Evaluation of the Health Promoting Hospitals Brief Information Session

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Background to Evaluation

Introduction

Hospitals as settings for health promotion are increasingly being recognized as ideal situations in which to maximize health gain and promote positive health for staff, patients their relatives and the community. The Health Promoting Hospital (HPH) concept includes the provision of information as well as health promotion activities in the hospital setting. It also includes the promotion of organizational change that focuses on hospital systems and on the attitude or way in which health care workers/ practitioners carry out their work. In order to introduce hospital employees to the concept of the Health Promoting Hospital an information session has been designed to be disseminated to all hospital employees. The Brief HPH Information Session, comprises a video and short presentation which introduces all hospital staff to the idea of health promotion and their role as health promoters within the hospital setting. The aim of the sessions is to raise awareness in 70-80% of staff, of the idea of health promotion and the health promoting hospitals (HPH) concept. It also highlights how staff can become involved in the whole idea of health promotion within the hospital setting. It is seen as the first of a series of activities designed to create knowledge of health promotion and its application initially in hospitals belonging to the health promoting hospital network. The evaluation of this initiative in seven hospitals around the country is reported here. The evaluation took place in two parts. One aspect of the evaluation will take the form of a process evaluation as the evaluation objectives suggest that process evaluation would be appropriate in this instance (Hawe, 1990, Bracht, 1994). Process evaluation is a natural complement to impact evaluation (Scheirer, 1994) which will be used to assess the main aim of the intervention which is raising awareness of the HPH initiative.

Background to Health Promoting Hospitals

'A Health Promoting Hospital combines a vision, a concept and a set of strategies for hospital development. It seeks to incorporate the values and standards of health promotion into the organizational culture and structure of any health care organisation' (Moeller & Seghezzi, 2001). The World Health Organisation's 'Health for All' strategy (1981) initiated the framework for health gain, equity and health care, which is accessible to all. The Ottawa Charter (1986) included as a principle the reorientation of health services, which required a change of attitude and reorganisation of service provision to focus not just on those of poor health, but also on all people, in differing communities and societies through the use of health promoting strategies. While primary health care continues to be the key approach to achieve health for all, hospitals have much potential to expand their diagnostic and therapeutic functions to participate on a larger scale in the area of health promotion and in disease prevention. Hospital health promotion is now increasingly being recognised as a feasible concept to maximise health gain not just for patients but also staff, patient's relatives as well as the community in general.

Hospitals across Europe are adapting to the challenges that are presented to them by the health care reforms in every country. The respective governments are currently reviewing their health care systems, focusing on effectiveness and efficiency in order to increase availability, patient satisfaction and quality of care. To facilitate the new hospital orientation towards the broad concept of health, to generate health gain in line with the WHO health for all strategy, the WHO-Regional Office for Europe (WHO) started a project in 1989 called Health Promoting Hospitals (HPH), which involves the creation of a network of hospitals that have or are in the process of incorporating the idea of health promotion into their practice to a greater extent.

Hospitals are not usually considered to be the main agents in health promotion, however looking at hospitals from a settings approach, they are institutions in which a large number of people work and visit for care, and can therefore reach a large sector of the population. Furthermore, as centres that practice modern medicine, research and education, and accumulate knowledge and experience, they can influence professional

practice in other centres and social groups. In sum, it appears that the concept of a hospital as a health promoting institution, seeks to improve the performance of hospitals by broadening their scope through a comprehensive approach to health gain for staff, patients and their relatives. The Health Promoting Hospital (HPH) concept is much more than giving information or providing health promotion activities in the hospital setting. It is about organizational change that focuses on hospital systems and on the attitude or way in which health care workers/practitioners carry out their work.

Health Promoting Hospitals in Ireland

The Health Promoting Hospital concept was introduced to Ireland in 1992 by the Dublin healthy cities project. One of the primary partners in this development was the Eastern Health Board. The James Connolly Memorial Hospital was selected to be among the first hospitals in Ireland to join the European Health Promoting Hospitals network. Today there are a total of sixty-four hospitals actively involved in the Irish Health Promoting Hospital National Network.

The HPH concept is not without contention though. Many healthcare professionals suggest that health promotion is not part of the hospitals function (Aujoulat et al., 2002). As a result people may appear reluctant to incorporate the concepts of health promotion into the structure and culture of their healthcare establishments. Aujoulat et al. (2002) identify that there is a lack of standard solutions for developing and implementing health promotion activities within the hospital organisation. These authors also identify obstacles in relation to the implementation of activities/projects which are concerned with the hospital as an organisation, which include a lack of experience with and structures for interdisciplinary work, a general lack of personnel and a specific lack of skilled personnel. There appears to be a paucity of published research on the HPH concept and its application in the literature, which potentially limits diffusion of the idea.

Use of Media in Raising Awareness

There are numerous accounts suggesting that mass media channels are the leading source of public information about health issues and is influential in forming public opinion. The media is also very successful in raising awareness, providing information and inspiring people to change if their environment is supportive.

The method of media of most interest here is the effectiveness of video in raising awareness. A number of studies have been conducted into its effectiveness and have shown for example that a video is more effective than a leaflet in terms of increasing awareness of information contained therein. Leonard (1995) in quoting from the British audiovisual society claims that adding an element to hearing, reading and seeing significantly enhances what the individual recalls.

The HPH Brief Information Session

The Information Session is seen as the first of a series of activities designed to create knowledge and raise awareness of health promotion and its application in the hospital setting. To facilitate the running of the brief information sessions a ring bound pack has been developed which includes a list of guidelines on how to introduce, plan and run the brief information sessions. This pack also includes a short video.

Overall Aim of Session

The overall aim of the intervention was to briefly introduce and raise awareness of health promotion and the health promoting hospitals (HPH) concept to all hospital employees. And further to highlight how staff could become involved in health promotion within their own hospital setting.

The Session

The planning and management of the sessions was undertaken by the HPH co-ordinator in each hospital. The Information dissemination sessions included a short verbal

presentation, a video supported by a handout for participants to take away. The total duration of the session was planned to be between 20 –30 minutes in total, to take place over a short number of weeks and be open to all employees so that the audience was envisaged to have representation from a combination of employee groups.

The Brief Information Session Content

A short verbal introduction and presentation was conducted by a facilitator and focused mainly on the issues outlined in the video, aiming to introduce staff to health promotion initiatives within their respective hospital environments, and outline health promotion strategies which are ongoing nationwide.

The video was planned to be shown from start to finish without any interruptions, the duration of which was approximately twelve minutes. The format of the video itself incorporated four parts:

Part one; Demonstrated the fact that health promotion is for everyone, in all societies around the country, and everyone should and can participate in different health promotion strategies within their community.

Part two; Supported the settings approach of the hospital being an ideal place for health promotion as well as the notion that health is not only important for patients, but also for staff employed by the hospital.

Part three; Demonstrated examples of ways in which staff can become involved in maintaining and improving their own health through for example healthy eating.

Part four; Summarised the significance of connecting health promotion activity at a local level with regional, national and international developments and strategies.

The handouts given at the sessions, with details specific to each hospital, reinforced the information obtained from the video and the presentation with names and addresses of those currently involved in health promotion hospital projects.

Background to Evaluation

Evaluation can increase the quality and effectiveness of any initiative by contributing to its processes of planning, development and implementation (Rootman et al, WHO 2002). Hawe (1990) states that "A commitment to good health promotion practice means a commitment to planning and evaluation of programmes and interventions". The purpose of evaluation is that it should demonstrate either whether an activity has been successful or to what degree it has failed to meet some of its stated aims and objectives (Williams, 1987). Increasingly it is being recognised that there is a need in health promotion evaluation to have not only impact evaluation but also process (Tones and Tilford 1994). In evaluating the brief information session a combination of process and impact evaluation was undertaken.

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Process evaluation covers all aspects of the process of a programme or intervention delivery.

Process evaluation questions include the following:

- Who has the intervention failed to reach and why?
- Was the session implemented as planned?
- What were the facilitating and restraining forces in relation to session dissemination?
- Was the programme perceived as relevant by the target group?

The answers to these questions provide information that will help to improve the programme and develop it into a better form. Unless a programme is getting to the right people, is being implemented in the right way and people are satisfied with it, it is unlikely that the intervention will work.

Evaluation also needs to determine whether the aims and objectives of the intervention have been reached. Impact evaluation is concerned with this aspect of a programme in terms of immediate effects. In this instance the impact question is:

- Did the level of awareness of health promotion and the health promoting hospitals (HPH) concept among hospital staff increase as a result of the intervention?

Method

Synthesis of Qualitative and Quantitative Methodologies in Health Promotion Evaluation

For many years researchers have claimed that there are many benefits in progressing beyond the customary practice of choosing either qualitative or quantitative methods of analysis (Firestone, 1987; Fraser, 1988). Increasingly it has been shown that there are many benefits from combining qualitative and quantitative methods (Dorman et al, 1994;Tobin et al, 1990). Researchers claim that patterns or relationships can be strengthened by a variety of qualitative and quantitative data sources (Erikson, 1986; Tobin & Fraser, 1998). Evaluation in a health promotion context often involves assessments of different kinds of events at varying time points (Naidoo &Wills, 1994). This is further supported in this instance by the use of both process and impact methods of evaluation. Therefore in this study a combination of qualitative and quantitative methods were used.

Sample

Hospitals participating in the Health Promoting Hospital Network and planning to use the brief information session were invited to participate in the evaluation process. A random selection of hospitals from those who put themselves forward to participate were selected. The initial sample included Our Lady's Hospital, Navan. However, as a result of this hospital not being able to provide the research team with a comprehensive staff listing within the given timeframe, another hospital, namely the James Connolly Memorial Hospital (JCM) is included in this report. The participating hospitals were divided into two groups – small and large hospitals, based on staff numbers within the institutions. The participating hospitals are indicated in the table below.

Table 1

Larger Hospitals	No. of employees	Smaller Hospitals	No. of employees
Sligo General Hospital	1176	National Maternity Hospital	675
James Connolly Memorial	982	St. Vincent's Psychiatric Hospital	230
Cavan General Hospital	754	Monaghan Hospital	273
Beaumont Hospital	2571		

The seven hospitals that took part in the evaluation exercise varied by size, location and type of work carried out. Two hospitals were specialist the remainder provided general services. Four were located in Dublin, the remainder outside. All hospitals were participants in the Health Promoting Hospital Network and had been members for at least two years. Four hospitals had full time HPH co-ordinators the remainder part time posts.

A proportionally distributed random sample (by occupation) of 250 people employed in each hospital was generated both before and after the intervention. The sample frame of a complete list of hospital employees was provided by the respective hospital personnel departments. For a detailed description of the final sample with regards to proportional distribution of various occupational groupings by hospital see Appendix 1.

Data Collection Methods

Pre intervention Questionnaire

Questionnaire 1 formed the baseline measure and assessed level of awareness of the health promoting hospital concept prior to the session as well as occupational status and gender of the participant. For the format of the questionnaire a postcard style (Ryan, 2001 personal communication) was used, in order to aid response. In each hospital these 'postcard' questionnaires were distributed through the internal mailing system and returned to various people who were involved in the facilitation of the project. These baseline measures were purposely not returned to the respective Health Promotion

contact person within the hospitals in order to reduce the prompting of recall among survey respondents.

Post intervention Questionnaire

Questionnaire 2 formed the outcome measure and again assessed level of awareness of the HPH concept after the session as well as recall and recognition of the session, and employees' perception of how they could become involved in health promotion activities within their hospital.

As part of a follow-up staff were reminded to complete and return the questionnaires through a combination of media channels such as e-mail, phone, letters and personal communication in each hospital to increase the response rates of both baseline and follow-up surveys.

Questionnaire at the session

Further information was also obtained from the attendees of the actual session on variables such as job type and previous knowledge/awareness of the Health Promoting Hospital initiative.

Overall, the information obtained as part of this research project was handled on a strictly anonymous basis.

Qualitative Process Evaluation

The Process evaluation data was gathered through the use of semi-structured diaries, which were filled out by the respective facilitators of the session in each of the hospitals throughout the process of the intervention.

Comments on the questionnaires as well as information obtained from session attendees were also used.

Context of Data Collection

The brief intervention sessions and therefore the evaluation data collection for practical reasons was planned to take place in May and June 2002. In many of the hospitals the actual sessions took place in June and July, some going into August 2002. It was recognised that this is not an ideal time for such an intervention due to employees taking annual leave resulting in staff shortages. This was further compounded at this time by the economic climate, which resulted in temporary staff not having their contracts renewed and contributed to an increase in the turn over of staff. This was evident in the comparison of employee listings pre and post intervention. The annual movement of medical personnel to new posts also occurred during the period of the intervention dissemination and evaluation data collection. Another factor that may have impeded attendance at the brief information sessions and data collection process was the winter vomiting virus, which broke out in some of the hospitals, in some instances precluding staff attendance.

One hospital participating in the evaluation experienced a reduction in service provision and a threat of closure prior to and during the brief information session dissemination.

Analyses

Quantitative Data

The data that was obtained by means of the surveys was entered into a SPSS database, which allows the conduct of quantitative analyses. SPSS is a comprehensive statistical software system designed to handle all steps in an analysis ranging from data listings, tabulations and descriptive statistics to complex statistical analyses. For this report, the research team mainly availed of the use of frequency and percentile summaries. Cross tabulations were another useful tool provided by the SPSS software package, which facilitated the process of summarizing the data with respect to certain groupings (i.e. gender, occupation, time).

Qualitative Data

In this study the method of analysis utilised for the semi-structured diaries was content analysis. This type of analysis stresses quantification, procedural transparency and theoretical relevance (Holsti, 1969, Krippendorf, 1980).

Results

The results for both the process and impact evaluation will be presented in this section. Initially a profile of the participants will be provided. This will be followed by presentation of the results in order of the process of dissemination. Therefore initially initiation of the process and organisation of sessions will be presented followed by information on attendance at sessions, positive and negative aspects of the sessions and finally levels of awareness.

Sample Size and Response Rate

The sample size varied quite dramatically among the three time points of the evaluation. A total of 617 baseline questionnaires were received from all the participating hospitals. Session attendees filled out a total of 1202 feedback back forms. Finally, 340 follow-up questionnaires were retrieved as shown in Table 1.

Table 2: *Sample size*

	Time one	***Time two***	***At session***
Total	617	340	1202

The overall response rate for the postal questionnaires was poor. A difference in response was noted between small and large hospitals with the combined yielding a response rate of 48 per cent at time one, and a 22 per cent rate at time two. In comparison, the larger hospitals had a response rate of 26.6 per cent for time one and 15.6 per cent for time two. Overall, all participating hospitals showed a response rate of 35.7 per cent for time one, 18.2 per cent rate for time two, and an overall response of 26 per cent.

It must be noted that these response rates, particularly at time two severely restricts the interpretation of the quantitative data.

Sample Profile

Difficulty was found in accessing sample frames for all personnel working in the hospitals. In one hospital no list could be obtained within the time frame of the evaluation. However in other hospitals, although not all, staff in the hospital were employed under various auspices. In one hospital staff were employed by three different health organisations, in another people employed by community care, such as dental staff were not included on hospital staff listings although they worked in the building. Many hospitals also employed contract workers, such as security staff and again while the people worked in the hospital they did not appear on staff lists. The sample frames therefore comprise all specifically hospital employees.

The distribution of males and females was assessed at baseline and at follow-up as can be seen in Table 3 with many more women participating than men.

Table 3*: Gender Distribution*

	Time 1 (N=617)		***Time 2 (N=340)***	
	Total	***%***	***Total***	***%***
Males	*92*	***14.9***	*38*	***11.2***
Female	*525*	***85.1***	*302*	***88.8***

The Occupational Grouping was assessed at all 3 time points. The majority of the baseline sample with 43 per cent comprised nursing and midwifery staff, followed by clerical and administrative staff, which formed 19.6 per cent of the sample. Finally, 11.5 per cent of the baseline sample was staff involved with education and training. For all other occupational groupings see Table 4. It appears that the representation of each of the occupational groupings is quite consistent across baseline, session and follow-up, which gives some validity to the findings and allows for some comparison to be made.

Table 4*: Occupational Groupings*

Occupational Group	***Time 1***		***Time 2***		***At session***	
	Total	*%*	***Total***	*%*	***Total***	*%*
Nursing/Midwifery	261	***43***	*163*	***47.9***	*432*	***35.9***
Care Assistants	*19*	***3.1***	*13*	***3.8***	*78*	***6.5***
Technicians	*10*	***1.6***	*8*	***2.35***	*42*	***3.5***
Maintenance/Stores	*11*	***1.8***	*4*	***1.2***	*8*	***0.7***
Portering/Household	*33*	***5.4***	*9*	***2.6***	*95*	***7.9***
Medical	*22*	***3.6***	*16*	***4.7***	*20*	***1.7***
Clerical/Administrative	*119*	***19.6***	*79*	***23.2***	*226*	***18.8***
Catering	*14*	***2.3***	*4*	***1.2***	*57*	***4.7***
Education/Training	*70*	***11.5***	*7*	***2.1***	*120*	***10***
Paramedical	*5*	***0.8***	*6*	***1.8***	*1*	***0.1***
Other	*43*	***7.1***	*31*	***9.1***	*123*	***10.2***
Total	*607 (1730)*	***35.1***	*340 (1730)*	***19.7***	*1202 (6661)*	***18***

Initiation of process of information dissemination

The semi-structured diaries provided qualitative information on how the facilitators managed organisational issues including the introduction of the brief information sessions to the hospital as an organisation. In all hospitals managerial permission and support was requested by the facilitators as suggested by the brief information session pack. Managers were contacted by phone, letter or were directly approached in person. In general it was reported that management were very helpful and responsive to the idea of implementing the information session. This was identified as a key facilitating factor in the implementation of the sessions.

Organisational Planning

Facilitators in some hospitals recognised that the organisational planning of the information sessions was greatly assisted by their own previous experience of managing similar interventions. In some hospitals facilitators recruited other members of staff to present and run sessions, it is notable that these facilitators did not identify the increased workload created by the dissemination of the sessions as a difficulty. Facilitators in their diary entries in some hospitals, notably the smaller ones identified difficulties in accessing video equipment and rooms to hold the sessions. However, this was not a

problem for most facilitators. Through the diaries it became evident that facilitators had to face certain other problems. As a result of the sessions being implemented mainly over the summer months it became difficult to organize the sessions due to increased annual leave. Resultant staff shortages and lack of locum cover made it difficult for present staff to take time out to attend the sessions. Rotating rosters as well as annual leave seemed to create particular difficulties in terms of accessing permanent night staff.

Notification of Hospital Staff: Facilitators

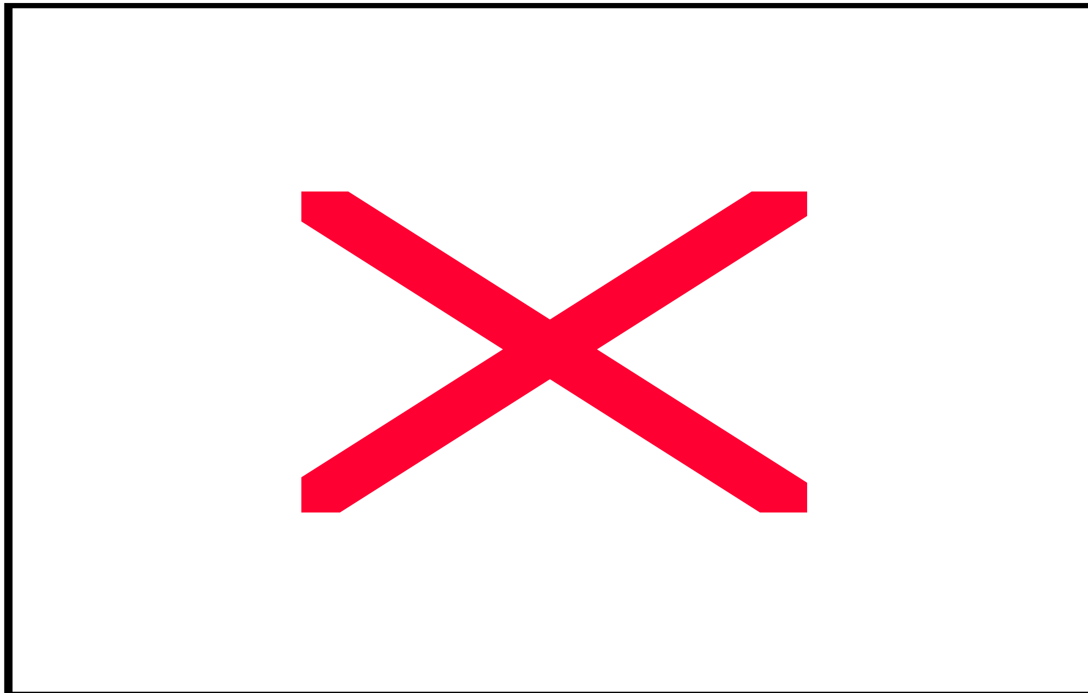
When it came to notifying hospital staff about the session and the proposed schedule and venue, facilitators circulated letters/ newsletters which were sent either directly to staff or the directing heads of the various departments within the hospitals via the internal post system. While the sessions were up and running, the facilitators sent out further letters, e-mails or directly phoned staff to remind them about the information sessions and to allow them to reorganize alternative times and venues in order to facilitate the attendance of all staff. The internal postal system of the hospitals was identified as facilitating notification of staff. Some facilitators also mentioned that they personally reminded people that they met in the course of their day-to-day work. While e-mail was identified by facilitators as a helpful communication tool to get in touch with some of the staff, it was mentioned more than once that not all staff members have access to a computer or e-mail. All facilitators reported using two or more channels of communication in order to notify staff. The quality and efficacy of the channel of communication was reported as impacting on the ease or otherwise of staff notification. For example, inaccurate mailing lists, technical difficulties with the internal e mailing system and unclear printing of a newsletter with information under health and safety news section is likely to impact negatively on levels of staff notification.

Media Path of Notification:Participants

Data was gathered in the follow up questionnaire from both, session attendees and non-attendees, who were asked to retrospectively recall how they were notified about the information session. Of the session attendees, the majority (61.4 per cent) had heard

about the session by word of mouth. A further 38.6 per cent were notified of the session via letter, followed by 18.6 per cent of attendants who knew about the upcoming session through posters. Of the non-attendees however, 35.4 per cent heard about the session both via posters and through word of mouth from their colleagues. A further 26.6 per cent were informed through a letter. While distinguishing between large and small hospitals, it was found that in small hospitals attendees of the session had mainly heard about the session through word of mouth (62.8 per cent) or letter (35.1 per cent), while non-attendees had mainly heard about the HPH information session through word of mouth (40.7 per cent) or posters (39.8 per cent). In the participating large hospitals 58.8 per cent of session attendees knew about the session by word of mouth and a further 45.1 per cent via a letter. Staff that had not attended the session but knew about it had mainly been informed through posters (32.4 per cent) or word of mouth (31.5 per cent) as well as letters (25.9 per cent). For more detail on how staff were informed about the session see a graphical presentation in Graph 1 and tabular information in Appendix 2.

Graph 1*: How were staff informed about the Brief HPH Information Session?*



Attendance at Session

A total of 1202 (18 per cent) staff members across all participating hospitals attended the Brief HPH information session. Monaghan General hospital had proportionally the largest attendance with a 65.2 per cent attendance rate of its hospital staff, followed by James Connolly Memorial Hospital (JCM)with a 40.9 per cent and St. Vincent's Hospital with a 39.1 per cent attendance rate. For other hospitals see Table 5. When comparing small and large hospitals, the results showed that the participating small hospitals had an overall attendance rate of 38.2 per cent, which was almost twice the rate of the large hospitals (13.7 per cent).

Table 5: *Attendance rates at HPH information session*

	Total	***%***
Sligo	***101*** *(1176)*	***8.6***
Holles Street	***182*** *(675)*	***27***
St. Vincents	***90*** *(230)*	***39.1***
JCM	***402*** *(982)*	***40.9***
Cavan	***179*** *(754)*	***23.7***
Monaghan	***178*** *(273)*	***65.2***
Beaumont	***70*** *(2571)*	***2.7***
Small hospitals	***450*** *(1178)*	***38.2***
Large hospitals	***752*** *(5483)*	***13.7***
All hospitals	***1202*** *(6661)*	***18***

However, it must be noted that of the total of 340 respondents of the follow-up survey, only 145 (42.6 per cent) had actually attended the session.

Attendance: Facilitators

Facilitators in some hospitals reported that certain staff groups were more responsive to the sessions than others. These groups appear to mainly but not exclusively belong to the support services. One facilitator reported that the CSSD department was very appreciative of inclusion in the intervention and others cited similar experiences with Catering, Laundry and Library staff. In one hospital the Physiotherapy Department was

particularly keen to be involved. In relation to the support services one facilitator commented that the group approached where surprised and delighted to be included in a way that they had not been previously in hospital initiatives.

It was recognised by the facilitators in many of the hospitals that attendance was less than hoped. A number of facilitators took action to promote attendance. This included one facilitator reviewing staff groups that had attended and actively targeting the groups that had not attended. It had been intended that the sessions would be run for mixed groups of employees so supporting the idea that health promotion is for all and facilitating multi disciplinarity. Some facilitators actively recruited groups by specific employment for example all catering staff or all nurses from a particular ward. The facilitators that used this technique considered that it promoted attendance at the sessions.

Perceptions of Session: Facilitators

Many of the facilitators in their diary entries reported that the format of the sessions was clearly laid out in the pack and guidelines and that the video was clear and concise. Some concern was raised about the speed of the video with the perception expressed that it was too fast for some people to follow. Different levels of interest was reported from the various hospitals with one stating that staff appeared to find the sessions very informative and it generated discussion and another that the level of staff awareness was already high so that the session was not very effective and staff were disinterested. It is interesting to note that in the hospital where discussion was generated and interest increased the facilitator reported using the video and handout as an aid to the session to support a 10-12 minute talk followed by discussion. In the hospital where the session proved less effective difficulties with time constraints and staff shortages were highlighted and the facilitator stated that time for discussion around the issues would greatly benefit the session.

Perception of Session: Participants

As part of the follow-up survey, hospital staff were asked about positive and negative aspects of the information session. When assessing the comments staff made with regards to the sessions, various themes emerged.

Positive Aspects of the Session

Session Format/Presentation

In response to the format of the individual sessions staff generally agreed that the sessions were “well presented”. Overall, as one person stated “the video sessions were good, the availability to attend sessions was flexible and the speakers were clear and good”. The session was “short and to the point” which was considered positive. It was also acknowledged that “the session was the first of its kind” in terms of informing hospital staff about the Health Promotion Hospital Initiative

Awareness

Session attendees stated that the session “made (them) more aware of health promotion in hospitals”, particularly with regard to “helping people to be more health conscious”. Overall, it appeared that the information session on the HPH initiative “re-opened (people’s) awareness of the value of Health Promotion”. This increase in awareness was perceived as positive. Not only did the session raise people’s awareness of health promotion generally but more particularly at an organisational level, with positive comments from staff including “informed (them) of the health boards’ plans of health promotion and although not all strategies mentioned were in place, that it gave something to aim for”.

A number of comments from attendees stated that the session was comprehensive in that it “covered all areas of Health Promotion, from psychological to mental to physical”. The session also “promoted forward thinking and planning and encouraged staff to take part in Health Promotion activities”.

Negative Aspects of the Session

Session attendees also made some critical comments that concerned organisational issues or content of the sessions.

Content of session

Some, even though few, critical remarks were made with regards to session content. It was expressed that the "information was fairly basic" and that the "video was very dull and could have been made more interesting". Others again felt that the session provided "too much info to take in at end of hard working day". Furthermore, it was mentioned that the session somehow failed to "give an idea of what (staff) could do (themselves)" and somehow could have provided "more information on what is available in different health promotion areas".

Time issues

With regards to session attendance, many found that they had "insufficient time to attend the full session" as a result of staff shortages or lack of locum cover and hence throughout the session "felt the pressure of having to return to work". Given the short amount of time allocated to the session it was felt that there was "no time for discussion afterwards". It was also noted that as a result of the lack of time the session was "too fast" and hence "too much information (was presented) at 190 mph".

Attendance

Further comments showed that different hospitals had differing experiences with regards to attendance. There was an overall consensus that "not everybody got involved". However, with regards to individual sessions, some respondents from two hospitals felt that there were "too many people" at the particular session they attended and that the venue had therefore been "too crowded". Others, however, stated that in their hospital "attendance was poor" as a result of "not enough people being interested".

While in the positive comments people appear to have taken the information presented on board the follow up questionnaire asked questions to ascertain whether the session was personalised. The results of these questions are now reported.

Personalisation of Information

Hospital staff were asked in the follow-up survey as to whom they thought the information session applied to. The majority of respondents (68.8 per cent) agreed that the HPH information session applied to everyone. Only 1.5 per cent felt that the session did not apply to anyone. For further detail see Table 5.

Table 6*: Frequencies and Percentages on question: 'Who did the information session apply to?'*

Item	Total	%
Women	*1*	***0.3***
Everybody	*234*	***68.8***
Nobody	*5*	***1.5***
Missing	*100*	***29.4***
Total	*340*	***100***

When staff were asked about whom they felt the HPH initiative in general was aimed at, the majority (58.8 per cent) agreed that it was indeed aimed at all hospitals. 5 per cent perceived it to be aimed at only general hospitals, followed by 4.4 per cent, who perceived it to be aimed at larger hospitals. For more detail see Appendix 3.

The follow-up survey also showed that more than half of the respondents (61.5 per cent) perceived the HPH initiative to be aimed at all occupational groupings. 5.3 per cent regarded the HPH initiative more important for nursing and midwifery staff. See Table 7 for further detail. However, to be noted here is that approximately 30 per cent of the respondents of the follow-up questionnaire omitted this question.

Table 7*: Frequencies and Percentages on question:*
'Which occupational group is the HPH aimed at?

Item	Total	%
Nursing/Midwifery	*18*	***5.3***
Care Assistants	*2*	***0.6***
Maintenance/Stores	*1*	***0.3***
Portering/Household	*1*	**0.3**
Medical	*4*	**1.2**
Clerical/Administrative	*3*	**0.9**
All	*209*	**61.5**
Other	*4*	**1.2**
Missing	*98*	***28.8***
Total	*340*	***100***

Level of Awareness

The ultimate objective of the Brief HPH information session was to increase the level of awareness of the HPH initiative among staff in the participating hospitals. Considering the differing sample sizes at the three evaluation times, the results show that level of awareness was indeed highest at baseline with 72 per cent of the respondents stating that they were aware of their hospital being involved in the Health Promoting Hospital Initiative. However, comparing level of awareness between the session and follow-up, the results show a slight 2.8 per cent increase in level of awareness at follow-up. Furthermore, it appears that the overall level of awareness at the session is smaller than at baseline, which suggests that session attendees were not self selected and hence not necessarily interested in health promotion prior to the session. For further figures see Table 7. However, as mentioned earlier, before interpreting these results the rate of response must be taken into account.

Table 8*: Frequencies and Percentages of Levels of Awareness across baseline, At session and follow-up*

Item	***Time one***		***At session***		***Time two***	
Awareness of HPH Initiative	***Total (N=617)***	***%***	***Total (N=1202)***	***%***	***Total (N=340)***	***%***
	444	***72***	*790*	***65.7***	*233*	***68.5***

Involement in Health Promotion Initiatives

Part of the impact evaluation was to determine whether staff would be more willing to be become involved in the HPH initiative within their respective organization as a result of the information session. The results as presented in Table 9 showed that while 64.9 per cent of session attendees wanted to become more involved in the HPH initiative, only 39.4 per cent of the follow-up sample felt this way.

Table 9*: Frequencies and Percentages of perception of wanting to become involved in the HPH initiative within their hospital.*

Item	***At session***		***Time two***	
Would you like to become more involved in the HPH initiative within your organization?	***Total (N=1202)***	***%***	***Total (N=340)***	***%***
	780	***64.9***	*134*	***39.4***

Discussion

An important factor to consider before interpreting the present findings is that the response rates with regard to the baseline and follow-up questionnaires were very poor. The process evaluation has shown that staff shortages due to the economic climate and annual leave may have been the cause of the lack of response, particularly of the follow-up. However, this finding makes it very difficult to compare the two samples (pre-and post session) particularly with regard to awareness levels. However the sample profile is very similar at all three time points and there were almost equal levels of positive and negative remarks at follow up. A difference was noticed between small (33.2%) and large hospitals (20.7%) with regards to response rates. This is reflected in attendance rates at the session, where small hospitals outreached large hospitals by nearly 25 per cent.

Was the intervention implemented as planned?

All facilitators sought and gained management and key personnel support for the programme as planned in the information pack. It is likely that this facilitated the programmes development. One area that was not stipulated in the pack was the active use of other personnel to disseminate the information and run some of the sessions. This appears to be advantageous for the programme and the facilitator.

The targeting of a mixed group of people from a range of occupations while stipulated in the planning appears to be idealistic and many of the facilitators either resorted to single occupational groups when attendance was poor or did this from the start. This would appear to be far more practical in terms of accessing staff, but also more successful in terms of recruiting staff for the sessions. This was notable for groups in the support services such as laundry or catering staff. In this instance where the hospitals have been in the network for some time and are disseminating the sessions over a fixed period it is likely to be more practical to target specific occupational groups. A further advantage of this is that the session through the verbal presentation can be more specifically targeted to the specific occupational groups needs.

While the response rate from groups in the support services generally was poor in all hospitals facilitators identified the value these groups placed on being actively approached and included in the sessions. This highlights the opportunity for health promoting interventions in these groups and suggests that the process of the dissemination of the sessions contributed to raising awareness of health promotion in the hospitals. It also suggests that these groups are likely to have a low level of awareness of the health promotion concept and that the active targeting of support services for hospitals that have been in the network for some time may be beneficial.

The repeated, varied and multiple use of communication channels to inform staff of the information sessions shows the amount of effort put into this initiative by the facilitators. The perceived need and actual use of such multiple strategies coupled with the difficulties identified in the lack of efficient, effective and comprehensive formal channels through which to inform and notify staff acts as a barrier to information dissemination exercises such as the HPH brief information session. The difficulty experienced by the researchers in accessing a comprehensive list of all people working in the specific hospital settings compounds this situation. The finding that, for small hospitals particularly, word of mouth acted as the most cited channel of communication further supports the lack of formal communication systems as it is likely that informal channels have developed to compensate for the lack of formal systems. This appears to be more successful for small hospitals but mitigates against very large organizations. The implications of this lack of comprehensive formal communication systems are likely to be reflected to some degree in the relatively low attendance rates.

It would appear that the content and presentation of the sessions was carried out as planned but with some variation by hospital. All facilitators appear to have shown the entire video during the session but the role that the video played varied from being an audio visual aid to being the focus of the sessions. Where the video was the focus, lack of opportunity for discussion was identified as a barrier to effectiveness. This lack of discussion appears to be due to time constraints caused by staff shortages. The session

was planned to be relatively short and last 30 minutes at most to facilitate management support and attendance. This poses a difficulty and it would appear that a balance needs to be reached between time available and the form of the session. While staff shortages resulting in time constraints can occur at any time of year, it is likely that they are more severe during the summer months. Therefore these sessions would be more effective if run either earlier or later in the year. It must also be noted that the hospitals participating in the evaluation had all been members of the Health Promoting Hospital Network for some time. Due to the active work of the co-ordinators in each hospital it is likely that members of staff are familiar with the concept already. This is supported by the high level of awareness of the HPH concept found prior to the sessions in all hospitals and the negative comments that identified the perception that the information provided was “fairly basic”. The sessions were designed to introduce people to the concept of health promoting hospitals and it may be that as many attending the sessions were already aware the video did not add to their awareness and knowledge but acted as a reminder rather than an introduction. Discussion in the sessions therefore afforded groups an opportunity to develop their knowledge further. This has implications for the use of the dissemination process and it is likely to be more effective as planned (ie maximum 30 minutes with focus on video) for hospitals joining the Network where levels of knowledge and awareness are likely to be low and also for members of staff joining established Health Promoting Hospitals. For hospitals that have been Network members for some time the use of the video in the session as an aid and prompt for discussion may be more beneficial but this would require more time.

Session Content

The majority of comments in relation to facilitators of the sessions was very positive with clear, concise presentations prior to the video showing. The speed of the video was identified as a negative aspect of the presentation by some participants and highlighted by some facilitators also.

Who has the Intervention reached?

Generally the intervention reached proportionally more staff in the smaller hospitals than the larger, which may reflect efficacy of communication channels as discussed earlier. The analysis of the three samples (baseline, at session and follow-up) has provided some interesting findings with regards to the staff profile of the participants. It appears that females by far outnumbered males at baseline (Females: 85.1%; Males: 11.2%) as well as at the follow-up (Females: 88.8%; Males: 11.2%) survey. This in some way reflects employment patterns in the hospital setting where a large number of staff both medical, notably in nursing and clerical as well as support services are women. However it may also suggest that men may be more difficult to reach than women and men may need to be actively and specifically recruited.

Perceived Relevance

Staff who had attended the sessions and completed a follow up questionnaire perceived the sessions to be aimed at all hospitals and all members of staff in hospitals suggesting that they were aware that the health promotion hospital concept is for all. This suggests that staff do understand to some degree the multidisciplinary approach conveyed by the HPH initiative even if the attending groups themselves were made up of one occupational grouping.

Level of Awareness

The results indicate that awareness in hospitals was indeed highest before the information sessions had been implemented (72%). At the sessions 65.7% of attendees reported being aware with a very slight increase to 68.5% at follow up. However, considering the very small and decreasing sample sizes across the three time points, this result should be interpreted with caution.

Involvement in Health Promotion

When asked whether the sessions raised people's interest in wanting to become actively involved in Health Promotion activities within their hospital, it seems that people were

more interested while actually attending the sessions compared with their response at follow-up. While the objective of the sessions was not necessarily to get people involved in activities if this becomes an objective of the sessions then it may be worth having follow on activities that people recruited can actively participate in planned so that motivation for participation is not lost.

Conclusion:

The barriers created by a lack of effective communication channels coupled with time constraints due to staff shortages have resulted in relatively low levels of attendance at sessions in most hospitals. This reflects the organizational infrastructure of the hospital settings rather than the design and implementation of the brief information sessions themselves. The actual sessions, including content were generally positively received and professionally managed and presented by facilitators in all hospitals. While it is difficult to infer any change in levels of awareness from the data due to the response rate it would appear that the majority of staff were already aware of the health promoting hospital concept prior to any intervention. It is likely that the brief information sessions while acting as a prompt in established health promoting hospitals will raise awareness for hospitals introducing this idea to staff.

Recommendations:

It is recommended that:

- The brief information sessions are targeted at specific occupational groupings from the outset with specific reference to support services

- A cascade approach is used by facilitators in that health promoting hospital co-ordinators actively identify and recruit a number of staff representing various occupational groupings with the requisite skills to deliver the sessions.

- The sessions should not be planned to be delivered over the summer months.

- The focus of the sessions is tailored so that it is recognised that staff in established health promoting hospitals are likely to be more aware and therefore the session allows for more discussion than hospitals joining the network where the video information should form the focus of the session.

- The session be included in induction and orientation of all new staff to health promoting hospitals.

- Health promotion co-ordinators work with hospital management and personnel to develop effective and efficient communication networks and channels within the hospital setting.

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Appendix 1

Table 1: *Frequencies and Percentages of occupational groupings In Holles Street Hospital sample*

Occupational Group	***Time 1***		***Time 2***		***At session***	
	Total	***%***	***Total***	***%***	***Total***	***%***
Nursing/Midwifery	37	***39.4***	*2*	***6.1***	*45*	***24.7***
Care Assistants	*1*	***1.1***				
Technicians	*3*	***3.2***	*2*	***6.1***	*7*	***3.8***
Maintenance/Stores	*1*	***1.1***				
Portering/Household	*12*	***12.8***			*18*	***9.9***
Medical	*6*	***6.4***	*4*	***12.1***		
Clerical/Administrative	*11*	***11.7***	*13*	***39.4***	*37*	***20.3***
Catering						
Education/Training	*18*	***19.1***	*2*	***6.1***	*63*	***34.6***
Paramedical			*1*	***3***		
Other	*5*	***5.3***	*9*	***27.3***	*12*	***6.6***
Total	*94 (250)*	***100***	*33 (250)*	***100***	*182 (675)*	***100***

Table 2: *Frequencies and Percentages of occupational groupings In St. Vincent's University Hospital sample*

Occupational Group	***Time 1***		***Time 2***		***At session***	
	Total	***%***	***Total***	***%***	***Total***	***%***
Nursing/Midwifery	69	***38.5***	*44*	***65.7***	*45*	***50***
Care Assistants	*8*	***4.4***			*10*	***11.1***
Technicians						
Maintenance/Stores	*3*	***1.7***			*2*	***2.2***
Portering/Household	*10*	***5.6***	*3*	***4.5***		
Medical	*3*	***1.7***				
Clerical/Administrative	*25*	***14***	*17*	***25.4***	*14*	***15.6***
Catering	*5*	***2.8***				
Education/Training	*50*	***27.9***	*2*	***3***	*15*	***16.7***
Paramedical						
Other	*6*	***3.3***	*1*	***1.5***	*4*	***4.4***
Total	*179 (230)*	***100***	*67 (230)*	***100***	*90 (230)*	***100***

Table 3*: Frequencies and Percentages of occupational groupings*
In Monaghan General *Hospital sample*

Occupational Group	***Time 1***		***Time 2***		***At session***	
	Total	***%***	***Total***	***%***	***Total***	***%***
Nursing/Midwifery	42	***54.5***	*45*	***58.4***	*55*	***30.9***
Care Assistants	*5*	***6.5***	*4*	***5.2***	*39*	***21.9***
Technicians					*7*	***3.9***
Maintenance/Stores	*1*	***1.3***	*1*	***1.3***	*2*	***1.1***
Portering/Household	*2*	***2.6***	*1*	***1.3***	*3*	***1.7***
Medical	*1*	***1.3***	*3*	***3.9***	*5*	***2.8***
Clerical/Administrative	*18*	***23.4***	*16*	***20.8***	*33*	***12.1***
Catering					*8*	***4.5***
Education/Training			*1*	***1.3***		
Paramedical			*1*	***1.3***		
Other	*8*	***10.4***	*5*	***6.5***	*26*	***14.6***
Total	*77 (250)*	***100***	*77 (250)*	***100***	*178 (273)*	***100***

Table 4*: Frequencies and Percentages of occupational groupings*
In Sligo General Hospital sample

Occupational Group	***Time 1***		***Time 2***		***At session***	
	Total	*%*	***Total***	*%*	***Total***	*%*
Nursing/Midwifery	12	***22.6***	*22*	***53.7***	*43*	***42.6***
Care Assistants			*1*	***2.4***	*5*	***5***
Technicians	*3*	***5.7***	*2*	***4.9***	*3*	***3***
Maintenance/Stores						
Portering/Household	*4*	***7.5***	*1*	***2.4***		
Medical	*3*	***5.7***	*1*	***2.4***	*10*	***9.9***
Clerical/Administrative	*21*	***40***	*9*	***22***	*15*	***14.9***
Catering	*2*	***3.8***	*2*	***4.9***	*7*	***6.9***
Education/Training					*14*	***13.9***
Paramedical			*1*	***2.4***		
Other	*8*	***15.1***	*2*	***4.9***	*4*	***4***
Total	*53 (250)*	***100***	*41 (250)*	***100***	*101 (1176)*	***100***

Table 5: *Frequencies and Percentages of occupational groupings In James Connolly Memorial Hospital sample*

Occupational Group	***Time 1***		***Time 2***		***At session***	
	Total	***%***	***Total***	***%***	***Total***	***%***
Nursing/Midwifery	47	***63.5***	*16*	***45.7***	*155*	***38.6***
Care Assistants	*2*	***2.7***	*2*	***5.7***	*3*	***0.7***
Technicians	*2*	***2.7***	*2*	***5.7***	*2*	***0.5***
Maintenance/Stores	*2*	***2.7***	*1*	***2.9***	*1*	***0.2***
Portering/Household					*72*	***17.9***
Medical	*1*	***1.4***	*1*	***2.9***		
Clerical/Administrative	*12*	***16.2***	*7*	***20***	*82*	***20.4***
Catering	*2*	***2.7***	*1*	***2.9***	*32*	***8***
Education/Training	*1*	***1.4***	*1*	***2.9***	*11*	***2.7***
Paramedical			*1*	***2.9***	*1*	***0.2***
Other	*5*	***6.8***	*3*	***8.6***	*43*	***10.7***
Total	*74 (250)*	***100***	*35 (250)*	***100***	*402 (982)*	***100***

Table 6: *Frequencies and Percentages of occupational groupings In Cavan General Hospital sample*

Occupational Group	***Time 1***		***Time 2***		***At session***	
	Total	***%***	***Total***	***%***	***Total***	***%***
Nursing/Midwifery	37	***50.7***	25	***49***	62	***34.6***
Care Assistants	*3*	***4.1***	*4*	***7.8***	*19*	***10.6***
Technicians					*10*	***5.6***
Maintenance/Stores	*2*	***2.7***				
Portering/Household	*1*	***1.4***	*1*	***2***	*2*	***1.1***
Medical	*5*	***6.8***	*5*	***9.8***	*5*	***2.8***
Clerical/Administrative	*17*	***23.3***	*9*	***17.6***	*37*	***20.7***
Catering	*3*	***4.1***			*5*	***2.8***
Education/Training					*8*	***4.5***
Paramedical	*5*	***6.8***	*1*	***2***		
Other			*5*	***9.8***	*31*	***17.3***
Total	*73 (250)*	***100***	*51 (250)*	***100***	*179 (754)*	***100***

Table 7*: Frequencies and Percentages of occupational groupings In Beaumont Hospital sample*

Occupational Group	***Time 1***		***Time 2***		***At session***	
	Total	***%***	***Total***	***%***	***Total***	***%***
Nursing/Midwifery	17	***29.8***	*9*	***25***	*27*	***38.6***
Care Assistants			*2*	***5.5***	*2*	***2.9***
Technicians	*2*	***3.5***	*2*	***5.5***	*13*	***18.6***
Maintenance/Stores	*2*	***3.5***	*2*	***5.5***	*3*	***4.3***
Portering/Household	*4*	***7***	*1*	***2.8***		
Medical	*3*	***5.3***	*2*	***5.5***		
Clerical/Administrative	*15*	***26.3***	*8*	***22.2***	*8*	***11.4***
Catering	*2*	***3.5***	*1*	***2.8***	*5*	***7.1***
Education/Training	*1*	***1.8***	*1*	***2.8***	*9*	***12.9***
Paramedical			*1*	***2.8***		
Other	*11*	***19.3***	*6*	***16.7***		
					3	***4.3***
Total	*57 (250)*	***100***	*36 (250)*	***100***	*70 (2571)*	***100***

Appendix 2

Table 8*:* *How did staff get informed about the Brief HPH Information Session?*

		Posters		***E-mail***		***Letter***		***Word of Mouth***		***Other Medium***	
		Total	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*
All Hospitals	***Session Attendees (N=145)***	*27*	***18.6***	*16*	***11***	*56*	***38.6***	*89*	***61.4***	*17*	***11.7***
	Non-Attendees (N=192)	*68*	***35.4***	*14*	***7.3***	*51*	***26.6***	*68*	***35.4***	*5*	***2.6***
Small Hospitals	***Session Attendees (N=94)***	*13*	***13.8***	*5*	***5.3***	*33*	***35.1***	*59*	***62.8***	*11*	***11.7***
	Non-Attendees (N=83)	*33*	***39.8***	*6*	***7.2***	*23*	***27.7***	*34*	***40.7***	*1*	***1.2***
Large Hospitals	***Session Attendees (N=51)***	*14*	***27.5***	*11*	***21.6***	*23*	***45.1***	*30*	***58.8***	*6*	***11.8***
	Non-Attendees (N=108)	*35*	***32.4***	*8*	***7.4***	*28*	***25.9***	*34*	***31.5***	*4*	***3.7***

Appendix 3

Table 9*: Frequencies and Percentages on question: 'Who is the HPH initiative aimed at?*

Item	Total	%
Small hospitals	*3*	***0.9***
Large hosp	*15*	***4.4***
General hosp	*17*	***5***
Specialist hosp	*1*	**0.3**
Hospitals like this	*10*	**2.9**
All hospitals	*200*	**58.8**
Missing	*94*	***27.6***
Total	*340*	***100***