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What Are the Perceptions, Experiences, and Behaviors of Health Care Providers After Implementation of a Comprehensive Smoke-Free Hospital Policy?

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Abstract

The aim of this study was to explore the perceptions, experiences, and behaviors of health care providers (HCPs) after the implementation of a comprehensive smoke-free policy. This qualitative descriptive study, using semi-structured interviews, was conducted with 28 HCPs working in a Canadian hospital. Four overarching themes emerged from the analysis including (a) greater support for tobacco reduction, (b) enhanced patient care and interactions, (c) improved staff morale, and (d) some barriers still exist. The main findings suggest a comprehensive smoke-free hospital environment can strengthen the tobacco-free workplace culture within a hospital setting among HCPs where support for tobacco reduction is amplified, patient care and interactions regarding tobacco dependence are improved, and staff morale is enhanced. While there are still some challenging barriers as well as opportunities for improvements, the implementation of a comprehensive smoke-free policy heightened the call-to-action among HCPs to take a more active role in tobacco reduction.

Keywords

smoke-free policy, hospitals, healthcare providers, environmental tobacco smoke, tobacco, qualitative description, tobacco-free culture

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Many gains in tobacco reduction have been made over the past decades in areas of health promotion, disease prevention, and public health policy; however, to preserve these gains and hasten the decline of tobacco use and the burden associated with smoking-attributable morbidity and mortality, further innovations and action are required (U.S. Department of Health & Human Services, 2014). One such example, suggested as the most profound health promotion initiative a hospital can make (Kunyk, Els, Predy, & Haase, 2007), is comprehensive tobacco control policies, including a ban on smoking anywhere on a hospital property. Smoke-free hospitals have been shown to promote healthier choices and social attitudes regarding tobacco (Wheeler et al., 2007), reduce exposure of environmental tobacco smoke (ETS) (Callinan, Clarke, Doherty, & Kelleher, 2010), influence how tobacco dependence is managed, and reduce the use of tobacco and increase quit rates (Shopik, Schultz, Nykiforuk, Finegan, & Kvern, 2012; Unrod, Oliver, Heckman, Simmons, & Brandon, 2012). Smoke-free policies (SFPs) have also been associated with reduced mortality related to smoking-related illnesses (Frazer, McHugh, Callinan, & Kelleher, 2016). With numerous patients hospitalized due to tobacco-related disease, comprehensive SFPs can be the catalyst to improve the delivery of care for tobacco dependence and demonstrate institutional leadership (Fiore, Keller, & Curry, 2007).

As general hospitals continue to implement and refine SFP, challenges still exist, including non-compliance (Shopik et al., 2012; Wheeler et al., 2007), exposure to ETS, limited leadership, lack of tobacco dependence treatments, fears of negative public/staff perceptions, and issues related to patient care and safety (Schultz, Finegan, Nykiforuk, & Kvern, 2011). For such a large policy initiative to succeed, support and buy-in among hospital employees is critical (McNally

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et al., 2006); yet, research examining the effects of smoke-free hospital policies on hospital employees, health care providers (HCPs) in particular, is limited (Unrod et al., 2012). Many studies have explored staff attitudes toward these new policies, as well as the impact on staff's smoking behavior (Arack, Blake, Lee, & Coulson, 2009; Duffy et al., 2013; Lewis, Shin, & Davies, 2011; Parks, Wilson, Turner, & Chin, 2009; Unrod et al., 2012; Wheeler et al., 2007). While these previous findings suggest advancements in tobacco control, our understanding of what influence these newer smoke-free environments have on HCPs' perceptions, experiences, and behaviors is still lacking. Historically, however, studies have shown the promotion of tobacco reduction by HCPs in smoke-free hospitals has been less than optimal (Freund et al., 2008), despite the potential impact on the health of their patients (Rigotti, Clair, Munafò, & Stead, 2012) or supportive clinical practice guidelines (The Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-Informed Tobacco Treatment [CAN-ADAPTT], 2011; Fiore et al., 2008). Tobacco dependence treatments have been demonstrated to be clinically effective in smoking cessation, managing withdrawal and supporting abstinence (Rigotti et al., 2012), as well as cost-effective relative to other medical and disease prevention interventions (Fiore et al., 2008); still, tobacco dependence is typically not considered a frontline issue (Schultz, Bottorff, & Johnson, 2006). HCPs are often unacquainted with resources available and treatment is offered inconsistently (Freund et al., 2008; Kunyk et al., 2007; Schultz et al., 2011; Schultz, Bottorff, & Johnson, 2006; Shopik et al., 2012; Smoking and Health Action Foundation, 2013). In addition, HCPs are often hesitant to confront the smoking behaviors of patients (Arack et al., 2009; Ratschen, Britton, & McNeill, 2008; Shipley & Allcock, 2008).

Fiore et al. (2007) advocate that institutional, system-level approaches, such as those implemented as part of a comprehensive SFP, have the potential to enhance tobacco reduction interventions by HCPs; yet, few studies have had fully comprehensive policies in place to accurately assess the impact in general hospital environments. It is recommended that comprehensive SFPs encompass integrated tobacco dependence treatment systems and resources for patients and staff, with no exclusions or designated smoking areas, as well as hospital administration leadership and enforcement (Luck, 2016; Smoking and Health Action Foundation, 2013). Stockings et al. (2014) recognize that comprehensive SFPs are increasingly being implemented in hospitals; however, most studies on this topic have been conducted in general hospitals that allowed smoking for certain groups (i.e., psychiatry, palliative), had designated smoking areas, and/or did not have systems in place to adequately treat tobacco dependence. When comprehensive hospital policies have been implemented, delivery of tobacco dependence treatment and patient outcomes appeared more promising (Freund et al., 2009; Stockings et al., 2014).

If hospitals are to realize their intentions of SFPs, multiple influencers at various levels need to be better understood to build capacity and empower HCPs in tobacco reduction (Shopik et al., 2012). This could not only provide optimal health care for patients (Shopik et al., 2012) but also address other concerns around compliance, exposure to ETS, and negative perceptions (Kunyk et al., 2007; Schultz et al., 2011; Shopik et al., 2012). This study builds on research in this area by exploring the perceptions, experiences, and behaviors of HCPs following the implementation of a comprehensive smoke-free hospital policy.

Method

This qualitative descriptive study (Sandelowski, 2000), was conducted at the Saint John Regional Hospital (SJRH) located in Saint John, New Brunswick, Canada. Ethics approval was obtained from the University of New Brunswick and the Horizon Health Network, file numbers 034-2016 and RS 2016-2384, respectively.

Setting

The SJRH is the largest general hospital in the province, as well as the primary provincial health care referral center for major trauma and cardiac care. It employs approximately 3,000 people, has approximately 445 in-patient beds, and is situated on 30 acres of property. On September 29, 2015, the SJRH officially launched a comprehensive SFP that did not allow smoking anywhere on their property; anyone that wanted to smoke would have to leave the property to do so. There were no exceptions or exclusions to the policy. At the time of policy implementation, New Brunswick had the highest reported smoking prevalence in Canada at 19.6% (Reid, Hammond, Rynard, & Burkhalter, 2015). Through key lessons learned by others who implemented similar polices in this area (Gajendra, Ossip, Panzer, & McIntosh, 2011; Kunyk et al., 2007; Schultz et al., 2011; Shopik et al., 2012), the implementation team strived to address many of the shortcomings identified. An internal pre-launch of the policy commenced 5 months prior to the policy launch date to support the change management process and build a supportive environment for the new policy. This included raising awareness of nicotine addiction; communicating enforcement, compliance, and staff expectations; promoting available supports; explaining policy rationale and property boundaries; implementing staff training; and erecting policy signage. Hospital administration, security, and board members were mandated in the policy to enforce it (i.e., if they saw anyone smoking, they were expected to inform them of the policy and ask them to put out their cigarette or leave the property), while all other staff were strongly encouraged to enforce the policy, but not mandated to do so. Tools, such as scripts of what to say and videos, were developed to assist with enforcement. A systematic approach, using the Ottawa

Model for Smoking Cessation (Reid et al., 2010), was expanded to ensure all in-patients had access to tobacco screening and medications for cessation and/or nicotine withdrawal management, including referral access to a respiratory therapist for smoking cessation counseling and a hospital-wide nicotine withdrawal order set. All staff also had access to smoking cessation counseling and 12 weeks of free nicotine replacement medication through the staff health and wellness department.

Sample

To explore the perceptions, experiences, and behaviors of HCPs following the implementation of a comprehensive smoke-free hospital policy, HCPs were purposefully sampled, using maximum variation sampling, to gather data that would describe dominant themes that expanded across a range of professional backgrounds and practice settings within the hospital. Participants were recruited through promotional activities throughout the hospital, including recruitment posters, email, newsletters, small group presentations, and word of mouth. To be included, the HCPs were required to have worked at the SJRH for at least 1 year prior to the implementation of the smoke-free hospital property policy and work greater than 12.5 hours per week in direct patient care. Informed consent was obtained prior to conducting the interview using a written consent form. The sampling was terminated when enough data were available to develop a rich description of the phenomenon under study, and it was felt no new data on this topic would emerge through additional interviews.

Data Collection

Data were collected by the primary author through single in-depth, face-to-face, semi-structured interviews lasting 45 to 90 minutes. The interview guide contained open-ended questions and associated probes developed from the researchers' clinical experience and the current literature on tobacco, SFP, social ecology theory, and workplace culture. All interviews were audio recorded and transcribed verbatim. The locations used to conduct interviews were private and provided a comfortable, quiet setting, including meeting rooms at the SJRH and participant's homes.

Data Analysis

The six phases of thematic analysis outlined by Braun and Clarke (2006) were used to identify, analyze, and report patterns across the data set, as well as organize and describe the data in rich detail (Braun & Clarke, 2006). NVivo was used to assist in data storage and analysis. Reflexivity, peer debriefing, an audit trail, and member checking helped ensure trustworthiness (Creswell, 2013; Merriam, 2009; Milne & Oberle, 2005). For example, peer debriefing (Hammell, 2002; Kielhofner, 2006) with the second author allowed for ongoing discussion, scrutiny, and revision during the data analysis. The two researchers, with differing professional backgrounds, independently coded randomly selected transcripts for comparison of the coding scheme and emerging themes. All study participants were provided with a summary of the initial analysis via email. Eleven participants shared input and feedback, with unanimous agreement that the summary accurately represented their story.

Results

Sample Characteristics

Participants included 28 HCPs. Participant demographics are shown in Table 1. Although three participants reported using tobacco in the previous 12 months, the perceptions, experience, and behaviors shared did not remarkably differ from those HCPs that did not use tobacco. Due to small numbers of certain health care professions, both participating in this study and working in the research setting (i.e., social worker, dietician, physiotherapist, etc.), the type of HCP was not identified in the findings to protect anonymity.

Themes and Subthemes

Seventeen subthemes emerged from the analysis based on the stories shared by the participants; each were characterized using direct quotes that capture the overall meaning. These were mapped and merged into four overarching themes including (a) greater support for tobacco reduction, (b) enhanced patient care and interactions, (c) improved staff morale, and (d) some barriers still exist (see Figure 1).

Theme 1: Greater support for tobacco reduction. This theme described the perceptions, experiences, and behaviors HCPs shared related to endorsing and encouraging tobacco dependence treatment and promoting a smoke-free environment since the policy was implemented. Five subthemes illustrate the changes that enabled a positive shift in tobacco reduction within the hospital setting. These include "We have the policy to back us up. . . we are fully empowered"; "Difference in the engagement . . . post policy"; "I used to feel like such as hypocrite"; "It went better than I anticipated"; and "It's easy, whereas before it was a process."

We have the policy to back us up . . . we are fully empowered. The majority of HCPs shared they now promote the smoke-free environment and the value of tobacco dependence treatment with confidence feeling it is not just their own views and opinions they are advocating for but those of the entire hospital. As one HCP explained, "you have that back-up and that power of the policy behind you," whereas before, many felt saying something may be perceived as their individual opinion and thus they were less likely to promote

Table 1. Participant Demographics.

HCP (*N* = 28)	10 registered nurses 4 physicians (Specialists) 3 pharmacists 2 respiratory therapists 2 licensed practical nurses 1 dietician 1 physiotherapist 1 social worker 1 personal support worker 3 technologists (cardiology, X-ray, nuclear medicine)
Employment type	22 full-time 5 part-time 1 casual
Types of patients seen (in-patients/out patients)	15 only worked with in-patients 2 only worked with out-patients 11 worked with both in-patients and out-patients
Area of work	Various units throughout hospital, including cardiology, CCU, burns/plastics, family medicine, oncology, diagnostic imagining, medical/surgical ICU, emergency, neurology, neurosurgery, rehabilitation, psychiatry, nuclear medicine, general surgery, electrodiagnostics, nephrology/dialysis, transplant
No. of years worked at current hospital as HCP	*M* = 9.30, *Mdn* = 8.5, *SD* = 6.96
No. of years in total worked as health care provider	*M* = 14.27, *Mdn* = 10.5, *SD* = 10.16
Age	*M* = 41.32, *Mdn* = 38.5, *SD* = 10.75
Tobacco use in past 12 months	3 reported using tobacco regularly in the past 12 months, 2 of which currently smoke
Previous tobacco use	9 identified as a "past-smoker," 3 reported using tobacco socially on a regular basis

Note. HCP = health care providers.

tobacco reduction. Another HCP described how the policy changed her comfort level:

> I feel more comfortable having those conversations because it is a hospital policy . . . you don't want to cross boundaries and give them medical advice and that sort of thing so I think a lot of people just were worried that that line was kind of blurred if they were encouraging someone to seek help for nicotine replacement or . . . cessation of smoking long term . . . so I think having those resources available, having them laid out, it's sort of like the hospital saying . . . we encourage you to do this and it is okay to have those conversations with your patients so I think that's helpful.

Clear rules and a comprehensive SFP provided a consistent message and sense of control, independence, and autonomy to endorse the smoke-free environment and/or assist with tobacco dependence supports without hesitation or repercussions.

Difference in the engagement. . .post policy. While a few participants felt staff engagement did not drastically change since the policy was implemented, the vast majority adamantly pointed out a greater "buy in" among colleagues to support and promote the smoke-free environment. As one HCP expressed, "There was a time where some people thought it wasn't their job. I think that those people are now realizing that it is their job." The participants felt tobacco dependence treatment is now discussed more often, including a change in mentality toward it. For example,

> We have made positive inroads. When you start to make a difference it's a snowball and so then it's like wait . . . the people that are asking those questions and making those offers are making a difference and we are starting to see that there is some positive change so maybe I should get on board with that, too.

Tobacco use screening before the policy was often described as a box that needed to be checked, with little action taken afterward; post-policy when a patient was flagged as a tobacco user, more support by HCPs appeared to be happening. Participants felt physical cues in the environment, such as signage and posters, along with having a "champion" for tobacco reduction within the work unit further supported this enhanced level of engagement.

I used to feel like such a hypocrite. Although not all participants mentioned this during their interviews, the majority described feelings of hypocrisy prior to the policy, whereby their conviction in reinforcing a health promotion message

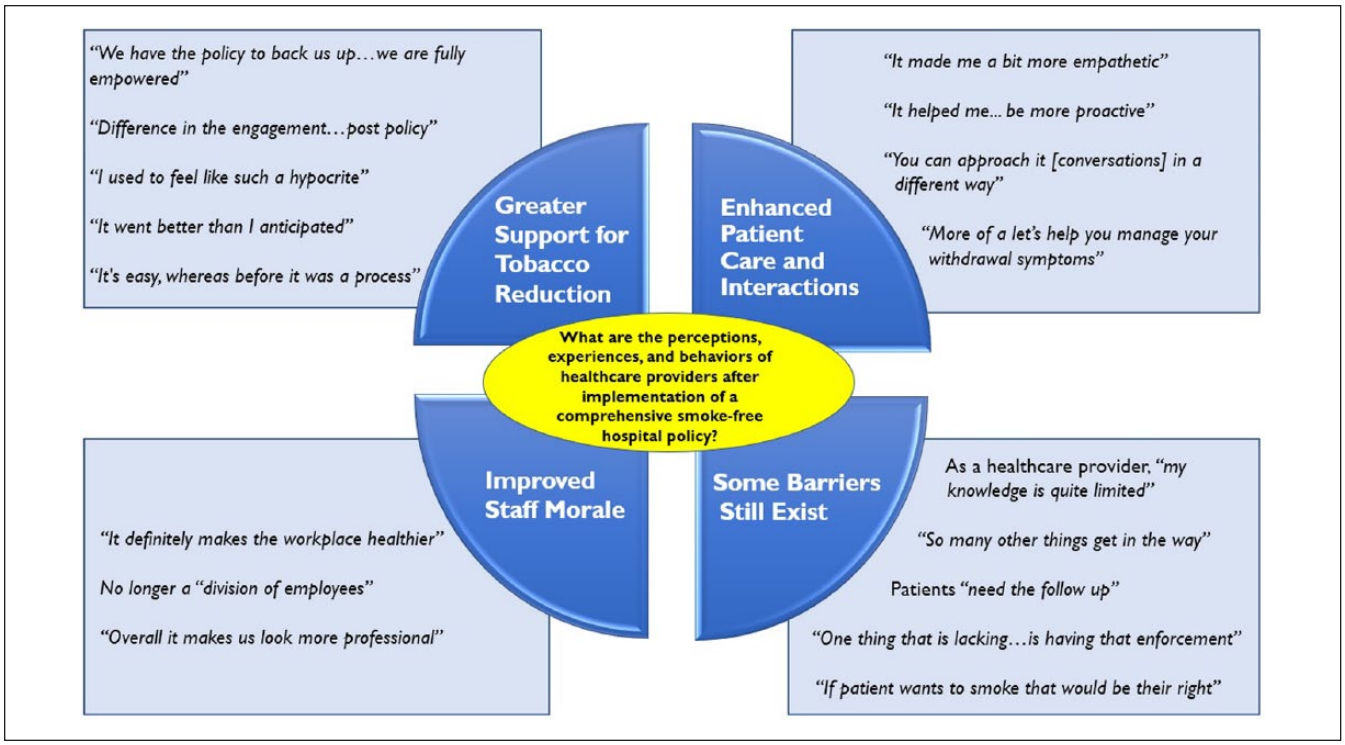

Figure 1. Themes and subthemes of perceptions, experiences, and behaviors of health care providers after implementation of a comprehensive smoke-free hospital policy.

was internally challenged when patients could just walk around the corner and have a cigarette or see others, oftentimes HCPs, smoking. As one HCP stated, "I didn't see any point," while another shared,

> It makes it easier for me . . . when telling somebody they shouldn't be smoking, I don't feel like I'm being a hypocrite because they're not walking outside and seeing health professionals smoking outside the hospital.

The participants described how the change in environment supported the message they delivered and motivated them to support tobacco dependence treatment and to promote a smoke-free environment.

It went better than I anticipated. Based on their previous experiences and failed attempts with other tobacco policies, many HCPs described feelings of skepticism and hesitation when the policy was first announced. Nevertheless, after seeing firsthand how the program worked to reduce exposure to secondhand smoke, decrease the number of people smoking on the property, and effectively manage their patient's withdrawal and cravings, most reported it had a positive influence on their receptivity and confidence to promote the policy and support tobacco dependence treatment. As explained by one nurse,

> Now that I've actually gone through and we've done the nicotine replacement therapy and they've coped quite well with that then I feel, I am pleased with it . . . I really think it's a good way to go.

One HCP did express disappointment with the success of the policy, relaying she still sees some patients and staff hiding and smoking on the grounds, noting her expectation was 100% compliance; however, this was the exception, rather than the norm among participants.

It's easy, whereas before it was a process. This theme was most prominent among HCPs that had a scope of practice that included medication management and treatment, such as nursing, medicine, pharmacy, and respiratory therapy. The new availability of resources and supports and, in some cases, the increase in awareness of previously existing resources, such as systematic screening and referral systems, medical directives, medications stored on the unit, and easier access to dedicated advice/support, all appeared to enhance the HCPs ability and motivation to offer tobacco dependence support, as well as improve efficiencies. As one nurse explained,

> It's just way more accessible to get that [NRT] and that was an issue in the past . . . I got to find the doctor, I got to page him, I gotta' wait for him to call me back. Sometimes that can be a long time especially if it's not something that's really pressing I might

> forget about it and then all of a sudden yeah, the patient's really edgy . . . you kind of missed the boat.

Another nurse shared, "you do not have to wait for approval," which contrasted the experiences described prior to policy where a traditional medical model and lines of authority in the hospital setting dictated if tobacco dependence treatment was offered to patients. As stated by one participant when referencing pre-policy, "It's a hierarchy, you better be in sync." The majority of allied HCPs (i.e., physiotherapists, social workers, dieticians, technologists, etc.) reported they would ensure someone on the unit knew if a patient was looking for tobacco dependence assistance; however, most did not have firsthand experience with implementing these screening or treatment processes for tobacco dependence within the hospital.

Theme 2: Enhanced patient care and interactions. Changes following the implementation of the SFP in patient care as it related to tobacco reduction were represented by the theme enhanced patient care and interactions. Four subthemes exemplifying the transformation in caregiver–patient dialogue, understanding, and approach include "It made me a bit more empathetic"; "It helped me . . . be more proactive"; "You can approach it [conversations] in a different way"; and "More of a let's help you manage your withdrawal symptoms."

It made me a bit more empathetic. Many HCPs described enhanced empathy and understanding of nicotine addiction, withdrawal symptoms, and the struggles their smoking patients may go through while trying to quit smoking and/or being in a smoke-free hospital. Some reported their philosophy changed from "smoking is bad for you" and "shaking their finger," to their patients are "withdrawing" and need their help. Others explained they are more in tune with nicotine withdrawal, realizing it could be a reason for their patient's attitudes and behaviors. For example,

> Before I wouldn't be so aware of what withdrawal they would be going through or how severe it may look . . . that it could contribute to some of the picture that I was seeing of agitation . . . a lot of different factors that I wouldn't have tuned in to . . . it gives you a bit more appreciation.

It helped me . . . be more proactive. Most HCPs shared that since the environment went smoke-free, tobacco use was more "top of mind" and meaningfully screened. Tobacco dependence treatment was viewed as a higher priority and was offered more often and proactively to patients on admission. In comparison, HCPs felt previously implemented tobacco screening procedures were done with less importance placed on them; as one HCP explained, "We were more lax because our patients could just go out front [to smoke]." Another HCP shared,

> I think the fact that we have a smoke-free policy definitely makes us talk to them a little bit more about it because before it used to be "are you a smoker?" and they would say "yes" or "no", "Have you thought about quitting?" . . . if they said no, you didn't push any further.

The safety concern of patients walking off the large property was described as a substantial influence and prompt for HCPs to offer tobacco dependence treatment. All HCPs reported they proactively promoted a smoke-free environment with their patients; however, nurses, pharmacists, and physicians and allocated smoking cessation respiratory therapists were now more likely to discuss and provide tobacco dependence treatment to patients. Allied HCPs shared they would now more readily discuss tobacco dependence if it was pertinent to treatment or if the patient initiated the conversation. A few allied HCPs conveyed they did not feel the organizational systems fostered their role in doing more than being "supportive" and connecting a patient with their nurse. Of the few HCPs that felt they were just as proactive prior to the policy, they still expressed the smoke-free environment helped to support their message, which enhanced patient receptivity.

You can approach it [conversations] in a different way. Many HCPs shared how the conversations with patients changed since the hospital went smoke-free. As one HCP described,

> Previously . . . people who were not interested in quitting . . . they'll say "I don't want to talk about this. I just want to go outside for a smoke" . . . now you can approach it a different way because you can say you can't just go downstairs and go outside. It's hard for you to walk way off the property and I don't want you lying in bed thinking about smoking, I want you to concentrate on getting well.

Before the policy, HCPs would often just direct patients to the designated smoking area to smoke; post-policy, the smoke-free environment (and large smoke-free campus) was leveraged to build interest with patients for smoking cessation or nicotine withdrawal management. This approach, shared by many HCPs, appeared to enhance patients' receptivity and discussions about tobacco dependence treatments, especially nicotine withdrawal management. As one HCP explained, "It's sort of leverage or reason to give them. . .if you do go out, you do have to leave the premises . . . just giving them that information I think helps them question whether they really need to go or not."

More of a let's help you manage your withdrawal symptoms. Although the ultimate goal in tobacco dependence treatment is quitting smoking, nicotine withdrawal management to "keep them comfortable" was the primary approach described by the majority of HCPs in this hospital setting. If patients were not interested in quitting smoking, nico-

tine withdrawal was readily offered to manage withdrawal symptoms and to support the smoke-free environment. As described by one of the HCPs, "Before. . .you would kind of gauge whether someone was ready to quit or they're not ready to quit and there wasn't anything in the middle." Many HCPs viewed nicotine withdrawal management similar to other treatments they would offer, such as medications for pain management.

Theme 3: Improved staff morale. The positive shift, after policy implementation, in staff attitudes toward their workplace that enhanced receptivity toward tobacco reduction is captured in the following theme: improved staff morale. Three subthemes that demonstrate these changes in job satisfaction include "It definitely makes the workplace healthier"; No longer a "division of employees"; and "Overall it makes us look more professional."

It definitely makes the workplace healthier. All HCPs shared their appreciation for less exposure to ETS in the workplace and improvement in the air quality. As expressed by one HCP, "It's been a lot better to work here because. . .there is not that cloud of smoke that we walk through." Another HCP explained, "it's a trickledown effect, by having an overall healthier work environment then you get people doing more healthy things." This was reinforced by experiences shared by a few HCPs conveying they were "more likely to go outside on break now." Some expressed being protected from ETS made them feel more valued and appreciated. As one HCP explained, "You feel protected. Stood up for . . . it's nice to have the big guns backing us up . . . you feel cared for." Others shared they felt great support for quitting smoking for themselves and/or their colleagues and it "improved the workplace in a positive way."

No longer a "division of employees." Many HCPs described less staff animosity felt toward colleagues who smoked since the policy was implemented; one nurse expressed her previous frustration saying, "If you don't smoke you actually end up with the short stick." This perception was further explained by one HCP:

> Previous to the policy, we would often see them [colleagues that smoke] going outside for a cigarette multiple times a day. It sort of creates that, I don't know if jealously is the right word, or you just feel like wow that person is going out for another break. They get all these 15 minutes breaks during the day . . . that was considered acceptable to do, but if you just wanted to step outside and sit on the grass for 15 minutes you know you couldn't do that.

It was suggested post-policy, the distance to travel was a deterrent and staff were less likely to leave and would wait to go on their allocated break time. As one HCP described, "There are people who run around all day and don't get a break, but you've got four because you're a smoker . . . that conversation has changed a little bit." Others shared they perceived an improvement in compliance and respect for the SFP among staff, as well as less smoking among colleagues overall. Many HCPs shared several staff appeared to quit smoking since the policy or they no longer smoked at work.

Overall it makes us look more professional. Most HCPs expressed feeling proud to work for a health care organization that showed unwavering leadership in promoting a clear message about smoking. They felt it projected a positive image for the organization as a whole, as explained by one HCP, "I think it's a huge positive step for the hospital. I think it changes the image of the hospital tremendously."

Theme 4: Some barriers still exist. Ongoing challenges experienced and perceived by HCPs related to tobacco dependence treatment and smoke-free promotion are identified and described in the final theme: some barriers still exist. Five subthemes illustrate continuing hurdles in tobacco reduction 1 year after a SFP was implemented. These include the following: As a HCP, "my knowledge is quite limited"; "So many other things get in the way"; Patients "need the follow up"; "One thing that is lacking. . .is having that enforcement"; and "If patient wants to smoke, that would be their right."

As a healthcare provider, my knowledge is quite limited. While the majority of HCPs, with a few exceptions among physicians and pharmacists, described an increase in overall awareness to tobacco reduction strategies, they still expressed a need for more training and the lack of skills and comfort in their roles regarding tobacco dependence treatment. For example,

> There really isn't the training. I mean the e-learning helps, helps you have some knowledge but . . . you're not really sure if you're saying the right thing . . . you don't learn that in school . . . It wasn't really something that was taught.

Many HCPs, in particular most allied HCPs, were unsure of their role in tobacco dependence treatment, and what was expected of them; nevertheless, most HCPs expressed an openness toward taking on a larger role if or when needed. It was also mentioned that with a dedicated hospital personnel allocated for smoking cessation/tobacco dependence treatment via referral, it often fostered thinking that "as long as someone is doing it, I am perfectly happy," which appeared to support a mind-set whereby many HCPs did not see their role going beyond screening, referral, and perhaps starting nicotine withdrawal management (vs. discussing smoking cessation). As articulated by one nurse,

> I'll put the consult in . . . and then I leave and I go do my own thing, when really I probably am the best person to have the conversation [about smoking cessation]. Because of the association with respiratory therapists as the gurus we sometimes pass that off on them.

Lack of resources and tools to assist with patient education and building awareness on tobacco dependence and smoking cessation was also identified as a need to improve overall knowledge and skills.

So many other things get in the way. Most HCPs mentioned time limitations as a barrier when trying to juggle all aspects of care for their patients. Although tobacco dependence was viewed as more "top-of-mind," as compared with before the policy, it did not take priority over the more acute issues that had to be dealt with in a hospital setting. For example,

> Time constraints and lack of staff means you have to prioritize what is the absolute MOST important. Getting people off cigarettes is absolutely important, but when it comes down to some guy dying in the next room it takes a back seat. Honestly, if we just had more staff we would have those opportunities to actually sit down with our patients and be like, "I've noticed, you're still smoking. Let's talk about it," but you can't. I don't, you don't have time. You don't have time.

Some HCPs also mentioned the degree of illness also influenced when, and if, tobacco dependence was a priority, such as psychosis, intubation, or severe illness.

Patients need the follow-up. A number of HCPs mentioned the challenges faced by patients for accessibility and affordability of smoking cessation medications once discharged from hospital, as well as lack of supports for smoking cessation counseling and support. All in-patients had access to medications while in hospital, but out-patients and discharged patients often had limited access to medication to assist with tobacco dependence; therefore, lack of treatment continuity was identified as a concern. One HCP shared their vision for change:

> Ideal world would be to have everything covered even after the people are discharged from hospital to have patches to send home with them, offer support that way. I find a lot of people say "Well, you know, it's great in here cause it's free but I get home and I can't afford it."

Another HCP proposed changes that would foster greater success:

> To have some better counseling and follow-up to help support them and reinforce . . . maybe you could argue that if they all had support when they went out the door then more of them would succeed.

One thing that is lacking. . .is having that enforcement. Even though all HCPs reported there was remarkably less smoking on hospital property since the policy was implemented, it was not 100% smoke-free. Many shared reports of patients, visitors, and staff still finding hiding spots to sneak in a cigarette instead of walking off the campus. Questions that emerged included "Whose job is it to enforce?" and "Why isn't security doing more?" Feelings of frustration and insincerity of hospital administration toward the policy were expressed, which challenged the "backing" felt to promote and discuss tobacco reduction. As shared by one HCP,

> They're not abiding by it. They're still going outside. They're still smoking . . . they have to have an external body to police it if they are going to be serious about it . . . I think it's going to start with your staff. If the patients and family members see the staff outside then you think, well they're allowed and they're smoking . . . I'm going to do it, too.

While many reported the policy did make them more aware of violations and made them think twice when seeing someone smoking on the property, most HCPs discussed their uneasiness in approaching someone smoking on the property. They found approaching a smoker to be too intimidating and uncomfortable. A few did convey the policy gave them the assurance to approach a smoker, but most had not actually done so. Of the HCPs that said they would address violations, it would only be with visitors or patients, not with staff. Also a few mentioned they would address it if it was directly affecting them, for example, having to walk through smoke or sitting outside at break. Although most HCPs stated they promoted the smoke-free environment, many felt they should not be the primary people responsible for enforcing the policy as it was viewed as security's role.

If patient wants to smoke, that would be their right. While many HCPs described a heightened appreciation for smoking as an addiction, the majority still expressed apprehensions when addressing smoking behaviors due to the "rights" of their patients to smoke. Some also reported they were hesitant to be viewed as judgmental or harassing, which could interfere with the therapeutic relationship. For example,

> I feel very judgmental that as a non-smoker I am going to tell you, you should stop smoking or cut back . . . so I am very hesitant to . . . do any of that without them bringing it up first.

Other concerns expressed included "too much is going on" in their patient's life during hospitalization and some patients just "need" to smoke, as one nurse explained, "we're supposed to be taking care of patients holistically and holistically some people just need to smoke. It's not our right to force people to stop." Although many HCPs did report offering

tobacco dependence more often, these internal conflicts were still described as an influence on the motivation and comfort to bring up or discuss tobacco dependence and treatment.

Discussion

To our knowledge, this study is the first to specifically explore the perceptions, experiences, and behaviors of HCPs after the implementation of a comprehensive SFP that included tobacco dependence treatment infrastructure, no policy exclusions, or designated smoking areas in a general hospital setting. The main findings suggest a comprehensive smoke-free hospital environment can strengthen the tobacco-free workplace culture within a hospital setting among HCPs where support for tobacco reduction is amplified, patient care and interactions regarding tobacco dependence are improved, and staff morale is enhanced. While there are still some challenging barriers, as well as opportunities for improvements, the implementation of a comprehensive SFP heightened the call-to-action among HCPs to take a more active role in tobacco reduction. Using an analytical lens, this discussion pulls many of the individual themes and/or subthemes together to provide context through comparison of previous research in this area, as well as to highlight noteworthy insights gleaned from the findings to make recommendations throughout for future initiatives and studies.

The described changes in mind-set and behaviors toward tobacco reduction and tobacco dependence were woven throughout many of the themes and subthemes, such as feeling supported and empowered, sensing differences in engagement among colleagues, perceiving a consistent message throughout the organization, being more proactive and empathetic, and initiating new conversations regarding tobacco. These findings suggest a strengthened tobacco-free workplace culture developed after the implementation of the comprehensive SFP. Manley, Sanders, Cardiff, and Webster (2011) propose such examples are the manifestations of culture, reflecting values, beliefs, and assumptions. They advise the term "workplace culture" is the most immediate culture experienced by HCPs, which has the most substantial impact on everyday experiences and frontline care. It is made up of social and environmental contexts that influence how people behave, as well as accepted norms (Manley et al., 2011; Schein, 2010). This is in keeping with previous studies suggesting the way in which tobacco is routinely framed, and the related actions among colleagues influence how others view tobacco and their workplace culture (Schultz, Bottorff, & Johnson, 2006; Schultz, Hossain, & Johnson, 2009). Additional facilitators proposed by the HCPs to support this culture change included physical cues, such as less visibility of smoking on the campus, smoke-free signage, information pamphlets, and having tobacco "champions" to foster engagement. Such examples have also been shown effective in reinforcing SFPs and changing attitudes and behaviors (Fiore et al., 2007; Movsisyan, Petrosyan, Harutyunyan, Petrosyan, & Stillman, 2014; Schultz et al., 2009). It has been suggested workplace culture has a substantial impact on how clinical approaches and health care policies are implemented (Hung, Leidig, & Shelley, 2014; McCormack et al., 2002) and the achievement of clinical outcomes (Jacobs et al., 2013; McCormack et al., 2002). Tobacco-free workplace culture has also been identified as a critical success factor in building support for tobacco reduction among staff in hospital settings (Ratschen et al., 2008; Schultz, Bottorff, & Johnson, 2006). Poder, Carroll, Wallace, and Hua (2012) suggest without a strong internal workplace culture that promotes and reinforces the SFP, tobacco dependence treatment delivery will often fall short.

Along with a strengthened tobacco-free workplace culture, the descriptions by most participants of support and empowerment to promote a smoke-free environment also suggest that after the hospital went smoke-free, tobacco reduction activities and behaviors among HCPs were amplified. This included an improvement in tobacco dependence treatment delivery. In contrast, most studies have concluded tobacco dependence treatment is inconsistently offered by HCPs in hospitals settings even after implementation of SFPs (Poder et al., 2012; Ratschen et al., 2008; Schultz et al., 2011; Shopik et al., 2012; Stockings et al., 2014). Some HCPs did report hesitation to discuss tobacco dependence treatment, feeling it may affect the therapeutic relationship, infringe on their patient's "right to smoke," or be viewed as judgmental; yet, most HCPs still reported they were more likely to discuss tobacco dependence treatment as compared with pre-policy. Such reluctance has been identified as a common issue among HCPs in previous studies (Arack et al., 2009; Chapman, 2000; Ratschen et al., 2008; Shipley & Allcock, 2008), despite that, most hospitalized smokers, especially if they are in hospital due to a smoking-related disease, have been shown to be receptive to an offer of assistance with nicotine withdrawal management and smoking cessation (Balmford, Leifert, & Jaehne, 2014; Rigotti et al., 2012). One partial explanation for the encouraging difference in tobacco dependence treatment delivery seen in this study could be the new or re-discovered systematic tobacco dependence treatment systems described by participants, including full access to pharmacotherapy, screening and referral systems, and prescribing guidelines, which made it "easy" to take an active role in tobacco dependence treatment. The lack of integrated system-wide approaches and inadequate resources for tobacco dependence treatment are frequently identified as reasons tobacco dependence treatment delivery is suboptimal (Arack et al., 2009; Freund et al., 2009; Gajendra et al., 2011; Parks et al., 2009; Ratschen et al., 2008; Shopik et al., 2012). Such infrastructure has been shown to influence the integration of tobacco reduction activities (Freund et al., 2009; Schultz, Johnson, & Bottorff, 2006), enhance perceived ability to provide tobacco

dependence treatment (Schultz, Johnson, & Bottorff, 2006), and produce more favorable patient outcomes (Rigotti et al., 2012; Stockings et al., 2014). Despite the positive influence these systems can have on tobacco dependence treatment delivery for patients while in hospital, commonly reported shortfalls of these systems in continuity of care have still been identified (Chang et al., 2016; Freund et al., 2008; Freund et al., 2009; Schultz et al., 2011). This was consistent with the findings of this study, including limited follow-up and access to medications and cessation resources for discharged patients and out-patients. Although this deficit in continuity did not appear to greatly impact day-to-day adherence to the SFP in the current study, this aspect of patient care still requires more attention if hospitals want to ultimately improve their patients' overall health and reduce smoking prevalence.

While this study confirms infrastructure is a critical element for tobacco dependence treatment delivery (Fiore et al., 2007; Freund et al., 2009), it illustrates systems alone will not fully enhance tobacco dependence treatment delivery behaviors among HCPs and improve SFP success. Many participants who worked on wards that already had tobacco dependence treatment systems in place (prior to the policy) reported tobacco dependence treatment was not as "top of mind" or viewed as a priority until after the SFP was implemented. This suggests the change in environment and the associated influencers, in addition to resources and systems for tobacco dependence treatment, had an impact on tobacco dependence treatment delivery and, hence, the improvement in patient care. Similar findings have been suggested by Freund et al. (2009), where the implementation of multistrategic interventions have been shown to increase rates of both initiating discussions with patients and tobacco dependence treatment delivery by HCPs. In this study, a combination of factors, including infrastructure, could be an explanation for the reported changes in tobacco dependence treatment delivery described by participants. Another factor that appeared to contribute to the overall mind-set shift toward tobacco dependence treatment delivery was the elevated tobacco-free workplace culture previously discussed. An additional factor could include the commonly identified concern for patient safety when leaving the property to smoke (Harolds, 2015; Schultz et al., 2011; Shopik et al., 2012; Unrod et al., 2012; Wheeler et al., 2007), which was also reported by many participants as a motivator to be more prudent when it came to discussing tobacco use. Restrictions on where smoking is permitted have been shown to elevate the importance placed on managing withdrawal symptoms and enhancing conversations about tobacco, irrespective of patient's interest in quitting smoking (Scharf, Fabian, Fichter-DeSando, & Douaihy, 2011). Harolds (2015) advocates that preventing patients from leaving in the first place is the best way to ensure patient safety, which she notes could be accomplished through consistent tobacco dependence treatment delivery. Finally, many HCPs described greater empathy and understanding for nicotine addiction and the struggles their patients face when quitting or abstaining from smoking, which supports the inclination for nicotine withdrawal to be viewed as any other medical condition needing treatment to improve comfort and manage/minimize symptoms (Rigotti et al., 2000; Schultz et al., 2011). Consistent with this study, the idea of tobacco dependence being reframed from cessation to abstinence has been advised as a viable option to manage nicotine withdrawal while in hospital, improve current health conditions, reduce safety risks, and improve compliance (Rigotti et al., 2000; Shopik et al., 2012). The tendency to violate a SFP is mitigated when nicotine withdrawal is managed (Rigotti et al., 2000). The preference in this study for nicotine withdrawal management over smoking cessation counseling may have been influenced by the reported gaps in knowledge, lack of time, and conflicting priorities, all of which are also commonly cited challenges in tobacco dependence treatment delivery (Chang et al., 2016; Schultz, 2011; Schultz, Bottorff, & Johnson, 2006; Schultz, Johnson, & Bottorff, 2006). While both approaches are important in tobacco dependence treatment (CAN-ADAPTT, 2011; Fiore et al., 2008), nicotine withdrawal management is less resource intensive and does not require as much time or training to implement. This approach, however, is not as effective as a combination of medications and counseling for long-term smoke-free success (CAN-ADAPTT, 2011; Fiore et al., 2008).

Many hospitals that have considered smoke-free hospital policies have been hesitant due to concerns of potential push back from smoking employees and the impact on their staff morale (Unrod et al., 2012; Wheeler et al., 2007). However, similar to this study, noteworthy differences have been demonstrated in the expected negative impact and the actual impact of SFPs (Ratschen et al., 2008; Sheffer, Stitzer, & Wheeler, 2009; Unrod et al., 2012; Wheeler et al., 2007). Not often do hospital administrators appear to spend the same energy and concern to consider the effect of not implementing SFPs on employees that do not smoke, which is too say the majority of hospital employees (Reid et al., 2015). All participants in this study, including the three who were identified as smokers, felt their employer's actions to reduce exposure to ETS and promote a healthier environment made them feel "cared for" and valued as employees. Similar findings have shown not only improvements in overall job satisfaction but also a positive impact on job abilities and interactions with others (Unrod et al., 2012; Wheeler et al., 2007). Many employees expressed the worst part of their job pre-policy was walking through a cloud of smoke to come and go from work, which in turn created negative experiences and perceptions toward the hospital where they worked. Paradoxically, the impact of exposure to ETS for nonsmoking employees could be suggested as an even greater consideration when contemplating such policy changes.

Another consideration that is often overshadowed by potential concerns of smoking employees is the impact on staff interaction between those employees that smoke and those that do not. As demonstrated in the literature

(Gadomski, Stayton, Krupa & Jenkins, 2010; Unrod et al., 2012; Wheeler et al., 2007), smoking prevalence is often altered or reduced after such a policy is implemented. A noteworthy outcome of such change is potential improvement in staff comradery. This was expressed by a number of nonsmoking HCPs in this study, as many felt the workload was then more evenly dispersed and that there were more "hands on deck" when needed. The support offered to quit or reduce tobacco use, along with the inability to quickly pop outdoors for an unauthorized break, appeared to improve the working relationships and reduce the expressed "division" among hospital staff. Previous findings from research on SFP have been mixed in this regard, where some studies have shown improvements in staff relationships (Sheffer et al., 2009; Unrod et al., 2012), while others have shown animosity toward smoking staff (Arack et al., 2009; Ratschen et al., 2008). The smoke-free environment was also perceived by all HCPs to be a healthier place and conveyed a constructive health message, all the while projecting a very positive image for a health care institution, expressed by one HCP as "walking the walk, talking the talk." This type of unwavering leadership and consistent message have been proposed as critical success factors in implementing such changes (Luck, 2016; Ratschen et al., 2008; Wheeler et al., 2007). These perceptions and experiences in turn further supported a vibrant tobacco-free workplace culture and enhanced pride in working at this health care institution.

While tobacco reduction was embraced more often by most HCPs, many still identified that limited knowledge and inadequate resources for education and awareness led to discomfort and deficient skills in this area. These are commonly cited barriers (Chang et al., 2016; Schultz, Bottorff, & Johnson, 2006; Schultz, Johnson, & Bottorff, 2006) that can restrict tobacco reduction and tobacco dependence treatment delivery. This was particularly prominent among most of the allied HCPs interviewed. Even though all allied HCPs reported being more proactive in promoting a smoke-free environment, they felt their role in tobacco dependence treatment was unclear and somewhat limited to a "supportive" role and connecting patients to their nurse for more thorough tobacco dependence care. Logistics around patient interactions in a hospital setting, such as timing of first contact and assessment of a patient; duration and number of patient interactions; access to tobacco dependence treatment screening and treatment systems; and role expectations identified or inferred by hospital structures may have contributed to these findings. In contrast, both the joint position statement on the role of health professionals in tobacco cessation (Canadian Association of Occupational Therapists [CAOT], 2011) and the clinical practice guidelines for treating tobacco use and dependence (CAN-ADAPTT, 2011; Fiore et al., 2008) recommend every HCP has a role to play in tobacco reduction. The role may include assessing and documenting tobacco use, offering assistance to quit, providing referrals to smoking cessation resources, and using a collaborative, interprofessional approach. With so many studies identifying a need for better tobacco dependence treatment delivery (Poder et al., 2012; Ratschen et al., 2008; Schultz et al., 2011; Shopik et al., 2012), the role of allied HCPs in tobacco dependence treatment may be a missed opportunity that could further enhance patient care in a smoke-free hospital setting.

In keeping with many studies exploring smoke-free properties (Arack et al., 2009; Ratschen et al., 2008; Shipley & Allcock, 2008), the lack of enforcement was regularly identified by participants in this study as a barrier to implementing a smoke-free property. Previous study findings also concur that most hospital staff are uncomfortable to approach smokers and enforce the SFP, with some feeling this responsibility should fall on security services (Ratschen et al., 2008; Shipley & Allcock, 2008). Despite the expressed frustrations around enforcement, most participants noted their exposure to secondhand smoke had decreased remarkably, which diverges from many studies that have shown little difference in compliance after the implementation of such a policy (Arack et al., 2009; Ratschen et al., 2008; Schultz et al., 2011; Wheeler et al., 2007). Compliance is one of the primary challenges identified in the published literature on smoke-free hospital properties (Ratschen et al., 2008; Schultz et al., 2011; Shopik et al., 2012; Wheeler et al., 2007). The expectation of the property being 100% smoke-free and still seeing individuals smoking, albeit substantially less than before, may be why some participants felt so strongly about the need for better enforcement. The reluctance to approach smokers themselves and the view that it should be security's role may have also been contributing factors. In contrast, the noted improvement in compliance after policy implementation could be due to the enhanced tobacco-free culture, which supported the promotion of the policy and the surge in tobacco dependence treatment delivery/systems for patients and staff; this in turn served to minimize the need to venture outside for a cigarette. As suggested in the literature, infrastructure, enforcement, appropriate tobacco dependence resources, and workplace culture (Arack et al., 2009; Ratschen et al., 2008; Schultz et al., 2011; Shopik et al., 2012) are essential components to successful SFP implementation, as also evidenced by this study.

In the current study, there were varying views on having dedicated personnel responsible for smoking cessation counseling within the institution. Some HCPs viewed them as a welcomed resource within a busy hospital setting, while others felt it limited their role in tobacco dependence treatment delivery. It has been proposed that tobacco champions enhance engagement among other HCPs in tobacco reduction (Fiore et al., 2007; Schultz et al., 2009; Schultz, Johnson, & Bottorff, 2006), as well as create opportunities to support a team approach and systematize how tobacco use is addressed (Fiore et al., 2007). However, it did appear to limit some HCPs perceptions of their role in tobacco dependence treatment and their need to further develop knowledge or skills in

this area. As suggested by Schultz et al. (2009), perceived ability to address tobacco can be a strong predictor of tobacco reduction behaviors, highlighting the importance for expanding opportunities for training and skill development to build self-efficacy and enhance tobacco reduction throughout the health care system. In contrast to previous studies, these findings suggest dedicated personnel for smoking cessation, even though they offer great value in tobacco dependence treatment delivery, may inadvertently contradict tobacco dependence treatment delivery guidelines and position statements (CAN-ADAPTT, 2011; CAOT, 2011; Fiore et al., 2008) by creating the impression that it is someone else's role.

Limitations

Although new understandings on this topic have been gained through this exploration, these results must be reviewed in light of study limitations. Data collection was limited to one hospital and the HCPs working within this institution. As such, the findings provide valuable insights for similar hospital sites with comparable policy infrastructure and for future policy implementation; however, the findings cannot be generalized to all hospital settings or HCPs. As well, due to the low number of participants that used tobacco, these findings may not accurately represent the experiences, perceptions, and behaviors of this cohort of HCPs. However, similar to the findings found by Eby and Laschober (2014), the data collected from the few participants that used tobacco did not differ markedly from those that did not. A more balanced sample of both smokers and non-smokers and the inclusion of multiple hospital sites could add to the insights gleaned from the data and enhance our understanding in this regard. In addition, expanding the input from various HCPs would also serve to augment our current knowledge. While this study used a diverse group of participants from various health care fields, which provided breadth to the research question, logistics around patient interactions in a hospital setting may have enabled some HCPs to more thoroughly discuss tobacco dependence treatment over other providers. For example, although all HCPs reported promoting a smoke-free environment and most would discuss tobacco dependence, many allied HCPs felt they had a limited role to play. An exploration specific to allied HCPs may further identify unique facilitators and/or barriers for this subset of HCPs. Finally, the necessity for participants to share experiences and events from before policy implementation, as well as the timeframe since policy launch, was largely dependent on participant recall and recollection, potentially affecting the accuracy of details shared. As this SFP was a building block to previous tobacco reduction initiatives, some hospital units already had systems in place for tobacco dependence treatment, which could have made it difficult to weed out the new from the preexisting in some instances. Although very positive that HCPs re-discovered or increased their awareness of new, or in some cases preexisting resources available, the perception that these were part of the policy implementation may have muddied the waters when discussing how the environment had changed. Further exploring what particular aspects of this SFP enhanced the engagement and buy-in of staff regarding tobacco reduction would add to the current body of knowledge available on the successful implementation of such initiatives.

Conclusion

This exploration of perceptions, experiences, and behaviors of HCPs following the implementation of a SFP provides insights into how policy changes, when done comprehensively, can improve tobacco reduction within a hospital setting, as well as identifies existing barriers, areas for improvement, and future research. The main findings of this study suggest implementing a comprehensive SFP can empower and build capacity for tobacco reduction among HCPs through a strengthened tobacco-free workplace culture. This in turn can enhance patient care, improve staff morale, and help to address commonly identified SFP challenges, such as compliance, exposure to ETS, and negative perceptions. This study also supports the critical role SFPs play in supporting the overall decline of tobacco use and the burdens associated with smoking-attributable morbidity and mortality.

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