Smoking Cessation: a briefing for midwifery staff
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Background

Smoking in pregnancy poses significant health risks to the mother and to the baby. Many women who smoke will give up by themselves prior to becoming pregnant and others will stop immediately, once pregnancy is confirmed; other pregnant women who smoke and who want to stop smoking will need considerable support to stop successfully. Most local stop smoking services have a specialist pregnancy smoking cessation practitioner who can provide behavioural support and advice on medication to pregnant women who smoke and who want to stop.

The National Centre for Smoking Cessation and Training (NCSCT) has developed a specialist online training course for practitioners who have Full NCSCT Certification entitled *Smoking cessation in pregnancy and the post-partum period*. This course provides information on the health effects of smoking in pregnancy, the benefits of cessation and effective methods to help pregnant women to stop smoking; it also focuses on best practice in assisting pregnant women to stop smoking and has links to useful resources.

This briefing is written for the midwifery team to complement the NCSCT *Smoking cessation in pregnancy and the post-partum period* training module in an attempt to maximise the opportunity for pregnant women who smoke to get expert support before, during and after their quit attempt.
Introduction

There are three simple steps to intervening with pregnant women who smoke:

ASK
Establish the smoking status of pregnant women

ADVISE
Inform pregnant women that the best way of stopping smoking is with a combination of behavioural support and medication

ACT
Give pregnant women who smoke the best possible chance of stopping by putting them in contact with the local stop smoking service

This is known as Very Brief Advice and a generic training module (focusing on all smokers and not just pregnant women) on this is available on the NCSCT website: www.ncsct.co.uk/VBA
1. ASK

1.1 Intervention opportunities

- Any contact with a pregnant woman offers an opportunity for health interventions
- Pregnant women have regular antenatal appointments (see below) which allow for the delivery of Very Brief Advice by the midwifery team
- Pre-conceptual consultations
- First Pregnancy
  - 6–16+ weeks: Booking Appointment by Community Midwife (home or clinic)
  - 10–13 weeks: Dating ultrasound scan (hospital)
  - 15 weeks: Blood test by Community Midwife
  - 20–21 weeks: Anomaly scan (not-standard) by ultrasonographers (hospital)
  - 25 weeks: Community Midwife appointment (home or clinic)
  - 28 weeks: Community Midwife appointment (home or clinic)
  - 32 weeks: Community Midwife appointment (home or clinic)
  - 36 weeks: Community Midwife appointment (home or clinic)
  - 38 weeks: Community Midwife appointment (home or clinic)
  - Term: Community Midwife appointment (home or clinic)
  - Term +7 days: Community Midwife appointment (home or clinic)
  - New Birth visit: Health Visitor (home)
- Subsequent pregnancies
  - Same schedule, except the 25 week appointment is omitted
- All pregnant women follow this schedule unless they become classified as ‘high risk’ when they may be admitted into hospital for antenatal care or investigation, or transferred to obstetrician-led care
1.1.1 Smoking interventions during routine antenatal care

- Midwives are especially well placed to deliver Very Brief Advice (VBA) to pregnant women because most women choose to book their antenatal care with a midwife; although women can choose to see their GP

- It is important that, when taking the full medical history at the booking appointment (generally between weeks 6–16), past and current smoking status is included

What you need to do

- Include past and present smoking status in the full medical history. Ensure that this is a mandatory field in the electronic and/or written notes. See Appendix 1 for a form of words that will encourage the accurate recording of this

- Ask all women about their smoking status at every opportunity during the pregnancy, but at least once within each trimester, record status and advice given

- Assess the pregnant woman’s exposure to tobacco smoke through discussion and use of a carbon monoxide (CO) test. See 1.1.2 for further information on this

- Encourage cessation during any antenatal admissions, including appointments for investigation into issues such as intrauterine growth retardation (IUGR). Use the opportunity to link smoking to the presenting medical problem

Why you need to do this

- The stigma around smoking in pregnancy means that some women find it difficult to disclose that they smoke and this can prevent them receiving appropriate advice and support. They will need to be explicitly asked about their smoking status, but sensitively so (see Appendix 1 for a suggested form of words to use)

- If the subject of stopping smoking is only raised at the initial booking visit, there is a danger that stopping smoking will not be deemed important throughout the pregnancy

- Pregnant women who stop smoking prior to conception, or after the pregnancy is confirmed, may well relapse and so it is important that the topic is raised repeatedly, even with those who are recorded as ex-smokers or non-smokers

- Antenatal problems may emerge during the pregnancy and women may be unaware of the link between the problem and their smoking, or the immediate health benefits to them and their pregnancy of stopping smoking. Many women do not understand how smoking affects their pregnancy and may misinterpret information given to them
1.1.2 Conducting carbon monoxide (CO) monitoring in pregnancy

A CO test is an immediate and simple method for helping to assess whether or not someone smokes.

**What you need to do**

- Explain that CO is a poisonous gas contained in cigarette smoke and that CO monitoring is a simple, routine part of antenatal care. Say: “Carbon monoxide is a gas inhaled when you smoke a cigarette. It passes via your bloodstream to your baby. Fortunately, CO levels return to normal very quickly once someone stops smoking. One of the routine antenatal checks we carry out tests the CO level in your bloodstream. It’s a simple breath test which only takes a couple of minutes to do and we can give you the results immediately.”

- Explain that CO affects the body’s ability to transport oxygen around the body, which reduces the oxygen available to the baby

- Explain that CO crosses the placenta and enters the bloodstream of the baby: it increases the risk of miscarriage and slows the baby’s growth and development

- Conduct the CO test (see Appendix 2 for how to carry out the CO test correctly and how to respond to different results)

**Why you need to do this**

- A good explanation of CO monitoring by you, will help the women you see understand the significance of the test

- It is a useful way of raising the topic of smoking

- A raised CO level (above 4ppm) is a sign that further intervention and support is needed

- Explaining that CO levels rapidly return to normal if there is not even a single puff on a cigarette can encourage pregnant women to stop smoking
2. Advise

2.1 Interpreting the carbon monoxide (CO) result in pregnancy

- The recommended cut-off for detecting smoking in pregnant women is 4 parts per million (ppm)
- When trying to identify pregnant women who smoke, it is best to use a low cut-off point to avoid missing someone who may need support to quit.
- CO tests are a good measure of recent smoke intake. However, because CO is eliminated from the body rapidly, they will not usually detect smoking from over 48 hours ago or even from the day before.
- CO readings will also typically be lower in the morning than afternoon because CO levels build up over the course of the day.

What you need to do if the reading is under 4ppm

- Inform the woman that this is a normal reading (CO is produced by the body anyway and so rarely reaches 0ppm), that this is good news for her and her baby and that you will repeat the test at every visit so that she can know that her and her baby are safe from high levels of carbon monoxide.

What you need to do if the reading is over 4ppm

- Say: “Exposure to tobacco smoke is the most common cause of carbon monoxide being found during the breath test. Do you or anyone else in your household smoke?”
- If the pregnant woman says that she has stopped smoking but the CO reading is higher than 4ppm, advise her about possible CO poisoning and give her the details of the Health and Safety Executive gas safety advice line (0800 300 363). It is, of course, possible that the woman is a current smoker but is reluctant to admit this; and so any further questions should be phrased sensitively to encourage a frank discussion (see Appendix 3 for suggested wording).

Why you need to do this

- NICE recommend CO monitoring at every stop smoking consultation with pregnant women.
- Many pregnant women are unaware of the high risks associated with smoking in pregnancy and CO tests provide visible proof of the effects of smoking on the body.
2.1.1 Assessing motivation to stop smoking

- Once you have established whether a pregnant woman smokes, either through asking them or after a carbon monoxide test, the next step is to see whether they are interested in stopping smoking.

- Pregnant women can be highly motivated to make lifestyle changes in pregnancy (e.g. reducing alcohol consumption, avoiding certain foods and giving up smoking) because of their desire to have a healthy baby.

What you need to do

- Explain that the best way of stopping smoking is with support from specially trained stop smoking practitioners; that this is a free and friendly service that you can refer her for to. Say: “We know that the best way of stopping smoking is with the help of a trained stop smoking practitioner. We have a local stop smoking service that many pregnant women have found very useful – would you like me to put you in touch with them?”

- If the pregnant woman agrees then you can be encouraging about her decision and refer her to the local stop smoking service for specialist advice and support.

- If the pregnant woman does not feel able to stop now or is reluctant to receive help you can say: “It is your choice and if you’d like to talk it through with someone then the stop smoking service will be able to do this with you. Why don’t I give them your number and they can give you a call for a chat?”

- You can also ask whether the pregnant woman’s partner smokes, if their partner is motivated to stop smoking and whether they would also like support to do so. If the partner or other family members smoke, and do not want to quit, you will need to offer on-going support to help her manage this.

Why you need to do it

- Simply informing pregnant women that there is a local service that is effective and that other pregnant women have found it useful can help motivate them to make an attempt at stopping smoking.

- The support of family and friends, particularly partners who share the home, is crucial in any attempt to stop smoking but is especially so for pregnant women. Research shows that the support from family and friends is important in determining whether a pregnant woman will be successful in stopping smoking; and that pregnant women are more likely to notice their partner’s social support during a quit attempt than are non-pregnant women.

- If partners or significant others can also make a quit attempt then the pregnant woman stands a better chance of quitting herself. If both are successful then the home will also be free from tobacco smoke for the new born baby.
2.2 Documenting smoking cessation interventions

It is important for all healthcare professionals to keep a written record of the stop smoking advice given to each woman throughout her pregnancy.

Any personal information collected from the pregnant woman by a stop smoking practitioner is subject to the usual confidentiality and data protection regulations and safeguards.

What you need to do

- Healthcare professionals must respect the right of a pregnant woman who smokes to decline a referral for help to stop smoking. It should be recorded that the woman has declined treatment at this time but has been informed that she can ask for help at any point in the future
- Reassure the pregnant woman that any records containing information about them will be confidential

Why you need to do it

- Systematic recording has been shown to be an important motivation for healthcare workers in supporting pregnant women to stop smoking
- It is important to keep accurate and updated records on the smoking status of pregnant women; what advice has been given; what assistance has been offered; and what follow-ups have been arranged
- All records on smoking should be consistent in the woman’s hand-held and hospital notes, and on computerised records (if appropriate), to allow everybody involved in antenatal care to monitor progress and to track success rate
3. Act

3.1 Role of Stop Smoking Services

Local stop smoking services vary in the way they are set up across the country. Many services have a specialist midwife or stop smoking practitioner who works supporting pregnant women to quit smoking.

What you need to do

- It is important that healthcare professionals know what support is available locally or nationally and know what that support involves

- Stop smoking service practitioners will provide a combination of behavioural support and information on stop smoking medications, and will be able to help pregnant women make an informed choice about using nicotine replacement therapy to help them stop smoking

- As a healthcare professional, you can make pregnant women aware of the ‘smoking in pregnancy’ information available on the NHS Smokefree website (http://smokefree.nhs.uk/smoking-and-pregnancy/), and give the NHS Smoking in Pregnancy Helpline number (0800 169 9 169) and local helpline numbers if appropriate

Why you need to do it

- The evidenced-based behavioural support programme provided by local stop smoking services offer pregnant women their best chance of quitting before, during and after a pregnancy
3.1.1 Supporting pregnant women to remain abstinent from smoking

Pregnant women can find stopping smoking incredibly difficult and the relapse rate in pregnancy is high. Boosting their motivation to quit and their confidence in quitting successfully is an important part of the behavioural support programme offered by the stop smoking service.

Community midwives, who see the pregnant woman regularly, can be a valuable extra source of support to complement that provided by the stop smoking in pregnancy specialist practitioner.

What you need to do

■ Record recent non-smoking status in notes, congratulate pregnant women on their achievement thus far and encourage them to remain a non-smoker

■ Continue to conduct carbon monoxide (CO) tests. These readings will provide powerful evidence of the benefits to themselves and the baby of not smoking

■ Ask pregnant women how confident they are that they can stay stopped and if they need any additional support. Provide information on how the NHS Pregnancy Smoking Helpline can continue to offer them help, for example through their telephone support programme

■ Sensitively enquire about how pregnant women are finding their quit attempts. For example: What strategies do they have in place if they feel tempted to smoke? Are they using any stop smoking medications?

■ As postnatal relapse is common, ask: “Have you thought about what you might do to remain a non-smoker after your baby is born?” Use the discussion to emphasise the advantages for the new baby of a home free from smoke

■ Provide encouragement to pregnant women to continue with their quit attempts at every opportunity; let them know that as each day goes by without a cigarette that they are significantly increasing their chances of never smoking again

Why you need to do it

■ Many smokers lack the confidence to succeed and may lose heart if it is more difficult than they anticipated

■ A crucial ingredient of behavioural support is helping pregnant women to maintain their resolve to stay off cigarettes
3.2 Pregnant women who express little or no interest in stopping smoking

Pregnant women have the right to decide to not stop smoking.

All healthcare professionals should make a note of what discussions have taken place, what advice was given and what the pregnant woman has decided. The issue of stopping smoking should be raised with pregnant women at every opportunity.

Discussing stopping smoking with pregnant women who say they do not want to stop needs to be done in a sensitive manner.

Pregnant women should be reassured that they are not being judged, but that you are keen to ensure the best possible outcome for their pregnancy.

What you need to do

■ Explain why you are discussing smoking status. Say: “As a healthcare professional I frequently see women for whom things have gone wrong because they smoked. People come for antenatal care because they want a safe pregnancy. My role is to do everything I can to make sure you have a healthy pregnancy and safe delivery. Stopping smoking is one of the main things you can do to reduce your risks of problems in the pregnancy and during delivery.”

■ Say: “I’m not going to be nagging you. However, I will talk with you again about this at future antenatal appointments because there are health benefits to your baby whenever you stop and help is available throughout your pregnancy.”

■ Midwives and other healthcare professionals must record their advice and whether a referral was accepted in the pregnant woman’s hand-held record (or follow local protocols on recording this information)

■ Provide the NHS Pregnancy Smoking Helpline number 0800 169 9 169 and the contact details of the local stop smoking service

Why you need to do it

■ Smokers frequently deny or minimise the health risks of smoking to themselves and their baby and may avoid having a discussion on stopping smoking unless you raise it

■ Pregnant women may change their mind about stopping smoking as their pregnancy progresses and this discussion lets them know that help is available

■ A quit attempt can be started at any point during the pregnancy and as soon as pregnant women express an interest in doing so
3.3 Smoking reduction in pregnancy

Many pregnant women, aware of the health risks of smoking during pregnancy, try to reduce their consumption of tobacco in an attempt to reduce the risks to their baby. It is fairly common for women who smoke to tell their midwife that they have ‘cut down’ their smoking at their booking appointment.

What you need to do

- Recognise that pregnant women who try to reduce the number of cigarettes that they smoke have some awareness of the health consequences of smoking and are already doing something to try and reduce the risk to their baby
- Explain the concept of compensatory smoking: that smokers used to regular doses of nicotine will subconsciously get similar amounts from fewer cigarettes through more ‘efficient’ smoking (taking more puffs, inhaling deeper and longer and smoking cigarettes closer to the butt)
- Describe what help is available and boost their motivation to make a quit attempt by building on the fact that they have already tried to do something about their smoking
- Use carbon monoxide (CO) measurements to monitor cigarette intake and provide feedback on the health effects of continued smoking for them and the unborn child (although if their CO levels are very low this could be counter-productive)

Why you need to do it

- A reduced number of cigarettes does not equate to significantly reduced health risks and stopping smoking completely is the only way of ensuring that the unborn baby is not at risk from smoking
- Reinforcing the importance of abrupt cessation as a goal can help pregnant women focus their attention on the effort required
3.4 Antenatal admission of a pregnant woman who smokes

Women who smoke are more likely to be admitted for antenatal care than non-smokers, especially for intrauterine growth retardation (IUGR).

Although these women are frequently on bed rest, some women suffer from acute nicotine withdrawal symptoms and request to leave the ward to smoke.

What you need to do

- An admissions protocol for pregnant smokers should be developed, by the hospital midwifery team with the support of the local stop smoking service, to include:
  - A system that ensures that the smoking status of pregnant women is recorded as part of the hospital admission procedure
  - The delivery of very brief advice on smoking to all pregnant women admitted for antenatal care
  - The referral of pregnant women who smoke for inpatient stop smoking support or to the local stop smoking service
  - Access to nicotine replacement therapy (NRT) to help manage withdrawal symptoms, made available via the hospital pharmacy
  - Provision of the details of the NHS Pregnancy Smoking Helpline 0800 169 9 169

- Monitor the progress of pregnant women who stop smoking and encourage them to stay stopped and use NRT if necessary for withdrawal relief and to prevent lapse once they are discharged

Why you need to do it

- Stopping smoking is particularly important for all pregnant women, but especially those with IUGR

- Using behavioural support and NRT to deal with nicotine withdrawal will help improve compliance with treatment
4. The Post-Partum Period

4.1 Smoking at Time of Delivery (SATOD)

As well as being mandatory, collecting data on the smoking status of pregnant women at the time of delivery offers another opportunity to raise the topic of smoking and secondhand smoke; and the harm that these can cause to the new born baby.

Smoking at Time of Delivery (SATOD) data covers information on the prevalence of smoking at the time of delivery (child birth). Hospital trusts are required to submit figures each quarter from the following:

- Number of maternities
- Number of women known to have been smoking at time of delivery
- Number of women known not to have been smoking at time of delivery

What you need to do

- Health professionals should carry out a carbon monoxide (CO) test to assess smoking status
- Midwives or midwifery assistants may need to say something like this: “We routinely ask all women to blow into a monitor so that we can record the amount of carbon monoxide in their lungs. The main source of carbon monoxide is from smoking. Are you currently smoking or have you recently given up?”

Why you need to do it

- It is a requirement to accurately record smoking status so that smoking prevalence at delivery can be calculated at local and national level
- Smoking status at delivery can influence the support given to women immediately after the baby is born, including referral to local stop smoking services
- Information on collecting and submitting SATOD data can be found here www.ic.nhs.uk/services/omnibus-survey/using-the-service/data-collections/smoking-at-time-of-delivery
4.1.1 Inpatient care following the delivery of the child

Women who have smoked throughout their pregnancy are likely to experience symptoms of nicotine withdrawal following the delivery of their baby.

This will be particularly pronounced in women who have a prolonged postnatal admission (e.g. following a premature birth or a caesarean section).

New mothers may ask maternity staff to look after their baby while they go outside to smoke. Some units have policies in place and do not allow the practice; or may make the patient sign a disclaimer.

What you need to do

■ Work closely with the local stop smoking service to ensure that all healthcare professionals are confident discussing smoking with pregnant women and delivering very brief advice (VBA) on smoking

■ Ensure that a protocol for inpatient smokers is developed by the hospital midwifery team with the support of the local stop smoking service, to include:
  ■ Making women aware of the hospital smokefree policy and maternity ward policies regarding leaving the ward to smoke
  ■ The delivery of VBA on smoking (Ask – Advise – Act)
  ■ Referral of women who smoke for inpatient stop smoking support or to the local stop smoking service
  ■ Access to nicotine replacement therapy (NRT) via the hospital pharmacy
  ■ Provision of the details of the NHS Pregnancy Smoking Helpline 0800 169 9 169

■ Ensure that there are clear and simple referral procedures to stop smoking services in place. See Appendix 4 for information on the NCSCT’s Electronic Referral System

■ Agree what, and where, information relating to smoking is recorded (e.g. hand-held notes, postnatal discharge summary, Personal Child Health Record ‘Red book’)

Why you need to do it

■ Establishing protocols of when to discuss smoking, how to refer and where to record information will help the discussion of smoking to become part of routine practice

■ If pregnant women are aware of hospital policies they can plan accordingly for their admission and might even be prompted to stop smoking, even if temporarily
About the National Centre for Smoking Cessation and Training (NCSCT)

The National Centre for Smoking Cessation and Training (NCSCT) is a social enterprise committed to support the delivery of effective evidence-based tobacco control programmes and smoking cessation interventions provided by local stop smoking services.

The NCSCT works with and for the field to deliver training and assessment programmes, support services for local and national providers and conducts research into behavioural support for smoking cessation.

Our training programmes are based on research into what competences (skills and knowledge) are required by stop smoking practitioners and has proven to be effective.

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Appendix one:
How to accurately record smoking status as part of the medical history

In many areas, and as part of the routine maternity booking, smoking status is simply determined by asking: “Do you smoke or have you smoked in the past?” and then filling in ‘yes’, ‘no’ or ‘ex-smoker’ in the appropriate fields.

How to explore whether someone is a smoker

This can be phrased depending upon what form of words you find easiest:

Ask: “What age were you when you first started smoking?”

Or: “How many cigarettes a day do you usually smoke? Is that always the same or do you sometimes smoke more or less?”

Alternatively: “Has your smoking changed since you discovered that you are pregnant?”

These questions allow you to convey the message that you are not being judgemental about smoking in pregnancy and that you simply want to gather the information.
Appendix two:
Conducting CO monitoring during pregnancy

For the first test

Explain that carbon monoxide (CO) is a poisonous gas contained in cigarette smoke, that there is a simple test that can be carried out to determine CO levels and that it is used to show objective proof of improved health once someone has stopped smoking.

When doing a CO test on a pregnant smoker, you should tell her:

“Carbon Monoxide is a poisonous gas and is very harmful to your baby. It is present in exhaust fumes, faulty gas appliances and cigarette smoke. It deprives your baby of oxygen and nutrients and slows the baby’s growth and development. Your baby’s heart has to beat harder and faster because of this and your baby’s health is at risk.

We test all pregnant women for carbon monoxide, because it is so harmful, using this machine. I will be able to give you the result straight away. This machine measures the amount of carbon monoxide in your lungs in parts per million. A normal reading would be below 4 parts per million.”

It is worth emphasising that clients will be required to hold their breath for a minimum of 15 seconds before blowing into the CO monitor; allowing time for the CO in the blood to pass into the air in the lungs.

“What I am going to ask you to do in a minute is to take a big deep breath, hold your breath and then exhale into this machine. You will need to hold your breath for about 15 seconds. After you have taken your breath I will hand the machine to you, the machine will count down and I will then tell you when to exhale into it.”

During the test

“I’d like you to take a nice big breath ... well done ... keep holding your breath, only 10 seconds left now ... OK, take hold of the machine ... place your lips around the tube and 5,4,3,2,1 ... blow now.”

After the test

If test wasn’t completed adequately (i.e. client did not hold their breath for the required time or did not place their lips around the tube properly) then politely advise the client that the test needs to be repeated. Allow them a couple of minutes to get their breath back before repeating the test.
If reading was below 4 parts per million:

“This reading is classed as that of a non-smoker; within the normal range for a pregnant non-smoker of between 1 and 4 ppm and your baby is already benefiting from this.”

If the woman admits to being a smoker but blows a low reading of below 4 ppm then tell her:

“Any cigarettes you have from now on will cause the level of carbon monoxide to rise quickly and your baby will then be at risk.”

If reading was 4 parts per million or above:

“The monitor is showing a reading of over 4 parts per million which is the level above which pregnant women are classed as a smoker and is what we would expect from you as you are still smoking. The normal range for a non-pregnant smoker is between 1 and 4 ppm and so you can see that your reading is ... times higher than what we would expect from a non-smoker. I am very concerned about your reading, as it means that this level of carbon monoxide is harmful to your baby and your baby’s health is at risk.

Your baby’s oxygen, growth and development will be affected. Because of this I need to send your information to the Stop Smoking Service and someone will contact you to discuss this further and tell you how you can reduce this level and reduce the risks to your baby.”

If the woman is a non-smoker you can use this opportunity to raise the issue of secondhand smoke and ask about smokers around her at home. Offer of help and advice should be given for partners and significant others and a referral made if appropriate.

If she says she has not been exposed to smoke from cigarettes there are other possible reasons for this high reading and you should tell her that either:

1. she has been exposed to carbon monoxide fumes from a faulty gas boiler, car exhaust or from paint stripper (it might be worth you checking these things out as exposure to carbon monoxide is dangerous); the National Gas Helpline number 0800 111 999 should be given to her at this point. It is a free phone number with a 24 hour helpline. Deaf or hearing impaired and have a Minicom or Textphone the number to call is 0800 371 787

2. that you are lactose intolerant (most people know if they are) and the high reading is a consequence of you consuming dairy products which can produce gases in your breath.

Do say “The good news is that if you do not smoke at all after your Quit Date then you can get this down to the levels of a non-smoker.”
Appendix 3:
What to do if there is an elevated CO reading

If a pregnant woman has a CO reading of above 4ppm you will need to sensitively explore the likelihood that she is a current smoker:

- Say: “Exposure to tobacco smoke is the most common cause of carbon monoxide being found during the breath test. Do you or anyone else in your household smoke?”

- If the pregnant woman is a smoker explain that the best way of stopping is with help from specially trained stop smoking practitioners; that this is a free and friendly service and that you can refer her for help

- If the pregnant woman says that she has stopped smoking but the CO test reading is higher than 4ppm, advise her about possible CO poisoning and give her the details of the Health and Safety Executive gas safety advice line (0800 300 363)

It is of course possible that the woman is a current smoker but is reluctant to admit this and so any further questions should be phrased sensitively to encourage a frank discussion.
Appendix 4:
NCSCT Stop Smoking Referral System

With the knowledge that hospital patients are often highly motivated to stop smoking, but are not always referred on to support, the NCSCT Stop Smoking Referral System introduces a standardised method of identifying and referring hospital patients to stop smoking support. It focuses on supporting hospital staff to ask and record smoking status for every patient, to deliver 30 seconds Very Brief Advice (VBA) and refer patients on to stop smoking support with their local stop smoking service.

The electronic referral system included within the approach sorts patients by their postcode and refers them on to their local stop smoking service or support, anywhere in England; thus ensuring speedy conversion from referral to support.

After a hugely successful pilot in 2012, it is now implemented in a number of hospitals, including Imperial College Healthcare Trust, Portsmouth Hospitals NHS Trust, South London Healthcare NHS Trust, and Lewisham Healthcare NHS Trust (funded by the London Health Improvement Board).

For more information on the system please contact Liz.Gilbert@ncsct.co.uk
This briefing gives expert, concise guidance on how to deliver Very Brief Advice (VBA) to pregnant women who smoke and how to carry out routine carbon monoxide (CO) testing with all pregnant women.

Smoking in pregnancy is a significant health problem for the mother and the baby. Many women who smoke will quit by themselves before becoming pregnant and others will stop once their pregnancy is confirmed; other pregnant women will need considerable support to stop smoking successfully.

Local stop smoking services have specialist pregnancy smoking cessation practitioners who provide behavioural support and advice on medication to pregnant women who smoke and who want to stop. Guiding pregnant women who smoke towards these services is an important and potentially life saving intervention.

For more information and courses on smoking cessation, including a short online module on delivering Very Brief Advice on Secondhand Smoke, visit www.ncsct.co.uk