literature (Aujoulat, Marcolongo, Bonadiman & Deccache, 2008). It could also be due to the missing knowledge or trust in the nurses' capability of enhancing older patients' motivation for self-care through the process of empowerment (Aujoulat et al., 2008). The discussion about the learning capabilities of the older persons (Istance, 2015; Voelcker-Rehage, 2008) could be a further point for the hesitation of some health care experts'. This argument contrasts the demand for intercultural competences in clinical nursing. The health care experts requested nurses' awareness of the existing learning skills by all older persons regarding diversity.

Finally it would be interesting to know if the threat of missing personnel resources or the analysis of costs and benefits are the foundation for these arguments. This discussion leads to health values, a further predisposing factor for nurses' health promotion. Hence, a most reliable consensus could be found in relation to the

nurses' conviction of the meaningfulness of health promotion at any stage of life, as old age does not assume bad quality of life. As far as the cultural diversity of older persons, the nurses' awareness of different health comprehension and the different relevance of life and death of older persons are strongly demanded by the health care experts.

Enabling factors

Enabling factors are necessary skills and the nurses' self- efficacy to perform health promotion interventions. Further enabling factors are resources such as educational material, reminders, time or financial resources and the patients' expectations, which can support the nurses' health promotion performance (Green & Kreuter, 2005).

The identified enabling factors named by the health care experts are divided in two themes, the skills or competences and time.

The health care experts expect the nurses' to implement health promotion interventions proficiently, this includes communication, management, and assessment skills. Among the communication skills the health care experts named counselling, establishing a professional relationship, providing confidence and active listening. Further identified were the management skills and the assessment skills integrated in the nursing process. The named skills of the health care experts are similar to the findings in the literature (Kempainen, Tossavainen & Turunen, 2012). Nevertheless, the listed competences are not exhaustive and there are additional required skills for nurses' health promotion for older persons. One such example is that of "the motivational interviewing" (Lundahl, Kunz, Brownell, Tollefson & Burke, 2010; Miller & Rollnick, 2012) which is widely used in health promotion and health behaviour change activities. Also the majority of the health care experts were of the opinion without the most reliable consensus, that nurses perform health promotion simultaneously with the prevention of diseases, so called prophylaxis. This might be a result of the various health promotion definitions for nursing practice (Kelly & Abraham, 2007). It could also shed a light on the actual situation of the Swiss DRG at the hospitals with the missing or unclearly defined mandate for nurses' health promotion activities. The Delphi participants expected nurses to be capable of identifying health promoting opportunities during their daily clinical work. They demanded the nurses' analyse the situation and react

based on their own perception. The health care experts' did however admit that the definition of nurses' health promotion competencies at the hospital is missing and a barrier for nurses' health promotion. Finally, the experts agreed on the needed time resources enabling nurses' health promotion for older persons at the hospital. They had diverse opinions regarding if nurses' have the possibility to get to know their patients, especially when considering diverse cultures and traditions. This is, due to the short hospitalisation stay.

Reinforcing factors

Reinforcing factors relate to interpersonal factors such as feedback and support from colleagues in the interdisciplinary health care or medical teams. Reinforcing factors may include visible results for example; the attitudes and feed-back from patients and their relatives. Further reinforcing factors can be the commitment to health promotion by the hospital management, additionally, support from professional associations and from nursing training institutions or nursing education – and study programs (Green & Kreuter, 2005).

The reinforcing factors identified in the findings are divided in three themes, the support from team colleagues, interprofessional cooperation and nurses' education including the educational institutions and professional associations.

The health care experts agreed that the missing defined scope of health promotion activity by nurses in general, is a major barrier of the nurses' health promotion for older persons at the acute hospital. It has to be taken into account that if the scope of health promotion activity by nurses in general is missing and the lack of team support is evident, an important reinforcing factor is obviously missing. If there was the shared health promotion expertise and knowledge available it would definitely improve the quality of health promotion activities by nurses for the elderly patients (Nancarrow et al., 2013). Related to this are the diverse statements made by the health care experts' about the interdisciplinary performance of health promotion. Professional nursing and Health promotion by nurses' is per se an interdisciplinary and interprofessional task as mentioned before in chapter 2. The diversity of opinion begs the question; are the statements connected to the missing scope of nurses' health promotion or is the discussion more about the performance of the inter-professional collaboration. Some health care experts disagreed that health promotion should only be performed interdisciplinary. A

further argument for the interdisciplinary collaboration discussion is the diversity of statements made by the Health care experts, who stated that medical diagnoses are treated and the patients are discharged without any further investigations. A good collaboration between hospital nurses' and external health care services would improve the relevance and impact of nurses' health promotion for the older persons at the hospital.

The literature acknowledges difficulties in interprofessional cooperation in acute hospitals and various problems have been identified (Kvarnström, 2008; Zwarenstein, Goldmann & Reves, 2009). The study by Kvarnström (2008) confirmed the missing understanding of the health professional's own and other's roles. This is an important statement keeping in mind the role of nurses' in health promotion and the inquiries as described above and in chapter 2. Still the expertise and cooperation of the different health professionals is an important reinforcing factor for nurses' health promotion for older persons in hospitals. The importance of inter-professional collaboration is supported in nursing education and research (Reichel, Dietsche, Hölzer & Ewers, 2016). According to the health care experts statements in the Delphi study the nursing study programs, currently being performed in Switzerland, can be assigned to the reinforcing factors and are strengthening nurses' health promotion activities.

7.1.2 Health Promotion by nurses for older persons: the view and experiences of bedside nurses

The findings from the bedside nurses of different medical- or surgical wards provide the perception of nurses' health promotion and of how it is actually being performed in the daily clinical practice in Switzerland. Furthermore they confirm that the bedside nurses' experienced barriers, describe what they are, and give recommendations for nurses' health promotion for elderly persons at the acute hospital. The educational and ecological assessment (PRECEDE- PROCEED Model phase 3) with the three categories of behavioural and organisational influence predisposing, enabling and reinforcing factors support the classification of the performance or the experience of nurses' health promotion by the bedside nurses.

Figure 7 illustrates the nurses' health promotion dimensions of influencing factors identified by the bedside nurses based on the Precede- Proceed Model.

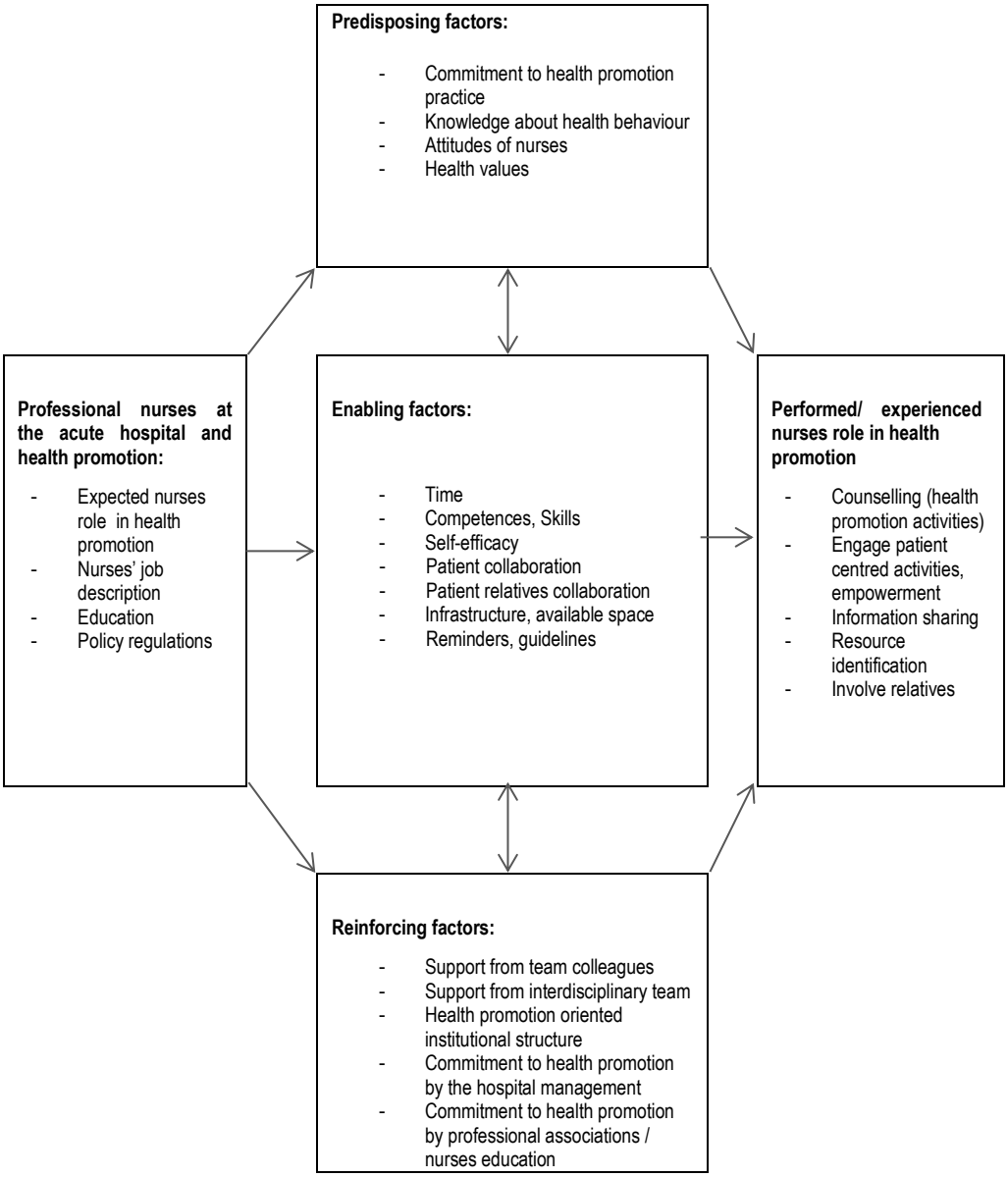

Figure 7. Nurses' Health promotion, dimensions of influencing factors identified by bedside- nurses based on the Precede- Proceed Model

Predisposing factors

The predisposing factors acknowledged by the bedside nurses study findings are divided in four themes, the commitment to health promotion practice, the knowledge of health promotion, the nurses' attitudes and health values in general.

As described above, the commitment to health promotion is an important predisposing factor for nurses' health promotion in the daily clinical practice. In contrary to the health care experts, the participating bedside nurses had, in general, some hesitation regarding the commitment of nurses' health promotion for elderly patients. Their experience was that nurses' health promotion is given only on specific hospital wards or disciplines. They argued that health promotion is a long-term process and of minor relevance as nurses' health promotion is performed on a short term base due to the short hospitalisation period. Also the bedside nurses do not have any influence on older patients' after hospital discharge. Moreover, the bedside nurses declared that priority is generally given to the medical treatment and the described health promotion activities were mainly bound to prevention of diseases, like diabetes counselling or fall prevention. This goes along with the statements made by the health care experts, they agreed to the missing scope of nurses' health promotion activities in the daily clinical life. However, the bedside nurses did not consider health promotion for patients 65+ as a part of their nursing role in the daily clinical life. This remains in contrast to the requirements of the health care experts and to the definition of professional nursing (Spichiger et al., 2006) as described in chapter 2.

Interesting enough in this study the bedside nurses explained that health promotion is performed by health experts in specific therapeutic fields or nurses with advanced education (e.g. diabetes advisor) only. More often than not, the bedside nurses only act as an intermediator.

The nurses pointed out the gap in theory and practice, as health promotion does not receive the attention demanded in daily clinical practice. This demonstrates their awareness of the nurses' health promotion in theory and there might be a correlation to the statements of some of the health care experts who declared, that nurses' are unaware of performing health promotion in the daily clinical life. The participating bedside nurses claimed strongly that there was missing visibility and lack of attention paid to nurses' health promotion in acute hospitals. The

discussion is about the need and importance of bridging theory to practice for nurses' health promotion for older persons at the hospital (Whitehead, 2009).

Even so the bedside nurses' confirmed that the nurses' expertise in general and the specific knowledge about health promotion are important predisposing factors for nurses' health promotion. According to the experienced bedside nurses, health promotion knowledge is acquired through the current nursing education. Hence they pointed out the challenge of gaining and maintaining essential state of the art knowledge, to be updated on the latest techniques remains the responsibility of each professional nurse. This could be an explanation for the judgment of the health care experts, who claimed missing health promotion knowledge in nurses.

The attitudes and behaviours of bedside nurses as an important predisposing factor for nurses' health promotion for older persons were in line with the requirements of the health care experts. The bedside nurses' own perception contained individual resource oriented behaviour toward the elderly patients. They named empowerment and declared nurses' must consider the patients' participation and collaboration. Moreover, they must respect and be aware of the older person's autonomy and self- responsibility. Interestingly enough the Swiss Academy of Medical Sciences (SAMW) recognized that patient participation and the development of making shared decision has to increase in Switzerland (SAMW, 2016).

Additionally, they pointed out the importance of being a role model for nursing students as a required attitude of nurses at the hospital. This interesting focus of experienced nurses acting as teacher to nursing students, and its impact on the future was not considered by the health care experts during the Delphi survey. Nevertheless, it leads to a further discussion about the integration of health promotion theory into practice. If bedside nurses have to play a role model for nursing students they should maintain and act upon the state of the art knowledge and must be clinically skilled (Landers, 2000; Wilson, 2008). The challenge lies in overcoming the gap between theory and practice as mentioned above.

An additional predisposing factor is the health values of a health-promoting nurse. For example, the nurses' conviction towards the meaningfulness of health promotion for patients' at any stage of age as required by the health care experts. The experiences of the bedside nurses' were different. The conviction of the meaningfulness of nurses' health promotion for older patients was given on some

specific wards (e.g. oncology ward) only. This is similar to the variety of statements given by the health care experts. They were diverse on the importance of health promotion for older patients by the health care experts. Specifically, in one group the bedside nurses argued that health promotion for older people was not given a high priority as older persons' are not receptive to health promotion anymore. These debatable diverse health values with regards to the older persons might be caused by the different understanding of health promotion of health professionals in the daily clinical practice. The bedside nurses claimed they had common health values and understanding of health promotion in the acute hospital setting. Nevertheless, the profound discussion goes further, when considering different health values for younger and older patients.

Enabling factors

The identified enabling factors for nurses' health promotion are divided into skills, self- efficacy, patient and patient relatives' collaboration, time, infrastructure and reminders. With regard to the skills named by the health care experts the bedside nurses described the skills for nurses' health promotion on a more sketchy level. Nevertheless, the experiences of the bedside nurses showed a number of skills, which support the nurses' health promotion performance at the clinical practice. Nurses' health promotion is enabled by counselling and communication skills. In addition the nurses' assessment identifies the older patients' needs and resources for health promotion. Thus this qualified information given by nurses enables the health experts to fulfil their role in health promotion.

The experience of the bedside nurses indicates that knowledge has to be reactivated on a regular base to enable the nurses' self-efficacy for the health promotion performance.

As described before in chapter 2, the health-promoting nurse takes care of the patients and their relatives to help them cope with the changing circumstances. However, the support is hindered without the collaboration of patients and their relatives. The bedside nurses claimed all too often the collaboration is delayed due to the missing interest of the older patients' in health promotion as they are absorbed by their health condition. This leads to the discussion of several problems. Patients might be overwhelmed by too much information from different health professionals. Nurses' should also be aware of their professional

communication skills, as the older persons might not understand the nurses' information or the advice being given. Older persons might possibly be unaware of their barriers and own resources regarding their self-health management.

The bedside nurses expressed that especially the collaboration with relatives is a major challenge and often missing. This barrier for nurses' health promotion has to be recognised as relatives play an important role for the health outcome of the older patients. (Lindhardt, Nyberg & Rahm Hallberg, 2008). More relatives play an important role in providing health care for older persons after hospital discharge in Switzerland (Perrig-Chiello, Höpflinger & Schnegg, 2010).

A relevant enabling factor for nurses' health promotion is time. In contrast to the health care experts, the bedside nurses' mentioned time constraints when considering the heavy workload and the short hospitalisation of patients. Essential for success is to clearly determine the appropriate point of time for the introduction of the first health promotion activities. Ideally, this should occur right after the older patients' hospital admission. According to the participating bedside nurses this is not the case in the daily clinical life. This goes along with the experienced missing commitment of nurses' and low relevance of health promotion by nurses for older persons at the hospital.

Additional enabling or disabling factors, that were identified, are the infrastructure on the hospital ward in general, the lack of organisation and the missing meeting rooms. The respect of privacy is surely needed for a professional communication.

In the daily clinical practice the evaluation of nursing students could be a good time for experienced nurses to give them reminders about health promotion. The given evaluation criteria should support the supervising nurse and the nursing student in the attainment of competences in health promotion. Similar to the evaluation criteria a health promotion guideline would enable the performance of nurses to be measured in health promotion for older persons at the hospital.

Reinforcing factors

Again the identified reinforcing factors named by the bedside nurses are divided in five themes, the support from team colleagues and the support by the interdisciplinary team, the health promotion oriented institutional structure, the professional associations and nurses' education.

An important reinforcing factor for health promotion is the nurses' role model to motivate colleagues and nursing students to follow health promotion activities in daily clinical life. Moreover the bedside nurses' suggested the need for a common aim for health promotion by the ward team to reinforce the nurses' commitment to health promotion.

A strengthening factor for nurses' health promotion for older persons is the proficient interdisciplinary collaboration and the commitment to health promotion by all health professionals. The missing scope for health promotion by health professionals should be addressed inter-professionally. There might be some activities already on going but the bedside nurses' did not recognise them (Martin, Ummenhofer, Manser & Spirig, 2010). The healthcare experts were of the same opinion and claimed that there was missing collaboration with the interdisciplinary team and missing interest in health promotion in daily clinical work did exist.

Furthermore, the institutional commitment, including an institutional health promotion policy would enable and increase nurses' health promotion performance at the hospital. This however requires the support from the hospital management with the transparency of approval, the impact and the economic benefit of health promotion.

The support of the professional association and especially the nursing education institutions should be more aware of their enabling influence for nurses' health promotion for older persons at the acute hospital.

7.2 Analysis - the Older Persons Study

The following chapter presents the combined analysis from the findings of the open-ended questions and the structured interviews with the older persons. This study was conducted to get an insight into the needs and requirements for nurses' health promotion of the participating older persons. The aim of the analysis is to record the experiences and perceptions of the older people 65+ on the presence of nurses' health promotion at the hospital and after discharge at home. Again the educational and ecological assessment (PRECEDE- PROCEED Model phase 3) with the three categories of behavioural and organisational influence predisposing, enabling and reinforcing factors provide the classification of the experienced nurses' health promotion by the older patients. Figure 8 below illustrates the nurses' Health promotion dimensions of influencing factors identified by the older persons based on the Precede-Proceed Model (Green & Kreuter, 2005).

7.2.1 The experiences and perception of the older persons of nurses' health promotion at the hospital

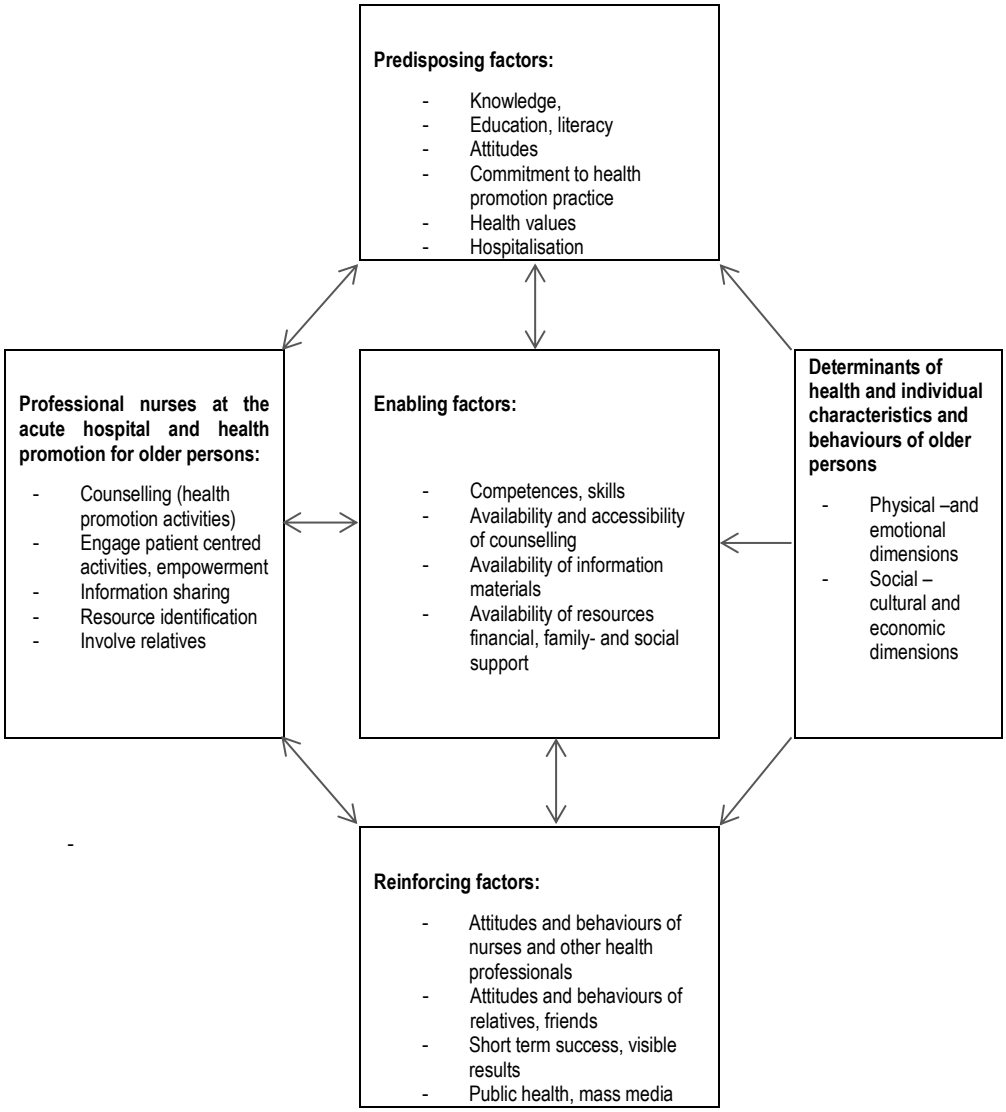

Figure 8. Nurses' Health promotion, dimensions of influencing factors identified by the older persons based on the Precede- Proceed Model

Predisposing factors

The predisposing factors acknowledged by the older persons' study findings are divided into five themes, knowledge, education, attitudes, and the commitment to health promotion practice, health values and the hospitalisation of the older people.

A predisposing factor for the older persons is their education, their knowledge and understanding. All the participating older persons' were in favour of good education and were able to communicate in Swiss German. The older peoples' knowledge of health promotion and their attention to and understanding of their own health improvement are strong predisposing factors for any health promotion activities. The older persons' health promotion knowledge per se was not investigated through the interviews. However, information was given through their statements about their regular activities to be healthy. Among the "activities to be healthy" the older persons primarily named physical activities on a regular base and healthy nutrition. Additionally to their regular activities the elderly named healthy behaviour (refrain from smoking and alcohol), socialising, rest and good sleep as an important health factors. Secondly they named the adherence to their prescribed medication and visits to local health services (general practitioner, physiotherapist, dentist or foot care). This is interesting and has to be considered in regards to the findings of the nurses' study. The bedside nurses' explained that health promotion activities were mainly bound to prevention of diseases, like diabetes counselling or fall prevention. These results show a different focus of priorities, which could have been influenced by the circumstances of when the question was posed. However the bedside nurses concentrated more on the prevention of diseases idea (biomedical model, Naidoo & Wills, 2009) whilst the older persons concentrated more on health promotion with the salutogenetic concept (Antonovsky, 1996). The older people also mainly focused on disease prevention when they explained the nurses' health promotion activities. Nevertheless, the participating older people confirmed their health promotion knowledge, which is an important predisposing factor for nurses' health promotion activities at the hospital.

Further predisposing factors are the attitudes of the older persons. The older person emphasised the importance of ones owns autonomy and independency, also the awareness of healthy lifestyle behaviour which is similar to the attitudes described by the nurses' study participants.

A precursor for nurses' health promotion success is the older persons' own interest in health promotion advice, their compliance and their internal motivation practice.

The majority of the participating older persons admitted to their appreciation for health promotion by nurses during their hospital stay. The findings of the older persons' study show, the inclining factors for nurses' health promotion are the older persons' prediction and self-assessment; the awareness of their self-responsibility and the consciousness of their own active behaviour in seeking help if needed. The findings show that self-assessment by women, in regards to the foreseen versus the actual experience at home after discharge, was more reliable in contrast to the participating older men. Overall men and women admitted that they could actively improve their health themselves.

However the older persons' empathy and confidence in nurses is essential for any health promotion activity and is a strong predisposing factor. The majority of the participants confessed their confidence in nurses. A minority of older women however declared that they could not talk to nurses about their personal concerns.

To analyse the older persons' commitment to nurses' health promotion, the older peoples' commitment to health behaviour change can be addressed. The findings show a diverse commitment to behaviour change by the older persons. After discharge, at home, a minority of the older persons affirmed their behaviour change and a minority of the participants stated that they had acted on the advice given by the nurses. There are various complex influences, besides knowledge, understanding and empathy that influence the attitude and commitment to health behaviour of older persons (Naidoo & Wills, 2009, pp.70; Peerson & Saunders, 2009). The minority of elderly patients', who confirmed their behaviour change, could influence the health carer's opinion of the relevance of nurses' health promotion for the elderly.

Remembering, for the health care experts and the bedside nurses' the relevance of health promotion for older patients was under discussion, and there were statements arguing that older persons' are not receptive to health promotion anymore.

Nevertheless, the assessment of the older persons' health behaviour, their commitment to health behaviour change and their adherence to the recommended behaviour change is essential to have an impact on nurses' health promotion.

Additional predisposing factors for health promotion are the health values of the older persons. The health values were identified using the findings of the "needs to be healthy" of the participating older persons. The responses of the older persons indicate the high importance of living autonomous at home and in harmony with their relatives and friends. Also, the health values of the participants are linked with financial resources and social contacts.

The hospitalisation per se is a predisposing factor for nurses' health promotion for older persons even its worthiness still is discussed (Groene & Jorgensen, 2005; McBride, 2004). However, the participants confirmed their interest for nurses' health promotion during their hospital stay. They did not consider the length of their hospitalisation period in contrast to the bedside nurses' who declared the minor relevance of nurses' health promotion is due to the short hospitalisation period.

Enabling factors

The identified enabling factors for the older persons are the necessary skills and the availability of counselling by nurses. Also recognised are resources such as informative material and financial means as well as the family and social support.

A major support for nurses' health promotion is the communication skill of the older persons. An effective communication requires being able to formulate the intention, ideas and views and involves verbal- and nonverbal communication. Moreover, the older persons' health literacy which includes the skill to seek, communicate, understand and use the health information to make appropriate health decisions is a major enabling factor for nurses' health promotion (Jordan, Buchbinder & Osborne, 2010; Miller, 2016).

The participating older people declared that they had been well advised by the nurses. Nevertheless attention has to be given to the fact that especially women stated difficulties in understanding of the information given to them. The participating older people all spoke Swiss German and had a good educational background. The findings show, men had a higher education average and among the participating women a small number attended only the mandatory school years. Thus it might be that the nurses' did not pay enough attention to the health literacy of the older patients. Nevertheless, the older persons were trained step by step on

the skills needed and were satisfied with the required self-commitment asked for by the nurses. The investigation into the older persons' transfer skill, such as their performance during the hospitalisation and later after discharge at home, was partially considered during the data collection. Thus the older persons explained using various examples, such as the application of wet packs, breathing exercises or bed gymnastics, their performance back home.

Also an enabling factor for health promotion is the availability and accessibility of counselling and the majority of the participants confirmed that they did receive oral counselling by nurses. However during the second interview at home fewer women and men stated that they received advice during the hospitalisation. Albeit the majority was satisfied with the amount of information given, older women and men requested additional counselling. Interesting enough the bedside nurses claimed to be dissatisfied with the collaboration and the missing interest of the older patients' in health promotion as they are too absorbed by their health condition.

An indispensable aid for nurses' health promotion is the availability of informative materials. Although the majority understood the written information, there were some older persons who did not understand the full message, this should be considered. Furthermore the participants showed additional barriers for the nurses' health promotion impact when they announced that they did not pay attention to the pamphlets, and only realised the importance of them back home. The information from demonstration materials and available information by the media or web were not considered by the older persons during the interviews.

The findings of this study give information about another important enabling factor for nurses' health promotion. The participants confirmed the nurses' time and support was given whenever they asked for it. They could also ask for clarification if they did not fully understand the information given. The participating older persons stated that the information received from the nurses was given at a convenient time and was performed over several days during their hospital stay. This is astonishing as the bedside nurses' mentioned time constraints when, considering the heavy workload and the short hospitalisation of patients.

A further strong enabling factor for the impact of nurses' health promotion is the joint counselling of patients together with their relatives. The findings prove more attention should be given to the relatives' involvement. As the figures clearly show

half of the elderly women and men were not in the favour of joint counselling together with their closed relatives or spouses.

This is actually confirmed by the bedside nurses who declared that the collaboration with relatives is especially a major challenge and often missing. As mentioned before this point should be reflected, discussed and further action should be taken. Also the majority of the older patients' argued that they did receive support by their relatives during their hospitalisation and after discharge at home. Family and social support truly is an enabling factor for the impact of nurses' health promotion. The needed support and the strong influence of relatives and friends has to be considered at any stage of the health promotion implementation process by nurses.

The availability of the older persons' financial resources must be recognized as an additional enabling or disabling factor for health promotion. In Switzerland the majority of costs for home care services, aids materials and the modification of buildings are not covered by insurances. The male participants mainly mentioned the need for financial resources.

Reinforcing factors

Reinforcing factors influence the motivation for attitudes and behavior (Green & Kreuter, 2005). The acknowledgement received can support or hinder the older persons' commitment to health promotion action and influences the impact and sustainability of the nurses' health promotion activities. The identified reinforcing factors for the older person are divided in five themes; attitudes and behaviours of health professionals, attitudes and behaviours of relatives and friends, support services, short-term success and public health services including the mass media.

The nurses' support, as confirmed by the participants, can be an enabling and a reinforcing factor. The findings do not give any information about the rewards of the interdisciplinary health professionals and the participants did not mention if they had experienced any shared decision making amongst the health professionals.

A further reinforcing factor for nurses' health promotion for older persons' is the attitudes and behaviour of the patients' relatives or friends. The majority of the older persons mentioned the support given by their relatives. More so, the older

persons stated that they would act upon the advice given by their spouses and daughters. Again the nurses' collaboration with the patient's relatives was requested.

A strong reinforcing factor for nurses' health promotion is the support by allied health professionals such as the medical team or other health experts at the hospital and the general practitioner (GP) as well as the community nurse after discharge back home. In this study 12 from 32 older patients had community nurse services but the data gathered did not give any information about the experiences of the older people and the collaboration between hospital nurses and community nurses. Nevertheless, a small number of participants declared that the hospital nurses' offered a call back service if questions arose after discharge.

Mostly short- term successes for health promotion interventions are not obvious as little or no visible results can be observed. Nevertheless the participants' statements about the foreseen versus the actual experience at home two weeks after discharge may give some information about it. The judgement of the older persons was diverse, they mentioned from "better than I expected" to "worse, as unexpected problems arose". However, the statements reflect not only the impact of nurses' health promotion. The different influences of determinants such as health and individual characteristics of the older person have to be considered. Likewise the influence of the social norms in general, the health promotion projects in public and the reports of the mass media cannot be underestimated.

7.3 Summary of the Analysis- Integration

The secondary analysis was performed using the PRECEDE-PROCEED model (Green & Kreuter, 2005). This model helps to explain the multiple factors that influence nurse's health promotion for older persons at the acute hospital in Switzerland. To get a profound understanding of the nurses' health promotion, the categories of behavioural and organisational influence are used. The expectations of the health care experts, the experiences of the bedside nurses and the perceptions of the older persons were categorized by the predisposing, enabling and reinforcing factors (Green & Kreuter, 2005). This summary of the analysis acts as the integration, in terms of the mixed method research, and should support the holistic view of nurses' health promotion for older persons' at the hospital.

In regards to the predisposing factors, the older persons endorsed the strongest interest and commitment to health promotion. Also the health care experts expressed the need for the commitment to health promotion but then pointed to the missing scope of health promotion activities by nurses. The gap between theory and practice was acknowledged by the bedside nurses, thus they confirmed the low priority of nurses' health promotion at the acute hospital. Considering knowledge as a predisposing factor, the health care experts expected the nurses' expertise in health promotion. Nevertheless the health care experts and the bedside nurses accepted the nurses' expertise in general, but admitted to the missing health promotion knowledge of nurses. As an additional barrier, the bedside nurses pointed out difficulties in gaining and maintaining the essential state of the art knowledge. The older people's knowledge was not investigated but they acknowledged their awareness and knowledge of health promotion through their statements. The identified attitudes and behaviours of all the involved groups are indeed a motivator for nurses' health promotion. The expected and experienced attitudes and behaviours of nurses correlate to the identified attitudes and behaviours of the older people. The health care experts' and the older peoples' health values resemble each other. The older persons' health values contain living autonomously and independently at home in harmony with their family and friends. The health care experts professed the value of health promotion for patients at any stage of life, as old age does not assume a bad quality of life. The bedside nurses described the meaningfulness of nurses' health promotion only on specific wards. Moreover they remarked on the threat or barrier of the older persons' receptiveness to health promotion.

In relation to the enabling factors for nurses' health promotion, the identified skills and competences of all the study participants (health care experts, bedside nurses and older persons) are associated to each other. Furthermore, the availability of nurses' health promotion activities, and the requested time for implementation was acknowledged by the older people. The health care experts admitted time was a restraining factor, however the bedside nurses' experienced multiple barriers such as the lack of time and organisational resources. Additionally identified was the lack of patients' and their relatives' collaboration. Interesting enough, the missing joint counselling for patients' and their relatives was a clear obstacle identified by the older persons.

The analysis of the reinforcing factors indicates motivators and barriers for nurses' health promotion. Whilst the older persons admit different motivators such as the rewards of their family and the medical and health care professionals, the health care experts and the bedside nurses confess barriers. They identified the missing scope of health promotion activities by the nurses. As well as the missing support by nurses' and other health professionals' and the lack of reinforcement by the hospital management in general. As a motivator they accepted the nurses' education, which supports and requests the professional nurses' role model in health promotion.

8 DISCUSSION

8.1 Health Promotion by Nurses for Older Persons in Hospitals

This chapter presents the overall discussion of the findings of the nurses' study and the older persons' study. The research question about the expectations and requirements, hence the actually performed role of nurses' in health promotion for older people is examined. The definition and the competences of nurses in health promotion for elderly people in an acute hospital setting in Switzerland have been discussed. Moreover, if the requirements of the health care experts meet the experienced performance of the bedside nurses has also been addressed. A further focus is on the experiences and perceptions of the older people and their correlation to the nursing professionals' including the actual situation in the daily clinical work.

The study participants in the nurses' study consisted of a heterogenic group of health care experts and clinical nurses employed at different acute hospital settings in Switzerland. As described in chapter 5, the health care experts of the Delphi survey consisted of a reasonable balance between hospital clinical nurses, district nurses and professionals from either health care management, policy building, nursing research or nursing education. Participants in the second study, the focus group discussions, were undergraduate nurses enrolled in a bachelor degree for Nursing Studies at the Bern University of Applied Sciences and were employed part-time in different hospitals. These nurses all had prior experience caring for older people on different wards.

The participants in the older persons study consisted of forty older patients 65+ (20 female and 20 male) who were recruited from the surgical and medicine wards in the general county hospital of Basel (Switzerland). For this study face-to-face interviews with older persons during their hospital stay and two weeks after discharge at home were conducted. The first part of the interview included open-ended questions and the second part was conducted using a structured questionnaire.

To support the common basic comprehension of health promotion, all the study participants, were presented with the following definition of health promotion. *"Health promotion is defined as the process of enabling people to apply and increase control over the determinants of health as well as improving their health to live an active and productive life"* (Erikson & Lindstrom, 2008; Nutbeam, 1998; WHO, Ottawa Charter, 1986).

According to the findings of this study the definition of nurses' health promotion for older people at the acute hospital setting can be formulated as:

"The health promoting nurse supports older patients and their families through the assessment of their needs and resources. They advocate, mediate and support the patients and their families through means of counselling, empowerment and health education; consequently improving the patients' autonomy and participation in making sound choices and their ability to cope with the changing circumstances of their ill-health and life situation.

Professional health promotion nursing is an integral part of the nursing process and nursing diagnosis. Health promotion competences are coherent with the salutogenic concept; the promotion of people's health potential and the biomedic model along with the prevention of risks and diseases are relevant. The nurses' health promotion competences and attitudes are closely tied to health education, empowerment, counselling and professional communication skills. Furthermore attention to family nursing, ethical nursing and holistic nursing expertise is required.

The nurses' health promotion process runs in collaboration with the patient and the family; and the allied health and medical professionals. This has to be recognized and supported by each individual nurse, both at the ward level and at the institutional management level of the hospital, along with external health care services.

In the acute hospital setting, the nurses' health promotion process starts at the entry assessment and continues up until the patient's discharge. Throughout this process individual, cultural and socio- economic factors must be recognised and addressed. Considering recent research, in order to achieve this goal, nursing education institutions and advance training activities have to be involved".

According to the findings of this study, the health care experts' expected performance competences (knowledge, attitudes and skills) of nurses' health promotion for older persons in Swiss hospitals do not meet the bedside nurses' experiences of daily clinical life. The main argument was related to the missing health promotion expertise and the missing health promotion definition of nurses in the clinical field. The expectations of the older persons correspond more with the expectations of the health care experts; multiple requirements of the older persons, with regards to nurses' health promotion, are not addressed in daily clinical life. There is a definite gap between theory and practice; a disparity between the opinions of bedside nurses and the perception of their elderly patients clearly exists.

8.1.1 The commitment to nurses' health promotion practice

Already in the second round of the Delphi survey healthcare experts were clear that health promotion by nurses for older persons is of core relevance as it leads to the reduction of health care costs. This is supported by the study of Wieser et al. (2010), which was published in Switzerland, during the same time period (Eichler & Wieser 2009; Wieser et al., 2010). The economic benefit of health promotion is under discussion, as the evaluation of the long-term effect brings with it challenging difficulties (Meier, Stähli, & Szucs, 2006; WHO, 2013). The ongoing financial pressure and the continuously growing health care costs in Switzerland are recognized by the policy maker and are threat to the health care system in general. Moreover, these costs will carry on increasing due to the growing prevalence of multiple chronic diseases and the expensive treatments used to improve the quality of life for the older population. Thus, the question arises how can the nurses' health promotion activities at the hospital and the improvement of older persons quality of life, in relation to the long- term effect and the economic benefits, be measured (Meier et al., 2006)? In a policy summary, Merkur, Sassi & McDaid (WHO, 2013) discuss the pros and cons and admit that there is a base for an economic benefit for health promotion and disease prevention. They argue that some of the health promotion and disease prevention interventions are cost-effective, yet most of them generate additional costs. Health promotion by nurses for older people in hospitals still can be considered as health promotion and it should be implemented alongside general nursing activities.

The healthcare experts in this study agreed to the increasing relevance of nurses' health promotion due to the demographic changes in Switzerland and the increasing number of older people with chronic health problems. However, their argumentation is not only about the economic benefit. The health care experts expected a further commitment to nurses' health promotion for older people. A clear gap between the theoretical field and the daily clinical practice was underlined by the participating bedside nurses during the group discussions. The bedside nurses did not consider health promotion for patients 65+ to be part of their nursing role in the daily clinical life. They indicated that health promotion for older patients in an acute hospital setting is of low importance. The bedside nurses declared that priority is given to the medical treatment in general and the described health promotion activities were mainly tied to the prevention of diseases, such as diabetes counselling or fall prevention. This is reflected in the current literature (Whitehead, 2009). In a review by Kelley & Abraham (2007), they requested an awareness of health promotion for older people, in addition to the acute medical treatment. They argued that health promotion might increase the quality of life through the sustainable control of chronic conditions. However the bedside nurses considered nurses' health promotion for older people of minor relevance and only useful on specific wards only. Similar to the literature, the bedside nurses confirmed that health promotion was seen as more important on specific wards for example, on the cardiology, oncology or neurology wards (Casey, 2007b; Kelley & Abraham, 2007). One explanation might be that, due to popular projects such as outpatient cardiac rehabilitation or fall prevention programs, nurses' are more aware of health promotion and reflect this more in relation to their own activities at the hospital. Similarly, some of the health care experts declared that nurses' are mostly unaware of actively performing health promotion (Casey, 2007a, b). This could also be one of the reasons that at the beginning of the focus group discussions the bedside nurses' hesitated and only after some discussion was the awareness of their health promotion activities augmented.

If the relevance of health promotion is related to only a few specific therapeutic areas, the findings of this study prove that nurses' health promotion for older persons in acute hospital settings in Switzerland is of low importance.

The health care experts' argued about the missing scope and definition of nurses' health promotion activities in the daily clinical life. They had diverse views on the statement that nurses' health promotion plays a minor role compared to the

medical diagnoses and treatment, and that the patients are discharged without any further investigations. There is no clear argumentation for why the health care experts' had such different opinions. However, it does support the theory that there is a definite disparity between the theoretical expectations and the actual performance of nurses' health promotion. The presence of this gap is further supported by the answers given to the question in the focus groups discussions. The question referred to the nurses' role in health promotion and the first speaker mentioned: *"Well, what we do or what we are supposed to do?"* (Excerpt 1, participant Barbara). The bedside nurses' clearly identified the gap between theoretical and clinical practice; health promotion does not receive the "wished for" attention it is supposed to have.

In contrast, and of interest, are the findings from the participating older persons 65+ recruited from three different wards. The older patients strongly indicated their interest in health promotion by nurses during their hospital stay, similar to a former study performed by McBride (2004). The participants had experienced nurses' health promotion and explained the activities by describing individual scenarios. The majority of the elderly were satisfied with the support given, even though additional counselling by nurses' was requested. The findings also proved that some of the older patients were overwhelmed by the challenges of daily life activities back home. Thus, they admitted that they had only realised the importance of nurses' advice and/or the missing information after their discharge (McKeown, 2007). Additionally the older persons' commitment to health promotion was further demonstrated by the findings regarding the adherence to the advice given by nurses' or the admitted behavioural change.

The findings of this study show a diversity in the commitment to behaviour change by the older persons. After discharge at home a minority of the older persons confirmed their behavioural change and a small majority of the participants stated that they had acted according to the advice given by the nurses. In this study the named interventions were not observed nor controlled, they were just described by the individual examples of the older persons. Still it paints a picture regarding the nurses' health promotion outcome. It is also imperative to consider the various complex influences that exist; knowledge, understanding and empathy are all influencing factors, which influence the attitude and commitment to health behaviour (Naidoo, 2009, pp.70; Peerson & Saunders, 2009). A further strong influence is connected to the older persons' family members; this will be discussed

in more detail later. Nevertheless, the health care professionals have to consider these elderly patients' experiences and acknowledge that they did perceive the benefits of nurses' health promotion. In doing so they will recognise the significance of nurses' health promotion in general.

The health care experts, as previously mentioned had diverse opinions regarding the importance of nurses' HP for older persons. They did however feel that the nurses' comprehension of the importance of health promotion for patients' at any age was required. The fact that the experts did not believe the nurses fully understood the concept of HP could again be down to the gap in theory, their undefined expectations, and the nurses' experiences in daily clinical life. It could also be connected to the age of the patients in that some older patients are not receptive to HP. This was apparent in one focus group discussion with the nurses when a participant stated: *"What young Johnny did not learn, neither does John"* (Excerpt 6, participant Eric). In view of this, health promotion for older persons was deemed as not being essential due to the older patients' forgetfulness or lack of interest. These results echo the findings of others, such as Kelley & Abraham (2007).

They found that nurses were hesitant to discuss the effectiveness of health promotion for older persons. This may be caused by the diverse or missing understanding of health promotion by health professionals in the daily clinical practice (Whitehead, 2009). Furthermore, the missing knowledge or professionalism of enhancing older patients' motivation for self-care through the process of empowerment (Aujoulat et al., 2008) and the neglect of the learning capabilities of the older people (Istance, 2015; Voelcker-Rehage, 2008) all play a role.

A similar point was identified in the analysis of the influencing factors in the health care experts' study. The findings, in the previous chapter 7.1, indicated that there was no consensus found regarding the statement about the low value of empowerment in nursing for older patients (Kennedy, Hardiker & Stanilan, 2015). This could possibly open up a debate about the nurses' ethical attitudes, the lack of respect and missing dignity for older persons, which violate the fundamental nursing principles (ICN, 2012; Koskenniemi, Leino & Suhonen, 2013).

Added challenges to the commitment of nurses' health promotion activities are heavy workload, lack of time and missing resources in Swiss hospitals, which was

confirmed by the findings (Casey, 2007b; Kelley & Abraham, 2007). However, the participating older people did not complain about the nurses' time restrictions, they felt that the nurses had time for them and were well supported whenever they asked for support. It could be argued that the older patients know about the heavy workload of nurses' and it might also be due to their comprehension that they did not dare to criticise the nursing staff.

8.1.2 Knowledge, competences and skills of health promotion

The findings of this study, with regards to knowledge, competences and skills of nurses' health promotion for older people in hospital are similar to the findings in the related literature (Casey, 2007b; Kelley & Abraham, 2007; Kemppainen et al., 2012; Whitehead, 2009). Health care experts expected the nurses' to have the knowledge, the expertise, and understand the health promotion concepts. More so, they expected the nurses to be capable of identifying health promoting opportunities during their daily clinical work. Interesting enough they agreed upon the knowledge and expertise of nurses in general, and they acknowledged the missing health promotion competence of nurses. The bedside nurses' clearly stated that they had difficulties defining the nurses' role in health promotion properly. They were insecure in describing the application of health promotion interventions in daily clinical practice. This situation has also been reflected and documented in previous literature (Casey, 2007b; Kelley & Abraham, 2007; Whitehead, 2008). As discussed in the review from Kemppainen et al. (2012), the bedside nurses' stated that multidisciplinary knowledge, attitudes and the skill-related competences are mainly centered on the individual patient and their view to changing behaviour (Casey, 2007a; Kelley & Abraham, 2007). Furthermore, they stated that nurses' do have the knowledge for health promotion performance but it is a challenge to keep that knowledge up to date. Moreover they also explained their difficulties in communicating health promotion knowledge to the older patients; the bedside nurses commented on the dissatisfaction they felt when trying to collaborate with the patient, only to find there was a lack of interest in health promotion activities from the patients' side. The difficulty experienced in professionally communication competences affects the nurse-patient relationship and results in a barrier for nurses' health promotion performance (Carvalho, 2011; McCabe, 2004; Roter, 2011). The findings of this study confirmed this, especially older female patients commented on communication difficulties. Further attention should be given to the women and men who had difficulties understanding the oral or written

information (Coleman, 2011). Although the majority of the older people declared that they had been well advised by the nurses, some patients did request additional counselling; this need has to be investigated further. One possible cause could be that nurses' did not recognise low health literacy which is of prevalent in Switzerland (BAG, 2015; Jordan et al., 2010; Miller, 2016). The availability of appropriate informative material should be considered (DeSilets & Dickerson, 2009; McCray, 2005).

Although the majority received and understood the written information, the minority should also be taken in to account and their needs met. Another reason why lower health literacy should be considered in a future study is that they were omitted from this study; only well-educated older people took part. The findings give no information about why less educated older persons did not participate at the study. There are several reasons why this could be; assumptions are that patients were worried or afraid of being blamed for not having the right knowledge and/or misunderstanding things during the data collection, misunderstanding the study information pamphlet or the missing interest in health promotion and study participation in general (Flory & Emanuel, 2004; Mody et al., 2008; Tamariz et al., 2013). It could also be due to the fact that the nurses' did not recruit the more vulnerable elderly. This methodological challenge however will be discussed later on.

Specifically due to the small sample size of this study the findings are not generalised, thus the minorities and single statements should not be overlooked. Important to note is that the participating older persons did approve of and confirm their basic knowledge in health promotion and the interest in nurses' health promotion at the acute hospital setting. However the greater challenge is the transition of the theory of nurses' health promotion activities in older persons' daily life, given in a controlled hospital setting, to the autonomous environment at home (Mc Bride, 2004).

8.1.3 Family and relatives

The upmost importance has to be given to the discussion on the nurses' health promotion activities for older persons and their family at the hospital. The older persons' health values clearly identified the importance of living autonomously at home and in harmony with their family and friends. Social influences such as

spouses and relatives have a major impact on patients' health and well- being. The relevance between a person's health and well-being, and those of the family members is confirmed in the literature (Astedt-Kurki et al., 2009). It is predicted that there is an increase in hospital readmission for those patients living alone (Murphy et al., 2008). Relatives and especially wives and daughters play an important role in providing health care for older people after hospital discharge in Switzerland (Perrig-Chiello et al., 2010). In this study, the majority of the older patients were supported by their relatives both at the hospital and after discharge at home. Nevertheless, about half of the older patients', 17 out of the 32 older people, confirmed that they hadn't received any family counselling by the nurses when asked two weeks after discharge. Although the cause was not investigated in this study, some statements should be considered. In contrast, the bedside nurses stated that health promotion was not requested by patients and their relatives and complained about the missing support and collaboration. During the Delphi survey, the health care experts mentioned family and relatives on a trivial base only. This might be have been influenced by the method and it will be addressed later on (chapter 8.2.).

The findings indicated that health promotion counselling by nurses of patients and their relatives was not in line with the expectations of the patients (SAMW, 2016). As mentioned before the majority of the older persons agreed that they did follow the nurses' advice at home. However there were still some participants that stated that they did not act upon the advice given when at home. An understanding of the reasons for this would be of interest but were not investigated in this study. An important point to consider is that the older persons did say that they preferred to act upon the advice given by their family members. Hence joint counselling with spouses and/or family members would support the daily life activities of the older people back home. The family influence over the older persons compliance and adherence towards health activities is not be underestimated. The findings clearly showthat some of the participants misjudged their autonomy when they were in the hospital and support by spouses was needed at home after discharge. Likewise, described in the literature by McKeown (2007), the participating older persons confirmed that they realised too late, only after discharge, that they were missing information. Joint counselling would help to overcome this barrier and would support sustainability. Further support could also be considered, such as call back services, as mentioned by some of the participating older people. Additional support for example, online access to information pamphlets, which are now

handed out by nurses during hospitalisation only or automated telephone communication systems (Posadzki et al., 2016), should also be considered. This Web- service opportunity was not mentioned neither by health care experts or bedside nurses nor by older persons. The Web-service could tackle another problem; as described above, the bedside nurses identified missing support and collaboration with the older peoples' relatives as a problem. One reason for this could be due to travel difficulties of elderly spouses. Likewise younger family members, daughters and sons might face working organisation problems and are unable to participate in meeting at the hospital at the times given. Nurses' should consider these difficulties when planning their daily clinical work. Another important resource of support for the older people was their friends, neighbours and the external community health service. These challenges have to be addressed on a broader public health scale; context and appeals for solutions on a socio-political base are required. However, the small sample size and the findings of this study do not permit the further investigation into the correlation of older persons' family support and the support of the community health service (SPITEX) or rehospitalisation.

8.1.4 Interprofessional collaboration

As mentioned previously the nurses' health care process works in strong collaboration with the patient, the family and the allied health and medical professionals. The quality of nurses' health promotion for older people at the hospital is linked to the interprofessional collaboration and the way in which health care professionals communicate and interact amongst each other. The literature proves that well-functioning interprofessional collaboration can increase the quality of health care, health and the well-being of the patients' (Zwarenstein, Goldman & Reeves, 2009).

In this study the health care experts had diverse opinions about the existing, or the missing, interdisciplinary teamwork being performed by nurses' with regards to health promotion in the hospital. The reasons for these varied opinions were not investigated in this study. Nevertheless, the findings again point to a gap in the theory and the practice of health promotion activities; likewise the expected and experienced nurses' health promotion performance in daily clinical life.

Health care experts might have been influenced by the literature available that identifies multiple obstacles for interprofessional cooperation in the hospital setting (Rettke et al., 2015; Saxton, Hines & Enriquez, 2009; Zwarenstein et al., 2009). However the bedside nurses explained that nurses' do work in interprofessional collaboration during their daily clinical life; only when it comes down to nurses' health promotion activities for the older people did they argue that their role was to act as an intermediary. They confirmed that they perform health promotion through the advice given by the health experts of a specific therapeutic field for example, nutritionists, physiotherapists, physicians or nurses with advanced training (Diabetes counsellor). Nurses' do not control or monitor the achievement of the given interventions. Most nurses delegate the responsibility for health promotion to experts and they do not have the overall picture of the outcome regarding the enhancement of the health of their patients. This finding is in strong contrast to the definition of professional nursing and the requested nurses' disease prevention and health promotion role (Spichiger et al., 2006). Professional nurses motivate people to take care of and to be in charge of their own health, supported by their expertise and by their frequent and close contact to the patients. This was confirmed by the bedside nurses. They confirmed that the patients' problems and risks are identified through the nursing assessment, as nurses' are closest to the patient. Any identified problems are then delegated to health experts and interventions are evaluated during regular interdisciplinary exchange meetings. This discussion is about why nurses' delegate health promotion activities to allied health care professionals as described in the literature (Casey, 2007b). Missing time resources or missing nurses' knowledge could be among the various arguments for the conscious handing over of responsibility by nurses'. The discussion is also about the nurses' unawareness of carrying out health promotion interventions. As described in the literature, the missing knowledge about each other's role and the knowledge of the different health care professionals may lead to restrictions in collaborative resources. Consequently, this can lead to minor quality health care service at the hospital (Kvarnström, 2008). The question for this discussion is how can nurses'work in interprofessional collaboration if they are unaware of their own role in health promotion. It is important to recognise that if nurses perform a leading role they are responsible for their own actions and attitudes (Rettke et al., 2015).

A further point for discussion is the good collaboration between hospital nurses' and external health care services such as the community health service (SPITEX)

and the general practitioners. The findings of this study clearly illustrate the need for improvement in the nurses' interprofessional and interdisciplinary collaboration.

This is verified by the healthcare experts' diverse opinions about if only the medical diagnoses are treated and the patient is discharged without any further investigations being performed. Similarly, the bedside nurses discussed if health promotion can be applied during short hospitalisation stays as they do not have any influence after hospital discharge. Nurses' should have a collaboration and information exchange through a professional discharge management procedure (Gonçalves-Bradley et al., 2016). The interdisciplinary collaboration would not only improve the quality of health care given, it would increase the relevance and impact of nurses' health promotion for the older persons in the hospital. Professional collaboration with district nurses would provide a much-needed impact on the increase of nurses' health promotion in the hospital and at the community health care level (Irvine F, 2007). Nevertheless the support of the management and communication structures is indispensable (Nancarrow et al., 2013).

8.1.5 Hospital and management

If nurses' health promotion for older persons at the hospital is connected to the interprofessional collaboration, effective interdisciplinary team cooperation is required. In their study Nancarrow et al. (2013) describe principles for good interdisciplinary teamwork, which are mainly connected to positive leadership and management attributes. Similar to the study of Nancarrow et al. (2013), institutional communication strategies, personal management, supportive resources, Institutional development and common visions were also discussed by the health care experts and/or the bedside nurses (Nancarrow et al., 2013) in this study. The bedside nurses confirmed the missing visibility and lack of attention to nurses' health promotion in acute hospitals. The nurses' suggested that there is a need to increase the visibility and the core value of health promotion in health institutions in general. Strategies discussed by the participants included the development of an institutional policy concerning health promotion. They suggested implementing guidelines across the hospital aimed at increasing the relevance of health promotion. This is supported by the literature (Casey, 2007a; Kemppainen et al., 2012; McBride, 2004; Whitehead 2010, 2005) and the health care experts, without the most reliable consensus, confirmed it. Additionally, the

bedside nurses' suggested that it was the duty of the hospital management to highlight the impact and economic benefit of health promotion to their staff (Kelley & Abraham, 2007). The participating nurses' recommended further training for all health professionals as a method for increasing awareness of health promotion. This could be addressed by the organisation of multidisciplinary meetings along with an external facilitator; this would improve the collaborative working with a positive outcome for health care (Zwarenstein et al., 2009).

A further interesting discussion point relates to the perceived relevance of nurses' health promotion for older persons by the hospital management. It is important to remember that Swiss hospitals are not among the members of the International Network of Health Promoting Hospitals & Health Services (HPH) anymore. Still there might be some advantages at the economic and socio-political level. However the executive hospital management need to be aware of the gap between the theory and the experienced practice of nurses' health promotion for older persons at the hospital. Action at different organisational levels should be considered (Casey, 2007; Kemppainen et al., 2012).

8.1.6 Education and research

In this study the missing knowledge to perform nurses' health promotion for the older people and gap between theory and practice was identified. Moreover the bedside nurses' declared difficulties in remaining up to date with developments and state of the art knowledge. They stated that it would be up to each individual nurse to be responsibility for gaining the knowledge needed. As mentioned previously in the literature (Kelley & Abraham, 2007) advanced training on a regular base was requested. The health care experts declared that the current tertiary nurse education should be used as a resource, supporting the required knowledge and competences of a health-promoting nurse. However other training programs for health promotion integration at the nursing education are also of interest. According to the literature the evaluation of the health promotion curricula is requested (Piper, 2008; Whitehead, 2008). This was not a focus for investigation during this study. Nevertheless it should be reflected particularly with regards to student nurse training at the hospital. The bedside nurses' also pointed to the nurses' role model for nursing students at the hospital. Of upmost importance is the challenge of the integration of health promotion theory into the daily practice (Whitehead, 2008). If bedside nurses have to play a role model for nursing students they should be

supported to maintain and act upon up to date state of the art knowledge and they must be clinically skilled, which involves evidence nurse practice and the involvement of actual health promotion research (Landers, 2000; Saarikoski, 2009; Scully, 2011). The additional challenge lies in the actual linking of the older persons' and the nurses' knowledge and interest in health promotion. As described before in this study, the older persons demonstrated their interest in health promotion performed by nurses at the hospital (McBride, 2004). The identified barriers for health promotion activities, such as the integration of a health promotion concept have been documented in literature for over a decade; this study shows limited changes have been introduced to the clinical fields (Kemppainen et al., 2012; Piper 2008; Whitehead 2010, 2008). For example, in tertiary nursing education special focus has been given to communication training and an improvement is expected (Curtis, Tzannes & Rudge, 2011; Mullan & Kothe, 2010; O'Hagan et al., 2014). Furthermore, ongoing projects are among joint Interprofessional learning activities, which may support the nurses' tasks in health promotion for the older persons at the hospital (Lapkin, Levett- Jones & Gilligan, 2013; Reichel et al, 2016; Zwarenstein et al., 2009). Through joint interprofessional education the value of nurses' health promotion for older persons in the hospital might increase visibility particularly through the interdisciplinary projects. Moreover, the knowledge of each other's role and responsibilities in health promotion, and the common language among health professionals will be addressed (Kvarnström, 2008; Piper, 2008).

8.2 Methodological Considerations

The multiphase design used in this mixed method study was a sound choice to investigate the all-encompassing and complex research question regarding the actual situation of nurses' health promotion for older persons in the acute hospital setting (Creswell & Plano Clark, 2011).

The first strand, the Delphi survey identified the opinion of health care experts regarding health promotion by nurses for older persons in an acute hospital. Secondly, the focus group discussions with bedside nurses were conducted to analyse whether, and to what extent, nurses' working in the clinical setting supported and confirmed the opinions expressed by the health care experts. Considering the theoretical expectation and the actual daily clinical situation, from the view of health care professionals, the third and fourth strand additionally addressed the health care receivers' judgment. The face- to- face interviews with older persons, during hospitalisation and two weeks after discharge, included open-ended questions and a structured interview questionnaire.

Albeit the mixed method research design contains qualitative and quantitative data the overall philosophical paradigm is based on pragmatism (Creswell & Plano Clark, 2011; Johnson & Onwuegbuzie, 2007). This statement compliments the research question as the investigation was about the actual situation of nurses' health promotion for older persons presented at the hospital. The question is not only about how does it work in clinical practice, it is more about is the situation satisfactory. Creswell and Plano Clark (2011) recommend pragmatism instead of the mix of the two paradigms, which are traditionally used in quantitative research (postpositivism) or qualitative research (constructivism). For this study pragmatism will lead the methodological assumptions and discussion. The mixed method research design used for the different strands supported the weakness minimization (Onwuegbuzie & Johnson, 2006), and the explanatory sequential design for the nurses' study. The limitation of the Delphi survey is that of not being able to discuss arguments and what was considered for the selection of the following strands in the focus group discussions. On the other hand the limitation of influencing the discussion through the group dynamic was addressed by the anonymity of the heterogenic Delphi panel. The limitation of personal bias and narrow focus was addressed by the older persons study. In addition to the Health care experts' expectations and the bedside nurses' experiences, the older persons'

perception of nurses' health promotion was addressed to minimize the weakness. An additional focus could have been addressed by investigating of the view of the older persons' family and friends. Hence, the convergent parallel design of the older persons study along with the open-ended, structured interviews was selected to be able to compare and achieve a broad, in depth view. Additionally, the internal validity, or the credibility, was considered through the older peoples' explanation of nurses' health promotion using their own wording.

Nevertheless, in this mixed method study, multiple research questions and consistent samples had to be addressed to comprehend the holistic understanding of nurses' health promotion for older persons in the hospital. Limitations due to financial and time resources had to be considered. An attempt was made to place equal emphasis on the nurses' study and the older persons' study. It should be discussed if, in multiphase design, the different components should be equally weighted. The nurses' study, with the explanatory sequential design, was weighted more compared to the convergent parallel design for the older persons' study. If the equal weight of each strand is requested two different samples of older persons should have been recruited for the open-ended interviews and the structured interviews in order to compare the findings of each strand. Or alternatively, an additional strand consisting of the patient's relatives should have been considered.

Although the multiple methods were reflected for appropriateness several challenges appeared during the research project. One challenge was to maintain the methodological congruence to ensure the quality of this study (Thurston, Cove & Meadows, 2008). Particularly the older persons' study that required a sample size for the quantitative research method could not be fulfilled. Therefore, the findings cannot be generalised and importance has to be given to the trustworthiness of this study (Johnson, Onwuegbuzie & Turner, 2007). Trustworthiness includes credibility, transferability, dependability, confirmability and authenticity (Polit & Beck, 2012 pp.745). Subsequently constraints that threaten the quality of this study should be discussed as importance was given to trustworthiness through the transparent description of the strategies. Regarding the best possible representation and sound understanding of the findings the challenges of language differences also have to be considered. All the different strands were conducted in Swiss-German and the German transcripts were translated into English only after the analysis of the findings had been concluded. VanNes, Abma, Jonsson & Deeg (2010) recommend remaining in the original language as long as possible to avoid

potential limitations in the analysis. For this dissertation the translation into English was addressed in two steps. Firstly, a native English professional verified the translation; and secondly, in order to address any inconsistencies with wording the researcher was also the translator moderator during the side-by-side procedure (VanNes et al., 2010). Additionally the wording was approved by a second translator. Nevertheless, language biases have to be considered. Specifically the questions; what is the role of nurse's health promotion, and what is the importance of nurses' health promotion were a major problem. The difficulty lay in the translation from Swiss-German to German and then into English. The language problems where not considered when formulating the research questions and proven to be challenging throughout the project.

Attention was given to minimize the risks of bias; however some threats were not considered thoroughly enough. Literature requires that the methodological questions be discussed on each strand separately (Creswell & Plano Clark, 2011).

The secondary analysis using one part of the PRECEDE-PROCEED model was a sound choice (Green & Kreuter, 2005). With regards to the mixed method research design, the final integration of the different strands was of upmost importance. At this point of the research process the findings were presented under the main aim. The three categories, predisposing, enabling and reinforcing factors of the behavioural and organizational influences were used to identify barriers and motivators. The classification did match with the findings of the different strands and a comprehensive picture was drawn about the actual situation of nurses' health promotion for older persons' in Swiss hospitals.

8.2.1 Nurses study

Delphi-survey

For this study, the Delphi approach was applied to establish the most reliable consensus of opinions from the health care experts about the nurses' role in health promotion for older persons in an acute hospital setting (Häder, 2002). The literature requires the method to reach a high reliable consensus if it is assumed that experts are of diverse opinions in the field being considered (Keeney et al., 2011). However Keeney, Hasson & McKenna (2011) argue that even if the most reliable consensus was found it does not mean that it is the correct answer, it is the view or the convergence of opinions amongst the survey participants. Furthermore, they argue that the consensus might be forced, as the panel members do not have the possibility to discuss their arguments (Keeney et al., 2011), also there are no rules about the correct level of consensus given in the literature. For this study the consensus level of 80% with a mean score of 4.0 and above was determined before starting the study (Keeney et al., 2006). Hence, the capability of reaching a consensus has been discussed. Even if this method measures the consensus, there is no standard practice regarding the statistical analysis of the results, as this approach varies from study to study (Landeta, 2006). In addition, there have been critics made about its lack of accuracy and reliability check. The Delphi- technique has been criticised for not showing reliability, as there is no guarantee to achieve the same results each time if the same information is given to several panels (Häder, 2002). Considering the reliability, the recruitment of the Delphi panel was conducted using a purposive sample (n=31) of a heterogenic group of health care experts. Goodman (1987) argues that the participation of experts, who add self- experience and attention in the theme, may increase the content validity of the study (Häder, 20002). The selection of the expert panel of this strand was guided specifically considering this point. The validity is connected to the panel size, the response rates and the drop outs (Hasson et al., 2000; Keeney et al., 2011). For this strand the selection of 31 health care experts was to assure at least a sample size of 20 panel members. Due to the constraint of time and laborious workload for the ensuing rounds, some panel members were put off participating. The sample size was reached by 27 of the health professionals participating in the final third round. Nevertheless, the sample of 27 health professionals still has to be considered as a small sample and the bias for generalisability has to be considered (DeVilliers et al., 2005). The panel size is

widely discussed in the literature but no clear requirements were stated (Hasson et al., 2000; Keeney et al., 2011). However the literature requires that the diversities of the experts needed is reflected upon with regards to the relevant perspectives of the research field. This was considered when recruiting the heterogenic group of health care experts (Häder, 2002; Keeney et al., 2011). Attention was given to limitation bias through the interrater reliability of the qualitative analysis and the coding of the first round findings was ensured by a second researcher (Polit & Beck, 2012, 2006). With regards to the reliability, the entire wording of the panel members was respected when formulating the new items in round two. However, limitations by bias in phrasing the questions have to be considered, even though the panel members confirmed that their statements of the first round were included in the second round survey and that they had understood the questions well. During the second round the experts detected a bias for double-sided questions; the questions were removed in round three.

Although the pre-test was conducted satisfactorily, a further threat to validity was detected during the study. This is the large pool of items, which were elaborated on, in the first round of questions. Hence, not all questions were answered by the panel members considering the large amount of items accrued, as too many items carried over to subsequent rounds could end up clouding the consensus (Hasson et al., 2000; Keeney et al., 2011). Considering the heavy workload of the panel members it could be that the panel members were impatient to *"get on with the job",* in order to bring an end to the process by reaching consensus. The panel members declared they needed more time as suggested. To has be discussed if the questionnaire could have been reduced, without a further limitation bias, as the researcher could have misguided and influenced the development stages of the survey.

Keeney et al. (2011, 2006) advise that two to four iterations of Delphi were enough for most research projects being conducted. For this study three rounds were needed to answer the research question posed. Another concern is that participants with divergent opinions may not be recognized as only a few of the non-consensus reached results were taken to further discussion. Similarly, the mixed method research, according to the literature, requires trustworthiness as more appropriate than reliability and validity for Delphi surveys (Day & Bobeva, 2004). Credibility was enhanced by the ongoing repetition until the third round and the feedback was given to the panel members (Engles & Kennedy, 2007). Taking the above

described limitations into consideration the findings from the Delphi survey were taken for further investigation to the focus group discussions (Engles & Kennedy, 2007; Hasson et al., 2000).

Focus Group Discussion

The method used for the focus group discussion was chosen in order to get personal information about the individual experience of nurses' health promotion in daily clinical life. As presented in the literature previously, both focus group discussions allowed for the developing awareness of the theoretical knowledge, as the background of the daily clinical work, in addition to professional experiences (Berg et al., 2010). The main purpose of this method was the possibility for interaction, as the groups should react and discuss various opinions with each other on an impulsive base (McLafferty, 2004). Naturally the interactions are dependent on group size and group dynamics. The group should be big enough to hold a motivated discussion with negotiation and argumentation (Jayasekara, 2012). In this study two small groups of three and six participants discussed their subjective opinions and experiences and the group size has to be considered as a limitation threat. The number of participants required for focus group discussions varies in the literature from four to twelve (Jayasekara, 2012; Kean, 2000; Lamnek, 2005). The small group was made up of an odd number of participants to avoid arguments and stalemate as recommended by the literature (Bohnsack et al., 2010).

More information could have been gathered by adding additional focus group discussions. This should have been considered during the planning process as the literature describes the problems of non-attendance at focus group discussions (McLafferty, 2004; Webb, 2002). The small groups of three and six participants had the required experience of working with older patients in their daily practice. This was confirmed in the group discussion and the collective orientation with identical structured experiences. However using the documentary method a complex and time consuming qualitative analysis by Ralf Bohnsack (Bohnsack, 2010; Bohnsack et al., 2006; Bohnsack et al., 2010), both focus group discussions were of minimal interaction. Limited opinions and arguments with regards to the meaning of nurses' health promotion for older patients were oppositional and not shared experiences. An explanation could be that both groups were provided with an identical topic guide for discussion, which was based on the findings of the previous Delphi

survey. Thus the topic guide influenced the discussion, as the participants were aware of the statements made by the health care experts. Nevertheless through the use of the topic guide the two group discussions could be compared. Furthermore the findings proved that the opinions of the participants were often contrasting to their colleagues, they had their own individual opinions and these were not biased or heavily influenced by the statements made by the health care experts or those in hierarchical authority.

Additionally, the role of the moderator also has to be considered. Lamnek (2005) argues that the moderator should have the needed skills to guide the discussion without influencing the debate and should remain neutral. In these focus group discussions the author was in the role of the moderator and didactic qualifications were given to cover this bias. The moderator (author) was also a member of the teaching team but had never had any teaching contact with the participants; however, some influential bias cannot be neglected. The participants knew each other and communicated well; they were not disturbed by the video recorder. Through the additional use of a flipchart to record their points, the participants could connect visually; the point of the communicative validity was also addressed. The available literature addressing this point describes taking notes during the discussion as an interference with the process, this could be taken into consideration for one of the group discussions as the moderator was recording the discussions as well as moderating due to no assistant being available (MacLafferty 2004).

The interrater reliability bias is limited as the analysis, using the four steps of the documentary method (Bohnsack et al., 2010), was performed by the author then discussed and approved by a second researcher. Nevertheless, a matter of concern is the translation bias, from Swiss German to German to English, even though it was addressed by two different translators approving the various steps throughout.

8.2.2 Older Persons Study

Open ended- and structured interview

To discuss the older persons' health promotion needs and requirements their diverse understanding of health promotion has to be primarily considered. Recent literature proves that the persons' understanding of health promotion is correlated to the situational factors and socio-economic issues (Shoquirat & Cameron, 2013). This challenge was addressed through the use of open ended interviews using two open-ended questions. According to Broom (2005) the open-ended or "in-depth interview provides a way to enter into the older persons' world" exploring their understanding of illness and care and gaining insight into how meaning is constructed". The pre-test clearly demonstrated the importance of starting with the open-ended questions with no time restrictions. This way the data saturation could be achieved. The strand has some limitations, as in narrative interviews the quality of outcome might be influenced by the interaction of the interviewer and the interviewee. In their study Borge & Fagermoen (2008) discussed the outcome bias as the participants might feel the need to please the interviewer. This option could be disregarded for this strand as the researcher was in a neutral position. In contrast however, one could consider that the participants might have given less content in the narrative interview, as they were aware that a second structured part of the interview would follow. This has to be considered for the second identical interviews after discharge at home. Nevertheless the findings from the open-ended questions proved their practical usefulness as the older persons' clearly described their opinions and views about health promotion and they described their own and the nurses' activities using their own words. The trustworthiness or credibility of the findings was addressed by systematically comparing content and categories to the transcripts. The entire analysis was discussed and approved by a second researcher.

A further point of discussion is the time that it took to collect the data. The original estimate was planned for six months; in fact it took one and a half years to collect the necessary information. The reasons for the limitation of the data collection need to be discussed further, it could be down to the recruitment of the 40 participants. It might also be due to the threat of privacy some older persons' did not want to continue the interview at home and were not interested in discussing the content further. To minimise this limitation the participants were informed that they were free to choose the placement of the interview after

hospital discharge. The interviews could take place at home or in a café; one participant chose to perform the second Interview over the telephone. The literature suggests that it is more favourable to do face-to face interviews as telephone calls might be shorter in duration and the hold the threat of missing information (Irvine, 2012) or misleading information may not be detected (Garbett & McCormack, 2001). Nevertheless, the phone call discussion in this study was recorded and transcribed and no limitation could be detected.

The personal biases have to be discussed further; particularly if, the nurses' only chose, well-educated people. This threat of limitation was considered when developing the recruiting schedule with specific randomly selected days over a six months period. As mentioned before, this schedule could not be followed due to missing interview participants.

Further attention should be given to the barrier of the ongoing institutional reorganisation and the predominant heavy workload of the persons in charge. However, the quality of the data collection was not limited due to the long data collection period and it is comparable as the same person (author) performed all of the interviews,

As there was no validated questionnaire available for the topic under investigation, the structured interview questionnaire used was developed by the research team and included the findings from the literature and previous strands. The questionnaire used was not validated but approved in the pre-test. During the data collection several limitations were discovered. After a short while it was clear the similar formulated control questions were not necessary as the interviews were performed face-to-face and by the same person. Although the questionnaire was used identically for all of the interviews, due to the small sample size, the results gained cannot be generalized and the data produced may be limited in reliability. However the combination of the open-ended and structured questionnaires increased the trustworthiness through the exploration of the understanding of health promotion of the older persons. The linguistic validity, as to the wording of the questionnaire being understood in the same way was also considered. A further point of consideration is the small sample size of twenty older women and twenty older men. The combination of the two strands, having the same population lead to a time consuming qualitative analysis process and limited the sample size for the quantitative data collection and consequently limited the statistical analysis.

The method chosen should be reviewed critically. Would it have been better to use a much larger sample, the structured interview could have been conducted using a letter; newer better qualitative results may have been gathered and generalized. This would have met the mixed method design model and the relationship between the qualitative and quantitative data would have been satisfied.

However, due to missing computer resources for the elderly, a web-based survey with older persons' might be still challenging in Switzerland (Schelling & Seifert 2010). Moreover, the limitation that only the well-educated elderly participated would also not have been addressed. In this study the same population, for narrative a structured interview, was selected to make sure the older people reflected on the nurses' health promotion activities during the interviews. Given the situation that a larger representative sample population would usually complete a questionnaire this challenge would be a major limitation. Nevertheless the results of this study give a multi-faceted interpretation of the specific population under investigation and provide some interesting details to the overall investigation of this mixed method research study.

8.3 Ethical Considerations

With regards to the Delphi survey the "quasi-anonymity" of the expert panel was essential to the study approach. Due to this anonymity, it was easier for the experts to revise and thus improve an opinion that had already been set. Anonymity creates an objective atmosphere and sidesteps the subjective flow, which could be inherent otherwise (Häder, 2002). The panel population was informed about the group structure but all the members' personal data remained anonymous. The questionnaire was coded and only the research team had the ID number and the contact information to be able to send reminders.

The experts received recruitment information by mail and they were asked to indicate their participation interest and provide their signed consent form to participate in the study. They were informed that even if they agreed to participate in the study, they might withdraw at any time point. Considering the low risk, ethical approval for this study was not sought from the ethics committee.

The participants of the focus group discussion were informed about the group structure, but all personal data was kept anonymous. To ensure anonymity, participants were addressed only by first name during the focus group discussions (Lamnek, 2005). The participants received initial study information by mail, they were asked to indicate their interest in participating and their consent to participate in the study. Anonymity and confidentiality was assured and all participants were informed of their right to withdraw from the study at any stage, without giving prior notice.

The interviews with the older persons were approved by the Ethical Commission of Basel and County Basel Authorities (November 2011/ Ref. EK: 336/11. appendix II, 14.1.6). The participating older persons received a written description of the study including the aim, the method and the voluntary nature of the participation. The written and signed consent was obtained from the participants. The anonymity and confidentiality was ensured and no names were used. The participants were informed that they could withdraw at any moment and that the audiotape could be deleted at any time.

9 CONCLUSIONS AND RECOMMENDATIONS

9.1 Conclusions

The purpose of this dissertation was to analyse health promotion by nurses of older persons 65+ in acute hospitals from the perspective of health care experts, bedside nurses and older patients in Switzerland.

Having reviewed and analysed all of the findings from the Delphi survey, focus group discussions and the face-to- face interviews three obvious conclusions can be drawn.

Primarily, a health promotion framework has to be developed, agreed upon at all levels and distributed to the parties involved. Secondly, interprofessional collaboration must be promoted and supported throughout all of the involved organisations. Thirdly, shared decision making between the nurses, their patients and the patients family and relatives has to be emphasized and carried out actively.

It is essential to acknowledge that the major reason for all of the above points is that a substantial gap exists between the theoretical expectations and the clinical experiences of the nurses regarding health promotion for older persons.

With reference to the development of a health promotion framework; the definition of nurses' health promotion for older people at the acute hospital setting formulated during this study could be used to support and reinforce the development process. To further improve the quality management process the HP framework has to be approved, distributed and implemented by all of the involved parties. This is of upmost importance and supported by various existing studies, as previously described (chapter 2.3 the nurses role in HP). Moreover quality improvement can be achieved by encouraging the Nurses' to be more aware of planning, performing and analysing their own health promotion activities in the daily clinical practice. Nurses' health promotion could be assessed on their actual performance and rewards given based on a measurable format.

The second conclusion addressed interprofessional collaboration. Currently, the interprofessional collaboration is flawed; it is however, very important for the successful implementation of health promotion. This would augment the interdisciplinary communication and understanding with respect to each other's' role; to share resources the professional knowledge and experience is needed by all health professionals. Interprofessional meetings held on a regular basis would increase the cooperation, the exchange of knowledge and most importantly, the quality of health care for older persons'. In addition, regular advanced training courses could be introduced at the interprofessional level.

The final conclusion made was in regard to shared decision making. This is particularly important as nurses' should be aware of, and should trust in, the contribution of the older persons' opinions and participation. This resource orientated empowerment endorses the performance of health promotion in daily clinical work.

Furthermore, the outcome and sustainability of nurses' health promotion works in strong collaboration with the socio-economic situation of the older persons. The participating older persons' in this study clearly demonstrated that more importance should be placed on family health care and close cooperation with the older persons' relatives. In order to overcome the barriers in nurses' health promotion for elderly patients' and their family, health literacy and organisational problems encountered by the older persons' and their relatives has to be carefully considered.

To summarise, the findings of this study clearly indicated that daily clinical practice does not fulfil expectations. If the three points, described above, are taken seriously and the solutions considered, the gap between the theory and practice will automatically be narrowed and health promotion by nurses for older persons at the hospital improved.

9.2 Suggestions for Further Research

Further scientific research is needed to enforce the commitment towards nurses' health promotion and evidence based practice. As described previously there is an absolute need to create a framework or guideline, complete with performance-based indicators, for health promotion by nurses in an acute hospital setting. A further research study should focus on adapting and controlling the nursing curriculum; this should align with and include health promotion competence, knowledge and skills. With regards to the broad field of nurses' health promotion additional research on interprofessional education, work and communication with health professionals could be carefully considered.

A special focus should be given to future post discharge e-learning projects such as information platforms for patients and their relatives. These projects have to take into account the diversity of the population and their limitations; specific resources should be developed and critically evaluated.

In order to be able to generalise the identified topics follow-up studies are requested. Required are further investigations with nurses', older persons' and their family's to reach a comprehensive understanding of nurses health promotion in the acute hospital setting of Switzerland. An expansion of knowledge, through complementary perspectives of the nurses' and the older patients' viewpoints, is required to support the future implementation of nurses' health promotion in daily practice. Additionally, similar research should be conducted using diverse focus groups, for example, older patients living in lower social economic situations who tend to be difficult to reach and assemble.

9.3 Future Directions

The findings of this dissertation clearly show that there is a disparity, between nurses' health promotion for older persons' in theory and in practice. Moreover, a gap was identified in nurses' health promotion at the hospital between the perceptions of older persons and the opinions and experiences of health care professionals. The older persons' clearly indicated their interest in nurses' health promotion and demanded the increased of the involvement of their family. The bedside nurses stated that a low priority was placed on the relevance of health promotion in daily clinical life. They experienced health promotion performance on selective wards only. Efforts should be taken to ensure health promotion by nurses is routinely delivered and adapted to the needs of older patients and their families throughout entire hospital. Professional health care is not the treatment of medical condition only. Attention has to be given to time and personnel resources. The professional pride and the good work of a qualified nurse must be respected. Management and policy modifications are needed to promote the commitment to health promotion. Health promotion interventions by nurses have to be recognized and rewarded to achieve this goal. Holistic nursing, including health promotion for older persons and their families should be the level of quality that is demanded at medical institutions and should be the aim of every single professional nurse. The introduction and revision of interprofessional training and institutional guidelines for health promotion is recommended to improve the missing culture of health promotion in the daily life of nursing practice and reduce the gap between theory and practice.

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11 REFERENCES

Aartsen, M. & Jylhä, M. (2011). Onset of loneliness in older adults: results of a 28 year prospective study. *European Journal of Ageing*, 8, 31-38. doi:10.1007/s10433-011-0175-7

Ackley, B. J. & Ladwig, G. B. (2008). *Nursing Diagnosis Handbook: An evidence – based guide to planning care* (8th ed.) St. Louis, Missouri: Mosby Elsevier.

Ackermann- Liebrich, U., Paccaud, F., Gutzwiller, F. & Stutz Steiger, T. (2002). *Gesundheitsziele für die Schweiz. Gesundheit für alle im 21. Jahrhundert (WHO Europa)*. Schweizerische Gesellschaft für Prävention und Gesundheitswesen (Ed.).

Ajzen, I. (1991). The Theory of Planned Behavior. *Organizational Behavior and Human Decision Pozesses*, 50 (2), 179- 211. doi: org/10.1016/0749-5978(91)90020-T

Antonovsky, A. (1996). The salutogenetic model as a theory to guide health promotion. *Health Promotion International*, 11, (1), 11-18.

Asted- Kurki, P., Tarkka, M. T., Rikala, M. R., Lehti, K. & Paavilainen, E. (2009). Further testing of a family nursing instrument (FAFHES). *International Journal of Nursing Studies*, 46, 350–359. doi:10.1016/j.ijnurstu.2008.01.008

Aujoulat, I., LeFaou, A., Sandrin- Berthon, B., Martin, F., Deccache, A. (2001). Implementing health promotion in health care settings: conceptual coherence and policy support. *Patient Education and Counseling*, 45, 245- 254.

Aujoulat, I., Marcolongo, R., Bonadiman, L. & Deccache, A. (2008). Reconsidering patient empowerment in chronic illness: A critique of models of self-efficacy and bodily control. *Social Science & Medicine*, 66, 1228-1239. doi:10.1016/j.socscimed.2007.11.034

Baker, D. W., Wolf, M. S., Feinglass, J., Thompson, J. A., Gazmarian, J. A. & Huang, J. (2007). Health literacy and mortality among elderly persons. *Archives Internal Medicine,* 167(14), 1503-1509. doi:10.1001/archinte.167.14.1503

Bakken, S., Lantigua, R. A., Busacca, L. V. & Bigger, J. T. (2009). Barriers, Enablers, and Incentives for Research Participation: A Report from the Ambulatory Care Research Network (ACRN). *Journal of the American Board Family Medicine*, 22 (4): 436–445. doi: 10.3122/jabfm.2009.04.090017

Bandura, A. (1986). *Social Foundations of Thought and Action*: *A Social Cognitive Theory*. Englewood Cliffs, New Jersey: Prentice Hall.

Beattie, A. (1991). Knowledge and control in health promotion: a test case for social policy and social theory. In Gabe, J., Calnan, M. & Bury, M. (Eds.). *The Sociology of Health Service* (pp. 162-202). London: Routledge.

Behm, L., Dahlin- Ivanoff, S. & Zidén, L. (2013). Preventive home visits and health experiences among very old people. *BioMed Central Public Health*, 13, 378. doi:101186/1471-2458-13-378

Behm, L., Wilhelmson, K., Falk, K., Eklund, K., Zidé, L. & Dahlin- Ivanoff, S. (2013). Positive health outcomes following health- promoting and disease- preventive interventions for independent very old persons: Long-term results of three-armed RCT Elderly Persons in Risk Zone. *Archives of Gerontology and Geriatric,* 58 (3). Retrieved from http://dx.doi.org/10.1016/j.archger.2013.12.010

Berg, G. V., Hedelin, B. & Sarvimäki, A. (2005). A holistic approach to the promotion of older hospital patients' health. *International Nursing Review*, 52, 73-80.

Berg, G.V., Sarvimäki, A., Hedelin, B. (2006). Hospitalized older peoples‘ views of health and health promotion. *International Journal of Older people Nursing.* 1, 25-33.

Berg, G.V., Sarvimäki, A. & Hedelin, B. (2010). The diversity and complexity in health promotion and empowerment related to older patients- exploring nurses' reflections. *Vard I Norden*, 95, 30(1), 9-13.

Besdine, R. W., Wetle, T. F. (2010). Improving health for elderly people: an international health promotion and disease prevention agenda. *Aging Clinical and Experimental Research,* 22(3), 219-230.

Bohnsack, R. (2010). *Rekonstruktive Sozialforschung*: *Einführung in qualitative Methoden* (8th ed.). Opladen & Farmington Hill: Barbara Budrich.

Bohnsack, R., Pfaff, N., Weller, W. (2010). *Qualitative analysis and documentary method in international education research.* Opladen & Farmington Hills: Barbara Budrich.

Bohnsack, R., Przyborski, A. & Schäffer, B. (2010). Gruppendiskussion als Methode rekonstruktiver Sozialforschung. In: Bohnsack, R., Przyborski, A., Schäffer, B. (Ed.), *Gruppendiskussionsverfahren in der Forschungspraxis* (pp. 7-22). Opladen & Farmington Hills: Barbara Budrich.

Bohnsack, R., Marotzki, W., & Meuser, M. (2006). *Hauptbegriffe qualitativer Sozialforschung.* Opladen & Farmington Hills: Barbara Budrich.

Borge, L. & Fagermoen, M. S. (2008). Patients‘ core experiences of hospital treatment: Wholeness and self- worth in time and space. *Journal of Mental Health*, 17(2), 193 - 205. doi:10.1080/09638230701505996

Bosch-Capblanch, X., Abba, K., Prictor, M. & Garner, P. Contracts between patients and healthcare practitioners for improving patients' adherence to treatment, prevention and health promotion activities. Cochrane Database of Systematic Reviews 2007, Issue 2. Art. No.: CD004808. doi: 10.1002/14651858.CD004808.pub3.

Breitholz, A., Snellmann, I. & Fagerberg, I. (2013). Older people's dependences on caregivers‘ help in their own homes and their lived experiences of their opportunity to make independent decisions. *International Journal of Older people Nursing,* 8, 139-148. doi: 10.1111/j.1748-3743.2012.00338.x

Brieskorn- Zinke, M. (2003). "Die Rolle der Pflege in Public Health/ Gesundheitsförderung- Versuch einer Systematisierung." *Pflege,* 16, 66-74.

Briesekorn-Zinke, M. (2006). *Gesundheitsförderung in der Pflege. Ein Lehr- und Lernbuch zur Gesundheit.* (3rd ed.). Stuttgart: Kohlhammer.

Broom, A. (2005). Using qualitative interviews in CAM research: A guide to study design, data collection and data analysis. *Complementary Therapies in Medicine,* 13, 65-73. doi:10.1016/j.ctim.2005.01.001

Bundesamt für Gesundheit (BAG). (2016). Bevölkerungsbefragung «*Erhebung Gesundheitskompetenz 2015*»,Schlussbericht. Gfs.Bern. Retrieved from http://www.bag.admin.ch/themen/gesundheitspolitik/00388/02873/index.html

Bundesamt für Statistik (BFS). (2010). Szenarien der Bevölkerungsentwicklung in der Schweiz 2010- 2060. Weiteres Wachstum und markante Alterung der Bevölkerung in den nächsten Jahrzehnten. Neuchatel: Bundesamt für Statistik. Retrieved from https://www.bfs.admin.ch/bfs/en/home/statistics/.../publications.assetdetail.32699.html

Busato, A., & von Below, G. (2010). The implementation of DRG- based hospital reimbursement in Switzerland: a population- based perspective. *Health Research Policy and Systems.* 8, 31. doi: 10.1186/1478-4505-8-31

Büscher, A. & Wagner, L. (2005). *Munich Declaration: Nurses and midwives: A force for health. Analysis of the implementation of the Munich Declaration 2004*. Copenhagen: WHO Regional Office for Europe.

Caelli, K., Downie, J. & Caelli, T. (2003). "Towards a decision support system for health promotion in nursing." *Journal of Advanced Nursing,* 43(2), 170- 180.

Caplan, R. & Holland, R. (1990). Rethinking health education theory for health promotion. *Health Education Journal*, 49 (1), 10-12.

Carvalho, I. P., Pais, V.G., Almeida, S.S., Ribeiro-Silva, R., Figueiredo-Braga, M., Teles, A.,Castro-Vale,I. & Mota-Cardoso, R. (2011). Learning clinical communication skills: Outcomes of a program for professional practitioners. *Patient Education and Counseling* , 84, 84–89. doi:10.1016/j.pec.2010.05.010

Casey, D. (2007a). Findings from non- participant observational data concerning health promoting nursing practice in the acute hospital setting focusing on generalist nurse. *Journal of Clinical Nursing*. 16,580- 592.

Casey, D. (2007b). "Nurses perceptions, understanding and experiences of health promotion." *Journal of Clinical Nursing* 16, 1039 - 1049. doi: 10.1111/j.1365-2702.2006.01640.x

Cavanagh, S., Millar, A. & Mc Lafferty, E. (2007). The recognition and use of patient expertise on a unit for older people. *Nursing Older People*, 19 (8), 31-6, quiz 37. doi: 10.7748/nop2007.10.19.8.31.c6270

Coleman, C. (2011). Teaching health care professionals about health literacy: A review of the literature. *Nursing Outlook*, 59 (2), 70-78.

Creswell, J. W., & Plano, C. V. L. (2011). *Designing and conducting mixed methods research (*2 nd ed.*)*. Los Angeles: SAGE Publications.

Crews, D. E., Zavotka, S. (2006). Aging, disability and frailty. Implications for universal design. *Journal of Physiological Anthropology,* 25, 113-118.

Curtis K., Tzannes A. & Rudge T. (2011) How to talk to doctors – a guide for effective communication. *International Nursing Review,* 58, 13–20.

Day, J. & Bobeva, M. (2005). "A Generic Toolkit for the Successful Management of Delphi Studies". *The Electronic Journal of Business Research Methodology*, 3 (2), 103-116. Retrieved from http:// www.ejbrm.com

DeSilets, L. D., & Dickerson, P. S. (2009). Filling gaps in knowledge: educating nurses to provide appropriate patient materials. *The Journal of Continuing Education in Nursing,* 40(4), 148-149.

DeVilliers, M. R., DeVilliers, P. J. T. & Kent, A. P. (2005). The Delphi technique in health sciences education research. *Medical Teacher*, 27 (7), 639 – 643.

Doenges, M. E., Moorhouse, M. F., & Murr, A. C. (2008). *Nurse's Pocket Guide. Diagnoses, Prioritized Interventions and Rationales* (11 ed.). Philadelphia: F.A. Davis Company.

Duffield, C. (1993). "The Delphi technique: a comparsion of results obtaining using two experts panels." *International Journal of Nursing Studies*, 30(3): 227- 237.

Dykes, P.C., Caroll, D. L., Hurley, A., Lipsitz, S., Benoit, A., Chang, F., Meltzer, S., Tsurikova, R., Zuyov, L. & Middleton, B. (2010). Fall prevention in acute care hospitals: a randomized trial. *Journal of American Medical Association,* 304 (17), 1912-1918.

Eichler, K., Wieser, S., & Brügger, U. (2009). The costs of limitet health literacy: a systematic review. *International Journal of Public Health*, 54, 313-324.doi:10.1007/s00038-009-0058-2

Engles, T. & Kennedy, P. H. (2007). Enhancing a Delphi study on family-focused prevention. *Technological Forecasting and Social Change,* 74 (4), 433-451.

Eriksson, M., Lindstrom, B. (2008). A salutogenic interpretation of the Ottawa Charter. *Health Promotion International*, 23 (2), 190-199.

Ewles, L. & Simnett, I. (2003). *Promoting Health*: a practical guide (5th ed.). Edinburgh: Balliere Tindall.

Fischer, A., Danzon, M. (2000). *Munich Declaration. Nurses and Midwives: A force for health*. World Health Organisation, Geneva.

Flick, U. (2004). *Einführung in die Qualitative Sozialforschung*. Reinbeck bei Hamburg: Rowohlt.

Fourie, C., Biller-Andorno, N. & Wild, V. (2014). Systematically evaluating the impact of diagnosis- related groups (DRGs) on health care delivery: A matrix of ethical implications. *Health policy*, 115, 157-164. doi:10.1016/j.healthpol.2013.11.014

Flory, J. & Emanuel, E. (2004). Interventions to Improve Research Participants' Understanding in Informed Consent for Research: A Systematic Review. *The Journal of the American Medical Association*, 292, 13.

Garbett, R., & McCormack, B. (2001). The experience of practice development: An exploratory telephone interview study. *Journal of Clinical Nursing, 10*, 94–102.

Gesundheitsförderung Schweiz. (2014). Bevölkerung_ Downloads.

Retrieved from http://gesundheitsfoerderung.ch/bevoelkerung/downloads.html

Goodman, C. M. (1987). The Delphi technique: a critique. *Journal of Advanced Nursing*, 12, 729 -734.

Gonçalves-Bradley, D. C., Lannin, N. A., Clemson, L. M., Cameron, I. D. & Shepperd, S. Discharge planning from hospital. Cochrane Database of Systematic Reviews 2016, Issue1. Art.No.:CD000313. doi: 10.1002/14651858.CD000313.pub5.

Gott, M., & O'Brien, M. (1990). "The role of the nurse in health promotion." *Health Promotion International,* 5 (2), 137- 143.

Green, J. (2000). The role of theory in evidence- based health promotion practice. *Health Education Research*, 15(2), 125-129.

Green, L. W. & Kreuter, M.W. (2005). *Health Program Planning: An Educational and Ecological Approach.* (4th ed.). New York: McGraw Hill.

Green, L. W., Kreuter, M. W., Deeds, S. G. & Partridge, K. B. (1980). *Health Education Planning: A Diagnostic Approach.* Mountain View, California: Mayfield.

Grill, K. & Vogt, K. (2015). The case for banning cigarettes. *Journal of Medical Ethics*, 0,1-9. doi: 10.1136/medethics-2015-102682

Groene, O. & Jorgensen, S. J.(2005). Health promotion in hospitals- a strategy to improve quality health care. *European Journal of Public Health*, 15 (1), 6-8. doi:10.1093/eurpub/cki100

Groene, O., Alonso, J. & Klazinga, N. (2010). Development and validation of the WHO self-assessment tool for health promotion in hospitals: results of a study in 38 hospitals in eight countries. *Health Promotion International*, 25 (2), 221-229. doi:10.1093/heapro/daq013

Gschwind, Y. J., Wolf, I., Bridgenbaugh, A. & Kressig, R. W. (2011). Basis for a Swiss perspective on fall prevention in vulnerable older people. *Swiss Medical Weekly*, 141, 1-10. doi:10.4414/smw.2011.13305

Gustafsson, S., Wilhelmson, K., Eklund, K., Gosman-Hedström, G., Zidén, L., Kronlöf, …Dahlin-Ivanoff,S. (2012). Health-promoting interventions for persons aged 80 and older are successful in the short term- results from the randomized and three-armed elderly persons in the risk zone study. *The American Geriatrics Society,* 60, 447-454. doi:10.1111/j.1532-5415.2011.03861.x

Hall, J., Peat, M., Birks, Y., Golder, S., PIPS Group., Entwistle, V., … Wright, J. (2010). Effectiveness of interventions designed to promote patient involvement to enhance safety: a systematic review. *Quality & Safety Health Care*, 19, 1-7. doi:10.1136/qshc.2009.032748

Halldorsdottir, S. (2008). The dynamics of the nurse–patient relationship: Introduction of a synthesized theory from the patient's perspective. *Scandinavian Journal of Caring Sciences*, 22 (4), 643-52. doi: 10.1111/j.1471-6712.2007.00568.x

Häder, M. & Häder, S. (2000). *Die Delphi- Technik in den Sozialwissenschaften*. Wiesbaden: Westdeutscher Verlag.

Häder, M. (2002). *Delphi- Befragungen*. Wiesbaden: Westdeutscher Verlag.

Hasson, F., Keeney, S., & McKeena, H. P. (2000). "Research guidelines for the Delphi survey technique." *Journal of Advanced Nursing*, 32 (4), 1008- 1015.

Heaven, B., Brown, L. J. E., White, M., Erington, l., Mathers, J. C. & Moffatt, S. (2013). Supporting well-being in retirement through meaningful social roles: systematic review of intervention studies. *The Milbank Quaterly*, 91(2), 222-287.

Heinrich, E., DeNooijer, J., Schaper, N.C., Schoonus-Spit, M. H. G., Janssen, M. A. J., & DeVries, N. K. (2012). Evaluation of the web-based diabetes interactive education programme (DIEP) for patients with type 2 diabetes. *Patient Education and Counselling,* 86, 172-178. doi:10.1016/j.pec2011.04.032

Höpflinger, F., & Hugentobler, V. (2003). Pflegebedürftigkeit in der Schweiz- Prognosen und Szenarien für das 21.Jahrhundert. Bern: Hans Huber.

HPH, Health Promoting Hospitals, Retrieved June 23, 2016 from http://www.hphnet.org

Hughes, J. C., Poole, M. & Louw, S. J. (2013). Nudging the older persons into care: an end to the dilemma? *The American Journal of Bioethics*, 13(6), 34-36. doi: 10.1080/15265161.2013.781715

International Council of Nurses (ICN). (2012). The ICN Code of Ethics for Nurses. Geneva, ICN. Retrieved from http://www.icn.ch

Irvine, A. (2012). Duration, Dominance and Depth in Telephone and Face-to-Face Interviews: A Comparative Exploration. *International Journal of Qualitative Methods,* 10 (3).

Irvine, F. (2005). "Exploring district nursing competencies in health promotion: the use of the Delphi technique." *Journal of Clinical Nursing*, 14, 965- 975.

Irvine, F. (2007). Examining the correspondence of theoretical and real interpretations of health promotion. *Journal of Clinical Nursing*. 16, 593- 602.

Istance, D. (2015). Learning in retirement and old age: an agenda for the 21st century. *European Journal of Education*, 50 (2). doi: 10.1111/ejed.12120

Ivankova, N. V., Creswell, J. W., Stick, S. L. (2006). Using mixed methods sequential explanatory design: From theory to practice. *Field Methods*, 18, 3-20.

Janlöv, AK., Hallberg, I.R. & Peterson, K. (2006). Older persons'experience of being assessed for and receiving public home help: do they have any influence over it? *Health and Social Care in the community*, 14(1), 26-36.

Janz, N. K. & Becker, M. H. (1984). The Health Belief Model: a decade later. *Health Education Quaterly,* 11 (1). 1-47.

Jayasekara, R. S. (2012). Focus groups in nursing research: Methodological perspectives. *Nursing Outlook*, 60 (6), 411-416. doi:10.1016/j.outlook.2012.02.001.

Johnson, R. B., Onwuegbuzie, A. J. & Turner, L. A. (2007). Toward a Definition of Mixed Methods Research. *Journal of Mixed Methods Research,* 1(2), 112-133. doi: 10.1177/1558689806298224

Jordan, J.E., Buchbinder, R. & Osborne, R. H. (2010). Health Literacy and Communication: Conceptualising health literacy from the patient perspective. *Patient Education and Counseling*, 79, 36–42 37. doi:10.1016/j.pec.2009.10.001

Kelly, K., Abraham, C. (2007). Health promotion for people aged over 65 in hospitals: nurses' perceptions about their role. *Journal of Clinical Nursing*. 16, 569- 579. doi:10.1111/j.1365-2702.2006.01577.x

Kean, S. (2000). "Focus Group Interviews: Ein qualitativer Forschungsansatz in der Pflege." *Pflege* (13), 145 - 151.

Keeney, S., Hasson, F. & McKenna, H. (2001). "A critical review of the Delphi technique as a reserach methodology for nursing." *International Journal of Nursing Studies,* 38, 195- 200.

Keeney, S., Hasson, F. & McKenna, H. (2006). Consulting the oracle: ten lessons from using the Delphi technique in nursing. *Journal of Advanced Nursing*, 53 (2), 205–212.

Keeney, S., Hasson, F. & McKenna, H. (2011). *The Delphi Technique in Nursing and Health Research*. West Sussex: Wiley-Blackwell.

Kemppainen, V., Tossavainen, K., Turunen, H. (2012). Nurse's role in health promotion practice: an integrative review. *Health Promotion International*, 28 (4). doi:10.1093/heapro/das034.

Kennedy, S., Hardiker, N., & Staniland, K. (2015). Empowerment an essential ingredient in the clinical environment: A review of the literature. *Nurse Education today. 35, 487-492. doi:10.1016/j.nedt.2014.11014*

Koskenniemi, J., Leino- Kilpi, H. & Suhonen, R. (2013). Respect in care of older patients in acute hospitals. *Nursing Ethics*, 20 (1), 5-17. doi:10.1177/0969733012454449

Krueger, R. A. (1998). *Devloping questions for focus groups*. London, New Dehli: Thousand Oaks.

Kvarnstrom S. (2008). Difficulties in collaboration: A critical incident study of interprofessional healthcare teamwork. *Journal of Interprofessional Care*, 22 (2),191–203.

Lamnek, S. (2005). *Gruppendiskussion Theorie und Praxis*. Weinheim, Basel: Beltz.

Landers, M. G. (2000). The theory-practice gap in nursing: the role of the nurse teacher. *Journal of Advanced Nursing*, 32 (6), 1550-1556.

Landeta, J. (2006). Current validity of the Delphi method in social sciences. *Technological Forecasting and Social Change,* 73, 467- 482.

Lapkin, S., Levett-Jones, T., & Gilligan, C. (2013). A systematic review of the effectiveness of interprofessional education in health professional programs. *Nurse Education Today, 33* (2), 90-102. doi:10.1016/j.nedt.2011.11.006

Latter, S. (2001). The potential for health promotion in hospital nursing practice. In *Health Promotion: professional Perspectives*. Basingstoke: Palgrave.

Lavelle, E., Vuk, J. & Barber, C. (2013). Twelve tips for getting started using mixed methods in medical education research. *Medical Teacher*, 35 (4), 272-6. doi: 10.3109/0142159X.2013.759645

Levasseur, M., Richard, L., Gauvin, L. & Raymond, E. (2010). Inventory and analysis of definitions of social participation found in the aging literature: proposed taxonomy of social activities. *Social Science & Medicine*, 71(12), 2141–2149. doi: 10.1016/j.socscimed.2010.09.041

Lindhardt, T., Nyberg, P. & Rahm Hallberg, I. (2008). Collaboration between relatives of elderly patients and nurses and its relation to satisfaction with the hospital care trajectory. *Scandinavian Journal of Caring Sciences*, 22, 507–519. doi: 10.1111/j.1471-6712.2007.00558.x

Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D. & Burke, B. L. (2010). A Meta-Analysis of Motivational Interviewing: Twenty-Five Years of Empirical Studies. *Research on Social Work Practice,* 20 (2). 137-160. doi: 10.1177/1049731509347850

Maben, J. & Macleod Clark, J. (1995). "Health promotion: a concept analysis." *Journal of Advanced Nursing.* 22 (6), 1158 -1165.

Martin, J. S., Ummenhofer, W., Manser, T. & Spirig, R. (2010). Interprofessional collaboration among nurses and physicians: making a difference in patient outcome. *Swiss Medical Weekly*, 1;140:w13062. doi: 10.4414/smw.2010.13062

Marengoni, A., Angleman, S., Melis, R., Mangialasche, F., Karp, A., Garmen, A., … Fratiglioni, L. (2011). Aging with multimorbidity: a systematic review of the literature. *Ageing Research Reviews*, 10, 430- 439.

Markle-Reid, M., Browne, G. & Gafni, A. (2011). Nurse-led health promotion interventions improve quality of life in frail older home care clients: lessons learned from three randomized trials in Ontario, Canada. *Journal of Evaluation in Clinical Practice,* 19, 118- 131. doi: 10.1111/j.1365-2753.2011.01782.x

Mayoh, J., Bond, C.S. & Todres, L. (2012). An innovative mixed method approach to studying the online health information seeking experiences of adults with chronic health conditions. *Journal of Mixed Method Research*, 6 (1), 21-33, doi:10.1177/1558689811416942

Mayring, P. (2002). *Qualitative Sozialforschung*. Weinheim und Basel: Beltz.

Mayring, P.(2010). *Qualitative Inhaltsanalyse*: *Grundlagen und Techniken*. (11th ed.). Beltz: Weinheim und Basel.

McBride, A. (1994). "Health promotion in hospitals: the attitudes, beliefs and practices of hosptal nurses." *Journal of Advanced Nursing* 20, 92-100.

McBride, A. (2004). Health promotion in the acute hospital setting: the receptivity of adult in-patients. *Patient Education and Counselling*, 54, 73-78.

McCray, A. T. (2005). Promoting health literacy. *Journal of the American Medical Informatics Association,* 12(2), 152-163.

McCabe, C. (2004). Nurse–patient communication: an exploration of patients' experiences. *Journal of Clinical Nursing,* 13, 41–49.

McDonald, G., Bunton, R. (2002). Health promotion: disciplinary developments. In R. Bunton, G.Mcdonald (Eds.), *Health Promotion*: *Disciplines, diversities and developments*. (2nd ed.). London: Routledge.

McKeown, F. (2007). The experiences of older people on discharge from hospital following assessment by the public health nurse. *Journal of Clinical Nursing,* 16, 469-476.

McLafferty, J. (2004). Focus group interviews as a data collecting strategy. *Journal of Advanced Nursing*, 48 (2), 187- 194.

Meier, C., Stähli, R. & Szucs,T. (2006) Oekonomischer Nutzen und Kosten populationsbezogener Prävention und Gesundheitsförderung. *Gesundheitsökonomie & Qualitätsmanagement*, 11, 168–175. doi: 10.1055/s-2005-858850

Meraviglia, M., Stuifbergen, A., Parsons, D. & Morgan, S. (2013). Health promotion for cancer survivors: adaption and implementation of an intervention. *Holistic Nursing Practice,* 27 (3), 140.147. doi:10.1097/HNP.0b013e3182a0988

Miller, T. A. (2016). Health literacy and adherence to medical treatment in chronic and acute illness: A meta-analysis. *Patient Education and Counselling*, 99, 1079–1086. doi:10.1016/j.pec.2016.01.020

Miller, W. R. & Rollnick, S. (2012). *Motivational Interviewing: Preparing People for Change*. (3rd ed.). New York: Guilford.

Mody, L., Miller, D. K., McGloin, J. M., Freeman, M., Marcantonio, E. R. , Magaziner, J.& Studenski, S. (2008).Recruitment and Retention of Older Adults in Aging Research. *Journal of the American Geriatrics Society,* 56 (12), 2340–2348. doi:10.1111/j.1532-5415.2008.02015.x.

Moher, M., Yudkin, L., Wright, L., Turner, R., Fuller, A., Schofield, T. & Mant, D. (2001). Cluster randomised controlled trial to compare three methods of promoting secondary prevention of coronary heart disease in primary care. *British Medical Journal,* 322, 1-7.

Morey, M. C., Snyder, D. S, Sloane, R., Cohen, H. J., Peterson, B., Hartman. J., Diane C., …Demark-Wahnefried, W. (2009). Effects of Home-Based Diet and Exercise on Functional Outcomes Among Older, Overweight Long-Term Cancer Survivors: The RENEW: Randomized Clinical Trial. *The Journal of the American Medical Association,* 13, 301(18), 1883–1891. doi:10.1001/jama.2009.643

Mullan, B.A. & Kothe ,E. J.(2010). Evaluating a nursing communication skills training course: The relationships between self-rated ability, satisfaction, and actual performance. *Nurse Education in Practice,* 10, 374-378. doi:10.1016/j.nepr.2010.05.007

Murchie, P., Campbell, N.C., Ritchie, L. D., Simpson, J. A. & Thain, J. (2003). Secondary prevention clinics for coronary heart disease: four year follow up of a randomised trial in primary care. *British Medical Journal,* 326, 1-6.

Murphy, B. M., Elliott, P. C., LeGrande, M. R., Higgins, R. O., Ernest, C. S., Goble, A. J., …Worcester, M.U. (2008). Living alone predicts 30-day hospital readmission after coronary artery bypass graft surgery. *European Journal of Cardiovascular Prevention and Rehabilitation,*15 (2), 210-5. doi: 10.1097/HJR.0b013e3282f2dc4e

Naidoo, J. and J. Wills (2009). *Foundations of Health Promotion*: *Public Health and Health Promotion Practice.* (3rd ed.). London: Ballière Tindal.

Nancarrow, S. A., Booth, A., Ariss, S., Smith, T., Enderby, P. & Roots, A. (2013). Ten principles of good interdisciplinary team work. *Human Resources for Health*, 11,19. doi:10.1186/1478-4491-11-19

Neidrick, T. J., Fick, D. M. & Loeb, S. M. (2012). Physical activity promotion in primary care targeting the older adult. *Journal of the American Academy of Nurse Practitioners,* 24, 405- 416. doi:10.1111/j.1745-7599.2012.00703.x

Nutbeam, D. (1998). Evaluating health promotion- progress, problems and solutions. *Health Promotion International*, 13 (1), 27-44.

Nutbeam, D. (1996). Health outcomes and health promotion: defining success in health promotion. *Health Promotion Journal of Australia, 6, 58 -60.*

Nutbeam, D. (2000).Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International*, 15 (3), 259- 267. doi:10.1093/heapro/15.3.259

Nyqvist, F., Cattan, M., Andersson, L., Forsman, A. K. & Gustafson, Y. (2013). Social capital and loneliness among the very old living at home and in institutional settings: A comparative study. *Journal of Aging and Health*, 25 (6), 1013-1035. doi:10.1177/0898264313497508

O'Hagan, S., Manias, E., Elder, C., Pill, J., Woodward-Kron, R., McNamara, T., … McColl, G. (2 0 1 4). What counts as effective communication in nursing? Evidence from nurse educators' and clinicians' feedback on nurse interactions with simulated patients. *Journal of Advanced Nursing*, 70 (6), 1344– 1356. doi: 10.1111/jan.12296

Onwuegbuzie, A. J. & Johnson, R. B. (2006). The Validity Issue in Mixed Reseach. *Reserach in the Schools,* 13 (1), 48 -63.

Pender, N., Murdaugh, C. L., Parsons, M. A. (2006). *Health Promotion in Nursing Practice.* (5th ed.). Upper Saddle River, New Jersey: Pearson- Prentice Hall.

Perna, L., Mielck, A., Lacruz, M.E., Emeny, R.T., Holle, R., Breitfelder, A. & Ladwig, K.H. (2012). Socioeconomic position, resilience, and health behaviour among elderly people. *International Journal of Public Health*, 57, 341-349. doi:10.1007/s00038-011-0294-0

Peerson, A. & Saunders, M. (2009). Health literacy revisited: what do we mean and why does it matter? Debate. *Health Promotion International*, 24 (3), 285- 296. doi:10.1093/heapro/dap014

Perrig- Chiello, P., Höpflinger, F.,& Schnegg, B.(2010). Pflegende Angehörige von älteren Menschen in der Schweiz. Forschungs - Schlussbericht. SwissAgeCare-2010.

Phillips, J. L., Rolley, J. X. & Davidson, P. M. (2012). Developing Targeted Health Service Interventions Using the PRECEDE-PROCEED Model: Two Australian Case Studies, *Nursing Research and Practice*, 279431. doi:10.1155/2012/279431

Piper, S. (2008). A qualitative study exploring the relationship between nursing and health promotion language, theory and practice. *Nurse Education Today*, 28, 186- 193.

Piper, S. (2009). *Health Promotion for nurses*: theory and practice. (1st ed.). London: Routledge.

Pluye, P. & Hong, Q. N. (2014). Combining the power of stories and the power of numbers: mixed methods research and mixed studies reviews. *The Annual Review of Public Health,* 35, 29.45. doi: 10.1146/annurev-publhealth-032013-182440

Posadzki, P., Mastellos, N., Ryan, R., Gunn, L. H., Felix, L. M., Pappas, Y., …Car, J. (2016). Automated telephone communication systems for preventive healthcare and management of long-term conditions. *Cochrane Database of Systematic Reviews* 12, *CD009921. doi: 10.1002/14651858.CD009921.pub2.*

Polit, D. F., & Beck, C.T. (2006). *Essentials of Nursing Research*: methods, appraisal and utilisation. (6th ed.). Philadelphia: Lippincott Williams &Wilkins.

Polit, D.F., & Beck, C.T. (2012). *Nursing Research*: *Generating and Assessing Evidence for Nursing Practice*. (9th ed.). Philadelphia: Wolters Kluwer Health, Lippincott Williams &Wilkins.

Povlsen, L., & Borup, I. K. (2011). Holism in nursing and health promotion: distinct or related perspectives? - A literature review. *Scandinavian Journal of Caring Sciences*, 25, 798- 805. doi:10.1111/j. 1471-6712.2011.00885.x

Price, R. S. & Keady, J. (2010), Systematic review: role of health promotion in vascular dementia. *Journal of Nursing and Healthcare of Chronic Illness*, 2, 88–101. doi:10.1111/j.1752-9824.2010.01053.x

Prochaska, J.O., & DiClemente, C. C. (1984). *The Transtheoretical Approach: Crossing Traditional Bounderies of Therapy*. Homewood, Illinois: Dow Jones Irwin.

Przyborski, A. (2004). *Gesprächsanalyse und dokumentarische Methode*. Wiesbaden: VS Verlag für Sozialwissenschaften.

Rawson, D. (2002). "The growth of health promotion theory and its rational reconstruction: lessons from the philosophy of science". In Bunton, R. & Macdonald, G. (eds). *Health Promotion: Disciplines, diversity and developments*, (2nd ed.). London: Routledge.

Reichel, K., Dietsche, S., Hölzer, H. & Ewers, M. (2016). Interprofessional peer-assisted learning as a low-threshold course for joint learning: Evaluation results of the interTUT Project. *GMS Journal for Medical Educucation,* 33 (2), Doc30. doi: 10.3205/zma001029

Resnick, B. (2003). Health promotion practices of older adults: testing an individual approach. *Journal of Clinical Nursing*, 12, 46-55.

Rettke, H, Frei, I. A., Horlacher, K., Kleinknecht-Dolf, M., Spichiger, E. & Spirig, R. (2015). Pflege im Vorfeld von Swiss DRG – Erfahrungen von Pflegenden mit interprofessioneller Zusammenarbeit, Führungsverhalten, Arbeitslast und Arbeitszufriedenheit. *Pflege,* 28 (3), 133–144. doi: 10.1024/1012-5302/a000421

Rogers, E.M. (1983). *Diffusion of Innovations*, (3rd ed.). New York: Free Press.

Roter, D. L. (2011). Oral literacy demand of health care communication: Challenges and solutions. *Nursing Outlook*, 59 (2), 79-84.

Rygg, L. O., Rise, M.B., Gronning, K. & Steinsbekk, A. (2011). Efficacy of ongoing group based diabetes self-management education for patients with type 2 diabetes mellitus: A randomised trial. *Journal of Patient Education and Counselling*, 86, 98-105. doi:10.1016/j.pec.2011.04.008

Saxton, R., Hines, T. & Enriquez, M. (2009). The Negative Impact of Nurse-Physician Disruptive Behavior on Patient Safety: A Review of the Literature. *Journal of Patient Safety*, 5(3), 180-183. doi: 10.1097/PTS.0b013e3181b4c5d7

Schelling, H. R. & Seifert, A. (2010).Internet-Nutzung im Alter.Gründe der (Nicht-)Nutzung von Informations- und Kommunikationstechnologien (IKT)durch Menschen ab 65 Jahren in der Schweiz. *Zürcher Schriften zur Gerontologie***,** 7, Universität Zürich, Zentrum für Gerontologie.

Saarikoski, M., Warne, T., Kaila,P. & Leino-Kilpi, H. (2009). The role of the nurse teacher in clinical practice: An empirical study of Finnish student nurse experiences. *Nurse Education Today*, 29, 595–600. doi:10.1016/j.nedt.2009.01.005

Saylor, C. (2004). The circle of health: A health definition model. *Journal of Holistic Nursing*, 22: 97- 115

Schreier, M. (2012). *Qualitative analysis in practice*. London: SAGE publications.

Schweizerische Akademie der Medizinischen Wissenschaften, SMAW (2016). Patienten und Angehörige beteiligen. Swiss Academies Communications 11(10).

Seedhouse, D. (2004). *Health Promotion*: philosophy, prejudice and practice. Chichester: Wiley.

Sequeira, S. S., Eggermont, H. P., Silliman, R. A., Bickmore, L. E., Winter, M. R., Nelson, K. & Paasche- Orlow, M. K. (2013). Limited health literacy and decline in executive function in older adults. *Journal of Health Communication*: *International Perspectives*, 18, sup 1, 143-157. doi: 10.1080/10810730.2013.825673

Shariff-Ghazali, S., Browning, C. & Shajahan, Y. (2013). Interventions to promote physical activity in older people with type 2 diabetes mellitus: a systematic review. *Frontiers in Public Health,* 1 (71), 1-13. doi:10.3389/fpubh.2013.00071

Shoqirat, N. & Cameron, S. (2013). A qualitative study of hospital patient's understanding of health promotion. *Journal of Clinical Nursing*, 22, 2714- 2722. doi: 10.1111/jocn.12212.

Simek, E. M., McPathe, L. & Haines, T. P. (2012). Adherence to an efficacy of home exercise programs to prevent falls: A systematic review and meta-analysis of the impact of exercise program characteristics. *Preventive Medicine*, 55, 262-275. doi:10.1016/j.ypmed.2012.07.007

Scully, N. J. (2011). The theory-practice gap and skill acquisition: An issue for nursing education. *Collegian*, 18, 93—98. doi:10.1016/j.colegn.2010.04.002

Smith, B. J.,Tank, K. C. & Nutbeam, D. (2006). WHO Health Promotion Glossary: new terms. *Health Promotion International*, 21(4), 340-345.

Spichiger, E., Kesselring, A., Spirig, R., De Geest, S. und die Gruppe „Zukunft Medizin Schweiz" der SAMW (Schweizerische Akademie der Medizinischen Wissenschaften) (2006). Professionelle Pflege – Entwicklung und Inhalte einer Definition. *Pflege*, (19), 45-51.

SurveyMonkey ®. Retrieved from https://de.surveymonkey.com

Schweizerische Akademie der Medizinischen Wissenschaften, SAMW (2016).Patienten und Angehörige beteiligen. *Swiss Academies Communications* 11(10).

Swiss statistics, Federal Administration, admin.ch, population- key figures. Retrieved from http://www.bfs.admin.ch/bfs/portal/en/index/themen/01/01/key.html

Tamariz, L., Placio, A., Robert, M. & Marcus, E.N. (2013) Improving the Informed Consent Process for Research Subjects with Low Literacy: A Systematic Review. *Journal of General Internal Medicine,* 28(1), 121–6. doi: 10.1007/s11606-012-2133-2

Tao, H., Ellenbecker, CH., Chen, J., Zhan, L. & Dalton, J. (2012). The Influence of Social Environmental Factors on rehospitalisation among Patients receiving home health care services. *Advances in Nursing Science*, 35 (4), 346–358. doi: 10.1097/ANS.0b013e318271d2ado

Thurston, W. E., Cove, L., & Meadows, L. M. (2008). Methodological congruence in complex and collaborative mixed method studies.*International Journal of Multiple Research Approaches*, 2, 2–14. doi:10.5172/mra.455.2.1.2

Tones, K. & Tilford, S. (2001). *Health Promotion*: effectiveness, efficiency and equity (3rd ed.), London: Nelson Thornes.

Tramm, R., McCarthy, A. & Yates, P. (2012). Using the Precede–Proceed Model of Health Program Planning in breast cancer nursing research. *Journal of Advanced Nursing*, 68: 1870–1880. doi: 10.1111/j.1365-2648.2011.05888.x

Twinn, S. & Diana, L. (1997). "The practice of health education in acute carer settings in Hong Kong: and exploratory study of the contribution of registered nurses." *Journal of Advanced Nursing*, 25: 178- 185.

Van Nes, F., Abma, T., Jonsson, H. & Deeg, D. (2010). Language differences in qualitative research: is meaning lost in translation? *European Journal of Ageing,* 7:313–316, doi 10.1007/s10433-010-0168-y.

Voelcker-Rehage, C. (2008). Motor-skill learning in older adults-studies on age-related differences. *European Review Ageing and Physival Activity*, 5 (1), 5-16. doi: 10.1007/s11556-008-0030-9

Weaver, F., Jaccard Ruedin, H., Pellegrini, S. & Jeanrenand, C. (2008). Kostenentwicklung der Langzeitpflege von heute bis zum Jahr 2030 in der Schweiz. Neuchâtel: Schweizerisches Gesundheitsobservatorium (OBSAN).

Webb, B. (2002). Using focus groups as a reserach method: a personal experience. *Journal of Nursing Management,* 10, 27-35.

Whitehead, D. (2003). Evaluating health promotion: a model for nursing practice. *Journal of Advanced Nursing,* 41 (5), 490- 498.

Whitehead, D. (2004). "Health promotion and health education: advancing the concepts." *Journal of Advanced Nursing,* 47(3), 311- 320.

Whitehead, D. (2005). Health promoting hospitals: the role and function of nursing. *Journal of Clinical Nursing*, 14, 20-27.

Whitehead, D. (2006). Health promotion in the practice setting: findings from a review of clinical issues. *Worldviews on Evidence- Based Nursing*, 3, 165- 184.

Whitehead, D. (2007). Reviewing health promotion in nursing education. *Nurse Education Today*, 27, 225- 237.

Whitehead, D. (2008). "An international Delphi study examining health promotion and health education in nursing practice, education and policy." *Journal of Clinical Nursing,* 17, 891- 900.

Whitehead, D. (2009). Reconciling the differences between health promotion in nursing and 'general' health promotion. *International Journal of Nursing Studies*, 46 , 865–874. doi:10.1016/j.ijnurstu.2008.12.014

Whitehead, D. (2010).Health promotion in nursing: a Derridean discourse analysis. *Health Promotion International*, 26 (1). doi:10.1093/heapro/daq073.

Whitehead, D., Irvine, F. (2011). Ottawa 25+ -" All aboard the Dazzling Bandwagon"- developing personal skills:what remains for the future? *Health Promotion International,* 26 (52). doi:10.1093/heapro/dar072.

WHO, World Health Organisation (1986). Health Promotion Concepts and Principles in Action: a policy framework. World Health Regional Office for Europe, Copenhagen.

WHO, World Health organization (2000). Munich Declaration : Nurses and Midwifes : a force for health. WHO Regional Office for Europe, Copenhagen.

WHO, World Health Organization (2004). Standards for Health Promotion in Hospitals. WHO Regional Office for Europe, Copenhagen. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0006/99762/e82490.pdf

WHO, World Health Organization (2005). Update of the Health Promotion Glossary, WHO, Geneva.

WHO, World Health Organization. (2006) Implementing health promotion in hospitals: manual and self-assessment forms. WHO Regional Office for Europe, Copenhagen. Retrieved from http://www.euro.who.int/document/E88584.pdf unpublished observations.

WHO, World Health Organization. Health statistics and health information systems. Retrieved from http://www.who.int/healthinfo/en.

WHO, World Health Organization, Merkur,S., Sassi, F. & McDaid, D. (2013) Promoting health, preventing disease: is there an economic case? WHO Regional Office for Europe, Copenhagen. Permisson to quote received 16.8.2016

Wieser, S., Kauer, L., Schmidhauser, S., Pletscher, M., Brügger, U., … Jeanrenaud, C. (2010). Synthesebericht – Ökonomische Evaluation von Präventionsmassnahmen in der Schweiz: Bericht im Auftrag des Schweizerischen Bundesamtes für Gesundheit. Winterthur

Wilson, D. M. & Palha, P. (2007). A systematic review of published research articles on health promotion at retirement. *Journal of Nursing Scholarship*, 39 (4), 330-337.

Wilson, J. (2008). Bridging the theory- practice gap. *Australian Nursing Journal, 16* (4), 25-25.

Yamada, T., Chen, C.-C., Murata, C., Hirai, H., Ojima, T., Kondo, K., & Harris, J. R. (2015). Access Disparity and Health Inequality of the Elderly: Unmet Needs and Delayed Healthcare. *International Journal of Environmental Research and Public Health*, *12* (2), 1745–1772. doi.org/10.3390/ijerph120201745

Zamora, H. & Clingerman, E. M. (2011). Health literacy among older adults: A systematic review. *Journal of Gerontological Nursing*, 37 (10), 41-51. doi:10.3928/00989134-20110503-02

Zwarenstein M, Goldman J, Reeves S. Interprofessional collaboration: effects of practice-based interventions on professional practice and healthcare outcomes. Cochrane Database of Systematic Reviews 2009, Issue 3. Art. No.: CD000072. doi: 10.1002/14651858.CD000072.pub2.

12 LIST OF FIGURES

13 LIST OF TABLES

Appendix

14 APPENDIX

14.1 Nursing Studies

Delphi study with health care experts

Questionnaire (translated to English by the author)

Table 18. Questionnaire Delphi Study part 1

What is your opinion about the meaning of health promotion by nurses for older persons (65+) at the acute hospital setting? ***Welche Bedeutung hat das Thema "Gesundheits-förderung durch die Pflege bei älteren Menschen (+65 Jahre) im akut Spital" Ihrer Meinung nach?***	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Health promotion for older persons is a part of nursing	O	O	O	O	O
Health promotion by nurses for older persons, is of prime importance in the daily clinical life	O	O	O	O	O
Health promotion is performed interdisciplinary	O	O	O	O	O
Nurses are mostly unaware of performing health promotion	O	O	O	O	O
Health promotion is performed at the same time as prevention / prophylaxis	O	O	O	O	O
Empowerment is of low meaning in nursing for older patients	O	O	O	O	O

Table 18. Continued

Health promotion by nurses for older persons at the acute hospital is of low meaning, because: **Im akut Spital hat die Gesundheitsförderung (GF) durch die Pflege bei älteren Menschen wenig Bedeutung, da:**	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The medical diagnoses are treated and the patient are discharged without any further investigations	O	O	O	O	O
The medical diagnoses are treated and the social situation of the patient are not considered	O	O	O	O	O
The medical diagnoses are treated and the patient are discharged and transferred to external services without any further investigations	O	O	O	O	O
The missing time resources'	O	O	O	O	O
The missing knowledge of nurses to implement health promotion interventions	O	O	O	O	O
The missing skills of nurses to implement health promotion interventions	O	O	O	O	O
The medical diagnoses are treated and there is no more time left	O	O	O	O	O
The missing mandate for health promotion (costs are not covered)	O	O	O	O	O
The missing infrastructure	O	O	O	O	O
Many nurses do not pay attention to health promotion	O	O	O	O	O

Table 18. Continued

Health promotion by nurses for older persons at the acute hospital is of low meaning, because: **Im akut Spital hat die Gesundheitsförderung (GF) durch die Pflege bei älteren Menschen wenig Bedeutung, da:**	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Due to the heavy workload health promotion is not of priority	O	O	O	O	O
The missing guidelines for health promotion in the acute hospital setting	O	O	O	O	O
Missing documentation for health promotion activities	O	O	O	O	O
Missing interdisciplinary team work at the hospital	O	O	O	O	O
Missing interdisciplinary team work with external health care services	O	O	O	O	O
The challenge of sustainability of health promotion	O	O	O	O	O
Discharge documents do not have any information about health promotion activities	O	O	O	O	O

Health promotion by nurses for older persons at the acute hospital is of high meaning, because: ***Gesundheitsförderung durch die Pflege bei älteren Menschen im akut Spital hat eine hohe Bedeutung, da***	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The older population can be addressed during their hospitalisation	O	O	O	O	O
The patients are forced to think about health	O	O	O	O	O

Table 18. Continued

Health promotion by nurses for older persons at the acute hospital is of high meaning, because:	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The patients are thinking about their health and consider advise	O	O	O	O	O
Health promotion is efficient as nurses have a good relationship toward the older persons	O	O	O	O	O
During the hospitalisation new problems may be detected	O	O	O	O	O
Nurses can influence the patient health behaviour	O	O	O	O	O
Nurses can inform about health behaviour change to improve quality of life	O	O	O	O	O
Especially at old age health promotion is very important	O	O	O	O	O
High meaning is due to well-known examples in the past	O	O	O	O	O
Health promotion by nurses for older persons at the acute hospital will be of reduced meaning in the near future, because: ***Das Thema der Gesundheitsförderung durch die Pflege bei älteren Menschen im akut Spital wird in naher Zukunft an Bedeutung verlieren. Die abnehmende Bedeutung ist bedingt durch:***	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The missing mandate for nurses' health promotion	O	O	O	O	O
The cost of health promotion activities are not covered	O	O	O	O	O
Introduction of the DRG, no more health promotion activities can be implemented	O	O	O	O	O

Table 18. Continued

Health promotion by nurses for older persons at the acute hospital will be of reduced meaning in the near future, because:	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Short hospitalisation of the older patients	O	O	O	O	O
Discharge of the patients with short notice	O	O	O	O	O
The increase of meaning of health promotion at external health care services	O	O	O	O	O

The meaning of health promotion by nurses for older persons at the acute hospital will increase in the near future, because: ***Die zunehmende Bedeutung der "Gesundheitsförderung durch die Pflege bei älteren Menschen (+65 Jahre) im akut Spital" ist bedingt durch:***	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The requirements of the older persons	O	O	O	O	O
The requirements of the relatives of older persons	O	O	O	O	O
Health education can reduce rehospitalisation	O	O	O	O	O
For older persons, being hospitalised is one of the few possibilities for health promotion	O	O	O	O	O
The increase of life expectation, the age of 65 is still young	O	O	O	O	O
The increase of mental health and health promotion at the acute hospital setting	O	O	O	O	O
The changing process of the meaning of health promotion in daily life	O	O	O	O	O
The changing demographic situation in the future	O	O	O	O	O

Table 18. Continued

The meaning of health promotion by nurses for older persons at the acute hospital will increase in the near future, because:	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The increasing number of older persons with chronic diseases	O	O	O	O	O
The increase of requirements by older persons	O	O	O	O	O
The missing nursing homes placements in the future	O	O	O	O	O
The reduction of nursing home admissions due to self-care deficits	O	O	O	O	O
The reduction of health care costs by health promotion	O	O	O	O	O
The reduction of health care costs by the improvement of the vitality of the older persons	O	O	O	O	O

The meaning of health promotion by nurses for older persons at the acute hospital will increase in the near future, because: ***Die zunehmende Bedeutung der "Gesundheitsförderung durch die Pflege bei älteren Menschen (+65 Jahre) im akut Spital" ist bedingt durch:***	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Health promotion will be integrated at the DRG and costs will be covered	O	O	O	O	O
A recent study proved the economic cost efficacy of health promotion	O	O	O	O	O

Table 19. Questionnaire Delphi Study part 2

What are the knowledge, attitudes and skills, fundamental to and what are the resources needed and the barriers encountered to perform the role of a health promoting nurse for the older persons in an acute hospital setting?

Welche Kenntnisse, Wissen, Einstellungen, Verhaltensweisen und Fertigkeiten braucht das Pflegepersonal, um die Rolle der Pflege in der Gesundheitsförderung (GF) bei älteren Menschen (+65) im akut Spital aus zu führen? Und welches sind die Ressourcen und die Hindernisse? Es braucht folgendes Wissen und folgende Kenntnisse des Pflegepersonals:

The knowledge needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting are?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Additional knowledge about physiology and pathophysiology	O	O	O	O	O
Additional knowledge about chronic diseases of older persons	O	O	O	O	O
Expertise in gerontology	O	O	O	O	O
Additional knowledge of the ageing process	O	O	O	O	O
Knowledge about health promotion for older persons	O	O	O	O	O
Knowledge of health promotion concepts	O	O	O	O	O
Knowledge about health behaviour	O	O	O	O	O
Knowledge about risk behaviours of older persons	O	O	O	O	O
Salutogenic knowledge	O	O	O	O	O
Knowledge about the demographic changes	O	O	O	O	O
Knowledge of health indicators	O	O	O	O	O
Basic knowledge of sociology	O	O	O	O	O

Table 19. Continued

The knowledge needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting are?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Knowledge of the Swiss health system	O	O	O	O	O
Knowledge of the health economics	O	O	O	O	O
Knowledge of interdisciplinary management	O	O	O	O	O
Additional pedagogic knowledge	O	O	O	O	O
Basic knowledge of counselling	O	O	O	O	O
Knowledge of the various social institutions	O	O	O	O	O
Knowledge of self-support groups	O	O	O	O	O
Knowledge of aids materials	O	O	O	O	O
Basics of holistic nursing	O	O	O	O	O
Basics of kinaesthetic	O	O	O	O	O

The attitudes and behaviour needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting are?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The Interest of the patient health behaviour	O	O	O	O	O
The Interest to assess the patient health behaviour	O	O	O	O	O
Conviction that old age does not assume bad quality of life	O	O	O	O	O
Empowerment of the older persons	O	O	O	O	O

Table 19. Continued

The attitudes and behaviour needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting are?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Resources orientated behaviour	O	O	O	O	O
Conviction of the meaningfulness of health promotion	O	O	O	O	O
Being old does not go along with being sick	O	O	O	O	O
Autonomy	O	O	O	O	O
Appreciation	O	O	O	O	O
Empathy	O	O	O	O	O
Respect	O	O	O	O	O
Participation	O	O	O	O	O
Patience	O	O	O	O	O
Motivation	O	O	O	O	O
Openness	O	O	O	O	O
Patient centered nursing	O	O	O	O	O
Awareness of the individuality of the older persons	O	O	O	O	O
System theory orientated nursing	O	O	O	O	O
Family orientated nursing	O	O	O	O	O

Table 19. Continued

The needed skills to perform the role of a health promoting nurse for the older persons in an acute hospital setting are?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Additional communication skills	O	O	O	O	O
Able to lead a professional conversation	O	O	O	O	O
Active listening	O	O	O	O	O
Implement patient education	O	O	O	O	O
Establishing a relationship	O	O	O	O	O
Providing confidence	O	O	O	O	O
Counselling	O	O	O	O	O
Assessment skills	O	O	O	O	O
Management skills	O	O	O	O	O
Capability to work interdisciplinary	O	O	O	O	O
Skills to act guided by perceptions	O	O	O	O	O
Proficiency to implement the health promotion interventions	O	O	O	O	O
Support the activities of the daily life	O	O	O	O	O
Support the use of aids materials	O	O	O	O	O
Reflection of the nurses' own role	O	O	O	O	O
Implement the theory into practice	O	O	O	O	O

Table 19. Continued

The resources needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting are?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Plan of care	O	O	O	O	O
Nursing diagnosis	O	O	O	O	O
To be closed to the patient	O	O	O	O	O
Team discussions about health promotion	O	O	O	O	O
Time resources	O	O	O	O	O
Interdisciplinary team	O	O	O	O	O
Interdisciplinary team meetings	O	O	O	O	O
The new developed Nursing study programs	O	O	O	O	O
Additional nursing training programs	O	O	O	O	O
Nurses' expertise	O	O	O	O	O
Academic degrees of nurses	O	O	O	O	O
Self-confident nurses	O	O	O	O	O
Aids materials	O	O	O	O	O
Information brochures	O	O	O	O	O
Resources of the patients	O	O	O	O	O
Resources of relatives of the patients	O	O	O	O	O
Oecogram of the family centred nursing model	O	O	O	O	O

Table 19. Continued

The barriers to perform the role of a health promoting nurse for the older persons in an acute hospital setting are?	strongly agree	agree	undecided	disagree	strongly disagree
Heavy workload/ no time	O	O	O	O	O
Stress	O	O	O	O	O
Shortage of staff	O	O	O	O	O
Missing scope of health promotion activity by nurses	O	O	O	O	O
Missing definition of nurses health promotion competencies	O	O	O	O	O
Missing health promotion knowledge	O	O	O	O	O
Missing interest of working with older persons	O	O	O	O	O
The negative perceptions of older persons	O	O	O	O	O
The anxiety of older persons	O	O	O	O	O
The strict rules of processes in the daily clinical work	O	O	O	O	O
Diagnosis related groups (DRG)	O	O	O	O	O
The missing mandate for health promotion by nurses	O	O	O	O	O
Economic reasons	O	O	O	O	O
The barriers to perform the role of a health promoting nurse for the older persons in an acute hospital setting are? continued	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Short hospitalisation of older patients	O	O	O	O	O
Missing additional training for nurses	O	O	O	O	O

Table 19. Continued

The barriers to perform the role of a health promoting nurse for the older persons in an acute hospital setting are? continued	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Missing assessment	O	O	O	O	O
Missing assessment instruments	O	O	O	O	O

The barriers to perform the role of a health promoting nurse for the older persons in an acute hospital setting are?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Missing knowledge about the patient social situation	O	O	O	O	O
Missing health promotion culture at the institution (hospital)	O	O	O	O	O
Missing acceptance by the patients	O	O	O	O	O
Missing understanding of the patients	O	O	O	O	O
Missing health promotion guidelines	O	O	O	O	O
Health promotion is not trendy	O	O	O	O	O

Table 20. Questionnaire Delphi Study part 3

What are the essential differences related to health promotion for the older persons regarding the gender management?

Welches sind entscheidende Unterschiede in der Gesundheitsförderung (GF) für ältere Menschen im Fokus der Ge-schlechterfragen? (Gender bedeutet: Gesellschaftlich, sozial und kulturell geprägte Geschlechterrollen von Frauen und Männern. Im Gegensatz zum biologischen Geschlecht sind die Geschlechterrollen sozial erlernt und somit veränderbar.) Welches Wissen ist für das Pflegepersonal erforderlich um der Rolle der Pflege in Gesundheitsförderung im Fokus der Geschlechterfrage gerecht zu werden! Welches sind die entscheidenden Unterschiede? Es braucht folgendes Wissen und folgende Kenntnisse:

In regards to the essential differences of the gender management: What is the knowledge needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Knowledge about the different health comprehension of men and women	O	O	O	O	O
Knowledge of gender related health behaviour	O	O	O	O	O
Knowledge about gender specific interventions	O	O	O	O	O
Knowledge about gender specific health indicators	O	O	O	O	O
Knowledge about gender specific anatomy and physiology	O	O	O	O	O
Knowledge about gender specific demographic developments	O	O	O	O	O
Awareness about the increase of isolation of older women	O	O	O	O	O
Awareness about the increase of isolation of older men	O	O	O	O	O
Knowledge about the gender specific biography of the patients	O	O	O	O	O
Knowledge about social and cultural gender differences	O	O	O	O	O
Knowledge of the gender specific roles in a family	O	O	O	O	O

Table 20. Continued

In regards to the essential differences of the gender management: What is the knowledge needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Knowledge about gender specific problems	O	O	O	O	O
Knowledge about the changing gender roles in the society	O	O	O	O	O
Knowledge of the history, lived by the older generation	O	O	O	O	O
Facts and knowledge is more relevant for men	O	O	O	O	O
Sympathy and feelings are more relevant for women	O	O	O	O	O
Men are less interested to learn something	O	O	O	O	O
Men leave the responsibility to their spouse	O	O	O	O	O
Knowledge about the gender specific nursing diagnosis	O	O	O	O	O
Knowledge about the gender specific communication	O	O	O	O	O

In regards to the essential differences of the gender management: What are the attitudes and behaviour needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Openness towards specific gender questions	O	O	O	O	O
Interest towards specific gender questions	O	O	O	O	O
Understanding of gender questions	O	O	O	O	O
Sensibility of specific gender problems	O	O	O	O	O

Table 20. Continued

In regards to the essential differences of the gender management: What are the attitudes and behaviour needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Reflection about the gender role	O	O	O	O	O
Acceptance of the gender differences	O	O	O	O	O
Respect of the gender roles	O	O	O	O	O
Respect for a person's own attitude	O	O	O	O	O
Respect of the gender roles in the families	O	O	O	O	O
Awareness of no gender differences	O	O	O	O	O
In regards to the essential differences of the gender management: What are the skills needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Gender specific communication skills	O	O	O	O	O
Gender specific assessment skills	O	O	O	O	O
Interventions in regards to gender specific requirements	O	O	O	O	O
Implementation of the gender specific knowledge	O	O	O	O	O

Table 20. Continued

In regards to the essential differences of the gender management: What are the resources needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The nurses interest in gender topics	O	O	O	O	O
Male nurses should be responsible for male patients	O	O	O	O	O
The majority of female nurses due to the majority of female patients	O	O	O	O	O
The actuality of gender specific topics	O	O	O	O	O
The gender specific competencies of nurses	O	O	O	O	O
Team discussions about gender topics	O	O	O	O	O
Cooperation with the patient relatives	O	O	O	O	O
Gender specific networks	O	O	O	O	O
Women are more available for discussions	O	O	O	O	O
Men are more interested in physical activities	O	O	O	O	O
Nurses do have the possibilities to discuss gender topics with patients	O	O	O	O	O

In regards to the essential differences of the gender management: What are the barriers to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The given structures at the hospital	O	O	O	O	O
In nursing there is an existing gender bias (more female)	O	O	O	O	O
Male nurse are less attractive in society	O	O	O	O	O

Table 20. Continued

In regards to the essential differences of the gender management: What are the barriers to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The value of a woman in the Swiss society	O	O	O	O	O
Missing knowledge about gender specific topics	O	O	O	O	O
Missing scientific literature about gender topics in nursing	O	O	O	O	O
Social structures	O	O	O	O	O
The specific role of man and woman in the society	O	O	O	O	O
The hierarchic male structures	O	O	O	O	O
Missing time resources	O	O	O	O	O
Gender is not a topic of discussion at the hospital	O	O	O	O	O
Gender specific topics are ignored	O	O	O	O	O
The own gender role of the nurse	O	O	O	O	O
The different gender comprehension of older persons	O	O	O	O	O

Table 21. Questionnaire Delphi Study part 4

What are the essential differences related to health promotion for the older persons regarding the diversity management?

Welches sind entscheidende Unterschiede in der Gesundheitsförderung für ältere Menschen im Fokus der Diversität? (Diversität, Verschiedenheit wird in dieser Studie als kulturelle Vielfalt, ethnische Herkunft, sprachliche Vielfalt, Religion, alle Formen von geistiger- und körperlicher Behinderung verstanden. Es gilt zu erkennen und respektieren, dass jedes einzelne Individuum ist einzigartig ist.) Welches Wissen des Pflegepersonals ist erforderlich um der Rolle der Pflege in Gesundheitsförderung im Fokus der Diversität gerecht zu werden! Welches sind die entscheidenden Unterschiede? Es braucht folgendes Wissen und folgende Kenntnisse:

In regards to the essential differences of the diversity management: What is the knowledge needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Knowledge of different languages	O	O	O	O	O
Knowledge of ethics concerning diversity	O	O	O	O	O
Knowledge about the principle of careful decision making	O	O	O	O	O
Knowledge about old age and different religions	O	O	O	O	O
Knowledge about old age and different cultures	O	O	O	O	O
Knowledge about transcultural nursing	O	O	O	O	O
Additional knowledge of patient education	O	O	O	O	O
Knowledge about intercultural gerontology	O	O	O	O	O
Knowledge about the Swiss culture and history	O	O	O	O	O
Knowledge about the institutional support possibilities in regards to diversity	O	O	O	O	O
Knowledge about the restrictions by law in regards to diversity	O	O	O	O	O
Knowledge about cooperation with translators	O	O	O	O	O

Table 21. Continued

In regards to the essential differences of the diversity management: What are the attitudes and behaviour needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Awareness of diversity	O	O	O	O	O
Interest in diversity	O	O	O	O	O
The cultural openness of nurses towards diversity	O	O	O	O	O
Empathy for diversity	O	O	O	O	O
Tolerance towards diversity	O	O	O	O	O
The commitment toward diversity management	O	O	O	O	O
The acceptance of different ambitions of older patients	O	O	O	O	O
Awareness of different health comprehension	O	O	O	O	O
The awareness of existing learning skills by all the older persons	O	O	O	O	O
Different relevance of life and death	O	O	O	O	O
In regards to the essential differences of the diversity management: What are the skills needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The nurses expertise in verbal and nonverbal communication skills	O	O	O	O	O
The communication in different languages	O	O	O	O	O
The comprehension of different cultural behaviours	O	O	O	O	O

Table 21. Continued

In regards to the essential differences of the diversity management: What are the skills needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The adaption of the nursing assessment in regards to the diversity	O	O	O	O	O
The adaption of the nursing intervention in regards to diversity	O	O	O	O	O
Providing professional confidence in regards to diversity	O	O	O	O	O
Identification of existing of health literacy deficiency	O	O	O	O	O
Competences to support low health literacy	O	O	O	O	O
Competences to integrate the family focused nursing in regards to diversity	O	O	O	O	O
In regards to the essential differences of the diversity management: What are the resources needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The interest in diversity management	O	O	O	O	O
The nurses' experiences with diversity	O	O	O	O	O
Ethics is an important topic in nursing	O	O	O	O	O
The cultural diversity of nurses	O	O	O	O	O
The infrastructure of the hospital in regards to diversity	O	O	O	O	O
The expertise of the professionals	O	O	O	O	O
The relatives of the older patients	O	O	O	O	O

Table 21. Continued

In regards to the essential differences of the diversity management: What are the resources needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Professional translators	O	O	O	O	O
Institutional support and external services	O	O	O	O	O
Professional education material in regards to diversity	O	O	O	O	O
Information brochures in different languages	O	O	O	O	O
Additional transcultural training for nurses	O	O	O	O	O
Team meetings	O	O	O	O	O
Guidelines for nursing interventions	O	O	O	O	O
In regards to the essential differences of the diversity management: What are the barriers to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The missing knowledge as an obstacle for health promotion concerning diversities	O	O	O	O	O
Communication barriers	O	O	O	O	O
The impossibility to know each other due to the short hospitalisation	O	O	O	O	O
The anxiety of unknown of older persons	O	O	O	O	O
The anxiety of unknown of nurses	O	O	O	O	O
The intolerance of nurses in regards to diversity	O	O	O	O	O

Table 21. Continued

In regards to the essential differences of the diversity management: What are the barriers to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The intolerance of older persons in regards to diversity	O	O	O	O	O
The inflexible structure of the institutions	O	O	O	O	O
The missing time resources in the daily clinical work	O	O	O	O	O
Economic barriers, missing financial resources	O	O	O	O	O
Cultural misunderstandings	O	O	O	O	O
Language barriers	O	O	O	O	O
Unknown needs and recommendations of older persons	O	O	O	O	O
Low health literacy	O	O	O	O	O
Different level of competence of nurses	O	O	O	O	O
The slow learning capabilities of older persons	O	O	O	O	O

Table 22. Questionnaire Delphi Study part 5

What are the essential differences related to health promotion between the older persons and younger persons?

Welches sind entscheidende Unterschiede in der Gesundheitsförderung für ältere Menschen im Vergleich zu jüngeren Menschen? Welches Wissen des Pflegepersonals ist erforderlich um der Rolle der Pflege in der Gesundheitsförderung für ältere Menschen, im Vergleich zu jüngeren Menschen gerecht zu werden! Welches sind die entscheidenden Unterschiede? Es braucht folgendes Wissen und folgende Kenntnisse:

In regards to the essential related to health promotion between the elderly and younger persons: What is the knowledge needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Knowledge about the age group diseases pattern	O	O	O	O	O
Knowledge about the comprehension of health of the older versus the younger persons	O	O	O	O	O
Knowledge about the higher comprehension of health during the hospitalisation at any stage of life	O	O	O	O	O
The understanding of physiological development of the age group	O	O	O	O	O
Knowledge about the socialisation of the age group	O	O	O	O	O
Knowledge about the risk factors of the age group	O	O	O	O	O
Knowledge to support the quality of life at any stage of life	O	O	O	O	O
Additional communication knowledge in regards to the age group	O	O	O	O	O
Additional knowledge of health education in regards to the age group	O	O	O	O	O
Knowledge that addiction has to be considered among young persons	O	O	O	O	O
No major differences for health promotion in regards to the age group	O	O	O	O	O

Table 22. Continued

In regards to the essential related to health promotion between the elderly and younger persons: What is the knowledge needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Knowledge that autonomy is more important for older persons	O	O	O	O	O
Longer hospitalisation of the older persons versus the young persons	O	O	O	O	O
Health promotion for older persons is more complex	O	O	O	O	O
In regards to the essential related to health promotion between the elderly and younger persons: What are the attitudes and behaviour needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The awareness that older persons are often supported by the relatives after discharge	O	O	O	O	O
The awareness that health promotion is important and reasonable for patients at any stage of life	O	O	O	O	O
The awareness that health promotion is more important for young persons	O	O	O	O	O
Awareness that older persons are the experts of their health situation in contrast to the young patients	O	O	O	O	O
Young patients are well informed through the media and the web in contrast to the older persons	O	O	O	O	O
There is no difference between the elderly versus the younger persons in regards to health promotion	O	O	O	O	O

Table 22. Continued

In regards to the essential related to health promotion between the elderly and younger persons: What are the attitudes and behaviour needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The young and the older patients should understand the nursing interventions	O	O	O	O	O
The awareness that younger patients are more close to the age group of nurses	O	O	O	O	O
Nurses have to be more patient with older persons	O	O	O	O	O
In regards to the essential related to health promotion between the elderly and younger persons: What are the skills needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
Communication knowledge in regards to the age group	O	O	O	O	O
Due to the diseases of the older persons, more complex and additional competences are needed	O	O	O	O	O
In regards to the essential related to health promotion between the elderly and younger persons: What are the resources needed to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The knowledge and competences of nurses	O	O	O	O	O
The older persons are a bigger patient group at the hospital	O	O	O	O	O

Table 22. Continued

In regards to the essential related to health promotion between the elderly and younger persons: What are the barriers to perform the role of a health promoting nurse for the older persons in an acute hospital setting?	**strongly agree**	**agree**	**undecided**	**disagree**	**strongly disagree**
The different communication of older persons versus young persons	O	O	O	O	O
Nurses have to consider the cognitive factors of the older patients this is not relevant for the young persons	O	O	O	O	O
Older persons are more likely to be overstrained by the nursing recommendations	O	O	O	O	O
The infrastructure might not be adapted to the young or the older persons	O	O	O	O	O
In contrast to the young persons the older patients do not understand the meaning of health promotion	O	O	O	O	O
In contrast to young patient, health promotion is not visible among older patients	O	O	O	O	O
The missing professional expertise of nurses performing health promotion	O	O	O	O	O
The loneliness of the older persons in contrast to the young patients	O	O	O	O	O

Table 23. Questionnaire Delphi Study copy of original

3. Runde Delphi_ Pflege und Gesundheitsfoerderung bei aelteren Menschen im akut Spital

6. Delphi- Befragung dritte Runde

1. Welche Bedeutung hat das Thema "Gesundheitsförderung durch die Pflege bei älteren Menschen (+65 Jahre) im akut Spital" Ihrer Meinung nach?

	Ich stimme sehr zu	Ich stimme eher zu	Ich stimme weder noch zu	Ich stimme eher nicht zu	Ich stimme überhaupt nicht zu
Die Gesundheitsförderung bei älteren Menschen im akut Spital gehört zum Berufsbild der Pflege. Resultat der 2. Runde: 74.1%(20);22.2%(6);3.7%(1);0%(0);0%(0)	○	○	○	○	○
Die Gesundheitsförderung durch die Pflege bei älteren Menschen im akut Spital hat einen hohen Stellenwert in der täglichen Praxis. Resultat der 2. Runde: 23.1%(6); 19.2%(5); 19.2%(5);30.8%(8); 7.7%(2)	○	○	○	○	○
Die Gesundheitsförderung durch die Pflege bei älteren Menschen im akut Spital erfolgt in interdisziplinärer Zusammenarbeit. Resultat der 2. Runde: 23.1%(6); 42.3%(11); 11.5%(3); 23.1%(6); 0%(0)	○	○	○	○	○

Copy: part of original questionnaire Delphi study round 3 / 20.09.2010 Survey Monkey ®

14.2 Older Persons Study

Older persons study: open-ended and structured interviews

Table 24. Interview questionnaire older persons study

Gesundheitsförderung durch die Pflege bei älteren Menschen im Akutspital

Health promotion by nurses for older persons' at the acute hospital

Interview Leitfaden ca 30 Minuten

Version 4: 03. Januar 2012

Interviewerin:

Datum (T/M/J):

Code: m11

m für männlich/ w für weiblich

Interview 1 im Spital /Interview 2 zu Hause

Nummer Interview 1-40

Alle Antworten bleiben anonym und selbstverständlich ist die Teilnahme freiwillig

Teil 1: Keine Zeitlimite (ca 10 Minuten) wird auf Tonträger aufgenommen

Erzählen Sie mir frei was Ihnen bei den folgenden Aussagen in den Sinn kommt

1 Gesundheit ist etwas Subjektives; je nach Lebenssituation kann es etwas anderes bedeuten. Was machen Sie selber, damit Sie gesund bleiben?

2a Während der Hospitalisation: Was denken Sie, wie wird es Ihnen ergehen, wenn Sie nach diesem Spitalaufenthalt wieder zu Hause sind? Werden die Ratschläge der Pflegenden Ihre Gesundheit und Selbständigkeit zu Hause unterstützen?

2b Zu Hause: Erzählen Sie mir, wie ist es Ihnen nach dem Spitalaufenthalt ergangen, seit Sie wieder zu Hause sind? Haben die Ratschläge der Pflegenden Ihre Gesundheit und Selbständigkeit zu Hause unterstützt?

Teil 2: ca 15 Minuten

Wählen Sie auf die nachfolgenden Fragen die zutreffende Antwort aus		trifft voll zu (5)	trifft zu (4)	trifft teilweise zu (3)	trifft kaum zu (2)	trifft nicht zu (1)	keine Antwort/ missing (-1)
3	Die Pflegefachperson hat Sie während der Hospitalisation unterstützt, damit Sie sich schnell wieder gesund fühlen können	o	o	o	o	o	o
4	Sie sind immer gut beraten worden	o	o	o	o	o	o
5	Wenn Sie etwas nicht verstanden haben, konnten Sie auch mehrmals nachfragen	o	o	o	o	o	o
6	Die schriftlichen Informationen, die Sie im Spital erhalten haben, haben Sie gut verstanden	o	o	o	o	o	o
7	Die Pflegefachperson hat Ihnen während der Hospitalisation hilfreiche Tipps und Rat-schläge gegeben, damit Sie selbstständig sein können	o	o	o	o	o	o
	Beispiel:						

Wählen Sie eine Antwort aus		trifft voll zu (5)	trifft zu (4)	trifft teilweise zu (3)	trifft kaum zu (2)	trifft nicht zu (1)	keine Antwort/ missing (-1)
8	Sie sind dankbar, für die gesundheitsför-dernden Ratschläge/Tipps, die Ihnen die die Pflegenden im Spital gegeben haben, weil:	o	o	o	o	o	o
8.1	Im Spital habe ich Zeit zum Nachdenken	o	o	o	o	o	o
8.2	Im Spital interessiere ich mich für Gesundheitsförderung	o	o	o	o	o	o
8.3	Gesundheitsförderung ist nicht nur für junge Leute	o	o	o	o	o	o
8.4	Ich kann aktiv mein Gesundheit fördern	o	o	o	o	o	o
8.5	Zu Hause denke ich weniger an meine Gesundheit	o	o	o	o	o	o
8.6	Im Spital will ich, dass nur mein Einweisungsgrund behandelt wird	o	o	o	o	o	o
8.7	Ich weiss nun, wie ich meine Gesundheit fördern kann	o	o	o	o	o	o
8.8	Ich ändere meine Lebensgewohnheiten nicht	o	o	o	o	o	o
8.9	Andere	o	o	o	o	o	o
9	Sie konnten Ihre Anliegen /Probleme mit den Pflegenden besprechen	o	o	o	o	o	o

Wählen Sie auf die nachfolgenden Fragen die zutreffende Antwort aus		trifft voll zu (5)	trifft zu (4)	trifft teilweise zu (3)	trifft kaum zu (2)	trifft nicht zu (1)	keine Antwort/ missing (-1)
10	Im Spital haben sich die Pflegenden Zeit genommen, um Ihnen zuzuhören	o	o	o	o	o	o
11	Sie sind erstaunt, wie schnell Sie wieder selbstständig Ihren täglichen Aktivitäten nachgehen können	o	o	o	o	o	o
12	Sie hatten die Möglichkeit, die Fertigkeiten schrittweise zu üben, bis Sie diese selbständig machen konnten	o	o	o	o	o	o
13	Die Pflegenden haben Sie und ihre Angehörigen gleichzeitig beraten	o	o	o	o	o	o
14	Wann immer Sie Hilfe benötigten, haben Sie diese von den Pflegefachpersonen im Spital erhalten	o	o	o	o	o	o
15	Wann immer Sie Hilfe benötigten, haben Sie diese von Ihren Angehörigen erhalten	o	o	o	o	o	o
16	die Pflegenden haben von Ihnen zu viel Eigenverantwortung verlangt	o	o	o	o	o	o
17	Sie haben es genossen verwöhnt zu werden und nicht alles selber machen zu müssen	o	o	o	o	o	o
18	Sie haben bei diesem Spitalaufenthalt nichts Neues erfahren	o	o	o	o	o	o
19	Die Pflegenden haben Ihnen an mehreren Tagen wichtige Informationen gegeben	o	o	o	o	o	o

Wählen Sie eine Antwort aus		trifft voll zu (5)	trifft zu (4)	trifft teilweise zu (3)	trifft kaum zu (2)	trifft nicht zu (1)	keine Antwort/ missing (-1)
20	Die Pflegenden haben Ihnen die Infor-mationen zum richtigen Zeitpunkt gegeben	o	o	o	o	o	o
21	Die Pflegenden haben Ihnen während der Hospitalisation gute Hilfsmittel empfohlen	o	o	o	o	o	o
22	Es kann sein, dass Sie nicht alle Infor-mationen verstanden haben. Mögliche Gründe können sein:	o	o	o	o	o	o
22.1	Die Informationen waren schwer verständlich	o	o	o	o	o	o
22.2	Die Informationen waren langweilig	o	o	o	o	o	o
22.3	Es waren zuviele Informationen	o	o	o	o	o	o
22.4	Ich hatte keine Zeit sie zu lesen	o	o	o	o	o	o
22.5	Andere	o	o	o	o	o	o
23	Im Allgemeinen hätten Sie gerne mehr Beratung / Informationen von den Pflegfachpersonen erhalten	o	o	o	o	o	o
	Beispiel						
24	Zu Hause werden Sie einige Tipps , die Ihnen die Pflegefachpersonen gegeben haben, weiter anwenden	o	o	o	o	o	o
	Beispiel						

Wählen Sie eine Antwort aus		trifft voll zu (5)	trifft zu (4)	trifft teilweise zu (3)	trifft kaum zu (2)	trifft nicht zu (1)	keine Antwort/ missing (-1)
25	Ihre Angehörigen werden Sie zu Hause nach dem Spital unterstützen	o	o	o	o	o	o
	Wie						
26	Sie brauchen keine Hilfe zu Hause; Sie sind selbständig	o	o	o	o	o	o
27	Die Spitex wird Sie nach dem Spital zu Hause unterstützen	o	o	o	o	o	o
27.1	Pflege: Körperpflege, Wundpflege, Injektionen, Diagnostik	o	o	o	o	o	o
27.2	Hauswirtschaft: Kochen, Reinigung, Einkaufen	o	o	o	o	o	o
27.3	Noch nicht bekannt	o	o	o	o	o	o
28	Möglicherweise haben Sie ein unbehagliches Gefühl, nun nach Hause entlassen zu werden. Gründe können sein:	o	o	o	o	o	o
28.1	Ich kann noch nicht selber alles machen	o	o	o	o	o	o
28.2	Ich habe Angst vor dem Stürzen zu Hause	o	o	o	o	o	o
28.3	Ich habe Angst vor Schmerzen	o	o	o	o	o	o
28.4	Ich bin allein zu Hause	o	o	o	o	o	o

28.5	Ich bin nicht mobil	o	o	o	o	o	o
28.6	Die Treppen machen mir Angst	o	o	o	o	o	o
28.7	Ich kann nicht selber zur Toilette gehen	o	o	o	o	o	o
28.8	Ich kann nicht selber duschen	o	o	o	o	o	o
28.9	Ich kann nicht kochen	o	o	o	o	o	o
28.10	Ich kann nicht selber einkaufen	o	o	o	o	o	o
28.11	Andere						
29	Einschätzung zum Gesundheitszustand: Sie fühlen sich gesund	o	o	o	o	o	o
30.1	Wie beurteilen Sie Ihre Sehkraft (ohne Brille)	o	o	o	o	o	o
30.2	Wie beurteilen Sie Ihre Sehkraft (mit Brille)	o	o	o	o	o	o
31.1	Wie beurteilen Sie Ihr Gehör ohne Hörhilfe	o	o	o	o	o	o
31.2	Wie beurteilen Sie Ihr Gehör mit Hörhilfe	o	o	o	o	o	o
32.1	Wie beurteilen Sie Ihre Mobilität ohne Hilfsmittel	o	o	o	o	o	o
32.2	Wie beurteilen Sie Ihre Mobilität mit Hilfsmittel	o	o	o	o	o	o

Teil 3: persönliche Fragen nur beim 1. Interview ca 5 Minuten

Zum Abschluss bitten wir Sie noch um einige Angaben zu Ihrer Person. Diese werden nur für statistische Zwecke verwendet

		Ja (1)	Nein (0)	Missing (-1)
34	Ihr Geschlecht:	o	o	o
34.1	Weiblich	o	o	o
34.2	Männlich	o	o	o
35	Ihren Jahrgang:	o	o	o
36	Ihre Muttersprache:	o	o	o
36.1	Deutsch	o	o	o
36.2	Französisch	o	o	o
36.3	Italienisch	o	o	o
36.4	Andere	o	o	o
37	Hospitalisationsgrund	o	o	o
37.1	Unfall	o	o	o
37.2	Krankheit	o	o	o
37.3	Geplante Hospitalisation	o	o	o
37.4	Jahr 2011 waren Sie zwei Mal im Spital	o	o	o
37.5	Jahr 2011 waren Sie mehr als drei Mal im Spital	o	o	o

		Ja (1)	Nein (0)	Missing (-1)
38	Haushalt:	o	o	o
38.1	Allein lebend	o	o	o
38.2	Zu zweit (Ehepartner/ Partnerin)	o	o	o
38.3	Mehrere Personen	o	o	o
38.4	Mit jüngeren Personen lebend	o	o	o
38.5	Mit Personen in der gleichen Altersgruppe	o	o	o
38.6	Mit Kinder unter 14 Jahren	o	o	o
38.7	Haus/ Wohnung mit Treppen (mehr als 2 Stufen)	o	o	o
38.8	Eingang zum Haus/ Wohnung auf einer Etage (weniger als 2 Stufen)	o	o	o
39	Haushalthilfe:	o	o	o
39.1	Angehörige	o	o	o
39.2	Raumpflegerin	o	o	o
39.3	Spitex	o	o	o
39.4	Freunde	o	o	o
39.5	Nachbarn	o	o	o
39.6	Keines	o	o	o
39.7	Andere	o	o	o

		Ja (1)	Nein (0)	Missing (-1)
40	Höchster Bildungsabschluss:	o	o	o
40.1	Obligatorische Schule	o	o	o
40.2	Anlehre	o	o	o
40.3	Matura/ Berufslehre	o	o	o
40.4	Höhere Fach- und Berufsausbildung	o	o	o
40.5	Hochschule	o	o	o
41	Hobby:	o	o	o
41.1	Gartenarbeiten	o	o	o
41.2	Eigene Tiere (Hund, Katze, Kaninchen)	o	o	o
41.3	Spazieren	o	o	o
41.4	Sport	o	o	o
41.5	Lesen (Bücher, Zeitschriften, Zeitung)	o	o	o
41.6	Musik hören/ TV	o	o	o
41.7	Musik machen	o	o	o
41.8	Verein aktiv	o	o	o
41.9	Reisen	o	o	o
41.1O	Keines	o	o	o

Herzlichen Dank für Ihre Teilnahme