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*A report on an evaluation of
Saskatoon Health Region's
Tobacco and Smoke-free Policy*

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*Strategic planning ■ Environmental scanning ■ Partnership and proposal development
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Summary

Background

On April 2, 2007, use of tobacco products was banned in Saskatoon Health Region (SHR) buildings and grounds. The goal was to de-normalize tobacco use and strengthen the Health Region's position as a leader of health and wellness. As well as banning tobacco use, the Health Region offered a number of tobacco cessation services and supports, increased policy enforcement and enhanced cleaning of grounds. This set of policies and activities together are known as the Tobacco and Smoke-free Policy (the Policy). In late 2007, the Saskatoon Health Region engaged Laurence Thompson Strategic Consulting (LTSC) to evaluate the implementation and impact of the Tobacco Policy. This is the report of that evaluation.

Methods

The evaluation plan agreed to by LTSC and the Tobacco and Smoke-free Policy Evaluation Sub-Committee included both formative and summative evaluations. The evaluation assessed the effectiveness of the planned implementation process -- the extent to which planned inputs were obtained, planned activities carried out, and planned outputs and outcomes achieved. The evaluation included key informant interviews, analysis of program records and administrative data, a staff survey, and analysis of community surveys of smoking rates.

Findings

Overview

The overall program plan and what is known of its implementation and its impact from this evaluation are summarized in Table S1.

Program planning

Overall, there was a clear, well-developed program plan, based on research evidence and experience of SHR managers, structured into a logic model, and formulated as a detailed policy document.

Goals, objectives, and target groups of the Policy implementation were clearly established and agreed upon. A logic model for Policy implementation was developed. A comprehensive final plan for implementation of the Policy was developed and laid out in detail in a nine-page policy approved by the SHR Board (SHR, 2007). This Policy updated and incorporated previous versions of a tobacco use policy adopted by the SHR Board. The Policy included an implementation plan that included three major initiatives:

- accessible smoking cessation support (nicotine replacement therapy and counselling);
- a tobacco-free environment, including authorizing, communicating, and enforcing the Policy, and grounds keeping;
- motivating support for the Policy.

The required inputs were clearly identified and evidence experience-based. Because the Saskatoon Health Region was only the third health region in Canada to implement such a tobacco ban, there was little previous experience to go on. The Tobacco and Smoke-free Policy Committee used research evidence, a communications consultant, and its own members' experiences and best estimates to determine the extent of inputs required to successfully establish the policy. A budget to support the implementation of the policy and logic model was developed and approved by senior leadership of the Health Region.

The activities were based upon good evidence, from research or previous experience, of what would work to accomplish the planned outputs. The Policy and supporting activities were based on extensive research evidence on effective strategies for tobacco cessation, and on the experience of a broad range of 20 SHR staff involved in the Tobacco and Smoke-free Policy Committee.

External factors that could also affect outcomes were identified and taken account of in the program plan. The Tobacco and Smoke-free Policy Committee and the Health Region leadership were aware of and linked to City bylaw and provincial legislative developments in tobacco bans.

Program implementation

Activities

For the most part the planned resources were obtained and applied to the planned activities. Allocation of an implementation budget by the senior leadership team (SLT) was key to being able to implement the Policy.

Activities to provide accessible cessation support were partly implemented as planned. The original train-the-trainer model met with resistance and was largely replaced by direct education provided by Tobacco and Smoke-free Policy Committee trainers.

Activities to ensure a tobacco-free environment were partly implemented as planned. Grounds keeping to remove butts and enforcement by regular security staff was partly implemented and less effective in accomplishing the activities than planned.

Communicating messages to motivate and support reduced tobacco use was effectively implemented.

Outputs

Assessment of whether the planned outputs were achieved was more difficult, as parts of the evaluation plan designed to answer that question could not be achieved in the time frame available, with the delays experienced.

Small numbers of clients accessed tobacco cessation counselling (85 over 13 months). Similarly, 42 staff members over 17 months and 744 patients over 11 months accessed nicotine replacement. All these numbers were well below planned numbers.

No indicators were available for butt counts, but key informants commented that butts on the ground concentrated in certain problem areas.

Staff were well aware of the policy; 86 per cent of those surveyed reported they were aware of the policy at the time of implementation. Support for the policy among staff, both at implementation and currently, was lukewarm. A minority of staff do not support the policy because of the risk they perceive to themselves or to

clients smoking off SHR property at night. Another minority support the policy and would like to see it better enforced. We were unable to evaluate patients' and visitors' awareness of and support for the policy.

Outcomes

External factors that had an impact on smoking rates in the Saskatoon Health Region at the same time as the Policy included the City of Saskatoon ban on smoking in public places, introduced provincial Tobacco Control Act amendments that banned smoking in enclosed public places, both in 2004.

As of 2005, Saskatoon Health Region had the second highest population smoking rate among prairie urban centres, at 23.3% of those aged 12 years and over. The lowest rate, Calgary, was 19.8 per cent. New data will shortly be available comparing these smoking rates as of 2007.

Among staff surveyed, smoking rates increased slightly since the April 2, 2007 implementation of the full ban. However, thirty per cent of staff smokers as of April 1, 2007 reported reducing the amount they smoked.

What worked well

Key informants identified the following as having worked well in implementing this policy:

- communication of the Policy;
- leadership (both of the Tobacco and Smoke-free Committee and senior leadership commitment);
- the planning process;
- the approach of “educational enforcement;” and
- the Tobacco Ambassador - the commissioner charged with enforcement.

Improvements

When asked what they would change or improve next time, key informants listed the following:

- Implement the Policy in one stage, without exemptions;
- Stronger, ongoing enforcement; and
- Provide exemptions, especially in mental health.

Conclusions

Challenges

The implementation of the Policy in Saskatoon Health Region faced, and continues to face, challenges to its effectiveness. These include, in the consultant's assessment:

- engaging nursing leadership and staff;
- application of the policy to mental health patients;
- effective grounds keeping; and
- effective enforcement.

Facilitators of policy effectiveness

Facilitators of policy effectiveness include:

- a participatory planning process;
- leadership commitment;
- the educational enforcement philosophy;
- communication of the policy; and
- sufficient budget for implementation.

Recommendations to improve and strengthen the Tobacco and Smoke-free Policy

One year after full implementation, the two key initiatives that would strengthen the implementation of the Policy in the Saskatoon Health Region are to ensure ongoing educational enforcement, and to monitor outcomes.

Reinstating the Tobacco Ambassador commissionaire, at least part time, together with ensuring that the Tobacco Ambassador's efforts are consistently backed up by security staff and the warning and discipline process of the human resources office, would all considerably strengthen the application of the Policy.

The Health Region should continue to monitor smoking rates in the Health Region in relation to those in other prairie health regions, with a view to continuing to take population and clinically based initiatives on tobacco use reduction, as needed.

Table S1. Summary of the implementation of the Saskatoon Health Region (SHR) Tobacco and Smoke-free Policy

Plan	Inputs	Activities	Outputs
Goal: Reduce tobacco use in region ✓	✓	⊗	?
Objectives:			
1. Accessible cessation services ✓	Budget and staff for:	Provide accessible cessation services:	
	tools and training for staff to intervene with tobacco users ✓	staff training ✓	
	cessation counselling ✓	cessation counselling ✓	SHR staff assess, provide clients/ patients/ residents with tobacco reduction intervention ✓
	nicotine replacement therapy ✓	nicotine replacement therapy ✓	Clients, SHR staff members access cessation counselling Δ
			SHR staff/clients access nicotine replacements ✓
2. Ensure a tobacco-free environment in SHR ✓	Budget and staff to:	Implement tobacco-free environment in SHR facilities:	Tobacco use is no longer part of the SHR environment:
	provide tools, training for staff on enforcement ✓	authorize policy ✓	
	communicate policy ✓	communicate to staff and clients ✓	
	enforce policy ✓	enforce policy Δ	reduced infractions of policy Δ
	clean grounds ✓	clean grounds so no butts in view Δ	reduced butts Δ
3. Staff and clients support the policy ✓	Budget and staff to inform staff and clients about policy ✓	Communicate messages to motivate reduced tobacco use:	Staff and clients:
		build and support champions ✓	are aware of policy ✓
		inform staff, public of policy ✓	support policy Δ
		provide signage in facilities, grounds ✓	follow policy Δ

Legend: ✓: as planned Δ: partly implemented ⊗: not implemented ?: cannot assess

External factors:

- General decline in smoking rates
- City and provincial legislation banning smoking in public areas
- Other health regions also implementing similar policies

Planned outcomes: (cannot yet be assessed):

- Smoking rates in SHR residents decline
- Staff and volunteer smoking rates decline
- Client smoking rates decline

1. Background

On April 2, 2007, use of tobacco products was banned in Saskatoon Health Region (SHR) buildings and grounds, except for cultural and ceremonial purposes. The goal was to de-normalize tobacco use and strengthen the Health Region's position as a leader of health and wellness. As well as banning tobacco use, the Health Region offered a number of tobacco cessation services and supports, increased policy enforcement and enhanced cleaning of grounds. This ban was the end of a four-year development process of a Tobacco Policy for the Health Region that had begun in August 2003.

In late 2007, the Saskatoon Health Region Tobacco and Smoke-free Policy Committee sought to evaluate the implementation and impact of the SHR Tobacco Policy (hereafter referred to as the Policy). Management of the evaluation was delegated to an Evaluation Sub-Committee. The Sub-Committee asked for proposals for this work; Laurence Thompson Strategic Consulting (LTSC) submitted a proposal that was accepted by SHR. This proposal called for an initial assessment process followed by delivery of a final evaluation plan.

The Evaluation Sub-Committee requested both a formative and a summative evaluation. This evaluation report includes both. The evaluation report provides guidance on the ongoing implementation of the Policy in Saskatoon Health Region, and on future implementation elsewhere. It also assesses the impact of the Policy within Saskatoon Health Region.

The beginnings of the policy date back to the early 1990s, when the Medical Health Officer of Saskatoon District Health presented to the Board proposals for tobacco control in the District. In 2002, a Medical Health Officer report recommended a comprehensive approach to tobacco control, led by the Health Region. That report drew heavily on a report by the US Surgeon-General on tobacco control. Those earlier reports set the stage for the development of the Tobacco Policy beginning in 2003.

The direct origins of the policy began at City Hospital in 2003. Staff complained about coming through smoke on entering the main entrance and identified it as an occupational health issue. The site leader at the time reviewed smoking policy at that site and created a fenced smoking courtyard to segregate smokers and create a safe smoking area at night. From there, discussion progressed at the health authority level to a Region-wide smoking ban in facilities.

In August 2003, the Vice-president of Primary Health sponsored a first meeting of a committee to develop a plan for a Health Region-wide anti-smoking policy. This committee was called through most of its history the Smoking Policy Committee. It is now referred to including in this report, as the Tobacco and Smoke-free Policy Committee. This committee spearheaded development of a Tobacco Policy for the Saskatoon Health Region over the next four years.

A time line of the development of the Policy is attached as Appendix 1.

2. Methods

The evaluation plan agreed to by LTSC and the Tobacco and Smoke-free Policy Evaluation Sub-Committee included both formative and summative evaluations. The contract for the evaluation was signed December 17, 2007. The evaluation was to be completed by March 28, 2008. Both the evaluator and the Saskatoon Health Region agreed to responsibilities for achieving completion of the evaluation plan within this time frame.

The formative evaluation assessed the effectiveness of the planned implementation process -- the extent to which planned inputs were obtained, planned activities carried out, and planned outputs achieved.

Where implementation was not fully completed as planned, the formative evaluation identified and analyzed the challenges to policy effectiveness that were met during planning and implementation. Where implementation was completed as planned, the formative evaluation assessed the facilitators of policy effectiveness that enabled success. The formative evaluation report includes recommendations to improve and strengthen further activities to implement the Policy in this health region, or elsewhere.

Formative evaluation

Overview

An overview of the planned implementation of the Policy is provided in Table 1. This program logic model is based on one provided by the Evaluation Sub-Committee, and developed by LTSC in discussion with that group. The logic model is read from left to right as a series of logically linked steps starting with planning and ending with achievement of outcomes.

The formative evaluation assessed the implementation activities designed to support the three planned outputs of the Policy logic model:

- accessible cessation services;
- a tobacco use ban in buildings and on grounds; and
- communication mechanisms/messages to motivate and support implementation of the ban;

This report on the formative evaluation:

- describes the planning process of setting objectives and deciding upon planned activities and resources required; and
- evaluates the implementation process of obtaining inputs, implementing activities and creating outputs.

The plan for the formative evaluation included both qualitative and quantitative methods. Specific methods and data sources planned for each element of the evaluation are outlined in Appendix 2.

Qualitative methods planned included interviews with 30 key informants involved in implementing the Policy. All but one key informant identified for interviews were interviewed; this informant had indirect input through another key informant. Key informants interviewed are listed in Appendix 3. The key informants interview guide is attached as Appendix 4. Quantitative methods planned included surveys of staff,

obtaining administrative data on nicotine replacement prescriptions, and chart review of the use and results of tobacco assessments in inpatients.

Staff surveys of attitudes and self-reported behaviour of all staff were carried out in five nursing units, including community and in-patient services, and mental health and medical treatment. The survey instrument is attached as Appendix 5. The surveyed units were located in four sites, including all three acute-care sites in the City of Saskatoon. The staff surveys did not include rural sites. Surveys were distributed to 187 staff; 80 were returned for an overall response rate of 43 per cent. Response rates varied by site, from 17 to 84 per cent.

Administrative data on nicotine replacement prescriptions, tobacco cessation counselling, and enforcement of the smoking ban were obtained and reviewed.

Chart review of nursing records of tobacco assessment and treatment in the five nursing units where staff surveys were conducted were also planned, but were not completed. The process of obtaining permissions and cooperation of the nurse managers, arranging for pulling charts and arranging for a health region nurse employee to review the charts required too much time to implement. The budget allocation for the evaluation expired before the chart review could actually be undertaken.

Similarly, client surveys were also planned, but we were unable to undertake these within the time period allocated because of the lengthy time required for making contacts and obtaining permissions. LTSC did develop a proposed client survey instrument; this is attached as Appendix 6.

Table 1. A program logic model framework for the evaluation of the Saskatoon Health Region (SHR) Tobacco and Smoke-free Policy

Program description (Goals, objectives, target groups)	Inputs (resources used)	Activities (activities carried out / services provided)	Outputs (actual products of program for target groups)	External factors (other relevant factors in environment)	Outcomes (actual changes in target groups)		
<p>Goal: Reduce tobacco use/exposure in Saskatchewan for:</p> <ul style="list-style-type: none"> • residents of SHR • workers / volunteers within SHR • those receiving services from SHR 				<p>Smoking rates in general are declining in Canada; to account for this changes in smoking rates will be compared to comparable smoking rate changes in other health regions without a similar policy</p>	<ul style="list-style-type: none"> • Smoking rates in SHR residents decline • Staff and volunteer smoking rates decline • Client smoking rates decline 		
Objectives:							
<p>1. Accessible cessation services</p>	<p>Budget and staff for</p> <ul style="list-style-type: none"> • tools, training for staff to intervene with tobacco users • cessation counselling • nicotine replacement therapy 	<p>Provide accessible cessation services:</p> <ul style="list-style-type: none"> • staff training • client assessments • cessation counselling • nicotine replacement therapy 	<ul style="list-style-type: none"> • SHR staff members access cessation counselling • SHR staff assess, provide clients/patients/residents with tobacco reduction intervention • SHR staff/clients access nicotine replacements 				
<p>2. Ensure a tobacco-free environment in SHR.</p>	<p>Budget and staff to</p> <ul style="list-style-type: none"> • provide tools, training for staff to know how, when to intervene to enforce policy • enforce policy • clean grounds 	<p>Implement tobacco-free environment in SHR facilities:</p> <ul style="list-style-type: none"> • authorize policy • communicate to staff and clients • enforce the policy • clean the grounds so no butts are in view 	<p>Tobacco use is no longer part of the SHR environment as shown by:</p> <ul style="list-style-type: none"> • reduced butts • reduced infractions of policy 				
<p>3. Staff and clients support the policy.</p>	<p>Budget and staff to</p> <ul style="list-style-type: none"> • inform and remind staff and clients about policy 	<p>Communicate messages to motivate and support reduced tobacco use:</p> <ul style="list-style-type: none"> • build, support champions • inform staff, public of policy • provide signage in facilities, grounds 	<ul style="list-style-type: none"> • Staff are aware of policy • Staff support policy • Staff follow policy • Clients are aware of policy • Clients support policy • Clients follow policy 				

Summative (outcome) evaluation

Overview

The plan for the summative evaluation was to assess the extent to which the planned outcomes of the Policy outlined in the logic model had been achieved. This evaluation also planned to assess external factors that may have also affected outcomes. The plan for the summative evaluation component of the report was to assess the outcomes of the Tobacco Policy from available data already collected from other sources.

Methods

The summative evaluation planned to identify and use available data on tobacco use rates from SHR, provincial, and Canadian surveys of smoking and tobacco use behaviours. To the extent possible from these data, the plan was for this component of the evaluation to compare the change in use rates before and after the implementation of the Policy in SHR. The evaluation planned to adjust for external factors by comparing these changes to available data on rates of change of tobacco use in comparable jurisdictions. Detail is provided in Appendix 7. The plan for this component of the report also included recommendations for future assessment of outcomes.

3. Findings

Evaluation findings are presented both in summary and detail under headings of the evaluation questions listed in Appendices 2 and 5. The presentation of findings provides the response to these evaluation questions. Quotes presented from key informants are based on notes and may not be verbatim.

Program planning

Overview

What was the program plan? Was it a clear, evidence-based plan? If not, what could have been clearer or more based on evidence?

Overall, there was a clear, well-developed program plan, based on research evidence and experience of SHR managers, structured into a logic model, and formulated as a detailed policy document.

Goals, objectives, and target groups

Were the goals, objectives and target groups of the program clearly established and agreed upon? If not, where and why not?

Key informant interviews and a review of Tobacco and Smoke-Free Committee documents show that goals, objectives, and target groups of the Policy implementation were clearly established and agreed upon. Various versions of a logic model for implementation of the policy clearly laid out these goals and objectives, and indicated the target groups. Several versions of the logic model were developed; all were similar to the version included in this evaluation report as Table 1.

A comprehensive final plan for implementation of the Policy was developed and laid out in detail in a nine-page policy approved by the SHR Board (SHR, 2007). This Policy updated and incorporated previous versions of a tobacco use policy adopted by the SHR Board. As well as defining the Policy, the document defined a plan to implement it that included three major initiatives:

- accessible smoking cessation support (nicotine replacement therapy and counselling);
- implementation of the tobacco-free environment, including authorizing, communicating, and enforcing the Policy, and grounds keeping; and
- motivating support for the Policy;

A budget to support the implementation of the policy and logic model was also developed.

Inputs

Were the required inputs clearly identified? Was the plan for inputs (the budget) based on evidence that the inputs would be sufficient to accomplish the planned activities?

Yes, as much as possible. Required inputs were identified in detail. (See the detailed logic model in Appendix 2.) The plan for inputs was based on research evidence on the value of nicotine replacement and cleaning up cigarette butts. The

communication strategy was based on the experiences of the SHR Communications staff and of the company engaged to advise on signage for communication of the smoking ban, Tap Communications. Enforcement was based on the estimates by the Tobacco and Smoke-free Policy Committee of what would be required.

Because the Saskatoon Health Region was only the third health region in Canada to implement such a tobacco ban, there was little previous experience to go on in developing the implementation plan. The Tobacco and Smoke-free Policy Committee used its own experiences and best estimates to determine the extent of inputs required to successfully establish the policy.

One key informant noted that, despite the budget allocated, in the implementation of the Tobacco Policy “we struggled; we needed a bigger campaign; . . . the in-kind contributions from Public Health were huge [in the form of] staff time for development of resources.”

The original three-year budget plan approved by the Health Region is summarized in Table 2. Senior leadership later substantially reduced the authorized budget for the second budget year (2007-08) from \$284,000 to \$150,000. This reduction was offset by subsequent substantially lower actual costs for nicotine replacement. The actual 2008-09 budget has not yet been established.

Table 2. Original budget for SHR Tobacco Policy implementation (Sept. 2006) (\$000s)

Strategy component	Fiscal year		
	2006-07	2007-08	2008-09
Communication	15	4	--
Addiction counsellor	48	72	72
Nicotine replacement therapy			
staff	61	60	12
patients	--	80	80
Enforcement	25	25	--
Grounds keeping	19.5	40	40
Nursing practice	<u>20</u>	<u>3</u>	<u>5</u>
Total	188.5	284	209

Activities/ Outputs/ Outcomes

Were the activities based upon good evidence (from research or previous experience) of what would work to accomplish the planned outputs?

Yes. The Policy and supporting activities were based on extensive research evidence on effective strategies for tobacco cessation. This research is documented in the records of the Tobacco and Smoke-free Policy Committee. Three pieces of research evidence were particularly influential.

- “Brief literature review: smoking policies, interventions, and smoking cessation” (no date, no author). This document summarized evidence that smoke-free policies accelerate reduced smoking prevalence in populations, indicated a strategy of “de-normalizing” tobacco use, and suggested support for smokers wishing to quit through nicotine replacement therapy and counselling.

- A report of a survey of staff in the Saskatoon Health Region to assess readiness to implement a full smoking ban (SHR, 2006). The survey asked whether staff supported continuing existing exemptions to the smoking ban. Staff showed levels of support for continuing smoking ban exemptions of 42 per cent for exemptions for staff, 31 per cent for exemptions for visitors, and 44 per cent for acute care patients. Forty-nine to 58 per cent of staff supported exemptions for specific groups of in-patients, such as mental health, addictions, and palliative care patients. Slightly fewer than half of staff members surveyed supported additional initiatives to support implementation of a full smoking ban, such as nicotine replacement, education, and tobacco use cessation counselling. This survey influenced the Tobacco and Smoke-free Policy Committee to move slowly towards a full ban.
- A guideline to integrating smoking cessation into nursing practice (RNAO, 2007). This document was the foundation of the tobacco assessment and intervention approach for patients in the Policy. It included the protocol for nursing assessment and intervention that the SHR adopted, the “Ask, Advise, Assist, Arrange Protocol” (RNAO, 2007, Appendix H). The SHR 5As include “Ask, Advise, Assess, Assist, Arrange”.

Communications activities were based on the experience of the SHR communications department and the consulting communications company. Investments in grounds keeping were based on research evidence that butt cleaning communicated that the area was non-smoking. Nicotine replacement was based on research evidence of effectiveness. Investments in enforcement were not based on previous evidence, but were based on a philosophy, developed and agreed to by the Tobacco and Smoke-free Policy Committee, of educational engagement around improving health as the strategy of enforcement, rather than a focus on punishment.

External factors

Were external factors that could also affect outcomes identified and taken account of in the program plan?

Yes. The Tobacco and Smoke-free Policy Committee and the Health Region leadership were aware of and linked to City bylaw and provincial legislative developments in tobacco bans in public places. SHR synchronized the implementation of its partial ban in July 2004 to the implementation of a City of Saskatoon bylaw restricting smoking in public places. SHR synchronized exemptions to its full tobacco ban to provincial legislation that provided for residents of long-term care (nursing homes) to have access to outdoor smoking areas on site.

Program implementation

Overview

Was the program implemented as planned? If not, where and why not?

For the most part the planned resources were obtained and applied to the planned activities. Allocation of an implementation budget by the senior leadership team (SLT) was key to being able to implement the Policy.

The overall plan called for three main activity initiatives:

- accessible smoking cessation support
- implementation of the Policy; and
- motivating support for the Policy.

Activities to provide accessible cessation support were partly implemented as planned. The original train-the-trainer model met with resistance and was largely replaced by direct education provided by Tobacco and Smoke-Free Committee trainers.

Activities to implement a tobacco-free environment were partly implemented as planned. Grounds keeping to remove butts and enforcement by regular security staff was partly implemented and less effective in accomplishing the activities than planned.

Communicating messages to motivate and support reduced tobacco use was effectively implemented.

Inputs

Were the planned inputs realized?

Key informants reported that for the most part the planned resources were obtained and applied to the planned activities. The budget authority to implement specific activities was granted to Public Health Services and to Mental Health and Addictions. These departments then paid for or transferred budget authority to the various departments that actually incurred the costs. The three-year plan was approved; however, the budget must be submitted and approved annually.

Key informants noted that allocation of an implementation budget by the senior leadership team was key to being able to implement the Policy. "Initially, we had verbal support from SLT for the concept, but no financial support. Lack of funding was the biggest barrier." Senior leadership made a commitment to implement the policy with approval of a three-year funding plan, subject to annual confirmation. The full planned amount was provided in the first year (2006-07). However, in the second year (2007-08), the budget was reduced from the \$284,000 originally planned to \$150,000. This reduction reflected nicotine replacement costs in the previous year that were much lower than planned.

Activities

Overall, were activities implemented as planned?

Overall, the activities to provide accessible cessation support were partly implemented as planned. Almost one thousand nursing staff were trained in tobacco use assessment. However, the original train-the-trainer model met with resistance from nurse educators, and was replaced by direct education by Tobacco and Smoke-free Policy Committee trainers. The tobacco counselling position was

established, and a Region-wide tobacco “hot-line” to make requests or referrals for counselling was established. Nicotine replacement therapy was established and offered, at shared or no cost for a period of time, to both staff and clients. Available evidence indicates that the majority of direct care nurses and mental health workers did conduct client assessments.

Activities to implement a Policy were partly implemented as planned. The Board of SHR authorized the Policy and that was communicated to those responsible for enforcement. Additional staffing for enforcement and for grounds keeping was put into place. The added staffing for enforcement, the Tobacco Ambassador (commissionaire) was very effective. Grounds keeping to remove butts, and enforcement by regular security staff was partly implemented and less effective in accomplishing the activities than planned.

Communicating messages to motivate and support reduced tobacco use was effectively implemented. The Tobacco and Smoke-free Policy Committee built a diverse group of champions for the Policy across the Health Region. The one weak link in that network was nursing management. Staff and public were effectively informed of the policy. Signage was provided in facilities and on grounds as planned.

Were accessible cessation services provided as planned?

Were staff trained as planned?

Overall, almost one thousand nursing staff were trained in tobacco use assessment.

The plan called for all nursing staff in the Health Region to be trained on tobacco use as an addiction, the health effects of tobacco use, and the application of a nursing assessment tool on tobacco use, and tobacco cessation interventions (referral for counselling and provision of nicotine replacement). Beginning in the fall of 2005 and continuing through 2006, all Clinical Nurse Educators in the SHR were trained on delivering the 5As assessment tool by Public Health and Mental Health and Addictions staff members allocated to this activity.

The original plan was that CNEs would take the Tobacco Policy education to the nursing staff. In fact, this train-the-trainer model was only partly implemented, as it faced resistance from both nurse educators and nurse managers. CNEs felt that the training staff were better equipped to provide the education. As a result, the training staff took the Tobacco Policy education directly to nursing staff in many units. A summary of the direct training provided by Mental Health and Addictions and Public Health staff is provided in Table 3.

Informants reported that the best buy-in to implementing the Policy in nursing was in cardiac and respiratory care. In other units, the trainers reported less buy-in or even outright resistance to implementation of the nursing assessment and the training for it.

Table 3. Training sessions and participants in tobacco use assessment, by month

Month	Number of presentations	Number of participants
October 2006	4	0
November	3	0
December	4	0
January 2007	4	160
February	15	159
March	17	178
April	14	157
May	15	237
June	4	56
July	0	0
August	1	12
September	1	9
October	<u>0</u>	<u>0</u>
Total	82	968

Nurses responded to the trainers that tobacco assessment and counselling was not on their priority list. Comments reported from such nursing units included "What's the big deal if they are smoking outside?" and "It's their choice to smoke." Key informants also reported that the trainers got pushback from nursing staff who saw the tobacco assessment as "one more thing to do." Trainers reported "a lot of blank faces at [some] presentations." Resistance from nurses was particularly strong in in-patient mental health and addictions units and surgery units, and at St. Paul's Hospital. Informants reported that at one session nurses stopped a session half-way through to say "nurses didn't have time for the 5As," they "needed to focus on life and death issues." The Professional Leader, Nursing Affairs came to some meetings to back up the trainers; this helped with acceptance.

Nurse managers in nine sites opted their staff out of the training because they did not consider it relevant for their patients. These were mostly pediatric or critical care units. While six of seven rural acute-care sites received training for their nurses, one site did not receive training because trainers were unable to contact the manager.

Nurses in Special Care Homes (long-term residential care) also received training on the 5As assessment. Nurses unable to attend because of the difficulty of providing relief coverage were offered an educational DVD and self-directed learning package. All nursing units and long-term care facilities were provided with extensive written and audio-visual resources for reference and self-directed learning.

Informants reported that some direct-care nurses indicated that they would prefer to have someone else come and do tobacco assessments with patients. The trainers worked to present it to them as part of their nursing process, with varying acceptance. Nursing is now developing a new intake form. Tobacco assessment will be a part of the new admission form. This will help with implementation by integrating tobacco assessment and intervention further into regular nursing practice.

The Tobacco assessment (5A) forms required for implementation were delivered to all units; replacement forms are now ordered directly from printing services.

Informants reported that the underlying reasons for nursing resistance included that many nurses and CNEs viewed tobacco use as a “social” issue – one of morals and personal preference -- rather than an issue of health. They also saw it as an invasion of personal privacy. This was exacerbated by the fact that many nursing staff themselves smoke.

Inclusion of the Policy in in-service education for nurses was made more difficult because of the limited time available for in-service education, and the long list of other education topics competing for space, many of them mandatory training. Although SHR policy is for nurses to get two -in-service education days per year, some unit managers cut back education to one day per year when the Family Day holiday was implemented.

All security staff were also briefed on the policy and the expectations for their role in implementing it.

Were client assessments and interventions completed as planned?

Available evidence indicates that the majority of direct care nurses and mental health workers did conduct client assessments. However, we were unable to fully evaluate this.

Responses to a survey of staff in selected units indicated that of the staff expected to carry out assessments and counsel patients on tobacco cessation (nurses and mental health counsellors), almost all did so (Table 4.).

Table 4. Implementation of tobacco cessation assessment and counselling

Survey item	%
Survey responses of 62 staff members surveyed who were RNs or Mental Health Counsellors:	
Since April 2, 2007, I have:	
. . . counselled a patient, client or resident to stop smoking or using tobacco products.	92
. . . used the 5A flow chart with a patient, client or resident.	95

The evaluation plan for this component of the Policy activities also called for chart review of 300-400 randomly selected charts in each of four selected representative, diverse units (75-100 each), selected from admissions from April 1, 2007 to Sept 30, 2007. The evaluator was unable to start this chart review during the time frame allowed for the evaluation. This was because of the lengthy time required to select the units for review, make contacts, obtain required permissions, agree on a process to protect patient confidentiality, and arrange for a Health Region employee to conduct the review. After three months, we still had not reached the stage of having such an employee identified. At this point, the budget allocation for the evaluation lapsed.

The preparatory work for the chart review did indicate that such a chart review is feasible. The chart review would include extracting data from the admission record, any tobacco assessment (using the 5As flow chart), a smoking-off-the-grounds liability waiver, and the Medication Administration Record. Abstracting these data from patient charts would allow us to determine whether each patient was

assessed for tobacco use, whether the patient used tobacco, and what action was taken for tobacco cessation.

Was cessation counselling completed as planned?

The tobacco cessation counselling service and hotline were implemented as planned.

The evaluation plan for this section of the original plan was not completed. See the previous section for an explanation.

Was nicotine replacement therapy (NRT) implemented as planned?

The evaluation plan for this section of the original plan was not completed. See the earlier section for an explanation.

Informants in Pharmaceutical Services reported implementation of the nicotine replacement therapy was time consuming, but not excessively complicated. Agreements had to be worked out with pharmacies in the Region, tracking and reimbursement systems set up, and approvals gained from formulary committees and Saskatchewan Health. Informants in Pharmacy reported that NRT forced them to expand their distribution network and solve many process issues, especially in rural areas. Once these issues had been resolved, however, NRT ordering and distribution worked smoothly.

One informant reported that their choice of NRT was initially affected by budget considerations. Use of inhalers, the most expensive format, was discouraged at first. However, the actual cost of NRT for both staff and patients proved substantially less than originally budgeted.

One informant reported that in one mental health site, the tobacco assessment is being applied, but NRT is not encouraged. Most patients continue to smoke, off property. The ones who use NRT are the ones who cannot leave the unit because they have been certified under the mental health act. Other patients use it at night so they don't have to leave the property.

Was the Policy implemented in SHR facilities as planned?

Was the policy authorized as planned?

The Policy came into effect upon SHR Board approval September 20, 2006. It provided for a complete ban on the use of tobacco products in any health service organization operated or funded by the SHR, on the grounds of any such facilities, in vehicles operated or funded by SHR. This prohibition applied to all SHR staff, physicians, students, volunteers, contract workers, visitors, clients and patients upon the coming into force of the policy. Temporary exceptions were allowed until April 2, 2007 for mental health, palliative care, and addictions in-patients and acute care patients and visitors at any 24-hour site between 2000 and 0600 hours only. A second exemption applied to residents in some special care homes, who are permitted to smoke in a designated outdoor location. A permanent exemption applied to tobacco used for ceremonial purposes.

The policy also provided for:

- one-time access to nicotine replacement therapy (NRT) for staff, using a cost sharing arrangement, until August 2008;
- unlimited access to NRT for admitted patients, at no cost to them, until March 2009;

- a brief smoking assessment and cessation intervention for all inpatients, conducted by nursing staff (in acute care) or addictions counsellors (in residential addictions treatment facilities);
- tobacco cessation services (counselling) for patients, staff, and the public;
- regular cleaning of SHR grounds.

The Tobacco Policy can be reviewed in full on the SHR website. (SHR, no date)

The full ban on smoking was approved by the Saskatoon Regional Health Authority Board September 20, 2006, with two board members opposed. It was updated as of April 2, 2007. Concerns about the policy raised at the board level included:

- staff safety;
- fairness to mental health in-patients required to go off grounds to smoke; and
- the impact on referrals from other health regions to in-patient addictions services.

The policy went to the SHR Board not because it was a board-level policy, but because senior leadership wanted the board's endorsement on such a high-profile policy that affected the public.

The original plan of the Tobacco and Smoke-free Policy Committee had been to stage implementation, and eventually to eliminate the evening exemption. In early 2006 the Tobacco and Smoke-free Policy Committee carried out a staff survey on readiness to move to a full ban. The Committee concluded from that survey that staff were ready to fully ban smoking for the public, but not for staff. The Tobacco and Smoke-Free Committee took this position to senior leadership, who then directed them to implement the full ban. The Tobacco and Smoke-free Policy Committee responded with a list of what they said they needed to successfully implement a full ban. This included the tobacco ambassador (commissionaire) to be continued, grounds keeping, access for staff and patients to nicotine replacement therapy and support for a communications strategy. Senior leadership approved these requests.

Informants reported that involvement of unit and program managers in enforcement of the Tobacco Policy was key to successful implementation. Wide involvement and consultation of managers in the planning process facilitated buy-in and commitment.

Implementation faced several issues, but all were resolved. One was RN coverage in sites at night where there was a sole RN (such as in long-term care sites). The implementation of the policy where required was that there was no smoking on paid breaks, and meal breaks for smoking had to be scheduled.

Unions did not oppose the implementation of the policy. Informants reported that staff unions wanted to and did remain neutral on the policy.

Informants involved in developing the policy reported that push back on the Policy happened during the first stage the partial (day-time) ban. Overcoming this initial resistance required leadership energy. However, informants reported that in implementing the full ban they faced far less resistance than they had expected.

Was the policy communicated to staff and clients as planned?

Overall, the policy was communicated to staff and clients as planned.

A main communications channel for the development and implementation of the Policy was the Tobacco and Smoke-free Policy Committee. The Committee has had extensive involvement of a broad range of SHR departments involved in implementing or affected by the policy. The Committee included about 20 participants over the four years it was active. A list of participants as of January 2007 is provided in Appendix 8.

Informants reported that the communications consulting company the SHR engaged, Tap Communications, provided sound advice on the design and message of signage and its location. Tap helped reshape the communications plan for signage slightly. Tap favoured a direct, no smoking message, with locations where smoking was and was not permitted. They also provided good advice on where to put the signs.

Was the policy effectively enforced as planned?

From June 1, 2005 through December 31, 2006, a commissioner responsible for enforcing the partial smoking ban (the "Tobacco Ambassador") worked 20 hours per week rotating among the three Saskatoon acute care sites. During this time, the commissioner reported encountering 2,682 smokers violating the policy. Six per cent of these were staff, 73 per cent visitors, and 21 per cent patients/clients. Ninety-nine per cent complied with the policy by moving off the grounds or putting out their smoking material when approached. In one per cent of cases, the person approached refused to comply and the commissioner called security.

Staff compliance improved during this time. Table 5 shows the proportion of enforcement contacts who were staff in the months of June and December 2005, by site.

Table 5. Proportion of non-compliant individuals who were staff

Site	June 2005	December 2005
RUH	39%	1%
SPH	18%	0%
SCH	29%	1%

Site abbreviations: RUH: Royal University Hospital; SCH: Saskatoon City Hospital; SPH: St. Paul's Hospital (affiliate).

A review of program records and interviews with key informants indicated the following about the role of enforcement in implementing the policy:

- Some security guards did not see it as their role to conduct education with smokers: they reported that they had been asked to do education and to hand out pamphlets but "it is not our responsibility to talk to smokers or do education; we should do enforcement."
- Many security guards themselves smoked. One security supervisor noted, "90% of officers smoked." One informant commented: "sometimes security guards were smoking on the grounds."

- Informants indicated that enforcement is still an issue. The security staff don't want to be "bad guys." As well, the strategy of all staff being responsible for enforcing smoking is not working.
- Patient and visitor enforcement has been the main problem since the initial implementation.
- Key trouble areas are the east side of Royal University Hospital (where the sidewalk next to the hospital is University of Saskatchewan property), the areas around emergency rooms, and smoking provisions for psychiatric in-patients.
- One informant commented, "a year later we have gone backwards. . . We got to a certain point and now it's stopped. . . We did very well for the first 6 months and now we have faded." This informant argued that the Health Region needs "a commissioner for enforcement and we need nurse managers to enforce discipline."

Were grounds kept clean, so no butts were in view, as planned?

No indicators were available on grounds maintenance (such as butt counts, inspection reports). Key informants indicated that grounds keeping was a problem area with the Policy implementation. Particular sites where smokers congregated after the on-site ban, either because they were hidden or conveniently off-site, continue to be most problematic. These include the east, cafeteria entrance of the RUH (where the sidewalk just outside the building is University of Saskatchewan property), the grassy knoll across the road from the east RUH entrance, and the RUH parkade. One informant noted that cigarette butts in these areas are worse than before the Tobacco Policy. A grounds keeping supervisor noted that on occasion people smoking would get "very aggressive with us when cleaning up."

Were messages to motivate and support reduced tobacco use communicated as planned?

Did the program build and support champions as planned?

Yes. As described previously, there was widespread staff engagement at the middle management level through the Tobacco and Smoke-free Policy Committee. This ensured wide involvement and consultation in planning, implementation process.

Did the program inform staff and the public as planned?

Key informants were all aware of the communication of the Tobacco Policy. Many noted it as a strong point of the implementation of the policy. Of staff surveyed retrospectively in five units and who were Health Region employees at the time, 86 per cent agreed that they were aware of the policy when the full ban was implemented April 2, 2007.

Communication of the policy was the most frequently mentioned response in informant interviews to the question, "What worked well in implementing this policy?"

Was signage in facilities and grounds provided as planned?

Yes. Informants commented that this phase of the communications plan went very well. The involvement of a communications consulting company was valuable in honing the message, designing the signage, and providing advice on appropriate placement for best communication. The signs are consistent and highly visible, are

posted in places where they are very noticeable, and have a simple, clear message: don't smoke here; smoke off health region property.

Outputs

Overview: Were the outputs produced as planned?

Assessment of whether the planned outputs were achieved was more difficult, as parts of the evaluation plan designed to answer that question could not be achieved in the time frame available, with the delays experienced.

Small numbers of clients accessed tobacco cessation counselling (85 over 13 months). Similarly, 42 staff members over 17 months and 744 patients over 11 months accessed nicotine replacement. All these numbers were well below planned numbers.

No indicators were available for butt counts, but key informants commented that butts on the ground concentrated in certain problem areas.

Staff were well aware of the policy; 86 per cent of those surveyed reported they were aware of the policy at the time of implementation. Support for the policy among staff, both at implementation and currently, was lukewarm. A minority of staff do not support the policy because of the risk they perceive to themselves or to clients smoking off SHR property at night. Another minority support the policy and would like to see it better enforced. We were unable to evaluate patients' and visitors' awareness of and support for the policy.

Were cessation services used by the target groups?

Did the target groups access cessation counselling?

Overall counts of clients seeking tobacco cessation counselling are reported in Table 6. These data show use of the tobacco cessation counselling service of ten or fewer clients per month, for a total of 85 clients over the 13 months, through October 2007.

Table 6. Clients seeking tobacco cessation counselling, by month

Month	No. of clients
October 2006	9
November	10
December	4
January 2007	9
February	5
March	9
April	10
May	7
June	5
July	2
August	3
September	2
October	<u>10</u>
Total	85

The survey of staff described earlier identified a small number of smokers in the surveyed units. Of these smokers, none accessed counselling and ten percent accessed NRT.

Table 7. SHR employee use of tobacco cessation therapy

Survey item	% yes
Survey responses of ten smokers as of April 2, 2007:	
Since April 2, 2007, I have	
... used the tobacco cessation counselling services offered by the Health Region.	0
... used the free nicotine replacement offered by the Health Region.	10
... used tobacco cessation services offered outside of the Health Region.	0

We were unable to further assess use of cessation services by target groups for the reason described in the section of this report on Activities. Key informants were able to provide little information on actual use of cessation services.

Did target groups access NRT?

The evaluation plan for this section of the original plan was not completed. See the Activities section of this report for an explanation. However, we did obtain overall statistics on NRT use and on staff claims for NRT coverage.

The statistics on overall NRT use, by site and by the four acute-care units where we surveyed staff, are reported in Table 8. These data show that in the four surveyed units a substantial number of patients did in fact receive NRT.

Table 8. Clients receiving NRT, April 2007 through February 2008, by site

Site	No. of discrete patients receiving NRT
SCH	157
SPH	155
RUH	429
St. Elizabeth's, Humboldt (April 2007 not included)	<u>18</u>
Total, above four sites*	744
In four acute-care units where staff surveys were carried out** (included in above counts)	319

Site abbreviations: RUH: Royal University Hospital; SCH: Saskatoon City Hospital; SPH: St. Paul's Hospital (affiliate).

Notes: Counts are of discrete patients with orders for NRT written and processed on any admission during this time period, counted at discharge site.

Humboldt data only available as of May 1, 2007

NRT for Calder Centre, Larson House, Rosthern and Wakaw hospitals is supplied by the SHR Pharmacy department as wardstock; Pharmacy cannot track use of this product by site or number of patients. Humboldt supplies Watrous and Wynyard hospitals in the same fashion.

* Total does not add exactly to sum of components because of difficulties reconciling data due to patient transfers within one acute stay.

** Discrete patient count in the four in-patient sites where staff surveys reported elsewhere in this report were carried out.

Table 9 presents data on the take-up of NRT by SHR employees. These data show that a total of 41 staff have applied for NRT replacement under the Policy.

Table 9. SHR employee take-up of nicotine replacement therapy

(number of staff by month applying for and receiving nicotine replacement funding from SHR)

Month	# of staff
September, 2006	10
October	5
November	6
December	4
January, 2007	4
February	2
March	3
April	2
May	2
June	0
July	1
August	1
September	0
October	0
November	1
December	0
January, 2008	0
February	<u>1</u>
Total	42

Is tobacco use in SHR facilities consistent with the Policy?

Are apparent butts reduced?

No indicators were available on grounds maintenance (such as butt counts, inspection reports). One informant noted that cigarette butts in certain problem areas (just off-property or in hidden areas) are worse than before the Policy. This was confirmed by this consultant, who on visits to the various sites in the course of this project observed smokers and butts on SHR grounds in specific problem locations, in violation of the Policy.

Were staff and clients aware of, supportive of, and did they follow the policy?

Were and are staff aware of the policy?

All 30 key informants (most of whom had been directly involved in planning and implementing the Policy) were aware of the Policy. Among staff 80 surveyed in five units, 86 per cent reported they were aware of the Policy at the time it was implemented (Table 10).

Table 10. SHR employee awareness of and support for the Policy

Survey item	Response
Survey responses of current SHR employees who were also employees on April 2, 2007 (n=77) ((average score on a 5-point scale, with 1 = strongly disagree, and 5 = strongly agree)	
When The Policy was introduced on April 2, 2007, I:	
. . . was aware of The Policy (% agreeing)	86%
. . . supported The Policy (average score on a 5-point scale, with 1 = strongly disagree, and 5 = strongly agree)	3.5
I support The Policy now.	3.4

Did and do staff now support the policy?

Results of the survey of staff in selected units (Table 10) show moderate, stable support for the Policy among staff at the time of its introduction and currently.

The survey of staff in selected units garnered comments from 31 of the 80 staff responding. Many of these comments were lengthy and passionate. The majority of those commenting were non-smokers currently. These comments reflected the following themes (number of comments under each theme in parentheses):

- Policy increases risk to patients or is unfair to patients because of smoking off-grounds (mainly psychiatric patients) (18);
- Support the Policy (7);
- Policy increases risk to staff / staff are not available with smoking off-grounds/staff should have a safe place to smoke (mainly at St. Paul's Hospital) (7);
- Policy needs to be better enforced (6); and
- Smoking assessment takes too long/ is not nursing's role (3).

Did and do staff follow the policy?

Security supervisors reported several incidents around smoking enforcement that required security intervention at RUH, and none at other sites.

A security manager reported that he had to discipline security officers for violating the policy; many, perhaps most security officers smoked. However, security supervisors reported that many of their colleagues (14/20 smokers in one site) and probably half of the staff they used to observe smoking have quit since the Policy came into force.

Are clients aware of and do they support the policy?

We were unable to evaluate this, as we were unable to undertake a client survey within the time frame of the evaluation.

Do clients follow the policy?

In the absence of survey or administrative data, we have key informants views of whether clients are following the Policy. Key informants' comments included:

- "Implementation was quite smooth; it was supported by staff."
- "The smokers not thrilled with it, but accepted it and abide by it [from a security supervisor]."

- “On April 2 [2007] we were expecting a lot of phone calls, but it was very quiet - people accepted it.”

Summative evaluation

External factors

What external factors also affected smoking rates during this time?

At the same time as the Saskatoon Health Region introduced its partial ban on smoking July 1, 2004, the City of Saskatoon also introduced a smoking ban in public places.

Changes in smoking rates in comparable health regions

Data from the Canadian Community Health Survey (CCHS) reports smoking rates by health region. The most recent data is for 2005. These data show that Saskatoon Health Authority's population is at the top end of the range of smoking rates among prairie large urban health authorities.

Table 11. Percentage of current daily or occasional smokers, both sexes, aged 12 years and over, in the household population, prairie urban health regions, 2005

Health Region	Percentage current daily or occasional smokers
Calgary	19.8
Winnipeg	20.1
Regina Qu'Appelle	21.6
Saskatoon	23.3
Edmonton (Capital Health)	23.4

Source: Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005. The CANSIM table 105-0427 is an update of CANSIM table†105-0227. (Accessed: February 18, 2008)

Outcomes

Did smoking rates among the three target groups (staff, visitors, and patients) decline during the study period?

We were only partly able to assess this as part of this evaluation.

Table 12. SHR employee smoking behaviour at and after introduction of the Tobacco Policy

Survey item	Yes (%)
When the Policy was introduced on April 2, 2007, I was a smoker or a tobacco user.	13
Today, I smoke or use tobacco (March 2008).	17
[Of smokers on April 2, 2007] Since April 2, 2007, I have decreased the amount I smoke or use tobacco.	30

Options for future tracking of outcomes in the Saskatoon Health Region

Saskatoon-based Inshightrix Research (www.inshightrix.com) now offers a monthly omnibus poll. The poll offers 400 telephone interviews in Saskatoon, selected randomly each month. To obtain a larger sample, SHR could combine two or three months to obtain a quarterly sample estimate. Clients can purchase a single closed-ended question on the Inshightrix omnibus poll for \$800 per monthly survey.

Turnaround time for survey results is within ten days of submitting a question on the first Friday of each month.

The Canadian Community Health Survey is carried out by Statistics Canada every two years. It reports smoking rates by health region. The next CCHS survey, carried out in 2007, is scheduled to be available “spring 2008.” LTSC will monitor the Statistics Canada Daily and report the smoking statistics to the SHR, along with statistical analysis of changes, when they are released. The sample size is sufficient that reasonably robust statistical comparisons can be made to test whether changes in rates have occurred and whether the changes differ by health region.

4. Discussion

What worked well

Key informants identified the following as having worked well in the implementation of the Policy. (Numbers in parentheses are the number who identified the theme in response to an open-ended question.)

Communications (14)

Key informants identified the communication of the Policy, both internally and externally, as having worked very well. Comments of informants included:

- “There was good communication and education from the Region about the Policy -- posters, newsletter, email.”
- “The Policy was very well publicized to staff -- everyone knew it was happening and what was happening.”
- “The Policy was well communicated -- people knew about it well ahead of time.”
- “The signage and communications plan was very good.”
- “There as a good campaign of letting people know -- lots of notice.”

Leadership (12)

Informants interviewed identified leadership, both of senior leadership and of the Tobacco and Smoke-free Policy Committee, as another strength of the implementation of the Policy. Comments included:

- “The senior leadership supported us and told us to be braver.”
- “The new CEO told us to be bold -- that started the action. The SLT [Senior Leadership Team] intervention created the tobacco cessation position. It had been committed [before] by senior leadership, but not resourced -- the message that sent [from the senior leadership] was ‘no commitment.’ When SL said ‘get on with it’ they provided resources for this position.”
- “[There were] ‘consistent messages from management to push forward: ‘we are doing it, so suck it up.’ That has been helpful. There was no wavering [from senior leadership].”
- “There was excellent leadership of the Tobacco and Smoke-free Policy Committee.”
- “Dedicated staff time [from Public Health Services] with dollars, and focus [worked well.]”

A senior leader reported that that leader’s push to accelerate implementation had several sources. The leader had come from an organization that had already implemented the policy; Saskatoon was lagging behind other health regions in implementation of such a policy; and there were many complaints from staff about second-hand smoke.

The planning process (10)

- “There was strong planning.”

- “The committee was very thorough in reviewing the issues.”
- “There was lots of consultation and communication.”
- “There was lots of input from stakeholders, lots of meetings to plan.”
- “Involvement of a wide range of stakeholders - the time to do it - it showed the bigger picture of impact. Twenty people were involved on the Tobacco and Smoke-free Committee to hash out the implementation issues. We were able to act proactively in implementing when we hit issues because we had already discussed them.”
- “Talking it through with staff - the implications, the need to ensure consistency and do problem-solving [worked well].”

The educational approach (10)

Informant comments about what worked well in the educational approach taken included:

- “communication, education before the ban;”
- “integration of smoking cessation into nursing practice;”
- “education piece was important, also enforcement;”
- “training nurses was well done -- we didn't have to chase them that much - the training went well;”
- “enforcement was humane - [we used] the strategy of engagement -- “educational enforcement” was effective;”
- “we attempted a gentle implementation rather than shove it down their throats;”
- “make sure all staff are on board -- having a few months to prepare, involve staff in the process helped.”

The “Tobacco Ambassador” (6)

- “The Tobacco Ambassador [enforcement commissioner] was key.”
- “I miss the smoking cop.”
- “The commissioners were very effective. They were passionate about their job and good communicators.”

A consistent policy (4)

Informants commented:

- “It was a clear unambiguous policy. This also caused anxiety. It was easy to implement, easy to interpret.”
- “A consistent policy with no or few exemptions is an easier sell. It was more black and white. There was less push back about expanding the exemptions.”
- “It was a regional policy that applied everywhere [rather than previous facility policies].”

Tobacco cessation support (3)

“We framed it as ‘a caring employer’ by paying for cessation programming. This was an important olive branch [to smoking staff].”

What would you change or improve?

Implement in one stage, without exemptions (7)

- “The patients could smoke on the grounds, the staff couldn't. It was inconsistent. I would change and do together.”
- “Don't do it in stages - go whole hog and deal with the fall-out.”
- “Go harder, faster.”
- “Don't draw out the exemptions. Get on with implementing the policy. Exemptions weaken the policy and draw out the process.”
- “Get clear direction from senior leadership early on, so the direction doesn't change for the middle managers leading the process.”

Stronger, ongoing enforcement (7)

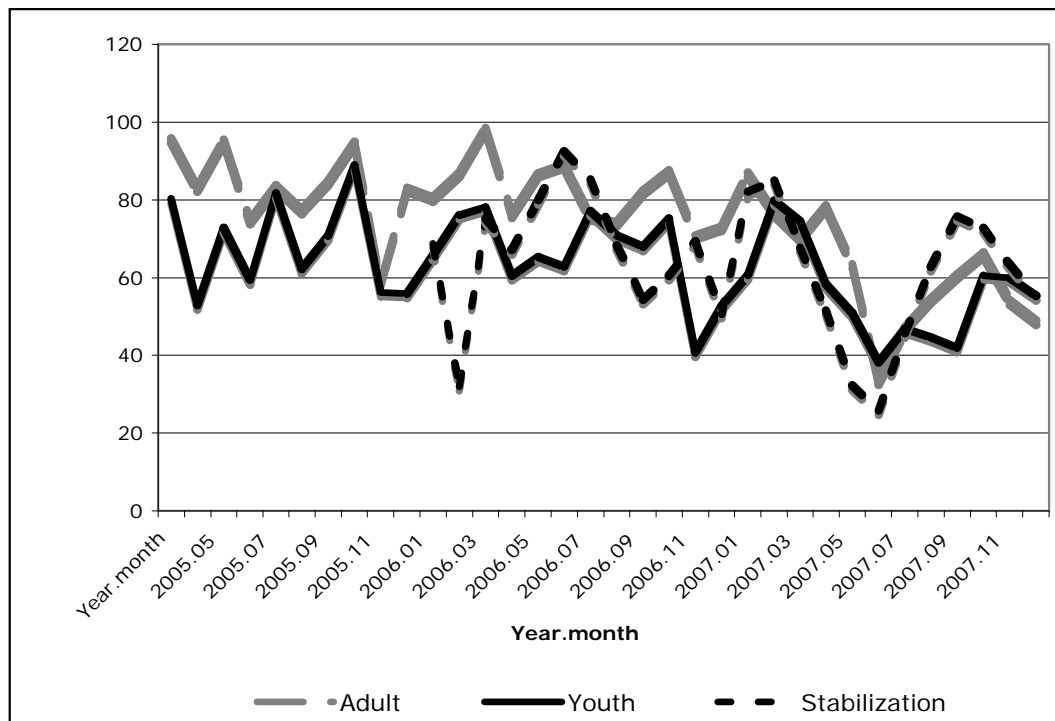
- “There should have been discipline. There are people still smoking. Have more commissionaires to enforce the Policy. They only worked three 8-hour shifts per week. Get more buy-in from managers, especially in nursing, to enforce it. The managers in acute care were happy with the policy, they just didn't want anything to do with it.”
- “More commissionaires; educate the officers.”
- “The policy is not enforced at all any more.”
- “Implementation has dropped off as a priority; we need to ensure ongoing support.”
- “Ongoing support [is needed]. . . . [Provide] more security to deal with the public who smoke in parking lots. . . . There are still a few sites where many staff smoke, and smoking is still an issue there.”
- “Mental health programs were always a struggle. Smoking is used as a reward for appropriate behaviour. This is an inappropriate practice.”

Provide exemptions, especially in mental health (6)

- “What do we do around youth? The Policy requires time to implement. There is a real dilemma around patient care (access) that has been pushed to the staff level [in in-patient addictions and mental health].”
- “I am concerned about access to services for clients [at the Calder Centre, for residential addictions treatment].”
- “Designated smoking area, such as just off emergency, would be good. Also allow smoking to calm down psychiatric patients or family members in emergency.”
- “Some people are exiting early while in active withdrawal from other substances [at residential addictions treatment].”

Data provided on service use at the Calder Centre (Figure 1) indicates that percentage utilization of beds dropped by approximately half following introduction of the on-property smoking ban in April 2007 (2007.04). Since then, percentage utilization has recovered somewhat, but not fully to previous levels.

Figure 1. Calder Centre percentage utilization by month and program.



Communications and training materials (3)

- “Avoid extra work to do these things. We all thought it would be a bigger issue than it was.”
- “More follow-up of managers to ensure they distributed communication packages to staff.”

Evaluation and learning (3)

- “We didn't pay enough attention to evaluation indicators while implementing the plan. Pay more attention to strategy and evaluation.”
- “We need sharing of implementation experiences, one year later. We need a way to learn from each other.”
- “We should have documented the process and barriers better, for learning, to learn the predictors of success.”

5. Conclusions

The following reflect the consultant's assessment of the key challenges and facilitators of policy effectiveness, recommendations to improve and strengthen the Tobacco Policy, and future evaluation work.

Challenges to policy effectiveness

The challenges to effectiveness that implementation of the Policy has faced, and continues to face, are the following:

Engaging nursing leadership and staff

Nursing educators and staff were lukewarm about the implementation of the nursing aspect (assessment and referral for counselling or nicotine replacement). This reflects both the pressure nursing staff are under, and the fact that some nurses themselves smoke. Integration of the nursing assessment into the overall routine of nursing assessment, and support from the nursing professional leadership, have and will continue to help overcome this resistance.

Application of the policy to mental health patients

Application of the Policy to mental health in-patients has been and continues to be a hot button issue in the implementation of this issue. This reflects that many patients and staff smoke, that staff are concerned about patient safety off-grounds in a particularly vulnerable population, and that the Policy increases the workload for staff. Ongoing staff education, enforcement, and management involvement in these units will be required to fully implement the Policy.

Effective grounds keeping

The issue with grounds keeping appears to have been that while staffing was added to grounds keeping to carry out butt clean ups, there was no one staff person specifically accountable for this and no regular inspection of problem areas. The use of a dedicated staff person accountable for cigarette butt clean up, together with regular inspection by managers of problem areas, would have improved, and would now improve, this output.

Effective enforcement

Enforcement was made more difficult by resistance among security staff to their assigned role in enforcement. This reflected the fact that many security staff smoked, that the educational role was not consistent with their training or self-image as security staff, and that they may not have had sufficient training to deal with conflict situations. The Tobacco Ambassador was highly successful.

Ongoing enforcement is the key area for the ongoing success of the Policy. There is some sense among key informants that the initial gains of the Policy have been partly lost because of lack of ongoing enforcement. Strategies to ensure ongoing enforcement would include:

- Reinstating the Tobacco Ambassador as a permanent role;
- Providing training to security staff in conflict resolution around smoking enforcement;
- Ongoing intervention by the management of security services to ensure the Policy continues to be actively enforced.

A second issue here is the particular problem status of the sidewalk next to the east entrance of Royal University Hospital and next to the Cancer Clinic. Although not Health Region property, frequent smoking in this area has a direct effect on the Health Region staff and visitors and Cancer Clinic staff and patients who must walk through this area to access services. The Health Region should negotiate with the University of Saskatchewan and the Cancer Agency for consistent regulation and increased enforcement of a smoking ban in this area.

Facilitators of policy effectiveness

The facilitators of the success of this policy have been:

A participatory planning process

The lengthy, participatory planning process in the Tobacco and Smoke-free Policy Committee involved many mid-level managers in the planning process. This facilitated buy-in and awareness, and allowed the Committee to anticipate and work out many of the implementation issues. This facilitated a relatively trouble-free implementation of the policy.

Leadership commitment

On two occasions, senior leaders directed the Tobacco and Smoke-free Policy Committee to make the policy more stringent and to speed up the implementation timetable. On the second occasion, senior leadership made a significant budget commitment to implementation. These senior leadership interventions and support were the difference between a half-hearted policy implementation, seen as one among many initiatives, and an effective, high-priority and high-visibility policy implementation.

Educational enforcement philosophy

The approach of educational enforcement, designed and adopted by the Tobacco and Smoke-free Policy Committee, was highly effective in allowing a smooth implementation, overcoming staff resistance, and avoiding potentially nasty confrontations. As part of this philosophy, the offering of nicotine replacement therapy was symbolically important, even though the actual take-up has been much less than expected. Symbolically, NRT helped reinforce the framing of the Policy as being aimed at the good health of staff and clients.

Communications

The communications strategy for implementing the Policy, both the in-house and contracted-out components, was highly successful. Activities created virtually complete awareness of the Policy by staff, and made the Policy visible and easily interpretable for patients and visitors.

Sufficient budget for implementation

Senior leadership's providing an adequate implementation budget was essential to successful implementation, both because of the resources supplied, but also because of the message it sent that senior leadership was serious about implementation.

Recommendations to improve and strengthen the Tobacco and Smoke-free Policy

One year after full implementation, the two key initiatives that would strength the implementation of the Policy in the Saskatoon Health Region are:

Ensure ongoing educational enforcement

Reinstating the Tobacco Ambassador commissionaire, at least part time, together with ensuring that the Tobacco Ambassador's efforts are consistently backed up by security staff and the warning and discipline process of the human resources office, would all considerably strengthen the application of the Tobacco Policy.

Monitor outcomes

The Health Region should continue to monitor smoking rates in the Health Region in relation to those in other prairie urban health regions, with a view to continuing to take population and clinically based initiatives on tobacco use reduction, as needed.

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Acknowledgements

From the Saskatoon Health Region:

- The thirty key informants listed in Appendix 3 shared their time and insights into the implementation of the Policy.
- Leah Heilman prepared NRT data for patients.
- Deanne Karr shared data and facilitated interaction with nursing units.
- Michelle Robson shared her extensive, well organized records of the Tobacco and Smoke-free Policy Committee and facilitated the cooperation of nursing units.
- Tanya Dunn-Pierce acted as liaison between the Health Region and LTSC on this evaluation and facilitated the obtaining of permissions for data collection and contacts with key informants and others within the Health Region.
- Nicole Schumaker shared data on utilization of the Calder Centre.
- Laura Wiwchar, Health Information Analyst, helped develop a workable approach to reviewing charts.
- Donna Mitchelmore, Administrative Coordinator, Worksafe and Employee Wellness provided data on employee use of nicotine replacements.

Barb Crockford of LTSC scheduled interviews, provided administrative support, and proofread this report.

Appendix 1. Policy timeline

SHR Tobacco and Smoke-free Policy Evaluation Time line

August 2003	The Vice-President of Primary Health sponsored the first meeting of a committee to develop a plan for a health region-wide anti-smoking policy.
April 2004	Policy proposal completed by SHR Tobacco Proposal Committee (SHR TPC). While calling for a general ban on tobacco use within any health region buildings or on the grounds, the policy allowed for a number of exceptions for staff, patients/clients and visitors.
May 5, 2004	SHR TPC presents policy proposal to senior management (Senior Leadership Team), which asked for development of a stronger policy with no smoking exemptions.
May 10, 2004	Policy proposal approved by SHR Board, with exemptions.
July 1, 2004	SHR implements a partial smoking ban as per May 5 proposal at same time as a City of Saskatoon bylaw banning smoking in public places.
November 2004	SHR Smoking Policy Committee (SPC) identifies major pushback issues around staff safety and continuous RN coverage in long-term care (cannot allow RN to leave building during breaks without having coverage).
January 1, 2005	Saskatchewan Tobacco Control Act comes into force, which prohibits smoking in enclosed public places.
November 2005	SHR Senior Leadership approves SHR SPC proposal for a staff survey to determine readiness to remove smoking exemptions.
January 2006	Tobacco survey of SHR staff on readiness to move to more complete ban.
June 2006	Based on the survey results, SHR SPC recommends removing staff and visitor exemptions as of April 2007, but maintaining patient exemptions.
April 19, 2006	Senior Leadership asks SPC for an accelerated implementation of total ban.
May 19, 2007	SPC agrees on policy recommendation for total ban.
June 16, 2006	SHR Board approves revised smoking policy.
September 1, 2006	Staff smoking ban on grounds comes into force.
April 2, 2007	Full ban on all tobacco products on grounds comes into force, with only limited exemptions for LTC residents.

Appendix 2. Formative evaluation plan in detail

Item	Evaluation question	Indicator	Data collection plan
Program planning	What was the program plan? Was it a clear, evidence-based plan?	Description; Yes/ No; If no, identify what could have been clearer or more based on evidence	<ul style="list-style-type: none"> Review meeting minutes and documents, Interview steering committee participants individually
Goals, objectives, and target groups	Were the goals, objectives and target groups of the program clearly established and agreed upon?	Yes/No/if not, where and why not	
Inputs	Were the required inputs clearly identified? Was the plan for inputs (the budget) based on evidence that the inputs would be sufficient to accomplish the planned activities?		
Activities/ Outputs/ Outcomes	Were the activities based upon good evidence (from research or previous experience) of what would work to accomplish the planned outputs?		
External factors	Were external factors that could also affect outcomes identified and taken account of in the program plan?		

Program implementation	Was the program implemented as planned?	Yes/No/if not, where and why not	See detail below
Inputs	Were the planned inputs realized?	Yes/No/if not, where and why not	Review program records; Interview key informants
Activities	Were activities implemented as planned?	Yes/No/if not, where and why not	See detail below
1. Provide accessible cessation services:	Were accessible cessation services provided as planned?	Yes/No/if not, where and why not	
o staff training	Were staff trained as planned?	Number of staff trained, by unit	Review training records
o client assessments	Were client assessments and interventions completed as planned?	Proportion of admissions with assessments completed, by unit, calculated from: <ul style="list-style-type: none"> number of admissions, by unit; number of clients with evidence of assessment on chart, by unit; 	<ul style="list-style-type: none"> Obtain complete list or random sample of admissions Carry out chart review of 300-400 randomly selected charts in each of four selected representative, diverse

Item	Evaluation question	Indicator	Data collection plan
<ul style="list-style-type: none"> ○ cessation counselling 	Was cessation counselling completed as planned?	Proportion of clients with positive assessments for tobacco use offered cessation counselling, calculated from: <ul style="list-style-type: none"> • Number of clients with chart report of positive assessment • Number of clients with chart report of offer of cessation counselling • Number of clients with evidence of use of cessation counselling 	units (75-100 each), selected from admissions from April 1, 2007 to Sept 30, 2007
<ul style="list-style-type: none"> ○ nicotine replacement therapy (NRT) 	Was nicotine replacement (NRT) implemented as planned?	As for cessation counselling, above	
2. Implement tobacco-free environment in SHR facilities	Was the tobacco-free policy implemented as planned?	Yes/ No/ If not, where and why not	See detail below
<ul style="list-style-type: none"> ○ authorize policy 	Was the policy authorized appropriately? Was that authorization communicated to those responsible for implementation/enforcement?		Review SHR records showing authorization by appropriate authority
<ul style="list-style-type: none"> ○ communicate to staff and clients 	Was the policy communicated to staff and clients?		Program records of communication of policy
<ul style="list-style-type: none"> ○ enforce the policy 	Was the policy effectively enforced?		Review program records, interview key informants
<ul style="list-style-type: none"> ○ clean the grounds so no butts are in view 	Were grounds kept clean?		
3. Communicate messages to motivate and support reduced tobacco use	Were messages to motivate and support reduced tobacco use communicated as planned?	Yes/ No/ If not, where and why not	Review program records, interview key informants
<ul style="list-style-type: none"> ○ build, support champions 	Did the program build and support champions as planned?		
<ul style="list-style-type: none"> ○ inform staff, public of policy 	Did the program inform staff and the public as planned?		
<ul style="list-style-type: none"> ○ Provide signage in facilities, grounds to remind of policy 	Was signage in facilities and grounds provided?		

Item	Evaluation question	Indicator	Data collection plan
Outputs	Were the outputs produced as planned?	Yes/No/ If not, where and why not?	See detail below
1. Accessible cessation services	Were cessation services used by the target groups? If not, why not?	Yes/ No/ If not, where and why not?	See detail below
o SHR staff members access cessation counselling	Did the target groups access cessation counselling?	Proportion of staff and patients who use tobacco who accessed cessation counselling	Counts of staff and patient use of cessation counselling from Addictions Services
o SHR staff assess, provide clients/patients/residents with tobacco reduction intervention	Did SHR staff provide the tobacco reduction intervention? If not, why not.	Proportion of clients with tobacco use assessed and offered intervention	Counts from chart reviews Perceptions and explanations from key informant interviews
o SHR staff/clients access NRT or other cessation products	Did target groups access NRT?	Counts of staff and clients who accessed NRT	Counts of staff and client use of NRT from program records
2. Ensure a tobacco-free environment in SHR.			
Tobacco use is no longer part of the SHR environment as shown by:	Is tobacco use in SHR facilities consistent with the Tobacco Policy?	See detail below	
o reduced butts		Butt counts	Program data or key informant interviews
o reduced infractions of policy		Policy infractions reported	Program data
3. Motivate and support staff and clients to support the policy.	Were staff and clients aware of, supportive of, and did they follow the policy?		
o Staff are aware of policy		Staff self-reports of attitudes and behaviour	Staff survey in selected units
o Staff support policy			
o Staff follow policy			
o Clients are aware of policy		Client self-reports of attitudes and behaviour	Client survey in selected units
o Clients support policy			
o Clients follow policy			

Appendix 3. Key informants interviewed

Participant	SHR Department	Position Title	TPC*
Abel, Barb	Acute Care, Mental Health and Addictions	Program Manager	
Beauchemin, Grant	Facilities and Engineering Service	Supervisor for Grounds	
Beisel, Maureen	Parkridge Centre	Manager	M
Davies, Maura		President, Chief Executive Officer	
Drummond, Greg	Mental Health & Addictions	Director	S
Elliott, Tony	Security Services - Avord Towers	Supervisor	M
Fornwald, Aaron	Labour Relations	Manager	M
Gentes, Rob	Community Adult Services, Mental Health and Addictions	Manager	
Gibson, Brian x	Security Services - SPH	Supervisor	
Goodman-Eifler, Daphne	Tobacco Reduction Program, Public Health Services	Supervisor	
Grauer, Karen	Healthy Lifestyles, Public Health Services	Manager	C
Heilman, Leah	Pharmaceutical Services	Drug Utilization Evaluation Pharmacist	
Kaar, Deanne	Community Addiction Services, Mental Health and Addictions	Tobacco Cessation Services Coordinator	
Kayto, Denise	Acute Care, Mental Health and Addictions	Manager	
Korsberg, Edmee	Community Services, Rural Health South (Lanigan), Rural Services	Manager	
Mahaffey, Suzanne	Public Health Services	Director	S
Melymick, Carol	Hemodialysis (SPH)	Manager	M
Metcalfe, Judy	Occupational Health & Safety	Manager	M
Morrison, Jean		Vice-President, Performance Excellence, Chief Nursing Officer	
Neudorf, Cory	Public Health Services	Chief Medical Health Officer	
Ostafie, Cynthia	Public Health Services	Tobacco Educator (now Dental Health Educator)	M
Penner, Doug	Security Services - RUH	Supervisor	
Ridsdale, Val	Clinical Nurse Educator, Nursing Affairs	Core Educator - SCH	M
Robson, Michelle	Clinical Services, Adult Community Services, Addictions, Mental Health & Addictions	Manager	C
Sabadash, Helen	Clinical Nurse Educator, Nursing Affairs	Core Educator - RUH	
Schumaker, Nicole	Calder Centre (residential addictions treatment), Mental Health and Addictions	Program Manager	

Participant	SHR Department	Position Title	TPC*
Squires , Lisa	Corporate and Public Affairs	Advisor	M
Stone, Jerre	Facilities and Engineering Services	Manager, Special Projects	M
Tekanoff, Reese	Security Services - SCH	Supervisor	
Thiessen, Brenda	Clinical Pharmacy Services, Pharmaceutical Services	Manager	M
Trischuk, Heather	Larson House (detox centre), Mental Health and Addictions	Manager	

Notes: All positions with Saskatoon Health Region April 2, 2007, unless otherwise noted.
Brian Gibson was not interviewed, but had input through messages he submitted through a colleague.

Site abbreviations: RUH: Royal University Hospital; SCH: Saskatoon City Hospital; SPH: St. Paul's Hospital (affiliate).

* Tobacco and Smoke-free Policy Committee. C: Co-chair, M: Member at time of evaluation, S: executive sponsor

Appendix 4. Evaluation interview guide

1. Were you aware of the policy when it was implemented?
 - 1.1. How did you become aware?
 - 1.2. What was your understanding of the policy?
2. Did you support the policy?
 - 2.1. Why or why not?
3. Did you follow the policy?
 - 3.1. Where or where not?
4. What did you understand to be the **plan** for implementing the Tobacco and Smoke-free Policy your area?
5. Did you receive the **inputs** you needed? (staffing, supplies and materials, budget)?
 - 5.1. If not, where and why not?
6. Query about input indicators/data.
7. Were the **activities** in your area implemented as planned?
 - 7.1. Yes, no, or partly?
 - 7.2. Where or where not?
 - 7.3. Why or why not?
8. Query about activity indicators/data.
9. Query about output indicators/data.
10. What **worked well** in implementing this policy?
11. What would you **change** next time?
12. Anything **else** that will help us understand how this policy was implemented?

Appendix 6. Staff survey of attitudes and behaviours



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February 2008

Dear Saskatoon Health Region staff member:

I am inviting you to help evaluate Saskatoon Health Region's Tobacco and Smoke-Free Policy. Your experience is a valuable part of knowing how we might change the process to improve everyone's health.

What do you do if you wish to participate in this survey?

- ⇒ Read the information below that explains the survey.
- ⇒ Fill in the enclosed survey.
- ⇒ Mail the survey in the enclosed prepaid envelope.
- ⇒ That's all! Thank you!

The Saskatoon Health Region has asked us to do an independent evaluation of its Tobacco and Smoke-Free Policy. The purpose of the evaluation is to find out how well the Tobacco and Smoke-Free Policy is working. We want to see if changes need to be made to the policy or how it is being implemented. The evaluation includes several parts. This staff survey, in selected units, is one part. The survey asks both about your role in patient assessment and your own smoking behaviour. We are interested to hear about both.

The Health Region is delivering this survey to you for us. We do not know your address or who you are. You are not asked to identify yourself on the survey. You will return your survey directly to us at Laurence Thompson Strategic Consulting in the enclosed stamped envelope. Participation in this survey is voluntary. There is no penalty for not participating.

Neither your unit manager nor we will be able to identify your survey response. Saskatoon Health Region, including your unit manager, will see only overall results for your unit. They will not see your survey or your individual survey results. We will report results only from groups of five people or more.

We have, however, marked your survey to show which unit you work in, because that is important for us to know for our evaluation. We will be collecting other data from your unit by chart audit and from other sources and comparing it to this survey. None of this data will identify individuals.

If you have any questions about this survey, please call me, Laurence Thompson, directly at 306-230-7753 during daytime hours.

When the study is finished, Saskatoon Health Region will post a summary on its website.

Laurence (Laurie) Thompson
President, Laurence Thompson Strategic Consulting

Saskatoon Health Region Tobacco and Smoke-Free Policy Evaluation Staff Survey 2008

On April 2, 2007 use of tobacco products was banned in Saskatoon Health Region buildings and grounds. The Health Region also offered tobacco cessation services and supports to staff, patients, residents, and clients. These questions refer to these changes as "The Policy."

Please answer all questions, as best you can, unless you are directed to skip. Please mark with an "X" the box under the number or under Yes or No that best shows your response. For the questions with answer boxes on a scale of 1 to 5, 1 is *strongly disagree* and 5 is *strongly agree*.

Section A.		Strongly disagree					Strongly agree				
When The Policy was introduced on April 2, 2007, I:		1	2	3	4	5					
1. . . . was aware of The Policy.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
2. . . . supported The Policy.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
		Yes	No								
3. . . . was an employee of Saskatoon Health Region.		<input type="checkbox"/>	<input type="checkbox"/>								
4. . . . was an employee in this unit or program (where I work today).		<input type="checkbox"/>	<input type="checkbox"/>								
5. . . . was a smoker or a tobacco user. (If you answer "No", skip to Section C).		<input type="checkbox"/>	<input type="checkbox"/>								
Section B.											
Since April 2, 2007, I have											
6. . . . used the tobacco cessation counseling services offered by the Health Region.		<input type="checkbox"/>	<input type="checkbox"/>								
7. . . . used the free nicotine replacement offered by the Health Region.		<input type="checkbox"/>	<input type="checkbox"/>								
8. . . . used tobacco cessation services offered outside of the Health Region.		<input type="checkbox"/>	<input type="checkbox"/>								
9. . . . decreased the amount I smoke or use tobacco.		<input type="checkbox"/>	<input type="checkbox"/>								
Section C.											
Since April 2, 2007, I have:											
10. . . . counseled a patient, client or resident to stop smoking or using tobacco products.		<input type="checkbox"/>	<input type="checkbox"/>								
11. . . . used the 5A flow chart with a patient, client or resident.		<input type="checkbox"/>	<input type="checkbox"/>								
Section D.											
Today:											
12. I am a Registered Nurse.		<input type="checkbox"/>	<input type="checkbox"/>								
13. I am a Mental Health Counsellor		<input type="checkbox"/>	<input type="checkbox"/>								
14. I smoke or use tobacco.		<input type="checkbox"/>	<input type="checkbox"/>								
		Strongly disagree					Strongly agree				
		1	2	3	4	5					
15. I support The Policy now.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

If you wish to make any other comments about the Tobacco- and Smoke-Free Policy, please write them on the back of this survey.

Now put this finished survey into the enclosed stamped envelope and drop it in the mail. That's it.

Thank you for your help!

SHRSPH5M

Appendix 6. Proposed client survey



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2008

Recently you used Saskatoon Health Region hospital or clinic services. I want to invite you to help us find out how well Saskatoon Health Region's Tobacco and Smoke-Free Policy is working. Hearing about your experience as a patient or client is valuable for us to improve this policy.

What do you do if you wish to participate in this survey?

- ⇒ Read the information below that explains the survey.
- ⇒ Fill in the enclosed survey.
- ⇒ Mail the survey in the enclosed prepaid envelope.
- ⇒ That's all! Thank you!

The Saskatoon Health Region has asked us to do an independent evaluation of its Tobacco and Smoke-Free Policy. The purpose of the evaluation is to find out how well the Tobacco and Smoke-Free Policy is working. We want to see if changes need to be made to the policy or how it is being implemented. This survey in selected units is one part of the evaluation.

The Health Region is delivering this survey to you for us. We do not know your address or who you are. You are not asked to say who you are on the survey. You will return your survey directly to us at Laurence Thompson Strategic Consulting in the enclosed stamped envelope. Participation in this survey is voluntary. There is no risk if you choose not to reply.

Neither anyone at Saskatoon Health Region or in our office will be able to identify your survey response. People in Saskatoon Health Region will only see overall results. They will not see your survey or your individual survey results. We have, however, marked your survey to show the unit where you received service, because that is important for us to know for our evaluation. We will report results to the Saskatoon Health Region only from groups of five people or more.

If you have any questions about this survey, please call me, Laurence Thompson, directly at 306-230-7753 during daytime hours.

When the study is finished, Saskatoon Health Region will post a summary on its website.

Laurence (Laurie) Thompson
President, Laurence Thompson Strategic Consulting

Saskatoon Health Region Tobacco and Smoke-Free Policy Evaluation
Patient / Client Survey
 2008 v02

These questions are about your recent visit to a Saskatoon Health Region hospital or clinic and what the staff there said to you.

Please mark an "X" in the box under "Yes", "No", or "Don't know/Not sure", whichever is your best answer to each question.

	Yes	No	Don't know/ Not sure
1. On my recent visit, someone asked me whether I smoked or used tobacco.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Someone explained to me that there is no smoking or tobacco use in Health Region buildings or on the grounds.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Before my most recent clinic visit / hospital stay I smoked or used tobacco.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If you answered "No" to question 3, stop here. Your survey is complete. Please put your survey into the envelope and mail it to us. If you answered "Yes" to question 3, go on to question 4.</i>			
4. On my recent visit, someone asked me if I was thinking about quitting smoking or using tobacco.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If you answered "No" to question 4, skip to question 7.</i>			
5. Someone discussed nicotine replacement with me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Someone referred me to Community Addictions Services for stop-smoking counseling.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Since my recent visit, I have stopped smoking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If you answered "Yes" to question 7, stop here. Your survey is complete. Please mail your survey to us. If you answered "No" to question 7, please answer question 8.</i>			
8. Since my recent visit, I smoke less than before my visit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If you wish to make any other comments about smoking and tobacco use and the Saskatoon Health Region, please write them on the back of this survey.</i>			
<i>Put your finished survey into the enclosed stamped envelope and drop in the mail.</i>			
<i>Thank you for your help!</i>			

Appendix 7. Summative evaluation plan in detail

Item	Evaluation question	Indicator	Data collection plan
External factors	What external factors also affected smoking rates during this time?	Changes in smoking rates in comparable health regions	Use available data from existing health surveys, such as by Health Canada
Outcomes			
<ul style="list-style-type: none"> Smoking rates in SHR residents decline 	Did smoking rates among the three target groups decline during the study period?	Smoking rate changes in target populations from early 2007 through late 2007	
<ul style="list-style-type: none"> Staff and volunteer smoking rates decline 			
<ul style="list-style-type: none"> Client smoking rates decline 			

Appendix 8. Membership of Smoking Policy Committee

Membership of SHR Smoking Policy Committee (Terms of Reference, January 2007):

Co-chairs:

- Manager, Mental Health and Addictions Services
- Manager, Public Health Services

Members:

- Pharmacy
- Mental Health and Addictions Services - Tobacco Cessation Counsellor and one other representative
- Long Term Care - representative from the Directors of Care Group
- Nurse Managers - one representative from 3 urban hospitals
- Security Services
- Public Health Services - representative from the Tobacco Reduction Team
- Corporate and Public Affairs
- Occupational Health and Safety
- Clinical/Core Nurse Educator
- Rural Services
- Human Resources - Labour Relations
- Facilities Services
- Community Services - representative from the Director Group
- Ad Hoc Member Representative from Senior Leadership Team