Smoke Free Health Care: an organisational change to increase effective intervention for tobacco

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Abstract: In 1999, the *NSW Health Smoke Free Workplace Policy* directed that grounds of health sites would become smoke free, in addition to the existing policy requiring smoke-free buildings. This was one of the first attempts by any health service to exclude tobacco entirely from health sites. This task required the adoption of evidence-based management of tobacco dependence and changing the culture of smoking in the health service. There were many barriers to implementation.

In North Coast Area Health Service (NCAHS), the Health Promotion Tobacco Team adopted a change-management approach called Smoke Free Health Care to increase effective intervention for tobacco across the health service. This used a 'hearts and minds' communication strategy to maximise the belief that change was possible. This report describes the process by which smoke-free status was achieved in all NCAHS hospital, community health and drug and alcohol detoxification sites by July 2007.

The *NSW Health 1999 Smoke Free Workplace Policy* (SFWP) directed all area health services to go smoke free before September 2002, subject to a review process.[1] However, by 2002, the most concerted efforts to implement the SFWP had been frustrated by multiple barriers. There was major risk of non-compliance in moving sites to a smoke-free status in the face of resistance.

The former Northern Rivers Area Health Service (NRAHS) responded by successfully rolling out smoke-free policies, using a systematic and innovative change management process consistent with Kotter's steps for transformation in organisations.[2] Kotter's eight steps include establishing urgency, forming a powerful coalition, creating a vision, communicating the vision, empowering others to act, creating short-term wins and consolidating and institutionalising new approaches.[2] The NRAHS process was affected by the 2005–2006 restructure of NSW Health, but ultimately became stronger after the Mid North Coast Area Health Service and NRAHS merged to become North Coast Area Health Service.

2002: leadership, sharing the vision, mapping and consultation

During 2002, within the former NRAHS, it was recognised that the existing SFWP Working Group was ineffective because it lacked influence. The Chief Executive therefore established a high-level Smoke Free Steering Committee, which he chaired, and a Smoke Free Co-ordinator was appointed to facilitate the transition. This began a five-year process of sustained engagement to bring about effective change across the health service.

In late 2002, a forum was held for senior managers and union representatives to prioritise tobacco control and address participants' concerns. Following the forum, where attendance was compulsory, the Co-ordinator met with managers, union representatives and staff across the NRAHS, presenting the reasons for addressing tobacco (503 people in 29 sessions). Concerns were voiced as were valuable ideas, which were subsequently developed. These consultations revealed that many staff had a poor understanding of tobacco addiction and nicotine titration and dosing. Many staff members, both smokers and non-smokers, were resistant, believing the smoke-free policy offended smokers' 'rights', could lead to violence, was impractical or would just 'never happen'.

It emerged that some settings had a 'culture of smoking', with considerable positive social reinforcement through shared breaks with colleagues in smoking areas. In mental health, Aboriginal health and youth work settings, it was not unusual for staff to smoke with clients during health service delivery. It was also accepted practice for staff to facilitate the smoking of inpatients by helping them to smoking zones, and some emergency department staff kept cigarettes for patients to help manage behaviour. Exposure of staff to second-hand smoke was common.

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Changing attitudes and behaviour regarding tobacco is challenging because nicotine is a drug of dependence and smokers need to dose themselves frequently to avoid withdrawal.[3] This had implications for how staff managed smoking of inpatients in smoke-free hospitals, and also for the approximately 22% of staff who smoked at the time that the policy was launched.[4] While many staff became champions of the policy, not all could separate their personal smoking from their professional role.

Implementing the policy therefore involved a transformational effort in a large organisation, covering human resource management, corporate governance, workforce development and clinical care. However, the challenges of implementation were matched by corresponding opportunities for tobacco control. With a workforce of approximately 8000 people and a large public interface, the now-amalgamated NCAHS has a large potential to deliver congruent messages about tobacco control to the population.

In response to the issues that emerged from mapping and consultation, the Health Promotion Team in NRAHS developed an innovative approach to change attitudes and behaviours across the workforce. Because of anxiety about the policy, this needed to acknowledge both thinking and feeling elements to bring the majority of staff 'on board'. The project was renamed *Smoke Free Health Care* (SFHC) to signal that this was about improved care when addressing tobacco wherever it intersected with the health service. Effective intervention incorporated both the delivery of evidence-based care for tobacco dependent patients and the delivery of congruent 'tobacco messages' via environmental policies. The clinical and environmental dimensions were conceived as interdependent: success in one domain supported success in the other.

Since the scope of the organisational change was broad, health settings were addressed sequentially, starting with community health. The primary tool in changing the thinking, beliefs and behaviours of staff was mandatory education. This education that reached the majority of staff across NCAHS (Table 1), countered myths about tobacco and presented reasons of change.

2003–2004: getting runs on the board – *Smoke Free Community Visits Policy*

Early consultations revealed exposure of staff to tobacco smoke during home visits. To address this, a *Smoke Free Community Visits Policy* was developed with positive

Table 1. A summary of evaluation and monitoring of Smoke Free Health Care compliance and education in North Coast Area Health Service

Item	Sites	Evaluation findings
Smoke-free status	43 health sites including 22 hospitals, 20 non-inpatient services, 1 Drug and Alcohol Detoxification facility	All sites adopted 100% total smoke-free status between October 2002 and June 2007
Compulsory education sessions (smoke-free transition, smoke-free community visits and other)	Senior Managers, education and consultation sessions, hospital transitions, Community Health, Oral Health, Aboriginal Health, Allied Health, Mental Health	Smoke-free transition education: 280 sessions and 2789 people. Smoke-free community visits and other education sessions: 79 sessions, 1072 people
Evaluation of smoke-free community visit education	Community Health, Oral Health, Aboriginal Health, Allied Health	Significant improvements in knowledge and attitudes in relation to tobacco intervention pre to post education sessions
Clinical practice improvement project	Tweed Hospital pilot implementation 2004	15-week ward audit before, during and after implementation. Substantial increase in information provided to patients; NRT offered or provided; and nicotine-withdrawal monitoring
Physical site reviews	15 Smoke Free Health Care inpatient hospitals	Signage: more than 90% appropriate at all sites. Butts: cigarette butt litter now rarely seen on site. Smokers: majority of inpatients, visitors and staff comply and smoke off hospital grounds
Detailed clinical audit	Grafton, Maclean and Lismore Hospitals	39% were given verbal advice to quit, 52% were offered NRT, 52% were not smoking during admission
Retrospective medical record audit of identified smokers	Grafton Hospital	18% used NRT during their hospitalisation, 73% had completed Substance Use History Forms in notes, 43%1 had completed the Smoke Free Health Care Patient Waiver
Staff smoking survey	Grafton, Maclean	1999 NRAHS staff smoking survey: 22% of staff were current smokers. 2006 Grafton and Maclean health sites one year after going smoke free: 16% were current smokers, 5% of all staff had quit smoking during last 12 months

leadership from community health. The policy directed that staff should not smoke while delivering a health service, nor allow themselves to be exposed to second-hand smoke during home visits. It was implemented via compulsory training for all staff who conducted home visits (290 staff at 25 sites).

Evaluation showed that these one-hour sessions delivered by a persuasive and credible communicator could significantly shift knowledge and beliefs, and increased workers' intentions to discuss smoking with smoking clients whenever possible.[5] These sessions became the model for implementing all smoke-free guidelines and policies. Despite anxieties expressed at the beginning of the change-management process, the *Smoke Free Community Visits Policy* was implemented without difficulty and was well accepted by clients. This success provided leverage when it came to addressing smoking in inpatient facilities.

Smoke-free initiatives were presented to the peak Mental Health Community Participation Forum, and were made a standing item on the NRAHS Aboriginal Health Council. Early on, some Aboriginal Health Workers expressed concern about the smoke-free policy. It was agreed that smoke-free initiatives should be conveyed through stories in the Aboriginal media and letters to Aboriginal Land Councils. A culturally appropriate leaflet was developed asking Aboriginal clients to protect the health of staff by making their home smoke-free during health service delivery.

The implementation experience of *Smoke Free Community Visits* involving shifting staff through anxiety–resistance–adaptation was repeated as SFHC actively sought to change norms in successive health settings through compulsory education. Once managers and staff were given well researched information, anxiety abated and staff began to believe that smoke-free policies might work. Good compliance outcomes could only be achieved if there was a critical mass of staff willing to approach those smoking on health sites and ask them to take their cigarette off health grounds.

2003–2004: developing a means to care for inpatients who smoke

Following the mapping phase, a Nicotine Addiction Clinical Advisory Group (NACAG) was created via a partnership with NCAHS Chronic Care to develop a best practice guideline for the management of nicotine-dependent inpatients, underpinned by the option of nurse-initiated nicotine replacement therapy (NRT). Formalising this important process took longer than anticipated because of the discrepancy between the evidence for NRT safety and the overly cautious contra-indications on product information.

The membership of NACAG was strategically chosen and included key clinicians representing chronic care, nursing, medical officers, drug and alcohol, mental health, pharmacy, and health promotion. The Area Pharmacy Manager provided guidance where NRT product information was not consistent with the evidence for safety. The group reviewed the literature on the assessment of nicotine dependence and on the safety and efficacy of NRT in relation to pregnancy, lactation, cardiovascular disease, mental health and concurrent smoking with NRT.

The group developed a comprehensive *Practice Guideline for Management of Nicotine Dependent Inpatients* that incorporated nurse-initiated NRT under Standing Orders. In response to the nurses' concerns about compliance and liability, a Patient Smoking Waiver form was developed with advice from the Legal Branch at the NSW Department of Health. Focus groups with nurses revealed a consensus of opinion that all inpatients identified as smokers should be asked to sign the Waiver. The Waiver stated 'I have been advised against smoking while receiving care from this health facility' and 'I agree to not hold the Health Service responsible if my condition gets worse or some harm comes to me as a result of me leaving a health service building to smoke'. During subsequent mandatory education, it was helpful to inform nurses that the Waiver had arisen from a consultative process.

To help nurses implement the guideline, a user-friendly ward-kit was developed. This included: a laminated flowchart and summary; tear-off pads for a nicotine withdrawal monitoring form; the Patient Smoking Form Waiver; and two resources – an *NRT Fact Sheet* explaining how to use the different types of NRT as single or combination therapy and a brochure, *Caring for Smokers in Hospital*, explaining the smoke-free policy, tobacco dependence and treatment.

The draft *Guideline* was distributed to a wide range of clinicians including all medical officers, including cardiologists, gynaecologists and paediatricians, requesting feedback. This *Guideline* became the basis for progressing hospitals to smoke-free status.

2003–2007: building on successes – making sites smoke free

The progression of sites to smoke-free status began in 2003, starting with non-hospital sites where there was strong management support. Each success was acknowledged by the Chief Executive. Over the next four years, the regular reporting of each site's progression to smoke-free status created momentum and eventually a demand that the roll out be accelerated.

In May 2004, the Tweed Hospital became the first of 20 hospitals to go smoke free. This provided a pilot site for implementation of the *Guideline*. To identify and resolve any barriers, a Clinical Practice Improvement Project involving ward nurses, the Nurse Unit Manager, Night

Supervisor, Pharmacist and Resident Medical Officer was conducted. This project resolved issues surrounding the availability of NRT on the ward.

During the 4 weeks before the hospital went smoke free, compulsory 1-hour Smoke Free Transition education sessions were provided for nursing and allied health staff. These sessions covered the reasons for going smoke free, compliance management, tobacco addiction and treatment and the *Guideline*. The *Guideline* was also explained to senior and junior medical officers at a hospital Grand Round, which presented evidence-based treatment for tobacco addiction.

In addition to these education sessions, flexible education was provided via the Smoke Free Quiz. This tested knowledge regarding tobacco addiction, compliance and clinical management and clinical teams could compete for a small prize. The quiz focussed attention on the smoke-free launch day, enabled managers to show their strong support for the process, and generated an atmosphere of goodwill.

The affective side of the change management process was also addressed by two humorous costumed figures called 'Nic n Tina' – the 'cold turkeys'. The appearance of Nic n Tina helped switch anxiety to humour while drawing attention to the smoke-free launch date. Their narratives reinforced key educational messages, and they also attracted media coverage.

The continuation of weekly ward audits for eight weeks after the Tweed Hospital went smoke free provided quantitative evidence that there had been an increase in the provision of information to patients about smoking and the provision of NRT for patients and staff (Table 1). Nursing staff commented that most inpatients were now abstaining from smoking during their admission. Anecdotal reports indicated that some staff had quit smoking and that those who continued to smoke were leaving the site to do so.

Transferring the vision to other sites

The pilot at Tweed Heads enabled the refinement of what became known as the smoke-free transition blitz, an intensive period of intervention in the weeks before making a hospital smoke free, with the goal of increasing the capacity to manage nicotine-dependent patients while changing the culture of smoking. The blitz contained the following elements:

- Establish a hospital action plan to ensure implementation in all settings
- Hold an initial Smoke Free Transition session for all managers to enable informed leadership
- Organise for the attendance of all staff (clinical, administrative, ancillary) at compulsory Smoke Free Transition training
- Address the affective element via the Smoke Free Quiz and Nic n Tina
- Inform staff of their role in managing compliance
- Support staff smoking cessation via education and subsidised or free NRT.

The sequential roll-out enabled learning and continuous improvement, because each time success was achieved in a difficult setting, this could be shared with other sites. For example, when Lismore Base Hospital went smoke free in 2005, the positive leadership of management at the emergency department (ED) led to the development of an *ED Guide for Managing Nicotine Dependent Patients with Mental Illness*. This effective tool enabled compliance from patients that many staff had previously considered too difficult to manage in a smoke-free environment. After this, this Guide supported progress in other hospitals.

Review processes and outcomes

In order to help anchor the behavioural changes in organisational culture, a review of hospital sites was conducted 4–12 months after each site went smoke free. Senior managers were interviewed about their perceptions of the change process, and opportunistic interviews provided a sample of staff responses. Site inspections revealed that, in general, there was good compliance from staff, patients and the public, and that the 'disaster scenarios' anticipated by some staff did not eventuate. While most of the smoking behaviour had shifted off-site, there were still some occasions when inpatients and staff smoked on the grounds of hospitals. These reviews showed that a positive approach from managers and staff could produce good public compliance even in challenging environments such as needle syringe programs and emergency departments. Unexpected positive outcomes were noted, such as the observation that staff time was no longer absorbed by taking patients outside to smoke. A site review report was provided to the hospital executive team as evidence of effective management of tobacco, for their accreditation process.

During the review process there were many reports of staff who quit smoking as a result of the site going smoke free. A survey conducted at Maclean and Grafton Hospitals revealed that the staff smoking rate had dropped after those sites went smoke free (Table 1).

Ward audits conducted at the Tweed Hospital before and after implementation showed that SFHC resulted in an increase in information about smoking being provided to patients, NRT being offered to patients, and nicotine withdrawal monitoring (Table 1). However, subsequent site reviews at 15 hospital sites and three clinical site audits conducted after the intervention also revealed that a significant number of tobacco-dependent patients continued to receive suboptimal clinical care for nicotine depend-

ence (Table 1). One of the greatest challenges of implementing the smoke-free policy was that no part of the clinical system carried responsibility for updating clinicians on evidence-based treatment of tobacco dependence. SFHC sought to deal with this deficit by providing ward resource kits and extensive compulsory education during implementation. However, the issue of where responsibility rests for ongoing education of clinical staff in treatment for tobacco dependence remains uncertain, presenting a risk to sustainability.

Conclusion and recommendations

While there has been a range of successful outcomes, the issue of suboptimal clinical management of nicotine dependent inpatients is yet to be resolved. This reflects ongoing barriers, mainly related to the fact that no part of the clinical system is responsible for knowledge mobilisation in the clinical field of tobacco addiction and treatment. Indeed, while the prevention end of the health service continuum is clearly carried by population health services, there is no clear carriage for the treatment end of this continuum in the clinical services. While SFHC has been successful in changing the culture of smoking in health settings, there is clearly further work to be done to ensure that evidence-based treatment for tobacco addiction is underpinned by clinical structures.

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