Integrating *Smoking Cessation* into Daily Nursing Practice
Greetings from Doris Grinspun
Executive Director
Registered Nurses’ Association of Ontario

It is with great excitement that the Registered Nurses’ Association of Ontario (RNAO) disseminates this revised nursing best practice guideline to you. Evidence-based practice supports the excellence in service that nurses are committed to deliver in our day-to-day practice. The RNAO is committed to ensuring that the evidence supporting guideline recommendations is the best available, and this guideline has been recently reviewed and revised to reflect the current state of knowledge.

We offer our endless thanks to the many institutions and individuals that are making RNAO’s vision for Nursing Best Practice Guidelines (NBPGs) a reality. The Government of Ontario recognized RNAO’s ability to lead this program and is providing multi-year funding. Tazim Virani – NBPG program director – with her fearless determination and skills, is moving the program forward faster and stronger than ever imagined. The nursing community, with its commitment and passion for excellence in nursing care, is providing the knowledge and countless hours essential to the creation, evaluation and revision of each guideline. Employers have responded enthusiastically to the request for proposals (RFP), and are opening their organizations to pilot test the NBPGs.

Now comes the true test in this phenomenal journey: Will nurses utilize the guidelines in their day-to-day practice?

Successful uptake of these NBPGs requires a concerted effort of four groups: nurses themselves, other healthcare colleagues, nurse educators in academic and practice settings, and employers. After lodging these guidelines into their minds and hearts, knowledgeable and skillful nurses and nursing students need healthy and supportive work environments to help bring these guidelines to life.

We ask that you share this NBPG, and others, with members of the interdisciplinary team. There is much to learn from one another. Together, we can ensure that Ontarians receive the best possible care every time they come in contact with us. Let’s make them the real winners of this important effort!

RNAO will continue to work hard at developing and evaluating future guidelines. We wish you the best for a successful implementation!

Doris Grinspun, RN, MSN, PhD (cand), OOnt

Executive Director
Registered Nurses’ Association of Ontario
Integrating Smoking Cessation into Daily Nursing Practice

Project Team:

Tazim Virani, RN, MScN, PhD(cand)
Program Director

Heather McConnell, RN, BScN, MA(Ed)
Program Manager

Samantha Mayo, RN, BScN, MN
Program Coordinator

Janet Chee, RN, BScN, MN
Program Coordinator

Julie Burris
Program Assistant

Jill-Marie Burke, BA
Public Relations/Communications

Elizabeth Chiu, HBSc, MPC
Program Assistant

Meagan Cleary, BA
Program Assistant

Carrie Scott
Program Assistant

Citlali Villa Singh
Program Assistant

Registered Nurses’ Association of Ontario
Nursing Best Practice Guidelines Program
158 Pearl St.
Toronto, Ontario M5H 1L3
Website: www.rnau.org/bestpractices
Revision Panel Members (2006/2007)

Janet Nevala, RN, BScN  
**Team Leader**  
Consultant, The Program Training and Consultation Centre  
Ottawa, Ontario

Carol Bossenberry, RN, BN, TTS  
Tobacco Use Prevention Coordinator  
Oxford County Public Health & Emergency Services  
Woodstock, Ontario

Jennifer Hart, MPA  
Director, Clinical Tobacco Intervention Program  
Ontario Medical Association  
Toronto, Ontario

Sherrie Hertz, BScPhm., R.Ph  
Director, Pharmacy Programs  
Ontario Pharmacists’ Association  
Don Mills, Ontario

Sharon Lawler, RN, BA, MEd  
Co-Director and Manager, Leave the Pack Behind Program  
Community Health Science Dept.  
Brock University  
St. Catharines, Ontario

Joan Mitchell, RN(EC),  
Primary Health Care Nurse Practitioner  
Byron Family Medical Centre  
London, Ontario

Annette Railton, RN, BScN  
Operating Room (CPT)  
Welland Hospital Site Niagara Health System  
Welland, Ontario

Annette Schultz, RN, PhD  
Assistant Professor, Cancer Prevention  
Cancer Nursing Research  
Faculty of Nursing, University of Manitoba  
Winnipeg, Manitoba

Declarations of interest and confidentiality were made by members of the guideline revision panel. Further details are available from the Registered Nurses’ Association of Ontario.

The RNAO also wishes to acknowledge Dawn Kingston, RN, BSc, MSc, PhD (student) for her work in conducting the quality appraisal of the literature and preparation of evidence tables.

The RNAO would also like to acknowledge Bonnie Quinlan, RN for her contribution to this guideline revision as a reviewer.

Declarations of interest and confidentiality were made by all members of the guideline development panel. Further details are available from the Registered Nurses’ Association of Ontario.
Original Contributors

Development Panel Members (2003)

Janet Nevala, RN, BScN
Team Leader
Coordinator, Program Training and Consultation Centre
Ontario Tobacco Strategy
City of Ottawa
Ottawa, Ontario

Carol Bossenberry, RN, BN
Tobacco Use Prevention Coordinator
County of Oxford, Department of Public Health & Emergency Services
Woodstock, Ontario

Debbie Cooke, RN, BA
Cardiac Prevention and Rehabilitation Nurse
Smoking Cessation Counsellor
University of Ottawa Heart Institute
Cardiac Prevention and Rehabilitation
Ottawa, Ontario

Nancy Edwards, RN, PhD
Professor, School of Nursing
Director, Community Health Research Unit
University of Ottawa
Ottawa, Ontario

Sharon Lawler, RN, BA, MEd
Manager, Leave The Pack Behind
Community Health Sciences Department
Brock University
St. Catharines, Ontario

Heather Logan*, RN, BScN, MHSc(c)
Manager, Cancer Control Policy
Canadian Cancer Society
National Cancer Institute of Canada
Toronto, Ontario

Joan Mitchell, RN(EC)
Primary Healthcare Nurse Practitioner
Community Care Access Centre
London Middlesex
London, Ontario

Shirley Saasto-Stopyra*, RN, PHN
ONA Representative (Local 014)
Public Health Nurse
Family Health Program
Thunder Bay District Health Unit
Thunder Bay, Ontario

Josephine Santos, RN, MN
Facilitator, Project Coordinator
Nursing Best Practice Guideline Project
Registered Nurses’ Association of Ontario
Toronto, Ontario

Louise Walker*, BA, BSc
Provincial Coordinator, Smokers’ Helpline
Canadian Cancer Society
Ontario Division
Hamilton, Ontario

*Contributed to the initial development of the guideline
Stakeholder Acknowledgment

The Registered Nurses’ Association of Ontario wishes to acknowledge the following individuals and/or groups for their contribution in reviewing this nursing best practice guideline and providing valuable feedback during the initial development of this document (2001–2003):

- **Monique Bouvier** Centre for Addiction and Mental Health, Hammond, Ontario
- **Wendy Burgoyne** Algoma Best Start, Wawa, Ontario
- **Ruth Busija-Lowe** Registered Nurse (retired), Woodstock, Ontario
- **Donald Dery** Tobacco Project Officer, City of Ottawa, Agent de projet sur le tabagisme, Ottawa, Ontario
- **Dr. Roberta Ferrence** Director, Centre for Addiction and Mental Health, Ontario Tobacco Research Unit, Toronto, Ontario
- **Sherrie Hertz** Program Manager, Clinical Tobacco Intervention Drug Information Pharmacist, Ontario Pharmacists’ Association, North York, Ontario
- **Simon Hoad** Health Promotion Planner, Thunder Bay District Health Unit, Thunder Bay, Ontario
- **Colleen Kearns** Public Health Nurse, Prenatal Tobacco Use Prevention, City of Ottawa, Ottawa, Ontario
- **Cheryl Kee** Acute Care Nurse Practitioner-Cardiology, London Health Sciences Centre, London, Ontario
- **Dana Martin** Registered Nurse, Gane Yohs Health Centre, Ohsweken Ontario
- **Elizabeth Martin** Manager of Operations, Woodingford Lodge, Woodstock, Ontario
- **Dr. Paul W. McDonald** Director, Centre for Applied Health Research, University of Waterloo, Waterloo, Ontario
- **Dr. William McLeish** Oxford Interagency Council on Smoking and Health, Woodstock, Ontario
- **Phil Onafrychuk** Occupational Health Nurse, Timberjack Inc., Woodstock, Ontario
- **Dr. Andrew Pipe** Director, Smoking Cessation Program, University of Ottawa Heart Institute, Ottawa, Ontario
- **Nancy Pogson** Public Health Nurse, Kitchener, Ontario
- **Lorraine Repo** Coordinator, Healthy Babies/Healthy Children, Thunder Bay District Health Unit, Thunder Bay, Ontario
- **Linda Ritchie** Chair, Department of Nursing, Brock University, St. Catharines, Ontario
- **Sherryl Smith** Health Promotion Coordinator, Somerset West Community Health Centre, Ottawa, Ontario
- **Tracey E. Taylor** Program Manager, Healthy Lifestyles and Disease Prevention Branch, Social and Public Health Services Department, City of Hamilton, Hamilton, Ontario
A special acknowledgment also goes to:

Barbara Willson, RN, MSc, and Anne Tait, RN, BScN, who served as Project Coordinators at the onset of the guideline development.

RNAO also wishes to acknowledge the Centre for Addiction and Mental Health in Toronto, Ontario for their role in pilot testing this guideline.

As well, RNAO sincerely acknowledges the leadership and dedication of the researchers who have directed the evaluation phase of the Nursing Best Practice Guidelines Project, in 2002–2003. The Evaluation Team was comprised of:

Principal Investigators: Nancy Edwards, RN, PhD; Barbara Davies, RN, PhD – University of Ottawa

Evaluation Team: Maureen Dobbins, RN, PhD; Jenny Ploeg, RN, PhD; Jennifer Skelly, RN, PhD – McMaster University
Patricia Griffin, RN, PhD – University of Ottawa

Project Staff: Barbara Helliwell, BA(Hons); Marilyn Kuhn, MHA; Diana Ehlers, MA(SW), MA(Dem); Christy-Ann Drouin, BBA; Sabrina Farmer, BA; Mandy Fisher, BN, MSc(cand); Lian Kitts, RN; Elana Ptack, BA – University of Ottawa
Integrating Smoking Cessation into Daily Nursing Practice

Disclaimer
These best practice guidelines are related only to nursing practice and not intended to take into account fiscal efficiencies. These guidelines are not binding for nurses and their use should be flexible to accommodate client/family wishes and local circumstances. They neither constitute a liability or discharge from liability. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors nor the Registered Nurses’ Association of Ontario (RNAO) give any guarantee as to the accuracy of the information contained in them nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omission in the contents of this work. Any reference throughout the document to specific pharmaceutical products as examples does not imply endorsement of any of these products.

Copyright
First published in 2003 by the Registered Nurses’ Association of Ontario. This document was revised in March 2007.

With the exception of those portions of this document for which a specific prohibition or limitation against copying appears, the balance of this document may be produced, reproduced and published in its entirety only, in any form, including in electronic form, for educational or non-commercial purposes, without requiring the consent or permission of the Registered Nurses’ Association of Ontario, provided that an appropriate credit or citation appears in the copied work as follows:

How to Use this Document

This nursing best practice guideline is a comprehensive document providing resources necessary for the support of evidence-based nursing practice. The document should be reviewed and applied, based on the specific needs of the organization or practice setting/environment, as well as the needs and wishes of the client. Guidelines should not be applied in a “cookbook” fashion but used as a tool to assist in decision making for individualized client care, as well as ensuring that appropriate structures and supports are in place to provide the best possible care.

Nurses, other healthcare professionals and administrators who are leading and facilitating practice changes will find this document valuable for the development of policies, procedures, protocols, educational programs, assessments and documentation tools. It is recommended that the nursing best practice guidelines be used as a resource tool. Nurses providing direct client care will benefit from reviewing the recommendations, the evidence in support of the recommendations and the process that was used to develop the guidelines. However, it is highly recommended that practice settings/environments adapt these guidelines in formats that would be user-friendly for daily use. This guideline has some suggested formats for such local adaptation and tailoring.

Organizations wishing to use the guideline may decide to do so in a number of ways:
- Assess current nursing and healthcare practices using the recommendations in the guideline.
- Identify recommendations that will address identified needs or gaps in services.
- Systematically develop a plan to implement the recommendations using associated tools and resources.

RNAO is interested in hearing how you have implemented this guideline. Please contact us to share your story. Implementation resources will be made available through the RNAO website at www.rnao.org/bestpractices to assist individuals and organizations to implement best practice guidelines.
# Table of Contents

Summary of Recommendations.................................................................14  
Interpretation of Evidence........................................................................16  
Responsibility for Guideline Development..............................................16  
Purpose & Scope.........................................................................................17  
Original Development Process – 2001....................................................19  
Revision Process 2006/2007......................................................................20  
Definition of Terms....................................................................................22  
Background Context...................................................................................23  
Practice Recommendations........................................................................26  
Education Recommendations.....................................................................34  
Organization & Policy Recommendations...............................................35  
Evaluation & Monitoring...........................................................................38  
Implementation Strategies.........................................................................40  
Research Gaps & Future Implications.......................................................41  
Process for Update/Review of Guideline.................................................42  
References..................................................................................................43  
Bibliography...............................................................................................47
Appendix A – Search Strategy for Existing Evidence .......................................................... 54
Appendix B – Glossary of Terms ...................................................................................... 57
Appendix C – The Health Risks of Smoking ..................................................................... 60
Appendix D – The Benefits of Quitting Smoking ............................................................... 65
Appendix E – Stages of Change Model .............................................................................. 67
Appendix F – Identifying Your Client’s Readiness to Quit .................................................. 69
Appendix G – Motivational Interviewing ......................................................................... 70
Appendix H – Ask, Advise, Assist, Arrange Protocol ....................................................... 74
Appendix I – The WHY Test ............................................................................................ 76
Appendix J – Fagerstrom Test for Nicotine Dependence (Revised Version) ..................... 78
Appendix K – Intensive Nursing Intervention: Tips for the Client ...................................... 79
Appendix L – Quit Smoking First-Line Medications Compared ....................................... 80
Appendix M – Strategies to Avoid Relapse ....................................................................... 83
Appendix N – List of Resources Available for Smoking Cessation .................................. 84
Appendix O – Description of the Toolkit ........................................................................... 87
# Summary of Recommendations

<table>
<thead>
<tr>
<th>RECOMMENDATION</th>
<th>STRENGTH OF EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Practice Recommendations</strong></td>
<td></td>
</tr>
<tr>
<td>1.0 Nurses implement minimal tobacco use intervention using the <em>Ask, Advise, Assist, Arrange</em> protocol with all clients.</td>
<td>A</td>
</tr>
<tr>
<td>2.0 Nurses introduce intensive smoking cessation intervention (more than 10 minutes duration) when their knowledge and time enables them to engage in more intensive counselling.</td>
<td>A</td>
</tr>
<tr>
<td>3.0 Nurses recognize that tobacco users may relapse several times before achieving abstinence and need to re-engage clients in the smoking cessation process.</td>
<td>B</td>
</tr>
<tr>
<td>4.0 Nurses should be knowledgeable about community smoking cessation resources, for referral and follow-up.</td>
<td>C</td>
</tr>
<tr>
<td>5.0 Nurses implement smoking cessation interventions, paying particular attention to gender, ethnicity and age-related issues, and tailor strategies to the diverse needs of populations.</td>
<td>C</td>
</tr>
<tr>
<td>6.0 Nurses implement, wherever possible, intensive intervention with women who are pregnant and postpartum.</td>
<td>A</td>
</tr>
<tr>
<td>7.0 Nurses encourage persons who smoke, as well as those who do not, to make their homes smoke-free, to protect children, families and themselves from exposure to second-hand smoke.</td>
<td>A</td>
</tr>
<tr>
<td><strong>Education Recommendations</strong></td>
<td></td>
</tr>
<tr>
<td>8.0 All nursing programs should include content about tobacco use, associated health risks and smoking cessation interventions as core concepts in nursing curricula.</td>
<td>C</td>
</tr>
<tr>
<td><strong>Organization &amp; Policy Recommendations</strong></td>
<td></td>
</tr>
<tr>
<td>9.0 Organizations and Regional Health Authorities should consider smoking cessation as integral to nursing practice, and thereby integrate a variety of professional development opportunities to support nurses in effectively developing skills in smoking cessation intervention and counselling.</td>
<td>B</td>
</tr>
<tr>
<td>All corporate hospital orientation programs should include training to use brief smoking cessation interventions as well as information on pharmacotherapy to support hospitalized persons who smoke.</td>
<td></td>
</tr>
<tr>
<td>10.0 Nurses seek opportunities to be actively involved in advocating for effective smoking cessation services, including “stop smoking medications”.</td>
<td>C</td>
</tr>
<tr>
<td>11.0 Nurses seek opportunities to be actively involved in advocating for smoke-free spaces and protection against second-hand smoke.</td>
<td>C</td>
</tr>
<tr>
<td>12.0 Nursing best practice guidelines can be successfully implemented only where there are adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes:</td>
<td>C</td>
</tr>
<tr>
<td>- An assessment of organizational readiness and barriers to education.</td>
<td></td>
</tr>
<tr>
<td>- Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process.</td>
<td></td>
</tr>
</tbody>
</table>

*See page 16 for details regarding “Interpretation of Evidence”*
## Summary of Recommendations

<table>
<thead>
<tr>
<th>RECOMMENDATION</th>
<th>*STRENGTH OF EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Dedication of a qualified individual to provide the support needed for the</td>
<td></td>
</tr>
<tr>
<td>education and implementation process.</td>
<td>C</td>
</tr>
<tr>
<td>■ Ongoing opportunities for discussion and education to reinforce the</td>
<td></td>
</tr>
<tr>
<td>importance of best practices.</td>
<td></td>
</tr>
<tr>
<td>■ Opportunities for reflection on personal and organizational experience</td>
<td></td>
</tr>
<tr>
<td>in implementing guidelines.</td>
<td></td>
</tr>
</tbody>
</table>

In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the *Toolkit: Implementation of clinical practice guidelines*, based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of the RNAO guideline *Integrating Smoking Cessation into Daily Nursing Practice*. 
**Interpretation of Evidence**

When this RNAO guideline was originally published, the material was a synthesis of a number of source guidelines. At that time, in order to fully inform the reader, every effort was made to maintain the original level of evidence cited in the source document. No alterations were made to the wording of the source documents involving recommendations based on randomized controlled trials or research studies. Where a source document demonstrated an "expert opinion" level of evidence, wording may have been altered and the notation of RNAO Consensus Panel 2003 added. In the guidelines reviewed, the panel assigned each recommendation a rating of A, B or C to indicate the strength of the evidence supporting the recommendation.

Through the revision process, additional literature was reviewed and used to update the recommendations and discussion of evidence. As these materials were considered, the strength of evidence were updated to reflect the state of the knowledge in that area. It is important to clarify that these ratings represent the strength of the supporting evidence to date.

**Strength of Evidence**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Requires at least two randomized controlled trials as part of the body of literature of overall quality and consistency addressing the specific recommendations.</td>
</tr>
<tr>
<td>B</td>
<td>Requires availability of well conducted clinical studies, but no randomized controlled trials on the topic of recommendations.</td>
</tr>
<tr>
<td>C</td>
<td>Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates absence of directly applicable studies of good quality.</td>
</tr>
</tbody>
</table>

**Responsibility for Development**

The Registered Nurses’ Association of Ontario (RNAO), with funding from the Government of Ontario, has embarked on a multi-year program of nursing best practice guideline development, pilot implementation, evaluation, dissemination and support of uptake. This guideline was originally developed, and subsequently revised, by a panel of nurses and researchers convened by the RNAO and conducting its work independent of any bias or influence from the Government of Ontario.
Purpose and Scope

This best practice guideline is intended to provide direction to nurses during daily practice in all care settings, both institutional and community. This guideline does not describe in-depth interventions for special populations such as youths, although the recommendations may also be applied to this group. This guideline contains recommendations for all Registered Nurses (RNs) and Registered Practical Nurses (RPNs). It is acknowledged that the individual competency of nurses varies between individuals and across categories of nursing professionals, and is based on knowledge, skills, attitudes and judgment, enhanced over time by experience and education.

Best practice guidelines are systematically developed statements to assist nurses and clients in decision making about appropriate healthcare (Field & Lohr, 1990). This guideline focuses on four areas of smoking cessation:

1. Practice recommendations, directed at the nurse and nursing practice.
2. Education recommendations, directed at competencies required for practice.
3. Organization and policy recommendations, directed at the organizational setting and the environment to facilitate nursing practice.
4. Evaluation and monitoring criteria.

Although this best practice guideline contains recommendations for Registered Nurses (RNs) and Registered Practical Nurses (RPNs), it is acknowledged by the development panel that promotion of smoking cessation is enhanced by the involvement of healthcare providers from a range of disciplines. Thus, other healthcare providers may also find this guideline useful in their practice.

Rationale for a Smoking Cessation Guideline

Globally, efforts to reduce tobacco use and exposure to second-hand smoke are gaining momentum. Both the federal and provincial governments’ efforts to regulate advertising, packaging, restricting minor’s access by increasing cost of cigarettes through taxation and imposing restrictions on public exposure to second-hand smoke are good examples. The movement to reduce tobacco use has been furthered by knowledge of the health effects that tobacco use poses and the recognition that tobacco use is an addiction. There is also heightened public awareness about the dangers of second-hand smoke through media campaigns. In Ontario, the Smoke-Free Ontario strategy introduced in May 2006, will improve the health of Ontarians by preventing children and youth from starting to smoke, helping Ontarians quit smoking and protecting Ontarians from involuntary exposure to second-hand smoke (Ontario Ministry of Health Promotion, 2006). See Appendix N for further information regarding resources to support smoking cessation.

The most important outcome of this guideline is to motivate and support all nurses to identify the tobacco use status of their clients and encourage them to intervene with those identified as individuals who smoke in a sensitive, non-judgmental manner about the importance of cessation.

It is suggested that if a substantial number of healthcare providers implement minimal smoking cessation interventions, there will be a significant reduction in the number of tobacco users, a decrease in related tobacco diseases and a lowering of healthcare costs. Tobacco-related diseases cost the Ontario economy at least $1.7 billion in healthcare annually, result in more than $2.6 billion in productivity losses and account for at least 500,000 hospital days each year (Ontario Ministry of Health Promotion, 2006).
Guiding Principles/Assumptions about Smoking Cessation
The guiding principles and assumptions that underlie this nursing best practice guideline related to smoking cessation are as follows:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Regular tobacco use is an addiction that requires support and repeated interventions.</td>
</tr>
<tr>
<td>2.</td>
<td>The offer of assistance to quit smoking will benefit every person who smokes.</td>
</tr>
<tr>
<td>3.</td>
<td>The client has the right to accept or refuse smoking cessation intervention.</td>
</tr>
<tr>
<td>4.</td>
<td>Individuals who smoke deserve to be treated with respect, dignity and sensitivity, while receiving smoking cessation intervention.</td>
</tr>
<tr>
<td>5.</td>
<td>The public values and trusts specific advice provided by nurses in the practice of their profession.</td>
</tr>
<tr>
<td>6.</td>
<td>Nurses are key members of the healthcare team and have a unique, credible and powerful position within the team.</td>
</tr>
<tr>
<td>7.</td>
<td>Nurses are involved with clients at multiple entry points to care. This provides many opportunities to identify persons who smoke and implement smoking cessation interventions.</td>
</tr>
<tr>
<td>8.</td>
<td>Actively implementing smoking cessation interventions in every care setting will increase successful quitting.</td>
</tr>
<tr>
<td>9.</td>
<td>Nurses who currently smoke have a professional responsibility and can effectively provide smoking cessation intervention.</td>
</tr>
<tr>
<td>10.</td>
<td>Nursing students have the right to education about evidence-based practice interventions and strategies for smoking cessation.</td>
</tr>
<tr>
<td>11.</td>
<td>Nurses have the right to education to enable them to provide the best evidence-based standard of care.</td>
</tr>
<tr>
<td>12.</td>
<td>Nurses are ideally positioned to provide a leadership role related to smoking cessation at the individual, program and/or policy level.</td>
</tr>
</tbody>
</table>

In February of 2001, a panel of nurses and researchers with expertise in practice and research related to smoking cessation, from community and academic settings, was convened under the auspices of the RNAO. At the onset the panel discussed and came to consensus on the scope of the best practice guideline. A search of the literature for systematic reviews, clinical practice guidelines, relevant articles and websites was conducted.

The panel identified a total of 14 clinical practice guidelines related to smoking cessation. An initial screening was conducted using the following inclusion criteria:

- Guideline was in English.
- Guideline was dated no earlier than 1996.
- Guideline was strictly about the topic area.
- Guideline was evidence-based (e.g., contained references, description of evidence, sources of evidence).
- Guideline was available and accessible for retrieval.

Eight guidelines were short-listed for critical appraisal using the Appraisal Instrument for Clinical Practice Guidelines (Cluzeau et al., 1997). This appraisal tool allows for evaluation in three key dimensions.

The panel, following the appraisal process, identified the following guidelines, and related updates, to adapt and modify in the development of recommendations:


A critique of systematic review articles and pertinent literature was conducted to update the existing guidelines. Through a process of evidence gathering, synthesis and consensus, a draft set of recommendations was established. This draft document was submitted to a set of external stakeholders for review and feedback – an acknowledgment of these reviewers is provided at the front of this document. Stakeholders represented various healthcare professional groups, clients and families, as well as professional associations. External stakeholders were provided with specific questions for comment, as well as the opportunity to give overall feedback and general impressions. The results were compiled and reviewed by the development panel – discussion and consensus resulted in revisions to the draft document prior to pilot testing.

A pilot implementation practice setting was identified through a "Request for Proposal" (RFP) process. Practice settings in Ontario were asked to submit a proposal if they were interested in pilot testing the recommendations of the guideline. These proposals were then subjected to a review process, from which a successful practice setting was identified. A nine month pilot implementation was undertaken to test and evaluate the recommendations. The evaluation took place in a recently amalgamated organization comprised of four different sites and serving clients with addictions and mental health. An acknowledgment of this organization is included at the front of this document. The development panel reconvened after the pilot implementation in order to review the experiences of the pilot site, consider the evaluation results and review any new literature published since the initial development phase. All these sources of information were used to update/revise the document prior to publication.

* During the original guideline development process between 2001-2003, these materials were retrieved online at the indicated web addresses and were current at that time, however, these links may no longer be active.

**Revision Process – 2006/2007**

The Registered Nurses’ Association of Ontario (RNAO) has made a commitment to ensure that this best practice guideline is based on the best available evidence. In order to meet this commitment, a monitoring and revision process has been established for each published guideline.

A “current awareness” review has been completed twice each year since the nursing best practice guideline *Integrating Smoking Cessation into Daily Nursing Practice* (2003) was originally published. Guideline development staff reviewed abstracts published in key databases on the topic of smoking cessation, focusing on systematic reviews, randomized controlled trials and recently published clinical practice guidelines. The purpose of this review was to identify evidence that would impact on the recommendations, either further supporting the published recommendations, or indicating that a
recommendation was no longer appropriate. In the latter case, an “action alert” would be issued, or a full review would be conducted prior to the three-year schedule. No evidence of this nature was identified during the ongoing monitoring phase, and this guideline moved into the revision phase as originally scheduled. In June of 2006, a panel of nurses with expertise in smoking cessation from a range of practice settings (including institutional, community and academic sectors) was convened by the RNAO. This group was invited to participate as a review panel to revise the Integrating Smoking Cessation into Daily Nursing Practice guideline that was originally published in October 2003. This panel was comprised of members of the original development panel, as well as other recommended specialists.

The panel members were given the mandate to review the guideline, focusing on the currency of the recommendations and evidence, keeping to the original scope of the document. This work was conducted as follows:

**Planning:**
- Clinical questions were identified to structure the literature search.
- Search terms were generated with input from the panel team leader for each recommendation in the guideline.
- Literature search was conducted by a health sciences librarian.
- Structured website search was conducted by program staff, focusing on recently published clinical guidelines.

**Critical Appraisal:**
- Search results were reviewed by a Research Assistant assigned to the panel. This review included assessing for inclusion/exclusion related to the clinical questions. See Appendix A for a detailed description of the search strategy.
- Studies that met the inclusion/exclusion criteria were retrieved. Quality appraisal and data extraction was conducted by the Research Assistant. These results were summarized and circulated to the panel.
- Panel members reviewed identified guidelines with the AGREE Instrument (AGREE Collaboration, 2001). See Appendix A for details of this review.

**Panel Review:**
- Panel members reviewed the data extraction tables, systematic reviews, and where appropriate, original studies and clinical guidelines.
- Recommendations for additional search strategies were identified, if required.
- Through a process of consensus, recommendations for revision to the guideline were identified.
**Definition of Terms**

An additional Glossary of Terms related to clinical aspects of the document is located in Appendix B.

| Clinical Practice Guidelines or Best Practice Guidelines: | Systematically developed statements (based on best available evidence) to assist practitioner and client decisions about appropriate healthcare for specific clinical (practice) circumstances (Field & Lohr, 1990). |
| Consensus: | A process for making policy decisions, not a scientific method for creating new knowledge. At its best, consensus development merely makes the best use of available information, be that of scientific data or the collective wisdom of the participants (Black et al., 1999). |
| Education Recommendations: | Statements of educational requirements and educational approaches/strategies for the introduction, implementation and sustainability of the best practice guideline. |
| Evidence: | Evidence is information that comes closest to the facts of a matter. The form it takes depends on context. The findings of high-quality, methodologically appropriate research are the most accurate evidence. Because research is often incomplete and sometimes contradictory or unavailable, other kinds of information are necessary supplements to or stand-ins for research. The evidence base for a decision is the multiple forms of evidence combined to balance rigour with expediency – while privileging the former over the latter. (Canadian Health Services Research Foundation, 2006). |
| Meta-Analysis: | The use of statistical methods to summarize the results of independent studies, thus providing more precise estimates of the effects of healthcare than those derived from the individual studies included in a review (Clarke & Oxman, 1999). |
| Organization & Policy Recommendations: | Statements of conditions required for a practice setting that enables the successful implementation of the best practice guideline. The conditions for success are largely the responsibility of the organization, although they may have implications for policy at a broader government or societal level. |
| Practice Recommendations: | Statements of best practice directed at the practice of healthcare professionals that are ideally evidence-based. |
| Randomized Controlled Trial: | For the purposes of this guideline, a study in which subjects are assigned to conditions on the basis of chance, and where at least one of the conditions is a control or comparison condition. |
| Stakeholder: | A stakeholder is an individual, group or organization with a vested interest in the decisions and actions of organizations who may attempt to influence decisions and actions (Baker et al., 1999). Stakeholders include all individuals or groups who will be directly or indirectly affected by the change or solution to the problem. Stakeholders can be of various types, and can be divided into opponents, supporters and neutrals (Ontario Public Health Association, 1996). |
Systematic Review: Application of a rigorous scientific approach to the preparation of a review article (National Health and Medical Research Council, 1998). Systematic reviews establish where the effects of healthcare are consistent and research results can be applied across populations, settings, and differences in treatment (e.g., dose); and where effects may vary significantly. The use of explicit, systematic methods in reviews limits bias (systematic errors) and reduces chance effects, thus providing more reliable results upon which to draw conclusions and make decisions (Clarke & Oxman, 1999).

Background Context

Facts on Tobacco Use (adapted from several sources; see Appendix C for references)
- Tobacco use is the leading preventable cause of premature death, disease and disability.
- Tobacco use increases the risk of cardiovascular disease, cancers, respiratory diseases, adverse effects in pregnancy, gastrointestinal problems and tooth and gum problems.
- In 2005, 16 percent of Ontario adults aged 18 years and older were current smokers of cigarettes (i.e., smoked daily or occasionally in the past month and smoked at least 100 cigarettes in their lifetime) which is lower than the current national rate of 20% (Ontario Tobacco Research Unit, 2006).
- More than 47,000 Canadians, aged 35 or older, are estimated to die annually as a direct result of smoking.
- Tobacco kills over 16,000 Ontario residents each year (Ontario Ministry of Health Promotion, 2006).
- In 2002, the total economic cost of tobacco use in Ontario was almost $6.1 billion (Ontario Tobacco Research Unit, 2006).
- Smoking is responsible for about one-third of potential years of life lost due to cancer, about one-quarter of potential years of life lost due to diseases of the heart and about one-half of potential years of life lost due to respiratory disease.
- 80 percent of persons who smoke, who have been identified and advised to stop smoking, report that they want to stop smoking (Brodish, 1998).
- Cigarettes and other forms of tobacco are addictive. Smoking is both a psychological and a physical addiction. Nicotine is one of the most highly addictive substances known.
- Second-hand smoke or environmental tobacco smoke is a toxic mixture of chemicals produced during the burning and smoking of tobacco products.
- There are approximately 4,000 chemical compounds in second-hand smoke. More than 40 of them are known to cause cancer.
- The average additional annual cost to an employer of employing a person who smokes has been estimated by the Conference Board of Canada to be $3,396.00 (Conference Board of Canada, 2006).
Benefits of Quitting Smoking
Quitting smoking is the single most effective thing that a person who smokes can do to enhance the quality and length of their life. For some conditions, such as ischemic heart disease, the benefits of quitting smoking are substantial, both immediately and in the long term. The risks of dying from tobacco-related diseases are reduced over time, in comparison with those who continue to smoke (Health Canada, 2001). The risk of smoking related disease continues to decrease as the duration of abstinence increases. (See Appendix D for a list of health benefits.)

Understanding Tobacco Addiction
- Tobacco contains nicotine, which is a powerful and highly addictive substance. Smoking delivers nicotine to the brain very rapidly and effectively, bringing on the rapid onset and maintenance of addiction. The resulting physiological need for tobacco, as well as the accompanying psychological need, explains the continuing use of tobacco products in spite of all the known health risks.

- Nicotine dependence consists of both physical and behavioural components. Tobacco use triggers the release of dopamine – a chemical in the brain that is associated with feelings of pleasure (relief of withdrawal symptoms). Persons who smoke need greater and greater amounts of nicotine to achieve the same levels of satisfaction. Further smoking alleviates the withdrawal symptoms that set in as soon as the effects of nicotine wear off.

- Smoking cessation is not a single event but a process that involves a change in lifestyle, values, social circles, thinking and feeling patterns, and coping skills.

- Most researchers agree that individual users of tobacco differ to the degree to which they are dependent (Heatherton, Koslowski, Frecker & Fagerstrom, 1991).

- Historically, addiction to nicotine is one of the hardest substance use dependencies to break. Pharmacologic and behavioural characteristics that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin and cocaine (Surgeon General of the United States, 2000).
How to Help People Stop Smoking

- The most important step in addressing tobacco use and dependence is screening for tobacco use and offering minimal smoking cessation intervention messages to all persons who smoke, at every opportunity. When surveyed, over half of Ontarians who currently smoke expressed an intention to quit smoking within six months of their interview; one quarter indicated a serious intention to quit within 30 days (Ontario Tobacco Research Unit, 2006).

- Organization of the clinical environment indicates to the client that the healthcare team will provide cessation assistance. A powerful message can be delivered to clients, families, the public and staff by prominently displaying "quit smoking" posters and ensuring cessation materials are visible, accessible and available.

- A cueing system for the chart (e.g., labeling each client’s smoking status clearly and visibly with stickers, stamps or on a flow sheet) prompts healthcare providers to consistently and effectively integrate smoking cessation into their care.

- Prochaska and DiClemente’s Stages of Change Model (see Appendix E), recognizes that individuals who smoke are at different stages of readiness to quit smoking. The use of the model can assist nurses in smoking cessation intervention by understanding the various stages of willingness to change. Progress is accomplished when a person who smokes moves onto the next stage or closer to the stage of quitting. Appendix F shows an example of how to assess and identify a client’s readiness to quit.

- Provide information and support for the use of pharmacological and non-pharmacological aids for persons who smoke, who want to quit. The risks of short term nicotine replacement therapy as an aid to smoking cessation in healthy people are acceptable and substantially outweighed by the risks of cigarette smoking (Surgeon General of the United States, 2000).
Integrating Smoking Cessation into Daily Nursing Practice

Practice Recommendations

Recommendation 1.0

Nurses implement minimal tobacco use intervention using the “Ask, Advise, Assist, Arrange” protocol with all clients.

(Strength of Evidence = A)

Minimal Smoking Cessation Intervention (Lasting 1 to 3 minutes)

Every nurse will:

ASK:

About tobacco use with all clients (e.g., “have you used any form of tobacco in the past six months?”) and assess readiness to quit. If time allows, assess the person’s level of motivation to change behavior, using motivational interviewing techniques (see Appendix G).

■ Document tobacco use status (e.g. non-smoker, smoker, ex-smoker).

ADVISE:

Every tobacco user of the importance of quitting in a non-judgmental and unambiguous manner.

ASSIST:

By providing minimal intervention:

■ Refer to the Canadian Cancer Society’s Smokers’ Helpline 1-877-513-5333 or www.smokershelpline.ca.

■ Offer support and self-help resources, such as booklets (See Appendix N for a list of resources).

■ Inform about, or refer to a community stop smoking clinic or service.

■ Refer to other healthcare provider.

ARRANGE:

Follow-up or referral.

For a flow chart of the Ask, Advise, Assist and Arrange protocol for minimal intervention, see Appendix H.

Discussion of Evidence

It is essential to provide at least a minimal intervention (1 – 3 minute duration) to all tobacco users at every appropriate occasion. There is good evidence that even brief advice from health professionals has a significant effect on smoking cessation rates (National Health Committee, 2002). Brief advice from a health professional decreases the proportion of people smoking by about 2 percent per year (NHS Centre for Reviews and Dissemination – The University of York, 1998). The literature suggests that minimal intervention may encourage a committed person who smokes to think about their smoking and to start to look at the disadvantages as well as the benefits. It has also been stated that for clients not ready to quit at this time, providing self-help material will increase their awareness and motivation to quit (U.S. Dept. of Health and Human Services, 2000).

All nurses have opportunities to assist clients to stop smoking through brief counselling and minimal interventions. The results indicate, with reasonable evidence, that minimal interventions can be effective as the nurses provide clients with information about the potential benefits of smoking cessation and counselling (Rice & Stead, 2003).

A study conducted by the University of Ulster (2001), showed that nurses constitute 65 percent of the healthcare workforce and are well placed to share the health promotion message with a large proportion of
the population. Healthcare personnel should treat inquiries about tobacco use and smoking cessation as a standard assessment question at every visit, recording current use, history and amount (Fiore et al., 2000; Fiore, Jorenby, & Baker, 1997).

**Recommendation 2.0**

Nurses introduce intensive smoking cessation intervention (more than 10 minutes duration) when their knowledge and time enables them to engage in more intensive counselling.

*(Strength of Evidence = A)*

### Intensive Smoking Cessation Intervention (Lasting more than 10 minutes)

Every nurse will:

**ASK:**

- About tobacco use with all clients (e.g., “have you used any form of tobacco in the past six months?”) and assess readiness to quit. If time allows, assess person’s level of motivation to change behaviour, using motivational interviewing techniques (see Appendix G).

  - Document tobacco use status (e.g. non-smoker, smoker, ex-smoker).

**ADVISE:**

- Every tobacco user of the importance of quitting in a non-judgmental and unambiguous manner.

**ASSIST:**

- By providing intensive intervention:

  - Determine and discuss the stage of change (Appendix E);
  - Reasons for smoking (WHY Test) (Appendix I);
  - Nicotine Dependence (Fagerstrom Test) (Appendix J);
  - Discuss strategies to quit and treatment options
  - Offer information re: pharmacotherapy options (see Discussion of Evidence);
  - Set a quit date;
  - Review quitting history, past quit attempts and discuss these experiences;
  - Review potential challenges and triggers (Appendix M); and
  - Encourage support of family and friends.

**ARRANGE:**

- Follow-up or referral.
- Schedule follow-up or refer to a community stop smoking clinic or service.

*For a flow chart of the Ask, Advise, Assist and Arrange protocol for intensive intervention, see Appendix H.*

**Discussion of Evidence**

Motivation is the key to giving up smoking (Royal College of Nursing, 1999). It was found that increasing the intensity of advice (time spent giving advice and duration of follow up) improves effectiveness, decreasing the proportion of persons who smoke by approximately 3 to 5 percent (U.S. Dept. of Health and Human Services, 2000). Counselling interventions could include areas such as smoking history, motivation to quit, identification of high risk situations and help with problem solving strategies to deal with high risk situations (Lancaster & Stead, 2003a). The more components added to the intervention, the more intensive the intervention (Rice, 1999). Individual counselling increases the likelihood of cessation compared to less intensive support (Lancaster & Stead, 2003b).
**Integrating Smoking Cessation into Daily Nursing Practice**

Intensive intervention is appropriate for all persons who smoke and are willing to participate and is especially recommended to be offered to “special populations” (pregnant women, cardiovascular clients, clients with other chemical dependencies or psychiatric disorders and various health issues) of persons who smoke.

Proactive telephone counselling, group counselling and individual counselling formats are effective and should be used in smoking cessation interventions (U.S. Dept. of Health and Human Services, 2000). Research shows that telephone counselling can significantly improve quit rates in young adults and older adults wanting to quit (Rabius et al, 2004). All Canadian provinces have telephone quitlines for persons who smoke. For a list of telephone resources, see Appendix N.

Proactive counselling helps persons who smoke to quit. In a review conducted by Stead, Lancaster and Perera (2003), it was found that a call from a counsellor is likely to increase the chances of quitting by approximately 50 percent and certainly by 2 to 4 percentage points, compared to a minimal intervention such as providing standard self-help materials. Smoking cessation interventions that are delivered in multiple formats increase abstinence rates and should be encouraged (U.S. Dept. of Health and Human Services, 2000).

In a systematic review conducted by Rigotti, Munafo, Murphy and Stead (2003), it was found that smoking cessation interventions delivered during a period of hospitalization, with follow-up support after discharge, increased smoking cessation. However, there was no clear evidence that clients with different clinical diagnoses responded in different ways.

**Pharmacotherapy Options**

Before recommending over-the-counter (OTC) drugs, nurses must have knowledge, skill and judgment about the client’s situation, their condition and medication profile and the medication (College of Nurses of Ontario, 2003). Pharmacological therapy should be recommended to all clients except in the presence of special circumstances or in cases of contraindications (Orsetti, Dwyer, Sheldon, Thomas & Harrison, 2001). In special circumstances or in cases of contraindications, nurses must work in collaboration with the client’s physician to determine the appropriate treatment for the client.

It is found that pharmacological options approximately double the long term abstinence rates over those produced by placebo interventions (U.S. Dept. of Health and Human Services, 2000; University of Toronto, 2000). As part of tobacco-dependence treatment, nicotine replacement therapy (NRT) and bupropion hydrochloride should be considered first as they have been proven to significantly improve cessation rates. Nicotine is highly addictive and by using NRT or Zyban® instead of smoking, thousands of other chemicals associated with tobacco smoke are no longer being inhaled (University of Toronto, 2000). The therapy used must depend on such factors as ease of administration, cost, compliance and particular vulnerabilities to side effects (National Health Committee, 1999a). Client preference, previous experience and contraindications should also be considered in recommending which pharmacological option to pursue.

The following first-line medications have been documented to significantly increase the rate of long-term smoking abstinence, and each has been approved as safe and efficacious by the U.S. Food and Drug Administration (Anderson, Jorenby, Scott & Fiore, 2002).
A) Nicotine Replacement Therapy (NRT)

NRT is the most commonly used pharmacological treatment for smoking cessation, which provides a “clean” alternative source of nicotine that the person who smokes would have otherwise received from tobacco. The aim of NRT is to partially replace the nicotine otherwise obtained from cigarettes. This may reduce the incidence and intensity of withdrawal symptoms induced by nicotine abstinence during the first few weeks of smoking cessation (Ontario Tobacco Research Unit, 2000b). It should be noted that oral nicotine replacement products reduce the effects of irritability, anxiety and overall withdrawal discomfort (West & Shiffman, 2001). The advantage of using NRT is that it supplies nicotine in a safe manner without the harmful constituents contained in tobacco smoke (National Health Committee, 1999a). Systematic reviews show that all forms of NRT increase quit rates at 12 months, approximately 1.5 to 2 fold compared with placebo, regardless of the setting (National Health Committee, 2002).

Perhaps the most useful approach to pharmacotherapies is to recognize that non-pharmacological interventions (counselling and other supports) remain vital contributors to successful smoking cessation; they should not be considered inferior to drug treatment. In fact, a robust evidence base exists supporting the combination of non-pharmacological and pharmacological interventions to aid in smoking cessation (Coleman, 2004).

Types of NRT:

1. **Nicotine patch** (e.g., Habitrol®, Nicoderm®)
   - Can be purchased over the counter (no prescription needed).
   - Is available in three strengths (7 mg, 14 mg, and 21 mg).
   - Provides a rate-controlled delivery of nicotine that is absorbed through the skin.
   - Is applied to non-hairy, clean, dry site above waist and held in place for 10 seconds to secure. The placement site must be changed with each application.
   - Usual schedule –21 mg x 4 wks, 14 mg x 4 wk, 7 mg x 2 wks (start with strength matching to nicotine dependence).
   - Has a slow onset and contains lower levels of nicotine than cigarettes and higher levels than gum.
   - May cause sleep disturbance (if these become serious, patch should be removed once in bed and immediately reapplied in the morning).

2. **Nicotine gum** (e.g., Nicorette®, Nicorette® Plus)
   - Can be purchased over the counter (no prescription needed).
   - Substitutes a piece of gum for the craving for a cigarette, providing gratification for oral needs and nicotine cravings.
   - Is absorbed by buccal mucosa.
   - Is not chewed continuously, rather, chewed 2-3 times, then parked between the cheek and the gum. “Bite, bite and park” between cheek and gums – wait a minute then repeat over 30 mins or less.
   - 1 - 2 pieces per hour, or with urge, up to 20 pieces day, gradually reduced over 4-12 weeks.
   - 25 cigs or more/day = 4 mg gum. (Nicorette® Plus) <25 cigs/day = 2 mg gum (Nicorette®).
   - Absorption diminished by concomitant use with coffee, tea, alcohol, juice and soft drinks.
There is evidence that combining the nicotine patch with nicotine gum increases long-term abstinence rates over those produced by a single form of NRT (Centres for Disease Control and Prevention, 1999). Bupropion hydrochloride can be used in combination with nicotine replacement therapies (U.S. Department of Health and Human Services, Public Health Service, 2000).

3. Nicotine inhaler (e.g. Nicorette® inhaler)
- Can be purchased over the counter (no prescription needed).
- Is a mouthpiece with a nicotine cartridge insert. A 10 mg inhaler cartridge delivers 4 mg nicotine vapor with 2 mg absorbed. One puff delivers less nicotine than one puff from a cigarette.
- Addresses both the physical and behavioural dependency of smoking as it mimics the hand-to-mouth ritual of smoking.
- ‘Puff (into mouth) and hold’. Nicotine is absorbed by blood vessels in the buccal cavity. The number of puffs taken depends on the amount of nicotine required to meet individual’s cravings and dependence (most users require > 2 puffs at a time). The same cartridge may be used to address the next craving. Once opened, each cartridge should be changed every 2-4 hours, as the unused nicotine will evaporate.
- Manufacturer recommends starting dose of 6 - 12 cartridges per day but many need significantly less. Taper amount over 3 months (max. 6 months).
- Acidic foods or drinks interfere with absorption. Do not eat or drink (except water) for 15 minutes prior.

4. Options such as nicotine nasal spray, sublingual tablets and lozenges are not currently available in Canada, but have been tested in placebo controlled trials, demonstrated to be effective and recommended as first-line pharmacotherapies in the United States (University of Toronto, 2000).

B) Bupropion Hydrochloride (Zyban®)
Bupropion hydrochloride is also marketed as the anti-depressant medication Wellbutrin®. It is a non-nicotine medication and requires a prescription. The exact mechanism by which bupropion hydrochloride works is unknown, but it is presumed to alleviate cravings associated with nicotine withdrawal affecting noradrenaline and dopamine, two chemicals in the brain that may be key components of the nicotine addiction pathway (National Health Committee, 1999a).

C) Other Options:
Varenicline tartate will be available in Canada in 2007, and was approved by the U.S. Food and Drug Administration in May 2006. Studies have shown Varenicline to increase the odds of quitting by four times compared to placebo, and double compared to Zyban® at 12 weeks and at 1 year. Varenicline targets nicotinic acetylcholine receptors to decrease craving, withdrawal and the reinforcement associated with smoking cigarettes. Studies have found varenicline to be safe and well tolerated, with the most common adverse effects reported being nausea and sleep disturbances (Gonzales et al., 2006; Jorenby et al., 2006; Tonstad et al., 2006).

Clonidine and Nortriptyline are second-line prescription medications used in smoking cessation. These are pharmacotherapies for which there is evidence of efficacy for treating tobacco dependence, but which have a more limited role than first-line medications.

For a comparison and explanation of the medications used in smoking cessation treatment, see Appendix L.
Non-Pharmacological Interventions
There are numerous options to assist a person who smokes, who is planning to stop smoking:
- Self-help books and materials;
- Individual counselling (e.g., physicians, nurses/nurse practitioners, pharmacists, dentists);
- Group programs; and
- Mutual aid and self-help group support.

While acupuncture and hypnotherapy are popular, there is insufficient evidence to support their effectiveness (Joanna Briggs Institute, 2001). However, if the individual has faith in acupuncture or hypnotherapy, they may benefit from the counselling that these approaches offer (U.S. Dept. of Health and Human Services, 2000; University of Toronto, 2000). Other potential quit methods that haven’t been clinically proven include herbal supplements, herbal patches and laser therapy.

Recommendation 3.0
Nurses recognize that tobacco users may relapse several times before achieving abstinence and need to re-engage clients in the smoking cessation process.

(Strength of Evidence = B)

Discussion of Evidence
Nicotine dependence is increasingly being recognized as a chronic, relapsing condition similar to that of other addictive substances.

Most relapse occurs within the first three months after quitting. Because of the chronic, relapsing nature of tobacco dependence, relapse prevention is especially important during this period. Strategies designed to prevent relapse should be included in the initial preparation for a quit attempt. It is important to encourage clients to report difficulties (lapses, depression, side effects) promptly while continuing their efforts to quit (U.S. Dept. of Health and Human Services, 2000). A variety of interventions targeting relapse prevention exist. In one significant review, researchers conclude that there is insufficient evidence to recommend particular interventions for relapse prevention; rather, they recommend continued focus on primary cessation attempts as well as the identification and resolution of tempting or high-risk situations (Hajek et al., 2006).

Relapse is perfectly normal and does not mean that a person who smokes has failed. Researchers have found that the more past attempts to stop smoking a person has made, the more likely they will be to successfully stop in the future. All experiences learned in previous attempts are useful and can be built on for a future successful attempt (Royal College of Nurses, 1999). Even after withdrawal symptoms pass, the risk of relapse continues to be high, largely due to exposure to temptations, social situations and other smoking triggers. All attempts to quit should be congratulated. Never condemn the person who smokes for lapsing. Encourage the person who smokes to take time to plan for their next stop smoke attempt and to use the information learned from the last one (University of Toronto, 2000). For Strategies to Avoid Relapse, see Appendix M.
Integrating Smoking Cessation into Daily Nursing Practice

Recommendation 4.0
Nurses should be knowledgeable about community smoking cessation resources, for referral and follow-up. *(Strength of Evidence = C – RNAO Consensus Panel, 2003/2007)*

Discussion of Evidence
There is evidence that self-help materials alone are of some benefit. A Cochrane review by Lancaster and Stead (2003b) did not find evidence that self-help materials produce incremental benefits over other minimal interventions, such as advice from a healthcare professional or nicotine replacement therapy. However, they found there is increasing evidence that materials that are individually tailored to the person who smokes have an effect. Tailoring materials to the characteristics of an individual who smokes and adding follow-up telephone calls improves effectiveness *(National Health Committee, 1999a)*.

The following are examples of community resources (for a complete listing, see Appendix N):
- The Canadian Cancer Society Smokers’ Helpline number is 1-877-513-5333.
- Local smoking cessation programs (inquire via local Public Health Unit).
- Employee Assistance Programs, accessible through an individual’s employer.
- Physicians and other healthcare providers.

Recommendation 5.0
Nurses implement smoking cessation interventions, paying particular attention to gender, ethnicity and age-related issues, and tailor strategies to the diverse needs of populations. *(Strength of Evidence = C – RNAO Consensus Panel, 2003/2007)*

Discussion of Evidence
There is substantial evidence in the literature citing the long-term benefits of “targeting” smoking cessation interventions at different populations (e.g., youth, women, older adults, ethnic groups). The Royal College of Nursing (1999), states that nurses are in a unique position, and have access to the population at all levels, citing several examples of successful implementation of smoking cessation programs with different target groups. The RNAO guideline development panel supports this concept of tailoring strategies where possible, during the implementation of minimal intervention.

In 2005, males aged 25-29 had the highest prevalence of current smoking at 39 percent, almost double that of their female counterpart (21 percent) *(Ontario Tobacco Research Unit, 2006)*. More research is needed to determine the most effective quit methods as many young adults do not consider themselves ‘smokers’ because they don’t smoke every day or they only smoke in certain situations. Please see Appendix N for resources which may be of use to nurses working with this population.

Additional research is also needed in the area of co-morbidity and smoking. Eighty percent of alcohol dependent people currently smoke and concurrent cannabis use is becoming increasingly relevant to smoking cessation as it has been linked to depression, suicidal ideation and difficulty of tobacco cessation *(Wilhelm, et al. 2006)*. These populations require the nurse’s special attention and consultation with other mental health practitioners to establish a smoking cessation care plan, especially with the use of nicotine replacement therapies.
Recommendation 6.0

Nurses implement, wherever possible, intensive intervention with women who are pregnant and postpartum. *(Strength of Evidence = A)*

Discussion of Evidence

In 2005, 10 percent of mothers in Ontario (aged 20-44) who gave birth in the past five years had smoked during their most recent pregnancy, with 5 percent having smoked daily and 5 percent having smoked occasionally (Ontario Tobacco Research Unit, 2006).

Pregnancy, and the period preceding and following, provides a unique opportunity to help women stop smoking. Many women are motivated to quit smoking during pregnancy and healthcare professionals can take advantage of this motivation by reinforcing the knowledge that cessation will reduce health risks to the fetus and that there are postpartum benefits to both the mother and the child. Women who stop smoking before or during the first trimester of pregnancy reduce risks to their baby to a level comparable to that of women who have never smoked (National Health Committee, 2002). Self-help manuals, particularly material specifically directed to pregnancy, are more effective in this population than in other groups (National Health Committee, 1999a).

Smoking during pregnancy has harmful effects for both the woman and the fetus. Approaches to smoking cessation for pregnant women often focus on the health of the fetus and give less attention to the woman's own health. Greaves et al., (2003) emphasize a woman-centred approach, focusing on the health of the woman in addition to the health of the fetus, thus encouraging a sustained abstinence in the postpartum period.

Stopping smoking during pregnancy may be treated as a suspension of the habit and is not always a change that is intentional or permanent or made for personal benefit. The research on process of change for smoking cessation suggests that pregnant women may experience the stages of quitting in a unique way, moving through the pre-contemplation and contemplation stages into preparation and action stages very quickly (Prochaska et al. 1983; 2001) which may be detrimental to smoking cessation and maintenance, resulting in postpartum relapse. Another study found that some women reported that they had never really quit because they quit for the fetus/baby and not for themselves (Bottorff et al., 2000).

There are many helpful resource agencies, websites and help lines that the consumer can access to increase their knowledge base about smoking cessation. Information for accessing these resources, like the Ontario program PREGNETS which provides information for pregnant women who intend to quit smoking, are listed in Appendix N. However, programs are still needed to raise awareness and motivate behavioural change among pregnant women and their partners, to reduce the harmful effects of prenatal and postnatal exposure to tobacco smoke (Ontario Tobacco Research Unit, 2000b).

According to the National Health Committee (2002), “NRT should be considered when a pregnant/lactating woman is unable to quit, and when the likelihood of quitting, with its potential benefits, outweighs the risks of NRT and potential continued smoking” (p. 22). A nurse can then recommend NRT to the client and suggest that the pregnant woman discuss this option with the healthcare provider who is monitoring her pregnancy.
Recommendation 7.0
Nurses encourage persons who smoke, as well as those who do not, to make their homes smoke-free, to protect children, families and themselves from exposure to second-hand smoke. *(Strength of Evidence = A)*

Discussion of Evidence
All involuntary exposure to tobacco smoke is harmful and should be eliminated (Ontario Tobacco Research Unit, 2000a). The scientific evidence indicates that there is no risk-free level of exposure to second-hand smoke. Second-hand smoke causes premature death and disease in children and in adults who do not smoke. Children who are exposed to second-hand smoke are at an increased risk for Sudden Infant Death Syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children. Exposure of non-smoking women to environmental tobacco smoke during pregnancy also causes reductions in fetal growth (Ontario Tobacco Research Unit, 2000a). Children do not choose this exposure. Their right to grow up in an environment free from tobacco smoke must be safeguarded through actions by national and local governments, voluntary bodies, community leaders, health workers, educators and parents (Ontario Tobacco Research Unit, 2000a).

Exposure of adults to second-hand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer (U.S. Department of Health and Human Services, 2006). In 2005, more than 600,000 Ontarians (7.3 percent) 12 years and older were exposed every day or almost every day to second-hand smoke at home (Ontario Tobacco Research Unit, 2006). A short-term objective of the Smoke-free Ontario Strategy is to increase the adoption of voluntary policies to make homes smoke-free (Ontario Tobacco Research Unit, 2006).

Education Recommendations
Education is the foundation of the success of all activities in smoking cessation. Education must be continually reinforced, and the best methods for educating must be chosen, in order to ensure practice change in the adoption of the best practice guidelines. The literature demonstrates that initiating and maintaining behavioural change is a complex process that requires the implementation of intensive and sustained efforts using strategies that influence a number of factors.

Recommendation 8.0
All nursing programs should include content about tobacco use, associated health risks and smoking cessation interventions as core concepts in nursing curricula. *(Strength of Evidence = C – RNAO Consensus Panel, 2003/2007)*

Discussion of Evidence
Several sources, including the U.S. Department of Health and Human Services (2000), widely support the inclusion of education and training in tobacco dependence treatments in the required curricula of all clinical disciplines. The RNAO guideline development panel also supports this need for educational programs at all levels of nursing.
Nurses require education and guidance so they can develop their understanding and a positive view as to the effectiveness of smoking cessation programs (Lawvere, 2003). Nurses described concern about their ability to motivate their clients. Education about the health risks of tobacco, assessing clients’ nicotine dependency and motivation to cease smoking is necessary to include in nursing curricula (Pelkonen, 2001).

**Organization & Policy Recommendations**

**Recommendation 9.0**

Organizations and Regional Health Authorities should consider smoking cessation as integral to nursing practice, and thereby integrate a variety of professional development opportunities to support nurses in effectively developing skills in smoking cessation intervention and counselling.

All corporate hospital orientation programs should include training to use brief smoking cessation interventions as well as information on pharmacotherapy to support hospitalized persons who smoke. *(Strength of Evidence = B)*

**Discussion of Evidence**

Educational development in the area of smoking cessation, for nurses in all specializations and practice settings, is needed to provide additional background knowledge and expertise in the practice of smoking cessation interventions. In particular, there is a need to educate nurses concerning the mechanisms underlying the additive nature of tobacco use (Schultz, Bottorff & Johnson, 2005); tobacco use is not a habit or choice. Increased awareness and knowledge would assist nurses in adequately treating withdrawal symptoms, which is necessary to support abstinence from tobacco use and eventual successful cessation. As well, organizations must provide professional development opportunities for nurses that are tailored to individual and group learning styles. Health professionals who receive training are much more likely to intervene with people who smoke than those who are not trained (University of Toronto, 2000).

To promote providers addressing tobacco cessation, organizations need to systemically approach tobacco cessation through education, resources, cues embedded in patient care documents, and feedback to providers. The healthcare system should ensure the following:

1. Nurses have sufficient training to treat tobacco dependence. For example, in Ontario, the Centre for Addiction and Mental Health launched a workshop Training Enhancement in Applied Cessation Counselling and Health (TEACH) that trains practitioners in the area of tobacco cessation.
2. Healthcare providers and clients have cessation resources; for example, access to patient resources that address stopping smoking (which includes addressing relapse and community supports available to address the process of stopping); protecting their environment from tobacco smoke exposure; options to refer for future cessation support.
3. Environmental prompts promote the integration of cessation support being offered by health providers (U.S. Dept. of Health and Human Services, 2000). For example, patient history forms, patient care forms, referral forms, and discharge forms should include cues regarding tobacco use status and cessation support. Currently, many of these components of health records document tobacco use while indications of cessation support are absent (Schultz et al., 2006).
4. Healthcare providers are given feedback about their tobacco dependence treatment practices (U.S. Dept. of Health and Human Services, 2000) and are referred to self-help resources specifically tailored for nurses and students who wish to stop smoking (i.e. Nurses Quit Net available on-line at www.tobaccofreenurses.org).

For a list of training and self help resources available to nurses, please see Appendix N.

**Recommendation 10.0**

Nurses seek opportunities to be actively involved in advocating for effective smoking cessation services, including “stop smoking medications”.


**Discussion of Evidence**

Suggested advocacy roles for nurses can include:

- Lobbying governments and third-party payers for funding to support the provision of smoking cessation services by health professionals.

- Advocating for the provincial government to have the Ontario Drug Benefit Plan (ODB) cover the cost of all nicotine replacement products and other smoking cessation related pharmaceuticals. At present, nicotine replacement products are not covered by most insurance plans.

- Advocating for employer sponsors, (for example, health insurance companies) to cover the cost of all nicotine replacement products and other smoking cessation related pharmaceuticals. In the longer term, the health consequences of tobacco use may prove more costly to the insurance industry than covering the cost of NRT products and other pharmaceuticals.

**Recommendation 11.0**

Nurses seek opportunities to be actively involved in advocating for smoke-free spaces and protection against second-hand smoke.


**Discussion of Evidence**

Smoke-free workplaces are associated with a decrease in prevalence of tobacco consumption of nearly four percent (Fichtenberg & Glantz, 2002; Moher et al., 2003; Smedsund et al., 2004). Smoke-free workplaces also make it easier for persons who smoke to reduce or stop smoking, and substantially reduce tobacco industry sales (Fichtenberg & Glantz, 2002). Most adults spend about a third of their day in a workplace environment, therefore the workplace is a setting through which large groups of people who smoke can potentially be reached by smoking cessation messages. The workplace has the potential for a higher participation than non-workplace environments and may encourage sustained peer group support and positive peer pressure (Moher, 2004).

On June 27, 2006 the U.S. Surgeon General released a report on involuntary exposure to second-hand smoke, concluding that secondhand smoke causes disease and death in children and non-smoking adults. The report finds a causal relationship between second-hand smoke exposure and Sudden Infant Death Syndrome (SIDS), and declares that the home is becoming the predominant location for exposure of children and adults to second-hand smoke.
Eliminating smoking in indoor spaces fully protects those who do not smoke from exposure to second-hand smoke. Separating persons who smoke from those who do not, cleaning the air, and ventilating buildings alone cannot eliminate exposures of nonsmokers to second-hand smoke (U.S. Department of Health and Human Services, 2006).

Nurses can help by:

- Promoting smoke-free environments, such as smoke-free initiatives on hospital grounds. Nurses can provide smoke-free task force leaders with valuable information and strategies to support patients, families, public and staff during implementation.

- Advocating for smoke-free outdoor recreation areas, and encouraging nurses to set an example by being smoke-free.

- Supporting and educating the public regarding the Ontario legislation that shields workers and the public from the harmful effects of tobacco by banning smoking in enclosed public places and enclosed workplaces.

**Recommendation 12.0**

Nursing best practice guidelines can be successfully implemented only when there is adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes:

- An assessment of organizational readiness and barriers to education.
- Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process.
- Dedication of a qualified individual to provide the support needed for the education and implementation process.
- Ongoing opportunities for discussion and education to reinforce the importance of best practices.
- Opportunities for reflection on personal and organizational experience in implementing guidelines.

In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the “*Toolkit: Implementation of clinical practice guidelines*” based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of the RNAO guideline *Integrating Smoking Cessation into Daily Nursing Practice.*

A critical step in the implementation of guidelines must be the formal adoption of the guidelines. Organizations need to consider how to formally incorporate the recommendations to be adopted into their policy and procedure structure (Graham et al., 2002). This initial step paves the way for general acceptance and integration of the guideline into such systems as the quality management process.

New initiatives such as the implementation of a best practice guideline require strong leadership from nurses who are able to transform the evidence-based recommendations into useful tools that will assist in directing practice. Refer to Appendix O for a description of the *Toolkit.*
Evaluation & Monitoring

Research on smoking and tobacco use has begun to focus not just on outcomes, e.g., quitting, reduction, and cessation, but on stages of smoking behaviour, based on stages of change. Understanding the cycle is important for developing and implementing interventions directed specifically to the individual’s current stage of change. Minimal intervention has been shown to decrease the proportion of persons who smoke by around 2 percent.

Organizations implementing the recommendations in this nursing best practice guideline are advised to consider how the implementation and its impact will be monitored and evaluated. The following table, based on the framework outlined in the RNAO Toolkit: Implementation of clinical practice guidelines (2002), illustrates some suggested indicators for monitoring and evaluation.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Structure</th>
<th>Process</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives</td>
<td>To evaluate the supports available in the organization that allow for nurses to implement minimal and intensive smoking cessation interventions.</td>
<td>To evaluate changes in practice that lead towards integration of minimal and intensive smoking cessation interventions into daily nursing practice.</td>
<td>To evaluate the impact of implementing the recommendations.</td>
</tr>
<tr>
<td>Organization/Unit</td>
<td>Review of best practice recommendations by organizational committee(s) responsible for policies or procedures, e.g., list of referral sources for smoking cessation.</td>
<td>Documentation systems available for recording smoking status and related strategies.</td>
<td>Smoke-free environment.</td>
</tr>
<tr>
<td></td>
<td>Availability of client education resources that are consistent with the guideline recommendations.</td>
<td></td>
<td>Incorporation of smoking cessation intervention education in staff orientation program.</td>
</tr>
<tr>
<td></td>
<td>Organizational mission statement that supports a smoke-free environment.</td>
<td></td>
<td>Incorporation of smoking cessation intervention in client information material.</td>
</tr>
<tr>
<td>Provider</td>
<td>Percentage of nurses and other healthcare professionals attending education sessions on smoking cessation.</td>
<td>Nurses’ self-assessed knowledge of the importance of:</td>
<td>Percentage of persons who smoke indicating they were advised to quit smoking by one or more nurses and/or other healthcare professionals during their most recent contact as indicated in chart audits.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assessing and implementing minimal or intensive smoking cessation interventions using the Ask, Advise, Assist and Arrange protocol.</td>
<td>Percentage of nurses and/or other healthcare professionals referring clients for follow-up to community smoking cessation programs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Documenting the smoking cessation interventions provided to clients.</td>
<td>Percentage of clients admitted to unit/facility with their smoking status and smoking history recorded.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Understanding the various stages of readiness to quit smoking.</td>
<td>Percentage of clients with documented interventions charted.</td>
</tr>
</tbody>
</table>
### Nursing Best Practice Guideline

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Structure</th>
<th>Process</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td>Total percentage of persons who smoke.</td>
<td>Percentage of persons who smoke who received cessation advice from a nurse and/or healthcare professionals at each clinic encounter and on each admission to hospital.</td>
<td>Percentage of clients who set quit date.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Percentage of clients accessing referral sources in the community.</td>
<td>Percentage of clients who made quit attempts 2 weeks post-cessation counselling.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Client confidence to quit smoking and maintain smoking cessation.</td>
<td>Percentage of clients who successfully quit smoking 8 weeks or 2 months post-cessation counselling.</td>
</tr>
<tr>
<td>Financial Costs</td>
<td>Provision of adequate financial resources for the level of staffing necessary to implement minimal and intensive smoking cessation interventions. Provision of designated individual to coordinate and support smoking cessation program initiatives throughout healthcare organization.</td>
<td>Cost for education, other interventions and supports.</td>
<td>Overall resource utilization (identify organizational specifics, new staff hires, medications, etc.).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cost related to implementing the guideline.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Education and access to on-the-job supports.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>New documentation systems.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support systems.</td>
<td></td>
</tr>
</tbody>
</table>

Examples of evaluation tools that were used to collect data during the pilot implementation can be found at the RNAO website [www.rnao.org/bestpractices].
Implementation Strategies

The Registered Nurses’ Association of Ontario and the guideline development panel have compiled a list of implementation strategies to assist healthcare organizations or healthcare disciplines who are interested in implementing this guideline. At the time of its original publication, this best practice guideline was pilot tested in four clinical settings within one organization, and many of these strategies were found to be helpful during the implementation. A summary of these strategies follows:

■ Have a dedicated person such as a clinical resource nurse who will provide support, clinical expertise and leadership. The individual should also have good interpersonal, facilitation and project management skills.

■ Establish a steering committee comprised of key stakeholders and members committed to leading the initiative. A work plan can assist as a means of keeping track of activities, responsibilities and timelines.

■ Provide educational sessions and ongoing support for implementation. At the pilot site, a core education session of approximately two hours was developed by a steering committee. The education session consisted of a Powerpoint presentation, discussion of case scenarios and was designed to be informal and interactive. The content drew on the recommendations contained in this guideline. Reminders, such as buttons, posters, laminated cards summarizing the steps in the Ask, Advise, Assist and Arrange strategy, were also used as education strategies.

■ Attitudes on smoking are shaped by a number of factors including an individual’s personal value system. Early attention to attitudes and values is needed by providing staff the opportunity to talk and problem solve on the job. This can be achieved using case scenarios to reflect the situations each group of participants faced with their clients.

■ Organizational support, such as having the structures in place to facilitate the implementation. Examples include: hiring of replacement staff so participants would not be distracted by concerns about work and having an organizational philosophy that reflects the value of best practices through policies and procedures and documentation tools.

■ Teamwork and collaboration through interdisciplinary work is beneficial in helping clients quit smoking. It is essential to be cognizant of smoking cessation programs and to tap the resources that are available in the community. An example would be linking and developing partnerships with nicotine addiction clinics for referral process. The RNAO’s Advanced Clinical/Practice Fellowship (ACPF) Project is a resource for registered nurses. They apply for a fellowship and have an opportunity to work with a mentor who has expertise in smoking cessation programs. With the ACPF, the nurse fellow will also have the opportunity to learn more about new resources.

In addition to the tips mentioned above, the RNAO has developed resources that are available on the website. A Toolkit for implementing guidelines can be helpful if used appropriately. A brief description of the Toolkit can be found in Appendix O. A full version of the document in .pdf format is also available at the RNAO website, www.rnao.org/bestpractices.
An e-learning module on smoking cessation has also been developed by the RNAO. The e-learning module can be used in conjunction with other teaching/learning modalities and it is available at www.rnao.org/smokingcessation.

The Program Training and Consultation Centre's website also provides resources that might be helpful as teaching tools. These teaching tools are available at www.ptcc.on.ca. (See Appendix N for listing of other resources.)

It is most important to emphasize the minimal intervention aspect of this best practice guideline. This takes less than three minutes. Nurses and others need to know that minimal intervention can be easily integrated in their daily practice. The minimal intervention is crucial for implementation. It can be implemented not only by nurses, but by all healthcare providers in any clinical setting.

**Research Gaps & Future Implications**

In reviewing the evidence for the revision of this guideline, it is clear that future research opportunities involve:

- Interventions to prevent relapse in individuals who have recently quit smoking.
- Attitudes of nurses towards smoking cessation counselling, and the impact on practice.
- The needs of special populations as they are reflected in program development and delivery.
- The benefits of NRT, to persons of various levels of nicotine dependency.
- The impact of the cost of accessing NRT on smoking cessation outcomes.
The Registered Nurses' Association of Ontario proposes to update the Best Practice Guidelines as follows:

1. Each nursing best practice guideline will be reviewed by a team of specialists (Review Team) in the topic area every three years following the last set of revisions.

2. During the three-year period between development and revision, RNAO Nursing Best Practice Guidelines program staff will regularly monitor relevant literature in the field.

3. Based on the results of this monitoring, program staff will recommend an earlier revision period. Appropriate consultation with a team of members comprised of original panel members and other specialists in the field will help inform the decision to review and revise the guideline earlier than the three-year milestone.

4. Three months prior to the three-year review milestone, the program staff will commence the planning of the review process by:
   a. Inviting specialists in the field to participate in the Review team. The Review Team will be comprised of members from the original panel as well as other recommended specialists.
   b. Compiling feedback received, questions encountered during the dissemination phase as well as other comments and experiences of implementation sites.
   c. Compiling new clinical practice guidelines in the field, systematic reviews, meta-analysis papers, technical reviews and randomized controlled trial research, and other relevant literature.
   d. Developing a detailed work plan with target dates and deliverables.

The revised guideline will undergo dissemination based on established structures and processes.
References


Integrating Smoking Cessation into Daily Nursing Practice


Moher, M., Hey, K., & Lancaster, T. (2005). Workplace interventions for smoking cessation. The Cochrane Library (Oxford) [ID #CD003440],


Ontario Tobacco Research Unit. (2006). Indicators of smoke-free Ontario progress, special reports: Monitoring and evaluation series. 12(2). Toronto; Ontario Tobacco Research Unit.


Integrating Smoking Cessation into Daily Nursing Practice


Bibliography


Ashley, M. J., Ferrence, R., Boardway, T., Pipe, A., Cameron, R., Schabas, R. et al. (1999). *Actions will speak louder than words: Getting serious about tobacco control in Ontario.* Toronto, Ontario: Ontario Tobacco Research Unit – Centre for Health Promotion – University of Toronto.


Integrating Smoking Cessation into Daily Nursing Practice


Integrating Smoking Cessation into Daily Nursing Practice


Nursing Best Practice Guideline


Integrating Smoking Cessation into Daily Nursing Practice


Nursing Best Practice Guideline


Appendix A: Search Strategy for Existing Evidence

The search strategy utilized during the revision of this guideline focused on two key areas. One was the identification of new guidelines published on the topic smoking cessation since the original guideline was published in 2003, and the second was to identify systematic reviews and primary studies published in this area from 2003 to 2006.

STEP 1 – DATABASE Search
A database search for existing evidence related to smoking cessation was conducted by a university health sciences library. An initial search of the Medline, Embase and CINAHL databases for guidelines and studies published from 2003 to 2006 was conducted in March 2006, using the following search terms and key words: “smoking cessation”, “smoking addiction(s)”, “relapse”, “practice guidelines”, “practice guideline”, “clinical practice guideline”, “clinical practice guidelines”, “standards”, “consensus statement(s)”, “consensus”, “evidence based guidelines” and “best practice guidelines”. In addition, a search of the Cochrane Library database for systematic reviews was conducted using the above search terms.

STEP 2 – Structured Website Search
One individual searched an established list of websites for guidelines related to the topic area in April 2006. This list of sites, reviewed and updated in April 2006, was compiled based on existing knowledge of evidence-based practice websites, known guideline developers, and recommendations from the literature. Presence or absence of guidelines was noted for each site searched as well as date searched. The websites at times did not house a guideline but directed to another website or source for guideline retrieval. Guidelines were either downloaded if full versions were available or were ordered by phone/email.

- Alberta Heritage Foundation for Medical Research - Health Technology Assessment: http://www.ahfmr.ab.ca/hta
- Alberta Medical Association - Clinical Practice Guidelines: http://www.albertadoctors.org
- Bandolier Journal: http://www.jr2.ox.ac.uk/bandolier
- Canadian Coordinating Office for Health Technology Assessment: http://www.ccohta.ca
- Canadian Institute of Health Information: http://www.cii.ca
- Canadian Health Network: www.canadian-health-network.ca
- Centers for Disease Control and Prevention: http://www.cdc.gov
- Clinical Evidence: www.clinicalevidence.com
- Cochrane Database of Systematic Reviews: www.thecochranelibrary.com
- European Observatory on health Care for Chronic Conditions, World Health Organization: http://www.euro.who.int/observatory/About/london/20041215_3
- Evidence-based On-Call: http://www.eboncall.org
- Guidelines Advisory Committee: http://gacguidelines.ca
- Guidelines International Network: www.g-i-n.net
Institute for Clinical Systems Improvement: http://www.icsi.org/index.asp
Institute for Clinical Evaluative Sciences: www.ices.on.ca
Joanna Briggs Institute: http://www.joannabriggs.edu.au
Monash University Centre for Clinical Effectiveness: http://www.mhsr.monash.org/cce
National Electronic Library for Health: http://www.nelh.nhs.uk
National Institute for Clinical Excellence (NICE): http://www.nice.org.uk
New Zealand Guidelines Group: http://www.nzgg.org.nz
NHS Centre for Reviews and Dissemination: http://www.york.ac.uk/inst/crd
NHS R & D Health Technology Assessment Programme: http://www.hta.nhsweb.nhs.uk/htapubs.htm
NIH Consensus Development Program: http://consensus.nih.gov/about/about.htm
Periodic Task Force on Preventive Health Care: http://www.ctfphc.org
Queen’s University at Kingston: http://post.queensu.ca/~bhc/gim/cpgs.html
Royal College of General Practitioners: http://www.rcgp.org.uk
Royal College of Nursing: http://www.rcn.org.uk/index.php
Royal College of Physicians: http://www.rcplondon.ac.uk
Sarah Cole Hirsh Institute – Online Journal of Issues in Nursing: http://fpb.cwru.edu/HirshInstitute
Scottish Intercollegiate Guidelines Network: http://www.sign.ac.uk
SUMSearch: http://sumsearch.uthscsa.edu
The Qualitative Report: http://www.nova.edu/ssss/QR
TRIP Database: http://www.tripdatabase.com
University of California, San Francisco: http://medicine.ucsf.edu/resources/guidelines/index.html
University of Laval – Directory of Clinical Information Websites: http://132.203.128.28/medecine
Virginia Henderson International Nursing Library: www.nursinglibrary.org

STEP 3 – Search Engine Web Search
A website search for existing practice guidelines on smoking cessation was conducted via the search engine “Google”, using key search terms. One individual conducted this search, noting the results of the search, the websites reviewed, date and a summary of the results. The search results were further reviewed by a second individual who identified guidelines and literature not previously retrieved.

STEP 4 – Hand Search/Panel Contributions
Additionally, panel members were asked to review personal archives to identify guidelines not previously found through the above search strategy. Results of this strategy revealed no additional clinical practice guidelines.

SEARCH RESULTS:
The search strategy described above resulted in the retrieval of 362 abstracts on the topic of smoking cessation. These abstracts were then screened by a research assistant related to duplications and inclusion/exclusion criteria. A total of 83 abstracts were identified for article retrieval and critical appraisal.
In addition, four recently published clinical practice guidelines were identified for review and critical appraisal by the panel, using the “Appraisal of Guidelines for Research and Evaluation” (AGREE Collaboration, 2001) instrument. These guidelines included:

Appendix B: Glossary of Terms

**Acupuncture:** A treatment involving the placement of needles in specific areas of the body, in this instance with the intent to promote abstinence from tobacco use.

**Bupropion HCI (bupropion sustained-release) (Zyban®):** A non-nicotine aid to smoking cessation originally developed and marketed as an antidepressant. It is chemically unrelated to tricyclics, tetracyclics, selective serotonin re-uptake inhibitors and other known antidepressant medications. Its mechanism of action is presumed to be mediated through its capacity to block the re-uptake of dopamine and norepinephrine centrally.

**Clonidine:** An alpha-2-adrenergic agonist typically used as an anti-hypertensive medication, but also documented in this guideline as an effective medication for smoking cessation. The U.S. Food and Drug Administration (FDA) has not approved clonidine as a smoking cessation aid.

**Continuous abstinence:** A measure of tobacco abstinence based on whether subjects are continuously abstinent from smoking/tobacco use from their quit day to a designated outcome point (e.g., end of treatment, 6 months after the quit day).

**Cotinine:** Cotinine is nicotine's major metabolite, which has a significantly longer half-life than nicotine. This is often used to estimate a client's tobacco/nicotine self-administration prior to quitting, and to confirm abstinence self-reports during follow up. Cotinine can be measured in urine, saliva or blood.

**Dependence:** Is defined by the DSM IV (American Psychiatric Association, 2000) as: tolerance to a substance; withdrawal from a substance; taking a substance for a longer period and in larger amounts than intended; having a persistent desire or unsuccessful efforts to cut down or control substance use; spending a great deal of time obtaining, using or recovering from the effects of the substance, giving up important social, occupational, or recreational activities because of substance use; substance use continues despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

**Diazepam:** A benzodiazepine anxiolytic medication intended to reduce anxiety.

**Environmental tobacco smoke (ETS):** Also known as “second-hand smoke.” The smoke inhaled by an individual not actively engaged in smoking, but due to exposure to ambient tobacco smoke.

**First-line pharmacotherapy for tobacco dependence:** First-line pharmacotherapies have been found to be safe and effective for tobacco dependence treatment and have been approved by the FDA for this use. First-line medications have an established empirical record of efficacy, and should be considered first as part of tobacco dependence treatment, except in cases of contraindications.
**Hotline/help-line:** See telephone hotline/help-line.

**Hypnosis (hypnotherapy):** A treatment by which a healthcare provider attempts to induce an altered attention state and heightened suggestibility in a tobacco user for the purpose of promoting abstinence from tobacco use.

**Informal support:** Support and resources provided by persons associated with the individual receiving care. Persons providing informal support can include: family, friends, members of a religious group, and neighbours.

**Intensive intervention:** Refers to interventions that involve extended contact between healthcare provider and client (greater than 10 minutes of time spent in intervention).

**Interdisciplinary:** A process where healthcare professionals representing expertise from various healthcare disciplines participate in the support of clients/families in the care process.

**Minimal intervention:** Refers to interventions in which there is brief contact between healthcare provider and client (1 to 3 minutes of time spent in intervention).

**Motivational Interviewing:** Is a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence. Compared with nondirective counselling, it is more focused and goal directed. Motivation to change is elicited from the client not imposed from without by healthcare providers, peers, or others.

**Nicotine:** This is often used to assess a client's tobacco/nicotine self-administration prior to quitting, and to confirm abstinence self-reports during follow up. Nicotine can be measured in urine, blood and saliva.

**Nicotine replacement therapy (NRT):** Refers to a medication containing nicotine that is intended to promote smoking cessation. The nicotine chewing gum, nicotine inhaler and nicotine patch are currently approved for use in Canada.

**Person-to-person intervention:** In-person or face-to-face contact between a healthcare provider and a client, for the purpose of tobacco use assessment or intervention.

**Point prevalence:** A measure of tobacco abstinence based on smoking/tobacco use occurrence within a set time period (usually 7 days) prior to a follow-up assessment.

**Practical counselling (problem solving/skills training):** Refers to a tobacco use treatment, in which tobacco users are trained to identify and cope with events or problems that increase the likelihood of their tobacco use. For example, quitters might be trained to anticipate stressful events and to use coping skills such as distraction or deep breathing to cope with an urge to smoke. Related and similar interventions are coping skills training, relapse prevention and stress management.

**Proactive telephone counselling:** Treatment initiated by a healthcare provider who telephones and counsels the client over the telephone.
**Psychosocial interventions**: Refers to intervention strategies that are designed to increase tobacco abstinence rates due to psychological or social support mechanisms. These interventions comprise such treatment strategies as counselling, self-help and behavioural treatment and contingency contracting.

**Quit day**: The day of a given cessation attempt during which a client tries to abstain totally from tobacco use. Also refers to a motivational intervention, whereby a client commits to quit tobacco use on a specified day.

**Relaxation/breathing**: An intervention strategy in which clients are trained in relaxation techniques. Interventions using meditation and breathing exercises fit this category. This category should be distinguished from the category of problem solving, which includes a much wider range of stress-reduction/management strategies.

**Second-hand smoke**: See “environmental tobacco smoke”.

**Second-line pharmacotherapy for tobacco dependence**: Second-line medications are pharmacotherapies for which there is evidence of efficacy for treating tobacco dependence, but they have a more limited role than first-line medications. Second-line treatments should be considered for use on a case-by-case basis, after first-line treatments have been used or considered.

**Self-help**: An intervention strategy in which the client uses a non-pharmacologic, physical aid to achieve abstinence from tobacco. Self-help strategies typically involve little contact with a healthcare provider, although some strategies (e.g., hotline/help-line) involve client-initiated contact. Examples of types of self-help materials include: pamphlets, booklets, mailings, manuals, videos, audio tapes, referrals to 12-step programs, mass media community-level interventions, list of community programs, reactive telephone hotlines/help-lines and computer programs/internet resources.

**Smokeless tobacco**: Any used form of unburned tobacco, including chewing tobacco and snuff.

**Smoking cessation**: Smoking cessation is a process whereby a person who uses tobacco products quits smoking and stops using tobacco products for a minimum of 24 hours.

**Smoking cessation intervention**: Smoking cessation intervention is formally identifying, assisting, motivating and advising the person who smokes to become, and remain, smoke-free.

**Telephone hotline/help-line**: A reactive telephone line dedicated to over-the-phone smoking intervention. A hotline/help-line treatment occurs when a hotline/help-line number is provided to a client, or a referral to a hotline/help-line is made. The key distinction between hotline/help-line and proactive telephone counselling is that in the former the client must initiate clinical contact.

**Transdermal nicotine**: Refers to delivery of nicotine by diffusion through the skin. Often used as a synonym for a “nicotine patch.”
Appendix C: The Health Risks of Smoking

Toxic Components of cigarettes
Exposure to these chemicals occurs whenever a tobacco product is burned:

- Tar
- Nicotine
- Carbon monoxide
- Formaldehyde
- Hydrogen cyanide
- Benzene

For further details on the toxic components of cigarettes, visit Health Canada's Toxic Emissions Statement, webpage at: http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/legislation/label-etiquette/tox/index_e.html

- More than 47,000 people die prematurely each year in Canada due to tobacco use.
- The average person who smokes will die about eight years earlier than a similar non-smoker.

Tobacco use increases the risk of:

1. Cardiovascular disease 7. Rheumatologic conditions
2. Cancers 8. Kidney damage
3. Respiratory diseases 9. Type 2 Diabetes
4. Adverse effects in pregnancy and early childhood 10. Skin conditions
5. Gastrointestinal problems 11. Cataracts
6. Orthopedic conditions 12. Tooth and gum problems

1. Cardiovascular Disease
- About 30 percent of all heart disease deaths are due to smoking.
- Smoking accounts for about three quarters of all cases of peripheral vascular disease. The risk of peripheral vascular disease may be as much as 16 times higher in persons who smoke than in those who do not.
- Smoking is a dominant cause of heart disease, stroke and diseases of the blood vessels.
- Each year in Canada, more than 17,600 cardiovascular deaths result from smoking.
- Each year in Canada, more than 2,000 deaths from stroke result from smoking.
- Many of these deaths occur prematurely, before the age of 70.
- The incidence of coronary heart disease (CHD) is 2 to 4 times greater in smokers.
- Health Canada estimates that at least 700 non-smokers will die each year of coronary heart disease caused by exposure to second-hand smoke.
- Smoking is a major risk factor for heart attacks and sudden cardiac death.
- Smoking acts synergistically with other risk factors (high cholesterol and blood pressure) to increase the risk of CHD.
- Smoking increases the risk of recurrence in persons who have survived a heart attack.
- Smoking increases the risk of stroke in women more so than men.
- Quitting smoking substantially reduces the risk of CHD and stroke.
2. Cancers
- Smoking is responsible for more than 21,000 deaths (Canadian Cancer Society et al., 2000) from cancer each year, almost 30 percent of all cancer deaths. The risk of developing cancer increases with duration of smoking, number of cigarettes smoked per day and degree of inhalation. The risk of lung cancer is significantly reduced with smoking cessation in comparison to those individuals who continue to smoke.
- Smoking causes cancer of the lung, oral cavity, larynx, esophagus, pancreas, kidney and urinary bladder.
- Recent evidence links smoking with cancer of the large intestine and some forms of leukemia. Tobacco causes 80 to 85 percent of all lung cancers and 30 percent of the total cancer burden.
- Smokeless tobacco is a major cause of cancer of the mouth.
- Cigarette smoking is estimated to account for about 30 to 40 percent of bladder cancers.
- Since 1993, lung cancer exceeded breast cancer as the leading cause of cancer deaths in Canadian women.

3. Respiratory Diseases
- Each year smoking is responsible for more than 8,000 deaths in Canada from respiratory diseases. Chronic Obstructive Pulmonary Disease (COPD) includes chronic bronchitis, chronic airway obstruction, emphysema and related disorders. Persons with these conditions often suffer long periods of disability marked by progressive shortness of breath and limitations in daily activities.
- Smoking accounts for 80 to 90 percent of all COPD deaths.
- Smoking far outweighs all other factors, including air pollution and occupational exposures, in causing these conditions.
- Smoking depresses the body’s immune system and other defense mechanisms.
- Smokers are at increased risk of respiratory infections compared to non-smokers.
- Smoking may increase susceptibility to the common cold.

4. Adverse Effects in Pregnancy and Early Childhood
- Bleeding during pregnancy.
- Ectopic pregnancy.
- Miscarriage.
- Premature delivery.
- Stillbirth.
- Abnormalities of the placenta.
- An increased risk of childhood allergies.
- Higher blood pressure in childhood.
- A greater likelihood of obesity.
- Being shorter in childhood.
- Poorer lung function.
- A greater likelihood that the child will have asthma.
- Women who smoke during pregnancy risk complications including.
- Low birth-weight newborn (less than 2500 grams).
- Babies receive nicotine and carbon monoxide from their mother’s blood.
- Smoking may contribute to Sudden Infant Death Syndrome (SIDS).
- Nicotine and other chemical components of cigarette smoke are found in the breast milk of nursing mothers who smoke or are exposed to environmental tobacco smoke (ETS).
- Smoking appears to decrease the quantity of breast milk which, combined with the effects on the quality of breast milk, may lead to early weaning.
5. **Gastrointestinal Problems**
- Peptic ulcer disease is more likely to occur in smokers than non-smokers.
- When ulcers are present, they heal less readily in smokers and are likely to recur.
- Smoking increases the risk of death from ulcers.
- Smoking is a risk factor for Chronic Bowel Disease and Crohn's Disease.

6. **Orthopedic Conditions**
- Osteoporosis
  - Smoking increases the chances of developing osteoporosis and of breaking bones. Smoking decreases the amount of calcium absorbed from food.

7. **Rheumatologic Conditions**
- Rheumatoid arthritis.

8. **Kidney Damage**
- Smoking worsens kidney damage in people who have medical problems that affect the kidneys, such as diabetes or high blood pressure.

9. **Type 2 Diabetes**
- Persons who smoke are at least 50 percent more likely than nonsmokers to get Type 2 diabetes.
- Among people who have diabetes, those who smoke are more likely to develop diabetes-related kidney damage, nerve damage, eye problems and heart disease.

10. **Skin Conditions**
- Contact allergies occur more often in persons who smoke than in those who do not.

11. **Cataracts**

12. **Tooth and Gum Problems**
- Smoking causes oral cancer.
- Smokers are more likely than non-smokers to lose their natural teeth, for their remaining teeth to be decayed, and to have significant gum loss (periodontal disease).

Additional Hazards for Males
- Erectile dysfunction.
  - Men who smoke are about twice as likely as men who don't smoke to suffer from erectile dysfunction and impotence.
  - Fertility may be impaired in men who smoke.

Additional Hazards for Women
- Smoking is a risk for cancer of the cervix.
- Natural menopause occurs earlier.
- Smoking increases the risk of menstrual disorders.
- Fertility may be impaired in women who smoke.
- Smoking, and the use of oral contraceptives, greatly increases the risk of strokes, heart attacks and other vascular complications.
Health Risks of Second-hand Smoke

Exposure to second-hand smoke causes the following diseases and conditions:

In adults:
- Heart disease.
- Lung cancer.
- Nasal sinus cancer.

In children:
- Sudden Infant Death Syndrome.
- Fetal growth impairment including low birth-weight and measuring small for gestational age.
- Bronchitis, pneumonia and other lower respiratory tract infections.
- Asthma exacerbation.
- Middle ear disease.
- Respiratory symptoms.

Exposure to second-hand smoke has also been linked to other adverse health effects, although the relationships may be causal. These include:

**In adults:**
- Stroke.
- Breast cancer.
- Cervical cancer.
- Miscarriages.

**In children:**
- Adverse impact on cognition and behaviour.
- Decreased lung function.
- Asthma induction.
- Exacerbation of cystic fibrosis.

Exposure to second-hand smoke causes between 1,100 and 7,800 deaths per year in Canada, at least one-third of them in Ontario.

Second-hand smoke is more dangerous than directly inhaled smoke. It is harmful even when you cannot see or smell it. Second-hand smoke releases the same chemicals as smoke that is directly inhaled, but in even greater quantity.
References:

* At the time of the original publication, these resources were retrieved at the web addresses above. These links may no longer be active.
# Appendix D: The Benefits of Quitting Smoking

<table>
<thead>
<tr>
<th>Timing</th>
<th>Benefits</th>
</tr>
</thead>
</table>
| **Within 20 minutes of last cigarette:** | - Blood pressure may drop to normal level.  
- Pulse rate drops to normal rate.  
- Body temperature of hands, feet increases to normal. |
| **Within 8 Hours:**           | - Carbon monoxide level in blood drops.  
- Oxygen level in blood increases. |
| **Within 24 Hours:**          | - May reduce chance of heart attack.                                                        |
| **Within 48 Hours:**          | - Nerve endings may regrow.  
- Ability to smell and taste enhanced.                                                        |
| **Within 72 Hours:**          | - Bronchial tubes relax; if undamaged, will make breathing easier.  
- Lung capacity increases.                                                               |
| **2 Weeks to 3 Months:**      | - Circulation improves.  
- Walking becomes easier.  
- Lung function may increase up to 20 percent.                                              |
| **1 Month to 9 Months:**      | - Coughing, sinus congestion, fatigue, shortness of breath may decrease markedly over a number of weeks.  
- Potential for cilia to regrow in lungs, increasing ability to handle mucous, clean the lungs, and reduce infection. |
| **1 Year:**                   | - The risk of heart disease is reduced by half.  
After 15 years, the risk is similar to that of persons who have never smoked. |
| **2 Years:**                  | - Cervical cancer risk reduced compared to continuing smokers.  
- Bladder cancer risk halved compared to continuing smokers.                                 |
| **5 Years:**                  | - Lung cancer death rate for average smoker (one pack a day) decreases from 137 per 100,000 to 72 per 100,000.  
- 5 to 15 years after quitting, stroke risk is reduced to that of someone who has never smoked. |
| **10 Years and Longer:**      | - Precancerous cells are replaced.  
- Risk of other cancers – such as those of the mouth, larynx, esophagus, bladder, kidney and pancreas decrease.  
- After long-term quitting the risk of death from Chronic Obstructive Pulmonary Disease is reduced compared to someone who continues to smoke. |
Time periods mentioned are to be taken as a general measure only and will naturally vary from individual to individual and are dependent upon length of habit and amount of cigarettes smoked.


Originally adapted from:


# Appendix E: Stages of Change Model

## Pre-contemplation
- Unaware or unwilling to change.
- Not thinking of quitting in the next 6 months.

**Goal:**
- To help the client begin to think seriously about quitting.

**What to do**
- ASK regarding feelings about smoking.
- ASK about the pros and possible cons of smoking.
- ADVISE by offering quitting information and assistance at any time.

## Contemplation
- Ambivalent, but thinking about quitting within 6 months.

**Goal:**
- To help smoker move towards a decision to stop smoking.
- To help the client feel more confident.

**What to do**
- ASK about the pros and cons of both continuing to smoke and quitting (decision balance).
- Acknowledge ambivalent feelings.
- ASSIST by reinforcing their reasons for change, and exploring new ones.
- Suggest they cut back or stop for a day.
- ASSIST by offering a future visit and information.

## Preparation
- Getting ready to stop within the next 30 days.
- Have set stop smoking date.
- Have made a 24 hour quit attempt in the last 12 months.

**Goal:**
- To help smoker prepare for and anticipate positively a quit date.

**What to do**
- ASK about concerns, preparations and lessons learned from previous attempts.
- ADVISE by identifying barriers to stopping and elicit solutions.
- ASSIST by Booklet, Action Plan, Nicotine Replacement, Date for quitting (BAND).
### Action
- Have quit smoking within past 6 months and are actively applying cessation skills.

### Goal:
- To help client stay off tobacco products and recover from relapses.

### What To Do
- **ASK** how the client is doing: relapses, temptations, successes, NRT use.
- **ADVISE** re: relapse prevention, weight gain, triggers.
- **ASSIST** by focusing on successes, encourage self rewards and increase support, elicit solutions for problems.

### Maintenance
- Quit for more than 6 months.
- Integrating smoke-free living into their routine.

### Goal:
- To help client remain smoke-free for a life time.

### What To Do
- **ASK** how the client is doing: risk situations, relapses.
- **ASSIST** by offering suggestions for difficult times, support, encouragement.
- **Congratulate**!

### The Cycle of Change
- Most smokers will cycle through the stages 3 to 4 times before quitting for life.
- Each attempt offers new opportunities to learn new skills and new techniques that will help them in their next attempt.

### Relapse:
**a normal event in the process of making behavioural change**

### Reference:
### Appendix F: Identifying Your Client’s Readiness to Quit

**Question:** Have you quit smoking cigarettes? Check one:

<table>
<thead>
<tr>
<th>Answer</th>
<th>Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Yes, I have, for more than 6 months.</td>
<td>❑ Defines maintenance.</td>
</tr>
<tr>
<td>❑ Yes, I have, but for less than 6 months</td>
<td>❑ Defines action.</td>
</tr>
<tr>
<td>❑ No, but I intend to in the next 30 days and have tried for at least 24 hours in the past year.</td>
<td>❑ Defines preparation.</td>
</tr>
<tr>
<td>❑ No, but I intend to in the next 6 months</td>
<td>❑ Defines contemplation.</td>
</tr>
<tr>
<td>❑ No, and I do not intend to in the next 6 months.</td>
<td>❑ Defines pre-contemplation.</td>
</tr>
</tbody>
</table>

Appendix G: Motivational Interviewing

Adapted from the Heart and Stroke Foundation of Ontario and RNAO’s Nursing Management of Hypertension (2005) guideline.

Motivational Interviewing is a focused, goal directed client-centred counselling style for eliciting behaviour change by helping clients explore and resolve ambivalence (Miller & Rollnick, 1991; Rollnick & Miller, 1995). To enhance motivation and change, motivational interviewing, through an assessment of the change process, systematically directs the client toward motivation for change; offers advice and feedback where appropriate, selectively uses empathic reflection to reinforce certain processes, and seeks to elicit and amplify the client’s discrepancies about their unhealthy behaviour(s). Motivational interviewing is facilitative rather than coercive and tentatively challenging rather than directly confrontational. The strategies support the client through the change process by fostering self-reflection rather than arguments between practitioner and client (Botelho & Skinner, 1995).

Searching for a method to facilitate behaviour change in clients with substance abuse, psychologists William Miller and Stephen Rollnick developed motivational interviewing. Behaviour change should be negotiated, not dictated. Healthcare practitioners do not motivate clients, but assess motivation and apply the appropriate skills and strategies to address readiness to change. This point is critical. Clients vary in their readiness to change a behaviour (e.g., take medications, make lifestyle changes) and must be assessed to determine how prepared they are to do what is needed to integrate change into their lives. How important do they think the changes are? Are they confident they can do so? Will they need help? Do they understand the benefits? What barriers do they perceive? How will they reduce them? By assessing the degree of readiness, nurses can choose specific communication skills and appropriate strategies to facilitate change. This is the heart of motivational interviewing (Berger, 2004a,b). The role of the nurse is to understand and accept, in a non-judgmental way, clients’ needs and concerns and not be coercive by trying to talk them in or out of these behaviours. This will create a favourable and supportive climate for change – problems are attacked, not people.

Motivational interviewing, designed to take 3-5 minutes per session, is a psychosocial or socio-behavioural approach to client care that contrasts with the traditional biomedical approach. The psychosocial model is client-centred and stresses that the client’s needs and concerns must be appropriately addressed; otherwise, non-adherence may occur. Asking if there are questions or concerns the client may have about the illness or treatments is a positive way of assessing this possibility. The psychosocial model also views the encounter between client and healthcare provider as a meeting of experts. The nurse or other healthcare providers may be an expert on disease management, but clients are experts on themselves and how they will be affected by the proposed changes in their lives. It is the client’s decision (with input from healthcare providers) to choose healthy or unhealthy behaviours. Clients manage their illness, not nurses. However, nurses can create an environment through caring, sufficient information, and understanding to improve the chance that the client will manage their illness effectively (Berger, 2004a,b).

Change and resistance are opposite sides of the same coin. Change often evokes resistance because change inherently questions one’s motivation and ability to do what is needed. If the pros of the change outweigh the cons, clients will make the change. Alternatively, ambivalence kills change. When people are ambivalent, they do nothing. The pros and cons of the change seem the same. Some examples of ambiguity are: client doubts
that the medication will actually work; they are unclear about what to do; or if they doubt they have the necessary skills. Resistance is information and provides insight into what the person is thinking and feeling: “I need to explore this and see if it works for me.” Exploring and understanding what has been said with the client, not persuasion or criticism, are the keys to managing resistance. If nurses try to move people too quickly toward a behaviour change, they will dig in and resist. An appropriate response to a client who indicates that he/she does not want to take a medication would be: “What bothers you the most about taking this medicine?” This way the client can explain their reasoning, and the nurse can specifically address his/her concern.

Motivational interviewing creates dissonance in a person. Dissonance, or an inconsistency between two behaviours (attitudes, values, etc.), creates a discomfort that, in itself, can be motivating. For example, if a person's attitudes are inconsistent with their behaviours, dissonance occurs. Dissonance is uncomfortable and the person may be motivated to explore ways to reduce this uncomfortable feeling. The spirit of motivational interviewing is collaboration, evocation and autonomy. Healthcare professionals using this approach desire a relationship with the client in which they can collaborate on mutually agreed upon goals. Questions are asked to determine and understand the client’s resistance or ambivalence – the client knows the answers, not the healthcare provider. Additionally, clients must make informed choices. It is not enough to simply provide information. One needs to evaluate that the client has understood the information, knows how to use it, and has a feeling of self-efficacy or confidence in their ability to do what is needed. This includes assessing the client’s understanding of the illness and its treatment.

**How does motivational interviewing work?**

Motivational interviewing uses the general process of elicit-provide-elicit. The nurse elicits information from clients to better understand who they are and what they already know about the illness and its management interventions. This is done to facilitate clients’ movement forward with the treatment plan. Then, nurses elicit information again to check for concerns or questions resulting from the new information.

Motivational interviewing uses **five principles or counselling techniques** to assess and create motivation within the client (Berger, 2004a,b; Miller & Rollnick, 1991; Smith, Heckemeyer, Kraft & Mason, 1997).

1. **Express empathy** – Empathy is defined as the “ability of the provider to accurately reflect what the client is saying” (Moyers, 2000; p.155). Empathy is an objective identification with the affective state of another (not his or her experience) – nurses identify with the client’s affect (emotions), not with the experience. Empathetic responding, through active listening, helps identify and understand resistance and reasons for unhealthy behaviours (or non-adherence). For example, your client smokes and you are advising him to quit. You ask him what he likes about smoking, and he says it relaxes him. Instead of creating defensiveness by asking, “Can't you think of something else to relax you?” you state empathetically, “It would be difficult to give up something that was relaxing.” As a result, the client sees you as an advocate, and is in a better position to hear what you have to say.

2. **Avoid arguments** – By avoiding arguments, the client is more likely to see the healthcare provider as being on his/her side. It is important to note that motivational interviewing is confrontational; however, it should not be argumentative or judgmental. For example, “Mrs. Jones, I see that you have been getting your medication refilled about every 40 days or so, but you receive only a 30-day supply. Can you tell me what happened?” Also, it should be noted that feelings a client may express (e.g., fear or concern) are not arguable but real for the client.
3. Develop discrepancy (dissonance) – Creating dissonance can be achieved in two major ways. The goal is to elicit from the client those aspects of his or her life that are important but may be compromised because of the behaviour. For example, the client may say that he or she enjoys going to the bar and drinking with his or her friends for most of the weekend, and how he or she hates taking medication especially those that do not make him or her feel well. In the next sentence, he or she may add that since he or she was diagnosed as having high blood pressure, he or she is very worried about having a stroke. The healthcare provider needs to understand what is important to the client in terms of short- and long-term goals. Ask the client about the pros and cons of the changes that are needed and then listen carefully for discrepancies that allow for the creation of dissonance. Remember, dissonance is motivating. We develop discrepancies by repeating back the pros and cons as stated by the client. Then, ask the client to discuss his or her goals relative to the treatment.

4. Roll with resistance – Ignore antagonistic elements in the client’s comments in order to focus on the important underlying issues. For example, the client says, “Look, I haven’t had any real problems with my smoking so far, so don’t worry about it.” Instead of rejecting this comment by saying, “If you continue smoking, I can assure you that you will suffer some major consequences,” the healthcare provider can roll with the expressed resistance by saying, “I hope your health continues to stay that way. I would like you to consider getting your lungs checked because early stages of cancer and lung disease may not have symptoms. That way, you can make a better decision about whether you want to keep smoking. I am worried that your smoking is going to make your heart disease much worse in the future. However, the decision to smoke or quit smoking is yours.” Do not meet resistance with confrontation but instead utilize reflection to create dissonance. This allows the client to hear information without being chastised. In the end, the decision belongs to the client.

5. Support self-efficacy – A person’s belief in the possibility of change (Bandura, 1977; 1982) is an important motivator. Clients, based on their abilities and the resources and strengths they possess, need to be encouraged by the healthcare provider. Questions such as: “What worked before?” or “What do you think helped you to be successful last time?” provide valuable information about the client’s strengths. Examine past successes (or failures) and offer genuine support for the successes. It is important to notice not only actual changes in behaviour, but also contemplated changes, expressed in a positive manner. The client must be able to imagine that success is a possibility before actually trying to change.

When using Motivational Interviewing, there are six general skills that should be utilized.

1. Asking open-ended questions: Asking questions in such a way that it is the client who is encouraged to do most of the talking. Some examples: “What concerns you about your health?” or “What is it that you like about smoking” or “What reasons might you have for not quitting smoking?” or “Tell me about the difficulties you encounter when trying to refill your prescriptions.” Miller and Rollnick (1991) recommend not asking more than three questions in a row. Asking open-ended questions sets the stage for reflective listening, affirmations and summation.

2. Reflective listening: As a foundational skill in motivational interviewing, reflective listening is useful to address resistance. Reflections can be simple “you’re feeling sad” to more complex, “It sounds like you are concerned what smoking all these years may have done to your overall health.” Reflective
statements, whether simple, amplified or double sided, tells the client that you have heard what he or she is saying and encourages them to explore their feelings. Simple reflection acknowledges the client’s thoughts, feelings and positions in a neutral manner.

3. **Affirmations:** Support for what the client is saying should occur frequently throughout the conversation. Praising or complimenting and exploring past successes help to build a therapeutic relationship.

4. **Summarizing or reframing:** Reframing pulls the information together so that the client can reflect upon it. By reframing, you tell the client that you have been listening and are open to exploring the situation further.

The summary links together the main points of the interview, both past and present. The ambivalence is clear and the reflection in the end encourages the client to address the ambivalence (whether to continue to struggle to get her prescriptions filled or ask someone to help).

5. **Self-motivational statements:** Clients must be responsible for change and motivated to acknowledge ambivalence when change is being considered and set the stage for dialogue to occur. The client argues the pros and cons of changing the behaviour and the healthcare provider gets insight into the client’s feelings and values as he listens to the argument.

6. **Personalized feedback:** This can be done on a one-to-one basis or through the use of standardized tools; for example, a chart showing the change of blood pressure toward the target levels as the client adheres to the goals set at a previous visit. The feedback must not be confrontational to the client. Instead, the data will do the confronting if the client has not been adherent.

**References:**


Appendix H: Ask, Advise, Assist, Arrange Protocol

ASK
“Have you used any form of tobacco in the past 6 months?”
Do you smoke (even a puff now and again) or use tobacco products of any kind?
(cigarettes, pipe, cigars, chew, spit, bidis)

Yes ❑ No ❑

Non-Smoker ❑ Smoker ❑ Ex-Smoker (greater than 6 months) ❑ Quit Date __________
Have you ever considered stopping?

ADVISE
“As your nurse, the most important advice I can give you is to quit smoking.”

ASSIST
Offer help for a stop smoking attempt

Minimal Intervention
1 – 3 minutes

Provide basic information about smoking and successful stopping
- Referral to community resource.
- Pharmacotherapy, i.e. NRT
  (for hospitalized patients this should be a standard of care)
- Self-help material.
- Referral to other healthcare provider.
- Smokers’ Helpline (1-877-513-5333).

Intensive Intervention
Personalize tobacco use to current health OR illness, readiness to stop and the impact of tobacco use on others in the household (social and economic costs).

Discuss strategies to quit and treatment options – check client preferences
- Determine & discuss the stage of change.
- Reasons for smoking (WHY Test).
- Nicotine Dependence (Fagerstrom Test).
- Offer information re: pharmacotherapy options.
- Set a quit date.
- Review quitting history.
- Review potential challenges and triggers.
- Encourage support of family and friends

ARRANGE
Follow-up
or refer client to smoking cessation program.
Support use of telephone counselling or community/public health programs.
References:

Fiore, M. C. (1997). AHCPR smoking cessation guideline: A fundamental review. Tobacco Control, 6 (Suppl. 1), S4-S8.


* At the time of the original publication, these resources were retrieved at the web addresses above. These links may no longer be active.
Appendix I: The WHY Test

Next to the following statements, mark the number that best describes your own experience.

1 = Never   2 = Rarely   3 = Once in a while   4 = Most of the time   5 = Always

- A. I smoke to keep myself from slowing down.
- B. Handling a cigarette is part of the enjoyment of smoking it.
- C. Smoking is pleasant and relaxing.
- D. I light up a cigarette when I feel angry about something.
- E. When I'm out of cigarettes, it's near-torture until I can get them.
- F. I smoke automatically, without even being aware of it.
- G. I smoke when other people around me are smoking.
- H. I smoke to perk myself up.
- I. Part of enjoying smoking is preparing to light up.
- J. I get pleasure from smoking.
- K. When I feel uncomfortable or upset, I light up a cigarette.
- L. I'm very much aware of it when I'm not smoking a cigarette.
- M. I often light up a cigarette while one is still burning in the ashtray.
- N. I smoke cigarettes with friends when I'm having a good time.
- O. When I smoke, part of my enjoyment is watching the smoke as I exhale it.
- P. I want a cigarette most often when I am comfortable and relaxed.
- Q. I smoke when I'm “blue” and want to take my mind off what's bothering me.
- R. I get a real craving for a cigarette when I haven’t had one in a while.
- S. I’ve found a cigarette in my mouth and haven’t remembered that it was there.
- T. I always smoke when I’m out with friends at a party, bar, etc.
- U. I smoke cigarettes to get a lift.
SCORECARD

Write the number you put beside each letter in The WHY Test beside the same letter on the scorecard. For example, if you marked a “3” beside question “C” on the test, put a “3” beside the letter “C” on the scorecard. Then, add up the numbers to get the totals for each category.

<table>
<thead>
<tr>
<th>A ___ H ___ U ___</th>
<th>“IT STIMULATES ME”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stimulation Total</td>
<td>With a high score here, you feel that smoking gives you energy, keeps you going. So, think about alternatives that give you energy, such as washing your face, brisk walking and jogging.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B ___ I ___ O ___</th>
<th>“I WANT SOMETHING IN MY HAND”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handling Total</td>
<td>There are a lot of things you can do with your hands without lighting up. Try doodling with a pencil, knitting or get a “dummy” cigarette you can play with.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C ___ J ___ P ___</th>
<th>“IT FEELS GOOD”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pleasure/Relaxation Total</td>
<td>A high score means that you get a lot of physical pleasure out of smoking. Various forms of exercise can be effective alternatives. People in this category may be helped by the use of nicotine chewing pieces or a nicotine transdermal patch if medically indicated.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D ___ K ___ Q ___</th>
<th>“IT’S A CRUTCH”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crutch/Tension Total</td>
<td>Finding cigarettes to be comforting in moments of stress can make stopping tough, but there are many better ways to deal with stress. Learn to use relaxation breathing or another technique for deep relaxation instead. People in this category may be helped by the use of nicotine chewing pieces or a nicotine transdermal patch if medically indicated.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E ___ L ___ R ___</th>
<th>“I’M HOOKED”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Craving Addiction Total</td>
<td>In addition to having a psychological dependency to smoking, you may also be physically addicted to nicotine. It’s a hard addiction to break, but it can be done. People in this category are the ones most likely to benefit from the use of nicotine chewing pieces or a nicotine transdermal patch if medically indicated.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>F ___ M ___ S ___</th>
<th>“IT’S PART OF MY ROUTINE”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habit Total</td>
<td>If cigarettes are merely part of your routine, one key to success is being aware of every cigarette you smoke. Keeping a diary or writing down every cigarette on the inside of your cigarette pack is a good way to do it.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>G ___ N ___ T ___</th>
<th>“I’M A SOCIAL SMOKER”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Smoker Total</td>
<td>You smoke in social situations, when people around you are smoking and when you are offered cigarettes. It is important for you to remind others that you are a non-smoker. You may want to change your social habits to avoid the “triggers” which may lead to smoking again.</td>
</tr>
</tbody>
</table>

Appendix J: Fagerstrom Test for Nicotine Dependence (Revised Version)

The following test is designed to help you determine the strength of your nicotine addiction. Circle the appropriate score for each question. Total the number of points to arrive at your score. The highest possible score is 10.

<table>
<thead>
<tr>
<th>Question</th>
<th>Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>How soon after you wake up do you smoke your first cigarette?</td>
<td>Within 5 min .................................... 3 points</td>
</tr>
<tr>
<td></td>
<td>5-30 min ....................................... 2 points</td>
</tr>
<tr>
<td></td>
<td>31-60 min ....................................... 1 point</td>
</tr>
<tr>
<td></td>
<td>after 60 min .................................... 0 points</td>
</tr>
<tr>
<td>Do you find it hard not to smoke in places that you shouldn’t smoke such as in church, in school, in a movie, on the bus, in court or in a hospital?</td>
<td>Yes ......................................................... 1 point</td>
</tr>
<tr>
<td></td>
<td>No ..................................................... 0 points</td>
</tr>
<tr>
<td>Which cigarette would you hate most to have to give up?</td>
<td>The first one in the morning .................. 1 point</td>
</tr>
<tr>
<td></td>
<td>Any other one ..................................... 0 points</td>
</tr>
<tr>
<td>How many cigarettes do you smoke each day?</td>
<td>10-fewer........................................... 0 points</td>
</tr>
<tr>
<td></td>
<td>11-20............................................ 1 point</td>
</tr>
<tr>
<td></td>
<td>21-30............................................ 2 points</td>
</tr>
<tr>
<td></td>
<td>31 or more....................................... 3 points</td>
</tr>
<tr>
<td>Do you smoke more in the first few hours after waking than you do during the rest of the day?</td>
<td>Yes.............................................. 1 point</td>
</tr>
<tr>
<td></td>
<td>No .................................................. 0 points</td>
</tr>
<tr>
<td>Do you still smoke, even if you are so sick that you are in bed most of the day, or if you have the flu or a severe cough?</td>
<td>Yes.............................................. 1 point</td>
</tr>
<tr>
<td></td>
<td>No .................................................. 0 points</td>
</tr>
<tr>
<td>Total</td>
<td>........................................................................... ___ points</td>
</tr>
</tbody>
</table>

Interpretation of Scoring

7 to 10: You are highly dependent on nicotine and may benefit from a smoking cessation program based on treatment for nicotine addiction. Start with 21 mg patch or 4 mg gum.

4 to 6: You have a low to moderate dependence on nicotine, however this does not rule out a smoking cessation program based on treatment for nicotine addiction. Start with 14 mg patch or 2 mg gum.

< 4: You have a low to moderate addiction, but are not likely to need Nicotine Replacement Therapy.

Reprinted with permission of Dr. Karl Fagerstrom.
Appendix K: Intensive Nursing Intervention

Tips for the Client

■ Make a plan ahead of time for coping with stressful situations.
■ Pick a day for stopping that will be relatively stress-free and stick to this date.
■ Think positively – you can do it – and concentrate on the benefits of not smoking.
■ Take it one day at a time.
■ Congratulate yourself frequently.
■ Ask a friend to stop with you and support each other.
■ Remember that using NRT doubles the chances of quitting and lessens withdrawal symptoms.
■ Avoid visiting places where you usually smoke (when you first stop smoking).
■ Keep yourself busy and try to increase your level of physical activity.
■ Count or save the money you would have spent on cigarettes and treat yourself to something special.
■ Don’t try “just one” cigarette – it will take you back to the beginning.

Reprinted with permission.

# Appendix L: Quit Smoking
## First-Line Medications Compared

<table>
<thead>
<tr>
<th>Quit Smoking Aid</th>
<th>How to use</th>
<th>How long to take it</th>
<th>Possible side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>-Nicotine gum</strong> (Nicorette®)</td>
<td>• “bite &amp; park” gum</td>
<td>• several weeks to several months or longer if necessary</td>
<td>• burning in throat</td>
</tr>
<tr>
<td></td>
<td>• 1 piece of gum every 1-2 hours</td>
<td></td>
<td>• hiccups if chewed too quickly</td>
</tr>
<tr>
<td></td>
<td>• 2 mg if you're a light smoker (20 cigarettes per day)</td>
<td></td>
<td>• dental problems</td>
</tr>
<tr>
<td></td>
<td>• 4 mg if you're a heavy smoker (&gt;20 cigarettes per day)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• stop smoking before starting</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nicotine patch</strong> (Habitrol®, Nicoderm®)</td>
<td>• if you’re a light smoker (&gt;20 cigarettes per day), start 14 or 7 mg</td>
<td>• 8-12 weeks or longer if necessary</td>
<td>• local skin reaction</td>
</tr>
<tr>
<td></td>
<td>• if you’re a heavy smoker (&gt;20 cigarettes per day) start 21 mg for 4-8 weeks. Discuss tapering to lower doses with your doctor.</td>
<td></td>
<td>• disturbed sleep, nightmares</td>
</tr>
<tr>
<td><strong>Nicotine Inhaler</strong></td>
<td>Consists of a mouthpiece and a cartridge containing nicotine. Inhaled into the mouth and held so nicotine is absorbed into buccal mucosa. Most users require 2-10 puffs per craving.</td>
<td>6-12 cartridges a day for approximately 3 months is recommended by the manufacturer, although many may need significantly less.</td>
<td>• burning throat, cough, sneezing and hiccups.</td>
</tr>
<tr>
<td><strong>Bupropion</strong> (Zyban®)</td>
<td>• 150 mg once a day (in the morning) for 3 days, then twice a day (morning and evening, with at least 8 hours between doses)</td>
<td>• 7-12 weeks or longer if necessary</td>
<td>• dry mouth</td>
</tr>
<tr>
<td></td>
<td>• start 7-14 days before quit date</td>
<td></td>
<td>• insomnia</td>
</tr>
<tr>
<td>Cautions</td>
<td>When not to take it</td>
<td>Advantages</td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------------------</td>
<td>----------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| • pregnant and breastfeeding*    | • check with doctor if pregnant and breastfeeding* or if have had unstable medical conditions (e.g., unstable heart condition in the past 2 weeks) | • you can control when to take nicotine and how much  
• satisfies oral cravings  
• delays weight gain while you use it |
| • pregnant and breastfeeding*    | • check with doctor if pregnant and breastfeeding* or if have had unstable medical conditions (e.g., unstable heart condition in the past 2 weeks) | • you need only apply it once a day  
• can control your craving for 24 hours  
• delays weight gain while you use it  
• remove patch at night if sleep disturbances occur |
| Avoid acidic drinks like coffee, soda pop or juices for 15 minutes before and after using the inhaler because the nicotine will be absorbed in the stomach instead of the mouth and throat |                                            | Satisfies need for hand-to-mouth action, addressing the behavioural dependency of smoking, as well as the physical. |
| If you:  
• drink > 4 drinks containing alcohol a day  
• take St. John’s wort  
• take drugs that reduce seizure threshold  
• are pregnant and/or breastfeeding* | If you:  
• are pregnant or breastfeeding*  
• have a seizure disorder  
• have an eating disorder  
• take monoamine oxidase inhibitors | • inexpensive  
• improves depression  
• minimal weight gain while you use it |

*Nursing Best Practice Guideline*
Nicorette® (nicotine polacrilex); registered trademark of Aventis Pharma Inc.
Habitrol® (nicotine): registered trademark of Novartis Consumer Health Canada Inc.
Nicoderm® (nicotine): registered trademark of Aventis Pharma Inc.
Zyban® (bupropion HCL): registered trademark of Glaxo Wellcome Inc.

*Many doctors believe that using nicotine gum or the patch is better than smoking during pregnancy because, by stopping smoking, you are not inhaling thousands of toxic chemicals from cigarette smoke. However, there is not enough evidence to show that using nicotine gum or the patch is safer than smoking during pregnancy.

If you are pregnant or breastfeeding, always check with your doctor before using nicotine gum or the patch.

NB: Additional products may be available

Reprinted with permission:
Appendix M: Strategies to Avoid Relapse

- Encourage client to identify tempting situations and develop a specific plan to handle them (e.g., write down three strategies and carry this list at all times).
- Reframe a lapse (slip) as a learning opportunity, not a failure.
- Recommend that the client:
  - Learn stress management and relaxation techniques;
  - Learn to balance lifestyle so that pressures and triggers are not overwhelming.

Common Factors Associated with Relapse:
- Alcohol use
- Negative mood or depression
- Negative self-talk
- Other smokers in household
- Prolonged withdrawal symptoms
- Exposure to high-risk situations, such as social situations, arguments, and other sources of stress
- Dietary restriction
- Lack of cessation support
- Problems with pharmacotherapy, such as under-dosing, side effects, compliance or premature discontinuation
- Recreational drug abuse

Reprinted with permission:

Appendix N: List of Resources Available for Smoking Cessation

- **Canadian Cancer Society**
  National Office, Suite 200
  10 Alcorn Avenue
  Toronto, Ontario M4V 3B1
  [www.cancer.ca](http://www.cancer.ca)
  E-mail: tobacco@cancer.ca
  Toll Free: 1-888-939-3333

  Offers booklets and self-help resources for smokers, such as “For Smokers who want to Quit”, and “For Smokers who don’t want to Quit”, available in English, French and Chinese.

- **Ontario Smoker’s Helpline**
  1-877-513-5333 [www.smokershelpline.ca](http://www.smokershelpline.ca)

  Offers a free self-help smoking cessation program called One Step at a Time.

- **Canadian Council of Tobacco Control (CCTC)**
  170 Laurier Avenue West, Suite 100
  Ottawa, Ontario K1P 5V5
  Tel: 613-567-3050
  [www.cctc.ca](http://www.cctc.ca)
  E-mail: infor-service@cctc.ca

  This is a national, non-profit organization specializing in tobacco and health issues.

- **Canadian Health Network (CHN)**
  [www.canadian-health-network.ca](http://www.canadian-health-network.ca)
  CHN is a national, non-profit, bilingual web-based health information service, sponsored by Health Canada.

- **Centre for Addiction and Mental Health**
  33 Russell Street
  Toronto, Ontario M5S 2S1
  416-535-8501 ext 1600

  Operates a Smoking Cessation Clinic and has launched a workshop, TEACH The Training Enhancement in Applied Cessation Counselling and Health for health practitioners.

- **TEACH (Training Enhancement in Applied Cessation Counselling and Health)**
  33 Russell Street, Room 1081
  Toronto, Ontario M5S 2S1
  Tel: 416-535-8501 ext.1600
  Fax: 416-260-418
  E-mail: TEACH@camh.net
  [www.teachproject.ca](http://www.teachproject.ca)

  Trains practitioners in tobacco cessation interventions.

- **Health Canada**
  Tobacco Control Programme P.L. 3507C
  Ottawa, Ontario K1A 0K9
  Tel: 1-866-318-1116
  (Monday-Friday, 8 a.m. to 4 p.m. ET; voice-mail available at all other times)
  Fax: 613-954-2284
  [www.gosmokefree.ca](http://www.gosmokefree.ca)
  E-mail: TCP-PLT-questions@hc-sc.gc.ca

  This website contains a variety of new tools to help Canadians quit smoking. Persons who smoke can sign up with the e-Quit program for a 30-day series of free e-mail messages to help them through the cessation process.
Nursing Best Practice Guideline

- **Heart & Stroke Foundation of Canada**
  222 Queen Street, Suite 1402
  Ottawa, Ontario K1P 5V9
  Tel: 613-569-4361
  [www.heartandstroke.ca](http://www.heartandstroke.ca)
  E-mail: info@hsf.ca

- **Leave the Pack Behind**
  Brock University
  500 Glenridge Avenue,
  St. Catharines, Ontario
  Tel: 905-688-5550 ext. 4992

- **Physicians for a Smoke-free Canada (PSC)**
  1226 A Wellington Street
  Ottawa, Ontario K1Y 3A1
  Tel: 613-233-4878
  Fax: 613-233-7797
  [www.smoke-free.ca](http://www.smoke-free.ca)

  PSC is a national health organization, founded in 1985 as a registered charity. It is a unique organization of Canadian physicians who share one goal: the reduction of tobacco-caused illness through reduced smoking and reduced exposure to second-hand smoke. It also provides information on a variety of tobacco issues.

- **Pregnets**
  [www.pregnets.org](http://www.pregnets.org)

  Up-to-date information on smoking cessation practices for pregnant and postpartum women can be found here.

- **Program Training and Consultation Centre**
  Toll free: 1-800-363-7822
  [www.ptcc-cfc.on.ca](http://www.ptcc-cfc.on.ca)

  Provides training and consultation services in Ontario to implement effective community-based tobacco use reduction strategies.

- **The Lung Association National Office**
  1900 City Park Drive, Suite 508
  Blair Business Park
  Gloucester, Ontario K1J 1A3
  Tel: 613-747-6776
  [www.lung.ca](http://www.lung.ca)
  E-mail: infor@lung.ca

- **Ontario Lung Association**
  Tel: (416)-864-9911
  Toll Free: 1-800-972-2636
  [www.on.lung.ca](http://www.on.lung.ca)

  Nurses Quit Net available on-line for nurses and nursing students who want to quit smoking: [www.tobaccofreenurses.org](http://www.tobaccofreenurses.org)

- **Registered Nurses Association of Ontario (RNAO)**
  [www.rnao.org/smokingcessation](http://www.rnao.org/smokingcessation)

  RNAO offers an e-learning course to help educate health professionals on smoking cessation interventions.
Additional Online Support Help to Quit Smoking

- **American Cancer Society**
  Great American Smoke Out

- **Centers for Disease Control and Prevention (CDC)**
  Quit Tips: Don't let another year go up in smoke
  [http://www.cdc.gov/tobacco/quit/quittip.htm](http://www.cdc.gov/tobacco/quit/quittip.htm)

- **Nicotine Anonymous**
  [http://www.nicotine-anonymous.org](http://www.nicotine-anonymous.org)
  Nicotine Anonymous is a non-profit 12 Step help program for those who would like to cease using tobacco and nicotine products. Group support and recovery using the 12 Steps, as adapted from Alcoholics Anonymous, help to achieve abstinence from nicotine.

- **Smokefree.gov**
  [www.smokefree.gov](http://www.smokefree.gov)

- **The Foundation for a Smoke Free America**
  [www.tobaccofree.org](http://www.tobaccofree.org)
Appendix O: Description of the Toolkit

The Toolkit provides step-by-step directions to individuals and groups involved in planning, coordinating, and facilitating the guideline implementation. Specifically, the Toolkit addresses the following key steps in implementing a guideline:

1. Identifying a well-developed, evidence-based clinical practice guideline
2. Identification, assessment and engagement of stakeholders
3. Assessment of environmental readiness for guideline implementation
4. Identifying and planning evidence-based implementation strategies
5. Planning and implementing evaluation
6. Identifying and securing required resources for implementation

Implementing guidelines in practice that result in successful practice changes and positive clinical impact is a complex undertaking. The Toolkit is one key resource for managing this process.

The Toolkit is available through the Registered Nurses’ Association of Ontario. The document is available in a bound format for a nominal fee, and is also available free of charge from the RNAO website. For more information, an order form or to download the Toolkit, please visit the RNAO website at www.rn ao.org/bestpractices.
Nursing Best Practice Guideline

Integrating Smoking Cessation into Daily Nursing Practice

This program is funded by the Government of Ontario