Audit: Smoking status documentation and the prescription of nicotine replacement therapy for acute medical admissions

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WHAT’S WRONG?

1. Smoking status is often poorly documented in medical clerking.
2. Active smokers are therefore not identified on admission, and nicotine withdrawal not addressed appropriately.
3. Active smokers are not offered referral to smoking cessation services upon discharge from hospital.

All of the above appear to stem from a lack of awareness and knowledge among junior doctors in nicotine replacement therapy and the promotion of smoking cessation.

GOLD STANDARDS

1. All patients admitted into hospital should have their smoking status documented.
2. All inpatient active smokers should be offered Nicotine Replacement Therapy (NRT).
3. All active smokers should be offered referral to smoking cessation services.

Gold standards from NICE PH1, NICE PH10, and GHNHSFT Trust Policy on Smoking Cessation.

METHODOLOGY

1. Patients admitted to our Medical Admissions Units (MAU) over a 48 hour period were included. Clerking notes scrutinised retrospectively to see if (a) the patient’s smoking status was documented, (b) whether NRT was prescribed/offered, and (c) whether any referral to the local smoking cessation service was offered.
2. An online survey was sent to junior doctors (F1-ST7) to assess knowledge and opinion regarding smoking cessation and nicotine replacement products.

INTERVENTION & RE-AUDIT

We invited a Smoking Cessation Advisor from the Gloucestershire Stop Smoking Service (GSSS) to give a talk to junior doctors on MAU. We also organised 5-minute sessions during the F1 and F2 fortnightly local teaching to raise awareness about NRT and the GSSS. A re-audit was performed 1 month following intervention.

RESULTS (cont)

2. Only 50% of patients had their smoking statuses documented in the pre-intervention audit. This has improved significantly to 81% post-intervention (Figure 2).

3. In the pre-intervention audit, 13 smokers were identified, and only 1 was offered NRT. We enquired the remaining 12 whether they would have wanted NRT whilst in hospital if offered:

   4 would have wanted NRT
   1 would have wanted NRT and referral to GSSS
   7 would not have wanted NRT/referral to GSSS

4. Disappointingly, there was no improvement in the prescription of NRTs and referrals to the smoking cessation service post-intervention (Figure 3).

CONCLUSION

Acute medical admissions represent a frequently overlooked opportunity for encouraging smoking cessation. Junior doctors play a very important role in this ‘teachable moment’ that should not be missed.

The management of nicotine withdrawal for inpatients should be given as much emphasis as the management of alcohol withdrawal.

Results from this audit cycle showed that we were able to improve the documentation of smoking status via simple, brief educational sessions aimed towards junior doctors. Further work needs to be done to improve the prescription of NRT and referrals to smoking cessation services - this will need to include collaboration with our ward nurses, pharmacists, and the stop-smoking advisors.

REFERENCES