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Reframing tobacco dependency management in acute care: A case study

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ABSTRACT

Effective tobacco dependence treatment within acute care tends to be inadequate. The purpose of the Utilizing best practices to Manage Acute care patients Tobacco Dependency (UMAT) was to implement and evaluate an evidence-based intervention to support healthcare staff to effectively manage nicotine withdrawal symptoms of acute surgical patients. Data collection for this one-year longitudinal case study included: relevant patient experiences and staff reported practice, medication usage, and chart review. Over the year each data source suggested changes in tobacco dependence treatment. Key changes in patient survey responses ($N = 55$) included a decrease in daily smoking and cigarette cravings. Of patients who used nicotine replacement therapy, they reported an increase in symptom relief. Staff ($N = 45$) were surveyed at baseline, mid-point and end of study. Reported rates of assessing smoking status did not change over the year, but assessment of withdrawal symptoms emerged as daily practice and questions about cessation diminished. Also delivery of nicotine replacement therapy products increased over the year. Chart reviews showed a shift in content from documenting smoking behavior to withdrawal symptoms and administration of nicotine replacements; also frequency of comments increased. In summary, the evidence-based intervention influenced unit norms and reframed the culture related to tobacco dependence treatment.

1. Introduction

Evidence of health risks associated with tobacco use and exposure to tobacco smoke [1–6] have supported the development of smoking cessation clinical practice guidelines [7,8] and adoption of tobacco control strategies in healthcare settings [9,10]. Within hospitals, these strategies typically focus on banning smoking on hospital property, with the aim to: decrease exposure to tobacco smoke; communicate messages concerning patient safety, health risks and tobacco; and motivate patients to quit [10–15]. With smoking bans on hospital property, smoking patterns of patients addicted to nicotine are disrupted and they will experience withdrawal symptoms during admission. While support to quit smoking is mentioned in smoke-free grounds policies, research suggests tobacco

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dependence is inadequately treated in acute care settings and the enforcement of smoking restrictions is problematic [10,11,16–19]. Two cited barriers underlying the inadequate treatment of patients' tobacco dependence are patients lack of interest in quitting smoking and healthcare providers lack of time to address this need [20–23].

Tobacco dependence treatment that focuses on a long-term goal of cessation is a well-documented healthcare practice expectation [7–9]. In acute care hospitals, patient care focuses on short-term goals to manage symptoms with the intent to stabilize and improve health status so the patient can go home. While tobacco dependent patients may be encouraged or told to quit due to health concerns and/or setting restrictions, the advice is rarely delivered with adequate resources to support a quit attempt at that time. Nicotine replacement therapies (NRT), such as the gum and patch, can assist with quitting by managing withdrawal symptoms, but tend to be inconsistently offered during acute care hospitalizations. Furthermore, as NRTs are offered as aids to quit smoking, when patients refuse to quit, there are rarely further conversations about tobacco use or quitting during their hospital stay [10,12,16–18]. For patients who refuse to quit smoking, their inevitable withdrawal symptoms are managed by leaving the unit to go outside and off of hospital property (or not) to have a cigarette, a practice that reportedly compromises patient safety and increases workload stress for healthcare providers [10,16]. Reframing tobacco dependence treatment expectations to focus on the management of withdrawal symptoms aligns with routine practice expectations of symptom management versus behavior change in acute care [10,20], and may also increase the delivery of effective tobacco dependence treatment within the context of acute care.

Utilizing best practices to Manage Acute care patients Tobacco Dependency (UMAT) was a demonstration study to evaluate the implementation of an evidence-based practice protocol and tools designed to support healthcare staff with managing patients' nicotine withdrawal symptoms on one acute care in-patient unit. This strategy was designed to reframe expectations for treating tobacco dependence away from getting patients to quit, and toward effective symptom management. In this paper, we provide an overview of the study methods, protocol and tools (intervention), as well as the evidence of practice changes tracked through multiple data sources.

2. Methods

A longitudinal case study approach [24,25] was used to investigate the uptake and to track practice changes from a multi-component nicotine withdrawal treatment intervention in an acute care setting. Beyond implementation of the intervention, the research objectives to track changes in tobacco dependence treatment included monitoring patient experiences, staff reported practice, medication usage, and documentation regarding patient care. As is common with case study approaches, the sampling strategy was purposive and included all eligible participants involved with the case site [24,25]. The case in this study was the unit, and all patients and healthcare providers involved with the unit between April 2013 and May 2104 were eligible to participate. Approvals were obtained through the Education and Nursing Research Ethics Board at the University of Manitoba and the St. Boniface Hospital Research Review Board.

2.1. Case study site context

The case study site was a 25 bed acute surgical unit within a large Canadian tertiary hospital, with a 10-year history of a smoke-free grounds policy. This adult unit specializes in vascular, urology, and plastic surgical procedures. Discussions with unit management revealed that pre-study practice norms included assessment and documentation of patients' tobacco status on admission and advisement of smoking restrictions. It was estimated that approximately 25% of patients on the unit were smokers. As well, nicotine patches were inconsistently offered on admission, and when a patient refused to quit, the patch was unlikely to be offered again. Considerable effort was required of patients determined to smoke, including an elevator ride down 4 floors, a relatively long walk to exit the hospital, and further walking to leave hospital property. Patients with mobility issues would occasionally be accompanied by a health care aid, which in turn affected staffing resources and also exposed that staff member to secondhand smoke.

While no tobacco policy changes were implemented within the hospital during the study year, two other unit changes were implemented just prior to the beginning of this study. First, the unit implemented an Electronic Patient Record (EPR) system, which included a newly designated space to document care related to tobacco dependency. While this was great news for the study, documentation of tobacco-related patient care activities had been uncommon practice on the study unit and the staff was also adjusting to a new format for charting. In addition, the long-time unit manager was temporarily transferred and an interim unit manager was assigned for a year. Although perhaps not a significant influence, the change in management may have influenced dynamics among the staff and the collective ability to adopt a new protocol.

2.2. The Intervention: protocol and practice tools

The evidence-based multi-component nicotine withdrawal treatment intervention was designed to help healthcare providers and patients reframe treatment of tobacco dependence during hospitalization (see Table 1: list of intervention components). The specific aim was to focus on a short-term goal of managing nicotine withdrawal symptoms rather than a long-term goal of cessation. Protocol and tool development occurred simultaneously with the revision of the local health authority's (Winnipeg Regional Health Authority [WRHA]) practice guidelines for the management of tobacco use and dependence. The WRHA guidelines were also shifting focus from cessation to symptom management during hospitalization; the hospital where the study unit is located began adopting the revised WRHA guidelines in 2015.