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ORIGINAL ARTICLE

Implementing a tobacco-free hospital campus in Ireland: lessons learned

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Abstract
Background The Irish Health Service Executive (HSE) had set a target that all HSE facilities should implement the HSE Tobacco Free Campus (TFC) policy by 2015.
Aim The aims of this study are to examine hospital staff awareness and to assess the progress of selected HSE health care facilities towards a TFC policy.
Methods Three health care facilities that were conveniently located were self-selected in County Cork, namely, an acute hospital, a mental health service and an older person's facility. Three different types of quantitative data were collected between May and September 2016 drawn on Standards 3, 4 and 5 of the European Network for Tobacco Free Health Care Services (ENSH-Global) tools: (1) face-to-face consultation with health care facility managers on their progress towards the HSE TFC policy, (2) self-administered questionnaire to a purposive sample of 153 staff members across three health care facilities and (3) physical observation of signs of smoking and smoking-related information across each health care facility for objective verification of compliance.
Results Of the 153 staff who completed the questionnaire, 64% were females, 39% were nurses, 20% were smokers and 76% agreed with the TFC policy. However, only 26% of the 153 staff had received training on motivational and tobacco cessation techniques. Seventy-seven percent of the 153 staff stated that the campus was not tobacco-free. Physical observation suggested signs of smoking within the campus across all three health care facilities surveyed.
Conclusion Staff awareness of the HSE TFC policy across selected health care facilities in Ireland is positive but is not sufficient. There are gaps in the implementation process of the HSE TFC policy in the health care facilities. Therefore, proper communication on the importance of the ENSH-Global standards and cessation training to all staff is necessary to help reduce smoking rates across the health care facilities and also to move towards a Tobacco Free Campus in Ireland.

Keywords Brief intervention training · ENSH-Global tools · Ireland · Tobacco Free Campus policy

Introduction

Tobacco smoking is the single most preventable cause of disease, disability and death in the world today [1]. In Ireland, it is estimated that 6000 people die each year from smoking-related illnesses [2].

The World Health Organisation (WHO) Framework Convention on Tobacco Control (FCTC) [1] provides countries with guidelines to implement and manage tobacco control. The WHO introduced MPOWER measures which include a ban on advertising, raising prices and taxes, protection from second-hand smoke and the availability of services to assist persons to quit smoking [3]. The main aim of these measures is to protect the world's population from the health, economic, social and environmental hazards associated with exposure to tobacco and tobacco smoke.

In March 2004, the Republic of Ireland became the first country in the world to legislate for an outright ban on indoor smoking in the workplace with many countries following suit [4, 5]. An assessment of the economic cost of smoking in Ireland, by the Department of Health in 2016, makes it clear that the reduction of tobacco use is one of the highest priorities

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of the health services [2]. In 2010, the Health Service Executive (HSE) adopted the Tobacco Control Framework to inform HSE policy and provide a coherent response to tobacco use in Ireland. A number of actions from the Framework have been prioritised in the HSE National Service Plan 2015 [6] with a set number of targets in relation to smoking cessation which include:

- All HSE campuses and services implement the HSE Tobacco Free Campus (TFC) policy and become tobacco free by 2015 [7]
- Frontline staff are trained on interventions in relation to smoking cessation
- Patients receive interventions in relation to smoking cessation

The TFC policy will assist in helping change social norms surrounding tobacco use, highlight tobacco addiction as a health care issue and promote smoking cessation [7]. However, this underlying principle of a TFC policy towards reduced smoking prevalence and increased uptake of smoking cessation rates is not entirely supported by the recent updated Cochrane Review [8]. Nonetheless, the TFC policy is supported by the processes and tools developed by the European Network for Tobacco Free Health Care Services (ENSH-Global) [9]. ENSH-Global is an international, independent non-governmental organisation which coordinates national and regional smoke-free networks in 21 countries which include over 1400 hospitals. The aim of ENSH-Global is to promote common strategies to encourage tobacco-free environments and provide active support to assist patients, visitors and staff quit tobacco smoking among hospitals within Europe [9].

Furthermore, one of the most influential settings in advocating smoke-free environments and abstinence is health care facilities. Due to ill health, patients are more likely to refrain from smoking as a result of forced abstinence [10]. Evidence suggests that smoking cessation interventions delivered by trained health care professionals are effective tools in increasing quit rates in patients [10]. However, implementation and maintenance of successful smoking cessation programmes have been identified as an ongoing worldwide challenge [11]. The Healthy Ireland Survey (2016) found that a third (33%) of smokers who saw their GP in the past 12 months had discussed ways of giving up smoking [12].

Despite an inconclusive statement in the recent Cochrane Review [8], there is evidence suggesting that the introduction of a smoking ban increases the rates of persons abstaining from smoking when coupled with smoke-free health care facilities [13]. Since 2009, several hospitals and health care facilities in Ireland have either implemented or are in the process of implementing the HSE TFC policy, which bans smoking within the health care facility complex. It is important to note that one of the objectives of a smoke-free hospital campus is to set a good example by providing a clear and concise message to all patients, visitors and staff of the hazards of tobacco smoking and the associated health risks [7].

Based on this background, we set out for a descriptive observational study design, with two key study objectives: first, to subjectively observe compliance and some elements of an implementation process of this HSE TFC policy across three selected health care facilities in County Cork through an in-person brief consultation process of few selected managers available to this study and also by systematically surveying staff drawn from different disciplines based in these three health care facilities.

The second aim was to objectively assess compliance (impact) and some elements of the implementation process of the HSE TFC policy across these three selected health care facilities through physical observation of signs of smoking and smoking-related information within these health care facilities.

Methods

Study design This section includes a descriptive observational study of quantitative data.

Study setting Three different health care settings were self-selected in County Cork: (1) an acute hospital (AH) in Cork City, (2) a mental health (MH) service and (3) a service for older persons (OP).

The AH has implemented the TFC policy since May 2010, while the other two sites are in the processes of implementing the TFC policy and are at various stages of implementation.

Study period The study was conducted between May 10 and September 19, 2016.

Data collection This was undertaken at three different levels.

Firstly, brief consultations with management on their progress towards the TFC policy and their subjective assessment of compliance with Standards 3, 4 and 5 of the ENSH-Global tools (details below). This consultation process included a set of questions that was based on the ENSH-Global Network for Tobacco Free Hospitals Self-Audit Questionnaire [9]. However, no qualitative data were collected for any qualitative analysis. The managers were purposively selected across the three health care facilities subjected to their availability

and thus may not represent the actual management structure of the individual health care facility surveyed.

Secondly, quantitative data were collected through self-administered questionnaires, which were distributed directly to staff based in these three health care facilities. A direct opportunistic approach was chosen for staff recruitment so as to ensure completion and immediate collection of the questionnaire. Nonetheless, this was an opportunistic sampling and therefore could not capture the general representation of all staff working in these three health care facilities. At the outset, verbal consent was obtained from staff who were also introduced to the purpose of this study. Staff included nursing, medical, administrative, emergency medical technicians, allied health professionals (e.g. physiotherapists, occupational therapists), health care staff and maintenance staff. All staff were asked to complete the questionnaire at their own convenience.

This detailed questionnaire comprised 25 questions and was also based on the three standards of the ENSH-Global Network for Tobacco Free Hospitals Self-Audit Questionnaire (details below), with the following additional information:

- Gender: male or female
- Profession
- Smoking status: smoker, non-smoker or former smoker
- If staff agreed with the TFC policy
- Is the TFC implemented in their place of work

Thirdly, to objectively assess compliance (impact) and to implicitly examine some elements of an implementation process towards the HSE TFC policy (Standard 3 of the ENSH tool), physical observation of signs of smoking and smoking-related information were noted across these three health care facilities. This included observation of tobacco-free signage at each site and whether signage displayed indicated the facility was a TFC or that smoking was not permitted in certain areas. Observation was carried out on the grounds of each facility as to the number of patients/staff/others smoking within the campus and whether the smoking was in a designated area or other areas around the facility. This was carried out over a 3-h period at each facility by the researcher (DMc) between 13.00 and 16.00 GMT on August 11 and 19 and September 4, 2016, respectively. The presence of indicators of tobacco smoking within the grounds of the facility was also noted, namely, people smoking, presence of ashtrays, presence of cigarette butts, tobacco smoke and odour.

The three specific standards of the ENSH-Global tools are:

- Standard 3: Education and Training: examine if intervention training is offered to staff and that staff are also trained in motivational and tobacco cessation techniques
- Standard 4: Identification and Cessation Support: examine if interventions are in place to motivate tobacco users to quit and whether nicotine replacement therapy is available within the organisation
- Standard 5: Tobacco Control: observation of the campus grounds to determine if it is tobacco-free and observation of the number of patients/staff/others smoking within the campus and whether it is within a designated area or in general around the campus

Ethical considerations

Ethical approval for this study was obtained from the Clinical Ethics Committee of the Cork Teaching Hospitals (Appendix).

Data analysis

All data collected were analysed as quantitative data by employing descriptive statistical techniques. No qualitative data were collected, and therefore, no qualitative analysis was undertaken. The statistical software Stata Version 13.1 (StataCorp, TX, USA) was utilised. The only test of significance, the chi-square test for independence, was applied to determine whether there was a significant association between persons observed smoking and presence or absence of a designated area.

A p value of $p < 0.05$ was assumed to be statistically significant.

Results

Table 1 outlines details on the subjective assessment of compliance of the ENSH tool based on the consultations between the researcher and a selected number of members from the management structure of individual health care facility. Table 1 reports that policy briefing information (Standard 3) and a systematic procedure for identifying smokers (Standard 5) are in place across all the three health care facilitates. However, Standard 5 on Tobacco Control has not been achieved in any of these three health care facilities. However, these categorisations of the levels of implementation were arbitrary and self-reported, with no objective verification.

Table 2 outlines the staff profile surveyed in this study (n = 153) across the three health care facilities. The majority of the staff were nurses (39%).

Table 3 details the study findings of the 153 self-administered staff questionnaires based on the ENSH tool.

Table 1 Results of discussion with management as to current implementation status of ENSH-Global Standard 3—Education and Training

Criteria	Acute hospital (AH)	Service for older persons (OP)	Mental health (MH) service
Standard 3: Education and Training			
3.1 Policy briefing/instruction is provided for all personnel on how to approach tobacco users and inform them of the organisation's tobacco-free policy.	Y	N	N
3.3 Brief intervention training offered and available to all staff.	Y	L	L
3.4 Key clinical staff are trained in motivational and tobacco cessation techniques.	M	L	L
Standard 4: Identification and Cessation Support			
4.1 A systematic procedure is in place to identify and document the tobacco status of all patients/residents.	Y	Y	Y
4.4 Interventions to motivate tobacco users to quit during the health care stay are documented in the patient/resident care plans.	M	N	N
4.5 Nicotine replacement therapy/pharmacological therapy is available within the organisation.	Y	L	M
Standard 5: Tobacco Control			
5.1 The campus (grounds) and property owned by the health care organisation are completely tobacco-free.	N	N	N
5.2 If tobacco is used, it is completely away and separate from designated tobacco-free areas, windows and entrances.	N	N	N

N no/not implemented, *L* less than half implemented, *M* more than half implemented, *Y* yes/fully implemented

Of the staff who completed the questionnaire (n = 153), 64% were females, 20% were smokers, 67% agreed that they work in a tobacco-free campus and 76% overall agreed with the TFC policy.

Standard 3: Staff working in the AH had the highest prevalence of having received policy briefing and instruction at 72%. The availability of brief intervention training was also the highest in the AH at 61%. The overall rates of key clinical staff who received training on motivational and tobacco cessation techniques were low in all three sites with the AH having the highest prevalence at 26%.

Standard 4: Staff response to having systematic procedures in place to identify and document the tobacco status of residents/patients was high with the MH service response (94%). The staff response to the availability of nicotine replacement therapy within each site was 100% in the MH service. Information on tobacco cessation methods being widely available at each site was also 100% at the AH.

Standard 5: Only 33% of the staff who worked in the AH, which has implemented the TFC policy, stated that the campus was tobacco free.

Figure 1 illustrates the percentage (%) distribution of the types of personnel that were physically observed to be smoking on the campus of the three health care facilities.

Of the persons observed smoking in both the MH service and OP service, 85% were in the designated areas (Fig. 1). There was a significant association between persons observed smoking and presence or absence of a designated area (p = 0.0008).

Other details on the objective assessment of Standard 3 of the ENSH tool are described subsequently.

In all three sites, indicators of tobacco use (people smoking, presence of ashtrays, the presence of cigarette butts and tobacco smoke and odour) were evident.

- In the AH where the TFC policy is implemented, smoke-free signage was evident throughout the campus including the use of a public address system at the two main entrances informing people that the campus is tobacco free.
- There was no presence of ashtrays on the site where the TFC policy is in place; however, there was evidence of the

Table 2 Staff profile who completed the questionnaire

Occupation	Acute hospital (AH)	Service for older persons (OP)	Mental health service (MH)	n = 153 (%)
Nursing	35	9	15	39
Medical	16	1	0	11
Administrative staff	19	5	1	16
Health care staff/porter/-maintenance	16	10	0	17
Allied health professional	13	2	1	10
Ambulance service	6	4	0	7
Total	105	31	17	

Table 3 Results of the staff questionnaire (n = 153)

Standard 3: Education and Training		
3.1 Policy briefing/instruction is provided for all personnel on how to approach tobacco users and inform them of the organisation's tobacco-free policy		
Acute hospital	Yes	No
	72%	28%
Older persons service	Yes	No
	16%	84%
Mental health service	Yes	No
	6%	94%
3.3 Brief intervention training offered and available to all staff		
Acute hospital	Yes	No
	61%	39%
Older persons service	Yes	No
	16%	81%
Mental health service	Yes	No
	12%	88%
3.4 Key clinical staff are trained in motivational and tobacco cessation techniques		
Acute hospital	Yes	No
	26%	69%
Older persons service	Yes	No
	16%	84%
Mental health service	Yes	No
	12%	88%
Standard 4: Identification and Cessation Support		
4.1 A systematic procedure is in place to identify and document the tobacco status of all patients/residents		
Acute hospital	Yes	No
	69%	29%
Older persons service	Yes	No
	48%	26%
Mental health service	Yes	No
	94%	0%
4.3 A tobacco cessation service or direct access to cessation service is available for patients/residents (in-patients and out-patients)		
Acute hospital	Yes	No
	84%	0%
Older persons service	Yes	No
	61%	13%
Mental health service	Yes	No
	100%	0%
4.4 Interventions to motivate tobacco users to quit during the health care stay are documented in the patient/resident care plans		
Acute hospital	Yes	No
	65%	0%
Older persons service	Yes	No
	48%	17%
Mental health service	Yes	No
	100%	0%
4.5 Nicotine replacement therapy/pharmacological therapy is available within the organisation		
Acute hospital	Yes	No
	73%	18%
Older persons service	Yes	No
	48%	13%
Mental health service	Yes	No
	100%	0%
4.8 Information on tobacco and tobacco cessation methods are widely available in the organisation		
Acute hospital	Yes	No
	100%	0%
Older persons service	Yes	No
	82%	12%
Mental health service	Yes	No
	100%	0%

Table 3 (continued)

Standard 3: Education and Training		
Standard 5: Tobacco Control		
5.1 The campus (grounds) and property owned by the health care organisation are completely tobacco free		
Acute hospital	Yes	No
	33%	77%
Older persons service	Yes	No
	26%	74%
Mental health service	Yes	No
	0%	100%
5.2 If tobacco is used, it is completely away and separate from designated tobacco-free areas, windows and entrances		
Acute hospital	Yes	No
	33%	67%
Older persons service	Yes	No
	90%	10%
Mental health service	Yes	No
	88%	12%

presence of cigarette butts littering the campus grounds and tobacco smoke and odour in all areas where people were observed smoking.

- In the other sites, smoke-free signage was limited; however, there were designated areas for smoking which included ashtrays and these areas included signage. Ashtrays were evident in these areas and the presence of cigarette butts littering the grounds was minimal.

Discussion

This study on assessing the implementation of a Tobacco Free Campus policy across three selected health care facilities in County Cork based on a previously validated ENSH-Global standard tool provides interesting insights. First, we summarise the main results across the three different levels of data thus collected. Next, we discuss these results in details in the light of the three standards of the ENSH-Global tool.

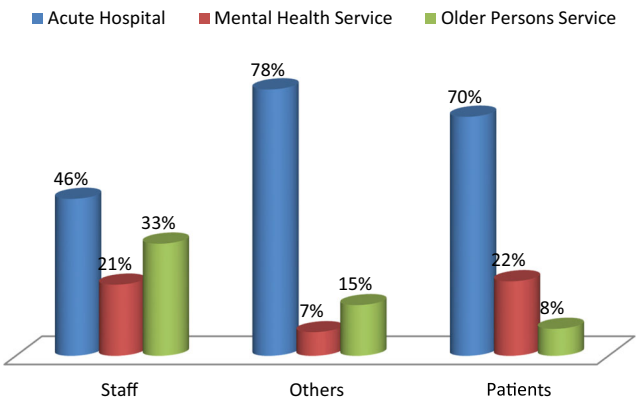

Fig. 1 Groups of persons observed smoking on the campus grounds of all three sites

The brief individual consultations with management at each site highlighted the different stages each service was at in relation to the TFC policy and their compliance with Standards 3, 4 and 5 of the ENSH-Global Self-Audit Questionnaire. The AH, having implemented the TFC policy, uses this tool to enable them to monitor and review their progress. This service also has a dedicated smoking cessation officer on site. The other sites were aware of the ENSH-Global Self-Audit Questionnaire but did not currently use the tool. The use of this tool regardless of the stage of implementation of the TFC policy would enable the other services to monitor and review their progress towards achieving a tobacco-free environment.

Of the 153 staff who completed a self-administered questionnaire, 64% were females, 39% were nurses, 20% were smokers, 67% agreed that they work in a tobacco-free campus and 76% overall agreed with a TFC policy. However, those staff who did not agree with a TFC policy happened to be mostly smokers. A recent audit in Ireland reported that 15% of the HSE staff smoked, and only 63.6% of the staff were aware of HSE quit services [14].

Finally, in the physical observation piece to objectively assess compliance, the proportion of staff smoking across these three health care facilities varied. For instance, 50% of the staff were found smoking in the health care facility catering for older persons, as compared to only 11% staff smoking in the mental health care facility. All these study findings highlight the fact that there are still challenges to overcome in relation to implementing the TFC policy across specific health care facilities in County Cork.

There is a commitment in the HSE that all campuses and services will become tobacco free by 2015 [15]. This study examined how three different health care services are implementing

the TFC policy of the Tobacco Control Framework 2010–2015. Of the three services in the study, the AH had implemented the TFC policy and the remaining two sites are in the processes of progressing towards implementing the TFC policy. The aim of the TFC policy is to assist with helping to change social norms surrounding tobacco use, highlight tobacco addiction as a health care issue and promote smoking cessation [7]. The TFC policy is supported by the processes and tools developed by the European Network for Tobacco Free Health Care Services [9].

Standard 3: Education and Training

Staff in the AH received policy briefing and instruction on how to approach tobacco users. This is included in induction training. However, such training briefs have not been implemented in other services. Since the TFC policy is not implemented in the other services, this policy briefing and instruction was not a priority. However, the management is aware of the fact that once dates for the implementation of TFC policy are finalised, this briefing/instruction would be delivered to all staff.

The HSE Service Plan 2015 [6] sets a national target of 1500 frontline health care staff to be trained in brief intervention smoking cessation. A study in 2011 on attitudes, training and smoking profile of European Respiratory Society members [16] highlights the need for appropriately trained health care staff as being essential to assist smokers to quit, and there should be more focus on training health care staff. Sixty per cent of staff in the AH had received brief intervention smoking cessation training. This training is available to all staff on site with the other services having to nominate and release staff to attend this training off site. Key clinical staff in all services have been trained in motivation and tobacco cessation techniques. However, more staff need to be targeted for this training. Staff who had received training in these techniques were nursing staff (81%) and medical staff (92%). These staff are ideally positioned to deliver this training at service level. However, it would be more beneficial if all disciplines of frontline health care staff received this training.

Furthermore, managers at each site highlighted the difficulty with releasing staff and that priority must be given to mandatory training. However, efforts must continue to ensure that staff are released for appropriate training as per the TFC policy [7]. Evidence suggests that delivering this training to those patients/residents and indeed staff members who express an interest in quitting has a positive impact on attempts at quitting smoking [17]. This highlights the need for a service-wide systematic approach in delivering this training to staff. This will also result in building capacity and in empowering staff to routinely advise and support patients/residents. Staff need to be motivated and endorse the smoke-free policy, as staff reluctance may be one of the main challenges to a successful TFC policy [18]. It is imperative that in all services, patients/residents and staff who smoke are not in any way victimised for smoking. Evidence suggests that smoking is clearly associated with disadvantage [19] and support needs to be offered to assist smokers to quit.

Standard 4: Identification and Cessation Support

All sites have a systematic procedure in place to identify and document the tobacco status of patients. Interventions to motivate tobacco users to quit smoking during the health care stay are not being fully documented. Results of the staff questionnaire showed that although management stated this is not currently being implemented, 100% of staff in the MH service and 48% of staff in the OP service answered "yes" to this question. This inconsistency can only be explained by misinterpretation of this standard by staff who completed the questionnaire and was compared to the results following discussion with management. To validate this further requires investigation, whereby health care records can be viewed to determine if interventions are documented or not.

The AH, with support from the Health Promotion Department, has introduced an individual electronic smoking cessation care plan for patients which documents the smoking status of the patient and interventions received to motivate and assist patients to quit. This example of good practice could be shared with other services.

The availability of nicotine replacement therapy (NRT) in all services is positive. NRT is freely available to persons who hold a medical card[1]; however, it would be more beneficial if NRT was freely available to all. This study reports that 39% of staff in the OP service were unsure as to whether this is available. Ninety-two per cent of these staff were health care assistants, which highlights the need for the dissemination of this information to particular frontline staff by management.

Standard 5: Tobacco Control

Each site is continuing in its efforts to discourage smoking within the grounds of their facilities. The MH service and OP service in this study have not implemented the TFC policy, whereby smoking is prohibited on the grounds. However, these two sites have introduced designated smoking areas which are being used by service users/residents and staff. All services highlighted the difficulty they have experienced in trying to implement the TFC policy when there is no legislation in place to enforce it. There is a need for legislation to be agreed at the

[1] A medical card is issued by the HSE following a mean test, whereby persons who are deemed eligible for a medical card are entitled to a range of health services free of charge.

national level to facilitate the enforcement of the TFC policy similar to that of the Queensland government in Australia which has introduced warnings and on the spot fines for breach of the law [20]. Seventy-seven per cent of staff working in the AH stated that the campus grounds were not completely tobacco free, which further indicates the challenges in enforcing the TFC policy. These results suggest that although 99% of staff are aware of the TFC policy, there appears to be a non-acceptance by the general public and patients alike in adhering to the policy. To successfully implement the TFC policy, there is a need for a reinforced cohesive approach to ensure enforcement of the policy by the existing structures that are currently in place. The Centres for Disease Control and Prevention (CDC) also advocates for a comprehensive approach by applying a mix of clinical, educational, social and economic strategies [21].

Finally, in the physical observation for objective verification of compliance, 85% were smoking in the designated areas in both the MH service and OP service. A review carried out in 2009 on public attitudes towards certain outdoor areas being smoke free supported restrictive smoking in hospitals [22]. Another study conducted in Italy in 2012 found that 79% of the general population supported tobacco-free hospitals [23]. During the collation of observational data, there was evidence of smoking in all the three sites. Such observations included people smoking on site, the presence of cigarette butts littering the sites and the presence of cigarette smoke and tobacco odour. Both the MH service and the OP service have designated areas for smoking, and these areas are actively used by residents/service users, staff and other persons. Ashtrays were provided within these areas, and the presence of cigarette butts littering the grounds was minimal. Such observations would suggest that in providing a designated area within a site, smokers are most likely to adhere to smoking within this area rather than smoking in other areas and thus reducing littering of cigarette butts. However, this contradicts the TFC policy.

A study in 2014 in college campuses found that designated smoking areas may limit second-hand smoke exposure and reduce cigarette consumption [24]. A study in 1996 found that the introduction of smoke-free signage in health care facilities may have an impact on reducing but not eliminating smoking within these settings [25]. The presence of smoke-free signage was evident in all sites. In the AH where the TFC policy has been implemented, smoke-free signage was evident throughout the campus, including the use of a public address system at the two main entrances informing people that the campus is tobacco-free. However, people were observed smoking at both entrances, despite the smoke-free signage and the public address system repeatedly stating that the campus is tobacco-free. Such observations clearly lend support to non-acceptance in adhering to the policy. This study clearly highlights the need for stricter enforcements so as to achieve better compliance with the TFC policy. However, evidence on voluntary policies is also not comprehensive. Nonetheless, ignoring non-compliance sends out a counterproductive message. Services need to commence frequent unannounced walk rounds by management and observational audits to monitor the TFC. There is a need for all services to improve the education, communication and training for all staff and award recognition to those who support and implement the TFC policy.

Limitations

There are a number of limitations in this study that must be recognised. Firstly, this is a small-scale study of three services; and hence, its findings are limited and cannot be generalised because of the self-selection process of a convenience sampling. The study only focused on three of the ten ENSH-Global standards [9] and did not examine the attitudes of persons observed smoking within the campus grounds of the facilities. As the managers of the hospitals studied have responsibility and are accountable to more senior managers in the HSE, it would have been interesting to have asked them what strategies they might consider to accelerate progress and achieve compliance with the TFC. However, this was not addressed in the current study. Nonetheless, a study of this nature would be beneficial in gaining more insight into attitudes on the TFC policy. We did not have a control group in this study, and no causal inferences can be drawn.

Conclusions

The three health care facilities selected in County Cork were at various stages of implementing the HSE TFC policy. Moreover, significant progress has been made in their work and planning to date towards a tobacco-free environment. However, all sites face challenges in implementing the TFC policy. Staff awareness of the TFC policy is positive; however, results show that there are significant shortcomings in addressing smoking within sites. Nevertheless, designated areas appear to curtail the smoking in and around sites. Communication on the importance of the ENSH-Global standards and cessation training for all staff including frequent audits and monitoring is required to help reduce the prevalence of smoking on sites and achieve a TFC.

Compliance with ethical standards Ethical approval for this study was obtained from the Clinical Ethics Committee of the Cork Teaching Hospitals (Appendix).

Appendix

Clinical research ethics committee approval

UCC

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Coláiste na hOllscoile Corcaigh, Éire
University College Cork, Ireland

COISTE EITICE UM THAIGHDE CLINICIÚIL
Clinical Research Ethics Committee

Lancaster Hall,
6 Little Hanover Street,
Cork,
Ireland.

Our ref: ECM 4 (gggg) 14/04/15

14th April 2015

Dr Zubair Kabir
Senior Lecturer
Department of Public Health and Epidemiology
University College Cork
Western Gateway Building
Western Road
Cork

Re: Examination of selected global network of smoke free health services standards and the HSE Tobacco Free Campus Policy of the Tobacco Control Framework 2013 in selcted Health Service Executive facilities.

Dear Dr Kabir

Expedited approval is granted to carry out the above study.

The following documents have been approved:

- Signed Application Form
- Study Protocol
- CV for Chief Investigator.

We note that the co-investigator involved in this study will be:

- Ms Denise McArdle, MPH Student.

Yours sincerely

Professor Michael G Molloy
Chairman
Clinical Research Ethics Committee
of the Cork Teaching Hospital

The Clinical Research Ethics Committee of the Cork Teaching Hospitals, UCC, is a recognised Ethics Committee under Regulation 7 of the European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004, and is authorised by the Department of Health and Children to carry out the ethical review of clinical trials of investigational medicinal products. The Committee is fully compliant with the Regulations as they relate to Ethics Committees and the conditions and principles of Good Clinical Practice.

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