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How Mental Health Nurses' Perceive their Role with Respect to Patients' Smoking Behaviors

by

Debra Scharf

A thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of

Master of Nursing

Faculty of Nursing

Edmonton, Alberta
Fall 2008

Your file Votre référence
ISBN: 978-0-494-47175-3
Our file Notre référence
ISBN: 978-0-494-47175-3

Abstract

Historically nurses in mental health settings have accepted their patients' heavy smoking. Recently smoking bans were introduced in psychiatric units in the Capital Health Region of Northern Alberta. A gap found in the literature review was little knowledge regarding mental health nurses' current roles in relation to patients' smoking behaviors. An interpretive inquiry approach was used to explore how mental health nurses perceived their roles with respect to patients' smoking. Data from individual interviews with 12 participants were analyzed and reduced into two sets of categories. Several themes emerged that described nurses' roles and experiences in respect to their patients' smoking. The findings suggest nurses are frustrated with their roles in relation to patients' smoking and are experiencing conflict between health promotion and the rights of patients to make their own decisions. Some nurses were not adequately prepared to integrate smoking cessation interventions into practice which contributed to the conflict.

Acknowledgements

It is a pleasure to thank those individuals who made this thesis possible.

First, I would like to express heartfelt gratitude to my supervisor, Dr. Anne Sales. Her steady guidance, stimulating suggestions and great effort to explain things clearly helped to make this thesis possible. Her encouragement and sound advice throughout the writing period was especially appreciated.

I would like to thank Dr. Alexander Clark for helping me to understand the qualitative research process. His thought-provoking discussions allowed me to be open with regard to analyzing the data.

I warmly thank Dr. Charl Els for his enthusiastic support of my research. His passion and interest in helping psychiatric patients with their tobacco addiction helped me maintain a perspective and realize how important it was to acquire a deeper understanding on this topic.

A special thanks to Joanne for her friendship and wonderful support throughout the process.

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Chapter One

Registered Psychiatric Nurses (RPNs) and Registered Nurses (RNs) who work in psychiatric settings have experienced changes in managing patients' smoking addiction. For years psychiatric units and hospitals were exempt from non-smoking policies. In 2006, the Capital Health Authority (CHA) of Edmonton, Alberta closed all the smoking rooms in psychiatric units and banned outdoor smoking on their property. This included Alberta Hospital Edmonton (AHE), a large psychiatric facility. CHA implemented the policy to protect staff, patients and visitors from the exposure of second hand smoke. Tobacco smoke is responsible for the preventable morbidity and mortality of hundreds of thousands of non-smokers world wide (Baliuna, Patra, Rehm, Popova, Kaiserman & Taylor, 2007). For years the province of Alberta was reluctant to introduce comprehensive policies that would keep the population from the harms of tobacco and tobacco smoke. When CHA announced their intentions to implement a complete smoking ban on their property the provincial government at that time was against having a province wide smoking bylaw. Policies are designed to create awareness and encourage smokers to quit and ultimately produce new behaviors. Given that the public at large had not been exposed to complete smoking bans, there were many protests from staff, patients and the public. Not only did smokers in the general public have to adjust but so did the smokers in the psychiatric community where smoking was engrained into the culture.

Smoking is a dominant behavior of psychiatric patients and the introduction of the policy was met with resistance from staff at all levels. Those against the policy argued it would increase patient aggression, that patients rely on smoking and it was against their rights. Staff beliefs and resistance to non-smoking policies in Edmonton are similar to those staff working in psychiatric settings in several countries. Professionals within the psychiatric community hold beliefs such as: patients are not capable of smoking cessation; smoking promotes relaxation, reduces agitation and is one of their rare sources of receiving pleasure (Els & Kunyk, 2006). Progressive smoking bans in psychiatric facilities are creating passionate uprising of protest from staff (Hempel, Kownacki, Malin, et al 2002). From experience, support from staff and patients for smoking bans also increases after the implementation of bans (el-Guebaly, Cathcart, Currie, & Gloster, 2002).

Cancer, heart disease, stroke, and chronic obstructive pulmonary disease related to tobacco dependency are high in the mental health population and accompanied by a substantial premature mortality rate (Bradshaw, Lovell &Harris, 2004). Ischemic heart disease is the most common cause of premature death in schizophrenic smokers (Baker, Richmond, Haile, Lewin, Carr, Taylor, Jansons, & Wilhelm, 2006). The Treating Tobacco Use and Dependence Guidelines 2008 Update was developed by a panel of experts who found an abundance of research that supports smoking cessation to be the number one thing any individual can do to improve and protect their health (Treating Tobacco Use and Dependence guideline Panel, 2008).

Nurses spend more time with patients than other health professionals. They provide holistic care to patients in all settings and therefore are influential with the health promotion choices their patients make (Cataldo, 2001). Taken from one study, psychiatric patients rated their smoking as more important than food (Ziedonis, & Williams, 2003). Many psychiatric nurses are in a paradoxical role for they either support their patients smoking as a means of comfort or they attempt to protect the person's physical health by discouraging the behavior.

Few nursing research studies exist on the topic of health promotion and smoking cessation interventions for mental health nurses (McCloughen, 2003). Historically some nurses have accepted their patients' heavy smoking as normal and their role in promoting smoking cessation has been minimal. Tobacco dependency issues have tended to be ignored, delayed or discouraged by health care professionals in mental health care settings (Williams & Zeidonis, 2004). Recent smoking ban policies in mental health settings have not examined how nurses have reacted to the changes. My research question was: how do mental health/ psychiatric nurses currently perceive their role with respect to psychiatric patients' smoking behaviors? Additional questions included nurses' attitudes towards patients' smoking and the smoking bans. It is intended that the results from the study will provide a deeper understanding of the barriers to providing effective smoking cessation for psychiatric inpatients.

Literature Review

I conducted an extensive literature search beginning with an online search, accessing databases through Ovid and the Cochrane Collaboration, namely

PsychoInfo, Computerized Index of Nursing and Allied Literature (CINAHL), Medline and Allied Health. A few journal articles were found from searches of reference lists. The majority of the searches focused on the literature between the years 1996 – 2007, although citation searches went as far back as 1986. Terms used for the literature search were psychiatry and nicotine dependence, mental health nursing and tobacco dependence, nicotine dependence, nursing practice and smoking cessation interventions, indoor and outdoor hospital smoking bans.

Two purposes of the literature review were to uncover what is known about the subject and to assess gaps in the body of research (Polit & Beck, 2003). This literature review found only one research study that specifically examined mental health nurses' attitudes towards patient smoking or knowledge to provide smoking cessation intervention. Numerous research studies on nurses' tobacco education and psychiatric patient smoking are available. The evidence reviewed supports a lack of tobacco cessation education in undergraduate and graduate nursing programs which may be related to the lack of tobacco cessation interventions done by nurses in practice (Hornberger & Edwards, 2004). In studies done directly with mental health workers the evidence indicates they are not trained to deliver smoking cessation interventions (Ziedonis & Williams, 2003).

Smoking cessation for those with a psychiatric illness is achievable, however it may be more difficult for them to achieve than it is for the general population therefore interventions have to be tailored to be effective with this population (Dalack & Meador-Woodruff, 1999) (Ziedonis & Williams, 2003). Since the late 1980s several schizophrenia smoking cessation studies have been

published. The after effects of smoking bans in psychiatric hospitals and nurses' attitudes about patients' smoking are less studied. Literature pertaining to how patient smoking bans in psychiatric facilities influence mental health nurses' role in delivering smoking cessation could not be found.

Smoking Prevalence

Compared with the general population smoking rate of 21%, those with psychiatric disorders smoking rate is 50% (Campion, Checinski, Nurse & McNeill, 2008). Individuals with serious mental disorders are the heaviest smokers, and with smoking rates estimated from 75% to 85% (Harris, Parle & Gagne, 2006). While over the last 30 years the smoking trend in the general population has moved downwards, there has not been a decline within the mental health population. Several reasons are responsible for this trend including history, the environment, treatment options and health care worker's perceptions of the issue. Mental health nurses contribute to the outcome of smoking rates in terms of how they perceive their role in delivering smoking cessation interventions.

Cigarette smoking was found to be proportionally similar between schizophrenia and depression groups and smoking was higher in actively suicidal patients (Malone, Waternaux, Haas, Cooper, Shuhau & Mann, 2003). Heilligenstein & Smith (2006) examined the effects of heavy smoking in a large clinically diverse sample of university students, and reported more severe psychiatric symptoms when compared to the non- smoking population. A population based data collection from the German National Health Interview and Examination Survey in 2003, found

more than half of the subjects with nicotine dependence fulfilled the criteria for a mental disorder (Schmitz, Kruse, & Kugler, 2003).

Mental Illness and Smoking

Arguments which support psychiatric patient smoking suggest their smoking extends beyond social conditioning, that the illness is responsible for their desire and need to smoke. For the past 20 years researchers have examined the correlation between psychiatric disorders and nicotine, recognizing that the smoking rates are significantly higher in a psychiatric population than the non-psychiatric population (McCloughen, 2003). The accumulation of research provides significant evidence to support nicotine involvement with altering several neuroregulators, such as dopamine and serotonin (Cataldo & Talley, 2001). Nicotine normalizes an auditory evoked potential deficit found in individuals suffering from schizophrenia Adler et al. (1998). Further, patients with schizophrenia have fewer nicotinic receptors, which is linked to possible sensory processing and cognitive deficits. Heavy smoking therefore may be a way of compensating for the deficits (Leonard & Adams, 2006). Depression and cigarette smoking are also correlated. Research has discovered a correlation between cigarette smoking and impaired levels of the neurotransmitter that affects depression, serotonin (Malone, Waternaux, Haas, Cooper, Shuhua & Mann, 2003).

Smoking Cessation

Current evidence suggests mental health staff have feelings of ambiguity about their clientele smoking (Meadows, Strasser, Moeller-Sacone, Hacking, Stanton & Kee, 2001). They reported concerns that smoking cessation may increase

aggressive behavior, and therefore are reluctant to support policies that restrict smoking (McChargue, Gulliver & Hitsman, 1997). There are abundant myths claiming psychiatric patients cannot achieve smoking cessation however with successful smoking cessation is possible with comprehensive treatment (Els & Kunyk, 2006). This includes smoking bans, nicotine replacement treatment, group work and individual counseling.

Heavy schizophrenia smokers using the nicotine patch have little change in their psychiatric symptoms as demonstrated in a study conducted on 10 subjects with schizophrenia (Dalack, & Meador-Woodruff, 1999). Further studies examining various methods to help the psychiatric patient population with smoking cessation have reported no worsening of psychotic symptoms over time (Baker, Richmond, Haile, et al, 2006).

My systematic review of the literature found 16 studies specific to smoking cessation research with the psychiatric population. Different psychiatric disorders resulted in varied quit rates. The quit rates varied, but the desire to quit smoking was similar. As with the general population, individuals with a psychiatric illness also wish to quit for financial and health reasons (el-Guebaly, Cathcart, Currie, Brown, & Gloster, 2002).The limitations of these pilot studies include small sample sizes, inconsistent pre and posttests, self-reports and naturalistic studies. Even though these studies are limited, there is a consensus that smoking cessation can occur within mental health populations.

Smoking Bans

During the past ten years smoking bans have been implemented in public places throughout Canada. Where psychiatric facilities once were exempt, they no longer are. A few unique smoking bans took place in the early nineties in acute psychiatric units with few reported problems with changing from an indoor smoking environment to non-smoking. Their experiences were not empirically or qualitatively studied. Nevertheless it inspired the psychiatric community to consider the possibilities of implementing smoking bans, without extreme episodes of violence. In recent years health organizations and authority boards are insisting psychiatric units and facilities become completely non-smoking. Within the CHA free nicotine replacement therapy (NRT) are to be available to patients who need them. The purpose for offering NRTs is to prevent patients from experiencing nicotine withdrawals during involuntary abstinence (Kunyk, Els, Predy, & Haase, 2007).

Research tracking the effect of smoking bans in psychiatric settings has limitations because data collection may have been biased. Administrators tended not to report negative events, such as increased aggression or more pronounced psychotic symptoms. Mental health nurses experienced confusion identifying the difference between withdrawal symptoms of nicotine and psychiatric symptoms. The nurse's role with helping patients with smoking cessation is not clear.

Smoking bans in psychiatric treatment centers are opposed because of the fear of increasing patients' symptoms of illness. A study to estimate the intensity of illness affecting the subject's mental state and their nicotine dependency level administered the Brief Psychiatric Rating Scale and Nicotine Withdrawal Checklist

and the Fagerstrom Tolerance Questionnaire (FTQ) (degree of nicotine dependence) within a short period of time following the subject's admission to a non smoking unit. Comparisons between smokers and non- smokers and change in behaviors were measured and correlated. Investigators did not find significant behavioral differences between smokers and non-smokers. Smokers with schizophrenia were psychiatrically more disturbed than smokers with depression and bipolar illness (Smith, Pristach & Cartagena, 1999). These findings did not support findings of Glassman, Convey, Stetner & Rivelli (2002) who reported that smokers with a history of depression who abstain from smoking significantly increased their chances of developing depression within a six month period of abstaining.

Research conducted at a San Francisco hospital acute psychiatric unit measured pre and post smoking activities, psychiatric symptoms and nicotine withdrawal symptoms of their subjects. Variables included whether or not patients used nicotine replacement therapy (NRT). The study concluded that more randomized trials have to be done in order to validate evidence demonstrating the difference in the behaviors of patients using nicotine replacement therapy and those who do not. An interesting and significant finding of this study was even though patients were living in a smoke free environment many of them remained heavy smokers as they were allowed to smoke outside (Prochaska, Gill, & Hall, 2004). The study did not provide information about the nurses' experience with providing NRTs or counseling patients with smoking reduction.

A recent Canadian empirical study on the clinical effects of a total smoking ban in a mental health facility started several months after implementing

the ban and gathered data for a period of two years. An initial increase in patient-staff aggression and smokers obliged to quit gained weight was observed (Harris, Parle & Gagne, 2006). Pulmonary functions of the smokers improved. According to the study, patients in the non-forensic areas of the hospital did not significantly reduce their smoking. The authors attribute the finding to clinical staff's pessimistic attitude towards patients smoking behaviors and the ban.

Nurses' Role

In psychiatric hospital settings cigarettes are used by patients as currency and social exchanges which nurses acknowledge as part of the culture (Reilly, Murphy & Alderton, 2006). The nursing role in promoting smoking cessation in the psychiatric population is frequently referred to in the literature but few studies actually explore the role of the nurse. Studies prior to the implementation of smoking bans found nurses supported patients' smoking behaviors and the complex roles that accompanied smoking. One example of a role a nurse played was managing patients' tobacco supplies.

Several empirical studies looking at psychiatric patients' smoking suggest the role of the mental health /psychiatric nurse could be more involved with promoting smoking cessation education for patients. It was interesting to note the words *should* or *can* were used in discussion about what nurses ought to be doing. Advice was offered for the nurse to promote healthy living, yet at the same time acknowledged that mental health/psychiatric nurses have a responsibility to ensure their patients are not denied the opportunity to smoke and to assist patients by monitoring their cigarettes (McCloughen, 2003). One paper suggests that the

psychiatric nurse is presented with a double edged sword where the nurse should advise their patients to stop smoking but on the other hand claim it is more the role of the advanced nurse practitioner to handle smoking cessation programs with patients (Cataldo, 2001).

Speculation has been offered as to the beliefs and attitudes of mental health nurses about psychiatric patients smoking, such as causing too much stress for the patient, fear of nicotine withdrawals provoking aggression, believing it is their rights and that the patient cannot quit smoking. Lawn (2004) feels nurses play a variety of roles associated with their patients' smoking, such as behavior modifier, cigarette source, educator and custodian. Lawn saw nursing staff as having acquired the belief that cigarettes were soothing to their patients. With the exception of the survey by Dickens, Stubbs & Haw (2004), no empirical studies were found that actually examine the mental health/psychiatric nurse's role in tobacco cessation, control and how they perceive changes in smoking restrictions.

The gap found in this literature review is the lack of studies examining and exploring nurses' current perceived role in the managing patients' smoking behaviors in non smoking hospitals and institutions with psychiatric patients. Research in this area will help in understanding the complexity of the nurse's role in this process and therefore supports the research question: How do mental health nurses' perceive their role with psychiatric patients' smoking behaviors?

Purpose of Study

Since the introduction of comprehensive smoking bans in Canadian settings, only two studies measured the smoking rate of patients and found little significant

change following smoking bans in mental health facilities (Harris, Parle & Gagne, 2006; Prochaska, Gill & Hall, 2004). These studies suggest that more than smoking bans are needed to reduce the number of psychiatric patients who are dependent on tobacco. Nurses are strategically aligned to address patient's smoking because they are the 24 hour care givers and therefore experience the reality of what is happening with the dynamics of patients' smoking behaviors. In turn how the nurse perceives and responds to the needs of their patients captures the context of the full issue with psychiatric patients' current smoking behaviors. The purpose of this interpretive inquiry was to understand the perceived role of RNs and RPNs with regards to the smoking behaviors of patients in psychiatric units in the Capital Health (CH) region. Previous to this research study nurses working in psychiatry were reported as having ambiguous attitudes towards patients' tobacco dependency. This study explored how nurses experienced managing their roles in regards to patients' smoking behaviors at five psychiatric inpatient settings in CHA 27 months following the implementation of a comprehensive smoking ban.

Significance

Findings from this study may generate future research focusing on the smoking issues among psychiatric patients and understanding the barriers to effective smoking cessation interventions for patients in a psychiatric facility. It may also be used as information to develop nursing educational material for nicotine dependence and mental health/psychiatric nursing.

Chapter Two

Methods

I used an approach called interpretive inquiry as the primary methodological approach in this study about how mental health/psychiatric nurses perceived their role in respect to their patients' smoking. I chose this qualitative method because my question was to explore the current experiences of nurses and their perceptions of patients' smoking behaviors. Minimal literature exists about this phenomenon and therefore the clinical experience is not understood. The interpretive inquiry method facilitates the freedom to explore the context of nurses' experiences which cannot be assumed prior to the investigation. The interpretive framework is useful in nursing as it is a mode of inquiry that allows for the freedom to explore the human experience of a phenomenon (Streubert & Carpenter, 1999). "...Interpretive description acknowledges the constructed and contextual nature of human experience that at the same time allows for shared realities." (Thorne, Kirkham,& O'Flynn-Magge, 2004.) I chose this method as it supported capturing the everyday world of nursing practice in terms of how nurses perceived their role with patients' smoking behaviors in the current culture of non smoking environments (Munhall, 2001). This study focused on exploring how nurses perceived the smoking ban's influences in regards to their care with patients who smoked. The process of inquiry was designed to illicit each nurse's experience surrounding their patients' smoking and accept their experience as the truth about the reality and in turn generate knowledge and understanding of their clinical experience.

Setting

This study took place in the Capital Health Authority of Edmonton, Alberta between January 2008 and April 2008. Participants Registered Nurses (RN) and Registered Psychiatric Nurses (RPN) were recruited from the psychiatric units of the University of Alberta Hospital, Royal Alexander Hospital, Grey Nuns Community Hospital, Misericordia Community Hospital and Alberta Hospital Edmonton. These sites were chosen as all sites have had a comprehensive smoking ban in place since October 2006 and the purpose for the study was to understand how RN/RPNs perceived their role with patients' smoking behaviors after smoking bans from all hospital property. Including participants from a number of sites within the same region allowed me to capture a more complete and clearer description of the nursing perspective and maintain consistency with nurses experiencing the same smoking ban.

Sample

Sample participants where chosen using purposive sampling and criterion sampling principles (Creswell, 2007). Purposeful sample is useful when specific knowledge is required from the participants and my goal was to have nurses describe their unique experiences with patients' smoking behaviors (Speziale & Carpenter, 2007). For this study I was seeking RN/RPNs who had worked a minimum of two years in psychiatry because it allowed for the number of years the non-smoking ban had been in place. Two years also ensured that the participants had acquired a relevant amount of experience or insights about their patients' smoking behaviors. With each person who contacted me I asked for basic

screening information such as the particular site they worked at, how long they have been working in mental/psychiatric nursing and their own smoking status. I included all the participants that contacted me as all of them had worked a minimum of two years in psychiatry and were from different CHA hospital sites.

The purpose of qualitative research is not primarily for generalizability instead, the goal was to achieve saturation using the criteria of adequately understanding the nurses' perception of their patients' smoking behaviors. The content is more important than numbers (Creswell, 2007). The participants in this study allowed for variation to facilitate comparisons and capture both typical and atypical experiences mental health nurses have experienced in their roles with patients' smoking behaviors.

Controversy surrounds the number of participants needed for a qualitative study. I worked with the concept that I could not predict a specific number of participants and I would continue with data collection until I felt saturation had occurred. I decided saturation would be known when the data collected was similar or repetitive. I expected this to occur after several interviews and it would have to be experienced a few times before concluding that saturation had been reached.

In addition to direct interviews, all participants were invited to participate in a focus group following the completion of the interviews. The purpose of the focus group was to confirm with participants the findings of the data. By meeting participants in a different venue and group setting it would change the dialogue and conversation about the topic. In turn the conversation could lead members to recall new things about the topic. The focus group therefore provided an opportunity to

clarify previous analysis of the data and offered additional understandings to how nurses perceived their role in relation to their patients' smoking behaviors. Holding a focus group allowed me to hear again from the sources (Miles & Huberman, 1994).

Permission to recruit nurses was sought and granted from the Health Research Ethics Board of the University of Alberta as well as the regional approval process for the other two hospitals. Strategies for recruitment included posters placed in the nursing units of the psychiatric units/facility, two electronic ads and word-of-mouth where two nurses were referred from nurse educators.

Data Collection

Strategies to collect and analyze data were consistent with the guidelines suggested in Creswell (2007) for interpretive inquiry. Without a set hypothesis I approached the study with an open mind. Due to the nature of the method I had some subjectivity present which I suspended as much as possible during the data collection and analysis. My goal during data collection was to allow the participant the full opportunity to share their experience. I used semi-structured interviews for data collection. Questions for the interview were based on theory drawn from the literature review and my own working experience in psychiatry. When interpreting the data I questioned my coding by asking critical questions that included asking if my selection from the data was limited to my experiences and if I was examining other possible explanations for the descriptions offered in the data.

At the beginning of the interview, the participant was given an explanation of the study prior to obtaining consent. Interviews were interactive and lasted

approximately forty-five minutes to one hour. I received written permission from each participant to audiotape the session.

Questions were designed to allow the participants the freedom to explain their experiences in their words. See Appendix (A). I began using open ended exploratory questions about their nursing setting such as "Describe your work setting and your particular role." At the beginning of the interview I asked about the participant's own smoking history. I then explored their knowledge of their patients' smoking behaviors. I asked if their patients smoked and how frequently they addressed patients' smoking during the course of a day. During the course of an interview, I modified the questions according to how the participants responded (Munhall, 2001). For instance I found when I asked about their experience with denying a patient the opportunity to smoke they would sometimes describe an aggressive situation. To understand fully what the experience meant to them I had to include questions to explore their feelings in relation to the situation. I then found it useful to ask how the situation made them feel. The object was to attain a deeper understanding of the experience which is purpose of interpretive inquiry (Streubert & Carpenter, 1999).

Throughout the interviews when I sensed a change in the participant where their tone changed or they were becoming more passionate in their descriptions, I would explore the issue further with them. For instance a participant was describing a patient getting noisy due to not smoking and how the doctor responded and her tone was more intense and her language changed. For this description I encouraged her to explore how she felt about what was happening and had her clarify the

meaning of the words she chose. This was important with obtaining data for accurate interpretation. The value of the interview allowed me to ask questions to help participants explain things in more detail, allowed for observation of the non verbal communication and provided an opportunity to seek clarification and use flexible questions (Brink & Wood, 1998; Speziale & Carpenter, 2007). Following each of the interviews I would journal the experience to describe the person, place and setting of the interview. I tried to capture my initial sense of the participant's point of view.

I requested and received additional ethics permission from the Health Research Ethics Board to hold a single focus group following the interviews. The intent was to ensure accuracy of the interpretations of the data collected in the interviews. I anticipated the focus group would help members recall additional information and provide a format for a stimulating discussion (Speziale & Caprenter, 2007). The focus group was held at Alberta Hospital Edmonton, which was a convenient location for the majority of those participants that could attend.

Data Analysis

Interpretive frameworks are used to search out relationships between knowledge and context. It requires a hands-on process that begins with the data collection (Streubert & Carpenter, 1999). As I was doing the interviews I was discovering new information that led to new questions which was the beginning of my immersion into the data. The intent was for me to report the actual words of people being studied and their different perspectives of the experience.

First, eight of the twelve interview tapes were professionally transcribed verbatim and I transcribed four. I read the transcripts in their full entirety a few times and then made notes. I began to formulate thoughts regarding the meaning of the text. Reflecting upon the data is an important step in qualitative research (Richards, 2005). I chose to code the data by hand rather than using computer software. I stored all notes and all records of the analysis processed electronically on my personal computer.

My second step was to identify patterns of meaningful connections. I had to think about the relationship between the written word and context. For example I had to interpret the word "unsettled" and its relationship to the nurse and the smoking ban because the interpretation of the behavior can mean several different behaviors such as aggressive, suicidal, and hyperactive. I also had to understand if the nurse perceived the behavior was caused from not smoking or if the behavior was the reason the patient could not smoke. This process of reading and rereading the transcripts and questioning the meanings led to coding the text according to descriptions, topics and then analysis. Initially I coded frequently used words and connected them to broader topics. I had 15 topics during the first coding and narrowed it to eight topics in a second set of categories. Under the topics I used full passages so as not to lose the context. I questioned the context of the categories and how they related to other concepts from the data. I looked for the reasons when significant differences were noted between the participants' descriptions of similar issues. I questioned how the differences could be related. I made comparisons regarding the participants' attitudes and experience. From the notes and using my

own intuition I noted the similarities and variance in the patterns of attitudes of the participants.

The next step I took was to examine the patterns and look for common meanings of the patterns that were emerging. I looked for significant statements and grouped statements into meanings. I am an experienced psychiatric nurse and tobacco cessation is my specialty. Therefore my interpretation of emerging themes included my own critical understanding of the topic. With the few outliers I purposefully spent time developing an understanding of the full meanings of the experience because "one personally experienced dramatic event means more than several you have read about" (Miles & Huberman, 1994 p. 269). I interpreted outliers to be extreme examples of patient behaviors or a nurses' role as described by a participant. When a nurse was intense or more passionate about an issue in comparison to other participants I considered it to be an outlier.

The finial step was interpreting the context of the categories in terms of a deeper understanding of the experience. These themes evolved from noting overlap under the topics in both sets of categories and from my total absorption of the data over a period of three months.

Rigor

In this interpretive inquiry my job was to report the perspectives of the participants as clearly and accurate as possible (Morse, & Field, 1995). As this study was subjective, the potential existed for my personal assumptions and bias to influence the interpretive process. Throughout the research process I had to keep in mind my own beliefs about patients' smoking behaviors. I maintained my

awareness to remain open and actively pursue the participants' experiences and contemplate their opinions by journaling my subjective interpretations following the interviews. When I read transcripts I made memos, and in my data analysis I wrote questions next to my interpretations to help guard against limiting my analysis to initial assumptions. For example when I recognized contradictions in a participants' transcript, instead of making it fit with my questions, I questioned why it had occurred. I compared my data and memoing next to the existing literature to help broaden my understanding of the data. I used a co-analyst who read the transcripts, performed her own interpretations and then reviewed my analysis of the data. By using a co-analyst allowed for an accurate reporting of the data and prevented premature acceptance of the analysis (Gillis, & Jackson, 2002).

Chapter Three

The Results

The purpose of this qualitative research study was to describe the complexity of how nurses perceived their role in regards to psychiatric patients' smoking behaviors in context to a total ban on smoking. With the data collected I reduced it into two sets of reduction analyses. The first set was reduced from the transcripts into several categories organized by clusters of meanings. The second analysis further reduced the categories and integrated the results into themes of patients' smoking behaviors and how nurses responded. These themes emerge from the participant's narrative description of their roles in response to their patients' reaction to the ban. Nurses described patients' smoking trends, reactions to the smoking ban, health and their own behavioral and behavioral change in relation to the smoking ban. Nurses had to adjust and adopt new roles to meet the challenges presented by the smoking ban and patients. The themes and narrative descriptions are described in this chapter.

Sample

Interpretive inquiry using interviews to gather information requires 5 – 25 participants (Creswell, 2007). I had twelve participants. Seven were registered psychiatric nurses and five were registered nurses. Two RNs were also graduates of a psychiatric nursing program and three had BScN degrees. All were female and ranged from 25- 60 years of age. Clinical psychiatric nursing experience ranged from two to 35 years. One participant was a nurse educator, another nurse worked in outpatient program attached to an inpatient unit and the remainders of

participants were inpatient staff nurses. Two participants were from the Misericordia Community Hospital, two from the Royal Alexander Hospital, one from the University of Alberta, three from the Grey Nuns Community Hospital, and four from Alberta Hospital Edmonton. Three participants were current smokers. After eight interviews I was experiencing repetition with the information provided which suggested I had reached saturation. For clarity of the participants I have organized their information in the table below. Names of the participants are pseudonyms to protect confidentiality.

Name	**Site**	**Education**	**Years Experience**	**Smoking Status**
Pam	AHE – acute psychiatry	RPN	> 30 years	Smoker
Jody	AHE – acute psychiatry	BScN	> 25 years	Non Smoker
Cathy	AHE - Forensic	BScN	10 years	Non Smoker
Joan	AHE – general psychiatry long term	RPN	20 years	Non Smoker
Jessica	RAH – acute psychiatry	RN	12 years	Non Smoker
Tracy	RAH – acute psychiatry	RPN	5 years	Non Smoker
Donna	Misc. – acute psychiatry	BScN – nurse Educator	> 20 years	Non Smoker
Cate	Misc – acute psychiatry	RPN	2 years	Smoker
Wendy	GNH – acute psychiatry	RN	> 30 years	Non Smoker
Lisa	GHN – inpatient day hospital	RPN	20 years	Smoker
Lindy	GHN – acute psychiatry	RPN	20 years	Non Smoker
Fay	U of A – acute psychiatry	BScN	2 years	Non Smoker

The interviews were conducted in the months of January to April 2008 where in Edmonton the winters are cold. Some interviews were done at the work site of the participant and others in the privacy of the participant's home, depending on their preference. To assess inter-rater reliability, a second reviewer then reviewed interview transcripts, themes, and the organization, description, and interpretation of the findings. By having a second reviewer it provided an opportunity to see new relationships and understandings in the phenomenon (Thorne, Kirkham, & O'Flynn- Magee, 2004). The reviewer and I discussed our findings. Our discussion led to exploring the overlapping data and questioning whether or not this was pertinent to understanding the perceptions of the nurses. Because of this discussion, a new understanding was reached where the overlapping data was considered relevant and captured into two different categories which were **"ambivalence and conflict"**, and **"nurses caught in the middle between policy, patient and psychiatrist."**

My own experience influenced my interpretation of the meanings and relationships of the data. I have over twenty five years experience working as a staff nurse in an acute psychiatric setting and as well, I have extensive education with tobacco cessation. I used my knowledge and experience to question the data and to critique the deeper meanings of the issues discussed by the participants. For example I felt comfortable judging whether a participant accurately understood how nicotine replacement treatment (NRTs) worked.

Findings

In the first analysis of the interview data, I organized the data in to 15 categories to describe clusters of meanings. These were:

- Indoor smoking
- Smoking outside
- Smoking is all they have
- Not so nice behavior
- Using NRTs
- Nicotine withdrawals
- Frequency of dealing with patients' smoking issues
- Dealing with cigarette privileges
- Patients' smoking rates
- Reduction
- Cessation
- Nurse's role
- Nurses' perception of the incidents
- Smoking policy
- Concerns with patients' smoking.

See appendix (B) for a full description of these categories.

In the second analysis I reduced the categories into eight themes. I found that the context occasionally overlapped and so I have incorporated the overlap into the narration of the information. The themes are:

- Meaning of patient smoking for the nurse
- Aggressive behaviors
- Nicotine Replacement Therapy
- Smoking as a patient social network
- Nurses' caught in the middle of the policy/psychiatrist/patient
- Understanding between smoking cessation and temporary quitting
- Role Frustration
- Ambivalence and Conflict

For details see Appendix (C).

Nurses' Story about their Patients' Smoking

Inpatient psychiatric care settings approach care by fostering individual and group interactions. On acute admission units patients are assessed, symptoms are stabilized and discharged as quickly as possible. Longer term units focus on rehabilitating the patient into the community. Nurses are at the centre of patient care. They are responsible for organizing the care for the patient by administering medication, assisting with aides to daily living, promoting healthy activities, counseling and managing patients' behaviors. Specific to patients smoking nurses may monitor and determine whether to intervene. For example patients' cigarette

supplies might be kept in the nursing office and handed out to patients by nurses. Specific nursing units have their own ways for addressing patients' smoking. Nursing roles were similar between different settings, yet there was a variation between the nurses' understanding of their roles.

Background

Nurses initially provided a background of their work setting and their patients' smoking rates, and how tobacco issues were addressed. Despite different settings all nurses were cognizant of whether or not their patients smoked and had a good idea of how much and how often they smoked. The following are descriptions from the nurses that are informative of their patients' smoking trends. Donna from an acute setting described her patients' smoking rate as: "*Approximately 75% of the inpatient population smokes. A lot of them when admitted are smoking more than a pack a day. I suspect they are smoking more than one at a time when they go outside to smoke.*"

In a long term care unit patient smoking was described as "*85% of our patients do smoke, if they have privileges and no activities and the money they would be outside the whole time.*"

Nurses reflected on the changes with patients' smoking that included patients smoking less. Wendy stated "*over my 30 year career there are fewer smokers and you don't get the really really heavy smokers. I don't see the two packs a day smokers, I see more half pack a day that is all they can afford.*" A few thought the smoking trend was directly related to the outdoor smoking ban and the

weather. Comments made were "*Ones who have been here a long term a lot of times have cut down their smoking.*"

"*In the winter time, if it is really cold then they don't want to go in the cold and so they will only go a few times a day.*" Jody also noted the same trend "*He wasn't smoking as much and occasionally he would say it's too cold, I don't want to go out for a smoke.*"

Meaning of Patient Smoking for Nurses

Nurses have adopted new roles and behaviors to accommodate patients' needs with their smoking. Fay who worked on a general hospital psychiatric unit said "*When a patient first comes in it takes up a lot of time because they keep asking for cigarette privileges.*"

Jessica felt patients were taking up nursing time about smoking privileges "*Patients are at the desk constantly asking if they can go out to smoke.*" Jessica also described patients needing more assistance if they smoked "*When I am nursing a smoker it comes up several times a shift and what I can do to help them out with that.*"

Tracy who worked in the same unit as Jessica made a similar comment "*At least five to ten times a day I am either doing one thing or the other in relation to patients smoking.*"

Most likely to upset the nurse are patients smoking in the unit. Patients are described as sneaking cigarettes in bathrooms, bedrooms and corridors. With these types of situations nurses find themselves in the enforcer role. Cathy described part of her daily routine as "*We monitor for patients smoking in the bathrooms.*"

Tracy's unit dealt with noncompliance with a new rule where patients were not allowed to keep their cigarettes *"They have cigarettes at the desk and pick them up before going outside and return them when they come back."*

Pam described the nurse's role as an enforcer as: *"We spend a lot of time giving out cigarettes but we spend even more time paroling and catching people smoking, asking people not to smoke. We spend a lot of time doing this, and have a lot of conflict."*

On Joan's unit the rules were simple *"If they are caught smoking they are put on close observation."*

Jody described interventions with smoking as specific to the patient *"We are dishing cigarettes out to him because he is smoking so much on the unit."*

The unit Pam worked on had experienced several patients smoking in their bathrooms. *"It is a work place hazard. It's a huge fire hazard. We have to search them for cigarettes all the time."*

Jody had a difficult male patient who frequently smoked in the unit. "*The doctor told him he was not going to get 'grounds' but some how he got cigarettes and was smoking on the unit.*"

Jessica described a similar patient problem smoking behavior: *"A few minutes later he is in the bathroom smoking and you have to do another cigarette search.*"

Apparently smoking indoors is not a constant issue on the units but seems to go in cycles. Tracy observed that the cycles were related to weather: "*Winter is worse."*

When patients are on these observation level nurses must escort them off the unit and check them every 15 minutes which is added work. Most smokers do not like close observation because it restricts their smoking. However, Pam felt it didn't always work that way *"In the winter they are quite happy to be on close observation and smoke inside where it is nice and cozy."*

Most of the indoor smoking occurs at night. Jody who worked night shift in her rotation stated *"They are not to smoke at night but they do far too often."*

And no matter what the time of day, weather conditions and observation level Cathy's observation of patients was: *"Patients have grounds and smoke on the units. They want a cigarette and they want it now."*

Nurses saw patients smoking on the unit as a hazard and felt it necessary to intervene. Difficult behaviors demonstrated by patients caused nurses to conduct room searches. Pam said "*We catch them smoking in their rooms and, we search their rooms and sometimes they get mad because we find their hidden cigarettes."* Nurses at different sites had to take on the role as manager of patients' cigarettes. Jody had a patient who was constantly smoking indoors and made a blanket statement about all the patients *"The reason the cigarettes are at the desk is because patients will go smoke in their rooms."*

Tracy described problems when she caught patients smoking in the bathrooms and the futility of searching patients for cigarettes *"They get cigarettes from other patients and hide them."*

Many patients were compliant and smoked outside the building. They tended to smoke on the hospital property even though it was not allowed on any

Capital Health property. Nevertheless nurses tended to accept patients smoking on outdoor property. Wendy saw her enforcer role as limited to indoor smoking: *"We are not monitoring them outside."*

Lindy from the same site was indifferent about the outdoor smoking *"I can look out my window and see people smoking in front of the doorways where no smoking signs are clearly posted."*

Jody felt the outdoor ban was not reasonable and accepted patients' arguments to allow outdoor smoking *"They go outside light up and say I'm outside why am I not allowed to do it? "Initially I tried to direct the smokers at the doorway to go off the property. I did it 6 or 8 times and saw absolutely no movement and decided why am I wasting my breath and there has been no enforcement."*

The use of cigarettes as an incentive to motivate patients is no longer considered to be a reasonable practice. From the interviews it seems current practice has found ground privileges to be the new incentive. Tracy used smoking to help a patient control self harming behavior: *"I had a patient who had thoughts of hurting himself and I would say you know what if you have suicidal thoughts or you are going to hurt yourself or others, you will not be allowed out for the rest of the day because you are a danger to yourself and others. I am not going to let you out for cigarettes. Which I thought was perfectly logical. It ended up that whole day and evening the patient never mentioned it once because he would have had his smoking revoked."*

In Donna's unit nurses did not use cigarettes as incentives however she said *"It's more as an incentive with having the privilege to go smoke. We use their cigarettes*

and say if you stay calm you can go for a smoke. There are so few rewards in mental health."

Cathy said smoking incentives helped her chronic patients attend programs *"If they don't attend programs consistently they get put on close observation which motivates them as they want to smoke."*

Pam commented*: "The motivation is to go outside and smoke."*

Fay like other nurses did not use the cigarette as the incentive *"The cigarette is not an incentive, but you kind of do it indirectly with getting them smoking privileges if they are settled."*

Nurses thought their role with controlling patients' cigarettes helped maintain patient order. Jessica said*: "I guess we control their cigarettes."*

Cathy described it as inconvenient but helpful: *"Locking up their cigarettes is inconvenient but as least it gives us control."*

Fay related using cigarettes to help a patient maintain self control: *"We say if things are going well if your behavior is good, than you can go outside and smoke."*

Donna spoke for her team*: "We end up in a power struggle in a situation of having control over someone's cigarettes, but sometimes it is beneficial to the patient in the long run."*

Cathy elaborated: "*We are the gatekeepers to their supply. It is frustrating but we know if they run out of cigarettes they will have withdrawal symptoms and that would not be great as it would trigger their psychiatric symptoms. If they are having a lousy stressful day the cigarette is used to calm them down versus using a prn medication."*

Patients' Aggressive Behavior in Relation to Smoking Ban

All nurses interviewed had experienced or knew of an aggressive incident by a patient that was in relation to a patient not being able to smoke. Some incidents are worse than others, and in the worse cases smoking was reported as part of the patient issue. Aggressive incidents were cited as not the normal and for the most part how the patient was managed contributed to the level of aggression demonstrated. Managing aggressive behaviors is a necessary role of mental health nurses.

Pam was quite descriptive: *"I have seen everything when you can't give them a cigarette, they get on the floor and start kicking and screaming, kicking their feet at the walls, screaming give me a cigarettes, some will try and burn you with the cigarette, spit at you."*

Wendy experiences were different: *"I have never had a physical altercation, just verbal."*

Cathy described a patient behavior that took place when the unit was short staffed: *"When we couldn't escort a patient outside for a fresh air break, he was quite upset, ranting and raving. He did the typical temper tantrum, but he didn't get to the point where we had to restrain him."*

Lindy who works on an intensive care unit described an incident as *"He escalated being verbally aggressive and then became physically aggressive to the point that security had to be called and he needed to be secluded. But certainly that is the exception to my experience."*

Fay who was upset with the policy and felt it caused unsettled behaviors from patients later in her narrative commented: *"Some heavy smokers will call staff down, and yell and scream and demand to have a cigarette. It is surprising it is minimal and does not happen all that often in the acute area."*

Two nurses interviewed had recently experienced aggressive behaviors and felt these behaviors happened too often. Pam whose unit's patient turn over was rapid *"It happens often when patients are first admitted and find out they cannot smoke. They become agitated."*

Jessica in her narrative commented *"It happens more frequently than people want to believe it does. They are in a volatile state and to teach them something else is very difficult."*

Cate summed it up as *"It causes more conflict than anything else I can think of."*

When first admitted to a psychiatric unit, patients are on close observation which ultimately implies they cannot smoke. Nurses have experienced a variety of behaviors from their patients in response to the smoking policy. Ground privileges are the patient's ability to leave the unit without a staff escort. They can be revoked due to a patient's mental state or behavior. Nurses saw patients' reactions as more extreme when this occurred. As Tracy described "*When you say they cannot smoke, they start yelling and cussing. At times there have been people that have thrown things across the room, usually the psychotic people."*

Lindy described an incident: *"He became verbally aggressive and then physically aggressive, but certainly this is the exception to my experience."*

Using Nicotine Replacement Therapy

Capital Health's policy is to make available NRTs to all patients who are restricted from smoking. The rationale is to treat temporary nicotine withdrawals, not necessarily to have smokers quit. Patients in the psychiatric units are routinely offered them. Cate described part of the admission routine was to ensure NRTS were prescribed "*We take a history and if they are a smoker we phone the doctor for orders.*"

Donna who worked at the same site described it as: *"The majority of time nurses phone to get the NRT orders; we do the teaching about the medication."*

Lindy was matter of fact with how it is done: *"As soon as they come in it is ordered up and offered right away."*

Jody described included teaching into her role when offering NRTs to patients when first admitted. "*We suggest the patch, gum, and my role partly is to inform them that those products are available and to do the teaching around that. I also teach the benefits of not smoking while in hospital."*

Jessica described the frequency to which patients requested NRTs: *"They will be at the desk every hour or two requesting a cartridge or a gum."*

Jody described nurses offering it: *"Night staff offer if frequently when they cannot go outside to smoke."*

How NRTs work was a matter of opinion.

"*It's not as satisfying to them as having an actual cigarette."*

"They are offered the NRTs and do quite well with them."

"The patch gets into their blood stream and they literally just forget and that is nice. It seems to take the edge off."

"Patients tell me they really help. They can go through an extended period of time without smoking with using the NRTS."

"It's not like a cigarette but at least they have nicotine in their system."

"It helps with withdrawals, but not initially like the first day. You can fill them up with all the nicotine you want but they are going to miss the whole idea of smoking, the part of the relaxation."

"On night shift I will give out maybe two or three NRTs a shift. They get the gum and go back to sleep." And *"Everybody kinda has one that works. And some say it is crap and none works."*

In some cases patients were offered the NRTs but refused the option. Cate's experience was: "*You offer the NRTs sometimes they are interested, sometimes they are not."*

Fay didn't find patients that responsive to the option: *"They are offered the NRT but don't want to entertain the idea."*

Tracy described a common reaction from agitated patients: *"If you offer the NRT they will throw it your face."*

Donna described an incident when a smoker was confined *"A patient was put in seclusion and offered the inhaler which he threw. He was on constant for a while, but a few days after refusing the inhaler he accepted it to cope with cravings."*

How NRTs work was not fully understood by most nurses or by their colleagues and as a result they appeared to be giving mixed messages to patients. Comments reflecting this were:

"I have to do teaching with saying "you cannot chew this gum on the hour, have a cartridge and go smoking because their heart rates go up really high. I encourage them to stop or at least cut down, but you also have to monitor them because they think the more nicotine the better."

"The nicorette gum helps them reduce because they don't like the gum so they will put it off until they have that real intense withdrawal feeling. The nicotine inhalant I don't know, I just see it helping because it is reducing the cigarette intake but they are still having the same nicotine intake."

"My issue is the patient was getting patches in the morning and then smoking all day and that was not safe."

"There are some nurses who tell patients put a patch on and try smoking a little less today. Based on what I understand, I cannot do this."

Nurses were coping with the policy because of NRTs. Before the policy was in place NRTs were not routinely offered or supplied by pharmacy. Comments reflecting this concept were positive. Fay when talking about NRTs said: "*We use them a lot. We have to offer them something."*

Lindy said *"I don't mind the policy now because the NRTS are available."*

Jody when talking about smoking withdrawals said *"I don't see a problem in my practice because I offer the replacement and say it's either that or cold turkey."*

She also liked them because: *"When a patient runs out of money we offer the NRTs which is nice because we couldn't before."*

Wendy made a similar comment: "*It's not too often but the one's that don't have money or have financial problems take the replacement.*"

Generally the nurses interviewed were impressed with how NRTs helped patients reduce or quit smoking.

"*They will take the inhalant and cut down on their smoking.*"

"One woman accepted the NRT for cravings and ended up quitting."

"Even those smoking on the patch, it's minimal and they are gradually reducing."

Nurses found the NRTs helpful with calming patients. Jessica described how they usually work: *"It has calmed down the cigarette altercations because they do have an alternative. They are less combative because they have an option. I always encourage them to use it."*

Jody related the same effect: *"Sometimes they are ready to blow and you give them the NRT and it takes the edge off and right away you can see they are more cooperative. So it usually works that way."*

Using NRTs meant more work for nurses.

"*They will be at the desk every hour or so requesting for the gum or cartridge.*"

"When we are busy I forget to mark it off."

Jessica shared her new practice: *"Lately I am keeping gum in one pocket and cartridges in the other ready to give as needed."* Some nurses found tracking them to be additional work: *"It's a lot of documentation; it would be nice if they weren't classified as medications. It is extra work."*

Smoking as a Patient Social Network

Well known to mental health nurses is the social network of patients which historically has been dominated by smoking. Patients' smoking revolves around their day, activities, associations with others, and their general interests. Nurses

have come to know smokers will borrow, sell and occasionally steal tobacco from each other. They know smokers will help smokers, which means even when nurses control a patient's tobacco supply another patient will help them with extra cigarettes. When the majority of patients are smokers it can influence how nurses react to the smoking issues. From the narratives of nurses they referred to the smoking behaviors of their patients interfering with the effectiveness of their roles to maintain a safe environment.

Jessica referenced the social network as part of the reason they managed patients' cigarettes: *"The issue of borrowing, stealing and begging so we keep their cigs at the desk and give them out one at a time if they request it."*

When explaining why patients keep their cigarettes at the desk, Tracy commented: *"Some patients will pass out their cigarettes, which they cannot afford to do."*

Fay who has been nursing for two years was surprised by the power of the smokers: *"I know someone who started smoking while they were in hospital so they could be part of the group."*

Joan described it as: "*They feel it is a social thing."*

Wendy's observation was: *"They are very social with the other smokers but not with much else."*

Other nurses described patients who smoke as centering their day around smoking. Jody said*: "A lot of their smoking is centered around coffee time, meal times, that first smoke and then at night a lot of them rush out the last ten or fifteen minutes to get that last cigarette. If they have been at a program or group for an hour they need that cigarette."*

Pam described smokers' day as: *"They sit around all day smoking and drinking coffee. It's relaxing for them but it becomes a habit."*

Smokers influence the milieu of the unit. Pam found: *"I find if one starts smoking indoors it teaches the others ones the deviant behavior."*

Nurses are expected to help their patients incorporate meaningful activities into their day and when a patient would rather smoke its more difficult to motivate them to participate in structured programs or even have a conversation with the nurse. Jessica described it as: *"Smokes spend a lot of time outside, they skip out of their groups, they huddle at the doorways."*

Lindy found: *"They spend a lot of their time off the unit so if you got a smoking patient you might not see them or get a chance to talk to them because they are gone so much."*

Their social network influences new behaviors as described by Jody: *"They come and ask when they see others using the NRTs."*

Caught in the Middle of the Policy/Psychiatrist/Patient Relationships

1.) The Policy

The introduction of the non-smoking policy at CH has personally affected nurses. No longer are nurses exposed to second hand smoke, or obligated to escort patients outside to smoke. On the other hand they are sensitive to their patient's desires to smoke.

Lindy expressed ambivalence regarding the smoking policy. When discussing how it affects patients she explained *"I have mixed feelings about it. I appreciate not*

having to breathe in smoke but there are times when I feel it is about people's rights."

Joan who works where patients' hospital stay can exceed a year thought "*I support giving patients the ability to smoke and they don't have privileges to leave the building and so I feel really strongly that this is the one thing that they have that brings them happiness in life and than we should give them the opportunity."* However she also expresses her dislike for smoke. *"I will stand a few metres away from someone outside smoking because I don't want exposure to second hand smoke."* Others just accept it, as Jessica said: *"I feel it is harsh but that is the way."* Some nurses are happy with the policy.

"I am happy about it because I don't smoke and I didn't like it when it was on the unit." "It's provided a better work place for me."

"I thought there was going to be a big rebellion here because we had the smoking rooms but I have found since they stopped with the smoking rooms and have nicotine replacements, there are a lot less altercations. There were so many altercations as well as health issues because you could smell the cigarette smoke throughout the unit."

"I think it is for the better. I am surprised with how smoothly it has gone."

And smokers didn't find it difficult. "*As a smoker the policy doesn't affect me as much as the weather does. Which means when it is cold outside, I smoke less."*

The majority of nurses agreed with the health benefits from the policy and that patients were adapting. Wendy felt: "*The policy is good because I see patients*

smoking less, and they are not spending all their time in a smoking room being exposed to second hand smoke."

Donna noted changes over the two years: *"People are more informed of the policy and accept it, but the first year it was hard."*

Lisa, a smoker, commented: *"There are a lot of patients happy with the policy, they like the clean air, even the smokers. It's made me more aware, I am a smoker."*

Tracy was positive about the smoking ban: *"I explain they are on close observation and not allowed off the unit and offer NRTs. I apologize and they are accepting of that. If you seem empathetic with them it helps."*

Pam noted: *"Most of the patients accept the policy, even the hard core smokers, unless they are totally psychotic."*

The outdoor smoking ban and the ability to escort patients outside to smoke were not as clearly accepted by nurses. Jody thought: "*The policy is not working patients are still smoking at the front and back doors and everywhere. That is the part that I don't agree with. I agree with no smoking. We got if off the site and it is not here anymore but it is good in saying that they can't on the grounds, but it is very hard to enforce. My own idea would have been to have a place where the patients can go on the hospital grounds, like in the middle of winter where are they going to go?"*

At different sites, the same thoughts were expressed.

Jessica thinking was: "*I wish they had a smoking room in the hospital, not on the units."*

Pam thought was: *"I wish we had an open courtyard where they could go outside, get fresh air and have their cigarettes and come in even if they are on close."*

The policy stopped the practice of escorting patients outside to smoke and a few participants did not support the policy.

Joan did not support the concept: *"We are not supposed to but I would escort a patient outside to smoke. If they have to be escorted, there is a reason."*

Cate, a smoker said: *"I think everybody has their right to decide whether they are going to smoke or not smoke so I wouldn't have a problem escorting them out. The other thing is I am a smoker."*

Jessica experienced an extreme reaction when a patient could not smoke. She felt: *"Some accommodations should be made. Having a cigarette will de-escalate whatever is going on for them. Take them outside to have a smoke."*

Different sites had conflicts with how nurses followed the policy. Jody explained: *"We can't take patients outside because there was a time when certain staff would do it if they had time but other staff were upset and it just created problems on the unit so nobody does it now."*

Donna saw it as: *"I would never take a patient outside to smoke, and it's a problem because you have a shift where a staff voluntarily will do it and than another shift is not prepared to do that. You end up with a patient adjusting to different answers and in our experience it becomes more agitating to the patient. If we can give those NRTS to get over the hump of cravings, they would not be bounced around."*

There are nurses pleased with having the escort duty removed. Lindy said: *"I enjoy the policy I don't have to spend time supervising people outside smoking."*

Wendy who disliked the smell of smoke said: *"I am not obligated to take patients out to smoke, so that is very nice."*

Smoking privileges mean the patient has ground privileges or general observation and therefore can choose to smoke when outside. Ground privileges can be full without restriction or limited to 15 – 30 minutes before the patient has to check back with the nurse. The physician in charge of the patient makes the decision whether a patient is safe and responsible to be outside unsupervised by staff. The comprehensive smoking ban has introduced ground privileges as smoking privileges and thus creating new dynamics in the unit culture. Nurses are pressured by patients to advocate for them to the doctor to get privileges. Jessica said: "*When patients first come in it takes up a lot of time because they keep asking for cigarette privileges.*"

Fay described how she responded to newly admitted patients "*We tell them they have to adjust their smoking and discuss with the doctor their options like being placed on general observation.*"

Smoking privileges can mean more work for the nurse because the unit stores cigarettes and lighters for the patient. Cathy described her role when patients had smoking privileges as: *"If they have general observation that means they can go outside and smoke but we keep their lighter and cigarettes. It's a locked drawer so somebody has to this and there are days when we spend a lot of time opening and closing that drawer."*

Pam saw the nurses' role as: *"If they have smoking privileges their cigarettes are locked up with their lighters and they have to be given out maybe three times an hour."*

Smoking privileges can also mean less work for the nurse. Tracy described one of her long term patients as *"She goes off and has her smokes and she is not a problem."*

2.) The Psychiatrist

Nurses perceived they were responsible to make patients aware of the policy, enforce it at least indoors, help patients deal with nicotine withdrawals and prevent them from acting as a fire hazard. The psychiatrist has the authority to dictate the level of observation for the patient and the prescribing rights for the NRTs. The relationship between the nurse and psychiatrist with dealing with their patients' tobacco dependency is not always smooth. Carla described the usual routine as *"It is still a problem when they come because when they are admitted the duty doctor is not asking them if they are a smoker or informing them that they will be on close observation and not allowed to smoke. We have to do it on the unit level. Like phone them right away or later or a few hours later and ask for NRTs."* Not all doctors are consistent. Jessica who worked at two different sites was frustrated in regards to how doctors prescribed NRTS. "*At one site almost every doctor orders full NRTS without batting an eye, and at another hospital there is a bit of a bad attitude you have to write it yourself after calling the doctor because they say whatever.*"

Psychiatrists were giving patients ground privileges that were not congruent with the observation policies. Nurses expressed major concerns during the interviews and again in the focus group regarding this. Fay described an incident when a patient asked for privileges as: "*The doctor does not feel he is safe or reasonable to be on general observation but we let him out for smokes. That is a conflict of ideas.*"

At a different site a similar situation was described. "*We will phone and say please let them and we get strange orders where somebody is on close observation but they are allowed off for ten minutes for a smoke. Simply to manage behavior!*"

3.) The Patient

Nurses enforce the policy which can evoke degrees of anger from patients. Nurses are the staff who endorses consequences such as taking away patient's cigarettes, or smoking privileges (nurses have authority to put patients on a higher observation level, but cannot reduce it). Nurses end up monitoring cigarettes, providing NRTs, monitoring nicotine withdrawals, policing the unit and running interference when patients demonstrate deviant behavior such as stealing cigarettes etc. Comments reflecting these experiences were:

"Patients are at the desk constantly asking for smoking privileges."

"We get irritable having to deal with cigarettes constantly and NRTS and they get tense with us. Often they ask why can't you just give me a smoke. Why can't; you just take me off the unit for a smoke? So it adds another layer of tension to our relationships." "Nurses end up mediating when patients borrow cigarettes from each other and some how; the nurse ends up in the middle."

Nevertheless nurses saw smoking as a choice patients ought to be able to make.

"I think it is everyone has the right to decide whether to smoke."

"I think it is the final assault on their rights to be able to do something for themselves." "It's the only think they have control over."

And some sympathize as Jessica illustrated. "*I have gone out to the bus stop with them to smoke, because I see them trying and really trying to cope, so it's at the nurse's discretion."* And some nurses were struggling:

"I think our patients see it as their only pleasure and it is hard to take it away."

"We are putting people in a position where they have no choice so you really should be offering the NRTs."

Understanding Smoking Cessation and Temporary Nicotine Withdrawals

The policy is in place to protect all individuals from the harmful effects of second hand smoke which means when one visits or stays in the hospital they are not permitted to smoke for that time. All the participants' settings offered patients the opportunity to receive outside privileges. Nurses did not consistently interpret the meaning of the policy as intended.

"They just wait until they have privileges and go and smoke anyways."

"As soon as they get their privileges they are off smoking."

"I think it is a hard thing for them to quit when they are first admitted. It just adds to their anxiety."

"Quite honestly I don't think the policy is working. I still see them smoking."

"I am not 100% on board that everyone should quit smoking."

NRTs are supplied by the organization to treat nicotine withdrawals patients experience when not allowed to smoke. Nurses interpreted using NRTs more for cessation than immediate nicotine withdrawals. Fay thought: *"They are useful but they are not used appropriate no matter what kind of teaching you do they still go back to their cigarettes."*

Jessica described how nurses had different approaches *"Some nurses will say go put the patch on and smoke a little less today. I can't do this based on what I understand."*

Cathy when describing an aggressive incident commented: *"A patient was ranting and raving to be escorted out for a cigarette wasn't offered the NRT because he was not on the smoking program."*

Role Frustration

Nurses expressed feeling frustrated. They had conflicting feelings about their patients smoking, experienced practice inconsistencies from psychiatrists and their colleagues, enforced the policy and were caught in the middle of the policy, patient and psychiatrist. The policy has created more demands for the nurses, such as phoning doctors to prescribe NRTs, or asking for smoking privileges for the patient, or monitoring patients with odd observation privileges, handing out cigarettes, storing cigarettes, supplying NRTS and policing for fire hazards. Throughout the interviews a sense of frustration was expressed. Donna talked about the discussions around smoking that she heard from other nurses: *"Some nurses express that they are not here to police someone's smoking, but to help them get better."*

Pam described her role of monitoring for fire hazards as: *"It's a lot of wasted time dealing with those issues."*

Cathy saw the problem more in relation to helping patients quit smoking: *"It's frustrating you try but they don't want to quit."*

Jessica described her roles dealing with the smoking issues and added: *"We get irritable having to deal with cigarettes constantly and NRTs and they get tense with us."*

Wendy thought patients had a right to decide to smoke, however felt frustrated: *"Its frustrating because you think to yourself smoking is bad."*

Pam frustrated with the policy stated: *"We are the ones enforcing it."*

Cathy saw her patients as attempting to quit smoking only when they had no money: *"Staff wonder why waste our time and money because the only reason they are trying to quit is because of money, nothing other than money."*

Ambivalence and Conflict Between Rights and Health

As nurses talked about their perceptions of patients' smoking behaviors they oscillated between supporting their patients' right to smoke and their role as a health professional to condone health promoting behaviors. Jody described smokers' rights as: *"Once they get their privileges and want to smoke, I think it is their right."*

Wendy described her role as: *"I try and discourage them from smoking, but it is an option they have."*

Joan thoughts were: *"I think they see it as the final assault on their rights to be able to do something for themselves."*

Donna described the concept as: *"It's a tough call to taking away that liberty away from someone to make their own choices."*

Lindy who liked the policy supported patients' right to decide: *"They can make the decision whether they want to smoke or not."*

Cate felt: *"It should be a personal choice."*

Smokers were described as more active and social. During the interviews nurses saw smoking as positive for patients and later would comment on the harmful effects of smoking. Fay was adamant patients need to smoke and at the same time described her self to be health conscious. *"I am anti-smoking obviously for health, because I am very health conscious. They don't care about the consequence and I think we can teach them until the cows come home about how sick they are going to get but their lives aren't very good anyways, so really."*

Jessica felt smoking offered comfort to her patients. "*My basic premise as a nurse is they should be clothed warmly or comfortable, they should be well fed, should have medications that keep them calm and should have cigarettes."* Later she described smoking as *"I don't think smoking is healthy but in terms of harm reduction, there are a lot more unhealthy things*." She reasoned: *"We are on the 6th floor and it's a lot of work for them to get down there to smoke, so they are getting a lot of fresh air and movement."*

They acknowledged their role in promoting better health. Wendy stressed: *"If they are tolerable of teaching, I would certainly do it around the health benefits. But also just to reiterate that is not my choice, it is theirs."*

Jody made references to physical illnesses as a time to do more teaching: *"People with COPD and congested heart failure you really try and encourage them to stop smoking."* She also thought: *"Patients don't have the drive to quit; it is something they have been used to for years. I think the young ones coming from a different era are more open to that."*

Lindy spoke about when patients are first admitted: *"I don't think it is the right time to preach or teach them about it."*

Fay who supported patient smoking said: *"We do a lot of health teaching."*

Lisa felt admission into hospital was not the right time to quit smoking *"It's not fair to the patient when they first come in, let them get settle and then gauge when to do teaching."*

Pam explained: *"Our patients in their forties and fifties; they got COPD, and they are asthmatic which compounds it. They are on a couple of inhalers; they are very short of breath. We try and point it out to the younger people but they don't see it that way, they want their cigarettes. I think the younger ones are maybe the ones we should really be kind of targeting."*

Cathy described a time when the whole health team tried to get a patient to quit smoking: "*We had this one guy and eventually he passed away, this is one even the doctor really really tried to have him quit but he didn't want to."*

Jody made the observation: *"You know patients over the years and you see them develop chronic illnesses."*

Cathy supported her reasons to allow patients to smoke: *"As patients age and they are smokers you see the long term physical effects, hacking coughs, high blood*

pressure, but because of their mental illness and antipsychotic medications that are hard on their kidneys and liver so their quantity of life is already shorten so if cigarettes give them happiness why not."

Jessica described smokers as: *"Some have chronic coughs, yellow fingers and lots of colds."*

Wendy's reason to do health promotion teaching was*: "It has so many health risks as well as being expensive as well as picking up butts from other peoples dirty old used cigarettes."* She added: *"You know the patients over the years and you see them develop chronic physical illness. You see them in the community smoking outside in the cold, or picking up butts."*

Nurses found they responded to their patients' smoking in relations to their finances. As part of their role, nurses often teach money management skills.

Jody frequently tells her patients*: "Why you don't quit, look at the money you would save."*

Wendy said*: "I often ask them if they have thought about quitting especially if their funds are really limited."*

Tracy encouraged smoking reduction: "*You talk to them about cutting back if they don't have funds."*

Joan spoke about the past: "*Smokers are sick more, have less money. We used to budget their cigarettes for them but we can't anymore. They don't have the willpower to limit their cigarettes. In some case I think we should still be budgeting for them so their smokes will last them for the week."*

Nurses' perceptions in relation to aggressive incidents tended to be ambivalent. Fay described a male patient craving cigarettes with no smoking privileges "*He just started to get frustrated with not being allowed off and he was starting to disturb the unit. I talk him down eventually, he took some stuff but I heard the next day had Accuphase for the same reason. This would not have happened if he could have smoked.*"

Not all nurses are convinced it is about the smoking. Jessica used humour when she dealt with patients unhappy with the policy *"You have to separate the nicotine-wanting behavior from the mental health issues and I do this firmly and kindly with big people standing beside you."*

Wendy felt it didn't matter what caused the aggression: *"I feel no different about the incident than I would about any type of situation that escalates like that but you deal with, its part of your job regardless of the reason for it."*

Jessica's experience included an assigned patient successfully hanging himself an hour following an incident where he was upset because he could not smoke. The patient had refused the NRT she offered, but accepted medication to calm him down. It was a week later when she was interviewed and this is how she described it. *"Sometimes I wish they could just smoke because at least 30% of the reason they are upset could be dealt with. Despite the issue of smoking it would be another issue."*

Pam had experienced a few incidents with patients acting out when denied smoking privileges: *"It gets a bit mixed up because some of the acting out behavior*

they will focus on the smoking and act out but maybe they would be acting out anyway."

As a result of new practices nurses saw new behaviors occurring in their patient populations which made a difference to their roles. Jody reported: *"I see progress with patients accepting the inhaler when they initially didn't."*

Pam near the end of the interview changed her mind about the smoking rates and said *"Quite a few patients have actually quit smoking. They just quit with help from staff and the smoking cessation groups."*

Nurses expressed a need to examine and adjust their practice in response to the new behaviors and situations. Jessica after her experience thought: *"We have to figure out something where people are comfortable when they come on the unit in terms of smoking so whether that is better NRTs or more free flowing NRTs."*

Cathy was not convinced that NRTs worked: *"We need some other type of medication."*

Fay saw helping patients with nicotine withdrawals as more than offering medications: *"We are limited to what activities we can offer a patient when on close observation, and they need something other than smoking."*

Cathy also thought: *"Maybe they need extensive counseling for which we are not trained for."*

Donna found the process of the interview made her more thoughtful about patients' smoking: *"We have started a 'metabolic thing' to help people make healthier choices. So, I guess that is no different from making a life style choice for stopping smoking."*

Jody believed it was important from the beginning to start teaching: *"Some nurses will tell patients it is a bad time to think about quitting, but some nurses would support it."* Nurses found it more comfortable with helping patients reduce their smoking.

"Even if they cut down half of what they are smoking, that is a big step."

"We don't say quitting completely but maybe cut down."

"It's very addicting and difficult especially being in an acute area. Getting them to decrease is the focus, than getting them to smoking cessation programs."

Focus Group

Due to illness and babysitting issues three participants attended the focus group. The duration of the group was approximately 70 minutes and was tape recorded. In the focus group nurses confirmed patients smoking less over the years and reasoned the trend was related to the majority of nurses being ex- smokers or non- smokers and general societal norms. During the discussion there was an emphasis placed on the biggest difference in practice is having NRTs available. Not only did it help manage patients' nicotine withdrawal symptoms but it facilitated opportunities for patients to such as: *"It's an opportunity for exposure with using the NRTS."*

Nurses at the focus group discussed problems with how psychiatrists understood the policy and managed patients' smoking behaviors. They agreed that the physicians' practice created heavier work loads because nurses were having problems tracking the where about of these patients when they were given 15

minute smoking breaks. They felt psychiatrists didn't support the smoking policy and therefore made up new formulas for patients' ground privileges. Nurses also didn't like NRTs prescribed as needed because of the documentation involved. They wondered why the doctors prescribing habits varied so much with something that was so frequently used by the patients. In fact the nurses expressed them as so routine they no longer saw them as medication.

At the focus group the consensus was that long before the increase cost of tobacco and introduction of smoking restrictions, patients had problems maintaining a supply of cigarettes. Further their behaviors with seeking cigarettes were described as not changed. *"They were going off in the bushes and doing favors for cigarettes thirty years ago."* The policy has created new patient needs and behaviors and nurses do not have a blueprint on how to respond. Rules in place do not address the entire phenomena. Participants expressed it as a challenge and described their pragmatic adjustments. Lindy put forth: *"Maybe I am cold, but I don't have a problem with patients not being able to smoke. I see patients as having the ability to cope."* Jody added: *"I think we short change them and pamper them and maybe this is harming them. From my experience most patients are okay with not being able to smoke."* All of the nurses saw positive changes. *"It's an opportunity for success to go without a cigarette for an extended period of time." "It's a good time for them to try and quit because they are in a supportive setting."*

Chapter Four

Discussion

This research described how mental health nurses perceived their role in respect to patients' smoking behaviors. With a smoking ban in place patients were smoking less, experiencing nicotine withdrawals and sometimes displaying difficult behaviors. As a consequence nurses had to manage the patients' withdrawal symptoms and related behaviors which added to their workload. Nurses also described colleagues including psychiatrists, as being inconsistent in their attitudes and support of the smoking ban. This led nurses to feel frustrated in their role with dealing with patients' smoking behaviors. Along with feeling frustrated nurses described a conflict between assisting patients to practice healthy behaviors and allowing them to make their own choices.

I found new concepts were raised in my research as compared with previous studies. First, I have identified nurses as experiencing more frustration and a heavier workload managing their patients' smoking behaviors. Second, the recognition that NRTs have become an established routine in psychiatric nurses' practice but may increase workload, especially when physicians relatively take the responsibility for prescribing and managing NRTs. Third, nurses described a cultural shift by incorporating smoking cessation interventions into their routines and adopting attitudes that psychiatric patients can cope without smoking. To my knowledge these concepts have not been adequately explored in the existing literature.

Expression of Value Conflict

The experiences of the nurses in regards to their response to patients' smoking behaviors are understood in terms of a conflict between the ethical principles used to guide nursing practice. These ethical principles are values that include promoting the health and well being of patients and promoting and respecting informed decision-making. Before the introduction of the smoking bans the majority of nurses accepted heavy rates of smoking with their psychiatric patients and fell into the practice of promoting smoking rather than providing advice about the harmful effects of smoking. There was little or no controversy about whether a patient had the right to smoke as they chose. At the time of this study smoking bans in psychiatric care units had been in place longer than two years and nurses were no longer able to fully ignore the consequences of smoking for their patient population. The smoking ban has left mental health nurses in a position of simultaneously supporting patients' smoking behavior and smoking cessation. As a result many maybe torn between acting as an advocate to promote their patients' right to make their own decision and actively intervening to help a patient achieve health-related goals. The results of this study found some nurses tended to contradict their value of promoting health and minimized the effects of tobacco in relation to their patients' health.

Nurses guide their practice following a code of ethics set out by the Canadian Nursing Association. In no order of importance the code of ethics

providing safe, compassionate, competent and ethical care is listed as number one, number two is promoting health and well being and promoting and respecting informed decision making is number three (Code of Ethics for Nurses, 2008). Ethics in nursing are guided by values and norms and how a nurse assumes responsibility for them is influenced by the context of their work environment, policies and sociopolitical community. The complexity of ethical decision making is difficult to resolve as values are related and overlapping or are in direct conflict with the health care practice. The codes of ethics are intended to guide nurses in their practice, promote self reflection and dialogue with other nurses and ultimately promote optimal health. In the process of ethical decision making questions have to be asked and discussed and contemplated. Knowledge about a subject is required in order to make informative decisions or develop practice guidelines. Nurses require, many types of knowledge in order to execute a reasonable ethical decision making process (Hawley, Young & Pasco, 2000).

The majority of adults in Alberta recognize the health risks of tobacco use; however those who smoke are least likely to agree with the public perceptions of risk (AADAC, 2007). The nurses interviewed were cognizant of the effects of tobacco use; however they tended to rationalize the harmful effects of tobacco because they perceived that it offers psychological and physical comfort to their patients. Most nurses interviewed had a vague understanding for the dynamics involved between psychiatric patients, smoking and smoking cessation. They were not consistent in their understanding or acceptance of the smoking ban. Despite not having full knowledge and understanding it was nurses who informed patients of

the smoking ban and enforced it, at least indoors. Further nurses worked in environments where the cultural and leadership condoned patients' smoking and therefore made their role more of a paradox.

Nurses have adapted their practice based either on their own beliefs or the collective beliefs of their co-workers. Without the knowledge, decisions are based on opinion wants and desires of patients (Kikuchi, & Simmons, 1996). Patients that experience intense nicotine withdrawals symptoms can provoke nurses to feel helpless and provoke them to make emotional decisions. Nurses rationalized their decision making to support patients' smoking as to be in the patient's best interest and thus allowing them the right to make their own health related decisions.

Issues Related to Smoking Cessation, Especially Nicotine Replacement Therapy

Nicotine replacement therapy (NRT) appeared least understood by nurses who did not support the policy or felt patients were being forced to quit smoking. They also thought patients misused NRTs because they were not motivated to permanently quit smoking. Nurses in this study described physicians to be inconsistent with how they prescribed NRTs which affected how they were actually able to use them. Nurses who regularly provided patients with NRTs for temporary and long term smoking cessation found it made a difference with how patients reacted to the ban. In turn these nurses felt they were able to comfort a patient experiencing nicotine withdrawals.

Nurses assumed several roles in response to patients' smoking behaviors. They were policy enforcers, manager and distributor of patients' tobacco supplies,

provider of the NRTs and health educators. Most nurses were happy that they no longer had to escort patients outside to smoke, although a few perceived this as increasing their workload because they had to find other ways to deal to help an agitated patient. Nurses usually assumed the responsibility to ensure patients who smoked had NRTs prescribed. Nicotine replacement therapies were routinely prescribed as whenever necessary which meant nurses were handing them out frequently at odd times throughout the day and had more required documentation. Some nurses complained about the additional work.

During a normal shift nurses had to meet the several requests for NRTs, cigarettes, and lighters from the majority of their patients. Non-adherent patients who smoked on the unit were perceived as fire hazards and their behaviors had to be closely monitored by the nurses. Patients that were unhappy with the smoking ban were noisy and described as unsettled. Occasionally a patient's aggressive behavior would escalate and require intensive management. Nurses did not describe patients who could not smoke to display a change in their affective state such as depression. Ethical conflicts, NRTs, inconsistent staff practices and increased workloads have led nurses to feel frustrated with their patients' smoking behaviors.

Perceptions of Organizational Support and Lack of Support for Smoking Cessation: Smoking and Privilege or Using Smoking for Social Control

Few of the hospital unit settings have changed their practice with the way they manage their patients' smoking. Cigarette smoking continues to dominate culture in the psychiatric unit. Nurses described patients' behaviors to be much as it has been for the past 30 or more years. The majority of patients smoked. The

smokers were more social, non- smokers enter the facility and took up smoking, patients smoked to alleviate boredom, bartered for cigarettes between each other, and smoked cigarette butts. Nurses stored patients' tobacco either to help them budget their supply or prevent them from smoking on the unit. Managing patients' tobacco supply forced patients to have regular contact with the nurse and ultimately gave nurses control. Indeed nurses no longer use cigarettes as an incentive because they acknowledge it as an unethical practice; however nurses in the study reported using smoking privileges as an incentive. Patients' consumption of cigarettes was described to have changed over recent years, where they smoked less, coughed less and slept better at night.

Findings from this study are similar to the ethical dilemma of mental health nurses investigated by Lawn & Condon (2006). In their study nurses' ethical decision making was based on the context of the environment and cultural that condoned smoking. They felt the practice and beliefs of the nurses were a group based phenomena. In my study I found the nurses who liked the smoking ban and promoted smoking reduction with patients tended to refer to their practice in personal terms rather than "the team" or "we". Individualist thinking nurses felt their practice was different from other team members in terms of how they promoted smoking cessation with their patients. This suggests the majority of the health care team were less likely to promote smoking cessation and their actions and ability to reason are influenced by the norms of the unit.

Nurses assumed several roles in relation to patients' smoking behaviors such as budgeting and controlling patients' cigarettes that were consistent with the roles

noted in studies done prior to the introduction to smoking bans in psychiatric facilities. Cigarette privileges were used as an incentive which is similar to using a cigarette. In this study nurses excused this behavior due to the lack of incentives available to use with mental health patients. Lawn & Condon (2006) cited similar reasons regarding this practice from the nurses in their particular study.

Knowledge Deficits Create Barriers to Smoking Cessation

Lack of knowledge of tobacco, tobacco cessation and treatments among health care professionals working in mental health is recognized as a barrier to helping. Psychiatrists are reported as having a poor record with offering tobacco cessation interventions. In one survey done of patients in a smoke-free psychiatric unit, NRT was prescribed to just over half of the smokers (Kisely & Campbell, 2008). This supports how nurses in my study reported psychiatrists to be inconsistent with prescribing NRTs and basically not supporting the smoking ban.

In my study nurses felt the smoking ban had increased their workload by the ubiquitous use of NRTs, monitoring for non-compliance and the continuous management of patients' cigarettes. In other studies nurses in settings where smoking was permitted spent an average of 15 minutes per 8 -hour shift managing patients' cigarette use. Units that allowed smoking privileges outside spent up to four hours a day managing patients' off -unit smoking behavior (Prochaska, Fletcher, Hall & Hall, 2006).

Several nurses described a decline in the amount their patients smoked. They attributed this to smoking restrictions, finances, and societal norms. This is anecdotal information but nevertheless may be an accurate reflection of recent

trends. There was a significant drop in smoking rates in a community of outpatients diagnosed with schizophrenia according to a recent Canadian longitudinal survey. Multifactorial reasons were attributed for the declining rates (Goldberg, J. & Van Exan, J., 2008).

Limitations

Limitations to the study include the sample size and selection of participants. I was not able to select participants because of a poor response to my recruitment efforts. The research was conducted during the winter months and nurses' perceptions reflected upon their patients' current behaviors. For example more patients are likely to sneak a cigarette indoors when it is -25° C outside and this may have contributed to the emphasis nurses placed on the non- adherence issue. My questions were semi-structured and did not include exploring in depth how nurses perceived their patients' feelings in regards to being placed in a position where each time they were craving they had to ask for a cigarettes or NRT from a nurse. Nurses who volunteered to participate in the study were more likely to have been interested in the issues and had a higher level of critical thinking than nurses who did not participate. Therefore my data should not be considered representative of all mental health nurses' experience with patients' smoking behaviors.

Implications

The main findings of this research indicate nurses are struggling with a conflict between ethical principles and are working with inadequate knowledge of tobacco cessation interventions. The implications are that nurses in this study were not consistent in their practice which ultimately affected their patients. Lack of

tobacco cessation education came from issues related to nursing education programs and organizational commitment and support once nurses were in the workforce. According to the nurses in this study tobacco cessation was not taught in their education program or in the work place. If they received any information it was for less than two hours.

Nurses must have the support of their organizational administration to reinforce the value of tobacco cessation. This can be demonstrated with supporting and encouraging nurses to participate in tobacco cessation education. Nurses in this study had yet to develop goal directed care or standardized careplans to help patients deal with temporary nicotine withdrawals or to help them achieve long term smoking cessation. The practice of using smoking privileges as an incentive reinforces the value of patients' smoking for nurses. Smoking is an addiction which means a smoker feels a strong and unconscious drive for cigarettes that may override some rational thought and behavior. This makes it more powerful than other desires and therefore it is effective with motivating their behaviors. Promoting smoking may not help patients make healthy behavior choices. Perhaps nurses have to be more cognizant of their values between the patient's behavior that needs motivation to change and the behavior used as the incentive.

Conflicts between nurses, psychiatrists and inadequate protocols to manage patients' smoking behaviors have led to nurses feel frustrated. Ultimately this affects the messages patients receive about their smoking behaviors. Conflicts stem from having an inadequate knowledge base, and when one has adequate knowledge understanding the dilemma is clearer. To understand their ethical conflict and

develop clarity of the issue, nurses need an avenue to open up dialogue. Having the opportunity to discuss their understanding of the issues, exchange ideas and planning care can promote new meaning to their roles in relation to patients' smoking. Education is recommended for nurses to learn tobacco as a chronic relapsing disorder, the neurobiology of nicotine, and the pharmacological interventions available for smoking cessation. If all nurses were to have accurate and reasonable levels of tobacco knowledge than consistent and effective protocols could be developed and practiced. Further studies at different settings are needed to examine these phenomena to help generate clinical knowledge and understanding of the challenges nurses have in their roles with patients' smoking behaviors.

Conclusion

This study described the experiences of mental health nurses working on psychiatric units within the Capital Region of Alberta. Interviews were conducted immediately following the Alberta Government passing comprehensive tobacco smoke legislation and therefore it would not have had any influence over the results of the study. With little support from other professionals and the organization nurses have adopted new routines to adapt to a non smoking policy forbidding patients to smoke indoors and on hospital grounds. Little has changed with those patients who were allowed to smoke. Nurses continued to practice traditional management with patients smoking behaviors along with providing NRTs for periods when their smoking was restricted. There were some exceptions where nurses incorporated teaching and support with patients to reduce or quit smoking.

Without supports, minimal tobacco cessation knowledge, no goal-directed care plans and inconsistent practices between staff, nurses felt frustrated with additional workloads related to the smoking ban. This suggests mental health nursing is in need of letting go of traditional practices such as controlling patients' cigarettes and focus on tobacco cessation interventions that are beginning to emerge. By receiving more tobacco cessation education and changing their own behaviors then perhaps nurses will be able to work through the ethical conflicts they are presently experiencing.

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Appendix A

Participants Screening Questions

To screen participants these were the following questions developed:

1. How many years experience have you had working in a psychiatric setting?
2. Have you used tobacco in the past six months?
3. What is your work place setting?
4. What is your level of education?
5. Where did you graduate from?
6. What is your current job title?

Interview Questions

Present role with patients' smoking
Please describe your workplace.
open unit, forensic setting, locked doors, type of patient population
What role do you currently have in practice?
Do your patients smoke? How often?
How frequently is patients' smoking addressed in your daily practice?
What do you see as your role around them smoking?
Monitoring their smoking behaviors, controlling their supply
Offering cessation interventions
Have you used cigarettes as an incentive with patients?
If so, when and why?
Have you ever withheld a patient's cigarette to modify their behavior?
If so, when and why?
How frequently do you provide smoking cessation interventions?
For example providing NRTs, brief counseling
If you were asked to escort a patient outside to smoke, what would you do? *Why?*
Can you describe an experience where you had to deny a patient the opportunity to smoke?
Are you comfortable with your current practice in regards to patients' smoking? Why?
Explore possible dilemma or ambivalence they may have

Smoking cessation support knowledge
What experience have you had with patients achieving smoking cessation?
Do you feel psychiatric patients have the ability to quit smoking?
What experience have you had with patients achieving smoking cessation?
What are your views on how smoking affects your patient's mental health?
What are your views on how smoking affects your patient's physical health?
If a patient tells you he wants to quit smoking. What is your response?
What type of supports come to mind? What influences guides you for example the mental state/physical status of the patient?
What are your views about using nicotine replacement therapy?
Does it help patients with nicotine withdrawal? How do patients use it?

Tell me about the counseling you might do with a patient who is a heavy smoker?
Explore harm reduction, smoking cessation interventions,
What do you document in regards to patients' smoking and smoking cessation interventions? *Explore if documenting is a barrier to providing interventions*

Effects of Smoking Policy
Are you aware of the local health polices around smoking?
How well do you think these are working? Why?
What are your thoughts regarding patients who quit smoking concurrently when being treated for a mental illness?
How do you see the smoking policy affecting your patients?
How does the smoking policy personally affect you?

Influences patients' smoking/restrictions have on unit atmosphere and relationships
For individual patients, what influences your approach to managing their smoking behaviors?
How do patients react to your intervention? How if any does your intervention affect your relationship with the patient?
What experience have you had with patients becoming aggressive when they are not able to smoke? Can you describe one experience? How was the aggression managed?
Explore how effective it was. How did you feel about the incident?
Please describe how your patients who smoke spend their day.
For example do they attend programs?
Are they preoccupied with smoking?
Is there a difference between patients who smoke and those who do not?
Explore patients –socializing, health, finances
Have you experienced a patient who has been non-compliant with the ban? Tell me what happen.
What happens when a patient who smokes runs out of tobacco?
Explore how they cope -do they borrow, smoke butts, use of NRTs. What role might the nurse play when this happens?

Influences and Education
What are you views of smoking in general society?
Tell me about what training or education has influenced your approach with patient's smoking behaviors?
Explore formal education, workshops, work experience, literature, informal teachings
Which model or care plan do you use to guide your tobacco cessation interventions?
Does your institution have protocols in place? And are they used?
How does your treatment team approach smoking cessation interventions?
Is it important to the treatment plan? How? What role do nurses play? For example who initiates interventions?

Do you feel the treatment team you work with share you views and understanding of the smoking issue? Explain.

Explore the differences if any

Are there any identifiable barriers preventing smoking cessation promotions at your place of work?

What do you see as future issues surrounding psychiatric patients' smoking?

For example cost, housing, stigma, need for smoking cessation programs

Appendix B

Problems with patients smoking Indoors

One girl irritable and edgy and she smoked in her bathroom…she ended up getting accuphase at the end of the incident because she was really angry

A few minutes later he is smoking in the bathroom and you have to do another search

We monitor the patients smoking in the bathrooms

Smoking in the bathroom or in their room we document it.

Winter is worse.

Patients that have ground smoke on the units. They want a cigarette and they want it now.

Doctor told him that he was not going to get grounds but some how he gets cigarettes and he is smoking on the unit. The doctor gave up and gave him grounds but he has to come and ask for a cigarette when he goes out. So they are dishing the cigarettes out to him. Because he smokes so much on the unit

It's a bit annoying because you have to deal with other things going on. The reason the cigarettes are at the desk is because he patients will go smoke in their rooms or shower or somewhere.

We will catch them smoking in their rooms, we search their rooms and sometimes they get mad because we find their hidden cigarettes. I find that it is more that if one starts to do it, it almost teaches the others ones the deviant behavior

The issue of smoking in their rooms is a huge issue for Nurses for fire hazard

They are not supposed to smoke at night but they do far too often. Some more likely o than others.

For patients smoking on the unit we intervene

Those not allowed off the unit smoke on the unit, they get cigs from other patients, hide them even though we check. In the winter they are quite happy to be on close observation and smoke inside where it is nice and warm.

Its becoming a strong hazard, work place hazard because there are people smoking on the unit, they are hiding in the bathrooms, locking themselves in bath rooms stalls to smoke and they won't let us in. There could be a fire in there and they won't let us in. They are at risk locking themselves in areas that are dangerous.

No Smoking Outside Policy

Can't escort patients outside - there was a time when certain staff would do it if they had time but other staff were upset and it just created problems on the Unit so nobody does it now.

They are not really meant to cross the street in our area. I am sure they will cross the street. It adds a whole other set of complications because I think if they are hit by a bus on the street then we are not liable because they're off property, and the insurance issue with that.

Some will go down every hour for a smoke some will go and won't see them

We stopped taking them outside to smoke; it's usually the aides that take them outside for walks. I know one aide was doing it, but I don't know if he still is. One

aide tells the patients no smoking when she takes them out because she is not going to lose her job over it.
Once they get their grounds and they want to smoke, I think it is their right.
We had a lady who was a heavy smoker like two packs a day, she came in depressed and couldn't smoke, and I offered the patch which she took. I think it was a month and she didn't have any cravings at all. She got better and able to go off on grounds. Even with the patch when she was out there in the company of other patients and they were smoking, she said "I can't, I just went right back to smoking"
They feel it is a social thing. They go out and a lot of the patients are smokers and they just kind of light up. Patients have this thing. "I'm outside why am I not allowed t do it?" it's what patients have the great grief about"
Non smoker spends more time on the unit than smokers
He wasn't smoking as much and occasionally he would say it's too cold, I don't want to g out for a smoke. I am craving but I am going to take the inhalant. So for two hours, three hours he was able to take the inhalant, he didn't take a cigarette.
Some on general get there cigarettes and stay outside longer.
I gone out with patients that are long term and they are still on close observation and I just feel bad for them. They are not a behavior problem and just waiting for placement.
You see patients smoking right at the door all the time
Smokers spend a lot of time outside, they skip out, they know their group is in five minutes and they say I am going for a quick smoke and then they don't come back.
They are huddled at the door way entrances its, a big pile of smoke for people to go through
I think everybody has their right to decide whether they are going to smoke or not smoke so I wouldn't have a problem escorting them out. The other thing is I am a smoker
I have gone outside to the bus stop with patients to let them smoke because I see them trying and really trying to cope, so it's at the nurse's discretion. It takes a lot of time and traveling around
We are on the 6th floor and it's a lot of work for them to get down there to smoke, so they are getting a lot of fresh air and movement
They spend their day off the unit a lot so if you a smoking patient you might not see them or get a chance to talk to them because they are gone so much. They are very social with all the other smoking patients but not with much else
If they don't attend programs consistently may get on close observation so it motivates them to attend
If they are going out lots to smoke it is recorded
We are not supposed to but I would escort a patient outside to smoke. If they have to be escorted, there is a reason. They didn't request to be mentally ill. So why are we penalizing them. I don't understand that, they are just cigarettes.
Ones with privileges go outside about once an hour to smoke
When they have privileges to go outside, smokers arrange their day around it
We have to stop patients from smoking in the bathrooms
Some patients will smoke in their bathrooms or any corner they can find

I would never take a patient outside to smoke, and it's a problem because you might have a shift where a staff voluntarily will do it and that a shift that is not prepared to do that. So you got a patient adjusting to a different answer and in our experience it becomes more agitating to the patient. If we can give those NRTs to get over the hump of craving, then they are not being bounced around.
I have an ethical issue with people going to the edge of the property to smoke; sending people to the edge of a busy street is not safe
85% of our patients smoke, if they have privileges and no activities and the money they would be outside the whole time.
I don't have a problem escorting a patient outside to smoke. If people have a concern with smoke they would have left for a different type of work. Staff that work here are used to patients smoking.

Smoking is all they have
They often don't have anything else in their life except smoking.
It's their coping mechanism, it is the only thing they have and we take that away from them too. I think they see it as the final assault on their rights to be able to do something for themselves.
Their lives are pretty, excuse the word, you know, messed up anyways t they really do not care about their health, their overall health.
You have to have something in our life worth quitting for and I don't think heir health is enough of an incentive.
It gives them pleasure and they enjoy it and they don't have anything else, usually the rest, and a lot of the times the rest of their life is in ruin or in a mess.
They are an unhealthy group to begin with
One of the problems I see is that there isn't enough for them to do on the unit.
Patients tell me they are more relaxed when they smoke
We have patients say "this is my only pleasure in life, my only vice and I am probably going to die from complications but I don't want to give it up" I think a lot of our patients think this is the only thing they have and it is hard to take that away
In their minds it is beneficial. They use it like comfort
It would be the non smoking that affects their mental health
It is the only thing that they have in their life that they enjoy.
It's a calming thing for them, it brings them psychological pleasure. It's the one thing they have control over if they have money. It's their coping mechanism to ease stress

Not so nice behavior (Violence)
They are rude and obnoxious in response to any attempt to teach
One girl irritable and edgy and she smoked in her bathroom…she ended up getting accuphase at the end of the incident because she was really angry
He came to the desk wanted to go off for a smoke and I said "no" and he started yelling abuse at, the hospital
He was just starting to get frustrated with not being allowed off and starting to disturb the unit. I talked him down eventually, he took some stuff but I heard the next day that he got an accuphase for the same reason

If you offer the NRT he will throw it in your face
It gets bit mixed up because some of the acting out behavior, they will focus on the smoking and act out but maybe they would be acting out anyway.
Going into other people's rooms and taking cigarettes
Stealing cigarettes at night. The night staff was not impressed, they were upset, and they said the cigarettes should be put away at 1000 PM
Getting agitated because they cannot go out numerous times in a day. Or else they are not allowed to go off because they are supposed to be going to groups and they get annoyed with that. They get annoyed because they cannot go out first thing in the morning.
There are still patients when you say you can't go out for a cigarette and they might start yelling and cussing at you. At times there have been people that have thrown things across the room, usually the psychotic people
I have never had a physical altercation, just verbal
I feel bad for the patient but it is no excuse to become violent and aggressive.
We get irritable as nurse having to deal with cigarettes constantly and NRTS and they get tense at us. "Why can't you just give me a smoke? Why can't you just take me off the Unit for a smoke" so it does add another layer of tension to our relationship
He starts demanding cigarettes and of course there is nothing that you can do. And there is no way that he could get off the unit because it was a locked unit and the policy is they don't go off the unit. He escalated being verbally aggressive and hen became physically aggressive to the point that security had to be called and he needed to be secluded. But that is certainly the exception to my experience.
On an acute unit, come in as heavy smokers, they call staff down and yell and scream and demand to have a cigarette. Its surprising it is minimal and does not happen all that often in the acute area.
It happens often when patients are first admitted and find out they cannot smoke. They become agitated.
A patient was agitated, put in seclusion, and offered the inhaler which he threw. He was on constant for a while, but a few days later he did accept the inhaler for cravings.
It happens more frequently than people want to believe it does. Someone becomes very anxious and wants a cigarette to relax which they use at home. When they are in a volatile state and to teach them something else is very difficult. It's not a teaching time. You try and deal with in a different way but it is hard.
I have seen everything when you can't give them a cigarette, they get on the floor and star kicking and screaming, kicking their feet at the walls, screaming give me a cigarette, some will try and burn you with a cigarette, spit at you. You end up having to get a doctors order and give them an injection. They are offered the NRT but they won't even entertain the idea.
Smoking is a pleasure they have and they have very few things
When we couldn't escort a patient outside for a fresh air break, he was quite upset, ranting and raving. He did a typical temper tantrum, but he didn't get to the point where we had to restrain him. He ended up reporting it to the program manager

saying his rights were denied. He wasn't on the smoking program so he didn't have NRTs prescribed otherwise we would have offered him one.
Smoking is the one thing they have that brings them happiness in life, the only quality of life that they see, than we should give them the opportunity.

Using NRTS
They are offered to everybody
We have puffer, patch, and the gum. The gum is offered q hourly
Some get 4 mg and some get 2 mg so it is offered every hour if they want it or if they ask for it. If they are pushing, than obviously to get a cigarette then we offer it but normally we wait for them.
Soon as they come, its order up and offered right away
We use them a lot - we have to offer them something
We have people who take the patch and go smoking anyways which is bit of a problem
One lady used to take the patch at night because during the day she could smoke and night she could just get a little nicotine feed.
They are useful but they are not used appropriate no matter what kind of teaching you do they still go back to their cigarettes.
They are used as a way of helping patients until they can go and smoke
It keeps them quite
It helps with withdrawals, but not initially like the first day. You can fill them up with all the nicotine you want but they are going to miss the whole idea of smoking, the part of the relaxation
If you offer the NRT he will throw it in your face
They never choose t take it if it's their choice, like if they are a voluntary patient and they are on general observation and they're smoking, they never take that stuff.
I let them know they have the option
A lot of them only tried the gum, they didn't know about the inhalant. I make sure they are aware of these
He is using the nicotine inhalant and it seems to curb his cravings
He is a heavy smoker, we offered him the patch at time sand he just doesn't want it. After he got grounds four days later be is out here smoking
I don't mind the policy because the NRT are so available now that I am comfortable with that, you know for the people that are n close.
Our doctors are really good, they say just write it down and we will order it for you. We find some people come in and nothing is written and they say "I'm a smoker, a pack a day, how am I to survive you're locking me up." I don't see problems in my practice because I offer the replacement them and say "it's either that or cold turkey"
It's not like a cigarette but at least they have that nicotine in their systems.
Sometimes you see that they are ready to blow and they say they're not going to be able to, but once hey get, it just takes the edge off and right away you can see that they are more cooperative. So it usually works that way.
They will take the inhalant and cut down on their smoking

Some of them just don't want to take the patch. Some of them have a real misconception that we are trying to get them to quit. We are always reinforcing and teaching all the time that the patch will help them from being cranky.
He wasn't smoking as much and occasionally he would say it's too cold, I don't want to g out for a smoke. I am craving but I am going to take the inhalant. So for two hours, three hours he was able to take the inhalant, he didn't take a cigarette.
Will be at the desk every hour or two requests a cartridge or a gum
I thought there was going to be a big rebellion here because we had the smoking rooms but I have found since they stopped with the smoking rooms and have nicotine replacements, there is a lot less altercations. There were so many altercations as well as the health issues because you could smell the cigarette smoke throughout the unit.
It's not too often but the ones that don't have money or financial assistance take the replacement
As soon as the doctor knows they smoke it is ordered
I have to do teaching with saying "you cannot chew this gum on the hour, have a cartridge and go smoking because their heart rate goes up really high. I encourage them to stop or at least cut down but you also have to monitor them because they think the more nicotine the better
It's not as satisfying to them as having an actual cigarette but at the same time I have found that does. It has calmed down with cigarette altercations because they do have an alternative. They are less combative because they have an option. I always encourage them t use it.
We mark it off on the computer each time they have a gum or cartridge but when it is busy people just hand it out and forget to mark it off.
It might not be the right time for them quit and maybe after they have tried the NRTS it might give hem the initiative to quit in the future when they are at home and doing well.
They offer them NRTs and do quite well with them
Lately I have been keeping some gum (NRT) in my pocket and some cartridges in my other pocket. Ready to give it as they need it.
If a patient is trying to quit depending on how much of a smoker they are, a patch once a day and then to it up with as much inhalers and gum as they need and to attend groups or whatever
I really push the inhaler because I think it is a good thing
A patient was getting the patch and smoking all day, and that is not safe. I have read depending on the health of the patient you can get chest pain and cardiac issues from smoking and wearing the patch at the same time
It's a lot of documentation; it would be nice if they weren't classified as medications. Its extra work
We have to figure out something where people are comfortable when the come on the unit in terms of smoking so whether that is better NRTs or more free flowing NRTs
Some nurse go "put on the patch and maybe smoke a little less today than yesterday" I can't do this based on what I understand

At the RAH almost every doctor orders full NRT, patch, gum & inhaler without batting an eye, and at another hospital there is a bit of bad attitude you have to write my own order
The information from the website on NRTs was enough to get me going
The patch gets into their blood stream and they literally just forget and that is nice. It seems to take the edge off
On nights will give out NRTs maybe 2 to 3 times a shift. They get the gum and go back to sleep
We suggest the patch, gum and my role partly is to inform them that hose products are available and do the teaching around that, but also to teach the benefits of not smoking while they are in hospital
The most popular is the gum, but there has been favorable response to the patch.
You automatically make them aware that here are NRTS available in the hospital and they can be ordered. You are putting people in a position where they have no choice so you really should be offering it.
Offer the NRTs sometimes they are interested, sometimes they are not
We tell them they are on close observation and cannot smoke and we offer the NRTs.
Patients tell me they really help. They can go through an extended period of time without smoking and using NRTs
Smokers find each other; they go out in groups of 3 or 4s. They use company and cigs. If they go out to smoke alone they are not out as long
We offer if when they are trying to quit or when they are on close observation
Everybody kinda has one that works. And some say it is crap and none works
Many just use it to cut down rather than quit
When a patient is out of tobacco we offer the NRT, sometimes they take it
We take the history and if they are a smoker we phone the doctor for orders
We try and empathize with the patient and offer the NRTs as the second best thing when they are unable to go outside to smoke. We don't do anything in terms of health promotion; we are just trying to diffuse the situation
Night staff offer it frequently as patients cannot go out to smoke.
One woman accepted the NRT for cravings and ended up quitting
You end up having to get a doctors order and give them an injection. They are offered the NRT but they won't even entertain the idea.
Some patients are positive about them. . Even those who smoke on the patch some very minimal and gradually kinda reduce.
They come and ask when they see others using NRTs
I do see them helping with withdrawals, it's a different way of curbing the smoking, and however, the hard part it is still not stopping them from smoking.
The nicorette gum helps them reduce because they don't like the gum so they will put it off until they have that real ad withdrawal feeling. The nicotine inhalant I don't know, I just see it helping because it is reducing the cigarette but they are still having the same nicotine intake.

Nicotine withdrawals

Use getting smoking privileges to calm them down and help them deal with the Withdrawals of their cravings and stuff

I am not a smoker but I can see they are craving for it and you have to have something to replace that craving. It is still a problem when they are admitted, the duty doctor is not asking the "are you a smoker? You are on close observation you are not going to be able to." We have to do it on the unit level. Like phone them right away or later on a few hours later and say that we need all these replacements. When a patient runs out of money we offer the NRT
Patients with chronic illnesses such as schizophrenia smoking becomes part of their coping skills and if they cannot smoke they become irritable and anxious. Being allowed to smoke reverses that, they become more approachable, more amiable
It happens often when patients are first admitted and find out they cannot smoke. They become agitated. We give the NRTs and see how that works, which sometimes it does
I would never take a patient outside to smoke, and it's a problem because you might have a shift where a staff voluntarily will do it and that a shift that is not prepared to do that. So you got a patient adjusting to a different answer and in our experience it becomes more agitating to the patient. If we can give those NRTs to get over the hump of craving, then they are not being bounced around.
I have seen progress with accepting an inhaler when they initially didn't
They go on the smoking cessation program, try out the nicoderm patch, they finish step one, go to step 2 and than they come into money and decide that they didn't want to continue in stop smoking and they will smoke.

Frequency of dealing with patients smoking issues
Maybe 3 times an hour
If they have smoking privileges their cigarettes are locked up with their lighters and they have to be given out maybe 3 times an hour
We have to search him for cigarettes all the time
I don't think I address the NRTS everyday
We don't really monitor what they smoke. With cigarettes they are independent
We monitor the patients smoking in the bathrooms
Doctor told him that he was not going to get grounds but some how he gets cigarettes and he is smoking on the unit. The doctor gave up and gave him grounds but he has to come and ask for a cigarette when he goes out. So they are dishing the cigarettes out to him. Because he smokes so much on the unit
Will be at the desk every hour or two requests a cartridge or a gum. Otherwise, we have the cigarettes behind the desk because they are supposed to pick them up when they go out and return then when they come in. And that can be every half-hour to an hour.
It's a bit annoying because you have to deal with other things going on. The reason the cigarettes are at the desk is because he patients will go smoke in their rooms or shower or somewhere.
Some patients are so obsessed about their cigarettes they are at the desk constantly asking when can I go out for a cigarette
Staff get annoyed that a big part of their time is spent getting cigarettes, putting away cigarettes and giving nicotine replacement therapy. There are many smoking

related requests per shift. It depends on how they are and how self directed they are. Some on general get there cigarettes and stay outside longer.
We mark it off on the computer each time they have a gum or cartridge but when it is busy people just hand it out and forget to mark it off.
The issue of borrowing, stealing and begging so we keep their cigs at the desk and give them out one at a time if they request it. But we don't control cigs. I am giving out cig arêtes every 10 to 15 minutes, or giving out NRTS
We get irritable as nurse having to deal with cigarettes constantly and NRTS and they get tense at us. "Why can't you just give me a smoke? Why can't you just take me off the Unit for a smoke" so it does add another layer of tension to our relationship
We strip them of addictions and that does cause a lot of conflict, it causes more conflict than any thing else I can think of
We spend a lot of time giving out cigarettes but we spend even more time paroling and catching people smoking, asking people not to smoke, fires in the garbage cans, we spend a lot f time and have a lot of conflict
If you are caught smoking you are put on close observation
When I am nursing smoker it generally comes up several times a shift. It is generally their concerns over their ability not to smoke while they are on the unit and what I can do to help them out with that
Some of patients keep cigs in office because of smoking in their rooms or other patients will pass out their cigarettes, sometimes when they are going out for a cig we give them the whole package or maybe one at a time. Give one at a time is a financial issue.
5 – 10 times a day I am either doing wanting or other in relation to smoking
Dealing with it quite frequently, at admission they assess how much a person does smoke. They make sure there are orders for NRT. Patients smoking in the bathrooms, so than they are securing patients' cig and lighters. Time is spent with doling those out and in setting limits on that. Limits are set because of patient's limited income and have a public trustee/sw assisting with managing their money. We budget to ensure they have cig in the evening for those whose judgment is impaired. It's a tough call taking that liberty away from someone to make their own choices
Hourly at least, they keep their cigarettes in the office and they got them in their lockers than you have to help them by getting them and going down with them to the locker. It takes up a lot of your day dealing with the smoking issue. Those not allowed off the unit smoke on the unit, they get cigs from other patients, hide them even though we check. In the winter they are quite happy to be on close observation and smoke in side where it is nice and warm.
It takes a lot of nursing time to go around and a lot of wasted time to deal with those issues. With 28 people on the unit it takes quite a bit of time.
Sometimes we have people on the smoking program and they have doctor's orders for certain prns or smoking cessation strategies. It is not always and usually only 3 to 4 patients.
Ones not on smoking program we are busy rationing out their cigarettes

Locking up cigs is inconvenient but at least it gives us control, because smoking indoors is a fire hazard
Maybe they will be more successful the next round, and we give the teaching but we feel what is the point hat it is the same thing that they are going to go back to smoking. Staff wonder why waste our time and money because the only reason they are trying to quit smoking is because of money, nothing other than money.
They have no tools to help them quit. We give the nicorette gum and have to deal with the rest on their own.

Dealing with cigarette privileges
When patients first come in it takes up a lot of time because they keep asking for cigarette privileges
They just wait until they have privileges and go and smoke anyways, off the premises
If they have smoking privileges their cigarettes are locked up with their lighters and they have to be given out maybe 3 times an hour
If they have general observation that means they can go outside and smoke but we keep their lighter and cigarettes. It's a locked drawer so somebody has to this and there are days when we spend a lot time opening and closing that drawer
Once there was a young girl and her behavior was quite inappropriate and we used cigarette privileges as a behavior modification thing for her but that was just once and it was like I said a young girl. You have nothing to use except the cigarette
As soon as they get their privileges they are off smoking
She goes off and has her smokes and she is not a problem
So they will be at the desk creating problems, they will be noisy
We will phone and say please can we let them and we get strange orders where somebody is n close observation but they are allowed off for ten minutes for a smoke. Simply to manage behavior.
So now we are letting them off the unit so we're jeopardizing our belief that he should be on close because but he's allowed off for smokes. The doctor does not feel he is safe or reasonable enough t be on general but we let him out for smokes. That is a conflict of ideas.
By the time they are teachable they have general observation and really don't have control.
As an incentive – we used to do that, maybe one or two nurses are still doing that but personally I don't
It's a matter of safety we will take them away from them. When I was working nights..
Some patients are so obsessed about their cigarettes they are at the desk constantly asking when can I go out for a cigarette
Used as incentive with patient who had thoughts of hurting himself. "You know what if you have suicidal thoughts or you are going to hurt yourself or others, you will not be allowed out for the rest of the day because you are a danger to yourself and others I am not going to let you go out for cigarettes. Which I thought was perfectly logical. It ended up that the whole day and evening he never mentioned it once because he would have had his smoking revoked.

If patients have general observation they can smoke off the unit but on the short stay unit they are not allowed to smoke. It means at times they will discharge against medical advice so they can go smoke after sometimes within an hour, sometime within a day, but often they cut short their admission because they are not allowed to smoke
The motivation to go outside is to smoke at the bus stop
Ones with privileges go outside about once an hour to smoke
When I am nursing smoker it generally comes up several times a shift. It is generally their concerns over their ability not to smoke while they are on the unit and what I can do to help them out with that
Some of patients keep cigs in office because of smoking in their rooms or other patients will pass out their cigarettes, sometimes when they are going out for a cig we give them the whole package or maybe one at a time. Give one at a time is a financial issue.
Sometime we have them wait to go out for a cig because the temp is too cold, or perhaps the doctor is coming to see them. We say no you have to wait for your smoke but it is always rational
We tell them they are on close observation and cannot smoke and we offer the NRTs. We tell them they have to adjust their smoking and discuss with the doctor their options, like being placed on general observation, or getting orders for NRT
Patients see ground observation as an incentive, without it they cannot smoke. We say "if things are going well if your behavior is good, than you can go outside and smoke.
When dealing with a patient who smokes, a non smoking nurse is less understanding
We budget to ensure they have cig in the evening for those whose judgment is impaired. It's a tough call taking that liberty away from someone to make their own choices
It's more as an incentive with privilege to go smoke. We use their own cigs, and say if you stay calm go can go for a smoke. I have seen done to attend groups. There are so few rewards in a mental health unit and we really need to look at changing that. It is an easy one to slide into using.
It is something they choose to do and really like to do, it's more of a reward. It helps to modify behavior, say something like you can't go for a cigarette yet.
They sit around all day smoking and drinking coffee. It's relaxing for them but it becomes a habit
Honestly a large chuck of stuff is not documented because of time it takes including when they smoke on the unit

Patients' Smoking Rates
About 90% of our patients smoke, maybe 95%
We have heavy smokers
Some say they smoke 5 or 6 times a day
Probably 50% are heavy smokers and hen you get a variety with the other 40 – 45%
I don't agree with it at all because it is well known fact that psych patients smoke more than others.

I know someone who started smoking while they were on a psych unit so they could be part of the group
Some will go down every hour for a smoke
Some will smoke constantly if they have cigarettes
Some of them smoke 2 packs a day it depends on weather, in summer time they smoke more.
In the winter time, if it is really cold, then they don't want to go in the cold and so they will only go a few times a day
A lot of their smoking is centered around coffee time, meal times that first smoke and then a lot of them before privileges e over they all have to rush out that last ten or fifteen minutes to get that last cigarette. They have been to some kind of groups or they have been there for an hour so they need a cigarette.
More than half the patients smoke
They smoke half a pack to pack a day
They go outside to smoke about 12 times a day
I have withheld them going outside to smoke because their behavior is erratic
Even a 2 pack day smoker would be hard pressed to smoke two packs a day in hospital Ones with privileges go outside about once an hour to smoke
One third to one half of patients on the unit smoke, some only go out to smoke a couple times a day
Over my 30 year career here are fewer smokers and you don't get the really really heavy smokers.
Approximately 75% of the inpatient population smokes. A lot of them when they come are smoking more than a pack a day. I suspect they are smoking more than one at a time when they go outside to smoke
The majority of our patients smoke, maybe 1 an hour, but given a chance they would smoke more.
They sit around all day smoking and drinking coffee. It's relaxing for them but it becomes a habit
85% of our patients smoke, if they have privileges and no activities and the money they would be outside the whole time.

Cessation
So they never quit smoking. I have yet to see a patient who has quit smoking
They just wait until they have privileges and go and smoke anyways
As we get better we say to them "you know this is a good opportunity to quit, you are not allowed off. Some will respond but I honestly don't think we have helped anybody quit.
Cough when they are not allowed to smoke. It is almost like the system is clearing out so then as soon as they smoke they feel better, the aren't coughing as much. So they feel really bad when the quit.
We would be thrilled if a patient quit smoking
We had one girl who did try to quit, but she ended up smoking again.
My problem here is that they are stressed and need to be discharged and your life fairly smooth and then think about quitting.

People have t choose something instead of smoking like exercise…we don't have that available We are limited as to what we can offer while they are a patient on close. If there are groups they go to them.
Maybe they need extensive counseling that we are not trained for
We will push at the doctor's request, who thinks he is going to quit, but then he r she will tell you that they are not going to quit.
People who have everything going for them and they still can't quit and then we are asking these people to quit and they have nothing. They don't care. We can teach them until the cows come home about how sick they are going t get. I don't think they care to quit.
I'll say "have you ever thought about cutting down or have you ever thought about giving it up?" Some of them will say they have been smoking for 30 years, and "I'm not going to stop now, I am in the hospital, I am too depressed, or I am stressed here. I need my cigarette.
Even the young ones I will mention it to
Its Good time to ask them if they have ever thought about quitting
He keeps saying he is going to quit but he doesn't follow through
With some patients that are really resistant I don't even address it.
There have been a few patients who have quit. They come to your smoking cessation program even on the unit. They have decided that they are not going to smoke. There have been a couple out of the lot, it's not a lot but.
A lot don't want to quit
It's frustrating you try but I am not a smoker so maybe I don't feel how they do.
There have been a lot of patients where you try but they don't want to quit so what do you do?
Maybe they have smoked for too long hey can't quit, thirty years is a long time.
I don't know if there is ever a time for the patients to quit I think the younger ones that are coming in the first time, are maybe the ones we should really be kind of targeting. But I am not giving up on the chronic ones
When a patient says they want to quit we give positive reinforcement
Then they change heir mind the next day
Sometimes we are so surprised that someone wants to quit that we just encourage them and we know about your group so we refer them
Patients while here have quit or cut down. It's not too often but the ones that don't have money or financial assistance take the replacement
Sometimes patients don't have cigarettes for weeks but he second they get out they are puffing
If they didn't quit when they were healthy they are not going to quit when they are really ill.
People with COPD and congested you really try and encourage them t stop smoking
I think it's a hard time for them to quit when first admitted, it just adds to their anxiety and frustration
It's very difficult to get them to quit, I don't know how a person can even get them t stop. How do you even start? They have enough issues to deal with so quitting is the last thing on their minds.

There is the odd time that an outpatient wants to do something about their smoking. They will do it on their own or ask the physician for a prescription. In the last 16 years I can count maybe two people that might have mentioned something abut quitting smoking.
If they have quit, most of them by that time have generally already started smoking again
With someone with a mental illness it takes an awful lot of courage for them to try and that the chances of them succeeding are less.
If a patient wants to quit smoking the treatment team and staff would do anything they could to help them with that
It will be the patient that completely surprises you, the 20 year smoker, the 2 pack a day smoker and those with a low IQ they get it in their heads. And that they are going to quit.
It's been the 5% rather than the 95%
I think it is a good time for them to do it, that they are in this setting, a very supportive setting
Quite a few patients actually quit smoking. They just quit with help from staff and the smoking cessation groups
It is their own choice, if they choose for one they will save money
If someone is really ill then let's leave it and deal with quitting at another time. I am not 100% on board for that everybody should quit
When they are admitted for treatment of mental illness it may not be the most successful time to try, but I highly commend them as it is difficult to do.
If they were tolerable of teaching, I would certainly do around the health benefits. But also just continue to reiterate that it is not m choice, it's theirs
I try to discourage them from smoking but that is an option they have
I personally haven't had the opportunity with patients actually quitting smoking while in hospital
When they are working through some other issues, smoking is not a priority to them
The illness (mental illness) itself is a barrier to quitting smoking
They just quit when they are on close observation
One woman accepted the NRT for cravings and ended up quitting
Patients need support with coping skills to quit, we can help teach coping skills, but I don't know if we are skilled to help with smoking cessation
Some nurses will tell patients it is a bad time to think about quitting, but some nurses would support it.
We are trying to deal with psychiatric problems and more acute short term medical problems and not really seeing smoking as a place to invest a great deal of energies, unless on their own initiatives they are looking for that. Although we have started a metabolic thing so we are starting to look at helping people make healthier choices.
It's difficult to get people on smoking cessation in an acute are. The real focus it to get people to smoking cessation programs, getting to stop or decrease.
Patients don't have the drive to quit; it is something they have been used to for years. I think the young ones coming in from a different are and are more open to that. Most nurses used to smoke

I do see them helping with withdrawals, it's a different way of curbing the smoking, and however, the hard part it is still not stopping them from smoking. We need some other type of medication to help them. The tobacco program set up in the hospital is well organized and so we send the referrals there.
The fact that there are a lot of patients smoking is a barrier to smoking reduction/cessation
They go on the smoking cessation program, try out the nicoderm patch, they finish step one, go to step 2 and than they come into money and decide that they didn't want to continue in stop smoking and they will smoke.
Quitting is challenging and hard, and for forensic patients they are already mandated to give up their other addictions.
It should be a personal choice
Most of the time when patients want to quit smoking it is because they can't afford to smoke

Reduction
I don't see the 2 pack a day smokers, I see more half pack a day that is all they can afford
Some of them limit themselves
It depends on weather, in summer time they smoke more.
In the winter time, if it is really cold, then they don't want to go in the cold and so they will only go a few times a day.
I'll say "have you ever thought about cutting down or have you ever thought about giving it up?" Some of them will say they have been smoking for 30 years, and "I'm not going to stop now, I am in the hospital, I am too depressed, or I am stressed here. I need my cigarette.
Even if they cut down half of what they are smoking, that's a big step
You talk to them about cutting back if they don't have funds
They will take the inhalant and cut down on their smoking
The greatest barrier is they feel that they can't' do it so it is for us to try and say "you know why don't you try and do it one day at a time. We don't say quitting completely but maybe cut down.
He wasn't smoking as much and occasionally he would say it's too cold, I don't want to g out for a smoke. I am craving but I am going to take the inhalant. So for two hours, three hours he was able to take the inhalant, he didn't take a cigarette.
Patients while here have quit or cut down
Ones that have been here long term a lot of times have cut down
They take one cigarette out due to being bombarded by others for cigarettes and they don't want to lie
I find it positive that they smoke less
I rarely see a patient come in with the goal to reduce the amount they smoke
Some are quitting

Nurses Role
We provide counseling
We give medication

We do behavioral mod a bit
I guess we control it. I mean we monitor and control it maybe which I suppose is similar to monitoring/controlling their behavior in general
Cigarette not an incentive, but you kind of do it indirectly in that when they are acting out about smoking; you say "well you know, in a couple of days you will be able to go smoking"
Use getting smoking privileges to calm them down and help them deal with the withdrawals of their cravings and stuff
As we get better we say to them "you know this is a good opportunity to quit, you are not allowed off. Some will respond but I honestly don't think we have helped anybody quit.
I always say to the guys when I give them a cigarette "you know this is bad for you, its bad for your health" they don't care.
I don't think that is the time to preach or teach them about it
We have to search him for cigarettes all the time. I don't really mind he goes along with it.
We're the ones enforcing it.
I take care of their physical, social and psychological needs
Some people have problems with COPD or they have eczema and this health issue so I will talk to them about it.
Even the young ones I will mention it to
We do a lot of health teaching.
They will take the inhalant and cut down on their smoking
The greatest barrier is they feel that they can't' do it so it is for us to try and say "you know why don't you try and do it one day at a time. We don't say quitting completely but maybe cut down
Some of the nurses feel they don't want to quit so just leave it, but I think that is wrong. I think you should still try.
Group therapist and individual therapist
My basic premise as a nurse is they should be clothed warmly or comfortably, they should be well fed, they should have medications that keep hem calm and should have cigarettes.
Just make sure everyone is safe and in their place
If smoking at nights, I take away their cigarettes and put them in garbage the ones that I have had to d are okay with it, they know what's happening.
The outlook on smoking has changed. Beyond the whole of CH and everywhere. Like, it's a bad thing to smoke right now.
We are not supposed to but I would escort a patient outside to smoke. If they have to be escorted, there is a reason. They didn't request to be mentally ill. So why are we penalizing them. I don't understand that, they are just cigarettes.
Nurse's role in the non-smoking policy…they are taking the lead
We suggest the patch, gum and my role partly is to inform them that hose products are available and do the teaching around that, but also to teach the benefits of not smoking while they are in hospital
I don't know if counseling to a heavy smoker would make a difference

Nurse's first line is to offer them the NRTS, also distraction, helping them to self-soothe.
Nurse's role is to inform them NRTs are available, and then it is the patients' role to ask for them
From what I hear the vast majority of nurses didn't like the role of monitoring or policing the cigarettes.
I try to discourage them from smoking but that is an option they have
Monitoring, for cigarettes/lighters it is a safety issue for fires. Its part of the process of working with the patients
Get the doctor to order it, inform patient it is available and try and encourage hem to use it
Majority of time nurses phone to get the orders for NRT
For patients smoking on the unit we intervene
It's hard to minimize the power difference. It heightens the power difference. It's just another barrier to stabling that therapeutic relationship, but it is not an insurmountable barrier.
Nurses end up mediating when patients borrow cigarettes from each other. Some how the nurse ends up in the middle.
We do teaching about the NRTs like any other medication
Take care of them when you are in need, and get them back on their feet again, and ready for the community
We make they aware of the smoking cessation program from the get go

Nurses' perception of incidents
And what is really sad is that now she is on general and there is no acting out behavior at all. Some people may say it is the Accuphase but I don't think it is the Accuphase , its that she can smoke
He had been good during the day and I think he was just starting to get frustrated with not being allowed off and starting to disturb the unit. I talked him down eventually, he took some stuff but I heard the next day that he got an accuphase for the same reason. So, two in the last week.
Personally I think the incidents have lessen, its not so bad. Patients have accepted the fact.
But we don't control cigs
You have to try and separate the nicotine-wanting behavior from the mental health issues and I do this firmly and kindly with big people standing beside you
Sometimes I wish they could just smoke because at least 30% of the reason they are upset could be dealt with. Despite the issue of smoking it would be another issue
We strip them of addictions and that does cause a lot of conflict, it causes more conflict than any thing else I can think of
Not being able to smoke at the times they want to adds another layer of stuff we have to deal with
I feel no different about the incident than I would of about any type of situation that escalates like that but you deal with it, it's part of your job regardless of the reason for it.

Its unfortunate, but it is expected when people are going through emotional crisis, it is frustrating because you think to yourself smoking is bad, but you work through it the way you would with any sort of crisis.
There was a patient who was getting very agitated, and I guess if that patient could have gone out for a cigarette and all of this could have been avoided.
We budget to ensure they have cig in the evening for those whose judgment is impaired. It's a tough call taking that liberty away from someone to make their own choices. I think there is differing thoughts about on the unit in terms of what is the right thing to do. Some nurses express that they are not here to police someone's smoking, but to help them get better. It's kind of a necessary evil. I don't like power struggles, and we end up in a situation of power having control over someone's cigarettes. It's undesirable, but sometimes beneficial to the patient in the long run.
A lot of them smoke less than when they came in
You have to watch the non verbal of each person they give you cues of how to respond, it varies and dependent on the other patients on the unit at the time because it changes the atmosphere.
In one incident we could have taken a pt out and supervised, knowing that she was going to have a cigarette would have probably calmed her. Staff time and the intervention we had to do with her was not pleasant and wasn't for her, and wasn't for us.
The nursing team rations out cigarettes so they last longer
Our role is to educate and assist with dealing with recovery symptoms
When we are rationing cigs we are more gatekeepers to their supply. It's frustrating but we know if they run out of cigarettes they will have withdrawal symptoms and that would not be great as it would trigger their psychiatric symptoms. If they are having a lousy stressful day cig are used to calm them down versus using a prn medication. We use cigs to do their ADLs, it's a token economy and to bribe them with a cig that other people have left behind we give them an extra cig just as an incentive to do something.
We delay giving their own cig when we want them to do something. There is a bit of catch to it, its one of those little loopholes, it's a grey area that we have the capability of manipulating. Especially if we feel strongly about something

Smoking Policy
I don't agree with it at all because it is well known fact that psych patients smoke more than others.
I think they see it as the final assault on their rights to be able to do something for themselves
I hate I hate it. It makes me feel and a lot of staff are very upset about it because none of us want to do it.
We go through a lot of hassle not allowing them smoke privileges and then as son as they get them they are smoking. We haven't done anything except create a lot of problems for ourselves and upset for them, they get very upset here.
I was very upset because I knew if he had been allowed outside to smoke this would not have happened

We have weeks when it is not so bad
We're the ones enforcing it.
I don't mind the policy because the NRT are so available now that I am comfortable with that, you know for the people that are on close.
I don't see problems in my practice because I offer the replacement them and say "it's either that or cold turkey"
Policy is not working patients are sill smoking at the front and at the back and everywhere. That is the part that I don't agree with. I agree with no smoking. We got if off the site and it is not here anymore but it is good in saying that they can't smoke at the front or back of the building but it is very hard to enforce. My own idea would have been to have a place where the patients can go like on the hospital grounds, like in the middle of winter where are they going to go? If we had a place where they could go to smoke maybe they wouldn't be smoking close to the door.
Patients have accepted the fact.
Patients have this thing. "I'm outside why am I not allowed t do it?" it's what patients have the great grief about"
I am happy about it because I don't smoke and I didn't like it when it was on the unit.
It's hard to go outside, there is like 10 patients smoking, how you are going to tell them to go off the grounds. They are going to tell me to go somewhere else. So I just turn a blind eye. Winter is worse. Patients that have ground smoke on the units. They want a cigarette and they want it now.
It hasn't been that long and we need to give it some more time.
I explain they are on observation and not allowed off the unit and that there is NRT. I apologize and they are accepting of that. If you seem empathetic with them it helps. The ones that are not okay with it are the ones that are very very sick and don't understand what you are telling them or just can't accept it.
I thought there was going to be a big rebellion here because we had the smoking rooms but I have found since they stopped with the smoking rooms and have nicotine replacements, there is a lot less altercations. There were so many altercations as well as the health issues because you could smell the cigarette smoke throughout the unit.
You see patients smoking right at the door all the time. I am not going to police them outside, there are too many out there
I wish they had a smoking room in the hospital, not on the units
Most of the patients accept the policy, even the hard core smokers, unless they are totally psychotic
We will catch them smoking in their rooms, we search their rooms and sometimes they get mad because we find their hidden cigarettes. I find that it is more that if one starts to do it, it almost teaches the others ones the deviant behavior
I wish we had an open courtyard where they could go outside, get fresh air and have their cigarettes and come in even if they are on close.
Some accommodations should be made. Having a cigarette will de-escalate whatever is going on for them. Take them outside to have a smoke.
Quite honestly I don't' think they are working. They are still smoking

As a smoker the policy doesn't affect me as much at the weather does. Which means when it is cold outside I smoke less.
People are more informed of the policy, but the first year it was hard. They thought we still had a smoke room.
They should have cigarettes if they need them we strip them of addictions and that does cause a lot of conflict, it causes more conflict than any thing else I can think of
Not being able to smoke at the times they want to adds another layer of stuff we have to deal with
Sometimes all they want is a smoke and coffee and so you can't give them that basic comfort that would reassure them, calm their nerves and that is frustrating as a Nurse that you have taken away their ability to choose to smoke. It is probably the least of harm in terms of addictions
I feel it is harsh but that is the way
It's provided a better work place for me they are not supposed to smoke at night but they do far too often. Some more likely than others
I know they are supposed to off the grounds but they don't we are not supposed to but I would escort a patient outside to smoke. If they have to be escorted, there is a reason. They didn't request to be mentally ill. So why are we penalizing them. I don't understand that, they are just cigarettes
They can make the decision whether they want to smoke or not.
When I come to work, I can smell smoke and there are butts on the floor
I thought there would be a lot more people pissed off about it but it hasn't been that way
The policy did not influence me quitting, it was the cost
I am not 100% on board for that everybody should quit
Policy not working. I can look out my window and see people smokng. I can look out the window to the front of the building where there are clearly signs posted not to be smoking and there are people smoking in front of the door ways
I personally enjoy the policy. I don't spend time supervising cigarettes.
I think it is for the better. I have been surprised at how smoothly it has gone.
I am mixed, I appreciate not having to breathe in smoke but there are times when I feel that it is about people's rights
Working well enough within the hospital site, what actually happens when the patients go outside the hospital building, I am not aware.
The policy is good because I see patients smoking less, and they are not spending all their time in a smoking room being exposed to second hand smoke.
I am not obligated to take patients out to smoke, that is very nice
Its one of those things that is difficult
They are smoking at the doors, not just patients from the mental health program. I am wasting m breath saying anything. There is no enforcement
People smoking on the grounds everyday and you can tell a person, but they don't
Night staff says it has made a huge difference; people are going to bed and sleeping at night, on the other hand since closing the smoking room some patients get agitated that they cannot smoke
I have an ethical issue with people going to the edge of the property to smoke; sending people to the edge of a busy street is not safe

Most patients have come to realize and accept that the no smoking policy is part of the deal. It's positive in a way as it is an opportunity for exposure with using the NRTS.
It's an opportunity for success to go without a cigarette for an extended period of time.
Its becoming a strong hazard, work place hazard because there are people smoking on the unit, they are hiding in the bathrooms, smoking under mattresses locking themselves in bath rooms stalls to smoke and they won't let us in. There could be a fire in there and they won't let us in. They are at risk locking themselves in areas that are dangerous.
There are cig butts everywhere.
I would prefer a designated indoor smoking area, but the emphasis shoulder on smoking cessation.
The grounds are too large and most people don't make it to the edge of the property and if they go off the property they are actually AWOL, and no they don't get too much past the front doors, especially in the cold weather
It's not fair to the patient when they first come in, let them get settle and then gauge when to do teaching
There are a lot of patients happy with the policy, they like the clean air, even the smokers
It's made me more aware, I am a smoker and have used some of the NRTs, and I have reduced
It's taking away their rights.
AHE is different from other sites because it is long term. They don't have another place to escape to smoke.
It should be a personal choice
It's not working because it upsets patients when they cannot smoke and we have to give out more prns to pacify them

Concerns with patients smoking
But our patients somehow, even if they don't have any money, they find the money, that is the first thing they buy.
In my teachings if they say they don't have any money and I say "what about trying to cu down?" Even if they cut down half of what they are smoking, that's a big step.
He smokes it all in three days and then he has nothing
Our patients have been smoking the majority of hem since hey were in their teens and a lot of the time you see the end result. Our patients are in the forties and fifties; they got COPD, asthmatic so that compounds it. They are on a couple of inhalers; they are very short of breath. And when we try and point it out to the younger people they don't see it that way, they want their cigarettes. I think the younger ones that are coming in the first time, are maybe the ones we should really be kind of targeting, I think. And let them know that there are these aides and have them to groups and talk with them.
I often ask them if they have thought about quitting especially if their funds are really limited.
You talk to them about cutting back if they don't have funds

We had one guy and eventually he passed away, this is one the doctor really really tried but he didn't want to.
I think a lot of our patients think this is the only thing they have and it is hard to take that away.
I always find those who don't smoke have a little more money
Our patients can't afford this
It would be good if we target he young patients that are smoking and try to get them to se the end result of smoking. Encourage them to go through the smoking programs
It has so many health risks as well as being expensive as well as picking up butts from other peoples dirty old used cigarettes.
Smokers have chronic coughs and yellow fingers and lots of colds. It seems they get sick quicker but they don't lie around.
They should have cigarettes if they need them
Sometimes all they want is a smoke and coffee and so you can't give them that basic comfort that would reassure them, calm their nerves and that is frustrating as a Nurse that you have taken away their ability to choose to smoke. It is probably the least of harm in terms of addictions
They smoke out of boredom …being on aish can be quite boring
The heavy smokers have horrible coughs; they get really bad bronchitis in the winter
It affects their ability to exercise and keep fit because they are sitting and smoking instead of being active
Smokers look more weathered and haggard, but smokers keep their weight down, I don't think smoking is healthy, but in terms of harm reduction there are a lot more things such as gambling that is more unhealthy, food and obesity is more unhealthy than smoking
They choose to quit, for one they will save money
Smokers are sick more, have less money. We used to budget their cigarettes for them but we can't anymore. They don't have the willpower to limit their cigarettes. In some cases I think we should still be budgeting for them so their smokes will last them for the week.
If they were tolerable of teaching, I would certainly do around the health benefits. But also just continue to reiterate that it is not m choice, it's theirs
Smokers are much more engaged you automatically make them aware that here are NRTS available in the hospital and they can be ordered. You are putting people in a position where they have no choice so you really should be offering it.
I think smoking is very unhealthy, I tell patients why you don't quit, look at the money you would save.
Patients with chronic illnesses such as schizophrenia smoking becomes part of their coping skills and if they cannot smoke they become irritable and anxious
Chronic coughs, decreased appetite
Finances, picking up butts, although seeing this less over the years
In the long run they are going to end up with emphysema, lung cancer, CPD. I see this happening with heavy smoking patients. You know patients over the years, and

see them develop this chronic illness. You see them in the community smoking outside in the cold, or picking up butts.
Some nurses express that they are not here to police someone's smoking, but to help them get better. It's kind of a necessary evil. I don't like power struggles, and we end up in a situation of power having control over someone's cigarettes. It's undesirable, but sometimes beneficial to the patient in the long run.
I would never take a patient outside to smoke, and it's a problem because you might have a shift where a staff voluntarily will do it and that a shift that is not prepared to do that. So you got a patient adjusting to a different answer and in our experience it becomes more agitating to the patient. If we can give those NRTs to get over the hump of craving, then they are not being bounced around.
Patients going around picking up cig butts, having stained fingers reinforce the stigma of mental illness
You try and deal with in a different way but it is hard.
Its becoming a strong hazard, work place hazard because there are people smoking on the unit, they are hiding in the bathrooms, locking themselves in bath rooms stalls to smoke and they won't let us in. There could be a fire in there and they won't let us in. They are at risk locking themselves in areas that are dangerous.
They don't eat properly because their taste isn't quite the same
If they are on oxygen and smoke I encourage not to, or if they are confused.
Patients who smoke tend to be more active, non smokers are calmer and more relaxed
I think most people who are smokers, or ex smokers understand it more than people who have never smoked.
The fact that there are a lot of patients smoking is a barrier to smoking reduction/cessation
As patients age and they are smokers you see the long term physical effects, hacking coughs, high blood pressure, but because of their mental illness and antipsychotic medications that are very hard on their kidneys and liver so their quantity of life is already shorten so if cigarettes give them happiness why not.

Appendix C

Second Set of Categories

Nurses caught in middle of policy/psychiatrist/patient

Patients want a cigarette and they want it now
Doctor told him he was not going to get grounds but some how he gets cigarettes and he is smoking in the bathroom
So we are dishing out cigarettes to him from the office because he smokes so much on the unit
Sometimes they get mad at us because we find their hidden cigarettes
Some staff were escorting patients outside to smoke which upset the rest of the staff so now we can't.
Once they get their privileges and want to smoke, I think it is their right
I have gone out with patients that are long term and they are still on close observation and I just feel bad for them.
You see smokers at the doors smoking all the time so the policy is not working
I think everyone has the right to decide whether they smoke or not so I would not have a problem taking them outside to smoke, I am a smoker.
I have gone out to the bus stop with them to smoke, because I see them trying and really trying to cope, so it's at the nurses' discretion.
They didn't request to become mentally ill. So why are we penalizing them? I don't understand. They are just cigarettes
I would never take a patient outside to smoke and it's a problem because you might have a shift where a staff voluntarily will do it and then a shift that is not prepared to do that.
I have an ethical issue with people going to the edge of the property to a busy street to smoke is not safe.
I don't have a problem escorting patients outside to smoke. If people have a concern with smoke they would have left for a different type of work. Staff that work here are used to patients smoking.
It's their coping mechanism, it is the only they have and we take that away form them too. I think they see it as the final assault on their rights to be able to do something for themselves
I think our patients see it as their only pleasure and it is hard to take it away
It's the one thing they have control over We get irritable having to deal with cigarettes constantly and NRTs and they get tense with us "Why can't you just give me a smoke? Why can't you just take me off the unit for a smoke?" So it adds another layer of tension to our relationships
When you say they cannot smoke, they start yelling and cussing. At times there have been people that have thrown things across the room, usually the psychotic people.
He became verbally and than physically aggressive, but certainly this is the exception to my experience.

On an acute unit, they come in as heavy smokers, call staff down and yell, scream and demand to have a cigarette. It is surprising it is minimal and does not happen all that often in the acute area.
It happens often when patients are admitted and find out they cannot smoke, they become agitated
Smoking is the one thing they have that brings them happiness in life, the only quality of life that they see than we should give them the opportunity.
Our doctors are really good they say just write it up and we will order it
We find some people come in and nothing is written
As soon as the doctor knows they smoke it is ordered
I have to do teaching with saying "you cannot chew this gum on the hour, have a cartridge and go smoking because their heart rate hoes up really high. I encourage them to stop or at least cut down, but you have to monitor them because they think the more nicotine the better.
At the RAH almost every doctor orders full NRTS without batting an eye, and at another hospital there is a bit of bad attitude you have to write it yourself after calling the doctor.
You are putting people in a position where they have no choice so you really should be offering it.
We take the history and if they are a smoker we phone the doctor for orders
We try and empathize with the patient and offer the NRTS as the second best thing
You end up having to phone the doctor for an order and giving them an injection
It is still a problem when they are admitted the duty doctor is not asking "are you a smoker?" You are on close observation you are not going to be able to smoke. We have to do it on the unit level. Like phone them right away or later or a few hours later and ask for NRTs
The doctor told him that he was not going to get grounds but some how he gets cigarettes and he is smoking on the unit. The doctor gave up and gave him grounds but he has to come and ask for a cigarette when he goes out. So they are dishing the cigarettes out to him.
Patients are at desk constantly asking if they can go out to smoke
There a many smoking related requests per shift
We strip them of all their other addictions and that does cause conflict. Not being able to smoke causes more conflict than any other thing I can think of
We spend even more time paroling and catching people smoking, asking people not to smoke. We have fires in garbage cans when they sneak cigarettes.
When I am nursing a smoker it comes up several times a shift. It generally concerns their ability not to smoke on the unit and what I can do to help them out with that.
It's a tough call taking away that liberty from someone to make their own choices.
We are letting them off the unit so we are jeopardizing our belief that they should be on close. The doctor does not feel he is safe or reasonable to be on general observation but we let him out for smokes. That is a conflict of ideas
We tell them they have to adjust their smoking and discuss their options with their doctor
We will push the doctor for orders because they want to quit, and than we get the order and the patient tells us they don't want to quit

We are the ones enforcing it
My basic premise as a nurse is they should be clothed warmly or comfortably they should be well fed, they should have medications that keep them calm and should have cigarettes
The majority of the time nurses phone to get the NRT orders, we do the teaching about the medication
For patients smoking on the unit we intervene
Nurses end in the middle mediating when patients borrow cigarettes from each other.
You have to separate the nicotine wanting behavior from the mental health issues and I do this firmly and kindly with big people standing beside you
Sometimes I wish they could just smoke because at least 30% of the reason they are upset could be dealt with
It's the final assault on their rights
I hate it, I hate it, I just hate it.
We go through a lot of hassle not allowing them smoke privileges and then as soon as they get privileges they are smoking
There are still patients when you say you cannot go out they will start yelling and cussing at you.

Understanding between cessation and temporary quitting
A patient quit for a month on the patch, but got privileges and even with the patch relapsed into smoking
When they are in a volatile state and to teach them something else is difficult. It's not a teaching time
Maybe just use it to cut down rather than quit
I don't see a problem in my practice because I offer the replacement and say "it's either that or cold turkey
We spend even more time paroling and catching people smoking, asking people not to smoke, fires in garbage cans.
Maybe they will be more successful the next round, and teach but feel what is the point as it is the same thing, they are going to go back to smoking. Staff wonders why waste our time and money because the only reason they are trying to quit is because of money, nothing other than money.
It helps with withdrawals, but the hard part is getting them to quit smoking
When a patient first comes in it takes up a lot of time because they keep asking for cigarette privileges
As soon as they get their privileges they are off smoking
We will phone and say please can we let them and we get strange orders where somebody on close observation is allowed off for 10 minutes to smoke. Simply to manage behavior
By the time they are teachable they have general observation and I really don't have control
I have yet to see a patient quit
I honestly don't' think we have helped someone quit
We would be thrilled if they quit smoking

Maybe they need extensive counseling which we are not trained for
We will push the doctor for orders because they want to quit, and than we get the order and the patient tells us they don't want to quit
We can teach them until the cows come home about how sick they are going to get.
I don't think they care to quit
He keeps saying he is going to quit, but never follows through
There have been a few who have quit smoking; they have gone to your smoking cessation group
There have been a lot of patients where you try but they don't want to quit. What do you do?
Maybe they have smoked too long and can't quit
I think it is the younger ones we should be targeting
They change their minds the next day
Patients while here have quit or cut down
Sometimes they don't have cigarettes for weeks but the second they get out they are puffing
If they didn't quit when they were healthy they are not going to quit when they are really ill
I don't know how a person can even get them to stop
If they have quit, most of them have started when they get general observation
With someone with mental illness it takes a lot of courage for them to try and quit smoking and the chances of them succeeding is less
It will be the patient that completely surprises you, the 20 year smoker, the 2 pack a day smoker and those with a low IQ
I think it is a good time for them to it in this setting, a very supportive setting
Quite a few patients actually quit smoking. They just quit with help from staff and the smoking cessation groups
They need support with coping skills to quit, we can teach coping skills, but we are not skilled to help with smoking cessation
They don't have the drive to quit, I think the young ones coming in from a different era are more open to that.
The fact there is still a lot of smoking is a barrier to quitting
Most of the time when patients want to quit smoking it is because they cannot afford to smoke
I always say to the guys when I give them a cigarette "you know this is bad for you" they don't care
I don't know if counseling a heavy smoker would make a difference
We go through a lot of hassle not allowing them smoke privileges and then as soon as they get privileges they are smoking
I explain they are on close observation and not allowed off the unit and that there is NRT. I apologize and they are accepting of that. If you are empathetic it helps.
Obesity is more unhealthy than smoking
They have no tools to help them quit.

Role Frustrations

A few minutes later he is smoking in the bathroom and you do another search
It's a bit annoying as you have to deal with other things going on

Some staff were escorting patients outside to smoke which upset the rest of the staff so now we can't.
I would never take a patient outside to smoke and it's a problem because you might have a shift where a staff voluntarily will do it and then a shift that is not prepared to do that. So you got patients adjusting to a different answer and in our experience it becomes more agitating to the patient.
Stealing cigarettes at night, the night staff was not impressed they were upset and they said the cigarette should be put away at 1000 PM.
We get irritable having to deal with cigarettes constantly and NRTs and they get tense with us "Why can't you just give me a smoke? Why can't you just take me off the unit for a smoke?" So it adds another layer of tension to our relationships
You try to deal with in a different way but it is hard
Will be at the desk every hour or so requesting for the gum or cartridge
We have to figure out something where people are comfortable when they come on the unit in terms of smoking. Whether it is better NRTs or more free flowing NRTS
Some nurses go "put on the patch and maybe smoke a little less today than yesterday" I can't do this based on what I understand.
Their cigarettes are locked up with their lighters and they have to be given out 3 times an hour
We have to search him for cigarettes all the time
We have the cigarettes at the desk and they can be at the desk every half hour to an hour, and than they have to return them when they come in. It can be a bit annoying. Cigs are at desk patients will sneak a smoke on the unit
It's a lot of wasted time dealing with those issues.
Patients are at desk constantly asking if they can go out to smoke
There is an issue of borrowing, begging and stealing so we kept their cigs as the desk and give them out one at a time. I am giving out cig every 10 to 15 minutes.
There are so many smoking related requests per shift
We spend even more time paroling and catching people smoking, asking people not to smoke, fires in garbage cans.
Staff wonders why waste our time and money because the only reason they are trying to quit is because of money, nothing other than money.
They have no tools to help them quit. We give the NRT and they have to deal with the rest on their own.
We spend a lot of time opening and closing the cigarette drawer
They will be at the desk creating problems, being noisy
We will phone and say please can we let them and we get strange orders where somebody on close observation is allowed off for 10 minutes to smoke. Simply to manage behavior
We are letting them off the unit so we are jeopardizing our belief that they should be on close. The doctor does not feel he is safe or reasonable to be on general observation but we let him out for smokes. That is a conflict of ideas
When dealing with smokers, a non smoking nurse is less understanding
We will push the doctor for orders because they want to quit, and than we get the order and the patient tells us they don't want to quit

We can teach them until the cows come home about how sick they are going to get.
I don't think they care to quit
It's frustrating, you try but they don't want to quit
They change their minds the next day
Some nurses will tell patients it is a bad time to think about quitting, but some nurses would support it
Some of the nurses feel they don't want to quit so just leave it, but I think that is wrong. I think you should still try.
Staff time and the intervention we had to do was not pleasant and wasn't for her, and wasn't for us
I am wasting my breath saying anything to the smoking at the doorways
Some nurse express that they are not here to police someone's smoking, but to help them get better. It's kind of a necessary evil, I don't like power struggles and we end up in a situation of power having control over someone's cigarettes. It's undesirable, but sometimes beneficial to the patient in the long run.
Its frustrating because you think to yourself smoking is bad
My problem is they are stressed and need to be discharged and life fairly smooth and than think about quitting
If they didn't quit when they were healthy they are not going to quit when they are really ill
It just adds to their anxiety and frustration when they are first admitted
We are trying to deal with psychiatric problems and more acute short medical problems and not really seeing smoking as a place to invest a great deal of energies

Smoking is a patient social networking system
Doctor told him he was not going to get grounds but some how he gets cigarettes and he is smoking in the bathroom
I find if one starts smoking indoors it teaches the others ones the deviant behavior
Some will go down every hour for a smoke and we won't see them
They feel it is a social thing
Non smokers spend more time on the unit than non smokers
Smokers spend a lot of time outside, they skip out of their group, they huddle at the door ways
They spend a lot of their time off the unit so if you got a smoking patient you might not see them or get a chance to talk to them because they are gone so much. They are very social with the other smoking patients and not much with much else.
Once they have privileges, they arrange their day around smoking
We have people who take the patch and go smoking anyways which is a bit of a problem
Once he got grounds four days he was out there smoking
Some patients will pass out their cigarettes so we keep them in the office
I know someone who started smoking in the psych unit to be part of the group
Smokers find each; they go out in groups of 3 or 4s. They use company and cigs. If they go out to smoke alone they are not out as long.
Nurses end up mediating when patients borrow cigarettes from each other. Some how the nurse ends up in

NRTs

Patient ranting and raving to be escorted out for cigarette, wasn't offered NRT because he was not on the smoking program

If they are pushing for a cigarette then obviously we offer the NRT, but normally we wait for them

He used the inhalant when it was too cold to smoke outside so for two hours, three hour he was able to take the inhalant and not smoke

We have people who take the patch and go smoking anyways which is a bit of a problem.

They (the NRTs) are useful but they are not used appropriately no matter what kind of teaching you do they still go back to their cigarettes

Inhalant curbs the cravings

Sometimes you see they are ready to blow, you give them the NRT and it takes the edge off and right away you can see that they are more cooperative. So it usually works that way.

I have to do teaching with saying "you cannot chew this gum on the hour, have a cartridge and go smoking because their heart rate goes up really high." I encourage them to stop or at least cut down, but you have to monitor them because they think the more nicotine the better.

If a patient is trying to quit depending on how much of a smoker, they get the patch daily, inhalers and gum as they need and to attend nonsmoking groups or whatever.

If a patient is wearing the patch and smoking it's not safe. I read some place you can get chest pain and cardiac issues from smoking and wearing the patch at the same time.

We have to figure out something where people are comfortable when they come on the unit in terms of smoking. Whether it is better NRTs or more free flowing NRTS.

Some nurses go "put on the patch and maybe smoke a little less today than yesterday" I can't do this based on what I understand.

I provide them the option of the NRTS and teaching surrounding them and to teach the benefits of not smoking while in the hospital.

They can go without smoking for an extended period of time with using the NRTS

One lady accepted the NRT for cravings and ended up quitting

Some patients are positive about them. Even those who smoke on the patch, it's minimal and they are gradually reducing

If they don't like the gum they go a longer period of time before asking for a piece so it helps because they put off using it until they have really bad withdrawals. The inhalant I don't know, I just see it helping because it is reducing the cigarette intake, but they are still having the same nicotine intake.

They go on the smoking cessation program, try out the nicoderm patch, they finish step one go to step 2 and than come into money and decide not to continue with the cessation.

We give the NRT and they have to deal with the rest on their own.

Staff get annoyed that a big part of their time is spent getting cigarettes, putting away cigarettes and giving NRT

Some of them just don't want to take the patch because of a misconception that we are trying to get them to quit. We are always reinforcing and teaching all the time that the patch will help them from being cranky.
Will be at the desk every hour or so requesting for the gum or cartridge
They come and ask when the see others using the NRTs
A patient quit for a month on the patch, but got privileges and even with the patch relapsed into smoking
He used the inhalant when it was too cold to smoke outside so for two hours, three hour he was able to take the inhalant and not smoke
If we can give those NRTs to get over the hum of cravings then they are not being bounced around
When they are angry if you offer the NRT they will throw it in your face
We get irritable having to deal with cigarettes constantly and NRTs and they get tense with us "Why can't you just give me a smoke? Why can't you just take me off the unit for a smoke?" So it adds another layer of tension to our relationships
When very aggressive, they are offered the NRT but wont' even entertain the idea
They are offered to everybody
It's ordered up and offered right away
We use them a lot – we have to offer them something
They are useful but they are not used appropriately no matter what kind of teaching you do they still go back to their cigarettes
They never choose to take it if it's their choice, like if they are a voluntary patient and they are on general observation and they are smoking, they never take that stuff
Inhalant curbs the cravings
I let them know they have the option
I don't mind the policy now because the NRTs are available now that I am comfortable with that, you know for people on close observation
I don't see a problem in my practice because I offer the replacement and say "it's either that or cold turkey
It's not like the cigarette but at least they have nicotine in their system
Sometimes you see they are ready to blow, you give them the NRT and it takes the edge off and right away you can see that they are more cooperative. So it usually works that way.
Will be at the desk every hour or so requesting for the gum or cartridge
Since they closed the smoking rooms and have NRTs there is a lot less altercations.
It's not too often but the ones that don't have money or have financial problems take the replacement
It has calmed down the cigarette altercations because they do have an alternative.
They are less combative because they have an option. I always encourage them to use it.
It might not be the right time for them to quit but maybe if they try the NRTs it will give them the initiative to quit in the future when they are at home and doing well.
When we are busy we forget to mark it off
Lately I am keeping some NRT in my pocket ready to give as needed.
If a patient is trying to quit depending on how much of a smoker they get the patch daily, inhalers and gum as they need and to attend nonsmoking groups or whatever.

If a patient is wearing the patch and smoking it's not safe. I read some place you can get chest pain and cardiac issues from smoking and wearing the patch at the same time.
It's a lot of documentation; it would be nice if they weren't classified as medications. Its extra work.
We have to figure out something where people are comfortable when they come on the unit in terms of smoking. Whether it is better NRTs or more free flowing NRTS
Some nurses go "put on the patch and maybe smoke a little less today than yesterday" I can't do this based on what I understand.
On nights we will give out NRTs maybe 2 or 3 times a shift. They get the gum and go back to sleep
You are putting people in a position where they have no choice so you really should be offering it.
They can go without smoking for an extended period of time with using the NRTS
Everybody has one that kinda works. And some say it is crap none works.
Maybe just use it to cut down rather than quit
We try and empathize with the patient and offer the NRTS as the second best thing
They come and ask when the see others using the NRTs
It might not be the right time for them to quit but maybe if they try the NRTs it will give them the initiative to quit in the future when they are at home and doing well
Some patients are positive about them. Even those who smoke on the patch, its minimal and they are gradually reducing.
It helps with withdrawals, but the hard part is getting them to quit smoking
When a patient runs out of money we offer NRTs

Ambivalence and conflict between rights & health
Some staff was escorting patients outside to smoke which upset the rest of the staff so now we can't
Once they get their privileges and want to smoke, I think it is their right
We are on the 6th floor and it's a lot of work for them to get down the to smoke, so they are getting a lot of fresh air and movement
If they need to be escorted outside to smoke, there is a reason for it. They need to be escorted outside to smoke there is a reason for it. They didn't request to become mentally ill. So why are we penalizing them. I don't understand. They are just cigarettes
I don't have a problem escorting patients outside to smoke. If people have a concern with smoke they would have left for a different type of work. Staff that work here are used to patients smoking.
You got to have something in life worth quitting for and I don't think their health is enough of an incentive
They are an unhealthy group to begin with
One thing I see is there isn't enough on the unit for them to do.
I think our patients see it as their only pleasure and it is hard to take it away
It gets a bit mixed up because some of the acting out behavior, they will focus on the smoking and act out but maybe they would be acting out anyway
I feel bad for the patient but it is no excuse to become violent and aggressive

Patients with chronic illness such as schizophrenia, smoking is part of their coping skills and if they cannot smoke they become irritable and anxious. Being allowed to smoke reverses that, they become more approachable, more amiable.
We strip them of all their other addictions and that does cause conflict. Not being able to smoke causes more conflict than any other thing I can think of.
My problem is they are stressed and need to be discharged and life fairly smooth and than think about quitting
People have to choose something besides smoking, like exercise, and we don't have that available.
Some of them have been smoking for 30 years and don't want to quit
When some patients are really resistant I don't even mention it
They have enough issues to deal with
I try and discourage them from smoking, but it is an option they have
When they are working through issues, smoking cessation is not a priority to them
Even if they cut down half of what they are smoking, that is a big step
You talk to them about cutting down if they don't have funds
We don't say quitting completely but maybe cut down
My basic premise as a nurse is they should be clothed warmly or comfortably they should be well fed, they should have medications that keep them calm and should have cigarettes
Sometimes I wish they could just smoke because at least 30% of the reason they are upset could be dealt with. Despite the issue of smoking it could be another issue
Its frustrating because you think to yourself smoking is bad
Some nurses express that they are not here to police someone's cigarettes. It's undesirable. It's kind of a necessary evil. We end up in a power struggle in a situation of having control over someone's cigarettes, but sometimes beneficial to the patient in the long run.
I am mixed, I appreciate not having to breathe in smoke but there are times when I feel that it is about people's rights
It has so many health risk as well as being expensive as well as picking up butts from other peoples dirty old used cigarettes
They have chronic coughs, yellow fingers, lots of colds. They get sick quicker but they don't lie around
It affects their ability to exercise and keep fit because they are sitting and smoking instead of being active
In terms of harm reduction there are a lot worse things, obesity is more unhealthy than smoking
They don't have anything else in their life except smoking
It's their coping mechanism, it is the only they have and we take that away form them too. I think they see it as the final assault on their rights to be able to do something for themselves
Patients with chronic illness such as schizophrenia, smoking is part of their coping skills and if they cannot smoke they become irritable and anxious. Being allowed to smoke reverses that, they become more approachable, more amiable.
It's hard to minimize the power difference. It's just another barrier to stabling that therapeutic relationship When there is an aggressive incident related to smoking, it

is no different than any other situation that escalates, you deal with, and it's part of your job regardless of the reason for it.
Some nurses express that they are not here to police someone's cigarettes. It's undesirable. It's kind of a necessary evil. We end up in a power struggle in a situation of having control over someone's cigarettes, but sometimes beneficial to the patient in the long run.

Meanings of patient smoking for the nurse
We monitor the patients smoking in the bathrooms
So we are dishing out cigarettes to him from the office because he smokes so much on the unit
Sometimes they get mad at us because we find their hidden cigarettes
The issue of smoking indoors is a huge issue because it is a fire hazard
They smoke on the unit far too often on night shift or after ground privileges
We intervene with patients smoking on the unit
Smoking indoors is dangerous because of fire hazard
They spend a lot of their time off the unit so if you got a smoking patient you might not see them or get a chance to talk to them because they are gone so much. They are very social with the other smoking patients and not much with much else.
If they don't attend programs consistently they get put on close observation which motivates them
I don't have a problem escorting patients outside to smoke. If people have a concern with smoke they would have left for a different type of work. Staff that work here are used to patients smoking
Their cigarettes are locked up with their lighters and they have to be given out 3 times an hour
The doctor told him that he was not going to get grounds but some how he gets cigarettes and he is smoking on the unit. The doctor gave up and gave him grounds but he has to come and ask for a cigarette when he goes out. So they are dishing the cigarettes out to him.
We have the cigarettes at the desk and they can be at the desk every half hour to an hour, and than they have to return them when they come in. It can be a bit annoying. Cigs are at desk patients will sneak a smoke on the unit
Patients are at desk constantly asking if they can go out to smoke
There is an issue of borrowing, begging and stealing so we kept their cigs as the desk and give them out one at a time. I am giving out cig every 10 to 15 minutes.
We strip them of all their other addictions and that does cause conflict. Not being able to smoke causes more conflict than any other thing I can think of.
We spend even more time paroling and catching people smoking, asking people not to smoke, fires in garbage cans.
Some patients will pass out their cigarettes so we keep them in the office
Giving one at a time is a financial issue, we budget to ensure they have enough cigarettes for the evening
If you are caught smoking you are put on close observation
Locking up cigarettes is inconvenient but at least it is giving us control
We spend a lot of time opening and closing the cigarette drawer

We had a young girl with behavioral problems, and we used cigarette privileges as a behavior modification thing, you have nothing to use except the cigarette
They will be at the desk creating problems, being noisy
By the time they are teachable they have general observation and I really don't have control
Used smoking privileges as an incentive with a patient who had thoughts of hurting himself
The motivation is to go outside and smoke
Sometimes we have them wait to go outside to smoke, either wait to see doctor or the temperature is too cold
We say if things are going well if your behavior is good, than you can go outside and smoke.
Smoking privileges are used as an incentive to attend groups. There are so few rewards in a mental health unit; it is an easy one to slide into using
It helps to modify behavior
We would be thrilled if they quit smoking
I find it positive they smoke less
I guess we control it.
The cigarette is not an incentive, but you kind of do it indirectly with getting smoking them smoking privileges if they are settled
We have to search him for cigarettes, he doesn't mind he goes along with it
What I hear from the vast majority of nurses they did not like the role of monitoring or policing cigarettes
Its part of the process of working with patients
It's hard to minimize the power difference. It's just another barrier to stabling that therapeutic relationship.
When there is an aggressive incident related to smoking, it is no different than any other situation that escalates, you deal with, and it's part of your job regardless of the reason for it.
Some nurses express that they are not here to police someone's cigarettes. It's undesirable. It's kind of a necessary evil. We end up in a power struggle in a situation of having control over someone's cigarettes, but sometimes beneficial to the patient in the long run.
The nursing team rations out cigarettes so they last longer
We are the gatekeepers to their supply. It is frustrating but we know if they run out of cigs they will have withdrawal symptoms and that would not be great as it would trigger their psychiatric symptoms. If they are having a lousy stressful day cig are used to calm them down versus using a prn medication.
We give them an extra cig as an incentive to do something
I am not going to police them outside there are too many of them
I enjoy the policy I don't have to spend time supervising people outside smoking
I am not obligated to take patients out to smoke, that is very nice

Problems with aggressive behaviors
When they are angry if you offer the NRT they will throw it in your face

It gets a bit mixed up because some of the acting out behavior, they will focus on the smoking and act out but maybe they would be acting out anyway
When you say they cannot smoke, they start yelling and cussing. At times there have been people that have thrown things across the room, usually the psychotic people.
He became verbally and than physically aggressive, but certainly this is the exception to my experience.
On an acute unit, they come in as heavy smokers, call staff down and yell, scream and demand to have a cigarette. It is surprising it is minimal and does not happen all that often in the acute area.
It happens often when patients are admitted and find out they cannot smoke, they become agitated
A patient put in seclusion offered inhalant which he threw, a few days later still in seclusion he took the inhalant
When they are in a volatile state and to teach them something else is difficult. It's not a teaching time.
When very aggressive, they are offered the NRT but wont' even entertain the idea
It might not be the right time for them to quit but maybe if they try the NRTs it will give them the initiative to quit in the future when they are at home and doing well
When a patient first comes in it takes up a lot of time because they keep asking for cigarette privileges
A patient was agitated and I was thinking all this could be avoided if he was allowed out to smoke
The ones that have a problem with the policy are too sick to understand and don't understand what you are telling them or just cannot accept it.
I have seen everything when you cannot give them a cigarette, they get on the floor and start kicking and screaming, kicking their feet at the walls, screaming give me a cigarette, some will try and burn you with a cigarette, spit at you. You end up having to get a doctors order and give them an injection.