Researching Interventions that Promote Ethics in social care (RIPE) Project

EXECUTIVE SUMMARY

17th November 2016

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The RIPE Project was funded by the Ethox Foundation & the Wills Charitable Trust
INTRODUCTION

All day, every day, in care homes across the United Kingdom care-workers are responding to ethical issues. Their responses make the most profound difference to the lives of older people, their families and others in residential social care. People in care can be made to feel respected or disrespected, appreciated or unappreciated, that they are valued human beings or tasks to be completed. Despite this, social care ethics work is invisible. It is seldom recognised as integral to good care nor is it understood as work deserving of time, space, education and organisational support.

These were the starting assumptions behind the RIPE project. The Ethox Foundation recognised that there has been a lot of ethics-related activity in recent years in health care, for example, in medical and nursing ethics education. There has been very little attention to ethics in social care and we know little of the impact of ethics education on care-workers’ ability to respond confidently and competently to everyday ethical issues.

With this in mind the Ethox Foundation, approached the International Care Ethics (ICE) Observatory research team at the University of Surrey to respond to the research question: **Which is the most effective ethics education intervention to promote ethics for care-workers in residential social care?**

This Executive Summary provides an overview of the RIPE project methodology, participants and findings. **Six overall themes** emerged from project data:

1. **Making the invisible visible** – findings have illuminated the everyday ethical issues that arise in residential care and confirm that care-workers have had few opportunities to engage in ethics education;

2. **Supporting a mixed ethics education approach** – findings suggest that each of the three approaches has merit as each engages with different elements of ethical competence;

3. **Valuing time and safe space for ethical reflection** – participants highlighted the importance and benefits of facilitated reflection and interaction in contributing to team learning with a view to promoting ethical care;

4. **Providing expert facilitation** – findings support the need for expertise and experience in facilitating each of three interventions so that participants understand the aims and approaches and are made to feel safe and valued;

5. **Engaging social care organisations in research** – the RIPE project highlighted challenges in recruiting care homes to research. The care homes recruited tended to be those with positive organisational cultures; and

6. **Viewing ethics education as a 3 level activity** – findings suggest that the promotion of ethical care is dependent on the ethical competence of individuals (micro-level); the moral climate of care organisations (meso-level); and the societal context of care (macro-level).
RIPE PROJECT DESIGN

The Researching Interventions to Promote Ethics in social care (RIPE) project was designed as a 2 year research trial. We aimed to find out which intervention worked best by using ethics-related measurements (quantitative data). We also invited the views of participants in interviews and focus groups (qualitative data) before and after the interventions. The RIPE project aim and objectives are as follows:

The overall RIPE project aim was to determine the impact of three educational interventions on care-workers in residential care homes. The objectives were:

(i) To evaluate/measure the impact of face to face ethics teaching on the moral sensitivity, work-related moral stress, ethical leadership, and empathy of residential care-givers working with older people;

(ii) To evaluate/measure the impact of reflective ethics discussion groups on the moral sensitivity, work-related moral stress, ethical leadership, and empathy of residential care-givers working with older people;

(iii) To evaluate/measure the impact of immersive simulation, on the moral sensitivity, work-related moral stress, ethical leadership, and empathy of residential care-givers working with older people;

(iv) To explore care-givers’ experiences of care-giving within a residential care home setting for older people, specifically considering challenges and enablers to ethical care practices;

(v) To explore residential care-givers’ perceptions of induction, training, support and supervision, and ethics resources within their organisation;

(vi) To explore residential care home managers’ perceptions of induction, training, support and supervision, and ethics resources within their organisation;

(vii) To explore residential care-givers experiences of face to face ethics teaching in relation to their care practice;

(viii) To explore residential care-givers’ experiences of reflective ethics discussion groups in relation to their care practice;

(ix) To explore residential care-givers’ experiences of immersive simulation in relation to their care practice.
There were four groups of research participants: one group participated in face to face ethics teaching sessions; one group participated in reflective ethics discussion group sessions; one group experienced an immersive simulation intervention; and a fourth control group received no intervention. A diagram of the project design is below:

Each of the four groups completed a questionnaire which contained four measurement tools. This was completed by participants at 3 time points. For the intervention groups, this was before the intervention, one month after the intervention ended and then 3 months afterwards. For the control group, completion was invited at approximately the same timings.

The four ethics-related measurement tools in the RIPE project questionnaire aimed to measure moral sensitivity, moral stress, empathy and ethical leadership.

Based on a search of the literature and of previous experience, it was agreed that the following 3 interventions would be evaluated:

**Group 1 - Face to face ethics teaching** in care homes – this involved six 90 minute sessions in each of 7 care homes where a facilitator came to teach ethics topics to a group of up to 8 care-workers. A handout was given to participants to summarise content in each session.

**Group 2 – Reflective ethics discussion groups** in care homes – this also involved six 90 minute sessions in each of 7 care homes. This time the facilitator came to lead discussion on ethical aspects of practice situations rather than to teach ethical
concepts or theories as in Group 1. The facilitator encouraged participants to bring examples from their own practice experience to reflect on.

**Group 3 – Immersive simulation** experience in the university skills laboratory – participants who volunteered spent a weekend in the profile of a care home resident with care delivered by student nurses. The simulation was based on a project in Belgium and Holland called the sTimul model.

Before the project commenced, the proposal was submitted to the University of Surrey Ethics Committee for ethical review and a favourable ethical opinion was received.

A summary of participants in each of the project groups is presented in the table below:

<table>
<thead>
<tr>
<th></th>
<th>Number of participants at start of intervention</th>
<th>Number of care homes represented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face-to-face teaching</td>
<td>47</td>
<td>7</td>
</tr>
<tr>
<td>Reflective groups</td>
<td>49</td>
<td>7</td>
</tr>
<tr>
<td>Simulation</td>
<td>38</td>
<td>11</td>
</tr>
<tr>
<td>Control group</td>
<td>44</td>
<td>14</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>178</strong></td>
<td><strong>39</strong></td>
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</tbody>
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Of those who completed Questionnaire 1, 17% were male and 83% female. The age range is as follows: age 18-24 (17.2%); age 25-34 (27.8%); age 35-44 (21.1%); age 45-54 (20%); age 55-64 (12.2%); and age 65-74 (1.7%). Regarding the ethnicity of participants, there were four main groupings: English, Welsh, Scottish, Northern Irish, British (55%); Black and minority ethnic (27%); other white/traveller (14%); choose not to answer (3%); and 1% said ‘other’.

Regarding those who spoke English as a first language, 65% said yes and 35% did not have English as a first language. Responding to the question: ‘How well do you speak English?’ 75% said ‘very well’, 22% said ‘well’; and 3% ‘not well’.

Participants described themselves as ‘carer’ (42%), ‘senior carer’ (23%) and ‘nurse’ (13%). A significant percentage (22%) described themselves as ‘other’ and these included 2 matrons; 12 managers, 2 housekeepers, 2 catering staff, 2 administrators and 1 physiotherapist.
RIPE PROJECT FINDINGS: 6 OVERALL THEMES

1. Making the invisible visible – RIPE project findings have illuminated the everyday ethical issues that arise in residential care and confirmed that care-workers have had few opportunities to engage in ethics education. Participants’ reflection after the interventions showed their awareness of the complexity of ethics in care:

   "It’s black and white when you’re outside and you’re not involved. Everything is black and white. You step into this building and you actually have to make a decision with real people. It’s a whole other ball game."

Other participant referred to people’s lack of understanding of care work:

   "I think a lot of people from the outside think to care is easy. Oh, you’ve just got to wash and dress someone, sit them in a chair all day. Put them in front of the telly in a line (laughs)."

Another said:

   "They just assume that Mum’s in a care home and don’t really know what everybody’s roles are and what our responsibilities are. And you know protecting and making sure the person is safe and the families are trusting you to look after them."

And relating to the lack of previous ethics education:

   "We do a lot of mandatory training, we talk about physical care a lot with this training, but what we don’t talk about is [ethics], there is no mandatory ethical training at all."

After the simulation experience, participants reflected on powerful insights gained in relation to previous training. In a published paper the research team referred to these as ‘epiphanies’:

   "Because the thing is we have so many trainings…but if you do have a one on one experience it’s totally different because it’s your body, it’s your value, it’s your morality and it’s your way of doing it, and how you like it, why you like it. And then when someone gets into your private sector with all your physiological needs and your peace of mind, that’s when fear sets in and then you actually know why people react in such a way."

Following the face to face ethics teaching sessions a participant said:

   "[…] but it makes you think that really everything’s got an ethical…there’s ethics in absolutely everything isn’t there?"

A participant who completed the reflective ethics discussion group intervention said:

   "But now it makes you realise everybody’s got a role, and everybody is here because without everybody being here we wouldn’t have a home, they wouldn’t have the care […] I’ve been here 36 years – that doesn’t
mean anything, because there’s always a chance to learn. I’m still learning, you know […]"

Specific questions, relating to everyday ethical issues in care, that were raised by participants in the three intervention groups included:

- What should I do when a resident refuses a shower?
- What should I say to a relative who complains that her mother is neglected when the resident has decided she wants to stay in bed?
- What should I do when I am on the receiving end of racism or other abuse or disrespect from residents, relatives or others?
- How should I respond when a resident insists on being washed first in the morning and other residents appear to have greater need?
- What should I do when a relative brings in alcohol for a resident and the resident becomes aggressive and at risk of falling?
- How do I manage a manager who does not seem to appreciate care-workers’ experiences and views regarding the care of residents? And
- Why doesn’t the media report the ‘good stuff’ relating to care?

The RIPE project draws attention to lighter and darker aspects of everyday residential care, to aspects that should be recognised and celebrated and to aspects that require individual, organisational and political responses.

2. Supporting a mixed ethics education approach  – Findings suggest that each of the three approaches has merit as each engages with different elements of ethical competence. The project generated a large amount of quantitative (numbers) data from tools designed to measure moral sensitivity, empathy, ethical leadership and moral stress. These tools were a good match for the RIPE project as they measured aspects of ethical competence we were interested in, namely, moral sensitivity, moral stress, empathy and ethical leadership. Each of the groups fared well with the measurement in the first questionnaire with scores comparable with measurements from previous groups who had been researched.

We aimed to find out which of the three ethics education interventions was most effective using the four tools for before and after measurements. We found, for example, that both face to face teaching and reflective ethics discussion group interventions were associated with significantly higher levels of moral responsibility (subscale of moral sensitivity scale) and significantly lower levels of work related moral stress. Before and after comparisons suggested that taking part in an immersive simulation was associated with significantly higher scores on empathy (the Interpersonal Reactivity Index) and in particular with higher scores on the IRI Fantasy subscale, which measures the tendency to empathise with fictional characters. Whilst these results are interesting, we cannot make robust claims as the tools are not a perfect fit for our participants. An option for future research would be to develop a specific measurement tool that addresses ethical competence for social care and perhaps also a tool to measure organisational ethical competence.
Findings from the interviews and focus groups support the value and effectiveness of each of the three interventions. Participants’ feedback overall suggest that the three interventions engage with different elements of one model of ethical competence as follows:

**Ethical knowing** – The face to face ethics teaching focused on facilitating learning of ethics approaches, concepts and an ethical decision-making framework. Examples from care practice were used to illustrate how ethics can be applied to care.

**Ethical seeing** – This involves paying attention, and being sensitive to, the experiences of residents, families and colleagues. It has been described as ‘looking feelingly’ and as exercising moral imagination. The immersive simulation experience would appear to engage most acutely with ethical seeing.

**Ethical reflecting** – Reflection helps care-workers to think through and consider different perspectives on care situations. Reflective ethics discussion groups provide opportunities to consider different views and face to face ethics teaching enables participants to apply a range of ethical concepts and approaches. The post-simulation focus groups also facilitate ethical reflecting.

**Ethical doing** – An aim of ethics education is that participants will act well, in addition to knowing, seeing and reflecting - that their conduct in care will be ethical. The RIPE project did not directly research the impact of the interventions on residents or families, however, reports from participants suggest that positive changes were made in care homes. This is an area deserving of further research.

**Ethical being** – This involves the development of qualities of character or virtues and aspiring to improvement. Discussion of virtues took place in both the face to face ethics teaching intervention (for example, justice, respectfulness, trustworthiness, patience…) and in the reflective ethics discussion group intervention (for example, compassion, dignity, autonomy…). As participants reflected on their immersive simulation experience, they also highlighted a wide range of virtues relevant to the experience (for example, trust, courage, attentiveness, fairness, empathy and friendship…).

Overall, then, it seems that to fully engage with the complexity of ethical competence for everyday care practice there is much merit in combining the 3 ethics education interventions.

3. **Valuing time and safe space for ethical reflection** – participants highlighted the importance and benefits of facilitated reflection and interaction in contributing to team learning with a view to promoting ethical care. The RIPE project has given voice to care-workers who may, as one said, have ‘suffered in silence’. The project was

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described as an ‘eye-opener’, as giving staff ‘a boost’ and as contributing to their feeling more confident and empowered. A reflective group participant said:

*Gives them the opportunity to have a voice and not be, you know not be judged on it, isn’t it really? Cos what tends to happen is people clam up […] Whereas it give you a safe space environment to actually have a voice […]*

Another said:

*I think like you say sometimes he [facilitator] was learning from us, which was quite amazing because you think gosh, you assume everybody knows all of this, but in actual fact they don’t. And then you suddenly think, well, I do know something (laughs) I actually do know something. It’s like you’re teaching someone else.*

An unexpected consequence of the RIPE project is that care-workers were made to feel valued. The fact that managers support staff to attend the sessions gives the message that they and the care they deliver are valued. We would go further and suggest that organisational support reinforces the dignity of individual care-workers and the dignity of care practice. Insights from ‘slow ethics’² support the need for time and space to develop ethical competence and positive organisational cultures.

4. Providing expert facilitation – findings support the need for expertise and experience in facilitating each of three interventions so that participants understand the aims and approaches and are made to feel safe and valued. Our experience of running an intervention with a less experienced facilitator highlighted the importance of adequate preparation for the role of ethics facilitator and this applies to all three interventions. The knowledge and skills necessary for ethics facilitation can be developed and this will be necessary to support a programme of sustainable ethics education. This underpins our decision to develop two programmes of ethics education: one skills-based, focusing on the development of ethical leadership in care organisations using a train the trainers model; and another programme for those who wish to work towards an academic qualification in ethics as applied to care, for example, a certificate, degree or masters’ programme.

5. Engaging social care organisations in research – the RIPE project highlighted challenges and opportunities in recruiting care homes to research. The challenges related to: access to and recruitment of care homes (over 200 approached to recruit 41); retention of care-workers and care homes (6 homes withdrew from the study); and the measurement of project outcomes which was inconsistent due to different response times. The homes we recruited tended to be those with positive organisational cultures. The benefits for participating care homes were identified as: staff development opportunities; value of engaging with a university; and evidence of practice improvement.

6. Viewing ethics education as a three-level activity – Findings suggest that the promotion of ethical care is dependent on the ethical competence of individuals (micro-level); the moral climate of care organisations (meso-level); and the societal context of care (macro-level). The RIPE project findings are in accord with previous research showing that, although the behaviour, knowledge and values of individual care-workers is very important, organisational culture and wider issues support or inhibit the delivery of ethical care. Findings also reveal that care-workers are not always treated with the respect they deserve and are sometimes on the receiving end of abuse from residents and relatives. Whilst care-givers were understanding when the abuser had compromised capacity (due, for example, to dementia), they found it difficult to respond to when this was not the case.

We have learnt from the RIPE report and from previous research that the impact of the media only reporting negative stories about care can be demoralising. Also political issues impact on care and reductions in social care funding have a direct impact on care-workers. All three levels that impact on ethical care are deserving of further research with questions developed with care-workers, care-recipients and families.

CONCLUSION AND NEXT STEPS

The RIPE project has taken us on an unmissable journey. We have been privileged to work with many committed care-workers and with care organisations that prioritise ethical care. We have learnt a great deal about everyday ethical issues in residential care and about the value of 3 different ethics education interventions. The perspectives of project participants have led us to conclude that each of the three interventions is necessary but none is sufficient by itself. The rich qualitative data enabled us to conclude that a mixed approach to ethics education is the most defensible approach. This is also in accord with our model of ethical competence.

The project tools have generated some interesting findings but have had limitations in that they were not validated for our study population. Whilst we place great value on the qualitative data, we also appreciate the value of appropriate measurement tools that are fit for the purpose of assessing the impact of ethics-promoting interventions in social care. This is an area for further research.

The most immediate initiative to follow from the RIPE project is our commitment to develop a train the trainer skills-based ethics education programme and a Masters level academic course in ethics as applied to care from January 2017. We have significant expertise in the School of Health Sciences to draw on with the core research team and visiting professors in feminist ethics, business ethics, regulation, Islamic ethics, Buddhist ethics, regulation and law.

We look forward to working with conference participants on 17th November, to gather feedback on the findings and to discuss with participants and other key stakeholders what should follow from the RIPE project.
ACKNOWLEDGEMENTS

This research would not have been possible without the support of the Ethox Foundation and we thank the Chair and Trustees – Ms Maura Buchanan, Professor David Perry, Professor Annie Young & Mr Glyn Pritchard - for their unwavering commitment to the project. We are grateful also to the Wills Charitable Trust who provided additional funding for the RIPE project.

We would like to thank project participants who gave freely of their time and reflections. We are also indebted to care home managers who enabled care-givers to participate in the project. We thank the student nurses who participated in the simulation weekends and colleagues in the School of Health Sciences who assisted us in their own time (Jane Leng, Mary Raleigh, Cilla Jones, Nicola Carey and Alison Wiseman).

We thank members of the RIPE project Advisory Group: Mr Simon Bettles, Teaching Fellow, School of Health Sciences, University of Surrey; Dr Anna Cox, Research Fellow (also involved in study design); Mrs Jane Leng, Lead for Student Health and Wellbeing, School of Health Sciences, University of Surrey; Ms Emily Spearing, Manager, The Old Vicarage Care Home, Dorset; Dr Martha Wrigley, Clinical Trials Manager, R & D Department, Ashford & St Peter’s Hospitals NHS Foundation Trust, Chertsey; Ms Katie Bennett, Partners in Care, Education & Community Training, Poole; and Dr Kathy Curtis, Head of Professional Development, School of Health Sciences, University of Surrey (until December 2015).

We are grateful to sTimul advisors (simulation group) – Ms Trees Coucke; Dr Nele Janssens; and Dr Linus Vanlaere – for their generosity in sharing their experience of immersive simulation with us.

We owe a debt of gratitude also to Professor Geoffrey Hunt who facilitated the Reflective Ethics Discussion Groups. We thank also those who read the draft project report and provided constructive feedback, which contributed to its development, namely, Professor David Perry, Dr Anna Cox and Mr Rob Jago.

Others who deserve a special mention include Dr Jane Fielding who helped us with the adaptation of the tools in the project questionnaire, Mr Mick Daley and his team for pilot testing, Ms Katie Bennett for support with the simulation group, Partners in Care for assistance with recruitment and Dr Sue Westwood and Dr Tula Brannelly who contributed to early stages of the project. We are grateful to Dr Mark Joy who conducted the final statistical analysis and to Dr Sig Johnsen who advised on the initial power calculation. Thank you also to Mr Dan Blood who assisted with setting up the simulation suit.

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