



## Short Communication

## Maintenance of tobacco cessation programmes in public hospitals in Catalonia, Spain



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## HIGHLIGHTS

- Few studies have described the availability of smoking cessation drugs in hospitals.
- Public health administration helped to implement smoking cessation protocols.
- Most of the hospitals included smoking cessation drugs in their services' portfolio.
- Some hospitals refused to buy these drugs, jeopardising these protocols.

## ARTICLE INFO

Available online 26 November 2014

## Keywords:

Hospitals  
Smoking cessation  
Inpatients  
Health personnel  
Drug therapy  
Nicotine

## ABSTRACT

**Introduction:** The provision of smoking cessation interventions in hospitals has been strongly recommended. The aim of this study is to determine the maintenance of smoking cessation programmes for inpatients and hospital workers in hospitals of Catalonia (Spain) seven years after the implementation of a Tobacco Cessation Programme. **Methods:** A cross-sectional survey was conducted in all hospitals that offer public service in Catalonia, Spain ( $n = 73$ ). An online questionnaire was sent to all coordinators of the smoke-free hospital project or managers of each hospital. The survey included questions about the type of hospital, type of programmes implemented and availability and source of smoking cessation drugs. **Results:** Responses to the questionnaire were submitted by 58 hospitals (79.5%). 74% and 93.1% of the hospitals had smoking cessation programmes for inpatients and workers, respectively. Most of the hospitals maintained the programmes and started routinely buying smoking cessation drugs after a period of receiving them free-of-charge. However, 17.2% of the hospitals refused to buy these drugs and 24% never had these drugs available. **Conclusions:** Through a supportive Tobacco Cessation Programme, most hospitals have smoking cessation programmes for both patients and workers. Most of them have incorporated smoking cessation drugs as a regular resource in their services' portfolio. The lack of these resources may jeopardise the maintenance of well-established programmes in hospitals.

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### 1. Introduction

Clinical guidelines and reviews have strongly recommended the provision of smoking cessation interventions in all clinical health-care settings (Fiore, Jaén, & Baker, 2008; Rigotti, Clair, Munafò, & Stead, 2012). The Framework Convention on Tobacco Control (FCTC) also

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endorses smoke-free environments and the provision of smoking cessation aids as the most comprehensive and suitable policies that hospitals can adopt to effectively reduce smoking (WHO, 2008). Indeed, smoke-free hospitals have the opportunity to provide tobacco cessation treatments to hospitalised patients and employees who smoke in a favourable healthy environment (Carlfjord, Kristenson, & Lindberg, 2011; Global Network for Tobacco Free Health Care Services (ENSH); Reid et al., 2010; Ripley-Moffitt, Viera, Goldstein, Steiner, & Kramer, 2010). Hospitals that provide adequate access and support for smokers increase smokers' attempts to quit, improve cessation rates, and reduce medical expenditures (Reda, Kotz, Evers, & van Schayck, 2012). Furthermore, hospital smoking cessation programmes for both patients and staff that include behavioural and pharmacologic interventions increase cessation rates (Fiore et al., 2008; Martínez et al., 2012; Rigotti et al., 2012).

Maintaining tobacco cessation programmes beyond their implementation remains a challenge. The sustainability of tobacco cessation programmes relies on some hospital organisational and managerial features (France, Glasgow, & Marcus, 2001; Taylor, Miller, Cameron, Fagans, & Das, 2005). To date, few studies have described the availability and provision of pharmacotherapy necessary to successfully treat nicotine addiction in hospital tobacco cessation programmes (Centers for Disease Control and Prevention (CDC), 2010; Knudsen & Studts, 2011; Knudsen, Muilenburg, & Eby, 2013).

In Spain, the National Health System funds the costs of hospitalisation, including most pharmacotherapy (García-Armesto, Abadía-Taira, Durán, Hernández-Quevedo, & Bernal-Delgado, 2010). Each hospital provides a variety of drugs that can be purchased within the assigned governmental budget. The provisions for nicotine replacement therapy (NRT) and other drugs for smoking cessation depend on the criteria of each hospital, since NRT is not publicly funded. The aim of this paper is to determine the maintenance of tobacco cessation interventions for hospitalised patients and hospital workers in Catalan hospitals seven years after the implementation of a Tobacco Cessation Programme (Programme). The Programme was coordinated by the Catalan Network of Smoke-free Hospitals with the support of the Governmental Department of Health, including cost-free pharmacotherapy for smoking cessation.

## 2. Methods

### 2.1. Design

The data were obtained from a cross-sectional survey that was conducted from April to July 2012. The survey was administered seven years after launching the Programme, which was coordinated by the Catalan Network of Smoke-free Hospitals. The aim of this Programme was to facilitate the implementation of smoking cessation programmes in acute hospitals after an indoor smoking law ban came into force (Law 28/2005) (Fernández & Nebot, 2011). This Programme included free-of-charge pharmacological aids, tobacco cessation training and education to health workers and external expert support to engage hospitals in the implementation of the new strategy (for more information see Martínez et al., 2012). Among the 73 hospitals that offered public service in Catalonia, only six and five hospitals provided smoking cessation interventions to hospitalised patients and hospital workers, respectively, prior to this coordinated Programme (in 2005).

The Programme provided NRT for both patients and hospital workers, and bupropion and varenicline were additionally available for hospital workers; the drugs were offered for inpatients during their hospital stay plus three days after discharge, and over approximately three months for hospital workers. The smoking cessation drugs were provided free-of-charge by the Department of Health and distributed by the Catalan Network of Smoke-free Hospitals to the hospitals during the period from January 2005 to January 2012. After 2012, the Programme was redefined to support special populations in

hospitals (e.g., patients with chronic obstructive pulmonary disease and/or mental health disorders). Therefore, the hospitals had to provide their own cessation pharmacotherapy after January 2012.

### 2.2. Questionnaire and procedure

We developed an ad hoc online questionnaire composed of 26 items that considered four main dimensions:

- i) *Hospital features*: level of technology (general, reference and high technology), number of beds ( $\leq 300$  or  $>300$ ) and number of staff ( $\leq 700$  or  $>700$ ).
- ii) *Type of programme implemented*: programme for hospitalised patients, hospital workers or both.
- iii) *Availability of pharmacotherapy*: NRT (patches, gums and lozenges), bupropion and varenicline (before and after January 2012).
- iv) *Source of the pharmacotherapy*: provided by the Department of Health through the Catalan Network, bought by the hospital, bought by the staff and other situations (before and after January 2012).

The questionnaire was piloted among five smoke-free hospital project coordinators to assess their level of understanding and response in February 2012. The survey was sent to all smoke-free hospital project coordinators and/or managers from the 73 hospitals that offer public service in Catalonia. 68 of the 73 hospitals (93.2%) were members of the Catalan Network of Smoke-free Hospitals.

To increase participant response, the link to the questionnaire was sent with a personalised e-mail explaining the study aims and asking for their participation. Participants were contacted a maximum of five times by means of the on-line invitation to participate in the study. After the fifth contact, we reached participants by phone. The data collection period was four months, from April to July 2012.

### 2.3. Data analysis

A descriptive analysis of the main variables was accomplished by calculating the frequency and percentage for qualitative variables and the mean and standard deviation for quantitative variables. We also performed Chi-Square tests to compare proportions.

## 3. Results

Of the 73 hospitals in Catalonia, 58 submitted completed surveys (79.5%). Among the participating hospitals, there were 29 general hospitals, 15 reference hospitals, 6 high technology hospitals and 8 other hospitals. The 58 hospitals included 15,704 beds (mean: 275.5; SD: 255.2) and 63,527 staff workers (mean: 1134.4; SD: 1299.1). 43 (74%) hospitals had tobacco cessation programmes for inpatient smokers with specific clinical protocols, and 40 (69%) hospitals had pharmacotherapy for this purpose.

We did not find statistical differences in the provision of NRT among the hospital types or the number of staff members (less or more than 700). 15 (62.5%) of the smallest hospitals (number of beds  $\leq 300$ ) compared to 26.7% in the hospitals with more than 300 beds had never bought NRT at the time of the survey. 8 (53.3%) of the biggest hospitals ( $>300$  beds) compared to 16.7% in the smallest hospitals had increased the purchase of NRT before January 2012 ( $p = 0.038$ ).

Until January 2012, 40 hospitals (69%) received NRT from the Catalan Network, 3 (5.2%) bought the entire supply of NRT for themselves, and 15 (25.9%) did not have NRT in the hospital. After the Catalan Network redefined the Programme and stopped the provision of NRT, 21 hospitals (36.2%) were buying or were about to buy NRT. Of the hospitals that did not provide the pharmacological treatment, 4 (6.9%) were debating the purchase of NRT, 9 (15.5%) did not debate this issue and 10 (17.2%) refused to buy these drugs once the provision of NRT by

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