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

It is with great excitement that the Registered Nurses Association of Ontario (RNAO) disseminates this nursing best practice guideline to you. Evidence-based practice supports the excellence in service that nurses are committed to deliver in our day-to-day practice.

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

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

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

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

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

Doris Grinspun, RN, MScN, PhD (candidate)

Executive Director  
Registered Nurses Association of Ontario
How to Use this Document

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

Nurses, other healthcare professionals and administrators who are leading and facilitating practice changes will find this document valuable for the development of policies, procedures, protocols, educational programs, assessment and documentation tools. It is recommended that the nursing best practice guidelines be used as a resource tool. It is not necessary, nor practical to have every nurse have a copy of the entire guideline. Nurses providing direct client care will benefit from reviewing the recommendations, the evidence in support of the recommendations and the process that was used to develop the guidelines. However, it is highly recommended that practice settings/environments adapt these guidelines in formats that would be user-friendly for daily use. This guideline has some suggested formats for such local adaptation and tailoring.

Organizations wishing to use the guideline may decide to do so in a number of ways:

- Assess current nursing and healthcare practices using the recommendations in the guideline.
- Identify recommendations that will address identified needs or gaps in services.
- Systematically develop a plan to implement the recommendations using associated tools and resources.

RNAO is interested in hearing how you have implemented this guideline. Please contact us to share your story. Implementation resources will be made available through the RNAO website at [www.rnao.org/bestpractices](http://www.rnao.org/bestpractices) to assist individuals and organizations to implement best practice guidelines.
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Integrating Smoking Cessation into Daily Nursing Practice

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Stakeholders representing diverse perspectives were solicited for their feedback and the Registered Nurses Association of Ontario wishes to acknowledge the following for their contribution in reviewing this Nursing Best Practice Guideline.

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A special acknowledgment also goes to Barbara Willson, RN, MSc, and Anne Tait, RN, BScN, who served as Project Coordinators at the onset of the guideline development.
RNAO also wishes to acknowledge the Centre for Addiction and Mental Health in Toronto, Ontario for their role in pilot testing this guideline.

**Pilot Project Sites**
- Addiction Research Foundation
- Clarke Institute of Psychiatry
- Donwood Institute
- Queen Street Mental Health Centre

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

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Nursing Best Practice Guideline

Integrating Smoking Cessation into Daily Nursing Practice

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

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# Summary of Recommendations

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<tbody>
<tr>
<td><strong>Practice Recommendations</strong></td>
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<tr>
<td>1. Nurses implement minimal smoking cessation intervention using the &quot;Ask, Advise, Assist, Arrange&quot; protocol with all clients.</td>
<td>A</td>
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<tr>
<td>2. Nurses introduce intensive smoking cessation intervention (more than 10 minutes duration) when their knowledge and time enables them to engage in more intensive counselling.</td>
<td>A</td>
</tr>
<tr>
<td>3. Nurses recognize that tobacco users may relapse several times before achieving abstinence and need to re-engage clients in the smoking cessation process.</td>
<td>C</td>
</tr>
<tr>
<td>4. Nurses should be knowledgeable about community smoking cessation resources, for referral and follow-up.</td>
<td>C</td>
</tr>
<tr>
<td>5. Nurses implement smoking cessation intervention, paying particular attention to gender, ethnicity and age-related issues, and tailor strategies to the diverse needs of populations.</td>
<td>C</td>
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<tr>
<td>6. Nurses implement, wherever possible, intensive intervention with women who are pregnant and postpartum.</td>
<td>A</td>
</tr>
<tr>
<td>7. Nurses encourage smokers, as well as non-smokers, to make their homes smoke-free, to protect children, families and themselves from exposure to second-hand smoke.</td>
<td>B</td>
</tr>
<tr>
<td><strong>Education Recommendations</strong></td>
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<tr>
<td>8. All nursing programs should include content about tobacco use, associated health risks and smoking cessation interventions as core concepts in nursing curricula.</td>
<td>C</td>
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*See page 12 for details regarding “Interpretation of Evidence”*
### Organization & Policy Recommendations

9. Organizations consider smoking cessation as integral to nursing health promotion practice, and thereby integrate a variety of professional development opportunities to support nurses in effectively developing skills in smoking cessation intervention and counselling.  
**Strength of Evidence:** B

10. Nurses seek opportunities to be actively involved in advocating for effective smoking cessation services, including "stop smoking medications".  
**Strength of Evidence:** C

11. Nurses seek opportunities to be actively involved in advocating for smoke-free spaces and protection against second-hand smoke.  
**Strength of Evidence:** C

12. Nursing best practice guidelines can be successfully implemented only where there are adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes:
- An assessment of organizational readiness and barriers to education.
- Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process.
- Dedication of a qualified individual to provide the support needed for the education and implementation process.
- Ongoing opportunities for discussion and education to reinforce the importance of best practices.
- Opportunities for reflection on personal and organizational experience in implementing guidelines.

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

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Interpretation of Evidence

This RNAO guideline is a synthesis of a number of source guidelines. In order to fully inform the reader, every effort has been made to maintain the original level of evidence cited in the source document. No alterations have been made to the wording of the source documents involving recommendations based on randomized controlled trials or research studies. Where a source document has demonstrated an "expert opinion" level of evidence, wording may have been altered and the notation of RNAO Consensus Panel 2003 added.

In the guidelines reviewed, the panel assigned each recommendation a rating of A, B or C to indicate the strength of the evidence supporting the recommendation. It is important to clarify that these ratings represent the strength of the supporting research evidence to date.

**STRENGTH OF EVIDENCE A:** Requires at least two randomized controlled trials as part of the body of literature of overall quality and consistency addressing the specific recommendations.

**STRENGTH OF EVIDENCE B:** Requires availability of well conducted clinical studies, but no randomized controlled trials on the topic of recommendations.

**STRENGTH OF EVIDENCE C:** Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates absence of directly applicable studies of good quality.
Responsibility for Guideline Development

The Registered Nurses Association of Ontario (RNAO), with funding from the Ontario Ministry of Health and Long-Term Care, has embarked on a multi-year project of nursing best practice guideline development, pilot implementation, evaluation and dissemination. Integrating Smoking Cessation into Daily Nursing Practice is one of six best practice guidelines developed in the third cycle of the project. The RNAO convened a panel to develop this guideline which conducted its work independent of any bias or influence from the Ministry of Health and Long-Term Care.

Purpose and Scope

This best practice guideline is intended to provide direction to practicing nurses during daily practice in all care settings, both institutional and community. This guideline does not describe in-depth interventions for special populations such as youth, although the recommendations may also be applied to this group.

This guideline contains recommendations for all Registered Nurses (RNs) and Registered Practical Nurses (RPNs). It is acknowledged that the individual competency of nurses varies between nurses and across categories of nursing professionals, and is based on knowledge, skills, attitudes and judgment, enhanced over time by experience and education.

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

1. Practice recommendations, directed at the nurse and nursing practice.
2. Education recommendations, directed at competencies required for practice.
3. Organization and policy recommendations, directed at the organizational setting and the environment to facilitate nursing practice.
4. Evaluation and monitoring criteria.
Although this best practice guideline contains recommendations for Registered Nurses (RNs) and Registered Practical Nurses (RPNs), it is acknowledged by the development panel that promotion of smoking cessation is also effective with the involvement of healthcare providers from a range of disciplines. Thus, other healthcare providers may also use this guideline.

Rationale for a Smoking Cessation Guideline

Globally, efforts to reduce tobacco use and exposure to second-hand smoke are gaining momentum. Both the federal and provincial governments’ efforts to regulate advertising, packaging, restricting minor’s access by increasing cost of cigarettes through taxation and imposing restrictions on public exposure to second-hand smoke, are good examples. The movement to reduce tobacco use has been furthered by the knowledge of the health effects that tobacco use poses and the recognition of tobacco use as an addiction. There is also heightened public awareness about the dangers of second-hand smoke through media campaigns.

The most important elements of this guideline are that it motivates and supports all nurses to identify the smoking status of their clients and encourages them to intervene with those identified as individuals who smoke in a sensitive, non-judgmental manner about the importance of cessation.

It is suggested that if a substantial number of healthcare providers implement minimal smoking cessation interventions, there will be a significant reduction in the number of tobacco users, a decrease in related tobacco diseases and a lowering of healthcare costs.
Guiding Principles/Assumptions About Smoking Cessation

The guiding principles and assumptions that underlie this nursing best practice guideline related to smoking cessation are as follows:

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

In February of 2001, a panel of nurses and researchers with expertise in practice and research related to smoking cessation, from community and academic settings, was convened under the auspices of the RNAO. At the onset the panel discussed and came to consensus on the scope of the best practice guideline.

A search of the literature for systematic reviews, clinical practice guidelines, relevant articles and websites was conducted. See Appendix A for a detailed outline of the search strategy employed.

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

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

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

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


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

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

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

<table>
<thead>
<tr>
<th><strong>Clinical Practice Guidelines or Best Practice Guidelines</strong></th>
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<tr>
<td>Systematically developed statements (based on best available evidence) to assist practitioner and client decisions about appropriate healthcare for specific clinical (practice) circumstances (Field &amp; Lohr, 1990).</td>
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<th><strong>Consensus</strong></th>
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<td>A process for making policy decisions, not a scientific method for creating new knowledge. At its best, consensus development merely makes the best use of available information, be that of scientific data or the collective wisdom of the participants (Black et al., 1999).</td>
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<th><strong>Education Recommendations</strong></th>
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<td>Statements of educational requirements and educational approaches/strategies for the introduction, implementation and sustainability of the best practice guideline.</td>
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<td>&quot;An observation, fact or organized body of information offered to support or justify inferences or beliefs in the demonstration of some proposition or matter at issue&quot; (Madjar &amp; Walton, 2001, p.28).</td>
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<tr>
<th><strong>Meta-Analysis</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The use of statistical methods to summarize the results of independent studies, thus providing more precise estimates of the effects of healthcare than those derived from the individual studies included in a review (Clarke &amp; Oxman, 1999).</td>
</tr>
</tbody>
</table>
Organization & Policy Recommendations
Statements of conditions required for a practice setting that enable the successful implementation of the best practice guideline. The conditions for success are largely the responsibility of the organization, although they may have implications for policy at a broader government or societal level.

Practice Recommendations
Statements of best practice directed at the practice of healthcare professionals that are ideally evidence-based.

Randomized Controlled Trial
For the purposes of this guideline, a study in which subjects are assigned to conditions on the basis of chance, and where at least one of the conditions is a control or comparison condition.

Stakeholder
A stakeholder is an individual, group or organization with a vested interest in the decisions and actions of organizations who may attempt to influence decisions and actions (Baker et al., 1999). Stakeholders include all individuals or groups who will be directly or indirectly affected by the change or solution to the problem. Stakeholders can be of various types, and can be divided into opponents, supporters, and neutrals (Ontario Public Health Association, 1996).

Systematic Review
Application of a rigorous scientific approach to the preparation of a review article (National Health and Medical Research Council, 1998). Systematic reviews establish where the effects of healthcare are consistent and research results can be applied across populations, settings, and differences in treatment (e.g., dose); and where effects may vary significantly. The use of explicit, systematic methods in reviews limits bias (systematic errors) and reduces chance effects, thus providing more reliable results upon which to draw conclusions and make decisions (Clarke & Oxman, 1999).
Background Context

Facts on Tobacco Use (adapted from several sources; see Appendix C for references)

- Tobacco use is the leading preventable cause of premature death, disease and disability.
- Tobacco use increases the risk of cardiovascular disease, cancers, respiratory diseases, adverse effects in pregnancy, gastrointestinal problems and tooth and gum problems.
- More than 40,000 Canadians, aged 35 or more, are estimated to die annually as a direct result of smoking (30,000 men, 16,000 women).
- Tobacco kills over 13,000 Ontario residents each year (one-fifth of all deaths in the province), or over 35 per day, compared to 3,000 annual deaths from traffic accidents, suicides, homicide and AIDS combined.
- Every year in Ontario, tobacco-related deaths costs taxpayers between $3 and $4 billion in direct healthcare costs and $7 billion in indirect costs.
- Smoking is responsible for about one-third of potential years of life lost due to cancer, about one-quarter of potential years of life lost due to diseases of the heart and about one-half of potential years of life lost due to respiratory disease.
- 26 percent of all Ontario households report that at least one person smokes inside the home every day or almost every day.
- 80 percent of smokers who have been identified and advised to stop smoking report that they want to stop smoking (Brodish, 1998).
- Cigarettes and other forms of tobacco are addictive. Smoking is both a psychological and a physical addiction. Nicotine is one of the most highly addictive substances known.
- Second-hand smoke or environmental tobacco smoke is a toxic mixture of chemicals produced during the burning and smoking of tobacco products.
- There are approximately 4,000 chemical compounds in second-hand smoke. More than 40 of them are known to cause cancer.
- The average additional annual cost to an employer of employing a smoker has been estimated by the Conference Board of Canada to be $2,565 (Conference Board of Canada, 1997).
Benefits of Quitting Smoking
Quitting smoking is the single most effective thing that smokers can do to enhance the quality and length of their lives. For some conditions, such as ischemic heart disease, the benefits of quitting smoking are substantial, both immediately and in the long term. The risks of dying from tobacco-related diseases are reduced over time, in comparison with continuing smokers (Health Canada, 2001). The risk of smoking related disease continues to decrease as the duration of abstinence increases. (See Appendix D for a list of health benefits)

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

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

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

- About half of those who give up smoking do so as a result of a health problem or crisis.

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

- Studies have shown that tobacco is as addictive as heroin or cocaine (Royal College of Physicians of London, 2000).
How to Help People Stop Smoking

- The most important step in addressing tobacco use and dependence is screening for tobacco use and offering minimal smoking cessation intervention messages to all smokers, at every opportunity.

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

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

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

**Recommendation • 1**

Nurses implement minimal smoking cessation intervention using the "Ask, Advise, Assist, Arrange" protocol with all clients. (*Strength of Evidence = A*)

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Minimal Smoking Cessation Intervention (Lasting 1 to 3 minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASK:</strong></td>
<td>about tobacco use with all clients (e.g., non-smoker, smoker, ex-smoker) and assess readiness to quit.</td>
</tr>
<tr>
<td><strong>ADVISE:</strong></td>
<td>every tobacco user of the importance of quitting.</td>
</tr>
<tr>
<td><strong>ASSIST:</strong></td>
<td>by providing minimal intervention:</td>
</tr>
<tr>
<td></td>
<td>■ Referral to community resource;</td>
</tr>
<tr>
<td></td>
<td>■ Self-help material;</td>
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<tr>
<td></td>
<td>■ Referral to other healthcare provider; and</td>
</tr>
<tr>
<td></td>
<td>■ Smokers’ Helpline.</td>
</tr>
<tr>
<td><strong>ARRANGE:</strong></td>
<td>follow-up or referral.</td>
</tr>
</tbody>
</table>

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

Discussion of Evidence

It is essential to provide at least a minimal intervention (1 – 3 minute duration) to all tobacco users at every appropriate occasion. Brief advice from a health professional decreases the proportion of people smoking by about 2 percent per year (NHS Centre for Reviews and Dissemination-The University of York, 1998). There is good evidence that even brief advice from health professionals has a significant effect on smoking cessation rates (National Health Committee, 2002).

The literature suggests that minimal intervention may encourage a committed smoker to think about their smoking and to start to look at the disadvantages as well as the benefits. It has also been stated that for clients not ready to quit at this time, providing self-help material will increase their awareness and motivation to quit (U.S. Dept. of Health and Human Services, 2000).
All nurses have opportunities to assist clients to stop smoking through brief counselling and minimal interventions. The results indicate, with reasonable evidence, that minimal interventions can be effective as the nurses provide clients with the potential benefits of smoking cessation and counselling (Rice & Stead, 2003).

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

**Recommendation • 2**

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

*(Strength of Evidence = A)*

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

**Every nurse will:**

**ASK:** about tobacco use with all clients (e.g., non-smoker, smoker, ex-smoker) and assess readiness to quit.

**ADVISE:** every tobacco user of the importance of quitting.

**ASSIST:** by providing intensive intervention:

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

**ARRANGE:** follow-up or referral.

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

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

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

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

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

Pharmacotherapy Options

Before recommending over the counter (OTC) drugs, nurses must have the knowledge, skill and judgment about the client's situation, their condition and medication profile and the medication (College of Nurses of Ontario, 2003). Pharmacological therapy should be recommended to all clients except in the presence of special circumstances or in cases of contraindications (Orsetti, Dwyer,
In special circumstances or in cases of contraindications, nurses must work in collaboration with the client’s physician to determine the appropriate treatment for the client. For these types of situations, a medical note must be obtained before initiating any pharmacological therapy.

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

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

**Nicotine Replacement Therapy (NRT)**

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

1. **Nicotine patch** (e.g., Habitrol®, Nicoderm®)
   - Can be purchased over the counter (no prescription needed).
   - Three strengths are available (7 mg., 14 mg. and 21 mg.).
   - The patch provides a rate controlled delivery of nicotine that is absorbed through the skin.

2. **Nicotine gum** (e.g., Nicorette®, Nicorette® Plus)
   - Can be purchased over the counter (no prescription needed).
   - Two strengths are available (2 mg. and 4 mg.).
   - The gum provides gratification for oral needs and nicotine cravings.

There is evidence that combining the nicotine patch with nicotine gum (or nasal spray) increases the long-term abstinence rates over those produced by a single form of NRT (Centres for Disease Control and Prevention, 1999). Bupropion SR can be used in combination with nicotine replacement therapies (U.S. Department of Health and Human Services Public Health Service, 2000).

3. **Nicotine inhaler**
   - Available in some locations by prescription, 10 mg. strength.

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

**Bupropion HCL (Zyban®)**

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

**Other Options:**

- **Clonidine** and **Nortriptyline** are second-line prescription medications used in smoking cessation. These are pharmacotherapies for which there is evidence of efficacy for treating tobacco dependence, but which have a more limited role than first-line medications.
For a comparison and explanation of the medications used in smoking cessation treatment, see Appendix K.

Non-Pharmacological Interventions
There are numerous options to assist an individual smoker who is planning to stop smoking:
- Self-help books and materials;
- Individual counselling (e.g., physicians, nurses/nurse practitioners, pharmacists, dentists);
- Group programs; and
- Mutual aid and self-help group support.

While acupuncture and hypnotherapy are popular, there is insufficient evidence to support their effectiveness (Joanna Briggs Institute, 2001). However, if the individual has faith in acupuncture or hypnotherapy, they may benefit from the counselling that these approaches offer (U.S. Dept. of Health and Human Services, 2000; University of Toronto, 2000).

**Recommendation • 3**
Nurses recognize that tobacco users may relapse several times before achieving abstinence and need to re-engage clients in the smoking cessation process.

*(Strength of Evidence = C - RNAO Consensus Panel, 2003)*

Discussion of Evidence
Most relapse occurs within the first 3 months after quitting, therefore relapse prevention is especially important during this period. Strategies designed to prevent relapse should be included in the initial preparation for a quit attempt. It is important to encourage clients to report difficulties (lapses, depression, side effects) promptly while continuing their efforts to quit (U.S. Dept. of Health and Human Services, 2000).

A greater emphasis on the importance of follow-up care and offering of additional training in relapse prevention may improve long-term quit rates. More clients may achieve abstinence if offered alternative counselling options, other than proactive telephone counselling (e.g., face to face counselling or group therapy) (Katz et al., 2002).
Relapse is perfectly normal and does not mean that a smoker has failed. Researchers have found that the more past attempts to stop smoking a person has made, the more likely they will be to successfully stop in the future. All experiences learned in previous attempts are useful and can be built on for a future successful attempt (Royal College of Nurses, 1999). Even after withdrawal symptoms pass, the risk of relapse continues to be high, largely due to exposure to temptations, social situations and other smoking triggers. All attempts to quit should be congratulated. Never condemn the smoker for lapsing. Encourage smokers to take time to plan for their next stop smoke attempt and to use the information learned from the last one (University of Toronto, 2000). For “Strategies to Avoid Relapse”, see Appendix L.

**Recommendation • 4**
Nurses should be knowledgeable about community smoking cessation resources, for referral and follow-up. *(Strength of Evidence = C - RNAO Consensus Panel, 2003)*

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

The following are examples of community resources *(for a complete listing, see Appendix M):*
- The Canadian Cancer Society Smokers’ Helpline number is 1-877-513-5333 for Ontarians.
- Local smoking cessation programs (inquire via local Public Health Unit).
- Employee Assistance Programs, accessible through an individual’s employer, is another avenue for referral.
- Physicians and other healthcare providers.
Recommendation • 5
Nurses implement smoking cessation intervention, paying particular attention to gender, ethnicity and age-related issues, and tailor strategies to the diverse needs of populations. *(Strength of Evidence = C – RNAO Consensus Panel, 2003)*

Discussion of Evidence
There is substantial evidence in the literature citing the long-term benefits of "targeting" smoking cessation interventions at different populations (e.g., youth, women, older adults, ethnic groups). The Royal College of Nursing (1999), states that nurses are in unique position, and have access to the population at all levels, citing several examples of successful implementation of smoking cessation programs with different target groups. The RNAO guideline development panel supports this concept of tailoring strategies where possible, during the implementation of minimal intervention. Nursing intervention reinforces or compliments advice from physicians and/or other health providers, and is likely to be an important component in helping smokers to quit *(Rice, 1999)*.

Recommendation • 6
Nurses implement, wherever possible, intensive intervention with women who are pregnant and postpartum. *(Strength of Evidence = A)*

Discussion of Evidence
Pregnancy, and the period preceding and following, provides a unique opportunity to help women stop smoking. Many women are motivated to quit smoking during pregnancy and healthcare professionals can take advantage of this motivation by reinforcing the knowledge that cessation will reduce health risks to the fetus and that there are postpartum benefits to both the mother and the child. Women who stop smoking before or during the first trimester of pregnancy reduce risks to their baby to a level comparable to that of women who have never smoked *(National Health Committee, 2002)*. Self-help manuals, particularly material specifically directed to pregnancy, are more effective in this population than in other groups *(National Health Committee, 1999a)*.
There are many helpful resource agencies, websites and help lines that the consumer can access to increase their knowledge base about smoking cessation. *(For a list of a number of such resources, see Appendix M).* However, programs are still needed to raise awareness and motivate behavioural change among pregnant women and their partners, to reduce the harmful effects of prenatal and postnatal exposure to tobacco smoke *(Ontario Tobacco Research Unit, 2000b).*

According to the National Health Committee (2002), "NRT should be considered when a pregnant/lactating woman is unable to quit, and when the likelihood of quitting, with its potential benefits, outweighs the risks of NRT and potential continued smoking" (p. 22). A nurse can then recommend NRT to the client and suggest that the pregnant woman discuss this option with the healthcare provider who is monitoring her pregnancy.

**Recommendation • 7**

Nurses encourage smokers, as well as non-smokers, to make their homes smoke-free, to protect children, families and themselves from exposure to second-hand smoke.

*(Strength of Evidence = B)*

**Discussion of Evidence**

All involuntary exposure to tobacco smoke is harmful and should be eliminated *(Ontario Tobacco Research Unit, 2000a).* Exposure to environmental tobacco smoke causes increased risks of several illnesses in children and may increase the risk of death from sudden infant death syndrome (SIDS). Exposure of non-smoking women to environmental tobacco smoke during pregnancy also causes reductions in fetal growth *(Ontario Tobacco Research Unit, 2000a).* Children do not choose this exposure. Their right to grow up in an environment free from tobacco smoke must be safeguarded through actions by national and local governments, voluntary bodies, community leaders, health workers, educators and parents *(Ontario Tobacco Research Unit, 2000a).*
Education Recommendations

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

Recommendation • 8
All nursing programs should include content about tobacco use, associated health risks and smoking cessation interventions as core concepts in nursing curricula.
(Strength of Evidence = C- RNAO Consensus Panel, 2003)

Discussion of Evidence:
Several sources, including the U.S. Department of Health and Human Services (2000), widely support the inclusion of education and training in tobacco dependence treatments in the required curricula of all clinical disciplines. The RNAO guideline development panel also supports this need for educational programs at all levels of nursing.
Organization & Policy Recommendations

Recommendation • 9
Organizations consider smoking cessation as integral to nursing health promotion practice, and thereby integrate a variety of professional development opportunities to support nurses in effectively developing skills in smoking cessation intervention and counselling. 

(Strength of Evidence = B)

Discussion of Evidence
Educational development in the area of smoking cessation, for nurses in all specializations and practice settings, is needed to provide additional background knowledge and expertise in the practice of smoking cessation interventions. Specifically, organizations must provide professional development opportunities for nurses that are tailored to individual and group learning styles. Nurses are responsible for pursuing professional opportunities. Health professionals who receive training are much more likely to intervene with smokers than those who are not trained (University of Toronto, 2000).

Education, resources, and feedback should be provided to promote provider intervention. The healthcare system should ensure the following:
1. Nurses have sufficient training to treat tobacco dependence.
2. Healthcare providers and clients have cessation resources.
3. Healthcare providers are given feedback about their tobacco dependence treatment practices (U.S. Dept. of Health and Human Services, 2000).
Recommendation • 10
Nurses seek opportunities to be actively involved in advocating for effective smoking cessation services, including "stop smoking medications".

(Strength of Evidence = C - RNAO Consensus Panel, 2003)

Discussion of Evidence
Suggested advocacy roles for nurses can include:

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

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

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

Recommendation • 11
Nurses seek opportunities to be actively involved in advocating for smoke-free spaces and protection against second-hand smoke.

(Strength of Evidence = C - RNAO Consensus Panel, 2003)

Discussion of Evidence
Smoke-free workplaces are associated with a decrease in prevalence of tobacco consumption of nearly 4 percent (Fichtenberg & Glantz, 2002). Smoke-free workplaces also make it easier for smokers to reduce or stop smoking, and substantially reduce tobacco industry sales (Fichtenberg & Glantz, 2002).

Nurses can help by:

- Promoting smoke-free environments, and encouraging nurses to set an example by being smoke-free.

- Advocating for change in local "smoke-free public places" by-laws.
Recommendation • 12

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

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

In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the _“Toolkit: Implementation of clinical practice guidelines”_, based on available evidence, theoretical perspectives and consensus. The RNAO strongly recommends the use of this Toolkit for guiding the implementation of the best practice guideline on "Integrating Smoking Cessation into Daily Nursing Practice". (_Strength of Evidence = C_)

For a description of the Toolkit, see Appendix N.

Evaluation & Monitoring

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

Organizations implementing the recommendations in this nursing best practice guideline are advised to consider how the implementation and its impact will be monitored and evaluated. The following table, based on the framework outlined in the RNAO Toolkit: Implementation of clinical practice guideline (2002), illustrates some suggested indicators for monitoring and evaluation.
Examples of evaluation tools that were used to collect data during the pilot implementation can be found at the RNAO website (www.rnao.org/bestpractices).

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Process</th>
<th>Outcome</th>
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<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td>• To evaluate changes in practice that lead towards integration of minimal and intensive smoking cessation interventions.</td>
<td>• To evaluate the impact of implementing the recommendations.</td>
</tr>
<tr>
<td><strong>Organization/Unit</strong></td>
<td>• Review of best practice recommendations by organizational committee(s) responsible for policies or procedures e.g., list of referral sources for smoking cessation.</td>
<td>• Smoke-free environment.</td>
</tr>
<tr>
<td></td>
<td>• Availability of client education resources that are consistent with the guideline recommendations.</td>
<td>• Incorporation of smoking cessation intervention education in staff orientation program.</td>
</tr>
<tr>
<td></td>
<td>• Organizational mission statement that supports a smoke-free environment.</td>
<td>• Incorporation of smoking cessation intervention in client information material.</td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td>• Nurses' self-assessed knowledge of the importance of:</td>
<td>• Percentage of smokers indicating they were advised to quit smoking by one or more nurses and/or other healthcare professionals during their most recent contact as indicated in chart audits.</td>
</tr>
<tr>
<td></td>
<td>• Assessing and implementing minimal or intensive smoking cessation interventions using the Ask, Advise, Assist and Arrange protocol.</td>
<td>• Percentage of nurses and/or other healthcare professionals referring clients for follow-up to community smoking cessation programs.</td>
</tr>
<tr>
<td></td>
<td>• Documenting the smoking cessation interventions provided to clients.</td>
<td>• Percentage of clients admitted to unit/facility with their smoking status and smoking history recorded.</td>
</tr>
<tr>
<td></td>
<td>• Understanding the various stages of readiness to quit smoking.</td>
<td>• Percentage of clients admitted to unit/facility with their smoking status and smoking history recorded.</td>
</tr>
<tr>
<td></td>
<td>• Percent of nurses self-reporting:</td>
<td>• Percentage of clients who were advised to quit smoking by one or more nurses and/or other healthcare professionals during their most recent contact as indicated in chart audits.</td>
</tr>
<tr>
<td></td>
<td>• Adequate assessment of a client's desire to be an active partner in the smoking cessation process.</td>
<td>• Percentage of smokers indicating they were advised to quit smoking by one or more nurses and/or other healthcare professionals during their most recent contact as indicated in chart audits.</td>
</tr>
<tr>
<td></td>
<td>• Adequate knowledge of community referral sources for smoking cessation.</td>
<td>• Percentage of clients admitted to unit/facility with their smoking status and smoking history recorded.</td>
</tr>
<tr>
<td><strong>Client</strong></td>
<td>• Total percentage of smokers.</td>
<td>• Percentage of clients who set quit date.</td>
</tr>
<tr>
<td></td>
<td>• Provision of adequate financial resources for the level of staffing necessary to implement minimal and intensive smoking cessation interventions.</td>
<td>• Percentage of clients who made quit attempts 2 weeks post-cessation counselling.</td>
</tr>
<tr>
<td><strong>Financial costs</strong></td>
<td>• Cost for education, other interventions and supports.</td>
<td>• Percentage of clients who successfully quit smoking 8 weeks or 2 months post-cessation counselling.</td>
</tr>
<tr>
<td></td>
<td>• Cost related to implementing the guideline:</td>
<td>• Overall resource utilization (identify organizational specifics, new staff hires, medications, etc.)</td>
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<tr>
<td></td>
<td>• Education and access to on the job supports.</td>
<td>• Overall resource utilization (identify organizational specifics, new staff hires, medications, etc.)</td>
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<tr>
<td></td>
<td>• New documentation systems.</td>
<td>• Overall resource utilization (identify organizational specifics, new staff hires, medications, etc.)</td>
</tr>
<tr>
<td></td>
<td>• Support systems.</td>
<td>• Overall resource utilization (identify organizational specifics, new staff hires, medications, etc.)</td>
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</tbody>
</table>
Implementation Tips

This best practice guideline was pilot tested in four clinical settings within one organization. The lessons learned/results of the pilot may be unique to the organization and not generalizable to a public health, community care or general hospital setting. However, there were many strategies that the pilot site found helpful during the implementation, and those who are interested in implementing this guideline may consider these strategies or implementation tips. A summary of these strategies follows:

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

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

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

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

- Organizational support, such as having the structures in place to facilitate the implementation. For examples, hiring of replacement staff so participants would not be distracted by concerns about work and having an organizational philosophy that reflects the value of best practices through policies and procedures and documentation tools.
Teamwork and collaboration through interdisciplinary work is beneficial in helping clients quit smoking. It is essential to be cognizant of the smoking cessation programs and to tap the resources that are available in the community. An example would be linking and developing partnerships with nicotine addiction clinics for referral process. The RNAO’s Advanced Clinical/Practice Fellowship (ACPF) Project is another resource that registered nurses may apply for a fellowship and have an opportunity to work with a mentor who has expertise in smoking cessation programs. With the ACPF, the nurse fellow will also have the opportunity to learn more about new resources.

In addition to the tips mentioned above, the RNAO has developed resources that are available on the website. A toolkit for implementing guidelines can be helpful if used appropriately. A brief description about this toolkit can be found in Appendix N. A full version of the document in pdf file is also available at the RNAO website, www.rnao.org/bestpractices.

An e-learning module on smoking cessation has also been developed by the RNAO. The e-learning module can be used in conjunction with other teaching/learning modalities and it is available at www.rnao.org/smokingcessation.

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

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

The Registered Nurses Association of Ontario proposes to update the Best Practice Guidelines as follows:

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

2. During the three-year period between development and revision, RNAO Nursing Best Practice Guideline project staff will regularly monitor for new systematic reviews, meta-analysis and randomized controlled trials (RCT) in the field.

3. Based on the results of the monitor, project staff may recommend an earlier revision period. Appropriate consultation with a team of members, comprising of original panel members and other specialists in the field, will help inform the decision to review and revise the best practice guideline earlier than the three year milestone.

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

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


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


Health Canada (1997b). *Helping pregnant and postpartum women and their families to quit or reduce smoking*. Ottawa: Minister of Public Works and Government Services Canada.


Integrating Smoking Cessation into Daily Nursing Practice


Bibliography


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


Integrating Smoking Cessation into Daily Nursing Practice


Appendix A: Search Strategy for Existing Evidence

STEP 1 – Database Search
An initial database search for existing guidelines was conducted in early 2001 by a company that specializes in searches of the literature for health related organizations, researchers and consultants. A subsequent search of the MEDLINE, CINAHL and Embase databases, for articles published from January 1, 1995 to February 28, 2001, was conducted using the following search terms and key words: "smoking cessation", "smoking addiction(s)", "relapse", "practice guidelines", "practice guideline", "clinical practice guideline", "clinical practice guidelines", "standards", "consensus statement(s)", "consensus", "evidence based guidelines" and "best practice guidelines". In addition, a search of the Cochrane Library database for systematic reviews was conducted using the above search terms.

STEP 2 – Internet Search
A metacrawler search engine (metacrawler.com), plus other available information provided by the project team, was used to create a list of 42 websites known for publishing or storing clinical practice guidelines. The following sites were searched in early 2001.

Agency for Healthcare Research and Quality: www.ahrq.gov
American Medical Association: http://www.ama-assn.org/
Best Practice Network: www.best4health.org
Canadian Centre for Health Evidence: www.cche.net
Canadian Institute for Health Information (CIHI): www.cihi.ca/index.html
Canadian Medical Association Guideline Infobase: www.cma.ca/eng-index.htm
Canadian Task Force on Preventative Healthcare: www.ctfphc.org/
Cancer Care Ontario: www.cancercare.on.ca
Centre for Clinical Effectiveness – Monash University, Australia: http://www.med.monash.edu.au/publichealth/cce/evidence/
Centre for Disease Control and Prevention: www.cdc.gov
Centre for Evidence-Based Child Health: http://www.ich.bpmf.ac.uk/ebm/ebm.htm
Centre for Evidence-Based Medicine: http://cebm.jr2.ox.ac.uk/
Centre for Evidence-Based Mental Health: http://www.psychiatry.ox.ac.uk/cebmh/
Centre for Evidence-Based Nursing: www.york.ac.uk/depts/hstd/centres/evidence/ev-intro.htm
Centre for Health Services Research: www.nci.ac.uk/chsr/publicn/tools/
Core Library for Evidenced-Based Practice: http://www.shef.ac.uk/~scharr/core.html
CREST: http://www.n-i.nhs.uk/crest/index.htm
Evidence-Based Nursing: http://www.bmj.com/data/ebn.htm
Health Canada: www.hc-sc.gc.ca
Institute for Clinical Evaluative Sciences (ICES): www.ices.on.ca/
Institute for Clinical Systems Improvement (ICSI): www.icsi.org
Journal of Evidence-Base Medicine: http://www.bmj.com/data/ebm.htm
McMaster University EBM site: http://hiru.hirunet.mcmaster.ca/ebm
McMaster Evidence-Based Practice Centre: http://hiru.mcmaster.ca/epc/
Medscape Women’s Health: www.medscape.com/Home/Topics/WomensHealth/directories/dir-WH.PracticeGuide.html
Netting the Evidence: A ScHARR Introduction to Evidence-Based Practice on the Internet: www.shef.ac.uk/uni/academic/
Primary Care Clinical Practice Guideline: http://medicine.ucsf.edu/resources/guidelines/
Royal College of Nursing (RCN): www.rcn.org.uk
The Royal College of General Practitioners: http://www.rcgp.org.uk/Sitelis3.asp
Scottish Intercollegiate Guidelines Network: www.show.scot.nhs.uk/sign/home.htm
TRIP Database: www.tripdatabase.com/publications.cfm
Turning Research into Practice: http://www.qwent.nhs.gov.uk/trip/
University of California: www.library.ucla.edu/libraries/biomed/cdd/clinprac.htm
www.ish.ox.au/guidelines/index.html

One individual searched each of these sites. The presence or absence of guidelines was noted for each site searched – at times it was indicated that the website did not house a guideline, but re-directed to another website or source for guideline retrieval. A full version of the document was retrieved for all guidelines.
STEP 3 – Hand Search/Panel Contributions
Panel members were asked to review personal archives to identify guidelines not previously found through the above search strategy. In a rare instance, a guideline was identified by panel members and not found through the database or internet search. These were guidelines that were developed by local groups and had not been published to date.

STEP 4 – Core Screening Criteria
The search method described above revealed fourteen guidelines, several systematic reviews and numerous articles related to smoking cessation. The final step in determining whether the clinical practice guideline would be critically appraised was to apply the following criteria:
1. Guideline was in English.
2. Guideline was dated no earlier than 1996.
3. Guideline was strictly about the topic area.
4. Guideline was evidence-based (e.g., contained references, description of evidence, sources of evidence).
5. Guideline was available and accessible for retrieval.

Eight guidelines were deemed suitable for critical review using the Cluzeau et al. (1997) Appraisal Instrument for Clinical Guidelines.
RESULTS OF THE SEARCH STRATEGY
The results from the search strategy and the initial screening process resulted in the critical appraisal outcome as itemized below.

<table>
<thead>
<tr>
<th>TITLE OF THE PRACTICE GUIDELINES CRITICALLY APPRAISED</th>
</tr>
</thead>
</table>
**Appendix B: Glossary of Terms**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acupuncture</strong></td>
<td>A treatment involving the placement of needles in specific areas of the body, in this instance with the intent to promote abstinence from tobacco use.</td>
</tr>
<tr>
<td><strong>Bupropion HCl (bupropion sustained-release) (Zyban®)</strong></td>
<td>A non-nicotine aid to smoking cessation originally developed and marketed as an antidepressant. It is chemically unrelated to tricyclics, tetracyclics, selective serotonin re-uptake inhibitors and other known antidepressant medications. Its mechanism of action is presumed to be mediated through its capacity to block the re-uptake of dopamine and norepinephrine centrally.</td>
</tr>
<tr>
<td><strong>Clonidine</strong></td>
<td>An alpha-2-adrenergic agonist typically used as an anti-hypertensive medication, but also documented in this guideline as an effective medication for smoking cessation. The U.S. Food and Drug Administration (FDA) has not approved clonidine as a smoking cessation aid.</td>
</tr>
<tr>
<td><strong>Continuous abstinence</strong></td>
<td>A measure of tobacco abstinence based on whether subjects are continuously abstinent from smoking/tobacco use from their quit day to a designated outcome point (e.g., end of treatment, 6 months after the quit day).</td>
</tr>
<tr>
<td><strong>Cotinine</strong></td>
<td>Cotinine is nicotine's major metabolite, which has a significantly longer half-life than nicotine. This is often used to estimate a client's tobacco/nicotine self-administration prior to quitting, and to confirm abstinence self-reports during follow up. Cotinine can be measured in urine, saliva or blood.</td>
</tr>
<tr>
<td><strong>Diazepam</strong></td>
<td>A benzodiazepine anxiolytic medication intended to reduce anxiety.</td>
</tr>
<tr>
<td><strong>Environmental tobacco smoke (ETS)</strong></td>
<td>Also known as “second-hand smoke.” The smoke inhaled by an individual not actively engaged in smoking, but due to exposure to ambient tobacco smoke.</td>
</tr>
<tr>
<td><strong>First-line pharmacotherapy for tobacco dependence</strong></td>
<td>First-line pharmacotherapies have been found to be safe and effective for tobacco dependence treatment and have been approved by the FDA for this use. First-line medications have an established empirical record of efficacy, and should be considered first as part of tobacco dependence treatment, except in cases of contraindications.</td>
</tr>
</tbody>
</table>
**Hotline/help-line:** See telephone hotline/help-line.

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

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

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

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

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

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

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

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

**Point prevalence:** A measure of tobacco abstinence based on smoking/tobacco use occurrence within a set time period (usually 7 days) prior to a follow-up assessment.
### Practical counselling (problem solving/skills training):  
Refers to a tobacco use treatment, in which tobacco users are trained to identify and cope with events or problems that increase the likelihood of their tobacco use. For example, quitters might be trained to anticipate stressful events and to use coping skills such as distraction or deep breathing to cope with an urge to smoke. Related and similar interventions are coping skills training, relapse prevention and stress management.

### Proactive telephone counselling:  
Treatment initiated by a healthcare provider who telephones and counsels the client over the telephone.

### Psychosocial interventions:  
Refers to intervention strategies that are designed to increase tobacco abstinence rates due to psychological or social support mechanisms. These interventions comprise such treatment strategies as counselling, self-help and behavioural treatment and contingency contracting.

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

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

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

### Second-line pharmacotherapy for tobacco dependence:  
Second-line medications are pharmacotherapies for which there is evidence of efficacy for treating tobacco dependence, but they have a more limited role than first-line medications. Second-line treatments should be considered for use on a case-by-case basis, after first-line treatments have been used or considered.
**Self-help:** An intervention strategy in which the client uses a non-pharmacologic physical aid to achieve abstinence from tobacco. Self-help strategies typically involve little contact with a healthcare provider, although some strategies (e.g., hotline/help-line) involve client-initiated contact. Examples of types of self-help materials include: pamphlets, booklets, mailings, manuals, videos, audio tapes, referrals to 12-step programs, mass media community-level interventions, list of community programs, reactive telephone hotlines/help-lines and computer programs/internet resources.

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

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

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

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

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

Tobacco use increases the risk of:
1. Cardiovascular disease
2. Cancers
3. Respiratory diseases
4. Adverse effects in pregnancy
5. Gastrointestinal problems
6. Tooth and gum problems

1. Cardiovascular disease:
   - Smoking is a dominant cause of heart disease, stroke and diseases of the blood vessels.
   - Each year in Canada, more than 17,600 cardiovascular deaths result from smoking.
   - Each year in Canada, more than 2,000 deaths from stroke result from smoking.
   - Many of these deaths occur prematurely, before the age of 70.
   - The incidence of coronary heart disease (CHD) is 2 to 4 times greater in smokers.
   - Health Canada estimates that at least 700 non-smokers will die each year of coronary heart disease caused by exposure to second-hand smoke.
   - Smoking is a major risk factor for heart attacks and sudden cardiac death.
   - Smoking acts synergistically with other risk factors (high cholesterol and blood pressure) to increase the risk of CHD.
   - Smoking increases the risk of recurrence in persons who have survived a heart attack.
   - Smoking increases the risk of stroke in women more so than men.
   - Quitting smoking substantially reduces the risk of CHD and stroke.
2. Cancers:
- Smoking is responsible for more than 21,000 deaths (based on Canadian Cancer Society data) from cancer each year, almost 30 percent of all cancer deaths. The risk of developing cancer increases with duration of smoking, number of cigarettes smoked per day and degree of inhalation. The risk of lung cancer is significantly reduced with smoking cessation in comparison to those individuals who continue to smoke.
- Smoking causes cancer of the lung, oral cavity, pharynx, esophagus, pancreas, kidney and urinary bladder.
- Recent evidence links smoking with cancer of the large intestine and some forms of leukemia. Tobacco causes 80 to 85 percent of all lung cancers and 30 percent of the total cancer burden.
- Smokeless tobacco is a major cause of cancer of the mouth.
- Cigarette smoking is estimated to account for about 30 to 40 percent of bladder cancers.
- Since 1993, lung cancer exceeded breast cancer as the leading cause of cancer deaths in Canadian women.

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

- Evidence of the link between smoking and problems in pregnancy has been accumulating for more than 40 years.
- Women who smoke during pregnancy risk complications including:
  - Bleeding during pregnancy;
  - Low birth-weight newborn (less than 2500 grams);
  - Miscarriage;
  - Premature delivery;
  - Stillbirth; and
  - Abnormalities of the placenta.
- Babies receive nicotine and carbon monoxide from their mother’s blood.
- Smoking probably contributes to Sudden Infant Death Syndrome (SIDS).
- Nicotine and other chemical components of cigarette smoke are found in the breast milk of nursing mothers who smoke or are exposed to environmental tobacco smoke (ETS).
- Smoking appears to decrease the quantity of breast milk which, combined with the effects on the quality of breast milk, may lead to early weaning.

5. Gastrointestinal problems:

- Peptic ulcer disease is more likely to occur in smokers than non-smokers.
- When ulcers are present, they heal less readily in smokers and are likely to recur.
- Smoking increases the risk of death from ulcers.
- Smoking is a risk factor for Chronic Bowel Disease and Crohn’s Disease.

6. Tooth and gum problems:

- Smoking causes oral cancer.
- Smokers are more likely than non-smokers to lose their natural teeth, to have remaining teeth with decayed and filled root surfaces, and to have significant gum loss (periodontal disease).
**Additional Hazards for Women:**
- Smoking is a risk for cancer of the cervix.
- Natural menopause occurs earlier.
- Smoking increases the risk of menstrual disorders.
- Fertility may be impaired in women who smoke.
- Smoking, and the use of oral contraceptives, greatly increases the risk of strokes, heart attacks and other vascular complications.

**Additional Hazards of Second-hand Smoke Exposure:**
- Exposure to second-hand smoke causes the following diseases and conditions:
  - In adults:
    - Heart disease.
    - Lung cancer.
    - Nasal sinus cancer.
  - In children:
    - Sudden Infant Death Syndrome.
    - Fetal growth impairment including low birth-weight and small for gestational age.
    - Bronchitis, pneumonia and other lower respiratory tract infections.
    - Asthma exacerbation.
    - Middle ear disease.
    - Respiratory symptoms.
Exposure to second-hand smoke has also been linked to other adverse health effects, although the relationships may be causal. These include:

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

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

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

Reference


**Appendix D: The Benefits of Quitting Smoking**

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Benefits</th>
</tr>
</thead>
</table>
| Within 20 minutes of last cigarette: | - Blood pressure may drop to normal level.  
- Pulse rate drops to normal rate.  
- Body temperature of hands, feet increases to normal. |
| Within 8 Hours: | - Carbon monoxide level in blood drops.  
- Oxygen level in blood increases. |
| Within 24 Hours: | - May reduce chance of heart attack. |
| Within 48 Hours: | - Nerve endings may regrow.  
- Ability to smell and taste enhanced. |
| Within 72 Hours: | - Bronchial tubes relax; if undamaged, will make breathing easier.  
- Lung capacity increases. |
| 2 Weeks to 3 Months: | - Circulation improves.  
- Walking becomes easier.  
- Lung function may increase up to 20 percent. |
| 1 Month to 9 Months: | - Coughing, sinus congestion, fatigue, shortness of breath may decrease markedly over a number of weeks.  
- Potential for cilia to regrow in lungs, increasing ability to handle mucus, clean the lungs, and reduce infection. |
| 1 Year: | - The risk of heart disease is reduced by half. After 15 years, the risk is similar to that of persons who have never smoked. |
| 2 Years: | - Cervical cancer risk reduced compared to continuing smokers.  
- Bladder cancer risk halved compared to continuing smokers. |
| 5 Years: | - Lung cancer death rate for average smoker (one pack a day) decreases from 137 per 100,000 to 72 per 100,000.  
- 5 to 15 years after quitting, stroke risk is reduced to that of someone who has never smoked. |
| 10 Years and Longer: | - Precancerous cells are replaced.  
- Risk of other cancers – such as those of the mouth, larynx, esophagus, bladder, kidney and pancreas decrease (there are 60 chemicals in tobacco smoke that cause cancer).  
- After long-term quitting the risk of death from Chronic Obstructive Pulmonary Disease is reduced compared to someone who continues to smoke. |

Time periods mentioned are to be taken as a general measure only and will naturally vary from individual to individual and are dependent upon length of habit and amount of cigarettes smoked. 


Originally adapted from: 
## Appendix E: Stages of Change Model

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

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

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

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

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

**What to do**
- **ASK** about the pros and cons of both continuing to smoke and quitting (decision balance).
- Acknowledge ambivalent feelings.
- **ASSIST** by reinforcing their reasons for change, and exploring new ones.
- Suggest they cut back or stop for a day.
- **ASSIST** by offering a future visit and information.
**Preparation**
- Getting ready to stop within the next 30 days.
- Have set stop smoking date.
- Have made a 24 hour quit attempt in the last 12 months.

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

**What to do**
- ASK about concerns, preparations and lessons learned from previous attempts.
- ADVISE by identifying barriers to stopping and elicit solutions.
- ASSIST by Booklet, Action Plan, Nicotine Replacement, Date for quitting (BAND).

**Action**
- Have quit smoking within past 6 months and are actively applying cessation skills.

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

**What To Do**
- ASK how the client is doing: relapses, temptations, successes, NRT use.
- ADVISE re: relapse prevention, weight gain, triggers.
- ASSIST by focusing on successes, encourage self rewards and increase support, elicit solutions for problems.
## Maintenance
- Quit for more than 6 months.
- Integrating smoke-free living into their routine.

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

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

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

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

Reference:


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

Question: Have you quit smoking cigarettes? Check one:

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

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Appendix G:
Ask, Advise, Assist, Arrange Protocol

**ASK**

“Do you smoke (use tobacco)?”  Yes  ❑  No  ❑

Non-Smoker ❑  Smoker ❑  Ex-Smoker (greater than 6 months) ❑  Quit Date __________

**ADVISE**

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

**ASSIST**

**Minimal Intervention**
- Referral to community resource.
- Self-help material.
- Referral to other healthcare provider.
- Smokers’ Helpline (1-877-513-5333).

**Intensive Intervention**
- Determine & discuss the stage of change.
- Reasons for smoking (WHY Test).
- Nicotine Dependence (Fagerstrom Test).
- Offer information re: pharmacotherapy options.
- Set a quit date.
- Review quitting history.
- Review potential challenges and triggers.
- Encourage support of family and friends.

**ARRANGE**

Follow-up
or refer client to smoking cessation program.

References:


Appendix H: The WHY Test

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

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

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

SCORECARD

Write the number you put beside each letter in The WHY Test beside the same letter on the scorecard.

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

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

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

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

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

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

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

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

**Appendix I – Fagerstrom Test for Nicotine Dependence (Revised Version)**

The following test is designed to help you determine the strength of your nicotine addiction. Circle the appropriate score for each question. Total the number of points to arrive at your score. The highest possible score is 11.

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

---

*RNAO*
**Interpretation of Scoring**

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

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

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

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Appendix J:
Intensive Nursing Intervention

Tips for the Client

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

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# Appendix K: Quit Smoking

## First-Line Medications Compared

<table>
<thead>
<tr>
<th>Quit Smoking Aid</th>
<th>How to use</th>
<th>How long to take it</th>
<th>Possible side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nicotine gum</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Nicorette®)</td>
<td>“bite &amp; park” gum</td>
<td>several weeks to several months or longer if necessary</td>
<td>burning in throat</td>
</tr>
<tr>
<td>Available over the counter</td>
<td>1 piece of gum every 1-2 hours</td>
<td></td>
<td>hiccups if chewed too quickly</td>
</tr>
<tr>
<td></td>
<td>2 mg. if you’re a light smoker (≤ 20 cigarettes per day)</td>
<td></td>
<td>dental problems</td>
</tr>
<tr>
<td></td>
<td>4 mg. if you’re a heavy smoker (&gt; 20 cigarettes per day)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>stop smoking before starting</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nicotine patch</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Habitrol®, Nicoderm®)</td>
<td>if you’re a light smoker (≤ 20 cigarettes per day), start 14 or 7 mg.</td>
<td>8-12 weeks or longer if necessary</td>
<td>local skin reaction</td>
</tr>
<tr>
<td>Available over the counter</td>
<td></td>
<td></td>
<td>disturbed sleep, nightmares</td>
</tr>
<tr>
<td></td>
<td>if you’re a heavy smoker (&gt; 20 cigarettes per day) start 21 mg. for 4-8 weeks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discuss tapering to lower doses with your doctor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bupropion SR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Zyban®)</td>
<td>150 mg. once a day (in the morning) for 3 days, then twice a day (morning and evening, with at least 8 hours between doses)</td>
<td>7-12 weeks or longer if necessary</td>
<td>dry mouth</td>
</tr>
<tr>
<td>Available only by prescription</td>
<td>start 7-14 days before quit date</td>
<td></td>
<td>insomnia</td>
</tr>
</tbody>
</table>

Nicorette® (nicotine polacrilex); registered trademark of Aventis Pharma Inc.
Habitrol® (S(-)-nicotine): registered trademark of Novartis Consumer Health Canada Inc.
Nicoderm® (nicotine); registered trademark of Aventis Pharma Inc.
PrZyban® (bupropion HCL); registered trademark of Glaxo Wellcome Inc.

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

#### Cautions
- pregnant and breastfeeding*

#### When not to take it
- Check with doctor if pregnant and breastfeeding* or if have had unstable medical conditions (e.g., unstable heart condition in the past 2 weeks)

#### Advantages
- you can control when to take nicotine and how much
- satisfies oral cravings
- delays weight gain while you use it

<table>
<thead>
<tr>
<th>Cautions</th>
<th>When not to take it</th>
<th>Advantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>pregnant and breastfeeding*</td>
<td>Check with doctor if pregnant and breastfeeding* or if have had unstable medical conditions (e.g., unstable heart condition in the past 2 weeks)</td>
<td>you can control when to take nicotine and how much</td>
</tr>
<tr>
<td>pregnant and breastfeeding*</td>
<td>Check with doctor if pregnant and breastfeeding* or if have had unstable medical conditions (e.g., unstable heart condition in the past 2 weeks)</td>
<td>you need only apply it once a day</td>
</tr>
<tr>
<td>pregnant and breastfeeding</td>
<td>Check with doctor if pregnant and breastfeeding* or if have had unstable medical conditions (e.g., unstable heart condition in the past 2 weeks)</td>
<td>no chewing</td>
</tr>
<tr>
<td>drink &gt; 4 drinks a day</td>
<td>Check with doctor if pregnant and breastfeeding* or if have had unstable medical conditions (e.g., unstable heart condition in the past 2 weeks)</td>
<td>can control your craving for 24 hours</td>
</tr>
<tr>
<td>take St. John’s wort</td>
<td>Check with doctor if pregnant and breastfeeding* or if have had unstable medical conditions (e.g., unstable heart condition in the past 2 weeks)</td>
<td>delays weight gain while you use it</td>
</tr>
<tr>
<td>take drugs that reduce seizure threshold**</td>
<td>Check with doctor if pregnant and breastfeeding* or if have had unstable medical conditions (e.g., unstable heart condition in the past 2 weeks)</td>
<td>inexpensive</td>
</tr>
<tr>
<td>pregnant and breastfeeding</td>
<td>Check with doctor if pregnant and breastfeeding* or if have had unstable medical conditions (e.g., unstable heart condition in the past 2 weeks)</td>
<td>improves depression</td>
</tr>
<tr>
<td>pregnant and breastfeeding</td>
<td>Check with doctor if pregnant and breastfeeding* or if have had unstable medical conditions (e.g., unstable heart condition in the past 2 weeks)</td>
<td>minimal weight gain while you use it</td>
</tr>
</tbody>
</table>

If you are pregnant or breastfeeding, always check with your doctor before using nicotine gum or the patch.
**Remember to tell your doctor about the other medications you are taking, if any.

NB: Additional products may be available

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Appendix L:
Strategies to Avoid Relapse

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

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

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Appendix M: List of Resources Available for Smoking Cessation

- **Canadian Cancer Society**
  National Office, Suite 200
  10 Alcorn Avenue
  Toronto, Ontario M4V 3B1
  www.cancer.ca
  Email: tobacco@cancer.ca
  Toll Free: 1-888-939-3333
  Ontario Smoker's Helpline: 1-877-513-5333

  They have a free self-help smoking cessation program called **One Step at a Time**.

- **Canadian Health Network (CHN)**
  www.canadian-health-network.ca

  Health information you can trust.
  CHN is a national, non-profit, bilingual web-based health information service, sponsored by Health Canada.

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

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

- **Canadian Council of Tobacco Control (CCTC)**
  170 Laurier Avenue West, Suite 1000
  Ottawa, Ontario K1P 5V5
  Tel: 613-567-3050
  www.cctc.ca
  Email: infor-service@cctc.ca

  This is a national, non-profit organization specializing in tobacco and health issues.
Integrating Smoking Cessation into Daily Nursing Practice

- Heart & Stroke Foundation of Canada
  222 Queen Street, Suite 1402
  Ottawa, Ontario K1P 5V9
  Tel: 613-569-4361
  www.heartandstroke.ca
  Email: info@hsf.ca

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

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

- Pregnets
  www.pregnets.org

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

- Program Training and Consultation Centre
  Toll free: 1-800-363-7822
  www.ptcc.on.ca

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

- The Lung Association
  National Office
  1900 City Park Drive, Suite 508
  Blair Business Park
  Gloucester, Ontario K1J 1A3
  Tel: 613-747-6776
  www.lung.ca/
  Email: infor@lung.ca

  Ontario Lung Association
  Tel: (416)-864-9911
  Toll Free: 1-800-972-2636
  www.on.lung.ca
Additional Online Support Help to Quit Smoking

- **American Cancer Society**
  Great American Smoke Out is the name of their program.

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

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

- **Registered Nurses Association of Ontario (RNAO)**
  [www.rnao.org/smokingcessation](http://www.rnao.org/smokingcessation)
  RNAO offers an e-learning course to help educate health professionals on smoking cessation interventions.

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

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

Toolkit: Implementation of Clinical Practice Guidelines

Best practice guidelines can only be successfully implemented if there are: adequate planning, resources, organizational and administrative support as well as appropriate facilitation. RNAO, through a panel of nurses, researchers and administrators has developed the “Toolkit: Implementation of clinical practice guidelines”, based on available evidence, theoretical perspectives and consensus. The “Toolkit” is recommended for guiding the implementation of any clinical practice guideline in a healthcare organization.

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

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

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

The “Toolkit” is available through the Registered Nurses Association of Ontario. The document is available in a bound format for a nominal fee, and is also available free of charge from the RNAO website. For more information, an order form or to download the “Toolkit”, please visit the RNAO website at www.rnao.org/bestpractices.
Notes:
Notes:
Integrating Smoking Cessation into Daily Nursing Practice

This project is funded by the Ontario Ministry of Health and Long-Term Care