

# Factors influencing whether nurses talk to somatic patients about their alcohol consumption

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## ABSTRACT

**AIM** – Many Danes drink so much that it is detrimental to their health. As they are at risk of suffering diseases which can lead to hospitalisation on somatic wards, hospitals are ideal arenas for identifying individuals whose alcohol consumption is excessive. However, literature points out that this identification rarely takes place in hospitals, and literature further suggests that the staff experience barriers to talking about alcohol use with their patients. The primary aim of this study is to identify potential factors that influence whether or not nurses talk to patients about their alcohol consumption on somatic wards. Secondly, we wish to examine whether a screening project may affect the nurses' readiness to talk about alcohol use with their patients. **METHODS** – A Glaserian Grounded Theory Method was used to collect and analyse data in this qualitative study. Semi-structured one-to-one interviews were conducted with seven nurses from somatic departments at two Danish hospitals. All seven nurses were already taking part in an alcohol screening project. **RESULTS** – In the analysis of the interview material, four categories emerged: The Nurse, The Patient, The Ward and The Relay Study. **CONCLUSION** – We identified a series of barriers and promoting factors for nurses to talk about alcohol use with patients in a hospital setting. The barriers and promoting factors emerged within four categories: The Nurse, The Patient, The Ward, and The Relay Study. The most important barrier to talking to patients about alcohol seemed to be factors within the nurses themselves, in particular personal experiences, lack of knowledge and lack of confidence. We found, however, that by participating in a screening project the nurses seemed to overcome some of these barriers.

**KEYWORDS** – alcohol, screening, brief intervention, promoting factors, barriers, nurses, hospital, qualitative study, Grounded Theory

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## Background

Danish alcohol culture differs from that of many other countries. Comparatively speaking, Danes tend to drink a lot, drink often (Hvidtfeld, Hansen, Grønabæk, & Tolstrup, 2008) and start drinking at a young age (WHO, 2013). The Danish Health

Authority estimates that 21% of all Danes below the age of 15 drink more than the recommended maximum of 7 units/week for women and 14 units/week for men (Hansen et al., 2011). It is a well-known fact that people with excessive alcohol

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consumption have an increased likelihood of being admitted to hospital with alcohol-related injuries or illnesses. However, it could be argued that also hospital admittance for reasons other than alcohol use offers a good opportunity to identify individuals with excessive alcohol consumption habits, and refer them to treatment for alcohol problems.

A study by Kääriäinen, Sillanaukee, Poutanen, and Seppä (2001) indicated that there were more patients with heavy alcohol consumption treated in hospitals than in the primary health sector in Finland. Between 16% and 26% of patients in Danish hospitals suffer from overconsumption of alcohol (Nielsen, Storgaard, Moesgaard, & Gluud, 1994). The percentage varies from hospital to hospital, however, with those in large cities having more patients reporting excessive alcohol consumption (Coder et al., 2008). When patients drink too much, it can affect their primary illness and treatment as well, and it has therefore been recommended that hospitals offer health counselling to patients who drink too much alcohol (Mundt et al., 2003). In spite of this recommendation, a survey of prevention efforts in Danish hospitals showed that only 10% of the wards offered preventive conversations on the subject of alcohol abuse (Mundt et al., 2003).

When it comes to detecting overconsumption of alcohol among patients, it has been suggested that nurses could play a key role, both because they have a basic knowledge of health and diseases and because they are usually the ones who have the most contact with the patients (Groves et al., 2010; Lock, 2004). At the moment, a randomised controlled trial (RCT) called the Relay Study (Schwarz et al., 2016) is

being conducted on seven somatic wards at two Danish hospitals. The purpose of the study is to investigate whether it is more efficient and cost-effective to rely on hospital staff to talk to patients about alcohol use or to have staff from outpatient alcohol treatment institutions come to the hospital and carry out brief interventions with the patients while they are hospitalised. In the Relay Study, all inpatients (+18 years) are screened using the Alcohol Use Disorder Identification Test (AUDIT) (Babor, de la Fuente, Saunders, & Grant, 1989). If they score 8 or more in the test, they are randomly offered either an intervention with an alcohol counsellor from the outpatient Alcohol Treatment Centre involving motivational interviewing techniques (the Relay Model), or talking to a nurse, which is called Treatment As Usual (TAU). The purpose of the Relay Model is to increase the number of patients suffering from Alcohol Use Disorder (AUD) to seek treatment for their alcohol problems, and thus decrease AUD-related human, healthcare and social costs. No final results have yet been reported from the study (Schwarz et al., 2016).

A small Danish study (Hoffmann, 2006) interviewed five nurses from one hospital about their attitudes to patients with alcohol problems. The main findings in this study were that the barriers to alcohol intervention consisted of confliction attitudes to alcohol abusers; the nurses' own alcohol consumption, which might be excessive; lack of knowledge about lifestyle diseases; lack of interview techniques and information material or books about alcohol abuse and intervention; lack of support from managers; and negative patient reactions. Another study also found numerous obstacles to implementing screening of the

patients' alcohol consumption, such as nurses' lack of knowledge, low confidence and lack of strategies. Broyles et al. (2013) recommended extensive training and ongoing support to enable nurses to play an active role in screening at hospitals. Broyles et al. (2013) indicates that there are still a lot of barriers to overcome for nurses to talk about patients' alcohol consumption.

The primary aim of our study is to identify the factors that influence whether or not nurses talk to patients about their alcohol consumption on somatic wards. Secondly, as the study was carried out in connection with the Relay Study on the same hospital wards, we wished to examine whether taking part in an alcohol abuse screening project had an effect on the nurses' readiness to talk about alcohol use with patients.

In a Danish hospital context, "Talking to patients about alcohol" refers to the guidelines issued by the Danish Health Authority, primarily the advice to limit alcohol consumption to a maximum of 14 units per week for women and 21 for men (Aabel & Sundhedsstyrelsen, 2013).

## Method

*The framework in which the present study is carried out – The Relay Model Study*

*The Relay Model for Recruiting Alcohol Dependent Patients in General Hospitals* is a single-blind pragmatic randomised controlled trial running at two Danish somatic hospitals from November 2013 to the beginning of 2016. Our study reports some of the qualitative results from the Relay Study (Schwarz et al., 2016).

### *Study design*

The theoretical perspective in this study

is epistemological constructivism, which states that different people construct meanings in different ways (Crotty, 1998). Phenomenology, used to examine the meaning of the nurses' experiences (Creswell, 2014), and the hermeneutic approach provided the theoretical framework for an interpretive understanding with attention to the context (Patton, 2015). For data collection and analysis, we used a modified Grounded Theory Method (GTM) (Glaser & Strauss, 1967) based on Urquhart (2013). This was chosen based on the method's availability to build a theory from the ground without focusing on existing theories. GTM also supports the phenomenological standpoint by concentrating on how individuals interact with phenomena (Urquhart, 2013). The main data collection method were one-to-one interviews with a total of seven nurses.

### *Recruitment*

A letter with an invitation to participate in the interview was sent to the head nurse at somatic wards in two hospitals. The head nurse was asked to suggest a nurse willing to participate in the study. The only criteria for inclusion in the study were that the nurse already participated in the Relay Study and that they had the time to participate in an interview. Nurses agreeing to participate in an interview received a letter with information about the interview and a statement of consent to be signed.

### *Participants*

Overall, the sample consisted of seven nurses from two Danish hospitals, one in a predominantly urban area (located in a town with 180,000 inhabitants) and the other in a predominantly rural area (a

town with 60,000 residents). The nurses were all women, aged 32–60 years, with 6–25 years of nursing experience. At the time of interview, all seven nurses were involved in the Relay Study, and all wards involved in the Relay Study project were represented in the interviews. The typical role of the nurses in the Relay Study was handing out AUDIT questionnaires to patients and collecting them when filled in. They were instructed to report patients scoring 8 or more in the AUDIT questionnaire to the specialised Alcohol Treatment Centre on a daily basis. The nurses worked on somatic wards which included orthopaedic, neurologic, gastrointestinal and emergency specialities. Additional interviews were performed until we obtained saturation of data (Kvale & Brinkmann, 2009). In this case, saturation occurred when we did not receive new information from the last three nurses.

## Data collection

### *Interviews*

The semi-structured interviews were carried out during April 2014 using an interview guide (Kvale & Brinkmann, 2009). The interview guide contained questions about demographic data (age, sex, years of experience, etc.) and questions relevant to the aim of this study. The interview guide was pilot-tested by the interviewer's colleagues, which led to a few minor changes in the phrasing of some questions. All interviews took place at the nurses' respective wards in a room offering privacy to reduce the time away from work and to ensure that they could go back to work if required. Each interview began by taking down the demographic data. The interview ended when all topics in the inter-

view guide had been covered and the nurse had nothing more to add. The interviews lasted between 40 and 70 minutes and were recorded on a digital voice recorder. All nurses were offered the opportunity to add information when the voice recorder was turned off. As one of the nurses was not comfortable with the voice recorder, it was turned off after 20 minutes. With her permission, the interviewer took notes during the rest of the interview. After each interview, the interviewer took notes of her impressions from the interview and of her own reflections on the interview.

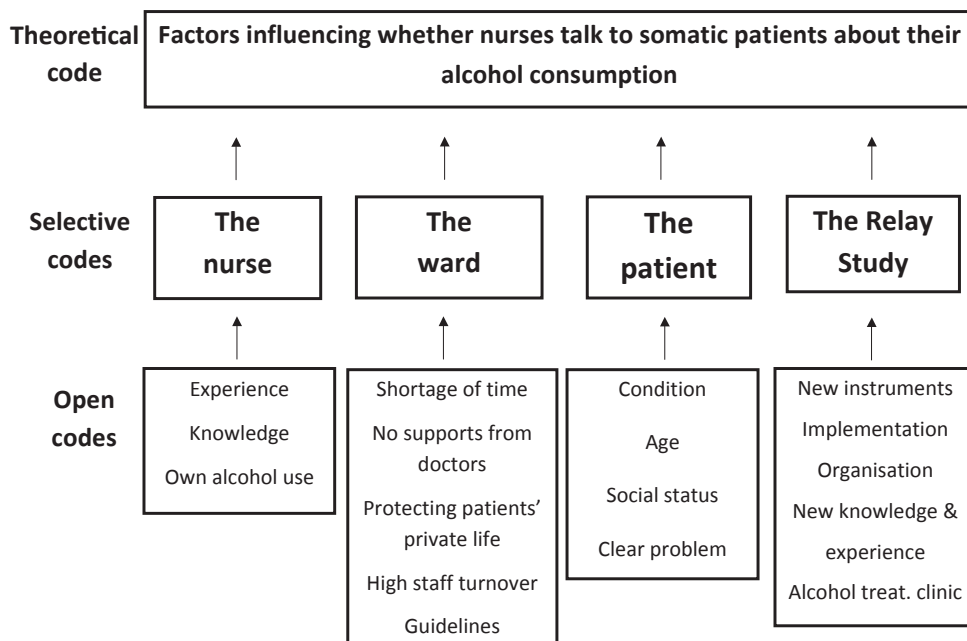
All interviews were conducted by the first author (RH), who is a physiotherapist. She had no role in the Relay Study, no conflict of interest with respect to the nurses' implementation of the Relay Study, and she was unknown to the nurses. This impartiality was explained to the nurses before the interview, in the hope that it would make them feel able to speak freely. The interviewer had limited interview experience, but had been trained by a researcher with extensive experience in qualitative interviewing.

### *Data management and analysis*

The audio files were transcribed shortly after the interviews by the researcher doing the interviews to make sure all details from the interview situation were captured and because the subsequent analysis was to be carried out by the researcher. All words were written out, except small talk not relevant to the interview.

The analysis was based on Glaserian Grounded Theory Method (Glaser & Strauss, 1967). The purpose of using GTM was to generate theory through analysis of the data. GTM uses bottom-up coding,

**Figure 1.** The steps of coding by using Grounded Theory Method.



which means that the themes of the theory derive from the data. This makes the GTM approach different from other types of analysis, in which themes are often derived from the literature (Urquhart, 2013).

The systematic analysis was divided into three steps: open, selective and theoretical coding. The open coding began by reading the transcript of the interviews. Line by line, the text was read closely, and labels were attached to the lines. In this step, codes stayed open until all texts had been read, in order to see what emerged from the data and to avoid premature focus. By constant comparison, the labels were grouped into larger codes. In the selective coding, open codes were organised into larger categories in accordance with the research problem of the study, alcohol consumption. In the last step, theoretical coding, the categories from the selec-

tive coding were related to each other, and any relationships between categories were considered, eventually leading to the creation of the theory (Urquhart, 2013). We built the theory on theoretical memos and interactive diagrams, using Spradley's semantic relationship, which helped us think about the relationships between the categories. These processes gradually built our evidence, indicating rigour and trustworthiness in the theory building (Glaser, 1978; Strauss, 1989; Urquhart, 2013). Figure 1 shows the three steps of coding.

## Results

Four categories of barriers and promoters emerged from the interview material: 1) nurse-related factors, 2) ward-related factors, 3) patient-related factors and 4) the Relay Study. In this section, the results will be presented together with illustrative

quotes. At the end of the section, we present a Grounded Theory (Glaser & Strauss, 1967) about “Barriers and promoting factors for nurses talking with patients about their alcohol consumption”.

### *1) Nurse-related factors*

Several factors related to the nurses themselves appeared to influence whether they talked about alcohol consumption with patients or not:

#### Knowledge and experience

It became clear from the interviews that the nurses’ knowledge about alcohol varied considerably. Most of the nurses were familiar with the recommendations about alcohol consumption issued by the Danish Health Authority, but not all nurses thought they had enough knowledge about the consequences of high alcohol consumption, which made them feel less confident about addressing patients’ alcohol consumption. The nurses also had limited knowledge about the guidelines on what to do if they saw patients with problematic alcohol consumption, and they did not know the various treatment options for alcohol problems. In general, the nurses claimed that they did not consider alcohol a taboo subject, but they were reluctant to start talking alcohol problems because they needed more knowledge about how to initiate the conversation in a way that the patient would be receptive to, as the following quote demonstrates:

It’s very difficult to say to a patient: I think you’ve got a problem and I think you should talk to the professionals from the Alcohol Treatment Centre. (ID 2)

Lack of knowledge seemed to be a huge barrier to addressing alcohol use. At the same time, one nurse felt it was natural to talk about alcohol consumption because she worked on a ward where AUD was very common among the patients, and the patients’ injuries were often the direct result of excessive alcohol consumption (e.g. liver diseases). This nurse did not see alcohol as a taboo.

I don’t think it’s difficult to talk about alcohol consumption with patients. Maybe others do, but I don’t. (ID 4)

#### The nurses’ own alcohol use

Some nurses found it hard to address patients’ alcohol consumption because they enjoyed drinking alcohol themselves. One nurse stated that she found drinking alcohol to be part of her quality of life, and she thought that she herself might score 8 or more in AUDIT. She felt sure that this circumstance influenced the way she talked to patients about their alcohol consumption.

We’ve actually discussed that some of us enjoy a glass of wine every day, and that we might often score 8 or more in AUDIT, and then we would qualify as candidates for the project. We’ve become more aware of this after we joined the project ... It can be a bit difficult if you like to drink wine yourself – it’s difficult to give others professional advice. (ID 7)

One nurse mentioned that the staff on her ward was relatively young and that they socialised a great deal. They drank alcohol, too, and this might influence their

attitude to whether to talk to the patients about alcohol problems or not.

We're mostly young people working here and we like go out and have a few drinks... (ID 7)

The points made in these quotes indicate that the nurses' own attitudes and experiences with alcohol influence how inclined they are to discuss alcohol with their patients, and that a patient's alcohol use needs to be really excessive before the nurses are willing to address it.

## *2) Ward-related factors*

Though not raised explicitly, questions about the appropriateness of the hospital as a place to talk about alcohol constituted a consistent theme in the interviews. Nurses mentioned several reasons why they felt that the hospital was not the right place to address alcohol use.

### Shortage of time

It was mentioned several times in the interviews that nurses experienced a shortage of time and resources. The delivery of care in hospitals is accelerated, which means that patients are often hospitalised for only a few days. This again means that the nurses' first priority is to treat the specific disease or injury that led to hospitalisation, and not to engage in potentially lengthy conversations about alcohol consumption.

Due to the short hospitalisations, some nurses commented that they did not have enough time to get the patients to realise that they had an alcohol problem, or to motivate the patients to change problematic habits of alcohol use.

Patients are hospitalised on my ward for up to 48 hours, how can I then go into a potential alcohol problem? Maybe the patient is only here for 6 or 12 hours, and if the patient isn't here any longer, I can't follow up on such a conversation. I should be able to do that. I think there is a tendency to shy away from the problem, but if I can't finish my job because I start talking to a patient about alcohol, that's also a problem.. (ID 3)

The nurses said that they would have liked to do some follow-up with the patients in the Relay Study who were not randomly assigned to a brief intervention with a professional alcohol counsellor, but they could not find the time to do so.

Lots of patients we have on this ward do have an excessive consumption of alcohol, but there's not a lot we can do while they are here, and we don't follow up on them when they go home. Often it's their entire life and network that will have to change. (ID 4)

The point made in this quote indicates that the nurses found alcohol a very complex topic to address and that they lacked knowledge about methods for addressing excessive alcohol consumption.

### Lack of support from doctors

Another barrier that made it difficult for the nurses to start conversations about alcohol was that they did not feel such initiatives would be supported by the doctors on the ward. The nurses commented that doctors did not address patients' overconsumption of alcohol unless it was really severe.



First of all, the doctors don't act on it [high alcohol consumption] or if they do, they score the patient for withdrawal symptoms... Only when a patient has really massive alcohol consumption, for example 60 units per week, then they (the doctors) react. (ID 6)

The nurses felt that, in general, the doctors were only interested in treating the issue for which the patients were referred to hospital and not any additional problems like alcohol abuse. The nurses noted that doctors always asked about patients' alcohol consumption at admission, but many nurses found that doctors subsequently completely ignored the issue of a patient's excessive alcohol consumption. Some of the nurses felt that it was their responsibility to follow up on a patient's alcohol consumption, for example in order to treat withdrawal symptoms.

Sometimes the doctor has written in the medical record that the patient drinks 5 units every day, but the doctor has not prescribed anything for withdrawal symptoms. It actually happens very often. I don't know if it's because the doctors specialise in orthopaedics and are only interested in that. But then it's up to the nurses to read the medical record and say: hey, this patient said 5 units per day; we need to be aware of that. (ID 1)

Some of the nurses mentioned the possibility that the doctors' attitudes affected the nurses' attitude to dealing with alcohol problems among patients. This point indicates that nurses' reluctance to take on the responsibility for patients' alcohol

consumption may be reinforced by the behaviour of other healthcare professionals.

#### Protecting the privacy of patients

Most of the nurses expressed concern that talking about alcohol on a ward was an invasion of the patients' privacy. The nurses pointed out that patients were often admitted in multi-bed rooms and that this setting was not private enough to talk about a patient's alcohol consumption. On the other hand, taking the patient into a private room would take up too much of their time.

It can be difficult to help patients filling in the questionnaire when they are in multi-bed rooms; I think that's problematic because we have to talk quite loudly about the questions in it. (ID 1)

One nurse suggested that, for these reasons, hospitals were an inappropriate place for a conversation about alcohol, arguing that such conversations should take place in the patient's own home:

I don't know if we should have the conversation here or it should be in the patient's home, or in the Alcohol Treatment Centre where the patient can show up voluntarily. Sometimes there's so much going on for the patient during their hospitalisation. Besides, a patient with an alcohol problem will have to talk to an alcohol specialist anyway, to deal with the problem properly. Sometimes it's just not the right time. (ID 3)

It appeared from the interviews that the nurses found alcohol consumption to be



an extremely private matter, not something to be talked about in front of strangers. By comparison, several of the nurses said in the interview that they found it easy to talk to patients about smoking, diet and exercise.

#### High staff turnover

Some of the nurses stated that the wards experienced a high staff turnover, adding that it took time to train new staff. This meant that experienced staff had less time to talk to patients about alcohol and that the new staff members were often too inexperienced to start alcohol use conversations with patients. As a nurse points out in the quote below, when you are newly employed, there is a lot to think about, and alcohol consumption is not the most urgent priority.

We've had a lot of changes in the staff group. Some of the new staff haven't even started thinking about talking with patients about alcohol yet. They do, of course, know that some of the patients are hospitalised due to alcohol-related diseases ... There's a lot of other things they have to learn, and then you don't just start talking about alcohol. (ID 4)

This comment indicates that the nurses find talking about alcohol to be less important compared to other tasks and that they think it is very difficult and time-consuming to talk to patients about their alcohol consumption.

#### Guidelines

The general guidelines for the Danish hospital sector state that all hospitalised pa-

tients should be asked about their alcohol consumption. The nurses confirmed that this did happen in their respective wards when patients were admitted to hospital. Moreover, some wards have guidelines instructing the staff to score patients for withdrawal symptoms. The nurses said that they often scored patients and treated them for withdrawal symptoms, but often did not talk to the patients about their drinking as such or refer them to specialised treatment for their alcohol problems. One nurse thought that more specific guidelines could be a promoting factor for screening for problematic alcohol consumption, because she had seen guidelines work in other areas.

If guidelines instruct you to screen all patients for alcohol consumption, you have to do so. Then you would have to screen the patients and start the treatment relevant to each patient. (ID 5)

However, the nurse also stated that guidelines cannot stand alone. She added that she needed some training and information about what to do if a patient's screening results indicated high alcohol consumption. In other words, the nurse explained her own lack of action to be a result of uncertainty about what to recommend rather than because she felt uneasy about talking about alcohol as such.

#### 3) Patient-related factors

Several factors related to the patients were repeated in the interviews. Most nurses considered it particularly difficult to talk about alcohol consumption with specific categories of patients.

### The patients' condition

One patient factor was the patients' physical and mental condition. Some nurses said they felt that the patients could not deal with anything beyond the illness they were hospitalised with. The nurses in the interview seemed not to focus on the probability that some of these illnesses could be alcohol-related. Like the doctors, the nurses appeared to have a *biased/unilateral* focus on treating the somatic disease or injury which brought the patient to hospital.

### Age

Another patient factor mentioned was age. Some of the nurses found it more difficult to talk to the young and the elderly patients about alcohol consumption. There is a general attitude in the Danish population that it is "normal" for young people to drink a lot of alcohol. This attitude was evident among the nurses as well. Several of the nurses said that their own teenage children drank quite a lot of alcohol, too.

There's a party at the weekend and they're admitted to hospital with an alcohol-related injury and you think – this is a phase they're going through and shouldn't we just let them grow out of it. (ID 3)

At the beginning of the project, we had a big discussion among the staff because some of the young people who had been partying all weekend scored high in AUDIT, should they then be included in the project ... we had a talk with the professionals from the Alcohol Treatment Centre and they told us that it's important to talk to the young

patients about alcohol, because some of them will be laying the foundation of a lifetime of alcohol abuse now. (ID 2)

Similarly, other nurses did not see any need to speak to elderly patients about alcohol use because, from the nurses' point of view, elderly people should be allowed to drink as much as they want in their "sunset years". Even if an elderly person was admitted to hospital after a fall caused by alcohol, the nurses would not talk about alcohol consumption with the patient, although they were aware that there can be good reasons to discuss alcohol issues with elderly people as well.

I don't talk to 80+ patients if they drink too much because I think it's too late, the damage has already been done ... But they do have slip and fall injuries so we really should talk to them about alcohol as well. (ID 2)

### Socioeconomic status

The patients' socioeconomic status (education and income) appeared to be another factor. The nurses perceived patients with high socioeconomic status to be more in control, even if they did have high alcohol consumption, and found it difficult to decide whether and how alcohol use should be addressed. The nurses reported that if a patient of high socioeconomic status scored 8 or more in AUDIT, it was often ignored by the doctor, the nurse and the patients themselves. Once again, only very excessive alcohol consumption was likely to cause healthcare professionals to act.

It's difficult to talk to affluent people about this. Often they're better

at hiding their alcohol consumption than low-income people who've had their 30 units per day for many years. There's a difference in what type of patient you talk to. (ID 3)

#### Does the patient have an obvious problem?

The two last patient-related factors identified were whether the patients' alcohol abuse was clearly visible, and whether the topic was raised by the patients themselves. In general, the nurses found it easier to talk about alcohol consumption when the patient had a clearly visible alcohol abuse problem. Another promoting factor in the nurses' decision of whether to talk about alcohol consumption appeared to be if the patients themselves expressed a wish to receive help. One nurse said that it was her job to give information about the consequences of high alcohol consumption and inform patients of treatment opportunities. However, if the patient did not want to talk about alcohol consumption, she found it hard to decide to what extent she should push the patient into a conversation.

It's difficult to get the patient to realise that he has a problem, especially when it comes to alcohol, and we don't know what to do. We fix their broken legs and send them home. Then we see them come back time and again, and maybe they'll die because of their abuse. I think we close our eyes because we don't have any alternatives. (ID 1)

#### *4) The Relay Study*

The nurses found that the Relay Study had given them new tools and knowledge which influenced their decision whether

to talk to patients about their alcohol consumption, but they also saw some challenges in the project.

#### New instruments

The nurses thought that the Relay Study had contributed with new and useful instruments, in particular the screening instrument. Several of the nurses found that AUDIT was a great approach to starting a conversation about alcohol consumption with a patient. However, the nurses sometimes found that their patients were in too bad a condition to answer the questions; hence the conversation did not take place. Furthermore, the nurses felt that they did not have enough time to spend with the patient on questionnaires and conversations:

Patients need to go for scans and other examinations, training with physiotherapists, etc. A patient's day is so full that it can be difficult to get the project up and running. Sometimes you have six patients who meet the criteria for filling in the questionnaire. (ID 7)

Another benefit of the project mentioned was that, as nurses were able to spot more patients with excessive alcohol consumption, patients received treatment for their withdrawal symptoms earlier than before.

We identify more patients who have an overconsumption of alcohol and we can get the patient in medical treatment earlier, and what's more, we can get something started that can maybe help the patient with their alcohol abuse. (ID 6)

Interviewer follow-up question: “So do you use the questionnaire as an approach to talking about alcohol?” “Yes, we do so. And it is very good that we can talk to the alcohol treatment specialists when they are present on the ward. We know more about the different treatment options now. So I see many benefits from the project” (ID 6).

As expressed in the above quote, the nurses were surprised to learn that such a large number of patients consumed alcohol to excess, and they believed they were discovering patients with an excessive consumption that they would not have discovered without the Relay Study.

#### *Implementation/organisation*

The Relay Study was organised differently on different wards, which implies a difference in the number of nurses involved in the project. In some wards, the project had been difficult to implement. The nurses often felt that they still lacked information on how to start conversations about alcohol consumption, and information about the project in general. Some mentioned that it was hard to run the project for practical reasons, such as shortage of time. Below, a nurse explains the difficulties in the start-up phase.

It's been difficult to implement and we are still not well organised, we're learning all the time... just something like distributing all the questionnaires and collecting them again. It's difficult because our time, and the patients' time as well, is filled up with lots of appointments. (ID 7)

One nurse said that to her it felt like an invasion of privacy to have to ask a patient to specify his or her alcohol consumption in a questionnaire; therefore the use of a very structured instrument felt inappropriate to her. This comment supports the previously discussed topic that nurses find alcohol consumption to be a very private matter, unlike topics such as smoking, diet, exercise, etc.

#### New knowledge and experience

The nurses found that the Relay Study had led to a bigger focus on alcohol for the participating nurses. Before the project, several of the nurses had never talked about alcohol with their patients. As a nurse notes in the quote below, it had become easier for her to talk about alcohol consumption since she joined the project:

As you distribute the questionnaires and talk to the patients about alcohol consumption, you get more relaxed about it because you experience that it's not that bad. The patients find it okay to talk about, and therefore it becomes easier for us (the staff) as well. (ID 6)

By participating in the project, the nurses had gained experience, which made it easier for them to talk about alcohol consumption. Some no longer considered these conversations difficult, and found that patients were generally willing to talk about their alcohol consumption.

The patients are more willing to talk about alcohol than I thought, and the patients are very relaxed about it. I think it was the staff that were most

afraid to talk about alcohol. Actually, the patients are very open about it and they are happy that someone talks to them about alcohol, which appears to have been a taboo. (ID 6)

The nurses agreed that it was only the nurses participating in the Relay Study that had changed their behaviour with regard to talking about alcohol consumption with patients.

I don't think that the project has made a difference on the ward as such, other than for those of us who now know that it's possible to offer treatment to the alcohol-dependent patients before they are discharged from the hospital. (ID 7)

Therefore several of the nurses said that awareness of alcohol abuse would be greater if more nurses took part in the project. This would also give opportunities for further discussions about the patients' situation and alcohol consumption in general.

#### The specialised Alcohol Treatment Centre

The nurses' comments suggested that participation in the Relay Study had improved their knowledge about the specialised Alcohol Treatment Centre. One nurse said that it was one of the most important benefits of the project.

I think the biggest advantage of the project is that we now know about the Alcohol Treatment Centre in the city. A place that our patients could actually benefit from. (ID 7)

The nurses' increased knowledge of the specialised treatment made them feel more comfortable about addressing alcohol issues. At the time of the interview, the nurses stated that now they knew where to refer patients with alcohol problems.

Some of the nurses would like the specialised Alcohol Treatment Centre to play an even bigger role on the wards, for example to act as a sounding board for the hospital staff. Others suggested that alcohol treatment consultants could be a part of the regular hospital staff, similar to dieticians.

...just as you can call a dietician when you have a question about diet and nutrition, there should be an alcohol professional at the hospital who could give the patient information and help the staff with techniques to address alcohol abuse. (ID 2)

#### *The Grounded Theory*

Drawing on the analysis of the nurses' testimonies, we developed our Grounded Theory (Glaser & Strauss, 1967), which is based on the material from the present study only. The headline of the theory is "Factors influencing whether nurses talk to somatic patients about their alcohol consumption". The four main categories are: The Nurse, The Patient, The Ward and The Relay Study. The Nurse as a category is the central part of our Grounded Theory, because the nurse is the one actually talking to the patients about their alcohol consumption. The Nurse may be influenced by the other three categories too, which can act as promoting factors or barriers. There are also factors within the nurse herself which influence her when talking

about alcohol consumption, such as experience, knowledge and factors in her private life. For example, a nurse with young children was emotionally affected when talking to a young male patient with high alcohol consumption who turned out to have young children as well, because she felt that she might ruin the entire family by addressing the patient's alcohol problem. The Grounded Theory is illustrated in Figure 2.

## Discussion

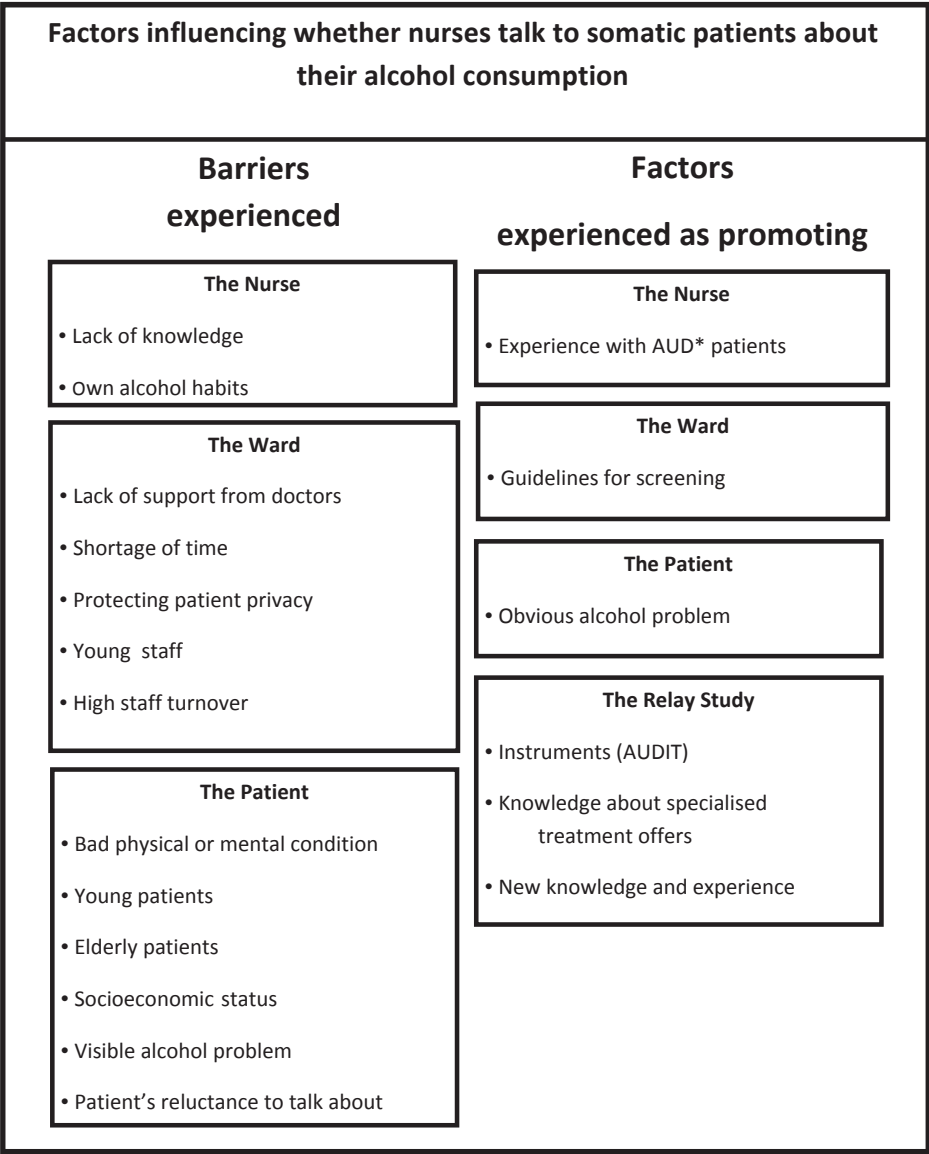
Our study identified promoting factors as well as factors acting as barriers to talking about alcohol consumption with patients on somatic hospital wards. We identified four categories that act as barriers or promoting factors.

First, we found several barriers related to the nurses themselves. Most of the nurses were not used to talking about alcohol consumption with patients and felt that they needed more knowledge in order to be able to do so. The nurses' lack of confidence about starting conversations with patients about their alcohol use may stem from lack of knowledge about interview techniques (e.g. motivational interviewing), but also from lack of knowledge about what kind of harm alcohol may do to the patient's health or condition. Additionally, the nurses avoided conversations about alcohol abuse because they did not know where to refer patients for treatment or what kind of treatment was available. Lack of knowledge seems to be a real barrier, but it may also be a barrier that is easier to confront than other, more personal barriers. For instance, lack of knowledge may cover a vague assumption that alcohol problems could be caused by

other more deep-seated problems; a view which may lead nurses to think that they need to know about all kinds of psychosocial problems and master additional therapeutic interventions in order to be able to address alcohol problems in inpatients at hospitals. Health staff's lack of knowledge has been identified as a barrier to starting this type of conversation in a number of other studies (Broyles, Rosenberger, Hanusa, Kraemer, & Gordon, 2012; Griffiths, Stone, Tran, Fernandez, & Ford, 2007; Johnson, Jackson, Guillaume, Meier, & Goyder, 2011).

According to the Danish Health Authority (Forebyggelse, M. f. s. o., 2010), patients have a right to be informed about the consequences of risky behaviour, so that they have a chance to take action and change their behaviour. When nurses fail to talk to patients about potential alcohol abuse, the patients miss an opportunity to get important knowledge that might motivate them to change their risky behaviour. A Danish study found that only 29% of medical nurses felt confident in counselling patients on reducing their alcohol intake (Willaing & Ladelund, 2005). Similarly, a study by Kääriäinen and colleagues (2001) demonstrated that although 68% of healthcare professionals felt that they were good at starting conversations about alcohol, only 18% of them felt that they did well or very well in motivating patients to change their drinking habits through a brief intervention. A review by Johnson and colleagues (2011) indicated that advice about diet, smoking and exercise is more often given than advice on alcohol, and that patients receive less alcohol advice than they expect. Such findings call for better education or information for

**Figure 2.** Grounded Theory: Factors influencing whether nurses talk to somatic patients about their alcohol consumption. Four categories: The Nurse, The Ward, The Patient and The Relay Project. Some factors are experienced as barriers and others as promoters when it comes to talking about alcohol.  
 \*AUD = Alcohol Use Disorders.



nurses about techniques to motivate patients to change their lifestyle. This was also the recommendation of a study by L. B. Bjerregaard (2011), which looked into

the role played by nurses in motivating parents of hospitalised children to change their alcohol habits.

Alcohol consumption among the nurses



themselves was revealed as another barrier to nurses' talking to patients about their alcohol consumption. The nurses found it difficult to recommend that patients should drink less if they were regular drinkers themselves. But by not doing so, it could be argued that the nurses let their own personal habits and experience with alcohol influence their treatment and hence the future state of health of their patients. In another Danish study, it was also found that nurses' own alcohol use, which might be moderate to heavy, could act as a barrier to offering alcohol interventions (Bagh, 2008). It is a well-known fact that the Danish population has one of the highest alcohol consumption rates in the world (WHO, 2013) and that this is a major cause of health problems in Danish society. Nevertheless, in Denmark a person's alcohol consumption is still considered a private matter, even by hospital staff, although the patients themselves are largely open to talking about alcohol with healthcare staff. It is extremely interesting that alcohol – in spite of the patients' relative openness towards discussing the topic with healthcare staff – is still regarded as a sensitive and stigmatising topic, a finding that is well known from other studies (Room, Babor, & Rehm, 2005). Among Danes, the official recommendations on alcohol consumption are often seen as bordering on the ascetic, which may make the nurses afraid of sounding self-righteous if they refer to them. Fear of hypocrisy can also make it difficult for nurses to talk about alcohol use if they themselves like to drink alcohol.

Second, we found several factors related to the category of The Ward. The nurses felt that shortage of time was a major bar-

rier to addressing alcohol consumption, similar to several other studies about nurses delivering brief interventions in hospitals (Johansson, Akerlind, & Bendtsen, 2005; Karlsson, Johansson, Nordqvist, & Bendtsen, 2005; Lappalainen-Lehto, Seppä, & Nordback, 2005). During short hospitalisations, the nurses felt that they could not make any difference anyway for patients overconsuming alcohol (Miller & Wilbourne, 2002). It is quite interesting that the nurses believed it to be impossible to carry out conversations about alcohol in a few minutes, unlike conversations about smoking or diet. A study has shown that among patients with hazardous levels of alcohol consumption, even very short conversations with healthcare professionals may be effective in reducing alcohol consumption for up to two years (Berglund et al., 2003). Additionally, a study by Emmons and Goldstein (1992) showed that patients were often highly motivated to change their lifestyle when admitted to hospital. In our study, however, the nurses seemed to fear that addressing alcohol might lead to lengthy and difficult discussions of complex topics. Their fear may be grounded in a common assumption in Danish society that excessive drinking is caused by a number of psychological or social problems in the person's life (Elmeland, 2016; Søgaaard Nielsen, 2004) rather than viewing alcohol habits as comparable to unhealthy eating or smoking habits. Drinking habits are taboo, and addressing them is considered difficult by healthcare professionals as well as by the general population (Mandag Morgen & Trygfondsen, 2009).

The stigmatisation of alcohol problems adds another barrier to nurses' talking

about alcohol use, in the form of a desire to avoid talking about alcohol consumption in front of strangers. The nurses rationalise that they are in fact protecting their patients' privacy when they do not address alcohol consumption, rather than perhaps admitting their own reasons for avoiding the topic. Another study found that nurses were concerned whether it would ruin their relationship with patients if they addressed their alcohol consumption, and this fear formed yet another barrier to initiating a conversation about alcohol with the patients (Johansson et al., 2005). The wards participating in the Relay Study were rewarded with an amount for each patient included, and participation was prioritised by the management. Still, the nurses felt that they did not have enough time to give the project top priority. Winter (2002) pointed out that successful implementation of an intervention depended on whether the task felt meaningful to the people performing it. Our study found that nurses felt rather ambivalent about the task of addressing alcohol problems among patients.

A major barrier for nurses when addressing alcohol was their perception of doctors not being interested in the patients' drinking habits. There is a hierarchy in the Danish hospital sector, with doctors at the top. In our study, the nurses seemed to feel less responsible for patients' alcohol consumption if the doctors did not prioritise the topic. In this case, the nurses concluded that they should not do so either. Hence, the non-concern of one staff group creates non-concern in others, making it less likely that the patients' alcohol consumption will be addressed. This finding indicates that the responsibilities of the various

healthcare professionals need to be stated more clearly.

Third, we found several patient-related factors that were experienced as barriers to addressing alcohol consumption. The nurses did not see any reason to talk to the young patients about alcohol consumption, as drinking was considered to be a natural part of being young in Denmark, and it was expected that consumption would decrease as the young person moved into adulthood. Studies have, however, demonstrated that it is important to talk to young patients about alcohol, for overconsumption of alcohol in youth may lead to alcohol dependence in older age (Fergusson, Horwood, & Lynskey, 1995). Similarly, the nurses were reluctant to address elderly patients' alcohol consumption, because they felt it was too late and even "unfair" to intervene. Alcohol was regarded as a pleasure that the elderly patient should be allowed to have.

The patients' socioeconomic status, condition and degree of alcohol use also acted as barriers to the nurses' talking about alcohol. It was an important finding that the nurses performed a subjective assessment of which patients to discuss alcohol consumption with. This finding suggests that alcohol problems are viewed in fairly black-and-white terms by the staff – either patients drink in a clearly unacceptable way or their drinking habits are perfectly acceptable (Elmeland, 2015). Consequently, it seems that the nurses imagine the aim of any conversation about unhealthy alcohol consumption to be to motivate patients to a complete cessation of drinking rather than lowering their consumption. In other words, the nurses did not seem to consider any possibilities between the two

extremes of alcohol consumption, such as recommending the patient to drink slightly less alcohol for the sake of their health.

These findings suggest that there is a need for guidelines, education and empowerment of nurses to enable them to talk to all patients about alcohol in a more nuanced way, which allows them to discuss unhealthy drinking habits without any stigma attached. A study from Sweden indicated that the more training nurses had and the more positive their attitude to screening was, the more likely they were to do exactly that (Geirsson, Bendtsen, & Spak, 2005)

Fourth, we found several factors related to the Relay Study. The nurses found that the Relay Study had contributed with positive factors, especially the screening of alcohol use and the possibility to refer patients for treatment. As a result of their participation in the project, the nurses found that it became easier to talk about alcohol. This indicates that some of the nurses' barriers were overcome by participating in the project. Through the Relay Study, the nurses also found that patients in general were open to talking about their own alcohol consumption. In a review by Watson, Munro, Wilson, Kerr, and Godwin (2009), patient negativity was identified as a barrier to health professionals talking about alcohol, but this was not found to be a problem in this study and in another Danish study (Bjerregaard, Rubak, Høst, & Wagner, 2012).

Overall, the nurses found that the Alcohol Use Disorder Identification Test AUDIT was useful in identifying patients who they would otherwise not have expected to have a "history" of overconsumption or unhealthy alcohol use. Before participat-

ing in the Relay Study, the nurses did not know what to do when they identified a person with problematic alcohol use, but their contact with the specialised Alcohol Treatment Centre made them more confident in this area.

Nurses have often been thought to be in a good position to talk to patients about their lifestyle (Watson et al., 2009) and, as mentioned above, studies have shown that the patients expect to be asked about alcohol consumption when admitted to hospital (Kääriäinen et al., 2001). Low confidence and lack of knowledge have been identified in this study and in previous studies as the main barrier to talking about alcohol use with patients (Anderson, Eadie, MacKintosh, & Haw, 2001; Lappalainen-Lehto et al., 2005; Willaing & Ladelund, 2005). In other words, the biggest barrier seems to be within the nurses themselves. Guidelines may help to make responsibilities clear and to promote talking about alcohol use (Grimshaw & Russell, 1993), as was also stated by a nurse in this study. At the same time, guidelines should not be too demanding but be kept as simple as possible (Aalto, Pekuri, & Seppä, 2003), as they may be difficult to implement in a busy everyday routine (Tran, Stone, Fernandez, Griffiths, & Johnson, 2009).

### *Limitations*

One limitation of this study is that the selection of nurses for interviews was undertaken by the head nurses of the different wards. This could have created bias in the results if the nurses selected had a more positive attitude towards alcohol treatment or the Relay Model. However, the results in this study cannot be taken to be representative of all nurses because the

nurses taking part in the Relay Study may well have a focus on alcohol treatment beyond that of other nurses to begin with. Second, the coding in the analysis process was conducted by the first author, and it is possible that another person would have coded differently. However, the analysis and interpretation of data were performed by first and second author, qualifying the process. The study was carried out on somatic wards that were, in many respects, similar. Hence, the results are not readily generalisable to other settings but they are transferable to similar settings.

## Conclusion

We identified a series of barriers and promoting factors for nurses to talk about alcohol use with their patients in hospital settings. The barriers and promoting factors emerged within four categories: The Nurse, The Patient, The Ward and The Relay Study. The most important barrier to talking to patients about alcohol use seemed to be factors within the nurses themselves, in particular personal experi-

ence, lack of knowledge and lack of confidence. We found, however, that by participating in a screening project the nurses seemed to overcome some of these barriers. Other studies have suggested extensive training and instruction as a requirement for nurses to be well-equipped to perform alcohol interventions or screening.

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