A buddy-led smoking cessation clinic can help patients with COPD to quit

Smoking cessation buddies in COPD

In this article...

- Developing a specialist buddy-led smoking cessation clinic
- The role of pulmonary rehabilitation buddies
- Results of Hope 2 Quit scheme

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After a buddy system was developed to support the pulmonary rehabilitation programme, staff at the Hope Street specialist respiratory service developed a buddy-led smoking cessation clinic to support patients with chronic obstructive pulmonary disease, and their family or carers, through their quit attempts.

Initial findings showed the buddy-led clinic helped 83% of those who enrolled in the first six months to quit within four weeks. Results were sustained, with a 12-month long-term quit rate of 50%.

Results suggest that specialist smoking cessation clinics for patients with COPD, supported by buddies with similar experiences, can improve motivation and short and long-term quit rates.

COPD is mainly caused by smoking and worsened by deprivation. This is reflected by the higher than average COPD prevalence of 2% of the local population (3,441); prevalence by 2020 is expected to be more than double this (Association of Public Health Observatories, 2010).

Hope Street’s specialist respiratory service has one of England’s most successful pulmonary rehabilitation programmes, which aims to provide health, optimisation, prevention and education (HOPE) for patients, carers and health professionals. It involves pulmonary rehabilitation “buddies” – expert patients with COPD who assist with the programme’s design and delivery, alongside the multidisciplinary team (Hancock and Cox, 2008).

The buddy system has a range of benefits (Box 1). Buddies motivate patients, provide peer and emotional support, help in the programme’s daily running and assist in developing patient-centred literature and information to improve self-management.

Developing the service

Some patients attending pulmonary rehabilitation were still smoking. When asked about their desire to quit, a common reply was they were uncomfortable attending large group sessions as they often felt judged because of their condition. Some felt embarrassed in public by their symptoms, particularly shortness of breath and productive cough.

Since quitting smoking is the most effective intervention for reducing decline in lung function (Fletcher and Peto, 1977), smokers should be given advice and support at every opportunity, alongside COPD treatment options to maximise long-term benefits (National Institute for Health and Clinical Excellence, 2010). Kanner et al (1999) demonstrated that smokers with COPD who were assigned to a smoking cessation intervention had fewer respiratory symptoms after five years of follow-up.

After identifying a gap in opportunistic support for smoking cessation alongside pulmonary rehabilitation, I decided to apply the idea of the pulmonary rehabilitation buddy to pilot a buddy-led specialist smoking cessation clinic for patients with COPD and their families or carers.

Having completed a smoking cessation diploma module and a level 2 intermediate adviser course, I had the knowledge and competency to support buddies. As an independent nurse prescriber I was able to issue nicotine replacement therapy (NRT) to improve the chance of a successful quit attempt (Strassman et al, 2009).

All volunteer pulmonary rehabilitation buddies, who must be ex-smokers,
attended level 1 brief intervention training provided by the local smoking cessation service. This focused on maintaining a non-judgemental and consistent approach.

For the six-month pilot, the drop-in clinic was held weekly at Hope Street immediately before the pulmonary rehabilitation sessions, and was supported predominantly by two pulmonary rehabilitation buddies and myself.

Initial results were extremely encouraging. The first 12 patients who attended and set a quit date achieved a four-week quit rate of 83.3%, compared with local and national data of approximately 55% (Fig 1). Smoking behaviour was measured by self-report and end-expired carbon monoxide.

Hope 2 Quit

The pilot was successful, so we brought in some changes to make it more sustainable and flexible. Changes were based on findings from a review of the pilot:

- The initiative needed to be branded and marketed to increase referrals;
- Housebound patients and those unable to attend the specific day of the clinic needed additional support;
- We needed to develop support to improve long-term quit rates.

A health trainer joined the team to provide support to the COPD nurse specialist and buddies. Flyers were printed for distribution at health promotion events and to health centres. A patient feedback form was designed to capture experience and comments.

Feedback from those who had relapsed included a reduced use of NRT products after the initial four-week quit because of difficulty in obtaining prescriptions from GPs, and reduced motivation due to diminished support. Patients are now encouraged to continue attending the clinic to obtain prescriptions and to continue carbon monoxide monitoring to help motivation.

To maintain and improve long-term quit rates, the buddies offer a fortnightly telephone call in the 4-12 week quit period to those who choose not to continue to attend clinic, then monthly calls between three and 12 months for all participants.

Sustained success

The clinic continues to sustain its excellent quit rates. Thirty patients have taken advantage of this support and Hope 2 Quit for Your Lungs was established.

Through collaboration with the local smoking cessation service, resources were identified to enable us to develop or purchase promotional and educational materials such as key rings, fridge magnets and pens for successful quitters. Educational leaflets were written jointly by the COPD nurse specialist and buddies. Flyers were printed for distribution at health centres. A patient feedback form was designed to capture experience and comments.

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Felt they could discuss issues they would not have discussed with a health professional (Table 1).

Summary

Results suggest providing this intervention opportunistically can increase motivation to quit smoking more than from a traditional smoking cessation clinic.

We are sure this joint method of working will continue to produce a quality-driven, patient-centred and innovative service. This model could be adapted easily to other locations and long-term conditions.

References


