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Systems First

Supporting smokefree leadership in New Zealand hospitals

Guidelines for District Health Boards

Systems First

"Without question, I view the most important thing a hospital can do is to implement institution-wide systems for intervening on tobacco use. Evidence tells us that when a programme is institutionalised the impact is increased dramatically."

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

Cover photo: Participants at the first Smokefree Hospitals Workshop in Wellington, March, 2004

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Patients
Families of children at Starship Children's Health and pregnant women and their families from National Women's Health, Auckland District Health Board

Update—August 2005

These guidelines will always be a working draft. Such is the nature of development.

Achievements

In the first months of implementation, Systems First has achieved the following:

- Established a network of hospital smokefree coordinators that is actively communicating with each other
- Involved 14 hospitals in an ongoing support process specific to the needs of the individual setting
- Established a 5 module "Smokefree Systems Coaching" Programme for new staff employed into the role of Hospital Smokefree Coordinator (certificated)
- Provided "as required" information, policy advice and systems coaching to managers and coordinators
- Established an internet Discussion Forum for systematic sharing of ideas and resources and for linking to a wider interest group (to visit or register with the forum go to http://www.efc.co.nz/forum)
- Developed a set of sample resources to short-cut development and support the introduction of hospital-wide systems in a coordinated way e.g.
  - "**Why we ask**" - a rack card explaining to patients why staff will ask about smoking. This is to support the implementation of systematic smokefree screening
  - "**Smokefree Essentials**" - a 10-30 minute presentation of essential knowledge, attitudes and skills needed for smokefree interventions with patients. This can be individual or small group education around a PC, or presented by a colleague to a larger group e.g. at a ward-based meeting. It is designed to enable a lot of staff to be at a minimum standard quickly

Challenges

We are working to strengthen understanding at board and senior management level that a smokefree policy includes a commitment to more smokefree people as well as to smokefree environments. Systems first as a principle, while old wisdom, is not well understood as requiring strategic more than service activity. There are many distractions, within this project and within hospitals, to staying focused on achieving priority systems. The goal for the next 12 months is to support the implementation of 100% smokefree screening systems into every New Zealand hospital. A bold goal perhaps, but an important one for achieving more smokefree people and improved health.

Introduction

Background

Experiences of Education for Change in introducing smoking cessation services into two Auckland hospitals, from 2001, raised awareness of the challenges facing hospitals in consistently referring to such services. Needs identified to support referral were strong policy, clear systems and ongoing staff education.

In 2003, Education for Change carried out a national assessment of the extent to which New Zealand hospitals identify and address the smoking of patients and found similar challenges across all hospitals. The report concluded that addressing smoking occurred on an ad hoc basis and that there was no base-line standard of care for smoke-exposed patients.

A five step approach was recommended as a best practice package and this was adopted by the Ministry of Health in February, 2004 and presented to DHB representatives at a national workshop in Wellington, in March, 2004. Following the workshop, the Ministry of Health discussed with Education for Change the possibility of extending support for DHBs in implementing the five step package, through more detailed guidelines and coordinated support for their implementation. In September, a contract to develop guidelines and provide coordination was confirmed.

The "Systems First" Project

The national coordination project has been named "Systems First" to emphasis its primary role in guiding the development of smokefree hospital systems. The gap is systems and the first system to have in place is one for identifying the exposure to first and second hand smoking for every patient. The project focus is on guiding management practices more than clinical ones. Support for clinical practices has been well provided for in the Guidelines for Smoking Cessation, published by the National Health Committee (2002). National Heart Foundation and other training programmes support their implementation.

David Smith, a participant from Nelson at the March Smokefree Hospitals workshop, has been appointed to drive the "Systems First" project and work with DHBs to achieve a smokefree standard across all hospitals. The project plan is to take a hospital by hospital approach to supporting change that

- starts with the board
- has as a first goal a smokefree identification system in place in all hospitals
- accounts for the uniqueness of each setting
- builds on what has already been achieved
- stays focused on achieving a defined minimum standard

These guidelines are the implementation tool of the "Systems First" national coordination project and a process tool for smokefree project teams in each hospital.

Evidence

Summary

There is an overwhelming body of evidence reporting the costs to health from exposure to smoking. There is also extensive evidence of the benefits of intervening with smokefree settings, health care practices and hospital systems. The evidence can be summarised as:

- Smoking is the biggest single cause of death and disease in New Zealand and the world
- It is a major determinant of inequality in health
- Interventions do exist that result in improved health and reduced costs
- Addressing smoking in New Zealand hospitals is ad hoc and intervention rates are low
- Hospital-wide, system-level changes greatly increase rates of intervention, programme uptake and cessation

Extent of the problem

In New Zealand each year approximately:

- One million adults smoke tobacco
- 18 000 pregnancies are exposed to tobacco
- 90 000 preschool children are exposed to second-hand smoke
- 4500 deaths are due to tobacco smoking (Source: NZHIS)
- 400 deaths are due to second-hand tobacco smoke (Source: NZHIS)

Key sources

These guidelines draw mainly on evidence and experiences reported in the following publications:

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 Services. June 2000
2. Cowan S and Langley L. *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. Christchurch, NZ: Education for Change. Jan 2004
3. Rigotti NA, Munafo MR, Murphy MFG, Stead LF. Interventions for smoking cessation in hospitalised patients (Cochrane Review). In: *The Cochrane Library, Issue 3, 2004. Chichester, UK: John Wiley* & Sons, Ltd.
4. Lumley J, Oliver S, Waters E. Interventions for promoting smoking cessation during pregnancy (Cochrane Review). In: *The Cochrane Library, Issue 3,* 2004. Chichester, UK: John Wiley & Sons, Ltd.
5. Reports from 14 hospital in North Carolina on their smokefree hospital initiatives. Medical Review of North Carolina Inc. September, 2002 (URL: http://www.mrnc.org/mrnchcqip/documents/HO_SMOKIN~1.PDF)

Guidelines

Purpose

The guidelines provide the steps for a designing setting-specific systems to address smoking in New Zealand hospitals. They include steps for board members, managers and professional education leaders so that the efforts of the individual health care provider and patient can be strengthened.

Development

The guidelines bring together the evidence from research as well as from development work since 2001. This includes contributions from the many people involved along the way. In particular, they embrace the perspectives of

- staff and families at Starship and National Women's Health, Auckland DHB
- 1271 survey respondents from the staff of Canterbury DHB
- 132 service leaders from 26 participating hospitals who also took part in the national assessment project.
- 22 New Zealand health leaders who contributed to the "Lead Comments and Sample Systems" resource
- 40 people in senior management positions who attended the DHB Smokefree Hospitals workshop
- 60 people in the network of the weekly email communiqué - "Momentum"

Design

The "Systems First" guidelines direct DHBs towards a smokefree hospital standard. They consider the key "why", "what", "how", "when", "where" and "who" questions for each step of the five step package and are underpinned by an educational purpose and the principles of building on strengths, a focus on solutions and shared responsibility.

Steps

- Step 1: Make strong smokefree policy
- Step 2: Design clear smokefree systems
- Step 3: Provide ongoing education for staff
- Step 4: Implement brief smokefree interventions
- Step 5: Have dedicated responsibilities and services

Intended use

The "Systems First" guidelines are offered as a process tool for project teams in each hospital and the wider "Systems First" project. They are intended to open up the options for what needs to be considered when designing clear systems and offer sample systems as examples. The are for everyone - board members, managers, administrators, service leaders, professional educators and all people in the health care team. While guidelines for clinical practice are elegantly packaged as the 5 As, guidelines for systems development cannot be so specific. What follows may guide, but hospitals themselves must decide.

Why?

- Overwhelming evidence of smoking harm
- Main cause of death and disease in NZ
- Major cause of inequalities in health
- Effective interventions do exist
- Policy drives systematic action
- Systems interventions increase quit rates

More people become and stay well

What?

A smokefree policy is a statement of intent.

- Directs action on smokefree environments
- Directs action on assisting people to become and stay smokefree
- Directs action on supportive systems
- Directs action on supportive staff education
  Directs action on supportive resources

When?

Promote policy at planned and chance times

- At pre-admission
- At admission and discharge
- As appropriate during hospital stay
- As part of new / rotating staff orientation
- Within continuing staff education
- During staff performance discussions

Step 1:

Make strong smokefree policy

How?

Principles for development and implementation

- Evidence-based
- Interdisciplinary collaboration
- Active champions to sustain momentum
- Strong, positive and widespread promotion
- Language of the solution (smokefree) used
- Walk the talk (show organizational integrity)

Where?

Promote policy anywhere and everywhere

- On signage that is clear, visible and positive
- In patient information handouts
- On hospital/DHB websites
- In professional and cultural forums
- In community print, TV and radio media
- Within hospital practices

Who?

All patients, visitors and staff stand to benefit

- Implementation task force to include a board member, quality manager, professional educator, service leader and referral service link (from the community)
- Dedicated responsibilities for ongoing policy monitoring, feedback and systems review

Step 2:

Design clear smokefree systems

Why?

Systems link policy to action; provide the steps

- Are a framework for improving health care
- Are a framework for accountability
- Support managers and the health care team with prompts, reminders and feedback
- Maximise capacity and the health resource

More people become and stay well

What?

Key systems needed for

- Promoting smokefree hospital environments
- Identifying smoke-exposed patients
- Guiding patient interventions
- Documentation and feedback
- Staff education and performance measures
- Referral and discharge planning

When?

Implement systems as appropriate

- At pre-admission and discharge
- At medical, nursing and clerical admission
- At pregnancy booking sessions
- At any time during hospital stay
- When staff are new/inexperienced/changing
- When care is ad hoc and people miss out

How?

Principles for design and implementation

- Consider the “why”, “what”, “how”, “when”, “where” and “who” questions at design stage
- Define roles for all: managers, administrators, allied health, midwives, nurses, doctors
- Integrate systems into existing care paths, documentation media and processes

Who?

Roles, responsibilities and measures defined for

- The management team for systems design, promotion, monitoring, performance, audit, feedback, resources, coordination
- The health care team for identification, documentation, treatment, referral, discharge
- Patients for their smoking-related needs

Where?

Systems need to be found

- Embedded in the day to day practice of staff
- In the day to day talk of managers
- Documented in practice manuals
- Documented in treatment protocols
- Following integrated care pathways
- In the hospital experience of patients

Step 3:

Provide ongoing education for staff

Why?

Education links professionals to evidence

- Develops understanding of the issues
- Increases knowledge and skill
- Aligns staff attitudes with best practice
- Manages expectations of what is realistic
- Increases confidence and competence

More people become and stay well

What?

Education needs to include

- Evidence of harm and scale of the problem
- Evidence of effective interventions
- Behaviour change and addiction theory
- How to ask, advise, assess, assist, refer
- Pharmacotherapy and brief counseling
- Knowledge of roles, responsibilities, systems

When?

Provide opportunities for staff education

- To all staff as new systems are introduced
- When staff are new/inexperienced/changing
- When feedback from audit identifies needs
- At updates and professional meetings
- In discussions on performance measures
- On an ongoing basis, and regularly

How?

Present education within familiar frameworks

- Chronic disease model for doctors
- Team approach to care for nurses
- Partnership model for midwives
- Family-centred care for paediatric teams
- Motivational moments for allied health
- Quality frameworks for managers

Where?

Formal and informal education offered in

- Modelling, demonstration and practice
- Staff change-over discussions on wards
- In-service education programmes
- Updates, grand rounds, journal clubs, CME
- Hospital bulletins, professional newsletters
- DHB / other web sites

Who?

Involve every one and match education to roles

- Board members and managers
- Consultants and junior medical staff
- Nurses and midwives
- Allied health professionals
- Ward clerks, orderlies and office staff
- Patients and visitors

Step 4:

Implement brief smokefree interventions

Why?

Interventions link patients to best practice

- Are mechanisms for improving health care
- Brief (1-3 minutes) and often, works
- Capacity for this is underutilised in hospitals
- "A little and often, by many, over time" makes the greatest difference of all

More people become and stay well

What?

Effective interventions summarised as the 5 A's

- **A**sk about exposure to first and second hand smoking (for adult and child patients)
- **A**ssess risk, readiness, interest in support
- **A**dvise on smoking risks/smokefree benefits
- **A**ssist with brief discussion, NRT (or other)
- **A**rrange follow-up, referral, discharge plans

When?

Intervene as appropriate

- At pre-admission and discharge
- At medical, nursing and clerical admission
- At booking and antenatal sessions
- At any time during hospital stay
- As personalised opportunities present
- When a patient requests support

How?

Principles for interventions:

- See smoking as addictive and people who smoke as trapped, immobilized, stuck
- See change as a step by step process
- See that more than "knowing" is needed
- Use positive, accepting, confident talk
- Include everyone; expect 70% participation

Who?

Intervene with every person exposed

- Ask everyone about exposure to smoking
- Offer support to every adult patient exposed
- Offer support to caregivers of every child patient exposed (to reduce child's exposure)
- Include pregnant women recently quit
- Share the intervention A's across all staff

Where?

Need agreed places to record smoking details

- With vital signs for current smoking status
- On visible sticker for assessment details
- In patient notes for counseling/NRT uptake
- On pharmacy request form for NRT/other
- On voicemail/email/fax for referral details
- With discharge letter for follow-up plans

Step 5:

Have dedicated responsibilities and services

Why?

Dedicated services link priorities to solutions

- Effectiveness increases as the frequency, intensity and duration of support increases
- Extend the impact of the brief intervention
- Enhance treatment of presenting concern
- Sick people have higher quit rates

More people become and stay well

What?

Coordination, “usual care” and cessation roles

- National coordination (“Systems First”)
- Smokefree coordinator and task force
- Defined roles and responsibilities for staff
- Dedicated referral programmes such as Aukati Kai Paipa, Smokechange, Quitline, local providers, primary care teams, others

When?

Dedicate responsibilities

- At recruitment and appraisal times for staff
- At preadmission / admission for patients

Offer support options at anytime

- Refer to services as soon as possible
- Refer pregnant women on confirmation of pregnancy where possible; treat as urgent

How?

Principles:

- Begin with the experience of the patient in mind from preadmission to follow-up
- Integrate responsibilities into existing roles
- Build on strengths; on achievements made
- Focus on solutions; on the bigger picture
- Work for shared responsibility with patients

Who?

Offer support to everyone exposed to smoking

- Patients ready to stop or reduce smoking
- Patients wanting smokefree homes and cars
- Patients wanting a smokefree baby/child

Dedicate responsibilities

- To every staff person within their usual role
- To the smokefree coordinator and task force

Where?

Dedicated services

- National coordination
- In hospital - coordination
- In hospital “usual care” interventions
- In hospital cessation services
- Referral services in the community
- National Quitline

Introducing systematic identification

Rationale

The first step in protecting patients from the effects of smoking is to identify those exposed. The evidence is that screening for tobacco use trebles intervention rates by the health care team and doubles abstinence rates for patients who smoke (Fiore et al). When identification is systematic and recorded for every patient, it opens up access to interventions for all and enhances healing and recovery from their presenting condition.

Example

Preparation

1. ***Have*** as a goal 100% identification rates for recorded smoke-exposure status (always ask everyone)
2. ***Prepare*** forms (or use a sticker or stamp) to include a dedicated space for recording.
3. ***Prepare*** all new and current staff to implement this ID system and understand its importance
4. ***Support*** with "Why we ask this question" leaflets for staff and patients to support implementation

Implementation

1. ***Identify*** both first-hand (patient) smoking and second-hand (household) smoking
2. ***Identify*** so as to document status and flag the need for intervention
3. ***Document*** smoke-exposure status on the admission problem list and as a discharge diagnosis
4. ***Ask*** and record for every adult patient, every child patient, at every admission to hospital and every clinic visit
5. First ***ask***: "Do you live with people who smoke (tobacco)?" to assess household smoking status
6. Then ***ask*** adult / older child patients: "Do you smoke (daily) yourself" to assess patient smoking status
7. ***Dedicate "***asking about smoking" to the admitting clerk/doctor/nurse/midwife as routine information gathering
8. ***Record*** visibly as: a) Household smoking? No / Yes b) Patient smoking? No / Yes

Monitoring, feedback and review

1. ***Dedicate*** responsibility for monitoring and feedback to the Quality Improvement Team
2. ***Audit*** "last admission" notes every month for evidence of recorded identification of smoke-exposure status
3. ***Audit*** notes of patients admitted during that month for a particular service area/department/ward
4. ***Feedback*** to Service Leaders on rates of: a) recording ID, b) household smoking, c) patient smoking
5. ***Audit*** and ***feedback*** regularly until identification rates increase to, and remain at, 100%
6. ***Have*** as a performance indicator for Service Leaders 100% identification rates for their service area

Providing systematic intervention

Rationale

Once identified as smoke-exposed, the next step in protecting patients is to intervene. One in ten people feel ready to stop smoking at any one time and effective interventions do exit. Brief discussion (1-3 minutes) with "usual care" providers, intensive programmes delivered by specialists and pharmacotherapy options all work. They are all efficacious and highly cost-effective relative to other treatment and disease prevention interventions (e.g. treatment for hypertension and mammography screening). (Fiore et al). The goal of interventions is "increased quitting" for those who are ready and "increased readiness" for those who are not. When the opportunity to discuss personal or family smoking is offered to every smoke-exposed patient, more people become and stay well.

Example

Preparation

1. ***Have*** as a goal 100% intervention rates for discussing smoking with smoke-exposed patients or their families
2. ***Prepare*** an intervention protocol for clarifying what is to be discussed by whom and when (the 5As).
3. ***Dedicate*** responsibility for ensuring smoking is discussed and interventions recorded as per the protocol
4. ***Prepare*** forms (or use a sticker or stamp) to include a dedicated space for recording intervention activity.
5. ***Prepare*** all new and current staff for implementing the 5As intervention protocol

Implementation

1. ***Check*** patient's admission notes for record of smoke-exposure status; do so for every patient in your care.
2. ***Schedule*** a brief smokefree assessment discussion early in their hospital stay
3. ***Assess*** risk***,*** management of withdrawal, quit readiness, and interest in support
4. ***Advise*** on the benefits to them or their child of being smokefree and the hospital support available to them
5. ***Say***: "Being smokefree is the best way to improve your health and protect your child/family. For you it will mean … (personalise) Someone will talk with you while you are here about your options for support."
6. ***Give*** every smoke-exposed patient or family the "Why we ask" leaflet following discussion
7. ***Assist*** with NRT, brief motivational counselling, details of support options, GP follow-up from discharge
8. ***Refer*** patient to an appropriate local smokefree service where these exist or to Quitline
9. ***Seize*** opportunities for discussion opening with "Has anyone talked with you about your smokefree times?"

Monitoring, feedback and review

1. ***Have*** as a performance indicator for Service Leaders 100% recorded intervention rates for their service area

Integrating into existing systems

Rationale

Addressing smoking cannot succeed as a stand alone issue in a hospital or be addressed by a single person or programme. It needs to be an integral part of usual care. (Fiore et al) Just as infection control needs to be embedded into a hospital's policies, systems, staff education and day to day practices, to prevent a lot of people from becoming sick, so, too, does tobacco control. Hospitals already have systems for screening, monitoring, communicating, referring, quality assurance, staff development and more. And health care staff already ask questions, assess risk, document, inform, advise, discuss concerns, understand fears, work for solutions. An integrated approach means staff draw on familiar skills and processes; routine intervening becomes standard care.

Suggestions

How do we integrate addressing smoking into smokefree policy?

1. ***Include*** the statement: "All patients and staff will be assisted to become and stay smokefree."
2. ***Support*** this intent with staff education, dedicated person and project team with responsibility for coordination
3. ***Support*** with pharmacotherapy, and patient resources

How do we integrate addressing smoking into promotion?

1. ***Include*** information about the hospital's smokefree policy in preadmission information (print and web)
2. ***Prepare*** smoking patients for taking responsibility for nicotine withdrawal effects (e.g. bring NRT with them)
3. ***Explain*** in printed material why we ask about smoking and why we encourage people to be smokefree

How do we integrate addressing smoking into the admission process?

1. ***Make*** asking about smoking as common as asking a patient's name
2. ***Ask*** every patient (or care-giver of a child) admitted if anyone smokes at home and if they smoke themselves
3. ***Have*** a place on the admission form to record household smoking and patient smoking status

How do we integrate addressing smoking into routine patient care?

1. ***Share*** responsibility for the 5 As across the team with primary responsibilities as follows: e.g.
   Admitting clerks ask, Doctors/all assess, Doctors /all advise, Nurses/all assist, Nurses/all arrange follow-up
2. ***Add*** "the 5As" to established care pathways and plans such as for asthma, diabetes, pregnancy
3. ***Encourage*** all professionals to seize the motivational moments for promoting smokefree discussions

How do we integrate addressing smoking into staff education?

1. ***Develop*** a core curriculum for education of staff on addressing smoking in the hospital setting
2. ***Include*** this as an annual professional development requirement of all health professional staff
3. ***Include*** the treatment of tobacco dependence as a required education topic for all clinical disciplines
4. ***Educate*** all new staff on the hospital's smokefree policies, systems and practices

How do we integrate addressing smoking into performance standards?

1. ***Define*** performance measures for valued outcomes: 100% ID rates, intervention rates and referral rates.
2. ***Assign*** responsibility for achieving the performance standard to Service Leaders

How do we integrate addressing smoking into quality processes?

1. ***Monitor*** performance with regular audits of patient notes (last admission information)
2. ***Dedicate*** responsibility for recorded smoke-exposure identification and intervention rates to Service Leaders
3. ***Feedback*** to Service Leaders on audit information

How do we integrate addressing smoking into interdisciplinary collaboration?

1. ***Form*** a project group to inform smokefree action in the hospital
2. ***Define*** membership to include representation from doctors, nurses, midwives, allied health professionals, managers, cessation specialists as well as champions from medical, surgical, obstetric, paediatric and pharmacy disciplines, management, cultiural and community environments.
3. ***Appoint*** a project leader to sit under this group and coordinate staff education, systems development, monitoring and cessation support

How do we integrate addressing smoking into discharge processes?

1. ***Prepare*** discharge page/form to include a dedicated place for recording standard intervention activity
2. ***Organise*** referral to cessation service, or, for NRT or counselling support to continue as appropriate
3. ***Advise*** GP or primary health care provider of smoke-exposure status and actions taken during hospital stay
4. ***Summarise*** patient's assessment information on smokefree readiness and interest in support
5. ***Discuss*** smokefree issues at next out-patient appointment

Sample resources

Intended use

Much was learned during the first six months of this project working on systems development with hospitals. The following resources have been developed to fill gaps, strengthen support, short-cut learning, link to current understandings and make it easy for hospitals to move as a coordinated whole in implementing smokefree systems. The resources are offered to district health boards as ideas, in the first instance. They can be used as is, modified to fit the needs of your setting, or, we will work with each hospital to adapt them as required, as part of "Systems First" support.

Available from the Systems First Internet Forum

A web-based discussion forum has been developed to encourage sharing of ideas, exchanging of documents and for storing project resources. New resources will be placed on the forum as they are developed. All resources are available in electronic copy only. To visit or register with the forum go to http://www.efc.co.nz/forum.

Sample leaflet : "Why we ask "

Purpose: To support the implementation of a hospital-wide smokefree screening system. To help shape discussions and build confidence in staff. To encourage self-assessment of readiness and self-referral to smokefree services.

Sample intervention protocol

Purpose: To guide staff through the five As with scripts and questions that are likely to reduce resistance and foster purposeful brief discussion.

Sample core curriculum for staff education

Purpose: To filter out from the vast body of smoking information, an essential minimum that all health care staff need to know in order to provide "best practice" care to smoke-exposed people. To respond to feedback about education priorities and pressures on staff release time. (Variations needed for pregnancy and paediatrics)

Sample staff education power point presentation: "Smokefree Essentials"

Purpose: To enable a hospital to include all staff in smokefree education in a short time as new systems are introduced. To offer an individualized PC-based option as well as a group option for ward-based meeting. To offer an "in-house" option to compliment programmes of other smokefree education providers.

Documentation

Documentation sticker (e.g. for discharge page of patient's notes)

This is an easily audited checklist of a standard intervention for smoke-exposed patients - adult, child or pregnant patients

For Audit	**Re smoking**
☐ Ask:	Household smoking? **N / Y** (Total No. _____) Patient smoking? **N / Y** (_____ c/d or g/w)
☐ Assess:	Recent quit (<6 mths ago)? **N / Y** Quit Readiness (1low—9 high): _____ Like support? **N / Y**
☐ Advise:	Being smokefree important to becoming and staying well Gave "*Why we ask*" leaflet? **N / Y**
☐ Assist:	Talk with someone (staff)? **N / Y** Treat cravings? **N / Y** (☐ NRT ☐ _____)
☐ Arrange:	Referral made to ☐ local cessation service _____ ☐ Quitline ☐ GP for follow-up
	Referred by: _____ Dept/Wd: _____ Date: ___/___/___

Audit tool

Count of recordings for brief interventions on smoking at last admission						
Total notes audited: _____		Dept/Wd:		Admissions From: ___/___/__ to __/___/___		
Patient smoking: _____/_____		Household smoking: ____/____		Audit Date: ___/___/___ Auditor:		
Patient ID	Ask	Smoke-exposed 2nd/1st/both	Advise	Assess	Assist	Arrange
1		/ /				
2		/ /				
3		/ /				
4		/ /				
5		/ /				
		/ /				
Totals		/ /				

Information for professionals

How to use this leaflet

Smokefree screening is the single most important thing a hospital can do to assist people to become and stay smokefree. The evidence is that it trebles intervention rates and doubles abstinence rates[1] (still smokefree after 5 months). It takes about 10 seconds.

[1] Fiore et al, 2000

This "Why we ask" leaflet is to support the health care team through the first stages of introducing a systematic smokefree screening process. Many may feel that this already happens, yet the evidence is that under-recording is as high as 50% in some hospitals. This is an equity issue. Too many people are missing out on standard care

The leaflet aims to:

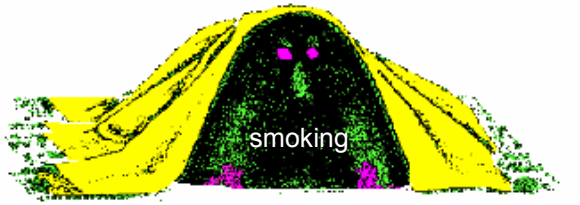
- Offer prompts to help shape discussion
- Build understanding of how smoking undermines recovery
- Restore perspective about numbers wanting support
- Build an expectation that every person will be asked about smoking
- Enable self-assessment of readiness
- Promote local support options
- Share responsibility with patients for discussing smoking

Ways to use:

- have available with other patient information
- offer to a patient and discuss key points
- highlight an aspect and leave with patient

Why we ask

"Are you smokefree?"



First reason

Smoking **hides** behind many of the reasons why people are in hospital. Tobacco smoke:

- harms blood vessels so that less food and oxygen get through to tissues
- harms airways so that dirt and phlegm build up and germs grow more easily
- makes the body change in all sorts of ways that get in the way of being well

Smokefree patients can expect to recover faster, need less medication, have less time in hospital and stay well for longer compared to people who breathe in smoke.

Second reason

Most people who smoke, or live with smoking, want to be smokefree. Most families want to protect unborn babies and children from smoking effects. Talking with us can help.

Thank you.

Sample leaflet produced by Education for Change (www.efc.co.nz)

Smokefree Quiz

How ready am I to be smokefree?

1. How many people at home smoke?
   - **2** just me
   - **1** one other
   - **0** two or more

2. When did I last try to quit?
   - **2** within the last 6 months
   - **1** more than 6 months ago
   - **0** never have

3. How soon after waking up do I have a smoke?
   - **2** after an hour or more
   - **1** in 15 to 60 minutes
   - **0** in the first 15 minutes

4. What is my confidence for quitting?
   - **2** high
   - **1** medium
   - **0** low

Smokefree Score: my guide to readiness

☐ 6-8 = high ☐ 3-5 = med ☐ 0-2 = low

Local support options

- Hospital staff /service
- Quitline …….. 0800 778 778
  for everyone
- Aukati Kaipaipa ……..
  for Maori women
- Smokechange ……. 03 379 9947
  for pregnant women 09 357 0781
- Your general practice team or midwife

Sample leaflet produced by Education for Change (www.efc.co.nz)

"Smokefree Essentials" - a core curriculum

Purpose

The "Smokefree Essentials" power point presentation offers support to district health boards wanting to prepare a lot of staff, in a short time to intervene with smoke-exposed patients. (Available at http:// www.efc.co.nz/forum)

Design

This course is designed as minimum smokefree education for all hospital staff. It is stripped down to the minimum knowledge, attitudes and skills required in order to provide a baseline standard of care to smoke-exposed patients. It builds on tobacco related knowledge and behaviour change principles and is designed to take 10-30 minutes to present or complete. The course can be delivered to individuals as a presentation on a PC, or to larger groups as a presentation at ward hand over. Any person on the staff with professional education competence could present it.

Content

This course covers the bare essentials. More comprehensive education is available from specialist providers such as the National Heart Foundation. Such education is recommended, to build on this core programme as required. In particular, programmes specific to pregnancy[1] and paediatrics[2] are recommended for staff in these settings as intervention needs are different.

Smokefree Essentials			
Essential Facts	The priority	Hospital implications	Effective interventions
Essential Understandings	Behaviour	Change	Readiness
Essential Attitudes	Language	Expectations	Evidence-based practice
Essential Skills	Asking and Recording	Assessing and Advising	Assisting and Arranging
Essential Systems	Screening	Intervention	Referral

Intended use

The "Smokefree Essentials" programme is intended to be used across all staff to support the introduction of a hospital-wide smokefree screening system. It is to prepare staff to integrate minimum interventions into "usual care". The presentation can also be built into ongoing staff education and used for the orientation of new staff.

[1] "Partners in Change" - peer to peer education for midwives supported by Education for Change

[2] Smokefree Children - peer to peer education for paediatric staff supported by Education for Change

Intervention protocol

Rationale

Brief interventions are effective when whole teams participate. The evidence supports "a little and often by many over time" as the most effective smoking cessation strategy. It is in the "many" more than the "little" that effectiveness lies. Certainly, there is a "dose effect" of increased effectiveness from a more intensive intervention for any one person. Yet, one million smoke-exposed people cannot be reached in this way. The impact of each brief intervention is magnified when the whole health care team unites in its commitment to frequent and brief smokefree discussions with patients. The protocol below is for all smoke-exposed, whether first or second-hand smoke.

Protocol

Ask about household and patient smoking	Do you/your child live with people who smoke? Is there any smoking inside? Do you smoke yourself?
Record information in notes	Household smoking? ☐ N ☐ Y Inside smoking? ☐ N ☐ Y Patient smoking? ☐ N ☐ Y
Assess smokefree readiness and interest in support	Check the "Smokefree Quiz" score on the "Why we ask" leaflet and/or ask: ● How do you feel about smoking? Would you like to be smokefree? ● Would you like to talk with someone while you are here? ☐ Y ☐ N ● Would you like NRT (patches) to help with cravings? ☐ Y ☐ N
Advise on smokefree health benefits	Offer patient the "Why we ask" leaflet and/or advise on smokefree benefits: ● Being smokefree will help your wounds health faster ● Being smokefree will make it easier for you to breath ● Being smokefree will make your cough work better
Assist with a smokefree action plan	Invite patient to "tell their story" using open questions to guide the discussion: ● What do you see as the good/not so good things about smoking? ● What do you see as the good/not so good things about being smokefree? ● When are you already smokefree? How can you build on this? ● What do you feel you *can* achieve as a next step to being smokefree?
Arrange Follow-up discussions and/or referral	Arrange follow-up as: ● 1-3 phone calls in the month following discharge ● Referral to a smokefree service or Quitline (0800 778 778) ● Follow-up with nurse, GP, midwife, or at clinic visits

The patient's experience

A good experience

Mr Jones smokes and has elective surgery in 4 weeks He has been advised in preadmission information that the hospital is smokefree and people who are smokefree have better outcomes from surgery. He discusses the preadmission information with his GP and decides to start NRT patches in preparation. On admission he was asked if he was smokefree and offered NRT to manage cravings while in hospital. During his time in hospital, a doctor explained the benefits to airway function and healing from being smokefree. He was visited by a smokefree worker and offered support to stay smokefree on discharge. A record of his participation in the smokefree programme was included in the discharge letter to the GP and follow-up was advised and happened within one week. Regular support from the general practice team was maintained for an eight week period.

A smokefree hospital standard

Steps	How well does your hospital provide a supportive environment for assisting people to become and stay smokefree?
Policy	☐ All DHB buildings smokefree ☐ All DHB grounds, vehicles, and non DHB vehicles in grounds smokefree ☐ Smokefree status of all patients identified (first and second hand smoking) ☐ Assistance to become smokefree offered to all patients identified as smoke-exposed ☐ Ongoing smokefree education offered to all staff ☐ Dedicated responsibility for smokefree coordination within the hospital/DHB
Systems	☐ Promotion ☐ Identification ☐ Documentation ☐ Patient care (patient interventions) ☐ Referral ☐ Monitoring and feedback
Education	☐ Evidence of damage from smoking ☐ Intervention effectiveness ☐ Behaviour change ☐ Brief intervention (5A's) skills ☐ Pharmacotherapy/counselling ☐ Knowledge of roles, responsibilities, hospital's smokefree systems
Interventions	☐ Ask ☐ Record ☐ Assess ☐ Advise ☐ Assist ☐ Arrange follow-up
Services	☐ Smokefree project group (high level) ☐ Smokefree project leader ☐ Dedicated responsibilities for nurses/midwives/allied health professionals ☐ Dedicated responsibilities for medical consultants / junior medical staff ☐ Dedicated responsibilities for managers / administrators ☐ Referral programmes accessed