Quality Improvement and Patient Safety

510 A MOMENT FOR CHANGE. ADDRESSING PARENTAL SMOKING IN THE PAEDIATRIC EMERGENCY DEPARTMENT

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Background Everyday in A+E children are attending with serious and life threatening breathing problems which we know are adversely affected by third hand smoking within the home.

In not addressing smoking with parents during their time in A+E, we fail to assist them in making a positive change for the health of their children. Using the biopsychosocial model, the impact on the child of their respiratory illness is wide ranging and far reaching.

Objectives
1. All respiratory cases presenting through A+E to have a smoking status asked and documented
2. For smoking cessation advice to be given to every case for which a positive smoking status is recorded

Methods
Fishbone I used a fishbone diagram to explore the potential causes of poor smoking status history taking, and to establish potential change ideas

Main causes identified
1. Doctors forgetting to ask for smoking status
2. Fear of confrontation when asking smoking status
3. Lack of confidence in how to deliver smoking cessation advice
4. Doctor’s workload pressures

I then used the Plan Do Study Act (PDSA) Cycle to implement change ideas

PDSA Cycle 1

CAUSES ADDRESSED
1. Doctors forgetting to ask for smoking status

Change Ideas:
1) Prompt sticker in clerking booklet

PDSA Cycle 2

CAUSES ADDRESSED
1. Doctors forgetting to ask smoking status
2. Lack of confidence in delivering smoking cessation advice

Change Ideas:
1. Prompt sticker in clerking booklet
2. Leaflet on smoking cessation and the harmful effects of third hand smoking

Data collection following change ideas

The change ideas were implemented, and data collected on what percentage of paediatric respiratory cases presenting to A+E had parental/carer smoking status documented, and of these what percentage were given smoking cessation advice following a positive smoking status.

Results

PDSA Cycle Percentage Improvements
Following PDSA Cycle 1 there was an increase from 35% to 71% of smoking status being documented and from 0% to 83% of the positive smoking status cases were given smoking cessation advice. Following PDSA Cycle 2 the status and advice given were 50% and 66% respectively.

Conclusions Cycle 1 Change Idea achieved our aim; to improve the frequency of smoking status being asked and documented.

Cycle 2 Change Idea failed to achieve our aim. Smoking cessation advice is still not offered in the A+E setting for those with a positive smoking status.

Using a prompt sticker in the clerking booklet helped to improve the frequency of smoking status being asked and documented, however it still seems that doctors are not providing smoking cessation advice, even when a leaflet handout is provided. It is well known that third-hand smoking exacerbates childhood respiratory illness, increasing the frequency and severity of presentations. In not providing support and encouragement to parents who smoke in the home, we are failing to help them implement positive change for the health of their child. Further work to assist doctors in giving smoking cessation advice in the A+E setting is needed.