Non-Smokers' Rights Association
Smoking and Health Action Foundation

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Smoke-free Hospital Properties

The Smoke-free Trend

Gone are the days of doctors smoking in hospitals, and designated smoking rooms are quickly becoming obsolete. Many hospitals now boast 100% smoke-free facilities, inside and out. Over 1200 hospitals and health care facilities in the United States now have 100% smoke-free properties.[1] Since 2002 when the Calgary Health Region (CHR) became Canada's first health organization to ban smoking on its property, numerous other hospitals and health organizations have followed suit. Current bans are the result of individual facilities voluntarily making the decision to be smoke-free. However, despite the enthusiasm, there is a debate emerging about property bans and zero tolerance of smoking being reasonable public policy. In September of 2008, Woodstock, Ontario, became the first municipality in Canada to pass a bylaw requiring hospital property to be smoke-free.

There is a difference between a hospital property smoking ban and a comprehensive smoke-free policy which includes a cessation programme, although there can be much overlap between the two. Indeed, a hospital property smoking ban that lacks cessation support for patients and staff is arguably short-sighted and ill-advised. The "Ottawa Model" is an excellent example of a hospital-based smoking cessation programme—it identifies smokers upon admission, provides stop-smoking counseling and medication during hospitalization, connects the patient with community-based resources and provides follow-up after discharge. The Ottawa Model approach has led to a 50% cessation rate at 6 months post-discharge, but despite the success the model has not yet been widely adopted.[2]

Rationale for a Hospital Property Smoking Ban

Reasons commonly cited for a 100% smoking ban on hospital property include:

- To protect patients, staff and visitors from second-hand smoke (SHS);
- To reflect a hospital's health mission;
- To promote healthy choices and to provide a healthy environment for patients, staff, volunteers and visitors; and
- To be a leader in health promotion in the community.

[1] Americans for Non-Smokers' Rights. www.no-smoke.org/pdf/smokefreehealthcare.pdf
[2] Champlain Cardiovascular Disease Prevention Network. *Champlain Hospital-based Smoking Cessation Network.* www.ccpnetwork.ca/priorities/smoking-cessation_e.php

The benefits of patients being smoke-free while in hospital cannot be overstated, as it creates opportunities for improved outcomes. It is well documented that smoking is linked to admittance to intensive care, increased mortality risk, delayed wound healing, plus a whole host of other post-surgical complications.[3] Proponents of hospital-based cessation programmes state that quitting smoking is the single most important intervention for the prevention and management of major chronic diseases, including heart disease, stroke and cancer. It should also be noted that the vast majority of smokers want to quit—a new Canadian study reports the figure at over 90%.[4]

A smoke-free workplace is also a supportive environment that helps employees who smoke cut down and even quit smoking. Studies have demonstrated that a totally smoke-free workplace is associated with reductions in prevalence of smoking and fewer cigarettes smoked per day per smoker.[5] Also, reduced smoking rates decrease absenteeism and increase productivity.

Success Stories

As previously noted, Calgary Health Region (CHR) became the first health organization in Canada to ban smoking on its properties indoors and out. The ban was implemented in two phases with special consideration given to mental health services, long-term care and palliative care. CHR credits the success of its ban to the following key factors:

- Board and senior executive support;
- Dedicated funding;
- Committed staff, including project coordinators;
- Inpatient supports (nicotine replacement therapies, or NRT);
- Bold signage (part of a multi-pronged and on-going communications strategy);
- Identification and accommodation of special consideration groups; and
- Extensive consultation.

In addition, experience suggests that other keys to success include adequate education and training of staff, adequate resources for enforcement and a 6-12 month lead-up time to mentally prepare people for the policy change. Feedback from CHR staff one year after implementation revealed that the policy was generally considered a success—there were visibly fewer people smoking on the property, fewer calls from non-supporters, more requests for staff training, increased patient use of NRT and increased use of staff benefits for smoking cessation.[6]

When the Mental Health Centre Penetanguishene (MHCP), which includes Ontario's only maximum-security psychiatric hospital, began to look more closely at its costs

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[3] Theadom A, Cropley M. Effects of preoperative smoking cessation on the incidence and risk of intra-operative and postoperative complications in adult smokers: a systematic review. *Tobacco Control* 2006;15:352-358.
[4] The Lung Association. *Making Quit Happen: Canada's Challenges to Smoking Cessation.* 2008.
[5] Fitchenberg CM, Glantz SA. Effect of smoke-free workplaces on smoking behaviour: systematic review. *BMJ* 2002;325:188-191.
[6] Calgary Health Region. *Tobacco Reduction Policy Evaluation: Creating Smoke-Free Property* (focus groups and interviews).

related to smoking, the Centre found it was spending approximately $500,000 per year to escort smokers outside. In terms of staff time, MHCP ultimately decided it could not justify staff time to support an activity known to be harmful at best and fatal at worst over beneficial therapies such as recreation and education.[7] One clinical advantage noted at MHCP after its ban was put in place was that some inpatients benefited from lower medication dosages—smoking had previously interfered with their medication's efficacy. The lower dosages reduced side effects, made it easier to keep dosage within the therapeutic range and decreased expenses for the hospital.[8] It is interesting to note that a year after the MHCP went smoke-free, the concurrent disorders program remained full despite staff concerns that outpatients might seek care at facilities with less stringent smoking restrictions.[9]

Second-hand Smoke and Outdoor Bans

The science is still emerging on outdoor SHS exposure, and no broad consensus regarding the ideal distance for buffer zones around doorways and air intakes has yet been reached. There are currently just a few in-depth scholarly articles published in peer-reviewed journals that measure outdoor SHS particles. The authors of one study report that outdoor SHS concentrations are highly dependent on wind conditions and source proximity (how close the smokers are). However, average fine particle levels near smokers over the course of one or more cigarettes can be comparable to indoor SHS particle levels in living rooms or bedrooms during active smoking. Average, not peak, particle concentrations can reach hundreds of micrograms per metre cubed (µg/m^3). As a reference, the U.S. Environmental Protection Agency's Air Quality Index indicates that concentrations over 150.5 µg/m^3 are considered very unhealthy.[10] The study's authors conclude that outdoor SHS levels approach zero at distances greater than about 2 m from a single cigarette.[11]

James Repace, a world renowned SHS expert, has conducted his own experiments in a variety of outdoor settings to measure SHS pollution. Repace has concluded that his experiments dispel the misconception that smoking outdoors can be ignored because smoke immediately dissipates. His studies, and those of others, indicate that under the conditions studied, smoke levels do not decrease to background levels for fine particles or carcinogens until about 7 m from the source.[12] Therefore, from a protection standpoint, science supports smoke-free buffer zones around doorways, operable windows and air intakes.

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[7] D Parle et al. Going 100% smoke-free in a secure setting: One hospital's successful experience. *Healthcare Quarterly* 2004; 7:42-48.
[8] Ibid.
[9] Ibid.
[10] U.S. Environmental Protection Agency. Personal communication with Michelle Wayland, December 5, 2007.
[11] Klepeis NE, Ott WR and Switzer P. Real-time measurement of outdoor tobacco smoke particles. *Journal of the Air & Waste Management Association* 2007;57:522-534.
[12] Repace JL. *Fact sheet: Outdoor air pollution from secondhand smoke.*(2008).

Challenges

Most smokers are nicotine addicts, and quitting can be as hard as coming off cocaine or heroin. Cessation research dictates that smokers are at different stages of readiness to quit, and that personal motivation plays a huge role in quitting success. Although hospitalization can be an ideal time to quit, it can also be a very stressful experience, especially if it is not planned. Noted tobacco control advocate Simon Chapman believes that regardless of all the benefits of quitting smoking, the decision to bring benefit to oneself is a decision that should be up to the individual, and should not be one for others to impose.[13]

In addition to ethical considerations, a totally smoke-free hospital property can give rise to numerous management challenges. Some previously 100% smoke-free facilities, such as the Ottawa Hospital and the Children's Hospital of Eastern Ontario, have reversed their policies and now provide outdoor designated smoking areas (DSAs). Patient safety and public relations are two reasons cited for the policy change. For example, depending on a hospital's layout, patients may need to dodge traffic to leave hospital property for a cigarette. In addition, some hospitals have had to deal with complaints from their surrounding communities regarding litter, butts, public urination and patient loitering. Those opposed to property bans say such policies push a hospital's problems into the community instead of dealing with them on site. In addition, if a policy involves confiscating patients' cigarettes found on hospital property, some patients may resort to hiding them off site. Other policies which prevent patients from taking hospital equipment such as IV poles and wheelchairs off the property arguably go beyond offering a safe and healthy environment and actually punish smokers.

An evaluation by staff following the property ban at CHR revealed that some of the frontline nursing staff felt that the policy was an additional burden, and that addressing smoking was not part of their acute care role. This sentiment echoes findings from a recent Canadian study that found that although protection strategies (smoke-free property bans) were relatively well integrated into organizational culture and practice activities at two hospitals in British Columbia, patient cessation strategies were not. The study found that nurses were ill-prepared to deal with nicotine dependence and withdrawal, and that they reported feeling uncomfortable being policy enforcers.[14]

These observations speak volumes to the importance of educating and supporting staff, particularly nurses who often become de facto policy enforcers, throughout policy planning, implementation and follow-up. The Registered Nurses Association of Ontario (RNAO) has published nursing best practice guidelines regarding smoking cessation. The RNAO advocates that smoking cessation be considered integral to nursing health promotion practice. However, the organization cautions that best practice guidelines can only be successfully implemented with adequate planning, resources, and organizational and administrative support.[15]

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[13] S Chapman. Banning smoking outdoors is seldom ethically justifiable. *Tobacco Control* 2000; 9:95-97.
[14] ASH Shultz et al. An ethnographic study of tobacco control in hospital settings. *Tobacco Control* 2006; 15:317-322.
[15] Registered Nurses Association of Ontario. *Integrating Smoking Cessation into Daily Nursing Practice.* 2003. www.rnao.org/bestpractices/PDF/BPG_smoking_cessation.pdf

Unintended Consequences?

What happens to hospital admissions when a 100% property ban is put into place? Do people actually seek healthcare elsewhere, or even forgo a hospital visit? For many institutions that have only recently adopted property bans, it is likely still too early to tell. As previously mentioned, the concurrent disorders program at the MHCP remained full a year after their property ban was put into place. However, there are stories of reduced hospital/treatment admissions elsewhere. For example, it has been reported that the Youth Detox centres in British Columbia saw their occupancy rates plummet following a property ban.[16] The Regina Detox Centre allows patients to smoke in outdoor gazebos, and its director claims that many of her patients live closer to other smoke-free centres but choose hers instead because of the provision of an outdoor smoking area.[17]

According to the London (UK) Health Observatory, there is evidence that stopping smoking immediately before surgery may actually *increase* lung complications, although other risks are reduced. The organization cautions that if a patient's admission date is less than 4 weeks away, special consideration should be given to the risk of lung complications and these should be balanced against other benefits.[18] Clearly, to maximize success and minimize possible negative repercussions, hospital administrators need to consult widely with all stakeholders prior to adopting a complete property ban.

Non-Smokers' Rights Association (NSRA) Position

Given that cigarettes kill 50% of all long-time smokers, the NSRA believes that every hospital in Canada has a duty to:

- Ban smoking indoors;
- Provide smoke-free buffer zones (at least 7 m) around doorways, operable windows and air intakes;
- Limit smoking on hospital property to outdoor designated smoking areas (DSAs).

However, DSAs should be tucked away from plain view and be located away from doorways, operable windows, air intakes, outdoor common areas and pedestrian routes. Significantly, there should be at least two geographically separate DSAs—one for staff and one for patients and visitors. There is something fundamentally wrong with hospital staff smoking alongside patients—an act that blurs professional boundaries. As articulated by one nurse, *"When people smoke together there is a different level of conversation that can occur and this puts both the nurses and patients in an awkward position."*[19]

[16] "Hard habits to break." Ottawa Citizen editorial. August 14, 2008.
[17] Ibid.
[18] SmokeFree London. *Stop before the op! A briefing on the short-term benefits of preoperative smoking cessation in London.* www.lho.org.uk/viewResource.aspx?id=10495
[19] ASH Shultz. An ethnographic study of tobacco control in hospital settings. *Tobacco Control* 2006; 15:317-322.

If a hospital is not in a position to offer patients a comprehensive cessation programme in conjunction with its 100% smoke-free property ban, such a ban is ill-advised.

Conclusion

Despite the challenges of managing a 100% smoke-free hospital property, many administrators have decided that the benefits outweigh the drawbacks and are moving ahead with implementation. For example, all six British Columbia health authorities are moving forward with smoke-free property policies in 2008. Other smoke-free hospitals include the IWK Health Centre in Halifax, all facilities that make up the Winnipeg Regional Health Authority, all facilities in the Calgary Health Region and all Capital Health property in Edmonton, which includes 18 hospitals.

As social norms continue to change, it is expected that more hospitals and healthcare organizations will embrace smoke-free policies. Lessons learned from early adopters will help to pave the way for others, highlighting the need for on-going monitoring and evaluation. Some useful resources available include those developed by the Program Training and Consultation Centre[20], Calgary Health Region,[21] and Algoma Public Health.[22]

[20] Program Training and Consultation Centre. *Smoking Cessation Toolkit for Health Care Settings: Resources to Support Implementation* (CD-ROM). 2006. http://www.ptcc-cfc.on.ca
[21] Calgary Health Region. *Tobacco Reduction Policy Evaluation: Creating Smoke-free Property.* (Available on the PTCC CD-ROM).
[22] ME Szadkowski. *Worksites Innovation Project Report.* Algoma Public Health. 2007