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Introducing a new stop smoking service in an acute UK hospital: A qualitative study to evaluate service user experience

Susan E. Jones*, Sharon Hamilton

Health and Social Care Institute, Teesside University, Parkside West Offices, Borough Road, Middlesbrough TS1 3BA, UK

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A B S T R A C T

Purpose: Smoking is a risk factor for numerous cancers yet many smokers do not become motivated to quit until they are admitted to hospital with a smoking-related illness.
The provision of smoking cessation services in hospitals could therefore be helpful to these patients. This study aimed to explore the user experience of one such service in a UK hospital and identify whether the service assisted patients to quit smoking.
Method: A qualitative approach was used which incorporated face-to-face structured interviews with 44 patients across 4 clinical specialties in an acute hospital in the UK. Data collection also involved follow-up telephone interviews with nineteen participants approximately 6 weeks later. Data were analysed using a thematic analysis.
Results: Patients with a variety of diagnoses, including cancer, participated in the study and all welcomed the opportunity to access the hospital service. Hospital was seen as an appropriate venue, where it was easier to make a quit attempt and there was ready access to nicotine replacement therapy (NRT) and a supportive environment. A number of 'pushes' towards, and 'pulls' away from quitting emerged from the data and were demonstrated outwardly by how ready the patient was to quit.
Conclusions: The hospital environment provided a prime opportunity to offer stop smoking advice, assessment and treatment to patients. The provision of this service outside of traditional locations broadened opportunities for access particularly when patients were ready to quit. This service therefore made a positive contribution to the stop smoking agenda.

Introduction

The causal link between cigarette smoking and a range of cancers is well established (Peterson et al., 2005). Yet interestingly, once a diagnosis of cancer is given the evidence shows that there are still positive benefits from giving up (Nayan et al., 2011). Continuing to smoke reduces survival times, increases the risk of recurrence or development of further primary tumours and reduces treatment efficacy (Schnoll et al., 2003). All cancer patients who smoke will be affected by delay in wound healing, experience a greater risk of wound infection and an increase in tissue and bone necrosis (Nayan et al., 2011). Patients with head, neck and lung cancers are particularly prone to exacerbation of complications associated with surgery and radiotherapy as smoking directly affects these tissues (Nayan et al., 2011). Reducing smoking rates would lower the incidence of smoking-related cancers overall and improve outcomes for smokers treated for cancer. However, there is strong evidence to show that smokers find it very difficult to quit, particularly without assistance and support, even after a cancer diagnosis (Schnoll et al., 2003; Carlebach and Hamilton, 2009). Those who continue to smoke are considered by Schnoll et al. (2003) to be 'hard core'; but John et al. (2006) and Chan et al. (2010) found this pattern to be consistent with other groups suffering from life-limiting, smoking-related diseases such as stroke. Since the 1980s the evidence associated with smoking and ill-health has been strengthening and the effectiveness of certain stop smoking interventions has also been becoming clearer (Schnoll et al., 2003).

Stop Smoking Services (SSS) have been established in primary care settings in the UK for over a decade and more recently such services are becoming available in acute hospital settings. Hospital-based services would seem particularly appropriate because many smokers do not become motivated to take action until they are admitted to hospital with a smoking-related illness, such as cancer (Twardella et al., 2006; Eadie et al., 2008; Department of Health

* Corresponding author. Tel.: +44 01642 342984; fax: +44 01642 342983.
E-mail addresses: Susan.Jones@tees.ac.uk (S.E. Jones), Sharon.Hamilton@tees.ac.uk (S. Hamilton).

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(DH), 2011). Rigotti et al. (2009) refer to this situation, where the patient is more ready than usual to consider a health-related behavioural change, as a 'teachable moment'. However, Gritz et al. (2005) conclude from their systematic review that diagnosis of cancer remains an underused opportunity.

Nurses provide the majority of patient care in hospitals and findings from a Cochrane Review, Nursing Interventions for Smoking Cessation (Rice and Stead, 2008), suggest they have a role in supporting patients to quit smoking. The review highlighted that interventions delivered and supported by nurses, especially in hospital, increased a smoker's success in quitting. There is however some evidence to show that there is reluctance on the part of nurses to introduce the subject of smoking cessation to patients who smoke (Lally et al., 2008). Another Cochrane review, Interventions for Smoking Cessation in Hospitalised Patients (Rigotti et al., 2009), concluded that there was insufficient evidence to recommend any one particular hospital-initiated intervention.

What is clear is that smoking behaviour is multi-factoral and therefore multi-method approaches are recommended to support quit attempts (National Institute for Health and Clinical Excellence (NICE), 2007, 2008). A first step in a multi-method approach is a brief intervention (NICE, 2008; DH, 2011). This involves an opportunistic, routine enquiry to all patients on their smoking status and, if they smoke, their readiness to quit (NICE, 2006; DH, 2011). If they smoke and are open to advice to quit, advice should be clear and tailored to the individual's health and include information on the availability of stop smoking services (Ghodse et al., 2008). Patients have often been given advice to quit by different people, over a long period of time. Research suggests that the hospital admission has the potential to offer the patient the opportunity to act upon this advice. Although the quit attempt can be started in hospital, appropriate community support needs to be available after discharge home to reduce the likelihood of patients returning to smoking (NICE, 2007, 2008). This is supported by evidence from a Cochrane review which showed that smoking cessation counselling delivered in acute hospital settings, combined with follow-up support that lasts at least one month post discharge, increases smoking cessation rates (Rigotti et al., 2009).

Hospitals in the UK are being encouraged to capitalise on the 'teachable moment' by offering smoking cessation support to patients, so they can start a quit attempt when their motivation is high (DH, 2011). As this is a new service in acute hospitals it is important to explore patient experiences so that developments reflect patients' needs and expectations. The purpose of this paper therefore is to report the user experience of such a service and provide information for the development of similar services.

The new stop-smoking service

The new service was based in a 1000-bed acute hospital in an industrial area in the north of England and targeted four clinical specialties: cardiac, respiratory, Ear, Nose and Throat (ENT) and women's services (including maternity). Any patients referred from outside these target specialities were assessed, as it was important that no patient was refused access. Therefore patients with a variety of diagnoses, including cancers, were referred. The service aimed to provide swift, smoking cessation opportunities for all patients who wished to access them. Many aspects of the service from the initial contact, to the advice and counselling given to patients by smoking cessation staff, were influenced by evidence of best practice (DH, 2009). The service was provided in a range of locations including at the bedside, in the hospital clinics and as a drop-in service in the hospital reception area. The service comprised a team of four part-time smoking cessation facilitators, each of whom worked 15 h per week, led by a stop smoking specialist working 30 h per week. All the facilitators had a nursing background, although this was not a specification of the role. The team offered a brief intervention to all smokers on targeted wards. For patients who wanted more, a further assessment with advice and counselling was offered.

Methods

Study design

A qualitative design was used to collect data via face-to-face structured interviews with service users ($n = 44$) and follow-up telephone interviews with those who could be contacted, approximately 6 weeks later ($n = 19$). A structured interview schedule was developed with questions informed by themes that emerged from the literature review. Data were also collected from staff and addressed broader themes including hospital systems and health staff roles that promoted smoking cessation and are reported elsewhere (Jones and Hamilton, 2011).

Sample selection and data collection

Once approval had been secured from the University Ethics Committee and Trust Research and Governance department, the initial approach to patients was made by the smoking cessation team. They used a standard script, prepared by the researchers, to explain the study aims to the 328 patients whom they assessed during the 4 month study period (January 2010 to April 2010 inclusive). The contact details of those wishing to take part were passed to the research team. Recruitment was frustrated by the short length of stay of patients, part-time hours of the smoking cessation team and limited availability of the researcher. Therefore, those who stayed in hospital longer were more likely to be recruited. Also some contextual factors influenced sample selection e.g. only smokers who were made aware of the service, those who chose to access it and those who agreed to be interviewed were invited to participate.

Once the research team had obtained written informed consent from participants, a face-to-face structured interview was conducted at the bedside or in the clinic room. Forty-four participants took part in the interview; 21 women and 23 men, aged from 23 to 73 years. Most were white British ($n = 42$) with one participant classing themselves as 'White Other' and another as 'Asian British' (Tables 1–3).

During the interview the researcher documented the participant answers and verbatim quotes. Questions related to: their thoughts about being given stop smoking advice in hospital and having a stop smoking service available, the extent of their tobacco dependency, experiences of previous quit attempts and if any healthcare professional had prompted their quit attempt on this occasion (Table 4).

At the end of the interview, participants were asked if a follow-up telephone interview could be undertaken with them 6 weeks

Table 1
Age range of participants.

Age range	No. of patients given initial questionnaires	No. of patients successfully contacted by telephone
Under 18 years	0	0
18–29 years	3	1
30–39 years	6	3
40–49 years	9	2
50–59 years	12	6
60–69 years	9	6
70 years and over	5	1
Total	44	19