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Health Behavior

Challenges of implementing routine health behavior change support in a children's hospital setting

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ABSTRACT

Objective: Evidence indicates that health behavior change initiatives are often not implemented successfully. This qualitative study aims to understand the barriers and facilitators to implementation of health behavior change brief advice into routine practice in an acute children's hospital setting.
Methods: Semi-structured interviews were conducted with health professionals working at a UK children's hospital ($n = 33$). Participants were purposively sampled to incorporate a range of specialties, job roles and training.
Results: An inductive thematic framework analysis identified two emergent themes. These capture the challenges of implementing routine health behavior change support in a children's hospital setting: (1) 'health professional knowledge, beliefs and behaviors' and (2) 'patient and family related challenges'.
Conclusion: This study enhances findings from previous research by outlining the challenges pediatric health professionals face in relation to supporting health behavior change. Challenges include failure to assume responsibility, low confidence, prioritization of the health provider relationship with patients and families, health provider and patient knowledge, and low patient and family motivation.
Practice implications: Skills-based behavior change training is needed for pediatric health professionals to effectively support health behavior change.

1. Introduction

Lifestyle behaviors such as smoking, excessive alcohol consumption, poor diet and lack of physical activity are the main causes of mortality and morbidity worldwide [1–3]. Such lifestyle behaviors place financial burden on healthcare services. The estimated cost of treating obesity-related illness in the UK reaches £4.2 billion each year [4], and smoking and alcohol equally cost the health service in the UK £5.4 billion [5,6]. Reduction of behavioral risk factors is now consistently advocated by healthcare policy-makers as a solution to prevent and reduce the associated costs [4,7,8].

Policy-makers have mandated that healthcare professionals have a responsibility to routinely provide health behavior change brief advice to service users during everyday contacts [9]. This is also recommended in evidence-based guidance on individual behavior change [10]. In the UK this policy-driven activity is being referred to as an initiative called 'Make Every Contact Count (MECC)'. MECC is currently being rolled out across NHS healthcare contexts in England, United Kingdom. Evidence suggests that healthcare policy-driven initiatives are often not implemented successfully in practice [11]. It is argued that this may stem from a failure to identify barriers and facilitators to implementation of evidence-based practice [11–13]. Exploration of the behavioral factors that influence implementation is necessary so that contextual barriers can be fully understood and appropriate solutions developed in accordance with these [14].

Studies that have sought to understand why initiatives are not successfully implemented have offered a range of perspectives. Healthcare organizational barriers such as lack of time and financial constraints are frequently cited as reasons lifestyle factors are not addressed with patients [15–18], as well as absence of effective mechanisms for communication [19].

Other studies have highlighted the role of healthcare professional attitudes and beliefs in shaping implementation of health

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behavior change interventions. Beliefs about roles and responsibilities [19–27], health professional skills in addressing behavior change [24,27,28] and beliefs about capabilities including self-efficacy [16,29,30] and confidence [22] have shown to be related to addressing patient health behavior change. Health professional perceptions regarding patient knowledge [19], motivation [19,26,31–33] and acceptability [17,20,21,26] are also important.

The focus of this study was to explore the views of health professionals on talking about health behavior change with pediatric hospital patients aged 12 and above and their families. This study was necessary firstly because the majority of previous research has been conducted with primary care practitioners, and those providing care to adult acute patient populations [22,27]. Secondly, few studies have been conducted to understand the challenges for pediatric health professionals in relation to delivering health behavior change brief advice as part of routine practice in the acute setting. Studies that have are predominantly qualitative and relate specifically to smoking [34,35]. Except for recent qualitative research examining the challenges of lifestyle change conversations for medical professionals and trainees [24] which found that the quality of the doctor–patient relation could influence decisions to discuss behavior change with patients. Thirdly, it is unclear whether the triadic approach to conversations between health professionals, patients and families may lead to additional challenges for pediatric health professionals. This study addresses gaps in the literature by exploring health professional views on providing health behavior change brief advice to patients and families in an acute children's hospital.

2. Methods

2.1. Participants and recruitment

Thirty-three participants were purposively sampled to incorporate a range of medical specialties, job roles (nurses, junior doctors, allied health practitioners and clinical support staff) and levels of training in relation to providing brief opportunistic advice. Two potential participants were approached but did not participate due to limited availability. Table 1 details the medical specialties represented within the sample. During the period of data collection MECC was in its early implementation phase with four general medical wards trialing provision of routine health behavior change brief advice. These brief contacts include activities such as advice giving and directing to other support services, raising awareness of risks, or providing encouragement or support for lifestyle change. It is suggested that these activities range from 30 seconds in duration to a couple of minutes [10]. Health professional training was also taking place in the hospital in relation to MECC; therefore six health professionals had received training.

Table 1
Participant characteristics and pediatric specialties represented in the sample.

Female	91%
Median age	29.7 (18–55)
Mean time in profession (range)	10 years and 1 month (3 months to 34 years)
Mean time worked for hospital (range)	6 years and 10 months (1 month to 24 years)
Speciality	Number of participants
Emergency medicine	2
Hospital outpatient care	2
Allied therapies (e.g. physiotherapy and occupational therapy)	3
General medicine	10
Mental health	5
Neurology	1
Oncology	4
Neonatology	2
Surgery	1
Burns care	3

Ethical approval was not required as the NHS National Research Ethics Service defined this study as service evaluation. Informed consent was obtained for interview content to be used in publications. The anonymity of participants was protected by reporting only generic professional titles, e.g. nurse, doctor, allied health professional and clinical support staff.

2.2. Data collection and analysis

Interviews were conducted by the first author (LE) at the hospital in locations convenient for participants during February and March 2012. The interviewer explained the study details and obtained informed consent, and was not personally known to the participants. Interview lengths ranged from 7 to 45 min (mean 19 min) and were arranged at a convenient time dependent on clinical workload and to ensure maximum variation relating to job role, training levels and medical specialties.

A semi-structured topic guide was used throughout the interviews. The main focus of the interview questions was to understand health professional attitudes and beliefs in relation to MECC and delivering brief advice to patients and families (including parents and carers) which for the purpose of this study was defined in relation to smoking and obesity-related behaviors as these were a priority focus for the hospital. This included questions relating to current knowledge and skills, as well as beliefs in relation to responsibilities. Table 2 details topics covered during the interviews.

2.3. Analysis

Interview findings were analyzed using a thematic framework analytical approach [36]. Thematic framework analysis was chosen as it is considered appropriate for policy-related applied research that has short timescales [37]. A realist orientation was adopted, as this is not aligned to a specific epistemological or theoretical approach, suitable for policy-related research [37].

Ten interview transcripts were open-coded initially by the first author and then a preliminary coding framework was developed and applied to a further 10 interview transcripts. During this process any additional codes which arose and were not detailed in the preliminary coding framework were incorporated into the framework in an iterative process. A second coder (fourth author) also used the framework to code a different set of 10 interviews out of the 33. Subsequent discussions took place between the two authors to further refine the coding framework. The revised framework was then applied to the remaining 13 interviews, which were also coded by a third coder (third author).

Following coding of all interview content, codes were collated into key themes for the entire data set. Subsequently, all coded data were chartered into a matrix for each theme. Mapping and interpretation were then performed whereby associations between themes were examined, as well as between and within participants. Qualitative analysis software was used to support the analytical process throughout (NVivo version 9.2).

3. Results

Table 3 provides sample demographic information. Two master themes from the analysis are presented in this section; 'health professional knowledge, beliefs and behaviors' and 'patient and family related challenges' (Table 4 details master themes and sub-themes). A third theme "pediatric hospital environment"

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