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SHAPING PRACTICE : THE NURSE'S ROLE IN NUTRITION EDUCATION : A GROUNDED THEORY APPROACH

Judith Ann Mahood

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Abstract

The purpose of this grounded theory study was to identify, describe, and provide a theoretical explanation of nurses' perceptions of their nutrition education role. Fifteen staff nurses from medical and paediatric wards of a large public hospital in New Zealand were interviewed, providing thirty-two hours of tape-recorded data. Through the process of constant comparative analysis the core category of shaping practice was identified.

Shaping practice, in the context of this study, means that although education is an integral function of nursing, nurses are continually creating, moulding, challenging and adapting their nutrition education practice. Shaping practice can only be understood when each of the intertwining, interdependent components that make it up are considered as a whole. These components are establishing a niche, dealing with the obstacles and being part of the team.

Shaping practice identifies the unique contribution that nurses can make to the nutrition education process, but also highlights the difficulties that are encountered along the way. Shaping practice has implications for the bureaucratic organizations in which nursing practice occurs; for the individual nurses themselves who provide the nursing care; and for the educational institutes that prepare nurses for their future role as health professionals.
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# Table of Contents

Abstract ii  
Acknowledgements iii  

1 Introduction 1  
1.1 Background 3  
1.2 Significance of the Study 6  
1.3 Structure of the Thesis 7  

2 Review of the Literature 9  
2.1 The Nurse’s Role in Nutrition Education 10  
2.2 Knowledge, Skills and Attitudes of the Nurse 13  
2.3 Preparation of the Nurse for the Role 20  
2.4 Principles and Methodology of Patient Education 25  
2.5 The New Zealand Situation 29  
2.6 Summary 31  

3 Research Methodology 33  
3.1 Grounded Theory as a Research Method 33  
3.1.1 The Steps of Grounded Theory 35  
3.2 The Design and Method of the Present Study 38  
3.2.1 The Setting for the Study 38  
3.2.2 Access to the Field 38  
3.2.3 Participant Selection 39  
3.2.4 Profile of Study Participants 39  
3.2.5 Ethical Considerations 40  
3.2.6 Researcher Involvement 41  
3.2.7 Data Collection Methods 42  
3.2.8 Data Analysis 43  
3.2.9 Rigorousness of the Research 46  
3.3 Summary 48
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Establishing a Niche</td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>Being There</td>
<td>50</td>
</tr>
<tr>
<td>4.1.1</td>
<td>Maintaining Consistency</td>
<td>51</td>
</tr>
<tr>
<td>4.1.2</td>
<td>Building Relationships</td>
<td>54</td>
</tr>
<tr>
<td>4.2</td>
<td>Looking Holistically</td>
<td>57</td>
</tr>
<tr>
<td>4.2.1</td>
<td>Acknowledging the Wider Needs</td>
<td>58</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Resisting the Pressure</td>
<td>62</td>
</tr>
<tr>
<td>4.3</td>
<td>Summary</td>
<td>65</td>
</tr>
<tr>
<td>5</td>
<td>Dealing With the Obstacles</td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>Skimming the Edges</td>
<td>67</td>
</tr>
<tr>
<td>5.1.1</td>
<td>Weighing up the Tasks</td>
<td>68</td>
</tr>
<tr>
<td>5.1.2</td>
<td>Making Time</td>
<td>74</td>
</tr>
<tr>
<td>5.1.3</td>
<td>Educating on the Spot</td>
<td>76</td>
</tr>
<tr>
<td>5.2</td>
<td>Recognizing the Limits</td>
<td>79</td>
</tr>
<tr>
<td>5.2.1</td>
<td>Understanding the Importance of Knowledge</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>and Skills</td>
<td></td>
</tr>
<tr>
<td>5.2.2</td>
<td>Developing Knowledge</td>
<td>85</td>
</tr>
<tr>
<td>5.3</td>
<td>Summary</td>
<td>89</td>
</tr>
<tr>
<td>6</td>
<td>Being Part of the Team</td>
<td></td>
</tr>
<tr>
<td>6.1</td>
<td>Finding a Place</td>
<td>91</td>
</tr>
<tr>
<td>6.1.1</td>
<td>Making Connections</td>
<td>92</td>
</tr>
<tr>
<td>6.1.2</td>
<td>Filling in the Gaps</td>
<td>95</td>
</tr>
<tr>
<td>6.2</td>
<td>Learning to Work With Others</td>
<td>98</td>
</tr>
<tr>
<td>6.2.1</td>
<td>Communicating with Others</td>
<td>99</td>
</tr>
<tr>
<td>6.2.2</td>
<td>Feeling Complete</td>
<td>104</td>
</tr>
<tr>
<td>6.2.3</td>
<td>Maintaining in Spite Of</td>
<td>109</td>
</tr>
<tr>
<td>6.3</td>
<td>Summary</td>
<td>115</td>
</tr>
</tbody>
</table>
7 Discussion

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>The Process of Shaping</td>
<td>117</td>
</tr>
<tr>
<td>7.2</td>
<td>Shaping Nutrition Education Practice</td>
<td>120</td>
</tr>
<tr>
<td>7.3</td>
<td>Limitations of the Study</td>
<td>132</td>
</tr>
<tr>
<td>7.4</td>
<td>Implications for Nursing Practice</td>
<td>134</td>
</tr>
<tr>
<td>7.5</td>
<td>Implications for Education</td>
<td>136</td>
</tr>
<tr>
<td>7.6</td>
<td>Implications for Research</td>
<td>138</td>
</tr>
<tr>
<td>7.7</td>
<td>Concluding Statement</td>
<td>139</td>
</tr>
</tbody>
</table>

References

Appendices
1 Introduction

It is now generally accepted that lifestyle choices, such as diet, have a powerful influence on health and well being. The high incidence of nutrition-related diseases in New Zealand reflects this. For example, coronary heart disease, cancer and cardiovascular disease accounted for almost fifty percent of deaths in New Zealand in the year 1987 and diet may have been an associated factor in nearly one-third of the deaths (Report of the Nutrition Taskforce, 1991:1). Nutrition is also implicated in other diseases such as diabetes mellitus, hypertension, diverticulitis and osteoporosis. In the United States osteoporosis alone costs more than ten billion dollars annually in healthcare costs (Dairy Advisory Bureau, 1994:7). The incidence of osteoporosis in New Zealand is increasing, and predictions are that one in four women over the age of sixty will have a broken bone due to the disease (Dairy Advisory Bureau, 1991:7). The financial strain that nutrition-related diseases place on the health care system therefore becomes obvious. What is not represented by the statistics, however, is the ongoing stress that is experienced by individuals and their families when they are affected by one of these diet-related diseases.

As diet is a major contributing factor in lifestyle diseases it is important, if not essential, that nutrition education plays a significant part in any strategies aimed at either prevention or treatment. Education on its own
is no guarantee that individuals will change their behaviour or attitudes (Hornblow, 1992). But when educational strategies are supported by food and nutrition public health policies or where people themselves are motivated to make changes, "education can be a powerful and cost-effective strategy if used appropriately and with skill" (Report of the Nutrition Taskforce, 1991:105).

As will be seen in Chapter two, the reviewed literature reveals that the registered nurse is ideally situated to have an influential role in nutrition education. It is also interesting to note that contrary to these findings, the literature reveals that nurses do not always take the opportunity to educate or when they do, that it is often ineffective.

The purpose of this study is to explore the nurse's role in nutrition education. The study investigates the nurses' perspectives on the importance of nutrition education; how they go about educating; how prepared they feel for the role; whether or not they see nutrition education as a nursing function; and indeed, whether or not they even want the role.

A grounded theory approach is used to identify, describe and provide a theoretical explanation of nurses' perceptions of their nutrition education role. Grounded theory, with its roots in symbolic interactionism, is based on the premise that behaviour can be understood only when it is examined in interaction. It is through the process of social interaction that individuals give meaning to things, and this meaning subsequently guides their behaviour. It follows, that to fully understand behaviour, it must be
examined in the social context in which it occurs (Chenitz and Swanson, 1986).

1.1 Background

An explanation of the context of a study is important within qualitative research because it takes into account the social world of the participants (Strauss and Corbin, 1990). This section addresses the context of the current study by providing an outline of the events which have influenced the development of the nutrition education role of nurses.

One of these influences was the change occurring in the educational preparation of nurses for this role. In Jessie McGrath Greene's article on the history of nutrition education in nursing in the United States, she pointed out that in the early part of the twentieth century food service was a responsibility of nursing (1960). The subject of nutrition was taught by nurses and the courses were designed to assist students to prepare and serve food for sick patients. With the development of nutrition as a science and dietetics as a profession in the 1920s, the emphasis of teaching shifted from food preparation to nutrition principles, and teaching was taken over by dietitians. By 1937 most curriculums provided for around one hundred hours of nutrition content but nursing and dietary functions were becoming increasingly separated (Greene, 1960). Nutrition became isolated in separate blocks within the nursing curriculum and was taught by nutrition experts with little understanding of the needs of nursing students or patient care (Morse and Corcoran-Perry, 1993).
A further event impacting on the development of the nurse’s nutrition education role was the growing influence of nursing theories. Nursing theory had its beginnings in the 1950s (Morse and Corcoran-Perry, 1993) and its development has continually been reflected in the nursing curriculum. Nurses have always been challenged to articulate the uniqueness and essence of nursing (Doheny, Cook and Stopper, 1992) and it is through the use of theories that they, as a profession, have been able to do this. The proliferation of nursing theories in the 1960s led to dramatic changes in the curriculum. The result was the development of an integrated curriculum which brought nursing and nutrition together in a more connected, meaningful way (Morse and Corcoran-Perry, 1993). The aim of the integrated curriculum was to achieve "a more holistic conception of man, in health as well as illness..." (Redman, 1978:26). Since the 1960s nursing theories have continued to develop and influence nursing curriculums. Holism appears in almost all nursing theories and has been significant in shaping nursing care (Allen, 1991). Chaska (1990) maintains that holism has always been a part of the value system of nursing. Allen agrees, but also suggests that holism serves two critical professionalization functions: it helps to distinguish nursing from other disciplines, in particular medicine; and it enables nursing to carve out a unique position as a professional domain which allows for autonomous practice (Allen, 1991:268). But we are also reminded by Jacono and Jacono (1994) that the concept of holism is open to abuse because of a limited understanding as to what it really implies. The concept of holism, to Chinn and Kramer (1991), means that nothing is reduced to discrete elements or isolated from its context. Putting holism into practice means that the nurse looks at all
aspects of the client's life in order to promote healthy lifestyles and prevent occurrence or recurrence of illness. The physical, psychological, social, emotional, and spiritual dimensions of the client are considered in helping the individual reach and maintain an optimum level of health (Doheny et al, 1992). When holism is applied to patient education it implies that education should include more than just teaching about a single, specific dysfunction or problem (Rankin and Duffy, 1983). It is important to point out that even though some attempts have been made to define holism, understanding about the meaning of holism is continually growing (Jacono and Jacono, 1994).

Although there is nothing documented in the New Zealand literature about the history of nutrition education in the nursing curriculum, one can assume that there are similarities with the North American situation. In the United States nursing education moved from the hospital to the university setting in 1909 (Morse and Corcoran-Perry, 1993:171), whereas in New Zealand nursing education only began to transfer from the hospital to the technical institute setting in 1973 (New Zealand Nurses’ Association, 1980). As a result, the developments in nursing theory may have reached New Zealand much later, but their eventual impact on the teaching of nutrition in nursing curriculums, and ultimately on the practice of nursing itself, would be equally significant.

As well as changing in response to the maturation of the nursing profession itself, nursing practice also adapts in response to the needs of a complex and ever-changing society (Doheny et al, 1992). Whereas a
century ago infectious and communicable diseases were a major cause of death in developed countries, the situation today is quite different (Whitney and Rolfes, 1993). Some infectious diseases remain as serious threats, but it is the chronic lifestyle diseases outlined at the beginning of this chapter which are currently the leading causes of death in New Zealand and other developed countries. These diseases which are, in part, preventable (Report of the Nutrition Taskforce, 1991:ix) have led to an increased awareness in society of the need for health education. Consumers are becoming more aware that they can, and should have, more control and responsibility for their own health (Close, 1988). This increased need for health education in New Zealand today obligates the nurse to take opportunities to develop this role. This is supported by the New Zealand Nurses’ Association in their statement that nursing "...is a profession concerned with health; it exists in response to the health needs of society..." (1984:3).

1.2 Significance of the Study

Most of the research conducted on the nurse’s role in nutrition education to date has been quantitative and focused on specific hypothesis testing. This study is significant in that it avoids an "a priori" perspective by using a grounded theory approach to generate new knowledge about nutrition education behaviour. The knowledge that is generated sheds new light on the subject because it comes from the perspective of the individual nurse and it takes into account the perceived realities of the social environment in which nursing practice occurs. The study reveals that nurses do want to play a part in the nutrition education process and also highlights some of
the factors that need to be addressed in order to make it easier for nurses to do this.

This study is also significant in that it takes place within a New Zealand setting. The majority of reported studies have been conducted in overseas countries and this limits the potential for generalizing their findings to the New Zealand situation.

1.3 Structure of the Thesis

Chapter one of the thesis provides an introduction to the topic with a discussion of events that have significance for nutrition education practice today. A discussion and critique of relevant literature is presented in Chapter two. Chapter three begins with a discussion of the researcher’s rationale for using a grounded theory approach and then goes on to describe the design and method of this particular study.

Chapters four through to six present the conceptual categories that emerged from the data. Specifically, chapter four looks at the process of establishing a niche; Chapter five explores the process of dealing with the obstacles; and Chapter six is a discussion of the participant’s experiences of being part of the team.

Integration of the three processes from Chapters four through to six occurs in Chapter seven where the process of shaping practice is discussed. The chapter concludes with a discussion of the limitations and implications
of the study and suggestions for future research in nutrition education.

Although it is acknowledged that the nursing profession is made up of both males and females, the researcher has purposely used the feminine pronoun throughout this study when referring to the nurse.
2 Review of the Literature

In this chapter literature related to the nurse’s role in nutrition education is presented and reviewed. Although there has been a lot of interest in the role of the nurse as an educator, research relating to the nurse’s role in nutrition education specifically, is sparse. The majority of available information is also of a non-research, opinionated nature.

Rankin and Duffy make a distinction between the terms educating and teaching. They define patient education as "the process of influencing patient behaviour, producing changes in knowledge, attitudes and skills required to maintain or improve health." To them patient teaching is only one component of the education process - "the actual imparting of information to the patient" (Rankin and Duffy, 1983:302). The terms educating and teaching are used interchangeably in this discussion because most of the reviewed literature either failed to define meanings when the terms were used or used the terms interchangeably.

The literature can be divided into four main areas: the nurse’s role in nutrition education; knowledge, skills and attitudes of the nurse; preparation of the nurse for the education role; and principles and methodology of patient education. As stated previously, literature referring to the nurse’s role in education is often in reference to education in general, and not specifically to nutrition education.
2.1 The Nurse's Role in Nutrition Education

As discussed in the introduction, there is consensus amongst the scientific community about the role of nutrition in the development and maintenance of good health, and the effectiveness of education in helping individuals to make appropriate food choices (Report of the Nutrition Taskforce, 1991). Health education involves input from many health professionals, but Ersser, Taylor and Wilkinson (1984:54) ask the important question, "But why the nurse?" To some, the answer to this question is obvious because they see education as an essential part of the nursing process and therefore an unquestioned function of nursing (Smith 1979, Redman 1971, Corkadel and McGlashen 1983, Hopps 1983, Cafferella 1984, Lorenz 1986, Close 1988). But to others, there are more practical reasons as to why the nurse should play a major role in the education process. Tones, for example, suggests that one of the underlying principles in deciding who should take responsibility for appropriate health education is that it should be done by those who have closest contact with an individual (1983). Many authors suggest that the nurse is the health professional who has the closest and most prolonged contact and therefore is in an ideal position to educate.

At the request of the National League for Nursing and the American Dietetic Association (ADA), Greene (1960) developed an historical perspective on the place of nutrition in the nursing curriculum from 1900 to 1960. In discussing the nurses' education function, she stated that:

The nurse is the one to come face to face with the
patient and his problems over longer periods of time and thus has the greatest opportunity to understand his attitudes and anxieties. So, to her, most logically falls the task of interpreting to the patient and his family the doctor’s dietary order and the dietitian’s plan for carrying it out (1960:39).

This line of thinking is still very evident in the current literature. It is believed that extended physical contact puts the nurse in the position of being the one who knows the most about the patient (Palm 1971, Winslow 1976, Murdaugh 1980) and enables the nurse to develop empathic relationships which assist the education process (Syred 1981, Thompson, 1983). Extended contact between the client and the nurse also provides the opportunity for assessment of the patient’s teaching needs and readiness to learn, and allows the nurse to individualize her teaching based on this knowledge (Corkadel and McGlashen, 1983). According to Pohl (1973) repetition strengthens learning, and nurses, offering twenty-four hour a day care, are in an ideal position to provide this repetition and reinforcement (Syred, 1981). The ADA not only agrees that nurses are a valuable asset because of their reinforcement role, but also because they approach nutrition education from a different focus to the dietitian (White, 1984).

Smith (1979) argues that nurses are ideal for education because they are the largest group of health workers and therefore have the greatest potential for influence. In a later publication, he goes on to say that nurses are "endowed by the public with charismatic qualities" and are therefore seen
as credible role models (Smith, 1984:18). The belief that nurses have an image of credibility and trustworthiness with the public is shared by others (Syred 1981, Cutler 1986).

It can be seen from the literature presented thus far, that there are several reasons why nurses are considered to be ideally situated to play a part in nutrition education. These comments, however, do not shed any light on what happens in actual practice.

It is a commonly held belief that nurses have neglected their education role in practice (Lask 1986, Webb 1985, Pohl 1965, Smith 1984, Syred 1981, Corkadel and McGlashan 1983, Redman 1971). This is supported by Close (1988) in the conclusion of her literature review on patient education in the United States and United Kingdom between 1966 and 1985. She stated that nurses often do not carry out their education role, even though there are proven benefits. According to Wilson-Barnett and Osborne (1983) the potential benefits to the patient include increased feelings of control over their lives, decreased levels of anxiety and greater participation in their own care.

It is important to point out that the above comments regarding nurses’ neglect of their education role are referring mostly to education in general, rather than to nutrition education. One recent study, however, is particularly pertinent to nutrition education. Weigley (1994) studied three hundred and eighty-eight nurses from seventeen nursing education programs in the United States, to determine the entry level of nutrition
knowledge that would be required by nurses in order to be competent beginning practitioners. All of the participants were surveyed within six months of graduation. Ninety-three percent were employed in hospitals: twenty-four percent in intensive care, twenty-seven percent in medical or surgical units, ten percent in pediatrics, seven percent in obstetrics or gynaecology, and five percent in oncology. In response to the question regarding nutrition related functions in which the nurse was currently involved, eighty-eight percent of the nurses stated that direct patient care was their major responsibility. This included tasks such as recording fluid intake and assessing hydration status. There was very little evidence of nutrition teaching by the nurses which the author suggested was due to the fact that thirty-eight percent of the respondents worked in areas with high client acuity. Several nurses also stated that dietitians did the nutrition plans and counselled patients in their areas.

A further explanation for the lack of nutrition teaching found in Weigley's study may be offered by Lapointe who is of the opinion that "nurses, conscious of their close relationship with patients, would like to throw some light into the dim corridor leading from the dinner table to the hospital, but have to endure certain restraints" (1975:30). The restraints that Lapointe is referring to are a lack of nutrition knowledge and practical skills.

2.2 Knowledge, Skills and Attitudes of the Nurse

The assessment of knowledge, skills, and attitudes of registered nurses
has been the focus for many nutritional studies. For example, Schwartz (1976) investigated the knowledge, attitudes and practices of three hundred and fifty two Canadian public health nurses and found that their nutrition knowledge was limited. There was also a significant and positive relationship between nutrition knowledge and attitudes (the strongest relationship) and between knowledge and practice (the weakest relationship).

There are some similarities in the findings of Schwartz's work and a study carried out by Wilt, Hubbard, and Thomas (1990), which also found an association between knowledge level and practice and between knowledge level and attitude. Substantial knowledge gaps regarding heart disease prevention and diet modification were reported, despite positive attitudes that the nurses had about the importance of diet and about their responsibility for nutrition counselling. The study was important in identifying factors that prevented nurses from expanding their role. Barriers perceived by nurses, from most to least influential, included lack of preparedness or confidence in counselling, lack of time, lack of financial reimbursement to the nurse for dietary counselling, lack of physician support and an unwillingness on the part of the clients to change their diet. It was apparent that the nurses in this study were aware of their knowledge deficits and the limits that this placed on their education role. This is not always the case, as was shown in a study by Francis, Roche, Mant, Jones and Fullard (1989), which involved fifty-three general practitioners and sixty-one registered nurses. The participants worked in practices that were participating in a prevention program in the area of cardiovascular risk.
factors, and were routinely required to give advice about healthy eating. Yet the results showed that there were significant gaps in knowledge and practical skills and that seventy-eight health workers were giving advice that would confuse or mislead the patient. Francis and her colleagues rightfully concluded that their results did not give cause for complacency!

A study by Story and Pontius (1988) examined nutritional knowledge and skills from a different angle. Four hundred and one health professionals, eighteen percent being nurses, were asked to rate their degree of competence for several knowledge and skill categories relating to the management of pregnant adolescents. The results showed that nurses felt most competent in areas which were not nutrition-related, such as knowledge of psychosocial development and communication skills, than they did in areas related directly to nutrition, such as nutrient needs of adolescents and counselling strategies for dietary change. It was pointed out by Story and Pontius, however, that the findings need to be viewed in light of the fact that a self rating questionnaire was used which may have resulted in under or over rating on the part of the participants.

The assessment of the nurses’ competency in nutrition education has been addressed, from the perspective of the patient, in a Canadian study by Tanaka, Yeung and Anderson (1989). The findings were based on interviews with four hundred mothers of infants, ranging from four to fifteen months of age. Hospital nurses and public health nurses were found to be the most important potential source of nutrition information because
of their accessibility in the first few months of infant life when the mothers were making crucial decisions about feeding. The perceived accessibility of nurses was in contrast to the mothers' opinions of their expertise. Hospital nurses were judged as being the least reliable or accurate source of information when compared with public health nurses, dietitians and physicians. It was also found that neither group of nurses provided information that was comprehensive enough to satisfy the needs of the mother.

These studies highlight the need to investigate the reasons underlying the knowledge and skills deficit that has been documented in the literature. This is the focus for discussion in the next section. But first it is important to acknowledge the studies which have reported somewhat contrary results.

For example, Vickstrom and Fox (1976) studied the knowledge and attitudes of eight hundred and sixty seven American registered nurses, five hundred of whom were hospital based, and found that nurses were well informed regarding basic aspects of normal nutrition and applied aspects of therapeutic nutrition. It was interesting to note that although most questions were answered correctly, nurses lacked confidence in the correctness of their answers when they were asked to rate their degree of certainty for each response. The study also revealed that nurses saw themselves as having a supportive rather than an active role in nutrition education, but viewed the dietitian as being very much in an education role as opposed to a service role. Another finding of interest was the unfavourable attitudes that nurses expressed toward their nutrition education
experience. The belief that poor attitudes toward nutrition are linked to negative educational experiences has been previously documented in the literature (Greene 1960, Newton, Beal and Strauss 1967). This highlights the need for educational institutes to address the way in which nutrition is taught to nursing students in order to prevent negative attitudes from developing and spilling over into practice.

A further Canadian study by Sabry, Hedley and Kirstine (1987) involving two hundred and thirty public health nurses, is supportive of the findings of Vickstrom and Fox. They reported that public health nurses were actively involved in nutrition education and that their level of nutrition knowledge was moderate. They did state, however, that comparisons with results of other studies was difficult because their knowledge test was based on a different framework from that used in other studies.

Intervention studies do exist which have addressed the knowledge and skills deficit problem that has been documented in the literature. Although not specific to nutrition, they are useful in highlighting the effectiveness that continuing education programs appear to have on the nurses' level of involvement in education.

Practice nurses have the potential to be effective educators of patients with diabetes mellitus (Tasker, 1987), and this was documented in a study by Lorenz (1986) which assessed the effectiveness of a training program in helping health professionals to improve their teaching skills. Results
showed that the participants’ use of skills was infrequent at the beginning of the program, but showed significant improvement from first to last session when assessed by direct observation.

Two further studies in diabetes education have shown similar encouraging results. Anderson, Funnell, Barr, Dedrick and Davis (1991) developed a program that allowed diabetes educators to maximize their empowerment skills. In their empowerment model, the primary purpose of diabetes education was to prepare patients to make informed decisions about their own care. Although the results indicated significant improvements in counselling skills and attitudes, it was not determined if the improvements were maintained over time.

Based on her belief that practice nurses were underutilized and limited to performing functional tasks, Reading (1987) set up a pilot program to encourage greater participation by the nurse in diabetes education. The nurse was given educational support by many specialists, including the dietitian, and was also given the opportunity to attend a conference on diabetes. The results were promising in that there were one hundred and twenty-one follow-up nurse consultations during the first year of the programme, mainly for dietary advice.

The effects of the nurses’ knowledge of teaching-learning principles on the knowledge of coronary care patients was the focus of a pretest/posttest study by Murdaugh (1980). The pretest findings revealed that nurses did not have adequate knowledge of teaching-learning principles to effectively
teach. The overall results showed that nurses were better able to teach, and that patients learned more, after the nurses had attended a twelve hour teaching-learning principles course. This was independent of the nurses’ knowledge of the clinical content.

To the author’s knowledge, only one qualitative study has been carried out that looks at the nurse’s involvement in education from the perspective of the nurse (Gott and O’Brien, 1990). The study, which involved sixty-five community nurses in England and Wales, assessed the impact that nurses’ own perceptions and orientations have on their health promotion activities, including education. The results of this study were interesting in that community nurses identified themselves as health promoters which they perceived as being quite different to nurses. They saw nurses as the ones that did "hands on" tasks and carried out treatments that were prescribed by a doctor, as opposed to health promoters who offered advice and lifestyle counseling. The authors concluded that the age-old struggle to get out of a "quasi-dependent relationship with medicine" was the reason behind the anti-nursing undercurrent which surfaced in the study (1990:31). Gott and O’Brien were justified in their concern that nurses were trying to escape their identity as nurses, rather than collectively challenging their relationship and asserting a nursing independence. The study also highlighted the nurses’ limited understanding of the wider variables involved in health promotion. To the nurse, health promotion was an attempt to "persuade, cajole or otherwise influence individuals to alter their lifestyle." In spite of the nurses’ avowed efforts to establish an independence, their focus on making lifestyle changes "was based on the
priorities and preferences of the medical profession, whose definitions and decisions about the nature of risk, formed the basis of the nurses' perceived health promotion function" (1990:31). The agenda of the patient or the public at large was missing.

2.3 Preparation of the Nurse for the Role

As discussed earlier, there is concern in the literature about the preparation that nurses receive for their education role. Some authors have been very specific in pinpointing where they think the training institutes have gone wrong. Smith (1979) and Hills and Lindsey (1994) claim that nursing training focuses on the study of disease, to the neglect of health education and promotion. If the needs of society are to be adequately addressed, they argue that nursing education must change its orientation. Other authors believe that poor preparation in general is the reason why nurses either neglect their education role or carry it out ineffectively. Although this view persists in the literature, it is often based on opinion rather than on the results of research (Lapointe 1975, Vickstrom and Fox 1976, Hopps 1983, Syred 1981, Winslow 1976, Redman 1971, Schweer and Dayani 1973, Webb 1985, Birkbeck 1990).

Early research, such as Pohl's (1965) study involving fifteen hundred nurses in the United States, supports the view that preparation for an education role is inadequate in the training that nurses receive. This was also the conclusion drawn by McDaniel and Savage (1974) in their study involving one hundred and thirty-eight nurses from various clinical settings such as hospitals, schools, and industry. They found that the hours
devoted to formal nutrition study in associate, baccalaureate and diploma nursing curricula had steadily declined from 1960 onwards. They also reported that increasing numbers of graduates from associate and baccalaureate programs were receiving no formal diet therapy education.

The teaching of nutrition education in nursing schools continues to be an area of concern in more recent years. Englert, Crocker and Stotts (1986), from their review of nutrition education in nursing schools in the United States from 1960 through to 1986, recommended that nursing schools needed to put stronger emphasis on nutrition content. They also recommended that there be a greater nutritional focus in the licensure examinations, based on the fact that nutrition questions constituted only five percent of the State Board Examination questions in the year 1982.

A recent American study by Stotts, Englert, Crocker, Bennum and Hoppe (1987) found that nutrition was an integral part of the two hundred and sixty-four baccalaureate nursing programs that responded to their survey. Contrary to the findings of McDaniel and Savage, they reported that all baccalaureate programs required nutrition content in their curriculum. Fifty-four percent of the schools reported at least one course devoted entirely to nutrition and sixty-one percent required the integration of nutrition into the nursing courses. In regards to post-graduate education, it was noted that less than half of the schools reported a significant emphasis on nutrition. Betts, Gott and Kershaw (1985:29) ask the important question, "who is responsible for providing continuing education for nurses?" They correctly suggest that if nurses understood what being a
professional meant - being accountable and responsible - that they would *demand* as professionals to be educated.

Cutler’s (1986) study on nutrition education in baccalaureate nursing programs in the United States offers insight into the factors which have an influence on the quality of nutrition education. One of the negative influences she identified was the teaching of nutrition content by registered nurses as opposed to dietitians. A study conducted back in 1976 found that nurses who received their nutrition training from a nursing instructor had significantly lower levels of knowledge than nurses who were taught by dietitians (Schwartz, 1976). Cutler’s suggestion that registered nurses do not have the broad knowledge base necessary to prepare students for entry level practice, may help to explain the findings from Schwartz’s study.

More recently, Morse and Corcoran-Perry (1993) promote the belief that both nurses and dietitians should be actively involved in teaching nutrition education to nurses. They have accurately articulated the reasons in the following quote:

Nurses who teach nutritional content need the assistance of dietitians in the identification of the most current, accurate nutrition knowledge and how that information is translated into foods that are eaten. Dietitians who teach nursing students need the assistance of nurse educators to help put nutrition information into the
context of a particular person's individual situation... (1993:178-179).

Other negative influences on nutrition education identified in Cutler's study were time constraints that resulted in nutrition content receiving low coverage and a lack of integration of diet therapy into the nursing course.

The importance of an integrated curriculum was documented as far back as 1960 by Greene, when she stated that the isolation of nutrition in the nursing curriculum contributed to nurses developing negative attitudes toward nutrition. Prater, who also recognized this factor, suggested that when nutrition was isolated from other subjects, nurses "may have seen that dietitians were providing dietary care and so felt that nutrition belonged to the province of the dietitian and ignored it" (1970:9). Morse and Corcoran-Perry did, however, raise a valid point about integrated curricula (1993). They suggested that in an integrated curriculum nutrition content could be inconsistently presented, could lack progressive development, and could even get lost in the more general content.

A further factor identified by Cutler as having a negative influence on the quality of nutrition education was a lack of clarity of roles between nurses and dietitians in practice. The ADA have recommended that a basic knowledge of the role of the dietitian in the delivery of nutrition care and counselling should be one of the five areas integrated into academic programs for health professionals (1991). This seems an important point in view of the consensus in the literature that the team
approach is the most efficient way to go about nutrition education. Caliendo and Pulaskim believe that a team approach to nutrition education is effective for several reasons: it initiates and maintains effective communication among health professionals and patients; it facilitates interdisciplinary cooperation and sharing of responsibility for the delivery of health services; and it helps professionals to develop and sustain close working relationships which can lead to the attainment of mutual patient care objectives (Caliendo and Pulaskim, 1979:571).

A more practical reason necessitating the team approach to nutrition education is the fact that there are not enough dietitians to disseminate all the knowledge that is needed to effect diet change. Guthrie has stated that dietitians should therefore find ways to work with other health professionals in order to "extend their sphere of influence in a responsive and responsible way" (1987:1397). Wilt and her colleagues (1990) agree that dietitians do not have the numbers to go it alone and therefore need to work with others who can fill in the gaps.

As well as a knowledge of the role of the dietitian, the ADA stated that the curriculum for health professionals should include a basic knowledge of: the relationship of food and nutrition to growth, development and health; the role of nutrition in the prevention and treatment of disease; methods for nutrition screening and dietary evaluation; and reliable sources of nutrition information and community nutrition resources (1991:611). In addition to having an awareness of the team approach and the possession of specific nutrition knowledge, opinions abound regarding
the most appropriate methodology that should be used by nurses in their nutrition education practice. This is the focus of the last section.

2.4 Principles and Methodology of Patient Education

The methodology of patient education in the literature is usually divided into formal and informal structures. Formal education refers to structured, planned presentations and is often associated with the use of the nursing process. Benbow Plewes, an advocate of using the nursing process for education, feels that the nursing process helps to "bridge the gap between principles which remain unused and practice which enriches patient care" (1984:42). The nursing process parallels the teaching process in that each has an assessment, goal setting, intervention and evaluation phase (Redman 1993).

Resler (1983) feels that a thorough nursing assessment is the single most important factor influencing or contributing to successful education. Black (1987) stresses that individuality is essential because generalized advice which is not personally relevant will not be taken on board by the individual. If the assessment is thoroughly carried out, it ensures individuality by finding out what the patient wants and needs to know (Wilson-Barnett, 1985). It follows that the teaching can be fit accordingly to the needs and capabilities of the individual. An important point raised by Redman is the necessity for the nurse to assess not only the needs of the client, but the client's readiness to learn. Failure to do so is the most frequent error made in practice (Redman, 1993).
The second component of the teaching process is goal setting which is based on the information gained in the assessment phase and should, again, take into account the patient’s readiness to learn (Hopps 1983, Syred 1981, Guzzetta 1981). Failure to do this may result in the setting of over-optimistic goals, which to Wilson-Barnett is "demoralising for the patient and nurse" (1985:29).

In the intervention phase, Resler (1983) emphasizes the point that nurses must be knowledgeable enough to be comfortable with their teaching. She also suggests that nurses need to be aware of their knowledge limits and have access to resources to update their knowledge. Although the importance of a solid subject knowledge base is recognized, Faulkner (1984) adds that an understanding of social and psychological factors is also essential when trying to educate patients about issues such as healthy eating, which involve changes to long term habits. As well as psychosocial skills, Webb (1985) feels that effective communication skills and a background knowledge in teaching theories is crucial. These suggestions would be welcomed by Lask (1986) who is of the opinion that nurses focus too much on advice and information-giving rather than concentrating on methods that will link the patient’s knowledge, attitudes, and behaviour. Previously cited studies (Lorenz 1986, Anderson et al 1991 and Murdaugh 1980) highlighted the benefits that occurred when nurses were given the opportunity to improve their skills and their knowledge of teaching-learning theories.

Achterberg and Larson Clark also support the view that sophisticated
models and theories are needed for nutrition education because of its uniqueness. To them, nutrition education differs from other education in that behaviours and attitudes are not individually based, but are influenced by family, peers, and society at large. In addition to this, Achterberg and Larson Clark believe that food behaviours are part of a long established pattern of behaviour and therefore any changes to nutrition behaviour require collaboration between the individual and significant others over a long period of time, and may also require changes in the social structure (Achterberg and Larson Clark, 1992:227).

Evaluation is the final step in the nursing/education process. Lask states that in evaluating the effectiveness of teaching, the nurse should ask herself two questions: "Did my patient learn what I aimed to teach him?" and "Was it useful, appropriate, relevant and of good value?" (1986:299). These are appropriate guidelines but it is important to keep in mind, however, that changes to nutrition behaviour are often long-term, abstract and less immediate than other preventative health measures (Achterberg and Larson Clark, 1992:227). Because of this, the evaluation phase may be unrealistic in the current hospital setting where fast client turnover rates are the norm.

Fast client turnover rates, as well as high client acuity, also have an influence on the methodology which is used by the nurse. Although a formal structured methodology of patient education is promoted in the literature, unplanned, unstructured, spontaneous teaching represents the most common type of patient education (Cohen, 1981). Unfortunately,
however, the nurses’ narrow view of teaching as a formal, structured activity is thought by Palm to have prevented nurses from recognizing opportunities for unstructured, incidental teaching (1971). Support is offered from others who agree that nurses take informal teaching opportunities for granted and underestimate the value of this type of learning (Schweer and Dayani 1973, Resler 1983).

Wilson-Barnett (1985) is of a different opinion regarding the place of informal, spontaneous teaching. She feels that if it is left until there is time, it will not occur, and strongly believes that planning the teaching makes it become more of a reality in the nurse’s daily work.

Another issue documented in the literature is the importance of an educational philosophy to the overall effectiveness of the education. Funnell, Anderson, Arnold, Barr, Donnelly, Johnson, Taylor-Moon and White (1991) take the stance that an educational philosophy is important because it influences professional behaviours, attitudes, satisfaction and effectiveness. Bille (1981) agrees and adds the following:

The activities performed in patient education programs derive from the basic assumptions and beliefs the educator holds. These assumptions and beliefs form the educator’s philosophy of education. The tenets of this philosophy have a profound effect on the success of teaching (1981:27).
The particular philosophy of Funnell and her colleagues is one of empowerment, which is seen as an interactive process of cultivating the power in others through the sharing of knowledge, expertise, and resources. The outcome of empowerment is to provide a combination of knowledge, attitudes, and self-awareness necessary to influence behaviour in order to improve the quality of patient’s lives (1991:41). They suggest that the empowerment model, in opposition to the traditional "medical disease-as-pathology" model, is more consistent with nursing models of care, which emphasize the whole person and views them as equal and active partners in the education process. They concluded that empowerment education has the potential to strengthen not only the power of persons with diabetes but also diabetes educators, and ultimately the entire health profession.

Carlson-Catalano (1992) goes a step further by suggesting that the way to assist students to make professional practice operational within the constraints of the bureaucratic hospital setting, is to incorporate empowerment strategies into the teaching in the nursing curriculum. Role modelling of empowerment principles by teachers would set the scene for students in their clinical practice.

2.5 The New Zealand Situation

Many of the themes noted in the international literature are mirrored in the New Zealand scene. There is, for example, a commonly held belief that nurses do not receive sufficient nutrition education and health
promotion training to assist them in their education role (Worsley 1987, Birkbeck 1990). These opinions were confirmed when the Nutrition Taskforce revised a selection of tertiary curricula and concluded that many health professionals do not receive adequate, reliable food and nutrition information in their training (Report of the Nutrition Taskforce, 1991). As an educator with ten years experience teaching in a nursing programme, I would have to agree with these opinions.

The nutrition knowledge of nurses has been the focus of a recent unpublished survey by Auckland Area Health Board (Smith, 1991). The survey revealed that the nurse’s nutrition knowledge was limited in many areas. Interestingly, it also found that those who had trained the most recently had the lowest average knowledge score.

Another study by Howie in 1989 included seventy Plunket nurses in New Zealand and one hundred child health nurses in Australia. The results of this study showed that although plunket nurses spent a considerable amount of their time advising on nutrition and feeding, seventy-four percent of the New Zealand nurses had come across a nutrition problem in the previous year which they needed assistance from other health professionals to deal with. Howie concluded that the nurses required further nutrition education in order to deal effectively with the variety of problems they encountered.

A further study, although not specific to nutrition education, revealed information about educational activities of nurses. The study, consisting
of questionnaires from six hundred and thirty-three registered and enrolled nurses and thirty-six interviews with staff nurses and midwives, focused on the nature and organization of nursing practice within New Zealand. The findings revealed that seventy-three percent of staff nurses were often involved in teaching clients. Three percent said that they were never involved in teaching and twenty-four percent were involved sometimes (Review of the Preparation and Initial Employment of Nurses: National Action Group 1989). Although the results suggest that nurses have not abdicated their teaching role, Winslow's (1976:220) plea for nurses to "awaken to the fact that patient education is not a luxury", seems appropriate.

2.6 Summary

This review has shown that nurses are generally considered to be in an ideal position as nutrition educators. The reality, however, is that they either do not perform this role or that they do it ineffectively because they lack the necessary knowledge and skills. The basic nursing program does not adequately provide them for this role. Although a planned methodical approach, based on the nursing process, is suggested as the logical way for nurses to approach nutrition education, the benefits of spontaneous, unplanned teaching cannot be ignored. In order to be effective educators it is necessary for nurses to possess not only the appropriate level of knowledge and skills, but a thorough understanding of teaching and learning theories relevant to nutrition education.

Limitations evident in the available literature include a deficit of
New Zealand based research and a bias toward quantitative, hypothesis-testing methodology. Funnell and her colleagues (1991) pointed out the significance of philosophy to the educative process. In order to fully represent what nutrition education means, the perspective of the nurse must be taken into account. The social world of the nurse must be acknowledged and factors such as philosophy, beliefs and values, which are equally as important as the nurse’s knowledge, attitudes and skills, must be considered. The paucity of this type of research highlights the need for a qualitative methodology in which the subject of nutrition education is approached from a much broader, open-ended perspective. This study aims to do this by using a grounded theory approach to identify, describe and provide a theoretical explanation of nurses’ perceptions of their nutrition education role.
3 Research Methodology

In this chapter the research methodology of the present study is detailed. It begins with a discussion of the rationale for using grounded theory as the qualitative method of data analysis. It goes on to provide an outline of the specific application of grounded theory and a description of the data analysis process. It concludes with an explanation of factors which relate to the stringency of this approach.

3.1 Grounded Theory as a Research Method

The research tradition in nutrition education has been largely quantitative in nature. However, other research approaches argue that sole reliance on hypothesis-testing and the generation of quantitative data only, are inadequate (Polit and Hungler, 1991). Moccia (1988) suggests that the selection of a research design is more than a technical choice and should reflect the researcher’s world views and philosophies. To Moccia, choosing between quantitative and qualitative methods means:

choosing to work either with a closed-system or open-system view of the world; choosing to seek either absolute or relative and contextual knowledge and to develop either a definitive or dynamic science; and choosing to learn how to predict and control phenomena with more reliability and validity or to understand and
explain phenomena more fully (1988:8).

Nevertheless, because they generate different kinds of knowledge, quantitative and qualitative research methods can complement each other (Burns and Grove 1993, Strauss and Corbin 1990).

This study uses the grounded theory approach to develop an understanding of how and why individuals shape and create their own experiences and meanings in nutrition education. Grounded theory research, based on the assumption that not everything has been discovered (Stern, in Leininger, 1985), examines a much broader scope of dimensions than is usually possible with quantitative research.

Grounded theory is a research method for studying social phenomena from the perspective of symbolic interactionism. Symbolic interaction is concerned with the way in which people define or make meaning of events in their lives and how the meaning subsequently guides their behaviour. The meaning is created from the dynamic social interaction that exists between individuals and their social environment (Blumer, 1969:2). Meanings are modified by the individual through an interpretive process. In other words, rather than automatically applying established meanings, the individual "selects, checks, suspends, regroups and transforms" the meaning in light of the situation in which the individual is placed (Blumer, 1969:5). It is through social interaction that the individual achieves a sense of self (Chenitz and Swanson, 1986).
The grounded theorist enters the world of the participants and attempts to understand it as they understand it. The researcher must then try to make sense of the participant’s reality by translating it into a conceptually dense theory that accounts for the complexity of the phenomena under study (Strauss and Corbin, 1990). The theory is considered to be conceptually dense when the individual concepts within the theory have been thoroughly examined for variation and fit logically together (Chenitz and Swanson, 1986).

Grounded theory is thus considered an ideal methodology for studying nursing phenomena because it allows the researcher to capture the complexity of problems and the richness of everyday life which are integral parts of nursing practice (Chenitz and Swanson, 1986).

Grounded theory differs from other research methodologies in many aspects. As Stern (1990:21) explains, the conceptual framework in grounded theory is generated from the data rather than relying on previous studies. The grounded theory approach includes distinct features such as constant comparison of data and theoretical sampling. It aims to discover dominant processes in the social scene rather than describe the unit under study. And lastly, rather than follow a linear direction, the researcher moves back and forth between designated steps which are operating at the same time.

### 3.1.1 The Steps of Grounded Theory

The five steps of grounded theory, according to Stern, Allen and
Moxley (1984), are: collection of empirical data, concept formation, concept development, concept modification and integration and production of the research report.

**Collection of empirical data:** Data for a grounded theory study may be collected from interviews, observation, documents or a combination of sources. A review of relevant literature is conducted at the beginning of the research process in order to identify what is already known about the phenomena and to establish the purpose and significance of the proposed study (Polit and Hungler, 1991). Chenitz and Swanson advise the researcher to maintain "a cautious and sceptical attitude" about the literature, particularly in the early stages when the researcher could unconsciously fall into the trap of accepting what is written and risk premature closure of ideas (1986:44).

**Concept Formation:** The transcribed data is analyzed line by line looking for processes which are labelled substantive codes. The substantive codes are often the actual words used by the participants. Substantive codes are compared to each other and to incoming data in a process called "constant comparative analysis". Substantive codes are put into categories according to similarities and differences.

**Concept development:** The researcher attempts to reduce the number of categories by comparing them with one another to see if they connect or can be clustered together. Broader, higher level categories are looked for under which existing categories can fit. During this step of theory
development selective literature is used as a source of data to verify and elaborate categories (Chenitz and Swanson, 1986). Another feature of this step is theoretical sampling in which the researcher looks for new data to (a) either prove or disprove the conceptual framework which is developing and (b) to expand existing categories to the point of "saturation", in which no new information is being received that can further develop the category (Glaser and Strauss, 1967).

**Concept modification and integration:** The researcher in this phase, is attempting to enhance the abstractness of the data. A feature of this step is the use of memos by the researcher. Memos are a way of preserving hypotheses, ideas, and hunches that emerge from the data.

The aim of grounded theory is to discover the core variable or basic social process. Stern (1985:156) reminds us that the core refers to the center or heart, and therefore the researcher is trying to establish what is the heart of the matter under study. The core variable is the central process which seems to dominate the study scene. Strauss and Corbin (1990) suggest that although grounded theory is an action oriented model, that the core variable itself does not have to be a basic social process, although it may be. Chenitz and Swanson (1986:135) conclude that a basic social process differs from a core category in that it accounts for movement, change or process which occurs over time.

**Production of the research report:** The research report presents the substantive theory, substantiated by supporting data from the study.
3.2 The Design and Method of the Present Study

3.2.1 The Setting for the Study

The setting for this study was a large public hospital in a New Zealand city. Eight medical wards were used, from a total of fourteen available wards. These included an infectious disease ward, a renal ward, a general medical ward, two assessment and rehabilitation wards, a coronary care unit, a paediatric general medical ward and a paediatric oncology ward. A variety of medical wards was chosen because this allowed the researcher to explore the categories under different contexts. Full exploration of the categories adds density and helps to guide the emerging theory (Chenitz and Swanson, 1986). Of the six wards that were not used, the researcher was unsuccessful in recruiting volunteers on one of them, and on two others, was denied entry by the charge nurse. The remaining three wards were not approached because at that point, it was felt that there was sufficient data to end the study. Medical wards were chosen in preference to other wards based on the researcher’s belief, from personal experience, that opportunities for educational initiatives abound in these settings.

3.2.2 Access to the Field

The initial approach to the field was by way of a letter to the Director of Nursing explaining the purpose of the study and requesting permission to approach staff. Permission was granted to contact the nurse managers of medical and paediatric services. Following a telephone call to the managers, a letter was forwarded to them to be distributed to the charge
nurses within their areas (Appendix I). A telephone call was then made to the individual charge nurses to further discuss the study and to schedule a time for the researcher to speak with the staff.

3.2.3 Participant Selection

The researcher met with staff nurses from the individual wards at various times throughout an eight month period. The research was explained and staff nurses were invited to participate in the study. Those who expressed interest were given a copy of the participant information sheet (Appendix II) and followed up with a telephone call. An initial interview was arranged, at which time a consent form was signed (Appendix III). Fourteen volunteers were recruited in this manner. The researcher approached a charge nurse about the possibility of meeting with male staff members because up to that point all of the volunteers were female. The researcher felt that a male perspective would enhance the study. A meeting was thus arranged which resulted in a male staff nurse joining the study.

3.2.4 Profile of Study Participants

There were fourteen female and one male participants in the study. Their ages ranged from twenty-three to fifty-two years of age. Nine of the participants received their education in a polytechnic system while the other six were hospital trained. The length of time since graduation varied from fifteen months to thirty-one years. One of the participants had a bachelor degree in psychology and sociology prior to entering nursing. Five of the other participants were in various stages of undergraduate study at

39
university.

3.2.5 Ethical Considerations

As this research involved the study of human beings, approval was sought and granted from the Area Health Board Ethics Committee prior to commencement of the study.

Polit and Hungler (1991:33) state that: "The principle of self-determination means that prospective subjects have the right to voluntarily decide whether or not to participate in a study, without the risk of incurring any penalties or prejudicial treatment". The researcher attempted to maintain strict adherence to this principle throughout the study. Explanations concerning the nature of the study were given both verbally and in writing to potential participants and every attempt was made to avoid coercion when recruiting volunteers. The participants signed a consent giving their permission to partake in the study and were reminded that they were free to withdraw from the study at any time if they wished.

The participants were also aware that data collection involved the use of tape recorded interviews and consents were signed to obtain permission for this. It was made clear that any information disclosed would remain confidential and that their identity would be protected at all times. Pseudonyms were used for all participants and the original tapes and transcripts were safely stored in the researcher's home.

The researcher was continually aware of subjects' right to fair treatment.
Although no negative effects were anticipated from the study, occasions arose in which insight gained from discussion led to self criticism on the part of the nurse. This was exemplified during a discussion with a paediatric nurse about furthering her nutrition knowledge:

I would further my knowledge if I needed to. I mean, it sounds slack. I mean maybe I should anyways (Diana, 6:80).

Care was taken to allow the opportunity for nurses to share and discuss any such issues that arose during the study.

3.2.6 Researcher Involvement

According to Lipson (1991), the researcher in grounded theory is both the data elicitor and the processor who does the ongoing analysis. Being the primary instrument for data collection, the researcher was aware of the influence her position and professional perspective as a nurse would have on the participants and the data obtained. Chenitz and Swanson (1986) suggest that researchers should be aware of their potential influence and learn to use the self to the advantage of the research project. Strauss suggests that researcher subjectivity can be positively managed so that it results in the development of a conceptually dense and carefully ordered theory. To him, the inclusion of personal experience not only adds theoretical sensitivity to the study, but also provides "a wealth of provisional suggestions for making comparisons, finding variations and sampling widely on theoretical grounds" (Strauss, 1991:11).
Although subjectivity can be exploited to the advantage of the research, it is also important that the researcher tries to diminish their effect on that being observed (Chenitz and Swanson, 1986). The researcher attempted to do this in the study by being on the look-out for personal bias or prejudices. For example, nurses in the study frequently talked about being up against "the system". The researcher had to put aside her interpretation of "the system" based on personal experience, and investigate the meaning of "the system" to the nurses in the study, and the effect that they perceived it had on their education role.

3.2.7 Data Collection Methods

The method of data collection for this study was formal unstructured interviews. Whereas the structured interview uses a preset interview guide which the researcher does not deviate from, the unstructured interview is not rigidly adhered to by the interviewer (Chenitz and Swanson, 1986). Unstructured interviews allow the researcher to be exposed to the unexpected because they focus on the participant’s perception of what is happening, rather than the researcher’s conception (Wilson, 1993).

Each of the participants were interviewed from one to three times over a thirteen month period. A total of thirty-five interviews were conducted, lasting from thirty to sixty minutes in length. Second and third interviews were carried out in order to clarify the meaning of issues that arose in the first interview and to obtain feedback on emerging categories and theory development.
As discussed previously, the research literature was used as a source of data to explain, support and elaborate categories during the steps of concept development and concept modification and integration. The purpose of the literature review at the beginning of the research process is to make the researcher aware of previously conducted studies (Burns and Groves, 1993).

3.2.8 Data Analysis

The collection and analysis of the data occurred simultaneously using the constant comparative method. The researcher progressively moved from ward to ward and back again, conducting interviews. Every transcript was analyzed for codes and categories and compared with other data. Further data collection was guided by the emerging theory. This is a process known as theoretical sampling which is "based on the need to collect more data to examine categories and their relationships and to assure that representativeness in the categories exists" (Chenitz and Swanson, 1986:9).

The transcripts were initially analyzed line by line looking for substantive codes which were often the exact words used by the participants. Codes were thus *grounded* in the data and named or described the data from which they were derived. For example:

I suppose like most nurses, you have your priority list...and you tend to work through it and you tend to stick to it (Jackie, 4:55).
In this description the substantive code was labelled "sticking to priorities". Another example of how a substantive code was formed is provided in this statement by Bernice:

Probably the things that I think of that are most important for me to do at the moment are safety issues and comfort. And then there could be a trillion other things that come after that (Bernice, 25:443).

The substantive code was labelled "safety and comfort is most important for me to do". As the analysis proceeded, substantive codes were clustered together into similar categories called selective codes. "Sticking to priorities" and "safety and comfort is most important for me to do" were put under the selective code of "weighing up the tasks".

Categories were constantly being compared with each other and to incoming data looking for similarities and differences. Data reduction occurred throughout the analysis as categories were compared and grouped together. This process helped the researcher to deal with the overwhelming number of categories that were generated and provided a way of connecting concepts. The researcher is looking for a higher order, or some umbrella under which several categories fit (Stern et al 1984). The researcher was also trying to discover the properties of the categories and instances of variation within the categories.

As selective codes were developed the researcher grouped them
together into theoretical codes. For example, the selective codes of "understanding the importance of knowledge and skills" and "developing knowledge" were put under the theoretical code of "recognizing the limits". Theoretical codes were then lifted to the higher level of conceptual codes. For example, the theoretical codes of "recognizing the limits" and "skimming the edges" were grouped under the conceptual code of "dealing with the obstacles".

Conceptual maps were used to keep track of the emerging categories and their relationships to each other. The map continually changed as the researcher's interpretation was refined. In the final interview the conceptual map was shown to twelve participants and feedback was requested. The researcher was unsuccessful in making contact with the remaining three nurses because they had left their place of employment. Each nurse could identify with the emerging theory that was represented in the map. For example, when the map was explained to one participant, this was her reply:

My first thought when you said shaping practice was "Oh no, just another word for prioritizing. Won’t the old word do?" But it’s not just prioritizing. Prioritizing is part of it...If you write an article about nurses and diet, or anything that nurses do for that matter, using those categories, you’d cover the subject quite well...What you’ve come up with is a good tool for assessing what nurses do. How they shape their practice
for whatever subject you’re looking at (Charlotte:31B).

The map continued to be revised as the researcher continued to refine the theory while writing up drafts.

During the entire process of data analysis, memos were written by the researcher. They served as the primary means of recording and preserving thoughts, ideas, and intuitive hunches about categories, their relationships and the emerging theory. The continual writing of memos and rereading of memos and original data helped to guide the researcher to the discovery of the core category.

The researcher was continually trying to discover the core category in the study. According to Strauss and Corbin (1990), the core category accounts for most of the variation in the pattern of behaviour and helps to integrate other categories. "Shaping Practice" was the core category that was identified as having the best fit to the data. The study suggested that nutrition education was an explorative, dynamic, ongoing process that was constantly evolving, as is the shaping process.

3.2.9 Rigorousness of the Research

Guba and Lincoln (1981) feel that in order to establish trust in the data and the interpretations that are drawn from it, certain tests of rigor must be met. In this study Sandelowski’s four criteria of credibility, fittingness, auditability and confirmability were used to measure trustworthiness (Sandelowski, 1986).
Credibility, or truth value, is assured when the participants recognize the descriptions and interpretations of experiences as being applicable to themselves. The researcher attempted to do this by going back to participants to clarify meanings and to get feedback about emerging categories throughout the process of data collection and analysis. Care was taken by the researcher to allow any preconceptions that may have been formed to be challenged by incoming data. Credibility was confirmed in the final interviews when the participants were able to identify with the conceptual map and see the emerging theory as a reflection of their reality. It is suggested by Stern (1985) that the participants are the most reliable judges of their reality in the situation being studied. The researcher also had the opportunity to present her findings to a group of registered nurses who were undertaking further study at a polytechnic. The feedback from the discussion also confirmed that the researcher’s interpretations of the data were accurate.

Sandelowski (1986) points out that the closeness of the investigator-participant relationship is a major threat to the truth value in qualitative research. As discussed previously, the researcher attempted to distance herself sufficiently from participants and the data, so that her interpretations were free from personal bias and reflected true meaning.

The criteria of fittingness, or applicability, was partially met by the methodology chosen, in that the processes followed in grounded theory ensure that the findings fit the data from which they are derived. The researcher made sure that the findings reflected both typical and atypical
descriptions that represented the position of all the participants in relation to the entire group. The researcher also looked for negative evidence that was inconsistent with drawn conclusions, and when found, tried to come up with an alternative conclusion that incorporated the evidence (Miles and Huberman, 1984). Fittingness is also confirmed when the findings of a study fit well into a context other than the one in which they were derived (Guba and Lincoln, 1981). This was demonstrated in this research when the findings were presented to a group of registered nurses outside of the study group. They were able to identify similarities between the experiences of the participants and their own experiences, both past and present.

The criteria of auditability is achieved when another researcher can clearly follow the processes in the study and understand their logic. The researcher attempted to fully describe, document and justify the entire process so that others would be able to follow in the researcher’s path.

Lastly, qualitative research is considered rigorous and "confirmability is achieved when auditability, truth value, and applicability are established" (Sandelowski, 1986:33). The researcher has illustrated how she tried to establish truth value, applicability and auditability throughout this study.

3.3 Summary

This chapter has outlined the investigator’s rationale for the use of grounded theory methodology. The grounded theory approach was selected
because it allowed the researcher to enter the social world of the participants and discover how they defined their reality. Grounded theory as a method of analysis was described, and the process of data collection and analysis for the present study was presented. Participant selection, ethical considerations and issues of trustworthiness were discussed.
Over the next four chapters the conceptual categories which emerged from the data will be presented. They are establishing a niche, dealing with the obstacles, and being part of the team. Together these conceptual categories constitute the basic social process of shaping practice. The nurses in this study are staking, establishing, creating, challenging, adapting and moulding their place in nutrition education. Shaping practice is a dynamic process which is affected by, and constantly changes in response to, the environment in which the nurse works. Thus, there is no end point.
In this chapter the conceptual code of *establishing a niche* is presented. It stems from the belief that nurses see themselves as being different from other health professionals. Their unique position and attributes validates their taking part in the process of nutrition education. What they have to offer is essential if the education is to be effective.

*Establishing a niche* is made up of the categories of *being there* and *looking holistically*.

### 4.1 Being There

In theory, the registered nurse spends more time with the hospitalized client than any other health professional involved in their care. This around-the-clock, extended contact allows nurses to get to know their clients and develop a special rapport, which many nurses see as the basis of the education process. The reality of the nurses' working environment, however, means that *being there*, in a quality physical and emotional sense, is not always possible.

*Being there* is made up of the selected codes of *maintaining consistency* and *building relationships*.

#### 4.1.1 Maintaining Consistency

Education involves a certain degree of interaction between the nurse and the client. The nurse is usually the first health professional to make contact with a client on arrival to the ward and is also the one who has the potential to maintain ongoing interaction with the client until the time of
discharge.

Underlined in this study was a concern about the continuity of care. Being able to follow the same client through from admission to discharge was seen as a more efficient use of the nurses’ time than the chopping and changing of clients on a daily basis. Continuity allowed the nurse to know the client much more intimately. Being aware of normal routines and individual likes and dislikes enabled the nurse to provide better care for the client. Rather than having to spend all her time getting to know the client over and over again, the nurse was able to go a step further, and use the knowledge gained from her client assessment to plan and initiate educational strategies. Margaret, who worked in an environment that fostered extended, consistent client contact, explains the negative effect that a lack of continuity had on her practice:

> How can you be committed when you’re changing clients every two days. If you can’t follow through. Continuity is the big thing. The biggest obstacle [to nutrition education] is lack of continuity (Margaret, 33b).

Other nurses expressed similar concerns about their perceived lack of commitment to the education process when quality contact with their client was denied. The commitment only came about if the nurse was given the opportunity for extended personal contact with the client. Chopping and changing had the opposite effect and was reflected in the effort that they put into their work:
I just notice myself if I have been in one room for a day you tend to become a little bit more task oriented. You just get through the day because you know you are only going to be there for one day. So you do what has got to be done. You don’t have quite that same commitment to each person maybe (Gaylene, 17:278).

For many nurses, however, room allocation rather than client allocation, was the reality in their work setting. There was an assumption, however, that continuity of contact with their clients, if fostered, would lead to greater feelings of satisfaction:

And also we don’t really follow, I mean like you’re put in rooms, but you don’t necessarily follow the patient from the time they come in to the time they go out. So in that way you lose your continuity as well, which makes it quite difficult. Like it would be quite neat to follow someone. You know, admit them and go through and discharge them. Cause that would be quite complete (Molly, 10:140).

Being there went beyond having a physical presence. It also implied some degree of emotional attachment to the client. When physical continuity of client care was encouraged, it provided a foundation on which a caring relationship could be built.
4.1.2 Building Relationships

Nutrition education was acknowledged as a much more complex process than the mere passing on of information. The nurses in this study recognized the importance of individualizing the message and the approach, if the educational needs of the client were to be met. Jackie explains:

...to be able to nurse you have to understand the people. The group of people that you’re nursing. What are their beliefs? What’s important to them? Before you can actually nurse them you have to have that information available and you have to be aware of it before you can understand their perspective. And therefore that’s a starting point to give them education. To know that (Jackie, 4:41).

The establishment of a good rapport with the client was a key factor in determining the success of the education. It instilled a sense of "feeling cared about" to the client and as Lucy explains, resulted in the individual being more receptive to the need for education:

...the effectiveness of it relates to the relationship you’ve built up with them, I think...They’re more likely to indicate that they’ll actually listen to what you’re saying if you’ve built that relationship with them (Lucy, 9:118).

A prerequisite to the establishment of a therapeutic caring relationship is the ability to communicate well. The nurses in this study
acknowledged that good communication skills were essential and generally felt comfortable with their level of skill in this area. A relationship built on trust and mutual respect resulted in the client revealing things to the nurse that other health professionals were not privileged to hear. An important consequence of this, was the potential for the nurse to "zero-in" to the needs of the client and tailor the nutritional message to meet the needs. One could only individualize the message if a relationship existed between the nurse and the client. Most participants felt that this potential to develop rapport with their clients was unique to nurses:

I wouldn’t expect that the patient would discuss with the dietitian as much as they would discuss with us unless they had a really trusting relationship. But that’s not likely because the dietitian might only pop in every now and then and it’s not the same sort of thing. Whereas we’re there all the time and we’re the main connection with the patient (Bernice, 26:447).

Other health professionals, such as the dietitian, were perceived as being able to address the needs of the client, but with the element of individuality missing. The nurse was the one who had the ability to tailor the needs because she was the one who spent the most time with the client and knew the most about them:

I still feel that we’re probably still the primary educator, if you like, health educator. And of course the dietitian sort
of comes into the scene and then goes out of the scene and
doesn’t really, I still think you have to know the patients
pretty well. And establish what their background and their
eating patterns, their social lifestyle and that sort of thing
was, before you can, out of hand, pronounce a diet for
someone. And the dietitian would tend to do that a little
bit. O.K. they’ll provide a diabetic diet or they’ll provide
a roughage diet, but it won’t be at all suitable for the needs
of that person (Margaret, 12:173).

Although a caring relationship was beneficial to the success of the
education process, not all nurses had the opportunity to develop this rapport
with their clients. The establishment of trust took time and as Annabel
explains, time was a luxury that often did not exist in the hospital setting:

I guess people don’t spend long enough time in hospital.
Like something like forty two patients in three days
[laughs]. I mean you can’t expect to educate people when
they’re just coming in, staying overnight and then going
home again. You don’t really get to know them...Yeah
most of the time you don’t get to develop a rapport with
the patient cause they’re not in the hospital long enough
(Annabel, 13:202).

Establishing relationships with clients was seen as being important to the
success of education, but it also had other benefits. Getting to know clients
was a rewarding part of nursing and added the human element to the situation. When nurses were unable to fulfil this part of their role, practice became very mechanistic and resulted in feelings of disappointment and emptiness, which Bernice had experienced:

I feel sometimes like I’m a robot. And I think sometimes the patient thinks that I’m a robot too, you know. Yeah. Throw them their pills, quick wash or whatever, Or they might think, "Oh. They never talk to me or spend time with me as such" (Bernice, 25:443).

If both the physical and emotional conditions were right for being there, the nurse had a foot in the door that other health professionals did not have access to. Their ability to establish a niche in nutrition education, was therefore dependent on the ability to be there. Once the door was opened and the relationship initiated, nurses could begin to look holistically at the needs of their clients.

4.2 Looking Holistically

The majority of the nurses in this study described their nursing practice as being holistic in nature. Being holistic meant the ability to look at every aspect of the client’s care, ranging from physical, environmental, cultural, social, to spiritual. The term holistic was often used in opposition to the "medical model" and was seen to be an attribute unique to the nursing profession.
The selective codes which made up this category were *acknowledging the wider needs* and *resisting the pressure*.

### 4.2.1 Acknowledging the Wider Needs

There was a recognition amongst the study participants of the complexity of dietary behaviour. Factors such as cultural background, age, gender, taste preference, habit, amount of social support, the influence of the media, and developmental stage were factors that were all identified as influencing an individual’s food choice. Being able to assess these wider needs and incorporate them into the education process was seen to be crucial to a successful outcome. Charles explains what a holistic assessment meant to him:

Someone who comes into the ward might present with ulcers on their feet. And that’s their diagnosis, bilateral ulcers. You can’t just treat the ulcers... You’ve got to look at their home situation. See how happy they are. How with it they are. What their moods are like. Are they depressed? Are they wanting to recover? Have they got something to go home to? You’ve got to look at all these things. Their religious beliefs, emotionally how they feel. And before you can actually start treating those ulcers and things, you’ve got to, it’s a total package. And you just can’t compartmentalize the different bits of their life you know, without actually dealing with each one individually... So yeah it’s a total package and you can’t
leave one bit out. So that’s what I mean by holistic, the
total health of a person (Charles, 27:464).

This ability to acknowledge the wider needs made it legitimate for nurses
to establish a niche in the education process. As Charlotte explains, being
able to look at the whole person was something that was often seen to be
far more developed in the nursing profession than with others health care
workers:

Well the way I see it the dietitians are coming from one
angle and one angle only. So that the dietitian’s priority,
all consuming priority, is to make sure the child is the right
weight and showing all signs of getting all the nutrition that
they need. Whereas I have got a whole lot of other things
on my mind, like the mother is very distressed about this,
that and the other problem…Whereas the dietitian, it seems
to me, is only thinking about the nutrition to a large extent
(Charlotte,20:331-332).

There was the potential for frustration on the part of the nurse, when
other health professionals were perceived to be limited in their ability to
respond to the wider needs of the client. In the following example, Sandra
tries to explain why educational efforts fail, resulting in adolescents being
repeatedly admitted to her ward:

With adolescents it is definitely a body image thing. Being
different to their peers, and pressure to, I mean how embarrassing for them to have to go out and give themselves an injection before lunch and so forth, and take their BM’s and things. Kids are cruel anyway without you being different. So that is the main issue with adolescents, but they are never addressed. They are just saying "Oh that’s typical adolescent, you know, going through that stage". And that will be about it (Sandra, 21:357).

Bernice describes another situation in which the wider needs of the client were assessed, but not addressed:

The other day I noticed that one of our patients was very obese. I didn’t know whether she wanted to do something about it or not. And I mentioned it to the dietitian… I thought that it was her role and the patient might feel a bit more comfortable [discussing it with her]. And the dietitian was quite reluctant to do that. She said "I only see overweight people if it’s on referral from the doctor." And I just couldn’t believe it and I said "Why?" And she said "It’s only if it’s medically a problem at the moment." I thought that was quite frustrating...I thought that was a real shame. Really disappointing. It has to be an active, obvious problem (Bernice, 35).

In the above example Bernice felt that she was trying to "look beyond the
medical diagnosis", but was stifled in her attempt because the clients’ nutritional status was not seen to be compromised. There was a common feeling that if the total needs of the client were not taken into account, that the client would be set up for failure once they left the hospital environment. "Using the system on them" was a term coined by Lucy to describe practice when it was not holistically based:

The system is kind of like you come in and you are looked at, things change, and you go out again. That’s kind of the system I suppose and you can actually do that to people without a hell of a lot changing for them. Like the system does that but you haven’t actually looked at the person. You haven’t really met half their needs...Their needs haven’t been met. Their wider needs haven’t been met (Lucy, 19:309).

Being holistic, although thought to be unique to nursing, was not a skill that was inherent to all nurses. Some nurses who described their own practice as being holistic, were critical of their colleagues who they felt were stuck in the "medical model":

I don’t think nurses still are educated as to how to fully assess a person, nursing wise. I still think too many nurses look at patients from a medical viewpoint or a surgical viewpoint. From the doctor. And don’t see a nurse’s role as such...A person comes in for a specific disease and
that’s all that’s looked at or thought of. The nurses would never dream of thinking of it in any other way (Margaret, 12:183).

Although the majority of nurses identified with a holistic approach to their care, it soon became evident that holism did not always guide their practice. There was an acknowledgement by many nurses of a constant struggle to remain holistic in an environment that was not supportive.

4.2.2 Resisting the Pressure

The participants believed in a holistic approach to health and were quick to describe their practice as being guided by holistic principles. But they were also aware of the limitations in their work environments that interfered with their ability to practice holistically. They identified the presence of a pressure that was pushing them to focus on the obvious physical needs of the client, to the neglect of the clients’ wider needs. Nurses had a constant struggle to remain holistic in what they often described as a "medical model" environment:

And of course you have got the pressure always from outside, well within the system. Yeah always channelling you into that medical mode all the time. Getting the job done...Just attending to the person’s physical needs (Alex, 23:401).

It was acknowledged by most nurses who spoke about the "system", that
nurses themselves were a part of this system. Resistance to holism often came from colleagues within the nursing profession:

You hear it with the people who are in hospital and the students. "Oh when they get out of training they will get into the real world. That is not the way it is." And they hear it all the time. You don't have time to do the holistic nursing cares...cause they have one patient as a student. So they can do everything for eight hours a day on that particular one person. We have five or six. You just don't do it" (Sandra, 21:358).

It was interesting to note that nurses who talked about their inability to be holistic still clung to the term holistic when describing their practice. When I asked Sandra about this contradiction, she replied:

I think there's only sometimes that you would actually treat them in a holistic way, maybe when you are not so busy. Whereas if you are busy you are just doing more the medical mode. I'd like to believe that we do a lot of holistic work. We are probably dealing in a more holistic way with the tertiary children than we would do with the acutes. So we are probably more medical orientated with the acutes, but more holistic with the tertiary. Because they are in longer and you know their needs a lot more (Sandra, 21:346).
Other nurses shared the opinion that the ability to be holistic varied with the acuity of the setting. This contradiction between being holistic and attending only to the physical tasks will be discussed again in Chapter five.

There was also a strong belief expressed by a few participants that the medical model and the holistic model were not mutually exclusive. Because it was not possible to work outside of the medical model, the key was to find a balance that allowed the nurse to hold on to a holistic framework:

I just sort of have to repeat, having my whole nursing experience in the acute medical situation, I don't really want to leave the medical model behind because it is valuable. It focuses on the dangerous thing that's wrong and fixing it. And I really don't want to leave that behind. It's a very valuable model. But it does get in the way...It really isn't two separate things. I think if we are holistically orientated, then you're not going to stop being holistically orientated because you go to an acute medical ward and you have to focus on getting children better from dangerous diseases quickly. There's no reason why it should drop away and disappear. That's your attitude to people. It's not going to go away (Charlotte, 24:416).

Charles agreed that the medical model and holistic model should both be used, but felt that the medical model tended to be the one that dominated
in the hospital setting:

Sometimes holistic care is a luxury in this day and age. It is a luxury. But like I said, there’s ways of getting around things. And you just become more adroit and clever at making things work for you. Just manipulating the system almost (Charles, 28:490).

Like many other nurses in the study, Charles was facing a constant struggle to retain holistic practices in an environment which was seen to value the completion of immediate physical tasks in a fast, cost efficient manner.

4.3 Summary

Being with the client both physically and emotionally were factors which influenced the potential for nurses to *establish a niche* in nutrition education. Continuity of physical contact fostered the development of a mutually caring relationship which was the foundation for education. The nurses also *established a niche* for themselves in nutrition education based on their unique ability to assess the client’s needs holistically. This allowed the opportunity for the nurse to identify the wider needs of the client, which was essential, if the education was to succeed. Looking at the total needs of the client was not easy when nurses were constantly having to fight the pressure that was forcing them to focus exclusively on the physical needs of their clients.
The nurses were also confronted with other obstacles that had the potential to interfere with their involvement in nutrition education. The next chapter describes these other obstacles.
As discussed in the previous chapter, nurses had the potential, theoretically, to *establish a niche* in nutrition education. However, their ability to *deal with the obstacles* in their working environment greatly influenced the degree of participation that they would ultimately have as educators. The obstacles and the impact that they had on the education role varied from nurse to nurse and from setting to setting. *Dealing with the obstacles* was a process that all nurses had to go through to some degree as they shaped their nutrition education practice.
The theoretical codes that made up this category were *skimming the edges* and *recognizing the limits*.

5.1 Skimming the Edges

One of the goals of the government in restructuring the health care services was to achieve greater financial efficiency (Upton, 1991). The results of this restructuring had a tremendous impact on the nurses working in this hospital setting. The common feeling amongst participants was that staff shortages were the norm and were here to stay. As a result, nurses had to learn ways to balance their heavy workloads in order to meet client needs more effectively.

Weighing up the tasks, making time and educating on the spot were the selective codes that made up the wider theoretical code of *skimming the edges*.

5.1.1 Weighing up the Tasks

Nursing practice occurs in a constantly changing environment as client needs change from minute to minute. As a result of staff shortages, most nurses felt that it was almost impossible to do everything that was expected for their clients in an eight hour period. The way to deal with the situation was to prioritize and respond to the immediate needs of the client. The immediate needs were frequently those of a physical nature. A feeling of dissatisfaction often accompanied the results of weighing up the tasks, as Chrissy explains:
I guess what I feel is that at the end of a month when somebody is looking back on my reports and they know that I have showered a patient, I've given them their IV adds, I've done their nine o'clock obs, you know, I've done all those sorts of things...then they're liable to say I'm a good nurse. But there may be big deficits in education there. Like these IV adds and these other things are just about sometimes I feel ahead of education. Though I'd like to act differently, it doesn't always happen that way (Chrissy, 1:9).

The priority that was afforded to nutrition education was affected by the type of ward which the nurse worked on. Client acuity was one factor which determined how busy the nurse would be and as a result, how high up the priority list education would be. Molly, who worked on an acute general medical ward felt that the education role was often unrealistic:

In terms of why we're here, in preserving life, well yeah, you have to prioritize. You can't really go in to a patient who's [at this point she imitates someone gasping for breath] and just say, "Here's a tomato. Here's a meat pie. Now which one are you going to have? This is better for you than the meat pie" (Molly, 10:151).

Annabel, who also worked on an acute general medical ward agreed:
I mean it [nutrition education] would be wonderful to do, but you’ve got so much to do anyway. Now I’ve got to go and read up about something or find out myself, when in actual fact it would probably do me the world of good if I did find out. But it takes up so much time to find something. It’s such a relief if [the dietitian] comes up and yeah, it’s easier to pass the buck (Annabel, 13:212).

When the "life and death" factor of the acute setting was removed, there was more of an opportunity for nurses to become involved in the education role, as Margaret, working in a chronic medical area, explains:

I mean nurses are busy. And I guess once again, they look at priorities first. A sick person with a disease and so the basics have got to be done...And at the end of it all, they’re too darn tired to bother with sort of side issues which don’t seem important. But when a patient isn’t acutely ill, then you can look at all the issues (Margaret, 12:183).

Nutrition education was not always assigned low priority in the acute setting. Jackie, a coronary care nurse, felt very strongly about the importance of nutrition education in her area and placed it near the top of her priority list:

We are less busy with perhaps cleaning up dirty bottoms
and having to reshower them or doing dressings or those sorts of things that they need to do in other areas. We have quite mobile patients. Although I suppose, on the other hand, it could be very busy because they are having arrhythmias. But you have to make time for it...The pressure is on us to teach the patients so you know that you have to at least attempt or make provisions for the dietitian if you are too busy...I put the pressure on myself I suppose because I know how important it is (Jackie, 18:289-290).

Jackie was not alone in her belief that nutrition education was an important part of the client's care. But the fact that she was less busy doing "tasks", meant that nutrition education took high priority not only in theory, but in her practice as well. The researcher also feels, from personal experience, that nutrition education is easier to do when working in a specialty area which has one main focus, such as heart disease. Other factors, such as wide publicity in the media and a multitude of written patient education resources, also gives nutrition education a high profile, both for treatment and prevention of heart disease.

It became obvious to the researcher that nurses only involved themselves in nutrition education if the nutritional status of the client was compromised or if the client was admitted with a nutrition related diagnosis. When the topic of nutrition education in relation to disease prevention and health promotion did not surface in the interviews, the researcher directed her questions in order to explore the area more fully. It seemed to be a logical
conclusion that if nurses were *skimming the edges* and being forced to attend to the most immediate physical needs, then preventative education would not be a priority of practice. This was verified by Diana:

> The ideal would be that you could do a lot of preventative education...But the reality is that you’re short staffed, you’re busy and you’ve got to do the necessities (Diana, 15:246).

Diana was not alone in her belief that preventative education could not be realistically practised in the hospital setting. Heather, a coronary care nurse, agreed, but for different reasons:

> I think often trying to educate people who don’t see the relevance to them is quite difficult. Because unless you can say "OK this is relevant to you because your cholesterol is at 6.8 so you ought to listen." If you start telling them about cholesterol, you know, "you must cut down on your fats". And they say "well do I have a high cholesterol?" And you say "No". They say "Well this doesn’t apply to me then does it." I think that people do need to see that it is relevant to them (Heather, 16:251).

Most nurses, however, still held the conviction that educating with the intention of preventing diseases or promoting health was of utmost importance, even though it was not routinely done by the hospital nurse:
I think in New Zealand, through no fault of anybody, a lot of our treatment and stuff is geared towards symptom management and those kind of things. We gear everything up to when something happens instead of the preventative side. And I think that nutrition education is to do with the preventative, prophylactic side of things. And it almost needs a whole cultural change. I mean all these people in education and research have been screaming the same thing for years. That we don’t spend enough time on risk management and all those kind of things. We wait for something to happen before we start cleaning up all the damage that occurs (Charles, 27:473).

The time constraints which necessitated prioritizing of care highlighted the struggle that was identified in Chapter four. The participants identified with a holistic model of nursing care, but were unable to look beyond the existing medical problem. Lucy, who described her approach as holistic, was able to articulate this:

I know it sounds a bit of a contradiction but that’s even with primary nursing, you can’t actually look at the whole, you don’t actually look at the whole health of the person, often because you haven’t got [time], unless there is a need... You are always aware of it, but unless you pick up a discrepancy you might not ask specifically about it (Lucy, 19:322-323).
Although there was the reality of high client acuity, staff shortages and heavy workloads, some nurses felt that there were other reasons why nurses were not involved in nutrition education to the extent that they should be. Every nurse in this study was of the opinion that nutrition education, whether it be on a treatment or a preventative basis, was essential. There were doubts, however, as to the value that nutrition education was given by others.

5.1.2 Making Time

Nurses, because of their professional training, are very aware of the contribution that nutrition makes to health, recovery and general well being. Although they verbalized the importance of providing nutrition education to their clients, some nurses, such as Molly, felt that there was a lack of valuing on the part of their colleagues and other health professionals:

> It is passing the buck. In a way, an excuse. It’s just not making time. I think it is a matter of making time and how much you value that. And unfortunately people don’t

(Molly, 10:149).

Sometimes the lack of valuing was expressed in subtle, rather than direct ways. Sandra, a paediatric nurse, recites an example that illustrates the unspoken lack of importance that nutritional issues receive:

> We are not given the time to do it. Because if you have a

74
diabetic kid, they look at it as a light load. So you would have to take up heavy loads to balance out everything. Whereas to sit down and assess and discuss the issues involved with the adolescent, you are not given the time to do that (Sandra, 21:357).

Other nurses agreed that there was an unstated lack of valuing of the importance of nutrition education in the hospital setting. It had the potential to influence the way in which practice was prioritized by the nurse, as Annabel explains:

If he [the doctor] medically clears them, there’s no way they’re going to keep them in hospital. It costs them too much money. Regardless if we’ve educated them or not...It’s like, well it’s numbers and beds and how much is it costing the hospital for this patient...It is very undervalued when in actual fact it could be the main cause for them being in hospital. We sort of see them as acute. We’re trying to get them better to get back out of hospital and we don’t see that as being a problem while they’re in hospital. I mean they can fix that once they’re out of hospital (Annabel, 13:202-203).

This perceived lack of valuing of the importance of nutrition education, coupled with the necessity nurses felt to prioritize their practice, meant that nutrition education was either not done at all, or it was pushed very low on
the priority list for many clients. These factors, which affected how often nurses initiated or were involved in nutrition education, also had an impact on the quality of the education. For most nurses, nutrition education was not a structured, preplanned activity.

5.1.3 Educating on the Spot

Although all nurses felt that they had a niche in nutrition education, heavy workload demands and time constraints dictated the extent to which nurses played out their role. As stated earlier, nurses had to find ways to adjust their workloads in order to accommodate the staffing shortages that they were experiencing in their work place. Nutrition education was not exempt from this balancing act, as Annabel relates:

When you’re at tech you’ve only got two patients ever to look after and you have miles of time to educate them. But it’s just so unrealistic when you come up here, and we used to have twelve patients. I mean how the hell you’re meant to sit down with one of them for five minutes. It’s impossible. It’s just so unrealistic. And like from tech I learned a lot of our role was educating patients. I mean that’s why they’re giving us all this knowledge so then we can feed it back to the patients, but I’ve never been able to do it (Annabel, 13:201).

Even though time constraints placed limits on the ability of the nurse to provide planned educational sessions, most nurses felt that they were still
involved in the education process on an informal basis. Education in the "formal" sense was not the norm for the nurses in this study:

Does educate mean that you have more than one session on it maybe? You actually make a specific time to talk about it. Well I don't do that. I have never done that (Gaylene, 17:279).

The reality of heavy workloads meant that nurses fitted education in around their other tasks and were often doing the education on a spontaneous, off-the-cuff basis, as the following example illustrates:

Formal education we don't do very often, but we do an awful lot of informal education all the time. Just at the moment when you might be giving out the lunch and they say "I don't like such and such." Or when you are giving out the medicines and they say "I have this ongoing problem of constipation." And you say "Well do you like kiwifruit? Because if you just have one of those a day you might be able to stop having to take..." "Oh yes, we'll try that." That type of education. Very informal (Margaret, 22:378-379).

This type of education was not always perceived by the nurse as ideal, but it was seen as the only available option:
While I am doing tasks I am talking to people all the time, so you always get a certain amount of education. For example while you are sticking an antibiotic up in the tube you are talking to the mother about nutrition. More often than not you are doing two things at once and you can slide a bit in here and a bit in there. Not to say that it wouldn’t be more effective if you could sit down and have a full half hour with them on nutrition. That would be more effective but you always do get some of it done...Sometimes it leaves a bit to be desired, because you haven’t got through as much as you would like to or got as much information as you would like. So it is fairly effective but not optimum (Charlotte, 20:336-337).

If education was needed beyond what the nurse had the time to provide, a referral was made to someone who was seen to be able to offer quality time:

It’s in a very bitsy way. You explain things. "You can’t have that and this is why." And that’s it. And you go off and you do something else. And you give them their pills, insulin or whatever. "This is what this is for. Have your meal in half an hour." And you go on and do something else. But you don’t actually get a formal time to sit down and talk to them and that’s where you have to refer them on (Bernice, 25:431).
Heather agreed that lack of time for sitting down and having a formalized session meant that the education was better suited to someone who was perceived to have the time:

I think you need uninterrupted time to educate someone and quite often, the time that we have is fragmented. And I think that that interferes with the education process. So a person who's job it is to do nothing but educate people on diet doesn't get that kind of interruption (Heather, 5:63).

The person who was perceived to have adequate time for providing nutrition education was the dietitian. If nurses were given the required amount of staffing and the time to educate their clients about nutritional issues, would they have become more involved in the education process? In the researcher's opinion the answer is probably "no". As will be shortly revealed, a lack of time was not the only factor accounting for the nurses' lack of involvement in nutrition education and for their reliance on the dietitian.

5.2 Recognizing the Limits

Education is a two way process which involves a "giver" of information, a message and a recipient. It was recognized by the participants, however, that in order for the education to be successful, the process involved more than an educator delivering information to a waiting recipient. Many attributes were mentioned in describing a "good" educator. Among these were the ability to: accurately assess the needs of the client, identify the
correct timing for the education, be a good listener, communicate in a non-threatening way, bring the level down to that of the client, possess a broad knowledge base, be approachable, empower the client, and be a good role model. Although these qualities and skills were not universally identified as being vital to the educator, the possession of a strong knowledge base was seen, unanimously, to be essential. The nurses in this study were aware of a knowledge deficit which would have to be addressed before they could participate more fully in the education process.

The selective codes which were identified were understanding the importance of knowledge and skills and developing knowledge.

5.2.1 Understanding the Importance of Knowledge and Skills

The majority of nurses described their level of nutrition knowledge as "basic". It was difficult for the researcher to ascertain exactly what was meant by the term "basic" because the evaluation of nutrition knowledge was not the intended purpose of the research. This was something which was made clear to the participants prior to entering the study.

It was, however, still important to try to understand what nurses meant when they used the term "basic" to describe their knowledge. Those nurses who used the term "basic", were often doing so in comparison to the perceived knowledge level of the dietitian, as the following example illustrates:

I suppose we're first line. We give out the basics and then
she comes in and sees that they have picked up the basics and then works on the specifics (Jackie, 18:294).

The participants were aware of the limitations that their knowledge level placed on the education process. Bernice explains how it necessitated the involvement of other health professionals who were able to pick up where the nurse left off:

Often when I discuss things with patients about their education to do with nutrition and I sort of give them a few pointers in passing or whatever, and then sometimes they turn around and ask questions and I don’t really know what to say. So you feel a bit, you know, it puts you on the spot a bit. You feel they want to know more and you just sort of say "Oh well. I’ll have to refer you to a dietitian." [laughs] You feel a bit dumb (Bernadette, 35).

There was one exception in the study to the way in which nurses described their level of knowledge. Alex, who admitted that "if I hadn’t been a nurse, I would have liked to have been a dietitian", described her knowledge as being very accurate and quite current. Two factors that contributed to her specialized knowledge were personal interest and her role as cardiac rehabilitation nurse:

A lot of us in coronary care feel that dietary role, that education of diet, is better handled by the dietitian. You
know, like they look upon her as another specialty again. So I think the system very easily does categorise people into specialities...I myself am sort of a product of the system really, in that I was slotted into a role and expected to know so many things about cardiac rehab (Alex, 23:402-403).

Alex acknowledged that when she was working as a staff nurse she was unable, because of lack of time and busyness, to do as much nutrition education as she would have liked. Her way of dealing with this was to become "a product of the system", where her position legitimized her extended involvement in nutrition education.

Other nurses, aware of the restrictions that their knowledge deficit imposed, acknowledged that there was a solution to the problem. Most nurses felt that if given the time and resources, they would be able to develop their knowledge and meet the needs of the client themselves. Lucy explains:

I would have to sit down and think of what I was going to say to someone and find the information and figure out a way of presenting it and that is the time that you haven’t got. It’s annoying. It would be good to be able to have all that information and give it there at the time. We just haven’t got the time. It is just annoying. We don’t even consider that as an option. Whereas the dietitian is doing
it all the time. Their training focus is on it the whole time and so they are much more likely to be able to answer off the spot questions. Like, they actually know more, right off (Lucy, 19:305).

However, as stated earlier, there was the realisation that current staffing levels would not improve and that lack of time would always be a factor which nurses had to work around.

In addition to a sound knowledge base, the nutrition educator must also have the skills that are needed to assist clients in making dietary changes. Merely imparting information is not a guarantee that learning will take place (Rankin and Duffy, 1983). In this study there was often a perception on the part of the nurse that the client was unwilling to change and was not receptive to learning, as Susie explains:

People who are naughty will eat naughty things. The older people who you’re wondering why they’re scoring seventeen to twenty eight sometimes, or over twenty eight [on their BM sticks], you know they’re pigging out on short bread and things like that...I mean that’s not all of them of course, but it’s just some people who take a long time to sort out, and it’s really that they’re just not compliant. And it’s a lot of sort of nutting out and sometimes they don’t want to learn (Susie, 3:32-33).
One nurse, who spoke frequently of the time constraints that prevented her from educating her clients, had this to say, when the researcher asked her if she would want more of an education role under ideal staffing conditions:

No...In my heart I suspect that nobody is going to listen all that much anyway...The apathy of humanity or whatever you like to call it...It’s just the nature of the beast...And certainly some people are open to new information...But there are very few (Gaylene, 11:169).

There was also a feeling of frustration and anger on the part of the nurse when speaking about clients who wouldn’t listen. The nurses varied in their approaches to dealing with the "non-compliance" that they encountered. A few nurses, like Annabel, resorted to threats:

Sometimes you get quite annoyed, cause it’s like this man has just about died and he doesn’t really want to listen to ways to prevent himself from having another one [heart attack]. And yeah, you can get quite firm, well not firm with them, but you just sort of get angry with them and your voice might go up an octave [laughs] and you say, "If you don’t do what they’re telling you to do, you’re going to die, so it’s up to you." It annoys you when people don’t really want to listen to what you’ve got to say (Annabel, 2:22).
Other nurses spoke about the importance of timing the education so that the client had time to accept everything that was happening and come to terms with it. Reinforcement and waiting for the information to "sink in" at the client's pace were perceived as being important steps when dealing with non-compliance. Although the participants were aware of many principles of teaching and learning, their lack of reference to specific learning theories was noticeable. There was only one nurse in the study who hinted as to the importance of learning theories to guide practice:

> It would help to have more of an understanding of peoples’ behavioral patterns. And how people perceive their illness. Sometimes I feel quite inadequate...I mean generally I say "It only takes a matter of time before you get your taste buds acquired to different things." And you can give them that sort of information, but I mean it depends on how they’re perceiving their illness as to whether they’re going to comply or not (Alex, 14:234).

If a lack of knowledge and skills was one of the main underlying factors limiting nurses from becoming more actively involved in nutrition education, one could postulate that nurses would be eager to accept the opportunity to develop their knowledge.

### 5.2.2 Developing Knowledge

Although the participants were aware of the importance of a strong knowledge base to the education role, this was not always accompanied by
a desire to increase their level of knowledge and ultimately, their involvement in nutrition education. Most nurses felt that their level of knowledge, although very superficial, was sufficient because of the circumstances under which they worked. The main factor influencing this reasoning was the presence of a dietitian who acted as a "safety net". Jackie explains:

I think it is important in this specific area to know what the heart rhythms are because you need to either treat or not treat, so it could be life threatening or not. And so therefore you put a lot of energy into knowing those things. Whereas nutrition is not in the same group as life or death at this particular stage and you have your back up services if you're busy (Jackie, 4:54).

There was an expectation on the part of the nurse to utilize the person who was considered to be the nutritional "expert". Recognition of others' expertise was seen to be part and parcel of the team concept:

I also think that I would tend to leave it more to a dietitian. Like we see more defined roles within the hospital system. I suppose it's just part of the team approach. Like the use of the physios, dietitian, diabetic nurse specialist, all of that. We're introduced to that and told to make use of the resources that are here (Molly, 7:89).
Diana agreed that the dietitian, being the nutritional expert, should be the one to provide the nutrition education. She explains the rationale behind her decision to utilize the recognized "expert":

The dietitian, that is her role. She gets contacted. She comes up and she does all the dietary education. And she'd rather we didn't so that everyone's not saying different things. We're told that...She'd have a fit. Oh, no, she'd probably like it cause it would be less work for her [laughs]. But no, I mean that is her role. We phone her, she comes, she does the dietary teaching...She's got all the literature...She's got all the information. And has been doing it for who knows how long...So I wouldn't even, you know, interfere with that at all (Diana, 15:239-240).

Although Diana felt that it was expected of her to rely on the dietitian to do the education, she felt that this was justified. Like every other nurse in the study, Diana saw the dietitian as the one who had the most time and the most knowledge to provide the education.

The accessibility of nutrition experts was important to the nurse, but at the same time, having a dietitian "on tap" contributed to a lack of incentive for nurses to expand their own knowledge:

It would be wasteful of my resources. If I increase my
nutritional knowledge and spend more time on nutrition, then I would obviously be spending less time on something else, so I would be wasting a resource. So as part of my time management that would not be a very good thing to do. I wouldn’t want to waste that resource. I mean if I was working in a smaller hospital out in the country or as a public health nurse I would probably have to make it a bigger part of my role because dietitians aren’t available. And I would have to increase my knowledge on nutrition (Charlotte, 20:338).

Although the nurses in this study did not feel that increasing their nutrition knowledge was a current priority in their practice, some nurses did express interest, provided the opportunity was made available to them. When I asked Susie if she had the desire to increase her knowledge, this was her reply:

It would be good to feel that you’re a bit more complete. But the time is a real factor. Most of us are doing extra study. And I do find this quite a physical ward and also we’re all on committees within the hospital and I find that you don’t want to start feeling overwhelmed. Or else it just sort of adds to stress and I don’t want to feel that I’m sinking and not noticing when enough is enough. I mean I would definitely attend lectures within my work time. That would be quite a pleasure (Susie, 3:37).
Inservice education for nurses on nutritional issues was not offered in this hospital setting. If the nurses did want to increase their knowledge, it was up to them to find ways to do this. But like Susie, most of the nurses did not feel that it was warranted if it meant extra work outside of their normal hours.

The participants had received their nutrition knowledge to varying degrees during their training and even though a few nurses had taken informal courses in nutrition since becoming registered nurses, none of them had done any formal updating up their knowledge and skills. Although the time constraints were a legitimate factor, there seemed to be a lack of recognition of the need for continuing education in the field of nutrition.

5.3 Summary

Even though nurses felt that they had a niche in nutrition education, they had to deal with obstacles in their work environment that got in the way of them fulfilling their role. The main obstacles that were identified were a lack of time and a knowledge deficit. Because of staff shortages and time constraints the nurses were often skimming the edges rather than providing comprehensive care. This meant that they had to weigh up the importance of the tasks that they performed. Nutrition education, particularly of a preventative nature, was not seen in the same light as other life or death issues. When the participants were involved in education, it was usually of a spontaneous, informal nature.
The participants admitted to their knowledge deficit, but with the accessibility of a nutrition expert there was not a perceived necessity to update their knowledge.

The next chapter describes being part of the team, a vital process which makes it easier for nurses to deal with the obstacles as they continue to establish their niche in nutrition education.
As discussed in the previous two chapters, nurses are in a unique situation and possess special qualities which enable them to establish a niche in nutrition education. One such quality is the ability to assess the client’s needs holistically. Alongside this is the opportunity for extended contact and the development of good rapport with the client. Even though the nurse is theoretically in the "best viewing suite" (Charles, 32b) for assessing the educational needs of the client, obstacles were identified which prevented nurses from taking advantage of their position. Lack of time and lack of knowledge meant that the nurse could not meet the
nutritional needs of the client on her own. The nurses in this study were learning to be part of the team in order to satisfy the needs of not only their clients, but of themselves and of other health professionals.

The theoretical codes which comprised being part of the team were finding a place and learning to work with others.

6.1 Finding a Place

Because the nurses were working with others to provide nutrition education, it was important that they identified the part they perceived themselves to play in the process. They tended to describe their contribution in relation to their place within a team. Role boundaries, describing the parameters of the nurse’s involvement, were individually established by each nurse. In some cases, the nurses were prevented from carrying out their defined part in the education process because of the existence of previously identified obstacles.

The selective codes of making connections and filling in the gaps made up the wider category of finding a place.

6.1.1 Making Connections

Education is generally accepted as part of a nurse’s role, and the participants in this study were no exception in their belief that education was integral to their practice. Although there was unanimous agreement on this point, there was, however, uncertainty as to the format or the extent of involvement that the nurse should have in the education process. The
fact that there were no formal, written rules or guidelines specifying the nurses' part in nutrition education, meant that they were left to shape their own practice. As a result, involvement varied from nurse to nurse and from setting to setting. Every nurse in the study, however, felt that they had a responsibility to at least assess the need for education:

The first thing is that there is a need for the education to start off with, as soon as the patient becomes yours, and you evaluate that there is a need for education...So basically once finding out that there is a need and then seeing if there is someone set up in the hospital system which has more time than I have...I'll put the contacts in place and get the wheel rolling (Susie, 3:30).

Most nurses, like Susie, did not feel that they had to be the ones to deliver the actual "technical" knowledge. As discussed in Chapter five, a lack of knowledge and time, and the availability of a nutritional "expert" influenced the extent of the nurses' involvement in the educational process. This was reiterated by Bernice:

I think probably nutrition is somewhere up in the air as to whose responsibility it is. But as I said before, assessment, I mean it should all come up in assessment anyway. So I think the assessment is our responsibility. The management, as long as it gets done to the best and to the patient's requirements [it doesn't matter who does it]
The way to overcome obstacles such as knowledge deficits and time constraints was to work with other health professionals who had skills and qualities that complemented those of the nurse. The health professional who the nurses tended to identify as the nutritional "expert" was the dietitian, although on occasions, they also used the expertise of the diabetic nurse educator, the district nurse, the cardiac rehabilitation nurse and the physician. Charles explains his views on the team concept to nutrition education:

I don't think one person takes responsibility. It's a team approach... Working in tandem, or whatever, with everyone else (Charles, 28:495-496).

Several nurses described their role within the team as that of a coordinator. Assessing the need and then making the connection between the client and other health professionals was seen as one of the most important and essential dimensions of their role, as Lucy relates:

If you didn't give them a referral, they wouldn't [see the patient]. So if you don't see the need, they mostly wouldn't see a person at all... Nurses make the system work. If someone's got diabetes, you have to call the diabetic nurse educator. You do it automatically. Nursing makes the system work for patients. The system doesn't work
otherwise (Lucy, 9:132).

Charles agreed. He recognized his limits and saw an essential part of his job as the linking of the client's needs to the person most qualified to meet those needs:

I think part of our job as a nurse is to harness whatever bit of expertise and whatever bit of, whatever the patient’s needs are. It should be harnessed. And yeah, pull it all together basically. I’m no expert on nutrition and I realize that (Charles, 27:478-479).

The participants did not see their contribution as a team member ending once they had made the connection with the dietitian. It continued in acknowledgement of the fact that they had the most physical contact with the client. This, theoretically, put them in an excellent position for reinforcing the nutritional message once it had been initiated by the dietitian.

6.1.2 Filling in the Gaps

All of the nurses in this study felt strongly that they had a role to play in reinforcing the "technical knowledge" once the dietitian had done the educating. Again they didn’t see themselves as the ones that delivered the technical knowledge, but the ones that helped the client to absorb and understand that information. The need to reinforce the nutritional message again and again was seen to be equally important as the initial delivery of
information:

I prefer to get the dietitian in. That’s their specialist field. I do it from the nursing input. Technical knowledge delivery, formal teaching, that’s her role. But reinforcement is important. The nurse is the reminder. They can get away with it with the dietitian cause she doesn’t follow up. She’s not physically there (Margaret, 33b).

Alex agreed:

Well [the dietitian] tries and sees most patients who come through the unit. But quite often she’s stretched to her limit. And so really we have to fill in the gaps. And even when she comes up, she may spend say half an hour, fifteen minutes with the person. And really it’s only enough to give them the information, give them the material. They read about it and really we have to fill in the gaps later (Alex, 14:217).

Other health professionals, because of their limited contact with clients, were not able to carry out the reinforcement role to the same extent that the nurse could:

The dietitian is not in a good position to have a very good
education role really. They don’t see the families enough to build up a rapport and they’re not in a position to repeat and repeat. We’re there twenty four hours a day so if they need to be told about it all again later that day, after five o’clock when everyone’s gone home, then you’re there to do it (Charlotte, 24:412-413).

As stated earlier, the nurse was theoretically in a good position to provide the reinforcement that was needed. This, however, did not necessarily mean that the reinforcement was being carried out. Alex’s experiences with her colleagues led her to this conclusion:

The reinforcement is not being done. It’s just "Did you see the dietitian?" It’s not thorough (Alex, 29a).

A few of the other participants agreed with Alex about their lack of involvement in reinforcing, although in theory, they believed that it was important. For some, it was a lack of time to provide the reinforcement and for others, it was a lack of knowledge about what needed to be reinforced:

We couldn’t actually sit down and carry on with the education. We would reinforce if we know about it. And like I’ve worked there longer than alot of people. And I probably would know alot more than them. And I ask, cause I’m the diabetic resource nurse. But a lot of the
Diana felt that the nurses’ inability to provide the reinforcement was a direct result of a lack of communication between the nurse and the dietitian. This lack of communication, however, was not because it was deemed unimportant. As Sandra explains, the reinforcement role was pushed to the bottom of the priority list, often because of the ever-present time constraints that had to be worked around:

Sometimes you just don’t even want [the dietitians] to come and tell you what they are doing because you just don’t have the time... You just go "yeah, yeah, yeah, O.K." And you’re off again (Sandra, 21:360).

As was revealed in Chapter two, the team concept is promoted as being the most efficient and effective way of approaching nutrition education. If a successful outcome is to be achieved, it involves the cooperation of many people, principally the client, and also requires a strong, unified and consistent team approach (Lask, 1986).

6.2 Learning to Work with Others

Rankin and Duffy (1983) suggest that because nurses work as part of a team rather than in a vacuum, that they must learn to define their roles and articulate their contribution as a team member. Although nurses are socialized throughout their training to work as part of a team, it was found that learning to work with others was an on-going learning process for
many of the nurses in this study. The participants were able to define their role in nutrition education, but they had not necessarily learned how to articulate this to other health professionals. Effective communication between team members is necessary if others are to understand and respect the nurse’s contribution to the team (Rankin and Duffy, 1983). This is certainly pertinent to the nurses in this study, for when the lines of communication were poor it impacted negatively not only on the effectiveness of the education for the client, but also on the nurses themselves.

The selective codes which made up learning to work with others were communicating with others, feeling complete and maintaining in spite of.

6.2.1 Communicating with Others

The nurses saw a very important role for themselves in assessing the need for education and in working with the dietitian to carry on the message once it had been initiated. After an assessment had been made, the nurse had to communicate the message to the dietitian in some way. Similarly, once the dietitian had delivered the "technical" knowledge, some form of communication had to exist between the dietitian and the nurse so that the reinforcement could be carried out by the nurse. The means and degree of communication varied considerably from nurse to nurse. For some it was purely a link on paper, and for Gaylene, that was adequate:

If it is important it will always be written down in the clinical notes. And it is our job to read them and make
sure they are carried through. Well I see it as that (Gaylene, 17:282).

Jackie, similarly, did not expect that verbal communication was essential to her carrying out her reinforcing role effectively:

It could be better team work I feel. Like it would be ideal if I discussed with the dietitian, after seeing one of my patients, "Oh, was there anything of relevance that I need to know?" and "How did you get on?" etc., etc. Very naughtily, I don’t do that...I’m busy doing something else and I suppose it hasn’t crossed my mind until now (Jackie, 4:52-53).

But, Molly, on the other hand, felt that unless a verbal exchange had taken place, she was left with gaps in her knowledge about the client:

You’re not getting a complete picture of what’s going on. Just the same as you know, with the doctors. It’s quite good sometimes to talk to the doctors if you can to get a more complete picture of what’s going to happen, what is happening, where that person’s at. Rather than just reading it in the notes which is often the case. Like coming back and having to read what they’ve written after they’ve gone. Yeah, it does give better care if you can, well I mean it’s part of the team isn’t it? The nursing, well the medical or
whatever you like to call it, the hospital team. If you can talk to each other and communicate about that person (Molly, 10:140).

Charles agreed that the education process was more effective if verbal dialogue had taken place between the nurse and the dietitian. It was an opportunity for the nurse to pass on relevant information that was gained from the client assessment. If the education was to be successful it was deemed essential to share this information:

I normally talk to her first before she goes in to the patient...I feel as if I’m doing her a disservice by pulling her in cold. So we talk about it and I’d say why I wanted to talk to her, why I think Mrs. So and So needs her specialist help, where she’s coming from, you know, a good time of the day for her to learn. All these little things, they really contribute (Charles, 27:479).

Importantly, it was not only client care that was jeopardized when there was a communication breakdown. When the dietitian, or other health care workers, took the time to discuss the client’s situation with the nurse, this was interpreted as a sense of valuing. It was important to the nurse to feel that she played an integral part in the client’s road to recovery and in order to be seen as a valued member of the team, it required work on the part of the nurse. She had to prove to the dietitian that the nurse’s contribution played a vital part in the education process. Lucy had been successful in
her ability to define and articulate her role within the team:

You have to work at it and establish relationships and get them [the dietitian] on your side. And they need to make the nurse feel part of the team...It’s part of "recognize me as being important to this patient and what you want to do for them. I am here to back up what you do." They need to see the nurse as being part. [They need] to support nursing (Lucy, 30a).

It was unfortunate that some participants in the study did not feel that their contribution was valued when it came to nutrition education. A lack of verbal communication from other members of the health care team equated to a lack of valuing of what the nurse had to offer, as Chrissy’s comment shows:

I do believe that when we’ve got a patient that we look after all the needs of that patient and we may not have the absolute intrinsic knowledge of one area, but we may need to get a specialist who does. But we will work with that person, like we may set it up and then we will hopefully, I’d like to think we could reinforce what that person says...I hopefully see nursing as a coordinator for that person, you know...It doesn’t happen in nutrition. I don’t know why...I wonder whether it’s partly [the dietitian]’s personality. I mean she’s nice, but yeah, she’ll go in and
do it, bang. And she goes out. Whether she doesn’t see me perhaps as needing to help any more (Chrissy, 1:11-12).

Chrissy was not the only nurse to hold this view. Charlotte also interpreted the lack of communication as a lack of respect for the nursing profession:

The doctors more often than not still act completely independently of the nurse. And do what they’re doing regardless of the nurse and without any communication with the nurse. And the dietitian is exactly the same. It’s not actually incorporated into their practice to see the primary nurse as the coordinator of care. They might say they believe that in effect, but they’re not actually, like you were saying before, they don’t read the nurses notes to see what the primary nurse has written in the chart for example. Or the nursing care plan. They’re not really all that interested. They do their own thing (Charlotte, 24:421).

It was suggested by Sandra, and a few of the other participants, that the quality of communication which existed between the nurse and the dietitian was partly due to the personality of the individual dietitian. Although it was acknowledged that good communication required effort on the part of the nurse, it was also thought to be dependent on the willingness of the
dietitian to regard the nurse as a vital team member:

We don’t get any feedback on the results of, you know, it is only written in the medical notes, "discussed with patient, blah, blah, blah." Oh we have one dietitian and she communicates with us quite well...Whereas the other one, she doesn’t generally communicate with the nurses very much at all. So I guess it is up to them. That’s their individual preference if they want to or not (Sandra, 21:360).

Good communication contributed to a feeling of satisfaction with one’s place within the team. It was a way of showing that the nurse’s contribution was respected, valued and essential to the education process and to a successful outcome.

6.2.2 Feeling Complete

Although several nurses in the study felt content with their place within the team and with their contribution as an educator, almost half of the nurses expressed a sense of disappointment. Their feeling of "incompleteness" was in response to what they saw as an erosion of their role:

You know the days that we’ve had time to actually sit down and talk to someone about their home situation or things like that. They just stand out those days. Like
you can say at the end of the duty, "Gosh, that was such a
good duty." Cause you had time to do everything. You
could really feel that you'd done everything for your
patients. And that's just not how the environment is now.
You finish the day feeling that you're not complete. And
often you'll write in the notes. "Can you see about such
and such tomorrow."...It would just be a referral to the
dietitian (Susie, 3:39).

Bernice, who described her involvement in nutrition education as that of
a coordinator, was also not content with the amount of involvement that
this entailed:

Sometimes I feel cheated by the system. I feel that I'm
overqualified for what I'm doing. I'm not giving it
everything that I've got (Bernice, 25:444).

On the other hand, many nurses were content with the extent of their
participation in nutrition education. They felt valued and did not feel that
they were sacrificing part of their role when they brought in an expert to
give nutritional knowledge:

No it's definitely still my role. And it's still part of what
I do but I delegate. Delegate isn't even the right word.
Because that means that you are giving a bit of the role to
the other person. No. I'm using a resource to get that role
done. So I’m doing it and I’m using the resource, is the attitude that I do it with. I’ve got the overall coordinating of the care job and I’m using a resource to do this bit. I’m not giving that bit of the job to the dietitian (Charlotte, 24:419).

Others agreed with Charlotte that the nurse could still be highly involved in the education process, even though they were utilizing the skills of an expert. Heather felt that the ability to let go was a developmental step which "younger" nurses had not yet learned:

The younger ones from tech feel they must do everything. The reality is that you assess the need and delegate so that you’re free to do other things. It’s an unrealistic expectation. You learn through experience that you can’t do everything and you delegate...But the nurse has a part. You don’t give it away. You delegate treatment or education and check up, so there is a role to play. There are people who can’t work as a team. They want to do everything themselves (Heather, 29b).

Molly, a "younger" nurse who had about one and a half years experience since graduation, had already come to the conclusion that she could not do everything that she thought she could when she first started out:

When you first come out of your training and then you start
to realize, because like you go through different stages of, just different phases of slowly integrating yourself from being a student to an R.N. And one of them is having to, the ideals that you have, having to reform them into reality, to practical everyday working life. And realizing that you can't do everything. Yeah, you can't be everything to everyone. That you've actually got to modify it down to what's realistic and practical...I mean what you were saying about educating while you're doing things, yeah I mean that's fine and I think we do do that. But more along the teaching plan, with your aim, your objectives, and all that sort of thing we were taught in tech. Maybe that's something that you just won't, isn't practical to do (Molly, 10:142).

Even though Molly realized the necessity of reforming her ideals, she had not yet come to terms with it. She felt that she was eroding her role by giving away a part of it to someone else in the team.

Charles, who had about two and a half years experience since graduation, felt that he did "give away" part of the education role to someone else, but was still left with a feeling of completeness:

I think it's a bit of both [the nurse and the dietitian]. I find it really hard to separate them. We've got the twenty four hour care so we do all the reinforcement...I think we really
under rate ourselves. We might be doing a lot of really good education in a really subtle way, like doing all the reinforcing and stuff. Which isn’t imparting the technical knowledge, but we’re still. It’s back to the holism again too. It’s all part of the whole package deal. OK we do the initial assessment, pass on our concerns to the dietitian. They come in, write whatever they need to do. Start the education by saying what they’re going to do. Leave it to the nurses to do the reinforcement. It’s all, like I find it really hard to separate them. It’s all part of a whole (Charles, 28:493-494).

The difference between feeling complete and feeling cheated did not seem to correspond to age or length of time since graduation. There were other more marked influences on whether or not the nurse felt professional satisfaction. These influences, which were discussed in Chapters four and five, had an impact on the degree of involvement that each nurse would have as an educator. For some, the role amounted to little more than assessing the need for education and writing the referral for the dietitian in a book. Although these nurses believed in the importance of reinforcing the nutritional message, they did not often do it. Obstacles such as lack of knowledge, lack of time and poor communication with the dietitian stood in the way. These same nurses also found it very hard to retain a holistic model of nursing practice in the environment which they were working. Weighing up the tasks often meant that they were working more from a "medical model" than from the holistic model which they identified with
as a nurse.

The other nurses were more involved in the entire education process, over and above the initial assessment. In spite of the obstacles, they still felt that they were able to nurse holistically and take the wider needs of the client, such as nutritional education, into account. They also tended to feel more involved in reinforcing the nutritional message because they had better communication with the dietitian and other members of the health care team. One of the factors which helped the nurse to maintain in spite of all the negative influences was the primary nursing role.

6.2.3 Maintaining in Spite Of

Eight of the nurses participating in this study felt content with their level of contribution in nutrition education. The others all expressed a sense of incompleteness because they wanted to be more involved than what they currently were. As stated earlier Charlotte was an exception. Her involvement in nutrition education as a staff nurse was limited, but she was able to fulfil this part of her role in her specialized position as cardiac rehabilitation nurse.

There were many factors which were shown to influence the nurses’ ability to take a more active education role. The researcher firmly believes that one of the most influential factors was the structural organization of the nursing care. Of the eight nurses who expressed a feeling of professional satisfaction with their education role, six were working as primary nurses. The other two were coronary care nurses who described
their nursing care as being a mixture of primary nursing and team nursing, as Jackie explains:

It's entirely different the system that we work. They have a room perhaps with six patients. They tend to do primary nursing. We do that too. Like we might have four patients each for instance, but we tend to interact with each other a lot more because it's a small area...And we need to know what's wrong with the particular patients in this area because it's an acute area. Mrs. So and So down the way could also have problems, heart arrhythmias or something, and we need to step in. We can't just say "Oh go and get the primary nurse and she can deal with it." You know, so it's a totally different set up than the ward really (Jackie, 4:46-47).

Of the seven remaining nurses who expressed dissatisfaction with their nutrition education role, only one was working in a primary care setting. The others were all working under a room allocation structure, although two of these nurses admitted that they fluctuated between room allocation and primary nursing depending on the needs of the ward. One of these nurses, Bernice, gave the following reply when the researcher tried to clarify if she identified as a primary nurse:

Well to a certain degree. We try and keep consistent with the areas we've been in the previous duty, but things
change a lot. Like if you’ve been off, you come back and you probably won’t be in the same area (Bernice, 25:437).

The researcher felt it was important to include some of the thoughts and feelings expressed by those nurses who were working in a primary nursing capacity. There were many comments about primary nursing that clearly identified in the researcher’s mind the positive influence that it had on the nurse’s potential for involvement in nutrition education:

Primary nursing makes more sense. The nurse is more accountable. What we do or don’t do makes a big difference. It’s your job to see that it happens for the patient. I want and expect to have a say in what happens. I expect to be listened to (Lucy, 30a).

Others agreed with Lucy’s comment that primary nursing gave a sense of accountability to the nurse. Being listened to and having your contribution respected gave the nurse a feeling of self-worth:

Primary nursing creates a system that works for nursing and gives satisfaction for the nurse and the client. Before that, nurses saw themselves as handmaids to everyone. Doctors, physios, they all had higher kudos than the nurse…With primary nursing you’re a partner in the team. It gives you pride in the profession that you’re making a difference…There’s accountability. You’re trying to do the
best that you can (Margaret, 33b).

Being a primary nurse did not necessarily mean more involvement in the actual delivery of technical knowledge, but it did instill a sense of responsibility in the nurse for making sure that all of the needs of the client were taken into account and addressed. Charlotte explains:

In my practice before primary nursing came in, I think I saw certain bunches of care as my role. And other things as not my role. I didn’t worry about those. So that yeah, nutrition for example, I always felt I had some role in nutrition. But I probably wouldn’t have seen the monitoring of the weight and the intervention for problems as necessarily my role. I perhaps would have thought of it as the doctor’s and the dietitian’s role (Charlotte, 24:420).

I asked Charlotte if it was different now that she was working as a primary nurse:

Yeah, in attitude it is. In practice, it’s not very different. Because we do have those resources [the dietitian]. But in attitude it is. In attitude I really see every single thing that affects the wellbeing of the family as part of my role (Charlotte, 24:420).

Charles agreed with the sentiment expressed by Charlotte:
I think the best thing about primary nursing is the empowerment and the advocacy and all those sort of thing. And primary nursing gives you responsibility and it calls for accountability...It almost gives you a professional obligation or a moral obligation to know all the bits of that person that makes them tick for you to get them on to that wellness, the illness to the wellness continuum thing (Charles, 27:469).

Although these nurses had definite ideas about the benefits of primary nursing, the researcher was aware of other factors that may have been important in helping them to maintain in spite of. One factor was the influence of personal philosophy on nursing practice. When the primary nurses used words such as accountability, advocacy, and empowerment, the researcher tried to determine if they were personal beliefs. In other words, would they still have the same views about nursing practice if they were not working in a primary nursing context? The nurses themselves did not know the answer to this question.

Time and resource constraints inherent in a limited piece of research meant it was not possible to investigate the issue of personal philosophy with those nurses in the study who were not practising as primary nurses. However, the researcher was aware of the influence that personal philosophy may have had on the nurses’ level of involvement in nutrition education. A case in point was Charlotte:
A philosophy is something that guides you through a storm. It helps you to prioritize all the time. If you go into a job trying to do the best that you can and cope with everything that comes your way, on its own, I can see how you get overwhelmed and give up. But if you go in with a philosophy, you can measure against your philosophy. For example, whether it’s important or whether it can be left. It helps a lot...Nurses need to have a philosophy. Maybe not formal, but at least certain principles that run through, like empowerment (Charlotte, 31b).

Charlotte happened to be working as a primary nurse, but the researcher reiterates the point that her philosophy may have been independent to her primary nursing status.

Another factor which could have influenced the nurses’ ability to maintain in spite of was the fact that many of these nurses were working in chronic medical areas rather than acute medical areas. This in itself may have had an influence on how involved they were in the education process. The average length of stay for clients is much longer in chronic areas and this, on its own, would have given the nurses an advantage over those working in acute areas with a high client turnover rate. The significance of familiarity with clients was raised by participants as a factor that was important to the education process. The chronic nature of the wards also meant that either there were not as many tasks to attend to or the nature of the tasks was different. These factors, as well as the primary
nursing role, would have most definitely contributed to the nurse’s degree of involvement and to their ultimate feelings of satisfaction with their role.

6.3 Summary

The nurses in this study were aware of the limitations that they faced when trying to be involved in the process of nutrition education. In order to get around the obstacles and still retain their stake in the process and their sense of personal satisfaction, it necessitated being part of the team. To do this, the nurses first had to find their place within the team. Assessing the need for education, liaising with the dietitian and then reinforcing the nutritional message were the nursing contributions to the education process which were identified by the participants.

Another important component of being part of the team was learning to work with others which was dependent on the establishment of open lines of communications between other members of the health care team. Although every participant identified as being part of a team, not all nurses were left feeling satisfied with the amount of involvement that they had as a team member in providing nutrition education. A major factor that surfaced in the study and which may have contributed to profession satisfaction was the opportunity for the nurse to practice in a primary nursing context. The researcher feels that it had a marked influence on the degree of involvement which nurses ultimately had in the nutrition education process.
The previous three chapters dealt with the conceptual categories that emerged from the data - establishing a niche, dealing with the obstacles and being part of the team. In this chapter the conceptual categories are brought together and woven into a theoretical framework around the core category - shaping practice. This is the core or central category around which all the other categories fit. It recurs frequently in the data, accounts
for the variation in behaviour, and explains the main action which has emerged from the study (Strauss, 1991). The chapter concludes with a discussion of the limitations and implications of the present study.

7.1 The Process of Shaping

Symbolic interactionism, from which grounded theory is derived, is based on the assumption that meaning guides behaviour and that meaning arises from social interaction which leads to a sense of self. Experience changes self and therefore changes behaviour (Chenitz and Swanson, 1986).

It is through interaction with clients, colleagues, other health professionals, their own guiding ideals and beliefs, and the organizational structure in which they work, that nurses develop a sense of self. The process of shaping is proposed as a conceptual framework to explain nurses' nutrition education practice.

To shape is to give a direction and character to (one's life, conduct, etc.) and includes the processes of making, fashioning, creating, moulding, carving, trimming and adapting (Shorter Oxford English Dictionary, 1973:1965).

Although the verb "shaping" is frequently used throughout the literature, there is little written specifically about the process of shaping practice. The researcher has included two examples from the literature which refer
to shaping practice and have relevance for this study. One of these is Leddy and Pepper (1989:269) who discuss two models which they believe underpin nursing practice. One is a model of dependence on medical practice in which the focus for nursing is the support of the medical regime. There is a heavy reliance on the doctor’s assessment and diagnosis of the client. The other model is one of autonomous professional practice based on nursing knowledge which is applied to the nursing process. Leddy and Pepper argue that the model which is accepted by the nurse will ultimately shape the knowledge needed and the nature of her practice.

A critical ethnographic study by Jones (1993) explored the "theory practice gap" in nursing. In this work she established that nurses were able to shape their nursing praxis through an ongoing developmental process which encouraged them to explore and become aware of their personal beliefs and perceptions about nursing. Jones defined praxis as reflection and action that transforms nursing practice. Through the active developmental process nurses began to move from a traditional, hegemonic, positivist paradigm which fostered the "theory practice gap", to a dynamic, humanistic, phenomenological, critical social theory paradigm in which there was no "theory practice gap".

Shaping, in the context of this study, is a process that nurses go through as they attempt to meet the nutritional needs of their clients. Although education is widely recognized as an integral part of nursing, the role of the nurse in regards to nutrition education is continually evolving as nurses learn about themselves through social interaction. Shaping
practice encompasses beliefs about nursing, recognition and strategies for dealing with obstacles which are incongruent with these beliefs, and nursing practice within the context of a team. Shaping practice subsumes the conceptual codes of establishing a niche, dealing with the obstacles and being part of the team. Although they are presented as distinct categories, the processes are intricately linked and occur simultaneously.

Establishing a niche can be regarded as the starting point for the process of shaping practice. Nurses want to be included in the education process because they have basic beliefs about nursing. Being there and looking holistically are two abilities believed to be unique to the nurses in this study, which influence the direction that their practice takes.

As nurses attempt to put their beliefs about education into practice, they go through a process of dealing with the obstacles. This involves a degree of moulding and adapting as they work around the barriers that they confront in their working environment. They shape their practice by skimming the edges, and recognizing the limits.

The final phase of shaping practice is being part of the team. Nurses do not work in isolation and are aware of the need to involve other health professionals who complement the contributions made by nurses. Working hand in hand with other members of the health team, in particular the dietitian, leads to a greater involvement on the part of the nurse. Nutrition education practice continues to evolve as nurses find their place within the team and learn to work with others.
7.2 Shaping Nutrition Education Practice

The main action in this study consists of nurses trying to link their values and beliefs about what it means to be a nurse with their actual nursing practice. Nurses do this within the context of their individual social environments. They are constantly confronted by a discrepancy between the values in the health care setting in which they work and their own beliefs about nursing. *Shaping practice* is the process that nurses go through as they deal with this conflict.

As outlined in Chapter four, every nurse in this study wanted to have some involvement in the nutrition education process. This desire to *establish a niche* is based on the belief that nurses have a contribution to make which enhances the education process and is essential to a successful outcome. The importance of treating clients as people, developing therapeutic relationships, looking at the whole person, and individualizing care are values that underpin practice for the nurses in this study. In order for nurses to be able to do this, it is essential that they *be there* for their clients, both in a physical and an emotional sense. The views of the nurses in this study coincided with many views in the literature which proposed that nurses are in an excellent position to carry out education because of their close and extended contact with clients (Greene 1960, Palm 1971, Pohl 1973, Winslow 1976, Murdaugh 1980, Syred 1981, Thompson 1983, Corkadel and McGlashen 1983). In the eyes of the participants, however, the environment was not always seen to be conducive to facilitating this. They saw their internal value system as professionals to be in conflict with the value system of their employer.
Staff shortages, high client acuity and fast client turnover rates supported their perceptions that financial efficiency was the driving motive of the organization in which they practised.

An extension of being there was the ability of the nurse to look holistically at the needs of the client. To understand nutrition one must understand human behaviour. The nurses in this study were aware of the importance of looking holistically at all of the factors that impinge on behaviour when assessing nutrition education needs. Vessey and Richardson (1993) state that when assessing a client holistically, the nurse must look at aspects of the client’s life that make him or her different from any other client, such as culture, development, gender, personality, health beliefs and socio-economic status. When nurses are not encouraged to be holistic, they resort to taking care of the immediate physical needs of the client, knowing full well that the underlying problem may have been totally missed in the process.

The difficulty of nurses holding on to their holistic roots, particularly in a hospital setting is well documented in the literature. Bowman (1993) points out that higher client acuity and increased technological nursing interventions compromise the nurse’s capacities for receptiveness to the complex needs of the whole person. Wilson-Barnett (1988) goes even further by questioning whether values such as holism are indeed a part of nursing. She feels that holism is given lip service and is not put into practice in nursing. To a certain extent this study supports her views, in that even though nurses identified as being holistic, the reality of practising
holistically in the current health care setting was not easy. The participants frequently spoke of having to resist the pressure that was preventing them from being able to practice the way they wanted to. Their philosophy of individualized, holistic care was undermined by the values of the bureaucratic organization which was seen to place higher value on tasks, fast turnover rates, cure, efficiency and cost-consciousness. Redman (1971) goes as far as to suggest that the "system" may actually discourage the nurse's education role because of the greater efficiency that is possible when teaching is not done.

The pressure that the nurses felt to "get the job done", came not only from the hospital bureaucracy but from their nursing colleagues. The importance of attending to the physical tasks took precedence and was seen to be valued by some colleagues over and above the educative role.

The result of the existing conflict between values and beliefs was that nursing practice tended to be dominated by the values of the bureaucracy. These were often incompatible with the beliefs held by nurses and left many of them with an uncomfortable feeling of having "used the system" on the patient, rather than having acknowledged the wider needs. This is supported by Perry & Jolley (1991) who feel that nursing has traditionally been overshadowed by an emphasis on physical and medical aspects of care.

Elements of oppression can be identified in this behaviour. Freire states that "any situation in which A objectively exploits B or hinders his pursuit
of self-affirmation as a responsible person is one of oppression" (1972:31). Bureaucratic power and the power of the "medical model" were dominant forces operating in the environment in which these nurses practised. Gray and Pratt (1991) describe medical model practice as that which aims to diagnose and treat disease, as opposed to the holistic model which involves caring practice directed towards wholeness of the individual, family and community. The result of this dominance was that the nurses in this study felt a lack of autonomy, accountability and control over their practice.

Although some nurses were able to identify isolated factors that interfered with their nutrition education practice, the recognition of a dominant-submissive relationship was not explicitly articulated. Nurses were not always aware that when they were weighing up the tasks, the decision about whether or not to initiate nutrition education was usually determined by the medical diagnosis of the client. Roberts (1983) is accurate in her view that dominance is most complete when it is not even recognized.

There are many similarities between the findings of this study and a qualitative study by Gott and O'Brien (1990), which was discussed in Chapter two. They found that although the nurses in their study were trying to divorce themselves from their relationship with medicine, that their nursing practice was driven, often subconsciously, by a medical model dominance. When nurses carried out health promotion activities in the community, the priority of their practice was to try to change lifestyle risk factors. Gott and O'Brien pointed out that although the nurses wanted
to establish their independence within the health services, that the focus of their practice was based on the priorities and preferences of the medical profession. It was claimed that the nurses had no insight into their limited health promotion behaviour.

Part of shaping practice was to find ways and means to deal with the obstacles that stood in the nurses' way. When faced with staff shortages, fast client turnover, and high client acuity, the nurses had to learn how to prioritize their practice. This often left the nurse with a feeling of dissatisfaction when weighing up the tasks meant a refashioning or compromise of held beliefs. A study by Benner (1984) also confirmed that when nurses are confronted with staff shortages they do just the necessary patient care tasks, learn the short cuts and do emergency nursing. She goes on to say that when nurses practice under these conditions, two important sources of satisfaction are missed; the "human connection"; and the "sense of competency and accomplishment that comes from knowing that you have been able of offer what you had to offer when it was needed" (1984:153). This was certainly highlighted in this study when nurses spoke of feeling incomplete when they were unable to carry out their educational role the way they wanted to.

Roberts (1983) argues that nurses have gradually learned to internalize the values of the mechanistic medical model of health. This is not surprising when nurses, "who have explicitly been taught that nursing values and beliefs reflect concern for the person rather than the disease, begin their practice within the constraints of medical and technological
ideologies and institutional regimes which do not recognize these values as being integral to nursing practice" (Perry, 1987:11). The findings in this study support this view. Practice often became disease-focused and task-orientated as nurses strove to be seen as "good" nurses. Education, particularly of a preventative nature, was often at the bottom of the priority list, and not because it was undervalued by the nurse, but because it was not always seen to be a priority of the system. The sentiment expressed by Chrissy when she did not educate her clients exemplifies this:

Though I'd like to act differently, it doesn't always happen that way (Chrissy, 1:9).

For many nurses, the answer to this problem was to improve staffing ratios so that time would be allowed for nurses to fulfil their educational role. There was an acknowledgement, however, that the power to do this was out of their control and that it would never happen in the current health care climate. Street (1992) suggests that being powerless to change anything is a common complaint of nurses. This feeling of powerlessness is also confirmed by Jolley and Brykczynska (1993:60) who believe that nurses have a relatively low status in the health care system and as a result, must abide by the rules and learn to "swim against currents and tides set by various deities who have more power..."

Nurses also recognized the limits of their knowledge as a barrier to being more involved in providing nutrition education to their clients. Most nurses described their knowledge as being adequate for the amount of
involvement that they currently had, but acknowledged that they would need to develop their knowledge if the dietitian was not available. The presence of a dietitian "on tap" precluded them from doing this. This view seems to the researcher to be inconsistent with the concept of holism. Morse and Corcoran (1993) agree and argue that nurses provide holistic care and that nutrition is part of the holistic care of people. Nurses therefore need nutrition knowledge regardless of the presence or absence of other health professionals.

The nurses in this study felt that their role was mainly one of assessment followed with making connections and filling in the gaps once the dietitian had presented the specific technical knowledge. There seemed to be no insight into the necessity of possessing current nutrition knowledge, including teaching and learning theories, in order to do this effectively. Winslow's (1976) suggestion that all too often nurses equate telling with teaching is evidenced in this study by the absence of the participant's reference to teaching and learning theories. Some nurses did refer to the importance of timing the education and making it relevant to the needs of the client, but there was generally a lack of awareness of the necessity for guiding theories. The tendency by some nurses to label clients as "non-compliant" when they were perceived as not wanting to learn, is consistent with a paternalistic philosophy common to the medical model. The responsibility for failure rests solely with the client and if they choose not to take the advice of the expert, clients are seen as undeserving of further care (Utz, 1990). Wilson-Barnett (1988) and Utz (1990) accurately state that strategies for encouraging or persuading are complex and involve an
understanding of motivation and learning. A view of motivation that is congruent with nursing's holistic perspective promotes an approach to the client which "has the potential for respecting personal autonomy in decision making, for capitalizing on the client's strengths, and for empowering the person to promote health and healing (Utz, 1990:14).

The nurses' lack of commitment to *developing their knowledge* could be seen as a result of their oppression or subservience to the organizational values. It is easy to interpret the paucity of nutrition education inservice as a lack of valuing of its importance by the organization. Nurses are unlikely to take opportunities for client teaching if it is not given top priority by both the nursing staff and the organization (Corkadel and McGlashan, 1983). Nurses will not be encouraged or rewarded for their attempts to improve their knowledge and skills, if it is not valued by those in power who hold the purse strings.

O'Connor (1985:157) refers to nursing as "a sleeping giant in the health care delivery industry", although she acknowledges the potential power that is within nursing to advance its ability to provide high quality health care. The way to harness this power is to develop nursing leadership that will guide and direct the advancement. O'Connor believes that the key to developing nursing leadership is through continuing education. The participants in this study were unaware, not only of the need for teaching and learning theories specific to nutrition, but of the need for *developing their knowledge* specific to the discipline of nursing. Although some participants were involved in undergraduate continuing education, nursing
was not the focus of their study. If nurses are to act as change agents, leaders, or decision makers in the health field a thorough knowledge and understanding of the discipline of nursing is essential, and this comes through advanced nursing study.

The nurses continue to shape their practice as they adjust, develop and conform to being part of the team. Many of the nurses in this study had learned to work successfully as a team member and felt that they were integral to the overall efficient functioning of the team. They spoke of having to put effort into making the team work. Open lines of communication existed between team members and the nurses felt confident about the importance of their contribution from a nursing perspective. Benner describes an "expert" nurse as one who no longer responds to every patient request with equal intensity and speed. They are able to "juggle and integrate multiple patient requests and care needs without losing important information or missing significant needs" (1984:146). She goes on to say that the expert nurse recognizes the team as an integral part of her own effectiveness and has learned to work successively as a team member. The nurses in this study who felt good about their practice could be said to be "expert" nurses; ones who had learned to work with others in the health team, but still managed to feel complete and retain their sense of self identity. They knew that what they did or didn’t do made a difference, but were also aware that they could not meet the needs of their clients on their own.

Not all nurses, however, were left with a feeling of satisfaction about
their practice. For many there was a perception that their nursing contribution was not valued and not seen as necessary to meeting the nutrition education needs of the client. This sense of not feeling complete could be linked to an inability to integrate well as a team member. Several nurses were left with a feeling that they were "passing the buck" and giving their role and their beliefs about education away. Even though these nurses described their practice as occurring within the context of a team, it was evident that the players did not really work together. Evident too, was a lack of communication between team members, such as the nurse and the dietitian, and a lack of awareness of what each team member’s role involved. Fragmentation did exist and the team effort suffered.

Woods feels that in order for the team to be successful, the individual team members must be effective. This necessitates that the nurse defines her role in the team and involves "the perceptions of others, your manager, your colleagues, and your own beliefs, regarding the behaviour which is expected in that specific role" (Woods, 1990:21). This same point is stressed by Doheny and colleagues (1992) who argue that nurses must respond not only to differing expectations of groups outside nursing, but to conflicting opinions within the nursing group itself as to role expectations. A solution to the problem is offered by Gray and Pratt (1991) who adamantly state that if nurses want to be seen as essential members of the health care team then it is vital that they clearly articulate what they want nursing to be and where they see that nursing, as they perceive it, should be practised. Jacobson and McGrath suggest that introspection is the key; a process that leads to a more even sharing of power in the team.
relationship:

Nurses must identify their individual power bases and those of others in their work environment...In many situations, the power of others is viewed as stronger merely because the nurse has not become fully aware of his or her own power sources nor tried strategies to use that power (1983:136-137).

Some nurses in this study were aware of the power that they held as the coordinators who *made connections*. Thomas (1983 in Benner, 1984:169) describes the nurse as the "invisible glue that keeps the complicated system of hospital care together." Because it is a taken-for-granted function of nurses, nurses themselves fail to recognize its importance. This study supports the opinion that not all nurses see themselves as coordinators of client care. Although they *made connections* between the client and other health team members, such as the dietitian, the importance of such a position was not appreciated or taken advantage of by all nurses.

A very important final influence on how nurses *shape their practice* was the mode in which nursing care was organized in the health care setting. Marram and colleagues (1979) question whether the way that nursing services are organized can make a difference to both quality outcomes and the humanistic delivery of care. In this study it was evident that primary nursing empowered nurses and gave them an opportunity to *maintain in spite of* the forces and obstacles that stood in the way of them practising the
Primary nursing can be defined as a way of organizing nursing service so that the same nurse has total responsibility for nursing care of a particular client over a twenty-four hour period so that continuity of care is facilitated (Doheny et al., 1992). When the primary nurse is absent, an associate nurse carries on with the plan of client care that was developed by the primary nurse, the client, and the family.

As discussed in Chapter six, the author was unable to determine whether or not primary nursing was a method of organization alone, or both an organization and a philosophy of care. The inability to answer this question is not unique to this study. Furlong (1994) studied twenty-six nurses and health care assistants working in a primary care setting and found that forty-six percent of nursing staff thought that primary nursing was a method of organization, while the majority of respondents (fifty-four percent) felt that primary nursing was both a philosophy of nursing and a method of organization. She concluded that there may be a relationship between the length of time that primary nursing had been practised and the individual's view. Perhaps this can explain the dissatisfaction that was expressed by three of the nurses in this study as to their level of involvement in nutrition education. One of them was working in a primary care setting and the other two were working in an environment which they described as "primary nursing to a certain degree." To these individuals primary nursing may have been only a method of organization, without the guiding philosophy behind it. Primary nurses talked about their practice
making a difference to the well being of their clients and used words such as partners in the team, accountability, commitment, and empowerment when describing their practice. The literature suggests that the organization of primary nursing is less important than the underlying values and beliefs of the nursing staff which are reflected in its philosophy (Furlong 1994, Eyres 1992).

The study revealed that primary nursing fostered continuity of care, a more holistic approach, individualized care, greater involvement by the nurses in the nutrition education process and an improved communication within the team. Garbett (1993) feels that the collegial relationships occurring within primary nursing help nurses to realise their potential rather than having their creativity stifled by the rules and procedures of the hierarchy that has traditionally existed.

Primary nursing appears to be an effective way of facilitating the nurses’ discovery of their "individual power bases", and as suggested by Jacobson and McGrath (1983), was a means by which nurses gained a stronger voice in the health care system. The results of this study revealed that primary nursing had a positive influence on the process of shaping practice.

7.3 Limitations of the Study

Contextual factors such as time and resource constraints have the potential to influence findings. Such was the case in this study in reference to the primary nurses’ discussion of personal philosophy. Ideally
the researcher should have gone back to earlier participants and asked for their views on philosophy in order to fully "saturate" the category. Nevertheless, the findings provide tentative explanations for the relationship between the philosophy and practice of nurses in regards to nutrition education. Further study into this area would be beneficial.

A study by Christensen (1990) revealed that contact between surgical nurses and clients was task-focused, of short duration and episodic. A period of constant observation of two patients throughout a nursing shift, however, revealed that the patient's nurses overestimated the amount of contact they had with their clients and perceived that their contact was continuous. This discrepancy between what the nurses reported and what was observed by Christensen, highlights the potential advantage of using observation as a data collection tool, in addition to the use of interviews. Greater theoretical depth may have resulted in this study if opportunities had existed for the researcher to observe the participants in practice. For example, more information could have been gathered about the incidence and opportunities for informal bedside teaching.

A further limitation to the study was the fact that some of the participants were ex-students of the researcher. It is possible that the findings may have been influenced by the nature of this relationship. The researcher was aware that there may have been a tendency to provide information to "please the teacher" rather than provide a true account of their own feelings. Every opportunity was taken by the researcher to establish distance from her teaching role, to encourage honest replies, to
accept information at face value without personal judgement and to emphasize the confidentiality aspect. One way of improving the "reliability" in future would be to use multiple interviewers. Guba and Lincoln (1988:147-148) suggest that "while it may be easy to dupe one inquirer, it is much harder to do it to two." The suggestion made earlier about combining interviews with participant observation is another way in which the researcher could lessen the consequences of familiarity by providing opportunities to "check-out" in practice what the participant is saying.

7.4 Implications for Nursing Practice

This study highlights areas of conflict that exist because of perceived differences between the beliefs and values of nurses and those of the hospital setting in which they work. The constraints that are seen to be part and parcel of the work environment have a negative impact on the ability of the nurse to carry out her nutrition education role effectively. The administration can play a role in improving the situation by addressing some of the problems that were identified. One of the major issues for nurses was their inability to maintain consistent contact with their clients. The ramifications of this were that nurses were unable to get to know their clients or to comprehensively address anything other than the client's immediate physical needs. Addressing the staffing levels would go some way towards alleviating this problem. The introduction of primary nursing to all the wards is another positive step forward, and may also provide other benefits to nurses in that it would foster feelings of autonomy, pride,
accountability and a sense of some control over their practice. An environment that allows nursing values such as holism to be put into practice would give positive direction to nurses as they shape their practice.

It is also essential that administration makes it easier for nurses to improve their knowledge and skills by providing readily accessible nutritional resources on the ward and by making inservice education more available.

This study not only identified problems particular to the organizational structure, but also highlighted areas that need to be addressed by the nurses themselves. Lack of insight into the necessity of possessing current nutrition knowledge is an area of concern. Although most nurses will not be the ones delivering the actual technical knowledge, an updated knowledge base, including teaching and learning theories, is essential if one is to accurately assess nutritional needs and successfully reinforce the work of the dietitian. This reinforces the importance of the availability of relevant inservice education, as mentioned above.

Another area that needs to be examined by nurses is their reluctance to speak out and promote their personal nursing beliefs. As suggested by O'Connor (1985) continuing education is the means for nurses to develop their leadership, exert their power and have a greater say in the health care arena. It is time for nurses to verbalize their concerns to their colleagues, other health professionals and the management structure in which they
work. If nurses sincerely believe that their contribution is essential to the client’s well being, then it is up to them to take control and meet the challenge through advanced nursing study.

7.5 Implications for Education

Several implications for future education of nurses were raised in this study. One was the fact that the participants were not involved in nutrition education of a formal, planned, structured nature. The finding that most education was of a spontaneous, informal format is well supported in the literature (Palm 1971, Close 1988). Nurse educators must therefore look at ways of promoting the effectiveness of this type of education as opposed to focusing on structured teaching plans which are unrealistic in the current hospital setting.

The lack of the participant’s reference to teaching and learning theories also has relevance for education. It may be that either this area is not addressed or that insufficient time is devoted to teaching and learning theories in the nursing curriculum. This assumption is certainly upheld in the New Zealand literature which suggests that nurses do not receive adequate nutrition education and health promotion skills in their training (Worsley 1987, Birkbeck 1990, Nutrition Taskforce 1991).

Pender and colleagues (1992) state that in order to improve the health of the nation, health promotion and disease prevention must be integral to the practice patterns of nurses. These activities were not integral to the practice of the nurses in this study. In future, nurse educators must
impress upon the future generation of nurses the importance of taking every opportunity to incorporate health promotion and health prevention activities into their practice. It is acknowledged that illness care priorities determine the amount of effort that can be devoted to health promotion and disease prevention interventions (Pender et al., 1992), but nurses should not think of these activities as belonging solely to the domain of community nurses.

Hills and Lindsey challenge nurse educators to radically revise their educational programs so that future nurses are taught to work from a health-promotion perspective rather than a biomedical model which emphasizes diagnoses and treatment of disease. "Only when nurses have fully incorporated the principles of health promotion into their repertoire of working with clients and colleagues will they be the desired and appropriate profession to lead health care into the future" (Hills and Lindsey, 1994:162).

It has been put forward by Carlson-Catalano (1992) that even though students are taught to be autonomous, creative care givers, once they are employed by the hospital, they abnegate the role. The findings in this study partly support the view of Carlson-Catalano. Some nurses spoke of having to reform their ideals and of being left with feelings that they were not able to do everything they were trained to do. This reported gap between theory and practice or between ideal and reality suggests that educational institutes may have failed, in some instances, to teach students to be "autonomous, creative care givers". Nurse educators must look for ways to help future nurses make their professional practice a working
reality within the hospital setting. Carlson-Catalano, as discussed in Chapter two, suggests that the way to do this is for educators to use specific empowering strategies throughout the nurses’ educational experience (1992). Assisting nurses to develop strategies which help them maintain their professional identity within the bureaucratic setting will hopefully lessen their feelings of having "passed the buck".

7.6 Implications for Research

The setting for this study was various medical wards of a public hospital. The conceptual framework, identified as the process of *shaping practice*, was grounded in the data and was therefore grounded in the world of the nurses practising in these areas. There is a real need for similar studies to be conducted in different settings, under different conditions. It would be useful to compare the results of this study with those obtained by studying nurses working in a private hospital setting under a different bureaucratic structure. It would also be enlightening to enter the world of practice nurses and find out if they go through the similar process of *shaping practice* as they carry out their nutrition education role.
7.7 Concluding Statement

Shaping practice was the basic social process that emerged from the data in this study to describe the role of the nurse in nutrition education. Previous studies have focused on isolated components of the shaping process such as the nutrition knowledge, skills and attitudes of nurses; the effectiveness of patient teaching; and the team concept of nutrition education. This study revealed that shaping practice was a complex social process in which the isolated parts intertwined and were interdependent on each other. The nurses established a niche in the nutrition education process based on their strong beliefs that nursing has a unique perspective to offer. They dealt with the obstacles as they tried to carry out nutrition education in the context of their working environments. Nursing practice takes place within the context of a team and the nurses in this study were trying to be part of the team, while maintaining their nursing identity. Blumer reminds us that:

Symbolic interactionism does not merely give a ceremonious nod to social interaction. It recognizes social interaction to be of vital importance in its own right. This importance lies in the fact that social interaction is a process that forms human conduct instead of being merely a means or a setting for the expression or release of human conduct. Put simply, human beings in interacting with one another have to take account of what each other is doing or is about to do; they are forced to direct their own conduct or handle their
situations in terms of what they take into account. Thus, the activities of others enter as positive factors in the formation of their own conduct; in the face of the actions of others one may abandon an intention or purpose, revise it, check or suspend it, intensify it, or replace it. The actions of others enter to set what one plans to do, may oppose or prevent such plans, may require a revision of such plans, and may demand a very different set of such plans. One has to fit one’s own line of activity in some manner to the actions of others. The actions of others have to be taken into account and cannot be regarded as merely an arena for the expression of what one is disposed to do or sets out to do (1969:8).

In order to gain a full understanding of the nurses’ world and how it affected their nutrition education practice, it was therefore essential that the parts which made up shaping practice be brought together, looked at and examined as a whole.
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144


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148


Appendix I

Dear Charge Nurse,

I am a nursing lecturer enrolled in a Masters of Science degree at the University of Otago, specialising in Community Nutrition.

For my thesis topic, I am studying the role that nurses on medical and paediatric wards play in educating their patients about nutrition. I intend to concentrate on how nurses perceive their educative role, rather than focusing on their knowledge of nutrition.

The findings of this study will help to develop a better understanding of the role that nurses play in nutrition education and may help to identify barriers that prevent nurses from fulfilling this role.

I would like to have the opportunity to recruit volunteers from your ward to participate in my study. This would involve tape-recorded interviews of approximately 1 hour duration to be conducted at a time and a place convenient to the volunteer.

I will be liaising with [nurse manager] regarding the possibility of contacting you in order that I may access your ward and recruit volunteers for my study.

Thank you very much for your time. I look forward to meeting you.

Judith Mahood R.N.
APPENDIX II

PARTICIPANT INFORMATION SHEET

I am a nursing lecturer enrolled in a Masters of Science degree at the University of Otago, specialising in Community Nutrition.

For my thesis topic, I am studying the role that nurses on medical and paediatric wards play in educating their patients about nutrition. I intend to concentrate on how nurses perceive their educative role, rather than focusing on their knowledge of nutrition.

The findings of this study will help to develop a better understanding of the role that nurses play in nutrition education and may help to identify barriers that prevent nurses from fulfilling this role. These results will be made available to you at the end of my study.

I invite you to participate in my research by volunteering to be interviewed. The interview will take about 45-60 minutes and will be conducted either in my home or at a location convenient to you. I anticipate that one interview will be sufficient, but I may contact you again for a second, shorter interview.

The interviews will be tape-recorded and all information will be kept strictly confidential. You will not be identified in any way when my study is written up. You also have the right to withdraw from the study at any time without consequence.

If you would like to ask questions relating to my research, you are welcome to contact me:

Judith Mahood
64 Warner Park Avenue
Laingholm
phone 817-3618 (home) or 307-9999 ext 7845 (work)
Should you have any concerns regarding the research that you do not wish to address with myself, please contact my thesis supervisor:

Stuart McNaughton  
Associate Professor  
Department of Education  
University of Auckland

I thank you for your time and interest.

Judith Mahood
CONSENT FORM

Title of Project: The Role of Nutrition Education: the Nurse’s Perspective

Principal Investigator: Judith Mahood

Name of subject: ______________________________  Age: ____

I have heard and understood an explanation of the research project I have been invited to take part in. I have been given, and I have read, a written explanation of what is asked of me, and I have had an opportunity to ask questions and to have them answered. I understand that I may withdraw from the project at any time, without having to give reasons.

I realize that my interviews will be tape recorded and give my permission for this to occur. I understand that this information will be stored securely until it is destroyed.

I consent to take part as a subject in this research.

Signed: ____________________________________ subject

In my opinion consent was given freely and with understanding.

______________________________________ witness name (please print)

______________________________________ witness signature

Date: ______________________________

156