

BMJ Open Hospital staff perspectives on the provision of smoking cessation care: a qualitative description study

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ABSTRACT

Objective To explore the perspectives of hospital staff regarding the provision of smoking cessation care.

Study design A qualitative description study using focus group discussions.

Study setting Data were collected across metropolitan regional and rural hospitals in Victoria, Australia, between November and December 2019.

Participants Clinical and non-clinical hospital staff.

Results Five focus groups were conducted across four hospitals. Staff (n=38) across metropolitan regional and rural hospitals shared similar views with regards to barriers and facilitators of smoking cessation care. Four themes were present: (1) *Clinical Setting* wherein views about opportunity and capacity to embed smoking cessation care, relevant policies and procedures and guidelines were discussed; (2) *Knowledge* consisted of the need for training on the provision of pharmacotherapy and behavioural interventions, and awareness of resources; (3) *Consistency* represented the need for a consistently applied approach to smoking cessation care by all staff and included issues of staff smoking; and (4) *Appropriateness* consisted of questions around how smoking cessation care can be safely delivered in the context of challenging patient groups and different settings.

Conclusions Staff across metropolitan regional and rural hospitals experience similar views and identified shared barriers in implementing smoking cessation care. Responding to staff concerns and providing support to address smoking with patients will help to foster a consistent approach to cessation care. Clear practice guidelines for multidisciplinary clinical roles need to underpin staff training in communication skills, include priorities around smoking cessation care, and provide the authorising environment in which clinical staff actively provide smoking cessation care.

INTRODUCTION

Tobacco smoking is a major international public health problem with more than 1 billion people smoking worldwide.¹ Prolonged smoking among the adult population can cause a wide range of diseases and lead to premature mortality.¹ Additionally, smoking-attributable diseases impose a heavy economic burden throughout the

Strengths and limitations of this study

- Participants were recruited from metropolitan regional and rural hospitals to explore the perspectives of smoking cessation care provision among a broad range of hospital staff.
- The study provides valuable insights into the need to address smoking cessation care provision as a clinical quality issue within hospitals, ensuring clinical staff treat smoking as an immediate clinical issue and routinely provide smoking cessation care to every patient who smokes.
- The findings are based on a thematic analysis of five focus groups discussions with hospital staff involved in various aspects of patient care to explore the perspectives of smoking cessation care provision in different hospital settings.
- This study recruited participants through convenience sampling and the views of medical practitioners were not obtained, which precludes generalisation of findings.

world costing billions of dollars in healthcare expenditure.^{2,3}

International policy recommendations highlight the importance of providing proven tobacco dependence treatment.⁴ This treatment involves the provision of multisession behavioural intervention along with evidence based pharmacotherapy, such as combination nicotine replacement therapy.^{5,6} Australian guidelines align with these recommendations and advocate for the provision of smoking cessation brief advice by clinical staff as part of routine practice.⁷ Such advice from clinical staff can motivate a quit attempt and facilitate patient access to best-practice tobacco dependence treatment.⁷

Hospital settings offer opportune moments for all patients who smoke to receive timely and appropriate best-practice smoking cessation care.⁸ Australian recommendations suggest that ‘the smoking status of all patients being admitted to hospital should be noted in their medical record. Smoking cessation

support and management of withdrawal symptoms should be offered during the hospital stay. Regular medications that interact with smoking should be reviewed, and doses adjusted for patients admitted to hospital' (p.75).⁷ However, the implementation of these recommendations varies widely across Australian hospital settings, and provision of pharmacotherapy and behavioural counselling to inpatients who smoke are limited. While advice on smoking cessation from clinical staff have shown to improve quit rates and is highly cost-effective,⁹ the main barriers to the implementation of smoking cessation care in hospitals include lack of time, lack of knowledge (regarding smoking cessation interventions), perceived lack of patient motivation to quit, lack of support (including from other colleagues, the hospital and the wider healthcare system), not enough training on addiction, lack of confidence and uncertainty around whose role it is to provide smoking cessation care.^{10 11}

Uncertainties among clinical staff about evidence-based smoking cessation care practices and whose responsibility it is to address cessation with patients need to be further explored. While the provision of cessation care may primarily pertain to a clinical role,⁷ support from non-clinical staff may be important to promote smoking cessation in hospital settings.¹²

There is a need to understand the perspectives of clinical and non-clinical hospital staff in relation to the provision of smoking cessation advice to patients who smoke. In order to address this gap in knowledge and understand barriers towards sustainable implementation of smoking cessation care in hospital settings, the current study explored the perspectives of hospital staff about practical enablers and challenges to provide smoking cessation care across metropolitan, regional and rural hospitals in the state of Victoria. We further explored whether there were any differences in perspectives associated with the hospital size or clinical setting.

METHODS

Design and setting

This research used a qualitative description approach to explore staff's perspectives. One-off focus group discussions were used with hospital staff that included clinical and non-clinical staff across four hospitals in metropolitan, regional and rural Victoria. Participating hospitals belong to a study led by Quit Victoria, the main tobacco control agency in the state of Victoria, Australia, promoting tobacco cessation. All hospitals were invited to join the study. Hospitals were chosen based on their size, track-record of service innovation and staffing profiles such that several clinical and non-clinical roles were represented in the study. Four hospitals were considered sufficient for this study balanced against resources for the study and a requirement to include one mental health inpatient hospital acknowledging that smoking prevalence in people living with a mental illness is almost double the general population.¹³ By including a mental

health inpatient hospital, we sought to identify possible differences in enablers and barriers to the provision of care in this setting. No attempt was made to include other sites. Online supplemental appendix 1 provides further detail about these hospitals. Two focus groups were conducted at two sites of a metropolitan hospital, and included staff working in the mental health acute inpatient setting. The three focus groups at regional and rural hospitals included staff working in various patient settings. All participants provided informed consent. Data collection occurred between November and December 2019.

The study adhered to the Consolidated criteria for Reporting Qualitative research checklist.¹⁴

Recruitment

Participants were recruited using a convenience sampling approach whereby all staff received an email invitation to participate in a focus group at their respective hospital. A plain language statement of the project was provided on request. Consent was implied with participation for three sites and signed consent was an ethical requirement for one site. Due to the nature of this recruitment process, non-participation data could not be collected. At the start of each focus group, the interviewers explained their reasons for conducting this study. The purpose of the research was reiterated, participants were informed that their responses were being recorded and opportunities were given to address any concerns about the recording and findings dissemination process. Subsequent to the research introduction, participants gave implied consent to record the discussions. The focus groups were conducted by authors AU and LR both hold PhD degrees and are female researchers in the field of psycho-oncology and health services research. Both bring experience in conducting focus groups among healthcare professionals and patient groups.

Data collection and analysis

Focus group guides were developed to explore the perspectives of clinical and non-clinical staff regarding the provision of smoking cessation care in hospital settings (online supplemental appendix 2). Discussions were scheduled to last up to 1 hour and were audio-recorded and transcribed for the purpose of analysis. Only the participants and the researchers were present during the focus groups. Participants were not provided a copy of the transcript for comment or correction. Field notes were not taken during the discussions.

Data were analysed using thematic analysis. Preliminary analysis of transcriptions was undertaken concurrently with data collection to enable identification of data saturation. An iterative process was used to derive key concepts from the data. Authors LR and AU reviewed each transcript. LR undertook initial coding which consisted of assigning labels to text segments of the transcripts and then developing themes with labels assigned to represent comparable groups of codes. The analysis process

aimed to be critical and reflective. To enhance rigour, an inter-rater process was taken out through reading of transcripts by AU and discussion of findings between LR and AU. Through this process, agreement on coding was established. Participant quotes are included in the results section to illustrate themes arising from the discussions.

Patient and public involvement

As this study explored the perspective of hospital staff on the provision of smoking cessation care, patients were not involved in its planning and conduct. However, representatives from each of the hospitals sit on a Project Advisory Group and provided input into focus group questions, and assistance in organising the focus groups.

RESULTS

Thirty-eight participants were involved in five focus groups conducted across four metropolitan regional and rural hospitals. Two focus groups were conducted at the metropolitan hospital that extends across two separate sites. Between 3 and 10 participants attended individual focus groups, which overall included 23 nurses, 3 pharmacists, 3 dieticians, 2 physiotherapists, 2 social workers, 1 occupational therapist, 1 project lead and 3 administrative staff. Thirty-three participants (87%) were women. All focus groups were conducted at the respective hospital and ran for approximately 45 min including an introduction and conclusion, which were not taped. Tape recordings covered the questions and discussions, and these ranged from 25 to 38 min.

Main findings

The thematic analysis showed that staff across all four hospitals, irrespective of size and clinical setting, shared similar views with regards to barriers and facilitators of providing smoking cessation care. The themes presented below arose in each focus group. Four themes were present: clinical setting, knowledge, consistency and appropriateness. Each of these themes has accompanying categories and are supported by participant quotes. These quotes are assigned in the text to the respective focus group (eg, focus group-one is FG-01).

A summary of the themes is presented in [table 1](#) along with their respective categories and related participants' perspectives.

Theme 1—clinical setting

This theme reflected an awareness of addressing smoking in the healthcare context. Two categories supported this theme: *Capacity* and *policies procedures and guidelines*.

Capacity

Many participants expressed concerns about their capacity to systematically address smoking with all patients due to high-volume workload and competing care priorities specific to clinical settings: 'There's more pressing issues than their smoking habits. They're here for acute reasons. We don't have all the time on the planet just to keep them off the cigarettes' (FG-04); 'We're counselling and questioning and educating on so many other things as well that the patients get overloaded and everything gets too lengthy' (FG-02).

Table 1 Summary of themes categories and participants' related perspectives

Themes	Categories	Participants' perspective
(1) Clinical setting	Capacity	Time constraints, competing priorities in clinical settings
	Policies, procedures and guidelines	Need for clearer brief and practical policies, procedures and guidelines
(2) Knowledge	Education and training needs	Needs for greater knowledge on best practice tobacco dependence treatment (combined behavioural intervention and pharmacotherapy) and communication skills to improve confidence
	Resources	Not familiar with existing resources Lack of availability of resources in some departments and wards
(3) Consistency	Addressing smoking consistently	Depends on individual staff attitudes Depends on individual needs of patients
	It's everyone's responsibility	All members of the hospital workforce should be involved
	Staff smoking	Negatively impacts on the delivery of a consistent message
(4) Appropriateness	Patient groups	Need for guidance for specific groups such as people living with a mental illness, experiencing dependence on alcohol and other drugs and in palliative care
	Context	Emergency department or surgery were not perceived as appropriate places to address smoking cessation
	Empathy	Acknowledge constraints for patients who smoke
	Safety	Concerns about escalation and patient violence

Policies procedures and guidelines

Participants often mentioned that the lack of policies, procedures and guidelines around smoking cessation care creates confusion and adds to their workload. They highlighted the need for clear and brief tailored practice guidelines to help them support routine discussions with patients who smoke: 'Having tailored information to our unit and our organisation is a priority' (FG-04); 'We just need just a quick little thing [guide to address smoking]' (FG-01).

Theme 2—knowledge

This theme reflects participants' needs for training on the provision of pharmacotherapy and behavioural intervention, and awareness of existing resources.

Training needs

The need for better knowledge around pharmacotherapy for smoking cessation was discussed: 'There's also a lack of knowledge about how to use NRT (Nicotine Replacement Therapy)' (FG-04); 'And, if, for example, I was the person talking to patients about quitting, it would be good to know what the options are to refer the patient to pharmacy' (FG-02). Some staff also recognised the need to improve their communication skills to build confidence to address smoking cessation with patients: 'There probably isn't enough education out there for everyone to feel confident to have that conversation with the patient. So, some communication strategies around how to ask the question would be helpful' (FG-02).

Resources

Most staff were unfamiliar with the existing smoking cessation resources or reported insufficient availability of these resources in some departments or wards: 'We actually don't have a lot of resources in our department. If we're talking about different ways to give up and the importance of support services, I don't have a leaflet for this' (FG-02). The need to promote current resources across all areas of the health service was discussed: 'If all this stuff [resources] was available on the wards, it would be handy' (FG-05). Ward specific resources were also suggested in focus group discussions: 'It'd be nice if [quitline] released something for people with mental illness, because it's not. Something more specific to that population group' (FG-01).

Theme 3—consistency

The need for consistent delivery of smoking cessation care was raised. The idea that smoking cessation care is everyone's responsibility was discussed under this theme, as well as issues of staff smoking, and how this may portray an inconsistent message.

Addressing smoking consistently

Consistently reinforcing smoking cessation advice in a clinical setting was perceived as impracticable by some participants due to the reluctance of some patients to follow to these advice: 'Sometimes we don't even bother

asking, because we know there's just no point' (FG-01). Patients smoking right outside hospitals were recognised as a major problem for a consistent message: 'We're a smoke-free hospital, but then people congregate, just in the outside area, a lot of the times they sit under the 'no smoking' sign smoking' (FG-03).

It's everyone's responsibility

Some recognised that addressing smoking cessation was usually left to the nursing staff: 'As an admin person, I guess it's probably not a big part of my role, I suppose. Patients are normally left to the nurses to deal with that' (FG-01). However, others acknowledged that this should be the responsibility of all members of the hospital workforce: 'It can be anyone. Like, it might be a cleaner that sees this person every morning that just has developed a really good rapport with the patient' (FG-02). Supporting this statement, others also agreed that discussing smoking cessation with patients should be a multidisciplinary approach: 'We shouldn't ever stop having the conversations. So reinforcing the message from different disciplinary perspectives - It's about what the patient picks up from each different person' (FG-01).

Staff smoking

Everyone agreed that staff working in a hospital who smoke counteracts the message that smoking is a health issue that needs to be addressed: 'Staff that smoke and then come to the ward and you can smell that they've been smoking. It provides an inconsistent message, when we, as health workers, are not living that best, healthy practice' (FG-02). Some staff expressed compassion towards their colleagues who smoke: 'Everyone is quite happy to assist [them to stop smoking]' (FG-03); 'I gave up smoking myself, so I know - you know what I mean? I get it. I understand it' (FG-01).

Theme 4—appropriateness

The appropriate patient groups, context, staff attitude and concerns for the safety of staff were discussed in relation to smoking cessation care.

Patient groups

Staff held consistent views about patient groups for which the provision of smoking cessation care was regarded as more challenging, due to the complexity of a patient's care or staff perceptions about a patient's motivation to quit, including patients in palliative care: 'It's very hard in palliative care to say to people stop smoking. Even people who have got end stage emphysema or heart disease or kidney disease, they don't want to stop smoking. They can't see the point' (FG-03); patients experiencing dependence on alcohol and other drugs: 'We have detox clients here and the last thing they want is for us to suggest for them to give up cigarettes as well. That's the one thing that they feel they have got' (FG-03); and patients living with a mental illness: 'We can encourage quitting permanently, but realistically the mental health population smokes a lot' (FG-01).

Context

Discussing smoking cessation in the emergency department (ED) was perceived as more challenging and less appropriate than in other places: 'Patients might have been sitting in ED for 72 hours. And then, suddenly, we're like, "So, are you thinking about quitting smoking?" Talking to patients about cigarettes when they first arrive is almost laughable. I mean, it's fine to have that conversation later with them, but generally they're overwhelmed' (FG-01). Some surgical interventions were perceived as less relevant to address smoking: 'On surgical, if they're coming in to have say a knee replacement so that's nothing really to do with their smoking so they're not interested in hearing about it' (FG-05).

Empathy

Staff expressed real empathy for patients who smoked, but their perspectives may preclude staff from providing smoking cessation care: 'Understand their [patients'] frustration. Because it's extremely stressful. You could be a 40-plus a day smoker. And, suddenly, you can't smoke. So, we do feel for them' (FG-01). Others noted that people who smoke were often excluded even outside of the clinical setting: 'I feel bad for smokers, that they are so ostracised... They've been excluded from so many areas. It started with, you couldn't smoke in pubs and bars. And then it was, 'You can't smoke around food service,' and stuff like that. And then, there are a lot of businesses that are smoke-free and you can't smoke at a bus stop. All those things. Well, where are they supposed to go? I know the idea is that they're trying to promote, 'Give it up because it's just too hard.' But I think it's a bit mean, too' (FG-02).

Safety

Some staff raised safety concerns relating to aggressive patients and discussing the appropriateness of addressing smoking cessation with such a cohort. These patients were usually described as living with a mental illness. While staff working in mental health setting raised this problem, it was also occasionally acknowledged by participants in rural and regional settings. 'We're threatened. We're screamed at, yelled at. It can get quite frightening. We have to look after our own safety and our colleagues' safety' (FG-01).

DISCUSSION

This study explored the perspectives of clinical and non-clinical staff on the provision of smoking cessation care across metropolitan, regional and rural hospitals. The views of hospital staff in metropolitan mental health acute inpatient settings were congruent with those from rural and regional generalist hospitals. The key themes deriving from this study were associated with clinical setting, knowledge, consistency and appropriateness. These indicated that while hospital staff discussed barriers for providing smoking cessation care in clinical

settings, they had a sense of responsibility to support quitting, and empathised with the difficulties experienced by patients who smoke. Findings highlighted opportunities for education and training around best-practice tobacco dependence treatment (combined behavioural intervention and pharmacotherapy), communication skills and greater awareness of existing resources to support hospital staff to confidently address smoking cessation with patients. As this study focuses on the perspectives of hospital staff exclusively, our results shed light on the specific barriers of sustainable implementation of smoking cessation care in hospital settings.

Findings from this study suggest significant gaps in hospital staff's knowledge of the clinical benefits of smoking cessation and nicotine withdrawal management in relation to common conditions procedures and treatments. For example, quitting smoking before surgery reduces risk of perioperative complications and improves surgical outcomes.^{15 16} Furthermore, supporting patients to quit smoking at the same time as treating alcohol and/or other drug dependence, improves likelihood of achieving long-term alcohol and other drug recovery goals by 25%.¹⁷ These knowledge gaps highlight a lack of understanding that tobacco use poses an immediate clinical risk. Addressing tobacco use should be part of best-practice, quality care, not only a primary preventative health intervention.

The knowledge gaps identified in this study are in line with observations made in a systematic review on facilitators, barriers and recommendations for smoking cessation care delivery.¹⁸ That review found that healthcare professionals did not feel they had the knowledge or skills to deliver smoking cessation care and they often had a desire to be trained in the area. Another review explored the barriers to providing smoking cessation interventions in hospital inpatient settings, finding that staff often lacked the knowledge to support quitting.¹⁰ Lack of knowledge and skills around smoking cessation care can affect staff's confidence to routinely provide best-practice cessation care to patients.¹⁹

Challenges in providing smoking cessation care to patient groups with advanced illnesses were acknowledged. This observation correlates with a previous study using focus group discussions with 16 healthcare professionals caring for patients with advanced lung cancer.¹¹ A common reason for not starting the discussion with palliative patients was a sense that it was not worth the effort or to allow the patient to enjoy smoking without the guilt or being stigmatised.¹¹ The study also included 19 interviews with patients who have lung cancer who interestingly reported a need for healthcare professionals to initiate the discussions. Similar to our study, staff may perceive a lack of motivation or ability from the patient side to quit and decide against providing smoking cessation care regardless of the clinical benefits to be gained from quitting. The discrepancy between the views of healthcare professionals about patients' needs further highlights the importance of supporting staff to practice



patient-centred care by asking about smoking status, providing salient advice and offering opt-out assistance that takes into account the patient's individual needs.²⁰

While participants in this study reported that it is mainly the nursing staff who address smoking with patients, all agreed that it should be everyone's responsibility. Non-clinical staff may have a role in advocating for the provision of smoking cessation care in hospitals, but the effectiveness of smoking cessation care in a clinical setting is associated with advice from clinical staff.⁷ However, heavy workload and time constraints of clinical staff were reported as barriers for prioritising smoking cessation care. It is noteworthy that no medical practitioners elected to or were able to participate in the study. Therefore, the view that it is 'everyone's responsibility' might not be shared by all clinical staff. This was also observed in another Australian study that surveyed 293 medical and radio-oncologists that found that oncologists expressed strong preference for smoking cessation care to be managed by other clinical staff.²¹ An apparent lack of clarity around whose role it is to provide smoking cessation care for inpatients was reflected in a study involving focus group discussions with 26 nurses.¹⁹ The study also found that nurses expressed a lack of confidence about their knowledge in smoking cessation care which may prevent them from consistently addressing cessation with all patients.¹⁹ Commitment and support from all clinical and administrative staff may require adjustment to existing roles to promote a multilevel approach to smoking cessation care across health services.²² The development of smoking cessation clinical guidelines and protocols, supported by staff training and regular monitoring and evaluation, will facilitate implementation of smoking cessation care into routine practice.^{23 24}

Empathetic words from participants towards patients and colleagues who smoke suggested recognition of the stigma surrounding smoking and understanding of the difficulties of attempting to quit. Staff reflected that quitting smoking is difficult and saw their roles as supporting, not judging patients who smoke. This experience aligns with smoking cessation brief advice that promotes best-practice tobacco dependence treatment to patients in a supportive and non-judgemental manner.²⁵

Staff safety concerns in addressing smoking with patients living with a mental illness echo those of staff in a psychiatric inpatient hospital with regards to the implementation of a total smoking ban in mental health services.²⁶ Among the 183 clinical and non-clinical staff surveyed, the most prevalent perceived barriers to a successful total smoking ban related to fear of patient aggression (89%).²⁶ Another study evaluated the antecedents and containment of smoking-related incidents of physical violence documented by staff in an inpatient mental health setting.²⁰ The authors noted that 'recognising the triggers to smoking-related violence is an essential first step to prevent and manage potential violence without recourse to containment interventions' (p.210).²⁰ Consequently, failure to adequately manage nicotine withdrawal

may result in increased potential for patient aggression and violence.²⁷

The management of nicotine withdrawal within the context of supporting patients to meet smoke-free health service policies was not raised by participants, suggesting a lack of knowledge of the symptoms of nicotine withdrawal and their consequences in the inpatient setting. Many staff acknowledged instances where patients were smoking on hospital grounds or spending long periods of time in the ED where addressing smoking was not seen as a priority against more immediate care needs. These instances indicate opportunities for the management of nicotine withdrawal to reduce the risks of occupational violence and aggression, and of the patient leaving the ED before treatment is completed and to increase treatment compliance.

Limitations

This study recruited participants through convenience sampling, which is vulnerable to selection bias and precludes generalisation of findings.²⁸ In particular, the views of medical practitioners were not obtained in this study and future research could explore this. Additionally, the metropolitan hospital included in this study was represented by staff from mental health inpatient settings who may hold different views on barriers and enablers of smoking cessation care provision compared with staff from the generalised regional and rural hospitals. Furthermore, one hospital in our study was represented by a focus group of only three participants, which might have impacted discussion and findings from that hospital. However, the perspectives of the study participants are consistent with previous studies conducted in various hospital settings^{10 12} indicating that current findings are credible and reinforce previously outlined imperatives for smoking cessation care promotion in healthcare settings.

Additionally, the quotes could not be related to the profession of the person stating these as associated notes were not taken during the focus groups. This information could help address role-specific information and training needs, and should be collected in future research.

Finally, this study did not formally assess participants' level of engagement with the provision of smoking cessation care. Consequently, participants' knowledge of smoking cessation care may have been diverse. While some participants may have had better understanding of best-practice smoking cessation care than others, there was strong congruence among all staff across four distinct hospital regions about the need for further education and training in smoking cessation care provision. This indicates that routinely addressing smoking in hospital settings needs to be clearly embedded in the role of clinical staff as an essential practice.

Implications for sustainable implementation of smoking cessation care in hospital settings

Education on the immediate clinical health impacts of smoking cessation, specifically on healthcare outcomes

from common procedures and treatments, is a critical need along with practical guidance, resources and communication skills training in the provision of smoking cessation care skills that enable staff to provide brief and timely smoking cessation advice can be adapted to specific patient groups and clinical settings to build staff confidence in providing effective and best practice care (either smoking cessation care or management of nicotine withdrawal). This would help dissipate reported hesitation and lack of time to routinely address smoking with patients and promote the significance of providing cessation care to all patients who smoke.

As clinical staff may still feel unsure about the necessary practical steps to engage in smoking cessation care provision, education needs to be underpinned by clear clinical practice guidelines for multidisciplinary clinical teams. These guidelines need to be framed within key elements of quality improvement including monitoring and evaluation systems to assess the provision of smoking cessation and provide access to treatment such as nicotine replacement therapy. Importantly, organisational priorities around smoking cessation care need to be clearly established to provide the authorising environment in which clinical staff can actively provide smoking cessation care.

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