SMOKE-FREE LONG-TERM CARE HOMES PROJECT

manual

Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

The Smoke-Free Long-Term Care Homes Project at the Centre for Addiction and Mental Health is funded by the Ministry of Health Promotion as part of the Government of Ontario's Smoke-Free Ontario Strategy.

This manual is also available at www.smokefreeltc.ca

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INTRODUCTION

The Ministry of Health Promotion is funding the Smoke-Free Ontario Strategy, the largest and most comprehensive tobacco control program in the country. This strategy is based on three major goals of tobacco control: **prevention** (helping youth remain smoke-free), **cessation** (helping people quit smoking) and **protection** (helping people avoid second-hand smoke). The target is to reduce per capita tobacco consumption between 2003 and 2007 by 20%.

The areas of investment include:

- youth prevention programs
- Aboriginal programs
- cessation programs
- public education
- local capacity building for Public Health Units
- provincial support programs, and
- evaluation, monitoring and surveillance.

The **Smoke-Free Long-Term Care Homes Project** at the **Centre for Addiction and Mental Health** is funded under the **cessation** goal. This manual is one of the resources developed as part of this project.

The manual has been designed to support Long-Term Care (LTC) Homes in building, implementing and sustaining smoke-free policies consistent with the regulations of the Smoke-Free Ontario Act. The manual will be useful for homes that have decided to go 100% smoke-free on their property, for those that have decided to go smoke-free indoors only, and for those that have decided to build a Controlled Smoking Area. The manual is divided into three sections:

Section 1 - Policy

This section includes a summary of the SFOA and how it applies to LTC Homes, smoke-free policy development tools and a sample smoke-free policy for your reference.

Section 2 - Implementation: Education and Communication

This section includes tips and templates for communicating with staff, physicians, residents, family and stakeholders about smoke-free policies and procedures, nicotine replacement therapy (NRT), quitting smoking and the dangers of second-hand smoke exposure.

Section 3 - Smoking, Second-Hand Smoke, and Quitting

This section includes information on smoking prevalence in LTC Homes, the dangers of second-hand smoke, the benefits of quitting for older adults and how to help residents quit smoking using NRT.

Additionally, in the **Appendices** you will find:

- A literature review that addresses staff, resident, family and administrative concerns regarding the design and implementation of smoke-free policies in LTC Homes.
- A fact sheet about the Community Care Access Centres and the SFOA.
- Case studies on LTC Homes that have successfully managed the change to a smoke-free environment.

An electronic copy of the manual can be found on the **CD** that is located at the front of the binder. This allows you to reproduce the manual and to modify the handouts to suit your needs.

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SECTION 1

Policy

1.1 *Smoke-Free Ontario Act* Summary
1.2 Policy Development
1.3 Policy Content Checklist
1.4 Sample Policy

1.1 *Smoke-Free Ontario Act* Summary

As part of the comprehensive Smoke-Free Ontario Strategy, the *Smoke-Free Ontario Act* (SFOA) was implemented on May 31, 2006. The purpose of the SFOA is to protect people from second-hand smoke (SHS) exposure by prohibiting smoking in all enclosed workplaces and enclosed public places.

The SFOA applies to Long-Term Care Homes as follows:

- Tobacco can no longer be sold in LTC Homes.
- Smoking is not allowed inside LTC Homes, except in Controlled Smoking Areas (CSAs).
- Smoking is permitted outdoors at least nine metres away from entrances and exits.
- At the request of an Aboriginal resident, the operator of a nursing home may set aside an indoor area separate from any area where smoking is otherwise not permitted, for the use of tobacco for traditional Aboriginal cultural or spiritual purposes. (See: http://www.hc-sc.gc.ca/fnih-spni/pubs/tobac-tabac/2003_sust-maint_part/part_2_e.html - whatis.)

If your home is constructing a Controlled Smoking Area:

- It must be enclosed and separated from the rest of the building and not be a thoroughfare.
- The area must be set aside specifically for smoking.
- It must be registered with the Ministry of Health Promotion by the proprietor and by the employer of the workers who maintain the CSA.
- The CSA must comply with all the applicable codes and standards.
- The CSA must be cleaned daily. Smoking is not allowed for two hours before custodial staff enters the area and while they are cleaning.
- A sign should be posted outside of the room with the hours the room is open.
- Residents must be able, in the opinion of the proprietor or employer, to smoke safely without assistance from an employee.
- Employees are not required to enter the controlled smoking area.
- Only residents (not staff or visitors) of the facility are allowed to smoke in the controlled smoking area.
- For more information, see: http://www.e-laws.gov.on.ca/DBLaws/Source/Regs/English/2006/R06048_e.doc.

The majority of the residents living in Long-Term Care Homes are non-smokers. In addition, many residents have health problems such as asthma, chronic obstructive pulmonary disease, and other breathing problems that tobacco smoke can trigger and worsen. Prior to this act, residents, staff, volunteers and visitors were unprotected from the harmful effects of second-hand smoke (SHS). The SFOA ensures that this is no longer the case.

In addition to the health benefits for residents and staff, there are some additional benefits of having a smoke-free policy in an LTC Home.

- **Eliminating the fire safety risks associated with smoking in an LTC Home:**
  20% of the deaths caused by fire in Ontario each year are smoking-related. The risks of fire are escalated in LTC Homes where smoking is combined with the declining physical and cognitive abilities often found in residents. Smoking is the leading cause of fatal fires for older adults.

- **Employee satisfaction and increased productivity:**
  In recent years, bans on smoking in public places have proliferated. According to Canada's National Health Population Survey (1996/7), 88% of people who smoke agreed that people who don't smoke should not be exposed to SHS in their work environment. The number of nonsmokers agreeing to this statement was 95%. There is data that points to people who smoke using more sick days, increased insurance premiums as well as taking more breaks throughout the day. Also, eliminating smoking in LTC Homes will reduce time and money spent on maintaining smoking areas.

- **Prevent legal action:**
  As the harmful effects of exposure to second-hand smoke become more widely known, there is an increased possibility that employees may take legal action. One court case involved a health care aide in an LTC Home in Ontario, who, despite the development of asthma, was required to enter the Home's Designated Smoking Room (DSR) to assist residents who smoked. When she refused, she was fired. The court declared in her favour. In another case, Heather Crowe, a former waitress, contracted lung cancer due to SHS exposure. Before her recent death, she was successful in receiving compensation from the Workers Safety and Insurance Board for her claim of workplace second-hand smoke exposure.

- **Increased cessation attempts by residents and potentially by staff:**
  Residents and staff of LTC Homes may consider quitting or reducing their tobacco use because of the restrictions imposed by the SFOA. Offering cessation programs and resources can be a valuable way to support them.

1.2 Policy Development

An internal policy, based on the SFOA, can provide staff and residents with the information they need to understand why and how their facility is implementing the provisions and regulations of the SFOA.

A policy that is designed well and implemented effectively can positively influence the way people live and the choices they make. Policies can encourage healthier choices and discourage unhealthy ones.

How to develop a Policy:

Before drafting a policy, it is important to get senior management approval for the policy development initiative. Once approval has been granted, proceed through the following steps:

1. Identify the reasons why your LTC Home needs a smoke-free policy

For example:

- To outline any changes that must be implemented in order to comply with the SFOA
- To clarify implementation procedures
- To encourage and ensure equal treatment for staff
- To encourage and ensure respect for residents

2. Gather a committee that is representative of your facility

Include human resources staff, management, union and non-union members, front-line nursing staff, physicians, recreation staff, occupational health and safety representatives, custodians, pharmacy staff, residents, and family. Limit your committee to a maximum of 12 people.

3. Circulate several articles for background reading

For example, provide a literature review and a case study. (Both can be found in the Appendices to this manual.)

4. Hold committee meetings

- Present SFOA legislation.
- Brainstorm issues that the SFOA will raise within your LTC Home.
- Present cases from similar facilities that have gone smoke-free.
- Establish the goal of the policy (e.g., to help your LTC Home go smoke-free indoors, to facilitate a Controlled Smoking Area (CSA), or to go completely smoke-free on all facility property).
- Develop a policy outline (see the sample policy in Section 1.4).
- Develop a draft policy and gather input from other staff and residents.
- Develop an education plan for staff (see Section 2.1).
- Develop a communication plan for staff, residents, families and other stakeholders (see Sections 2.2 - 2.4).
- Request senior management approval for the policy, education plan and communication plan.

1.3 Policy Content Checklist

Complete	Policy Content	Your Policy Recommendation
	Policy statement: Include the history and rationale of developing an organizational policy	
	Application: Who does this policy apply to?	
	Smoking: Where is smoking not allowed? Where is smoking allowed? - Controlled Smoking Area - Outside - Smoking shelter Can staff, clients and visitors use all smoking areas? During which hours is smoking permitted?	
	Signage: What signs are required and where will they be placed?	
	Cigarette and lighter storage: Will residents keep their own cigarettes and/or lighters? Will smoking materials be stored at nursing stations?	
	Support for staff and residents: What is available for smokers who want to quit?	
	Safe Smoking Assessment/Reassessment for residents: How is the assessment done? How often is it repeated?	
	Escorting residents outside or to smoking areas: Will this be allowed? Who will do it?	
	Compliance for staff and residents: Will this be the responsibility of all staff? Outline steps for dealing with staff or residents who are noncompliant	

1.4 Sample Policy

Smoke-Free Ontario Act: *(Name of LTC Home)* Policy

Date:

Policy Statement

On May 31, 2006, the Smoke-Free Ontario Act (SFOA) took effect. Homes wishing to allow indoor smoking are required to build a Controlled Smoking Area (CSA) according to specifications in the SFOA. After consultation with residents, councils and decision makers, it has been decided that _____ will not be constructing a CSA. The purpose of the policy is to ensure that those who work, visit or receive services at _____ do not experience the many detrimental health consequences associated with second-hand smoke.

Application

This Policy applies to all employees, clients, family members, visitors, physicians, residents, students, volunteers, suppliers, agency staff, Board members and independent, third-party contractors working in any capacity at _____.

No Smoking at _____

Smoking is prohibited:

1. Within all _____buildings and designated areas.
2. Within all _____ vehicles that are owned or leased for _____ business.
3. Within a nine-metre radius of any _____ entrance or air intake area.
4. At the designated smoke-free entrances.
- (*Description of the entrance locations.*)
5. Within all courtyards.

Signage will be provided to clarify the smoke-free areas.
A smoking shelter will be built according to the SFOA regulations.

Support for Staff and Residents at_____

Smoking is an addiction and it is acknowledged that changing one's smoking pattern is difficult. Therefore _____ is committed to taking a proactive approach in offering education resources and a list of community resources for assistance.

Residents and Safe Smoking

The SFOA legislation states that residents must be able, in the opinion of the proprietor or employer, to smoke safely without assistance from an employee in order to smoke in a Controlled Smoking Area. Although we do not have a CSA, _____ assesses those who wish to smoke outside to ensure they can do so safely. This is to ensure that the resident is independently safe to smoke.

Residents who are not allowed outside on their own

Health care staff will not escort residents who are not allowed outside on their own. This is not only for staff health issues, but also to ensure coverage of the residents' needs on the floor. We would also ask family or visitors to remember that if the resident is not independent enough to smoke, providing them with assistance to smoke on visits may mean that they will be in withdrawal after the visit.

Residents who are cutting back on smoking or quitting

Residents will be provided with smoking cessation programs and medical aids; support and education will be provided by the health care team.

Compliance

Employees who do not abide by the policy and are caught smoking in smoke-free areas will be disciplined according to existing human resource policies.

Those working at _____ are encouraged to enforce the policy to ensure its effectiveness. If one witnesses a resident or visitor smoking where smoking is prohibited, the following are steps to enforce the policy:

1. Approach the person and inform him/her that smoking is not permitted in that area. If appropriate, advise the person that if he/she wishes to continue smoking to go outside to an area where smoking is allowed.
2. If further assistance is required, contact a manager.

[This sample policy is adapted with permission from *Centre for Addiction and Mental Health Smoke-Free Policy* (CAMH) and from *Smoke-Free Ontario Act: Sunnyside Home Resident Smoking Policy* (Sunnyside Home, Region of Waterloo).]

SECTION 2

Implementation: Education and Communication

2.1 Education for Staff
2.2 Communicating with Staff
2.3 Communicating with Residents and Their Families
2.4 Communicating with Other Stakeholders

2.1 Education for Staff

As part of a good implementation strategy, it is important to provide staff with the proper training and education to help them manage the change to smoke-free.

Staff may benefit from the following three training topics:

1. Orientation to the smoke-free policy

This training should outline the policy in detail so that employees are fully aware of the rationale and guidelines for the smoke-free policy. Consider including the following sub-topics:

- *Smoke-Free Ontario Act*
- implication of the SFOA for LTC Homes
- assessing safe smoking
- second-hand smoke
- resident smoking and fire safety
- addiction
- available resources for staff

The training session should also incorporate a "Question and Answer" segment to allow staff to voice their concerns and questions regarding the policy.

2. Smoking Cessation

This training session is meant to familiarize staff with smoking cessation. Consider including the following sub-topics:

- benefits of quitting
- benefits of using Nicotine Replacement Therapy (NRT) to quit
- types of NRT
- nicotine withdrawal symptoms
- nicotine toxicity symptoms

3. Dealing with residents who are struggling with the new policy

This training is meant to provide staff with the skills to deal with residents who are struggling and need additional care or encouragement. Consider the following sub-topics:

- Motivational interviewing: engaging clients in thinking about their smoking behaviours.
- Behavioural techniques: changing behaviours to facilitate smoking cessation (e.g., engaging residents in relaxing activities such as deep breathing or gentle exercise, encouraging activities that stimulate the mouth such as snacking on raw vegetables or drinking a cold glass of water, encouraging activities that occupy the hands such as playing cards, knitting, doing a crossword or jigsaw puzzle).
- Managing residents' problematic behaviour: for example, if residents are found to be smoking in bathrooms or in their bedrooms, consider monitoring resident rooms more frequently. Also,

consider prescribing or increasing NRT to make residents more comfortable when not smoking.
- How to be a buddy for someone who is trying to quit or cut back on smoking.
- Nature of addiction.

2.2 Communicating with Staff

Communicate with staff by providing handouts, flyers or brochures; schedule presentations at meetings, posting notices or posters on bulletin boards, e-mail updates or related websites, screen savers, to help them understand the new policy and issues relating to the policy. Including information in staff orientation and encouraging them to include information in their unit communication book will help both staff and residents.

This manual includes examples of the following flyers and handouts for staff:

- Fire Risk and Safe Smoking
- Second-Hand Smoke
- NRT Summary Sheet
- NRT Decision Tree
- Tips for Communicating with a Resident
- Safe Smoking Assessment Form
- Resident and Client Smoking Agreement (used with permission from Sunnyside Home, Kitchener)

In addition, letters should be sent to staff and management to update them on the changes. This manual contains template letters that can be sent to:

- LTC Home management re: implementing the home's new smoke-free policy
- LTC Home unit managers re: closure of Designated Smoking Rooms

2.3 Communicating with Residents and Their Families

In addition to providing staff with training and communications, it is important to also provide residents and family members with the proper information to help them manage the change to smoke-free. Informing residents of the changes can help prepare them for the adjustment in a culture that is expected when making a home smoke-free. Keeping family members informed is also important, since they can support and encourage their loved ones in the home to help adapt to the smoke-free environment.

Communicating with residents and families can be done in a variety of ways:

- Community Care Access Centres can include the information as part of their placement process
- orientation/tour
- presentations
- one-on-one discussions
- resident council meetings
- family council meetings
- posters
- letters
- care plan

- monthly newsletters
- informal discussions with staff
- information on the home's website

Consider providing residents and family with the following information:

- Rationale: why the home has gone smoke-free
- Effects of second-hand smoke: for both smokers and non-smokers
- How the new policy will affect the residents
- Safe Smoking Assessment: why and how it is done
- How family and friends can help

This manual includes examples of the following handouts for residents:

- Fire Risk and Safe Smoking
- NRT information sheet
- Why Quit Smoking?
- Second-Hand Smoke Exposure
- Tips for Helping Family and Friends Quit Smoking

In addition to communicating with residents, consider putting materials in key areas such as:

- lobbies
- common areas(e.g., games rooms and lounges)
- cafeterias

Posters can also be useful tools to help inform family and visitors of a new policy. The manual includes a template for:

- homes that have a 100% smoke-free property
- homes that allow outdoor smoking (nine metres from the entrances)

This manual includes templates for letters that can be sent to residents' family/guardian regarding:

- the new smoke-free policy in the home (with or without a Controlled Smoking Area)
- the results of a resident's Safe Smoking Assessment

Involve residents in planning the upcoming changes in the home:

- if a home is closing a Designated Smoking Room, involve the residents in redesigning the use of this new space.
- residents who are in the process of quitting smoking will benefit from activities that prevent boredom and provide alternatives to smoking. Ask residents for feedback on what activities they would like to do.

2.4 Communicating with Other Stakeholders

This manual also includes templates for letters that can be sent to other LTC Home stakeholders (e.g., community members, patrons, partner agencies) regarding the new smoke-free policy in an LTC Home.

Templates are included for:

- LTC Homes **without** a Controlled Smoking Area
- LTC Homes **with** a Controlled Smoking Area

Resources

Staff and Physician Handouts

- **Fire Risk and Safe Smoking**
- **Second-Hand Smoke**
- **NRT Summary Sheet**
- **Signs/Symptoms of Nicotine Withdrawal or Overdose**
- **NRT Decision Tree**
- **Tips for Communication**
- **Safe Smoking Assessment Form**
- **Resident and Client Smoking Agreement**

Resident Handouts

- **Fire Risk and Safe Smoking**
- **Second-Hand Smoke**
- **Why Quit Smoking?**
- **NRT Info sheet**
- **Tips for Helping Family and Friends Quit Smoking**

Posters

- **Poster for homes with smoking allowed outdoors**
- **Poster for homes with non-smoking property**

Letters

- **To: Management**
  - re: implementing the home's new smoke-free policy
- **To: Unit Managers**
  - re: closure of Designated Smoking Rooms
- **To: Residents' Family Members**
  - re: Safe Smoking Assessment results
- **To: LTC Home Stakeholders**
  - re: the home's new smoke-free policy (for facilities without a CSA)
- **To: LTC Home Stakeholders**
  - re: the home's new smoke-free policy (for facilities with a CSA)

Staff and Physician Handouts

- **Fire Risk and Safe Smoking**
- **Second-Hand Smoke**
- **NRT Summary Sheet**
- **Signs/Symptoms of Nicotine Withdrawal or Overdose**
- **NRT Decision Tree**
- **Tips for Communication**
- **Safe Smoking Assessment Form**
- **Resident and Client Smoking Agreement**

Fire Risk & Safe Smoking

FIRE RISK

- According to a study by the Canadian Association of Fire Chiefs, smoking-related fires account for approximately 70 deaths and 300 injuries in Canada annually.
- Smoking is the leading cause of fatal fires among the elderly.
- In households where one or more members smoke, the risk of fire-related injuries to the people who smoke or a family member is five times higher compared to non-smoking residences.
- Compared to the general population, the risk of dying in a fire increases with age:
  65 to74 years – the risk is 1.8 times greater than the general population
  85+ years – the risk increases to 4.6 times greater than the general population
- As of Oct. 1, 2005, the Ignition Propensity Standard came into effect, requiring that:

> "...all cigarettes manufactured in or imported into Canada must burn their full length no more than 25% of the time when tested using ASTM International method *E2187-04: Standard Test Method for Measuring the Ignition Strength of Cigarettes*" (Health Canada, 2005 http://www.hc-sc.gc.ca/hl-vs/pubs/tobac-tabac/ignition-incend/index_e.html)

This means that all cigarettes manufactured or imported into Canada will be more fire safe with less chance of igniting other materials (upholstery, clothing, sheets, etc.).

Safe Smoking

- The Smoke-Free Ontario Act protects all staff and residents by reducing the risk of fire-related fatalities and injuries by requiring all residents who smoke in Controlled Smoking Areas (CSA) to be assessed as safe smokers.
- Sample safe smoking assessment forms are available to help staff assess residents' smoking ability.

For more information on fire risks and safe smoking or for an example of a safe smoking assessment form please contact:

_____

Let's Clear the Air at Work

The Problem

- Second-Hand Smoke (SHS) exposes staff and residents (both smokers and non-smokers) to several thousand chemicals, including more than 50 chemicals that are known to cause cancer.
- Some of the toxic substances are higher in concentration in SHS than in smoke inhaled directly when a cigarette is smoked.

- SHS increases the risk for heart disease, breast cancer, lung cancer, nasal sinus cancer, and respiratory diseases such as chronic bronchitis and emphysema.
- Exposure to SHS aggravates asthma and allergies and irritates the eyes, nose, throat and lungs.
- Approximately 80% of a non-smoker's exposure to SHS happens at work.

The Solution

- The Smoke-Free Ontario Act protects the health of all staff and residents in LTC Homes by eliminating exposure to SHS — it allows only the operation of Controlled Smoking Areas (CSA) indoors, and restricts outdoor smoking to nine metres from entrances.
- 90% of Ontario workers — including 70% who smoke — support smoke-free work environments that protect health.
- Smoke-free policies help people who smoke to cut down or quit. They also help former smokers stay smoke-free.

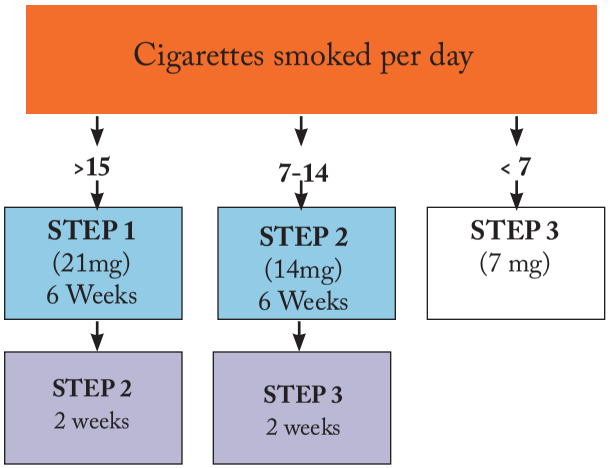
What You Can Do

- Focus on smoking, not on people who smoke.
- Support fellow residents and staff who want to cut down or quit.
- Find out more about SHS and workplace policies.

FOR MORE INFORMATION, PLEASE CONTACT:

NICOTINE REPLACEMENT THERAPY

Nicotine Patch: Alone or + gum/inhaler



How to use it:

- Apply to a clean, hairless, dry area (you may need to clean area with alcohol wipe)
- Remove old patch before applying new one
- Do not use soap or moisturizing lotion on the area where the patch is to be applied
- Touch only a small corner of adhesive
- Rub patch after application – ensure all corners are stuck
- Wash hands with water immediately after application – don't use soap
- After rising hands with water only, then you may use soap to wash hands
- Discard old patch out of reach of children and animals

Contraindications/Cautions:

Contact hypersensitivity: erythemia, pruritis,edema, hives, or generalized rash or urticaria. Recent CVA, immediately Post MI, angina, life threatening arrhythmias

Nicotine Gum: Alone or + patch/inhaler

Only those who are able to chew gum

↓

Start with **4mg**/hr to a maximum of 15 pieces/day

↓

If unable to tolerate (nausea, diaphoresis, irritated), switch to **2mg**/hr

How to use it:

- Chew one piece at a time
- Chew and park in between teeth and cheeks
- Repeat chew every minute or so
- Each piece lasts about 30 mins
- Do not chew within 30 mins of caffeine/ acidic products

Contraindications/Cautions:

Unable to chew gum, wears dentures, active TMJ dysfunction, immediately Post MI, angina, life threatening arrhythmias

Nicotine Inhaler: Alone or + patch/gum

(instead of gum, if unable to chew)

Use 6 to 10 cartridges per day for 3 to 12 weeks

↓

Reduce number of cartridges gradually over 6 to 12 weeks

↓

When daily use is reduced to less than 3 cartridges, stop using inhaler

How to use it:

- Inhale like a cigar NOT deeply into the lungs
- Can use continuously or as needed
- May notice a burning or warm cool sensation when inhaling – OK unless becomes bothersome
- Clean inhaler on a regular basis with soap and water

Contraindications/Cautions:

Immediately Post MI, angina, life threatening arrhythmias

NICOTINE WITHDRAWAL / NICOTINE OVERDOSE

Signs/Symptoms of Nicotine Withdrawal	
Immediate Onset	**Later Onset**
Cravings to smoke Frustration Anger Difficulty concentrating Restlessness	Nausea Diarrhoea/constipation Shakiness Dizziness Fatigue Sleep disturbances Headaches
Can occur within a few hours of cessation. Peaks in 1–4 days. Can last 6 months or longer.	Typically milder than immediate onset signs/symptoms. Can last 6 months or longer.

Signs/Symptoms of Nicotine Overdose
Nausea/vomiting Sweating Vertigo Tremors Confusion Weakness Racing heart Light-headedness

DECISION TREE TO ADDRESS NICOTINE WITHDRAWAL

Assess client's smoking status

- Pattern of smoking: daily/non-daily/ex-smoker/never smoked
- Amount smoked: cigarettes smoked per day
- Withdrawal when stopping and how soon after stopping in the past
- Any signs of withdrawal at time of assessment
- Goals (reduction, cessation, withdrawal management)
- Previous experience with NRT: cessation/reduction
- Med. Hx: Recent/previous MI, unstable angina, arrhythmia, TMJ dysfunction, dentures

Daily Smoker

No →

- Non daily smoker, or
- No withdrawal on stopping smoking

→ No Medication

Yes

Withdrawal Symptoms: *Cravings to smoke, irritability, frustration, anger, anxiety, difficulty concentrating, restlessness not accounted for by any other mental health or physical condition.*

Presence of heart disease, recent heart attack, angina, arrhythmias

Yes →

- Client can be started on NRT
- Instruct client not to smoke
- If client reports any chest pain, s.o.b., or increase in palpitations, *REMOVE PATCH* and implement care for chest pain accordingly.

No

Allergic to nicotine patch?

Yes →

Try alternative brand. If client has topical reaction to all brands, discontinue patch and provide nicotine gum or inhaler instead.

No

Smokes ___ cigarettes per day

<u>Less than or equal to 14 cigarettes per day</u>

- Start with 14 mg patch per day plus gum q/1hr prn for cravings.

OR

- Consider gum 2 mg or 4 mg q/1h alone.
- Use inhaler if gum is not suitable.

<u>More than 14 cigarettes per day</u>

- Start with 21 mg patch per day plus gum q/1hr prn.
- Use inhaler if gum is not suitable.
- Reassess in 3 days.
- If client is exhibiting signs/symptoms of withdrawal, is using more than the prescribed amount of nicotine gum or inhaler and/or is still smoking: increase patch strength by 7 mg.
- Increase the dose every 3-5 days until client no longer exhibits signs/symptoms of withdrawal.

If client has dentures, TMJ dysfunction or is unable to chew nicorette gum, provide the inhaler instead of gum.

TIPS FOR COMMUNICATING WITH STAFF AND RESIDENTS

- Be positive.
- Be objective — it won't always be smooth.
- Explain "why" by focusing on the health of residents and staff.
- Set an example.
- Be respectful of staff and residents' fears and concerns but also be sure to share stories with them of other places that have gone smoke-free successfully.
- Make sure staff have training in how to deal with residents who smoke, NRT, the Smoke-Free Ontario Act and the home's related policy.
- Offer alternative activities for people who do smoke so that the triggers for smoking, such as time and location, change.
- Make sure people who smoke are not stigmatized. Educate staff and residents about stigma and its impact. It is important to remember to look at the whole person and not one health issue when dealing with that person.

Sample Form for
Assessing Resident's Ability to Smoke Independently

Name of Resident _____ **Age** _____ **File #**_____

Date_____ **Time** _____

The *Smoke-Free Ontario Act* specifies several requirements for Controlled Smoking Areas (CSAs):

- **The room must be designated as a controlled smoking area.**
- **Residents must be able, in the opinion of the proprietor or employer, to smoke safely without assistance from an employee.**
- **Employees are not required to enter the controlled smoking area.**
- **Only residents (not staff or visitors) of the facility are allowed to smoke in the controlled smoking area.**
- **The controlled smoking area must be enclosed and fitted with ventilation in compliance with the regulations, is identified as a controlled smoking area by prescribed signs, and meets any other prescribed requirements.**

This form is to be completed when the resident is awake and alert, oriented to time, place and person and is able to ambulate independently or propel him- or herself safely in a wheelchair. **If the resident does not meet these criteria, they may not smoke.**

Information Sources: (check all that apply)

☐ Observation
☐ Discussion with resident
☐ Family caregiver
☐ Nursing/Team report
☐ Chart review for smoking incidents
☐ Staff physician/pharmacist re: medications

1) Resident Perspective

Source of information if not resident: _____

i) Would you like to quit smoking?
☐ Yes **(set up appointment with NP/MD)**
☐ No

ii) How many cigarettes do you smoke every day? _____

iii) When is your first cigarette of the day? _____

iv) Do you need assistance smoking?
☐ Yes
☐ No

Explain: _____

v) How often have you fallen asleep while smoking a cigarette?

☐ Never ☐ Number of times: ____

Explain: _____

vi) What would you do if there were an emergency in the smoking room/area? (*Resident should say, unaided, that they would call for help and leave the area.*)

_____

If resident has fallen asleep more than once while smoking or is unable to answer part vi) correctly, then resident is a fire risk. Stop questionnaire now. Refer to NP/MD for assistance with NRT if available.

Risk Factors

a) Are there any physical limitations that have implications on the resident's ability to smoke (i.e., arthritis, hand injury, paralysis)?

☐ Yes ☐ No
If yes, please specify: _____

b) Does the resident use assistive devices that may alter his/her ability to smoke (i.e., splints/neck collar)

☐ Yes ☐ No
If yes, please specify: _____

c) Is the resident known to engage in the following unsafe smoking practices?

i) Dispose of ashes/cigarette butts in an unsafe manner ☐ Yes ☐ No
ii) Burn marks on clothes or self ☐ Yes ☐ No

d) Is the resident known to attempt to set fires or use ignition materials unsafely?
☐ Yes ☐ No

e) Does the resident consume excessive amounts of alcohol?
☐ Yes ☐ No

f) Does the resident have a history of falling asleep while seated?
☐ Yes ☐ No

g) Does the resident take any medication that could affect his/her ability to smoke safely (e.g., cause drowsiness)?
☐ Yes ☐ No
If yes, please specify: _____

If YES to <u>any</u> of the above: resident is a fire risk and not safe to smoke independently.

If it appears from the interview that the resident is able to smoke independently, an observation must be done as follows:

2) Direct Observation

Take the resident outdoors and ask them to smoke a cigarette. Did the resident complete the following tasks safely and independently? If no, comment on the resident's action in the space provided. Indicate whether the underlying cause is related to physical, cognitive, perceptual and/or behavioural issues.

a) Get to smoking room? ☐ Yes ☐ No _____

b) Obtain cigarettes and lighter? ☐ Yes ☐ No _____

c) Obtain and use a smoking apron? ☐ Yes ☐ No _____ N/A ☐

d) Access an ashtray? ☐ Yes ☐ No _____

e) Light cigarette? ☐ Yes ☐ No _____

f) Hold cigarette securely? ☐ Yes ☐ No _____

g) Dispose of ashes in ashtray? ☐ Yes ☐ No _____

h) Put out cigarette? ☐ Yes ☐ No _____

i) Return cigarettes and lighter to storage? ☐ Yes ☐ No _____

j) Able to call for emergency assistance? ☐ Yes ☐ No _____

If NO to any of the above, the resident is a fire risk and is not able to smoke independently.
If yes to all, the resident is able to smoke independently.

Name of staff member completing assessment:

_____

Signature:

_____

SUNNYSIDE HOME

Resident and Client Smoking Agreement

Region of Waterloo
SOCIAL SERVICES

Effective May 31, 2006, the Smoke-Free Ontario Act took effect. There is no indoor smoking at Sunnyside Home. Outdoor smoking is available to residents and clients who are able to smoke safely on their own or with assistance from their family/friends.

Smoking is only permitted in the designated outdoor smoking area at the front of the buildings.

No smoking materials will be sold on site. The Home will purchase cigarettes for residents whose families are unable to purchase them.

Smoking cessation assistance is available to residents and can be requested through Nursing.

Residents/clients who are able to smoke independently and safely in the outdoor smoking area are permitted to smoke at Sunnyside Home. Staff do not assist with or transport residents/clients for the activity of smoking.

Residents/clients who require a secure home area (Special Care) are not able to leave the home area unless they are accompanied, due to wandering concerns.

Family members/friends can transport or assist residents/clients to smoke.

If a resident is not able to access the outdoor smoking area and/or is not able to smoke safely, they are not permitted to smoke while at Sunnyside Home. The assessment of smoking safety is made by the Registered Nurse.

Smoking materials will be dispensed to the resident/client by Nursing staff.

If a resident is attempting to smoke independently and they are not able to do so safely, the Home will advise the resident and their family that the resident is no longer able to smoke at Sunnyside Home. If a resident is found to be smoking inside of the Home, they will no longer be able to smoke at Sunnyside Home.

Visitors and volunteers may use the outdoor smoking area.

Contact a Registered Nurse for additional information about resident/client smoking.

Please sign below to confirm that you understand the smoking regulations at Sunnyside Home and agree to abide by them.

_____

Signature of resident

_____

Signature of resident's Power of Attorney for Personal Care/Substitute Decision Maker

_____

Signature of staff member who reviewed the smoking guidelines with resident and family

_____

Date

Resident Handouts

- **Fire Risk**
- **Second-Hand Smoke**
- **Why Quit Smoking?**
- **NRT Info sheet**
- **Tips Helping Family and Friends Quit Smoking**

Fire Risk

- According to a study by the Canadian Association of Fire Chiefs, smoking-related fires account for approximately 70 deaths and 300 injuries in Canada annually.
- Smoking is the leading cause of fatal fires among the elderly.
- In households where one or more members smoke, the risk of fire-related injuries to the people who smoke or a family member is five times higher compared to non-smoking residences.
- Compared to the general population, the risk of dying in a fire increases with age:
  65 to74 years – the risk is 1.8 times greater than the general population

  85+ years – the risk increases to 4.6 times greater than the general population

Safe smoking

- The Smoke-Free Ontario Act protects all staff and residents by reducing the risk of fire-related fatalities and injuries by requiring all residents who smoke in Controlled Smoking Areas (CSA) to be assessed as safe smokers.
- Safe smokers are those who can smoke safely and without the help of others.

For more information on fire risks and safe smoking or for an example of a Safe Smoking Assessment form please contact:

_____

Let's clear the air of

second-hand smoke (SHS)

The Problem

- Second-Hand Smoke (SHS) exposes staff, residents and families (smokers and non-smokers) to several thousand chemicals, including more than 50 chemicals that are known to cause cancer.
- SHS contains higher concentrations of some toxic substances than the smoke that is inhaled directly when a cigarette is smoked.
- SHS increases your risk for heart disease, breast cancer, lung cancer, nasal sinus cancer and respiratory diseases such as chronic bronchitis and emphysema.
- Exposure to SHS aggravates asthma and allergies and irritates the eyes, nose, throat and lungs.

The Solution

- The Smoke-Free Ontario Act protects the health of all staff and residents by eliminating exposure to SHS — it allows only the operation of Controlled Smoking Areas (CSA) indoors, and restricts outdoor smoking to 9 metres from entrances.
- Smoke-free policies help people who smoke to cut down or quit. They also help former smokers stay smoke-free.

For more information on second-hand smoke or for information on quitting smoking please contact:

_____

Why Quit Smoking?

Benefits for you:

It's NEVER too late to benefit from quitting smoking. Just look at the chart below for all the immediate, short- and long-term benefits for you once you have quit.

After…	Health Benefits
20 minutes	Blood pressure, pulse, and hand/feet temperature return to normal
8 hours	Nicotine and carbon monoxide levels in blood reduce by half, oxygen levels return to normal
24 hours	Carbon monoxide will be eliminated from the body, lungs start to clear out mucus and other smoking debris
48 hours	Chances of having a heart attack start to go down, nerve endings start to re-grow, and ability to taste and smell improves
72 hours	Breathing becomes easier, bronchial tubes relax, energy levels increase
2–12 weeks	Circulation improves, breathing improves, walking becomes easier
3–9 months	Coughing, wheezing and breathing problems improve and lung function increases by up to 10–30%
1 year	Risk of smoking-related heart attack is cut in half
10 years	Risk of lung cancer is cut in half

- All smokers (men, women, old and young) can experience the benefits of quitting.
- Even smokers who have already developed smoking-related problems like heart disease can look forward to the health gains of quitting smoking. According to Health Canada, smokers who quit smoking after having a heart attack reduce their risk of another heart attack by 50% and also of dying prematurely by 50%.
- Conditions like emphysema and bronchitis can stabilize and improve after quitting smoking.
- Quitting smoking is also beneficial for diabetics: diabetic smokers who quit are much less likely to suffer from serious health effects like heart disease, blindness and stroke.

- Continuing to smoke increases your risk of developing dementia, Alzheimer's disease and cataracts.

Benefits for your family, friends, and others around you

- You will have more energy to spend time with family and friends and take part in activities with them.
- You will help eliminate Second-Hand Smoke (SHS) exposure to your family, friends, and those around you. SHS exposure of as little as eight to 20 minutes can cause physical reactions linked to heart disease and stroke (heart rate increases, heart's oxygen supply decreases, blood vessels constrict, blood pressure goes up, and the heart has to work harder as a result).

You can quit smoking

- Many Canadians quit smoking each year and so can you.
- Remember, quitting smoking is a process and it will take some time.

Quitting help

- For a limited period of time, the cost of Nicotine Replacement Therapy (NRT) for residents in Long-Term Care Homes will be reimbursed by the Ministry of Health Promotion through the Ministry of Health and Long-Term Care.
- There are also a number of self-help booklets and other programs to help you to quit smoking.

For more information on quitting smoking or Nicotine Replacement Therapy please contact:

_____

Nicotine Replacement Therapy (NRT)

Nicotine Replacement Therapy:

- NRT has been around for more than two decades
- It is the most commonly used medicine to help smokers quit smoking
- In Ontario you can choose from 3 types: the patch, the gum, and the inhaler
- NRT is easy to use
- NRT has a low risk of addiction
- Almost anyone over the age of 18 can use NRT (even those with heart conditions, although a doctor should be consulted first)

NRT can help you quit smoking:

- Nicotine is the drug that is inhaled from tobacco while smoking; NRT is a safer way to provide the body with nicotine while trying to quit smoking
- NRT slowly provides the body with lower doses of nicotine which helps reduce nicotine withdrawal while trying to quit

Patch	Gum	Inhaler	Caution
• Looks like a large square sticker • Placed on a hairless, clean part of the body • Use 1 patch per day • Rotate the site daily • Can be used with nicotine gum or inhaler	• Looks like regular gum • Chew it and then park it in your cheek to absorb the nicotine • Chew 1 piece per hour to a maximum of 15 per day	• Resembles a cigarette • Nicotine cartridges are inserted into the inhaler • Use up to 10 cartridges per day • Each cartridge can provide up to 3 20-minute sessions	 Watch out for the following signs and symptoms of nicotine toxicity: • Nausea • Vomiting • Sweating • Vertigo • Tremors • Confusion • Weakness • Racing heart • Light-headedness
Use for at least 8-12 weeks	Use for at least 8-12 weeks	Use for at least 8-12 weeks	Consult a physician

Tips for Helping Your Friend
Quit Smoking

REMEMBER

- This may be one of the hardest thing your friend does
- Remember that their cigarettes or pipes, have been with them through good times and bad, births and deaths and for some it is like a friend
- Although the smoke and its smell may be annoying and bad for you it is important to remember that the addiction to smoking is as strong as the addiction to heroin. That means that it is extremely tough to give up for most people. Their physical withdrawal can last from 48 hours to four weeks.
- Remember as your friends, colleagues, clients try to cut back or quit smoking, to be patient and supportive, no matter how grumpy they are.
- Remember to look at the person as a whole and not in a bad light as "A SMOKER". Treat them with respect and compassion.

SUPPORT

- Ask what they need from you
- Listen and be supportive
- A person who is quitting smoking will crave nicotine, feel hungry and be restless
  - Suggest that they eat healthy and have small meals throughout the day
  - Drink lots of fluids, going easy on caffeine and alcohol
  - Avoid places that remind them of smoking if at all possible
  - Change some of your routine with them so that they don't think of the time and that it is time to have a cigarette
- Even if they start to smoke again, remind them that most people who quit smoking forever usually try several times before they are successful. Quitting takes practice.
- Celebrate each goal that they reach and each success!

Adapted from The Lung Association http://www.lung.ca/protect-protegez/tobacco-tabagisme/quitting-cesser/friend-ami_e.php

Posters

- **Poster for homes with smoking on property**
- **Poster for homes with non-smoking property**

WELCOME

TO OUR SMOKE-FREE HOME

_____

is proud to be a smoke-free home as of

_____

Please respect our smoke-free policy and smoke outside 9 metres from the entrances/exits at the designated smoking areas only

WELCOME

TO OUR SMOKE-FREE HOME

_____

is proud to be a smoke-free home as of

_____

Please respect our smoke-free property policy and do not smoke on our property

Letters

- **To: Management**
  - **re: implementing the home's new smoke-free policy**

- **To: Unit Managers**
  - **re: closure of Designated Smoking Rooms**

- **To: Residents' Family Members**
  - **re: Safe Smoking Assessment results**

- **To: LTC Home Stakeholders**
  - **re: the home's new smoke-free policy (for facilities without a CSA)**

- **To: LTC Home Stakeholders**
  - **re: the home's new smoke-free policy (for facilities with a CSA)**

To: (*Name of LTC Facility*) Management

Re: Implementing our new smoke-free policy

By now you will have heard that (*facility name*) is going **smoke-free**. We have developed a policy to clarify how we will be implementing the Smoke-Free Ontario Act on (date). The development of our policy was based on input from residents, families and staff.

Part of the process is to inform all managers on what their role will be in helping to implement the policy and legislation. As with all (facility name) policies, the managers' role in directing and supporting staff in the implementation of the policy is appreciated. We ask that managers provide encouragement and guidance so that staff can play an active role in helping to communicate the policy to residents and visitors as well as complying with the policy themselves. Staff members who do not comply with the policy will be accountable through existing human resource policies.

All staff will complete mandatory training on the policy. Training will be provided through (method of training).

Our smoking rooms will be turned into resident activity rooms. All smoking paraphernalia such as ashtrays should be discarded. In addition, it will be important to discuss the policy with residents in advance of the smoke-free implementation date in order to prepare them for these changes. Communication about the policy and implementation date via posters and immediate broadcasts has already begun.

Finally, we are also hoping that managers will work with their staff to develop consistent protocols for dealing with residents who continually do not abide by the policy. If residents believe that there are no consequences for smoking in non-smoking areas then the behaviour will continue. Most programs already have existing protocols/consequences in place for other behavioural issues, and may be able to apply or adapt these to smoking behaviour. However we would like staff to make sure that any consequences given are not punitive and that access to cigarettes is not used as a reward or punishment in helping to control behaviours.

Some suggestions that have come out of our consultations with other locations that have smoke-free policies include:

1. Educating residents on why we are going smoke-free and reviewing the legislation and policy with the residents.
2. Consistently approaching people who smoke in non-smoking areas to inform them of the legislation and policy (never ignoring the behaviour).
3. Ongoing monitoring of symptoms associated with nicotine withdrawal and Nicotine Replacement Therapy (NRT) adjustment as needed.
4. Addressing any repeated violations of the policy.

We realize that every program is different and has varying issues and challenges. We encourage you to meet with your staff ahead of time to discuss the operational implications the policy will have for your program or department, so that all staff are consistently giving the same message to residents. Smoking violations should be treated similar to any other behavioural infractions.

Your leadership and direction is requested in ensuring that the process proceeds as smoothly as possible. If you have any questions or concerns, please contact (*name and number/e-mail*).

Sincerely,

To: *(Name of Facility)* Unit Managers

Re: Closure of Designated Smoking Rooms

The Smoke-Free Ontario Act and *(facility name)* policy implementation date is approaching and we want to keep you informed of the steps involved in modifying existing Designated Smoking Rooms into new spaces for resident activities.

As you know, on *(date)* it is essential that all smoking rooms be locked, with smoking no longer permitted in these areas. In the days following, custodial staff will be cleaning each unit thoroughly including the walls and ceilings. Once the rooms have been cleaned maintenance staff will be painting each room. Upon completion of the painting, the custodians will refurbish the floors.

The housekeeping and maintenance departments will be in touch with each unit to schedule this work. This process will start immediately after *(date)*.

The smoking rooms will be retained for resident use. After the rooms have been cleaned and painted they will be transformed into an alternative resident space. We would like resident and staff input on the use of these new resident activity rooms. *(Insert instructions on how staff and resident can provide feedback for use of the new space.)*

If you have any questions please contact *(name and number/e-mail)*.

Thank you,

Dear *(family member's name),*

Re: Resident Safe Smoking Assessment

As you may already know, the Smoke-Free Ontario Act (SFOA) came into effect at the end of May 2006. To comply with the SFOA, we closed our Designated Smoking Room(s) and opened a Controlled Smoking Area (CSA). Under the SFOA, staff members are no longer required to assist residents to smoke. In order for residents to smoke in the CSA, they need to be able to smoke safely and independently.

We would like to inform you that *(name of resident)* has been assessed as unable to smoke safely and independently. As a result, we are developing a plan with *(name of resident)* on how to quit smoking. Our physician will provide medical assistance if *(name of resident)* is interested in using Nicotine Replacement Therapy. Our staff will provide support to *(name of resident)* to help *(him/her)* make this transition.

Older adults are generally more successful in quitting than younger adults. We hope that you will show support for *(name of resident)* in this transition. We have included information on how to be supportive of someone who is quitting smoking and we hope this will help you to help *(name of resident)*.

If you have any questions, please feel free to contact *(name and number/e-mail)*.

Sincerely,

Dear *(stakeholder's name),*

Re: The new smoke-free policy at *(name of LTC facility)*

(*Name of facility*) is committed to providing a safe and healthy environment for our residents, staff and visitors. We are therefore pleased to announce that we have become a smoke-free home, in accordance with the new Smoke-Free Ontario Act. We know from research that many detrimental health consequences are associated with second-hand smoke.

Going smoke-free means that all buildings located on *(name of facility)* property will be completely smoke-free, including *(locations that people may think aren't included)*. Smoking is allowed outdoors at least nine metres away from entrances and exits.

(Include information from your smoke-free policy if you developed one [i.e., staff escorting clients outside to smoke, supplying cigarettes and lighters. etc., no smoking near windows that open or air intake areas].)

We recognize that with the implementation of the legislation and our policy, you may be concerned about how our residents will be affected. We know that some of our residents smoke and that the closure of the Designated Smoking Rooms will be a transition for them, and one that may be challenging. Although the main purpose of the legislation is to provide a safe environment, we recognize that some residents may also choose or need to quit smoking if they are not able to smoke safely. Our medical staff has been trained to provide support to those who want to cut down or quit smoking.

As a family member, friend, partner agency or fellow community member we hope that you will inform others who may be affected by our new smoke-free policy. We are using the knowledge from other homes that have gone smoke-free to help us make this as smooth as possible a transition.

Enclosed with this letter is a copy of our smoke-free brochure that has been created for *(name of home)* residents. This resource offers some basic information about the legislation and our policy.

If you have any questions, please contact *(name and number/e-mail*).

Sincerely,

Dear *(stakeholder's name),*

Re: The new smoke-free policy at *(name of LTC facility)*

In accordance with the new Smoke-Free Ontario Act, (*name of facility*) wants to improve the health and safety of the residents, staff and visitors at our site. We know from research that many detrimental health consequences are associated with second-hand smoke and as such would like to increase our protection for residents and staff. We are therefore pleased to announce that from *(date),* a Controlled Smoking Area (CSA) will be available to our residents.

The CSA will be located *(describe location)*. Smoking will only be allowed in the CSA if the resident can safely smoke without assistance. No visitors or staff members are allowed to smoke in the CSA. Smoking will also be allowed outdoors at least nine metres from the doorways unless it is otherwise noted in our policy.

(Include information from your smoke-free policy if you developed one [i.e., staff escorting clients outside to smoke, supplying cigarettes and lighters. etc., no smoking near windows that open or air intake areas].)

We recognize that with the implementation of the legislation and our policy, you may be concerned about how our residents will be affected. We know that some of our residents smoke and that the closure of the Designated Smoking Rooms will be a transition for them, and one that may be challenging. Although the main purpose of the legislation is to provide a safe environment, we recognize that some residents may also choose or need to quit smoking if they are not able to smoke safely. Our medical staff has been trained to provide support to those who want to cut down or quit smoking.

As a family member, friend, partner agency or fellow community member we hope that you will inform others who may be affected by our new smoke-free policy. We are using the knowledge from other homes that have gone smoke-free to help us make this as smooth as possible a transition.

Enclosed with this letter is a copy of our smoke-free brochure that has been created for *(name of home)* residents. This resource offers some basic information about the legislation and our policy.

If you have any questions, please contact *(name and number/e-mail*).

Sincerely,

SECTION 3

Smoking, Second-Hand Smoke (SHS), and Quitting

3.1 Smoking

3.2 Second-Hand Smoke

3.3 Quitting

- **3.3.1 Nicotine Replacement Therapy (NRT)**
- **3.3.2 Myths and Facts about NRT**
- **3.3.3 Prescribing NRT**

3.1 Smoking

Approximately 5% of LTC Home residents smoke. Although the majority of these residents have been smoking for many years, research has shown that smokers aged 65 and older are able to quit smoking and benefit from abstinence. Advising and providing smoking cessation support to LTC Home residents will promote the goal of improving and maintaining health.

3.2 Second-Hand Smoke (SHS)

Second-hand smoke is the smoke that comes from the end of a lit cigarette as well as the smoke exhaled when a cigarette is smoked. Research shows that second-hand smoke contains 4,000 chemicals, of which more than 50 are known to cause cancer. Second-hand smoke ranks third as a major preventable cause of death behind active smoking and alcohol misuse. The purpose of going smoke-free in LTC Homes is to prevent those who live, work or visit in these homes from experiencing the health consequences associated with second-hand smoke. Such consequences include cancer, chronic pulmonary obstructive disease, asthma, delayed wound healing, osteoporosis and cardiovascular disease. Due to their existing health problems, many residents of LTC Homes have an increased susceptibility to the potential consequences of inhaling cigarette smoke.

3.3 Quitting

Residents who smoke should be encouraged to quit. There are many benefits of quitting smoking for the older smoker:

- Within just a few minutes of quitting, blood pressure returns to normal.
- Within a few days the risk of a heart attack starts to decline and breathing becomes easier.
- Within a few weeks circulation improves.
- By one year the risk of a heart attack is cut in half.

Residents who smoke and have already developed smoking-related problems such as heart disease can still look forward to the health gains of quitting smoking. According to Health Canada, smokers who quit smoking after having a heart attack reduce their risk of another heart attack by 50% and also of dying prematurely by 50%. Furthermore, conditions like emphysema and bronchitis can stabilize and improve after quitting smoking.

Quitting smoking is also beneficial for diabetics: diabetic residents who quit smoking are less likely to suffer from serious health effects like heart disease, blindness and stroke.

3.3.1. Nicotine Replacement Therapy

The importance of the use of NRT in a smoke-free facility cannot be underestimated. NRT is one of the key ingredients in making the process of going smoke-free successful. NRT can help to prevent or treat nicotine withdrawal when residents of LTC Homes are unable to smoke as much or as regularly as they normally would (i.e., when it is inconvenient to go outside to smoke). Nicotine withdrawal can be distressing for both residents and staff, as residents may experience symptoms such as stomach upset, irritability and possible behavioral changes. Having NRT readily available (preferably upon admission) to residents who will have their nicotine intake reduced can help prevent such consequences of withdrawal.

About Nicotine and NRT: Is It Safe?

NRT delivers nicotine in a lower dose and in a more controlled and steady manner compared to cigarettes. This can help avoid the "up and down" levels of nicotine that can contribute to withdrawal symptoms. There are currently three types of NRT available: the nicotine patch, gum and inhaler. Note that residents can still smoke while wearing the patch with the goal of reducing cigarette intake. Residents who are prevented from smoking as much as they normally would can still experience withdrawal; NRT can be used to help residents manage cravings and withdrawal "in between" cigarettes.

Signs/Symptoms of Nicotine Withdrawal

It is important for all health care professionals to be able to identify nicotine withdrawal. The following is a list of some of the signs of withdrawal. Typically nicotine withdrawal can occur within a few hours of abstinence from nicotine, peak in one to four days and can last six months or longer.

Immediate Onset	Later Onset
• Cravings to smoke • Frustration • Anger • Anxiety • Difficulty concentrating • Restlessness (Unaccounted for by other mental or physical conditions.)	• Nausea • Diarrhoea/constipation • Shakiness • Dizziness • Appetite changes • Fatigue • Sleep disturbances • Headaches • Clumsiness (Tend to be milder than immediate onset symptoms but can last for six months or longer.)

Signs and Symptoms of Nicotine Overdose

If residents have been started on any form of NRT, it is also important to monitor for signs that they may be receiving too much nicotine. If a resident presents with any of the following symptoms, reassessing their level of nicotine intake may be necessary.

- Nausea and/or vomiting
- Sweating
- Vertigo
- Tremors
- Confusion
- Weakness
- Racing heart
- Light-headedness

If the resident is smoking, he or she should be encouraged to further reduce their intake or the dose of the patch should be reduced. If a resident is not smoking, the current NRT should be discontinued or the dose should be reduced.

Cardiovascular Disease and NRT

NRT has not been shown to increase risk of cardiovascular events. The harmful effects of smoking far outweigh the risk of using NRT. Smoking causes increased blood pressure and heart rate; increased LDL and decreased HDL; and increased risk of arrhythmias and endothelial dysfunction. NRT does not have the same effects and should be offered when residents are unable to quit with behavioural interventions.

Staff Training on NRT

An important part of the smoke-free process is ensuring that staff members receive training about the identification and treatment of nicotine withdrawal—including use of NRT. If possible, a representative of each LTC Home could receive training on the use of NRT by working with residents who smoke. These "champions" could act as a resource to other staff.

3.3.2 Myths and Facts about NRT

The following information was prepared in June 1999 by Nicole de Guia, project manager and researcher, with direction and support from Dr. Ted Boadway, Patricia North, and Carol Jacobson of the Ontario Medical Association (OMA) Health Policy Department, and Michael Perley of the Ontario Campaign for Action on Tobacco. For the full text of the OMA position paper, see: http://www.oma.org/Health/tobacco/stopsmoke.asp

Myth 1

Nicotine is the harmful substance in cigarettes.

Fact:

It is not nicotine, but the thousands of toxins present in tobacco and its combustion products that are responsible for the vast majority of tobacco-caused disease. There are more than 4,000 compounds in tobacco and tobacco smoke and more than 50 of these substances — including benzopyrene, nitrosamines, vinyl chloride, arsenic, chromium and nickel — are known to be cancer-causing. Nicotine has not been shown to cause cancer.

Myth 2

Nicotine's addictive potential is the same regardless of whether nicotine is obtained through nicotine gum, the patch or cigarettes.

Fact:

Cigarettes are far more addictive than nicotine gum or the patch primarily because of the way in which they deliver nicotine. Nicotine is a highly addictive drug, as addictive as cocaine or heroin. Inhalation of nicotine through cigarettes is the most addictive method of nicotine delivery. Because nicotine is absorbed through the lungs, it takes only 10-19 seconds for the drug to reach the brain; faster than injecting nicotine. Nicotine levels in the blood reach a peak within seconds then decline rapidly, and this pattern is repeated and reinforced with every inhalation. The patch delivers nicotine through the skin much more slowly, in lower doses, and more evenly than cigarettes. Because of the rate and route of drug delivery, the nicotine patch has almost no addictive potential. Nicotine is absorbed more rapidly from the gum than from the patch, but more slowly than from cigarettes. Because of the rate and route of drug delivery, the nicotine gum has little addictive potential.

Myth 3

Nicotine replacement therapy is hazardous for smokers.

Fact:

Nicotine replacement therapy is safe for smokers. NRT provides nicotine without all of the dangerous toxins found in cigarettes. NRT is considered a "clean" nicotine delivery system. Additionally, the patch and gum have little to no addictive potential because of their delivery system.

Myth 4

Smoking while on the patch increases the risk of heart attack.

Fact:

Use of NRT while smoking does not increase the smoker's cardiovascular risk. Smokers are already at high risk for cardiovascular events. Smoking causes serious cardiovascular effects such as artherosclerosis, acute myocardial infarction, stroke and sudden death. These health hazards are caused primarily by cigarette combustion components, not nicotine.

Myth 5

Patients with heart disease should not use the nicotine gum or patch.

Fact:

It is more dangerous for patients with heart disease to continue to smoke than to use NRT. Given the seriousness of their medical condition, cardiac patients who cannot quit should be among the first considered for NRT. Cardiac patients who used the patch were not found to have greater rates of death, heart attacks, or cardiac-related hospitalizations compared to those who did not use NRT.

Myth 6

Stop-smoking medications are not effective in helping people quit.

Fact:

NRT and Zyban are effective, government-approved medications available to help smokers. NRT and Zyban have each been found to approximately double quitting rates compared to placebo. Both can help to alleviate withdrawal symptoms resulting from nicotine deprivation.

Myth 7

The nicotine patch and gum should not be used at the same time and/or in combination with Zyban.

Fact:

The nicotine patch and gum may be used at the same time and/or in combination with Zyban. Combining nicotine gum with the patch has been found to provide superior quit rates than those from the gum or patch alone. The combined use of gum and the patch is a convenient therapeutic option as it gives the user a steady intake of nicotine (the patch) that can be supplemented with nicotine gum to respond to momentary urges. For some people, combined use of Zyban with NRT may be an effective strategy, particularly if single therapy is inadequate. Patients using this combination should be closely monitored by their physicians.

Myth 8

NRT should only be taken in recommended doses.

Fact:

Smokers should be in control of how they use NRT and should vary the dose according to their own needs. It takes time to learn how best to use NRT in a manner that maximizes its benefits. Without cigarettes, a smoker may suffer withdrawal symptoms such as depressed mood, irritability, difficulty concentrating and anxiety.

Myth 9

Enforced smoking abstinence during hospitalizations often results in quitting.

Fact:

Enforced smoking abstinence during hospitalizations is unlikely to result in quitting. Smokers should be routinely offered stop-smoking medications prior to or during their hospital stay. Hospitalizations, regardless of the reason, induce a high level of anxiety and stress in both smokers and non-smokers alike. The combination of the two factors compounds stress on the hospitalized smoker. This may lead the smoker to reach for cigarettes at the first available opportunity.

Myth 10
Use of the nicotine patch or gum should not exceed three months.
Fact:
The nicotine patch and gum should be used as long as needed to maintain or prolong tobacco abstinence.

Myth 11
Nicotine gum or the patch should only be used to quit smoking.
Fact:
Nicotine gum or the patch can be used by people who are not yet ready or able to quit since, for some individuals, being tobacco-free is not a foreseeable goal. NRT may help these smokers take a "cigarette holiday" or, in some cases, substantially reduce their smoking as an interim, achievable step toward tobacco abstinence.

3.3.3 Prescribing NRT

Background

Within a few months of beginning to smoke, over 20% of people become physically dependent on the nicotine in cigarettes (DiFranza et al., 2000) (Karp et al., 2005). The half-life of nicotine is about 90 to 120 minutes and most smokers try to maintain nicotine levels. The excess health risks of heart disease, lung disease and cancer are due to the inhalation of tobacco smoke that contains about 4,000 chemicals and more than 50 proven carcinogens (Benowitz, 1999).

Rationale for prescribing NRT to residents

When residents are admitted to LTC Homes where there are no-smoking policies, adjusting to the smoke-free status can be difficult (Rigotti et al., 2000) (Greeman and McClellan, 1991). Inform residents that they will be assisted in dealing with acute nicotine withdrawal, whether or not they chose to quit smoking altogether in the long term (Rigotti et al., 1999). Adequate NRT leads to less aggression associated with nicotine withdrawal (Cherek et al., 1991).

Each cigarette smoked yields one to five milligrams of nicotine, depending on how the cigarette is smoked. Light and mild cigarettes do not reduce the amount of nicotine delivered to smokers and therefore the nicotine numbers posted on the cigarette packs are misleading (Kozlowski and O'Connor, 2002).

Nicotine patch (Fiore, 2000) (Cummings and Hyland, 2005)
- replaces about 50% of the nicotine
- duration of action is 24 hours

Nicotine gum (Cummings and Hyland, 2005)
- replaces about 20 – 25% of the nicotine
- duration of action is about 20 – 120 minutes depending on situational factors

Nicotine inhaler (Cummings and Hyland, 2005)

- replaces about 30 – 40% of the nicotine depending on technique
- duration of action is about 20 –120 minutes depending on situational factors

A resident watching others smoke may be triggered to smoke. Someone who is in a smoke-free environment may be able to go longer without smoking or being triggered to smoke (McClernon and Gilbert, 2004).

The patch is a "sustained release" preparation that creates a steady state, while the gum and inhaler are "immediate release" products used as "breakthrough" or 'rescue" medications on a prn basis (Fagerstrom et al., 1993). For further details on the products, read the product monograph.

Deciding on the dose and type of NRT

(Refer to NRT Decision Tree in Section 2 Resources)

- Residents who smoke 15 or more cigarettes per day (cpd) should be prescribed 21 mg of NRT patch.
- If they smoke between 7 to 14 cpd, start with the 14 mg patch
- Nicotine gum should only be used by those who are able to chew gum (no dentures) and are willing to learn the proper technique since the nicotine has to be absorbed across the buccal mucosa. Swallowed nicotine is metabolized almost completely in the liver (high first pass metabolism).
    - 2 mg: use only in combination with patch as a breakthrough medication (no more than 1 per hour to a total of 15 pieces per day).
    - 4 mg: use every hour to a total of 15 pieces per day, no more than 1 per hour. Can be used alone or in combination with the patch.

If the resident is complaining of withdrawal with 21 mg patch:

- Check compliance and adherence of the patch.
- Add prn 2 mg gum max 1 per hour to the regimen.
- For every 5 to 6 pieces used per day add another 7 mg patch to the regimen. Therefore someone using 15 pieces of gum while using 21 mg of nicotine patch will require another 21 mg of patch to be applied. If effective, the use of prn gum will reduce considerably.

Nicotine inhaler:

- Useful alone or in combination with the patch by those unable or unwilling to chew gum. The advantage is that the hand-to-mouth stimulation continues.
- Remember that the nicotine in the inhaler is also absorbed bucally and not via the lungs as smoke is. Residents should be taught to "puff" the inhaler like a cigar, rather than inhaling like a cigarette.

Addressing smoking while wearing the patch

The amount of nicotine replacement is variable with a transdermal patch and many patients continue to get the urge to smoke while using NRT especially if triggered by the sight, smell and other cues associated with smoking (eating, anxiety, etc.).

- If a resident smokes while using the patch, it is important to know if they had any aversive experiences. If they did, then the strength of the patch is adequate and they should use their prn nicotine more often.

- On the other hand, if the patient states that the cigarette relieved the craving/discomfort without any symptoms of intoxication/overdose, then the dose of NRT is inadequate and a dose increase is justified.

There is no scientific evidence that concurrent smoking while using NRT is a risk factor for an acute myocardial infarction (Benowitz et al., 1984). On the contrary, there is ample evidence of the safety of concurrent smoking while using NRT (Fagerstrom and Hughes, 2002) (Stahl et al., 2001). However, it is prudent not to prescribe NRT for those who have unstable angina or history of an MI in the previous two weeks (Mathew and Herity, 2001).

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APPENDICES

Appendix 1 – Literature Review

Appendix 2 – CCACs and the SFOA

Appendix 3 – Case Studies

Appendix 1

Literature Review

- **Summary**
- **Full Literature Review**

Summary

A literature review was conducted to address staff, resident, family member and administrative concerns regarding the designing and implementing of smoke-free policies in Long-Term Care (LTC) Homes. Below are the some of the main findings; the full literature review follows.

1. Feasibility of Smoke-Free Policy in Homes

- Despite much apprehension on behalf of staff, directors, administrators and family members of residents, smoke-free policies have been implemented in some LTC Homes with little resistance from residents.
- A study conducted by Adler et al. in 1997 found that when smoking was permitted in LTC Homes, there were an increased number of conflicts between residents, and between residents and staff.
- Non-smoking residents, who choose to avoid smoke exposure, complain about being excluded from Designated Smoking Rooms—areas of potential socializing and activity (Adler et al., 1997).
- The removal of Designated Smoking Rooms evens the playing field (Kochersberger, 1996).
- When smoke-free policies were in place, service providers not only faced minimal opposition from the elderly but also experienced increased participation in activities (Bergman and Falit, 1997).

2. Quitting Among Residents

- Bergman and Falit (1997) found that residents who smoke tend to be open-minded about quitting, often found to respond "yes" when asked if they had previously thought about quitting smoking, and acknowledged that with the proper supports in place, they would attempt to quit.
- Elderly people who smoke and are motivated to quit are more likely to experience successful attempts than younger smokers (Bergman and Falit, 1997).
- Studies have demonstrated that older people who smoke are highly responsive to cessation programs and are equally or more likely to succeed in quitting (using a variety of evidence-based approaches) than younger people who smoke (Ossip-Klein et al., 1999).
- Also, research has shown that it is never too late to quit smoking. There are substantial health benefits to gain for the elderly who quit (Hirsch, 1999).
- Cessation can reduce the overall risk of death and disability among this population; it has been shown that older former smokers have lower overall mortality, less risk of cardiovascular (CV) disease, myocardial infarction (MI), lung and other cancers, and better functioning lungs and physical body than people who continue to smoke (Ossip-Klein et al., 1999).

3. Residents with Psychiatric Disorder

- Carosella et al. (1999) specifically found that the prevalence of smoking was heightened (78%) in LTC Homes serving a large proportion of residents with psychiatric disorders.

- The investigators found that this core group of residents was less likely than the general population to believe in the risks of smoking and the benefits of cessation (Carosella et al., 1999).

- Approximately 93% of people who smoke in the general population agree that smoking affects health negatively and quitting improves health; only 68% of psychiatric LTC Home residents who smoke agree with these statements (Carosella et al., 1999).

4. Resident Education

- Carosella and colleagues concluded that only 50% of people who smoke and 56% of people who don't smoke were generally informed about the dangers of SHS exposure (Carosella et al., 2002).

- Carosella et al. (2002) found that the majority of elderly nursing home residents were pre-contemplators. That is, their behaviour and motives indicated that they had not contemplated quitting smoking.

- In the general elderly population, those who strongly believe that smoking increases the risk of developing lung cancer and heart disease were much more likely to be non-smokers or former smokers than current smokers (Hirsch, 1999). This implies a lack of awareness among smokers.

- In Carosella's study, only 50% of the residents who smoked reported that they had received cessation advice from doctors or nurses.

- They also reported that there were no education or cessation-based programs available in the home (Carosella et al., 2002). A similar finding by Bergman and Falit (2004) indicated that only 42% of LTC facilities provided education about the harms of smoking and only 11% offered cessation programs.

- This signifies a definite lack of and need for education, intervention and cessation programs that not only raise awareness about the harms of smoking and the benefits of quitting, but that counsel, motivate and provide the resources to help elderly smokers quit.

5. Barriers to Quitting for Residents

- It has been shown that the greatest barrier to smoking cessation is simply the pleasure that people who smoke receive from smoking. Carosella et al. (1999) found that 47% of their subjects had not contemplated quitting smoking due to the enjoyment they experienced from the activity.

- In this study, 12% of smokers claimed to smoke out of boredom, and 11% smoked due to anxiety (Carosella et al., 1999).

6. Key Recommendations

- Enable and promote communication.
- Acquire multidisciplinary support.
- Remove triggers to smoke.
- Encourage cutting down and cessation.
- Ensure effective monitoring and enforcement.

Smoke-Free Long-Term Care Homes Literature Review

Introduction

Scientific evidence has established an indisputable link between exposure to second-hand smoke (SHS) and serious health consequences. Numerous studies and six internationally recognized reviews of the literature on the health effects of SHS have concluded that exposure to SHS directly causes heart disease, lung cancer, nasal sinus cancer, sudden infant death syndrome (SIDS), respiratory diseases such as asthma, and middle ear infections in children. Exposure to SHS has also been linked to other adverse health effects including cerebrovascular disease and stroke, breast cancer and cervical cancer. As there is no safe exposure level to SHS, all involuntary exposure to tobacco smoke should be considered harmful and therefore eliminated.

In Ontario, it is estimated that SHS exposure causes more than 425 deaths per year, not including workplace exposure. Consequently, the government of Ontario introduced *Bill 164: The Tobacco Control Statute Law Amendment Act*, which replaces the former *Tobacco Control Act* with the *Smoke-Free Ontario Act (SFOA)*. This aggressive tobacco control strategy focuses on protection, cessation and enforcement. A primary objective of this legislation is to protect those inadvertently exposed to SHS. As such, the SFOA broadly prohibits smoking in all enclosed work and public places.

The Smoke-Free Ontario Act and Long-Term Care Homes

Long-Term Care (LTC) Homes are workplaces similar to any other, and despite the former tendency to exclude them from smoke-free legislation, the need to protect individuals from SHS prevails. Research has proven that older adults with health problems are at an increased risk of the health dangers of smoking if they smoke actively or passively (through SHS exposure) (Watt et al., 2004). The Smoke-Free Ontario Act that came into effect on May 31, 2006, provided the driving force for LTC Homes across Ontario to transition to a smoke-free environment. To ensure the safety and health of its residents, staff and visitors, LTC Homes are in the process of making several changes and adaptations related to implementing smoke-free policies. This includes the closing of Designated Smoking Rooms.

Search Strategy for Smoke-Free Long-Term Care Homes

The following databases were searched in July 2005 and May 2006: MEDLINE (1990-2006); Web of Science (1990-2006); EMBASE (1980-2006); PolicyFile (1990-2005); Proquest Digital Dissertations (1990-2005); CDC Smoking and Health Database (1990-2006); Ontario Tobacco Research Unit Library (1990-2005); Cochrane Library Database (1990-2006).

The search strategy used terms such as:

- smoking OR smoking cessation
- smoke-free OR No-Smoking
- health policy OR hospital policy OR policy
- long term care home OR long term care facility OR nursing home
- elderly OR elders OR aging OR age OR older
- psychiatric illness OR cognitive impairment OR Alzheimer's disease OR dementia.

Some articles were drawn from the reference lists of retrieved articles and some unpublished empirical studies were referenced through an Internet search. Only studies published in English were included.

Design and Outcome Measures

The literature review yielded 18 studies, of which six investigated smoking behaviours and cessation in the elderly (Bergman, Hirsch, Honda, Kviz, Ossip-Klein, Schroeder), and five investigated smoke-free policies in LTC Homes and similar facilities (Adler, Bergman, Hartz, Kochersberger, Wolfsen). The remaining studies investigated smoking knowledge, behaviour, beliefs and cessation among LTC Home residents and staff, nurse-managed cessation interventions, and smoking among elderly psychiatric LTC patients and patients with Alzheimer's disease (AD) (Carosella 1999, Carosella 2002, Hartz, Kochersberger, Sabbagh, Smith, Watt, White, Wolfsen). Some studies fell into more than one category. These 18 studies were examined and summarized in this review to provide a broad perspective on smoking and smoking cessation in Long-Term Care Homes.

Smoking behaviours and beliefs as well as the impact of smoke-free policies in LTC Homes were evaluated through written and telephone surveys, structured interviews and questionnaires, chart reviews, the analysis of nursing records, and documented observation.

Pre-Implementation Concerns

In implementing policy, it is crucial to address any concerns voiced. Typical concerns voiced by staff when designing smoke-free policies in LTC Homes include: 1) the infringement of resident rights, 2) residents' non-compliance leading to unsafe smoking indoors, 3) expected lack of health benefits to those who quit smoking at an old age, 4) nicotine withdrawal and its effects, 5) inexperience of staff in helping residents cope with withdrawal symptoms, 6) the expectation by staff that residents will be unable to tolerate a smoking ban without consequences (i.e., stress, boredom, irritability and behavioural changes), and 7) expected resistance from residents and family members (Adler, Kochersberger, Watt).

Studies revealed that staff members of LTC Homes, primarily nurses, were concerned with the notion of residents being "forced" to quit smoking. Since the majority of LTC Home residents have limited mobility and/or cognitive impairments that prevent them from being able to smoke independently, this group of residents will have no other choice but to quit smoking once the policy is implemented. Nursing staff believed that residents were not interested in quitting smoking, they sympathized and claimed that they did not wish to prevent residents from smoking in their own "home" (Watt). They worried that residents would begin to question their autonomy if they were forced to sacrifice one of their "last remaining pleasures and choices" in life (Adler).

Nursing staff also believed that "residents would be harder to manage if they were not permitted to smoke" (Watt). Staff were concerned that residents would experience nicotine withdrawal symptoms and that without proper cessation and Nicotine Replacement Therapy (NRT) training, as well as resources, they would be ill equipped to handle these symptoms. For these reasons, nursing staff have been less favorable to advising older smokers in LTC Homes to quit smoking, and advocating smoke-free policy.

Thus, to gain multidisciplinary support, it is important to design and implement a policy that takes into

account all of these concerns, and closely incorporates the ideas and feedback of residents, family members, staff, health care providers, administrators and directors. It is equally important to keep in mind and stress to others the primary purpose of a smoke-free policy—to prevent exposure to SHS. Due to the high level of care required by LTC residents, the majority of smokers require the help of nurses' aides and other staff. These workers have been frequently and unavoidably exposed to SHS on a daily basis.

Results: The Feasibility of Smoke-Free Long-Term Care Homes

Despite much trepidation on behalf of staff, directors, administrators and family members of residents, smoke-free policies have been implemented in some LTC Homes with little resistance from residents. A study conducted by Adler et al. in 1997 found that when smoking was permitted in LTC Homes, there were an increased number of conflicts between residents, and between residents and staff (Adler, 1997). When smoking is permitted, residents who smoke often complain about lack of appropriate space to smoke. Non-smoking residents, who choose to avoid smoke exposure, complain about being excluded from Designated Smoking Rooms – areas of potential socializing and activity (Adler, 1997). The removal of Designated Smoking Rooms evens the playing field (Kochersberger, 1996). Bergman and Falit, who investigated the extent of and reason for smoke-free policies in elderly facilities, found that when smoke-free policies were in place, service providers not only faced minimal opposition from the elderly but also experienced increased participation in activities (Bergman and Falit, 1997).

Furthermore, it is been found that residents who smoke tend to be open-minded about quitting. Residents were often found to respond "yes" when asked if they had previously thought about quitting smoking. Residents have acknowledged that with the proper supports in place, they would attempt to quit (Bergman and Falit, 1997). It has also been found that elderly smokers who are motivated to quit are more likely to experience successful attempts than younger smokers (Bergman, 1997). Ossip-Klein wrote a letter to the editor of *Nicotine and Tobacco Research,* underscoring the importance of smoking cessation in adults. She disputed the myth that the elderly are unable to quit smoking, claiming that studies have demonstrated that older smokers are highly responsive to cessation programs and are equally or more likely to succeed in quitting (using a variety of evidence-based approaches) than younger smokers (Ossip-Klein).

Also, research has proven that it is never too late to quit smoking. There are substantial health benefits to gain for the elderly who quit (Hirsch, 1999). Cessation can reduce the overall risk of death and disability among this population (Ossip-Klein et al., 1999). It has been shown that older former smokers have lower overall mortality, less risk of cardiovascular (CV) disease, myocardial infarction (MI), lung and other cancers, and better functioning lungs and physical body than continuing smokers (Ossip-Klein). Thus, there are proven benefits of implementing smoke-free policies in LTC Homes.

Behaviours, Beliefs and Barriers to Smoking Cessation

Education and counselling are integral to changing attitudes and behaviours surrounding smoking. Carosella et al. specifically found that the prevalence of smoking was heightened (78%) in LTC Homes serving a large proportion of residents with psychiatric disorders (Carosella et al., 1999). The investigators found that this core group of residents was less likely than the general population to believe in the risks of smoking and the benefits of cessation (Carosella et al., 1999). While approximately 93% of smokers in the general population agree that smoking affects health negatively and quitting improves health, only 68% of psychiatric LTC Home

residents who smoke agree with these statements (Carosella et al., 1999). Carosella and colleagues conducted a follow-up study in 2002, which investigated the attitudes, behaviours and knowledge about smoking among elderly nursing home residents. They concluded that only 50% of smokers and 56% of non-smokers were generally informed about the dangers of SHS exposure (Carosella et al., 2002).

Carosella et al. (2002) found that the majority of elderly nursing home residents were pre-contemplators. That is, their behaviour and motives indicated that they had not contemplated quitting smoking. In the general elderly population, those who strongly believe that smoking increases risk of developing lung cancer and heart disease were much more likely to be non-smokers or former smokers than current smokers (Hirsch, 1999). This implies a lack of awareness among smokers. Furthermore, in Carosella's study, only 50% of the residents who smoked reported that they had received cessation advice from doctors or nurses. They also reported that there were no education or cessation-based programs available in the home (Carosella et al., 2002). A similar finding by Bergman and Falit (2004) indicated that only 42% of elderly facilities provided education about the harms of smoking and only 11% offered cessation programs (Bergman). This signifies a definite lack and need for education, intervention and cessation programs that not only raise awareness about the harms of smoking and the benefits of quitting, but that counsel, motivate and provide the resources to help elderly smokers quit.

Given that nurses are so integrally involved in the care of LTC residents, their involvement in smoking intervention programs and provision of advice is crucial. However, it has been shown that, in general, nurses tend to view advice-giving and counselling as the responsibility of the doctor (MD) (Kviz, 1999). In a study conducted by Kviz et al. in 1999, MDs reported a seven to eight times higher performance of smoking cessation practices than registered nurses (RN) (Kviz). Also, both MDs and RNs were much more frequent in asking patients about whether or not they smoked than they were in advising, assisting and/or arranging for smoking cessation interventions or follow-up (Kviz). Schroeder et al. found that simple provision of advice by a health care practitioner was the most beneficial method of smoking intervention among elderly women (Schroeder).

Thus, it can be seen that in treating elderly patients, doctors and nurses should not only ask whether the patient smokes, but provide advice on smoking behaviour and how to quit. A more active smoking intervention approach is required. Smith et al. conducted a study to determine the effectiveness of a nurse-managed smoking cessation program for general hospitalized patients. Those who were eligible were offered this program free of charge (Smith). The nurses provided education, behaviour modification (stages of change) and counselling at the bedside. Patients were provided with take-home materials. Doctors were prompted to ask patients about their smoking habits and to encourage quitting. Also, patients who experienced severe withdrawal symptoms were offered NRT before discharge. The investigators found that 49% of smokers who enrolled in the study quit smoking at the one-year follow-up point (Smith). Nurses have the added benefit of increased points of contact with elderly residents in an LTC Home and so should view provision of advice and counselling as part of everyday work duties. This may require specialized training and educational workshops for nursing staff.

The first step to assisting residents overcome their addiction is gaining an understanding of the barriers they might face. It has been shown that the greatest barrier to smoking cessation is simply the pleasure smokers receive from smoking. Carosella et al. (1999) found that 47% of their subjects had not contemplated quitting smoking due to the mere enjoyment they experienced from the activity. In this study, 12% of smokers claimed to smoke out of boredom, and 11% smoked due to anxiety (Carosella et al., 1999). Honda's 2005 study reported that current smokers were much more likely than formers smokers to experience psychological distress (Honda, 2005). This correlation between smoking and anxiety should be taken into account when designing cessation

and intervention programs. These programs should also focus on suggesting or providing fun activities for residents to alleviate any boredom.

Smoking and Alzheimer's disease (AD)

Individuals are living longer now than ever before. However, along with longevity comes a host of diseases causing dementia. Approximately 65% of LTC Home residents have some form of mental disorder including AD and resulting dementia. Although more research is required to conclude significant findings relating smoking and AD, the research that is available points in the direction of smoking behaviour being harmful to AD. Sabbagh et al. conducted a prospective longitudinal study in 2005 to examine the effects of smoking on individuals with AD. It was found that those who smoked actively at the onset of AD suffered an altered clinical course and earlier age at death (Sabbagh). It was also found that if an individual ceases to smoke prior to the onset of AD, previous smoking behaviour has no effect on the onset, duration and outcome of the disease (Sabbagh). This finding has implications for the potential health benefits of smoking cessation among the elderly who are genetically at risk for AD.

Furthermore, investigators White et al. examined the effects of NRT on patients with AD in 1998. They found that use of the nicotine patch by AD patients could significantly improve attention span as measured by the Conner's continuous performance test (CPT) (White). More research is required to confirm these findings, as they suggest a potentially successful method of alleviating cognitive impairment among AD patients and added benefit of NRT for smokers with AD.

Key Recommendations

Much has been learned in the process of implementing smoke-free policies within Long-Term Care Homes. The key recommendations extracted from the reviewed literature reflect a number of important themes:

- Enable and promote communication
- Acquire multidisciplinary support
- Remove triggers to smoke
- Encourage cutting down and cessation
- Ensure effective monitoring and enforcement

Enable and Promote Communication

The majority of studies emphasized allocating significant time prior to policy implementation in order to communicate and dialogue with staff and residents. Potential residents should be made aware of the home's smoking policy prior to admission and again upon entry (Adler). Providing the opportunity for staff to air grievances and for patients to express their concerns vocally or through written submissions to hospital administration was identified as particularly important. Additional ways to promote the exchange of information included holding community meetings, posting signage prior to and during implementation, and running a smoke-free educational campaign to inform patients, family and staff on the harm of second-hand smoke. To address pre-existing staff concerns and dispel the belief that acting-out behaviour increases in the patient population after a ban on smoking, one study provided continuous updates on a number of behavioural outcome measures to overseeing staff during the process of implementation.

Acquire Multidisciplinary Support

It is important to understand that LTC Homes are a unique group under the umbrella of health care providers. They provide a permanent residence and constant care for their clientele, who are residents rather than patients. The majority of residents have cognitive impairments, cannot make their own autonomous decisions, and rely on family members and physicians to assist them in making health-related decisions. They also rely on staff, such as nurses, to facilitate their everyday activities. For these reasons, designing and implementing smoke-free policies in LTC Homes should involve residents and their family members, nursing staff, health care providers, social workers and administrative directors.

For implementation to proceed as smoothly as possible, a number of studies recommended taking a multidisciplinary approach to policy design and implementation. This included encouraging active involvement of various parties such as administrative staff, nurses, doctors, other care-giving staff, and residents and their families and friends in the policy design and implemention processes (Adler, Kviz, Watt, Wolfsen).

One study recommended that social workers work on behalf of residents with administrators to address smoking policies (Adler). The policy should be held consistent for everyone, including residents, staff and visitors in order to ensure compliance and avoid the smuggling in of tobacco products (Adler, Hartz). Family members should be actively involved in the process to provide support and prevent relapse (Schroeder, Wolfsen). This study also recommended that any decision-making regarding alteration to the policy should involve administration, residents, family, staff and an ethics committee; the decision-making team should consist of smokers and non-smokers to ensure an unbiased decision (Adler). There should be active campaigning for policy consistency between staff and residents (Adler) with staff encouraging the active involvement of patients and their families in implementation and evaluation to ensure compliance and avoid the smuggling in of tobacco products.

Beemer (1992) described a process of implementation with a great deal of procedural and jurisdictional wrangling. To ensure individual staff and patients had somewhere to air their grievances and consolidate communication and action, nurses from all units established a policy committee. The nurses then liaised with administrative members ensuring that all voices were heard and no one was left out.

This kind of team approach is also a component of effective surveillance and disciplining of patients for surreptitious smoking. Hoffman (1992), for example, developed a range of sanctions for patients who broke regulations. The options were developed as a policy by the treatment team and communicated to the patients upon admission. Regular staff meetings were instigated to ensure all staff members participated in informing patients and families of the rules and in disciplining patients when they broke policy.

Remove Triggers to Smoke

Studies evaluating the impact of partial smoking bans conclude that this approach to a smoke-free policy does not work. Hartz et al. (2004) conducted a study to examine the effects of and differences between partial smoking bans on some units of a geropsychiatric nursing home and full smoking bans on other units (Hartz, 2004). The investigators found that on units with a partial ban, restricting smoking for some residents (unsafe smokers) while allowing others to continue smoking (independent smokers) led some residents to perceive that others were receiving special treatment (Hartz, 2004). Increased agitation and non-compliance among restricted smokers on these units was seen (Hartz, 2004).

It is difficult to control surreptitious smoking in an environment where smoking is conditionally accepted. Hartz reported an increase in surreptitious smoking among both staff and residents immediately following the implementation of a partial smoking ban on their unit. Safe smokers began smuggling cigarettes into the

nursing home to sell to unsafe smokers. For these reasons, the particular nursing home under investigation became completely smoke-free (Hartz, 2004).

Downey et al. (1998) investigated the effects of a differential smoking ban in an inpatient psychiatric unit, and noted that when smokers were placed in a partially restricted environment where others were allowed to smoke, their motivation to quit smoking decreased. A complete smoking ban was proposed to be more effective as these environments enhance a patient's motivation to quit Downey et al. further recommend supplying NRT products and instructions for their use in the context of a complete ban as this "may be a better method of dealing with the competing needs of hospitalized smokers and nonsmokers and more likely to promote interest in cessation."

Designated Smoking Rooms and the sight and smell of cigarette smoke serve as social cues for smoking, provoking relapse in smokers attempting to quit (Hartz, 2004). It is important to enforce a smoking ban that removes all triggers to smoke (Carosella et al., 1999). To further enhance smokers' motivation to progress through the quitting process, it was recommended that smoking rooms be renovated post-ban so that no reminders of tobacco use, such as ashtrays, butts, stale smoke or cigarette damage, remain and thus trigger a desire to smoke (Adler, Bergman, Hartz).

Encourage Cutting Down and Cessation

It was recognized that LTC Homes should actively encourage residents to end their nicotine addiction (Adler) and staff should be supportive and encouraging of residents' attempts to quit (Honda). Providing additional resources for cessation was considered essential in the successful implementation of a no-smoking policy. Resources cited include NRT, such as a nicotine transdermal patch and nicotine replacement gum (Adler). However not all staff or clinicians will be familiar with NRT products, their use, or how to prescribe them. Consequently additional resources in the form of time and money need to be allocated to the ongoing training of staff and clinicians (Carosella et al., 1999). Nurses need to be trained to recognize the physiological aspects of withdrawal in order to distinguish them from psychological anxiety.

Smith et al. (2002) developed a nurse case-managed cessation program for hospitalized patients. This program was proven as effective and recommended for any health care facility (Smith). It was relatively simple to deliver and inexpensive, included standardization protocols for health care professionals, portability, program content, counselling scripts, patient educational materials and training (Smith).

Staff members may also use the no-smoking policy as an opportunity to quit, and as such may need treatment and therapy options (Bergman). Research suggests that the implementation of smoke-free policies is a trigger for smokers (both residents and staff) to attempt quitting, so this presents as the ideal time to initiate and make cessation programs available to both residents *and* staff.

Pre-implementation cessation workshops and clinics are recommended for LTC Homes. It is essential to provide residents with educational materials on quitting, and group as well as individual counselling (Adler). Bergman's study recommends refraining from the sole use of passive health education such as pamphlets and brochures. Speakers or more interactive methods should be considered in order to effectively educate on risks of tobacco use. Furthermore, it has been found effective to provide residents with cessation and education programs that are targeted at the elderly, rather than generic programs (Carosella et al., Wolfsen). These programs should incorporate stimulating activities to address stress management, alleviate boredom and facilitate social interaction (Wolfsen). The coordinators of such programs should be especially attentive to the unique obstacles facing residents who smoke (i.e., cognitive impairment, disability, dependability, etc.).

Social workers should take a proactive approach to ensure these resources and tools are available to residents (Adler).

Ensure Effective Monitoring and Enforcement

A no-smoking policy will not be effective without ongoing monitoring and consistent enforcement. A protocol to address non-compliance should be designed as part of the initial policy and the consequences for policy violations clearly established and communicated to all. For example, it has been demonstrated that without firm enforcement, residents will continue to smoke wherever they please (Wolfsen). Wolfsen et al. (2002) discovered that when a no-smoking policy was in place in an LTC Home, residents continued to smoke in non-designated areas because staff members neglected to discourage it (Wolfsen). At times, staff who smoked would even join residents to smoke in non-designated areas in secluded locations so as not to be seen by directors/administrators (Wolfsen). Thus, the policy should be enforced equally among staff and residents.

However, despite the need for strict rules, importance should also be placed on enforcing a no-smoking policy in a non-punitive fashion (Wolfsen). The reason for this is to prevent residents of an LTC Home from feeling as if they are being aggressively prohibited from smoking in their own "home." There may be greater compliance and fewer complications if residents understand that their autonomy is respected and that there are other options available (i.e., cessation counselling, NRT, smoke outside). The method in which the no-smoking policy is enforced is key to acceptance. If residents who smoke are encouraged to *live a healthier lifestyle* rather than forced to *put an end to a lifelong pleasurable habit*, their value of the policy will most likely change. Although the smoke-free policy should be consistently enforced for residents and staff, it should not be done so in a domineering fashion. Enforcement through education and raising awareness may be best.

Conclusions

Surveying the available literature suggests LTC Home staff and administration have much to be encouraged about regarding the success of a transition to a smoke-free environment. While some negative consequences should be expected and anticipated, these can be mitigated by an implementation process that includes measures to enable sufficient communication between residents, family members, and staff, and the development of multidisciplinary support among all interested parties. It is crucial to take into account the unique requirements and restrictions of residents, and to tailor all intervention programs to meet these needs. Once the policy is in place, it is extremely helpful to remove triggers to smoke such as smoking rooms and other tobacco paraphernalia, and to reinforce the smoke-free status of the institution by encouraging cessation in both staff and residents. Lastly, to ensure that the policy is adhered to, effective monitoring and enforcement procedures must be implemented so that incidences of surreptitious smoking are noted and dealt with in a consistent manner.

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Appendix 2

Community Care Access Centres and the SFOA

- **Fact Sheet**

FACT SHEET

Community Care Access Centres and the *Smoke-Free Ontario Act*

Information to applicants for admission to a long-term care home

As the placement co-ordinator for LTC Homes, CCACs are aware of their unique role in providing information to applicants about LTC Homes, including information about smoking policies and cessation programs that may benefit an applicant who smokes. CCACs are prepared to provide information to applicants about the new *Smoke-Free Ontario Act* (SFOA) and its implications. The CCACs will work with applicants, their families and LTC Homes to ensure that CCACs have provided all essential information. All LTC Homes have been requested to advise their local CCAC of the availability of a Controlled Smoking Area (CSA) and the policies on smoking, to enable the CCAC to assist clients in making an informed choice.

Explaining the options available to smokers under the *Smoke-Free Ontario Act*

CCACs should advise applicants to LTC Homes about the options they now have under the new legislation.

1. Smoking Indoors

Applicants who smoke and residents who wish to continue smoking *indoors* may choose to be placed on a waiting list for a home that will comply with the requirements for a CSA as defined under the SFOA and O. Reg 48/06.

These persons will need to be assessed by the LTC Home as to their physical ability to smoke safely without assistance. The legislation requires that a resident who wishes to smoke in a CSA must be able to do so safely without assistance from LTC Home employees. Employees are not required to enter a smoking area. Although the CCAC will likely have an idea about the applicant's ability to smoke independently from the application process and counselling prior to placement and will provide this information to the LTC Home, the LTC Home is responsible for assessing the applicant's ability to smoke safely without assistance. The CCAC would advise the client prior to admission that the client will be assessed by the LTC Home at the time of admission.

2. Smoking Outdoors

Applicants and residents who smoke may be able to smoke outdoors. If a resident wishes to smoke outside, the resident may do so, provided the individual is no closer than nine metres to the entrance or exit of an LTC Home. The resident may also smoke in a smoking shelter located no closer than nine metres from an entrance or exit of an LTC Home.

As a regular practice, residents are assessed at the time of registration by the LTC Home as to their physical ability to go outside the home for whatever purpose. The LTC Home should provide assistance to any resident wishing to go outside as part of their plan of care. In relation to smoking, staff would not be required to take the resident to the outdoor smoking area or provide any assistance to a resident who wanted to smoke once

outside. The LTC Home would not be required to provide assistance to a resident to go to another location on the property if it were determined that the resident were unsafe in that location.

3. Smoking Cessation

CCACs should advise applicants that if they are interested in reducing or quitting smoking, the LTC Home can provide support. Applicants should be advised that LTC Homes receiving smokers will likely engage the resident in discussions/counselling about smoking cessation. Residents may choose to participate in a smoking cessation program or nicotine replacement therapy. The choice to participate, or not, in cessation programs always remains a personal decision of the resident, if the resident is capable of making the decision. These programs will be offered by the home and must be explained clearly to residents and family members so that they can make an informed decision.

If the resident is not capable of making the decision, the resident's lawfully authorized substitute decision-maker with the authority to make treatment decisions may provide consent.

CCACs can further explain that applicants who smoke may wish to begin a cessation program prior to admission as a resident. Resources are available and the applicant may wish to discuss a goal of cessation with family and physician. There is also help provided by the Centre for Addiction and Mental Health (CAMH), Smokers' Helpline (1-877-513-5333) or Smokers' Helpline Online (www.smokershelpline.ca). Smokers can also visit the website of their local public health unit for a list of resources: http://www.health.gov.on.ca/english/public/contact/phu/phuloc_mn.html.

CCACs will provide applicants who are smokers with the information referred to above. CCACs will also document the provision of information to applicants and the applicant's response in the client record.

Appendix 3

Case Studies

- **Finlandia Nursing Home, Sudbury ON**
- **Lee Manor Nursing Home, Owen Sound ON**
- **Riverview Gardens, Chatham ON**
- **Sunnyside Home, Kitchener ON**

SUCCESS STORIES:

Finlandia Nursing Home
Sudbury ON

Background
In conjunction with Sudbury's 2003 Smoke-Free Bylaw, Finlandia Nursing Home administrators and directors decided to make their LTC Home smoke-free. They decided to also include the grounds in their smoke-free policy, with the exception of a smoking hut that was built to accommodate staff. The smoking hut will now be removed, as it does not meet the current standards under the new Smoke-Free Ontario Act. The new plans for the hut include cleaning and possibly offering it as a place of activity for residents.

Implementation
Before the policy, only eight out of 110 of the residents smoked (~7%). Nursing and other staff were responsible for storing and distributing the residents' cigarettes to prevent residents from "lighting up" unsupervised and in non-designated areas. To prepare residents who smoked for the upcoming change, letters were sent to family members of residents informing them that the smoking room would be closed. The administrators and directors took care to inform the Community Care Access Center (CCAC) to carefully advise potential residents of the no-smoking policy in effect, and that the grounds are also smoke-free. Staff were encouraged to quit as well.

Resident Reaction
There was not a great deal of resistance from residents who smoked or their family members (families were quite supportive of the new policy). Residents agreed to gradually reduce the number of cigarettes they smoked each day until they stopped smoking altogether (they previously engaged in little smoking to begin with).

NRT
Due to this gradual transition, the staff did not observe withdrawal symptoms in the residents, and there was no need for cessation programs or nicotine replacement therapy (NRT).

Non-compliance
One act of non-compliance was experienced: a man who was slightly defiant toward the policy took cigarettes from his son's car during a visit. He later lit and smoked the cigarettes in one of the home's lounges. Staff members stopped him, and his cigarettes were confiscated (residents are not permitted to keep/store their own cigarettes). No other incident has been observed.

Overall Success
After implementation of the policy in 2003, the home noted a drastic reduction in the number of individuals who smoked (residents and staff). One resident who continues to smoke has a private caregiver come in each day to take her outside to smoke. The other residents who smoked are too frail to go outdoors and have quit smoking altogether.

SUCCESS STORIES:

Lee Manor Nursing Home
Owen Sound ON

Background
With the passing of a 2003 bylaw, Lee Manor Nursing Home started implementing a smoke-free strategy. The home advised everyone that they would be required to use the smoking areas outside. At that time the home had about nine smokers.

Resident Response
A couple of residents who smoked were able to quit on their own. Cessation programs were also offered to those who wanted to quit.

Overall Success
Since then the home continues to enforce the rules with the remaining smokers. Those who can smoke safely and independently go outside to smoke, nine metres from the building, in both summer and winter. The home currently has four off-and-on smokers who frequent the smoking area in good weather. Three of these four smokers seem to be able to stop smoking during winter. The home is clear about its policy with people on tours and during orientation. Applicants have been turned down if they acknowledge that they do not intend to adhere to the policy.

SUCCESS STORIES:

Thamesview Lodge, Victoria Residence and Riverview Gardens Chatham ON

Background

A bylaw was passed in Chatham in 2003 requiring Thamesview Lodge and Victoria Residence to go smoke-free. Of about 320 residents altogether, approximately 40 smoked (~13%). Prior to the 2003 bylaw, both homes had Designated Smoking Rooms (DSRs).

(Later, Riverview Gardens opened and the residents from Thamesview Lodge and Victoria Residence were transferred to this new smoke-free LTC Home.)

Implementation

Thamesview Lodge and Victoria Residence held resident and family meetings with local public health unit staff providing information on NRT and smoking cessation methods.

The homes built outdoor smoking shelters that complied with the requirements of the bylaw. These were wooden shelters, with security and emergency measures in place such as a call bell alarm, fire blankets, fire extinguishers, aprons, etc. The home consulted with the local fire department prior to building the shelters. Staff members and administrators displayed pictures of the shelters for residents who smoked, so they were prepared for the change in atmosphere. All cigarettes and lighters were to be stored at nursing stations to prevent residents from smoking in undesignated and unsafe areas.

Student assistants were recruited during the months of June to September to assist residents to go outside to smoke. Residents enjoyed knowing that they would have the opportunity to go outside to smoke, even if it was not on their own schedule.

Resident Response

After being provided with the cessation support, including NRT, at least 10 smokers attempted to quit smoking and a few were successful.

Nicotine Replacement Therapy

These LTC Homes offered the patch free of charge for the first three months.

Non-compliance

There were only two occurrences of smoking in washrooms after the policy was implemented.

Family Reaction

Most of the families were supportive because of all of the support and assistance the home and its staff were providing. Family members' earlier fears were alleviated once the smoke-free policy was implemented and they saw how it worked.

SUCCESS STORIES:

Sunnyside Home
Kitchener ON

Background
Over the last four years the home has had up to 37 residents who smoked out of about 255 residents at a time. A lot of resources were being spent helping these residents to smoke. Prior to May 31, 2006, Sunnyside had indoor smoking rooms and outdoor smoking. Complaints were made by non-smoking residents in the vicinity of the smoking rooms, because of the level of smoke exposure/irritations to themselves and their visitors. On May 31, 2006, Sunnyside closed all indoor smoking rooms and went smoke-free indoors. Residents who are assessed as safe smokers by the Registered Nurse are allowed to smoke outdoors at designated areas. All cigarettes and lighting materials are now kept by staff. At the time of implementation, the home had approximately 17 residents who smoked.

Implementation
The implementation process occurred over the span of approximately three months. During the implementation phase, smoking rooms were left open but residents were notified of the upcoming closure. Notices were posted advising residents about the upcoming smoking policy changes and letters were sent to family members and legal guardians regarding the new non-smoking policy

Resident and Family Reaction
There was little reaction and no resistance from residents and family. The underlying tone was relief about the new non-smoking policy from family and non-smoking residents.

Staff Reaction
Some staff members were initially concerned about not being able to assist those residents who smoked but couldn't do so independently. However, these staff members soon recognized the rationale for going smoke-free and for not having staff assisting residents to smoke.

Non-Compliance
There have been no incidents of non-compliance to date.

Nicotine Replacement Therapy
None was offered, as the current list of residents who smoke are able to go outside unassisted to do so.

Currently
The home is operating its new non-smoking policy with little trouble. All smokers are going outside to smoke. The home is in the process of getting a smoking shelter built for the winter.