The implementation of a tobacco-free workplace policy within a hospital setting: A case study from Helsingborg General Hospital

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ABSTRACT

**Background:** Tobacco use and the involuntary exposure to smoking constitute major risks for health and are among the causes of increased healthcare costs. Contemporary hospitals are expected to be an example in tobacco control initiatives such as applying smoke-free environment policies.

**Method:** This case study investigates the implementation of the tobacco-free workplace policy at a health-promoting hospital using individual interviews and organizational documents. Content analysis and discourse analysis were used to interpret the information from different sources.

**Findings:** Three emerging themes implied that the implementation process of such policy encompasses *seizing social and organizational opportunities, embedding the new framework of practice* into the organization processes and hence, *re-shaping the organizational identity.*

**Conclusion:** In secondary healthcare centers, this study suggests that more emphasis should be put on the health-promoting role of hospital professionals. This is translated into allocation of resources and the integration of knowledge and evidence-based practices within organizational processes.
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INTRODUCTION

Background
Smoking is the leading cause of death in the 21st century. Tobacco use kills six million people each year and among these more than 600,000 die from the exposure to second-hand smoke (WHO, 2011). The serious consequences of smoking and involuntary exposure to tobacco smoke, which are well documented in the literature, are also considered to be one of the major causes of increased healthcare costs. In Sweden, tobacco-related diseases cost the society around 30 billion Swedish Crowns per year (Swedish national institute of public health, 2010).

Implementing public smoking-free policies is considered as the most cost-effective strategy in order to reduce these costs; first, because they decrease the exposure to passive smoking, and second, due to their significant impact on the attitudes and behaviors of smokers (Fichtenberg and Glantz, 2002). These policies promote a positive social norm that discourages smoking, reduce cigarette consumption, and increase the desire to quit and the likelihood of cessation (Bauer et al., 2005). They are also being commonly applied in workplace health-promoting programs. The restrictions in the workplace can range from limiting smoking to designated areas outdoors to mandating a total tobacco ban during working hours enforced by strict disciplinary measures.

Health-Promoting Hospitals and Health Services
In addition to their traditional roles to treat patients and handle diseases, contemporary hospitals should have health as corner stone and health promotion is to be incorporated in all strategic planning as well as in daily practices (Whitehead, 2004). Health promotion investments in hospitals are promising due to: 1) the availability of broad professional expertise, 2) the interaction with a wide and increasing portion of the society, 3) the large workforce and 4) the hazardous work environment (toxic chemicals, infections, physical agents but also stress) (Pelikan et al., 2001).

To enhance this health-promoting role, the World Health Organization (WHO) initiated, in 1991, the Healthy Hospitals network, later called Health-Promoting Hospitals and Health Services (HPH). This has become a worldwide network including more than 900 hospitals in
40 countries (WHO CC, 2013). In their efforts to promote health to patients, staff and the community, HPH are expected to lead the example in tobacco control initiatives such as applying tobacco-free environment policies.

**Health policy implementation**

The implementation process of any policy must be planned properly and tailored to anticipate different implications that it would have in the context where it is being introduced e.g. the workplace. Previous research analyzed different phases of- and components influencing the implementation of health policies in general and tobacco-free policies in particular. Fallin (2011) studied the effectiveness of implementing a campus tobacco-free policy by applying the “institutional analysis and development (IAD) framework” and concluded that the implementation of a health policy includes four stages: commitment, preparation, enforcement and compliance. The rules-in-use, community attributes (culture), and the involved actors influence these phases. Using the same framework, Martinez (2009) analyzed the implementation of tobacco control policies in hospitals and identified barriers and challenges at the collective and operational levels related to lack of follow up, evaluation and enforcement of the policies. In addition, low engagement of the hospitals' management was also a shortcoming that characterized the implementation of these policies.

**Sweden**

Sweden is known to have substantially lower smoking prevalence than other EU countries. In 2011, 11% of the adult population in Sweden smoked (Swedish National Institute of Public Health, 2011). As recommended by WHO, Sweden deploys information, education, advocacy, tobacco cessation programs and limiting legislation and regulation as measures to thwart the tobacco industry's efforts to make tobacco use socially accepted.

In recent decades, much has happened with the societal attitudes towards tobacco. The norm has shifted from focusing on tobacco users' rights to emphasize those of non-users. Each tightening of the Tobacco Act has led to less acceptance of tobacco and resulted in negative attitudes towards it (Swedish National Institute of Public Health, 2009). In addition to the efforts against tobacco use through the national public health policy, the introduction of the
smoke-free environments’ concept in 2003 was a contributing factor to the change in the social acceptance of tobacco.

As a member in the healthy hospitals network established by WHO, Swedish authorities developed in 1996 the national network of HPH. Today, the Swedish network includes 25 hospitals and healthcare providers from across the country (Swedish HPH, 2013). Since 2006, the referral hospitals as well as the primary healthcare units in Scania (Skåne) joined the national HPH network and founded a regional one as well. The common vision was to create a more effective and health-oriented healthcare system by promoting health among patients, employees and community. The members collaborate, regionally and nationally, to develop knowledge and create structures and routines that simultaneously fulfill the 6th objective of Sweden’s overarching public health policy, which is to develop a more health-promoting healthcare system (Swedish National Institute of Public Health, 2013).

The health-promoting work is being performed with four different perspectives:

1- Patient perspective: by developing health-promoting and preventive measures for patient care.
2- Employee perspective: by creating a more attractive workplace through a healthier work environment.
3- Community perspective: by providing wider knowledge and participating more actively in community’s health-promoting activities.
4- Administrative perspective: by using the health promotion concept as a strategy for creating a more cost-effective healthcare system.

**Aim of the thesis**

When reviewing the literature, many studies measuring effects and impact of anti-tobacco policies were found, but few described the complete recipe of how they had been implemented. This thesis will therefore attempt to describe the process of implementation in order to assist hospitals considering introducing a tobacco ban on their premises, but it can also provide guidance for future regulations in health-promoting hospitals. In other words, this study aims at exploring the implementation process of the tobacco-free workplace policy
at Helsingborg General Hospital and study why and how the policy was implemented within the hospital setting and to document the lessons that could be learned for future projects.

The objectives of the thesis are the following:
- To identify different factors influencing the implementation of a tobacco-free workplace policy at a hospital setting.
- To identify potential gaps between planned and implemented interventions.
- To provide input for future planning within the same policy area or in designing other health-promoting interventions.

METHODOLOGY

In order to answer the research question, a study design capable of capturing different parts of the health policy implementation within its own context was needed. The case study research design, which is an approach that facilitates the exploration of a phenomenon within its context using a variety of data sources (Hancock and Algozzine, 2006), was adopted. In this study, the phenomenon was "the implementation process of a tobacco-free workplace policy at Helsingborg General Hospital" which hereby is referred to as “the case”. Empirical data was collected from different sources: action plans, policy documents, communication letter, meetings minutes and individual interviews (Table 1). As suggested by Yin (1994), a case study protocol including different components of the case study design such as the objectives of the study, relevant theories, field procedures and specific questions to be addressed, was elaborated at the beginning and guided the whole study (Appendix I).

The setting
This study took place at Helsingborg General Hospital during November 2012-March 2013. The hospital is one of Region Skåne’s four highly specialized public referral hospitals, where patients come from all over the north-west of Skåne requiring specialized emergency care. Region Skåne is the political administration responsible for setting policies and general guidelines for healthcare, while municipalities, hospitals and healthcare centers at the local level are responsible for prioritizing and implementing strategies aligned with the regional recommendations.
Helsingborg hospital employs 2550 staff and includes 9 major independent departments headed by 9 department heads. They, together with the hospital’s Chief Executive Officer (CEO), senior physician, communication manager, human resources manager, Chief Financial Officer (CFO), and the senior nurse manager, constitute the management team. Each head of department is responsible for different section managers within the same department, called middle-line managers. The latter manage the unit managers, who are the front-line managers and directly in charge of responding to the patients’ and employees’ concerns (Figure 1). Interaction between staff and employer is regulated by the general collaboration agreement, which is a collective agreement that allows employees to participate, discuss and influence decisions at the workplace. This takes place in staff meetings where employees and managers at different organizational levels may raise and discuss key issues related to work, performance and professional development.

Since 2006, Helsingborg hospital has been a member in the international and Swedish HPH networks and has been represented by a process leader (Helsingborg hospital, 2013). Following the resignation of the process leader and for financial reasons, this responsibility is nowadays divided between three senior managers on top of their existing managerial duties. These managers (part-time (25%) process leader, tobacco project leader and emergency process manager) form a steering committee in charge of developing knowledge, creating and following-up health-promoting structures and routines at the hospital. They also collaborate with different operational groups at the hospital who have different expertise in: tobacco, alcohol, nutrition and physical activity.

**The tobacco-free policy at Helsingborg General Hospital**

Since 2003, Helsingborg hospital has been a smoke-free hospital where employees and patients have only been allowed to smoke in designated areas outdoors. In 2008, a committee, including a middle-line nurse manager and the former process leader, was assigned to review the smoking policy. The revised policy resulted in a more strict regulation that forbade: 1) cigarettes use and sale in the whole hospital campus and 2) employees from smoking during working hours (Appendix IIIc).
In 2011, Region Skåne decided on a policy that concerned tobacco use within healthcare organization settings. This entailed a strict tobacco-free working hours policy with no flextime allowed. While applying a restrictive ban on any form of tobacco during working hours, and considering its addictive nature, the policy mandated assistance to smokers through reimbursement of nicotine replacement and participation in cessation programs (Appendix IIId). Helsingborg hospital’s collaboration committee (Figure 1) adopted the new regional policy and communicated it through the management team and union representatives to the employees. The communication incorporated the implications on the hospital’s employees, i.e. the tobacco ban and one-year support program with nicotine replacement reimbursement (Appendix IIIe). The procurement of support was the immediate manager’s responsibility and its cost was deducted from the overall department’s budget.

**Data collection**

The empirical data in this study was derived from two different sources: organizational documents and semi-structured interviews.

**Organizational documents**

In order to understand the conditions that surrounded the implementation of the policy such as regional collaborations, policy goals, follow up measures, challenges faced by the involved actors but who were unreachable during the study period, health-promoting steering committee documents were accessed.

All documents related to the implementation of the tobacco-free policies were selected and included in the analysis. Internal emails related to the topic were excluded for lack of clarity and consistency. The selected documents are described in Table 1: the local smoking-free policy document that was put into action in 2008, serving as regulating document for staff and presenting intentions behind- as well as the implications of the policy. Other official documents were the 2011 regional tobacco-free policy document and the communication letter, aiming at introducing the regional decision to local employees. In addition, steering committee meeting minutes and action plans helped to describe the interactions within the hospital’s staff and with other hospital members in the region in addition to measures taken to follow up the whole process.
Semi-structured interviews

In order to gather in-depth information about the implementation process and identify possible gaps or unintended consequences of it, nine individual semi-structured interviews were conducted with top-, middle- and operational level employees.

In qualitative research, purposive sampling is the technique used to reach people within a study area "who can share their unique slice of reality" (Dahlgren et al., 2007, p. 33). The inclusion criteria for the study were "being employed at Helsingborg hospital and having witnessed the implementation of the policy". Although the sample is homogenous in terms of employment at the hospital, the nine informants had different backgrounds (Table 1) for a greater variation in the description of the process in question (Graneheim and Lundman, 2004).

After several meetings with the health promotion process leader and the tobacco project leader, different channels were accessed to recruit various groups of interviewees. In order to recruit managers, the study was introduced to middle-level managers during their regular management team meeting, followed by two follow-up emails with attached information about the study. Four managers from different organizational levels contacted the study team and interviews were appointed after obtaining their verbal consent but only three interviews were conducted since one manager opted out due to illness. In order to reach staff, an introduction letter about the study was sent to them individually or through unions’ representatives. Eight employees showed interest but only six could make it to the interview. The time for interview was then booked after the respondent had given verbal consent.

Individual interviews constitute a good data collection method to dig deeper into a process (Dahlgren et al., 2007). Interviews were conducted in a calm setting at the informants’ workplace; however, the specific venue and time were decided based on the informant’s preference. An interview guide was prepared, which assisted the interviewer during the interviews by including open-ended questions that covered the implications of a tobacco policy, different phases of the implementation process and the experienced challenges (Appendix I). When needed, probing questions, such as "Can you tell me more about that?", were used in order to gain a deeper understanding of the informants’ narratives. The interview guide was first tested in a pilot interview to ensure comprehensiveness and clarity, as recommended by Creswell (2007); subsequently minor changes were needed. As cited by
Dahlgren et al. (2007, p. 74), Boas emphasized that "in-depth interviewing should be done using the native language of the informant", interviews were thus conducted in Swedish and lasted between 40 and 50 min. Each interview started with the informant making a self-presentation and ended with allowing the interviewee to comment and reflect on the discussed questions. All interviews were audiotaped and observational notes were taken simultaneously. After a verbatim transcription in Swedish, the interviews were translated to English. Depending on the emerging codes, the design of the next interviews and the recruitment of informants were modified and hence, stopped when no new information was provided in the interviews.

Data Analysis
As stated by Hancock and Algozzine (2006), in case study research, the collected pieces of information from different sources are synthesized in order to identify and report meaningful findings. The analysis process included, as a first step, a content analysis followed by a discourse analysis of the text obtained from different sources as described below. The IAD framework served as an analysis tool complementing the discourse analysis. Other empirical findings related to organizational communication and identity were deemed necessary for the analysis.

Content analysis
When the aim of a study is to provide understanding of a phenomenon, content analysis is a suitable method that allows the researcher to interpret subjectively a text through systematic coding and identification of themes (Hsieh and Shannon, 2005). Texts from documents and interviews were read through several times to provide a holistic sense of the data. The interviewer herself performed open coding of the interviews and secondary data by adding the data to the "OpenCode" software as proposed by Dahlgren et al. (2007). Codes were assigned to different parts of the text. Relevant codes for the research question were further clustered in sub-categories, as suggested by Graneheim and Lundman (2004). Moving forward, similar sub-categories were pooled under smaller number of categories at a manifest level as shown in Table 2. In the light of the emerging categories, a revision of the entire data material was performed in order to look for more categories or
rename existing ones when needed. Further on, an interpretation of the categories’ latent content was done, which resulted in the formulation of the two first themes (Table 2).

**Discourse analysis**

In order to gain a deeper understanding of the discourse used in communicating each of the local and regional policies, a discourse analysis of different texts (interviews and documents) as suggested by Fairclough (1992) was later conducted. Fairclough (1992) suggests that the discourse affects and is highly affected by the context where it occurs. Therefore, he argues that the analysis of a communicative event should cover the three dimensions of language use: 1) linguistic features of the text, 2) processes relating to the production and consumption of the text and 3) the wider social practice where the communicative event is taking place. A reading through the whole text from the interviews and the documents was done with a focus on the linguistic features of the texts and their underlying meanings. Codes from the content analysis illustrating the elaboration process of each of the policies and how each was communicated and perceived by the employees were gathered into sub-categories which, in turn, were grouped into two categories. Consequently, one last theme emerged from the analysis process (Table 3). As supported by Jorgensen and Phillips (2002), the discourse analysis by Fairclough doesn’t allow a complete analysis of the social practice being studied. Therefore the institutional analysis and development framework was used to describe how the organizational practice influenced and got affected by the discourse used throughout the implementation.

**The institutional analysis and development Framework (IAD framework)**

Ostrom (2007) defines an organization as a set of institutional arrangements and participants who have a common set of goals and interact across multiple action situations at different levels of activity. The IAD framework is a systematic method for analyzing policies. The main concept of the IAD framework is the action arena which includes an action situation and the involved actors. The action situation is "a social place where individuals interact and engage in appropriation and provision activities, solve problems..." while the actors could be persons, groups or corporations involved in the process (Ostrom, 2007, p.28). The action arena is influenced by the physical world, rules-in-use and community attributes (Fig. 2). The IAD framework is a multidimensional framework that operates at three different levels which
can be applied to healthcare organizations: 1) the operational level, which includes daily activities; 2) the collective level, where decision makers create rules that have an impact on the operational levels; and 3) the constitutional level, in which decision makers determine the selection of collective participants and the relation among them (Ostrom, 2007).

Ethical considerations

A detailed introduction letter that included the aim and nature of the study and information about measures securing confidentiality was provided when the informants were recruited (Appendix II). To be transparent about workplace conditions may be demanding to some people, which was the reason why individual interviews were conducted instead of group interviews. Although the study was approved by the hospital’s administration, a verbal consent was obtained from each of the informants before the interview time was set, and informants were fully entitled to withdraw their participation at any time. Another way of ensuring that informants are freely willing to participate was to address them individually or through unions’ representatives and not through their managers.

FINDINGS

After analyzing the texts from interviews and secondary documents (Table 1), three themes with categories emerged: Seizing social and organizational opportunities with the categories perceived evidence supporting the policy, anti-smoking trend in society, society's perception of healthcare, previous worksite rules, employer's right to regulate and benchmarking organizational processes; Embedding a new framework of practice with the categories policy text as a solid ground, managers as implementers, one-way communication, policy's sustainability and the role of facilitators; and Re-shaping the organizational identity with the categories being a role model and coherent health-promoting identity.

The three themes resulting from the content analysis and discourse analysis are described below simultaneously with their subsequent categories. Quotes from documents and interviews have been used to illustrate the emerging theme or category. Employees with
managerial responsibilities are referred to as managers, while staff refers to operational or clinical employees.

Seizing social and organizational opportunities
When the informants were asked about the rationale behind the policy and factors influencing its implementation, many opportunities could be identified. Opportunities are favorable circumstances supporting the introduction of a new policy. These opportunities were found to be both external and internal, and they mainly derived from the conducted interviews. The external opportunities had predominantly social origins while the internal ones were at large related to the organizational characteristics or practices acting in favor of policymaking.

Perceived evidence supporting the policy
The harm related to smoking and the positive effect of the anti-smoking policy on smoking behavior and the work environment were repeatedly reported by the informants. They were all health professionals, basing their opinion on the evidence supported by the scientific community. According to the informants, "There is no doubt that in limiting smoking we are promoting the health of everybody" (Int.9). In other words, a smoking-free policy at the workplace would definitely result in reducing tobacco consumption and, if combined with personal will, may lead to a total cessation. The interviews commented on the long time spent at work and argued that abstaining from smoking during that time was a big step towards becoming tobacco-free.

"If smoking is not allowed during working time, smokers decrease their consumption which makes it easier to quit." (Int.4)

Anti-smoking trend in society
The informants explicitly mentioned how the introduction of the smoke-free public places policy in society facilitated the policy implementation at the hospital in Helsingborg. The staff, who were part of the society surrounding the hospital, were already exposed to
smoking-free policies in their environment which supported the introduction and survival of the new policy as one of the informants stated:

"It is a social trend now... a smoking ban is not controversial anymore." (Int.8)

Another informant explained that:

"The society in general is introducing smoking-free places, which helped the policy to survive." (Int.6)

**Society's perception of healthcare**

Another opportunity reported by the informants was the role of the healthcare provider as it is perceived by society. The interviewees reflected on their role as health advocates from both personal and societal perspectives. First, they described how doctors and nurses sat and smoked before the indoors’ smoking ban was introduced in 2003. According to the interviewees, healthcare organizations should, however, be a good example to their patients and the surrounding society by applying and holding to the information they declare and thus avoiding "double standards" (Int.5).

"We should reflect a good example. If we sit and talk about tobacco with patients and then we go out and smoke, for sure we are not being faithful". (Int.9)

While some informants stated that healthcare providers should act professionally regardless of their smoking status, other informants insisted on the image of healthcare staff as role models reflected by being totally tobacco-free. The latter discussed that smoking staff could possibly provide information about the risks behind smoking but "could never motivate a patient to quit smoking, because they lack the motivation to quit themselves". (Int.5)

However, some views expressed that health care professionals being ex-smokers would better understand the difficulties associated with quitting tobacco and could provide greater support to patients: "We should be a role model. It is not easy to say to someone to stop smoking if you are smoking yourself". (Int.2)

**Previous worksite rules**

In addition to societal opportunities, the previous indoors' smoking ban (2003) at the hospital, created a fertile ground for the introduction of the smoking-free workplace policy in 2008.
and the tobacco-free policy later in 2011. The informants described that the implications of the 2003 ban were practically the same as those of the new "tobacco-free workplace policies", since there was "low tolerance" at the workplace for the idea of leaving work to go out and smoke. One of the informants commented that:

"The work tempo at the hospital is so high that it is difficult to go out and smoke outside your lunch break. There is actually low acceptance for people who go out and smoke so it is difficult to go out and smoke." (Int.1)

However, the implementation of the indoors’ smoking ban and the local smoking-free workplace policy was not optimal; as both regulations resulted in moving smoking to balconies and staff using their flextime to go out and smoke during working hours (Appendix IIIj). Moreover, the policy was not applied equally between different hospital departments. This situation created a need for a stricter policy, which was described as a new opportunity to make a more defined and overarching policy at the regional level.

**Employer's right to regulate**

While discussing the reasons behind this policy, informants admitted the right of the employer to regulate staff behavior if it threatens their productivity and hence described the policy as legitimate.

"I work and get paid for the work I am doing so I am accountable toward my employer I should not go out and smoke". (Int.6)

Interestingly, staff, union representatives and managers reported this finding equally. They explained that part of the paid work time could be lost due to the need to go out and smoke.

"... so we explained that the employer own your time and pay your salary and wants you to work during this time." (Int.3)

From an employer perspective, improving productivity was also an opportunity justifying the implementation of the policy either through having healthy staff and decreasing sickness related to tobacco or through making sure that working time is being used for work and not
for smoking. Moreover, the informants also expressed promoting patient’s wellbeing and increasing patient’s satisfaction as a motivation for the employer to regulate staff behavior. One of the informants explained that "This policy is implemented for the patients’ sake so they don't get sicker due to smoke smell... and then to decrease staff sick leaves..." (Int.4), while his colleague defined the aim of the policy "to have more healthy staff who don't smoke, so they can take care of the patients" (Int.2).

**Benchmarking internal processes**

By being a member in the international HPH network, Helsingborg hospital had the opportunity to compare its processes with those of other member hospitals, and to borrow best practices in order to improve its performance; this could be described as "benchmarking internal processes".

"Helsingborg hospital is member in the HPH network since November 2006 ... The hospital process leader has participated actively in the ongoing work at the regional and national level. The process leader is a member in the national HPH network theme group: health-promoting workplace..." (Appendix IIIa).

Members of the national and regional networks collaborate to create pre-conditions and structures for health-promotion in hospitals and healthcare centers (Appendix IIIh). Tobacco-free policies, which were widely implemented to improve health within HPH, were adopted by Helsingborg hospital. After the implementation, the hospital became a "model to follow" by others in the regional network (Appendix IIIf).

**Embedding a new framework of practice**

Embedding a new practice into an organization, as supported by the collected data, implies the integration of the change being introduced into existing contextual structures and processes. The different aspects and actors of the implementation process in addition to the implementation gaps related to "embedding the new framework" are illustrated below by the following categories: Policy text as a solid ground, managers as implementers, one-way communication, policy's sustainability and the role of facilitators.
**Policy text as a solid ground**

The policy document, which included a well-defined set of practices, constituted a solid ground to build upon as expressed by the informants. Both local and regional policy documents presented the rationale behind the policy, the type of the ban, where it applies, and the implications to different stakeholders (Appendices IIIc and IIIId). The local policy document served as draft for the regional one, which, in turn, presented a clearer and more accurate text. Informants indicated the importance of having a rigorous policy document to avoid misinterpretations and ensure compliance: "The policy was clear from the beginning, this is what applies...the text was clear about what applies so to avoid misinterpretations" (Int.5). Managers considered the regional policy document as a supportive and "decisive reference in case of conflicts or non-compliance" (Int.5).

**Managers as implementers**

Managers at different organizational levels were the key-actors in the whole process. As revealed by the interviews, they were responsible for reviewing the official document of the local policy, communicating the local and regional policies to their staff, ensuring compliance and allocating resources for information and support. When asked to describe their own experience regarding the implementation process, managers denoted the importance of being clear about what rules apply in each case. They also highlighted the necessity of having such regulation to be able to "lead employees in the same direction" towards a tobacco-free behavior (Int.6). They actually indicated that the local smoking-free workplace policy was a framework for some employees to act within. According to interviewed manager: "you can't make some people do things without a strict regulation... people must have a framework to stick to and stay within" (Int.6).

This reflects a traditional leadership style, which was also mentioned by the interviewed staff who seemed to accept it as it provided them with a sense of security. They stated that "Managers should regulate and staff should follow" (Int.4), while managers expressed that "staff are secure because, in our department, we follow the set rules" (Int.5).

When discussing the challenges of the implementation process, informants were satisfied about how the process went on and reported that everything went smoothly but resources "could always be discussed" (Int.8). By resources, they meant time, knowledge and funds,
mainly managed by the middle- and front-line managers. Time and information were provided to inform staff about the policy in staff meetings at different levels of the organization. This was considered to be successful by the informants. However, some implementation gaps were identified such as the allocation of resources that depended sometimes on the manager’s level of engagement, which was, in turn, influenced by the manager’s smoking status.

"Resources were not enough and all depends on the manager, he can refuse to support..." (Int.1)

"It was easier to come in and talk about tobacco with anti-tobacco champion when the manager is positive to this issue and is not a smoker himself." (Int.9)

Moreover, as discussed in the interviews and the consulted documents, limited funds for supporting tobacco cessation were allocated (Appendix IIIe) since "a lot needs to be done, we have to prioritize" (Int.4). Financing of the cessation support program could only be deducted from the overall unit budget based on the manager’s judgment.

Informants highlighted, as well, the need to continue with tobacco-free campaigns at the hospital and to be completed by a proper evaluation in order to draw conclusions for future implementation. Nevertheless, the scarceness of financial resources was consistently reported as the major limitation.

"There should be a unit responsible for supporting smokers to quit... The hospital is struggling with the economy so different staff are sharing these responsibilities. It would have been good with more health promotion events for staff but the focus now is on doing as much as possible with little resources." (Int.6)

One-way communication

To establish how the policy was disseminated throughout the hospital, the respondents were asked about their opinion on this matter. They indicated that the communication and propagation had been guided by a top-down approach, making use of the hierarchical structure of the hospital organization through several existing channels. After the top-level management made the decision to adopt the policy, the collaboration committee (Figure 1) discussed its implications and approved it. The information was further communicated down
through the hierarchy until it reached the operational staff, mainly during regular staff meetings at different levels. Moreover, meeting minutes were sent, as it is routinely done, to those who did not attend. The policy was posted on the units, the internal webpage and an email was sent to ensure that staff of all age groups would be informed. According to the informants, the policy text was sent to different managers for comments but not to other employees. One informant explained: "It is a regulation issued by the hospital top management in collaboration with unions’ representatives... but was not discussed at the employee’s level" (Int.8). Some informants defended the top-down approach: "discussing this regulation with staff back and forth will lead to nowhere" (Int.4).

Policy's sustainability

In order to sustain the smoking ban, compliance was ensured through a strict sanction scheme: "First it is a verbal warning, then written warning and then there is risk for termination" (Int.6, 8).

In addition, sustainability was secured through a regular discussion of smoking habits that was incorporated in the annual performance appraisal meeting to provide support for quitting tobacco based on the employee’s demand. Furthermore, a routine was created at the recruitment of new staff, first by stating that it is a tobacco-free workplace on the job announcement (Appendix IIIi), and second by informing about it in the introduction program for new employees.

"All new employed staff are being informed about the workplace rules and tobacco-free policy is part of it." (Int.1)

The role of facilitators

In addition to the anticipated measures, the implementation process would not have been possible without appointed facilitators. These had the role to support managers during the implementation of the policy. They were also considered, in the interviews, as a source of information and support. The central steering committee, which authored the local policy text, consulted regional and national expertise and assessed the consequences of the policy, was considered a major facilitator (Appendix IIIb, IIIj).
Union representatives and unit-level champions were also facilitators who acted as back-up for managers and provided needed information to staff. Unions’ representatives described how "staff members were really angry so unions explained that the employer own your time and pay your salary and wants you to work during this time" (Int.3). In addition, "there was an anti-tobacco champion on the unit who distributed folders and advised about quitting.... one could get guidance from him" (Int.4).

**Re-shaping organizational identity**

While analyzing the discourse used in the different sources of data, a re-orientation of the organizational identity was noticed throughout the implementation process of the local and regional smoking-free workplace policies at Helsingborg hospital. This was identified in a discourse analysis of the policy documents and informants’ narratives using Fairclough’s three-dimensional model (Fairclough, 1992). A description of how the hospital’s identity evolved from "being a role model" for patients into reflecting a coherent health-promoting (anti-tobacco) identity is detailed below.

**Being a role model**

A close examination of the local policy document identified a discourse focusing on the image of healthcare as perceived by their customers in particular and the surrounding society in general. Through the local smoking-free workplace policy, the hospital administration was trying to defend its own image as a healthcare organization, as was explicitly described by the policy text: "healthcare providers as role models and source of expertise have a central role in health-related issues and should eventually abstain from smoking during the working time" (Appendix IIIc).

Moreover, the policy authors used metaphors to "sell" this "healthcare image" internally among staff in order for them to deliver it externally to patients.

"Staff are ambassadors of our smoking-free policy." (Appendix IIIc)

"A smoking-free hospital is everyone’s responsibility." (Appendix IIIc)
When asked about their image as role models, responses were quite controversial among informants. In fact, managers supported this image, whereas interviewed staff argued that if healthcare givers were role models then this should not be limited to tobacco use. It should rather be extended to other areas such as healthy diets and physical activity. While promoting the idealistic role of healthcare givers, the local policy was not clear enough about how the organization perceived tobacco. Moreover, the policy was ambiguous regarding the identity they want to reflect "by accepting smoking during job shifts if the employee had checked out from work" (Int.3). These informants considered it a liberal regulation, yet an important step toward a stricter ban.

"It is better not to proceed to implementation with a loose regulation... However this was a very important step taken by the administration in tobacco prevention..." (Int.5)

A coherent health-promoting identity
In order to promote equal work conditions to all employees in the region, the informants expressed a need for rigorous regulation that applies to all.

"Not all hospitals in the region had this smoking-free workplace policy... why here it is forbidden while it is allowed somewhere else?" (Int.6)

The regional tobacco-free policy was elaborated by incorporating international and local efforts in tobacco prevention. This could be described as a bottom-up approach since regional authorities responded to the local hospitals’ need and chose to collaborate with those who had already developed one (Appendix IIIf). Unlike the local policy, the regional policy took an explicitly negative stand on any form of tobacco and related it to the Swedish public health goals (Appendix IIIId). By adopting the new regional policy, Helsingborg hospital re-shaped a coherent identity as a tobacco-free workplace where tobacco use is tolerated neither in words nor in practice. This was considered by some informants to be part of the hospital’s health-promoting role.

"It is a health promoting hospital so no one ... should consume tobacco at all during working time." (Int.6)
"The intention is to work actively with prevention to help patients and staff to stop using tobacco and create pre-conditions and opportunities for quitting. It means that we focus on the health promotion perspective." (Int.8)

This was in practice translated into a total ban on tobacco during working hours and by acknowledging the right of smokers to get help to quit tobacco.

"First it was about referring patients and staff who smoke to designated places... but then came the regional policy and emphasized the health promoting aspect for patients and staff." (Int.8)

Furthermore, the new policy was fairly easily adopted by the hospital’s employees and considered as a step forward in tobacco prevention.

"The regional policy came as a next step after the local policy." (Int.6)

The same negative attitude toward tobacco exhibited by the policy was also reflected by the informants’ opinions, regardless of their smoking status, on reaching a "zero tolerance for tobacco." (Int.1)

This anti-tobacco organizational identity was also reflected by an equitable practice in the workplace and a sense of security for employees as reported by the informants.

"For me, the policy is empowering if there will be a problem or non-compliance; so it is a kind of support to me to refer to the policy." (Int.8)

"The work environment improved... sometimes we had smokers and non smokers... I sit and work because I don't smoke but you go out and smoke..." (Int.3)

As it appeared in the analysis process and as described by the informants and documented by implementers, this re-shaping process is described as an endless but rewarding process (Appendix IIIg).

"We have worked with smoking issue and struggled so much for many years... Now, only few smoke among employees and managers." (Int.9)
DISCUSSION

By investigating why and how a tobacco policy was implemented in the workplace, this study aimed at identifying different factors influencing the implementation of a tobacco-free workplace policy at a hospital setting in addition to discovering potential gaps between planned and implemented interventions. Both contextual and organizational conditions paved the way for the implementation of the local and regional policies. While the elaboration of a rigorous policy document created a solid ground to build upon, enforcement and embedment of the implementation process into existing organizational processes were crucial for its sustainability. Nevertheless, implementation weaknesses related to allocated resources, the characteristics of the implementers and the type of communication used to disseminate the policy were identified. Furthermore, an unanticipated feature of the implementation process was “the re-shaping of the organizational identity”.

A fertile ground for the tobacco-free policy

Hospitals are important societal institutions in continuous interaction with their environment. In this study, Helsingborg General Hospital’s membership in a health-promoting network, where health-promoting practices are being compared and exchanged, was among the major reasons for implementing the tobacco-free policies. Moreover, the anti-smoking trend and the introduction of smoking bans in the Swedish society have definitely affected the implementation process of the policy and how staff at the hospital received it. The evidence supporting the tobacco-free policy, as perceived by the employees, influenced indeed their attitudes toward smoking in general and the tobacco-free workplace in particular. On the other hand, the image of health professionals, as a source of expertise, role models and health advocates was also in favour of the policy implementation. The aforementioned circumstances correspond to the community attributes that affect the action arena (e.g. the implementation of the tobacco-free workplace) in the IAD framework studied by Fallin (2011).

In addition to the social opportunities, organizational circumstances worked in favor of the implementation mainly due to the previous smoking-free policy at the hospital but also because there was a low tolerance for people leaving their job stations to smoke. According to the informants, the employer had the right and duty to regulate staff behavior to maintain
or improve productivity. It is possible that this attitude is a result of tough job market where employees avoid unnecessary conflicts with their employer. It could also be a pure conviction originating from the evidence-base on the harmful effects of smoking. According to the informants, the legitimacy of the policy was anticipated, first by taking the decision at the top-level management and second by discussing it within the trade unions. These organizational opportunities can be related to the formal and informal rules-in-use analyzed by Fallin (2011) that largely influence the implementation process of a public or voluntary health policies.

**Determinants of the implementation process**

At an early stage of the implementation process, a rigorous policy document was elaborated by the hospital’s top-management. The informants described this as a positive step and a way to avoid misinterpretations and conflicts while introducing the intended change. In order for the policy to be sustained, an embedment of the new practice into the organizational routines (recruitment and regular performance appraisal) was deemed necessary as inferred from the data. Lack of adaptation of national and regional policies to local needs and the absence of solid regulations were among the limitations identified by Martinez (2009) when evaluating the implementation of tobacco-free policies using the IAD framework.

Furthermore, the tobacco policy at Helsingborg hospital was enforced through imposing strict sanctions to ensure compliance to- and survival of the policy. People and organizations create rules to solve problems or to achieve a change (Ostrom et al.,1994). In this case, the policy constituted a framework and a necessary tool for accomplishing the intended behavioral change. This reflects a value-based leadership style, where managers are expected to create visions and ensure that the organization and staff follow it.

According to Ostrom (1994, p.33), "actors are characterized by 1) the way they acquire, process, retain, and use knowledge contingencies and information, 2) the selection criteria actors use for deciding upon a particular course of action and 3) the resources that they bring to a situation". In this study, managers who were the key actors in the implementation were concurrently change agents and adopters, which in certain cases, influenced the process negatively. In other words, managers who were resistant or late adopters did not properly
play their role as implementers. This was translated into an insufficient allocation of resources for health promotion activities, especially when sustaining tobacco cessation among staff. On the other hand, trade unions played an essential role in regulating the employer’s authority, yet they admitted Region Skåne’s right to ensure that the paid time is used for work. However, the availability of champions on the units was not optimal since this also was dependent on the managers’ level of engagement in tobacco prevention.

Once the decision was made at the top-level management, the diffusion of the local and regional policies was achieved through a one-way communication strategy using different organizational channels to reach the front-line staff. McGuire (1989) has identified a number of success factors for dissemination: 1) the source of the policy, in this case, the hospital management which itself affected the credibility, the clarity and the relevance of the policy as perceived by the informants, 2) the quality of the message, in this study, a positive approach was followed by focusing on health promotion and the healthcare professionals as role models instead of the available sanctions for non-compliant, 3) the channels used to communicate the policy such as staff meetings, meeting minutes, emails, brochures and 4) how these ways of communication are adjusted to receiver's characteristics. For instance, age and computer/internet knowledge were characteristics taken into consideration through making the information about the policy available in both soft and hard copies and communicating it to all staff verbally and via emails.

**Towards a health-promoting identity**

Organizational identity is defined as “self-referential meaning” that is “an entity’s attempts to define itself” (Corley et. al., 2006, p. 87). The implementation of the local policy reflected an image of the healthcare providers as role models for their customers and prepared the way to the regional policy. The latter, in turn, re-shaped the organizational identity into a coherent anti-tobacco identity reflected in attitudes and practices. The evolving identity was revealed by the type of discourse used to communicate each of the policies and the resources deployed to implement them. In the local policy text, the discourse used to sell the image of healthcare givers as role models inside the organization is similar to the concept of "selling the brand inside" proposed by Mitchell (2002, p.314). This concept implies that the services to be delivered externally e.g. encouraging tobacco cessation among patients and relatives should
be first adopted internally. This required a tobacco-free staff, yet the local smoking-free policy allowed smoking (during flextime) and snuff use. However, the regional policy adopted by Helsingborg hospital contributed to a clearer stand toward tobacco, which revealed the emergence of a more health-oriented identity where tobacco is not accepted at all and promoting health is enhanced throughout all hospital processes. This influenced positively staff satisfaction and their sense of security. This relation between organizational identity and the individual behavior and identity of the employee was highlighted, as well, by previous studies (Pratt & Foreman, 2000; Huemer et al., 2004).

Nevertheless, the re-shaping process of the hospital identity was described to be challenging and continuous and depended on the interaction patterns of different organizational levels also addressed in the IAD framework (Ostrom, 2007). As presented by Unger et al. (2000), most of the European health systems are considered to be professional bureaucracies. Unfortunately, any new process with organizational and operational implications is challenging within a healthcare setting where different domains interact and compete with each other. At the constitutional level, regional and local policymakers prioritized health equity and strived to have health as an acquired right for everyone which was manifested by placing health promotion higher up on their agenda. However, the top- and middle level management were more interested in cost efficiency and the effective allocation of resources. In a healthcare setting like Helsingborg hospital, most resources are allocated for treatment and/or educational purposes, leaving only little resources for health promotion oriented activities and recruitments of expertise in the field. At the operational level, health professionals struggle, in turn, to maintain their role and advocate for quality of care which, in a hospital setting, is responding to the needs of the patients. These professionals, as represented by the front-line staff, focused on their image as the patients’ role models. They described the main goal of the policy as “not exposing patients, primarily, to cigarette smoke”. This was similarly shown in the policy documents; the regional document addressed the health promotion aspect of the policy focusing on health as equal right for everyone while the local hospital policy, written and reviewed by middle-level managers, focused on staff as role models for patients and ambassadors of the smoking-free policy.
Methodological considerations

With the aim to describe the implementation process of a tobacco-free policy in a hospital setting, the “case study” design was found to be a suitable research method. It gives a holistic picture of the phenomenon in its context through the inclusion of different sources of data (Yin, 2003). This case study contributed to the understanding of factors influencing the implementation of a tobacco-free workplace policy and the related challenges. In addition to the use of secondary data, the variation in informants’ background and positions allowed a more complete description of the phenomena.

As for data analysis, Buse et al. (2004) state that content analysis is a common policy analysis tool because it helps to reveal underlying themes. On the other hand, the discourse analysis was a helpful tool to reveal the role of discourse, through its three dimensions, in making a social change and re-orienting organizational identity as supported by Jorgensen and Phillips (2002) when describing the identity and relational function of the discourse analysis. However, the discourse analysis was not sufficient to analyze the wider organizational practice. Alternatively, the IAD framework complemented the interpretation of the policy implementation. The simultaneous collection and analysis of the data allowed the interplay between the data and the interpretation and contributed to the inductive nature of the study.

Nonetheless, a number of limitations could be identified. The retrospective reconstruction of the facts and experiences by the informants about the implementation process is one potential drawback since informants might miss some details of the implementation process and the challenges related to it. Moreover, interviews with policy elites can sometimes result in them only providing official positions rather than personal ones. Therefore, policy documents, staff meeting minutes and annual reports were consulted to reveal some aspects of the implementation process.

The trustworthiness of a qualitative study is reflected through its credibility, confirmability, dependability and transferability (Dahlgren et al., 2007). Due to the complexity of healthcare organizations, understanding the context where the study has been held was essential to ensure trustworthiness. Being a nurse and employed at the studied organization for some time before the start of the study helped the researcher to understand contextual conditions related
to the workplace and the decision making process. In addition, the academic nature of this study encouraged the informants to consider it as a self-learning experience for future health-promoting projects and an opportunity to reflect upon the implementation process and to share their own experience. The concomitant collection and analysis of the data allowed an emergent design in terms of selection of different sources of data. The triangulation in data collection, used in this study, enhanced its credibility and allowed an analysis of rich narratives leading to the formulation of themes that were well grounded in the data. This was exhibited in the text by the use of quotations from the recorded interviews and consulted documents, which would also demonstrate the confirmability of the findings. Credibility was also improved as the preliminary findings were discussed with a colleague outside the research team, in order to test the wording and the understanding of the formulated categories and themes. The elaboration of a study protocol and an interview guide played a major role in keeping track of the initial research questions and ensured consistency. Although case studies are known for their low transferability, a rich description of the context, method and analysis process aimed at increasing the confirmability of the study and its usefulness in other contexts e.g. educational settings.

**Implications for future practice**

The emerging themes with their corresponding categories serve as guidance for future improvements within health promotion in general and tobacco prevention in particular. This study stresses the importance of assessing contextual conditions while considering a new policy. In addition, the change should be integrated into existing processes in order for it to be sustained. This should be reflected in the organization’s vision and discourse as well as in the allocation of proper and sufficient resources. Therefore, more resources need to be allocated for health promotion to support the healthcare organizations’ health-promoting identity. Through their expertise, healthcare professionals specialized in promoting health, would contribute actively to the integration of health-promoting initiatives within organizations. In tobacco prevention, more resources should be deployed for continuous awareness and providing support for tobacco users e.g. cessation groups to prevent stigmatization of individuals at the workplace. This would constitute a long-term investment for both staff and employer. Efficient dialogue with staff needs to be ensured and managers must be provided with enough training on approaching smokers and adopting a health-
promoting leadership. Moreover, evaluation of these initiatives, aiming at detecting gaps and gaining knowledge and expertise for future projects must be well planned and budgeted.

CONCLUSION

This case study examined the implementation process of a tobacco-free workplace policy at a hospital setting. Factors influencing the implementation such as social and organizational opportunities were identified, in addition to a description of different actors involved and the measures followed to integrate the new practice into the organization’s routines and sustain it. A re-shaping of the organizational identity into a more health-oriented organization was the unanticipated feature of the policy, yet the most important since it affects attitudes and practices at different organizational levels. Due to the complexity of the health systems and organizations, more research studying how health-promoting initiatives are being integrated into the secondary healthcare, are needed. Moreover, the image of future health-promoting hospitals needs to be shaped through involving disciplines from outside the healthcare field such as business administration and architecture.

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Thank you, my beloved family, for your endless love and support during the entire study period.
REFERENCES


## TABLES

**Table 1: Different data sources**

<table>
<thead>
<tr>
<th>Source of data</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview 1</td>
<td>Administration staff (Non-smoker)</td>
</tr>
<tr>
<td>Interview 2</td>
<td>Administration staff (Smoker)</td>
</tr>
<tr>
<td>Interview 3</td>
<td>Union representative/practical nurse (Ex-smoker)</td>
</tr>
<tr>
<td>Interview 4</td>
<td>Union representative/practical nurse (Occasional smoker)</td>
</tr>
<tr>
<td>Interview 5</td>
<td>Front-line Manager (Non-smoker)</td>
</tr>
<tr>
<td>Interview 6</td>
<td>Middle-line manager (Non-smoker)</td>
</tr>
<tr>
<td>Interview 7</td>
<td>Registered nurse (Non-smoker)</td>
</tr>
<tr>
<td>Interview 8</td>
<td>Top-level management (Non-smoker)</td>
</tr>
<tr>
<td>Interview 9</td>
<td>Registered nurse (Ex-smoker)</td>
</tr>
<tr>
<td>Action plans</td>
<td>Two reports (10/2008; 01/2009)</td>
</tr>
<tr>
<td>Official policy documents</td>
<td>Local (11/2007) and regional (02/2010)</td>
</tr>
<tr>
<td>Policy communication letter</td>
<td>One document (02/2011)</td>
</tr>
<tr>
<td>Steering committee meeting minutes</td>
<td>Four meeting minutes (10,11/2008; 04,11/2009)</td>
</tr>
<tr>
<td>Tobacco survey</td>
<td>One report (04/2009)</td>
</tr>
</tbody>
</table>
Table 2: Example of the content analysis process

<table>
<thead>
<tr>
<th>Theme</th>
<th>Categories</th>
<th>Sub-categories</th>
<th>Codes</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seizing social and organizational opportunities</td>
<td>Perceived evidence supporting the policy</td>
<td>Harm related to smoking</td>
<td>Unhealthy</td>
<td>Everybody knows that smoking is unhealthy. It is known that smoking and passive smoking cause many diseases.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Smoking as risk factor</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Evidence-based</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rationale behind the policy</td>
<td>Decreased consumption</td>
<td></td>
<td>Tobacco-free working hours decrease consumption since we spend long time at work. By limiting smoking we are definitely improving wellbeing.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Opportunity to quit</td>
<td>Policy promotes wellbeing</td>
<td></td>
</tr>
<tr>
<td>Anti-smoking trend in society</td>
<td>Smoking-free public places</td>
<td>Public ban common</td>
<td>Smoking bans are being introduced in restaurants and public places.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ban not controversial</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Negative attitude towards tobacco</td>
<td>Smoking is not accepted</td>
<td>It is not cool to smoke anymore.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Smoking is not cool</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Society’s perception of healthcare</td>
<td>HC(^1) as patient advocates</td>
<td>Protector of patients</td>
<td>We should not expose patients to smoke so they don’t get sicker.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health promoters</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HC(^1) as source of expertise</td>
<td>Counselor</td>
<td>HC professionals know about the consequences of smoking. They should discuss smoking behavior with patients and provide help for cessation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Source of information</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Cessation expertise</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HC(^1) as role models</td>
<td>Double standard</td>
<td>HC professionals should motivate patients to quit. Thus, they should be themselves tobacco-free. Smokers can’t advise about cessation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nurses are role models</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Motivation to quit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous worksite rules</td>
<td>Formal smoking ban</td>
<td>Not practical</td>
<td>Smoking shifted to designated area, in addition you should change to casual clothes if you want to smoke</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Difficult to go out and smoke</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Informal organizational practices</td>
<td>Low acceptance</td>
<td>The work tempo is too high so it is not accepted to go out and smoke during work.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Workload implications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer’s right to regulate</td>
<td>Improving staff productivity</td>
<td>Decrease sick leaves</td>
<td>The policy aims at promoting employees health to take care of patients… and to decrease sick leaves.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Responsiveness</td>
<td></td>
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<td></td>
<td></td>
<td>Health promoting role</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Secured legitimacy of the policy</td>
<td>Collaboration with trade union</td>
<td>It is for the managers to make regulations and staff should follow. This is a regulating document that was discussed at the top level management and approved by trade unions; it was not discussed at the employee level.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accepted by staff</td>
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<tr>
<td></td>
<td></td>
<td>Employer as decision maker</td>
<td></td>
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<tr>
<td>Benchmarking organizational processes</td>
<td>Benchmarking</td>
<td>HPH(^2) status</td>
<td>The hospital is member in the HPH network and through its own smoking policy contributed to the elaboration of the regional policy.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Exchanging practices</td>
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<td></td>
<td></td>
<td>Networking</td>
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</tbody>
</table>

\(^1\)HC: healthcare, \(^2\)HPH: health-promoting hospital
Table 3: Example of the discourse analysis process

<table>
<thead>
<tr>
<th>Theme</th>
<th>Categories</th>
<th>Sub-categories</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-shaping organizational identity</td>
<td>A coherent health-promoting identity</td>
<td>Anti-tobacco identity (constitutional level)</td>
<td>Alignment with national goals</td>
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<td></td>
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<td></td>
<td>Engaged administration</td>
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<td>Zero tolerance for tobacco</td>
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<td></td>
<td>Integrating new framework of practice (Collective level)</td>
<td>Policy enforcement</td>
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<td>Rigorous policy text</td>
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<tr>
<td></td>
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<td>Resources allocated</td>
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<td></td>
<td>Workplace implications (operational level)</td>
<td>Workplace equality</td>
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<td></td>
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<td>Improved compliance</td>
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<td>Taking responsibility</td>
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<td></td>
<td></td>
<td>Increased satisfaction</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Zero tolerance for tobacco</td>
<td></td>
</tr>
<tr>
<td>Re-shaping organizational identity</td>
<td>Being role model</td>
<td>Defending HC:\textsuperscript{1} image (constitutional and collective level)</td>
<td>HC:\textsuperscript{1} as ambassadors</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>HC:\textsuperscript{1} as source of expertise</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>HC:\textsuperscript{1} as health advocates</td>
</tr>
<tr>
<td></td>
<td>&quot;Double moral&quot; (operational level)</td>
<td>Smoking cessation for patients</td>
<td></td>
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<td></td>
<td></td>
<td>Smoking during flextime</td>
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<td></td>
<td></td>
<td>No support for employees who smoke</td>
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<td></td>
<td></td>
<td>Unequal workplace</td>
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</tbody>
</table>

\textsuperscript{1}HC: healthcare
**Figure 1** Organizational structure of Helsingborg General Hospital through which the local and regional tobacco-free workplace policy propagated. Detailed explanations are given in the text ("The setting" in the "Methodology" section). A typical example of departmental structure is presented through the "Orthopedics department". Front line-, middle line-, and top level managers are distinguished by the red, green and dark blue colors, respectively. Note that the "trade unions' representatives" (dark grey box) come from different organizational levels (from regular staff to front- and middle line managers). "PA" stands for the performance appraisal meeting between staff and immediate boss.
Figure 2 Institutional analysis and development framework (Ostrom et al., 1994)
APPENDIX I. CASE STUDY PROTOCOL/ INTERVIEW GUIDE

BACKGROUND
The health consequences of involuntary exposure to tobacco smoke are well documented (WHO, 2011). In their efforts to promote the health of their patients, staff and the surrounding community, health-promoting hospitals are expected to be an example in tobacco control initiatives such as applying "smoke-free environment" policies. Tobacco-free policies have had a significant impact on the attitudes and behaviors of the smokers such as discouraging smoking, reducing cigarette consumption, and increasing the desire to quit and the likelihood of cessation (Martinez et al., 2008).
In order to promote effectiveness and sustainability of such programs, continuous monitoring of existing policies and protocols is deemed necessary and serves as a learning tool for designing future interventions.

PURPOSE
To explore how and why a "tobacco-free working hours" policy is implemented in a hospital setting.

OBJECTIVES
The objectives of the study are the following:
- Identifying different factors influencing the implementation process.
- Identifying potential gaps between planned and implemented interventions.
- Providing input for future planning within the same policy area or in designing other health-promoting interventions.

FIELD PROCEDURES
This is an exploratory case study that will be conducted at a health-promoting hospital in southern Sweden.
After getting the approval of the hospital’s administration to conduct the study, the project was introduced to heads of different departments at the hospital to engage them in the process.
Several meetings with the process leader of the health-promoting project were held to discuss different methods and ways to recruit informants.
Informants will be staff and managers at the hospital. Information will be collected during January and February 2013 through:

1- Documentation review: staff meeting minutes, policy documents, budget report, Quitting program report...

2- Semi-structured interviews with employees at different organizational levels.

The interview guide will include:

- Description of the new tobacco policy (understanding, goals, concept behind it, enforcement...)
- Communication of the policy
- Resources allocated
- Perceived challenges and/or success during implementation.
- Commitment to the policy (attitudes and perceptions)

ETHICAL CONSIDERATIONS

- The introduction letter will be sent to potential participants and verbal consent is obtained before fixing time for the interview.
- Confidentiality will be secured throughout the whole project (recruitment of informants, data collection and analysis, project report).
- At this stage, recruitment of staff will be done through unions to ensure transparency while managers will be addressed through their regular board meeting and follow-up emails.

REFERENCES


Hej!
Vill du vara med och påverka det framtida hälsofrämjande arbetet?
Syftet med denna studie är att följa upp genomförandet av den reviderade Rökfria policyn vid Helsingborgs Lasarett d.v.s. undersöka implementeringsprocessen och i vilken omfattning intentionerna bakom denna policy var uppfyllda. Studien ska bl.a. ge upplysningar om implementering av framtida hälsofrämjande aktiviteter.
Vi har valt en kvalitativ metod med semistrukturerade intervjuer. Deltagande i studien innebär att DU som genomförde och/eller påverkas av policyn kommer att intervjua om bl.a. DIN uppfattning om tobakspolicy, DIN upplevelse och implementeringsutmaningar...
Intervjuerna kommer att spelas in på band och intervjutid beräknas till max en timme.
Svaren kommer därefter att analyseras och sammanställas i en rapport som används som underlag i min akademiska uppsats och presenteras därefter i Lasarettets ledningsgrupp.
Jag svarar gärna på frågor om studien! Ring i så fall mitt mobilnummer nedan eller maila mig på nedanstående adress.

Vänliga hälsningar,
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## APPENDIX III. UNPUBLISHED DOCUMENTS

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<th>Document type</th>
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<td>b) Action Plan 2</td>
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<td>c) Policy document 1: Local</td>
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<td>d) Policy document 2: Regional</td>
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<td>e) Policy communication letter</td>
<td>10-02-2011</td>
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<td>f) Steering committee meeting minutes 1</td>
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<td>j) Tobacco survey</td>
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