



Safe Smoking: Fact Or Myth?

A detailed and thorough safe smoking policy can reduce the risk of fire with effective assessment, communication, and oversight.

A FIRE AT A NURSING HOME KILLS two residents and injures 15 others. Authorities attribute the fire to a resident smoking in his room while oxygen was being administered through a nasal cannula. This catastrophe occurred even though, according to the director of nursing, “The facility’s rules are clear about no smoking in resident rooms, and all of our smoking areas are located a safe distance from oxygen supplies.”

For nurse executives and the nursing facility community, this scenario is a worst nightmare. Careless smoking is a frequent cause of fires in nursing facilities. According to the National Fire Protection Association, people 75 years and older have the highest death rate as smoking material fire victims—nearly four times the rate of all ages combined. In addition, smokers are not always the only victims when smoking-related fires occur.

Facility operators and their administrative leadership teams are usually quick to recognize the importance of adhering to fire safety procedures. However, convincing residents, families, and staff members that failure to follow smoking rules can have devastating consequences is a much more overwhelming task.

More than ever before, long term care facilities are struggling to meet not only insurance company, state regulator, and consumer demands for safe smoking, they are also attempting to find ways to respect resident rights concerning this high-risk area.

Several corporations and nursing facilities have responded to the extent

of risk and recent smoking tragedies by banning smoking altogether on their premises and by advertising themselves as “non-smoking” facilities. Most facilities, though, are trying to find a middle ground—seeking to manage the risk and respond equitably to residents’

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wishes by creating outdoor smoking areas where residents can still have opportunities to smoke.

Whether the facility chooses to offer indoor or outdoor smoking, nurse executives should ensure that the facility’s risk management plan includes the following components.

Determine Safe Smoking Options

Based on risk, the company must determine its safe smoking options. For example, for some facilities, if a resident has been assessed to have any cognitive, mobility, dexterity, or visual impairments or the staff have concerns regarding his or her compliance, a care plan should be developed for the resident requiring supervision while smoking. For other organizations, determining safe smoking options may not be an “all or nothing” situation. The facility may determine that residents can be safe with modifications.

For instance, the interdisciplinary

team may decide that a resident, who requires a smoking apron and staff to light their cigarette, could continue to smoke unsupervised once the cigarette is lit. It is critical that the assessment of the resident’s ability to smoke independently or not be based on input from the interdisciplinary team, including the physician, and that facility policy, protocols, and guidelines be strictly adhered to regarding the assessment.

Communicate The Facility’s Policy

Define for existing residents, families, staff members, and new admissions what the facility’s specific smoking policies and procedures are, including:

- Smoking locations;
- Smoking times;
- Storage of oxygen and tubing;
- Safe smoking practices;
- Assessment and supervision practices; and
- Clearly defined consequences of noncompliance.

The outcome of not complying with smoking regulations can be fatal, so discharge from the facility may be an acceptable consequence for severe or recurrent infringements. Asking the Resident Council and the ombudsman for ideas and recommendations regarding safe smoking practices can result in better smoking practices.

A pre-admission screening should be conducted prior to admission to determine if the resident’s smoking habits

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are congruent with facility policy. The objective of pre-admission screening is to determine whether or not the resident is appropriate for placement. If the resident's ability to safely comply with the smoking policy is suspect, the interdisciplinary team must carefully consider the ramifications of admitting the resident.

The admitting nurse and the interdisciplinary team should be charged with conducting a comprehensive smoking assessment to ensure that avoidable accidents are prevented. Some of the key elements include:

■ *A cognitive status assessment.* Define the overall cognitive status of the resident. Residents with dementia should not automatically be ruled out as safe smokers. Residents who have smoked all their adult lives may be able to maintain safe habits even into the middle stages of Alzheimer's disease. Short-term memory, memory recall

ability, cognitive skills for daily decision making, and judgment should be considered. Be sure to evaluate those residents who must remove their oxygen in order to smoke. Often decreased—and sometimes significantly altered—cognitive levels can result from smoking without adequate oxygen.

■ *Mobility, dexterity, and vision evaluation.* Determine if the resident has mobility, dexterity, or visual limitations that could impact the resident's safe smoking practices or place other residents at risk. For example, stroke victims, residents with Parkinson's, head injury clients, or residents with other neurological diseases may have limitations in their ability to light, hold, or put out a cigarette, or they may not be able to quickly and adequately respond to live ashes that fall in their laps.

Physical and occupational therapy

can be of great assistance in determining whether a resident is physically able to be an independent smoker or whether the resident requires assistance and supervision.

■ *Review of the resident's smoking history.* Investigate residents' smoking habits prior to admission. Has a resident shown a pattern of good judgment related to smoking, or has there been minimal consideration for the rights and protection of others? Does the resident require any adaptive equipment to help with safe smoking, such as a smoking apron or cigarette holder? Does the resident religiously use these items, and is the resident a safe smoker when these items are used? Evaluate the resident's clothing, wheelchair upholstery, and skin for burn holes.

■ *Observe the resident* on multiple occasions and at different times of the day to see if the resident is able to:

- Light cigarettes safely;
- Dispose of ashes and cigarette butts in the approved container consistently;
- Smoke only in the approved smoking area during scheduled times;
- If oxygen is used, consistently remove the oxygen and tubing and leave it in the designated area before going to the smoking area;
- Respond quickly and appropriately to fallen ashes;
- Abide by smoking rules consistently, including not offering any other smoker cigarettes or other smoking paraphernalia; and
- Call for assistance if needed.

Evaluating safe smoking practices must be an ongoing process. Instruct front-line staff to communicate any changes in the resident's cognitive or physical status to the charge nurse. The interdisciplinary team will need to complete a new assessment, immedi-

ately addressing any new safety concerns in an updated plan of care.

Incorporate Options, Safety Plans

Regardless of the options the organization chooses, be sure to define and structure each intervention clearly so that there are no questions left unanswered. For example, if the facility chooses to have an outside smoking area and supervised smoking, the plan should include:

- Specific details about allowable outdoor smoking locations;
- Means for residents to summon staff assistance from the smoking area;
- Structured smoking times that address resident wishes whenever possible, such as smoking after meals and in the evening before bedtime;
- Adaptive equipment, such as smoking aprons, fire-safe ashtrays, and clip-on ashtrays;
- Smoking paraphernalia for super-

vised smokers secured at the nursing station;

- Quick access to fire blankets and fire extinguishers;
- Consistent staff assignments for supervision;
- Procedures for storing oxygen tanks and tubing away from smoking areas. Oxygen tanks and cannulas are a significant smoking hazard when they are within six to 10 feet of persons smoking. A spark from a match or lighter can easily cause combustion of a resident's clothing, hands, or face;
- Proper signage. Place "No Smoking" signs wherever oxygen is used or stored, or post no smoking signage at all major entrances for facilities where smoking is not allowed; and
- Routine resident, family, and staff education regarding the facility's safe smoking program and practices, the risks of oxygen use while smoking, and the consequences of noncompliance. ■