The RIPE Project protocol: Researching Interventions that Promote Ethics in Social Care

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Abstract

Background: Recent reports into failures in residential care resulting in avoidable suffering for older people and their families have highlighted the need for, and importance of, ethical practice. Although there is a wide range of training available for care-givers, there is no mandatory requirement for ethics education as there is for registered nurses. Little is known about the impact of ethics education on the ethical competence of care home staff.

Aim: To determine the impact of three ethics educational interventions on the moral sensitivity, work-related moral stress, ethical leadership, and empathy of care-givers in residential care homes.

Method: A pragmatic cluster randomised trial exploring the effectiveness of three ethics educational interventions for care-givers working in residential care homes for older people. Baseline data will be collected before randomising each care home to one of three ethics educational interventions: 1) conventional ethics teaching within care homes for older people; 2) reflective ethics discussion groups within care homes for older people; and 3) experiential learning – immersing participants in a care recipient's role within a simulation suite at the University of Surrey; or a control arm 4) where care-givers will receive no educational intervention.

Conclusion: At the time of publication, the research team are recruiting to the project. The project interventions, data collection and analysis will be completed by December 2016. The research team would be pleased to work with other researchers interested to replicate the study and to compare findings. More detailed information regarding the recruitment process and interventions is available on request.

Introduction

Recent reports into failures in residential care resulting in avoidable suffering for older people and their families (Department of Health 2012, Care Quality Commission 2014, Learner 2014) have highlighted the need for, and importance of, ethical practice. It is estimated that there are approximately 1.5 million care-givers in social care (Wills 2015). Although there is a wide range of training available for care-givers, there is no mandatory requirement for ethics education as there is for registered nurses. Previous care home research (Gallagher et al 2014) supports the value of ethics education in care homes. Little is known about the impact of ethics education on the ethical competence of care-givers in residential care homes. There have been no previous comparative intervention studies evaluating a range of approaches to ethics education in this area.

The RIPE (Researching Interventions to Promote Ethics in social care) project is a pragmatic cluster randomised trial which sets out to remedy this research gap by exploring the effectiveness of three ethics educational interventions for care-givers working in residential care homes for older people. Baseline data will be collected before randomising each care home to one of three ethics educational interventions: 1) conventional ethics teaching within care homes for older people; 2) reflective ethics discussion groups within care homes for older people; and 3) experiential learning – immersing participants in a care recipient's role within a simulation suite at the University of Surrey; or a control arm 4) where care-givers will receive no educational intervention. The same data collection methods will be used after the interventions to ascertain the impact of each approach in comparison to a control group. Data collection methods will be quantitative (using measures to evaluate the impact of the interventions on moral sensitivity, work-related moral stress, ethical leadership and empathy) and qualitative (gaining the perspectives of care-givers and their managers through semi-structured interviews). (See FIGURE 1 for project overview).

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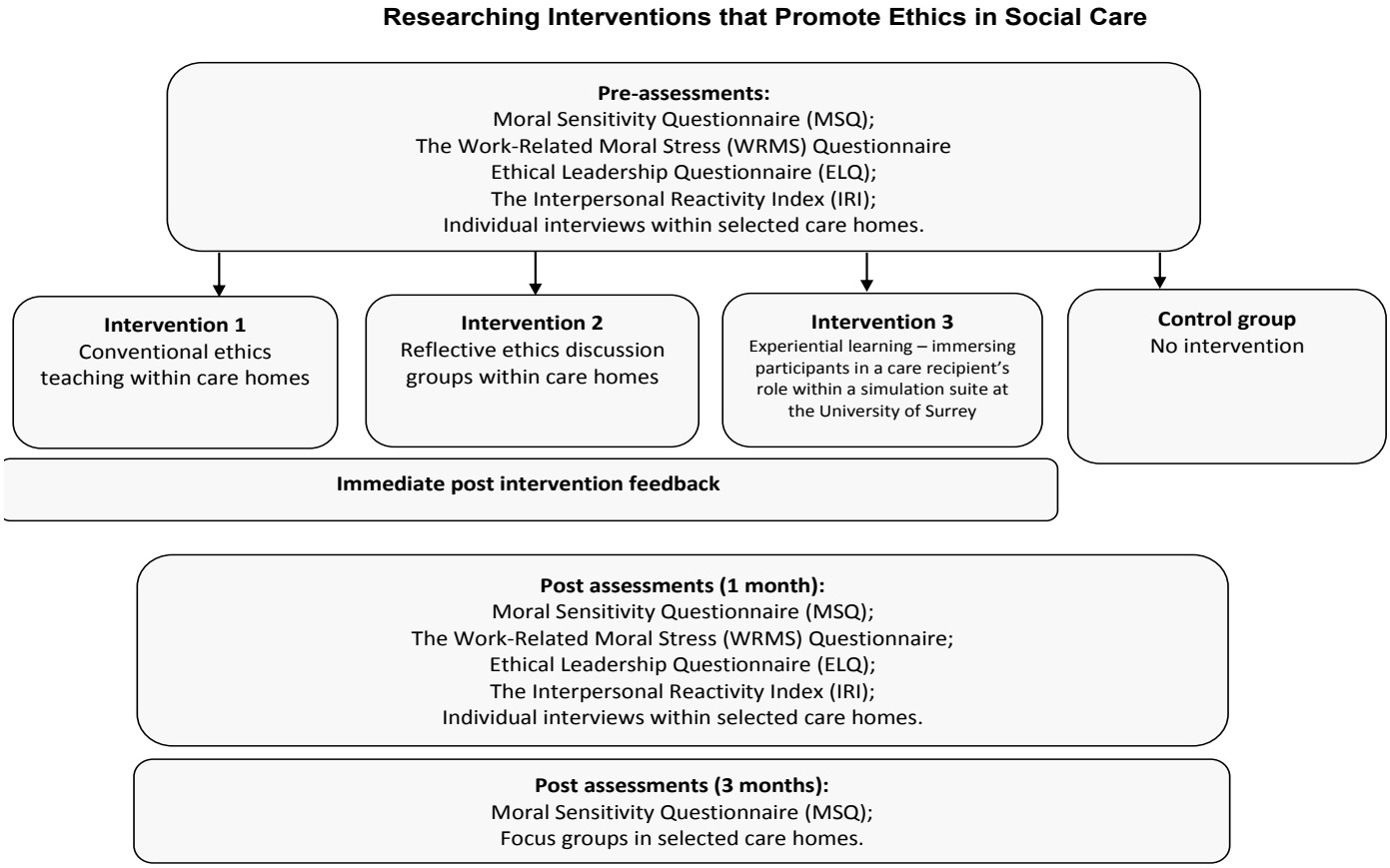

Figure 1: Researching Interventions that promote Ethics in Social Care

In the light of findings, this 24 month project will develop an evidence-based social care ethics education programme for care-givers in residential care homes for older people that can be rolled out across the UK. Researchers will work actively with the Ethox Foundation to apply for funding for the educational programme as we draw conclusions from the RIPE project.

Aim of the Project

To determine the impact of three educational interventions on the moral sensitivity, work-related moral stress, ethical leadership, and empathy of care-givers in residential care homes.

Objectives:

i. To evaluate/measure the impact of conventional 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 experiential learning, 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 conventional 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 experiential learning in relation to their care practice.

Summary Literature Review

The three approaches to ethics education have not been evaluated systematically although there is some evidence for effectiveness, for example, in relation to conventional teaching and simulation and also relating to the value of clinical ethics committees, similar to reflective ethics discussion groups, in other settings. A review of the literature was conducted for each approach to ethics education, a summary of these reviews is given below.

1. *Conventional ethics teaching*

Face to face classroom-based teaching in applied ethics is well-established in relation to healthcare professionals, although less so in relation to social care, especially residential care with older people. There is a good deal of literature regarding the aims and learning/teaching methods utilised on ethics education programmes particularly for nurses and doctors. Sofaer (1995), for example, examined four types of teaching methods namely, discussion, student-led seminars, structured debate and role play. The methods were not evaluated separately to understand which method was more effective, however Sofaer (1995) concluded that as a result of the health care professionals'

participation in the experimental learning, they were able to reflect analytically and participate in informed discussion. Johnson (1983) argued that small group discussions are very effective in increasing the ethical knowledge of health care professionals.

Park (2009) reported that because nurses encounter clinical issues on a daily basis that require ethical judgement they need to be trained, prepared and supported in making ethical decisions. It has been suggested that newly qualified nurses lack ethical confidence as nursing education does not prepare them well in dealing with ethical issues (Woods, 2005). Woods (2005) argued that there is a need for new approaches in teaching nursing ethics to health care professionals as the traditional ethics education tended to emphasize the acquisition of philosophical and theoretical knowledge that has created a gap between theory and practice. As Park (2009) maintained, the teaching of nursing ethics should address the day to day ethical issues in care delivery. But there was no specific teaching method suggested to address the day to day ethical issues encountered by care-givers.

Schluter et al (2008) explored nurses' moral sensitivity and hospital ethical climate. They argued that one way of addressing the ethical dilemmas and supporting nurses in resolving the ethical dilemmas is to make sure that as well as other health care professionals, nurses have a grounding in ethical decision making. We know of no evidence to date that examines the experience of residential care-givers in relation to the impact of conventional face to face ethics education.

2. *Reflective ethics discussion groups*

There has been a good deal of research attention given to ethical issues in healthcare practice, for example, in relation to the activity of groups discussing ethical issues in clinical ethics committees or practice discussion groups. One approach to supporting ethical reflection and ethical practice is a 'moral case deliberation' approach whereby healthcare professionals interrogate their moral and/or ethical questions during a structured dialogue about a particular case study. Such dialogue is usually facilitated by an ethicist. Van der Dam et al (2011) discussed their experience of organising 'moral case deliberations' in two Dutch nursing homes. They defined 'moral case deliberation' as a specific form of clinical ethics, with the objective of stimulating ethical reflection in daily practice, which improves the quality of care. They tried to understand how and where to most effectively organise moral case deliberation. In evaluating the implementation of moral case deliberation, van der Dam et al concluded that heterogeneous composition of moral case deliberation as well as having moral case deliberation separate from existing structures has benefits though some participants reported negative experiences. However the effect of moral case deliberation on care-givers' ethical sensitivity was not evaluated. Førde et al (2008) explored the views of eight clinicians who evaluated six committees' deliberations on 10 clinical cases. The research concluded that clinicians found the clinical ethics consultations useful, but it is vital to use a systematic approach to explore cases during the consultations.

Garcia (2001) argued that whether the different methodologies used in clinical ethics work well or not depends on certain external factors, such as the mentality with which they are used. Steinkamp and Gordijn (2003) analysed and compared four methods of ethical case deliberation namely: Clinical Pragmatism, The Nijmegen Method of ethical case deliberation, Hermeneutic dialogue, and Socratic dialogue. The researchers maintained that there is no one ideal method of ethical case deliberation, that fits to all possible kinds of moral problems. Every method has its strengths and weaknesses and this should be considered while choosing a method for deliberation. There was no discussion of how to evaluate the impact of these methods on the ethical practice of health and social care-givers. In 'clinical pragmatism: a method of moral problem solving', Fins et al (1997) presented a method of moral problem solving in clinical practice that is inspired by John Dewey's philosophy. This method integrates clinical and ethical decision-making. Clinical pragmatism focuses on the interpersonal processes of assessment and consensus formation as well as the ethical analysis of relevant moral considerations. The steps in this method are delineated and then illustrated through a detailed case study. The implications of clinical pragmatism for the use of principles in moral problem solving were discussed but there was no discussion on how to evaluate its effects. There is then a good deal of research on different approaches to ethical or moral deliberation, but no consensus regarding the most appropriate approach or effectiveness. This study provides an opportunity to test different approaches to ethical or moral deliberation in relation to the practice of UK residential care-givers, a group under-researched thus far.

3. *Experiential learning*

Simulation-based learning evolved in high-hazard professions, such as aviation, nuclear power, and the military, with the aim of maximizing training safety and minimizing risk. Simulation has lagged behind in health care for a number of reasons, including: cost; lack of rigorous proof of effect; and resistance to change (Ziv et al., 2006). Healthcare organisations are now embracing simulation as a learning experience and we are currently in what has been described as the 'golden age of medical simulation' (Carroll and Messenger, 2008), with high expectations for the impact of this major innovation on future health care provision. Whilst the literature on medical simulation is vast, evidence emerging from the literature is limited, for example, a review of high-fidelity medical simulations (Issenberg et al., 2005) identified only 109 out of 670 articles were sufficiently robust to be included. Similarly, a review of simulation-based learning in nurse education (Cant & Cooper, 2009) suggests that simulation using manikins is an effective teaching and learning method, but acknowledged that the generalizability of results may be limited due to the quality of study designs.

Bradley (2006) classified simulation into four types: part-task trainers; computer-based systems; simulated patients and environments; and integrated simulators. Within a health care setting, simulation has mainly focused on increasing knowledge and experience regarding technical care interventions. However, simulated patients (SPs) have become popular in medical education over the past two decades and focus predominantly on relational skills. Most commonly the SP is a trained actor or a patient who has been prepared for simulation and the learner plays their own (current or future) professional role, practicing the skills required for that position without any risks to a patient. There is also another very different approach to SPs in which the student/professional can adopt the role

of a patient or care recipient in order to develop an insight into their experience, with the intention of increasing their empathy for the population they interact with in their current or future professional roles. What appears to be common to the development of these interventions is a need to provide an educational experience which does not solely impart knowledge and theory but facilitates a deeper understanding of the lived experience of the patients or care recipient with whom they engage.

Compared to the literature relating to other forms of simulated learning there is only a small body of work published in this area which focuses mainly on training medical students (Crotty, Finucane & Ahern, 2000; Wilkes, Milgrom & Hoffman, 2002; Varkey, Chutka, & Lesnick, 2006; Pacala, Boult, & Hepburn, 2006; Zenni et al., 2006; Latham et al., 2011; Fornari et al., 2011), nursing students (Penny, 2008; Dearing & Steadman, 2009; Eymard, Crawford & Keller, 2010; Haddad, 2010; Tremayne, Burdett & Utecht, 2011), pharmacy students (Zagar & Baggarly, 2010; Whitley, 2012) and one example of residential care-givers (Vanlaere et al, 2012). It appears that to date, studies evaluating the impact of immersion into another's role in order to engender ethical practice are weak in methodology with poor generalizability. Robust research is required to substantiate the efficacy and effectiveness of this form of simulation-based education in relation to the moral/ethical competence of residential care-givers.

The Interventions

INTERVENTION 1 - Conventional ethics teaching within care homes
Six once monthly sessions will be facilitated in each care home in this arm of the study. These sessions will use a range of learning and teaching strategies including face to face teaching, directed reading, direction to online resources, role play, use of DVDs and situation-based discussions.

INTERVENTION 2 - Reflective ethics discussion groups within care homes
This arm will involve a series of meetings, facilitated by a specialist in ethics, in care homes to discuss ethical aspects of practice situations. Six once monthly sessions will be facilitated in each care home. This intervention provides space and time for care-givers to talk through an aspect of practice they find ethically challenging. It may be a situation where they felt they did the right thing or where they were unsure what the right thing to do was. In the group discussions there will be opportunities to try out different frameworks to enable participants to analyse different approaches to ethical reflection.

INTERVENTION 3 - Experiential learning – immersing participants in a care recipient's role
The experiential arm of the RIPE project is informed by an intervention developed and delivered within a care ethics lab 'sTimul' in Belgium (Vanlaere et al, 2012). Care-givers will have the opportunity to play the role of an older person's care home resident according to the profile they adopt for the simulation. Each simulation session will last for one and a half days in the simulation suite at the University of Surrey (including one overnight stay) and will include discussion groups facilitated by an ethics expert. Students in the second year of their adult nursing studies at the University of Surrey will be approached to play the role of 'care-givers' within the simulated care home.

Evaluation Methods

The impact of three educational interventions will be evaluated quantitatively and qualitatively:
1) Moral Sensitivity Questionnaire (MSQ) (Lutzen et al 2010, Kulju et al 2013) – primary outcome;
2) The Work-Related Moral Stress (WRMS) Questionnaire (Lutzen et al 2010);
3) Ethical Leadership Questionnaire (ELQ) (Langlois et. al., 2104)
4) The Interpersonal Reactivity Index (IRI) (Davis 1980, Davis & Franzoi, 1991)
5) Semi-structured individual interviews with a sample of participating care-givers, managers/leaders pre and post intervention;
6) Focus groups with a sample of care -givers post intervention.

Sample Size

Table 1, below, gives the smallest difference in mean total MSQ score change from baseline to one month post-intervention between any two selected pair of interventions that can be found significant with a 2-sided 5% level test with 80% power. This smallest difference has been calculated for a number of different scenarios to enable a final selection to be made of numbers of care homes to be enrolled into the study (the scenarios are numbers of care homes, for each of which the smallest difference is listed for 5 different scenarios of between subject data variability (standard deviations of (sigma) 1.5, 2, 2.5, 3 and 3.5). The calculations have been carried out assuming,

Table 1: Standard Deviations (SD) and statistically significant changes for varying care home sizes.

No. of n/homes	SD1.5	SD 2.0	SD 2.5	SD 3.0	SD 3.5
8	2.62	3.49	4.36	5.23	6.1
12	2.14	2.85	3.56	4.27	4.98
16	1.85	2.47	3.08	3.7	4.32
20	1.65	2.21	2.76	3.31	3.86
24	1.51	2.01	2.52	3.02	3.52
28	1.4	1.86	2.33	2.8	3.26
32	1.31	1.74	2.18	2.62	3.05
36	1.23	1.64	2.06	2.47	2.88
40	1.17	1.56	1.95	2.34	2.73

additionally, 8 participants per care home and an intra-cluster correlation coefficient of 0.3. This is based on Lutzen et al (2010), which quoted MSQ group mean differences as low as 1.5, and the figures in the table. It was decided to enrol 28 nursing homes into the study (14 in Surrey, 14 in SE1)

Recruitment of Care Homes

Twenty-eight residential care homes from Surrey and South East London will be recruited to the RIPE study. As 8 care-givers will be required to participate in the study from each home we will only approach care homes with at least 20 beds, we anticipate that smaller care homes would not have sufficient staff numbers to release 8 care-givers for an educational intervention. The participant information sheets inform staff that participation is dependent on there being sufficient number of staff within their care home willing to take part in the project.

Ethical Considerations

The RIPE project proposal and accompanying documents (participant information sheets, consent forms and recruitment text) were submitted to the University of Surrey Ethics Committee for ethical review. A favourable ethical opinion was obtained.

Data Analysis

Interviews and focus group data will be analysed using thematic analysis as described by Braun and Clarke (2006). This is a six- phase process:

1. Familiarising yourself with the data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

An analysis of variance (ANOVA) will be carried out as follows for the primary study objective: testing whether there is a difference in mean total MSQ score between any one of the 3 active intervention groups and the control group at one month post-intervention against a null hypothesis of no difference. The dependent variable in this ANOVA will be the individual subject one month post-intervention total MSQ scores for one of the interventions and for the control. Independent variables in the ANOVA will be the corresponding baseline total MSQ measurement and an indicator variable for intervention vs control (the estimate for this giving the intervention statistical significance).

Secondary objective statistical analyses will be carried out analogously using appropriate data subsetting and/or different questionnaire scores and considering data gathered at 3 months post-intervention.

Procedure

Managers of identified care homes will be sent a letter inviting their care home to participate and an information sheet on the project. The letter will advise managers that they will receive a phone call in one week's time from a member of the project team offering them a chance to request further information or ask questions and, if appropriate, to arrange a visit to the care home. If during the telephone call, the manager is interested in participation a visit to the care home will be organised. During this visit, permission will be sought to recruit eight care-givers from their care home to participate in the RIPE project, and with permission, a consent form will be signed. Managers will be given a set of selection criteria in order to identify appropriate care-givers for invitation to the project who have:

- Completed their induction to the care home;
- A contract to work at least 20 hours per week in the care home;
- Some flexibility in order to attend ethics education sessions during the week or at weekends.

Identified care-givers will be given a letter inviting them to take part, an information sheet on the project and a consent form.

When staff have been informed adequately, consent will be obtained from the first eight care-givers who are willing to participate in each home, arrangements will be made with the care home to collect baseline measures (the Moral Sensitivity Questionnaire, the Work-Related Moral Stress Questionnaire, the Ethical Leadership Questionnaire and Interpersonal Reactivity Index) and interviews (in selected homes). Permission has been sought to utilise the validated measurement tools. Following collection of baseline measures the care home will be randomised and the care-givers who have consented to participate in the study will be given details of their ethics education intervention. Those in the control group will not receive details of an intervention.

Immediately following the interventions, all participants (including student nurses from the experiential learning arm) will be given feedback forms to collect their perception of the experience and their views on what they have learned.

One month post-intervention the Moral Sensitivity Questionnaire, The Work-Related Moral Stress Questionnaire, the Ethical Leadership Questionnaire and Interpersonal Reactivity Index will be distributed to all participating care-givers. Care-givers within the homes selected for interview will also be invited to participate in a follow-up interview.

Three months post-intervention the Moral Sensitivity Questionnaire (primary outcome measure) will be distributed again to participating care-givers. In selected care homes a focus group will be run within the care home in order for participants to discuss the perceived impact of the specific intervention they have experienced, any change in culture within their organisation as a result of the study and any support they require in terms of developing/maintaining ethical practice in the future.

At the end of the study the International Care Ethics Observatory at the University of Surrey will host a one day conference where all participants and the managers of participating care homes will be invited to hear presentations of the results, as well as offering their own experience of participation and contributing to the planning of future research in the area. All care homes and care-givers who participate in the RIPE study will receive a certificate of participation at the close of the study.

Conclusion

At the time of writing, the RIPE Project research team are recruiting care homes to the project. The project interventions, data collection and analysis will run until December 2016. The research team would welcome communication with researchers interested to replicate the study. A detailed version of the study

proposal outlining in more depth the recruitment process and the three study interventions is available to those interested to conduct the study and to compare data with the University of Surrey team.

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