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How Can the Empowerment Role of Public Health Nurses (PHNs) Be Fostered? A Review of an Exploratory Research Study Conducted in Ireland and Current Evidence

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1. Introduction

Public Health nursing is complex because it incorporates an expectation of empowerment and advocacy on behalf of the public health nurse (PHN) in three functions: curative engagement, health promotion, and political advocacy (Cawley and Mannix McNamara 2011). Indeed, the mission of public health nursing calls for the health promotion approach (DOH 1997) and PHNs have a unique opportunity in their roles to work in a health promoting way. International trends are towards more population-focused objectives that concentrate on disease prevention and health promotion (Edgecombe 2005).

There is an established strong case for health professionals including PHNs to work to promote health (Who 1986) and empowerment of health professionals is central to health promotion as is evidenced by the priority it receives in the Ottowa Charter (WHO 1986). Added to this is, the evidence that the empowerment for the healthcare professional influences their ability to engage in empowering practices (DOHC 2003), p 13, Fulton, 1997, Kanter 1983 and Ryan et al, 2006). From management's perspectives, enablement of the achievement of the full potential of the health professional is key to the management of an effective health service (DOHC 2003). Therefore, if PHNs are to fulfil their diverse role it is essential they are empowered in order to effectively advocate for themselves and their clients.

Falk-Rafael (2004) and Fulton (1997) also found that nurses are being asked repeatedly to facilitate empowerment of their clients. The WHO (2000) through the Munich Declaration formally reiterated the pivotal role of nurses and midwives as a force for health in society's efforts to tackle the public health challenges of our time. Falk-Rafael, 2005, Stevens and Hall, 1992, Byrd, 1995, Williamson and Drummond, 2000 and McDonald, 2002) all argue that nurses have a moral/ ethical and professional obligation to be involved in socio-political activities that address structural conditions contributing to health inequalities because they see the impact of these conditions every day. Economic constraints and the need for healthcare systems to cut costs have led to a series of measures that influence nursing, including earlier discharge of patients, downsizing of the professional workforce, changes in staff mixes, restructuring of services and decreased support services for patient care (Swihart, 2006)

Labonte noted that many healthcare providers are relatively powerless in their organisations and need to claim legitimacy or power for themselves in order to be effective in their work with less powerful groups external to their organisation (Labonte 1994). When professionals are not granted professional status, they have great difficulty in establishing an empowering contract with their clients because they lack voice in the situation to be able to do so (Schon 1983). A dilemma facing health practitioners with regard to empowerment is that they are expected to engage in processes that are empowering for clients often without consideration as to whether they experience themselves as empowered practitioners (Ryan et al 2006). Nurses need to be empowered to make decisions about their practice (Barden et al 2011)

This chapter discusses the findings from an exploratory study titled "the empowerment approaches used by a sample of public health nurses in one of their child health programmes and the experience of these approaches by a sample of parents" in the context of current evidence. "*The study*"explored empowerment in relation to; Public Health Nurses (PHN) understanding of the concept, PHNs experience of empowerment in their work, the PHN role in relation to client empowerment, how PHNs perceive they empower their clients and how the empowerment of PHNs could be fostered. "*The study*" also explored the experience by clients of feeling empowered/ disempowered and the empowerment approach of PHNs in the context of the child health screening and surveillance programme in the Health Services Executive West Ireland. This study built on research by DoHC (2003) into the empowerment of nurses in Ireland and on research specific to empowerment and the empowerment role of the PHNs, performed by Jackson et al (1996) and Falk-Rafael (2001). "*The study*" findings indicated that PHNs did not perceive that they are empowered in their work and are unaware of this. This was related mainly to, their workloads and a lack of open access to structures of power and opportunity at work. The findings suggest that the empowerment of PHNs influences their engagement in empowering practices. The research suggests that PHNs need open access to organisational structures of empowerment. The study will be referred to in this chapter as "*the study*".

2. Background

The PHN role in child health is similar to that of health visitor in the United Kingdom and the PHN in the United States and Canada (Cohen & Reutter, 2007). The PHN in Slovenia, Finland, Iceland and Latvia (Scottish Executive) are generalist nurses with responsibility for providing primary, secondary and tertiary care to a variety of groups (Hanafin et al, 2002).

A number of critical factors were used as the framework for "*the study*". The autonomy of the healthcare professional/ was identified as the foundation to their achievement of potential and empowerment was the fundamental methodological approach. The empowerment role of the PHN is to foster the autonomy of her clients, so that clients can self-care and a political approach to support the empowerment of clients is proposed. The empowerment concept was reviewed by examining power as a concept, which involved exploring the theories of power. Kanter (1977, 1993) structural factors within the work environment have a greater impact on employee work attitudes and behaviour than personal dispositions or socialization experiences. The ability to mobilize others is directly related to one's own level of empowerment (Kanter 1983). Empowerment has been found to be an effective method to advance nurse's job satisfaction, and has been widely discussed

(Laschinger et al 2001). To support the healthcare practitioner's role as health promoter, Lewin and Urmston (2000) suggest that the Health Service needs to facilitate greater empowerment of nurses. Therefore, if PHNs are empowered in their work they are better placed to achieve their full potential and facilitate the empowerment of their clients.

On examination of the literature the author noted that illness has not declined significantly, and that the main causes of mortality have strong lifestyle factors. This is despite increasing education, screening, and vaccination (Naidoo and Wills, 2000). There have been significant changes in the area of primary healthcare, due in part to the ever-increasing needs by the health service users, and due to earlier discharge into the community. The Primary Care Strategy has also had a strong influence. The impact of such growing pressures means an increased belief that healthcare needs must be met in the community. There is also a greater emphasis on self-care, and this has added to the need for healthcare professionals in the community to work in a health promoting way. In fact, nurses are being asked to empower others (English Nursing Board (ENB) 1991).

Empowerment has a strong political dimension and this requires self-reflection, dialogue, action and commitment to change (Carey 2000). It is defined in political, management and organisational development terms. Real empowerment challenges the healthcare practitioner and the system and when asked to question structures of power, the practitioner begins to question their practices (Ryan et al 2006p 51). Empowerment is an ongoing process towards what Maslow (1968) termed as self-actualisation. Freire (1972) contended that the facilitation of empowerment is a moral obligation. The DoHC (1998) recommended that PHNs should be allowed to focus to a greater extent on their health promotion and disease prevention role. However to date, no mechanism or resources have been provided to support this. Empowerment strategies intended to enable individuals, groups and communities to have greater control over decisions affecting their lives are becoming a required part of public health nursing practice (Jackson et al 1996, p 7).

Health visitors and PHNs have an opportunity to meet clients in their homes, in the real world where health choices are made. The author therefore reflected on and a reviewed a sample of the literature related to public health nursing, health promotion and empowerment. The author noted that roles, workloads and the frameworks within which PHNs work in the republic of Ireland shows some variations to that of PHNs worldwide. The literature review highlighted that a number of studies had explored empowerment in the context of public health nursing internationally. Aston et al (2006) conducted research in Canada into how empowerment as an ideology and a practice in teaching and learning was understood and applied by PHNs in health education with child bearing and child rearing families through interviews with mothers and PHNs. Their findings identified a need for further investigation into the required skills of PHNs that enable them to co-create empowering relations.

A nurse's role of caring can be at odds with empowerment through moral and political dilemmas (Malin and Teasdale 1991). When healthcare workers like PHNs have large case loads and their communities have many and varied healthcare needs, these needs must be met. In meeting these needs, the PHN may be left with little time to work to support empowerment.

An approach that combines critical social theory, organisational theory, and social psychological theories of power and Foucault's work on power was identified by "*the study*"

as key to the empowerment of the PHN by supporting an environment that creates the conditions that support reflection and raising of PHN self-efficacy. A Health service that ensured structures of opportunity are maintained for PHNs and places increased emphasis on support, feedback and affirmation as part of the structure of power are needed. In addition, leadership of PHNs and leadership skills of PHNs are required. An action theory approach is needed in practice to bridge the knowledge practice gap to foster the empowerment of PHNs.

3. Methodology of original study

"*The study*" exploratory had two phases. Phase 1 comprised of two focus groups with a purposive sample of nine PHNs. The focus groups explored the concept of empowerment, and what empowered the PHNs and the strategies they use to support empowerment of their clients. Data generated by the focus groups was analysed by a model that integrated Burnard's (1991) method of analysing interview transcripts by thematic content analysis with the three-stage method outlined by Kumar (1999) and Skelton (1997) supported by the authors own methodological questions. Phase 2 consisted of the administration of questionnaires to a sample of 107 parents with a yield of 40.2% on the administered questionnaires. The questionnaires examined the experience by parents of the empowerment approach of PHNs at the child health screening and surveillance checks. SPSS (Statistical package for the social sciences) was used to analyse the data generated.

4. Theoretical framework

4.1 Empowerment as a concept

Empowerment is both an interpersonal process through providing resources to enable others to set and reach goals (Hawks and Hromek 1992, Rodwell 1996) and an outcome being translates as autonomous decision making, self-determination and feelings of self worth(Gibson, 1991). Combining both fosters autonomy and participation. Conger and Kanungo (1988) define empowerment as a process of enhancing feelings of self-efficacy amongst organisational members through the identification of conditions that foster powerlessness and through their removal by formal organisational practices and informal techniques of providing efficacy information. "*The study*" this chapter builds on defined empowerment as a process and an outcome in which the ability, self-efficacy and autonomy of the PHN is enabled and strengthened by the Health Service creating an empowering environment, where clients and healthcare professionals have open channels to all the resources they need to support them in achieving their personally defined potentials (Cawley and Mannix McNamara 2011). Therefore, the PHN has what Rodwell 1996 defined as "effectiveness which is capacity, ability and means".

4.2 Critical social theory

Emancipatory research has the intent to challenge inequalities and disrupt the status quo where necessary and Rose and Glass (2008) attest that its role in contemporary nursing practice is significant as it sets out to raise the consciousness of nurses who are located in marginalised and oppressed positions. It has oppression as its central focus and social change as key objective with fostering an ideology based on the belief that knowledge is

socially constituted, historically situated and valuationally based (Henderson, 1995, p 58). Paulo Freire popularised this theory in his efforts to liberate. Wittmann-Price (2004) argued that the first step towards creating an emancipatory healthcare environment is by first recognising the existence of oppression and in turn its impact on nursing care delivery. Indeed in critical social theory, nurses may be seen as oppressed (Gilbert 1995, Fulton 1997 and Ryles 1999).This needs to be followed by praxis which is a constant interaction between action for change and reflection on action. Educational Institutes and the Health Service need to facilitate reflection on power as it has influenced their role development from its inception and how the structures and systems within which they work impact on their empowerment. Foucault attests that power is not exclusively legalised power, decision making or technique (1978) and its disposal requires the assumption of some responsibility (Foucault 1994). Illich (1970, p 18) concurs and suggests that freedom and power are determined by a willingness to accept responsibility for the future. PHNs have many sources of power including; knowledge, skills, role, access to information and location in relation to power etc and these bestow responsibility and accountability.

4.3 Organisational theory

Kanter's (1977) theory postulated that access to structures of power and opportunity are related to position and job context. Kanter's (1977) theory proposes that access to structures of power and opportunity have a far greater influence on work performance than personality factors. The structures of opportunity are the opportunities for professional growth. They result in the display by the employee of a set of positive attitudes, such as higher levels of motivation and commitment. Kanter (1977) conceptualises that structures of power require open connections through the channels of the power sources within the system and if all channels are open then workers have the power needed to be productive. The channels of power are:

- Lines of supply or access to resources needed to carry out the job efficiently.
- Lines of information, knowing all one needs to know to do the job.
- Lines of support or feedback on performance and continuing approval of actions.

<div align="center">(Kanter 1977)</div>

Access to empowering structures is facilitated by formal and informal job characteristics. Formal power is enhanced when jobs are flexible, central to the organisational goals and allow employees to exercise creativity and discretionary decision-making. Informal power is derived from the development of effective relationships and communication channels with sponsors, peers, subordinates and cross-functional groups, both within and outside the organisation. The organisational factors that were found to influence PHN empowerment in "*the study*" were; role and workload of the PHN, the PHN management structures, and the Health Service structure. Psychological empowerment is the logical outcome of managerial efforts to create Kanter's structural conditions of empowerment (Laschinger 2001, p 11) ,so organisational factors have a significant role in the empowerment of PHNs.

4.4 Social psychological; theory

Organisation structures do not empower (Laschinger 2001) but the employee's responses to the structures form the basis of psychological empowerment (Spreitzer 7995). Social psychological theory examines how to foster the process of individual growth and

development. This theory supports empowerment by the removal of dis-empowering conditions. Authors like Kuokannen and Leino-Kilpi (2000) argue that this theory suits nursing as nursing is grounded entirely in human relations.

4.5 Critical social theory and social psychological theory

Critical social theory and social psychological theory both include reflection. Gilbert (1995) saw a problem with both in that they see power as located in the individual's minds and actions without identifying these individuals are products of power and how their identities are located within the material conditions of their lives and the social practices which operate there. Gilbert (1995) examined empowerment and the problem of power in relation to nursing and found that nurses need a clear conceptualisation of power and the ways it reduces conflict.

5. Literature review

5.1 Teaching critical social theories as an empowerment paradigm in nurse education

Fulton (1997) performed the first UK study to review nurses' views on the concept of empowerment and used a descriptive survey with focus groups and applied critical social theory and the work of Freire and Habermas to the enquiry. Their study group consisted of 16 nurses, some of them newly qualified from a variety of backgrounds. Four categories emerged from the focus groups: having personal power, relationship with the multidisciplinary team, empowerment, and feeling right about self.

The focus groups found nurses felt empowerment was a process and an outcome and conceptualised empowerment as freedom to make decisions with authority and to have choices and the process was reciprocal. The nurses did not feel they were empowered, and Fulton suggested that they showed signs of being oppressed. The nurses felt they lacked autonomy related to unequal relationships with medical staff. Their study recommended the teaching of critical social theories as an empowering paradigm in nurse education to promote reflection with action. Fulton claims this would support liberation and empowerment. Fulton's findings were in agreement with previous work by Gibson (1991) and Salvage (1992). The Health Service and the Educational institutions need to create environments for PHNs that create the conditions that make it possible for PHNs to reflect and act on their reality (Falk-Rafael 2004).

5.2 Empowerment by fostering ability

Haugh and Laschinger (1996) performed a comparative study using Kanters structural theory on the perceptions of power of two levels of nurses working in three public health agencies during a time of programme transition. A convenience sample of 46 PHNs and 10 nurse managers from three health centres in Ontario were surveyed as to their perceptions of the amount of power that existed in their own and their manager's jobs. PHN empowerment was found to be significantly related to their perceptions of their immediate manager's power in the organisation. Access to support was the factor perceived to be most lacking by nurse managers and Haugh and Laschinger (1996) identified that networking and seeking a mentor were substitutes they used. They distinguished in their research that managers perceived themselves to be more empowered in their work environments than the

PHNs had perceived themselves to be. The PHNs in their study presented a view that they perceived they had less access to empowering structures than their managers perceived they had. They (1996) suggested that nurse managers need to initiate efforts to improve access to power, opportunities, information, and resources for the PHNs. *"The study"* tallies with Kanter (1977) that in current organisational structures access to opportunities and power structures improve as one moves up the hierarchy. Therefore, PHN Managers need to initiate and sustain efforts to improve PHNs access to power structures and the Health Service needs to survey PHNs in relation to their access to power and opportunity structures and then act to remedy this.

Haugh and Laschinger (1996) argue that work environments must be structured in ways that empower PHNs to work effectively regardless of whether the focus is on individuals, families, or communities. So creating environments where PHNs are supported by empowering strategies will also contribute to the nurses and midwives working to their full potential and being empowered. Laschinger and Wong (1999) go on to argue that creating work environments that foster professional nursing practice by empowering nurses requires nurses to be accountable for their practice therefore supporting high quality patient care. Therefore, it would seem that there are political and professional, organisational and moral pressures on PHNs to work to support empowerment of their clients. In addition, if nurses are empowered in their work, the quality of patient care and the efficiency of the health services are improved. However, there are barriers, which constrain against the empowerment of the PHN and their role to facilitate the empowerment of their client.

McDermott et al (1996) used a descriptive correlation design survey applying Kanter's structural theory to examine the relationship between nurse's perceptions of job-related empowerment and their commitment to their organisation. Questionnaires were administered to a sample of 112 registered staff nurses in a 450 bed acute teaching hospital in Ontario. McDermott et al's (1996) study strongly suggested that nurses who perceive themselves as having access to resources, information, opportunity, and support in their work environments are more likely to be committed to the organisations. McDermott at al (1996) suggested that a vision of the nurse, as a knowledge worker is required to empower nurses and give them control over their own practice. All levels of nursing management must be genuinely committed to fostering empowering behaviours in staff, and this vision must begin with nurse managers (McDermott et al l996). PHNs may take the view that they have little power and this supports restricting their own professional freedom and their ability to support their client's power. When PHNs acknowledge the true sources of power as that generated through their actions, this will support a shift from the negative view of power. They will then be better positioned to take responsibility for their power and act on this power. To foster empowerment, Kanter suggests that power could mean efficacy and goal orientation and this he referred to as legitimisation. Robbins (1985) describes successful leadership with similar qualities. However, greater empowerment will be fostered if the Health Services also makes efforts to raise the self-efficacy of the nurses.

Barden et al (2011) conducted a descriptive correlational study to determine the relationship between perceptions of governance and empowerment among nurses working in an acute hospital setting in New York using Kanter's structural theory. These nurses were working in

an environment where shared governance had been in place with six to twelve months. Their study found that their was a significant relationship between perceptions of shared governance and empowerment and this suggested that as shared governance progressed so did empowerment. The nurses rated the access to opportunity as the highest empowerment sub-scale, followed by information, support and then resources. Barden et al (2011) suggested that shared governance provides a vital communication and decision making infrastructure.

So, it would appear that the tools that create the environment for empowerment also support the maintenance of power by all, and the environment that is empowering is also one in which successful leadership is demonstrated. Nurse's empowerment is fostered by shared governance and open access to structures of power.

5.3 Acting on responsibility

Laschinger and Wong (1999) performed a cross-sectional correlational survey on a random sample of 672 registered nurses from a medical centre in Ontario. Their study was based on Kanter's model and linked Staff Nurse perception of workplace empowerment and accountability to two indicators of work effectiveness. Their findings supported the proposed impact of nurse empowerment on nurse accountability and perceived work effectiveness. It highlighted the importance of creating environments, which provide access to structures that empower nurses to be accountable for their work and to assume accountability for their client outcomes. The findings suggested that in order to be effective organisational leaders must ensure that nurses have information, support, and necessary resources to act with accountability. Also they suggested that nurses need true governance so that they not only need to be involved in the decision making process through committees and on, but they also need to have control over their professional practice to have trust in the organisation to support them acting with accountability.

5.4 Empowerment by raising self-efficacy

Conger and Kanungo, (1988) propose that to facilitate empowerment, strengthen the self-efficacy belief or weaken the belief in personal powerlessness. If, empowerment is based on Bandura's self-efficacy, the individual will have an internal drive to achieve and management focusing on strengthening self-efficacy belief can foster this. PHN will then be motivated and well positioned to self-empower. Kuokkanen and Leine-Kipli (2001) performed a qualitative study into the qualities of an empowered nurse and the factors that contribute to the empowering process. Their study used the social psychological theory in interviews with 30 nurses participating in a career advancement project in a University hospital in Finland. Their study suggested that power is generated through the individual's behaviours, actions, and relations to another person. The factors they found that promote empowerment are: confidence and collaborative skills, support and leadership The factors that prevent empowerment are: lack of moral principles and factors, different views on the goals of care and an authoritarian leadership style as it prevents participation and there is a lack of trust and sharing from management. Their study suggested that empowerment is a process steered by personal values and endeavours and environmental factors and an empowered nurse has those qualities which make possible high self-esteem and successful professional performance and progress. Notwithstanding, organisational theory has a

significant impact on the empowerment of nurses, however an approach is needed that combines organisational and social psychological theory.

Kuokkanen et al (2003) used the social psychological theory of empowerment to perform a quantitative study into nursing empowerment, to identify the background factors associated with its realisation. "*The study*" group consisted of 200 critical care nurses from a university hospital, 200 long-term care nurses from 7 community hospitals and 20 trained PHNs from 25 health centres all health-care facilities were located in southern Finland. A questionnaire was developed, based on the moral principles and factors that were found to empower the nurse in their (2001) study. Their study found that empowerment had a significantly positive effect on affective commitment and trust in management. It also found that organisational commitment is highly related to job satisfaction. "*The study*" recommended that for empowerment to occur low hierarchical organisations were needed together with working practices orientated towards teamwork, coherent values and personnel management that creates opportunities and sufficient resources which acknowledges the influence of organisational theory on empowering work environments. Their study suggested that nurses need real influence and decision-making powers over the issues concerning their work.

Conger and Kanungo (1988) recommend the identification of conditions within organisations that foster a sense of powerlessness amongst subservients and their removal by empowering strategies and tactics (Conger and Kanungo 1988, p 474). Therefore, to raise the self-efficacy belief of employees raise their convictions of their own effectiveness. They also recommend personal efficacy information as vital to support this process. Empowering management practices involve the sharing of power and to be effective at individual level, must be perceived by employees as increasing their sense of self-efficacy, something they suggest a manager can accomplish through practices that are more informal, like verbal feedback (Conger and Kanungo, 1988).

Kuokannen and Leipo-Kilpi (2000) explored the empowerment concept to establish its compatibility as a theoretical framework for research into nurses' professional growth and development. They found that social psychological theory places emphasis on the individual and the environmental factors. Although, fostering the self-efficacy of the PHN in isolation may lead as Foucault and Freire suggest to a status quo. Self-efficacy needs to be fostering on an ongoing basis and needs to be supported by fostering ability.

5.5 Empowerment by raising self efficacy and fostering ability

Lewis and Urmston (2000) examined the concept of empowerment based on Kanters work (1993) and work on empowerment and the role of nursing and power relationships within organisations. They found that structural changes are not sufficient to allow greater empowerment greater effort is needed by all. Lewis and Urmston (2000) reflected on Seedhouse (1986) who viewed health as the ability to achieve human potential. They linked control over health and health promotion to organisational development and suggested that it was concerned with the provision of healthcare environments, which actively enable and encourage individuals to develop personal skills like internal locus of control, self-efficacy, and the ability to adapt. These environments foster freedom to practice with professional autonomy without too rigid authoritarian structures and will then support the fostering of the nurses self-efficacy.

Nurses need to be given the opportunity to participate more fully in decision making and to develop greater work ownership and power relationships where there is shared responsibility (Lewis and Urmston 2000). This calls for shared governance. Therefore, PHNs need their autonomy fostered and access to power and opportunity structure in their workplace to empower them.

5.6 Empowering environments and fostering self-efficacy of nurses

Laschinger et al (1999) reported that nurses perceived more structural empowerment and higher job satisfaction in their work settings when their leaders encouraged autonomy, expressed confidence in the nurse competence and facilitated participative decision making. Indeed Sabiston and Laschinger (1995) reported a statistically significant correlation between structural empowerment and work self--determination, and Wilson and Laschinger (1994) found a statistically significant correlation between structural empowerment and organisational commitment

Sun Ning et al (2009) conducted research to test Kanter's organisational empowerment model to examine the impact of nurse empowerment on job satisfaction using a cross-sectional design on a sample of 650 full-time nurses employed in six Chinese hospitals. They found a statistically significant positive correlation between empowerment and job satisfaction and concluded that nurses who view their environments as empowering are more likely to provide high quality care.

Laschinger et al (2001) performed a predictive non-experimental study using a questionnaire on a random sample of 412 nurses in Canada. Their study' purpose was to test Kanter's structural theory of power model and see if there was a link between staff nurse workplace empowerment, organisational trust, and perceptions of job satisfaction and organisational commitment. The model developed included measures of psychological empowerment. Trust they suggest comes from mutual respect, understanding and shared values. Whitney (1994 p 235) found that without trust individuals would not work together except under conditions of stringent control. Laschinger et al (2001) found a strong relationship between trust in management and nurses perceived access to information and support. Laschinger et al (2001) suggest that access to empowering structures was the strongest contributor to empowerment. They claimed that to be empowered nurses need real influence and decision-making power over work related issues, the work environment, and future projects. In addition, their research suggested that managers will need to focus less on control and more on co-ordination, integration and facilitation of nurse's work, together in a climate of trust. This fosters work satisfaction and genuine commitment to organisational goals to provide high quality client care.

Laschinger (2001) performed a predictive non- experimental design study including measures of psychological empowerment to test a model specifying relationships among structural and psychological empowerment, job strain and job satisfaction. The sample was a random sample of 404 Canadian staff nurses. They found that nurses need empowering organisational structures.

Underwood et al (2009) conducted research in Canada by focus groups with community nurses to identify what helps them and hinders them to work effectively and to identify organisational attributes that support public health nurses to practice to the full scope of

their competencies. To practice effectively, community nurses need professional confidence, good team relationships, supportive workplaces and community support. To succeed PHNs need a combination of factors including sound government policy, supportive organisational culture and good management practices. Interestingly, management practices were identified as the most important attribute for effective public health nursing. Organisational attributes identified as supports for optimal practice include: flexibility in funding, program design and job descriptions. Management understanding and promotion of the role of PHNs, clear organisational vision driven by shared values and community needs, co-ordinated public health planning across jurisdictions, and strong leadership that openly promotes public health, values their staff's work, allowing room for creativity and invests in education and training and nurses to take advantage of learning opportunities. To support sustained competencies and confidence in their professional abilities, PHNs need more access to continuing education, policies, evidence and debriefing sessions.

Chang (2008) conducted a study in China to investigate the relationships between employee empowerment, innovative behaviors and job productivity of PHNs by cross-sectional research that examined for organisational empowerment based on Kanter's four empowerment structures and psychological empowerment based on Spreitzer's 12—item scale, for job productivity based on Hackman and Oldham 1975 and McNeeseSmith 1996 and Liou 2000 and for innovative behaviour based on Yeh (2000) and Scott and Bruce (1994). Their study found showed that psychological and organisational empowerment had similar predictability on productivity which was not in line with previous research which showed organisational to have greatest effect. The authors suggest that this may be cultural. In predictors for job productivity, the self-efficacy subscale in psychological empowerment showed greatest contribution. This was in line with previous research. However the negative relationship between the meaning of the job and job productivity were contrary to findings by Laschinger (2001) and Spreitzer (1996). The findings indicate that access to information in an organisation had positive effects on job productivity which was shown in previous studies (Laschinger and Wong, 1999).

Meagher-Stewart et al, 2010 conducted research in Canada to gain an insight into the organisational attributes that support PHNs to work effectively using appreciative enquiry through focus groups with PHNs, their managers and policy makers. The attributes they identified were government and other system attributes in particular sufficient and flexible funding and public health leadership and public health planning and co-ordination, local organisational culture, values and leadership characteristics including a clear vision, mission and goals for public health and these are understood throughout the organisation, fostering a culture of innovation and effective leadership that demonstrates respect, trust and support for PHNs and frontline management practices to include effective planning based on evidence and outcome focused, that the roles and responsibilities in public health be defined in relation to the overall goals and accountabilities rather than tasks, that PHN managers need to acknowledge PHN contributions and to build stakeholder understanding of the PHN role to all, supporting autonomous practice of PHNs, investing in ongoing professional development, training and education of PHNs and fostering this responsibility in PHNs, effective human resource planning, supporting community health partnerships including the time needed to build them, fostering effective communication and information sharing between PHNs and all levels.

Meagher –Stewart et al 2010 recommended the need for strong leadership throughout the public health system to support empowered public health nursing practice and in particular how their managers do their job is a key driver for optimising public health nursing effectiveness.

Therefore, PHNs need continuous efforts to foster their self-efficacy. They need to be supported to act on their expertise including more access to continuing education and support in order to have a sense of trust and this will support their perception of being respected and their self-empowerment. PHNs roles need to be understood and communicated effectively by their managers to other service.

5.7 Raising political consciousness, raising self-efficacy and creating empowering organisational structures

The Department of Health and Children (DoHC) commissioned a national study into the understanding and experience of empowerment by nurses and midwives in the Irish health services in 2003. The theory base for "*the study*" combined organisational, psychological and critical social theory approaches to empowerment. Their study consisted of two phases. Phase one comprised of focus groups held to elicit nurses and midwives understanding and experience of empowerment. Phase two involved a national survey of nurses and midwives understanding and experience of empowerment to test the findings of phases one. The factors that were found to enhance empowerment and these factors were also individual factors were; education, skills, knowledge and self-confidence (DoHC 2003, p 11). The factors that inhibited empowerment were environmental factors, which were poor management style, lack of education, lack of support, lack of recognition (from management and other professionals) (DoHC 2003, p 11). They discerned that the prerequisite for an empowering organization is individual factor conditions such as self-esteem and self-confidence, which can drive the formal and informal structures. The findings from their literature review, and the research study supported each other and provide a model for the empowerment of nurses and midwives that takes a holistic approach and includes individual, organisational and historical factors.

6. Discussion

The findings of "*the study*" of what participants perceive empowers and disempowers PHNs were in agreement with research into the understanding and experience of empowerment of nurses and midwives in Ireland by the DoHC (2003). The participants distinguished that PHNs need ongoing access to knowledge, education, training, and up-skilling to raise their self-efficacy to foster their empowerment. The DoHC (2003) also identified similar findings for nurses and midwives. The participants recognised open access to these factors as a sign that PHNs were supported and this support was equated by the PHNs to them being respected and trusted by the health service, their clients, and other healthcare professionals. The lack of ongoing open access to education, training, and upskilling was pinpointed by the participants as disempowering to PHNs. The DoHC (2003) also discerned that the lack of open access to education, training, and upskilling education was disempowering to nurses and midwives. Factors related to the organisational structures of power were distinguished in the research as of greatest impact on the disempowerment of the PHNs.
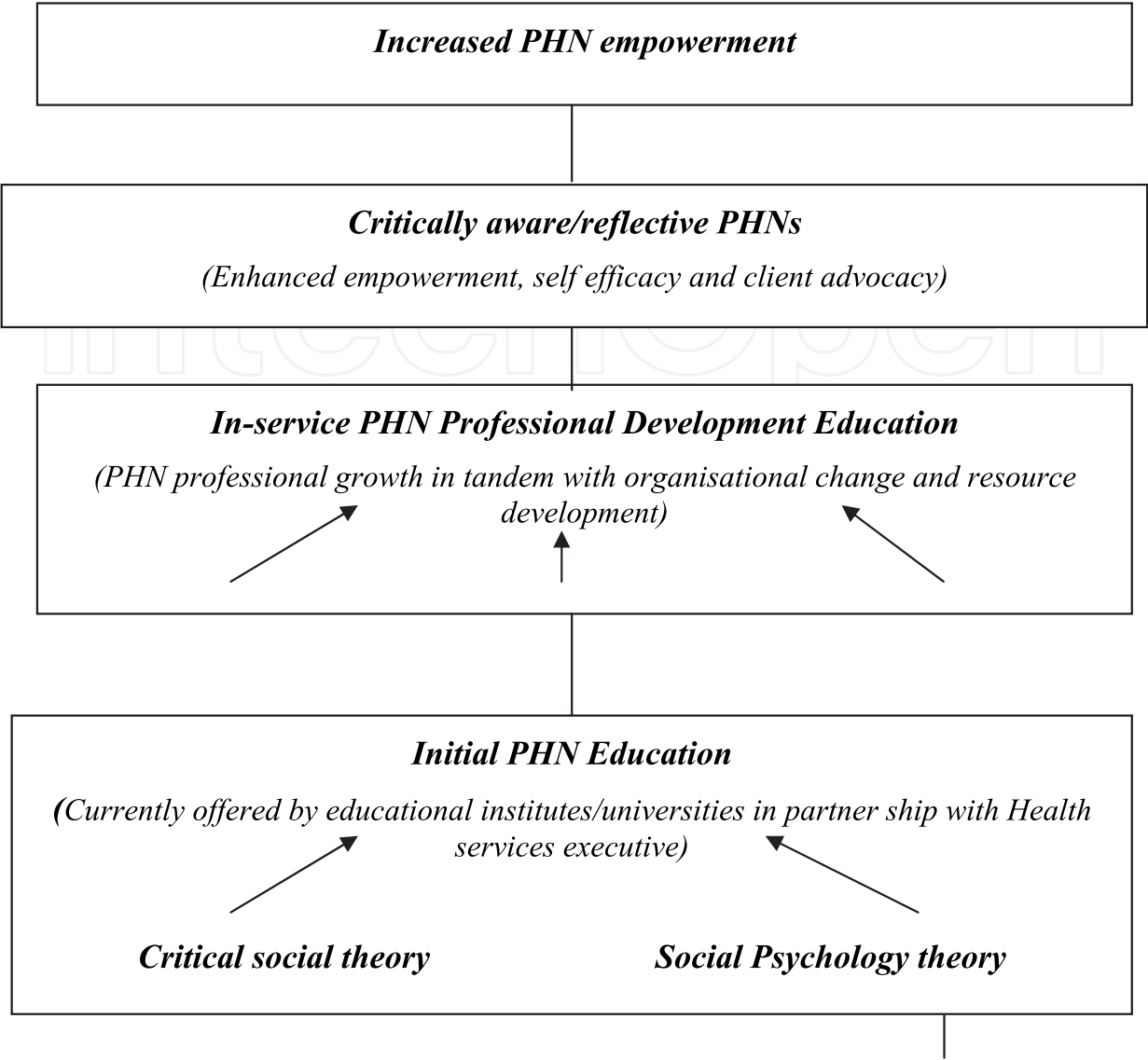
Increased PHN empowerment

Critically aware/reflective PHNs *(Enhanced empowerment, self efficacy and client advocacy)*

In-service PHN Professional Development Education *(PHN professional growth in tandem with organisational change and resource development)*

Initial PHN Education *(Currently offered by educational institutes/universities in partner ship with Health services executive)*

Critical social theory	*Social Psychology theory*

Table 1. The theory base proposed for empowerment of PHNs from *"the study"* (adapted from Cawley and Mannix McNamara, 2011)

Table 1 shows the theoretical base proposed by *"the study"* to support PHN empowerment. A critical social theory methodological approach is needed in the education, ongoing training, and workplace of PHNs. This approach must be coupled with organisational change specific to supportive resources and effective service provision by the health service. This approach is achieved by providing an organisational and social psychological theory approach to PHN empowerment. The potential outcome is the growth and development of the PHN. The process of facilitating client empowerment produces reciprocal empowerment including growth and development of the PHN.

6.1 PHN - role, workload and management structure

The traditional PHN role in Ireland was heavily influenced by a medical model approach to health with the PHN acting as an expert and telling the client what to do. This role was curative and preventative. Her responsibility included individuals of all ages requiring a

domiciliary clinical nursing service, infants and children including school aged children, children at risk, individuals with physical and mental disabilities, young chronically sick individuals, those discharged from the psychiatric services and older individuals (Leahy-Warren 1998, p 14).

The current role of the PHN is unchanged in terms of population groups and is described as a generalist role encompassing, primary, secondary and tertiary care at the level of the individual, family and community. The traditional focus had been on individuals and illness however, the current focus is on population health and health promotion. The mission of Public Health Nursing (DoH 1997) calls for a health promotion approach to practice and calls for PHNs to work in partnership with their clients. Despite this, the current job description in Ireland as outlined in Circular No 41/2000 (DoHC, 2000) confines Public Health Nursing primarily to a curative role in a series of tasks.

Zerweck (1992) suggests that the central purpose of PHN home visits is to encourage individuals to self-help and to foster their responsibility. Therefore, developing relationships with the community is fundamental to the role and this requires the resource of time. So, the health promotion approach needs the resource of time and interpersonal and communication skills. The needs for PHNs with regard to time and time management need to be prioritised by Health Service. Interpersonal and communication skills need to be fostered in the education and upskilling of the PHN and PHNs need to be facilitated through continuous development processes to include opportunities for their personal development to support this.

Despite larger populations, clients with more complex problems and earlier discharge from hospitals the geographical areas have remained unchanged in Ireland. This method of workload distribution has been heavily criticized in the literature (Hanafin et al 2002), because it masks different population demographics, different population needs and locally available services and social support (DoHC 1997). Chavasse (1998, p 174) criticized the large caseloads of PHNs as hampering their ability to 'provide primary as well as secondary nursing care.' Workload was identified by McDonald (1993) as an impediment to PHNs work to support client participation. Hanafin (1997) reiterated her concern by suggesting that the large caseloads of PHNs were eroding their management and health promotion role. Added to this, a significant weakness of Public Health Nursing is that 'the curative dimension of their work took precedence over the preventative' (O Sullivan 2005, p 38).

PHNs have a large clinical role and the literature suggests that as the clinical role demands increase, the health promotion role diminishes. Discursive analysis of the focus groups in "*the study*" identified language suggestive of a lack of freedom related to the demands of the role and the PHNs voiced that this showed a lack of respect to them. Participants also evidenced language related to

The PHN workload may interfere with their power at an individual level resulting in weakened work autonomy. The impact identified by the focus groups in "*the study*" was PHNs feeling that they were overstretched, disrespected and disempowered. The lack of taking responsibility for advocating for their role and for not becoming more political in their role and not acting accountably may be related to this disempowment. Although, PHNs may be unaware that their autonomy is affected. This lack of autonomy therefore may contribute to PHNs reverting to their traditional expert role to restore their autonomy.

PHNs need to be facilitated by Health Service to reflect on their role and the philosophy behind the role to realize the role calls for and needs a health promotion approach. In addition, the continued professional development of PHNs needs to include leadership skills to support PHNs to lead an empowering practice and power modules to support their critical reflection on how power operates to foster empowerment.

The service provided by the PHN is not only influenced by the needs of the community, but also by the level of other services (both nursing and non-nursing) provided in the community (Hanafin et al 2002, Begley et al 2004). By filling the gaps, PHNs support the masking of health service gaps and inequities and this reduces time for their health promotion work. It is imperative that the role is clarified. The range of activities and responsibilities of the PHN is broad and can lead to difficulty in articulating the boundaries of the PHN role (Begley et al 2004). In the report "An agenda for the future development of Public Health Nursing", (DoHC 2005) the need for role clarity and PHN concern about the demands of their workload (DoHC 2005, p 13). Many studies acknowledge that the workload and the organisation of the PHN service place unreasonable demands on the PHN (DoHC 2005, Begley et al 2005). These studies together with repeated attempts to define the role of the PHN suggest that the role is contested and that a reorganisation of the PHN service is required. The consequence of an unclear role and a large workload is that arguments can be made for not meeting the accountability of the role.

Fostering a health promotion approach to practice requires change management. Backward mapping is a bottom up approach that begins at the point at which administrative actions intersect with private choices and it emphasises that it is not the policy or the policymaker that solve the problem but the person closest to where the change is needed that does (Elmore 1989). The crucial difference between forward and backward mapping is that the forward mapping process relies primarily on formal devices of command and control that centralise authority and backward mapping relies primarily on informal devices of delegation and discretion that disperse authority (Elmore 1989, p 249). Backward mapping is the most effective way of ensuring a relevant and successful change implementation process (Elmore 1989). Elmore argues strongly that those nearest to the point of change have the greatest ability to influence it and the problem solving ability of complex systems depends not on hierarchical control but on maximising discretion at the point where the problem is most immediate (Elmore 1989, p 248). Therefore, those nearest to the point of change are best positioned to inform change agents of what changes are necessary and also of the most successful strategies for change (Ryan et al, 2006).

Because of PHNs workloads, unclear role together with innovation overload related to the expanse and expansion of the role, PHN could see themselves as the only practitioners delivering services in primary care. Innovation overload is a term used commonly in education fields related to an obsession with understanding or creating what makes consumers happy (Business Innovator Insider, 2006). The outcome is that PHNs have a huge body of expertise to meet their ever-expanding role and therefore do not want to let any part of their role go, as was evidenced in *the study*. Unfortunately, the consequence of holding on and not letting go of any part of the role is that the health promotion potential becomes limited. Interestingly, the literature evidenced that PHNs had mixed reactions to the entry into the community of RGNs. The 'Commission on Nursing' (DoHC1998) recommended a permanent role for RGNs in the community care team in Ireland, in line with public health

nursing service needs and circular no 41/2000 (DoHC 2000) asks PHNs to share power. RGNs can act as a threat and a resource because they perform tasks that have previously been performed by PHNs and PHNs have invested heavily in the role and the skills to support the role.

A revised strategy to ensure a sustainable community nursing and midwifery service that will effectively meet the health needs of the population of Ireland within a primary care setting (DoHC 2001) is awaited. This report should give a vision for the role of the PHN and he report should give a vision for the role of the PHN. Added to this are the moral, political and professional pressures and barriers on public health nurses working to the health promotion model. The impact of the many and varied influences on the role, its development and the workload of the PHN is that there is a lack of an integrated vision for the role of the PHN. The outcome is that PHNs feels undervalued, misunderstood, disempowered and responsible for all the needs in primary care and this makes the health promotion role impossible to fulfil. This is related to the disempowerment of PHNs and then PHNs may revert to their traditional expert role, which interferes with empowerment of the client. Therefore, it is fundamental that PHNs have a clear vision for their role and that their roles are clearly defined with equitable caseloads. Nic Philibin et al (2010) examined the role of the public health nurse in one Irish community care area to try to clarify the role of the PHN and they found PHNs have a role within each facet of community health. They recommended that PHNs need to define and redesign their role so that they no longer think that they are the catch-all in the community and so they can respond to the changes in need of their clients.

6.2 Health service management structure

The Health Service in Ireland has a characteristically hierarchical and bureaucratic management structure with attempts to flatten the structure as part of the current restructuring process. Bureaucratic systems are characterised by authority and accountability attached to roles with authority passing from senior to junior and accountability going from junior to senior (Bush 1995, p 43). This system is often associated with delegated power without acknowledging individual contributions. The management structure for Public Health Nurses is positioned inside this structure. PHNs are expected to work as autonomous practitioners with line management from their Assistant Directors of Public Health Nursing (ADPHN) and accountable for their practice to the Director of Public Health Nursing. Assistant Directors also have a role to support the PHNs.

Argyris (1964) was one of the strongest critics of bureaucracies and he argued they restrict the psychological growth of the individual and cause feelings of failure, frustration, and conflict. He (1964) suggested that organisational environment should provide a significant degree of individual responsibility and self-control, commitment to the goals of the organisation, productiveness and work, and an opportunity for individuals to apply their full abilities. This approach could foster the autonomy of the healthcare professional. It also add to calls for shared governance in the practice of Public Health Nursing together with the regular review of management systems to ensure they foster the growth and development of PHNs and meet the needs of the clients of the health service. Governance is not only the need to be involved in the decision making process through committees and so on, but also the need to have control over one's own professional practice. PHNs work as autonomous

practitioners and yet they are so entrenched in their ever-expanding role that their opportunity to develop their autonomy is hampered. In addition, the lack of vision for the development of the PHN role (including the recognition of the role of the PHN as specialist and the development of PHN practitioner roles) interfere with the development of governance in public health nursing. Notwithstanding this, application has been made for the role to be recognised as a specialist role, and this has to date not been approved. Clarification of the role of the PHN should support the recognition of the role of PHN as specialist and create a foundation for the fostering of governance in public health nursing. Ongoing and regular review of management systems is a normal part of management and needs to take place within the entire structure of the Health Service with the focus on the needs of clients of the health service. The participants in "*the study*" perceived that they needed their organisation to facilitate their empowerment. Clarke and Mass (1998) examined how empowerment and collaboration when actualised impacted on clients and nurses in British Columbia and recommended that if nurses are to integrate the principles of empowerment and collaboration in their practice, changes in healthcare reform must focus on vesting professional nursing organisations with sole authority to govern nursing, granting nurses authority for aspects of care necessary for care within the scope of advanced nursing practice and revising of reimbursement mechanisms to pay for these essential health care services.

The participants in "*the study*" identified that the Health Service did not empower them through political constraints on the services they were trying to assist their clients to receive. This suggests that PHNs feel dis-enfranchised themselves by the health system. Haugh and Laschinger (1996) used the organisational theory of power to examine empowerment of two levels of Public Health Nurses and found that nurse managers had overestimated the level of empowerment and the access to empowering structures of the PHNs. They suggested that managers need to initiate efforts to improve access to empowering structures for PHNs.

McDermott et al (1996) used a descriptive correlation design survey applying Kanter's theory of power to examine the relationship between nurse's perceptions of job-related empowerment and their commitment to their organisation. They found that if nurses perceive they have access to empowering structures at work they are more committed to the organisation. They suggested that self-efficacy can be fostered by providing feedback on performance, allowing nurses to have autonomy over their work and developing mechanisms to raise the profile of nurse's work as knowledge workers.

The participants in '*this study*' affirmed that the self-efficacy of the PHN needs to be maintained and affirmed and giving PHNs ongoing access to knowledge, training, and upskilling fosters self-efficacy. The participants acknowledged that this was recognised by them as a sign of respect and support for their role from the Health Service, their managers, clients and other healthcare professionals. They related this support as a recognition of the value of their role and this support was both formal by organisational structures and informally by feedback and affirmation by all, on their role. So, it is fundamental for the Health Services to examine the access PHNs have to empowering structures and make efforts to support improving access, feedback, support and self-efficacy of PHNs.

Laschinger and Wong (1999) performed research into nurse empowerment, organizational theory approaches to power and accountability and found that they need to open access to

structures of power, fostered empowerment, accountability, responsibility and effectiveness. They (1999) suggested that to support this, managers at all levels need to relinquish traditional controlling roles. The focus groups in "*the study*" related this to having flexibility in their time management and autonomy to manage their roles. Laschinger and Wong (1999) also suggested that nurses need true shared governance. They (1999) also suggested that PHNs need to have trust in the organisation and this supports them acting with accountability. Laschinger et al (2001) and Laschinger (2001) examined the link between staff nurse workplace empowerment, organisational trust, and perceptions of job satisfaction and organisational commitment using Kanter's model and incorporating social psychological theory. They found that access to empowering structures was the greatest contributor to empowerment. This access was equated to managements' trust. The participants in "*the study*" equated trust with their access to knowledge training and flexibility in their job management. Therefore, access to empowering structures is needed to foster accountability. This suggests that the organisational theory approach to empowerment acts to raise the ability and the self-efficacy of the PHNs. The participants in "*the study*" related their sense of empowerment to their access to access to knowledge, education, training, and support.

6.3 Knowledge

Knowledge was identified in "*the study*" as one of the cornerstones to PHN empowerment and fundamental to PHN autonomy and self-esteem. The participants recognised knowledge as essential to PHNs credibility and to their empowering role. Participants identified that knowledge raised their self-efficacy in their role and without it; they could not facilitate the empowerment of their clients.

The PHN is often referred to as a knowledge worker, because of the body of knowledge and the wide expanse of the role. McDermott et al (1996) suggested that a vision of the nurse, as a knowledge worker is required to empower nurses and give them control over their own practice. Knowledge according to the participants in "*the study*" gives the PHN power. This power is expert power. Having expert power implies having the necessary knowledge, competence and skill to perform their role effectively within the context of caring (Benner 1984). Interestingly, there is an understanding from the literature as the PHNs role continues to enlarge her concomitant knowledge and related expert power is raised and there is no letting go of any parts of the role. Foucault examined power and knowledge and argued that they were closely interwoven (Foucault 1980). He argued that the reorganisation of knowledge created new forms of power and this he called disciplinary power. Ryan et al (2006) remind us that expert power has the potential to disempower clients by oppressing them, through clients not understanding medical knowledge and medical discourses. Foucault (1980) claimed that power is everywhere and that it is distributed throughout complex social networks so that individuals are the means and the generators of power whether they are a healthcare professional or a client of the health service. If the 'Ottawa Charter' tenet of social justice is applied, then there is no place for an expert power approach and what is preferred is the empowerment approach, which is the client centred approach.

However, PHN power is anchored in expert power related to their knowledge. Therefore, PHNs need to relinquish their expert power to support working in partnership. This task is becoming increasingly difficult as the role continuously enlarges and therefore the knowledge base explands. Alongside this, PHNs do not share parts of their role.

Relinquishing power is achieved by PHNs questioning the structures and processes of power and this will lead PHNs to challenge their expert power and how this can disempower their clients. This process can be fostered through education in critical social theory and power modules and the facilitation of critical reflection by PHNs in their workplaces. The knowledge base of the PHN is still needed as a resource to be used in the context of the client centred partnership approach. Therefore, the focus in health promotion is not on building capacity with regard to power over another but rather is concerned with power to engage in action (Carey 2000). The relinquishment of expert power holds the potential for the PHN of a new form of power called intellectual liberation.

The literature confirmed the ability of the PHN to see the bigger picture and suggested that this is based on their broad educational base and knowledge of the community resources. Intercommunity knowledge (Hanafin et al 2002) is the knowledge that PHNs gain in practice and is fundamental to their health promotion approach. The huge investment by the Health Service into knowledge to support the PHN may negate against the PHNs intercommunity knowledge. The danger is that the determinants that affect health may be ignored by disqualifying intercommunity knowledge. In addition, for PHNs their intercommunity knowledge becomes of less importance to them and public health nursing practice fails to develop its own theory base. PHNs and their managers need to reflect on both sources of knowledge to bridge the knowledge practice gap. O'Halloran (1998, p 113) suggests that the generation of knowledge to support and inform the practice of nursing must by its very nature emerge from that practice. Action research holds the potential to improve practice, generate new theory, and bridge the gap between knowledge and practice.

Cohen and Reutter (2007) reviewed scholarly literature from Canada, United Kingdom and United States of America to ascertain support for PHNs roles in reducing poverty and its effects and then reviewed professional standards and competencies in Canada to support the development of the role of PHNs in addressing child and family poverty. They concluded that if given more organisational support and enhanced appropriate knowledge and skills, values, beliefs and attitudes this PHNs role would be supported. Development of PHNs that includes critical social theory needs to be facilitated by their educational institutes and workplaces.

6.4 PHN managers role

For PHNs to develop their health promotion role to a greater extent the Commission in Ireland on Nursing (DoH 1998) contended that PHNs need to have their professional autonomy supported by the public health nursing management system. Notwithstanding this, Begley et al (2004) who conducted research into the role and workload of PHNs identified that the Assistant Directors of Public Health Nursing' (ADPHN) work is primarily management, rather than leadership. A leadership and a support role is inferred in the role of the ADPHN, but not mandated The participants in 'this study' were explicit in identifying the role of their Assistant Directors as to provide them with support in relation to issues that arose in practice and providing them with flexibility around their time to meet the job demands. Although, when the participants in "*this study*" discussed the support, they received at work, they referred to relying on work colleagues and taking time out. This suggests that despite the need for their Managers to provide them with support, in practice they look elsewhere for this support. Kuokkanen and Leino-Kilpi (2001) examined empowerment and found that a democratic leadership style was needed and when support

is fostered this raises the empowerment of the nurse and the opposite is true. The democratic leadership style is one where the needs of the healthcare practitioner are the driving force. Interestingly, Directors also claimed they themselves had a lack of leadership at leadership level (DoH 1998). Leadership skills were identified as needed by all grades of PHN (Begley et al 2004).

Kuokannen et al (2003) examined empowerment using the social psychological theory and found that if nurses are empowered this correlates with them having trust and commitment in, and to the organisation, to their professional activity and job satisfaction. Mullins (1998, p 58) suggests that with rapid changes in the external environment, de-layering of the organisation, empowerment, and greater attention to meeting the needs of customers, there is an increasing need to organise for flexibility. PHNs also need to be flexible with their clients and therefore need flexibility from their managers. 'Flexibility and responsiveness will be essential as we continue to meet a progressing health service' (Armstrong 2000, p 138). The participants in "*the study*" identified flexibility in time and job management as key and this requires nurse management trust.

The participants in "*the study*" also identified that they needed support to raise their self-efficacy and training and education in isolation were inadequate. This support includes promoting the vision of the PHN as a knowledge worker, raising the profile of PHNs and ongoing feedback and support for the PHN. Do Assistant Directors have time to provide support to the PHNs and to work to raise the profile of the PHN? In relation to the continued professional development of PHNs, the Assistant Director had a vital role to play.

6.5 Self-efficacy

Self-efficacy is based on the idea that power lies within the person and education, training, and practice of PHN skills and support are essential to this. PHN self-efficacy needs to be maintained to foster their self-efficacy. The participants in "*the study*" equated their self - efficacy to their empowerment. The participants related their lack of self-efficacy to a lack of respect. The research suggests that respect can be fostered by enabling open access to the organisational structures of opportunity and power.

The discursive analysis of "*the study*" evidenced language suggestive of PHNs beginning to strive for liberation related to the PHNs perceiving and reflecting on their perception of feeling intimidated by other professions, and their perception of their lack of profile, in comparison with hospital nurses. The discursive analysis also pinpoints language suggestive of PHNs becoming liberated related to the PHNs feeling and reflecting on feeling misunderstood and undervalued and moving onto PHNs acknowledging their expertise. The research affirms that PHNs needed to acknowledge their expertise, advocate for, and ask others including their clients to advocate for their role to foster their self-efficacy.

Rose and Glass (2008) reviewed research on emancipatory research methodologies to highlight the importance contribution they can make to the ongoing development of contemporary nursing practice by exploring the relationship between the nurse's emotional well-being and their professional practice. They found that when nurses are involved in research that is focused on their own emotions and / or performance at work, such as 'from the heart' issues, this can result in states of empowerment and personal liberation and these processes can transform practice.

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The self-esteem of the PHNs is an important contributor to her autonomy and her self-efficacy and needs to be fostered by the Health Services and the PHN herself. The self-esteem of a person can be fostered by for example, pastimes, healthy lifestyles, stress management and life skills development amongst others. Fostering healthy self-esteem supports, a healthy internal dialogue for the PHN that will help when faced by work and personal life demands that impact on her emotional wellbeing. Therefore, PHNs will need to be more open about their need for and lack of support and this process will need to be fostered by their managers.

Conger and Kanungo (1988) advocated the social psychological theory to foster empowerment and suggested that empowering management practices should involve the sharing of power. They suggested that to be effective at individual level, they must be perceived by employees as increasing their sense of self-efficacy, something they suggest that can be accomplished through practices that are more informal like verbal feedback. They also suggest that to foster empowerment strengthen the self-efficacy belief or weaken the belief in powerlessness. Chandler (1991) examined and demonstrated that emotional support was the most relevant antecedent to empowerment when the empowerment of 267 staff nurses was surveyed. Feeling supported and affirmation was identified as a factor in raising self-efficacy by the focus groups. This suggested that there was a lack of support from the Health Service for the PHN and this was identified as a recurrent theme in the research findings. The participants in "*the study*" identified that support is needed from the Health Service and public health nursing management and that this fosters PHN self-efficacy. Although it is worth bearing in mind that the participants were all female and this may have impacted on their need for support.

Notwithstanding this, if PHNs do not feel empowered they may unknowingly retain their expert power to maintain their autonomy. However, PHNs also need organisational structures to focus more on ongoing support from the health service, feedback on their performance and affirmation to foster their self-efficacy and motivation. Self-efficacy of the PHN can be further fostered by PHNs evaluating their work, and taking an evidence based approach to their practice. Therefore an organisational and a social psychological theory approach to empowerment are needed in the workplace that includes mechanisms to foster support for the PHN.

The central themes emulating from the discussion are related to how to support PHNs in the change process related to relinquishing power to work in client centred partnerships with their clients. The change process is predicated on the empowerment of the PHN, which is essentially restoring and fostering the autonomy and self-efficacy of the PHN on an ongoing basis. The central themes are clarification of PHN role and workload, open access to organisational factors, time and its management, continuous professional development of PHNs and raising the self-efficacy of PHNs. This will require the Health Service to foster the clarification of the role and workload of PHNs and to foster the ability and self-efficacy and empowerment of PHNs to meet their empowerment role.

6.6 Clarification of PHN Role and workload

The PHN role including her health promotion role and the vision for the future of the PHN role is unclear. The mandate for PHNs does not make clear how PHNs are to work in a

health promoting way. To enable the empowerment of PHNs, the Health Service needs to actively involve PHNs in the decision making process, related to their role development (Clarke, 2004). Redefining the role will involve letting parts of the role go and sharing the role with other healthcare professionals. Perhaps a more specialist role (Nic Philibin et al 2010). This, together with workloads being distributed by a more equitable model will support the workload of PHNs becoming more manageable. This needs to be supported by open access to organisational structures of empowerment. The outcome will be increased self-efficacy and empowerment of PHNs.

6.7 Open access to organisational structures

Structures of power include open access to all the knowledge and information one needs to know to do the job, all the resources needed to carry out the job efficiently and support and feedback on performance and continuing approval of actions. Public Health Nurses needs to be surveyed as to their access to the organisational structures and to identify the exact resources (including support) that they need. The outcome of this open access is the empowerment of PHNs and the added bonus to the Health Service is their commitment, motivation, accountability, responsibility, and effectiveness are fostered.

Laschinger and Wong (1999) suggest that managers need to relinquish control and work to support co-ordination, integration, and facilitation. This supports PHNs working as autonomous practitioners. The Health Service needs to review its management systems and make efforts to support PHN managers to relinquish their control and support teamwork. Lewin and Urmston (2000) suggest that structural changes are not sufficient; nurses need to be supported with leadership skills.

Lewin and Urmston (2000) and Laschinger and Wong (1999) and Barden et al (2011) all recommend the development of shared governance to give nurses real autonomy over their practice and freedom to practice autonomously without management interference. This fosters ability and self-efficacy. Therefore, the Health Service needs to take steps towards addressing the need for leadership skills and shared governance for PHNs. This can be fostered by supporting the clarification of the PHN role and changing the workload distribution to a more equitable one. The Health Service also needs to reflect on management practice and critique itself on an ongoing basis to ensure it meets the growth and development needs of PHNs and the needs of the clients.

6.8 Continued professional development of PHNs

Continuous professional development is needed for PHNs to meet the demands of their role. This needs to include personal development to support PHNs in fostering and developing their client centred partnerships. Personal Development planning is a suitable mechanism to ensure the growth and development needs of the PHN are linked in with the needs of the Health Service. This will ensure PHNs develop the skills they need to meet the demands of their evolving role and their professional and personal growth plans. It also ensures the Health Service is developing its main resource to support the empowerment of clients.

Efforts at fostering and maintaining self-efficacy are fundamental to support the continued professional and personal development of the PHN. Modules are needed in health

promotion and power and health promotion needs to be integrated into the role of the PHNs. PHNs need training in evidence based practice and critical reflection skills.

Traditionally PHNs had high levels of expert power related to their traditional role and their body of knowledge. Working to promote health calls for PHNs to partner their clients (Chavasse 1992). As PHNs are called to work to the health promotion model, their role remains unchanged but enlarging, therefore they receive more knowledge, which supports their expert power, and they do not share any part of their role. Added to this, their caseloads are becoming greater with more complex needs leading to an increased focus on the curative aspects of the role. Coincidentally the PHNs nursing mandate and national strategy in Ireland do not make it clear how the PHN is to promote health. The result is increased expert power, reduced time to work to promote health, and reduced PHN autonomy and subsequent disempowerment. The consequence is the PHN may revert to their expert role and disempower clients and reciprocally disempower themselves.

The research findings from "*the study*" made little reference to PHNs analysing power to foster their empowerment and to support PHNs to relinquish power to support their empowerment role. Ryles (1999), and others suggest that nurses need to relinquish power. This calls for a critical social theory approach in education and practice to support PHNs. Sharing their expertise and partnering the client can liberate the PHN from feeling responsible for their client's outcomes. A critical social theory approach to the education of PHNs and as a methodology in practice should foster PHNs acting on their expertise and taking responsibility for their power. By reflecting on power as it relates to their role, this will support a process of conscientization that should lead to action. This action is the PHN taking responsibility for her own power and will support raising the autonomy of the PHN. This will support PHNs to analyse power and will lead PHNs to reflection on how they as PHNs are constrained by power and how they may use power in ways that do not support empowerment.

Reflective practice is needed to help PHNs to continue to analyse power and to continue to meet the needs of their evolving role. Also, Clarke (2004) suggests that raising the power of PHNs can be supported by PHNs getting a seat at the table of power, by making their invisible work visible, by advocacy for the role of the PHN by all, by the political education of PHNs and by PHNs receiving training with other members of the multidisciplinary team.

Simultaneously, PHNs need to raise their voice by other means. The focus groups in "*the study*" argued that PHNs need to advocate for their expertise, accountability, professionalism, and workloads. PHNs need to take responsibility for this body of expertise and act on it in order to support PHNs as autonomous practitioners. Raising their profile will raise the power of PHNs. To raise the profile of PHNs, Clarke (2004) and Hanafin et al (2002) suggest that PHNs need to make visible their non-quantifiable work because otherwise policy makers and practice developers will conceptualise their roles into simplistic tasks and ignore the special, creative, and artistic aptitude, capacity and strength which is public health nursing. This will improve the recognition and status of the PHN by other professionals and clients (Clarke 2004). PHN Managers are ideally placed to foster this.

Foucault (1994) suggests that the disposal of power requires the assumption of some responsibility. PHNs have power by virtue of their knowledge, skills role, and location in

relation to their clients. Illich (1970, p 18) suggests that, freedom and power are determined by a willingness to accept responsibility for the future. When the PHN uses her power, she is assuming responsibility. The current PHN mandate acknowledges PHNs autonomy and asks for PHNs to take and to share their responsibility. Notwithstanding this, PHNs are unlikely to advocate for themselves to support raising their power until they have a clear vision of their future. Having a vision for the role of the PHN will give the PHN confidence to reflect and challenge their current use of power and to be able to relinquish power.

6.9 Time as a resource and its management

Time was identified as a theme in "*the study*" preventing PHNs engaging in health promotion practices. The lack of role clarity has a huge impact on PHN time and these need to be clarified to ensure PHNs are clear on their role and its boundaries. The clarification of the role will lead to delegation of parts of the PHN role. PHNs need to be open to the needs for the role changing to meet the demands of the service including the health promotion approach. When the PHNs role is clear work, they can prioritise to facilitate a health promotion approach. The PHN workload is expansive and again needs to be reviewed to ensure equity in workload distribution.

The arguments regarding the lack of time are preventing the role and profile advancement of Public Health Nursing, and interfere with her self-efficacy. Time is a resource and time in motion studies will identify the time resource needed for the PHNs nursing tasks (including the time needed for the health promotion approach and non quantifiable work). Time needs to be planned and managed by PHNs. Claiming there is a lack of time is an argument for not engaging in health promotion but may be a symptom of resistance to change. To support this resistance, action sets are needed to facilitate reflection on the evolving role of the PHN and the National vision for the role. In addition, continued professional development of PHNs is needed to assist them in developing a healthier approach to power. The vision of the PHN is fundamental to fostering this approach to power.

6.10 Raising self-efficacy of PHNs

Some PHNs in "*the study*" expressed that they perceived themselves to be disempowered by their clients and by other healthcare professionals, but the scope of the research did not allow the researcher to evidence this. Efforts at raising the self-efficacy of the PHN will support this. Efficacy raising can be fostered by PHNs being supported through a combination of raising ability by the Health Service and efforts at raising self-efficacy by their managers. This requires their managers providing them with ongoing feedback on their performance and the development of mechanisms to raise the self-efficacy of PHNs on an ongoing basis like acknowledging good projects that PHNs develop and giving PHNs an opportunity to present their work to their colleagues and others. This will also foster the self-esteem of the PHN related to supporting her emotional needs. A democratic leadership style is also advocated to foster the self-efficacy of PHNs (Kuokkanen and Leino-Kilpi, 2001). PHNs need real influence and decision-making powers in their work and this calls for shared governance (Kuoknnen et al, 2003). This needs to be supported by ongoing professional development of PHNs.

7. Conclusion

Nightingale 1891 looked forward to the time when nursing would be no more for the sick but for the well. Empowerment is the approach proposed to promote health by efforts at restoring the autonomy of the individual. The empowerment of the PHN affects her autonomy and this affects her engagement in empowering practices. Fostering empowerment is related to supporting PHNs to relinquish their power and develop new power that support their growth and development and that fosters empowerment of their clients. The expert power of the PHN is related to their ever increasing knowledge base and their disempowerment is related to the expanse of the role and workload. The outcome of not relinquishing their expert power is that PHNs retain expert power and this interferes with the process of client empowerment.

To support empowerment of the PHN a multipronged approach is needed. The role and the workload of PHNs need to be reviewed and updated to reflect the challenges posed by the health promotion role and the reality of the barriers to this role. This should support the resource of time to health promotion. This should support raising the self-efficacy of the PHN but support from PHN managers is fundamental to sustain and maintain the PHNs self-efficacy. The management systems in place in the Health Service need to be analysed on an ongoing basis to foster management systems supportive of empowerment.

The process to support PHNs relinquishing power requires change management and Elmore's (1989) backward mapping process is proposed. This requires a critical social theory approach in their education and practice, to support their critical reflection on power and their role. This will support PHNs to understand power and support them to foster their own and their client's empowerment. Together with modules on power. PHN managers need to work to raise the PHN profile and to support the role becoming more visible. PHN managers need to foster the self-efficacy of PHNs on an ongoing basis by supporting PHNs to practice autonomously, acknowledging their work and working collaboratively with them. Shared Governance provides a vital communication and decision making infrastructure (Barden etc al 2011) in empowering PHNs.

The health promotion role of the PHN will require the continuing professional development of PHNs. This will need to include their personal development to support their maintenance of their self-esteem and to support the client centred approach.

Support and leadership were identified, as needed by PHNs and the research raised concerns over where this support and leadership is to come from. The support also needs to include mechanisms to foster the self-esteem of the PHN. How can the Health Service support raising the self-esteem of PHNs? Currently the support and leadership role is not allocated and defined. This is a gap to the empowerment and the empowerment role of PHNs. The research identified the ADPHN as one of the key people to provide this leadership and support.

The main issue emulating from the research is that PHNs need organisational empowering structures including ongoing support together with ongoing efforts to raise their self-efficacy (Cawley and Mannix cNamara 2011). This process is a change management process and requires the relinquishment of power by PHNs, their managers and the Health Service. By becoming aware and remaining cognisant of the fundamentality of the need for the client to be at the centre of care the health promotion approach becomes the only way forward.

7.1 Study recommendations

"*The study*" recommends that PHNs needs to be involved in a process to review their role and workloads and to identify their resource and support needs to enable them to work to promote health. Continuous professional development is needed for PHNs including the personal development of PHNs. This needs to be part of structured personal development plans that feed back into the Health Service to ensure the Health Service develops appropriate training to meet the needs for the health promotion approach. The self-efficacy of the PHN needs to be fostered on an ongoing basis. (Recommendations are in Appendix 1) A suggestion for further research arising from this research is that the Health Service survey PHNs as to their access to empowering structures.

8. Appendix

8.1 Appendix 1

Recommendations for PHN nurse managers

PHN role and workload

- PHN Managers need to engage in consultation with PHNs in order to gain clarity with regard to exactly how problematic workload issues are.
- PHN managers need to lobby for PHNs with regard to a comprehensive analysis of the PHN role and workload and solution to these issues.

If PHN roles and workloads can be altered, then PHNs will have time to engage in health promotion with their clients and this will decrease clients drawing on PHN time in the long run.

PHN access to empowering structures (including management structure)

- PHN managers need to initiate efforts to improve PHNs access to empowering structures.
- The management structure and management styles need to be reviewed on an ongoing basis to meet the growth and development needs of PHNs in order that they meet the needs of their clients.
- PHN managers need to foster democratic leadership styles.
- The debate about shared governance needs to be prioritised to foster the autonomy of PHNs.

PHNs equate access to organisational structures to having trust in management. Improved access, fosters PHN empowerment and is related to PHNs professional activities, PHNs having greater commitment and job satisfaction.

Continued professional development of PHNs

- PHN Managers need to prioritise professional development for PHNs in the area of empowerment, time management, and evidence based practice.
- PHN Managers need to encourage and facilitate PHNs to maintain personal development plan that feed back into the Health Service.
- PHN Managers need to facilitate PHNs engagement in individual and group reflective practice sets to identify their training needs in relation health promotion.

- PHN Managers need to include personal development in the continued professional development of PHNs to equip PHNs to develop their skills in client centred partnerships.
- PHN Managers need to support multi-disciplinary training for PHNs.

Managers need to demonstrate their commitment to PHN empowerment by supporting professional development for PHNs and supporting PHNs by giving them time to develop and critically analyse the implications of empowerment. This will support PHNs in taking responsibility for their power and this will support raising their power and their ability to integrate health promotion into their practice.

Raising PHN self-efficacy

- The education, training, and practice of PHN skills are essential to maintaining the self-efficacy of PHNs.
- Empowering management practices need to involve sharing power, but to be effective must be perceived at an individual level to raise the self-efficacy of the PHN and this is something that can be achieved by practices like verbal feedback. This needs to include supporting making visible PHNs non-quantifiable work and fostering a seat at the table of power for PHNs.
- Provide greater and ongoing support and feedback to PHNs and ongoing efforts to raise the profile of the role.
- The leadership style provided to PHNs needs to be more democratic.
- Efforts at maintaining the self-efficacy of PHNs need to be maintained to foster the empowerment of PHNs.

The outcome is PHNs feels supported to act on their self-efficacy and ability and advocate for their role and will be better positioned to provide reciprocal support to their clients.

Recommendations for PHNs

PHN role and workload

- Engagement in action research to begin to define the PHN role with clarity.

When the role is clearer it will assist PHNs in becoming open to the need for change in their role and the need for sharing responsibility. Then, PHNs will be able to make a concrete case to their managers and the Health Service regarding their caseloads. When PHN responsibility becomes shared, PHNs begin to have time to plan and deliver health care with the health promotion approach. Working with the health promotion approach will foster the PHNs health promotion skills and the PHN will be reciprocally empowered in the process.

PHN access to empowering structures (including management structure)

- Involvement in brainstorming work to begin to identify the resources and supports that they need to support their empowerment and their empowering role.

By identifying the resources and support needs of PHNs they can work in consultation with the Health Service in a process to support change. When PHNs have the resources they need, this may aid in raising their sense of empowerment, which in turn may increase their efforts to engage in health promotion practice.

Continued professional development of PHNs

- Engagement in individual and group reflective practice sets particularly on issues such as power and role.
- Completion of structured personal development plans that feed back into the Health Service.
- Upskilling of communication and listening skills of PHNs.

These recommendations will support PHNs to understand more clearly how power influences them in their role, particularly with regard to their perceptions of autonomy and empowerment and how it influences both health choices that they and their clients may have. This will support PHNs in taking responsibility for their power. This will also help PHNs to become open to approaching and analysing the dynamic of power as it relates to themselves and their clients in a fuller broader sense to meet the needs of the evolving role. This will support PHNs to foster their advocacy role by focusing on the power gap and working to positively influence the determinants of health on health choices, rather than focusing on providing information and sending referrals.

Raising PHN self-efficacy

- Advocate for the development of mechanisms both formal and informal to raise the profile of the PHNs role and their self-efficacy in their roles.

The leadership style provided to PHNs needs to become more democratic, particularly as if PHNs receive ongoing support and feedback the shared governance agenda will be supported. This has the potential to raise the profile of the PHN role and PHNs self-efficacy and empowerment and support PHNs in their health promotion role and in advocating for their role.

Recommendations for the health service/ DoHC

PHN role and workload

- The Health Service needs to engage in consultative partnerships with PHNs and their managers to enable the process of the clarification of the PHN role.
- The DoHC need to be mandated to complete and launch the NAMIC report.
- The Health Service needs to provide the resources and funding PHNs need for their professional development to meet the needs of the health promotion approach.

Clear role and appropriate workloads will assist PHNs to remain open to the need for change in the role and the need for sharing responsibility and this will give PHNs time to plan and foster their skills in health promotion.

PHN access to empowering structures (including management structure)

- The Health Service needs to commit itself to advocacy for PHNs including addressing the PHNs need for leadership and support.
- The Health Service needs to introduce systems of critique of management structures and styles to ensure they meet the growth and development needs of PHNs and their clients.
- The HSE needs to develop management development strategy to include personal development planning for PHNs and their managers that feed back into the HSE.

- The HSE needs to commit to shared governance for PHNs.

Continued professional development of PHNs

- Facilitate the provision of properly sequenced training modules on power, empowerment, and health promotion.
- Encourage Managers to encourage PHNs to maintain personal development plan that feeds back into the HSE.
- Facilitate PHNs engagement in individual and group reflective practice sets to reflect on power to foster the empowerment role.
- Identify their training needs in relation health promotion.

The advocacy role needs the resource of time and appropriate education to support PHNs to reflect on power and make its effects clear and to support addressing the power gap. Intercommunity knowledge of PHNs is fundamental to their advocacy role. Relinquishing power is needed at all levels to support the client centred approach. This will support PHNs in taking responsibility for their power and this will raise their power.

Raising PHN self-efficacy

- Foster the development of mechanisms both formal and informal to raise the profile of the PHNs role and their self-efficacy in their roles.

Self-efficacy needs to be maintained on an ongoing basis by efforts directed at fostered the ability and self-efficacy of PHNs. PHNs need shared governance and true autonomy over their practice and freedom to practice autonomously. When the profile of the PHNs role and her self-efficacy are raised, she is supported to act on her ability. This leads to the PHN playing a leadership role in working to raise the self-efficacy of their clients.

Recommendations for educational institutes

Continued professional development of PHNs

- Facilitate and foster reflective practice time and reflective sets on a variety of issues such as professional competence, professional confidence, power, empowerment and the role of PHN.
- Work simultaneously with the HSE and in particular, PHN Managers in the development of properly sequenced CPD programmes to meet the needs of the evolving role.
- Prioritise health promotion within PHN pre-service and career development.
- Facilitate multi-disciplinary training.

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Edited by Prof. Jay Maddock

Human behavior accounts for the majority of morbidity and premature mortality throughout the world. This book explores several areas of human behavior including physical activity, nutrition and food, addictive substances, gun violence, sexual transmitted diseases and more. Several cutting edge methods are also examined including empowering nurses, community based participatory research and nature therapy. Less well known public health topics including human trafficking, tuberculosis control in prisons and public health issues in the deaf community are also covered. The authors come from around the world to describe issues that are both of local and worldwide importance to protect and preserve the health of populations. This book demonstrates the scope and some of the solutions to addressing today's most pressing public health issues.

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