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▶ Does implementation of clinical practice guidelines change nurses' screening for alcohol and other substance use?

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Hospital nurses in Sydney in Australia were trained to implement a new screening and intervention policy aiming to upgrade the identification of hazardous drinkers and other substance users among medical and surgical inpatients. Disappointing results highlight the need to do more than inform and exhort if practice is to change.

Summary To improve nurses' screening of patients for substance use problems during routine admission procedures, a large metropolitan health service in Sydney in Australia developed a clinical guideline titled *Substance Use Screen Policy* which was distributed to all its facilities and implemented through an in-service education programme. Half-day workshops covered topics such as managing withdrawal, intoxication and overdose. Training in brief interventions included 'safe' levels of smoking or drinking, smoking cessation techniques, illicit drug use, access to needle exchange programmes, and patient education pamphlets. Nurses who could not attend were given education packages with workshop handouts. The featured study investigated the effectiveness of this dissemination effort.

Data for the study was derived from medical record audits conducted in selected medical and surgical wards of two metropolitan hospitals prior to and three months following implementation of the guideline. According to the new policy, records for newly admitted patients should document whether they had been asked about smoking, drinking and drug use, their substance use, withdrawal symptoms, any related treatment given, and whether any further actions or plans had been agreed. A preliminary audit found that only 20% of admission records had complete substance use histories. Implementation of the guideline was expected to raise this to 50%.

Main findings

Audits were completed on 79 pre-implementation and 84 post-implementation patient records. Respectively, these documented screening for alcohol use in 28% and 29% of cases which resulted in 14 and 5 patients being identified as drinkers. Corresponding figures for smoking were 29% and 23% and 11 and 8. Further evaluation of these medical records demonstrated no differences in the assessment of smoking habits and quitting between pre- and post-implementation audits. Screening for illicit drug use was more commonly documented after guideline implementation than before (16% v 8%), but no patients screened positive. Before or after implementation, none of the records documented interventions such as brief advice or referral to substance use services.

The authors' conclusions

This study highlighted the difficulties of introducing and sustaining change amongst health professionals. Implementation of the policy of substance use screening via in-service education was ineffective in changing the substance use screening practice of nurses. Computerised reminders which automatically alert nurses to the need to screen may have improved implementation. Also, the workshops and education packages simply gave nurses information rather than involving them in interactive learning, a sub-optimal teaching strategy, and follow-up consultation was left to the trainees (who sought little further advice) rather than actively pursued. Lacking too were management structures to monitor and promote implementation and to refresh training to cater for staff turnover.

Uptake of screening may also depend upon the nature of what was being asked. A companion study found that nurses and other health professionals often felt it was not easy to broach and discuss alcohol and other substance misuse, especially illicit drug use, due to social, cultural, legal and emotional reasons. They may consider substance use as personal issues, be reluctant to obtain information about criminal activities, or lack adequate skills in asking about substance misuse.

FINDINGS Guidance from Britain's National Institute for Health and Clinical Excellence (NICE) insists that health service commissioners and managers "must" provide the required training, resources and time to implement alcohol screening and brief intervention, including on general hospital wards. Reflecting this advice, the 2012 national UK alcohol strategy called for programmes to identify hazardous drinkers in NHS services. It was specific about how this will be done in primary care by GPs and pharmacists, where alcohol identification and any subsequent brief advice will be incorporated in the NHS Health Check for adults aged 40 to 75 from April 2013. Accident and emergency departments and hospitals in general were also encouraged to check for and offer brief advice about hazardous drinking, drawing on the services of alcohol liaison nurses who will also manage patients with alcohol problems, liaise with community alcohol and other specialist services, and support other healthcare workers in the hospital.

However, the evidence that brief advice on hospital wards cuts drinking is patchy, and for Britain in particular, unconvincing. Alcohol liaison nurses now seem common in hospitals, but are often diverted from identifying and advising hazardous drinkers and focus as much or more on managing alcohol-dependent patients. Findings has analysed this literature and offered a fuller account of UK studies and policy and practice.

For more on implementing screening and brief intervention run this Findings search. Among the retrieved

analyses is a UK-focused review for Britain's National Institute for Health and Clinical Excellence of what impedes or promotes the implementation of brief alcohol interventions.

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