Evaluating Tobacco Cessation Education Huddles as a Method of In-service Education: a Project Proposal

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A project proposal on educational huddles…
ABSTRACT

Tobacco is the leading cause of preventable death and disease in Canada. A growing body of literature supports the practice of consistently screening all patients for tobacco dependence, providing a brief intervention and offering Nicotine Replacement therapy (NRT) as a standard of care. Strong links have been documented between mental illness and tobacco dependence. For example, in the United States, there are a higher proportion of smokers among people with mental health symptoms than among the general population. Evidence shows that patients with mental health disorders are at greater risk for increased mortality and morbidity as a result of their tobacco dependence. Healthcare practitioners are well positioned to support patients in addressing this chronic relapsing dependence yet are reluctant to do so (Wye et al, 2010; Williams et al, 2009). Healthcare practitioners are presently working in an environment in which the context of scarcity impacts educational opportunities. For example, a scarcity of replacement staff creates decreased opportunities for staff members to attend educational workshops where knowledge transfer bridges the evidence to practice connection. The project comprises a detailed description of the Huddle curriculum, an implementation plan, and a proposed evaluation strategy to determine if Huddles: a) increase staff members knowledge of tobacco dependence and cessation, b) increase staff members comfort in engaging with patients about tobacco dependence and cessation, c) increase staff members comfort with advocating for and titrating NRT medication, and d) are an effective method to address staff members’ ongoing professional development learning needs while at the same time respecting organizational priorities of fiscal restraint and adequate workload coverage.
ACKNOWLEDGEMENTS

I would like to take this opportunity to thank all those who have supported me on this learning journey.

To my family, friends and colleagues thank you for your solid and lasting support. Jillian, Laura and Katelyn your “Mom” support has been invaluable. You have challenged me to keep up with you and be the best that I can be. I am very proud of you and grateful you are my children. Bob, I can not imagine my life journey without you. Thank You. Thank You.

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STATEMENT OF THE PROBLEM

There is considerable evidence pointing to improved patient outcomes when health care practitioners address a patient’s tobacco dependence. Vancouver Coastal Health (VCH) is moving towards a systematized approach to addressing tobacco dependence. Evidence-based practice prescribes screening patients for tobacco use, offering a brief intervention and nicotine replacement therapy (NRT), and monitoring for withdrawal symptoms and titrating NRT to effect as a standard of care (Health Canada, 2008; Centre for Addiction and Mental Health, 2008). To implement a systematized approach to addressing tobacco dependence there is a need to educate current VCH staff members (Wye et al, 2010; Williams et al, 2009). In the current health care climate there is a culture of scarcity. Scarcity refers to one or more of the following factors: too few nurses available, too little funding or economic decisions to reduce funding or cut budgets, lack of adequate training or orientation to the area, or inadequate measurements of patient acuity, staffing skill mix or support from support staff (Morgan & Lynn, 2009; Goldfarb, Goldfarb & Long, 2008). Health care providers find, due to their work environment, that they are unable to attend formal in-service continuing education workshops. Thus new knowledge is slow to bridge the evidence to practice gap. In this project, I intend to: target current working staff members, address the issue of in-service continuing education in the current climate of scarcity, and address the knowledge-practice gap by offering and evaluating the effectiveness of six short 20 – 30 minute Huddle education sessions delivered at the worksite.

Project Aims/ Objectives

• To develop a Huddle curriculum related to tobacco dependence and cessation, focusing on the In-patient Psychiatric Unit (IPPU).

• To conduct staff in-service education using the Huddle method.
• To propose an evaluation strategy to assess the effectiveness of Huddles in increasing: a) staff members’ knowledge of tobacco dependence and cessation, b) staff comfort in engaging with patients about tobacco dependence and cessation, c) staff comfort in advocating for and titrating NRT medications, and d) the number of staff members who log in to and complete the Ontario Tobacco Research Unit web based tobacco cessation module.

• To propose an evaluation strategy to assess the effectiveness of addressing the staff members’ ongoing professional development learning needs while at the same time respecting the organizational priorities of fiscal restraint and adequate workload coverage.

**BACKGROUND**

In the past several years, addressing tobacco dependence as a health damaging chronic condition has gained importance. On May 31, 2008 Vancouver Coastal Health implemented their Smoke Free Properties policy. “As a health care provider, Vancouver Coastal Health has an obligation to promote good health practices and a duty to protect people from the hazards of second hand smoke. We are committed to ensuring a safe, healthy and clean environment for our patients, clients, staff, volunteers, and the general public” (Vancouver Coastal Health, 2008). Nicotine Replacement Pre Printed Orders are available to staff, to address withdrawal management of tobacco dependent patients who are admitted.

In the Mental Health and Addiction services environment, there is a culture that tobacco dependence in that population is “the least of their worries” (G. Colvin, personal communication, April, 2009). I find a prevailing ideology of individualism, individual rights and individual
choice underpins much of the hospital discourse. Tobacco users are seen as choosing to smoke and therefore it is inferred that they can choose not to smoke. Knowles (1977) posits that, individual responsibility to make healthy choices supersedes individual rights and suggests that individuals have a moral responsibility to maintain their health as most individuals are born healthy. Browne (2001) states, in regard to the regained popularity of neoliberalism, that, individuals should be entitled to choose “one’s individual goals and ideal’s” (p.122) as separate rational agents who can construct their own context as beings capable of rational thought.

“Individualism is so intricately woven into the fabric of Western society as to make it impossible to recognize the extent to which it shapes our social, political and scientific assumptions” (p.121) which are then protected through legislation. Within the local hospital setting, the ideology of individualism as personal freedom to choose is underpinned by rights-based discourse related to patients as tobacco users. Thus, I have been challenged to explain why, on the IPPU, I would advocate for staff to take away the last piece of control a patient may have. By locating tobacco dependence in an ideology of individual freedom and right to choose, the onus is on the patient to take responsibility for his/her choice. Patients would be responsible to indicate if they were experiencing withdrawal symptoms. Allowing patients to suffer withdrawal without offering support seems unconscionable in relation to the ideology that the role of staff is to help and provide healthcare. Given the current cost of health care and the rhetoric of scarcity it would seem that priority would be given to any initiative that addresses the leading cause of preventable disease, disability and death (Reid et al, 2007), yet the ideology of individualism silences or at least muffles that discourse. Other barriers to addressing tobacco dependence in the Mental Health and Addictions setting include: smoking among health professionals, tobacco treatment is
Evaluating Huddles seen as a low priority, and lack of education on tobacco cessation and withdrawal management (Williams et al., 2009).

At present, nursing staff members are working in an environment in which the context of scarcity and staff shortages influence the daily workload, creating an environment in which the lack of intrinsic rewards leads to workplace dissatisfaction. Morgan and Lynn (2009) found that the aspects of work most rewarding to nurses were those things that were sacrificed to complete the workload tasks. “Nurses are finding it difficult to do ‘more with less’ and are frustrated they are not able to provide the care they were educated to be able to deliver” (p. 401). Appreciating that the work environment is operating within a climate of scarcity and staff shortages, and acknowledging the significant health impact of tobacco dependence on the mental health and addiction population, I have selected the IPPU staff members as my target population.

A literature search for educational in-service delivery methods, finds a plethora of articles citing utilization of a variety of formats. Seminars, workshops, conferences, courses, grand rounds are just some of the vehicles cited (Lee, Tiwari, Choi, Yen & Wong, 2005; Lannon 2007). Time frames are as short as 30 to 45 minutes (Resnick, Cayo, Galik & Pretzer-Aboff, 2009; Armistead, 2005) to several days. A search of the literature did not produce any results for Huddles as an educational tool. Resnick et al (2009) conducted a randomized control trial study of a Res-Care Intervention that included a 6 week, 30 minute weekly component; however, because the authors did not conduct a post-test in the control sites, they state that “no definitive conclusion can be made about the effect of the focused in-service” ( p. 359). Several other descriptors were entered into a selection of health-related and education-related data bases in hopes of eliciting similar educational knowledge transfer strategies but with little result.
I have chosen this Huddle format for in-service education specifically targeting IPPU staff members because the Huddle format seems likely to deal well with time constraints, respecting staffing and workload acuity. According to Dr. Auton-Cuff, the St Mary’s Hospital IPPU Manager (personal communication, June 2, 2009), although she is willing to release staff members to attend workshops, the lack of available staff to cover the IPPU unit is an issue. The nursing shortage, resulting in the inability of staff to attend in-service opportunities, is one of the underlying factors in proposing brief, on site educational sessions, and the study of Huddles, as an educational methodology. Longo (2007) identifies nursing shortage, workload acuity and workplace relationships as key components in staff leaving the workplace. A long term outcome for the huddle project is to have the IPPU considered a learning community, where Huddles are a regular occurrence, thus making it a desirable worksite. As a workplace safety tool, “one of the biggest advantages and best features of huddles is their simplicity” (Shermont Mahoney, Krepcio, Baccari, Powers, Yusah, 2008, p. 44). With this format I hope to provide 6 short, 25 – 30 minute weekly engaging and meaningful learning opportunities (see teaching plan in Appendix A) for staff to increase their understanding of tobacco addiction and cessation counseling skills, without adding undue workload pressures, while at the same time meeting the expectations of the managers.

LITERATURE REVIEW

In conducting a literature review, I searched Academic Search Premier EBSCO, CINAHL, Medline, Cochrane Data Base, Pubmed, PsycInfo, and Web of Science and found no research on Huddles as a method of in-service education. According to the literature, Huddles
Evaluating Huddles

have typically been used as a check-in for charge nurses to assess workload and patient care (Shermont et al, 2008).

There is extensive and overwhelming literature to support the need to address tobacco dependence in the health care setting (Health Canada, 2008; Centre for Addiction and Mental Health, 2008). Considerable evidence exists to show that patients with Mental Health or Addiction diagnoses are at increased risk for the harmful health effects of tobacco dependence (Centre for Addiction Research of British Columbia, 2006; Siru & Tait, 2009; Lasser, 2009; Naegle, Baird & Stein, 2009). The literature also shows that this population receives inequitable tobacco cessation service (Hitsman Moss, Montoya & George, 2009).

So… why is there a need for tobacco addiction and cessation counseling education? Tobacco use remains the number one preventable cause of illness and death in our society (Health Canada, 2008). Tobacco kills two times as many people as vehicle crashes, alcohol, suicide, homicide and HIV combined. Tobacco is the only legal product that kills one in every two people when used as intended (Centre for Addiction and Mental Health, 2008). According to the latest Canadian Tobacco Use Monitoring Survey (CTUMS) results, for data collected between February and June, 2008, 18% of the Canadian population aged 15 years and older were current smokers (about 4.9 million smokers). This statistic is unchanged from the same period one year ago.

Why the IPPU? There are strong links between mental illness and tobacco use and dependence. “A major barrier to smoking treatment in Mental Health and Addiction populations has been the perception that attempting to quit smoking and (or) successful smoking cessation will undermine mental health treatment efforts and eliminate a primary source of pleasure for the patients with MHA disorders” (Hitsman, et al, 2009, p.373). Due to the high consumption rates
of smokers with mental illness and addictions, they experience greater health consequences and deaths than the general public. In Canada, tobacco smoking accounts for about 80% of all deaths attributed to dependent substance use (Centre for Addiction Research of British Columbia, 2007). Individuals with mental health disorders smoke at greater rates and are more nicotine-dependent than individuals in the general population (Siru & Tait, 2009). Among persons in the United States diagnosed with mental disorders, including substance use disorders, the prevalence of smoking is 2 to 3 times that of the general population. These individuals suffer significant related health disparities of increased morbidity and mortality and shortened life expectancy of 20% more than that of the general population (Lasser, 2009). Worldwide, tobacco use rates are highest among those with psychotic disorders ranging from 54.0% to 67% (Leon & Diaz, 2005; Fagerstrom & Aubin, 2009). Heavy smoking, defined as the consumption of 25 or more cigarettes per day, was rare in persons without mental illness (Lasser, Boyd, Woolhandler, Himmelstein, McCormick & Bor, 2000). Only 10% of people without mental illness were heavy smokers. Persons with a past-month mental illness represented 40.6% of all current smokers in the United States. Study findings suggest that smokers with coexisting psychiatric or substance use disorders account for 44% of all cigarettes smoked in the United States (Lasser et al, 2000). Siru and Tait view tobacco cessation as a public health priority (2009). Naegle, Baird and Stein support the position stating that “failure to act on tobacco dependence equals harm” (2009, p.21).

THEORETICAL UNDERPINNINGS

I am approaching this project as an area of new knowledge development. A foundational assumption is that facilitated delivery of an educational curriculum will provide increased knowledge to the IPPU staff. Underpinning my curriculum is a belief that teaching and learning
Evaluating Huddles is a reciprocal partnership. As a systems thinker, I lean toward collaboration, interdisciplinary partnerships, and teamwork. Foundational to the curriculum are: a constructivist approach (Keating, 2006), an apprenticeship perspective (Young & Paterson, 2007), and student-centered learning.

**Constructivism**

Constructivism is “the belief that learners, having had some prior knowledge and experience as a basis from which to rest their hypotheses, build their own set of content to solve a particular problem posed by the instructor. Constructivism is a learner-centric educational paradigm in which content is constructed by the learners in a team-based, collaborative learning, constructivist learning environment rather than by the instructor” (Leonard, 2002, p.37-39). Knowles (1975), Bruner (1960, 1961) and Mezirow (2000) are considered constructivist theorists.

A “learner-centric educational paradigm” (Haw, 2006, p. 55) based on “the belief that learners, having some prior knowledge and experience as a basis from which to build content” and knowledge, fits with my view of adult education. Utilizing Mezirow’s learning theory (2000) I have, within the program, provides an opportunity for the staff to identify experiences and critically reflect on the experiences and material. I have also allowed space for discourse with others with the goal of shifting the culture on the unit in relation to the treatment of tobacco dependence. The building blocks or activities are: the entries in the communication tool, the narrative dialogue from the check-in and debriefing discussions, which are captured by the facilitator and on the post-Huddle program questionnaire. The causal mechanism is a cognitive
construction theory of education where knowledge building and meaning making is an active interpretive relational process (Young, Maxwell, Paterson & Wolff, 2007).

**Apprenticeship**

I also view the curriculum from an apprenticeship perspective (Pratt & Paterson, 2007, p. 66). “This view assumes that learning is both an individual cognitive process and a collective social process. Learning, therefore, is facilitated when students work on authentic tasks in real settings of application or practice and alongside other, more experienced practitioners” (Young & Patterson, 2007, p. 557-558). The relationship building, inherent in the Huddle sessions, I view as an equal partnership unlike how one may view a traditional apprenticeship with the Journeyman as teacher and a clear power imbalance. I have built into the lesson plans time for role-playing, have added dialogue boxes that give suggestions of potential language/phrases, and have given open space for discussion in which the staff will give context to the information shared. The Huddle format allows apprenticing staff to draw on the expertise of Huddle members, the Huddle facilitator, or other unit staff members, who would act as mentors by linking the Huddle education with the practice environment. When answering questions that arise during the Huddles I intuitively use a think aloud (Banning, 2008) process, which I believe fits well into this perspective.

**Student-centered Teaching and Learning**

Student-centered teaching is “teaching that focuses on the experiences of and interactions with the learners. The learner is in the forefront of the educational activity. The focus of teaching is on helping the students discover and construct new knowledge and understanding” (Young &
Paterson, 2007, p.578). Student-centered learning is “a term used to describe the teaching/learning process that actively engages students in the development of knowledge rather than being passive recipients of information transmitted by teachers” (p. 578).

The relationship I create within the educational sessions will be key to the success of the Huddle learning objectives. A student-centered approach allows me to act as a facilitator, empowering the IPPU staff to provide context and take ownership of the educational experience. The IPPU staff members are the experts of their environment and can assign meaning and usefulness to the material I am presenting. The assumption is that the staff members know their workplace best and will give meaningful context to the information shared during the Huddles. As in the apprenticeship perspective, the time for role playing, the dialogue boxes with language/phrase suggestions, and open space for discussion allowing participants to contextualize information, are also consistent with student-centered teaching and learning.

**Behavioural change theory**

Prochaska and DiClemente (1982) developed the Transtheoretical Model (TTM) of behaviour change or Stages of Change Theory as it is more commonly known. The TTM stages of change include pre-contemplation, contemplation, preparation, action, maintenance and relapse. Change involves progressing through these series of stages. The TTM has principally been developed, and is well studied, in relation to health behavior change. The early studies of the TTM found strong evidence indicating a progression through the distinct stages of change with each stage marked by different motivations, concerns and intervention requirements. The TTM of Change emphasizes the role of motivation “incorporating motivational, cognitive, social learning, and relapse theory (Harris & Cole, 2007, P.777). An individual may progress from pre-
contemplation to contemplation to preparation to action and then to maintenance. Prochaska, Levesque, Prochaska, Dewart, and Wing, (2001) used the TTM of Change as a tool to study employees ability to master change positing that effective staff members are employees who learn to master the change process through gaining skills in proactive learning, collaborative teamwork, and stress management.

Motivational Interviewing (MI) is a well known and scientifically tested method of counseling clients that had been developed into a coherent theory, with a detailed description of the clinical procedure, by Miller and Rollnick (2002). MI is a

“directive, client-centered counseling style for eliciting behaviour change by helping clients to explore and resolve ambivalence…. The strategies of motivational interviewing are more persuasive than coercive, more supportive than argumentative, and the overall goal is to increase the client’s intrinsic motivation so that change arises from within rather than being imposed from without” (Rubak, Sandboek, Lauritzen and Christensen, 2005, p.305-306).

Two of the sessions are on brief interventions (BIT) and MI (Rollnick, Miller & Butler, 2007). A readily apparent objective is to offer staff MI tools to utilize in their conversations with patients in order to help patients’ change their tobacco use behaviours. A less apparent objective is for the Huddle facilitator to utilize MI strategies during the curriculum delivery to assist staff change their behaviour/unit culture related to tobacco dependence. The open spaces where discussion, debriefing, and think aloud techniques are used, are places where MI techniques may be incorporated.
Evaluation Theory

Patton (1997) states the following:

“Utilization-Focused Evaluation begins with the premise that evaluations should be judged by their utility and actual use; therefore, evaluators should facilitate the evaluation process and design any evaluation with careful consideration of how everything that is done, from beginning to end, will affect use. Nor is use an abstraction. Use concerns how real people in the real world apply evaluation findings and experience the evaluation process. Therefore, the focus in utilization-focused evaluation is on intended use by intended users” (p. 20).

According to Patton “evaluation depends on and facilitates clear communication” (2008, p. 162). Communication is a key element in the Huddle sessions on Tobacco Cessation Education. An intended short term outcome of the educational Huddle program is for staff to gain an increase in their comfort and confidence in addressing tobacco dependence. Utilization of their increased knowledge may be demonstrated by initiating tobacco addiction and cessation counseling discussions with the IPPU patients. The Huddle education sessions may be utilized as a vehicle for the implementation of the Centre of Excellence for Clinical Smoking Cessation (CoE) Ottawa Model for Smoking Cessation program. Patton states “shared understandings emerge as evaluation logic and pushes senders of messages to be as specific as possible and challenges listeners to reflect on and feedback to senders what they think they’ve heard” (2008, p.162). Actively engaging the stakeholders in the development of the evaluation data capture, collecting the data, and reviewing the post huddle results will allow the staff members to intimately relate to the program and will increase the probability of utilization. It is Patton’s assertion that the act of actively participating in the development of the evaluation data capture,
achievements, and goals has a direct impact in creating a shared understanding of the program as well as on the level of participatory commitment (p. 163).

**Pre-implementation work**

**Stakeholders**

To operationalize the program I will need to meet with the stakeholder groups. The goal of the meeting is: a) to facilitate shared understandings as a result of coming to an agreement on the evaluation process, collected data, and outcomes/goals, and b) to create an advisory group to oversee and assist with the project. In utilization-focused evaluation, the stakeholders become key collaborators. I have organized the key stakeholders using Patton’s power versus interest grid (2008, p.80) categorizing the stakeholders into four quadrants: High-Power High-Interest (HPHI), High-Power Low-Interest (HPLI), Low-Power High-Interest (LPHI), and Low-Power Low-Interest (LPLI). Following Patton’s logic I intend to empower and collaborate with the HPHI stakeholders utilizing them as the primary intended users and key informants for the development of the Huddle project and evaluation. IPPU staff members are HPHI as they are the target population of the Huddle education sessions and the primary intended users. The HPLI will be a group to keep informed and consult with as the project progresses as well as to involve in the post Huddle session evaluation because this group has the ability to impact policy and encourage sustainability related to the project. LPLI stakeholders also need to be kept in the loop as Patton so wisely states-- “controversy can quickly turn this amorphous ‘crowd’ of …..stakeholders into a very interested mob” (p.80). Finally the LPHI stakeholder group will be involved as a group to keep informed. This group is particularly interesting as their HI brings ethical considerations into play as their involvement increases. Pfizer and Johnson & Johnson are the two companies that sell Nicotine Replacement (NRT) products, hence they have a vested
interest in Tobacco cessation counseling and the use of NRT. However, they are also a group
with the potential to increase the utilization of the huddle format of in-service education.

Table 1

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<th>Low Power Stakeholders</th>
<th>High Power Stakeholders</th>
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<tr>
<td>High Interest</td>
<td>• Pfizer representative</td>
<td>• IPPU Staff members</td>
</tr>
<tr>
<td>stakeholders</td>
<td>• Johnson &amp; Johnson representative</td>
<td>• Grad supervisor</td>
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<tr>
<td></td>
<td>• (staff – tipping point person)</td>
<td>• (staff – tipping point person)</td>
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<tr>
<td></td>
<td>• Manager of Mental Health &amp; Addictions</td>
<td>• Manager of Mental Health &amp; Addictions</td>
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<td></td>
<td>• Manager of VCH Tobacco Strategy</td>
<td>• Manager of VCH Tobacco Strategy</td>
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<td></td>
<td>• Director of the Western Canada Center of Excellence on Tobacco Cessation &amp; HC Ottawa Heart Project VCH rollout</td>
<td>• Director of the Western Canada Center of Excellence on Tobacco Cessation &amp; HC Ottawa Heart Project VCH rollout</td>
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<td></td>
<td>• In-patient Psych Unit PCC</td>
<td>• In-patient Psych Unit PCC</td>
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<td></td>
<td>• Huddle facilitator/ RTRC/MN student- Educator/ evaluator</td>
<td>• Huddle facilitator/ RTRC/MN student- Educator/ evaluator</td>
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<tr>
<td>Low Interest</td>
<td>• Staff members in other units</td>
<td>• Director of Coastal HSDA Powell River &amp; Sunshine Coast</td>
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<tr>
<td>stakeholders</td>
<td>• IPPU Clients</td>
<td>• Director of Coastal HSDA Powell River &amp; Sunshine Coast</td>
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<tr>
<td></td>
<td>• IPPU clients family members</td>
<td>• Manager of Acute Services, St Mary’s Hospital</td>
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<td></td>
<td>• VCH Nursing Education Department</td>
<td>• VCH Director of Career and Learning Development</td>
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<td></td>
<td>• VCH Research Department</td>
<td>• Manager of Public Health Nursing</td>
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*Note.* Stakeholder table is fluid as people can move
Funding

The Provincial/Federal funding is attached to the deliverables of the VCH Tobacco Strategy which is administered through the Medical Health Officer’s portfolio. Because I am involved in the CoE as a Manager of the ExTENDs project, the funding for my position is supplemented by project funds attached to the CoE. ExTENDs, is an extension of the proof of concept project at the University of Ottawa Heart Institute (UOHI). The proof of concept project is to determine if a systematized approach to smoking cessation decreases healthcare costs and increases smokers quit rates. ExTENDs is the application, of the in-hospital systematized approach, into the out-patient and primary care areas of practice. There are no additional funds available for the Huddle project. VCH Mental Health and Addictions (MH&A) staff time is paid for by MH&A and therefore requires partnership at the Manager level. I will be facilitating the Huddle session project, partly as a member of the VCH Tobacco Team on paid VCH time. Opportunities to attain project funding for the Huddle proposal may become available. If implementation of this proposal requires additional funding, close attention will need to be paid to applicable funding sources in order to apply and access project funding.

CURRICULUM BLUEPRINT AND IMPLEMENTATION

Curriculum Blueprint

The building of a curriculum is like building a house. The blueprint is the template upon which the implementation decisions are made. Like a solidly built house, the curriculum needs a good foundation. The curriculum foundation is the factual knowledge about tobacco, second hand smoke and their health effects, as well as their impact on special populations. The overall curriculum is laid out with a strong foundation; as well, within each session there is a foundation
component and opportunity for participant engagement. The factual knowledge component (Keating, 2006) lays the foundation for conceptual knowledge and procedural knowledge to develop with the end goal of meta-cognition and an IPPU cultural shift. The content/factual components of each session are interspersed with opportunities for dialogue and engagement. (See Appendix A)

The curriculum is based on the progression from factual evidence about tobacco use, reflections on the context of client-staff situations, health disparities related to specific populations, understanding of the physiology and long-term consequences of tobacco dependence to procedural assessments and communication techniques that can be used to impact behavior change for patients. This progression is depicted in Figure 1, which illustrates how each huddle session builds sequentially on the previous session as a foundation. The first session is a broad overview of tobacco addiction with a link to the recent VCH Smoke-free properties policy. I have included specific slides on myths and facts, what is nicotine, the anatomy of a cigarette, a snapshot of the tobacco industry, concluding with the impact of tobacco on health. Session two, deals with special populations, specifically tobacco users with mental illness and touches on the harmful health effects of second hand smoke. Session three looks at brain chemistry and addiction. Session four covers tobacco cessation and brief interventions. Session five is motivational interviewing based on the work of Miller, Rollnick and Butler (2007). The sixth and final session is a look at the pharmacotherapies available for supporting tobacco cessation.
Figure 1. Huddle session progression pyramid.
Evaluating Huddles

Pharmacotherapy

^ Motivational Interviewing

^ Cessation ^
  Brief Intervention training

^ Addiction ^
  Brain Chemistry

^ Special Populations ^
  Second Hand Smoke

^ Facts about Tobacco
Curriculum Implementation

The Huddle program as a delivery method of content

Let me outline the Huddle program delivery plan. All IPPU staff members working on the unit at the time of the Huddle are expected to attend the Huddle. Huddles occur for 20-30 minutes on site once per week for a period of 6 weeks. Multiple sessions will allow time for reflection on the content covered and promote vicarious learning opportunities (Banning, 2008) as the staff continue to accumulate work experiences on the unit between sessions. The Huddle facilitator will present knowledge content via PowerPoint to the Huddle participants. The sessions include weekly check-in discussions that provide an opportunity to discuss reflections and application of the information given the previous week. Staff will participate in the check-in by verbally offering reflections, instances of application, or concerns/issues that arose due to the huddles session information. “How are things going?” Having a weekly format of checking in will allow me to build relationships, assess the staff’s level of understanding of the material, assess the climate of the unit, give time for reinforcement of the previous week’s material, and encourage reflective practice (Zimmerman, 2009). The Check-in will also let me assess where to start since the staff participant group will fluctuate. The Check-in activity gives the facilitator a current group baseline that is pragmatic due to the potential change in membership, which will depend on the staff working on the Huddle day. At the end of the Huddle session is a weekly debrief or post-education discussion to provide an opportunity to anticipate application challenges related to the presented information for the coming week. Staff will participate in a debriefing discussion by verbally offering reflections, instances of anticipated application, and opportunities/challenges that may arise during the coming week related to the Huddle session information.
Due to the nature of the staff group, I intend to provide a tobacco communication tool to capture questions, areas needing clarification, unit situations that have arisen during the week that can be discussed, and comments. As a computer application, the communication tool will be available for staff to enter their thoughts, ideas, anecdotes, instances where they have or could apply their learning, and questions they may have for the following Huddle. Reflections are also appropriate and such entries are encouraged. The communication tool will also be a site where handouts, reference materials and copies of the PowerPoint sessions can be accessed. As an attempt to address the issue of staff moving in and out of the sessions, I would like to enable staff members who have missed Huddle sessions the opportunity to read about the sessions during their shifts as well as be able to participate should they be a late entry into attending the Huddle sessions. At minimum, the communication tool will be a place for the material to reside. Should no staff utilize the site by entering comments, the usefulness of the tool can be discussed during a session check-in. Staff members’ use of the communication tool will be evident by the tracking of logins.

The Huddle facilitator will have the opportunity to role model, for the staff, cessation counseling brief intervention (Prochaska & DiClemente, 1982) and motivational interviewing (Rollnick, Miller & Butler, 2007). There is also an internet component to the Huddle program that the staff are encouraged to complete during the six week Huddle session period. The Ontario Tobacco Research Unit (OTRU) provides a comprehensive web based course on tobacco dependence. The ability to access the free OTRU website assists in addressing the challenge of educating staff members who miss, some or most of the Huddle sessions due to shift work. Staff will show the print out of the OTRU certificate of completion as evidence.
Evaluating Huddles

The purpose of these six Huddle sessions is to bridge the gap between evidence-based practice and work-place practices that will be evidenced by IPPU staff stating an increase in knowledge on tobacco addiction and cessation; an increase in IPPU staff stating an increase in their comfort in engaging with patients about tobacco dependence and cessation; staff stating an increased comfort in assessing patients for nicotine dependence and advocating for and titrating nicotine replacement medications; as well as the IPPU staff demonstrating brief intervention and motivation interviewing techniques during nicotine dependence and cessation counseling. Pre-Huddle questionnaires, Post-Huddle questionnaires, and the communications tool will be completed by the Huddle participants in order to capture evidence of huddle effectiveness. The objective of the Huddles is to provide information to the staff while at the same time respecting workload and staffing expectations. All staff members working during the session time are expected to attend. Exceptions will be made for patient or unit crisis situations. Staff members not working during the session time are expected to read the material presented and discussed in the communications tool and comment on the information. In the event of a unit crisis, the session will be rescheduled for a later date within the week. (Appendix C)

Teaching sessions

I have incorporated a number of learning activities into these teaching sessions. I am using a huddle format, with PowerPoint visual aids, role play scenarios, quick quizzes, think aloud dialogue (Banning, 2008), and interspersed open ended questions in a transformative and narrative pedagogical approach (Arhin & Cormier, 2007). I have attempted to embed opportunities for self-referentiality. I posit that creating opportunities for the participants to refer to one’s self is the application of MI principles to the learning experience. It is my opinion that
self-referentiality is the enactment of Rollnick, Miller and Butler’s (2007) theoretical principle that I believe what I hear myself say. According to Arhin and Cormier “Students will be motivated and influenced by their knowledge, experience, self-referencing, and understanding of the topic” (2008, p.565).

The staff on the In-patient Psych unit is an eclectic mix of experienced practitioners. The education sessions are prescribed by the Mental Health and Addictions Manager and therefore attendance is mandatory for those working on the unit during the session time. Not all staff will be in attendance during all the sessions; in fact I suspect I may see some staff only once or twice. This will present a continuity challenge to the teaching and learning for those staff that will not be present for all the sessions. As the Huddle facilitator, I am a guest on the unit further adding to the challenge of engaging the staff in the learning activities. In light of these challenges I have utilized multiple educational strategies to engage the staff in the learning activities.

I have chosen the Huddle format for in-service education because it hypothetically will address the issue of knowledge transfer, staffing time constraints, while respecting staffing coverage and workload acuity. “One of the biggest advantages and best features of huddles is their simplicity” (Shermont et al, 2008, p. 44). With this format I hope to provide 6 short, 25 – 30 minute weekly learning opportunities that meet the expectations of the manager, which are engaging and meaningful for the staff without adding undue workload pressures. Multiple sessions will allow time for reflection on the contents covered and promote vicarious learning opportunities (Banning, 2008) as the staff continue to accumulate work experiences on the unit between sessions.

PowerPoint is the medium I have decided to use to present the educational content. Rather than take a didactic approach, I believe the visual presentation of relevant information
will engage the staff by delivering content both visually and verbally, meeting the needs of visual and auditory learners, as well as encouraging discussion and critical thinking. Nursing staff work in a technological environment; I believe they have an expectation of receiving well prepared information in a professional format and PowerPoint is viewed as a professional format. PowerPoint also gives me flexibility in the pace at which I can move through the content material; if information is generating considerable discussion I can linger or conversely if information is deemed already known then I can move quickly, providing a brief refresher.

Role play activities, fish bowl technique, and scenario discussions are incorporated into the sessions to give the staff opportunity to assimilate the content into their daily practice. My decision to use role plays, fish bowl, and scenario discussions was two-fold. First, these strategies allow the opportunity for staff to practice the discussed content. Second, they are likely to maintain engagement by providing an interactive experience for the participants. As a kinetic learner, I appreciate the opportunity to be involved in learning and am drawn to lively discussion. These activities are interesting for me to observe, participate in as a learner, and allow me to assess the learning outcomes I am attempting to achieve. I have also inserted a couple of quick quizzes into the sessions with the intent of eliciting staff engagement and active learning. Again, engagement is important as the staff is mandated to participate.

Banning describes the think aloud approach as a process-oriented teaching strategy in which “cognitive processing and cognitive development are fundamental to the process of clinical reasoning” (2008, p.10). I have used this approach for sometime as a technique to expose my rationale for arriving at a specific answer to a question, as a technique to assess for cognition, or as a strategy to enhance my understanding of a query. I often ask: Can you tell me more? My rationale for think aloud reasoning as a pedagogical tool for giving an answer is based on my
Evaluating Huddles

personal need for rationale as an underpinning to attaining knowledge, and my belief that context
is important. In sharing my thinking aloud, I believe I am articulating rationale with a cognitive
constructionist view (Young et al, 2007, p. 32) of educating those listening. Within the
PowerPoint presentation I have some dialogue boxes which give possible responses to the
concepts. These dialogue boxes I view as included in the think aloud approach. For the staff
attending these education sessions this approach will allow for praxis of the content presented.

Open ended questions are included in the session content but are also instrumental in
eliciting discussion. My intent with building in discussion times is to give opportunity for
reflection and dialogue.

I have designed the sessions to include a weekly check-in and post-session discussion
debriefs. Having a weekly format of checking in will allow me to build relationships, assess the
staff’s level of understanding of the material, assess the climate of the unit, and give time for
reinforcement of the previous week’s material. Check-in will also let me assess where to start
since the staff participant group will fluctuate. The post-session discussion is a time for content
clarification, allowing for informal evaluation of the content, learning, and gives the opportunity
for reflection.

EVALUATION APPROACH

Formative evaluation, according to Patton, often gives “an early picture of what progress
is being made toward desired outcomes and what unanticipated outcomes are emerging” (2008,
p. 120). The purpose is to improve an intervention and focuses on the “strengths and weaknesses
of the specific program, policy, product, or personnel being studied” with a key assumption that
“people can and will use information to improve what they are doing” (2002, p.224). As a
formative evaluation using a multi-method design I will be approaching it from several angles.
As a pragmatist I am cognizant that the purpose of utilization-focused evaluation is “intended use by the intended users” (Patton, 2008, p. 467) and because there is a variety of intentions within the HPHI stakeholder group, a multi-method design will be a logical choice. Primarily, this is outcome evaluation research that, in consultation with the primary users and with the logic model as a template, will be focusing on the short term outcomes and will ask to what extent have the desired changes/outcomes occurred? (Appendix B) The logic model constructed for this project is a means-ends hierarchy and “constitutes a comprehensive description of the program’s model” (p. 340). Evaluation research “investigates how well a program, practice, or policy is working” (Polit & Beck, 2008, p. 753). Priority questions for the purpose of program improvement are: Does the Huddle format work as a methodology for knowledge construction? What are the staff’s reactions to the Huddle sessions? What improvements can be made to increase the effectiveness of Huddles? Does increased knowledge of tobacco addiction increase the comfort of staff engaging in screening patients for tobacco addiction? Does the increased knowledge result an increased staff comfort to advocate for and titrate NRT medications? Does the increase in comfort result in an increase in NRT medication orders? I have also included an implementation evaluation component. I intend to use the stakeholders as a primary intended key informant advisory group for the evaluation process and utilize Appendix G to answer the implementation evaluation question of how closely the program followed the blueprint.

Key challenges that will affect the evaluation are: creating a learning climate with openness to feedback and change, building trust, and facilitating a learning opportunity for staff that may not be able to attend all Huddles due to shift rotation. Other components affecting the project are the educator’s/facilitator’s skill in facilitating learning, understanding the underpinning sentiment of scarcity, and keeping the Huddle process simple so as not to add to
workload. Positive findings will be related to the facilitator’s ability to make the learning, evaluation process, and the findings relevant and engaging to the staff participants.

Because there is a limited amount of time in which to complete the Huddle project, the medium and long term outcomes will be left for further study at a later date. In the Logic model (Appendix B) I have listed 3 long term outcomes. The first is that staff will consider themselves part of a learning community; the second is the IPPU being considered a desirable workplace; and the third is that tobacco addiction screening and cessation counseling will be considered a standard of practice. Because long term outcomes require a longer term of study, I will forgo including them in the proposed evaluation.

**DATA COLLECTION PLAN**

The IPPU staff, as the primary intended users, will be instrumental in the data collection. I am proposing data collection to occur at three points: 1) before the Huddle sessions are initiated to determine a knowledge base line; 2) as an ongoing process during the Huddle sessions; and 3) following completion of the Huddle sessions.

Pre-Huddle initiation data collection will consist of a pre-Huddle staff tobacco addiction and cessation counseling knowledge questionnaire (Appendix D). The pre-Huddle and post-Huddle questionnaires are adapted from the questionnaire used by the UOHI for evaluating their tobacco cessation education workshops. As well, statistical data may be collected via Synapse, the electronic data system used on the IPPU, and by review of patient charts. The statistical data will include a count of the number of patients screened for tobacco dependence, the number of patients offered NRT, and the number of NRT orders pre-Huddle. The data will be collected again post-Huddle. The pre-implementation data to be captured will be used to determine a
knowledge base line which will be compared to the post-Huddle knowledge-base. The statistical
data collected both pre and post Huddle will also be compared. The pre-Huddle questionnaire
includes questions designed to capture staff member’s pre-Huddle knowledge of tobacco
addiction, nicotine dependence, brain chemistry, brief intervention and motivational
interviewing. I am unsure if the questionnaire has been tested for validity; however, I am aware
that UOHI is involved in a Proof of Concept project to determine if their proposed systematic
approach to tobacco dependence is effective. The Pre-Huddle project questionnaire is a mix of
Likert scale rating questions and open-ended questions. The Synapse and chart review data will
be capturing the number of patients screened for tobacco addiction, the number of patients on
NRT, and the number of documented discussions of tobacco addiction and/or cessation
counseling. I anticipate this pre-project data may be captured over a month long period.

Data collected during the project will be a mix of qualitative and quantitative data. There
will be quantitative data as in staff attendance at the huddle sessions, number of sessions
attended by specific staff members, number of huddle sessions given, number of entries in the
communication tool, and number of staff completing the Ontario Tobacco Research Module. An
interpretive pedagogical epistemology lens will be used when asking participants to give context
to the Huddle sessions which will be captured in narrative/story telling/out loud forms via the
weekly check-in discussions, the facilitated out-loud discussions occurring during the huddle
session activities and during the weekly post Huddle debrief. Because these are facilitated
sessions, an appreciative inquiry approach will be utilized to support participants to discuss and
reflect on the concepts presented during the Huddle session. Appreciative inquiry is a component
of MI. Narrative data will be captured, listed, and used to add depth and context to the evaluation
findings.
Evaluating Huddles

The communication tool will be a source of data as it is designed to capture both reflections and praxis. As a context-based learning tool, the communication tool is a place for both staff members who have participated in the Huddles and those who were absent to document their critical reflections, criticisms, concerns, and application of the knowledge. I anticipate the entries by the facilitator and the staff will add richness to the data and project.

Post-Huddle project data will be collected by the administration of the Post-Huddle questionnaire. As well, a post-project interview/questionnaire utilizing an Appreciative inquiry format (Patton, 2002) would capture the qualitative understandings the staff members have given to the education information and method of delivery. What did you experience as the key components of Huddles as an education method? What, in your opinion, are Huddles’ strengths and weaknesses? How did this Huddle education compare to other in-service educations you have attended? What improvements can you suggest? How was this beneficial to you as a staff member? How was this beneficial to the IPPU patients? (Appendix E)

DATA ANALYSIS

Prior to presenting the post-project data to the participants I intend utilize the stakeholder advisory committee of HPHI primary users, convened during the pre-implementation phase of project, to assist with collating the raw data. I will work along side the committee to analyze and interpret that data collected. As I stated earlier, there is little in the literature on Huddles as an education methodology, therefore by striking a committee of primary users we can begin to develop an assessment framework for the Huddle methodology to complement the intended outcomes.
The pre-Huddle questionnaire (Appendix D) and the post-Huddle questionnaire (Appendix E) consist of 6 likert-scale data questions. The pre-Huddle questionnaire results will be compared to the post-Huddle questionnaire results using a Willcoxon signed-rank test to determine whether there is a significant increase in the level of knowledge following the program. “The Willcoxon signed-rank test involves taking the difference between paired scores and ranking the absolute difference” (Polit and Beck, 2008, p.596). Pre-Huddle questionnaire question number seven, asks participants to name their perceived barriers. Question eight, asks participants what they want to learn. These 2 pre-Huddle questions will give in-sight into the participants learning needs and allows for adaptation of the course material to meet these expressed learning needs. The post-Huddle question asks staff members to name and give examples of the three most valuable things they learned. The data collected from these questions will be listed and reported adding context to the evaluation findings. It is my contention that, the information gathered by these questions will enhance future delivery of tobacco cessation education. The data, will point the facilitator to areas of content that are a priority for the learners, thus impacting delivery of future tobacco cessation Huddles.

Electronic data collection systems and the chart reviews will capture, for comparison, both pre-Huddle data and post-Huddle data. The quantitative data collection will be: the number of patients who use tobacco (pre/post); the number of patients who are screened for tobacco use (pre/post); the number of patients that are offered NRT (pre/post); and the number of patients who are on NRT (pre/post). The quantitative data collected will be analyzed by the chi-squared test. The contingency table would be a comparison of: the number of patient’s who used tobacco, number of patients screened for tobacco use on admission, number of patients offered NRT, and number of patients prescribed NRT, before the Huddle education began to the same categories
after the Huddle education sessions are completed. The alternative to the null hypotheses is:
post-Huddle staff have an increased comfort with addressing tobacco dependence and counseling
activities which results in an increase in the activity of screening, offering NRT and NRT orders.

Check-in discussions and post-Huddle debriefings will require qualitative data capture. I am considering, for ease of application, using audiotape to capture the discussions and then have the audiotape transcribed. The communication tool will capture written qualitative data, notes, reflections and other writings the staff wish to document. The transcribed data and the communications tool data can be taken to the advisory group and will be used to add context and examples to the project report.

Taking the collected and collated data back to the primary participants for feedback as a final step is integral to the evaluation process. Health-evidence.ca posted December 8, 2009 on their web site, a tool to Improving Future Decisions: Optimizing the Decision Process from Lessons Learned. The purpose of this evidence-informed decision making tool is to: “highlight positive aspects of the decision process and the decision itself, document barriers and facilitators to effective decision making in this particular case, capture lessons learned about the decision making process, document practical suggestions for the improvement of the decision making process and future decisions. The draft document (Appendix F) is the tool that would guide the closing discussions on the Huddle project and provide valuable insight into the achievements of the outcomes. I would not use the word decision as it is used in the Health Evidence tool but instead replace the word decision with the word desired outcome.
FINDINGS DISSEMINATION

Reporting the information will happen in stages. The initial preliminary report will be discussed with the primary participants. At this reporting session the participants will validate analysis and interpretations made by the project (advisory) committee. I also see this as a developmental opportunity (Patton, 2008). “Nursing interventions are rarely static…” (Morse, Penrod & Hipcey, 2000, p.126). The second step will be reporting the results to the stakeholder advisory group as well as the stakeholder managers. The managers will be asked to participate in the validation of the data report with a goal of securing their continued promotion of the project findings. Manager participation will assist with meeting the long term intentions of this proposal which is to systematize the screening, counseling and treating of tobacco dependence as a standard of care. I see that utilizing the Improving Future Decisions: Optimizing the Decision Process from Lessons Learned draft tool (Appendix F) would give the results discussion a framework. Because these Managers are also HPHI stakeholders I anticipate they will provide valuable insights into the project. It is my hypothesis that, Huddles as an educational method, increase knowledge of working staff in a structure that is accepted by the stakeholders and results in a change in practice, thus bridging the evidence-practice gap.

The final step will be to write a project report. The report will provide evidence and direction for future tobacco cessation Huddles. Utilizing the report to formally write a scholarly paper, on the evidence produced by the Educational Huddles project, assists with the goal of bridging the evidence to practice gap.
CONCLUSION

In summary the proposed project comprises a detailed description of the Huddle curriculum, an implementation plan, and a proposed evaluation strategy to determine if Huddles: a) increase staff members knowledge of tobacco dependence and cessation, b) increase staff members comfort in engaging with patients about tobacco dependence and cessation, c) increase staff members comfort with advocating for and titrating NRT medication, and d) are an effective method to address staff members’ ongoing professional development learning needs while at the same time respecting organizational priorities of fiscal restraint and adequate workload coverage.
REFERENCES


Evaluating Huddles


### Teaching Plan

<table>
<thead>
<tr>
<th></th>
<th>Content</th>
<th>Activities</th>
<th>Time: 25-30 min. sessions</th>
<th>Outcomes</th>
<th>Evaluation</th>
</tr>
</thead>
</table>
| 1 | Facts about Tobacco                         | • Introduction  
• PowerPoint  
• Opening Quiz  
• PowerPoint  
• Story – sharing  
• PowerPoint  
• Debrief discussion and questions | 2 min  
1 min  
1 min  
10 min  
2 min  
5 min  
5 min | *To increase the staffs understanding of tobacco use and addiction as a preventable chronic disease condition.*  
*To increase staff support of the VCH smoke-free property policy.* | *Opening quiz – pre-assessment  
*story sharing – adding context  
*Debrief discussion – narrative evaluation* |
| 2 | Special populations/ Second hand smoke      | • Check In  
• PowerPoint  
• Quiz  
• PowerPoint  
• Quotes – discussion/sharing  
• PowerPoint  
• Quotes – discussion/sharing  
• PowerPoint  
• Debrief discussion and questions | 2 min  
2 min  
1 min  
10 min  
1 min  
1 min  
8 min  
4 min | *To increase the staffs awareness of tobacco use and addiction in relation to mental health/special populations.  
*To increase the staffs awareness of the health risks associated with second hand smoke.* | *Check –In – narrative evaluation  
*Quiz – knowledge assessment (context)  
*open – sharing and discussions – narrative evaluation  
*Debrief discussion – narrative evaluation* |
| 3 | Addiction Brain Chemistry                   | • Check In  
• PowerPoint  
• Video Discussion  
• PowerPoint  
• Debrief discussion and questions | 2 min  
8 min  
10 min  
2 min  
5 min | *To increase the staffs understanding of tobacco addiction and the effects of tobacco use on brain chemistry.* | *Check –In – narrative evaluation  
*narrative evaluation  
*open – sharing and discussions – narrative evaluation  
*Debrief discussion – narrative evaluation* |
| 4 | Cessation Brief Intervention training       | • Check In  
• PowerPoint  
• Changes - discussion  
• Role play - discussion/sharing  
• Debrief discussion and questions | 2 min  
10 min  
1 min  
10 min  
5 min | *To increase the staffs understanding of cessation.  
*To increase the number of cessation conversations occurring between staff and patients.  
*To increase the comfort of the staff in participating in Cessation conversations.* | *Check –In – narrative evaluation  
*discussions - narrative evaluations  
*Debrief discussion – narrative evaluation* |
| 5 | Motivational Interviewing                  | • Check In  
• PowerPoint  
• Role play - discussion/sharing  
• PowerPoint  
• Role play- discussion/sharing  
• PowerPoint  
• Debrief discussion and questions | 2 min  
6 min  
5 min  
8 min  
5 min  
4 min  
5 min | *To increase the staffs understanding of cessation.  
*To increase the number of cessation conversations occurring between staff and patients.  
*To increase the comfort of the staff in participating in Cessation conversations.* | *Check –In – narrative evaluation  
*discussions - narrative evaluations  
*Debrief discussion – narrative evaluation* |
| 6 | Pharmacotherapy                            | • Check In  
Handout VCH NRT order forms  
• PowerPoint  
• Discussion and questions  
• Evaluation | 2 min  
1 min  
20 min  
5 min  
2 min | *To increase the staffs understanding of the various NRT products available and the NRT applications.  
*To increase the staffs use of the NRT protocol.  
*To increase the number of patients utilizing NRT to manage withdrawal symptoms while admitted.* | *Check –In – narrative evaluation  
*discussions - narrative evaluations  
*Debrief discussion – narrative evaluation* |
Appendix B

Evaluating Huddles

Tobacco Cessation Education Huddles on the In-patient Psychiatric Unit.

**Input**
- IPFU Staff time
- MH&A Manager support
- Laptop
- Computer Internet access
- Communication book
- Huddle education binder
- CNE time
- VCH Tobacco strategy support

**Output**
- Staff Huddles for 20-30 minutes on site X 6
- 6 PowerPoint presentations
- 6 Weekly check in discussions providing an opportunity to discuss reflections and application of the information given the previous week
- 6 Weekly debrief: post education discussion to provide an opportunity to anticipate application/challenges related to the presented information for the coming week
- CNE role modeling - BIT/MI Conversations with patients
- Staff will utilize the Tobacco communication book
- Staff will utilize the Huddle binder information
- Staff will complete the OTRU web module
- Staff utilizing NRT orders

**Outcomes**
- Number of Staff attending huddle sessions.
- Qualitative data capture of staff participation in check-in and debriefing activities.
- Number and quality of entries in the Tobacco communication book
- CNE documentation of instances of use made flag conversations in communication book
- Completion of pre and post huddle session questionnaires
- Number of staff completing OTRU module
- Number of patients screened for Tobacco use
- Number of patients on NRT replacement
- Number of staff initiated discussion of tobacco addiction and/or cessation.
- IPFU Staff will show an increase in knowledge in post huddle questionnaire
- IPFU staff will initiate tobacco discussion with the unit patients
- IPFU staff will advocate for NRT utilization
- IPFU staff will log in and complete Ontario Tobacco Research Unit (OTRU) web based tobacco cessation module
- Staff will advocate for educational huddle opportunities
- IPFU staff will consider themselves a learning community of practice
- IPFU will be viewed as a desirable work site
- Tobacco Addiction screening and Cessation counseling will be considered a Standard of Practice
COURSE DESCRIPTION

The purpose of these six huddles sessions is to assist the In-patient psychiatric unit (IPPU) staff with 1) addressing the issue of nicotine dependence in the clients admitted to the IPPU 2) assessing patients for nicotine dependence and nicotine replacement therapy and 3) adopting brief intervention and motivation interviewing techniques in relation to nicotine dependence.

COURSE FACILITATOR

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604-240-3963

COURSE PROCESS

The course will be delivered in six short Huddles sessions. Huddles sessions will occur once per week on Tuesday afternoon. The course starts Tuesday September 15th at 1:30 pm at the nursing station on the IPPU and will run for six consecutive weeks. Each session will last for approximately 25 – 30 minutes.
STAFF EXPECTATIONS

The objective of the course is to provide information to the staff while at the same time respecting workload and staffing expectations. All staff members working during the session time are expected to attend. Exceptions will be made for patient/unit crisis situations. In the event of a unit crisis the session will be rescheduled for a later date within the week.

Staff members not working during the session time are expected to read the material presented and discussed in the communications tool and comment on the information. The communication tool is also a place for unit specific questions or scenarios where the information presented can or has been utilized. Reflections are also appropriate and encouraged entries.

As these Huddles are part of a project there is an expectation of staff to participate in both formal and informal evaluations.

SESSION OUTLINE

The first session is a broad overview of tobacco addiction with a link to the recent VCH Smoke-free properties policy. I have included specific slides on myths and facts, what is nicotine, the anatomy of a cigarette, a snapshot of the tobacco industry, concluding with the impact of Tobacco. Session two deals with special populations, specifically with mental illness and touches on the harmful health effects of second hand smoke. Session three looks at brain chemistry and addiction. Session four covers tobacco cessation and brief interventions. Session five is Motivational Interviewing based on the work of Miller, Rollnick & Butler (2007). The sixth and final session is a look at the pharmacotherapies available.
TEXTBOOK

There is no text book for these Huddle sessions. The session information will be presented via power point. The power point slides will be stored in the communications book for reference purposes and for those staff not working during the Huddle presentation to read and reflect on as an indication of their participation.

IPPU staff is encouraged to complete the Ontario Tobacco Research Unit on-line education course Tobacco & Public Health: From Theory to Practice. (www.tobaccocourse.otru.org/)

TEACHING/LEARNING METHODS

The sessions will be a blend of information sharing, check-in’s, open-ended questions, dialogue, role plays and story sharing, reflections, and post-Huddle session debriefings.

SESSION PLAN

<table>
<thead>
<tr>
<th>Activities</th>
<th>Time</th>
<th>Outcomes</th>
<th>Evaluation</th>
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<tbody>
<tr>
<td>Session 1</td>
<td></td>
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<td></td>
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<tr>
<td>Facts about Tobacco</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>2 min</td>
<td>*To increase the staffs understanding of tobacco use and addiction as a preventable chronic disease condition.</td>
<td>* Opening quiz – pre-assessment</td>
</tr>
<tr>
<td>PowerPoint</td>
<td>1 min</td>
<td>*To increase staff support of the VCH smoke-free property policy.</td>
<td>* story sharing – adding context</td>
</tr>
<tr>
<td>Opening Quiz</td>
<td>1 min</td>
<td></td>
<td>*Debrief discussion – narrative evaluation</td>
</tr>
<tr>
<td>PowerPoint</td>
<td>10 min</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Story – sharing</td>
<td>2 min</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PowerPoint</td>
<td>5 min</td>
<td></td>
<td></td>
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<tr>
<td>Debrief discussion and questions</td>
<td>5 min</td>
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<td></td>
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Session 2

Special Populations / Second Hand Smoke

<table>
<thead>
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<th>Duration</th>
<th>Objectives</th>
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<tbody>
<tr>
<td>Check In</td>
<td>2 min</td>
<td>*To increase the staffs awareness of tobacco use and addiction in relation to mental health/special populations. *</td>
</tr>
<tr>
<td>PowerPoint</td>
<td>2 min</td>
<td><em>Check –In – narrative evaluation</em></td>
</tr>
<tr>
<td>Quiz</td>
<td>1 min</td>
<td><em>Quiz – knowledge assessment (context)</em></td>
</tr>
<tr>
<td>PowerPoint</td>
<td>10 min</td>
<td><em>open – sharing and discussions – narrative evaluation</em></td>
</tr>
<tr>
<td>Quotes – discussion/sharing</td>
<td>1 min</td>
<td></td>
</tr>
<tr>
<td>PowerPoint</td>
<td>1 min</td>
<td></td>
</tr>
<tr>
<td>Quotes – discussion/sharing</td>
<td>1 min</td>
<td></td>
</tr>
<tr>
<td>Debrief discussion and questions</td>
<td>8 min</td>
<td></td>
</tr>
<tr>
<td>Debrief discussion and questions</td>
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</tr>
</tbody>
</table>

Session 3

Addiction and Brain Chemistry

<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check In</td>
<td>2 min</td>
<td>*To increase the staffs understanding of tobacco addiction and the effects of tobacco use on brain chemistry. *</td>
</tr>
<tr>
<td>PowerPoint</td>
<td>8 min</td>
<td><em>Check –In – narrative evaluation</em></td>
</tr>
<tr>
<td>Video/Discussion</td>
<td>10 min</td>
<td><em>Video discussion – evaluation of context/knowledge</em></td>
</tr>
<tr>
<td>PowerPoint</td>
<td>2 min</td>
<td></td>
</tr>
<tr>
<td>Debrief discussion and questions</td>
<td>5 min</td>
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</tr>
</tbody>
</table>

Session 4

Cessation and Brief Intervention Training

<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check In</td>
<td>2 min</td>
<td>*To increase the staffs understanding of cessation.  *</td>
</tr>
<tr>
<td>PowerPoint</td>
<td>10 min</td>
<td>*Check –In – narrative evaluation  *</td>
</tr>
<tr>
<td>Changes - discussion</td>
<td>1 min</td>
<td><em>discussions - narrative evaluations</em></td>
</tr>
<tr>
<td>Role play - discussion/sharing</td>
<td>10 min</td>
<td><em>Debrief discussion – narrative evaluation</em></td>
</tr>
<tr>
<td>Debrief discussion and questions</td>
<td>5 min</td>
<td></td>
</tr>
<tr>
<td>Debrief discussion and questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debrief discussion and questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debrief discussion and questions</td>
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</tr>
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</table>
Session 5

Motivational Interviewing

<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check In</td>
<td>2 min</td>
<td>*To increase the staffs' understanding of cessation.</td>
</tr>
<tr>
<td>PowerPoint</td>
<td>6 min</td>
<td>*To increase the number of cessation conversations occurring between staff and patients.</td>
</tr>
<tr>
<td>Role play - discussion/sharing</td>
<td>5 min</td>
<td>*To increase the comfort of the staff in participating in Cessation conversations.</td>
</tr>
<tr>
<td>PowerPoint</td>
<td>8 min</td>
<td></td>
</tr>
<tr>
<td>Role play - discussion/sharing</td>
<td>5 min</td>
<td></td>
</tr>
<tr>
<td>Power point</td>
<td>4 min</td>
<td></td>
</tr>
<tr>
<td>Debrief discussion and questions</td>
<td>5 min</td>
<td></td>
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</table>

Session 6

Pharmacotherapy

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<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check In</td>
<td>2 min</td>
<td>*To increase the staffs' understanding of the various NRT products available and the NRT applications.</td>
</tr>
<tr>
<td>Handout VCH NRT order forms</td>
<td>1 min</td>
<td>*To increase the staffs' use of the NRT protocol.</td>
</tr>
<tr>
<td>PowerPoint</td>
<td>20 min</td>
<td></td>
</tr>
<tr>
<td>Discussion and questions</td>
<td>5 min</td>
<td></td>
</tr>
<tr>
<td>Evaluation</td>
<td>2 min</td>
<td></td>
</tr>
</tbody>
</table>

Upon completion of the Huddles, IPPU staff participants will have an enhanced understanding of Nicotine Dependence, Brief Interventions, Motivational Interviewing techniques, comfort screening IPPU patients for tobacco dependence and initiating NRT orders.

Any IPPU staff member who has participated in all the Huddle sessions will be given a certificate of completion.
Appendix D  
Pre-Huddle Questionnaire
Prior to attending the Tobacco Huddle, please complete this questionnaire and return to one of the program staff.

| Name (Optional) ________________________________ |
| Occupation: ________________________________ |

1. How often do you identify the smoking status of your patients?
   - Never
   - Sometimes
   - Always
   - N/A

2. How comfortable are you in approaching patient-smokers?
   - Not at all comfortable
   - 1
   - 2
   - 3
   - 4
   - 5
   - Extremely comfortable

3. How confident are you in your ability to counsel patient-smokers?
   - Not at all confident
   - 1
   - 2
   - 3
   - 4
   - 5
   - Extremely confident

4. How confident are you in your ability to advise patient-smokers on the use of smoking cessation medications?
   - Not at all confident
   - 1
   - 2
   - 3
   - 4
   - 5
   - Extremely confident

5. How confident are you in your knowledge of nicotine addition and the effects it may be having on your patients?
   - Not at all confident
   - 1
   - 2
   - 3
   - 4
   - 5
   - Extremely confident

6. How confident are you that a systematic smoking cessation protocol can be implemented in your setting?
   - Not at all confident
   - 1
   - 2
   - 3
   - 4
   - 5
   - Extremely confident

7. What do you see as being some of the largest barriers to implementing a smoking cessation protocol in your setting?

8. List 3 things that you most want to learn/take with you from these Huddle sessions.

(Adapted from the University of Ottawa Heart Institute)
Appendix E

Post-Huddle Questionnaire

Please complete this questionnaire and return it to one of the program staff.

Name (Optional) ______________________________________

Occupation: ______________________________________

1. How often do you identify the smoking status of your patients?
   - Never
   - Sometimes
   - Always
   - N/A

2. How comfortable are you in approaching patient-smokers?
   - Not at all comfortable
   - 1
   - 2
   - 3
   - 4
   - 5
   - Extremely comfortable

3. How confident are you in your ability to counsel patient-smokers?
   - Not at all confident
   - 1
   - 2
   - 3
   - 4
   - 5
   - Extremely confident

4. How confident are you in your ability to advise patient-smokers on the use of smoking cessation medications?
   - Not at all confident
   - 1
   - 2
   - 3
   - 4
   - 5
   - Extremely confident

5. How confident are you in your knowledge of nicotine addiction and the effects it may be having on your patients?
   - Not at all confident
   - 1
   - 2
   - 3
   - 4
   - 5
   - Extremely confident

6. How confident are you that a systematic smoking cessation protocol can be implemented in your setting?
   - Not at all confident
   - 1
   - 2
   - 3
   - 4
   - 5
   - Extremely confident

7. What do you see as being some of the largest barriers to implementing a smoking cessation protocol in your setting?

8. Please give examples of the 3 most valuable things you learned from these Huddle sessions.

(Adapted from the University of Ottawa Heart Institute)
Appendix F

**Post Huddle Participant Questionnaire (part 2)**

What key components of the Huddles were the most important for your learning?

What, in your opinion, are Huddle’s strengths and weaknesses?

How did this Huddle education compare to other in-service education programs you have attended?

What improvements can you suggest?

How was this beneficial to you as a staff member?

How was this beneficial to the IPPU patients?
Appendix G

**DRAFT**

The Huddle project is grateful to Health Evidence and Peel Public Health, Communicable Disease Division for co-developing and Field testing the November 2009 version of this document.

**Improving Future Decisions: Optimizing the Decision Process from Lessons Learned**

**Issue:**
*Provide a brief description of the issue*

**Outcome:**
*Identify the final decision*

**Outcome process:**

Breakdown the process into discrete activities then determine, upon reflection on the process,
- What was supposed to happen?
- What actually happened?
  - Why?
- What’s the difference?
  - Why?
- What worked well that we’d want to ensure we incorporate into future decision making?
  - Why?
- What did not work that we definitely don’t want to do in the future?
  - Why not?
- What did not work that we want to ensure that we do differently?
  - Why?
- What, in your opinion, would be the ideal process?

**Lessons Learned**

- Highlight successes
  - How to sustain or expand upon them
- Identify things that did not go as well as planned
  - Ways to modify or improve performance

**Recommendations for future decision making**

What, if any changes, to process or direction should be made? Identify crisp and clear, achievable and future-oriented recommendations.

Put in place action plans, with assigned responsibilities and timelines, to sustain the successes and to improve upon the shortfalls.