

The health promotion work of the district nurse: interpreting its embeddedness

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Aim: This article presents an interpretation of health promotion within the work of a district nurse (DN). **Background:** Literature supports the centrality of health promotion within nursing. It also presents debate about its meaning and suggests uncertainties for educators and practitioners about its relationship to nursing care. Two studies in Scotland on community nurses' health promotion work with older people suggested that health promotion was evident and recognisable in planned initiatives or projects but could be hidden and unrecognised in day-to-day nursing work with individual patients and their families. **Methods:** An experienced DN's interpretation of health promotion embedded in her work with a patient with multiple sclerosis is presented. The case was one of a number derived from a study designed in the constructivist paradigm, which addressed health promotion in relation to community nurse education and practice for a range of community nursing roles, including district nursing. The case study data were derived from observation of practice, interviews with the DN and the patient and from field notes. **Findings:** Health promotion emerged as embedded within day-to-day holistic nursing care. The DN illustrated an understanding of the dimensions of health and of the significance of core health promotion concepts such as education, prevention, advocacy, empowerment, self-esteem and self-efficacy. However, health promotion could be invisible, described as weaved into everything and on the back of other things, and therefore not normally acknowledged and clearly articulated. Embeddedness highlighted the challenge for evaluation, when nursing and health promotion activities are intrinsically related and can be argued as sharing certain principles, processes and outcomes. **Conclusion:** Embeddedness is a significant issue for learning in practice. The ability of experienced community nurses to interpret and articulate the concept of health promotion clearly and to make tacit knowledge evident would be of benefit to students.

Key words: district nursing practice; embeddedness; health promotion

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Introduction

The health of ageing populations is of increasing concern globally (World Health Organization (WHO), 2012a). Active ageing and healthy ageing are accepted goals of health promotion, and many health problems and diseases of later life are

regarded as preventable. Health promotion is also seen as having potential to help older people with chronic conditions and disabilities maintain independence, improve health and prevent institutionalisation (WHO, 2012b). Health promotion is an element of work for which nurses are accountable. This is reflected in the UK's professional code of conduct (Nursing and Midwifery Council, 2008), which contains statements that express core health promotion concepts and well-being-related values.

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The code states as imperatives that the nurse must work with others to protect and promote the health and well-being of those in one's care, their families and carers and the wider community; share with people, in a way they can understand, the information they want or they need to know about their health; and act as an advocate helping people to access relevant health and social care information and support. This article outlines how, in the primary care context, a district nurse (DN) interpreted health promotion in her work with a patient with multiple sclerosis. An older person was defined, in line with national policy, as an individual aged 50 years or above.

Scotland is a small nation with a population of 5.2 million, and in line with worldwide demographic trends the number of older people is rising rapidly (Age Scotland, 2011). International and UK evidence suggests that older people have been getting healthier, with healthy life expectancy increasing. However, Scotland is addressing a legacy of health problems associated with high levels of coronary heart disease, stroke, cancers, diabetes, smoking, alcohol misuse, poor diet, obesity and low levels of physical activity (Bromley and Mindell, 2011). Older people's health-care needs reflect both this legacy and the sequelae of ageing processes. This picture results in policy emphasis on chronic disease management, on those with multiple conditions and complex needs, and it prompts concern for relatively frail older people living at home, often alone and for those in disadvantaged circumstances (Scottish Executive, 2007; Scottish Government, 2010).

It is a picture of particular significance to DNs. The central purpose of district nursing in the United Kingdom is the provision of home-based nursing care for all ages, but principally for frail older people with long-term conditions. The role is central to policy health priorities and it requires a high level of gerontological nursing expertise. The focus of DN work is skilled holistic and person-centred care, requiring knowledge of how to maximise individual health potential and sustain those with long-term complex problems, all in the context of sound understanding of a local community and its people (Goodman *et al.*, 2003; Jarvis *et al.*, 2006). It is within this profile of community-based nursing work that the concept of health promotion sits. Two studies, undertaken

in Scotland between 2002 and 2010, explored the concept in community nursing roles.

The two Scottish studies

The exploratory study (Watson *et al.*, 2004; Runciman *et al.*, 2006) first profiled using a questionnaire ($n = 1062$) the health promotion work undertaken by a range of community nurses with older people and then identified by means of a telephone interview ($n = 20$) their involvement in particular health promotion innovations and initiatives. Included were 250 DNs; 86 (34%) responded to the questionnaire and eight were interviewed. The telephone interviews illustrated DN involvement in what would be regarded as health promotion 'projects' – for example, setting up walking, well-being and lifestyle groups addressing exercise, healthy eating and mental health. Not known, however, was how the DNs interpreted health promotion within day-to-day nursing practice as being distinct from their involvement in health promotion innovations or initiatives. DN-free responses at the end of the questionnaire also suggested that health promotion could be elusive, hidden, unrecognised and *ad hoc*. These points of interest were further explored in the second study.

This two-phase qualitative multi-method study (Runciman, 2010) addressed health promotion with older people in relation to community nurse education for, and community nurse practice in, three roles: district nursing, general practice nursing and public health nursing/health visiting. Data presented in this article are drawn from the second study phase in district nursing practice.

The study was designed within the constructivist paradigm and adopted Stake's (1995; 2003) case study approach. The constructivist paradigm allowed the meaning of health promotion work with older people to be interpreted and illuminated (Mills *et al.*, 2010). It is described as hermeneutic and dialectic; that is, understanding study participants' constructions and meanings was sought in real work contexts through interpretation (hermeneutics) and discussion (dialectics).

The DN's role currently requires a challenging combination of clinical, management, leadership and educational expertise and advanced decision-making skills (Dickson *et al.*, 2011). The DNs

invited to participate in the study were experienced registered nurses who held a graduate-level qualification as specialist practitioners in community nursing and led a skill mix team of community staff nurses and health-care assistants. In light of the study's interest in both education and practice perspectives on health promotion, the participating DNs were those who held responsibilities as practice teachers/mentors providing educational support to DN students. Two DNs were actively engaged in the practice phase of the study. Each selected two patients whose nursing care represented usual day-to-day work and included health promotion elements. Of the four cases selected to illustrate health promotion, two represented nursing in the context of the long-term conditions of multiple sclerosis and diabetes and two related to long-standing alcohol-related health problems.

The DNs were accompanied and observed by the researcher at a visit to each patient. Field notes were recorded immediately after each observed period. Two interviews were then conducted: first, with the patient at home on a return visit by the researcher, and, second, a final interview with the DN. The interviews were audio-recorded and transcribed in full. Content analysis of data was undertaken, combining the conventional approach, in which coding categories were derived directly from data, and a directed approach informed by existing theory and research findings (Hsieh and Shannon, 2005). Both studies received ethical approval from the relevant health boards and academic institutions.

Health promotion: a challenging concept

Defining health promotion in nursing practice is not straightforward. It has been argued that the landscape of health promotion is confusing and troubled, given its plethora of concepts, theories, models, approaches, frameworks and paradigm wars (Whitehead, 2009). Much attention is given, for example, to the health promotion versus health education debate. Whitehead (2003; 2004) sees health promotion as a set of socio-economic-political processes transforming communities through concern for the major determinants of health, and sees health education as informing

individuals about the nature and causes of health and illness and their associated risks, motivating individuals towards prevention and recommended behaviour change. The biomedical-disease-illness model, associated with opportunistic lifestyle and behaviour-change health education, has been criticised as reductionist and professional-led with associated risk for a victim-blaming ethos. Alternatively, the empowerment paradigm is encouraged as a humanistic client-led approach (Green and Tones, 2010). Broadly, there is 'big picture' health promotion interpreted at global and national levels in relation to public health and health improvement policy; there is middle ground health promotion where policy and health priority issues are addressed at community levels often with local groups and through projects; and there is, for a DN in primary care, health promotion at the daily care interface with individual patients and their families in collaboration with health, social care and voluntary sector colleagues.

That health promotion presents challenges and sits uneasily within nurse education and practice is evident in many publications since the 1990s (Maben and Macleod Clark, 1995; Robinson and Hill, 1995; 1998; Macleod Clark and Maben, 1998; Smith *et al.*, 1999; Whitehead, 1999; 2000; 2002; 2007). For example, Smith *et al.* (1999) noted tensions for nurse educators, students and practitioners, between what they refer to as nursing's three discourses – caring for patients, treating disease and promoting health. The health promotion discourse was perceived as impractical for the realities of day-to-day work that related to treatment of disease and it was difficult to conceptualise a health promotion role within the care of sick people. Smith *et al.* (1999: 229) suggested that, although the three discourses make sense in isolation, they could be perceived as 'implausible, incomprehensible and occasionally absurd in combination'.

Health promotion and district nursing

Many years ago, Turton (1983) explored DNs' reluctance to spend time on health education. Conceptual separation of health education from nursing care was a fundamental constraint, together with lack of knowledge and effective communication skills to address older people's

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complex health issues. Gott and O'Brien (1990) similarly argued that community nurses regarded nursing as being different from health promotion. By the late 1990s, however, Sourtzi's (1998) findings of a study on community nurses' definitions of health promotion showed considerable development of conceptual awareness of health promotion in terms of its content, methods, target groups, goals and roles for nurse and client. However, Smith *et al.* (1999) suggested that, in giving priority to clinical needs of older people, DNs struggled to squeeze health promotion in to make it fit with everyday work demands.

Irvine (2003; 2005; 2007) explored interpretations of the concept of health promotion and its translation to practice in a study that included semi-structured audio-recorded interviews with 21 DNs. The DNs talked of health promotion in terms of lifestyle and behaviour change (outcome) as well as education and advice (process). A disease-oriented approach was typical, linked to three elements: to specific illnesses where their role related to preventing or containing conditions; to administration of vaccinations; and to screening. There was reference to the importance of choice in decision making regarding lifestyle and to the issue of patients taking responsibility for their own health. The goal for some DNs was to help patients towards 'optimum health'. Overall, however, Irvine suggests that there was no common understanding of the term health promotion, and the concepts of empowerment, community development and socio-political action did not feature in the DNs' definitions. In terms of the process of health promotion, Irvine concludes that the DN's role is limited to health education. However, she also claims evidence of three dimensions: a primary focus on preventative work; a secondary focus on restoring good health; and a tertiary focus directed at illness containment.

Health promotion in district nursing practice has also been seen as opportunistic, *ad hoc* and reactive (Irvine, 2003; Watson *et al.*, 2004; Runciman, 2010), or as planned and proactive, evident in specific health promotion projects or initiatives (Watson *et al.*, 2004; Hunt, 2005; Kane, 2007; 2008; De Kleijn, 2008; Runciman, 2010). It has also been described as being integral and invisible. Difficulty recognising and acknowledging health promotion is noted in the following

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comments (Runciman, 2010: 60) from two DNs in the early exploratory study:

Health promotion takes place, often without community nursing realising it, or necessarily being recognised as such.

Health promotion... often goes unacknowledged... Much of the HP/risk assessment and prevention of falls/accidents potentially prevents hospital admission but goes unseen and is difficult to demonstrate.

DNs in Irvine's (2003: 219) study felt that they were engaged in health promotion work 'all the time as we go', 'we do it automatically without thinking' and 'probably without knowing that we are doing it'. Irvine's (2003: 218) response to this is, however, interesting as she appears to sidestep and does not explore the significance of what she calls the 'integral' dimension of health promotion practice. She notes:

Some respondents indicated that health promotion is merely an integral part of the care that they provide for all their patients.

Invisibility suggests something that is difficult to articulate, is hidden, requiring interpretation. It is a term commonly linked to the work of DNs (Goodman, 2001; Low and Hesketh, 2002; Kennedy, 2004; Jarvis *et al.*, 2006). Goodman suggests that use of the metaphor of invisibility, in relation to the work of nursing in general and to its knowledge base, may in district nursing reflect both a general lack of understanding of the nature of DN work, much of which is out of sight in patients' homes, and possibly the relative invisibility and marginalisation of the DN's main client group, namely, older people. Cantrell's (1998) qualitative study of DNs' perceptions of their health education practice, using two focus groups and six individual interviews, found that health education was an aspect of care often engaged in but not consciously acknowledged; it was 'not obvious'. It equated with the concept of 'patient education' and, as an integral part of all DN work, was part of holistic nursing care. Bryans (2000a; 2000b), in her study on the use of simulation and post-simulation interviews with DNs to explore the knowledge involved in their nursing assessment practice, noted the problem of the 'invisible' elements of theoretical knowledge that

are deeply internalised, difficult to access and whose use is hard to describe. Hawe *et al.* (1998) found in a focus group study with health promotion workers, examining capacity building in health promotion, that professionals had difficulty in describing aspects of their health promotion work to others. They were unpractised in talking about what they did and were 'working invisibly'. Arnold *et al.* (2004), in exploring DNs' perceptions of their public health contribution, found that participants in their study had not recognised the extent of their role in health education and health promotion. Public health work 'was going on silently' and lacked clarity because of the integrated nature of DN activity; there was lack of awareness of the 'vastness of what we do' and failure to 'reflect and take stock' and recognise existing knowledge and skill. Arnold *et al.*'s (2004) participants linked this lack of recognition to failure to encourage the celebration of achievement in the culture of nursing, a culture that might also foster a sense of guilt about work not regarded as 'hands-on' activity, such as health education.

The case study

Drawing on data from the study by Runciman (2010), a case study from a DN and one of her

patients, Mrs H, is now presented. No claim can be made regarding the representativeness of this case within the workload of DNs in Scotland. However, the case was originally chosen by the DN, and is selected here, as one that would be familiar to community nurses, illustrating health promotion in the context of the complex health, nursing and social care needs of an older person with a long-term condition, rather than as one focused primarily on a topic of policy concern such as alcohol. The case generated a wealth of interview and observational data. The DN's interpretations of health promotion below are drawn principally from interview data. A vignette of Mrs H, drawn from interviews with both the DN and Mrs H and from fieldwork notes following the observed home visit, is shown in Box 1.

Health promotion in day-to-day district nursing practice

Health promotion as a core aim in chronic disease management

The DN linked health promotion to the management of chronic health problems, describing it as 'an aim of what we do'. It was 'Anything that helps them towards independence... or prevents ill health, even within their chronic health life'.

Box 1 Mrs H

Mrs H, 55 years of age, had been living with multiple sclerosis (MS) for 26 years. She was separated from her husband who had left five years ago and she now lived alone. She required daily help from two carers for personal care and she used a wheelchair for mobility. She was aware of progression of her MS: 'my body's tightening up an awful lot, especially my legs'.

Two years ago, she had a five week period in hospital admitted with an infected sacral pressure ulcer with fistula, and she acquired methicillin-resistant *Staphylococcus Aureus* infection of urine and wound. On returning home, care continuity was a problem. Carers long known to her left or retired. With many new carers, 'it was a pure nightmare trying to get them how to work with me. I was exhausted... I can usually cope with things but I just couldn't cope with that... it was terrible... I was crying and it's no like me... that didn't help my pressure sore being upset and stressed'. Following a case conference, with district nurse (DN) input regarding the impact of the problem on Mrs H's emotional health, enhanced care and continuity in the caring team was established.

The DN now visited Mrs H once a week with the carers. Her concerns were for continuing review of the sacral area and surrounding psoriasis, monitoring skin healing and care, supporting the carers and assessing Mrs H's emotional health. Mrs H felt that a nurse should understand 'your emotional problems... I definitely think that because (DN) is good that way... if you get depressed it brings you right down'.

Promotion of independence, a core nursing concept, was set beside prevention of ill health, a core health promotion concept. Facilitating independence could positively influence physical, emotional and social health:

... promoting independence can be big or it can be small and it varies from patient to patient... independence for one individual might mean nothing more than me going in at 10 past 8 on a Wednesday morning so she (Mrs H) can get the Dial-a-bus... it's not something we normally do, but just for that day I don't mind doing that because it's a big big thing and it means that she's got the day out... (Mrs H) goes to the homoeopathic hospital. Now that's not a medical thing, it is to us but it's not to her. To her this is a place for her to relax, to be massaged, to be with people who have a slightly different approach to multiple sclerosis and she comes home and she feels absolutely brilliant.

Health promotion as advice and education

The DN felt that there was 'a big health promotion thing with carers' and with patients. Citing the example of the need for effective skin care in multiple sclerosis, she had identified lack of supervision and 'a huge knowledge gap' in Mrs H's carers, and as a result she made it a priority to get to know them and make herself available:

There was a huge knowledge gap... there's nobody to supervise them because their supervisor doesn't do the hands on work... so how do you get round that? What I do is find out who's going in to my patients and I'll make myself available... and they'll phone me... (Mrs H) has got psoriasis. Got a phone call one day to say that her skin had erupted and I went down and I had a look at the skin... what had happened was that (Mrs H) was taking control and she was directing the carers about just put this on... and I had to stop that... they thought they were doing the right thing.

As a result, supervisors, carers and trainers got together and a set of skills was drawn up clarifying DN supervisory responsibilities and the extent/limits of work that carers would be allowed to do. The DN regarded the health education role

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in this context as 'crucial' and 'massive' but 'hidden'. For both Mrs H and her carers, control, self-efficacy and self-esteem were supported by knowledge and understanding.

Health promotion and an advocacy role

Mrs H spoke during the interview about her distress following discharge from hospital (Box 1) and her appreciation of the DN's help. The DN's contribution towards promoting Mrs H's physical, emotional and social health at that time was well illustrated in comments about Mrs H's health status and difficulties. Carer continuity and social contact were regarded as key elements in this 'success story':

The carers... really sustain her emotional health, because when they weren't there that was the need that I had identified, she was withdrawn, she was isolated, she wasn't going out, she was losing weight, she was sad. Once the assessment had been made and I got the carers in after the case conference... what a difference... the sadness lifted because she had the social contact and it's a different kind of contact to me... the carers were regular so she knew them so she developed that relationship... she was able to look beyond herself and her four walls... whereas she had withdrawn you know and had shrunk into the house, almost disappeared... that was through sheer lack of social stimulation, social contact.

The DN talked of being 'a bit of an advocate' for Mrs H at the case conference. She had to fight for appropriate carer support, fight family opposition and negotiate for a change to the long-established pattern of DN visiting. She was aware of working in an 'interlocking service' where collaboration with social care and an advocacy role were essential:

A bit of fighting had to be done, because the district nurses were visiting seven days a week and that had gone on for years... all she wanted really was more of your time, not to talk about medical stuff but to interact with her as a person. Now that was happening while they were there but with all the will in the world that wasn't going to move her from where she was. She needed

contact with a different set of people who weren't illness orientated, which has been the success story really of the social services... Once the folk were trained and they got themselves established and so long as it was continuous and the standard was being reached... it was just fantastic. That strength is coming back now and she can fight her corner... I mean it wasn't easy trying to get that set up because of the funding... within that household I had opposition, they didn't want the carers and I thought well who's important here and if the family lose the focus, you have to bring in the services.

Health promotion: 'it's just part of the mesh'

In talking about the processes and outcomes of work with patients, the DN showed awareness of health promotion concepts, but she noted that health promotion could be 'hidden' in day-to-day work. In the context of palliative care, she described exploring with a family their own health needs in working out how to care for a dying relative at home. Although intrinsically health promoting, it was not seen in this light:

I usually get them together and I'll say right 'Do you want Marie Curie in to sit? You're shattered, you need a sleep and your relative needs an eye kept on him over night and I'm getting the Marie Curie nurse set up.' 'No it's OK nurse, there's six of us.' ... and that's where you start to get to the nitty gritty... At the end of the day, two out of that six might be the only people that are available... so what you're trying to do there, is not just satisfy the need for your patient to be cared for, but to ensure that their health isn't affected by allowing them to take something on that you can see is going to be too much for them... they haven't been realistic and that's bread and butter stuff for district nurses... you need to say to them let's take some pressure off you. That's a big health promotion activity and yet you don't think about it do you.

The DN felt that, when mentoring DN students, health promotion could be 'planned' in the context of teaching a relative, patient or carer 'something particular'. However, it was generally

something that just 'happens'. When asked whether she dealt with health promotion directly with students, she felt that the term was not used explicitly. Health promotion was not 'up front' but 'hidden' and 'on the back of other things':

I don't think we give it its term. If we gave it its term, it would focus you on it more. I think it's on the back of other things. A new bed arrives... they have to go in and teach the family how to use the bed. Pieces of equipment is classic... but you wouldn't label that as health promotion, but it is... why is it health promotion? Because there's a risk inherent in all of this, so just as the organisation give you the equipment to prevent you getting injured, and I mean that's not labelled as health promotion either, but indirectly it is, that's the organisation looking after you... it should be called promoting health through risk assessment and it's to stop you and anybody else getting injured... It isn't up front, it's hidden. It's hidden in everything else that's going on... It's not separate from anything you do.

Findings and discussion

The DN made an insightful contribution to conceptualisation of health promotion within day-to-day practice and she acknowledged accountability for it as a core element of her work (Nursing and Midwifery Council, 2008). However, comments such as 'weaved into everything' and 'on the back of other things' and something one might not be 'consciously aware of' support the notion of health promotion as invisible and embedded (Goodman, 2001; Irvine, 2003). When working 'holistically', health promotion became 'just part of the mesh'. The DN's thoughts about her work with Mrs H reflect difficulties describing aspects of work and accessing internalised elements of theoretical knowledge (Hawe *et al.*, 1998; Bryans, 2000a; Appleton and Cowley, 2008a; 2008b).

However, it was notable that, when given time and opportunity to talk about her work, the DN was able to offer illustrations and interpretations of health promotion. It was, for example, linked to the promotion of independence, to the promotion of self-care, to secondary and tertiary prevention in the sense of health maintenance

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and prevention of progression of existing health problems, to the concept of advocacy, to health education in provision of information and advice, to skills training for patients and their family and carers, to risk assessment and management in relation to an older person, their family and to the health and safety of the DN herself. Even in the end-of-life care context, there were dimensions of health promotion work, but as the DN said, 'you don't think about it'. Benner (1984) noted that expert holistic practice and the experienced practitioner's intuitive grasp can be illuminated and their elements teased out. To achieve this, opportunities to describe and reflect on practice scenarios need to be created. Where knowledge, albeit embedded, together with skill and positive attitudes towards older people come together in expert practice of experienced nurses, this needs to be captured, celebrated and used in education. Perhaps the health promotion perspective within expert practice might usefully be teased out in dialogue between community nurses and colleagues familiar with health promotion theory and practice. However, given the complex and demanding context of the work of experienced DNs (Dickson *et al.*, 2011), which can limit opportunities for direct patient contact and hands-on care, some time targeted specifically by educators and practitioners for case analysis and building a bank of helpful practice scenarios might be of value.

Many years ago, Macleod Clark (1993: 258) called for a radical philosophical shift in thinking from 'sick nursing' to 'health nursing', to a 'process of promoting health through nursing care'. She suggested that it is not what the nurse does that defines sick nursing or health nursing, but rather it is how she does it. That is, awareness of process is required. The key features of Macleod Clark's (1993) health nursing model and ethos were:

- Recognising the uniqueness of each individual's need for care.
- Involving patients in decisions about their care and participation in it.
- Maximising potential for health and independence.
- Building on existing knowledge and experience.
- Helping patients become more autonomous.
- Fostering an empowering relationship, collaborative and negotiated.

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- Supporting patients to take responsibility where possible for their own health.

Cowley (2006: 663) notes that much energy has been expended on deciding whether actions represent 'health promotion' or 'health education' or 'disease prevention'. She suggests that the focus is gradually shifting towards their intent and the manner in which they are performed, the key question being, is this being done in a health promoting way:

... a more participative, enabling and holistic 'modern' approach to nursing appears to be developing... consistent with the principles of health promotion, and activities undertaken in this manner would promote health even if that was not their stated intention.

It could be argued that in the DN's conversations there was evidence of features of working according to Macleod Clark's (1993) health nursing model and of working in a health-promoting way. The DN recognised, however, that embedded aspects of work might not be explored explicitly with students. There was a continuing tendency in district nursing to regard health promotion as patient teaching or patient education (Cantrell, 1998), as giving information and advice around priority policy topics such as smoking cessation and alcohol use (Bromley and Mindell, 2011) and as a tacked-on activity. Opportunities to interpret health promotion elements in DN work were being missed: they were not, as the DN said, 'being given their name'. It seemed, where health promotion was embedded, that DNs would first need to identify and describe the hidden elements, to recognise processes and interventions that are intrinsically health promoting and to describe where and how the caring clinical responsibilities contribute to health gain, thus making health promotion visible and explicit. In suggesting that it is possible to make sense of the discourses of caring, treating disease and health promotion in combination, Mrs H's case perhaps addresses Smith *et al.*'s (1999) concerns about difficulty conceptualising health promotion within the nursing care of sick people. Analysis of day-to-day nursing care work in terms of its processes, of 'how' health promotion principles feature, and of its outcomes in terms of actual and potential

health gain could be fruitful exercises for DN education in both theory and practice.

Interpretation of the DN's descriptions of her work with Mrs H illuminates health promotion processes at work within her nursing role. The nature of the relationship and the way in which she worked showed evidence of an empowering partnership approach, collaborative, supportive and negotiated. There was confidence in communication and a leadership role in advocacy. Defined in these terms, her work demonstrated health promotion and features of Macleod Clark's (1993) health nursing model. Purists, whether nurses or health promoters, might not be happy about such a coterminous interpretation of the role as both health promotion and clinical caring, but concepts such as empowerment and advocacy are not exclusively owned by any single discipline or profession.

Where nursing and health promotion activities are seen as intrinsically related and coterminous rather than as mutually exclusive, there remains the difficulty for outcome measurement and evaluation. The challenge lies in interpreting and articulating the health promotion processes that can be regarded as measures of effectiveness, attributable to nursing.

Whether health promotion is regarded as a bounded and stand-alone activity, for example, as a project or particular initiative, or seen as embedded within nursing activity, within either interpretation an outcome might take the form of health gain. Macleod Clark (1993: 268) suggested that rather than a focus on 'absence of ill-health indicators', emphasis could be on 'health increments' such as changes in lifestyle or behaviour, adaptation and coping with chronicity, and facilitation of choice and decision making in care. However, as with the term health promotion, the meaning of the concept of health gain is debated. Ewles and Simnett (2003: 24) define health gain as 'a measurable improvement in the status of health and social well-being in an individual or population, which is attributable to an earlier intervention'. The attribution issue is a well-recognised problem in health promotion where many factors of attitudes, values and ethics and of interventions such as treatments, therapies, professional and lay inputs, and social and environmental determinants contribute over time to favourable outcomes and health gain. Therefore, it is difficult to see an easy

solution in terms of quantitative measurement to address the problem of defining health promotion, where both nursing and health promotion share processes and outcomes. The solution may emerge from increased acceptance of the value of qualitative descriptions of processes and outcomes, to better understand the integrated nature of much of health-care professionals' practice.

Conclusion

This case has illustrated the embeddedness of health promotion processes in DN practice and holistic care. Case material may be of value in both theoretical and practice-based learning – for example, to support interpretation of health promotion in relation to day-to-day work with older people, to prompt analysis and discussion about the inter-relationships within nursing between the discourses of health promotion, caring and treatment of disease, and to consider health promotion's wide conceptual landscape of health education, health gain and health improvement. The case presented here suggests that, when supporting learning in practice, the ability of experienced community nurses to interpret and articulate the concept of health promotion clearly and to make tacit knowledge evident would be of benefit to students.

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