

In the hands of nurses: A focus group study of how nurses perceive and promote inpatients' needs for physical activity

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Abstract

Aims: To describe how nurses perceive and promote inpatients' needs for physical activity during their stay at the ward.

Design: A qualitative descriptive design was employed providing an exploration of how nurses perceive and promote inpatients' need for physical activity.

Methods: Seven semi-structured focus group discussions were held between November 2016 and February 2017 with 29 nurses in three hospitals in Sweden. Both interaction analysis and content analysis of the data were conducted.

Results: Patients are dependent on nurses' prioritizations and promotions to be sufficiently physically active during their stay at the ward. The external environment and the integration of physical activity affected the promotion of physical activity. The nurses perceived that understanding the patient's expectations was important and that promotion of physical activity was a joint responsibility of patient, relatives and healthcare professionals. The interaction analysis revealed no clear hierarchical pattern as all members in each focus group took initiative to open the discussions. The Registered Nurses contributed with more new ideas.

KEYWORDS

content analysis, focus group discussions, interaction analysis, nurse–patient relationship, nurses, nursing practice, patient safety, physical activity, quality of care

1 | INTRODUCTION

Patients enrolled in hospital wards spend more time in bed than is medically indicated (Brown, Redden, Flood, & Allman, 2009). The importance of physical activity (PA) is well known, although patients are still not insufficiently active during their hospital stay (Peel & Kuys, 2013; Smith, Galea, Woodward, Said, & Dorevitch, 2008; So & Pierluissi, 2012). Few activities promote PA during the hospital stay and the patients spend most of the time alone, inactive and asleep (Peel & Kuys, 2013; Smith et al., 2008). Only 7%–9% of a monitored 8-hr period was spent on walking (Peel & Kuys, 2013). The inactivity causes a need for assistance with daily activities after the treatment

that did not exist before or is justified by the treated condition (Hoogerduijn, Schuurmans, Duijnste, de Rooij, & Grypdonck, 2007) and is associated with functional decline, readmission or transfer to permanent residential care (Patterson, Blair, Currie, & Reid, 2005).

2 | BACKGROUND

Physical activity prevents neuromuscular complications (Cameron et al., 2015) and improves patients' physical functioning and emotional and social well-being and can bring organizational benefits such as decreased length of stay and cost reduction (Cameron et

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al., 2015; Kalisch, Lee, & Dabney, 2014). Nurses in hospitals wards initiated PA for patients too infrequently and for too short durations (Doherty-King, Yoon, Pecanac, Brown, & Mahoney, 2014). Nurses' professional experience, personal confidence and the way they perceive PA as their personal responsibility (Doherty-King & Bowers, 2013) affect nurses' initiative to support patients in becoming physically active (Doherty-King & Bowers, 2011; Hoyer, Brotman, Chan, & Needham, 2015). Perceived stress and other workload affect the extent to which healthcare professionals initiate PA at the wards (Doherty-King & Bowers, 2011; Hoyer et al., 2015; Jolley, Regan-Baggs, Dickson, & Hough, 2014; Jolley et al., 2014). Lack of nursing personnel (Doherty-King & Bowers, 2011) and physiotherapists (Doherty-King & Bowers, 2013; Jolley et al., 2014) is associated with low levels of PA among patients in hospitals.

Physical activity in hospitals can be considered as a care process, containing a certain degree of inherent unsafeness (World Health Organization, 2017), which affects quality of care and patient safety. Patient safety is the absence of preventable harm to a patient during the process of health care and reduction of risk of unnecessary harm associated with health care to an acceptable minimum (Runciman et al., 2009). Every point in the process of caregiving contains a certain degree of inherent unsafeness (de Vries, Ramrattan, Smorenburg, Gouma, & Boermeester, 2008). The unique function of nursing involves assessing health status and assisting patients in the performance of activities contributing to health or recovery (Henderson, 1964). Promotion of PA should be viewed as a vital component of quality nursing care, as ongoing mobilization contributes to maintaining functional status during hospitalization and shortening length of stay. Despite that, previous studies have shown that nurses in hospital wards promote physical activity insufficiently.

This study contributes to increased knowledge and understanding of the team of nurses' perceptions and promotions of patients' PA. The results of the study can help to tailor interventions targeting sustainable work routines that enhance patient PA at hospital wards.

3 | AIM

The aim of this study was to describe how nurses perceive and promote inpatients' needs for physical activity during their stay at the ward.

4 | THE STUDY

4.1 | Study design

This study has an inductive descriptive design using data from semi-structured focus group discussions (FGDs) with Registered Nurses and assistant nurses working in hospitals. Focus groups facilitate the in-depth exploration of a person's perspective through group interaction and give data that are not obtained with other methods (Morgan & Böttorff, 2010). These interactions can weed out extreme or false views and thereby improve data quality (Krueger & Casey, 2000). Criteria for effective FGDs are summarized as a range

of relevant topics, specificity and depth to direct the discussions towards the participants' experiences and the interaction of different experiences (Morgan & Böttorff, 2010).

The research team consisted of female researchers: one physical therapist and two Registered Nurses, all with PhD degree and experience in conducting studies using qualitative methods. All researchers have experience of working in their professions in wards.

4.1.1 | Participants and setting

The setting for the study was a county in central Sweden with approximately 291,000 inhabitants, having three hospitals, including one university hospital. The study was conducted at all three hospitals.

A purposeful sampling procedure was conducted. A mixture of medical and surgical wards was selected to reach a variety of nursing experiences with the topics being discussed. An invitation with information about the study was e-mailed to the heads of wards in three hospitals. Ten wards were approached, seven agreed to participate, and three declined participation mainly due to high workload. Four surgical and three medical wards were finally included, three wards from a university hospital and four from smaller hospitals. Criteria for inclusion were being a Registered Nurse (RN) or a certified nursing assistant (CNA), employed in a medical or surgical unit and currently providing nursing care. The intention of the sampling for the FGDs was to bring nurses with dissimilar backgrounds together, which facilitates group discussions (Krueger & Casey, 2000). A heterogeneous sampling was therefore conducted, with Registered Nurses and certified nursing assistants. The members of each focus group were working together at the same ward. The research team proposed a date to conduct the focus group, and the head of the ward selected the participants.

Seven FGDs were conducted with 29 participating nurses, two RNs and two CNAs per group, except for the pilot FGD, which included three RNs and two CNAs. Before each FGD, the nurses were informed about the study, the researchers and the purpose of the project. They completed a short questionnaire with questions about age, sex, type of profession and years of experience as a nurse and at the ward (Table 1).

4.1.2 | Data collection

All FGDs were held between November 2016 and February 2017, during working hours at the respective hospital ward. One of the authors (x) was the moderator of the FGD, and one other author (y or z) observed and took field notes of the atmosphere, interactions and conversation flow and asked clarifying questions at the end of the discussions. The duration of the focus group discussions was 50–60 min.

The semi-structured interview guide was based on previous research and developed through discussions in the research group. A pilot FGD was conducted to test the questions of the interview

TABLE 1 Overview of the participants in the focus groups

Focus group	Total participants (N = 29)	Sex, W/M (27/2)	Age in years	Profession, RN/CNA (15/14)	Years of professional experience	Hospital ward	Years at the ward
FGD 1	5	5/0	26–57	3/2	1.5–39	Surgery	1.5–34
FGD 2	4	3/1	46 ^a	2/2	27 ^a	Medicine	16 ^a
FGD 3	4	4/0	26–64	2/2	3–45	Oncology	2–27
FGD 4	4	4/0	19–60	2/2	1–42	Orthopaedics	1–36
FGD 5	4	4/0	26–50	2/2	0.5–31	Surgery	0.5–18
FGD 6	4	3/1	20–49	2/2	2–6.5	Surgery	2–11 ^b
FGD 7	4	4/0	23–59	2/2	1–35	Medicine	4–35
Mean			40.2		15.2		11.8

Abbreviations: CAN, certified nurse assistant; M, men; RN, Registered Nurse; W, women.

^aData missing on three participants.

^bOne person worked as a CNA at the ward before becoming an RN.

guide and to establish smooth cooperation between the moderator and the observer. Data from the pilot focus group were included in the final analysis, since only minor revisions were made to the interview guide. The final version included questions about how the nurses perceived and promoted the patients' needs for PA. The participants were encouraged to speak freely and from their personal experience. Probes, loops and transitions were used to gain deeper knowledge. Each FGD took approximately one hour in free-flowing discussion in a friendly atmosphere. No other persons except the nurses in the focus group and two researchers were present in the room.

The discussions were digitally recorded and transcribed verbatim. The transcripts were checked for accuracy by the authors and then imported to QSR International's NVivo 12 Software. One FGD was not recorded due to technical problems, and the memory notes were made immediately after the interview.

The researchers had no former relationship to the participants, except for Y, who was a colleague to the participants in the pilot FGD, where she participated as an observer.

4.2 | Data analysis

After all seven FGDs were carried out, data were analysed using qualitative content analysis as described for FGDs (Krueger & Casey, 2000) and an approach for inductive category development was used. Discussions in focus groups depend on the individuals in the group, the group as a whole and the dynamics in the group, which means that the analysis has to balance the interplay between these units (Krueger & Casey, 2000; Morgan & Bottorff, 2010). An interaction analysis was therefore performed.

4.2.1 | Analysis of the interaction in the groups

The dynamics of the interaction, individual dominance, heated group discussions (dissent) and consensus were analysed in a manner similar to that described by Onwuegbuzie, Dickinson, Leech, and Zoran (2009). All significant new statements, agreement and dissent were recorded in the matrix for each member of each focus group (Table 2). An additional extraction of who took the initiative of answering first was added to the matrix. The purpose of the interaction analysis was to capture the group dynamics and eventual hierarchical construct of the group.

4.2.2 | Analysis of the transcribed text

To get a sense of the whole, the transcripts were read several times by all authors and two of the authors (x and y) coded the transcribed text independently of each other. Quotes directed by the aim were extracted and condensed into codes. From the codes, main categories and subcategories emerged as differences and similarities were identified. Efforts were made to ensure that categories were internally homogeneous and externally heterogeneous. The last FGD did not provide new information, that is, any new categories. Consensus

TABLE 2 Example of a matrix used for recording interaction in the focus groups

Topic	Opening the discussion	New statement	Agreement	Agreement + additional	Dissent
1	RN1	CNA1, CNA2,	RN2	RN3	CNA3
2	RN2	RN1, RN2	CNA1	RN2	
3	CNA1				
4	CNA2				

Note: The numbers represent the order in which the nurses entered the discussion and are unique for each person.

Abbreviations: CNA, certified nurse assistant; RN, Registered Nurse.

discussions were held continuously in the research group, moving between the origin of the text and the analysed parts, until a shared understanding of all the emerging categories was achieved. Each category was summarized, and quotes capturing the core of what was said were selected to illustrate the category. The quotes were translated into English and then translated back into Swedish to secure an accurate meaning of the quotation.

4.3 | Ethical considerations

The study was approved by the regional ethical board of X; 2016/212. All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

The participants provided written informed consent after receiving both written and oral information about the study, including the voluntary nature of participation, the possibility to withdraw at any time without explanation and assurance that all collected data would be handled confidentially and no individual would be identifiable in quotes or in the results. Only the research team had access to the original interview files and transcripts. The participants were informed of the moderator and the observer's professional background, reasons for interest in the topic and that the focus group data would be analysed and published in a research journal.

4.4 | Rigour

To ensure rigour, the authors conducted a systematic approach throughout the study, and provided a rich description of the context. Dependability (Polit & Beck, 2012) was enhanced by conducting an interaction analysis to ensure that the collected data were derived from all members of the group or not from a few nurses. The location of the FGDs were in three different hospitals, with both medical and surgical wards, as an attempt to enhance dependability.

Two of the researchers independently analysed and coded data, but the entire team reached consensus on the themes and subthemes. The team increased the rigour of the study as the members checked the analysis, discussed emerging interpretations and explored different positions. Discussion occurred between the members of the research team during data collection to ensure methodological

coherence and saturation (Morse, Barrett, Mayan, & Spiers, 2002). The study followed the guidelines for reporting qualitative studies (COREQ) (Tong, Sainsbury, & Craig, 2007) (Supplementary File 1).

5 | RESULTS

A total of 29 nurses, 15 Registered Nurses and 14 certified nurse assistants, participated in the study. Their age ranged from 19 to 60 years (Table 1). The results from this focus group study comprise data from both the interaction analysis and the qualitative content analysis of the transcribed FGDs.

5.1 | Results of the interaction analysis

The interactions are presented in Table 3. Of the 527 new statements in the discussions, the RNs contributed 69% and the CNAs 31%. A Registered Nurse took an initiative to open the group discussion 74 times, 56% of all the opening sentences. A total of 434 agreements were found, and RNs contributed 48% and CNAs 52%. Agreement with an additional new statement was given by the RNs in 72% of instances and by the CNAs in 28%. Registered Nurses provided dissent 15 times (45%) and the CNAs 18 times (54%) (not shown in table). The interaction analysis revealed no clear hierarchical pattern, as all members in each group took the initiative to open the discussions. The RNs contributed more new ideas.

5.2 | Results of the qualitative content analysis

The aim of this study was to describe how nurses perceive and promote inpatients' needs for PA during their stay at the ward.

5.2.1 | In the hands of nurses

An overarching theme was revealed, *In the hands of nurses*, supported by two main categories (Table 4): *Adapting patients' physical activity to the circumstances at the ward* and *Striving for a mutual understanding of patients' physical activity*. Patients are dependent on the nurses' prioritizations and promotions to be sufficiently physically active during their stay at the ward.

The main category *Adapting patients' physical activity to the circumstances at the ward* comprises two subcategories: *Physical activity*

TABLE 3 Interaction in the focus groups

Focus group	FGD 1 N (%)	FGD 2 N (%)	FGD 3 N (%)	FGD 4 N (%)	FGD 5 N (%)	FGD 6 N (%)	FGD 7 N (%)	Total N (%)	N (%)	Range
Answering first										
RN1	6 (18)		7 (39)	7 (44)	3 (12)	4 (22)	9 (42)	36	74 (56%)	3–7
RN2	15 (46)		2 (11)	4 (25)	6 (24)	4 (22)	4 (19)	35		2–15
RN3	3 (9)							3		
CNA1	8 (25)		7 (39)	5 (31)	9 (36)	9 (50)	6 (28)	44	58 (44%)	5–9
CNA2	2 (6)		2 (11)	0	7 (28)	1 (6)	2 (9)	14		0–7
Total	34		18	16	25	18	21	132		16–34
Range %	6–46		11–39	0–44	12–36	6–50	9–42			6–50
New input										
RN1	24 (26)		32 (33)	50 (45)	12 (27)	38 (32)	54 (38)	210	364 (69%)	12–54
RN2	14 (18)		26 (26)	35 (32)	10 (23)	30 (25)	24 (16)	139		10–35
RN3	15 (18)							15		
CNA1	17 (22)		19 (19)	19 (17)	12 (27)	39 (33)	56 (39)	100	163 (31%)	12–56
CNA2	7 (9)		21 (21)	6 (5)	10 (23)	11 (9)	8 (5)	63		6–21
Total	77		98	110	44	118	142	527		44–142
Range %	9–26		19–33	5–45	23–27	9–33	5–39			5–45
Agreement										
RN1	18 (26)		14 (16)	14 (48)	10 (29)	11 (21)	25 (15)	92	209 (48%)	10–25
RN2	15 (21)		33 (39)	9 (31)	6 (18)	8 (15)	34 (20)	105		6–34
RN3	12 (17)							12		
CNA1	19 (27)		24 (28)	4 (14)	10 (29)	23 (44)	24 (14)	104	225 (52%)	4–24
CNA2	5 (7)		14 (16)	2 (7)	8 (24)	10 (19)	82 (49)	121		2–82
Total	69		85	29	34	52	165	434		29–165
Range %	7–26		16–39	7–29	18–29	15–44	14–49			
Agreement + new input										
RN1	22 (35)		12 (21)	19 (32)	8 (32)	13 (39)	13 (18)	161	274 (72%)	8–22
RN2	13 (21)		23 (41)	25 (42)	5 (20)	4 (12)	28 (38)	98		4–28
RN3	15 (24)							15		
CNA1	7 (11)		17 (30)	10 (17)	6 (24)	13 (39)	18 (25)	71	108 (28%)	6–17
CNA2	6 (9)		4 (7)	5 (8)	6 (24)	3 (9)	13 (18)	37		3–13
Total	63			59	25	33	72	382		25–72
Range %	9–35		7–41	8–42	20–32	9–39	18–38			

Abbreviations: CAN, certified nurse assistant; FGD, focus group; RN, Registered Nurse.

TABLE 4 Categories and subcategories derived from the data

Overarching theme	In the hands of nurses			
Main category	Adapting patients' physical activity to the circumstances at the ward		Striving for a mutual understanding of patients' physical activity	
Subcategory	PA depends on the external environment	Integration of PA into daily work	Meeting expectations of others	Taking joint responsibility

depends on the external environment and Integration of physical activity into daily work.

The subcategory *Physical activity depends on the external environment* describes the nurses' awareness of the importance of PA and their efforts to promote PA according to the given conditions at the

ward. Their efforts could be hampered by the perceived lack of personnel, workload and time. Daily routines could occupy the nurse's day and reduce the focus on PA. These routines, with rounds, timing of dinner wagon and documentation of care could have a higher priority than promoting PA. In addition, waiting for treatments and

examinations could leave the patient waiting in bed. Whether or not these routines were described as obstacles varied across the wards:

CNA1: So, of course, we never know in advance and it also locks the person in if they're going to x-ray, because we can't take it up, because we don't know when they're coming

RN1: Yeah, they have to stay in the bed

CNA1: Yeah, that clogs things up, too.

(FGD 2)

The physical environment of the wards was described as boring and not optimally designed for promoting PA, lacking of areas for physical exercise and social activities. The corridors were narrow and often occupied with equipment. Promoting PA for patients could require an extensive plan, such as having gathering enough personnel or enough assistive suitable devices close to the patient. Another important factor was adequate medical pain relief before initiating PA. If the patient was in pain, the nurses had to postpone the activity, with a risk for being cancelled:

RN1: But that we are mindful of the fact that they have been given painkillers – that is surely the thing we sometimes aren't good at, that we intervene too late and they are already in pain and they might have to wait and they have to be given pain medication and it doesn't happen right away and then we have to do it later.

(FGD 3)

The number of patients in need of special care and extensive assistance reduced the time for initiating PA with all patients. When, due to shortage of hospital beds, the ward received patients with unfamiliar health conditions, the nurses expressed insufficient knowledge, information and support. The lack of knowledge was described as a reason for patients spending an entire day in bed:

RN2: And that's where it's really important that they get up, as regards their lungs and all this, but as I said, you don't quite dare because you don't know how much you can do with hip operations...

(FGD 2)

In the subcategory *Integration of physical activity into daily work*, the nurses described that there was a mutual awareness among the nurses that PA prevents complications such as pneumonia, thrombosis and decubitus as well as shortening the patients' time in hospital. The older nurses experienced that importance of PA has increased during recent years and a new culture of PA has arisen, from bed rest to early mobilization of the patients after the surgery. In some surgical wards, it was a requirement to implement

a programme such as "enhanced recovery after surgery" (ERAS). These programmes increased the knowledge about the importance of PA. The activities for enhancing PA were described as having several advantages; besides the physical benefits, PA could break the uniformity of the day for the patients.

It could be a conscious strategy to integrate PA into other daily routines or a task that could be left unexecuted. The nurses experienced that there was a deep-rooted culture to integrate PA into the daily routines and proudly described that promoting PA for all patients was a main task that was always an ongoing continuum. Those nurses had suggestions on how to further incorporate PA into care, such as letting patients make their own beds. In wards with integrated PA, they were proud of being better than wards that let the patients stay in bed:

RN1: Mm-hmm, but I think mobilising the person is such an enormously important part. I mean, it's the most important thing – it promotes well-being, eating, breathing, the pain gets better the more you move, so it's an extremely key word for us and no doubt for many other departments as well but I write the word 'mobilisation' at least 20 times a day, like when I'm working, so I mean for us it's really key.

(FGD 4)

By contrast, in some FGDs the nurses did not express a conscious idea of how to integrate PA into the daily chores. Instead, they pronounced that promoting PA was a task that was executed if the nurses had time. Some nurses stated that not all patients benefit from PA but rather were more in need of a calm and undemanding time in bed:

CNA1: He is ninety-nine years old, after all. If he's happy to get hot porridge at eight o'clock in the evening and likes to lie down, then I'm happy. I think he's had his physical activity. I think he has.

(FGD 7)

There was awareness that the patients easily become immobilized and of the risk of helping patients with activities that they could perform by themselves. Despite this awareness, the nurses described that they sometimes hesitated to motivate or persuade patients, since it could be time-consuming to wait for the patient to perform the activities independently:

RN1: And, unfortunately, you can easily end up raising her head instead of sitting her on the edge of the bed, I mean when you're stressed... but you've learned that you gain so much by spending these extra minutes having her sit on the edge of the bed.

(FGD 4)

The second main category, *Striving for a mutual understanding of patients' physical activity*, comprises two subcategories: *Meeting the*

patients' expectations and *Taking joint responsibility*. The nurses strived to have a mutual understanding of the patients' need for PA and to take joint responsibility together with the patient, the relatives and other healthcare professionals. It should be in the patients' interests to be physically active, although the nurses had to request support from the physician or physiotherapist as well as from the patients' relatives to succeed in convincing or persuading the patient to be physically active.

The nurses emphasized the importance of understanding the patients' expectations of the stay in the hospital as it influenced how successful the nurses were in promoting PA. Patients might have preconceived expectations of what the patient role included. Traditionally, a patient in a hospital stays in bed and waits for the doctor's orders. The nurses reported that they spent considerable time on motivating the patients about the importance of getting out of bed. Their methods included a considerable amount of nagging and persuasion, as well as encouraging, informing and explaining the importance of PA for the patients:

RN1: Then there's also how you need to talk to them and get them into the same way of thinking. That... that I'm not the one who decides they should get up, but rather that they themselves will understand the benefit of doing that, I think (Several others: "Mm-hmm.") that... and then it's also important to explain why.

RN2: And it's not easy to say. That "This is what we say." Because it varies. (Several others: "Mm-hmm.") It depends entirely on what kind of patient you're dealing with, what the patient will accept. (U1: "Mm-hmm.") What you say to one maybe another will not accept at all - you're always weighing what you can say.

(FGD 6)

With a personal relation to the patient, it was easier to understand and target the patient's experienced obstacles and successfully engage the patient in physical activities. Nurses described planning the optimal time for PA and taking into consideration the patient's preferences, mainly to avoid disturbing the patient while watching their favourite show on television.

The physical condition after surgery with pain and nausea could further obstruct the patient's attempt to be active. Some patients did not have a desire to be physically active, as they considered themselves not well enough to leave the bed. The nurses described that it was easier to motivate patients to get out of bed when the patients were informed before they entered the ward about the expectations of being physically active.

There was agreement within the FGDs that promoting PA was everybody's concern, although to what degree it was the nurses' concern could vary from emphasizing to understating their role. It was a common understanding that all healthcare workers and all relatives should strive towards the same goal of encouraging the patient to be physically active. Promoting PA was a main work task, especially at surgical wards, where some nurses described no need

to motivate or persuade a colleague about why they should promote PA:

RN 1: That maybe I shouldn't have to explain to my colleagues why I think it's important to make sure we're on the same page. That everyone understands it's important to just sit with the patient on the edge of the bed. That it promotes their breathing and circulation and prevention of hospital care-related infections and brings them one step closer to going home and so on. But I do think we have made some progress there.

(FGD 7)

The support from other healthcare workers was significant, since the nurses sometimes felt a lack of authority and a need for further professional competence to promote PA, such as provided by a physiotherapist, occupational therapist or physician. The authority of the physicians was important and helpful while promoting PA. They could further motivate patients by explaining the importance of PA based on the patient's health condition or type of surgery:

RN1: And even the doctors - sometimes we have to ask the physician doing the round, "Please, tell this patient how important it is that he gets up and moves around a bit." Sometimes it helps and it's like they need that.

(FGD 1)

Physiotherapy and occupational therapy competence were needed from the perspective of both nurses and patients, regarding assessments of patients' functioning and the need for assistive devices. Physiotherapists provided support and special expertise, such as manual handling when the patient had pain or other functional impairments. They could prepare patients for early mobilization postoperatively and explain physiological and functional gains of PA, thereby motivating the patients to be more physically active. They were also responsible for performing specific interventions such as breathing exercises. However, in some wards, the nurses set priorities for the physiotherapist regarding whom to meet and expressed that the physiotherapist spent too little time at the ward and was difficult to reach:

RN2: Plus, we have a physiotherapist and an occupational therapist. They help out in more advanced cases, or whenever we feel unsure whether we should get the patient up, if we should use a lift or if we should use "Turner", both to go easy on ourselves and our bodies and for the patient's own good, so we might engage a little expert help. Plus, they can also be pretty good at boosting the patient's motivation, I think.

CNA1: Yeah, they certainly are

RN1: Yes, if you send in the physiotherapist, they understand what the point is and then they're anxious to demonstrate their abilities. If it comes from those of us who are there every day, no doubt they think it's not that important.

(FGD 3)

The relatives, having personal knowledge about the patient, could be the best at encouraging the patient to simply get out of bed and take a walk together. On the other hand, they might also pamper the patient and impede him or her from being physically active. For good adherence, the nurses described the importance of having time to talk to the relatives about PA, especially before discharge:

RN1: Yes, but for a relative, when... that... that you perhaps... um... help motivate the patient. "Come on, now, you can get out of the bed and sit down in this armchair now that I'm here, or we can take a walk somewhere and I can... yes... so you can move around a bit." As a close relative, when your family member is at high risk of falling and uses a walker and so on, you might think, "Since I'm here, I'll just try to go for a little walk with my wife or husband in the hallway here."

RN2: Yes, it certainly helps... when family members help out a little

RN1: Yes, but I think the thing is that perhaps we don't get time to talk to the patient's relatives so much either.

(FGD 7)

The nurses strongly emphasized the patient's willingness and motivation to take personal responsibility for their own PA and recovery. By contrast, it was challenging to not take over the patient's responsibility by helping too much, thereby contributing to patients being passive. Several nurses described elderly patients as more compliant, that is, doing what the nurse has decided (based on respect/authority or preconceptions). Patient responsibility could be improved by giving the patients tools, such as schedules for breathing exercises.

In all FGDs, the nurses experienced that most patients were more in bed than not in bed, often including those not needing bed rest or those with independent moving and walking ability. Sometimes, it could take a while before patients were spontaneously physically active, such as taking a walk by themselves.

Some patients were difficult to motivate, and then, a colleague could be more successful in getting through to the patient and reaching an understanding of the benefits of taking personal responsibility. When patients really did not want to make an effort to be sufficiently physically active or preferred to stay in bed, some nurses described how they could begin to nag, until they gave up their efforts. "We cannot pull the patient out of the bed" and "We do not want to fight with the patient" were common statements:

CNA1: Suddenly, you find yourself in a hospital and you can't really take any personal responsibility – you're at the mercy of other people who make all the decisions

CNA2: Because if we explained how things are and how things can go a few times and you don't move and you still don't want to, I don't know how much you should complain either

CNA1 But sometimes you simply have to give up.

(FGD 3)

6 | DISCUSSION

The aim of this study was to describe how nurses perceive and promote inpatients' needs for PA during their stay at the ward. The analysis revealed an overarching theme, *In the hands of nurses*, supported by the categories *Adapting patients' physical activity to the circumstances at the ward* and *Striving for a mutual understanding of patients' physical activity*. Patients are dependent on nurses' prioritizations and promotions to be sufficiently physically active during their stay at the ward. The novelty of this result is that inpatients' PA is conditioned by how nurses perceive the importance of PA in relation to other work tasks at the ward.

6.1 | Discussion of the results

The aim of this study was to describe how nurses perceive and promote inpatients' needs for PA during their stay at the ward. The analysis revealed an overarching theme, *In the hands of nurses*, supported by the categories *Adapting patients' physical activity to the circumstances at the ward* and *Striving for a mutual understanding of patients' physical activity*. Patients are dependent on nurses' prioritizations and promotions to be sufficiently physically active during their stay at the ward. The novelty of this result is that inpatients' PA is conditioned by how nurses perceive the importance of PA in relation to other work tasks at the ward.

The nurses' initiatives to promote PA were affected by their feelings of personal responsibility. Some nurses believed that somebody else was responsible for the patients not being sufficiently physically active, while other nurses proudly pronounced that they took responsibility for getting everybody out of bed daily. Some blamed the management for the lack of instructions on how to mobilize patients instead of feeling personally responsible for gathering the necessary information. The same dichotomy was found in a previous study describing two attitudes among nurses, those feeling responsible for mobilization of patients and those attributing the responsibility to other disciplines (Doherty-King & Bowers, 2013). The study of Doherty-King and Bowers (2013) described how those taking responsibility for mobilization of patients focused on the independence and psychosocial well-being of the patients and collaborated with other professions to optimize the rehabilitation efforts.

The category *Striving for a mutual understanding of patients' physical activity* is describing mutual understanding of the need of PA in the healthcare team and among patients and relatives. A difference in work culture clearly emerged between the focus groups. Some wards had an obvious and clear culture of integrating and promoting mobilization and PA, while others described promoting PA as one work task among others. In some surgical wards, it was a requirement to implement a programme such as ERAS (Gustafsson et al., 2019). ERAS is a clear policy that guides the postoperative care at the ward. The programme generates knowledge about the importance of PA and serves as a control system for how well the ward complies with the programme. On wards with no guidelines or policies for mobilization, patients are omitted to nurses' personal opinions and priorities. Cultural values that promote and integrate mobilization of patients into the daily routines are significant for how actively health professionals work with mobilization of the patients (Doherty-King & Bowers, 2011).

All nurses in this study had knowledge of the importance of PA; nevertheless, PA was not prioritized at all wards. The gap between evidence and practice in health care found in our study is well known (Bryant et al., 2014) (Cochrane et al., 2007). Barriers or omission of nursing care due to organizational factors can be attributed to staff shortage, poor use of existing staff resources, time constraints, poor teamwork and ineffective delegation (Kalisch, Landstrom, & Williams, 2009). Most of those barriers were found in our study, although there were disparities between the FGDs. The results of this study indicate that implemented programmes such as ERAS may have an impact on inpatients' PA. Organizational factors important for successful implementation in healthcare settings are a learning culture, leadership enthusiasm, strong teamwork, resources (finances, staffing, time, education), champions advocating the implementation and monitoring and feedback activities (Li, Jeffs, Barwick, & Stevens, 2018). Reducing the gap between evidence and clinical practice reduces healthcare costs (Shapiro, Lasker, Bindman, & Lee, 1993) and patient morbidity and mortality (Saslow et al., 2012) and thereby yields benefits on both organizational and personal levels.

Daily routines of the ward, such as serving meals, could have an inhibiting effect on promoting PA at the ward. Such work tasks seemed to have a higher priority than promoting PA. The nurses in this study described lack of time as a reason for not promoting PA, a somehow counterproductive reasoning, as each hour in bed rest for elderly patients impairs or reduced their ability to independently ambulate (Tanner et al., 2015) and further increases the workload of the nurses. When patients are insufficiently physically active, their dependence on help will increase, as will their risk for complications (Hoogerduijn et al., 2007). Promotion of PA was described as a battle, especially when patients were not informed about the importance of PA before arriving at the ward. A paternalistic, parent-child attitude was present regarding the role of the physician as an authority confirming the importance of PA. "Paternalism is the intentional overriding of one person's known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefitting

or avoiding harm to the person whose preferences or actions are overridden" (Rodriguez-Osorio & Dominguez-Cherit, 2008). The nurses' intentions were to get the patients mobilized and to do no harm, although they revealed an attitude that suggested patients did not always understand their best interests and needed to be persuaded. This result differs from an Asian study where patients expected to be served by the nurses, especially since the patients paid for the care (Chan, Hong, Tan, & Chua, 2019).

The nurses in the FGDs expressed that PA should be a shared interest for the patient, the relatives and the healthcare team around the patient. However, there was no emphasis on empowering and engaging patient participation in the care.

The interior design of the ward was described as restricting patients' opportunities to be physically active and overthrowing the nurses' efforts to promote PA.

6.2 | Methodological considerations

The interaction analysis revealed that the method of collecting data through FGDs did fulfil the purpose of enabling participants to interact and speak freely in the setting of the FGD. No clear pattern of a hierarchy was found, as both RNs and CNAs took the initiative to answer first. The RNs contributed more new ideas, which was expected, given their university education. The hallmark of FGDs, the interaction between the members, stimulates thoughts and helps respondents contribute their experiences and feelings that might not be revealed in individual interviews, and seems to have been achieved. The interaction analysis enhanced the trustworthiness, as it shows that all group members contributed to the discussion.

A strength of this study is that the FGDs were conducted in three different hospitals, a university hospital as well as two smaller provincial hospitals. It could be seen as a limitation of the study that the head of each ward selected the nurses for the focus groups, as the research team had no control over the inclusion process. The heads' choices of participants could have influenced the FGDs, although the lively discussion with outspoken members did not show signs of the nurses being restrained.

A limitation of the study could be that the focus groups consisted of nurses from the same workplace, which might have had a restraining effect on the nurses. The lack of controversies and conflicting statements may reflect an uneasiness about expressing a different opinion in the group or not wanting to embarrass or offend a colleague with whom one needs to work every day. At the same time, it could also have been embarrassing to discuss the topic with strangers.

7 | CONCLUSIONS

Patients are dependent on nurses' prioritizations and promotions to be sufficiently physically active during their stay at the ward. Nurses are in a key position to ensure that inpatients are physical active but can be occupied with other work tasks at the ward. The inpatients' PA is conditioned by how nurses perceive the importance of PA in

relation to other work tasks at the ward. The results highlight that patients are in the hands of the nurses, implying that PA depends on the initiative of the nurses and not on the needs of the patients.

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CONFLICT OF INTEREST

The authors have no conflict of interest to disclose.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at more than one of the following criteria [recommended by the ICMJE (<http://www.icmje.org/recommendations/>)].

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