Rounding on the smokers: The myth of evidence based (nursing) policy

This is a draft of a chapter that will be appearing (as Chapter 15) in the forthcoming Routledge book Exploring Evidence-based Practice: Debates and Challenges in Nursing (2015), available for pre-purchase here:

http://www.routledge.com/books/details/9781138789906/

Introduction

The enterprise of evidence based practice is undertaken at many levels, from the funding and performance of international multi-centre trials and their incorporation into evidence based guidelines, to the individual nurse driven by professionalism or curiosity or by the requirements of an academic programme, accessing and appraising evidence in order to inform practice in line with what her regulatory body requires of her. As the chapters in this book make clear, conceptual and practical problems make this process far more complex than it might at first appear. However, at minimum, it could be argued that if a nurse follows properly constructed evidence based guidelines she can point to them, if she needed to, as justification for a claim that her care is based on '[…] the best available evidence and best practice.' (Nursing and Midwifery Council [NMC], 2015, p7). There can't be a guideline for every eventuality of course, and nurses 'must be able to respond autonomously and confidently to planned and uncertain situations…' (NMC, 2010, p.7). Autonomous practice is one of the defining features of professional practice but clearly does not amount to practicing exactly as each nurse sees fit, independent of all external considerations.

The NMC Standards for Competence document (NMC, 2010, p. 6) also requires that nurses 'must show professionalism and integrity and work within recognised professional, ethical and legal frameworks.' These sorts of regulatory and explanatory documents are candidates for analysis of almost infinite regress. What, for example, does 'recognised' mean in this context, and recognised by whom? This is an analysis for another day and of more immediate concern is a framework omitted from the list: a framework of employment. The large majority of nurses work for an employer under a contract which stipulates terms of employment, and these will include the expectation or requirement that employers' policies will be followed in the course of employment. These policies cover many aspects of work, governing behaviour by both employer and employee. They set out working arrangements like shift patterns and leave entitlement as well as the working environment to which employees are entitled. For example, safety is assured (or at least it should be) by health and safety policies which apply to all employees, capable of separation from professional considerations.   However, some policies also cover aspects of professional practice and it is often claimed that these are formulated on the basis of evidence. If these claims are not credible, there may be tensions between a requirement for nurses to follow reasonable instructions and policies required of her by her employer, and the professional requirement

articulated in standards documents, for autonomous and evidence-based practice, within ethical frameworks. This chapter explores these tensions offering critical and occasionally polemic analysis in relation to two developing areas of policy: the introduction of intentional rounding and hospital smoking bans. I will argue that policies concerning intentional rounding are defended by reference to evidence but its quality and application are so poor that a claim that it is evidence based policy is simply not credible; and though supported by authoritative bodies like the National Institute of Health and Care Excellence (NICE), authoritarian policies that seek to prevent smoking at hospitals are based not on factual evidence but on normative values. Before considering these practical nursing applications, the chapter proceeds with a brief discussion of the many levels of policy, how it differs from guidance and the claim that it is based on evidence.

The nature of policy

The word policy is used freely but its frequency of use belies a complexity uncaptured by simplistic definitions, such as 'something like "a formal course of action proposed or adopted"' (Traynor, 2013, p.126). In a standard textbook, Ham (2009) was tempted, following Cunningham, to suggest that 'policy is rather like the elephant – you recognise it when you use it but you can't easily define it' (Ham, 2009, p.131). In relation to public health policy, Coggon's (2012) discussion demonstrates that the notion of policy can be taken to mean both the aims of 'considered decision-making by an agent or agency' (Coggon 2012, p.75) and the means by which they are procured. Policies can be seen at many different levels. At the highest level, statements of intent are articulated by governments and these in some cases are implemented by detailed procedures, for example in contractual arrangements in the National Health Service (NHS) which must be followed by all commissioners of services. In other cases high level policy aims are implemented at local level, and discretion is sometimes allowed to account for local circumstances and preferences.

These conceptual details, though of great interest to policy makers and managers need not necessarily concern the practicing nurse caring for her patients, though the NMC standards can be read otherwise. The competence standards cited earlier go on to require that all nurses must ' […] contribute to the collection of local and national data and formulation of policy on risks, hazards and adverse outcomes' (NMC, 2010, p.8). In a sense this requirement typifies the sorts of tensions that the chapters in this book explore, as regulatory requirements of

practice, expressed in standards documentation, appear to leave little room for manoeuvre in what nurses are (theoretically) required to do, rather than what they are advised or exhorted or allowed to do, or what they actually do. In this particular clause it is not the collection of data but the contribution to the formulation of policy that is problematic; something that all nurses might be encouraged to do but hardly required to do. The recent revision of the revalidation process and professional code was the subject of wide consultation undertaken by the NMC but received only 1,649 individual responses (NMC, 2014), meaning that fewer than 1 in about 300 nurses contributed to the formulation of these policies, that is if they can be regarded as policies at all.[1]

Of more immediate concern to the practicing nurse, seeking to follow the injunctions of the NMC by practicing autonomously according to the best available evidence is the extent to which she must follow the policies and guidelines of her employing organisation. Whether something can be properly regarded as a policy or a guideline is likely to be settled, for her at least, by its title. There are clearly overlaps between them and the words are sometimes used interchangeably. However, there are also a number of differences between guideline and policy, but the discussion here focusses on two: justification and force.

Policies and guidelines

The first distinction between policies and guidelines is in their justification. I do not claim that guidelines are always and only based on evidence, but in the context of evidence based practice, their primary purpose is to locate and evaluate evidence and synthesise it so that it can usefully inform practice. Evidence based policy is, in contrast, a much more diffuse concept. It is far from clear about what counts as evidence and how causal links between policy and its claimed consequences can be demonstrated (Greenhalgh and Russell, 2009), yet these causal claims are made in many different areas of government activity. As I write this in December 2014, a decision to reduce night time street lighting has been criticised because it has led to an increase in accidents (British Broadcasting Corporation, 2014, Automobile Association, 2014). Here the policy debate requires both a view about the veracity of the causal claims and following this a weighing up of the different options. The

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[1] As a matter of logic it might be suggested that even if consultation on a new professional code is regarded as 'formulation of policy, it might not be regarded as policy on 'risks, hazards and adverse outcomes', but I suggest that few of the 299 (from 300) nurses failing to respond to the consultation would offer this in justification.

claimed increased number of road accidents and deaths is pitted against savings of energy and cost.

It is well recognised that there are a number of different drivers of policy making in addition to evidence, including ideology, values, public opinion and lobbying (Smith and Joyce, 2012), and in one sense the multiple drivers of policy might be seen as diminishing the need for evidential justification, but this is not how it is presented. Government ministers and others frequently make claims that policy is based on evidence, and yet even allowing for the difficulty in deciding what would count as good evidence, these claims sometimes lack credibility, and there is a reasonable suspicion that despite the rhetoric concerning the value of evidence, that policy is being directed for political reasons, including ideology and short term political advantage. Core values are emphasised in the most recent white paper on public health in England which claims to take a radical new approach to public health by setting out how the approach will

> reflect the Government's core values of freedom, fairness and responsibility by strengthening self-esteem confidence and personal responsibility; positively promoting healthy behaviours and lifestyles; and adapting the environment to make healthy choices easier (Department of Health [DH], 2010, p.6).

In the same document a claim to evidential justification is clear:

> […] the Government will balance the freedoms of individuals and organisations with the need to avoid serious harm to others. We will look carefully at the strength of the case before deciding to intervene and to what extent. This must be based on a rigorous assessment of the evidence about health and wider harms, with the potential benefits balanced against the social and economic costs to individuals, organisations and wider society (DH, 2010, p.28).

Is this a credible claim for the coalition government? The Liberal Democrat minister in the Home Office, Norman Baker, resigned following the publication of a report (Home Office, 2014) which detailed evidence about drugs policy in other countries. In his resignation letter (Baker, 2014) he expressed pleasure in what he had been able to achieve: 'not least to have been the first minister with responsibility for drugs to have put prejudice aside and published an evidence-based approach to this important issue, despite repeated Conservative efforts to block release.' Despite his claims, this is not primarily a party political manner. The previous Labour government also became embroiled in controversy about how evidence informs drug policy.

What evidence there is suggests that alcohol and tobacco, both legally available, are more harmful than cannabis and LSD, both of which are prohibited (Nutt *et al.,* 2007). According to an editorial in *The Lancet* (MacDonald and Das, 2006), the lack of appreciation of evidence by politicians has resulted in a classification system that 'almost defies belief' (p.559). It is perhaps unsurprising that the principal author of the study into comparative harms, Professor David Nutt, was dismissed by Home Secretary Alan Johnson in 2009 from his position as Chair of the Advisory Council on the Misuse of Drugs after claiming that alcohol (Nutt, 2009a) and horse riding (Nutt, 2009b) are more dangerous than some proscribed drugs. The year before he had criticised the reclassification of cannabis from class C to class B, reversing a decision taken five years previously. This decision, in effect increasing the penalties for cannabis use, was justified, politically, on the ground that evidence was strengthening that cannabis causes schizophrenia (see, for example BBC, 2009), though it has been estimated that even for heavy users, over 1000 people would need to be prevented from using cannabis to prevent a single case (Hickman *et al.,* 2009).

A similar lack of evidence has been claimed in relation to organisational changes which have increased competition in the NHS, introduced by successive governments. A review published by the independent think tank *New Economics Foundation* (Coote and Penny, 2014) argues that there is no sound evidence to support the claim that increased competition can improve efficiency and quality of care. Yet successive governments, most recently David Cameron's Coalition government have insisted not only that the reforms *will* improve care, but also that they *have* improved care. Coote and Penny (2014) cite a speech given to NHS staff in June 2011 in which the Prime Minister claimed that a study 'found hospitals in areas with more choice had lower death rates'. He referred to a paper by Cooper *et al.* (2006) which found that mortality fell fastest in areas where there was greater competition. This paper has been critiqued on several grounds not least for failing to show a causal relationship (Pollock *et al.,* 2011), and in a review, Bevan and Skellern (2011) concluded that most studies found that competition has been ineffective.

This is not the place to attempt an evaluation of these studies, but it could be done. Rigorous assessment of evidence of the sort that precedes guideline production would take account of contradictions within the body of evidence. Despite the claims made in the white paper, there has not been a 'rigorous assessment' of the evidence in relation to drugs and competition

policy. Instead there has been an attempt at *post hoc* evidential justification by the use of selected evidence to defend policy that has been decided upon for other reasons. In evidence based practice, evaluation of research comes prior to the production of guidelines. In much of evidence based policy evaluation of research evidence is a secondary and retrospective concern.

The second difference between guidance and policy is in their directive power. Properly formulated guidance assesses evidence and where necessary, also takes into account cost effectiveness. Thereafter, it is offered to the clinician as advice, and while justification may be required if the advice is disregarded, clinicians take other factors into consideration, not least patient preference and their own clinical experience and expertise. Guidance guides. In contrast, policy can be clearly directive, and this can cause problems for individual practitioners who wish to act outside policy in pursuit of their own professional (evidence-based) judgement and patients' wishes.

The implementation of intentional rounding

The widespread implementation of intentional rounding (henceforth IR) is an interesting and illustrative case study which demonstrates the way that spurious evidential claims are used to defend what are easily capable of being seen as politically motivated nursing interventions. Levenson (2013, p.5) defines IR as 'the timed planned intervention of health care staff in order to address common elements of nursing care, typically by means of a regular bedside ward round that proactively seeks to identify and meet patients' fundamental care needs and psychological safety.' The key features are that all patients are visited at set frequencies and that a standardised approach to care is used. In the UK, Castledine (2002) proposed them as 'a new idea' in nursing in 2002, and IR has been popular in the United States for some time.

In the wake of high profile failures in care, the idea of regular and universal checking was promoted by the Prime Minister, who said in January 2012 during a visit to Salford Hospital, 'that in place of non-essential paperwork and other unnecessary activities, nurses will be able to undertake regular nursing rounds which will ensure that every hour, they will be able to check that every patient is comfortable' (DH, 2012a). IR was noted with approval in the Francis Report (2013), and though open to some interpretation was recognised in recommendation 238 (2013, p. 1610): 'Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds.' In

its initial response to the Francis report, the government gave rounding as an example of a 'comply or explain' approach to be used in hospital inspections: 'inspectors will expect to see these being used across hospitals, or a valid explanation given if this is not the case.' (DH, 2013, p.17). It's not clear what would constitute a 'valid' explanation.

At the same time as the Prime Minister was setting out his expectations, claims about the effect of IR were released in the form of a press release from the Trust, supported by the Chief Nurse's Newsletter (DH, 2012b) which stated that quality improvement initiatives have led to

- 92 percent of patients harm free as measured by the safety thermometer
- 78 percent reduction in C. difficile
- 71 percent reduction in cardiac arrests
- 56 percent reduction in pressure ulcers
- 17 percent reduction in falls.

It should be noted that these figures were not claimed to be the result of IR alone. IR was also being promoted by the King's Fund, an influential independent think tank. A PowerPoint presentation available on their website presents the evidence base for intentional rounding as being from a study undertaken in the United States by the Studer Group (Mead *et al.,* 2006), which found the following in a 'controlled trial (Bartley, 2011):

- 38% reduction in call lights;
- 12 point mean increase in patient satisfaction;
- 50% reduction in patient falls;
- 14% reduction in pressure ulcers

These evidential claims are repeatedly given as rationale for local policies, for example at University Hospitals Coventry and Warwickshire (McDonagh and Smith, 2012). Even more impressive results, including a 56% reduction in pressure ulcers have been claimed in a further Studer Group publication (Studer Group, 2007).

Also in response to concerns in the quality of nursing case, notably at Mid Staffs, the Prime Minister established the Nursing and Care Quality Forum (NCQF), an 'independent group of nursing and care experts [which] aims to spread best practice in all care settings and make recommendations about tackling barriers to high quality, safe and effective care' (DH, 2012b). It is interesting to note that the word 'evidence' is absent from their mission statement which instead includes, as an aim to: 'achieve their ambition of providing the very highest quality of care through supporting the adoption of best practice and promoting

innovation' (DH, 2012a). In its initial recommendations to the Prime Minister, the NCQF (2012a) indicated its desire to accelerate the implementation of rounding, and a further report, in September 2012 (NCQF 2012b) noted that demonstrator sites had been established. The report on the implementation of the demonstrator sites for the NCQF was published in August 2013 (Levenson, 2013).

The report is clearly concerned with the implementation of IR rather than its effectiveness and has involved a good deal of work with observations and interviews. In a sense the report, and those like it, can be regarded as a form of qualitative enquiry. It has some significance, but despite its 39 pages cannot be properly regarded as academically presented qualitative research which can be properly evaluated. There was scant reference to the literature: 'while a systematic literature review was beyond the scope of the report, it was useful to look at recent key articles…' (Levenson, 2013, p.35), a cursory examination which would be unacceptable to any peer-reviewer. The report uncritically notes the extraordinary claims made by the Studer group about the effectiveness of rounding, simply noting that some see the evidence base as flawed and some are less than enthusiastic. The future of the NCQF is unsure, and it was reported, in March 2014, that its members feared that it has been disbanded (Stephenson, 2014). It seems odd that this body, established with an authoritative Prime Ministerial fanfare and an ambitious remit two years previously simply didn't know whether it existed or not. What can be said with some confidence is that it was influential in ensuring that IR has become established. However, not only were recommendations, including by Robert Francis, made without referral to evidence, but an evaluation report cited supporting evidence without evaluating it and simply noted that some people disagreed. So much for best practice.

Fuller evaluations of the evidence and process are available elsewhere (Snelling, 2013a, 2013b). There are a number of worrying issues concerning the quality of the evidence cited and the use to which it has been put. Nearly all evidential trails about IR lead to Mead *et al.* (2006). This was a multi-centre trial carried out by the Studer Group which found significant reductions in falls and increases in patient satisfaction following the introduction of hourly and two hourly rounding regimes. Some of the shortcomings of the study design were acknowledged by the researchers: The groups were not matched and individual units self-assigned to specific groups which may have been for self-interest. Data were provided by the hospitals themselves. Design and statistical concerns are reported by Vest and Gamm (2009).

Data were discarded from 19 of the original 46 units because the rounding logs had more than 5% data elements missing suggesting that 'nursing staff members hadn't consistently performed the rounding' (Meade *et al.* 2006, p. 62). The hourly rounding regime consisted of a visit every hour between 0600 and 2200 with two hour visits overnight, that is 20 visits per 24 hours, and so a single daily missed or unrecorded visit constitutes the cut-off point of 95% of data. This means that the results are generalizable (if they are at all) only to areas where this ludicrous level of compliance is maintained. For comparison, a more academically rigorous study (Tucker *et al.,* 2012) also undertaken in the US, which did not support Meade *et al.'s* findings, documented compliance to be 22 – 60%. A cursory read through of Mead *et al.*'s paper will suffice to show that it is not a disinterested and open minded study. A nested box within the text describes the conversion of a ward manager from sceptic to evangelist and another follows up hospital units a year later referencing further Studer Group publication. A video training package for IR based on the impressive results in the study is for sale for $995 via its website (Studer group, no date).

The second Studer Group publication (2007) takes the form of a best practice supplement, largely detailing implementation processes and documents. The first two pages simply state the results which were also cited uncritically by Levenson (2013). There is neither methodological detail nor data analysis; the reader is simply told, via bar charts, that five months after implementing IR patient satisfaction increased by 71 percentage points, falls reduced by 33% and hospital acquired pressure ulcers fell from 16 to 7, a reduction of 56%. These completely unsubstantiated and, as they are presented, meaningless claims published in what amounts to an advertising brochure for a management consultancy selling to US hospitals, have been cited by Levenson (2013) and elsewhere (for example Forde-Johnston, 2014) as evidential support for IR in the UK. Even more worrying is the claim that Meade *et al*'s study reduced pressure ulcers by 14% which has been cited in a number of publications (For example, Fitzsimons *et al*., 2011). This finding is simply not in the paper, and presumably indicates that those citing it have not read it. A review of the literature (Forde-Johnson, 2014) promulgated this error, and also failed to locate a paper (Snelling 2013a) which pointed it out. A systematic review completed in 2013 and published in 2014 (Mitchell *et al.,* 2014) found only one study (Saleh *et al*., 2011), since retracted, which used pressure ulcers as an outcome measure. The claim that IR reduces pressure ulcers has become accepted within 'evidence based' policies without the support of a single study that can be properly evaluated.

As well as uncritically reporting and serially misreporting findings of very poor quality research, there has been a complete failure to consider the wider concepts underpinning IR. The intervention has been claimed to increase patient satisfaction but it is far from clear that this is a valid indicator of quality of care, particularly in a different health care environment from that where most studies have been undertaken. In the UK, NICE (2012, p.10) states that:

> The concept of satisfaction has been explored in various formats over the last two decades within the NHS; it is now widely acknowledged that it is a poor indicator for evaluating quality from a patient experience perspective.

Of course patient satisfaction is important, but the oversimplification represented by the conflation of quality and perception of care can obscure a detailed analysis of what interventions improve quality. Additionally, the frequency of call bell usage has been used as an indicator to assess the effectiveness of rounding in a number of studies including Meade *et al.* (2006), but this is not supported by evidence or argument. Tzeng and Yin (2009) found that *increased* number of call bells correlated with less fall related harm, and their recommendation was that wards encourage call bell usage on their wards. In a further study Tzeng *et al.* (2012) confirmed this and also found that after correlating for covariates, that both the number of falls and number of injurious falls were associated with lower call bell response time rather than usage, something barely considered in the literature on IR.

Primary research on intentional rounding is of a very poor standard and what little there is has not been properly evaluated before being given as justification for widespread intervention. In the UK the National Institute for Health Research (NIHR) has awarded a grant approaching £450,000 to investigate further the implementation of intentional rounding. The grant application notes that:

> Ideally a randomized experimental study would be used to assess the effectiveness of a new intervention. However the use of this approach is not possible as the implementation of IR has been strongly advocated and promoted by the current government and very few trusts are reported not to have implemented it (Harris *et al*., 2014, p 5).

Instead, realist evaluation methodology will be utilised with the aim of investigating trends in patient outcomes rather than seeking to demonstrate cause and effect.

It is clear through the many poor quality local reports published largely in professional journals that there is some appetite within the nursing profession to undertake IR, and that some studies also report some benefit. It has become *de facto* national policy and this is

recognised locally as the vague recommendations have been operationalised in line with local experience. It should be clear that the preceding analysis does not suggest that there is anything necessarily wrong with IR. There is every possibility that it is effective in promoting increased quality of care. From the perspective of evidence based practice the rapid and widespread implementation is a case study of a top down political intervention which allowed the government to move debate away from institutional failings and lack of resources as an explanation for the poor care experienced by many at Mid Staffs and beyond (Paley, 2014). The *Daily Telegraph* reported the prime Minister's visit to Salford Hospital under the headline 'David Cameron: There is a real problem with nursing in our hospitals' (Kirkup and Holehouse, 2012), and while the Prime Minister's words were a little more circumspect, the effect of focussing, at this time, on simple measures to change nursing practice rather than addressing resource and organisational issues was a deliberately chosen political act.

There is at the heart of the implementation a simple logical conundrum. If IR is performed on all patients as the Prime Minister says that it should be, then it will be performed on many patients who do not need it and are as likely to by annoyed as reassured by the constant intrusion by nurses who, in these circumstances, are likely to see the intervention as an exercise in ticking boxes taking them away from more important work. Conversely, if regular checks are made only on patients who require them on the basis of sound nursing assessment, then it is not IR at all and cannot be presented as a political and managerial response to poor care. It's just, well, individualised nursing. There is some evidence that some local policies are adapting the Prime Minister's injunction by assessing patient needs and performing regular checks only if required (for example Royal Cornwall Hospitals NHS Trust, 2013a, 2013b) and this is to be welcomed. Until this is the norm (and Professor Harris' research will throw some light on this), IR cannot be regarded as evidence based policy. The evidence base, what little there is of it, is tainted by commercial self-interest and poor quality and this has been exacerbated by serial misreporting and a complete failure to evaluate the quality and transferability of primary sources. It is a clear example of politically based policy implementation, and the nursing profession has done a disservice to itself and its patients by acquiescing in its implementation, all the while claiming that it is underpinned by evidence. It is not.

Hospital smoking bans

The history of implementation of hospital smoking bans is a case study of the interplay between facts and values. Hume famously observed you cannot derive an ought from an is. Evidence is, mostly, factual though values guide its production, but it is helpful for analysis to attempt to keep facts and values apart as far as possible. If treatment A produces the best results in treating disease x (which leads to early death), it does not follow logically that treatment A should be offered. Factual and normative premises link something like this:

Factual premise (research):	Disease x causes early death
Normative premise (policy):	Early death (caused by x) should avoided
Normative conclusion (policy):	Disease x should be treated

Normative premise (policy):	The most effective treatment should be used
Factual premise (research):	Drug A is the most effective treatment
Normative conclusion (action):	Drug A should be used.

The normative conclusion would form the basis of a guideline. Of course it is not quite so simple. In a publically funded health service which places an opportunity cost on each treatment, it is not so much effectiveness as cost effectiveness that decides treatment. Funding allocation by use of Quality Adjusted Life Years (QALYs) is an attempt to get the most benefit for each health care pound spent, even though serious concerns are raised in relation to its fairness in regard to particular illnesses. See, for example, Garau *et al.* (2011) in relation to the difficulties in using QALYs in cancer. This could change the premises to 'cost-effective' instead of 'effective' and this would increase the evidence required (NICE, 2012b). Patient consent is also required before a treatment is administered so that the normative conclusion could be recast as 'Drug A should be *offered*' instead of used. In the context of evidence based practice, as in all forms of professional practice, consent is morally very important (as well as legally required) because it is the practical manifestation, albeit an imperfect one, of the bioethical principle of respect for autonomy (Beauchamp and Childress, 2013), seen by many (Gillon, 2003) as the predominant principle, based on the ultimate value. In these heuristic syllogisms for evidence based practice, facts derived from research and values from elsewhere are kept apart so far as is possible, but what is offered depends on

available evidence. In the ordinary run of events in EBP, much time and effort is spent on investigating the effects and costs of drugs and other treatments. In most cases, though not all, the values that drive empirical investigations are largely uncontested.

The development of policies to reduce smoking similarly involves facts and values, though here the emphasis is different. Some treatments, for example Nicotine Replacement Therapy offered to individuals follow the standard 'treatment' evidence cascade. Other public health measures to reduce smoking at the group level are also based on evidence, for example policies of enforcing plain packaging of cigarettes are based on evidence, derived from experience from other countries (Freeman *et al.,* 2008), that they would reduce smoking. Unsurprisingly, manufacturers are opposed but the provision does not directly restrict liberty and threatens autonomous decision making barely at the margins or not at all.

Some smoking policies are however more directly liberty threatening. The Health Act 2006 introduced a number of changes into the NHS but it will be best remembered for changing forever the experiences of smokers in England and Wales. From 1st July 2007 smoking was no longer permitted in public places and in certain places of work. The given justification for the ban was other-regarding, for example by House of Commons Health Committee (2005), para 41: 'The justification for the principle of a ban is straightforward: workers have a right to be protected from SHS (second hand smoke).' Unlike care homes and hospices which were excluded from the legislation, mental health units were given a temporary exemption order for one year, which, upon expiry, meant that where smokers could not be permitted to go outside, they were forced to stop smoking. The ban was unsuccessfully challenged by patients at Rampton and Carstairs hospitals using the European Convention on Human Rights (ECHR) in the English and Scottish courts where Lord Stewart, presiding in the Scottish Court noted that:

> Article 8(2) ECHR authorizes interventions which are 'necessary in a democratic society […] for the protection of health or morals: it is not a warrant for lifestyle fascism[2].

Despite his observations here, Lord Stewart found for the appellants only reluctantly[3]. His judgement also included: 'It is a perfectly reasonable proposition, given contemporary

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[2] *C M v The State Hospitals Board for Scotland.* 2013 WL 4411375. Paragraph 52
[3] There was a dissenting judgement (Keene LJ) in the English Court of Appeal. *R(N) v The Secretary of State for Health.* [2009] EWCA Civ 795

understanding about the effects of tobacco smoking, that patients in a hospital should not be permitted to smoke.'[4] His judgement was subsequently overturned on appeal.

In these political and judicial comments, a move can be seen from prevention of harm to others towards prevention of harm to the smoker. Similar justification can be found in NICE guidance: *Smoking cessation in secondary care: acute, maternity and mental health services* (NICE, 2013a). There is an extensive evidence base given in support of a wide range of guidance, including recommendation number 11: 'Develop smokefree policies' including removal of shelters or other designated outdoor areas, and ensuring policies are in place to 'facilitate compliance with, and resolve immediately, any breaches of smokefree policies' (p.16). There is a large amount of often weak evidence detailed in the accompanying evidence statement document (NICE, 2013b), mainly drawn from the US about impacts on patients, for example, frequency of violent episodes and use of restraint in mental health units. But there cannot be direct evidence for the important policy provision that smoking ought to be prohibited in hospital grounds, because it is a normative question. It does not follow from a fact that smoking bans *can* be implemented effectively that they *should* be.

The guidance is directed not at clinicians but at employing organisations, many of which have policies of the sort recommended. The NICE guidelines recommended 'no exceptions for particular groups' (p.6), but this is clearly incorporated into some local policies formulated before the NICE guidance was released (For example see the policies of West London Mental Health NHST, 2012 and Manchester Mental Health and Social Care Trust, 2012). Tameside NHS Trust's policy (2014), revised after the guidance, has no exceptions and includes the forthright clauses:

> Staff will not be permitted to assist patients who wish to smoke. Staff must not accompany patients who wish to smoke, and any member of staff who does so will be subject to disciplinary action in line with Trust policy. All staff should receive the support of senior colleagues and Security Officers if patients or visitors place staff under pressure to violate the Trust's No Smoking status (para 7.8).

> If a patient leaves a Ward without permission from Ward staff, the patient will be wholly responsible for anything that may occur as a result of their action (para 7.9)

The significant point for consideration for this chapter is that despite the evidential legitimacy offered by inclusion in NICE guidelines, sitting as they do at the very top rung of the evidence based practice ladder, these guidelines and the policies that follow are not based

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[4] *C M v The State Hospitals Board for Scotland*. 2013 WL 4411375. Paragraph 5

upon evidence but upon values. These values are in tension with both the professional requirement for autonomous practice and the patient's right to make decisions for himself in what he perceives to be his best interest.

Conclusion.

Policy is legitimately influenced by many considerations, and yet as I have argued, evidential justification is frequently sought and claimed. IR has been widely implemented in the interest of a political need for action, supported by appeasing managers in the absence of any credible evidence. Authoritarian and paternalistic smoking policies are given evidential gloss by NICE guidelines but are driven by imposed values. Despite claims made to the contrary, evidence based policy is often a myth and it exposes important tensions for practicing nurses and perhaps more importantly, nurse managers.

The NMC require nurses to practice autonomously based on the best available evidence. Both of these injunctions are significantly compromised by the policies I have discussed. It is plausible that a nurse is forced to choose between following these professional requirements, acting as an advocate for her patient, and following a policy that requires her to do neither of these things. Clarity about what regulatory injunctions amount to may prevent her having to argue the case for her autonomous evidence based practice before a disciplinary panel or employment tribunal.

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