

IGNITING AN ETHICAL DILEMMA: THE SMOKING POLICY
*Columbia University Center for the Study of Science and Religion & Terence Cardinal
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Introduction

Throughout this internship, I found that the staff and administration experienced some difficulty in trying to maintain the fragile balance between providing medical services and respecting residents' rights to self-determination. In hospitals, doctors have the advantage of almost exclusively focusing on the health needs of their patients as they are often dealing with life-threatening situations. While many patients get to return home after medical emergencies, those who are dealing with long-term injuries or chronic illnesses are often sent to nursing homes or skilled nursing facilities such as Terence Cardinal Cooke (TCC). These people must then make the difficult and disheartening transition from living independently to living in an institution. In addition to having their eating and sleeping altered, patients face the unyielding reality that their lives are now seemingly defined by their condition, which often can be psychologically traumatic. Moreover, looking at the contrasting perspective of the situation, the staff at TCC faces a difficult task in that it has less unrestrained control over patient care because, unlike the hospital, TCC is both a nursing facility and a home to hundreds of residents. While the staff is quite skilled at simultaneously executing these two functions of the facility, there is one area where issues constantly arise between staff and patients in efforts to maintain this dual identity: the smoking policy.

Smoking at TCC epitomizes the conflict between providing medical services and respecting residents' rights to self-determination. On the one hand, the simple medical argument would be that, as a healthcare facility, TCC should disallow its residents from

smoking since it is detrimental for one's health and exacerbates existing medical issues, both for the individuals themselves and the people around them. On the other hand, the more constitutional argument is that everyone has a right to self-determination and autonomy, that this is home for these patients, and therefore they have the right to choose and do what they want, within the obvious boundaries of safety and severe legal transgressions. At its core, this issue is an ethical dilemma. However, I quickly learned that when active in as diverse an environment as TCC, the conflict becomes much more complex.

Birth of a Project: The Plight of the Social Workers

"Addiction by proxy"- Staff member

Having no previous experience that could remotely compare to this internship, I set out with a goal to step out of my comfort zone and explore every branch of TCC. Using the morning report as an anchor, I'd spend the rest of the day exploring different units, talking with patients, and attending as many meetings as possible. One of the meetings that I attended quite early on was a case conference on 6 Cohen, one of the discrete units. The discussion began with patient reviews, whether it was a monthly, quarterly, or an annual follow-up, with a social worker acting as the spokesperson. For monthly reviews, the social worker asks if there are any problems with the patient. However, for quarterly reviews, the social worker specifically asks each service line (nursing, dietary, recreation, psychology, social work) to give an update on the patient. Afterwards, specific patients with recent behavioral issues are discussed and asked to come in and speak with the team. I quickly realized that these behavioral issues often are related to a breach in the smoking policy.

After attending several more case conferences and morning reports, I was astonished- and a bit bothered- by how much the staff's day was consumed by handling cigarette or smoking policy issues, especially for the social workers. A study examining the conflicts and challenges of smoking in nursing homes conducted in 1997 found that 86.9% of nursing homes that allowed smoking reported that the amount of staff decision-making time spent accommodating residents' smoking needs was equal to or greater than time spent addressing other issues (Adler, 1997). This also appears to be the pattern in TCC and as one social worker put it, the social workers are "addicted to their patients' cigarette addiction." The social workers are constantly plagued with anxiety about buying cigarettes for patients in time and dealing with the subsequent behavioral issues that surrounds such exchanges. There is one notorious patient who is constantly causing grief for the discrete staff. Not a week goes by in which this man doesn't cause some sort of hysteria, whether it is another thunderous and indignant demand for more cigarettes, an incident involving scorched fingers but undiminished resolve brought upon by smoking too far down his cigarettes, or even a desperate attempt for one more puff executed by pawing through other people's discarded cigarette butts in search for a salvageable sample. Unfortunately, he causes such a fuss that the only way to deal with the outbursts triggered by his addiction is to feed that very addiction itself, as the staff has to continue providing him cigarettes just to keep a semblance of peace. At the moment, he is forced to smoke alone, causing a back-up of the smoking line and an increasingly unruly crowd of craving discrete patients. To make the workers' anxiety worse, they have to confront the perception that they support smoking habits by continuing to supply cigarettes when in reality they are merely defusing a highly combustible situation. Somehow, the staff

needs to show the initiative that they don't approve of smoking and stop facilitating this action. Thus began my initial siding with the medical argument against allowing smoking in TCC.

Team Medical Argument: The Effects of Smoking on Health

"Tobacco use is the leading cause of preventable illness and death in the United States"- Aids.gov

The hazards of cigarette smoking are well documented, particularly the risk for cardiovascular disease, cancer, and chronic obstructive pulmonary disease (COPD). It is widely known that smoking is detrimental to one's health, causing nearly one out of every five deaths in the United States every year (Smoking & Tobacco Use, 2013). However, many people are less aware of how cigarette smoking exacerbates their preexisting medical conditions. At TCC, much of the population suffers from HIV/AIDS, diabetes, kidney disease, some form of dementia, and Huntington's Disease, all of which are conditions worsened by smoking. HIV positive individuals who smoke are at higher risk of developing lung cancer and other cancers, bacterial pneumonia, pneumocystis pneumonia (PCP), COPD, heart disease, oral candidiasis, and oral hairy leukoplakia than smokers without the disease (Smoking & Tobacco Use, 2013). Additionally, HIV positive people will likely experience an increase in HIV-related symptoms and have a worse response to their antiretroviral therapy, thereby increasing their stay at TCC and decreasing their life span. For individuals with diabetes, smoking can lead to the aggravation of the disease's complications as smokers have impaired insulin sensitivity, impaired beta-cell function and insulin secretion, chronic low grade inflammation, and endothelial dysfunction (Fagard, 2009). Many of the patients and residents at TCC also suffer from some form of kidney disease, necessitating the dialysis center located on the

second floor of the building. For patients with chronic kidney disease, smoking cigarettes can affect and accelerate the progression of their disease, as well as increase cardiovascular morbidity and mortality in hemodialysis patients (Orth, 2008). The research on smoking's effect on Alzheimer's disease is less clear. Some studies have suggested that smoking increases the risk of Alzheimer's disease and all types of dementia. Interestingly, however, some evidence shows that smoking could perhaps have a protective effect against Alzheimer's disease as nicotine could induce an increase in the level of nicotinic acetyl choline receptors, thereby counterbalancing the loss of these receptors and subsequent cholinergic deficits observed in the disease (Reitz, 2011). More research needs to be done in that area, but regardless, even if nicotine could perhaps have a positive effect for Alzheimer's disease, cigarette smoking would simultaneously be creating numerous other health hazards in the individual and putting them at high risk.

In addition to the internal, less visible health risks, those with Huntington's Disease face external, physical risks. This cohort is at risk of burns when lighting their cigarettes or smoking cigarettes down to the end due to their chorea. Furthermore, loss of impulse control could create behavioral problems for smokers. For example, at TCC there is a Huntington's patient who frequently gets very impatient waiting for the elevator to take him to and from the smoking room, as it is not located on his floor. One day his exasperation escalated out of control, and he attempted to hit a visitor while he was waiting for the elevator. Such aggression is a known symptom of Huntington's Disease, but unfortunately 911 still had to be called and the police took him away to the hospital in an effort to mend the situation. A trip to the hospital can be very emotionally traumatic, especially for a Huntington's patient. They are taken to a foreign environment, absent of

any familiar faces, and almost always on account of behavior that is out of their control. It is heartbreaking to witness Huntington's Disease overwhelm an otherwise peaceful individual as it did in this case. Thus, not only does smoking cause physical harm to individuals, but also it indirectly induces psychological damage resulting from the conflicts that emerge.

Along with the physical and mental health risks for the individual, cigarette smoking also poses risks for the people around the smoker. Both the staff and the patients are at risk for second-hand smoke as long as smoking is allowed at TCC. Research has illustrated that environmental tobacco smoke increases the risks of cancer and respiratory and cardiovascular diseases. Plus, in addition to those risks, a recent study has found that second-hand smoke should also be considered an important risk factor for severe dementia syndromes (Chen, 2013). In summary, there is tremendous and unmistakable evidence in support of banning cigarettes at TCC, particularly given the illness of the population. Then why allow smoking?

An Overly Simplistic Solution Negated: Facility-Wide Smoking Ban

"It is unconscionable to be handing out cigarettes to people who are ill"- Staff member

In addition to the health dangers to smokers and their fellow residents and staff, allowing smoking in a healthcare facility like TCC creates numerous behavioral issues and hinders the efficiency and quality of work from the staff, by no fault of their own. Staff is constantly forced to ignore the moral dilemma of not only allowing, but providing sick patients with cigarettes. Therefore, I decided to ask about the possibility of a facility wide smoking ban. The same study conducted in 1997 examining the conflicts and challenges of smoking in nursing homes found that smoking issues arose in 31% of

facilities with smoke-free policies, compared to 61% of facilities that permitted smoking (Adler, 1997). The cause of the conflicts in the smoke-free facilities included the difficulty enforcing regulation, something I quickly learned would be a big issue at TCC. The existing black market of cigarettes at TCC would grow and patients would smoke in their rooms, staircases, and other places hidden from staff, exponentially increasing the risk of fire hazards for not only the patients themselves, but everyone in the facility. Although the black market for cigarettes is a bit troubling, for the most part, people are currently declaring these cigarettes to security and are allowed to smoke them since they are following procedures. With a ban, the patients would stop declaring these cigarettes and smoke them surreptitiously in private and potentially dangerous areas. Another risk in declaring a facility-wide smoking ban would be a loss of patients; individuals would choose their addiction over the excellent care of TCC, leaving swaths of empty beds in the discrete units in favor of an institution that allows smoking. Therefore, I realized a facility-wide smoking ban was not a good proposition for TCC and that it was better to allow smoking and implement a smoking policy to ensure the safety of the patients, than risk unsupervised smoking and its accompanying problems, a flood of behavioral incidents, and the loss of a patient population to serve.

A Bunch of Loose Cannons: The Complicated Discrete Population

“One is too much, and a thousand is not enough”- Patient

I began to abandon my moral stance on cigarette smoking at TCC, in part due to the impossible logistics and obstacles that arise from such a diverse patient population. I found myself feeling more sympathy for the patients as my interactions with them increased. In addition to morning report, group therapy on Mondays and Wednesdays

became a consistent activity. I was astounded to hear what so many of these patients had been through, and how willing they were to share their stories. The stories were vast, recounting their struggles with substance abuse, run-ins with the police, and even family tragedies. One patient shared how the mother of his children was abusive, and as a result he was given custody of their two sons. Sadly, he could not handle the sudden and immense responsibility of being a single parent, and could not prevent his children from being taken to foster care. Heartbroken and alone, robbed of not only his own happiness but also the assurance of his children's, he slipped into a world defined by alcohol addiction. Only now was he finally starting to reemerge to clarity. Recently he has initiated some communication with his children, but every minute he spends with them now is trumped by the years he missed during their youth.

At least once during the meeting someone would share a struggle that elicited advice from another patient based on his or her own experiences, providing an upbeat balance to the often gloomy topics. The communal support in these groups from the residents themselves was incredible. Men and women, chased from near every comfort in their lives by aggressive and unyielding diseases, found solace in each other's comparable experiences. The tragic and clear silver lining around the darkness of their conditions was that, for all the doors that their declining health had shut—including, ultimately, the one to life itself—it had opened an avenue of connection and empathy to an eclectic but resolute community.

Another recurrent topic in group therapy was the desire to leave. They were constantly struggling with their loss of independence, and the boredom and lack of activities available. It was then that I slowly realized that banning smoking would take

away one of their remaining forms of independence and pleasure. Sitting in on group therapy I realized how proud these people were at overcoming their addictions to alcohol, crack cocaine, pain pills, and heroin. To them, since tobacco is lawful, their cigarette addictions were acceptable, especially when comparing them to the other drugs to which they were previously, and even still, addicted.

As one patient explained in group therapy, many of them were used to living unstructured lives absent of discipline, in respect to both drug use and the law. Thus, they often clashed with a staff that was trying to implement order into their lives. In addition, I slowly learned that several patients at TCC have criminal histories. This detail not only increases the likelihood of behavioral issues, but it also makes dealing with those issues more complicated. However, I realized that it is also unfair to label patients by their histories, rather than their current behaviors, as often it could create a self-fulfilling prophecy (Gibson, 2014). Many of the discrete residents are working through their drug addictions and trying to make a fresh start of their lives by staying clean and pursuing the appropriate medical measures to treat their HIV. I began to understand their perspective, and I realized it wasn't fair to take away their ability to choose whether or not to smoke. In the war they were waging against a litany of enemies- their disease, their histories, their despair- the luxury of smoking seemed like a fight worth forfeiting to them.

Team Constitutional Argument: Individual Resident Rights

"The medicalization of tobacco" - Dr. Lechich

The argument of whether or not to allow residents to smoke is complicated by the fact that by its very nature TCC brings "core societal values into direct conflict with one another (e.g., home vs. institution, individual vs. group, and, dependence vs.

independence), creating strongly contested versions of rights and duties, obligations and desires, morality and ethics” (Barker, 1994). The central themes of a hospital primarily focus on safety and health. Their main concern is responding to an emergency and identifying and possibly curing its underlying cause. In contrast, a place like TCC must also focus on patient autonomy and quality of life, as we serve as a permanent home to hundreds of patients, some of whom are beyond curing. For these patients, all we can do is treat the symptoms and make sure they are comfortable and experiencing little to no pain. The staff at TCC has a much more intimate relationship with their patients than traditional clinicians since they have more time to develop a connection. Additionally, the concept and practice of palliative care that Dr. Lechich constantly instills places the level of care at TCC above and beyond other facilities. This investment of the staff for their patients illuminates the importance and power of human interaction in healthcare. In addition to having open communication about the patients’ condition, the staff also has responsibility to provide the patients with a sense of autonomy, regardless of their capacities. In instances where patients don’t necessarily have capacity, “autonomy and respect for persons simply come to mean the creative, enabling use of dependency to give richer meaning to the lives of individuals who can no longer be self reliant” (Barker, 1994). If this means allowing them to choose whether or not they would like to smoke, then so be it.

Many of the patients at TCC have experienced loss of family, loss of limbs, loss of health, and most importantly, loss of independence. For many of them, smoking is their one remaining pleasure and the only aspect for which they can still control. When the stress, anxiety, and frustration about not getting better or not being able to leave

becomes overwhelming, a cigarette can provide them with an outlet and some relaxation. It is, in essence, a coping mechanism. Despite cigarettes' obvious detrimental health effects, one mustn't forget the "happiness quotient" (Tavernise, 2014). If one were to take away someone's right to smoke cigarettes, they are also taking away a portion of their happiness. This portion of happiness is disproportionately large in the vacuum of other sources of comfort for patients nearing the end of their lives, as is often the scenario for the population at TCC. Admittedly, some may try to apply this logic to other vices. However, the difference is that in our society, tobacco is lawful. Therefore, it should be up to the patient whether or not they can smoke.

Right vs. Privilege: The Solution

"You can lead the horse to the water, but you can't make him drink"- Patient

Although patients should be allowed to choose whether or not they smoke, that does not mean that the staff should idly just stand by. On the contrary, I think there should be more attempts to dissuade patients from smoking cigarettes and encourage tobacco cessation, both aboveboard and with discretion. An effectual effort to encourage tobacco cessation would require regular approaches from both the IDT teams and the doctors. The IDT team revisits the subject of smoking at each case conference. However, patients do not always attend their case conference so this effort is sometimes futile. The doctor, a figure with perhaps more influence over the patients, should also regularly make a concerted effort. There are studies that indicate that smoking cessation interventions, even as brief as 3 minutes in duration, when delivered by a physician, have a positive impact on abstinence rates of current smokers (Kwong, 2011). Some doctors have admitted to leaving the chronic smokers alone. However, one never knows when

someone could change their mind and as one patient who recently quit smoking jokingly put it, “If you keep getting bugged and harassed, you eventually get tired of it and realize that maybe what you’re doing is wrong.” Of course, not every patient will have this outlook and may get frustrated by the perceived intrusion, but once a month isn’t that often and even getting just one person to quit makes a difference. If patients saw that one of their fellow residents could quit, it could show them that quitting is possible for them too; that person and their motivated attitude could be contagious. Perhaps having a resident as their model and source of motivation could be more successful, particularly for patients who are stubborn and less receptive to the staff.

There is no doubt that quitting is difficult. What makes the situation even more difficult is that many of the smokers at TCC have been smoking since they were teenagers. One patient told me that it was ten times harder for him to quit smoking than it was for him to quit using heroin. He found cigarette smoking more addictive, and the fact that it was socially acceptable made it all the more difficult. Patients forced to quit are more likely to relapse than those who achieve that goal on their own, since the latter group is motivated by their own conscious decisions. Therein lies the importance for repeated efforts to encourage tobacco cessation and make those sources clearly available. It is the responsibility of the staff to express that although cigarette smoking is technically lawful, that does not mean that they approve of the behavior.

Conversely, there is a reality that not all the patients are receptive to staff, making more subtle efforts an important facet as well. One proposition is to divide floors into smokers and non-smokers to increase the safety and quality of life for patients who don’t smoke. Additionally, that set-up could decrease the impatience that several smokers feel

while waiting for the elevator to get to the smoking room. One other reason for the importance of putting smokers on the same floor as the smoking room is that often the building has fire alarm tests that cause the fire doors to shut. When patients leave to go smoke and return to find shut doors, they will sometimes attempt to open the doors beyond their physical abilities, leading to falls and subsequent injuries.

However, this proposition would only work for chronic smokers who have absolutely no intention of quitting. For smokers who have a desire to quit, no matter how small, we should have them live on a different floor of the smoking room, not only to keep them away from triggers, but also so that it is a chore and requires effort to get to the smoking room. Hopefully, they would eventually tire and decide to quit, or even just smoke less frequently. There was a time when the 7th floor of the discrete units didn't house any smokers, and the staff expressed that this organization had a positive effect on patients who were indecisive about continuing to smoke. However, room changes based on smoking requires support from administration and is made more difficult with an influx of admissions. Additionally, the amount of behavioral issues that occur between discrete residents is quite frequent, complicating the room situations. Though I do think that it could work for the 2 Hospital residents. The smoke room between 8 Cohen and 8 Annex must remain since the residents of 8 Cohen cannot leave their unit.

The most ideal situation would be having the smoke room on 8 Hospital, instead of 2 Hospital. I think that it would be beneficial to take advantage of the fact that no residents are living on 8H. This would decrease the risk of second-hand smoke, and force patients to really make an effort to get there and contemplate their decision to smoke. This could help alleviate some of the issues on the hospital side, and make 2 Hospital

purely a floor for those going to dialysis as it would be more convenient and help people arrive at their appointments on time. On the discrete side, I realize a proposition for assigning rooms based on smoking status would be difficult, but I believe it is worth trying. Additionally, I think a stronger, more intimidating presence of security by the smoking room could be useful. Perhaps someone from security could take on the job as smoke monitor, or regularly make visits, in efforts to keep the behavioral issues under control and stop people from abusing the smoking monitors and the staff around them.

Right now I am inclined to consider cigarettes a right, as opposed to a privilege, but it is a delicate balance. Residents should be able to decide whether or not they can smoke. However, if they are putting others in danger, then I think that staff should be able to tip the balance more to the side of privilege, and govern the availability of cigarettes in order to try to alleviate behavioral problems. Individuals have the right to treat their bodies in the manner they choose. But, as with all matters, that freedom must be considered within reason. Nursing homes are no different from society in “balancing issues of personal autonomy and the rights of others” as it relates to cigarette smoking (Kochersberger, 1996).

Conclusion: The Power of Humanity

“Listen for the golden nuggets within those streams of consciousness”- Ashley Shaw

Ultimately, the argument about whether or not to allow smoking in TCC gravitates towards what one considers the most important in regards to quality of care. If you consider health to be the number one priority, then you may side with the medical argument and take a more paternalistic approach to the issue. If you consider patient autonomy to be the most important aspect of healthcare, then you may focus on the

importance of maintaining an individual's right to choose, even if you disagree with their decisions. However, regardless of what you believe, you must remember that at the end of a patient's life, the goals of medical care must be revisited and often adjusted. When a patient is nearing the end, the importance of quality of life trumps all. Why sacrifice quality of care in order to try to extend patient lives by a miniscule, often painful fraction? The psychological and emotional well being of a patient is an integral part of quality of life, and sometimes when medicine fails, a cigarette is the only thing that can provide them with comfort. More than ever, it is important to honor the freedom of choice and the pursuit of happiness at the end of the spectrum of life.

APPENDIX

SMOKERS ROSTER

- 1 Hospital North: 1 smoker
- 1 Hospital South: 1 smoker
- 2 Hospital: 8 smokers
- 3 Hospital: 4 smokers
- 4 Hospital: 9 smokers
- 5 Hospital: 7 smokers
- 6 Hospital: 5 smokers
- 6 Annex: 7 smokers (*2 with special instructions for the smoking monitor*)
- 6 Cohen: 6 smokers
- 7 Annex: 8 smokers (*1 with special instructions for the smoking monitor*)
- 7 Cohen: 3 smokers
- 8 Annex: 14 smokers (*5 with special instructions for the smoking monitor*)
- 8 Cohen: 11 smokers (*2 with special instructions for the smoking monitor*)
- Of the 609 patients, 84 are smokers (~14%)
- Of the 84 smokers, 49 are from the discrete units (~58%)
- *Numbers collected on 7/17/2014

SMOKE LOG FORM

Example for 1HN, 1HS, 2H, 3H, 4H, 5H, 6H:

LAST NAME	FIRST NAME	UNIT	TIME IN	TIME OUT	SMOKING APRON USED

IF RESIDENT IS NOT ON SMOKE LOG AND RESIDENT ASKS FOR A CIGARETTE, NOTIFY THE NURSE IMMEDIATELY

Example for Discrete (6A, 6C, 7A, 7C, 8A, 8C):

LAST NAME	FIRST NAME	UNIT	TIME IN	TIME OUT	SMOKING APRON USED	"SPECIAL" INTERVENTIONS	ADDITIONAL COMMENTS

IF RESIDENT IS NOT ON SMOKE LOG AND RESIDENT ASKS FOR A CIGARETTE, NOTIFY THE NURSE IMMEDIATELY

PATIENT INTERVIEW QUESTIONS (*those living on 2H*)

1. Are you a smoker?
2. Do you mind living on a floor with a smoking room?
3. When you first came to TCC and you moved into your room, did TCC staff forewarn you about the smoking room on your floor?
4. Did TCC give you an option to move floors if you disliked the smoking room?
5. What do you think about people being allowed to smoke at TCC?
6. Do you think TCC has a good smoking policy?

7. What would you change about the smoking policy here at TCC?
- Of the 54 patients living on 2H, 8 are smokers
 → 15 participated in the survey

SMOKER INTERVIEW QUESTIONS

1. How long have you been smoking?
 2. Do you smoke more or less since you've come here? How frequently do you smoke? How many cigarettes a day?
 3. Have you ever tried to quit?
 4. Do you have any desire to quit right now?
 5. Do doctors, nurses, social workers, and the psychologist remind you of the dangers of smoking and offer ways to help you quit? How often? Did they educate you upon admission?
 6. What do you like about smoking?
 7. Do you like the smoking policy? What would you change about it?
 8. Would you like to live on a floor with a smoking room?
- 12 participated in the survey

DOCTOR INTERVIEW QUESTIONS

1. What do you tell your patients when they are smokers?
 2. How frequently do you approach them about their smoking?
 3. How do they respond to you?
 4. How often do your patients heed your advice and stop smoking?
- 3 participated in the survey

SMOKING POLICY

TERENCE CARDINAL COOKE HEALTH CARE CENTER POLICY AND PROCEDURES

DATE REVISED: 11/23/09, 1/19/12, 2/17/12, 9/23/12, 1/3/14, 1/28/14

APPROVED BY: DISCRETE QUALITY IMPROVEMENT COMMITTEE

DATE ISSUED: JUNE 17, 2003

CHAPTER: ADMINISTRATIVE POLICIES AND PROCEDURES

SUBJECT: POLICY AND PROCEDURES

TOPIC: SMOKING POLICY

POLICY:

It is the policy of the Terence Cardinal Cook Health Care Center to recognize and respect the rights of its residents to safely and legally smoke cigarettes. However, this provision is carefully weighed against the requirements of the NFPA Life Safety Code as well as

applicable state and local fire regulations. Smoking is limited to residents only.

Terence Cardinal Cooke Health Care Center has deemed the application and use of open-flame devices to ignite tobacco products to pose an unacceptable safety risk to the resident population and all other occupants of the Center. Accordingly, residents will not be permitted to have in their possession or in their room any smoking materials including but not limited to cigarettes, lighters, matches etc. Cigar and pipe smoking is also prohibited in Center designated smoking areas.

Electronic cigarettes (e-cigarettes) are treated like traditional cigarettes except that residents may keep them in their possession. E-cigarettes can only be smoked in designated smoking areas.

Smoking is prohibited in all areas of the Center except in the following designated locations: Hours of operation are posted outside each smoking area.

2nd Floor Hospital Smoke Room (for residents other than Discrete)

8th Floor Discrete Smoke Room (for Discrete residents only)

NOTE: Smoking is prohibited within 25 feet of all facility entrances and exits, on all outdoor facility grounds (The Mona Gold Garden, 3rd Floor Hospital Roof Patio, 6th Floor Roof Patio and 10th floor Roof Patio).

PURPOSES:

0.To comply with the NFPA Life Safety Code and all other federal, state, local fire safety regulations; and NYC Admin. Code 17-501

1.The facility considers smoking within the building a potential "Hazardous" condition. While the rights of every resident are respected and acknowledged, the overwhelming need to ensure safety of all residents has led to the development of procedures that require all residents who smoke:

- To secure smoking materials at the designated smoking area;
- To wear aprons at all times while in the smoke room and;
- To be supervised at all times while smoking in the smoke room.

RESPONSIBILITY	PROCEDURE	FORMS
Admissions / IDT	1. Upon admission, an Admission's Department representative will document the resident's smoking history on the TCCHCC's PRI Cover Sheet (attached to the PRI) when known.	PRI
Nursing	2. Document the resident's current smoking habits on	Nursing Admission Assessment

	the Nursing Admission Assessment, the care plan, the Nursing Order Accountability Record (NOAR), and on the 24-hour report.	
	3. All smoking materials, including cigarettes, cigars, pipes, matches, lighters, etc., will be confiscated from residents on admission and findings documented in a progress note. The nurse on the unit will give the cigarettes to the smoking monitor to be secured and logged in.	
	4. Designated smoking areas will be supervised at all times when open.	
	5. The Smoking Assessment will be completed by Nursing to assess the need for additional individualized interventions for safety such as adaptive equipment. The assessment will be completed on admission, readmission, quarterly, upon significant change and episodically, if there is a change from the previous assessment.	Smoking Assessment Form
	6. A Smoking Care Plan will be generated and placed in the Assessment Section of the Medical Record. Additional interventions, i.e. adaptive equipment will be added to the smoking list.	
IDT	7. Residents are not permitted to have any smoking materials, except for electronic cigarettes (e-cigarettes), on their person	

	or in their room. The Center may conduct room searches of any resident suspected of having smoking materials. Social Services will attempt to identify the source of any prohibited smoking materials found in a smoker's possession. When the source is a family or friend, the Social Worker will counsel the source individual regarding the Center's policy and document the counseling.	
Administrator on Duty / Social Services / Administration / Unit Clerks	8. Administration will update, maintain and circulate the smoking log to Unit Clerks, Nursing, Social Services, Security Staff, Administrators and others as appropriate.	Smoking Log
	9. The Social Worker or Administrator on Duty (AOD) will add the resident's name to the Smoking Log on the unit and on the Smoke Monitor's list. Additions/changes to the Smoking Log will be relayed to Administration for updating.	
	10. Unit Clerks will print off the smoke list and place in the Smoke Log binders on each unit and with the Smoke Monitors.	
Social Services/Psychology	11. As part of a review of the Smoking Agreement, the Social Worker (Geriatric and Discrete Units) and Psychologist (Discrete Units) will review with the resident the Center's smoking policies	Smoking Agreement

	<p>and consequences of non-adherence to them. These rules include, but are not limited to:</p> <p>a) All residents are prohibited from keeping cigarettes and/or lighting materials. These items will be kept with the Smoking Monitor.</p> <p>b) All smokers will obtain a smoking apron from the Smoking Monitor and wear it at all times while in the Smoke Room.</p> <p>c) Residents will light their cigarettes at the wall mounted lighter, or lit by the smoking attendant at the entranceway to the Smoke Room.</p> <p>d) Residents are never allowed to give cigarettes and/or lighting materials to other residents.</p> <p>e) Residents are not allowed to share cigarettes.</p> <p>f) Residents are never allowed to light the cigarettes of other residents.</p> <p>g) Resident are allowed in the Smoke Room for a maximum of 10 minutes (Discrete) and 20 minutes (remainder of the facility) and will not be allowed back in the room until 20 minutes have passed or based on space available.</p> <p>h) Residents are not allowed to enter the Smoke Room without a cigarette.</p> <p>i) Maximum of 5 residents at a time in the Smoke Room on the Discrete Units. Maximum 7</p>	
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	residents at a time in the 2H Smoke Room.	
Nursing / Smoke Monitor / Security / Social Work / AOD / ANCC	<p>j) Cigarettes for OOP can be obtained from the Smoke Monitor as follows:</p> <ul style="list-style-type: none"> o Resident and/or escort obtain an "Out of Facility Pass Request" from the Nurse and bring to the Smoke Monitor. o Smoke Monitor will indicate the number of cigarettes given to the resident directly on the form. o The resident and/or escort bring the form and the cigarettes to the Security Guard who then verifies possession of the number of cigarettes noted on the pass. o If Security is unable to verify, the resident will be prevented from going out on pass and Security will notify the Charge Nurse on the Unit. This will be considered a violation of the facility's policy and the Nurse will document same in a progress note and on the 24-hour report for review by the IDT. o Social Work and Psychology, where relevant, will follow-up with the resident. <p>Upon return from OOP:</p> <ul style="list-style-type: none"> o Security will review the "Out of Facility Pass Request" and question the resident regarding unused cigarettes. Security will advise the resident of the requirement to hand over 	

	<p>their cigarettes to the Smoke Room Monitor.</p> <ul style="list-style-type: none"> o Security will call the Smoke Monitor to give a verbal report. o The Smoke Monitor will note submission of the cigarettes on the Smoke Log. 	
Social Services / Psychology	<p>k) All residents who smoke will be educated on smoking cessation options by the Social Worker (Geriatric Units) or Psychologist (Discrete Units).</p> <p>l) Cigarettes which are purchased by and/or for residents will be labeled by Security and delivered by Security to the Smoke Monitors at scheduled intervals.</p>	
	<p>12. After reviewing the Center's policies, the resident will sign the Smoking Agreement form and Smoking Violations Protocol. The resident will be given copies of these documents. These original documents will be placed in the Assessment Section of the resident's chart.</p>	Smoking Agreement Form / Smoking Violations Protocol
	<p>13. The "Smoking Agreement" will be completed on Admission, Annually and with Violations/Significant Changes. For Readmission to the facility and non-compliance incidents the form will be reviewed with the resident and both parties will sign the back of the form.</p>	

IDT	14. All violations of the Smoking Policy will be documented in a progress note and on the 24-hour report. IDT members will review the 24-hour report and address concerns as applicable.	
	<p>15. For those resident who violate the smoking policy, the Smoking Violations Protocol will be implemented which follows a progressive pattern. The Social Worker or Psychologist will oversee this process, which includes but is not limited to:</p> <ul style="list-style-type: none"> a) Counseling and education on the smoking policy b) The staff will attempt to involve the resident in activities to redirect and use his/her time in a positive manner. c) Psychological services and participation in Smoking Cessation programs. d) Room search schedules by two authorized personnel (Licensed Nurse, Security, Social Work). The resident will be informed that his/her room and belongings will be thoroughly searched for smoking materials. Findings will be documented in a progress note. e) Enhanced monitoring. f) Develop a behavior management plan which may include revision of smoking privileges, 	

	<p>smoking schedule and/or unit restriction.</p> <p>g) Inclusion on the Red Star list, in which belongings will be searched upon entrance to/exit from the facility.</p> <p>h) May include discharge from the Center. The Social Worker will explore discharge planning, including transfer to another facility where the resident's needs can be met.</p>	
Smoke Monitor	16. Each Smoke Monitor will have a list of all of the residents who smoke in the Center.	Smoke Monitor Guidelines
	17. Monitors will write the names of the residents, Unit, time in, time out on the Smoker's Log.	
	18. Maintains an inventory of all residents' cigarettes. Records all distributions of smoking materials in the Smoking Log.	
	19. Monitors will supervise residents in the Smoke Room at all times to ensure safety is maintained. Any behavior or compliance issues will be documented on the log and the Charge Nurse notified immediately.	
	20. Labels cigarettes with the resident's name and room number and distributes one cigarette at a time.	
	21. Lights cigarette in entranceway of Smoke Room, or directs to wall mounted lighter.	
ALL STAFF	22. All staff has a	

	responsibility to actively participate in the enforcement of the smoking policies.	
	23. Report any observation of, or any evidence of unsafe smoking (i.e. cigarette butts or ashes, smell of cigarette smoke, possession of cigarettes, lights, matches or other smoking paraphernalia.	
	24. All cigarette purchases by the facility will only be done through the Director of Security/designee.	

TERENCE CARDINAL COOKE HEALTH CARE CENTER
1249 Fifth Avenue, New York, NY 10029
Smoking Agreement

Resident: _____ Room No. _____ Date _____
[Print Name]

This is acknowledgment that I have received a copy of the ***Terence Cardinal Cooke HCC Smoking Policy***.

I understand that:

1. I will not hold cigarettes, lighters, matches or any other smoking materials in my possession or my room.
2. I understand that only commercially manufactured cigarettes can be smoked in the smoking room. Cigars, pipes and, of course, illegal drugs are not allowed in the building.
3. I may only smoke in the designated smoking room. There is absolutely no smoking in any other areas of the Center including bedrooms, bathrooms, recreation areas, patios, etc.
4. The hours of operation for smoking rooms are posted and are subject to change.
5. Time spent in smoking rooms will be limited to 10 minute increments.
6. I may not:
 - a. give or sell cigarettes or lighting materials to another resident;

- b. purchase cigarettes or lighting materials from any other resident; or
 - c. light anyone else's cigarettes.
7. I must always use an ashtray when smoking.
8. I will always wear a smoking apron to prevent me from burning myself or my clothing.
9. If I am allowed out on pass I will or my escort will obtain cigarettes from the smoke monitor and then present them to the security guard for verification prior to leaving the facility.
10. Upon return to the facility I will or my escort will tell the security guard how many cigarettes I am returning with, including cigarettes, lighters and matches obtained while out on pass. I will identify at that time if I have cigarettes intended for other residents. Security will label all cigarettes. I will take the labeled cigarettes and other smoking materials to the smoke room monitor immediately for safe keeping.
11. I am aware that smoking cessation programs are available to me.
12. I understand that electronic cigarettes (e-cigarettes) are treated like traditional cigarettes except that residents may keep them in their possession. E-cigarettes can only be smoked in designated smoking areas.
- I understand that these rules are in place to provide a safe, structured and supervised environment for me and the other residents of the Center. I further understand that if I do not follow these rules, I will lose some or all of my smoking privileges and that:
- (a) There will be individual consequences.
 - (b) The Center has the right to revoke/restrict any and all of my smoking privileges.
 - (c) The Center can also assist me in finding placement in a more appropriate setting.

Resident's Signature

Date

Social Worker, Psychologist or RN Signature

Date

Print Name / Title
ADMIN/1-12/1-07, Rev. 3/31/08, Rev. 9/20/12

(Continued on opposite side)

Smoking Agreement (Page2)

Record of Follow-up Counseling and Consequences for Unsafe Smoking

1) I acknowledge that I have violated the TCCHCC smoking policy and have received additional counseling by the IDT.

2) I have been readmitted to the facility and have received education on the TCCHCC smoking policy.

Enter code (# 1 or 2) under signature of resident that reflects reason for review of policy.

Date	Signature of Resident	Signature of Staff Doing Counseling	Reason for Re-counseling/Comments

ADMIN/1-12/1-07, Rev. 3/31/08, Rev. 9/20/12

Terence Cardinal Cooke Health Care Center SMOKING VIOLATIONS PROTOCOL

First Violation: For use or possession of cigarettes and/or other smoking related materials

1. Immediate review of Smoking Agreement with resident by Social Worker, or if after business hours, Administrator on Duty or ANCC.
2. Case conference with the resident (and family where warranted) regarding the violation of the Smoking Agreement, explanation of the smoking policy.
3. Participation in counseling session with Psychologist, Substance Abuse Counselor, and monthly support group.
4. Search of room and belongings at the discretion of the IDT.
5. Referral by IDT to the Center's Smoking Cessation Program.

Second Violation: For use or possession of cigarettes and/or other smoking related materials

1. Steps 1-3 above
2. Mandated participation in Center Smoking Cessation Program
3. Implementation of smoking schedule as follows:
 - a. Residents who purchase their own cigarettes will be allowed to smoke only once per shift, for one (1) week.
 - b. Residents who receive community cigarettes will lose one cigarette per day, for one (1) week.
4. Resident will be notified that failure to participate in Center smoking cessation program or an additional violation may result in an Administrative Discharge.

Third Violation: For use or possession of cigarettes and/or other smoking related materials

1. Steps 1-2 above
2. Implementation of smoking schedule as follows:
 - a. Residents who purchase their own cigarettes will be allowed to smoke only once per shift, for two (2) weeks.
 - b. Residents who receive community cigarettes will lose two cigarette per day, for one (1) week.
3. Resident will be notified that failure to participate in Center smoking cessation program or an additional violation will result in an Administrative Discharge.

Fourth Violation: For use or possession of cigarettes and/or other smoking related materials

1. Case Conference with resident and family (if warranted) to advise of Administrative Discharge proceedings
2. Administrative discharge unless extenuating circumstances exist.

Resident Signature

Date

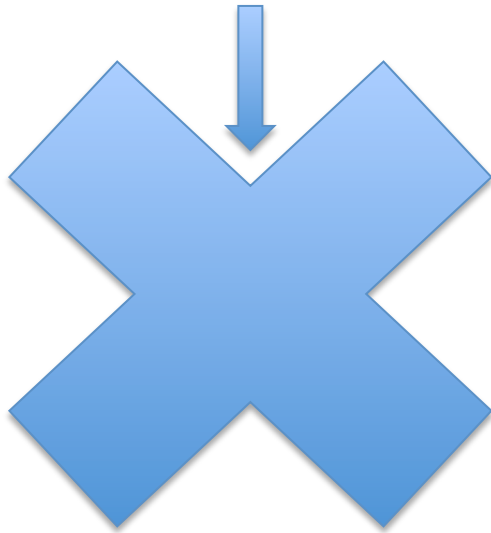
Staff Signature

Date

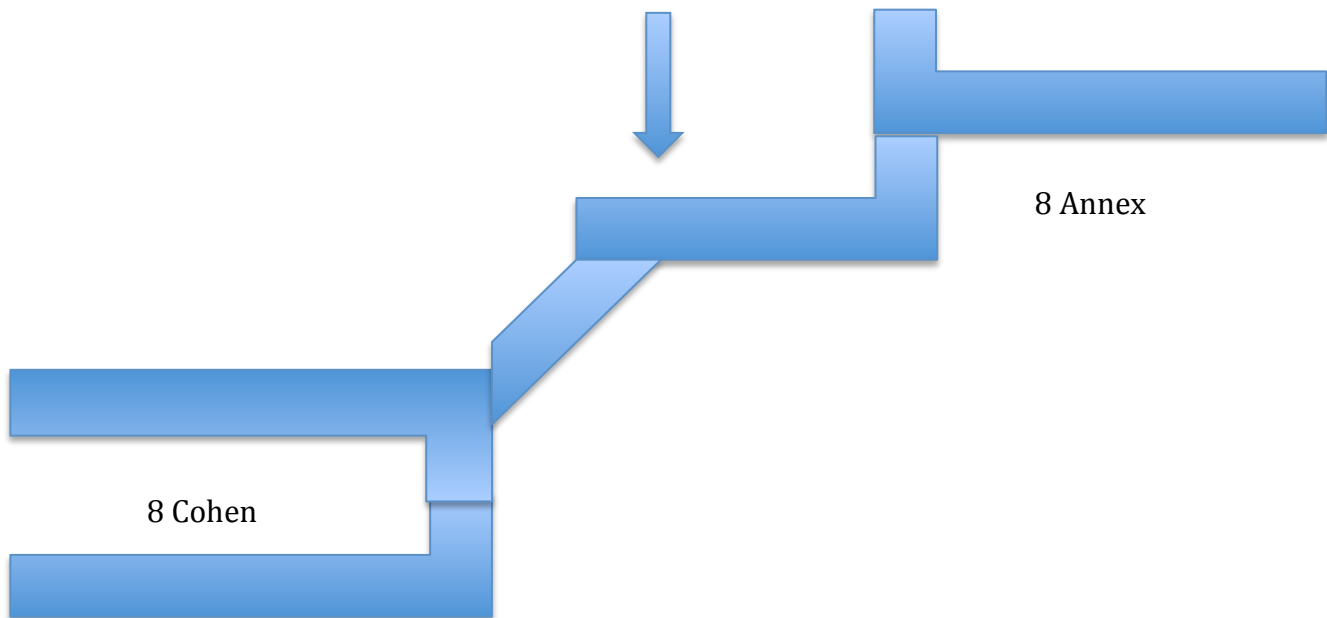
*Definition: **Community Cigarettes** are those provided by the Center to residents with no means of paying for, or acquiring their own. Residents are provided with three (3) cigarettes daily.*

SMOKE ROOM LAYOUT

Smoking Room on 2H



Smoking Room
between 8A & 8C



BLOG

<http://cssrtcc.wordpress.com/clinical-based-internship-for-pre-medical-students/summer-intern-impressions/>

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