



Education for Change Limited
PO Box 13 864
Christchurch
Tel: 03 379 9947
www.efc.co.nz

Identifying and addressing exposure to smoking for patients in New Zealand hospitals

*A report on a national assessment of
hospital policies, systems, practices
and staff attitudes.*

*Prepared by
Stephanie Cowan and Lisa Langley
Education for Change*

ISBN 0-476-00242-7

Identifying and addressing the exposure to smoking for patients in New Zealand hospitals

A report on a national assessment of policies, systems, practices and staff attitudes

A project funded by the Ministry of Health

Prepared by

Stephanie Cowan and Lisa Langley

Education for Change



Education for Change

PO Box 13 864 Christchurch, New Zealand

Tel: +64 3 379 9947 Fax: + 64 3 379 9946 Website: www.efc.co.nz

January 2004

ISBN 0-476-00242-7

•
•
•
•
•
•
•
•

If we truly want to take good care of patients we have to provide them with evidence-based tools to break free of tobacco. If we are about healthcare, about assisting people to become and stay healthy, then assisting them to quit smoking has to be a key part of our care.

Michael Fiore
Professor of Medicine, University of Wisconsin Medical School
Chairman of the US Public Health Services 2000 Smoking Cessation Clinical Practice
Guidelines Panel that wrote: Treating Tobacco Use and Dependence

August, 2003

Table of contents

Acknowledgements	5
Executive Summary	9
Background	9
Method	9
Results	9
Conclusion	10
Recommendations	11
Introduction	12
Method	13
Project Design	13
Intensive arm - Christchurch	13
Extensive arm - national.....	14
Support resource.....	14
Analysis.....	14
Results	16
The Christchurch Hospitals' survey	16
Responders.....	16
Staff attitudes	16
Staff practices	17
Comparisons	17
The audit of patient notes.....	18
The national survey.....	18
Responders.....	18
Staff attitudes	19
Perceptions of staff practices	19

•
•
•
•
•
•
•
•

“Best practice” ideas of service leaders	20
Comparisons	21
The assessment of smokefree policies	21
Discussion	23
Main findings	23
Limitations	24
Capacity issues	24
Conclusion	29
Appendices	31
A. Survey form: Christchurch hospitals’ staff survey	A1
B. Summary feedback to staff - Christchurch survey	A3
C. Letter to DHBs inviting participation	A4
D. Survey form: national survey of hospital service leaders	A6
E. Summary feedback to participating hospitals: national survey	A9
F. Tables	
1. Description of responders to Christchurch hospitals’ survey	A11
2. Description of Christchurch hospitals’ staff attitudes to addressing smoking	A12
3. Frequency of brief intervention practices of staff – Christchurch hospitals’	A13
4. Description of responders to the national survey of hospital service leaders	A15
5. Description of attitudes of hospital service leaders to addressing smoking	A16
6. Hospital service leaders’ perceptions of the frequency of brief intervention practices of their colleagues	A18
7. Availability of hospital smoking cessation programmes (and/or programmes for pregnant women) by frequency of “arranging follow-up”	A18
8. Ideas of hospital service leaders for what is “best practice”, challenges to “best practice” and support needed to achieve “best practice”	A19
9. Text responses of hospital service leaders	A21

Acknowledgements

Many people have supported and encouraged the Hospital Patient Smoking Identification project. (HPSI). Early discussions with **Dave Graham**, Paediatrician, Waikato Hospital, helped shape the original proposal. Consultation with **Philip Pattemore**, Paediatrician, Christchurch Hospital, helped shape the project design and a telephone interview with **Michael Fiore**, Professor of Medicine, University of Wisconsin Medical School, set the scene for the outcome of the project – the resource “Smokefree Hospitals – Supporting a systems approach to change”.

Although not a complete list, we acknowledge here, individuals and groups who assisted us in significant ways as the project progressed. Names are listed in alphabetical order. We thank you all.

Initial Consultation

The following people assisted in the early stages of the project, in particular in preparing the way for the Christchurch hospitals’ survey.

- Mandy Anderson:** Community and Public Health, Canterbury DHB
- Pauline Burt:** General Manager, Christchurch Women’s Hospital
- Sally Cook:** Ethics Committee, Canterbury DHB
- Evon Currie:** General Manager, Community and Public Health, Canterbury DHB
- Dave Graham:** Paediatrician, Waikato Hospital
- Judy Hutton:** Team Leader, Quit for our Kids, Quit Group, Wellington
- Jim Magee:** General Manager, Christchurch Public Hospital
- Shona MacMillian:** Quality Manager, Christchurch Hospital
- Jenny McWhaa:** Cardio-Respiratory Outreach Nurse Educator, Christchurch Hospital
- Jean O’Callaghan:** Chief Executive Officer, Canterbury DHB
- Philip Pattemore:** Senior Lecturer in Paediatrics/Respiratory, Christchurch Hospital.
- Quit coaches:** Quit for our Kids, through the Quit Group, Wellington
- Tahu Sterling:** Community and Public Health, Canterbury DHB
- Sue Teague:** Coordinator, Respiratory Outreach Services, Christchurch Hospital
- Ian Town:** Dean, Christchurch School of Medicine and Health Sciences
- Margaret Turnbull:** Personal Assistant to Jean O’Callaghan, Canterbury DHB

Implementing the Christchurch Survey

The following people assisted with administering and completing the Christchurch survey. Their involvement ranged from promoting the survey and distributing forms, to completing the survey and collecting returns.

- Catherine Dwan:** Manager, Gynaecology Services, Christchurch Women’s Hospital
- Sue Hayward:** Director of Nursing Services, Christchurch Hospital
- Fidelma Hughes:** Personal Assistant to Jim Magee

•
•
•
•
•
•
•
•

Robyn Hume: Director of Surgical Nursing Services, Christchurch Hospital
Bernard Hutchison: Manager Neonatal Services, Christchurch Women’s Hospital
Sue Imery: Personal Assistant to Sue Hayward
Michael Jamieson: Human Resources Department, Christchurch Hospital
John Kenny: Quality Facilitator, Christchurch Women’s Hospital
Gavin Lee: Orderlies Services, Christchurch Women’s Hospital
Responders: everyone who took the time to complete and return a survey form
Clare Scott: Human Resources Department, Christchurch Hospital
Shane Wooton: Orderlies Services, Christchurch Hospital
Jane Waite: Maternity Services Manager, Christchurch Women’s Hospital

Audit

The following people assisted with arrangements for the audit of patient notes in three service areas at each of Christchurch and Christchurch Women’s Hospitals.

George Abbott: Clinical Director, Paediatrics, Christchurch Hospital
Nicola Austin: Clinical Director, Neonatal Services, Christchurch Women’s Hospital
Harry Bashford: Clinical Director, Maternity Services, Christchurch Women’s Hospital
Kerrie Dixon: Information Analyst, Christchurch Hospital
Tom Flood and staff: Clinical Records Department, Christchurch Hospital
Helena Frapwell: Information Analyst, Christchurch Women’s Hospital
Mike Laney: Clinical Director, Gynaecology Services, Christchurch Women’s Hospital
Alan Pithie: Clinical Director, General Medicine, Christchurch Hospital
Diane Rodgers and staff: Clinical Records Supervisor and Clinical Records staff at Christchurch Women’s Hospital.
Eva Sabeki: Clinical Records Manager, Christchurch Hospital
John Utley: Clinical Director, General Surgery, Christchurch Hospital
Keith Young: Decision Support, Christchurch Hospital

National Survey

The following people accepted the role as the contact person for their hospital and assisted with distribution to appropriate service leaders of survey forms for the national survey.

Anne Amore: Group Manager, Human Resources, Mid- Central Health DHB
Karen Anderson: Services Manager Maternal, Child and Public Health Services, Good Health Whanganui
Emma Bale: Quality Manager, Counties Manakau DHB
Lynsey Bartlet: Quality Coordinator, Tairāwhiti DHB
Barbara Crawford: Manager, Quality and Risk, Waikato Hospital



Sarah Devine: Quality Manager, National Women’s Hospital, Auckland DHB

Karen Evison: Smokefree Advisor, Waikato Hospital

Lynne Grose: Services Manager: Primary, Older Person and Rural Services, Hawkes Bay DHB

Yvonne Kaeppli: Quality Manager, Starship Children’s Hospital

Anne Kemp: Quality Risk Manager, Taranaki DHB

Maureen Lee: Quality Manager, North Shore Hospital, Waitemata DHB

Bernadine Mackenzie: Quality Improvement Manager, Capital and Coast DHB

Christine McKerrow: Quality Manager, Whangarei Hospital

Anne McLean: Quality Manager, Masterton Hospital

Ian Macara: Patient Services Manager, Southland Hospital

Gordon MacKay: Human Resources Manager, Tauranga Hospital

Jenny Martelli: Human Resources Advisor, Lakeland Health

Carol Murphy: Quality Facilitator, Timaru Hospital

Margaret Perley: Clinical Practice Group Manager, Dunedin Hospital

Helen Smith: Quality Manager, Hutt Valley DHB

Sarah Toohey: Human Resources Manager, Waitakere Hospital

Robyn Whitehead: Health and Safety smoking policy group, Auckland DHB

Lead Comments

The following people accepted the invitation to make a lead comment for the support resource “Smokefree Hospitals – supporting a systems approach to change” developed as a result of the findings of this project. We thank them for their time and leadership.

Innes Asher: Respiratory Paediatrician, Starship Children’s Hospital

Candace Bagnall: Senior Portfolio Manager, Public Health Services, Ministry of Health

Denise Barlow: Smoking Cessation Practitioner trainer, National Heart Foundation

Wayne Brown: Chair, Auckland DHB

Cass Byrnes: Respiratory Paediatrician, Starship Children’s Hospital

Taima Campbell: Executive Director, Nursing and Midwifery, Auckland DHB

Stephanie Cowan: Director, Education for Change, Christchurch

Liz Edwards: Respiratory Paediatrician, Starship Children’s Hospital

Karen Evison: Senior Respiratory Physiotherapist, Waikato Hospital

Michael Fiore: Professor of Medicine, University of Wisconsin Medical School,

Karen Guilliland: Director, New Zealand College of Midwives

Diana Horner: Cardio-respiratory Senior Lecturer, Auckland University of Technology

Judy Hutton: Team Leader, Quit for our Kids, Quit Group

Leslie McCowan: Associate Professor of Obstetrics, National Women’s Hospital



Gillian Nixon: Respiratory Paediatrician, Starship Children's Hospital

Jean O'Callaghan: Chief Executive Officer, Christchurch DHB

Teresa Olsen: National Spokesperson, Aukati Kai Paipa smoking cessation programmes

Jan Pearson: National Coordinator, NETS (Nurse Education in the Tertiary Sector)

Liz Price: Communications Manager, Quit Group, Wellington

John Simpson: Executive Director, Surgical Affairs, Royal Australasian College of Surgeons

Robin Taylor: President of the Thoracic Society of Australia and New Zealand

Jim Vause: General Practitioner, President of the NZ College of General Practitioners

Executive Summary

Background

The evidence from research supports a hospital-wide approach to identifying, recording and intervening on smoking in hospitals over a non-systematic approach that relies heavily on individual practice. The authors' experience in introducing smoking cessation services into two Auckland hospitals raised awareness of the need for supportive policy, systems and staff education in order for such services to be effective. With the recent increase in government-funded smoking cessation services in both hospitals and the community the need to assess the readiness of New Zealand hospitals to intervene on smoking seemed pertinent. This *Hospital Patient Smoking Identification* (HPSID) project was proposed and accepted for a one-off funding grant by the Ministry of Health in November 2002.

Method

The main purpose was to describe the extent to which New Zealand hospitals identify and address the smoke exposure of patients. There were two arms to the project:

- an intensive arm involving a staff survey and a retrospective audit of case notes in two main Canterbury DHB (DHB) hospitals.
- an extensive arm involving a national survey of service leaders in the six areas of neonatology, obstetrics, paediatrics, general medicine, general surgery and outpatients, across all DHBs, as well as an assessment of DHB smokefree policies.

Results

Included in the analyses were 1271 responses to the Christchurch survey of individual staff members and 117 responses from 25 hospitals to the nationwide survey of service leaders.

- **Attitudes:** All respondents in both surveys felt it was important to know if patients smoked, and most (>73%) felt it was important to know about their second-hand smoke exposure. There was clear support for a hospital-wide system for identifying smoking status (>75%), although support was less from doctors than from nurses, midwives and allied health professionals. There was less agreement on what was the best time to ask about smoking and the best place and method for recording this information. The most frequent responses were to ask on medical admission and record on a sticker in the medical notes. There was general agreement in all these responses across professional groups, service areas and sizes of hospital.
- **Practices:** In both arms, there were reducing levels of action on the evidence-based interventions of asking, recording, advising, assessing, assisting and arranging follow-up. For example, in Christchurch, while 100% of respondents felt it was important to know if a patient smoked, 59% actually did ask, 55% recorded smoking status, 41% advised, 35% assessed, 26% assisted and only 10% arranged follow-up. This trend was at consistently higher levels in the national survey compared to the Christchurch survey, as shown in Figure 1. Overall, doctors reported the highest levels of asking (89%) and allied health professionals (25%) the least. There was consistent low reporting of arranging follow-up for smoke-exposed patients even where hospital referral services were

available (<30%).

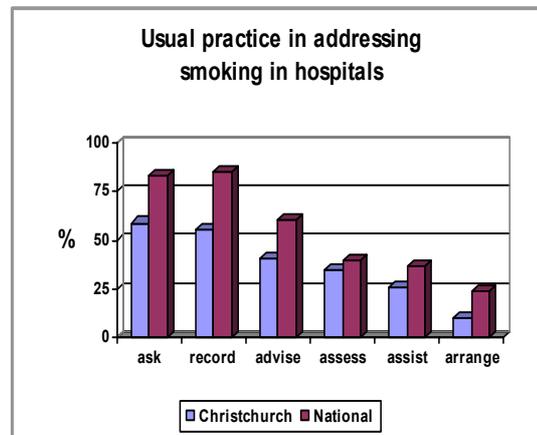


Figure 1.

Comparison of reported “usual” practices in addressing smoking in hospitals for the intensive Christchurch survey and the extensive national

- **Audit:** The Christchurch audit of 600 patient notes verified high levels of recording smoking status which averaged more than 80% in five of the six service areas audited, in good agreement with reported levels of recording by doctors. Only 19% of paediatric case notes recorded this data despite a reported rate of 62% by doctors. Referral information was recorded for just 2 of 122 patients identified as smoking.
- **Best Practice Ideas:** Two thirds of service leaders in the national survey indicated that identifying smoking patients was a “best practice” activity. Otherwise, there were low levels of agreement between service leaders’ ideas on best practice and evidence-based recommendations. The most common challenges reported in achieving best practice were related to patient and staff attitudes with “supportive systems” “staff education”, and ‘dedicated services’ the main needs for supporting “best” or “most desirable” practice.
- **Policy:** Of 18 DHB smokefree policies analysed only four stated that DHB buildings, vehicles and grounds were totally smokefree. Fourteen of the 18 policies allowed some smoking by some people in some places at some times and just one included a statement on systematic identifying, recording and acting on patient smoking within its policy.

Conclusion

We conclude that, currently, addressing smoking in New Zealand hospitals is on an ad hoc basis, relying heavily on the commitment of individual practitioners, service leaders, managers and DHBs. Effective interventions do exist resulting in reduced costs and improved health. To ensure there is a baseline standard of care for smoke-exposed patients, a systematic approach to identifying, recording and intervening on smoking is needed in hospitals. A chain of support from strong policy to clear systems, appropriate staff education, frequent and brief interventions, effective referral and dedicated services is recommended as a “best practice” package. This will require leadership by DHBs at governance and management levels to overcome the inertia of the status quo and create a supportive environment for action on smoking by the clinical team.



Recommendations

A five step approach to evidence-based smokefree leadership by DHBs is recommended.

Five steps to smokefree leadership in New Zealand hospitals	
1. Policy	1.1 Develop strong smokefree policy on <ul style="list-style-type: none"> ▪ Smokefree environments (buildings, vehicles and grounds) ▪ Smokefree systems ▪ Smokefree interventions
2. Systems	2.1 Develop clear smokefree systems to <ul style="list-style-type: none"> ▪ support smokefree policy implementation ▪ ensure consistent identification, recording and intervening on smoking ▪ audit and give feedback on recommended practices
3. Education	3.1 Provide appropriate education to all new and current staff on <ul style="list-style-type: none"> ▪ what effective interventions exist ▪ consistent identification of smoking ▪ how to deliver brief motivational interventions ▪ how to treat tobacco withdrawal for patients in hospital ▪ effective referring to cessation programmes 3.2 Present education within the practice frameworks of each professional group, e.g. <ul style="list-style-type: none"> ▪ chronic disease model for doctors ▪ team approach to care for nurses ▪ partnership model for midwives ▪ family-centred care for paediatric teams
4 Clinical Practice	4.1 Provide frequent and brief interventions to all smoke-exposed patients in line with the NZ Guidelines on Smoking Cessation
5 Dedicated services	5.1 Arrange for appropriate referral to intensive cessation services for smoke-exposed patients <ul style="list-style-type: none"> ▪ during their hospital stay and/or ▪ at discharge. 5.2 Offer smoking parents of child patients referral to intensive cessation services 5.3 Appoint a dedicated person or team to coordinate smokefree action in hospitals.

Introduction

Identifying the smoking status of patients is considered a starting place in any intervention to reduce the impact of smoking on health. The evidence from research supports a systems approach to identifying, recording and intervening on smoking in hospitals. Hospital policies and systems, where these support the clinical team to offer brief interventions and effective referral during a patient's hospital stay, greatly increase effectiveness over a non-systematic approach that relies heavily on individual practice.

A pivotal document on treating tobacco use and dependence is the updated US Clinical Practice Guideline (2000)¹. The Guideline Panel, chaired by Michael Fiore, MD, MPH, reviewed approximately 6000 articles published since 1975, 3000 for the original 1996 version and a further 3000 for the updated version. References for 311 articles meeting inclusion criteria are included in the document. The recommendation most relevant to this project states:

"It is essential that clinicians and health care delivery systems (including administrators, insurers and purchasers) institutionalise the consistent identification, documentation and treatment of every tobacco user seen in a health care setting." (Fiore et al., 2000)

The authors' experience in introducing smoking cessation services into two Auckland hospitals raised awareness of the need to support hospitals to develop policies, systems and staff education programmes in order for such services to be effective. While there was a clear commitment in principle to introducing smoking cessation services into both these hospitals, and at both clinical and management levels, more than this was needed to create a supportive environment for the consistent referral to and uptake of these services.

With the recent increase in government-funded smoking cessation services in hospitals and the community, the need to assess the readiness of New Zealand hospitals to intervene on smoking seemed pertinent. A call for proposals for one-off funding for projects relating to tobacco control was made by the Ministry of Health, and in November 2002 the proposed *Hospital Patient Smoking Identification* (HPSI) project was accepted.

The aims of the project were:

- to describe the extent to which New Zealand hospitals identify and address the smoke exposure of patients
- to raise awareness of systems interventions for addressing smoking, in particular patient smoking identification systems
- to develop a resource that personalises the evidence for the New Zealand setting and offers support to hospitals in taking a systematic approach to addressing smoking.

¹ Fiore MC, Bailey WC, Cohen SJ, et al. *Treating tobacco use and dependence*. Clinical Practice Guideline. Rockville, MD: US Department of Health and Human Services. Public Health Service. June 2000

Method

Project Design

The project was designed with an education purpose and not as scientific research. It built on evidence from the literature, practice experience and informant interviews in designing the assessment strategy reported here. It used four methods to describe the status quo and these were arranged into two project arms:

- an intensive arm involving one DHB. This included a staff survey of attitudes to and practices in addressing smoking and an audit of patient notes in two main Canterbury DHB hospitals.
- an extensive arm involving all DHBs. This included a similar survey of charge nurses, charge midwives and clinical directors working in six main service areas in main hospitals across all DHB regions in the country. The extensive arm also included an assessment of DHB policies as they related to smoking.

The intensive arm was designed to check consistency of findings. The audit was to be a check of self-reported practices against actual practices and the Christchurch survey was to be a check of reported practices of staff against those of service leaders. Advice from the Canterbury DHB Ethics Committee was that the project did not require ethical appraisal and approval if the audit of notes was undertaken by Lisa Langley (former respiratory nurse specialist) and under the supervision of the head of each departmental involved in the audit. These conditions were met.

Intensive arm - Christchurch

Support for the Christchurch survey was sought from the Chief Executive Officer of the DHB, the general managers of Christchurch and Christchurch Women's hospitals and the heads of departments of the audited service areas. Staff members were advised about the staff survey through internal communication.

The instrument was a questionnaire (see Appendix 1) seeking information about health staff attitudes to and practices in addressing smoking. People working as health professionals, across all shifts and service areas at Christchurch Hospital and Christchurch Women's Hospital, were invited to complete a questionnaire during the last week of January 2003. The questionnaire asked people if they thought it was important to know if patients were exposed to smoking, and if so, what approach they felt was best - a hospital-wide, department-wide or individual approach to identification. They were also asked what they thought was the best times to ask about smoking and where in the notes they felt was the best place to record a patient's smoking status. The survey asked for information on how frequently they practiced the recommended brief interventions promoted in the NZ Smoking Cessation Guidelines². Guideline interventions relate specifically to direct (first hand) smoking by the person and focus on quitting. These questions were framed so as to be suitable for responding to first and second hand smoking situations. Respondents were asked if they "always", "usually", "sometimes" or "never" asked about smoking, recorded smoking status in the notes, advised on effects, assessed exposure, assisted to reduce exposure and arranged follow-up. Information on their professional group and service area was also sought.

² National Health Committee. Revised Guidelines for Smoking Cessation. Wellington: National Health Committee; 2002

•
•
•
•
•
•
•
•

A retrospective audit was undertaken of a random selection of 100 case notes of patients admitted to hospital during a three month period, for each of the six service areas of, obstetrics, gynaecology, neonatology, paediatrics, general medicine, and general surgery. Notes were audited for evidence, on the last admission, of two things: the recording of smoke exposure status and, where appropriate, referral to a smoking cessation support programme. This allowed for an objective comparison with staff self-report data on the recording of smoking status.

Extensive arm - national

All DHBs were invited to participate in the project through a letter (see Appendix 2) sent to the Chief Executive Officer of main hospitals in March 2003. A request was made for a named person in each hospital to act as a link for communication purposes. The questionnaire used in the intensive arm was modified for the national survey (see Appendix 3) and copies were distributed in March, 2003 through the nominated link person. They were distributed to Clinical Directors, Charge Nurses and Charge Midwives working in the six service areas of neonatology, obstetrics, paediatrics, general medicine, general surgery and outpatients. Twelve survey forms were sent to each hospital. It was understood that not all hospitals had all six departments. Respondents were invited to complete a questionnaire reporting the perceived attitudes and usual practices of colleagues in their service area. They were also asked to describe what they understood as “best” or “most desirable” practice in addressing smoking for their service, the challenges faced in achieving that and the support needed.

The contact person for each hospital was asked to forward for analysis current smokefree policies for their DHB and to provide annual admission figures for their hospital.

Support resource

A support resource is being developed that acts on the findings of this assessment. The resource is being designed to offer leadership to hospitals wanting to extend their scope for addressing the first and second hand smoking of hospital patients. There are two parts to the resource: a collection of Lead Comments for influencing attitudes and a package of Sample Systems to support a consistent approach.

Lead Comments were invited from key people in various professional and administrative roles throughout New Zealand. These comments were designed to personalise the evidence on smoking interventions for individual nurses, midwives, doctors, allied health professionals, managers, DHBs and service areas. A guest comment has been provided from a telephone interview with Michael Fiore, Professor of Medicine, University of Wisconsin Medical School. Professor Fiore chaired the US Public Health Services 2000 Smoking Cessation Clinical Practice Guidelines Panel that wrote: *Treating Tobacco Use and Dependence*. The purpose of his comment is to strengthen support for the project and promote its importance. Lead commenters were invited to shape their comment around specific questions and provide it either in writing or by telephone interview. Sample Systems are being developed as simple checklists to assist managers to implement and monitor consistent processes for supporting the interventions of the clinical team.

The support resource will be provided as a separate document.

Analysis

Survey data were analysed by frequency distribution using MS Excel software. Text responses were searched for key words and common themes. Patient notes were audited for recordings of smoking status on last admission and data were presented as frequency distributions. Audit data were also compared to self-report data from the Christchurch Hospitals’ staff survey. The content of smokefree policies was analysed for clarity on when, where and who must be smokefree and for the presence, or not, of clear direction for achieving supportive clinical and management practices.

•
•
•
•
•
•
•
•

Comparative analyses were made to identify any differences due to professional group, service area, size of hospital, any differences between self-reported findings and those from the audit of case notes and any differences between the Christchurch and national results.

Percentages were of the total number of respondents.

Results

An analysis of survey data, audit of notes and smokefree policies

The Christchurch Hospitals' survey

Responders

Three thousand survey forms were distributed to an estimated 2500 health employees, 600 of whom were doctors. A total 1392 completed surveys were received and 1271 of these met the inclusion criteria for analysis giving an estimated response rate of 51%. Excluded were 71 responses from non-health professionals and 50 responses from health professionals who either indicated it was not important to know if a patient smoked (41) or who left this question blank (9).

Responders were grouped as “nurse/midwife”, “doctor” or as “allied” for all other professional groups. Of the 1271 responders, 664 (52%) were nurses (610) or midwives (54), 367 (29%) were doctors and 240 (19%) were allied health professionals.

Service areas were grouped as “woman/child” services (20%) (Obstetrics, Gynaecology, Paediatrics, Neonatal), “general” services (31%) (General Medicine, General Surgery, Outpatients, Accident and Emergency) and “other” (49%). The main contributors to “other” services were from Cardiology (60), Radiology (60), Oncology (43) and Orthopaedics (43). Frequency tables for responders' characteristics are in the Appendix (Table 1).

Staff attitudes

Staff were asked to indicate what they thought was the best option to questions about hospital systems for identifying smoke-exposed patients. Tables summarising responses are given in the appendix (Table 2)

- **Identification:** An indication that it was **important to know if a patient smoked** was a criterion for inclusion in the analysis. Ninety-six per cent of all health professional responses (1271/1321) indicated this and those that did not were excluded. There was less support for the importance of knowing if a patient was exposed to smoking by others (78% for adult patients and 92% for child patients).
- **Best system:** There was clear support for a **hospital-wide system** for identifying patients who smoke. Three quarters of responses identified a hospital-wide system as best, compared to 9% for a system decided by each department and 7 % for a system identified by each practitioner.
- **Best time:** The best time to ask a patient about smoking was “**on medical admission**” (53%) compared to nursing (38%) or clerical admission (22%) or “any time during hospital stay” (17%).
- **Best place:** There was less agreement about where was a “best” place to record smoking status. For 37% it was “**on a sticker in the patient records**” , for 19% “on a computerized record” and for 17% “with the

vital signs”. Of those who selected “sticker”, 67% made suggestions for whereabouts in the notes to place the sticker. The more common of these included: on the *admission* document (120), in *clinical/nursing notes* (93) and *front* of notes (92). Suggestions for “other” places were given by 32% and largely reiterated previous responses.

Staff practices

Responders were asked to indicate how they currently address smoking in their work against six recommended evidence-based³ practices for effective brief interventions. Responses were grouped as “always/usually” (defined as “usual” practice) and “sometimes/never” (“unusual” practice). Asking” and “recording” practices appeared to be better established than “advising”, “assessing” and “assisting”, with “arranging follow-up support” a usual practice for just 10%. For the 54 midwife responders, access to a Ministry of Health funded referral service (*Smokechange*) was available yet arranging follow-up was usual practice for just 13 midwives (24%).

Table A. “Usual” staff practices in addressing smoking – Christchurch Hospitals’ survey results

‘Usual’ staff practices in addressing smoking - actual		
Usual Practice	No.	%
Ask about smoking	748	58.9%
Record in patient records	702	55.2%
Advise about effects	518	40.8%
Assess degree of exposure	440	34.6%
Assist to reduce exposure	329	25.9%
Arrange follow-up	131	10.3%

Comparisons

The data were analysed to identify any differences in staff attitudes and “usual” practices due to professional group or service area. Tables of results are given in the appendix (Table 3)

- Professional groups were similar in their attitudes to identifying patients exposed to smoking with some variations in ideas about best systems to support this. All professional groups indicated strongly (>75%) that it was important to know if a patient was exposed to the smoking of others, especially if the patient was a child (>90%). Support for a consistent hospital-wide system for identifying patients who smoke was greater from nurses/midwives (80%) and allied health professionals (80%) than it was from doctors (65%). While the preferred time to ask about smoking was “on medical admission” for all three professional groups, there was twice the support from nurses/midwives (48%) for “on nursing admission” than from doctors (29%) or allied health professionals (25%). There was a range of ideas for where to record smoking status for all three groups.
- Overall, doctors reported the highest levels of brief interventions on smoking and allied health professionals the least. Doctors were more

³ National Health Committee. Revised Guidelines for Smoking Cessation. Wellington: National Health Committee; 2002

likely than nurses/midwives to “ask”, and “record” (89%, 87%, compared to 55%, 48%) and nurses/midwives were more likely than doctors to “assist” and “arrange follow-up” (32%, 15% compared to 24%, 6%). Allied health professionals reported reducing levels of intervention on smoking from a high of 26% for “asking about smoking” to a low of 6% for “arranging follow-up”.

- The three service area groupings of “women/children”, “general” and “other” were similar in attitudes to identifying second-hand smoke exposure in child patients and varied in attitudes to adult patients. More than 90% of responses from all three groups indicated it was important to know if a child was exposed to smoking by others. Less than half (46%) from “other” service areas thought it was important to know if an adult patient was exposed to smoking by others. All service areas were similar in attitudes to smoking identification systems, preferring a hospital wide system. “General” and “other” service areas preferred asking about smoking on medical (57%, 54%) rather than nursing (39%, 37%) admission whereas “women-children” service areas supported both times equally (44%).
- Practices of staff were similar across all three service area groupings for “ask”, “record”, “advise” and “arrange follow-up”. Staff in “women-children” service areas were more likely to “assess” (63%) and “assist” (35%) than staff in “general” (32%, 21%) or “other” (34%, 25%) service areas.

The audit of patient notes

A total of 600 case notes were audited. Using National Health Information (NHI) numbers, 100 case notes were randomly selected for patients admitted to hospital during the three months from 1 June to 31 August, 2002 and for the following six departments: obstetrics, gynaecology, neonatology, paediatrics, general medicine and general surgery. The audit looked for documented evidence, on last admission, of recording smoke-exposure status and referral to smoking cessation support services as appropriate.

- The audit verified high levels of recording smoking status for five of the six service areas of: obstetrics (88%), general surgery (87%) gynaecology (85%), general medicine (83%) and neonatology (78%), with low levels for paediatrics (19.0%). Overall, 440 (73.3%) of notes had smoking status of patient recorded at the last admission.
- Patient smoking was identified in 122 of the 600 notes (20%) and referral to cessation support recorded for 2 patients. Both of these were among the 21 smoking patients identified from obstetrics.

The national survey

Responders

Twenty-six hospitals participated in the national survey and 117 of 132 returned forms were included in the analysis. Excluded were 5 that indicated it was not important to know if a patient smoked (2) or where this question was not answered (3). A further 10 forms were excluded because, for 7 hospitals, they were not completed by the appropriate person or there were duplicates from the same service area and/or professional group.

Hospitals were grouped as smaller (annual admissions <30 000) or larger (annual admissions ≥ 30 000). Responses were proportional to hospital size. There were 68%



from the 18 smaller hospitals and 32% from the 7 larger hospitals. Responders were grouped as Nurse/Midwife (58%) or Doctor (38%). Professional group was not clear for 4%. Service areas were grouped as “woman/child” services (53%) (Obstetrics, Neonatal, Paediatrics) and “general” (47%) (General Medicine, General Surgery, Outpatients.) Frequency tables describing responders’ are in the Appendix (Tables 4).

Staff attitudes

Clinical Directors and Charge Nurses/Midwives were asked to indicate what they thought was the best option, for their service area, to questions about hospital systems for identifying smoke-exposed patients. Tables summarising responses are given in the appendix (Tables 5)

- **Identification:** Ninety-six per cent of all responders (117/122) indicated it was **important to know if a patient smoked** and was a criterion of inclusion in the analysis. There was less support for the importance of knowing if a patient was exposed to smoking by others (79% for adult patients and 73% for child patients).
- **Best system:** The strongest support was for a **hospital-wide system** (86%) for identifying patients who smoke. There was low support for a system decided by each department (9%) or practitioner (3%). Three hospitals did not respond.
- **Best time:** More people identified “**on medical admission**” (53%) as the best time to ask a patient about smoking than on nursing (29%) or clerical (15%) admission. A third indicated “at maternity booking” as best in pregnancy.
- **Best place:** The best place within patient notes to record smoking status was with the medical (54%) or social (36%) history rather than with diagnosis (6%) or baseline vital signs (5%).

Perceptions of staff practices

Responders were asked to indicate, for their particular service area, how their colleagues currently address smoking in their work. Responses were grouped as “always/usually” (defined as “usual” practice) and “sometimes/never” (“unusual” practice). “Asking” and “recording” practices appeared to be better established than “advising”, “assessing” and “assisting”, with “arranging follow-up support” a usual practice for less than 25%. For 69 responders, access to Ministry of Health funded referral services was available yet arranging follow-up was usual practice for just 28 (24%). Responses to staff practices questions are summarised on (Table 6) and the distribution of hospital smoking cessation referral services (Table 7) are given in the appendix .

Table A. “Usual” staff practices in addressing smoking – national survey result

Reported “usual” staff practices in addressing smoking		
Usual Practice	No.	%
Ask about smoking	97	82.9%
Record in patient records	100	85.5%
Advise about effects	71	60.7%
Assess degree of exposure	46	39.3%
Assist to reduce exposure	43	36.8%
Arrange follow-up support	28	23.9%

“Best practice” ideas of service leaders

With one exception, “*asking about smoking*”, there were low levels of agreement between service leaders’ ideas and evidence-based recommended practices for brief interventions on smoking. The most common challenges to achieving best practice were described as “*patient*” and “*staff*” related factors (including smoking by staff) with “*staff education*”, “*supportive systems*” and “*dedicated services*” the main needs for supporting “best” or “most desirable” practice. A single response could contain more than one idea. Full responses to each of the three questions are listed alphabetically in Table 8. of the appendix and the grouped responses are given below.

- Best practice:** Ideas were contributed by 116 of 117 respondents. To “*ask about smoking*” particularly at admission, or maternity booking/preadmission, was put forward as a “best” or “most desirable” practice by 68% of service leaders. Responses grouped as the practice “ask” included the key words or phrases: “*question*”, “*assess smoking status*”, “*discuss*”, “*find out*”, “*interview*”. Less consistent were ideas about recording information (24), advising on risks (20), assessing exposure (9) or intent to change (2), assisting to change (10) and arranging follow-up/referral (15). Six service leaders identified staff education and 4 considered advising patients about the hospital’s smokefree policy to be a “best” or “most desirable” practice. The comment below best reflects the evidence from research for what constitutes “best” practice.

All patients admitted would be assessed for risks of smoking and passive smoking as well as their willingness to stop or modify behaviour. Resources needed to support them would be identified. There would be a suitable method of supporting patients to deal with their desire / need to smoke. (Charge Nurse)

- Challenges:** Information was contributed by 94 respondents. “*Patient related factors*” was identified as a challenge in 40 responses (attitudes (25), crisis timing (9), low knowledge (6)), “*staff related factors*” in 35 (attitudes (21), staff smoking (9), lack of skill (5)), “*low support*” in 30 (cessation services (19), lack of materials (6) disregard for policy (5)) and “*not enough time*” in 27. The comment below is an example of a response about the challenge to “best practice” from smoking by staff.

Staff attitude is a challenge. We still have key staff members who smoke. Difficult to take advice from someone who doesn't follow their own. (Charge Nurse)

- Support needs:** Information was contributed by 104 respondents. The support needs identified were grouped as “*supportive systems*” by 44 service leaders (for intervention procedures (29), staff who smoke (9), policy enforcement (4), performance expectations (2)), “*staff education*” by 40 (on delivery of intervention (28), knowledge of risks (7), implementing systems (5)), “*access to dedicated services*” by 30 (community (18), on site (12)) and “*resources*” by 26 (patient information (18), time 5, nicotine replacement products (3)). Below is an example of support for an institutionalised approach to achieving “best” practice.



Organisation-wide procedure / protocol needed. Effective and prompt follow up of identified families at risk. (Clinical Director)

Comparisons

The data were analysed to identify any differences in staff attitudes and practices due to hospital size, professional group or service area. Results are given in (Tables 5 and 6)

- The size of the hospital made no differences to staff attitudes or usual staff practices. Smaller hospitals were just as likely to have access to referral services as larger hospitals.
- Doctors and nurses/midwives were similar in attitudes to hospital systems about identifying smoking and similar in staff practices although there was a tendency for doctors to “assess” exposure more than nurses/midwives (50% compared to 32%).
- Generally, “pregnancy/child” services were similar to “general” services with reducing frequency of practices from high levels of “asking” (79%, 87%) and “recording” (82%, 89%) and low levels for “arranging follow-up” (24%, 24%) There were higher levels of “advising”, “assessing” and “assisting” in “pregnancy/child” services (71,%, 44%, 47%) compared to “general” services (49%, 35%, 26%).

The assessment of smokefree policies

Twenty one DHBs were invited to submit their smokefree policy for analysis and 18 were included in the analysis. One DHB did not respond and two others did not have written policies. Of the eighteen policies analysed, most addressed smokefree environments and only one included clinical practices in the outreach of its policy. All 18 policies stated that smoking was not permitted in any DHB building or vehicle. Four also included no smoking by any person on DHB grounds. An example of such a statement is given below:

“Smoking will not be permitted in or on any of the facilities, grounds or vehicles belonging to the DHB unless specifically exempted by the Chief Executive Officer.” (Taranaki DHB Smokefree Policy, April 2003)

Of the fourteen policies that permitted smoking by some people, in some places, 12 had designated smoking areas within the grounds. Eight of these allowed both staff and patients to smoke there and 4 allowed patients only. Of these four, 2 limited patient smoking to mental health patients. The two policies that did not specify designated smoking areas both stated that smoking at hospital entrances was discouraged.

Policies from 14 DHBs stated that visible signage be displayed in hospital grounds informing the public and staff of the smokefree policy. Eight promoted their smokefree policy in job advertisements and, for ten, the smokefree policy was part of new staff orientation programmes. Fifteen policies stated that cessation support be offered to staff wishing to stop smoking.

One DHB extended its smokefree policy to encompass clinical practices, stating that every patient admitted would be asked about smoking, have their smoke-exposure status recorded and be offered support to cessation services, as appropriate.

Table C. Frequency of elements of smokefree policies – national survey.

Analysis of DHB smokefree policy statements	
Have a written policy	No = 2 Yes = 18
Totally smokefree buildings, grounds and vehicles	↳ Yes = 4 No = 14
Designated areas for smoking	↳ No = 6 Yes = 12
Patients only are permitted to smoke	↳ No = 8 Yes = 4
All patients permitted to smoke	↳ Yes = 2 No = 2*

* mental health patients only

Discussion

This project set out to describe the extent to which New Zealand hospitals identify and intervene on patient smoking. In particular, it investigated the attitudes and practices of staff, the perspectives of clinical service leaders and the content of smokefree policies. Evidence was gathered from four sources: a survey of health staff and an audit of patient notes in one DHB, and, a survey of clinical service leaders and analyses of smokefree policy documents across all DHBs.

The project came out of the experiences of the authors in introducing “Smokechange” (a smoking cessation service) into two Auckland hospitals. They found that, unlike in community settings, it was not enough to promote and provide the service in order for referrals to be made. It was not enough that the service was wanted by staff⁴, that it had the support of hospital leaders, that it was to address priority groups (pregnant women and sick children). It became clear, that much more was needed in order to create an environment supportive of these services. Assistance was given to hospitals in: advising on screening questions, designing referral systems, auditing referral practices, providing resources and educating staff in effective brief intervention. Still, patterns of referring were slow to establish and were largely dependent on a few individuals who consistently referred. This made the service vulnerable to staff and roster changes.

Discussions with providers of other hospital-based smoking cessation services identified similar challenges in introducing their services. Given the increased number of health-funded cessation programmes available, it seemed appropriate to take a more organized look at the readiness of New Zealand hospitals to support such services so as to identify and overcome barriers to referral. When the offer of one-off funding for small projects was made by the Ministry of Health in 2002, this project was proposed and accepted.

Main findings

Findings were generally consistent across professional groups, service areas and hospital sizes. The main ones were:

- high importance for knowing about the first and second hand smoking of patients
- strong support for a hospital-wide system for identifying patient smoking over a department by department or individual practitioner approach
- moderate overall levels of reported asking about and recording smoking status and high for doctors
- low levels of clinical intervention and arranged follow-up
- low levels of arranged follow-up where on-site dedicated services were available
- low agreement between service leaders’ ideas and evidence-based recommendations for “best” or “most desirable” practice
- low degree of consistency on smokefree policy between DHBs

⁴ Cowan S. Smokechange Starship Progress Report: Service development update. Christchurch. Education for Change; 2001

- main support needs identified by service leaders were: supportive systems, staff education and dedicated teams for addressing smoking in hospitals.

Limitations

Project findings need to be interpreted within the context of the project's background, purpose and design. Findings are suggestive, not conclusive. The purpose was education more than research. It may generate research questions for others to investigate, but such a purpose was beyond the scope of this project. Instead, it took an organized look at the smokefree culture of hospitals, from various viewpoints, to identify how consistent this was with recommended practice. The size of the denominator populations for both groups surveyed was estimated and so response rates of 50% are also estimates.

It could be argued that working for a high response rate from a representative sample would have been preferable. We argue that higher participation rates are more important to an education design than are response rates. Participation is a key principle of adult learning. The project was designed to raise awareness in participants as it developed. A raised awareness can be all that is needed for taking action. One DHB has reported⁵ that involvement in this project has led to the introduction of a patient smoking ID policy throughout all facilities.

Capacity issues

Findings suggest that capacity to intervene on smoking is underutilised in hospitals. This report highlights some issues for wider discussion and opens that discussion here

Policy

Capacity is maximized by strong policy. Organisations that know where they are going and why are more likely to get there. Good policy aligns purpose with practice. Smokefree policies of DHBs, analysed in this project, were far from clear. For most, some smoking was permitted by some people in some places at some times. A policy of exceptions is difficult to uphold and difficult to enforce. For all but one DHB, smokefree policies were smokefree environment policies. It was encouraging to see that one DHB had taken a lead from the literature and included clinical and systems interventions in its strategic direction, by including identifying, recording and acting on smoking in its smokefree policy statement. DHBs are developing as health organisations. Important progress has already been made towards smokefree hospital environments. Building on this, to include a systematic approach to clinical interventions, is the next step. Comments from respondents to this project confirm that clinical teams know what is needed – staff education, supportive systems and dedicated services.

Systems

Capacity is strengthened by clear systems. Strong support for a hospital-wide system for identifying smoking, found in this project, is recognition of the need for systems interventions to support clinical practice. Busy staff need systems to act as prompts and reminders if they are to be consistent in assessing and addressing smoking. Such proactive practice is especially important with smoking as smoking is rarely the presenting concern. It is the asthma or premature labour or heart disease that takes centre stage in treatment. Systems can ensure that important, but not urgent, matters are also addressed. The clinical team needs a step by step action plan from “asking” to “referring” that is built into induction, audit and performance review processes. This would standardise patient care and open access to cessation support to all patients who smoke and not just those under the care of a person or team more committed to addressing smoking. The following comments from service leaders reveal the reduced capacity for effectiveness from a non-systematic approach.

⁵ Personal communication Karen Evison, Waikato Hospital



We have major gaps - discharge planning forums need to address smoking

Each consultant has a differing opinion on how important smoking is to the disease process

Poor documentation of maternal smoking status in notes

Once we have the information we are very poor at taking any action

Lack of enforcement of hospital - wide no smoking policy

Need support for questions to ask. Easy documentation. Referral system

Specifically, systems are needed for quick and easy smoking identification, dedicated places to record information, training in brief interventions, treatment of nicotine withdrawal for patients who continue to smoke and systems for how to arrange follow-up support. They are also needed for audit and feedback purposes as practices develop, for orientation to protocols and standards of new or changing staff, for staff performance review and for promotion and enforcement of hospital policy, In these ways a hospital can increase its capacity to be effective through systems interventions that support the efforts of the clinical team.

Education

Capacity to intervene on smoking may be increased when staff education aligns with existing practice philosophies. For example, presenting the concepts of support and change as a partnership has made education about addressing smoking highly acceptable and useful to midwives⁶ who base their practice on a partnership philosophy. Likewise for medical staff, presenting nicotine addiction as a chronic disease rather than a lifestyle choice may make it easier for medical staff to draw on familiar processes for treating chronic disease. For nurses, presenting a team approach to action on smoking, where intervention tasks are shared and the “2 minute” intervention has value, may make it easier to see addressing smoking as a nursing activity. Staff working in paediatrics may be more likely to include addressing smoking in their role when brief intervention education is presented within a family-centred care model and parents perceived as part of the care team. Where addressing smoking is embraced as part of, rather than extra to the professional responsibilities of any particular group, capacity to be effective is likely to be enhanced.

Education on smoking has been found to be more effective when it is associated with the introduction of a new system rather than in isolation. It also needs to be regular and systematic. Education needs, identified either directly or indirectly by project findings, include

- Knowing what interventions are effective
- Understanding addiction and the pharmacological treatment of nicotine withdrawal syndrome
- Understanding change as a staged process
- Implementing effective brief interventions (1-3 minute discussions)
- Recognising and working with resistance, ambivalence and readiness for change

⁶ Partners in Change. Education for midwives in addressing smoking in pregnancy Christchurch. Education for Change. Service Report to the Ministry of Health; July, 2002

- Knowing what, when, who and how to ask the question
- Effective informing, advising, assessing and referring
- Motivational strategies for increasing the desirability of change

Need for smoking education to be part of annual competencies as CPR is currently

Strategies to raise the issue effectively. Knowledge of how to put message across

Attitudes

Capacity is a product of attitude. Staff attitudes to addressing smoking that align with evidence from research are likely to increase the number of times that smoking is discussed and therefore the capacity for effectiveness. Comments offered by survey responders painted a picture of smoking patients challenged by the addictive hold of tobacco, with low confidence in their ability to change and stressed by being in hospital. These attitudes are reflected in the sample comments below:

Smoking is a very addictive habit. It is also still very socially accepted and so people do not respond to information offered.

Patients not having the will power / strategies / support et cetera to stop or reduce.

Under stress with hospitalisation. Can promote aggressive attitude. Not all staff feel comfortable asking about smoking issues.

The picture for staff was of professionals focused on the presenting needs of the patient, feeling unsupported by systems, training and time, and with low confidence that their interventions on smoking will make any difference. These attitudes can be seen in the following sample comments:

The primary cause for the patients' admission is not smoking. It may be a contributing factor. The emphasis therefore is not on smoking cessation. It is on treating the patient. Smoking cessation / modification is therefore done on an ad hoc basis.

No time. Lack of a methodical approach. Lack of awareness of issues

Some staff feel it is a complete waste of time to mention smoking.

The general attitude portrayed for smoking patients and staff alike seemed to be that addressing smoking was too difficult. Yet evidence from research is that cost effective interventions do exist, (Fiore et al.), and that their effectiveness is greatly increased when there is institutional support for routine assessment and treatment. Identifying and documenting first and second hand smoking status of every patient would maximize the opportunity for effectiveness of both brief and intensive interventions. Staff education on nicotine dependence and what interventions work is likely to help manage expectations of what is realistic. It may lead to a shift in attitude towards "routine asking makes a difference", "this is an issue for my practice", "brief is OK", "my efforts are worthwhile", "addictions are demanding", "quitting may not happen on the first try", "change is a process, not an event" and "change is possible". With support for what to ask, who is to ask, how to ask, when to ask and where to record, there is likely to be an increase in the frequency of confident and purposeful discussions about smoking.

•
•
•
•
•
•
•

Opportunities

Capacity is also a product of opportunities. The literature can be summarized by the adage “a little and often by many over time” for effective intervention on smoking. It supports the extensive “two minute” approach for recognising and seizing the motivational moment as well as the intensive “dedicated programme” approach.. The elements of frequency (how often), intensity (how many) and duration (how long) influence the efficacy of both brief and intensive interventions. Opportunities abound for intervening on smoking in hospitals and this report suggests many may be being missed.

■ *Need skill to recognise window of opportunity and maximise this.*

- **Team involvement:** Nurses and allied health staff together make up about two thirds of the total clinical team yet just half reported routinely asking about smoking in the Christchurch survey. Increasing rates of “asking about smoking” by these groups to the levels of doctors and midwives is likely to increase actual intervention rates considerably. There are likely to be many opportunities for a “two minute” intervention in the course of an ordinary day. For a sonographer, an opportunity may present while performing a pregnancy scan; for a physiotherapist, while carrying out a treatment; for a dentist, while setting up for an examination, and for a nurse while dressing a wound.
- **Advising role:** That less than 50% of doctors in the Christchurch survey reported routinely advising on effects suggests they may not perceive it to be their role or to be a good use of their time. Effective education by doctors has been linked to perceptions of their role in health education more than their expectations that patients will act on their advice.⁷ There is strong evidence that advice to “quit” smoking, especially from doctors, increases abstinence rates⁸. Understanding this is likely to increase frequency of advising on effects, by doctors as well as by every other member of the clinical team. When this advice is framed as “benefits of change” motivational opportunities can be enhanced.
- **Giving advice:** How advice is given and the readiness of a person to receive it makes a difference to its uptake. Comments from staff and service leaders allude to low confidence in the art of advising. For some there seems to be an expectation that telling people they must “quit” should lead to action; that knowing is enough. When smoking continues they feel that the person has taken no notice or doesn’t care and they see no point to their effort. They are left feeling powerless to influence change.

■ *Most people who smoke are aware of the harmful effects and can see such advice as "nagging", i.e. it's counterproductive*

■ *Only if smokers care about others or consequences will it change how and where they smoke*

⁷ Rowland, N., Maynard A., Kennedy P. et al. Doctors and alcohol screening: the gap between attitudes and action. (1988) Health Ed J, 47 (4):133-6

⁸ Silagy C, Stead L. Physician advice for smoking cessation. In: The Cochrane Library; 2002: Issue 1, Oxford: Update Software.

•
•
•
•
•
•
•
•
•

Most smokers are well educated in long term effects but still choose to smoke

A person is more likely to comply with advice if they recognize there is a problem, feel concerned and vulnerable, feel able to do something about it and that the benefits of change would be worth their effort.⁹ Influencing these perceptions is the work of education. Simply “telling people things” is not. Personalised, sensitive and timely information delivered by a trusted professional can be the catalyst for action where people are also supported to act. Staff education to improve the quality of advice-giving is another way to maximize existing capacity for addressing smoking in hospitals.

- **Referring:** Support to act, as measured by “assist to reduce exposure” and “arrange follow-up support”, was reported to be low despite referral options being available. Even where on-site referral options existed, routine referring was not common. Just 12 of 59 (20%) staff working in obstetrics at Christchurch Women’s Hospital reported routinely arranging follow-up support for women who smoke, despite the *Smokechange* service being well established in the city and available to them. Similarly, just 20 of 70 (29%) service leaders in hospitals with access to on-site referral programmes reported that colleagues routinely arranged follow-up support for smoking patients. The national Quitline is the main smoking cessation service in New Zealand and a referral option for all hospitals. However, just 8 of 47 (17%) service leaders from hospitals with no on-site service reported that their colleagues usually arranged follow-up support for patients who smoke. Systematic referring during the hospital stay (or clinic appointment) to on-site services, where these are available, would strengthen “support to act”. Systematic referring at discharge to the general practice team, Quitline or other community services would also strengthen “support to act”.
- **Children:** Evidence from the audit of paediatric notes at Christchurch Hospital was not consistent with results from either survey for rates of recording the smoke-exposure status of children. Staff (62%) and service leaders (83%) reported considerably higher rates of routine recording than was evident in the audit (17%). These findings cannot be generalized beyond this project although a staff survey and audit at Starship in 2001, found a similar inconsistency and even lower level self-reported recording¹⁰. Of 505 Starship staff surveyed, 26% reported usually recording smoke-exposure status of children yet an audit of notes for 53 respiratory patients found 7 such recordings (13%) on last admission. The findings do allude to potential missed opportunities to address smoke-exposure for children if there is no consistent method for assessing and recording this.

The needs of children are urgent. They are highly sensitive to time. Developmental needs cannot be put off without undermining a child’s growth. Given the burden from smoking to health, development,

⁹ Fowler, G. Health education in general practice: giving advice. (1985) *Health Ed J*, 44 (3): 149-50

¹⁰ Cowan S. *Smokechange Starship Progress Report: Service development update*. Christchurch. Education for Change; 2001



wellbeing and survival of children¹¹, addressing their second-hand smoke exposure would seem a priority for action in any hospital. The literature acknowledges the differences in addressing the smoking of parents of child patients over that of parents who are themselves patients. Intensive counselling support is also needed for an intervention effect.¹² The comments below from paediatricians highlight two important points: the need for standardized assessment of second-hand smoking status and for hospital-wide screening questions and documentation systems to be appropriate to the paediatric setting.

Ensure that exposure to environmental tobacco smoke (ETS) is routinely asked about for every admission, not just when related to presenting complaint, and is recorded in the notes.

(System) Must be suitable to use in paediatrics - so often hospital policies don't allow for this.

Staff smoking

Smoking by colleagues was raised as an issue in several comments by responders of both surveys. It impacts on the capacity of the clinical team to be effective by being inconsistent with recommendations as comments below suggest:

We still have key staff who smoke. Difficult to take advice from someone who doesn't follow their own.

Having staff smoking in areas outside where clients can see them.

Staff who smoke not comfortable with enforcing this (smokefree policy).

Smoking by health professionals is a sensitive issue and needs to be discussed in a way that does not alienate staff who smoke, but rather involves them in finding solutions. The issue needs to move from the personal to the practice realm. As DHBs take a stand on smoking in order to have integrity as a health organization, so too, more and more health professionals who smoke may see this as an opportunity and be encouraged and supported to do the same.

Conclusion

Smoking cessation is a relatively new service area in New Zealand. The infrastructure of supportive policy, systems and education is building in hospital and community settings. Evidence is clear that both brief and intensive interventions can be effective in addressing smoking. It is also clear that, in hospitals, strong policy, clear systems and appropriate resources increase the impact of the clinical team.

This report has presented project findings in the light of their capacity to influence effectiveness. Often it is the individual health professional who is the focus of education for change. However, smoking crosses many disease entities and draws every health professional group into the intervention challenge. To ensure there is a baseline standard

¹¹ Royal College of Physicians. Smoking and the Young. A Report of a Working Party of the Royal College of Physicians. London: Royal College of Physicians; 1992. (Summary in J Roy Coll Phys Lond 1992; 26: 352-6.)

¹² Roseby R, Waters E, Polnay A, Campbell R, Webster P, Spencer N. Family and carer smoking control programmes for reducing children's exposure to environmental tobacco smoke (Cochrane Review) *The Cochrane Library, Issue 4, 2003*. Chichester, UK: John Wiley & Sons, Ltd.

•
•
•
•
•
•
•
•
•

of care for smoke-exposed patients, a systematic approach to identifying, recording and intervening on smoking is needed in hospitals. This puts the spotlight for action onto governance and management teams, as well as the clinical.

Recommendations from this project are for DHB leadership in assessing and addressing the first and second-hand smoking of hospital patients. A chain of support from strong policy to clear systems, effective staff education, frequent and brief intervention, appropriate referral and dedicated services is the recommended “best practice” package. Such a comprehensive approach is likely to strengthen the actions of individuals, share responsibility between governance, management and clinical teams, increase access to follow-up support for people who smoke, reduce costs, and improve the health and well-being of New Zealand people.

Appendices

A. Survey form: Christchurch hospitals' staff survey	A1
B. Summary feedback to staff - Christchurch survey	A3
C. Letter to DHBs inviting participation	A4
D. Survey form: national survey of hospital service leaders	A6
E. Summary feedback to participating hospitals: national survey	A9
F. Tables	
1. Description of responders to Christchurch hospitals' survey	A11
2. Description of Christchurch hospitals' staff attitudes to addressing smoking	A12
3. Frequency of brief intervention practices of staff – Christchurch hospitals'	A13
4. Description of responders to the national survey of hospital service leaders	A15
5. Description of attitudes of hospital service leaders to addressing smoking	A16
6. Hospital service leaders' perceptions of the frequency of brief intervention practices of their colleagues	A18
7. Availability of hospital smoking cessation programmes (and/or programmes for pregnant women) by frequency of "arranging follow-up"	A18
8. Ideas of hospital service leaders for what is "best practice", challenges to "best practice" and support needed to achieve "best practice"	A19
9. Text responses of hospital service leaders	A21