



Can a Healthcare Service Safely Operate a Controlled Smoking Area?

The Smoke-Free Ontario Act, which comes into law on May 31, 2006, is a commendable step forward for the province. Among other progressive changes, it provides a province-wide legislative framework for a ban on smoking indoors in public places. Unfortunately, it also places the operators of specified residential care facilities in a quandary.

The Act gives operators of long-term care homes, retirement homes, supportive housing and designated veterans' and psychiatric facilities an exemption to operate Controlled Smoking Areas (CSA). It remains the legal and moral obligation of the Chief Executive Officer to operate these rooms safely. The regulations of the Act provide detailed and stringent specifications for the construction of the CSA.

At the Mental Health Centre Penetanguishene (MHCP), where we went 100% smoke-free on our grounds and campus indoors and outdoors in May of 2003, we remain unconvinced that any healthcare service can operate a CSA without leaking smoke and affecting the health and safety of staff and patients. We tried unsuccessfully for decades.

Even if the new regulations do create a room that does not leak smoke (at significant expense), someone will have to clean it. The new Smoke-Free Ontario Act says all staff members can refuse to enter any CSA. Someone might volunteer to clean it if they are paid a premium and provided with a HAZMAT suit (short for hazardous materials).

However, our experience in a large psychiatric hospital indicates that a significant number of our Code Whites (security crisis) occurred in the CSAs – patients were fighting over tobacco. In the future, will any healthcare service management be in a position to order nurses to intervene in a Code White in a room filled with known toxins? We know the hazards of concentrated environmental smoke and we can avoid exposing staff by not operating CSAs.

There are also occasional Code Blue (medical crisis) calls in CSAs. The nurses will not have time to put on a HAZMAT suit before beginning cardio-pulmonary resuscitation.

Here's the quandary in the new Act: specified services can operate CSAs if they can do it safely, but it is impossible to operate them safely. This lamentable exemption in an otherwise commendable piece of legislation may lead some healthcare facilities to construct expensive CSAs only to shut them down later for safety and operational reasons.

Providing nicotine replacement therapy, effective smoking cessation counselling, withdrawal support, better health teaching and a smoke-free environment makes much more sense.

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Patient-Centred Care Problems

Use of the term “patient-centred care” has been a thorn in my side since I was introduced to it in the early 1990s. Until then no one used the term patient-centred, although the patient was the reason for everything done by healthcare professionals. The term trickled into nursing and healthcare literature and is now the norm for describing practice environments. A disturbing incident one night at work even made me wonder where patient-centred care stopped and nurse abuse began. That night, a cognitively intact patient spitefully defecated on the floor of her hospital room only a few feet away from the toilet because she was mad at me for not answering her call bell quickly enough. The philosophy of patient-centred care would have me respect her autonomy and right to express herself; I thought what she did was nurse abuse.

This incident illustrates the conflict between the philosophical ideal of patient-centred care and the reality of implementing it in everyday practice. From my perspective as a registered nurse, implementing patient-centred care is hampered by three basic problems: (1) lack of transparency – no one knows what patient-centred care really is because there is no common definition; (2) lack of truth – the term is used as a smokescreen for economic decisions; and (3) patients are not always right; therefore, respecting their autonomy does not mean we must totally accept their behaviour and actions.

First, although the term seems self-explanatory, “patient-centred care” is either used without being defined, or is defined by anything from a one-line statement to a lengthy document. There is even disagreement about whether we are caring for “patients” or “clients.” If we are going to base our healthcare on a philosophical ideal we should be able to develop one definition and description of what that ideal is. No one can argue with the idea that care ought to be centred on patients, but it means different things to caregivers, hospital administrators and patients. This leads to the next problem with the term patient-centred care, which is a lack of truthfulness.

A strange thing happened when the phrase “patient-centred care” was coined – it became a smokescreen to hide economic decisions that were being made during hospital restructuring. The term was used to mislead nurses and others into thinking that the dramatic changes imposed were actually good for patient care. Patient-centred care became the new mantra for institutions and organizations that in fact were shifting away from an individual patient mode to an economically driven, institution-centred business mode. Patient-centred care, in practice, became the total opposite of what the term should mean. Too bad a nurse did not write about that; it took an investigative journalist, Suzanne Gordon (2005), to state that patient-centred care is “one of those Orwellian formulations used to describe its opposite.” Nurses informed her that “under the guise of patient-

centred care ... they were losing their ability to centre on the patient” (Gordon 2005: 229).

A third problem with patient-centred care is the underlying assumption that all competent patients are always right, no matter what they do. This would mean that “nurses are to be guided by the business motto ‘the customer is always right’ ” (Kikuchi 2004: 5). But patients and family members are not always right. Like the defecating patient, they can be rude, offensive and abusive towards nurses and other members of the healthcare team. As Kikuchi further stated, when patients become “customers,” their satisfaction becomes the goal of nursing, and “professional judgment in relation to patients’ choices becomes irrelevant.”

Ensuring that effective patient-centred care can actually be accomplished requires some changes. The first change is honesty. All healthcare practitioners and decision-makers must stop pretending that patient-centred care can occur when healthcare budgets are being slashed and staffing is being reduced at the same time that patient acuity and nursing workloads in hospitals are being increased. Honesty may also help to solve the dilemma about a realistic definition of patient-centred care and how to differentiate between institutional and patient-centred interests.

The second change involves education. Many current nursing programs do not require courses in patient-centred care, although they may be offered as electives. Health Canada has launched an initiative, Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP), which has the potential to transform hospital environments by changing the way that healthcare providers are educated. If this initiative is successful, patient-centredness will be part of the education process of every healthcare discipline.

The third step involves changing our healthcare delivery systems and processes to ensure that nurses and all healthcare professionals are able to practise patient-centred care; this includes realistic staffing and workloads to ensure that the work can be accomplished safely. Patients deserve to be the centre of our care – all healthcare practitioners and decision-makers must make patient-centred care a priority and a reality.

References

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Kikuchi, J. 2004. “2002 CNA Code of Ethics: Some Recommendations.” *Canadian Journal of Nursing Leadership* 17(3). Retrieved February 7, 2005. <<http://www.nursingleadership.net/NL173/NL173Kikuchi.html>>.

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