Health Promoting Hospitals in Practice

JAMES CONNOLLY MEMORIAL HOSPITAL

EASTERN HEALTH BOARD
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From a personal perspective, I would like to thank Ms. Ann O’ Riordan for her support in the preparation of this book. Ann was the Project Co-ordinator from 1993-1997 and is currently the Director of the National HPH Network.
Foreword
Mila Garcia-Barbero
World Health Organisation

Overview
Mr. Tom Gorey
Hospital Manager

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Ms. Maria Lordan-Dunphy
Health Promotion Co-ordinator

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Ms. Maria Lordan-Dunphy

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Evaluation
Dr. Anna Clarke
Specialist in Public Health Medicine
UCD / Eastern Health Board

HPH Network Development
Ms. Ann O'Riordan
Director, National HPH Network

References


In recent years, health promotion has undergone many important changes and become part of many health policies. Governments have been looking at the WHO strategy for health-for-all as the framework for health gain, equity and accessible care. Emphasis has moved from the traditional "problem-based" approach to a "settings-based" approach that focuses on target population and plans interventions for different settings relevant to that population. The effectiveness of this approach to health promotion was endorsed in "The Jakarta Declaration on Leading Health Promotion into the 21st Century" (WHO, 1997). The WHO Regional Office for Europe has promoted many of the setting initiatives, such as health promoting cities, health promoting hospitals and health promoting schools and health promoting prisons.

As the main consumers of health care resources in the health care system, hospitals must be accountable for their expenditure; they need to provide better services at minimum cost, and they need to respond positively to the increasing demands of patients, relatives and the community. The health promoting hospitals concept is development within the framework of the health-for-all strategy and utilizes the Ottawa Charter for Health Promotion (WHO, 1986), the Budapest Declaration and the Vienna Recommendations on Health Promoting Hospitals (WHO, 1991) as a source of guidance and inspiration.

The concept of a hospital as a health promoter does not mean that the hospital has to change its main function, from curative to health promotion, but it should incorporate into its culture and daily work the idea of health promotion of its personnel, clients and their families and the community.

Hospitals within the European Pilot Project on Health Promoting Hospitals (Garcia Barbero, M, 1998) followed a comprehensive model, developing measures to improve the health of patients, hospital staff and the wider community. The main aim being to develop the existing organisational structures and culture of the hospital towards a "Healthy Organisation".

Since 1995, the national/regional HPH networks were developed, with most pilot hospitals continuing as co-ordinators of the networks. This book summarizes the work of James Connolly Memorial Hospital, a participant in the European Pilot Project on Health Promoting Hospitals and co-ordinator of the Irish HPH Network. It provides a good overview of the structures and programmes that were undertaken as part of the hospital’s Health Promoting Hospitals Project, to improve the health of their staff, patients and relatives and the community at large.
The story of the Health Promotions Hospital (HPH) development initiative in James Connolly Memorial (JCM) Hospital is one of growing success. By sharing our experiences and outcomes with others, we hope that valuable lessons learnt can be passed on. The HPH concept, originally a multi-city action plan of the WHO-Healthy Cities Project, was introduced to Ireland in 1992 by the Dublin Healthy Cities Project. One of the main partners of the Dublin Healthy Cities Project and owner of the James Connolly Memorial Hospital (JCM) is the Eastern Health Board.

It was logical, therefore, for JCM Hospital to be among the first hospitals in Ireland to join the European HPH Network. It became actively involved in the movement in 1993, when it was selected to participate in the European Pilot Project on Health Promoting Hospitals (Garcia Barbero, M., 1998). This World Health Organisation (WHO) initiated Project; based on the Ottawa Charter (1986) and the Budapest Declaration (1991) contained 20 hospitals from 11 European countries. It formally started in Warsaw, April 1993 and ended in April 1997, when 19 of 20 Pilot Hospitals presented their experiences and successful projects at the 5th International Conference on Health Promoting Hospitals, Vienna.

So, what has JCM Hospital achieved overall through its participation in this project? Quantifying the results in itself is a difficult task and it is realised that we still have some way to go to achieve this. Notwithstanding this, our achievements can be identified in two distinct categories: the tangible aspects that demonstrate subproject development and patient empowerment and the intangible aspects that focus on staff empowerment and management and staff awareness of health promotion issues.

In many respects, JCM Hospital has been successful in attaining the objectives set by the European Pilot Project. However, it must be acknowledged that more time is required before the level of ownership essential for the maintenance and development of the HPH concept, can truly be attained. The development of the sub-projects gave considerable impetus to the overall HPH Project, by creating visibility and status for

The Ottawa Charter, 1986

The Ottawa Charter should underpin all health promotional work. It identifies five major strategies for health promotion:

- Building healthy public policy
- Creating supportive environments
- Strengthening community action for health
- Developing personal skills
- Reorienting the health system to health promotion and disease prevention

The Charter recognises the importance of empowering individuals and communities to participate in and influence their own health, and that many of the determinants of health are beyond the control of individuals.
health promotion within the hospital. Key subproject results contributed greatly to the growth of the initiative, in that a wide range of staff became directly involved and saved substantial personal commitment to the development of the projects. Through their efforts, very positive results have been achieved in the improvement and quality of many of the hospital's services. Patient empowerment has occurred, particularly in the areas of Cardiac Rehabilitation, Stress Management, Smoking Cessation and others, where better patient facilitation actively encourages definite action towards a healthier lifestyle.

During the period of the European Pilot Project many difficulties and problems were encountered and many resolved successfully, although some still require on-going attention. Despite the difficulties encountered over the project period, enthusiasm remains high and greater effort is now being placed on the development of new subprojects, the encouragement of wider multidisciplinary co-operation and the provision of adequate feedback to all grades of staff on the development of change within the organisation. Our future plans aim to improve not only hospital-community participation but also community involvement in the development of hospital services and the creation of a healthier community environment.
CM Hospital, a large general hospital, servicing the north/western region of Dublin City, has a staff of over 800 and a bed complement of 380. Originally built in the mid 1950s as a TB hospital, its role gradually changed throughout the 70s and 80s to reach its present function, that of an acute general hospital. The resulting expansion in services provided has necessitated the hospital undertaking a major Capital Development Plan, scheduled to start in 1999 (J.C.M. Hospital, 1998).


• Orientation at reduction of disease + improvement of health
• Extension of targets: Patients + staff + community + organisation
• Change by introduction of new services + organisational development of existing services
• Combination of personal + organisational development strategies

The hospital's aim, through participation in the European Project, was to broaden the range of services provided, by developing an organisational focus that would go beyond the provision of high quality curative services. To attain this aim, it was acknowledged that a number of factors needed to be addressed and new strategies devised and implemented. As a participant in the European Pilot Hospital Project, the hospital was required to pilot a number of structures, as well as instigate, manage and evaluate at least five innovative subprojects. The subprojects were viewed as the means through which the HPH concept could best be introduced and developed within the hospital. It was imperative therefore, that the subprojects chosen should contain certain characteristics; they needed to reflect the needs of the organisation, be feasible to achieve within a short period of time and have as wide an appeal within the organisation as possible. The subprojects sought to incorporate the spirit of the HPH concept by establishing a multidisciplinary team and by bringing about change based on demonstrable outcomes.

The following account attempts to look at, under a number of headings, the successes and difficulties encountered during the European Pilot Project and by focusing on the planning, implementation and evaluation phases of the subprojects, provide other hospitals with practical information.
Overall Project Management

Introducing organisational change through the HPH philosophy, not only assists hospitals to respond positively to the National Health Strategy (Dept. of Health, 1994) but it fits in well with other initiatives such as the European Quality Initiative as one of the markers that distinguishes good hospitals. To be successful however, it must become an essential part of the hospital's organisational culture rather than an optional extra.

Overall HPH Project

Key elements:

- **Staff Consultation**

- **Formation of a Steering/Project Committee**

- **Evaluation Expert Involvement** (particularly in the planning phase of sub-projects).

- **Appointment of a Project Coordinator** (to manage the project, develop an internal newsletter for communication and liaise with the external evaluator on evaluation strategies)

A number of key elements were identified in the JCM Hospital experience as factors that contributed substantially to the successful implementation and development of the project. Incidentally, all these structures were requirements of participation in the European Pilot Project (O’Riordan et al, 1998). We hope to illustrate below how we found these structures helpful.

**A STAFF CONSULTATION**

Change can be difficult to initiate in any organisation, particularly if it is imposed without prior consultation and the process is not adequately understood. It was therefore, considered vital that we should consult with all staff prior to initiating the HPH project.

To this end, a general hospital meeting was organised during normal working hours and all staff were invited to attend. Heads of Department were asked to facilitate as many people as possible to attend. Following a formal presentation on the HPH concept, a general discussion session elicited staff views and opinions on the concept and the hospital's participation in the project. Through this process, the project team gained widespread agreement for the hospital's participation in the HPH project. Later staff were invited to submit ideas for sub-projects and indeed many did so. This resulted in many excellent suggestions being put forward for consideration.

**B. STEERING/PROJECT COMMITTEE**

The Steering/Project Committee was set up to provide support and structure for the development of the HPH Project. The initial committee was somewhat management oriented but quickly changed, in line with the HPH philosophy, to include wider hospital representation.

This was a radical change from traditional structures and proved to be very successful in establishing a multidisciplinary profile for the HPH Project. An important step because
staff not involved at a management level can often become disillusioned and feel that they have no input into the development of the organisation. However, continued management representation on the committee is vital, particularly in relation to policy matters and resource allocation.

C. EVALUATION EXPERTISE

Evaluation needs to be an integral part of all health promotion initiatives and projects. Feedback, as we know, is particularly powerful when it is technically sound and professionally presented. In our case, external expertise was enlisted from the Department of Public Health Medicine and Epidemiology, University College Dublin (UCD). Dr. Anna Clarke has provided the JCM project with valuable support and assistance on all evaluation aspects, since the commencement of the project in 1993.

D. PROJECT CO-ORDINATOR

The project co-ordinator role was viewed as a vital element in the JCM Hospital experience. The position had both a functional and operative aspect that contributed greatly to the development of the overall project. These aspects are outlined below:

• Functional - to ensure the efficient management of the administrative aspects of the project.
• Operative - to initiate and facilitate the development of a health promotion culture within the hospital (Irish National HPH Network, 1998).

Initially a part-time position, it subsequently became a full-time position when process evaluation demonstrated the effectiveness of the role. The Project Coordinator proved to be the stimulating force behind the development of the project, while providing a cohesive element that ensured the continuity of the overall project. The co-ordinator was also able to provide valuable support to the sub-projects leaders on matters of project development, documentation and evaluation. Furthermore, progress and difficulties in relation to the sub-projects could be effectively communicated via the Coordinator to the Steering Committee, where resource implications and difficulties could be speedily negotiated.

Internal Newsletter

Good communication with staff on a regular basis is considered fundamental to the successful implementation of the HPH Project. The HPH Project Office developed an internal newsletter for staff. It provided staff with regular information on the development of the project, while also maintaining staff interest and motivation in the project by creating visibility for the sub-projects. It also raised health promotion issues generally among staff and later, was extended to include a lead article from the Hospital Manager on current development plans within and for the hospital. It proved to be a very valuable tool that contributed greatly to improving communication within the organisation.

Sub-projects

To identify the subprojects, staff were canvassed for their suggestions through the normal hospital communication channels. This process helped to ensure that the sub-projects selected were relevant to the organisation, while also identifying potential
subproject leaders and possible members for the multidisciplinary subproject groups. The following section contains an outline of the various sub-projects undertaken by the JCM Hospital HPH Project. It demonstrates how they were implemented using project management as the development tool. These sub-projects are listed below:

- A Stress Management & Relaxation Programme for Hospital In-Patients
- An Ergonomics Approach to the Reduction of the Physical Load of Some Nurses
- Waste Management
- Continence Promotion
- Smoke-Free Hospital Policy
- Smoking Cessation Services
- Cardio-Pulmonary Resuscitation
- Cardiac Rehabilitation Link Programme
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- Violence Against Women in the Home
- The Safe Use of Glutaraldehyde in the Hospital Setting
RATIONALE

Studies have shown that hospital inpatients have high levels of stress. Research has also shown that stress plays a part in the development of many illnesses. Patients are often exposed to situations that they may perceive as stressful: these are potential and actual loss of control over events, inability to carry on routine daily activities and impersonal treatment by staff. Very often the focus in a general hospital setting is on cure while, the psychological care of patients receives scant attention.

For this reason, it was decided to develop a stress management project for hospital inpatients. A 20 bedded medical ward (8 West) was selected and staff agreed to participate in the project.

AIM

to introduce an effective stress management and relaxation programme into the hospital.

OBJECTIVES

• to develop an effective stress management and relaxation programme for inpatients and;
• train and support staff to enable them to identify appropriate stress reduction strategies for personal and professional use.

METHODOLOGY

Requirements

• Expertise in stress management
• Staff commitment
• Ongoing staff training and support
• Provision of resources i.e. personal stereos and tapes

Content

The programme was developed to include the following; a leaflet on stress management for hospital inpatients was compiled; this leaflet acknowledged that many patients experience stress following hospitalisation. It identified possible stressors and recommended appropriate strategies for managing stress. This leaflet was offered to all patients on admission.

Relaxation tapes and exercises were introduced; funding was provided for audio cassette players for individual patient use, a range of tapes which included; music, progressive relaxation and nature sounds were donated by staff and others. Initially patients chose the tapes based on recommendations from ward staff. Eventually a leaflet with a description of available tapes was compiled to enable patients to make informed choices regarding the tapes. A set of guidelines for patients was also developed to enable them to use the tapes effectively. It was also identified that nurses needed guidelines and these were drawn up by the project leader following a literature search.

Written information and ward manual; an information sheet on
ward routine was prepared and given to each patient on admission. Information on special tests was prepared by the ward team and offered to patients who expressed an interest in finding out more about procedures. Eventually a manual was developed that included information on guidelines for using tapes, description of tapes, ward information, breathing techniques and caffeine reduction. The manual was offered to all patients on admission. Patients were encouraged to ask questions about tests, diagnosis and other issues of concern. Stress management workshops were also introduced for staff to provide them with effective stress reduction techniques for personal and professional use.

**Evaluation**

Evaluation tools were devised to ascertain how the leaflets and tapes helped the patients. Overall project evaluation included a patients comments box and patient and staff self administered questionnaires.

**Timeframe**

Two years

**Outcome**

A high level of satisfaction was expressed by patients regarding information on medical condition, tests and results and ward routine. The majority of patients (77%) found the tapes helpful and stated that they helped them to relax. In addition most of them (97.4%) had read the leaflet 'Coping with Stress in Hospital' and 97% of respondents also said their needs were taken into account. The majority of staff reported that they were more self-aware of stressors. Staff also felt that they were more able to introduce appropriate stress reduction strategies at a personal and professional level. Medical staff, although not directly involved, used the audio-tapes when carrying out procedures and advocated their use to patients prior to discharge.

**CONCLUSION**

The project was very successful overall. Since the pilot study a new improved leaflet on helping patients cope with stress was developed. A pack entitled HELPING PATIENTS COPE WITH STRESS was developed and is now available for sale at a cost of £20. Transfer of the project is planned to other areas within the hospital.

**Key criteria**

- Expertise in stress management
- Patient participation and feedback
- Staff commitment

**Budget**

Hospital budget and donations

**Comments**

The feedback outlined above, while very encouraging, only examined the process of introduced the changes. Further questioning of these patients, following discharge would have revealed whether the stress management strategies helped individuals to cope better with stressors outside the hospital. Further extension of this project is recommended.

For further information please contact: Ms. Margaret Boland, Nurse Tutor, Nurse Education Centre, James Connolly Memorial Hospital, Blanchardstown.
RATIONALE

It is generally agreed that back pain is a common problem among health workers. Research indicates that nursing personnel in long term care facilities suffer more from disabling back troubles than those in acute hospital areas.

In view of this, it was decided that an ergonomic study should be carried out in one of the hospitals long stay care of the elderly units.

AIM

The aim was to reduce the physical overload placed on nurses and care staff in the care of the elderly unit by redesigning the working system and applying ergonomic principles.

OBJECTIVES

• to identify the ergonomic problems associated with the work of nursing personnel on a long stay geriatric unit and;
• test whether the physical load on the musculoskeletal system of the workers could be reduced by ergonomic interventions on the unit.

METHODOLOGY

Requirements

• Multidisciplinary team including an ergonomics expert;
• Support from staff in the selected 40 bedded unit;
• A work sampling study to identify tasks performed by nursing staff and the frequency of these tasks;
• Management commitment to provide essential ergonomic equipment;
• and, maintenance priority to implement structural changes.

Content

An ergonomic assessment of identified work activities and tasks was carried out. The assessment used the following headings:

Task - this included posture analysis on patient care activities, identification of stressful tasks based on workers perceptions and patient dependence level.

Worker - this looked at risk factors associated with the workers themselves such as training undertaken, history of injuries received, manual handling and lifting techniques practiced and individual strength testing.

Workplace - this reviewed all ward facilities, equipment and work designs that put nurses at risk from back injury while performing their work duties.
Using the collected data and following consultation with the ward staff, an action plan was drawn up outlining the necessary environmental changes and equipment required. Following approval by the Health Promotion Steering committee and Hospital Management Team the action plan was implemented. This resulted in changes to the daily working routine, provision of new equipment and ergonomic structural changes. In addition, training was provided on the correct use of new equipment, patient assessment documentation and the new work system. The recommended changes were successfully implemented during a three month period.

**Evaluation**

Evaluation was carried out one month after completion of all the ergonomic changes. This involved the use of pre and post staff questionnaires, analysis of hospital data, posture analysis of staff, work sampling and staff interviews.

**Timeframe**

Two years

**Outcome**

The ergonomic changes introduced led to a reduction in the physical load experienced by nurses in the pilot unit. Changes introduced were maintained as an integral part of the ward routine.

**CONCLUSION**

The outcome of this project supports the use of an ergonomic approach when trying to reduce the risk of musculoskeletal injury. It is recommended that an ergonomic approach be used in the design of all new hospital developments i.e. in terms of workspace, purchase of equipment and the allocation of staff. James Connolly Memorial Hospital is currently planning a new development and an ergonomic approach will be included in the design of this facility.

**Key criteria**

- Ergonomics expert
- Involvement by ward staff.
- Management commitment.

**Budget**

Hospital Budget with additional Health Board Funding

**Comment**

Long-term follow-up identified staff turnover as a vital factor in the sustainability of the new working practices. A new project is recommended to examine and overcome this problem.

For further information: please contact Ms. Maria Lordan-Dunphy, Health Promotion Co-ordinator, James Connolly Memorial Hospital, Blanchardstown.
RATIONALE
The world’s population is expanding rapidly with a consequent effect on global energy consumption and waste production. Hospitals are consumers of many different materials while also being producers of a variety of waste products.

With this in mind, the hospital set out to highlight this issue primarily through environmental awareness and waste minimisation.

AIM
To minimise hospital waste and promote environmental awareness both in the hospital and the local community.

OBJECTIVES
• to establish waste management guidelines for the hospital.
• introduce a pilot recycling programme.
• develop staff educational sessions on waste management.

METHODOLOGY
Requirements
• Multidisciplinary project team
• Management commitment
• In-service education
• Recycling outlets

Contents
Two pilot project areas were identified within the complex. Baseline data on staff knowledge and waste management practices was collected from the pilot units by means of a staff questionnaire and random waste audit. The staff questionnaire revealed that 73% of staff surveyed were either unclear or unaware of the existing hospital waste management policy and the audit found that 70-80% non-medical waste was found in medical bags. As a result of these findings a number of practical changes were introduced. Waste definitions were clarified and displayed in poster format in each unit. The waste segregation system was revised and the colour coded bagging system simplified, along with the introduction of new labelling and equipment. A comprehensive education programme for all staff was developed and implemented in each unit.

Evaluation
Pre and post intervention waste audit. Questionnaire was given to all staff pre and post educational programme.

Timeframe
18 months.

The Outcome
The volume of medical waste generated was considerably reduced. Recycling of cardboard, glass, clothing, cooking oil, tin
and aluminium cans, tea bags and some plastic was successfully introduced on a pilot basis. Staff knowledge and interest in waste management and environmental issues increased significantly following the educational sessions.

CONCLUSION

The project resulted in a substantial reduction in the amount of medical waste generated in the hospital. Subsequently, the project leader was assigned to assist in the development of a board policy and played a central role in the development of a general Waste Management Policy for the Eastern Health Board.

Success criteria

• Reduction of Medical Waste
• Increase staff awareness
• Identification of recycling outlets

Budget

Hospital budget

Comment

While, the initial project outcome was very positive, many of the interventions could not be sustained. This was due in part to the reassignment of the project leader, loss of outlets for some of the recyclable products and difficulties around staff release for educational sessions.

For further information please contact: Mr. William Roban, C/O Technical Services, Eastern Health Board, 1 James Street, Dublin 8.
RATIONALE

A major challenge in caring for the older person is dealing with incontinence. Studies show that between 40-60% of older people in residential care suffer from incontinence. It is further estimated that 25% of nursing time is spent in dealing with incontinence, emphasis being placed on dealing with incontinence as opposed to promoting continence.

With the associated social, psychological and monetary costs of incontinence, this poses a challenge to health care professionals working in this field. Nursing staff in our Care of the Elderly Units acknowledged this challenge and a continence promotion project was initiated.

AIM

The aim was to create greater staff awareness and knowledge on continence promotion and it’s management in the Care of the Elderly.

OBJECTIVES

• to educate staff on continence promotion and the appropriate usage of continence products,
• to introduce medical and nursing assessment tools to identify and manage cause of incontinence,
• to identify ergonomic requirements essential to the promotion of continence.

METHODOLOGY

Requirements

• Multidisciplinary team involving a Continence Advisor;
• Staff support in the project areas;
• Management commitment to provide essential equipment and implement recommended ergonomic structural changes.

Content

Staff knowledge and training requirements were reviewed and appropriate education and training provided. Several nurses were selected to attend a comprehensive continence promotion course run by the Eastern Health Board.

Product ordering and usage was reviewed and guidelines set. A standard statement was developed and implemented. The statement addressed the following issues;

• Medical assessment,
• Individual nursing care plans for continence promotion,
• Appropriate product usage.
• Staff education and training

Furthermore, an ergonomic survey was undertaken to identify the physical and environmental barriers to continence promotion in the project areas. This necessitated the purchase of essential...
equipment and the implementation of recommended structural changes.

**Evaluation**

Pre and post project audit of nurse education and training, economic survey and product usage. In addition, an interim and final audit of the standard statement was carried out.

**Timeframe**

2 years

**Outcome**

The project found that a more structured approach to continence promotion had successfully been implemented in most of the hospital's Care of the Elderly Units. An increase in staff knowledge had been attained, with twenty-four nurses completing the Eastern Health Board's continence promotion course. Furthermore, cost reduction was achieved due to more appropriate usage of products. One area alone achieved a cost saving of £2,200 in 1997. In addition, 80% of recommended ergonomic structural changes were implemented. However, a number of difficulties were also identified and these are as follows:

- large turnover of temporary staff,
- the need for continuous in-service training for new staff,
- time release for up-dating educational sessions
- poor participation by medical staff.

**CONCLUSION**

While many aspects of the project were successful, the project team considered that a new project phase was required to address and overcome the difficulties encountered. The long term aim is the development of an overall continence promotion policy for the hospital.

**Key criteria**

- Management commitment
- Full participation by ward staff
- Involvement of external Continence Advisor/Specialist
- Staff education and training

**Budget**

Hospital budget

**Comment**

Greater success was achieved in areas where key staff displayed a specific interest in continence promotion. It was found that motivation increased with the introduction of regular project updates, along with re-investment of savings in the relevant project areas.

For further information: please contact Ms. Kathy Kavanagh, Staff Nurse, Unit 6, James Connolly Memorial Hospital, Blanchardstown.
RATIONALE

Tobacco consumption is a major cause of ill health and a risk factor for many of our chronic diseases. The hospital has been identified as a natural setting for health promotion and should be an excellent example for other organisations to follow.

As a health promoting hospital, the provision of a smoke free environment for all staff, patients and visitors was identified as a priority. A hospital survey in 1994 highlighted the fact that smoking was widespread within the hospital.

AIM

The aim was to develop a realistic written policy on tobacco consumption within the hospital, one that would ensure a healthy environment for all who utilise the hospital facilities.

OBJECTIVES

- to establish staff attitudes to smoking, smoking in the workplace and to helping smokers to stop,
- to identify smoking practices within the hospital and create awareness of the need for a smoke-free hospital policy,
- and recruit a multidisciplinary Working Party to develop a realistic smoke-free hospital policy.

METHODOLOGY

Requirements

- Management commitment
- Multidisciplinary Working Party
- Widespread consultation
- Project Leader

Content

A review of existing practices and policy on smoking in the hospital was carried out. A random hospital survey established the smoking practices of staff, patients and visitors. It found that there was little or no compliance to existing signage and smoking areas were not clearly defined. General support for a smoke-free hospital policy was established and the following steps were taken:

- An extensive consultation process was carried out with the workforce, management and trade unions.
- A multidisciplinary working party was set up to develop and implement a hospital smoke-free policy.

The policy included the clear designation of smoke-free zones and a limited number of smoking areas for staff and patients. In 1995, the policy was officially adopted and launched publicly and implemented over the following year.
Evaluation methods included:
- use of staff questionnaires pre and post introduction of the policy, to establish attitudes to smoking in the workplace and the number of smokers among staff.
- random hospital survey, pre and one year post policy implementation.

**Timeframe**

3 years

**Outcome**

A significant reduction in the level of smoking in the hospital, along with greater compliance to signage. Whilst creating the changing environment, it was also considered essential to provide active support for smokers wishing to stop.

**CONCLUSION**

The introduction of the policy was successful overall. However, some problems still exist with compliance to the policy. The following recommendations were made to improve policy compliance:

- a copy of the policy should be given to all in-patients as soon as possible after admission and to all staff taking up employment in the hospital.
- Heads of departments should be responsible for ensuring that all staff implement and abide by the policy in their areas.
- smoking and non smoking areas should be clearly identified and appropriate signage used.
- introduction of a monitoring and review system.

**Key criteria**

- Management commitment
- Multidisciplinary Working Group

**Budget**

Hospital budget with additional Health Board funding

**Comment**

Changing long term practices is a very difficult process. Regular monitoring of the smoking policy is viewed as an essential element of the process, along with the provision of adequate support for smokers wishing to stop. Future plans are to review the policy on a yearly basis and to devise a strategy to improve compliance.

For further information, please contact: Ms. Mary Smyth, Smoke Cessation Facilitator, James Connolly Memorial Hospital, Blanchardstown.
RATIONALE

In Ireland tobacco kills (through cancer and cardiovascular diseases) about four times as many people as are killed by accidents and all other external causes. In addition, it is acknowledged that tobacco is a highly addictive substance and stopping smoking takes time.

The hospital recognised that whilst planning a smoke-free hospital policy, there was also a need to provide support services for clients and staff wishing to stop smoking.

AIM

The aim was to provide adequate support for all smokers wishing to stop by providing a one to one counselling service and regular Stop Smoking Support Group Sessions.

OBJECTIVES

• to train smoking cessation facilitators to provide appropriate services,
• to make Stop Smoking Support Group Sessions available to staff, patients and the community,
• and; introduce a referral system for inpatients and provide an inpatient counselling service.

METHODOLOGY

Requirements

• Stop smoking facilitators
• Provision of a suitable facility for group sessions

Content

The project leader was trained as a Stop Smoking facilitator. A suitable location for the provision of the these sessions was identified within the hospital. The Stop Smoking Support Courses were widely publicised both within the hospital, in the local community and General Practitioners were also informed. Hospital staff were also encouraged to take up the service.

The Group Support programme consists of a weekly one hour session, over a six week period. The course content includes the provision of information and open discussion on:
• Benefits of stopping smoking
• Smoking cessation
• Behaviour modification
• Illnesses caused by smoking
• Nutrition
• Stop smoking aids

An in-patient referral system was introduced in a number of acute wards and a formal inpatient counselling service provided. A
further seven ward-based nurses were trained as stop smoking facilitators to assist the project leader.

**Evaluation**

Evaluation methods included;

- telephone follow up of participants directly after the cessation courses and again at 1 and 2 year intervals
- evaluation of course content after each course.

**Timeframe**

2 years

**Outcome**

The demand for these services continued to grow throughout the project phase. In all 79 people attended for counselling, of which 34 (43%) made serious attempts to stop smoking and of these 13 (38%) were still non-smokers one year later. The two year follow-up of group support participants demonstrated that 22% were still non-smokers.

**CONCLUSION**

From our experience, it was evident that the provision of smoking cessation support services for staff, patients and the community was worthwhile. The introduction of a hospital smoke-free policy was also viewed as a supportive element. Extra training of facilitators made it possible to increase the number of courses provided annually. While referrals from the general wards were low, greater emphasis will need to be placed on clinical involvement in the future development of the hospital's smoking cessation services.

**Key criteria**

- Stop Smoking Facilitator
- Co-operation by clinical staff.

**Budget**

Hospital budget

**Comment**

Staff up-take and participation at the group support courses has remained low. It was agreed that greater effort should be made to encourage staff to stop smoking, by providing nicotine replacement therapies at a reduced cost through the hospital pharmacy.

For further information please contact: Ms* Mary Smyth, Stop Smoking Facilitator, James Connolly Memorial Hospital, Blanchardstown.
RATIONALE

Ireland has the fifth highest heart mortality rate in the under 70s age group in the world. Acute Myocardial infarction accounts for one third of all deaths in Ireland. It has been demonstrated in America that 40% of patients can be successfully resuscitated when they have received prompt basic life support followed by advanced cardiac life support.

With this in mind, it was acknowledged that the hospital's existing Cardiopulmonary Resuscitation (CPR) training required standardisation and the inclusion of information on heart disease, risk factors and healthy lifestyle behaviours.

AIM

To train and promote the efficiency of Basic Cardiac Life Support within the hospital and to raise cardiac awareness among hospital staff.

OBJECTIVES

• to appoint a Resuscitation Training Officer
• develop a basic cardiac life support training programme to incorporate health education on heart disease risk factors with skill acquisition.

METHODOLOGY

Requirements

• Multidisciplinary planning team;
• The appointment of a Resuscitation Training Officer;
• Identification of a suitable training centre;
• and, funding for essential training equipment.

Content

A standardised multidisciplinary training programme was developed using guidelines from the American Heart Association. The course incorporated health education on heart disease risk factors with a high standard of Basic Cardiac Life Support (B.L.S.) training. Baseline information on staff skills and knowledge was collected prior to training. The programme was available to all staff within the hospital.

Evaluation

Baseline evaluation of staff skills and knowledge was carried out prior to commencing the programme. Pre and post training assessment followed, that included both skill assessment in CPR efficiency and written assessment using multiple choice questions. Further assessment of both skill and knowledge was carried out two years post training.

Timeframe

2 years
Outcome

Approximately 600 of a total staff of 800, including 300 nurses, were trained over the two year period, using a standard four hour CPR course.

Initially, some difficulties were encountered with the evaluation process. Staff showed a marked reluctance to attend for assessment of their practical skills and knowledge. In fact, many had to be contacted several times by phone and by letter in order to encourage and ensure their attendance. It was questioned whether this reluctance was a reflection of their actual confidence and competence in the performance of CPR.

In all 30 staff (mainly nurses) were re-assessed two years post training. It was found that none could perform the correct sequence of skills required to provide adequate Basic Life Support to cardiac arrest victims. With regard to skill proficiency, some individual CPR skills could be performed satisfactorily but the coordination of skills together in an adequate manner was inapt.

CONCLUSION

A considerable decrease in skill retention was demonstrated two years post training but a higher degree of knowledge was retained. A second project phase was recommended to evaluate the effectiveness of an annual training programme for staff and it was suggested that priority should be given to staff in critical areas. In view of the high level of interest expressed by staff, continuation of the two yearly programme for all other staff was recommended.

Key criteria

- Management commitment
- Trained CPR instructor
- Standard training course for all staff
- Staff time release for training

Budget

Hospital budget plus private sponsorship/donations

Comments

It proved impractical and not financially feasible to train all hospital staff in a systematic way. However, there is a consistently high level of interest for CPR training among hospital staff and the general public. This provides an ideal opportunity for health promotion with regard to heart disease. This aspect of the course is called 'Prudent Heart Living' and promotes a lifestyle that minimises the risk of heart disease. It is questionable whether the same level of interest would be achieved, if only the health education aspect was offered.

For further information, please contact either Ms. Billie Lawlor or Ms. Mary Hannon. Resuscitation Training Centre, James Connolly Memorial Hospital, Blanchardstown.
RATIONALE
With an increase in the number of people surviving a myocardial infarction, much attention has turned to the quality of life experienced by these individuals. It is widely accepted that Cardiac Rehabilitation Programmes aim to restore patients to an optimal quality of life. These programmes include education, support and counselling for the individual and their families, to facilitate necessary lifestyle changes.

A sap was identified in the hospital's patient services for post myocardial infarction patients. Cardiology staff felt that these patients and their families lacked on-soins support and information at a critical time in their lives.

AIM
The aim was to determine the feasibility of establishing a Cardiac Rehabilitation Link Programme in the hospital and evaluate the effectiveness of such a service.

OBJECTIVES
• to appoint a Cardiac Rehabilitation Nurse to act as a link with the patient and family post discharge.
• to develop a service that will ensure that all post myocardial infarction patients are better equipped to deal with this life crisis and to make positive lifestyle changes.

METHODOLOGY

Requirements
• Multidisciplinary involvement
• Cardiac Rehabilitation Nurse

Content
Development of a service to educate, support and enable the patient and family to understand and live with their condition post myocardial infarction. Patients were randomised into an experimental or a control group. The experimental programme consisted of the followins:
• Individual assessment with Cardiac Rehabilitation Nurse with resard to cardiac risk factors, health beliefs and perceptions resardins the cause of their myocardial infarction.
• Development of an individual programme takins into account their risk factors and convalescence activities. The patient's partner was also included in at least one of these sessions.
• The Cardiac Rehabilitation Nurse acted as a link for the family and the patient post discharge ensurins continuity of advice, information and support. Telephone contact was made in the first week followins discharge and the families were siven a contact number for the Cardiac Rehabilitation Nurse.
• Formal contact was made at six-eight weeks and at the end of the three month experimental period.

**Evaluation**

Baseline data regarding patient's attitude, understanding of condition and risk factors of heart disease was collected from both groups after admission. A self administered questionnaire was given to patients 6-8 weeks and 3 months following discharge measuring behavioural change, knowledge and satisfaction with the service. A further telephone administered questionnaire was conducted with all patients 18 months after discharge.

**Timeframe**

1 year

**Outcome**

The study found that the cardiac rehabilitation programme was effective in providing advice, information and support to the post myocardial patient and family. Furthermore, statistically significant differences were found between the two groups. The experimental group were found to be more knowledgeable about heart disease and associated risk factors and had made more positive lifestyle changes. In addition, the experimental group expressed more confidence in contacting the hospital and indeed many of them frequently contacted the Cardiac Rehabilitation Nurse.

**CONCLUSION**

Although, the sample size was small due to the limited project time of six months, the feasibility and effectiveness of this limited Cardiac Rehabilitation service was clearly demonstrated. The Cardiac Rehabilitation Nurse's role was confirmed as a full-time position with recommendations that the service be extended to include educational sessions for cardiac patients and their families after discharge. Future plans include the development of a comprehensive service which will include an exercise programme.

**Key criteria**

• Allocation of a Cardiac Rehab. Nurse
• Consultant Cardiologist support
• Administrative support

**Budget**

Hospital budget

**Comments**

The successful implementation and effectiveness of this service, using minimal resource, has implications for other hospitals and services.

For further information please contact: Ms. Catherine Beilew, Cardiac Rehabilitation Nurse, James Connolly Memorial Hospital, Blanchardstown
RATIONALE
Cardiac rehabilitation programmes tend to place emphasis on the acute hospital phase, hospital recovery and resumption of normal activities, but the lack of continuity in patient follow-up during convalescence at home has been identified through research as a problem.

Evaluation of the hospital's Cardiac Rehabilitation Link Project identified a need to further develop its capacity to provide information and support to cardiac patients and their families.

AIM
To provide patients and their families with a relevant education and information programme during their convalescent phase at home.

OBJECTIVES
to establish an educational module using a multidisciplinary approach to provide on-going support for cardiac patients.
to provide greater support to partners/significant others by involving them in the educational programme.

METHODOLOGY

Requirements
Cardiac Rehabilitation Nurse
Multidisciplinary team
Cardiology support
Provision of a suitable facility.

Content
An educational module was developed by the project team incorporating:

- Risk Factors for heart disease- Consultant Cardiologist/ Cardiac Rehabilitation Nurse
- Nutrition- Nutritionist
- Medication - Pharmacist.
- Stress Management - Occupational Therapist
- Social Issues- Social Worker
- Explanation of Heart Disease - Health Promotion Coordinator
- Physical Activity, Relaxation- Physiotherapist.

All patients discharged following myocardial infarction, unstable angina, angioplasty and cardiac bypass were invited to attend. Family members were also invited.
Sessions were run over a seven week period.
Evaluation included:
• questionnaires were given to all participants prior to commencing the course.
• a follow up focus group at three months.

Timeframe
1 year

Outcome
Participants indicated that their knowledge and confidence levels had increased, and felt more empowered to come to terms with their condition. The sessions were considered to be well structured and gave relevant information for present and future use. A key issue identified by participants was the level of family involvement in these sessions. Evaluation from the follow-up focus group showed that lifestyle changes had been made and maintained.

CONCLUSION
This service has proven to be very valuable in the provision of information and support to our cardiac patients at a critical time in their lives. These sessions are now an integral part of the hospital’s cardiology service.

Key criteria
• Cardiac Rehabilitation Nurse
• Patient participation

Budget
Hospital budget plus private sponsorship/donations

Comment
Changes have been made to the course structure following evaluation. The duration of the sessions has been increased to two hours and the number of sessions have been increased to eight. The sessions were also relocated to a quieter area in the hospital following feedback from participants.

For further information please contact Ms. Catherine Bellew, Cardiac Rehabilitation Nurse, James Connolly Memorial Hospital, Blanchardstown.
RATIONALE

It is widely recognised that increased levels of stress are now found in employees of large organisations. In the health sector, these demands can be as a result of changes in clinical practice or wider policy and structural changes.

For this reason, a coffee morning was organised by the acute psychiatric service in our hospital, to both promote positive mental among staff and to investigate possible stress levels. The majority of participants identified the need for a stress management and assertiveness training course for staff. This was undertaken as a workplace health promotion initiative.

AIM

The aim was to establish a stress management and assertiveness training programme within the hospital setting.

OBJECTIVES

• to promote an awareness of the effects of stress among staff
• enable staff to deal more effectively with stress in their lives
• and; to use effective stress management and assertiveness techniques in their daily routine.

METHODOLOGY

Requirements

• Expertise in stress management
• Management support
• Administrative support

Content

A multidisciplinary team consisting of three Occupational Therapists and one Psychologist developed a six week course. The programme was publicised throughout the hospital. Eight participants were randomly selected from respondents. The course was held at lunch time and staff were given an extra half hour for lunch to facilitate attendance. The course objectives were as follows:

• To facilitate the identification and recognition of characteristics of stress among group participants,
• To train staff to understand their own individual stress response,
• To assist staff to analyse possible causes of stress in the workplace,
• To facilitate learnings of effective assertive communication techniques e.s. conflict resolution, negotiation skills,
• To design and implement strategies for managing stress e.g. relaxation techniques, time management and general coping skills.

**Evaluation**
Baseline data identified the need for the provision of the course. Pre and post course stress inventories were given to staff to determine individual sources of and effects of stress, as well as identifying coping skills and levels of assertiveness. The course content was also evaluated.

**Timeframe**
1 year

**Outcome**
Feedback from the majority was positive particularly in relation to course content, skill of facilitators and opportunity to participate in group discussion. The respondents also stated that they were more aware of stressors and coping mechanisms, most stating that their stress levels had decreased. A three month follow up of participants was also carried out. Staff indicated that they could now recognize sources of, and effects of stress on them but more importantly stated that they continued to use the skills learned when dealing with stressful situations.

**CONCLUSION**
This successful course was developed with minimal resources. However, following evaluation the length of the course has been increased to eight weeks to allow for more time to be spent on issues such as time management and practical application of skills learned. Funding has been provided for a proper course manual and other course materials. The course content was re-evaluated and updated.

**Key criteria**

• Management commitment

• Availability of in-house stress management expert

**Budget**
Hospital budget

**Comment**
Due to the positive response from participants it has been agreed that these courses should be continued on a regular basis as a workplace health promotion initiative.

Some major organisational issues were identified through the course, such as: lack of autonomy, poor role definition and communication. It is hoped to address these issues through another project in the future.

For further information please contact: Ms. Anne O’Connor, Head Occupational Therapist, Mental Health Services, Area 6, C/o James Connolly Memorial Hospital, Blanchardstown.
RATIONALE

Domestic Violence has been identified as a significant problem in our society. Research shows that medical personnel are the people to whom women are most likely to disclose abuse. In fact, it has been demonstrated that victims of domestic violence are most likely to enter the health care system through a hospital Accident & Emergency (A&E) Department.

For this reason, a project was initiated in this hospital's A&E Department. Furthermore, the hospital recognised that domestic violence was both a health and social issue. It was decided that this project should be developed in association with Women's Aid and other relevant local voluntary agencies.

AIM

The aim of the project is to identify, facilitate and enable women, already victims of domestic violence in the hospital's catchment area, to deal with their individual situations.

OBJECTIVES

• to establish a supportive environment the A&E Department to facilitate disclosure of domestic violence,
• develop a service that will provide women with appropriate support, advice and assistance to create a safer environment for themselves and their children.

METHODOLOGY

Requirements

• Management commitment
• Multidisciplinary team
• Involvement of Women's Aid / other community based agencies

Content

In the planning phase, the project team consulted widely with Women's Aid and other relevant agencies. The appointment of a full-time Social Worker to the A&E Department was secured and an assessment of staff knowledge on domestic violence was conducted. Key staff were then trained as trainers (to train hospital staff) by Women's Aid. All A&E staff received appropriate training at the beginning of project. A suitable interview area was identified in the A&E Department to facilitate disclosure and a good practice response / guidelines manual for staff was developed. Both a standard statement and a Mission Statement recognising domestic violence as a health issue have been developed. Furthermore, a database has been set up to record details of referrals, types of injuries, support provided and to facilitate follow up.
Evaluation

Baseline information was collected by means of:

- Staff questionnaire on staff knowledge and ability to deal with domestic violence; (Repeated on completion of training).
- Review of A&E Department procedures and documentation with regard to domestic violence;
- Audit of domestic violence referrals to the Social Work Department during period March 1997-98; (Further audits are carried out three monthly on domestic violence referrals to the department).

All case of domestic violence that present to the A&E Department are systematically documented.

Timeframe

2 years.

Outcome

Whilst the project is still in the implementation phase, process evaluation has demonstrated the following:

- the need for adequate staff training
- lack of knowledge and information on community resources for women.
- A marked increase in the number of referrals to the Social Work Department since the provision of training.

CONCLUSION

Final conclusions cannot be presented at this time, as the project has not yet been completed. Full evaluation is planned for autumn 1999 and a complete report will be available.

Key criteria

- Management commitment
- Expertise of Women's Aid
- Staff training
- Medical Social Worker in A&E Department

Budget

Hospital budget and additional public funding.

Comment

The value of this project has already been demonstrated by a marked increase in the referrals to the Social Work Department.

For further information please contact Ms. Imelda Morris, Medical Social Worker, James Connolly Memorial Hospital, Blanchardstown.
RATIONALE
It is generally acknowledged that the cold sterilant glutaraldehyde (cidex) poses health risks to staff. It causes nasal and respiratory irritation and has the potential to cause occupational^ induced asthma, that has life long implications.

With this in mind, the hospital decided to commence a workplace health promotion project to investigate and deal with this issue.

AIM
To introduce guidelines for the use of glutaraldehyde in the hospital setting and protect staff health by providing a safe working environment.

OBJECTIVES
• to increase staff awareness on the safe use of glutaraldehyde
• and; protect staff health by implementing adequate control measurements to ensure a safe working environment.

METHODOLOGY
Requirements
• Management commitment
• Expertise in Health & Safety
• Expertise in Occupational Health

Content
A committee was set up to look at glutaraldehyde use in the hospital. The Occupational Health Department and the Health and Safety Department carried out a risk assessment audit on glutaraldehyde use in the hospital. As a result, the following procedures were implemented:
• onsite staff training by the Occupational Health Unit
• guidelines for safe use were developed and implemented in all relevant departments
• personal protective equipment was standardized in the hospital
• staff health screening was undertaken
• provision of personal monitoring
• essential equipment was purchased
• changes were made in operational work practice.
A standard statement on glutaraldehyde use was also developed and implemented.

Evaluation
Baseline information was collected using staff questionnaires and surveys of the workplace. This provided information on the following:
• personnel exposed
• current work practices in glutaraldehyde use
- ambient environmental conditions and ergonomic work station audit
- personal protective equipment in use
- staff knowledge on glutaraldehyde handling

Staff questionnaires have been repeated.

**Timeframe**

2 years

**Outcome**

The project is still in the implementation phase. Staff questionnaires will be repeated, along with and interim and final audit of standard. However process evaluation has demonstrated that changes have already been made in relation to both work practices and work facilities. A significant finding is that susceptible members of staff have already been identified, necessitating their removal from exposure.

**CONCLUSION**

Final conclusions cannot be presented as yet. Full evaluation is planned for the Autumn of 1999 and a full written report will be available by the end of the year.

**Key criteria**

- Management commitment
- Direct site access by Occupational Health and Health and Safety personnel to the point of use.

**Budget**

Hospital budget

**Comment**

Two significant outcomes have arisen, the importance of identifying staff at risk from exposure and the successful co-operation of a multidisciplinary team.

For further information please contact: Dr. Fiona Donnelly, Occupational Health Physician, Eastern Health Board or Ms. Dolores Murphy, Staff Nurse, Endoscopy Unit, James Connolly Memorial Hospital, Blanchardstown.
**What is Evaluation?**

Evaluation can be defined as the systematic and scientific process of determines the extent to which an action or set of actions was successful in the achievement of predetermined objectives.

In other words it is a process which seeks to establish the value of a project / programme to the recipients.

**Why is it Important?**

Evaluation answers the following questions:

- Is project / programme achieving its objectives?
- How well did we do it? - Results?
- How did we achieve it?
- Can we improve the project / programme?

It feedbacks into the project / programme.

It provides models of good practice that can be used in other sites.

Therefore evaluation is an essential and integral part of a project / programme.

*Do not plan a project / programme without thinking about how it is going to be evaluated.*

**Process of an Evaluation:**

1. **Planning Stage**
   - Document clear aims and objectives. Set targets (what do we want to achieve?) based on the aim.
   - Plan evaluation process - Keep it simple and relevant to project.
   - Where are we now? Does baseline data need to be collected, e.g. lifestyle behaviour, current resource use? This may be readily available or a survey may need to be carried out.
   - Does quality need to be examined? If so, how?
   - Agree what data needs to be collected - keep data to be collected to a minimum. Decide how data will be collected, who will collect it, when the data will be collected and what are the resource implications? Make sure that the project team and management agree on what is being evaluated.

If carrying out a survey using a questionnaire, it is a good idea to seek specialist advice on the questionnaire design, sampling and analysis.
2. When Data has been Collected:

- Analyse it - were the set targets met and if so, at what cost? If targets were not met, is there an explanation?
- Provide feedback to members of project team and management.
- Use results for future planning of project.
- Disseminate results to other sites.

**Evaluation of a Sub-Project Example**

**BACK CARE WORKSHOP SUB-PROJECT**

Project involved setting up backcare workshops for interested staff.

Prior to starting, baseline data was collected using a survey to see if enough staff were interested in participating in such a workshop.

Throughout the project, data collected for evaluation included the following:

- Documentation of the number of staff who attended the courses.
- Resource implications.
- Questionnaires were developed and given to participants after each course, asking their opinions about the lectures, materials used, topics not covered, time and venue of the course.

Project feedback led to some changes in the format of the course. More courses were also offered at different times.
National Perspective

The Health Promoting Hospitals (HPH) concept uses a "Settings Approach" to health promotion. This approach has four main elements:

- It views the setting (in this case the hospital) as a social setting.
- Addresses Social Systems (hospital organisation), not individuals.
- Uses the setting as a target for interventions.
- And has an orientation for solving problems.

"from the viewpoint of organisational development the settings approach is the key issue of health promotion" (Grossman & Scala, 1993).

The HPH concept has its origin in the World Health Organisations Healthy City movement and has been a movement in its own right since 1992. The aim of the movement is to stimulate and influence hospitals to undertake, in addition to their responsibility for the provision of clinical and curative services, an active role in the promotion of positive health and well being in the hospital and through the hospital to the wider community.

As a concept, the settings approach to health promotion was endorsed by the Jakarta Declaration (WHO, 1997), with hospitals identified as a vital setting. This is because of its potential to influence major social groups - health service and health professionals and employees through workplace health promotion.

The World Health Organisation (1993) defines a health promoting hospital as one that:

"develops a corporate identity that embraces the aims of health promotion and demonstrates a healthy structure and culture within the hospital".

National HPH Network Objectives are:

- Establish a common language in the field;
- Promote quality standards;
- Produce protocols for evaluating health promotion in hospitals - in health gain and cost-effective terms;
- Development of managerial criteria;
- Encourage and implement research projects.

(WHO, 1998)

In 1992 JCM Hospital took the initiative and joined the European Health Promoting Hospitals Network. It was the only hospital in Ireland to join at that time. To further demonstrate its commitment to the HPH philosophy, the hospital agreed to participate in a five-year European Health Promoting Hospitals Project (EHPHP). The hospital's five-
year experience within this project appears in a Review Book, along with 19 of the European Pilot Project participants. The Review Book was launched on April 29th 1998 at the 6th International HPH Conference in Germany.

Since, the completion of the EHPH Project in 1997, the hospital has continued to show its support for the HPH concept, through the development of the Irish National HPH Network. The Network was initiated by JCM Hospital in 1995 and officially launched by the Irish Minister for Health & Children, Mr. Brian Cowan T.D. on October 14th 1997. The hospital continues to demonstrate its on-going commitment and support for this initiative through the provision of office space and facilities for the National Co-ordinating Centre.

The Network has a formal structure that can respond to the concerns and issues raised by the membership. It receives seed funding from the Health Promotion Unit, Dept. of Health and annual contributions from network member hospitals. It has a current membership of 20 full members, 7 affiliate members and 7 associate members. In all, over 40 individual hospitals across the country are represented within the network. Many hospitals are now working together on a number of core network projects that aim to address some common areas of interest and concern.

**National Network Initiatives**

- WHO/UNICEF Baby Friendly Hospital Initiative
- Smoke-free Hospital Initiative
- Hospital Waste/Energy/Recycling Initiative
- National Hospital Challenge Day Initiative
- Hospital Nutritional Initiative
- Staff Health Initiative

(Irish National HPH Network, 1998)

**European Perspective**

Arising out of the European Pilot Hospital Project, a European Project of National and Regional Networks of Health Promoting Hospitals was initiated in 1995. This WHO based project links with the WHO Health for all targets as part of the health policy in Europe, more specifically Target 29 (WHO, 1984).

To achieve this, more detailed strategies have been developed:

- To make the Health Promoting Hospital an important strategy in the health care policy and in the health sector throughout Europe;
- To integrate hospitals in all member states of the European Region into networks of Health Promoting Hospitals;
- To integrate national/regional networks in an international framework and to foster communication and exchange of experiences across national/regional boundaries;
- To develop and assure the quality of HPH projects by developing methods of proactive networking on national and regional level.

**Health for All**

Target 29 - describes the role of the hospital care:

"By the year 2000, hospitals in all Member States should be providing cost-effective secondary and tertiary care and contribute actively to improving health status and patient satisfaction."
To date, national/regional networks have been set up in 15 European countries: Austria, Belgium (regional French + Flemish community), Bulgaria, France, Germany, Greece, Hungary, Ireland, Italy (regional Veneto, Piemonte, Lombardia), Lithuania, Poland, Portugal, Slovakia, Sweden, United Kingdom (regional England, Scotland, Wales). It is well recognised that the Irish National HPH Network is at the forefront of this movement and a major contributor to the development of the WHO - European National/Regional HPH Networks Project (Ludwig Boltzmann - Institute for the Sociology of Health & Medicine, 1998).


