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Smoking Cessation Education for Acute Care Nurses

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Walden University

College of Health Sciences

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Dawn Garcia-Brinker

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Walden University
2018

Abstract

Smoking Cessation Education for Acute Care Nurses

by

Dawn A. Garcia-Brinker

MS, Washburn University 2009

BS, Baker University, 1995

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

November 2018

Abstract

Tobacco use among veterans is significantly higher than among members of the general population. The purpose of this quality-improvement project was to increase acute care staff members' knowledge and confidence in using tobacco cessation interventions to increase quit rates among the inpatients of a veterans' hospital in the midwestern region of the United States. An evidence-based, standardized Tobacco Tactics Toolkit was developed and implemented, and a 6 sigma method guided the quality improvement process to define, measure, analyze, improve, and control the tobacco-cessation education initiative. The reach, effectiveness, adoption, implementation, and maintenance framework was used to ensure that evidence-based interventions were applicable to practice. The transtheoretical model was also used to understand the changing behavior of individuals addicted to tobacco and explain the phenomena of nicotine dependence. A convenience sample method was used, and a 10-question pre- and posttest was administered to 12 staff members. Results showed a 60% increase in posttest scores indicating a significant improvement in staff confidence, knowledge, and willingness to implement tobacco-cessation interventions. The Tobacco Tactics Toolkit has the potential to positively impact social change by increasing quit rates, decreasing admissions, and improving quality of life among veterans.

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Dedication

To Devin, Zachary, Jordan, and Glen. The love, support, confidence, faith, hope and tolerance you give me every day has unselfishly given me wings to dream and accomplish those dreams that have brought me joy beyond my wildest imagination to share with you! Thank you for believing and trusting in me.

Acknowledgments

Thank you to my family, friends, mentors, coworkers, preceptors and all those kind souls who have touched my life in so many positive ways on this incredible journey I have blessed to take.

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Section 1: Nature of the Project

Introduction

The lack of education, confidence in, and utilization of tobacco cessation for Veterans by acute care nurses are issues that directly affect the practice of the intensive care and progressive care staff, which negatively impacts the Veteran's care regarding tobacco addiction and cessation. Chronic obstructive pulmonary disease (COPD) is the third leading cause of death in the United States (Blanchette, Gross & Altman, 2014). Approximately 20.1% or 1.6 million Veterans report smoking (U.S. Department of Veterans Affairs, Public Health [PH], 2012). In 2013, 2014 and 2015, 172,201, and 174 Veterans were diagnosed with COPD and were admitted to this Eastern Kansas Health Care System (Pyramid 2016). Currently no training for staff is provided in this facility regarding tobacco cessation. A great opportunity exists to fill the gap in knowledge and practice for front-line staff with evidence-based education and tools for inpatient tobacco cessation. Providing tobacco cessation education for acute care staff can improve the utilization of valuable inpatient interaction by providing staff with the resources to address smoking cessation for Veterans (Duffy, Reeves, Hermann, Karvonen, & Smith, 2008). The paper presents an evidence-based, educational program, Tobacco Tactics program, for bedside nurses to improve their knowledge, confidence, and utilization of skills to address inpatient tobacco cessation. Section 1 discusses the background, problem, purpose, objectives, framework, method, limitations, assumptions, scope, and significance of addressing tobacco cessation for acute care nurses.

Background

Recurrent admissions to acute care with a diagnosis of COPD continue to increase on an eight-bed intensive care and progressive care unit (ICU/PCU) in the EKHCS Veteran's Affairs (VA) in the Midwest. Many of the patients have a history of tobacco use, depression, mental illness, and COPD (Duffy et al., 2008). Tobacco addiction in the Veteran community produces twice as many admissions and greater lengths of stay compared to nonveterans and an estimated $75.5 billion annually for related medical costs (Duffy et al., 2008). Among Veterans, the smoking rate is 33% versus the 22% rate for nonveterans (Duffy et al., 2008). The number of inpatients admitted to EKHCS for FY2016 who reported smoking was 634 (Pyramid, 2016). Per the Centers for Disease Control and Prevention (2012), Veteran smokers are primarily non-Hispanic White and between the ages of 45 and 64.

The primary tobacco cessation services offered in the VA system are for outpatients rather than inpatients, and they are poorly attended (Duffy et al., 2008). A 2010 study in the VA suggested that 70% of Veterans who smoke had the desire to quit, but only 17% reported receiving tobacco cessation interventions while an inpatient (Fore, Karvonene-Gutierrez, Talsma, & Duffy, 2013). Smoking cessation counseling and pharmacotherapy guidelines have been established by the U.S. Department of Veterans Affairs since the 1990s, however, the gap in services available for hospitalized Veterans continues to be underdeveloped (Katz et al., 2014). Additionally, inpatient nurses lack the confidence and skills for inpatient tobacco counseling (Katz et al., 2014).

A large gap in knowledge of and training for tobacco cessation interventions and assessment of Veterans' needs exists for acute care nursing staff who provide care in the ICU/PCU (Duffy, Karvonen-Gutierrez, Ewing & Smith, 2009). The lack of preparation in nursing schools for students is a barrier to narrowing this gap, as well as inadequate professional on the job training in practice and insufficient leadership support (Sarna et al., 2009). Few programs have been developed specifically for nurses on tobacco cessation counseling despite the unique position they are in when trained to educate patients (Matten et al., 2011). Acute care nurses have not been trained on cessation techniques by management as a priority in their already demanding workflow (Katz et al., 2014). New nursing orientation to the facility does not include tobacco cessation at the current time. The emphasis for tobacco cessation has been on treatment for outpatients rather than inpatients. Nursing staff also report not feeling comfortable offering tobacco counseling. They report low patient motivation and lack of time to provide cessation interventions (Fore et al., 2013).

Problem Statement

The absence of a comprehensive assessment and education process for acute care nursing staff to utilize for Veterans on admission and throughout the continuum of their acute care stay is essential to improving practice in an eight-bed EKHCS ICU/PCU Veterans hospital. Improving the assessment, evaluation, and interventions for smoking cessation could consistently be conducted on inpatient units during the acute phase of hospitalization to improve outcomes (Leschisin & Martin, 2007). Early assessment and implementation of tobacco cessation education will improve the Veteran's success in

decreasing tobacco use. Education can empower staff who have direct access to patients during a prime opportunity for conversations to learn about patient's tobacco history and needs. to improve the patient's health and address micro- and macrosystem gaps in care (Katz et al, 2012).

Identifying problems with cessation interventions and patient needs presents opportunities to help patients achieve a better quality of life, while also addressing historical escalation of costs (Neugaard, Priest, Burch, Cantrell & Foulis, 2011). COPD is the third leading cause of death in the United States (Blanchette et al., 2014). The prevalence of deaths nationally from COPD have significantly increased from 40.7% to 67% with 66.9 deaths annually per 100,000 for individuals aged less than 75 years of age (Blanchette et al., 2014). The Topeka VA facility reported 81 deaths for Veterans diagnosed with COPD in 2014 and 53 in 2015 (Pyramid, 2016). The total deaths from all respiratory diagnoses which could potentially include undiagnosed COPD were 234 in 2014 and 187 in 2015 (Pyramid, 2016). During FY2016 there were 801 inpatients in the facility with COPD (Pyramid, 2016). It is estimated that 20.1% or 1.6 million Veterans report smoking (PH, 2012). Of 70% of Veterans in the VA who expressed the desire to quit smoking, 17% reported receiving tobacco cessation interventions while an inpatient (Fore et al., 2013). Evidence shows smokers may require multiple cessation attempts before they are successful (Porter, 2013). Improving the nursing's process for capturing data on nursing interventions, inpatient Veterans' tobacco cessation history, and educational needs will provide the comprehensive care that is missing for acute care nurses and their patients.

Purpose

The purpose of this project was to implement the Tobacco Tactics Toolkit for acute care nursing staff to improve knowledge and confidence and to practice interventions for tobacco cessation (Fore et al., 2013). Identifying the lack of tobacco cessation education and patient needs for inpatient Veterans can contribute to changes that may help to mitigate the historical escalation of costs incurred from readmissions for tobacco related illness (Neugaard et al., 2011). The improvements in practice will potentially provide opportunities for smoking cessation that Veterans are missing in the acute care setting currently (Sarna et al., 2014). Nursing practice will also be enhanced by improving the current process of assessing inpatients admitted to acute care with a comprehensive assessment of smoking cessation history, willingness to quit, knowledge of resources for quitting, and management of addiction. Critical care nurses who are educated about smoking cessation and the Tobacco Tactics Toolkit will potentially provide opportunities for smoking cessation that Veterans are missing in the acute care setting currently (Sarna et al., 2014).

The Tobacco Tactics Toolkit developed by S. A. Duffy has shown to significantly increase quit rates among Veterans (Duffy et al., 2012). The educational staff toolkit contains information on effective interventions, a clinician's guide, protocols, and a documentation template (Duffy et. Al., 2012). Tobacco Tactics is an evidence-based, clinician centered program that utilizes recommendations from the Agency for Healthcare Research and Quality (Duffy et al., 2009). The nursing toolkit includes a PowerPoint and

manual that covers nursing interventions, pharmacotherapy, protocols, and documentation that has been tested in the VA system (Duffy et al, 2009).

Practice Focused Question and Objectives

The practice-focused question was:

PFQ: Will implementation of the Tobacco Tactics Toolkit improve acute care nurses' knowledge, confidence, and utilization of tobacco cessation interventions to increase the quit rate of inpatient Veterans?

The first objective was to implement the Tobacco Tactics program, an evidence-based tobacco cessation education program for acute care nursing staff. The program included the Joint Commission recommendations for smoking cessation, stages of change, nicotine replacement therapy, assessment tools, importance and effectiveness of interventions, comfort in educating patients, resources, alternative behaviors, and the five A's of tobacco cessation (Fore et al., 2013). Success of the education was measured by a 50% increase in posttest scores after program implementation compared to pretest scores.

The second objective was to educate the nursing staff on additions to the nursing assessment template (Appendix E), order sets, and referral process in the computerized patient records system (CPRS). The additions include incorporating smoking cessation questions into the assessment template and order sets, as well as streamlining the referral process for tobacco cessation in the CPRS. The objective was measured by monitoring the utilization of the nursing assessment template by acute care staff for inpatient Veterans. Therefore, the expectation was that the admission assessment template would be a comprehensive tool to collect the patient's smoking history, willingness to quit,

order sets, and referrals for standardized tobacco cessation treatment that would be completed at least 75% of the time when a patient is admitted to acute care.

The third objective was to implement the Tobacco Tactics Toolkit for acute inpatients Veterans on smoking cessation. The Tobacco Tactics Toolkit for patients includes a handout, education video, manual written at an eighth-grade level, nicotine replacement therapy, helpline, and follow-up phone calls (Fore et al., 2013). Completion of the updated EK-inpatient admission assessment (IPAA) nursing assessment template (Appendix D) was to be monitored for each admission and will be deemed successful when completed on 90% of acute care admissions.

Frameworks for the Project

The reach, effectiveness, adoption, implementation, and maintenance (RE-AIM) model was utilized to focus on critical elements and external validity to achieve successful implementation, sustainability, and support of the Tobacco Tactics program to improve tobacco cessation education for acute care staff (White & Dudley-Brown, 2012). The generalizability of tobacco cessation education in acute care was improved by utilizing the RE-AIM framework (Polit, & Beck, 2008). The goal of the RE-AIM model was to ensure that interventions are evidence-based and applicable in practice (Vick, Duffy, Ewing, Rogers, & Zak, 2012).

Use of this model ensured translation of knowledge into practice by utilizing five steps. The first step was to reach the targeted population, twelve ICU/PCU staff, by identifying the gaps in care occurring with the current admission process and tools. The second step was to effectively implement the Tobacco Tactics program for acute care

staff. Implementation of the program was accomplished by conducting small group in-services for two to three staff over a 2-week period until all 12 ICU/PCU staff have taken the pretest, received education, and taken the posttest. The third step was to be the adoption by acute care nurses to improve the assessment process for tobacco cessation. The fourth was to implement the Tobacco Tactics program for acute care staff. The final step was to maintain, and support nursing's utilization of the education obtained through the Tobacco Tactics program by organizational changes in practice and policy (Polit & Beck, 2008). The RE-AIM model increased staff confidence in, knowledge of, and willingness to utilize tobacco cessation interventions in practice. Organizational leadership and support is critical for sustainability of the long-term goals of change (White & Dudley-Brown, 2012).

The transtheoretical model (TTM) is a psychology-based model that is used to help explain the phenomenon of nicotine dependence (O'Connell, 2009). The model focused on changing behavior and is frequently utilized in addiction research (O'Connell, 2009). Other influential factors of this model include decisional balance, self-efficacy, and temptation (Zaccagnini & White, 2011). The TTM describes stages of change as precontemplation, contemplation, preparation, action, and maintenance (Zaccagnini & White, 2011). Each stage can be modified as individuals move through the process of changing behavior (O'Connell, 2009). The precontemplation stage is when the patient is not considering change because they are unaware or do not have the education needed to change (Sare & Ogilvie, 2010). The contemplation stage is an awareness of change, but the individual is not currently considering change (Sare & Ogilvie, 2010). An increased

awareness and consideration of change within a month occurs in the preparation stage when there is a realization that change is required (Sare & Ogilvie, 2010). Implementation of change to a new behavior is the action stage where the behavior has affected self-esteem and self-efficacy (Sare & Ogilvie, 2010). The maintenance stage is the long-term commitment where coping mechanisms have been developed to sustain the changed behavior (Sare & Ogilvie, 2010). Understanding the fundamental stages of change will assist acute care nursing in becoming a key resource for tobacco cessation in the acute care setting.

Nature of the Project

The design used for this project was a nonrandomized, pre- and postintervention. Inpatient ICU/PCU nurses in an EKHCS were provided with the Tobacco Tactics training. The Tobacco Tactics Toolkit is focused on providing staff with education on tobacco cessation that includes Joint Commission standards, behavioral and pharmaceutical interventions, evidence-based protocols, a guide for clinicians from the U.S. Department of Health and Human Services and Tobacco Free Nurses, and a computerized documentation template (Fore et al., 2013). Education was administered in small groups of two to three staff members over a 2-week period until all 12 staff had taken the ten-item pretest, received education, and taken the ten-item posttest. The data for the pre- and post-education was collected and analyzed by utilizing descriptive statistics analysis to determine the success of implementing the Tobacco Tactics Toolkit. Success was determined by an increase in scores from the pretest to posttest, indicating a

positive effect of education, confidence, and interventions for tobacco cessation from implementation of the Tobacco Tactics Toolkit on the project proposal outcomes.

Pre-Test	1	5	3	VG G F P	YES/NO	YES/NO	VC C NVC	2	5
JC Recomm.									
Stages of Change									
NRT at EKHCS									
Assessment Tool									
Tob cess interv important									
Tob cess interv effect									
Comfort educ tob cess									
Tob cess resources									
Two altern behaviors									
5As tob cess									
Post-Test	1	5	3	VG G F P	YES/NO	YES/NO	VC C NVC	2	5
JC Recomm.									
Stages of Change									
NRT at EKHCS									
Assessment Tool									
Tob cess interv important									
Tob cess interv effect									
Comfort educ tob cess									
Tob cess resources									
Two altern behaviors									
5As tob cess									

Definitions

The following terms utilized for this project are defined below:

Ask, Advise, Assess, Assist and Arrange—5As: A method to guide smoking cessation (Porter, 2013).

Chronic obstructive pulmonary disease (COPD): An umbrella term used to describe progressive lung diseases including emphysema, chronic bronchitis, refractory (non-reversible) asthma, and some forms of bronchiectasis (COPD Foundation, 2017).

Define, measure, analyze, improve, control (DMAIC): A cycle that explicitly focuses improvement on root causes and addresses ongoing evaluation and control (Kelly, 2011).

Lean: A philosophical way of thinking based on eliminating waste with tools focused on production systems, scheduling, and wait times (Kelly, 2011).

Reach, effectiveness, adoption, implementation and maintenance (RE-AIM): A framework to ease the process of planning, conducting, reporting, and selecting interventions to be implemented (Vick et al., 2012).

Six Sigma: A rigorous and disciplined approach using improvement tools, methods, and statistical analysis (Kelly, 2011).

Stakeholder: A key individual who will be affected one way or another by the project (Zaccagnini & White, 2011).

Tobacco Tactics Toolkit: An effective, nurse-administered, evidence-based educational program for bedside nurses to improve knowledge, confidence, and utilization of skills to address inpatient tobacco cessation developed by S. A. Duffy (Vick, et al., 2012).

Transtheoretical model of change (TTM): A theory based on identification of 5 Stages of readiness for behavioral change: precontemplation, contemplation, preparation, action, maintenance (Zaccagnini & White, 2011).

Assumptions

The first assumption for this study was that after receiving a comprehensive, evidence-based education intervention on tobacco cessation, acute care nurses in an

EKHCS would have enhanced feelings of confidence, skill, and knowledge of the tools to implement tobacco cessation for inpatient Veterans. The second assumption was that staff will want to receive education and that new knowledge would lead to an increase in the number of Veterans who receive the Tobacco Tactics education as an inpatient, which would lead to an increase in tobacco cessation for Veterans. I also assumed that the nurses' responses obtained from the pre- and posttests were honest and truthful. Other assumptions are that Veterans want to quit smoking, are open to receiving the tobacco cessation information, and would utilize the resources offered in the patient toolkit.

Scope and Delimitations

The tobacco cessation education project was used for acute care nurses and inpatient Veterans with COPD admitted to the ICU/PCU. Nurses were educated on the Tobacco Tactics program, and a 50% increase in posttest scores after program implementation compared to pretest scores provided evidence that education was successful. Staff then assessed and educated patients with Tobacco Tactics Toolkit for patients and provided interventions learned from the program to be completed at least 75% of the time when a patient was admitted to acute care for program success. Completion of the IPAA admission template was monitored for each admission and would be deemed successful when completed on 90% of acute care admissions.

The project was restricted to the acute care ICU/PCU, which limited the number of staff to 12. Experience with other tobacco cessation programs were limited due to the small convenience sample, which may affect the outcomes of the project. The Tobacco Tactics program provided a standardized education on tobacco cessation that can be used

facility-wide for inpatient and outpatient staff and Veterans. The education took 2 weeks, and the project was completed in 4 weeks.

Limitations

I identified three limitations with this project. Firstly, the project was only tested and implemented at one Veterans hospital. Secondly, the sample size was small, as only 12 nurses participated in this project. The third limitation was the low census of inpatients on the chosen ICU/PCU unit. The average census for the previous 3 months had been 29 per month (ICU/PCU flowsheet). Fortunately, the Tobacco Tactics program has been tested in other VA facilities located in Ann Arbor, Michigan, Gainesville, Florida, and Dallas, Texas (Duffy, et al., 2010). Significant differences exist in facilities where Tobacco Tactics have been implemented and the EKHCS described in this project. For example, sample size was larger at the other VA facilities; Ann Arbor had 148 participants, Gainesville, 85, and Dallas, 128 (Duffy et al, 2010). Unit size was also larger at the other facilities. Ann Arbor is a 200-bed acute care facility (Vick et al., 2012). At the Ann Arbor facility, 283 RNs participated in the study (Fore et al., 2013). A fourth limitation was that only tobacco addiction was addressed in this project. Veterans may have other addictions that affect smoking; however, they were not part of this project.

Significance

Nursing has a valuable perspective when it comes to patient populations in need of tobacco cessation education (O'Connell, 2009). Empowering nurses with standardized education and tools to be successful will help patients achieve a healthier, tobacco-free lifestyle, and make healthier decisions (Scanlon, Clark, & McGuiness, 2008). Current

nursing outcomes were enhanced through improving the assessment process for acute care staff to obtain patient data on smoking cessation history, willingness to quit, education, knowledge of resources for assistance in quitting, and management of addiction. Evidence shows that inpatients who receive tobacco cessation counseling have higher quit rates (Katz et al, 2009). Tobacco cessation education for acute care staff can be successfully addressed and managed with the implementation of evidence-based tools and information to improve care outcomes in acute care that can also impact home care and health in the community (Duffy et al., 2009). Coordinating the care team by improving staff confidence and skills provided a valuable resource to educate patients while also empowering patients to actively participate in their care (Katz et al., 2009). Sustainability of this program can be attained by involving nursing with the opportunity to take ownership of their practice and care environment (Duffy et al., 2012). The program will be intertwined into the culture by selecting staff champions, orientating new staff, providing staff with the education and tools needed to complete interventions, and successfully teaching effective patient-centered tobacco cessation education (Duffy et al., 2009). Support of management and administration was also incorporated into the initial planning phases of change to ensure longevity and success of the Tobacco Tactics Toolkit.

Reduction of Gaps

Inpatient nursing staff only implemented tobacco cessation education to 17% of inpatients who had a desire to quit (Fore et al., 2013). The Tobacco Tactics Toolkit is an evidence-based educational program for inpatient staff with the objectives of measuring

and improving nurse's confidence in and perceived value of implementing tobacco cessation interventions (Fore et al., 2013). Significant statistical data on the effectiveness of the program has been achieved, 85% of staff were moderately to extremely confident in providing tobacco cessation education while almost 90% were extremely satisfied with the education they received (Fore et al., 2013). Despite evidence of the positive effects a nurse-administered tobacco cessation program produces for inpatients, a gap continues to exist between the current lack of smoking cessation offerings for Veteran inpatients and the dissemination and implementation of the Tobacco Tactics Toolkit (Duffy et al., 2014).

Changing nursing's willingness to learn and implement interventions for tobacco cessation have major implications for research, education, and practice (Scanlon et al., 2008). The new practice guidelines for acute care nurses of assessing and providing interventions on tobacco cessation are in line with the 2008 U.S. Public Health Service guidelines to directly improve quality and safety of patients with COPD and tobacco addictions (Katz et al, 2012). In 2011, the Joint Commission made recommendations for the screening of inpatients for tobacco use (Vick et al., 2012). Tobacco cessation implementation at the bedside could potentially impact quit rates as well as decrease the use of tobacco, increase management of disease processes, and decrease morbidity and mortality rates for Veterans (Vick et al., 2012). Approximately 100,000 Veterans per year are admitted into the VA system. This provides an enormous opportunity for improving patient health (Katz et al, 2012).

A major shift in thinking, theory, and practice is necessary to treat inpatients for tobacco addiction. A multidisciplinary care team program such as the Tobacco Tactics Toolkit can help manage chronic conditions such as COPD (Katz et al., 2012). A significant gap in staff knowledge exists that can be effectively solved by a change in the practice for acute care nurses (Scanlon et al., 2008). Identifying nursing champions and key stakeholders who will be significantly impacted by this change in practice will be necessary for project success and sustainability. When disease management programs were implemented for COPD patients, hospitalizations for complications decreased by 41% ($p < 0.05$; Rice et al., 2010). The study was the largest published randomized trial that occurred over a one-year period (Rice et al., 2010). Identifying practice gaps in care and implementing effective programs will reduce gaps and improve outcomes.

Implications for Social Change

Nurse-led tobacco cessation interventions for inpatients has the potential to reach many Veterans at an EKHCS. Acute care staff is the largest group that directly interacts with inpatients in a healthy, smoke-free environment where nicotine replacement therapy and other interventions can be offered to provide a chance to change unhealthy behaviors (Duffy et al., 2008). Dissemination of a nurse-delivered tobacco cessation intervention can reduce tobacco related morbidity and mortality among inpatients (Vick et al., 2012). Nurses are knowledgeable in health behaviors; the Tobacco Tactics Toolkit can enhance that knowledge with education on and interventions for tobacco cessation as well (Duffy, Scheumann, Fowler, Darling-Fisher & Terrell, 2010). Providing tobacco cessation education for inpatient nurses will address the lack of confidence and knowledge

currently present for staff at this EKHCS. Providing nursing staff with tobacco cessation education, tools, and interventions for inpatients has proven to be effective in improving patient outcomes for tobacco cessation (Duffy et al, 2008). The valuable education staff receive will be shared with their patients to improve quality of life, increase quit rates, decrease admissions for complications of COPD, and enhance nursing practice by improving the quality of their care (Duffy et al., 2008). As tobacco cessation education is successfully adopted by inpatient units, outpatient units, and throughout all VA health care facilities, it can be shared with systems outside the VA as well. The Tobacco Tactics Toolkit could become the standard of care to address tobacco cessation for all patients (Duffy et al., 2012). Changing nurses' view, comfort level, and willingness to learn and implement interventions for tobacco cessation have major implications for enhancing research, education, and practice (Scanlon et al., 2008).

Summary

Implementation of the Tobacco Tactics program improved knowledge, confidence and utilization of skills for acute care nurses to address tobacco cessation with inpatient Veterans. The program for staff included stages of change, nicotine replacement therapy, assessment tools, effective interventions, comfort in educating patients, resources, alternative behaviors, and the 5As counseling (Fore et al., 2013). Education also included the updated assessment template, order sets, and referral process in CPRS. The Tobacco Tactics Toolkit for patients includes a handout, education video, manual, nicotine replacement therapy, and helpline (Fore et al., 2013). Pre- and posttests for staff were administered prior to and after implementation of education. Monitoring the

utilization of knowledge and tools for staff and patients will be done for a 3-month period. The RE-AIM model was utilized to focus on critical elements of implementation, sustainability, and support of the Tobacco Tactics program (White & Dudley-Brown). The TTM helped explain the phenomenon of nicotine dependence and a focus on changing behavior (O'Connell, 2009). To sustain this program, it will be intertwined into the culture by selecting champions and providing staff with the education, tools, and leadership needed to support patient-centered tobacco cessation education (Duffy et al., 2012). The Tobacco Tactics Toolkit was well supported in the literature as an evidence-based, Veteran-centered source for acute care nurses that has been successfully trialed within VA inpatient settings.

Section 2: Review of Literature and Theoretical/Conceptual Framework

Introduction

Nurses interact directly with patients more than any other healthcare worker (Vick et al., 2012). Basic nursing education on tobacco cessation is not provided for nurses in training to help them seize the opportunity to implement smoking cessation services during hospitalization (Vick et al., 2012). The purpose of this project was to implement the Tobacco Tactics program for acute care nursing staff to improve their knowledge and confidence and to practice interventions for tobacco cessation (Fore et al., 2013). The program is an evidence-based, nurse-led tobacco cessation course that is also cost-effective, convenient, Veteran-centered, and meets Joint Commission standards (Vick et al., 2012). In Section 2 I present a review of the literature, theoretical model, framework, and the approach utilized in this study. I also provide a review of general and specific literature, as well as a detailed summation of the TTM, the Six-Sigma Lean approach, and the RE-AIM model.

Literature Search Strategy

I conducted a literature review utilizing the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, ERIC, MEDLINE with Full Text, and Military & Government Collection. I conducted a search utilizing the terms *smoking cessation, smoking cessation and education, smoking cessation and Veterans, tobacco cessation education, tobacco cessation education and nursing, tobacco cessation education and acute care, tobacco cessation and inpatients, tobacco cessation and acute*

care and inpatients, smoking cessation and hospitalized Veterans, and *Tobacco Tactics.* A thorough search of related articles published from 2010 to 2015 located 80, of which 14 were used.

Concepts, Models, and Theories

The TTM, describes the stages of change via precontemplation, contemplation, preparation, action, and maintenance, and individualizes movement through these stages to change behavior (Zaccagnini & White, 2011). Using all stages of change creates a stronger foundation for tobacco cessation for staff and Veterans. The TTM and self-efficacy theories are dominant in smoking cessation research (O'Connell, 2009). Other influential factors of the change process of the TTM are decisional balance and temptation (Zaccagnini & White). The expected outcome was based on the individual's perceived self-efficacy (Zaccagnini & White). At each stage of change, individuals vary in decisional balance; for example, considering the positive and negative aspects of tobacco cessation (O'Connell, 2009). The TTM is focused on behavioral change driven by factors such as environment, personal characteristics, and the behavior to be changed (Zaccagnini & White). Self-efficacy is how individuals view themselves as being able to carry out a specific behavior based on experience, modeling, persuasion, physiological arousal, and control (O'Connell). The National Advisor Committee on Health and Disability recommended the use of this model it its' 2002 Smoking Cessation Guidelines (Wong & Stokes, 2011).

A Six Sigma or Lean methodology was used to provide tools based on the philosophy that processes can be defined, measured, analyzed, improved, and controlled

(Kelly, 2011). It is a business method used to increase customer satisfaction and profit by providing tools to streamline processes, improve quality, and eliminate defects for organizations (International Six Sigma Institute, 2014). The root cause for acute care nursing staff in this proposal was the lack of available resources and knowledge for tobacco cessation. The Lean or Six Sigma method guides program planners in ways to improve a process once the problem has been identified (Kelly, 2011). It makes the process of doing what is right for patients and staff easier by helping to eliminate barriers and duplication, and by utilizing reminders to improve practice (Kelly, 2011). The DMAIC process improvement identifies high priority business problems, and trains teams to address those problems by defining the problem, measuring data, analyzing data to identify the root cause, improving the problem by implementing a solution, and controlling the new process by sustaining it (International Six Sigma Institute, 2014).

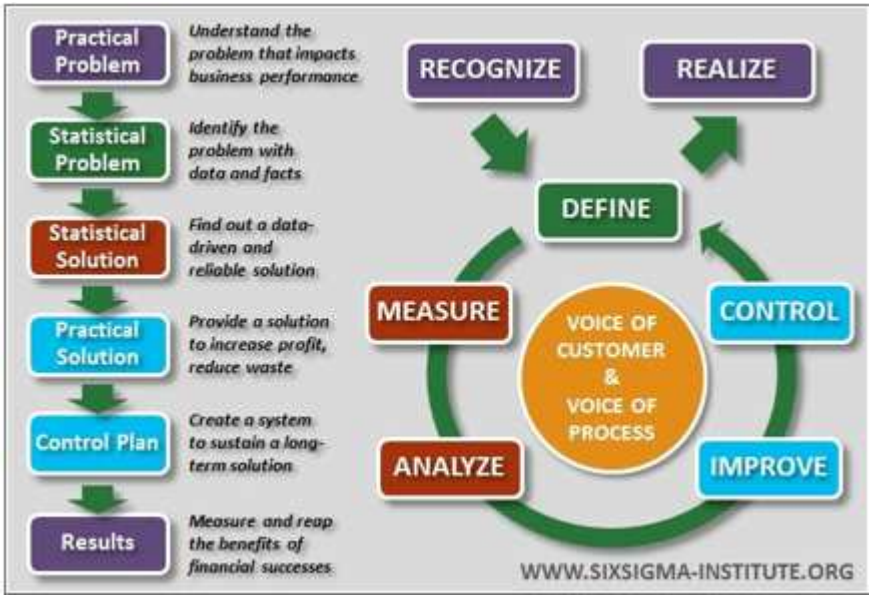

Figure 1. Six Sigma and DMAIC methodology overview.

Frameworks

The reach, effectiveness, adoption, implementation, and maintenance (RE-AIM) model was used to focus on the critical elements of providing an evidence-based education for staff and Veterans, practice changes in assessing inpatients, and offer effective knowledge and resources to achieve successful, valid implementation that is sustainable and supportive of the evidence-based change (White & Dudley-Brown, 2012). The RE-AIM model ensures interventions are evidence-based and applicable in practice (Vick et al., 2012). Use of this model translated knowledge directly into practice by providing guidance from implementation using five steps. The first step was to reach out to the targeted population, the 12 ICU/PCU staff and inpatient Veterans with the Tobacco Tactics educational program. The next step was to effectively implement the Tobacco Tactics knowledge and interventions to positively affect staff outcomes. The third step was the adoption of the Tobacco Tactics by ICU/PCU staff. The final steps included implementation of the updated nursing assessment for every Veteran admitted to the ICU/PCU unit. The evaluation, maintenance, and long-term outcomes of improving tobacco cessation education for acute care nurses and inpatient Veterans was successful by showing an increase in confidence, knowledge, use of interventions and tools, and the number of Veterans that remain tobacco-free after a year, and a decrease in the number of Veterans admitted to acute care for COPD complications, (White & Dudley-Brown, 2012). Completion of the IPAA template was also to be monitored for each admission.

Literature Review Related to the Methods

I conducted a literature search to identify current practice on tobacco cessation education for nurses and Veterans in the acute care setting. I discovered the Tobacco Tactics program in several articles that are evidence-based and Veteran-centered. Dr. Duffy, creator of the nurse-delivered Tobacco Tactics program, has been working on this program for 17 years (personal communication, S. A. Duffy, 2015). Dr. Duffy is a research investigator at the VA system in Ann Arbor, Michigan (Vick et al., 2012). Duffy identified that smoking was connected to a proportionately higher rate of death for Veterans and responsible for millions of dollars per year of smoking-related medical care (Vick et al., 2012). Dr. Duffy also pointed out that nurses make up the largest front-line clinicians who interact directly with patients (Vick et al., 2012). Dr. Duffy highlighted an enormous gap in practice, education, and prevention in the acute care setting (Duffy et al., 2009). A review of the specific literature covers acute care nursing education, Veteran tobacco cessation education for nurses and Veterans, barriers to education, and the Tobacco Tactics program.

Literature Review Related to Methods

Acute Care Nursing Education

The goal of this project was to improve the education of acute care nurses on tobacco cessation for inpatient Veterans. The knowledge of and training in tobacco cessation interventions and assessment for acute care nursing staff in the ICU/PCU are essential elements for tobacco cessation that were missing in the current admission process at this EKHCS. The lack of preparation in nursing schools for students is a major

barrier, as are inadequate professional on the job training in practice and a lack of leadership support (Sarna et al., 2009).

Sarna et al. (2014) highlighted limited knowledge and barriers to tobacco cessation interventions with a convenience sampling of eight hospitals utilizing the generalized linear model. The study included a convenience sample of 2,466 nurses who were provided with a web-based education program that included the 5As, assessment and reassessment of post-education use of new knowledge, and nurse attitudes toward tobacco cessation (Sarna et al., 2014). Statistically significant results in the frequency of smoking cessation interventions was achieved in this study ($p < 0.0001$; Sarna et al., 2014). Significant limitations noted by the researchers included confirmation of web-based program viewing and whether nursing interventions had increased because patient records were not visualized (Sarna et al., 2014). Despite limitations, the study supported the idea when nurses receive tobacco cessation education, they play a significant role in disseminating that education to patients (Sarna et al.,2014).

Few studies have been conducted on faculty perceptions and how students are prepared to provide patients with interventions (Lenz, 2013). Misconceptions such as tobacco cessation is time-consuming, will not change patient behavior, is not a valuable nursing skill, and is not valid content to add to an already overwhelming curriculum were provided (Lenz, 2013). The opportunity exists to educate faculty and nursing students at the undergraduate level and at the facility level to provide the nursing profession with tools to assume a leadership role with tobacco cessation (Lenz, 2013). Nursing is one of the most trusted and respected professions responsible for educating patients and carrying

out appropriate nursing care (Lenz, 2013). A qualitative focus group design was utilized because little data was available about faculty beliefs, barriers, and benefits (Lenz, 2013). The study included 90-minute focus group interviews and was based on the health-belief model (Lenz, 2013). The study found a mismatch between faculty beliefs, practices, and current evidence (Lenz, 2013). The study also revealed a pedagogical barrier as faculty did not view tobacco cessation education as a priority and viewed tobacco cessation as knowledge already acquired by students (Lenz, 2013). Lenz's (2013) study makes the case for implementing an evidence-based tobacco cessation education for faculty and undergraduate students to benefit patients and provide nurses with effective tobacco cessation interventions.

In a 2004, a national online survey was conducted to investigate the content of smoking cessation education in undergraduate nursing curricula (Wong & Stokes, 2011). The study used a cross-sectional descriptive survey design, an online questionnaire, the Ask Brief Advice and Cessation support (ABC), and the 2002 Smoking Cessation Guidelines from the National Advisory Committee on Health and Disability (Wong & Stokes, 2011). Most of the programs reviewed focused on the negative side-effects of tobacco, not on smoking cessation (Wong & Stokes, 2011). The concept of smoking cessation was primarily imbedded in curricula about health promotion, public health, and health and wellness, but was not included in pharmacology, and only 1 to 2 hours were dedicated to the topic (Wong & Stokes, 2011). Education on nicotine addiction and nicotine replacement therapy is an essential component in addressing and providing effective tobacco cessation treatment (Wong & Stokes, 2011). Barriers identified by

nursing instructors included their own lack of education on how to teach tobacco cessation, an already full curriculum, negative attitude about teaching smoking cessation, and students and staff who smoke (Wong & Stokes, 2011). Although educator results were positive, they were not generalizable due to the small sample size ($N = 14$; Wong & Stokes, 2011). It was also not clear to researchers how comprehensive the results were because of contradictory responses and unreliable or incomplete data from nursing schools (Wong & Stokes, 2011). Although there were weaknesses, this study validated the need for undergraduate students to receive smoking cessation education (Wong & Stokes, 2011). The resources are available for nursing schools to offer core smoking cessation competencies and curriculum based on national guidelines, including skills, knowledge, and assessment, which can be found in the Tobacco Tactics Program (Wong & Stokes, 2011).

Tobacco is one of the leading preventable causes of morbidity and mortality, therefore healthcare professionals should include it as part of their health promotion and education for patients (Scanlon et al., 2008). The study examined acute care nurses' attitude and knowledge of the National 5A guidelines for tobacco cessation interventions (Scanlon, et al., 2008). The Stages of Change model, the 5As from the Department of Health and Human Services guidelines to standardize smoking cessation interventions, and a survey was administered to a university affiliated acute unit staff (Scanlon et al., 2008). Of the 162 participants, 62% agreed that they had a responsibility to counsel patients on smoking (Scanlon et al., 2008). The study provided strong insight through use of a large, convenience sample derived from several clinical areas (Scanlon et al.,

2008). The study presented weaknesses in generalizability to other settings, some sub-groups were small, and other variables such as ethnicity, gender, and age were not included in the study (Scanlon et al., 2008). The findings confirmed that a gap in tobacco cessation education interventions exists in undergraduate nursing programs (Scanlon et al., 2008). The study also focused on the presence of simple, evidence-based guidelines such as the 5As be available to clinicians, yet available tools are still underutilized which are addressed in this proposal (Scanlon et al., 2008).

A 2011 study was conducted to evaluate the effectiveness of smoking cessation education on nurse knowledge, counseling, and confidence in counseling (Matten et al., 2011). Few programs have been developed specifically for nurses on tobacco cessation counseling, despite the unique position nursing holds and the increased likelihood they would educate others when trained (Matten et al., 2011). The results revealed a direct correlation between training and increased counseling skills and their use (Matten et al., 2011). The study offered many positives such as utilizing an efficient three-hour tobacco cessation program that brought about immediate changes in knowledge and behavior (Matten et al., 2011). Staff also gained self-confidence, skills in advising, assessing patient readiness, and counseling in smoking cessation (Matten et al., 2011). A single group prospective created a weakness due to the absence of a group to compare whether participation in the program could confirm the documented findings (Matten et al., 2011). Demographic information was not obtained on participants which limited researchers in describing their sample and determining associations of the participation groups (Matten

et al., 2011). The results support tobacco cessation programs to improve nurses' confidence in counseling inpatients on tobacco cessation (Matten et al., 2011).

Veteran Tobacco Cessation Education

A large gap exists in the Veteran population regarding the availability and access to interventions available in the acute care setting on tobacco cessation (Duffy et al., 2009). Duffy et al. (2009) reported that of the 70% of inpatient Veterans who smoked and were interested in quitting, only 17% were offered cessation services. A formative evaluation on the implementation of the Tobacco Tactics program incorporated both quantitative and qualitative data (Duffy et al., 2009). Interventions were based on the Agency for Healthcare Research and Quality (AHRQ) recommendations to focus interventions on a patient's medical condition as well as lifestyle (Duffy et al., 2009). The authors of the study reported an increase in interventions provided to inpatient Veterans after education of staff on the Tobacco Tactics program (Duffy et al., 2009). Patient satisfaction increased by 9% and a significant increase in patients receiving nicotine replacement therapy such as nicotine gum ($p = 0.02$) and patch ($p = 0.005$) were identified (Duffy et al.,2009). An area of weakness for this study was the small sample size (Duffy et al., 2009). The sample size consisted of three times as many psychiatric patients, creating an unequal sample and affecting the generalizability of research findings (Duffy et al., 2009). The study did produce an increase in the number of Veterans offered tobacco cessation interventions and patient satisfaction (Duffy et al., 2009). The study identified a crucial need of inpatient Veterans, improved methods for

tobacco cessation and created an environment resulting in an increase in services provided (Duffy et al., 2009).

Smoking rates and smoking related deaths are higher among the Veteran population compared to their civilian counterparts (Vick et al., 2012). In 2011, the Joint Commission made recommendations for the screening of inpatients for tobacco use (Vick et al., 2012). Outpatient programs are not being routinely promoted for inpatients, and inpatient interventions have the potential to reach larger numbers of patients addicted to tobacco (Vick et al., 2012). Tobacco cessation implementation at the bedside has the potential to impact quit rates, decrease tobacco use, morbidity and mortality and increase the ability to manage disease processes for patients outside the hospital setting (Vick et al., 2012). A quasi-experimental convenience sample of 54 inpatient Veterans were asked to report receiving tobacco cessation interventions and satisfaction with the interventions (Vick et al., 2012). Prior to implementation of the Tobacco Tactics program, participants reported smoking 15 cigarettes per day, post-implementation that number decreased to nine (Vick et al., 2012). Patient receipt of education and interventions, as well as satisfaction increased 10% post-intervention of the program (Vick et al., 2012). A key weakness of the study is that participants were primarily male, African-American, single and disabled which creates results that may not be representative of a general population (Vick et al., 2012). The study does support the project proposal by identifying the importance of the 2011 Joint Commission standards recommending screening and treatment for inpatient smokers (Vick et al., 2012).

Tobacco Tactics Toolkit Program

The Tobacco Tactics program, developed by Dr. Sonia A. Duffy, was developed in response to a higher incident rate of smoking among Veterans compared to that of the civilian population (Fore et al., 2013). The need for a nurse-administered, inpatient program to increase education and implemention of tobacco cessation interventions to improve quit rates among the Veteran population was also identified (Fore et al., 2013). It has been shown that nurse-led intervention on smoking cessation for inpatients are effective (Fore et al., 2013). Nursing staff report not feeling comfortable offering tobacco counseling, lack of patient motivation, and lack of time affecting cessation interventions being offered to inpatients (Fore et al., 2013). Studies within the VA suggest 70% of Veterans who smoke had the desire to quit, but only 17% reported receiving tobacco cessation interventions while an inpatient (Fore et al., 2013). Two cross-sectional surveys were administered to staff at two months and fifteen months post-training on Tobacco Tactics (Fore et al., 2013). The program is an evidence-based educational program for inpatient staff with the objectives of measuring and improving nurse's perceived confidence, knowledge of resources and importance of cessation interventions (Fore et al., 2013). The Tobacco Tactics program has provided significant statistical data on the effectiveness of the program, 85% of staff reported being moderately to extremely comfortable with providing education for patients on tobacco cessation post-education (Fore et al., 2013). Staff were extremely satisfied with the program interventions and expressed an increase in confidence in conducting cessation services ($p < 0.0001$; Fore et al., 2013). The use of only one facility may be a limitation

due to the generalizability of data, as well as a low response rate of 45% (Fore et al). The study presented data to support this proposal that the implementation of the Tobacco Tactics program to staff nurses and inpatients will increase staff confidence in offering tobacco cessation interventions and improve quit rates among Veterans (Fore et al).

The effectiveness of implementing the Tobacco Tactics Program for inpatient nurses and patients in a VA facility was investigated (Duffy, Ronis, Karvonene-Gutierrez, Ewing, Dallack, Smith, Carmody, Hicks, Hermann, Reeves & Flanagan 2014). A quasi-experimental, PRECEDE-PROCEED model, and a pre/post implementation design were used over a four-year period at three large Veteran hospitals (Duffy et al., 2014). The Tobacco Tactics program produced a statistically significant increase in Veteran inpatient quit rates among the three sites (p = 0.004, <0.001, and 0.07 respectively); (Duffy et al., 2014). One strength of this study was that it provided staff with an evidence-based program in-line with Joint Commission standards, and interventions were offered to all inpatients at any point during their stay (Duffy et al., 2014). The study was limited by the non-randomized trials which may impact interpretation of results (Duffy et al., 2014). Other factors such as depression rates, severity of illness, and socioeconomic status may create an unreliable representation of data for the target population (Duffy et al., 2014). Additional issues that may have affected the study were varying timeframes for training nurses, a severe nursing shortage, the low number of patients recruited at one site, and the difficult recruitment of African-American participants (Duffy et al., 2014). Significant improvement in quit rates among Veteran inpatients was achieved in this study and the program is now being tested outside

the VA system which will create research and data that are generalizable which supports the objectives of this proposal (Duffy et al., 2014).

Tobacco Cessation Programs Needed for Inpatient Veterans

A study to obtain data on the effectiveness of a disease management strategy for the care of patients with COPD was conducted at a VA medical center (Rice, Dewan, Bloomfield, Grill, Schult, Nelson, Kumari, Thomas, Geist, Beaner, Caldwell & Niewoehner, 2010). The study was a randomized controlled trial that included five VA facilities and 743 Veteran participants (Rice et al., 2010). Data to support the effectiveness of disease management on care of patients with COPD was found to be missing (Rice et al., 2010). When changes in staff knowledge were achieved, hospitalizations for COPD complications decreased by 41% ($p < 0.05$) (Rice et al., 2010). A decrease of 50% was seen in emergency room visits ($p < 0.001$) and participants spent 36% less time in the hospital ($p = 0.05$) (Rice et al 2010). Mortality rates for the usual group was 48 and 36 for the disease management group over a one-year period (Rice et al., 2010). The need for new and innovative ways to manage chronic diseases like COPD are lacking (Rice et al., 2010). The study was limited by use of an all-male study group, use of high-risk patients, and a low response rate (59%) of patient reported respiratory health status (Rice et al., 2010). The Tobacco Tactics program can decrease the gap in care by providing staff and inpatients with the knowledge to manage chronic disease and reduce readmissions for complications associated with COPD (Rice et al., 2010).

Readmission rates and length of stay for inpatients diagnosed with COPD are healthcare issues that can be addressed by providing inpatient staff and patients with the knowledge to manage chronic disease processes (Cope, Fowler & Pogson, 2015). The aim of the study was to develop and implement a clinical-nurse-specialist-led COPD "in-reach service for patients admitted through the emergency department (Cope, Fowler & Pogson, 2015). The variables studied were length of stay, readmission rates, discharge readiness, and patient experience (Cope, Fowler & Pogson, 2015). A survey distributed to participants included questions pertaining to the nurse specialist, what was discussed, whether the patient felt prepared for discharge, had they been seen in prior admissions, and if so, how did the different admissions compare (Cope, Fowler & Pogson, 2015). After implementation of the program, length of stay decreased from 7.68 days to 5.15 days, readmission rates decreased from 8.1 to 3.9 per month, and patients indicated that they were satisfied with the explanation of their diagnosis, review of respiratory medications, and felt prepared for discharge (Cope, Fowler & Pogson, 2015). A limitation of this study is that it is a service improvement, not a process, quality improvement or a research study (Cope, Fowler & Pogson, 2015). A drawback of this project was that the service was only provided during the week, not on weekends or holidays (Cope, Fowler & Pogson, 2015). The strengths of the project were the support and information inpatients received prior to discharge and that the COPD in-reach service could be replicated in other inpatient settings (Cope, Fowler & Pogson, 2015). Key aspects of the project that support this proposal are the education provided to inpatients

and that it is a nurse-led program to reduce length of stay, readmissions and improve the patient experience (Cope, Fowler & Pogson, 2015).

Smoking is the leading cause of most types of cancer, is the most preventable and reversible link to improving health, decreasing medical costs, and improving productivity and mortality rates (Porter, 2013). Evidence shows multiple cessation attempts may be required before smokers are successful (Porter, 2013). At least five attempts can lead to a 41% cessation for individuals who quit each year and a 4.7% rate who remain smoke free for approximately three months (Porter, 2013). The article presented information on the 5As method of patient interaction (Porter, 2013). Although this was not a research-based resource, it provides important information on tobacco use, effective interventions including the 5As, assessment, counseling, support groups, and nicotine replacement therapies (Porter, 2013). The material presented in this article supports the positive effects tobacco cessation programs can have on patients as does this proposal.

Leschisin and Martin (2007) investigated the importance of a multidisciplinary team approach when developing and implementing a tobacco cessation program. Pharmacists, like nurses have a unique opportunity to address tobacco cessation with inpatients by providing them with an assessment, the national quit hotline, utilizing the 5As approach, and tobacco cessation protocols (Leschisin & Martin, 2007). Barriers such as the fear of offending patients, working outside the scope of practice, and the lack of time were the same concerns nurses identified (Leschisin & Martin, 2007). The article provides and promotes tobacco cessation concerns and interventions to establish support

for inpatients, which are also concepts included in this proposal (Leschisin & Martin, 2007).

A case study was conducted to examine the opposition of smoking and tobacco sales in VA facilities (Offen, Smith & Malone, 2013). The importance of advancing the health of our Veterans through the advancement of tobacco control measures has been compellingly stalled by the tobacco industry's minimization of health concerns related to tobacco use (Offen, Smith & Malone, 2013). The fact that tobacco use is higher among the Veteran population compared to civilians has long been known (Offen, Smith & Malone, 2013). However, military personnel are negatively affected by inadequate tobacco control policies (Offen, Smith & Malone, 2013). The data for this article was collected from released internal tobacco industry documents (Offen, Smith & Malone, 2013). It is estimated that the VA spends an estimated $5 billion to treat Veterans diagnosed with COPD, of which 80% are smokers (Offen, Smith & Malone, 2013). Historically the VA was supportive in removing smoking from VA facilities, however, the tobacco industry formed a grassroots Veteran's opposition group and the U.S. Congress was forced to pass a law requiring smoking shelters at every VA (Offen, Smith & Malone, 2013). The cost of building the shelters was an estimated $27 million, not including maintenance (Offen, Smith & Malone, 2013). The funding for the smoking shelters, which are enclosed, heated and air-conditioned was taken out of the main VA budget (Offen, Smith & Malone, 2013). A Veteran coalition for smoker's rights described smoking as a "basic right" and that it was "one of the few joys" Veterans still had to gain support among Veterans (Offen, Smith & Malone, 2013). The tobacco

industry has set a precedence regarding Veterans, tobacco promotion, and policy (Offen, Smith & Malone, 2013). The use of tactics by the tobacco industry, including focusing tobacco use on freedom, personal choice and minimizing its' ill effects, their influence on Congress, exploitation of Veterans, and policies that are made at the federal level, create strong barriers against tobacco cessation for Veterans (Offen, Smith & Malone, 2013).

Relevance to nursing practice. For nursing to be successful in helping patients begin the journey to a healthier, tobacco-free lifestyle, standardized education can provide education for care teams and patients that is evidence-based (Scanlon et al., 2008). Tobacco is the only preventable risk factor for morbidity and mortality of tobacco related disease such as coronary artery disease and COPD (Scanlon et al., 2008). The nursing practice changes this project offers affected the assessment of inpatients admitted to acute care in the areas of smoking cessation history, willingness to quit, education, knowledge of resources for support in quitting, and management of addiction.

Evidence shows that inpatients who receive tobacco cessation counseling have higher quit rates (Katz et al., 2009). Improving the assessment, evaluation, and interventions for smoking cessation could be consistently conducted on inpatient units, during the acute phase of hospitalization to improve outcomes (Leschisin & Martin, 2007). Early assessment and implementation of tobacco cessation education improves Veteran's success in decreasing tobacco use. Educating can empower staff that have direct access to patient's during a prime environment filled with opportunities to converse with patients and learn about their tobacco history and needs to positively affect patient's health, while addressing micro and macro system gaps in care (Katz et al., 2012).

Among the Veteran population, the incidence of COPD is a common chronic disease process that contributes to frequent inpatient admissions. Tobacco cessation for our Veteran population with COPD can be successfully addressed and managed for inpatients through a collaborative, multidisciplinary education program for inpatient staff with evidence–based tools and information to improve health and care outcomes in acute care that has the potential to impact health in the home and in the community (Duffy, 2009). Coordinating the entire care team to improve staff confidence in their skills as a valuable resource to educate patients will also empower patients that have the desire to actively participate with the care team (Katz et al, 2009).

Local Background and Context

The need for tobacco cessation education for staff and inpatients was identified by conducting a Clinical Nurse Leader needs assessment of the ICU/PCU that revealed a lack of educational resources, organizational support for inpatient assessment, and interventions for acute care nursing staff on tobacco cessation. As I began considering what factors this group had in common, I found that many had a history of tobacco use, depression, mental illness and COPD. As I gathered evidence from literature that supported the common diagnoses, talked with staff, social work, providers, pharmacy, respiratory therapy and dietary, I also learned that Veteran's with COPD were among the most frequent and complicated types of patients readmitted for complications from their COPD. Tobacco addiction in the Veteran community contributes to twice as many admissions, increased length of stay and an estimated $75.5 billion annually for related medical costs (Duffy, Reeves, Hermann, Karvonen & Smith, 2009). Per the Centers for

Disease Control and Prevention (2012), smokers are primarily black (17.5%) white (18.2%) and Hispanic (11.2%) are in the age groups ranging from 25-44 (20%) and 45-64 (18.0%), have less than a high school education (22.9%), GED (43%) and live below the poverty level (26.3%).

The two policies currently guiding practice at this VA facility are the National Smoking and Tobacco Use Cessation Program from the Department of Veterans Affairs in Washington, DC and the facility Smoking and Tobacco Use Policy (VHA Directive 1056, 2014). Major issues with current policies include being outdated, not evidence-based, they contain areas of vulnerability, and are not consistently being translated into practice. For example, the policy states that "patients and employees will be offered tobacco cessation services to include nicotine replacement, but does not outline what services, how or where it will be offered, and who is responsible for presenting or providing information or services (VHA Directive 1056, 2014). Another weakness was the lack of information on the smoking risk assessment that is, per policy, to be done on all inpatients to obtain information regarding their tobacco and cessation history (Appendix D); (CPRS, 2016). The lack of education to address a specific population was identified.

The Tobacco Tactics program was discovered during an extensive literature search on Tobacco Cessation programs for inpatients. Dr. Duffy's program was highlighted as a program that was evidence-based and Veteran-centered. The Tobacco Tactics program was designed as a cross-sectional survey for nurses conducted by post-training at two months and again at 15 months (Fore et al., 2013). A pre-education test

was administered with a convenience sample of acute care staff, followed by implementation of the Tobacco Tactics program, a post-education test, and then 4 weeks of monitoring utilization of education and tools was conducted. The unit of analysis was an increase in the number of correct answers from pre-to post-test on material covering Joint Commission smoking cessation recommendations, stages of change, nicotine replacement therapies, tobacco cessation assessment, interventions, comfort with providing tobacco cessation education, resources, alternative behaviors to smoking and the five A's to tobacco cessation (Appendix B & C). Also, improvements in staff confidence, utilization of tobacco cessation interventions, and education for inpatient Veterans will be accomplished. A significant improvement from the absence of a comprehensive admission assessment and education for staff and inpatients on tobacco cessation to a 75% utilization of resources and knowledge from the Tobacco Tactics program provided evidence that the project goals were successful.

Summary

The literature review produced information to support the need for and presence of effective tobacco cessation programs for inpatient staff and Veterans. Research shows when tobacco cessation programs are provided to inpatients, smoking cessation rates increase, and mortality rates are reduced (Duffy et al., 2008). Tobacco cessation education also improves staff knowledge, confidence, and willingness to offer interventions to patients (Duffy et al., 2008). The Tobacco Tactics program provided a comprehensive, effective, staff and Veteran-based resource for education in the acute care setting to address unmet needs for Veterans and inpatient staff (Duffy et al., 2008).

The program has been tested, addresses nursing's need to receive education to improve knowledge, confidence, and implementation of interventions to inpatients while overcoming common barriers (Duffy et al, 2008). It provided inpatient Veterans with the interventions, resources and support to deal with addiction, the desire to quit, and obtain coping skills to conquer setbacks (Duffy et al., 2008). The education of nursing staff enhanced practice which will in turn fill the gap present for interventions and patient education on tobacco cessation. As an experienced ICU nurse, it is frustrating to not have the knowledge or resources available to better care for patients. Section 3 highlighted the specific gaps in knowledge regarding tobacco cessation and how the Tobacco Tactics Toolkit bridged those gaps.

Section 3: Collection and Analysis of Evidence

Introduction

The purpose of this project was to implement the Tobacco Tactics Toolkit for acute care nursing staff to improve their knowledge confidence, and practice interventions for tobacco cessation, and to provide education for Veterans admitted to the EKHCS. The project question was: Will implementation of the Tobacco Tactics Toolkit improve acute care nurses' knowledge, confidence, and utilization of tobacco cessation interventions to increase the quit rate of inpatient Veterans? In Section 3 of the DNP proposal I discuss project design, target population, sampling technique, team development strategies, ethical considerations, data collection, and data analysis. Implementing the Tobacco Tactics Toolkit provided acute care nurses with the knowledge and tools to address the need to decrease rates of tobacco use for Veterans and improve their overall health.

Project Design/Methods

The project design was a pre- and post-program implementation test, using a nonrandomized, single-group. I used a convenience sample method for the current inpatient acute care staff. I used a Six Sigma or Lean approach was used to provide tools, methods and analysis based on a philosophy that processes can be defined, measured, analyzed, improved and controlled to streamline the process and remove waste (Kelly, 2011). The Six-Sigma methodology is an ongoing process with the focus on the root cause of a problem (Kelly, 2011). The practice problem identified was the lack of educational resources and organizational support for inpatient nursing staff related to

tobacco cessation. The Lean or Six Sigma method guides program planners in ways to improve a process once the problem has been identified. It makes the process of doing what is right for patients and staff easier by helping to eliminate barriers and duplications and utilizing reminders to improve practice (Kelly, 2011).

Sources of Evidence

When changes in staff knowledge were achieved, hospitalizations for COPD complications decreased by 41% ($p < 0.05$; Rice et al., 2010). It is estimated that 20.1% or 1.6 million Veterans report smoking (PH, 2012). An estimated 8.7 million Veterans seek healthcare from the VA yearly; 1.6 million reporting smoking creates a population of Veterans that could receive assistance in addressing their smoking addiction and help them quit if they so choose (PH, 2012). COPD is the third leading cause of death in the United States (Blanchette et al., 2014). The prevalence of deaths from COPD have significantly increased from 40.7% to 67% with 66.9 deaths annually per 100,000 for individuals aged less than 75 years of age (Blanchette et al., 2014). Veterans with COPD were among the most frequent and complicated types of patients readmitted for complications from their COPD. Tobacco addiction in the Veteran community contributes to twice as many admissions and increased lengths of stay than for non-Veterans, accounting for an estimated $75.5 billion annually for related medical costs (Duffy et al., 2008). Smoking is the leading cause of most types of cancer and the most preventable and reversible link to improving health, decreasing medical costs, improving productivity, and lowering mortality (Porter, 2013). Evidence shows multiple cessation attempts may be required before smokers are successful (Porter, 2013). At least five

attempts can lead to cessation of the 41% of individuals who quit each year and 4.7% remain smoke free for approximately three months (Porter, 2013). Studies within the VA suggest 70% of Veterans who smoke had the desire to quit, but only 17% reported receiving tobacco cessation interventions while an inpatient (Fore et al., 2013). An estimated 8.7 million Veterans seek their care in the Veterans Health Administration (VHA) system (PH, 2012). There is a great opportunity to fill the gap in knowledge and practice for front-line staff with the evidence-based education and tools for inpatient tobacco cessation.

Population and Sampling

The project was conducted in a Midwestern EKHCS. The Colmery O'Neil Veterans Hospital is a 139-bed medical center. The 8-bed acute care inpatient ICU/PCU was chosen for the initial implementation of the Tobacco Tactics program. The ICU/PCU has 5 ICU beds and 3 PCU beds with an average of 39, 45, 38, and 34 patients per month for March, April, May, and June respectively for FY2017. The patients admitted to this ICU/PCU have diagnoses of COPD, CHF, sepsis, pneumonia, respiratory failure, renal failure, kidney failure, liver disease, postsurgical complications, suicidal and homicidal ideation, alcohol abuse, and drug withdrawal. Currently 12 nurses staff the ICU/PCU, there is one nurse manager, and a nurse to patient ratio of 1:2. Each staff member was asked and agreed to participate in this project, therefore no recruitment was necessary. In my role as the clinical nurse leader for the medical-surgical unit, I had developed a professional working relationship with all staff through prior collaboration on practice changes and as a clinical resource. All 12 nurses are registered nurses with a

bachelor of nursing degree and are advanced cardiac life support certified, with two having just completed their nurse practitioner education. Eight of the 12 nurses have worked outside the VA system and four have only worked within the VA in the ICU. Collectively, the 12 nurses have worked a range of 2-30 years in the ICU/PCU at the VA, and they range in age from 28 to 63 years.

Data Collection

Approval from EKHCS Institutional Review Board (IRB) and approval from Walden's IRB were obtained prior to implementation of the project. The retrospective data that I collected was obtained directly from the Veterans Health Administration Support Service Center warehouse for Pyramid data on smoking cessation rates and quit rates for inpatient Veterans through the ORYX (Joint Commission performance measurement initiative). ORYX is included in the Strategic Analytics for Improvement and Learning (SAIL) scorecard on tobacco use among Veterans. The data I gathered on smoking and admissions was also collected from the Pyramid and Reports and Measures Portal data cubes prior to implementation of the project. The data information was deidentified by only containing the number of Veterans for each outcome, and no personal information such as name, social security number, or date of birth was obtained. The information was maintained in a password protected computer, in a private, locked office at the VA facility. The information was compared to retrospective data on admissions to acute care, the number of smokers, and quit rates for Veterans after program implementation at one and three months to determine the effect of the Tobacco Tactics program. The pre-implementation and postimplementation data were compared

to determine whether there was a decrease in the number of Veterans admitted to ICU/PCU who reported smoking, an increase in Veterans who received tobacco cessation counseling, and an increase in quit rates.

The purpose of the quality improvement project and the Tobacco Tactics program was presented during a thirty-minute ICU/PCU staff meeting on the unit the week prior to implementation of the Tobacco Tactics program. Staff were given information on the team-based approach to improve the process of evaluating inpatient Veterans on tobacco cessation, including their desire to quit. Also discussed was the lack of staff and Veteran smoking cessation education, and a review of the current admission template and data on admission rates, smoking, and quit rates were also shared with staff. A project outline of the QI project was presented at this staff meeting to all twelve staff and the nurse manager, along with a short handout (Appendix A) that outlined the project process of pretest, Tobacco Tactics education, posttest, and implementation of the Tobacco Tactics program with inpatients. The nurse manager did not participate in the pre- or posttest or Tobacco Tactics education.

The Tobacco Cessation Pretest (Appendix B), a ten-item paper and pen test, was given to staff immediately after the staff meeting on the ICU/PCU unit, one week prior to implementing the Tobacco Tactics program. I administered the anonymous pretest that staff had thirty minutes to complete. The test was used to assess staff knowledge of tobacco cessation, staff confidence in teaching tobacco cessation education, and use of tobacco cessation interventions. To ensure anonymity and privacy for participants, the pretests did not have staff names or any other personal information to identify individual

staff members. When the pre-test was completed, each staff member placed the test in a manila envelope labeled pretest. I collected the envelopes and stored them in a locked file cabinet, in a private, locked office located within the VA facility.

The Tobacco Tactics Toolkit cessation program is an evidence-based education adopted from the Rx for Change: Clinician-Assisted Tobacco Cessation, originally an 8-hour curriculum for pharmacy students (Matten et al., 2011). I presented the education through face-to-face and small groups of staff on the ICU/PCU unit in a small conference room. Staff education, which took approximately 1.5 hours, was presented in a 56-slide PowerPoint presentation titled DNP Tobacco Tactics Nurse Training Spring 2018 (Appendix F) to all acute care staff. It took place over a 1-week period. The power point was followed by a question and answer discussion. Tobacco Tactics education reviewed (a) the Joint Commission smoking cessation recommendation, (b) stages of change, (c) nicotine replacement therapies (d) the Tobacco Tactics Toolkit for acute inpatient Veterans (Appendix G), (e) an updated EK-IPAA Nursing Assessment Template (Appendix E), and (f) the five A's (the ask, advise, assess, assist, and arrange method of tobacco cessation counseling). Education ensures a comprehensive assessment of all inpatients that includes smoking history, (a) tobacco cessation attempts, (b) treatments, (c) consults, (d) tobacco cessation interventions for inpatients, (e) Veteran education on tobacco cessation, (f) tobacco cessation resources, (g) alternative behaviors/activities to tobacco, and (h) interventions.

The Tobacco Cessation Posttest, (Appendix C), a ten-question paper and pen test, was administered to all 12 staff members immediately following the 56-slide, 1.5-hour

Tobacco Tactics PowerPoint presentation on the ICU/PCU unit, during which I was present. Staff had thirty minutes to complete the test that was used to assess staff knowledge after presentation of the Tobacco Tactics Toolkit. The data showed the effect implementation of the Tobacco Tactics Toolkit had on staff's knowledge, confidence in teaching tobacco cessation education, and prior use of tobacco cessation interventions. The test included questions on (a) Joint Commission smoking cessation recommendation, (b) stages of change, (c) nicotine replacement therapies, (d) current assessment template for patient's smoking history and willingness to quit, (e) tobacco cessation interventions for inpatients, (f) educating Veterans on tobacco cessation, (g) tobacco cessation resources for inpatients, (h) alternative behaviors/activities to tobacco, (i) how to implement interventions, and (j) the five A's of tobacco cessation. After completion of the anonymous posttest, each staff member placed the test in a manila envelope labeled posttest. I administered the test and collected the manila envelopes and stored them in a locked file cabinet, in a private, locked office located within the VA facility. To ensure anonymity and privacy for participants, no personal identification was collected on the posttest. The focus of the data collected from the pre- and posttest results was to show improvement of the acute care staff's knowledge of and confidence in using tobacco cessation interventions.

Instruments

The Tobacco Cessation pretest. The tobacco cessation pretest (Appendix B) is a ten-question paper and pen test assessing staff's knowledge of the Tobacco Tactics Toolkit on tobacco cessation, confidence in teaching tobacco cessation education, and use

of tobacco cessation interventions. The test also included questions on Joint Commission smoking cessation recommendation; stages of change; nicotine replacement therapies; current assessment template for patient's smoking history and willingness to quit; tobacco cessation interventions for inpatients; educating Veterans on tobacco cessation; tobacco cessation resources for inpatients; alternative behaviors/activities to tobacco, how to implement interventions, and the five A's of tobacco cessation. The pretest consisted of two five-point Likert scale questions on how satisfied staff are with the current assessment tool for patient's smoking history and willingness to quit, ranging from Extremely satisfied to Very unsatisfied; rating confidence level in educating Veterans on tobacco cessation from Extremely confident to Not very confident; eight questions asking "Yes/No" to whether tobacco cessation interventions are important for inpatients; and questions asking "Yes/ No" if tobacco cessation interventions are effective for inpatients. Also included were lists of two tobacco cessation resources available for inpatients, two alternative behaviors/activities to tobacco, that can be offered to Veterans, and the five A's of tobacco cessation.

The Tobacco Cessation posttest. The Tobacco Cessation posttest (Appendix C) was a ten-question paper and pen test that assessed staff's knowledge of tobacco cessation, staff confidence in teaching tobacco cessation education, and use of tobacco cessation interventions after presentation of the Tobacco Tactics Toolkit for tobacco cessation education. The test also included questions on Joint Commission smoking cessation recommendation; stages of change; nicotine replacement therapies; current assessment template for patient's smoking history and willingness to quit; tobacco

cessation interventions for inpatients; educating Veterans on tobacco cessation; tobacco cessation resources for inpatients; alternative behaviors/activities to tobacco, how to implement interventions, and the five A's of tobacco cessation including two five-point Likert scale questions on how satisfied staff were with the current assessment tool for patient's smoking history and willingness to quit ranging from Extremely satisfied to Very unsatisfied, rating confidence level in educating Veterans on tobacco cessation from Extremely confident to Not very confident and eight "Yes/No" to whether tobacco cessation interventions were important for inpatients; "Yes/ No" if tobacco cessation interventions were effective for inpatients; listing two tobacco cessation resources available for inpatients; listing two alternative behaviors/activities to tobacco, you can offer Veterans, and answering what were the five A's of tobacco cessation.

Human Protection and Ethical Considerations

Once approval from Walden's IRB (approval no. 02-26-18-0499983) was obtained implementation of the quality improvement project was began. Approval from the VA IRB was already obtained. Obtaining consent from ICU/PCU staff was not necessary because participation was not a perquisite as this is a quality improvement project. Data was collected, and no personal information was obtained. The pre- and posttests were given to the staff to highlight the difference in the staff's knowledge of tobacco cessation, staff confidence in teaching tobacco cessation education, and use of tobacco cessation interventions. All information generated from the project was considered confidential and was only used within the EKHCS health organization. Once the data was collected, it remained in an encrypted, password protected computer in my

locked, private office within the VA. The hard copies of the pre- and post-tests were stored in a locked file cabinet, in my private, locked office located within the VA facility. All information and results obtained from this project were anonymous and privacy was maintained by not utilizing staff or Veteran names to protect the privacy and confidentiality of all participants.

Data Analysis

The project question for this quality improvement project was: "Will the implementation of the Tobacco Tactics Toolkit improve acute care nurses' knowledge of and confidence in the use of tobacco cessation interventions to increase the quit rate of inpatient Veterans? Retrospective and prospective data on Veteran smoking rates, inpatient admissions, and quit rates were obtained from the SAIL value model. The SAIL data, which was collected on a 12-month rolling calendar, is the part of the ORYX metrics data ware house for inpatient outcomes. The three metrics currently collected are tobacco use screening, tobacco use treatment provided or offered, and tobacco use treatment provided/offered at discharge. Tobacco screening is 99%, tobacco use treatment is 30%, and tobacco use treatment at discharge is 30% (Http://vssc.med.va.gov/products.asp?PgmArea=15). An increase in quit rates were considered significant when 90% of inpatient Veterans are assessed and screened utilizing the Tobacco Tactics tools.

The pre- and post-test data were analyzed using descriptive analysis. The analysis provided a summary of the data that describes what was found by collecting the data (Terry, 2015). Data was formatted in a frequency distribution model to group variables

into a range from least improved score to highest improved score. The pre-test variables include questions rated on a five-point Likert scale on staff knowledge of Joint Commission smoking cessation recommendation; stages of change; nicotine replacement therapies at EKHCS; staff satisfaction with the current admission assessment ranging from Extremely satisfied to Very unsatisfied, and a confidence level for educating Veterans on tobacco cessation from Extremely confident to Not very confident. The "Yes/No" variables included questions about the importance and effectiveness of tobacco cessation interventions, tobacco cessation resources for inpatients, alternative behaviors/activities to tobacco, and the 5A's of tobacco cessation. The Pre-and post-test scores were displayed in a Microsoft Excel spreadsheet to show the difference in knowledge of and confidence in using tobacco cessation interventions at 1 and 3-month intervals post Tobacco Tactics Toolkit implementation. Increased scores from the posttest to pretest determined if there was a positive effect of the implementation of the Tobacco Tactics program on the project proposal outcomes.

Pre-Test	1	5	3	VG G F P	YES/NO	YES/NO	VC C NVC	2	5
JC Recomm.									
Stages of Change									
NRT at EKHCS									
Assessment Tool									
Tob cess interv important									
Tob cess interv effect									
Comfort educ tob cess									
Tob cess resources									
Two altern behaviors									
5As tob cess									
Post-Test	1	5	3	VG G F P	YES/NO	YES/NO	VC C NVC	2	5
JC Recomm.									
Stages of Change									
NRT at EKHCS									
Assessment Tool									
Tob cess interv important									
Tob cess interv effect									
Comfort educ tob cess									
Tob cess resources									
Two altern behaviors									
5As tob cess									

Table 1. **Pre and Posttest results displayed in a Pareto Chart**

Project Evaluation Plan

The evaluation plan included monitoring data on staff's knowledge of tobacco cessation assessment, interventions, template Tobacco Tactics program interventions documented in CPRS. The Six Sigma DMAIC tool was utilized to define, measure, analyze, improve, and control the practice change (Kelly, 2011). The goal of using this business model was to streamline the process of educating acute care staff and inpatients, improve quality, and eliminate defects that create waste in organizations (International Six Sigma Institute, 2014). The planning and evaluation framework looked at knowledge, comfort and willingness to utilize information. A major component of measuring success of the education for staff is for them to have the tools available to

conduct a comprehensive assessment and to evaluate and identify inpatient Veterans who have the desire and need to access tobacco cessation information and resources (White & Dudley-Brown, 2012). Once evaluated, the projects' success will be disseminated to all inpatient and outpatient units, neighborhoods and clinics at this VA facility as the standardized tobacco cessation education program for EKHCS.

The first goal of the project was to implement the Tobacco Tactics Toolkit to acute care nursing staff. Success was considered positive if a 50% increase in posttest scores after program implementation compared to pre-test scores were achieved. The second goal was to educate the nursing staff on additions to the nursing assessment template (Appendix E), order sets, and referral process in the CPRS. The objective was measured by monitoring the utilization of the EK-IPAA Nursing Assessment Template (Appendix E) by acute care staff for inpatient Veterans. Therefore, the expectation was that the admission assessment template will be completed at least 75% of the time when a patient is admitted to acute care. The third goal was to implement the Tobacco Tactics Toolkit for acute inpatient Veterans. Completion of the IPAA admission template was considered successful when completed on 90% of acute care admissions.

Summary

The main objective of this quality improvement project was to provide education on tobacco cessation to improve acute care nurses' knowledge, confidence, and use of the Tobacco Tactics program tools to improve tobacco quit rates for Veterans that will lead to improved health. The implementation of the Tobacco Tactics Toolkit was carried out in a Veteran's hospital to measure the effects of acute care staff education to improve

knowledge of and confidence in using of tobacco cessation interventions with inpatient Veterans. Retrospective data on smoking cessation rates and quit rates for inpatient Veterans were compared to prospective data on those same rates post-implementation of the Tobacco Tactics Toolkit. Data was collected with pre-and posttests prior to and immediately after staff education been provided to determine if there was an improvement in knowledge, confidence, and implementation of tobacco cessation interventions after implementation of the Tobacco Tactics Toolkit. Data was collected anonymously to highlight the difference in staff's knowledge of tobacco cessation, staff confidence in teaching tobacco cessation education, and use of tobacco cessation interventions. All information obtained was considered confidential and was only used within the EKHCS health organization. A quantitative analysis of measures was used to analyze the retrospective and prospective data on Veteran smoking rates reported on admission, inpatient admissions, and quit rates. The project question for this quality improvement project was analyzed by a descriptive analysis to compare preintervention and postintervention data with a one-way analysis. Pre-and posttest scores were analyzed to determine the difference in knowledge of and confidence in using tobacco cessation interventions at one and three-month intervals post Tobacco Tactics program implementation. The evaluation plan monitored data on staff's knowledge of tobacco cessation assessment, interventions, and template use on Tobacco Tactics Toolkit interventions documented in CPRS at one and six-month intervals after program implementation. The planning and evaluation framework evaluated knowledge, comfort and willingness to utilize information staff and Veterans have been given. The collection

and analysis of data from staff provided information to successfully implement the Tobacco Tactics Toolkit for acute care nursing staff to improve their knowledge confidence, practice interventions for tobacco cessation, and to provide education for inpatient Veterans. The Tobacco Tactics Toolkit provided acute care nurses with the knowledge and tools to address the need to decrease rates of tobacco use among the Veteran population. Improvement in scores from the pre-and posttests supported recommendations to implement the Tobacco Tactics Toolkit to other areas of the facility. The implications for nursing as well as the strengths and limitations of the proposal were discussed in the next section.

Section 4: Findings and Recommendations

Introduction

The purpose of this project was to implement the Tobacco Tactics Toolkit for acute care nursing staff to improve knowledge, confidence and practice interventions for tobacco cessation (Fore et al., 2013). The project question was: "Will the implementation of the Tobacco Tactics Toolkit improve acute care nurses' knowledge, confidence the and utilization of tobacco cessation interventions to increase the quit rate of inpatient Veterans?" Identifying and remedying the lack of tobacco cessation education for inpatient Veterans can contribute to decreasing the historical escalation of costs incurred from readmissions for tobacco related illness (Neugaard et al., 2011). The improvements in practice will potentially provide opportunities for smoking cessation that Veterans are missing in the acute care setting currently (Sarna et al., 2014). Nursing practice will also be enhanced by improving the current process of assessing inpatients admitted to acute care with a comprehensive assessment of smoking cessation history, willingness to quit, knowledge of resources for quitting, and management of addiction. Critical care nurses who are educated about smoking cessation and the Tobacco Tactics Toolkit will potentially provide opportunities for smoking cessation that Veterans are missing in the acute care setting currently (Sarna et al., 2014). In Section 4 I present a summary of findings, a discussion of results in the context of the literature, implications for nursing practice, and project strengths and limitations.

Findings and Implications

The practice-focused question was: "Will implementation of the Tobacco Tactics Toolkit improve acute care nurses' knowledge of and confidence in the use of tobacco cessation interventions to increase the quit rate of inpatient Veterans?" The first objective was to implement the Tobacco Tactics program, an evidence-based tobacco cessation education for acute care nursing staff. The second objective was to educate the nursing staff on additions to the nursing assessment template (Appendix E), order sets, and referral process in the CPRS. The third objective was to implement the Tobacco Tactics Toolkit for acute inpatient Veterans on smoking cessation.

Objective 1: Implement the Tobacco Tactics Program

The Tobacco Tactics Toolkit was implemented with 12 staff members during a 1-week period. The first objective for success of implementing this project was considered to have been met if there was a 50% increase in posttest scores after program implementation compared to pretest scores (Table 2). The Tobacco Tactics Toolkit concentrated on ten items: (a) Joint Commission recommendations for smoking cessation, (b) stages of change, (c) nicotine replacement therapy (d) assessment tools (e) importance and effectiveness of interventions, (f) comfort in educating patients, (g) resources, (h) alternative behaviors, and (i) the 5As of tobacco cessation (Fore et al., 2013). Table 2 displays the results from the 10 pretest questions which was answered prior to implementation of the Tobacco Tactics Toolkit. The scores range in correctness from 0 to 100% with most of scores, 7 out of 10, being below 50%. The three highest scoring questions were the questions on nicotine replacement therapy at EKHCS,

intervention importance, and comfort with educating on tobacco cessation. The seven lowest scored questions were: (a) the Joint Commission recommendations, (b) stages of change, (c) assessment tool, (d) tobacco cessation intervention effectiveness, (e) tobacco cessation resources at EKHCS, (f) two alternative behaviors/activities, and (g) the 5As of tobacco cessation. The data shows that the knowledge base of staff prior to implementation of the Tobacco Tactics Toolkit was high regarding the importance of tobacco cessation interventions, comfort with educating on tobacco cessation, and the tobacco cessation resources at EKHCS. It is interesting to note that staff's scores were relatively high on comfort with educating on tobacco cessation (67%), but the reported knowledge of the Joint Commission recommendations (33%), alternative behaviors/activities to tobacco use (42%), tobacco cessation resources available at EKHCS (25%), and the five A's of tobacco cessation (42%) were low.

Table 2

Pretest Question Results

PROBLEM AREA	OCCURRENCE	TOTAL PERCENT CORRECT
JC Recommendations	12	**33.00%**
Stages of Change	12	**25.00%**
Nicotine Replacement Therapy at EKHCS	12	**58.00%**
Assessment Tool	12	**17.00%**
Tobacco cessation intervention important	12	**100.00%**
Tobacco cessation intervention effective	12	**33.00%**
Comfortable educating on tobacco cessation	12	**67.00%**
Tobacco cessation resources at EKHCS	12	**25.00%**
Two alternative behaviors/activities	12	**42.00%**
The 5As tobacco cessation	12	**0.00%**

The three highest scoring questions were the questions on nicotine replacement therapy at EKHCS, intervention importance, and comfort with educating on tobacco cessation (Figure 2). It is important to note that this was a positive reflection of how acute care staff views nicotine replacement therapy, interventions, and their comfort or willingness to educate their patients on tobacco cessation. Also displayed are the seven questions with the lowest scores. which include the Joint Commission recommendations; stages of change; assessment tool; tobacco cessation intervention effectiveness; tobacco

cessation resources at EKHCS; two alternative behaviors/activities, and the five A's of tobacco cessation. The graph highlights the difference between the pretest knowledge of staff on comfort of teaching tobacco cessation at 33% and the posttest knowledge of staff comfort in teaching tobacco cessation interventions at 67% (Figure 2). The difference in scores on these questions suggest that staff could not be comfortable with, confident in, or willing to offer interventions if they did not know what the current tobacco cessation interventions are and if they are effective.

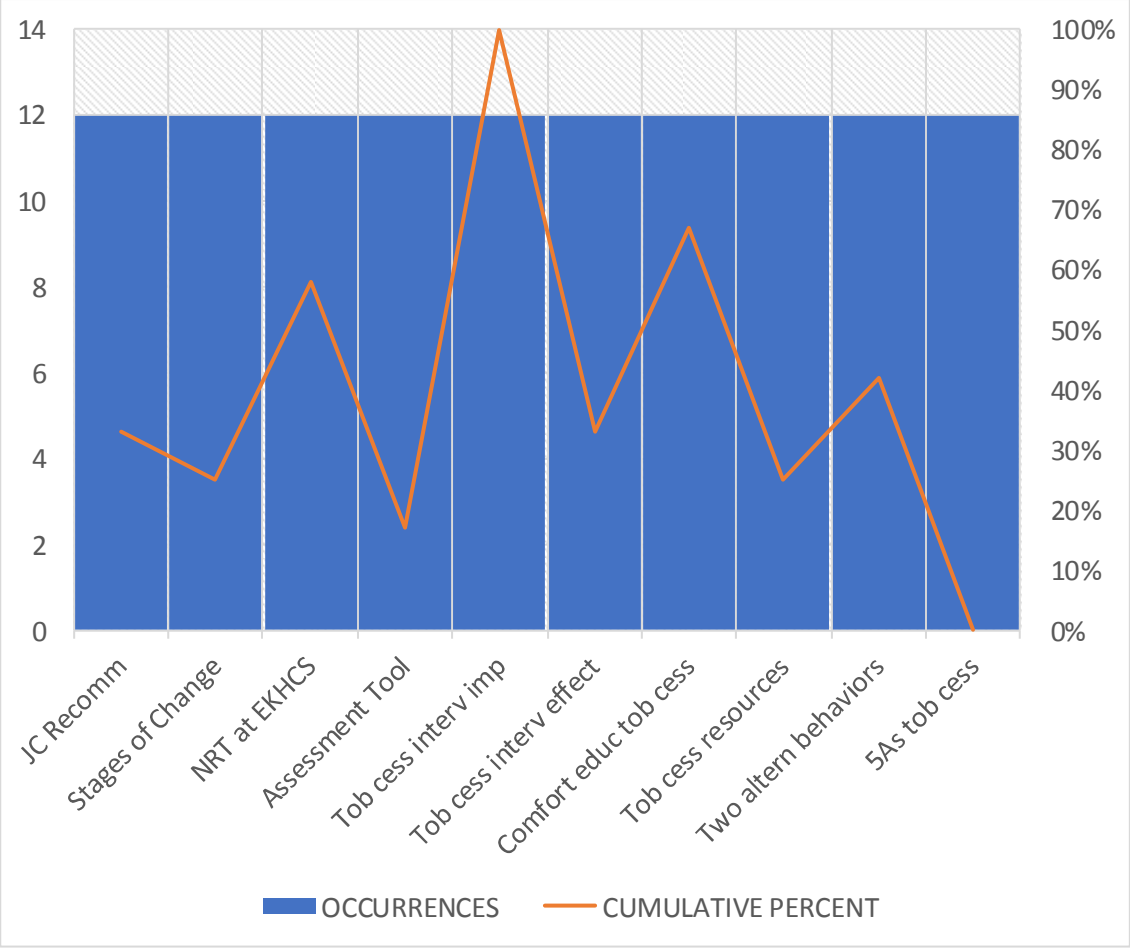

Figure 2. Pretest question results.

The descriptive analysis of the posttest scores revealed an increase in all ten test items, except question number five on importance of tobacco cessation interventions, which was 100% on the posttest as well (Table 3). The most remarkable increases in posttest knowledge were on questions about (a) the Joint Commission recommendations, (b) the 5 stages of change, (c) satisfaction with the current assessment tool, (d) effectiveness of tobacco cessation interventions, (e) naming tobacco cessation resources available at EKHCS, (f) alternative behaviors or activities to tobacco, and (g) listing the five A's of tobacco cessation. The data supports the importance and effectiveness of tobacco cessation education for acute care staff. The outcome of the approximately 1.5-hour presentation of the Tobacco Tactics Toolkit to acute care nursing staff suggests that meaningful results can be obtained by even short periods of education.

Table 3

Posttest Question Results

PROBLEM AREA	OCCURRENCE	TOTAL PERCENT CORRECT
JC Recommendations	12	**58.00%**
Stages of Change	12	**42.00%**
Nicotine Replacement Therapy at EKHCS	12	**92.00%**
Satisfaction with Assessment Tool	12	**58.00%**
Tobacco cessation intervention important	12	**100.00%**
Tobacco cessation intervention effective	12	**83.00%**
Confidence in educating on tobacco cessation	12	**75.00%**
Two tobacco cessation resources at EKHCS	12	**92.00%**
Two alternative behaviors/activities	12	**83.00%**
The 5A's tobacco cessation	12	**42.00%**

Figure 3 displays the occurrence and cumulative percentage of overall improvement in posttest results after the implementation of the tobacco cessation education. There was an overall increase in all posttest scores, except the question on intervention importance, which received a score of 100% on both the pre-test and the posttest. The data highlight the remarkable improvement in posttest knowledge of the questions on Joint Commission recommendations; 5 Stages of Change; satisfaction with

the current assessment tool; effectiveness of tobacco cessation interventions; naming tobacco cessation resources available at EKHCS; alternative behaviors or activities to tobacco and listing the five A's of tobacco cessation questions. The increase in scores, particularly on the questions testing knowledge on NRT at EKHCS; assessment tool satisfaction; tobacco cessation intervention effectiveness; tobacco cessation resources at EKHCS and the 5As of tobacco cessation, can clearly be seen. The knowledge gained from these areas will ensure that the education acute care nursing staff provide to inpatient Veterans will be effective and have a positive impact on tobacco cessation for inpatients.

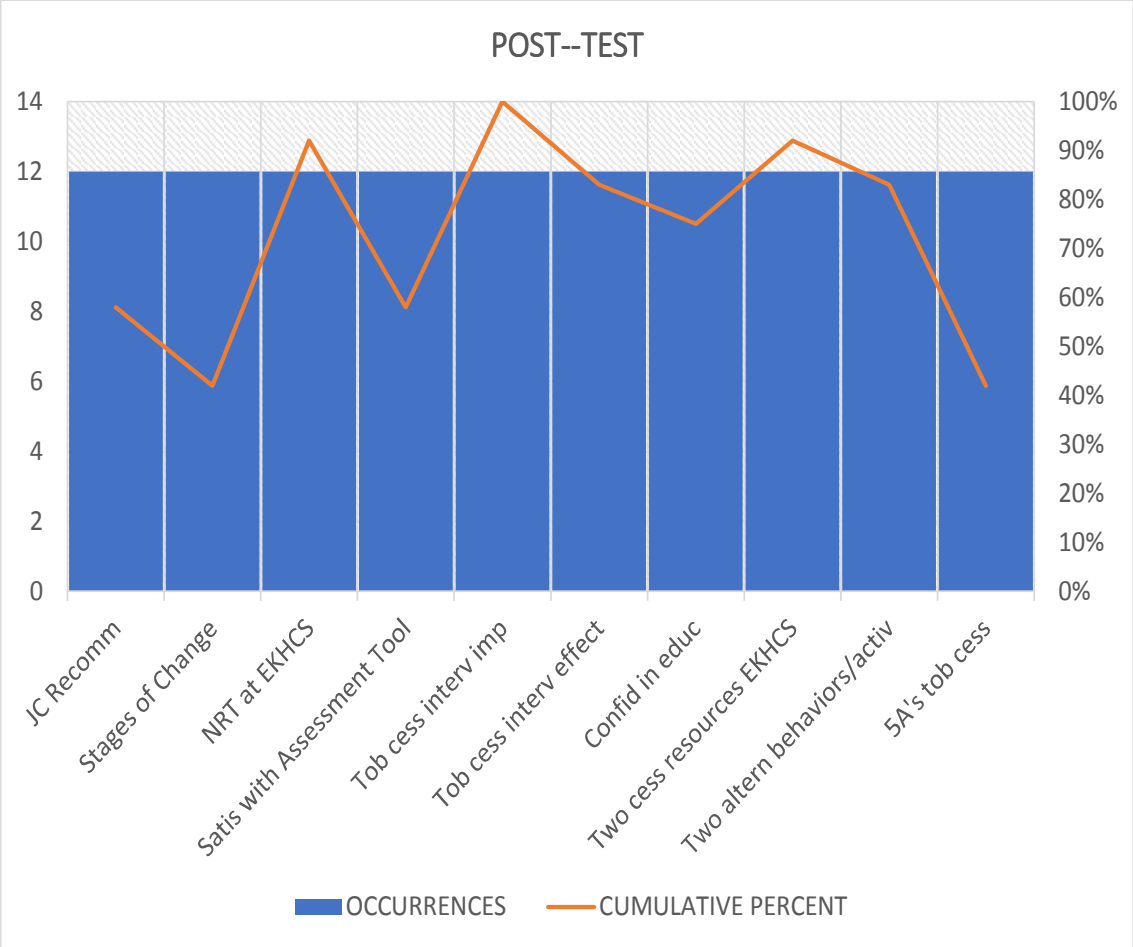

Figure 3. Posttest question results.

The majority of staff made significant improvements in scores from the pre-test scores to posttest scores which supports the projects outcome to improve tobacco cessation knowledge, confidence, and willingness to provide interventions to inpatient Veterans on tobacco cessation (Figure 4). The most impressive increases in test scores were from the three staff who increased their pre-test score of 32% to 86% posttest, 32% pre-intervention and 96% post-intervention, and 36% pre-test to 96% posttest.

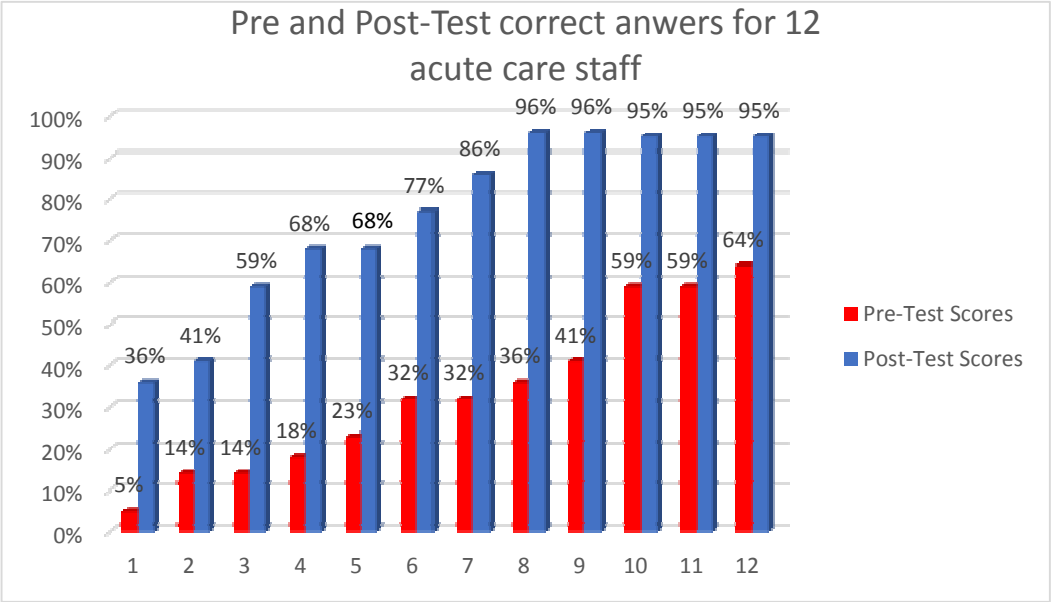

Figure 4. Pre- and posttest scores

The substantial increase in posttest scores for individual staff confirms that even brief interventions on tobacco cessation have positive improvements in knowledge (Underwood & Ryan, 2010). Lean methodology provided the tools necessary to define, measure, analyze, improve, and control (DMAIC) effective, applicable change and translate knowledge, tobacco cessation education, directly into practice (Kelly, 2011). The Lean model increases customer satisfaction and financial goals by providing tools to streamline processes, improve quality, and eliminate organizational defects and waste (International Six Sigma Institute, 2014). The root cause for acute care nursing staff was the lack of available resources and knowledge for tobacco cessation. The Lean or Six Sigma method provided a guide to improve a process by first identifying the problem (Kelly). Utilization of this model simplifies the process of doing what is right for patients and staff by helping to discover and eliminate barriers, duplication, and utilize reminders

to improve practice (Kelly). The DMAIC process improvement helps train teams to address those problems by defining the problem, measuring data, analyzing data to identify the root cause, improving the problem by implementing a solution, and controlling the new process by sustaining and building into the culture of care (International Six Sigma Institute).

For objective one of the project to be considered successful, the outcome was set to be a 50% increase in posttest scores as compared to pre-test scores. The cumulative percentage of correct answers on the pre-implementation testing was 33% and the percentage of correct answers on the post-implementation testing was an almost doubled increase to 60% (Figure 5). The posttest scores reveal an impressive increase in post-implementation knowledge. It would suggest that staff's knowledge, confidence and willingness to provide tobacco cessation interventions significantly improved post-intervention of the Tobacco Tactics Toolkit.

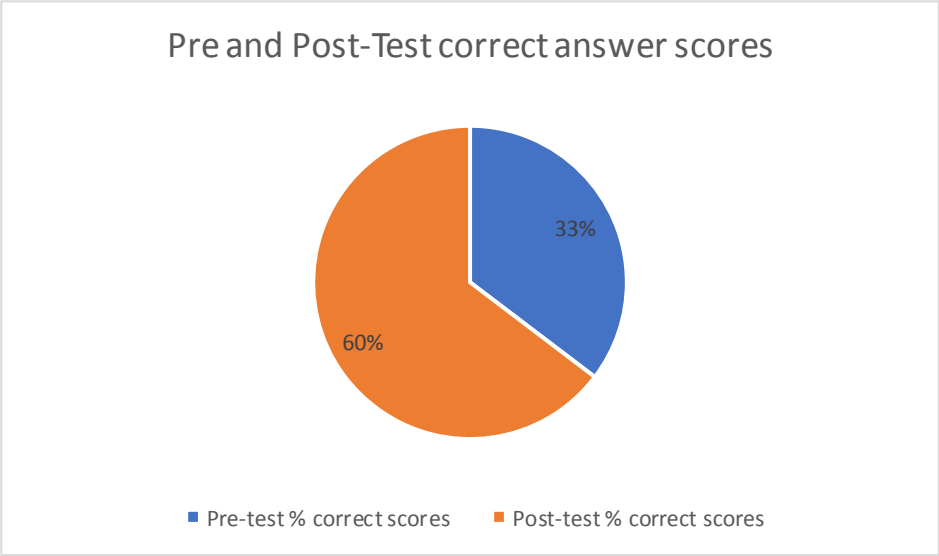

Figure 5. Pre- and posttest scores.

Objective 2: Educate the Nursing Staff on Additions to the Nursing Assessment Template, Order Sets, and Referral Process in Computerized Patient Records System

The additions were to include incorporating smoking cessation questions into the assessment template and order sets, as well as streamlining the referral process for tobacco cessation CPRS. The objective was to be measured by monitoring the utilization of the nursing assessment template by acute care staff for inpatient Veterans. The expectation was that the admission assessment template would be completed to collect the patient's smoking history, willingness to quit, order sets, and referrals for standardized tobacco cessation treatment at least 75% of the time when a patient was admitted to acute care. The objective was not achieved during the timeframe of this project. I was involved in my facility's workgroup for Ambulatory Care Sensitive Conditions (ASCS) on COPD for the outpatient or clinic staff and Veteran population. However, there was a separate workgroup I am now working with to get the Tobacco Tactics program approved for our inpatients and acute care staff. Part of obtaining approval for this program to become our standard of care will be to present the successful outcomes achieved though my DNP proposal to our Executive Leadership Team (ELT). Once the team approves the workgroup's proposal, education for implementation of the Tobacco Tactics program will be initiated facility-wide.

Objective 3: Implement the Tobacco Tactics Toolkit for Acute Inpatients Veterans on Smoking Cessation.

The Tobacco Tactics Toolkit for patients includes a handout, education video, manual written at an eight-grade level, nicotine replacement therapy, helpline, and follow-up phone calls (Fore et al., 2013). Completion of the updated IPAA Nursing Assessment Template (Appendix E) was monitored for each admission and with the goal of completing the IPAA in 90% of acute care admissions. Because the facility's ELT must approve the ACSC's proposal to implement the Tobacco Tactics Toolkit as our standard of care, therefore objective three was not accomplished within the timeframe of this project. I will also need to present the positive results from my DNP project to ELT to obtain the opportunity to implement the Tobacco Tactics Toolkit facility-wide.

Recommendations

Significance

Nursing is a valuable resource for patient education and empowering nurses with standardized education and tools will help patients achieve a healthier, tobacco-free lifestyle, and make healthier decisions (Scanlon et al., 2008). Current nursing outcomes can be enhanced with the improvement in the process for acute care staff to assess patient smoking cessation history, willingness to quit, education, knowledge of resources for, and management of addiction by using the Tobacco Tactics Toolkit. Acute care staff can successfully address and manage tobacco cessation with the evidence–based tools and research data that supports the tobacco Tactics Toolkit to improve tobacco cessation outcomes for Veterans in the VA healthcare system, while also significantly impacting

healthcare in communities outside the VA (Duffy, 2009). Improving staff confidence and skills will provide a valuable resource to educate patients while also empowering patients to actively participate in their own care (Katz et al, 2009).

Reduction of Gaps

The Tobacco Tactics Toolkit is an evidence-based educational program for inpatient staff with the objectives of measuring and improving nurse's perceived confidence and value of implementing tobacco cessation interventions (Fore et al., 2013). Evidence that the program has been effective is demonstrated by 85% of staff now feeling moderately to extremely confident in providing tobacco cessation education to inpatient Veterans (Fore et al., 2013). Despite successful evidence of the positive effects of a nurse-administered tobacco cessation program for inpatients, a gap continues to exist between the Tobacco Tactics Toolkit and the dissemination and implementation of the program (Duffy et al., 2014). By continuing to conduct testing and achieving successful outcomes, the gap in translating the Tobacco Tactics Toolkit into practice will decrease. The implementation of the tobacco cessation project found the nurses had an initial 67% confidence level which increased to 75% post-implementation of the Tobacco Tactics Toolkit.

Changing nursing's attitudes and willingness to learn and implement interventions for tobacco cessation have major implications for practice (Scanlon et al., 2008). In 2011, the Joint Commission made recommendations for the screening of all inpatients on admission and discharge for tobacco use (Vick et al., 2012). Tobacco cessation implementation at the bedside can increase quit rates and chronic disease management,

while also decreasing the use of tobacco, and morbidity and mortality rates for Veterans (Vick et al., 2012). As approximately 100,000 Veterans per year are admitted into the VA system, there is an enormous opportunity for improving overall patient health (Katz et al., 2009). If inpatient nursing staff are implementing tobacco cessation education for only 17% of patients who have a desire to quit, there is a vast opportunity to provide Veterans with the assessment, education, and knowledge of resources available for tobacco cessation (Fore et al., 2013). A significant gap in staff knowledge exists that can be remedied by a change in practice for acute care nurses (Scanlon et al., 2008). Identifying practice gaps in care and implementing effective programs will reduce gaps and improve outcomes.

Implications for Social Change

Nurse-led tobacco cessation interventions for inpatients have the potential to reach many Veterans at an EKHCS. Acute care staff are the largest group that directly interact with inpatients in a healthy, smoke-free environment where nicotine replacement therapy and other interventions can be offered to provide a chance to change unhealthy behaviors (Duffy et al., 2008). Dissemination of a nurse-delivered tobacco cessation intervention can reduce tobacco related morbidity and mortality among inpatients (Vick et al., 2012). As nurses are knowledgeable in health behaviors, the Tobacco Tactics Toolkit can enhance that knowledge with education on and interventions for tobacco cessation as well (Duffy Scheumann et al., 2010). Providing tobacco cessation education for inpatient nurses addresses the lack of confidence and knowledge barriers currently present for staff at this EKHCS. Providing nursing staff with tobacco cessation

education, tools, and interventions for inpatients has proven to be effective in improving patient outcomes for tobacco cessation (Duffy et al., 2008). Nurse-based tobacco cessation interventions are more efficacious because nurses have direct access to Veterans, more opportunity to interact, assess, and build trusting relationships to individualize patient cessation education (Duffy et al., 2010). The successful implementation of the Tobacco Tactics Toolkit will be shared with all inpatient, outpatient units, and throughout the entire VA health care facility to reach all Veterans that have the desire to quit. Improving nursing's confidence, comfort level, knowledge, availability of tools and resources to provide interventions for tobacco cessation have major implications for enhancing research, patient education, and practice outcomes (Scanlon et al., 2008). Approximately 70% of Veterans who have attempted cessation before are motivated to quit smoking within the next thirty days (Duffy et al., 2010). It is key to identify this population to provide Veterans with the successful resources available and improve the quality of tobacco cessation services (Katz et al., 2009). Promotion of effective programs such as the Tobacco Tactics Toolkit that have been translated into practice will provide insight into how policies, procedures and standards in healthcare can be improved (Katz et al., 2009). The two policies currently guiding practice at this VA facility are the National Smoking and Tobacco Use Cessation Program from the Department of Veterans Affairs in Washington, DC and the facility Smoking and Tobacco Use Policy will be positively affected by this program (VHA Directive 1056, 2014). Improving the consistency of information across the continuum of care from inpatient to outpatient settings will have major implications for increasing quit rates and

Veteran outcomes regarding tobacco cessation (Katz et al., 2009). The Tobacco Tactics Toolkit has the potential to become the standard of care to address tobacco cessation for all Veterans at this EKHCS (Duffy et al., 2012). Tobacco is one of the leading preventable causes of morbidity and mortality, therefore healthcare professionals should include it as part of their health promotion and education for patients (Scanlon et al., 2008). Tobacco addiction in the Veteran community requires twice as many admissions, increased length of stay, and an estimated $75.5 billion per year for related medical costs compared to non-Veterans (Duffy, Reeves, Hermann, Karvonen & Smith, 2009). Among Veterans the smoking rate is 33% versus the 22% rate for non-Veterans (Duffy et al., 2012). Evidence shows smokers may require multiple cessation attempts before they are successful (Porter, 2013). Improving the nursing process for capturing data on nursing interventions, inpatient Veterans tobacco cessation history, and educational needs will provide the comprehensive care that is missing for acute care nurses and their patients. Dissemination of a nurse-delivered tobacco cessation intervention can reduce tobacco related morbidity and mortality among inpatients (Vick et al., 2012). Participation in successful tobacco cessation programs will ultimately improve quit rates, quality of life, and survival for the Veteran population (Duffy et al., 2010). Based on the successful improvement in posttest scores on all twelve questions, providing tobacco cessation education increases staff's knowledge, confidence and willingness to provide interventions for inpatients who have a desire to quit which will ultimately increase quit rates and Veteran outcomes.

Strengths and Limitations of the Project

The main strength of this quality improvement project was the evidence-based tobacco cessation education program Tobacco Tactics Toolkit. The Toolkit is a cessation program that provides a comprehensive, effective, and consistent message to Veterans at all points of contact in the VA healthcare system (Duffy et al., 2009). It has population-based strategies to provide solutions to tobacco cessation and chronic disease self-management (Duffy et al., 2009). The use of the Tobacco Tactics Toolkit for this project in an acute care setting provided an impressive increase in staff knowledge, confidence, and willingness to implement tobacco cessation tools for inpatient Veterans. The training sessions proved to be successful in improving the likelihood acute care staff would provide inpatient Veterans with a nurse-delivered tobacco cessation program that can lead to a decrease in tobacco use rates, decrease morbidity and mortality, and increase quality of life.

A second strength of this project was the significant improvement in posttest scores obtained after implementation of the comprehensive, evidence-based education intervention on tobacco cessation. A 60% increase in knowledge from the implementation of the Tobacco Tactics Toolkit provides evidence that this education is what bedside nurses need to make improvements in care, education, and outcomes for inpatient Veterans. The acute care nurses in an EKHCS had enhanced feelings of confidence, comfort, and willingness to implement tobacco cessation interventions for inpatient Veterans after the Toolkit was implemented.

The third strength was how open staff were to the Tobacco Tactics Toolkit education which will increase the number of Veterans who receive the education as an inpatient leading to an increase in quit rates for Veterans. Finally, staff scores on intervention effectiveness post-implementation of education increased from 33% to 83% which supports staff's knowledge on interventions improved the likeliness of providing tobacco cessation education to the inpatients.

Three limitations were identified with this project. First, the project would only be tested and implemented at one Veterans hospital. Secondly, the sample size was small, as only twelve nurses participated in this project. The third limitation was the low census of inpatients on the chosen ICU/PCU unit. The average census for the past three months had been 29 per month (ICU/PCU flowsheet). Tobacco cessation is a national concern that can be addressed effectively with the Tobacco Tactics Toolkit and using models formulated for tobacco addiction. Therefore, future studies should include larger sample sizes, education and implementation for Veterans and staff in the inpatient and outpatient population. A longer study period is also recommended to enhance support of the Tobacco Tactics Toolkit by obtaining a larger amount of comparative data. Fortunately, the Tobacco Tactics program has been tested in other Veteran Administration facilities located in Ann Arbor, Michigan, Gainesville, Florida, and Dallas, Texas (Duffy et al., 2010). Sample size was larger at other VA facilities where Tobacco Tactics was trialed, Ann Arbor had 148 participants, Gainesville, 85 and Dallas, 128 (Duffy et al., 2010). Unit size was also larger, Ann Arbor is a 200-bed acute care

facility (Vick et al., 2012). At the Ann Arbor facility, 283 RNs participated in the study (Fore et al., 2013.

Summary

Section four reviewed a summary of findings, a discussion of results in the context of literature, implication for nursing practice, project strengths and limitations. The results partially answered the project question, "Will the implementation of the Tobacco Tactics Toolkit improve acute care nurses' knowledge of and confidence in the use of tobacco cessation interventions to increase the quit rate of inpatient Veterans." The first objective was to implement the Tobacco Tactics program, an evidence-based tobacco cessation education for acute care nursing staff with a goal of posttest scores increasing by 50% compared to pre-test scores. The first objective was achieved, there was an increase of 60% in posttest scores compared to pre-test scores. However, objectives two and three, to educate the nursing staff on additions to the nursing assessment template (Appendix E), order sets, and referral process in the computerized patient records system (CPRS) and implementation of the Tobacco Tactics Toolkit to acute inpatient Veterans were not able to be achieved in the timeframe of this project. I was involved in my facility's workgroup for ASCS on COPD for the outpatient Veterans and clinic staff. I am currently working with another workgroup to get the Tobacco Tactics Toolkit approved for our inpatient Veterans and acute care staff. Part of obtaining approval for this program to become our standard of care will be to present the successful outcomes achieved through my DNP proposal to our ELT. When I receive

approval from the ELT, I will then have the opportunity to implement objectives two and three facility-wide. Section five discusses the dissemination plan and analysis of self.

Section 5: Dissemination Plan

A final step in the process of completing the DNP scholarly project is dissemination of findings. The purpose of dissemination of results is to share new knowledge with stakeholders, the academic community, and professionals in similar clinical settings (Zaccagnini & White, 2011). The success of the DNP project can be generalizable beyond the borders of the test site as the problem being addressed is likely to be a current problem in other healthcare settings (Zaccagnini & White). The American Association of Colleges of Nursing's (AACN) Essential III–Clinical Scholarship and Analytical Methods for Evidence-Based Practice summarizes the DNP project as a comprehensive reflection of traditional academia including investigation and the synthesis of knowledge to solve a problem (AACN, 2006). The scholarly application and translation of new knowledge into practice by dissemination of the DNP project findings is the epitome of what a well-educated DNP student can successfully achieve to meet current and future healthcare needs while also meeting the needs of facilities and communities (AACN, 2006).

Dissemination of a nurse-delivered tobacco cessation intervention can reduce tobacco related morbidity and mortality among inpatients (Vick et al., 2012). My dissemination plan will include presenting my findings in a PowerPoint presentation to the hospital organization study site's ELT. The ELT is n leadership team comprising the director of EKHCS, the associate director of patient care services, chief of staff, and the associate director.

I also plan to disseminate data by writing and submitting a manuscript for consideration for publication in a professional journal such as the *American Journal of Public Health, Journal of Clinical Nursing, American Journal of Respiratory and Critical Care Medicine,* or *Critical Care.* I also plan to attend the 2019 Clinical Nurse Leader Summit and present my project and data that I have collected through implementation of the Tobacco Tactics Toolkit. The Clinical Nurse Leader Summit brings clinical nurse leaders from across the country to meet and share their research and quality improvement projects to then disseminate to their facilities and translate new information into their clinical practice. I have included the link below to the Tobacco Tactics Toolkit PowerPoint presented to the acute care nursing staff at EKHCS.

Analysis of Self

As Practitioner

Throughout the development of the project, I gained knowledge about why acute care nurses may be hesitant to ask about providing tobacco cessation with inpatient Veterans. Such barriers as lack of time, the perception that inpatients are not interested in tobacco cessation, and lack of knowledge about tobacco cessation education were addressed during the implementation of this project (Fore et al., 2013). The Tobacco Tactics Toolkit overcame barriers and misconceptions about tobacco cessation postintervention. I learned that there are major gaps in current practice regarding lack of knowledge of national recommendations from the literature that caused a major gap in bedside practice. Research has shown that of the 70% of Veterans who wanted to quit using tobacco products, only 17% were offered tobacco cessation interventions while an

inpatient (Fore et al., 2013). I believe the gaps in knowledge and practice are due to the lack of formal education of acute nurses regarding evidence-based education available to them and a lack of time to search literature, interpret, and translate new knowledge into practice to bring about change. The AACN (2006) Essential VI, Interprofessional Collaboration for Improving Patient and Population Health Outcomes discusses competencies of effective communication, developing effective, collaborative teams, analyzing data to solve complex practice issues, and developing leadership skills to create interprofessional teams to bring about necessary change in health care. The project has helped to develop my communication and leadership skills by requiring me to use tools and knowledge to identify, create, and implement a quality improvement project in its entirety. Investing time in partnering with the acute care nurses has given me the opportunity to understand why clinicians have been reluctant to provide tobacco education to inpatient Veterans which after implementation gave them confidence to use the Tobacco Tactics Toolkit. I also gained a clearer understanding of the challenges acute care nurses have with finding time to prioritize patient education in their nursing duties. The project has given acute care nurses at this facility a voice to identify their needs regarding educating Veterans and changes in practice that can positively affect patient outcomes. The skills acquired through my DNP education have prepared me to identify clinical practice needs, find the evidence to remediate these needs, and disseminate and translate solutions directly into practice.

As Scholar

With the development of the project, I have gained expertise in navigating the organization's complex health care system. Applying systems thinking at both the micro and macro levels enables the advanced-practice nurse to identify and implement new solutions to resolve practice issues (Zaccagnini & White, 2011). Conducting in-depth literature reviews and presenting the information in a clear and succinct manner in the context of the organizational issue facilitated my development as a scholar. Becoming immersed in the evidence and citing relevant research studies has given me credibility among key stakeholders of the organization. Furthermore, the project provided a platform to incorporate DNP Essential III, Clinical Scholarship and Analytical Methods for Evidence-Based Practice, which holds competencies to evaluate quality improvement methodologies and the use of information technology to analyze data from practice (AACN, 2006). Designing a quality improvement methodology to assess ordering adherence has generated interest for both our acute care nursing staff as well as our providers, data analysts, and quality department. The application of deep, scientific inquiry, a robust literature review, and use of supportive evidence in the project will serve as the foundation for future quality and process improvement projects (Zaccagnini & White, 2011).

Project Manager

The process of developing, implementing, and evaluating a project of this caliber has given me immense respect for continuing to obtain knowledge as I grow in my leadership role. I used many management tools to design a project that identifies the

needs of bedside staff and sets realistic, achievable goals, including timelines, while remaining flexible when adjustments were required (Zaccagnini & White, 2011). Identifying key stakeholders, setting goals, and celebrating each goal met along the way while also adhering to time and resource constraints are essential skills for successfully completing an effective project (Zaccagnini & White). I have learned to work diligently despite barriers such as months of multiple revisions on each section, waiting for my facility to decide who should sign the data use agreement for Walden, the slow process of making changes, and my own lack of motivation and feelings of frustration at times. Solutions I found to be useful were to talk with every stakeholder and perform a comprehensive needs assessment when planning a project to avoid problems later. Effective, closed-loop communication is also critical for avoiding unforeseen roadblocks. The key to successfully arriving at this point in my journey has been the support of my instructors, classmates, and the many outstanding mentors I have had the pleasure of knowing throughout my nursing career. The role of the project manager requires patience, flexibility, constant communication, soliciting feedback, and being passionate and committed to the project outcome. A major goal of a project manager is to sustain the change in practice. One way to sustain the Tobacco Tactics Toolkit education would be to not only educate current staff, but to also present this knowledge to new employees in orientation (Duffy et al., 2009). As I come to the end of my DNP journey and begin a new journey as a practicing DNP, I will continue to use the knowledge obtained from Walden. I will also follow my never-ending search of knowledge for the betterment of my practice and those I work with, teach, and care for.

Summary

Section 5 highlighted plans to disseminate the Tobacco Tactics Toolkit as well as educate the nursing staff on additions to the nursing assessment template (Appendix E), order sets, and referral process in the CPRS. Monitoring the use of the EK-IPAA Nursing Assessment Template (Appendix E) by acute care staff for all inpatient Veterans on admission will ensure sustainability and success of the program. The Tobacco Tactics Toolkit will also be offered to all acute inpatient Veterans on admission. I will present the findings in a PowerPoint presentation to the study site hospital's ELT. The ELT is a leadership team comprising the director of EKHCS, the associate director of patient care services, chief of staff, and the associate director. I will also disseminate data by writing and submitting a scholarly article for publication in a professional journal such as the *American Journal of Public Health, Journal of Clinical Nursing, American Journal of Respiratory and Critical Care Medicine,* or *Critical Care*. I also plan to attend the 2019 Clinical Nurse Leader Summit as either a speaker or poster presenter to share the project and data.

Reflecting on my role as practitioner and scholar has given me insight into all that I have learned over the past 4 years. The skills acquired through my DNP education have prepared me to identify critical gaps in practice and the needs of bedside clinicians and how to create successful projects by finding the evidence to disseminate and translate directly into practice. The AACN Essential VI, Interprofessional Collaboration for Improving Patient and Population Health Outcomes reminded me that effective communication and collaborative skills, ability to analyze complex practice issues,

leadership skills, and expertise in consulting with interprofessional teams are crucial to creating positive change in health care. The project helped to improve my communication and leadership skills by providing the opportunity to use tools and knowledge to identify need and create and conduct a quality improvement project in its entirety. I have gained expertise in navigating a complex health care system to meet the many challenges of ever-changing, complex systems, and I will continue to use that expertise going forward.

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Appendix A: DNP Tobacco Cessation Quality Improvement Project Outline

1. Introduction of why and what quality improvement project was chosen
2. Pre-test
3. Tobacco tactics education, changes to assessment template, Veteran education
4. Posttest
5. Implementation of new assessment template and Tobacco Tactics program with inpatient Veterans

Appendix B: Tobacco Cessation Pretest

1. What is the recommendation per the Joint Commission for smoking cessation?

2. What are the smoking cessation stages of change?

   _____ _____ _____ _____ _____

3. List three nicotine replacement therapies available for inpatients at EKHCS?

   _____ _____ _____

4. How satisfied are you with the current assessment tool for patient's smoking history and willingness to quit?

   EXTREMELY SATISFIED SATISFIED NEUTRAL DISSATISFIED VERY DISSATISFIED

5. Are tobacco cessation interventions important for inpatients?

   YES NO

6. Are tobacco cessation interventions effective for inpatients?

   YES NO

7. How confident are you in educating Veterans on the topic of tobacco cessation?

   EXTREMELY CONFIDENT CONFIDENT NEUTRAL NOT CONFIDENT NOT VERY CONFIDENT

8. List two tobacco cessation resources available for inpatients at EKHCS?

   _____ _____

9. List two alternative behaviors/activities to tobacco, you can offer Veterans?

   _____ _____

10. What are the five A's of tobacco cessation?

    _____ _____ _____ _____ _____

Appendix C: Tobacco Cessation Posttest

1. What is the recommendation per the Joint Commission for smoking cessation?

2. What are the smoking cessation stages of change?

   _____ _____ _____ _____ _____

3. List three nicotine replacement therapies available for inpatients at EKHCS?

   _____ _____ _____

4. How satisfied are you with the current assessment tool for patient's smoking history and willingness to quit?

   EXTREMELY SATISFIED SATISFIED NEUTRAL DISSATISFIED VERY DISSATISFIED

5. Are tobacco cessation interventions important for inpatients?

   YES NO

6. Are tobacco cessation interventions effective for inpatients?

   YES NO

7. How confident are you in educating Veterans on the topic of tobacco cessation?

   EXTREMELY CONFIDENT CONFIDENT NEUTRAL NOT CONFIDENT NOT VERY CONFIDENT

8. List two tobacco cessation resources available for inpatients at EKHCS?

   _____ _____

9. List two alternative behaviors/activities to tobacco, you can offer Veterans?

   _____ _____

10. What are the five A's of tobacco cessation?

    _____ _____ _____ _____ _____

Appendix D: EK-IPAA Nursing Assessment Part 1 Template

Template: EK-IPAA NURSING ASSESSMENT PART 1

☑ Report received: *☐ Yes - report received from: ☐ No

Has the veteran or anyone the veteran has had close contact with traveled outside the United States in the last 30 days? *☐ Yes ☐ No

☐ If yes, explain:

☐ Reason for admission:

☐ Source of information: ☐ Patient ☐ Significant Other ☐ Chart

☐ Patient declined to answer

☐ Medication or food allergies? ☐ Yes ☐ No ☐ Don't know

☐ Over the counter medications being taken:

☑ Smoking Risk Assessment:

Complete the following Smoking Safety Risk assessment. Check all that apply.

☐ Patient admits to smoking and has an order for oxygen.

☐ Patient attempting to hide smoking materials or activities from staff.

☐ Patient has a history of non-compliance with smoking rules.

☐ Patient smoking in a patient sleeping room or other areas designated as non-smoking area.

☐ Patient has had incident of injury involving oxygen and smoking.

If positive for any of the above patient is at risk for unsafe smoking.

☐ Patient at risk for unsafe smoking. Patient not allowed to go off the medical unit to smoke unattended, all smoking materials removed from patient's person.

☐ Patient not at risk for unsafe smoking.

☐ Comment:

☐ MRSA/ISOLATION PRECAUTIONS

☐ Prosthetic devices:

☐ Is patient fully independent?

☐ Identifying characteristics:

Eye color:

Hair color:

Other:

☐ Disposition of valuables: ☐ with patient ☐ at home with family ☐ in safe

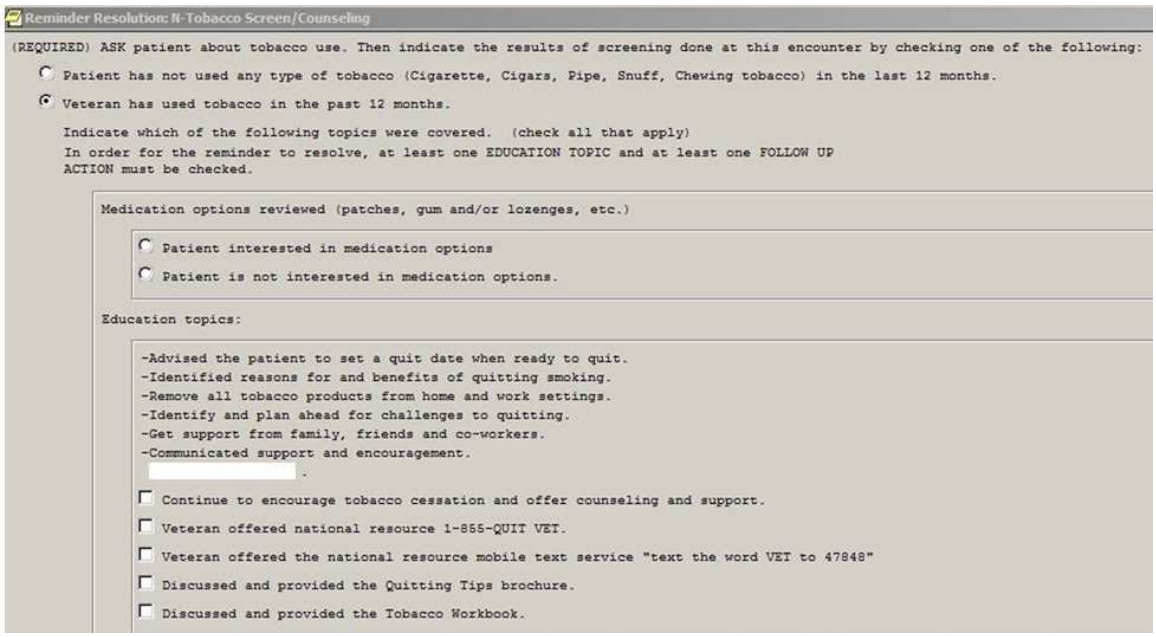
☐ Veteran/family has been informed about the VAEKHCS pain management program:

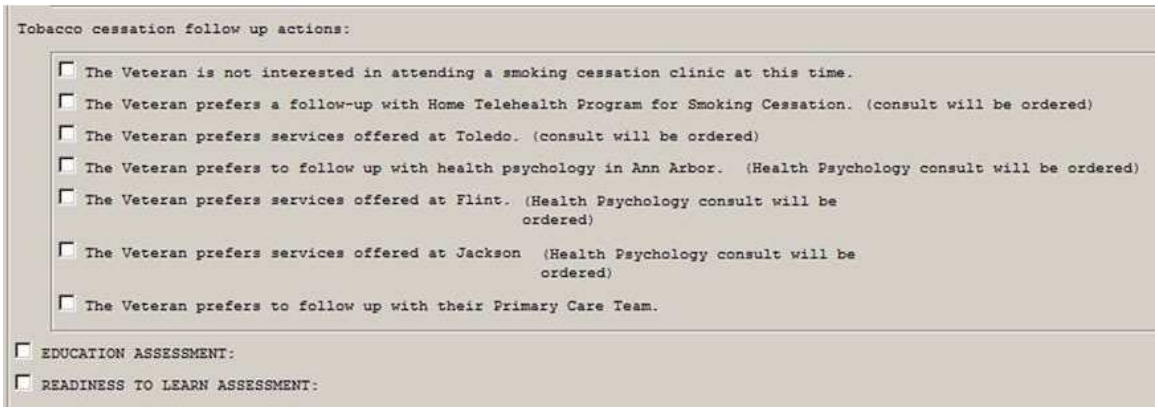
☐ Yes ☐ No

☐ Veteran/Family has been informed about the Seclusion and Restraining policy:

☐ Yes ☐ No

Appendix E: Tobacco Tactics Toolkit Template

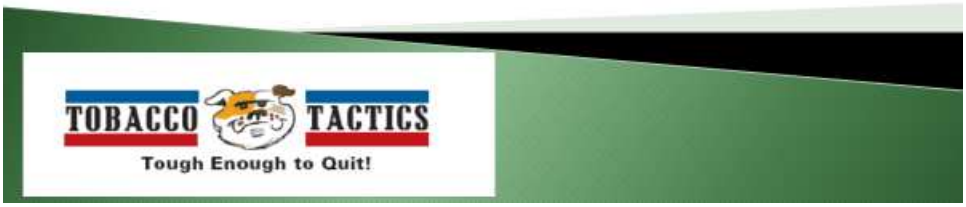




Appendix F: DNP Tobacco Tactics Nurse Training Spring 2018 Power Point

Tobacco Tactics

Dawn Garcia-Brinker, EKHCS
March, 2018

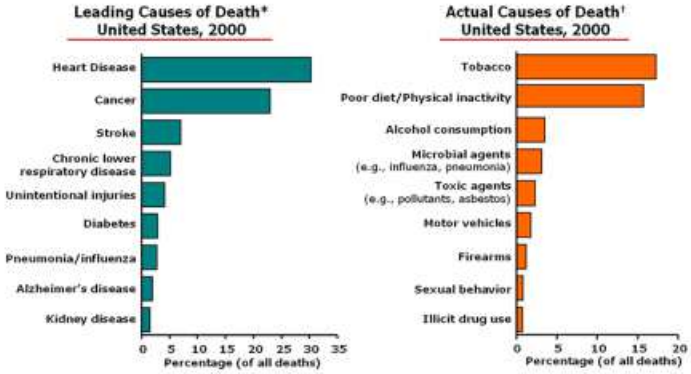


Learning Objectives

- Identify morbidity and mortality statistics related to the use of tobacco
- Identify the smoking cessation stages of change
- Review of Nicotine Replacement Therapy and prescription pharmaceuticals related to smoking cessation
- Identify behavioral therapy activities
- Review smoking cessation intervention documentation protocol

Introduction

Over 400,000 Americans die every year from diseases caused by tobacco.
More deaths are caused each year by tobacco use than by all deaths from HIV, illegal drug use, alcohol use, motor vehicle injuries, suicides, and murders combined.



* Minino AM, Arias E, Kochanek KD, Murphy SL, Smith BL. Deaths: final data for 2000. National Vital Statistics Reports 2002; 50(15):1-120.
† Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. JAMA. 2004;291(10):1238-1246.

Background

- 33% of veterans smoke
- 74.2% of veterans report a lifetime history of smoking
- At least 50% of all cancers occurring in veterans are associated with tobacco smoking

Chemicals in Cigarettes

There are over 4,000 dangerous chemicals in cigarettes

Ammonia: found in floor cleaner
Arsenic: rat poison
Butane: lighter fluid
Hydrogen Cyanide: poison used in gas chambers
Formaldehyde: used to preserve body tissue
Methane: rocket fuel
Cadmium: found in batteries
Carbon Monoxide: car exhaust
Acetone: a poisonous substance in paint stripper
Toluene: poisonous solvent
Polonium-210: a highly radioactive element
Benzene: poisonous toxin
DDT: highly poisonous banned insecticide
Tar: burned plant resins
Nicotine: also an active ingredient in some bug sprays

Cost of Smoking

- Compared to nonsmokers, smokers have twice as many hospital stays, have longer hospital stays, and incur greater expenses per admission.
- Compared with other preventive and invasive interventions, cessation programs represent one of the most cost-effective chronic disease prevention interventions.

Cessation Interventions

- Tobacco use is the number one preventable cause of premature morbidity and mortality
- Smoking cessation interventions work
- Although multi-component interventions are recommended, and increase quit rates significantly, brief interventions (3 min) can be effective.
- Smoking cessation interventions can and should be delivered to all smokers in all settings.

Quit Rate

- 80% of smokers say they want to quit. However, there is a wide gap between the number who say they wish to quit and those who do so.
- For example:
  - The annual self-quit rate is only 3%.
  - Physician delivered interventions result in 1-year cessation rates of about 6% with advice alone, 8% with counseling, and 10% with counseling plus nicotine replacement therapy (NRT).
  - Hospital inpatient programs result in the highest cessation rates ranging from 13.5% to 39% for general hospital patients and 35-70% for heart patients. Hospitalization itself has been shown to increase smoking cessation.

JC Standards

- Tobacco Use Screening for all admissions prevents relapse
- Tobacco Use Treatment Provided or Offered During Hospital Stay
  - Counseling
  - FDA-approved cessation medications
- Tobacco Use Treatment Provided or Offered at Discharge
  - Counseling
  - FDA-approved cessation and medications

The Five A's

- Ask if they smoke
- Advise to quit
- Assess motivation to change
- Assist if willing to quit
- Arrange for follow-up

Ask about Smoking Status

- Every patient should be asked at every encounter
- Document smoking status

Reasons why we don't ask

- Busy
- It won't make a difference
- They will quit when they are ready
- Perception as Nagging
- Current smoker

Advise to Quit

- Advise in a clear, strong, personalized manner.
  - "Quitting smoking is the most important thing you could do for your health."

Assess Willingness to Quit

- If willing to quit,
  - Provide resources
  - Present treatment options
- If not,
  - Enhance motivation

Smoking Assessment Stages of Change

- Pre-contemplation – not thinking of quitting; raise awareness & leave brochure
- Contemplation – thinking about quitting but no plan; help formulate plan
- Preparation – patient has a plan to quit in next 30 days; assist with planning and picking date
- Action – active phase of quitting; provide support
- Maintenance – provide support, at least 50% will relapse

* Prochaska and DiClemente

Assist with Quit Attempts

- If at all possible, assistance should go beyond brief interventions.
  - Quit Date
  - Counseling
  - Support
  - Pharmacotherapy
  - Educational Material

Arrange for Follow-Up

- Arrange contacts
- Provide support

Medications to Stop Smoking

- Methods to aid in the quitting process:
  - Non-prescription nicotine replacement therapy (NRT)
    - Patch
    - Gum
    - Lozenge
  - Prescription NRT (not available at VA)
    - Nasal Spray
    - Inhaler
  - Non-nicotine prescription medications
    - Bupropion (Zyban)
    - Varenicline (Chantix)
  - Behavioral Intervention (brief advice, smoking groups, 1 on 1).

Nicotine Patch

- Available over the counter
- Must be applied above the waist and below the neck. Rotate site.
- Releases a constant amount of nicotine.
- Possible side effects: local skin reaction, insomnia, vivid dreams.
- Contraindications/Cautions: recent MI (2 weeks) and chest pain; conflicting evidence

Nicotine Transdermal Patch Dosing

	1 ppd	½ ppd	¼ ppd	
21 mg	4 weeks			Quit
14 mg	2 weeks	4 weeks		Date is
7 mg	2 weeks	2 weeks	4-6 weeks	Day 1

* May extend treatment up to 16 weeks.

Nicotine Gum

- Available over the counter
- Delivers nicotine to the brain more quickly than the patch
- Reduces urge to smoke and takes the edge off cravings if used properly.
  - No Smoking
  - No eating or drinking within 15 minutes
  - "Chew and park" slowly for 30 minutes
- Possible side effects: indigestion, jaw soreness, hiccups
- Contraindications/Cautions: recent MI (2 weeks), chest pain, dentures, jaw impairment, head and neck cancer, salivary gland issues

Nicotine Gum Dosing

	1 ppd	w/patch for breakthrough	Maximum Dose
2 mg	1 gum every 1-2 hr x 6 weeks	1 gum when triggers* arise	24 pieces daily
	1 gum every 2-4 hr x 3 weeks	Taper use after 2-4 weeks	6 pieces daily for breakthrough*
	1 gum every 4-8 hr x 3 weeks		

***after meals, 1st thirty minutes upon awakening, stressful situations**

Nicotine Lozenge

- Available over the counter
- Can be used when gum is not tolerated
- Hard candy form, should dissolve in mouth.
- Not to be chewed or swallowed whole
- Similar dosage and restrictions as nicotine gum
- Possible side effects: nausea, soreness of teeth and gums, indigestion, throat irritation
- Contraindications/Cautions: recent MI (2 weeks), chest pain, salivary gland disorder

Nicotine Lozenge Dosing

	1 ppd	Duration	w/patch for breakthrough	Maximum
2 mg	1st cigarette 30 minutes after waking	1 piece every 1-2 hr x 6 wks; 2-4 hr x 3 wks; 4-8 hrs x 3 wks	1 piece when triggers arise; taper use after 2-4 wks	Max: 20 pieces per day Max: 5 pieces in 6 hours No more than one lozenge at a time
4 mg (non-formulary)	1st cigarette within 30 minutes of awakening	As above	As above	As above

Zyban (Bupropion)

- Available by prescription only
- Can be used in combination with the patch or gum
- Treatment begins while the user is still smoking (1 week prior to quit date).
- If no progress by 7th week, success may be limited.
- Possible side effects: insomnia, dry mouth, constipation, diaphoresis
- Contraindications/Cautions: seizure hx, eating disorders, bipolar hx, concomitant antidepressants, use of MAOI inhibitors, insomnia, excessive ETOH use

	Dose	Duration	
150 mg	1t q am	Week 1	Set quit date at week 2
	1t bid	Week 2-8	

Chantix (Varenicline)

- Must have documented contraindication, intolerance, or treatment failure to NRT and bupropion
- High annual quit rates (about 40%)
- Common side effect is nausea (30%). Dose titration helps with nausea
- Take after meals with full glass of water; use lower dose if nausea is intolerable
- Requires monthly follow-up
- Use restricted medication template for ordering

	Dose	Duration	
1 mg	½ t daily	Day 1-4	
	½ t bid	Day 5-8	
	1 t bid	Week 2-12	Set quit date week 2

* CrCl< 30 ml/min, keep maintenance dose at ½ t bid; hemodialysis patient s ½ t day.

▪Side effects: nausea, vomiting, sleep disturbances, headache, constipation, flatulence, decreased sense of taste, aggressive behavior or depression, suicidal ideation, vivid dreams

▪Contraindications/Cautions: Renal insufficiency (check baseline serum creatinine), aggressive behavior or depression, suicidal ideation, PTSD

Chantix (Varenicline)

- Health care providers should educate smokers and their families, if available, prior to starting varenicline about the possibility of changes in behavior or mood and particularly any thoughts of suicide, homicide, assault, self harm, or harm to others.
- Patients with current, untreated, or unstable mental disorders should be excluded from taking this medication.

Pharmaceutical Management

1. Recommend nicotine replacement (patch OR gum, OR lozenge) if:
   - Never used patch, gum, or lozenge before
   - Used patch, gum, or lozenge successfully in the past (smoke free >3 months)

Pharmaceutical Management Protocol (cont.)

2. Recommend nicotine replacement (patch AND gum OR lozenge) if:
   - Smoke greater than 1 pack per day
   - Failed nicotine replacement mono-therapy in past

Pharmaceutical Management Protocol (cont.)

3. Recommend Bupropion if:
   - Failed nicotine replacement monotherapy in the past (smoke-free <3 months)
   - Patch, gum, or lozenge intolerant
   - History of depression or currently has depressive symptoms.

Pharmaceutical Management Protocol (cont.)

4. Recommend combination nicotine replacement and Bupropion if:
   - Failed nicotine patch/gum or Bupropion in the past.

Pharmaceutical Management Protocol (cont.)

5. Recommend Varenicline if:
   - Intolerance or treatment failure to nicotine replacement or bupropion.

Behavioral Management Protocol

- Assess if patient interested in quitting
- If not interested, leave brochure
- If interested, leave brochure.
- *Tobacco Tactics* manual
- Using *Tobacco Tactics* manual, assist with behavioral intervention
- Discuss and arrange for cessation medications.

Behavioral Therapy Activities – See *Tobacco Tactics* manual

- Self-Assessment
- Fagerström Nicotine Dependance Scale
  (A score of 5 or more indicates a significant dépendance, while a score of 4 or less shows a low to moderate dependance.
- Smoker Type
- Change Plan Worksheet
- Cost of buying cigarettes for one year

**Note: See Tobacco Tactics Manual

Goal Setting

- Setting a date
- Understanding individual's smoking habit
- Start quitting before quit date
- Inform family and friends
- Remove cigarettes from house and car
- Review previous quit attempts
- Anticipate challenges
- Reward

Handling Thoughts About Smoking

- Drink plenty of water or juice.
- Avoid heavy meals.
- Go places where smoking is not allowed.
- Clean home and car to get rid of the smoke smell.
- Light incense or a candle instead of a cigarette.
- Keep a squeeze toy or a stress ball handy.
- Avoid coffee / other beverages associated with smoking.
- Leave the table when finished eating.
- Do something to keep mind off smoking.
- Place a rubber band around wrist and snap it each time a nicotine craving hits.

Assessing High Risk Situations

- Alcohol
- Stress/Depression
- People (other smokers)
- Environment (smoking)

Coping with Cravings

- Remembering the 3 R's.
  - Remind
  - Rehearse
  - Reward

- If that does not work, there are the 4 D's.
  - Delay
  - Deep Breathing
  - Drink Water
  - Distract

Specific Smoker Types

- Type 1: Stimulator
- Type 2: Handler
- Type 3: Relaxer
- Type 4: Stress Reducer
- Type 5: Nicotine Craver
- Type 6: Habit Smoker

Coping with Relapses

- Most relapses occur within three days of quitting
  - 70% of smokers make more than one quit attempt
  - Average smoker makes 5-7 quit attempts
  - Examine what triggered the relapse
    - Alcohol
    - Stress/Depression
    - Other Smokers
    - Withdrawal

- If relapse within first 24 hours of quitting with patch, Bupropion may be added.

Common Problems in Quitting

- Withdrawal Symptoms
  - Dizziness
  - Headache
  - Coughing
  - Lack of concentration
  - Stomach pain
  - Irritability
  - Fatigue or insomnia
  - Hunger

- Weight Gain
  - Average weight gain is 2-3kg (4-6lbs)
  - Temporary
- Things to consider
  - Review diet / make changes
  - Exercise
  - Choose healthy snacks
  - Nicotine gum (when using NRT)

Good Physical Effects from Quitting

- 15-20 minutes after the last cigarette, nicotine levels in the blood fall.
- Within two days, all nicotine and nicotine by-products are gone.
- After 6 hours, the heart rate and blood pressure become lower.
- After 12 hours, all of the harmful carbon monoxide is out of the system.
- After a few days, the sense of taste and smell improve.
- After several weeks, circulation improves
- Within 3 months, the lungs clean themselves.
- The risk of heart disease lowers 50% in the first year and the risk of lung cancer also steadily decreases.

Documentation – CPRS

Inpatient

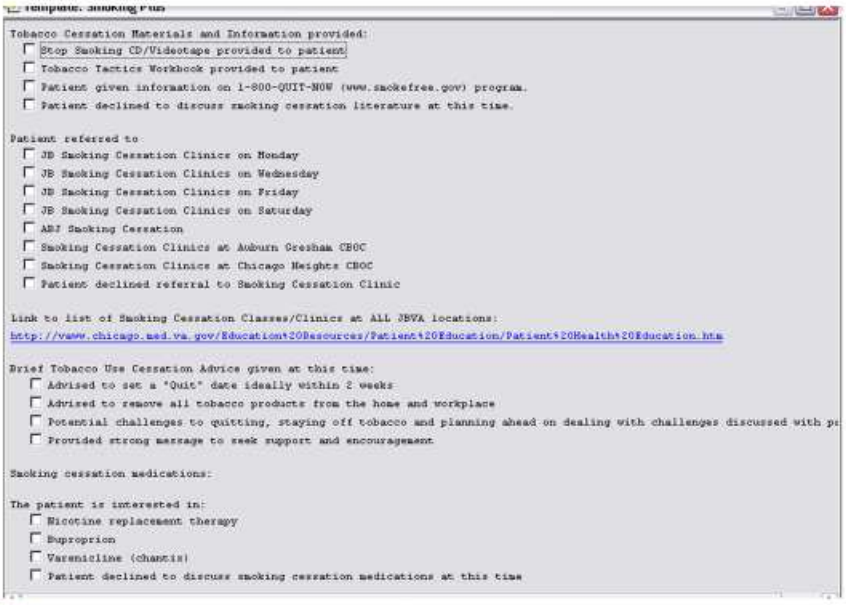
Nursing Admission Assessment

Outpatient

Clinical Reminders
Shared Templates
- Education Templates
- Smoking Cessation Outpatient
- Select note title

Primary Care CPRS progress note

Template varies depending on who is completing it
- Able to prescribe medication/not able to prescribe medication



Tobacco Cessation Materials and Information provided:
- ☐ Stop Smoking CD/Videotape provided to patient
- ☐ Tobacco Tactics Workbook provided to patient
- ☐ Patient given information on 1-800-QUIT-NOW (www.smokefree.gov) program.
- ☐ Patient declined to discuss smoking cessation literature at this time.

Patient referred to
- ☐ JB Smoking Cessation Clinics on Monday
- ☐ JB Smoking Cessation Clinics on Wednesday
- ☐ JB Smoking Cessation Clinics on Friday
- ☐ JB Smoking Cessation Clinics on Saturday
- ☐ ABJ Smoking Cessation
- ☐ Smoking Cessation Clinics at Auburn Gresham CBOC
- ☐ Smoking Cessation Clinics at Chicago Heights CBOC
- ☐ Patient declined referral to Smoking Cessation Clinic

Link to list of Smoking Cessation Classes/Clinics at ALL JBVA locations:
http://vaww.chicago.med.va.gov/Education%20Resources/Patient%20Education/Patient%20Health%20Education.htm

Brief Tobacco Use Cessation Advice given at this time:
- ☐ Advised to set a "Quit" date ideally within 2 weeks
- ☐ Advised to remove all tobacco products from the home and workplace
- ☐ Potential challenges to quitting, staying off tobacco and planning ahead on dealing with challenges discussed with pa
- ☐ Provided strong message to seek support and encouragement

Smoking cessation medications:

The patient is interested in:
- ☐ Nicotine replacement therapy
- ☐ Bupropion
- ☐ Varenicline (chantix)
- ☐ Patient declined to discuss smoking cessation medications at this time

Toolkit for Patients

- Brochure
- Videotape
- Tobacco Tactics manual
- Pharmaceuticals
- 1-800-QUIT-NOW help line

Tobacco Tactics Manual

Case Study 1

- Mr. Smith is a 54 year old patient admitted to the hospital for cardiac work-up. During a previous hospitalization he had quit smoking, but is now smoking 1-2 cigarettes/day.
- What can you do?

Suggestions

- Congratulate him on his reduction in smoking
- Give him brief advice: "Quitting smoking is the most important thing you can do for your health."
- Assess for depression (common in cardiac patients) and drinking
- Assess environment (smokers at home, work)
- Offer gum

More Information on Mr. Smith

- He does not drink
- He tells you since his heart attack he is feeling blue most days, but is not suicidal.
- His wife smokes
- What can you do?

Suggestions

- Assess whether his wife would be interested in cessation
- Counsel his wife to smoke outside and out of sight
- Consider Zyban for smoking and depression

Case Study 2

- Mrs. Jones is smoking a pack per day. In the past she has quit, but relapsed to smoking at times when she was drinking alcohol.
- What can you do?

Suggestions

- Assess how much she is drinking
- On an average week, how many days do you consume alcoholic beverages?
- On an average day drinking, how many drinks do you have?

More Information

- You find out that she was drinking 3-4 drinks every night after work, but quit 30 days ago by attending Alcoholics Anonymous
- She would like to quit smoking, but there are many smokers at AA
- What can you do?

Suggestions

- Congratulate her on quitting drinking and inform her that this might be a good time to quit smoking
- Brief or intensive cessation advice
- Nicotine patch
- Smoke free meetings

Conclusion

- Quitting smoking is the most important thing someone can do for their health.
- Clinicians are in a key position to counsel patients about quitting smoking and speak with patients about smoking cessation medications.

References:

- Duffy, S.A. (2). Tobacco Tactics: Tough Enough to Quit!.

Appendix G: Tobacco Tactics Toolkit

The Tobacco Tactics Toolkit tobacco cessation program for nurses

1. One-hour power point presentation on behavioral and pharmaceutical interventions. DNP Tobacco Tactics Nurse Training Fall 2017.pptx
2. Pocket-card "Helping Smokers Quit: A Guide for Clinicians developed by the US Department of Health and Human Services Public Health Service and Tobacco Free Nurses.
3. Evidence-based behavioral protocol.
4. Forty-Three Tobacco Tactics manual for Veterans.
5. Tobacco Tactics video for Veterans: http://www.milner-fenwick.com/health-education-videos/wellness/smoking-your-plan-to-quit

The Tobacco Tactics Toolkit tobacco cessation program for Veterans

1. Brochure
2. Educational video: http://www.milner-fenwick.com/health-education-videos/wellness/smoking-your-plan-to-quit
3. Tobacco Tactics manual
4. Pharmaceuticals
5. 1-800-QUIT-NOW helpline