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<th><strong>Title</strong></th>
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<tr>
<td><strong>Authors(s)</strong></td>
<td>Donnelly, Sarah</td>
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<td><strong>Publication date</strong></td>
<td>2019-10-15</td>
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<tr>
<td><strong>Conference details</strong></td>
<td>HSE National Safeguarding Office Learning &amp; Development Seminar 2019, The Strand Hotel, Limerick, Ireland, 15 October 2019</td>
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<td><strong>Item record/more information</strong></td>
<td><a href="http://hdl.handle.net/10197/11351">http://hdl.handle.net/10197/11351</a></td>
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ETHICS AND ETHICAL DECISION-MAKING IN ADULT SAFEGUARDING

HSE NATIONAL SAFEGUARDING OFFICE
LEARNING & DEVELOPMENT SEMINAR 2019

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VALUES

• The regard that something is held to deserve, the importance or preciousness of something

(Values) A person’s principles or standards of behaviour: one’s judgement about what is important in life (New Oxford Dictionary of English, 2001)
VALUES

A value determines what a person thinks he ought to do, which may or may not be the same as what he wants to do, or what is in his interest to, or what in fact he actually does. Values in this sense give rise to general standards and ideals by which we judge our own and other’s conduct; they also give rise to specific obligations.

(CCETSW, 1978:14)
PERSONAL VALUES: REFLECTION
(ADAPTED FROM BECKETT AND MAYNARD, 2013)

• Take a few minutes to reflect on your personal values. Think about beliefs you have about what is ‘right’ and ‘wrong’.

• Identify three of your most dominant personal values

• Where in your life do you think these values have come from?

• Consider how your values might differ if you were brought up in a different culture or a different time in history?

• How have your personal values influenced your decision to become a social worker?
HOW IMPORTANT ARE ETHICS IN CONTEMPORARY CULTURE?
(ADAPTED FROM BECKETT AND MAYNARD, 2013)

- Clothing?
- Buy Fairtrade?
- Abortion?
- Testing on Animals?
- Capital Punishment?
- Ethics of War?
- Euthanasia?
1. **Theories of Moral Philosophy**
   - Utilitarianism, Deontological, Teleological, Virtue, Care Ethics
     (Principle based or Character based)

2. **Traditional Values** - Biestek’s Casework Relationship (1961)

3. **Contemporary Emancipatory Values** (e.g. Thompson, 2000)
TELEOLOGICAL THEORIES

Teleios – brought to an end or purpose.

• Not based on duty or principle, but looks at the consequences that follow from the act.

“The rightness of any action is determined by the goodness of its consequences.” (The end justifies the means)

• Utilitarianism – when faced with a dilemma perform an action which will produce the greatest good.
DEONTOLOGICAL OR NORMATIVE ETHICS

“Deontos” – of the obligatory

- e.g. Rules, rights and principles are sacred and inviolable.

Deontological Theories

- Kant Universalism
- Aristotle Virtue Ethics
KANT’S MORAL PRINCIPLE 1785 (D)

I ought never to act except in such a way that I can also will that my maxim should become a universal law (Deontological)

Act in such a way that you always treat humanity whether in your own person or in the person of any other, never simply as a means but always at the same time as an end.
"All our knowledge begins with the senses, proceeds then to the understanding, and ends with reason. There is nothing higher than reason."

Immanuel Kant
The basic idea of utilitarianism is very simple – that the right action is that which produces the greatest balance of good over evil... However the principle of utility on its own tells us nothing about whose good we should promote, that is, about the distribution of the good.

(Banks, 2001)
Helen a lady whom you are working with is exhibiting severe behavioural and psychological symptoms of dementia including psychosis, sleep disturbance, disinhibition and physical aggression and requires placement in a specialist dementia unit which will cost €2 million per annum.

- Should this money be used to pay for Helen’s care or should it be used to provide a Home Care Package of 14 hours p.w. (€322 x 52=16,744 per package) to 120 community based people with dementia?

Application of different philosophical Models:

- **Deontological** – (emphasis on self-determination and individuality)
- **Utilitarian** - for the greater good of society, the funding should go to pay for Home Care Packages
- **Consequentialist** - would consider the outcome/consequences of either option
DEFINING ETHICAL DILEMMAS

An ethical dilemma may arise when a practitioner is faced with two or more competing values such as justice and equality, or confidentiality and protecting life (Dolgoff et al. 2009, p8)

An ethical dilemma is usually defined as a choice in which any alternative results in an undesirable action. When for example, we guarantee confidentiality to a client, who tells us something that endangers others, we have an ethical dilemma. If we uphold the confidence, we may contribute to harming others. If we violate the confidence, we violate our trust. Whatever we do, we seem to be ‘in the wrong’ (Rhodes, 1991, Pxi)
CHARACTERISTICS OF AN ETHICAL DILEMMA (ALLEN, 2012)

1. An individual, ‘the agent’ must make a decision about what course of action is best.
2. There must be different choices of action to choose from.
3. In an ethical dilemma, no mater what choice of action is taken some ethical principle is compromised (there is no perfect solution!)
ETHICAL DILEMMAS / COMPETING VALUES

Ethical dilemmas can occur between:

• Societal values and personal / professional values

• Competing personal and professional values

• Personal, professional and organisational values

Need to separate out and prioritise these conflicting values (Eby, 2000)
Implicit argumentation involves an internal dialogue, whereby the practitioner talks and listens to him/herself.

This internal dialogue involves interpreting events, monitoring one's behaviour, and making predictions and generalizations.

It is more intuitive and automatic, and this type of dialoguing to oneself has tremendous value because it can increase the practitioner's level of self-awareness.
• Research indicates that just because a professional code of ethics exists, *it does not automatically guarantee ethical practice.*

• Explicit argumentation involves a clear and explicit argumentation process that leads to the ethical decision.

• In other words, *the social worker must provide specific and explicit justification of factors for a particular course of conduct* regarding an ethical dilemma.

• Explicit argumentation is like *an internal and external documentation of one's course of action.* One can explain very clearly to oneself and others why one made the choices.
WHAT IS AN ETHICAL DILEMMA?

(Allen, 2012)
‘ETHIC’ DECISION-MAKING MODEL (CONGRESS, 1999)

- Examine personal, societal, cultural, client, agency and professional values
- Think about the various UN Declarations on rights, code of ethics and any laws or agency regulations
- Hypothesise different courses of action based on varied decisions
- Identify who is most vulnerable and who will be harmed or helped
- Consult with supervisors and colleagues
Suggested procedure for ethical decision making (CORU, 2019)

• Identify the problem and gather as much information as you can. Ask yourself if it is an ethical, professional, clinical or legal problem.

• Review the Code of Professional Conduct and Ethics and identify the relevant parts. Check other professional guidelines too, such as those of the Health Service Executive or government departments, as well as any relevant legislation.

• Discuss the issue with professional colleagues being mindful of your obligation to respect the confidentiality of the service user.

• Consider asking your professional body for advice.

• Evaluate the rights, responsibilities and welfare of everyone affected. Remember that your first obligation is to the service user.
Suggested procedure for ethical decision making (CORU, 2019)

• Keep notes at each stage of the process.
• Consider different solutions and decisions.
• Evaluate and document the potential consequences of each option.
• Choose the best solution or decision based on your professional judgment.
• If you have any concerns about the legality of your chosen course of action, seek professional advice at the earliest opportunity.
• Put the solution or decision into practice, informing all the people affected.
• Remember that you are accountable, as an autonomous practitioner, for the consequences of the solution or decision that you choose.
WHAT DO WE KNOW ABOUT HOW DECISIONS ARE MADE IN ADULT SAFEGUARDING?

• Killick and Taylor (2012)- in clear or extreme cases, practitioners are prepared to follow procedural guidance but, when faced with complex ethical dilemmas, they may act more autonomously using assessment/relationship skills.

• Adult Safeguarding referrals in relation to older people were more likely to be acted upon than those in relation to learning disability or physical and sensory impairment (Trainor, 2015).

• Self-determination prioritised over concerns about protection (Preston-Shoot & Wigley, 2002). Contradictory practitioner responses to the question of reporting safeguarding concerns against the wishes of the person perceived to have been harmed. (Graham et al., 2016).

• Practitioners may need more time to undertake investigations in conjunction with strong supervision which focuses on the uncertainties of an individual’s ability to safeguard rather than whether they have cognitive/decision-making capacity (Mackay, 2017).
RELATIONSHIP BASED PRACTICE AND DECISION-MAKING

• Ethics of Justice: if someone is assessed as having capacity, can exercise self-determination and are capable of choosing to live with harm, even if that harm is severe (Mc Dermott, 2011).

• Ethic of Care: need to consider the more sophisticated concept of ‘human interdependence’ (Tronto, 1993, p.102). Establishing a relationship with the person in the hope that over time, and through building trust, that changes could be negotiated which could potentially reduce the level of risk (Mackay, 2017).

• Sometimes harm cannot be avoided if an adult’s informed choices are to be respected (McDermott, 2011; Preston-Shoot and Cornish, 2014).

• Decision-making skills cannot be assessed on levels of cognitive impairment alone (Brown, 2011); capacity is both decisional and executional in nature (Braye, Orr, and Preston-Shoot, 2011)
IN VOLVING SER VICE-USERS IN DECISION-MAKING

• Older people have expressed reluctance about divulging possible harm due to fear, anxiety and shame (Mowlam et al. 2007). Potential negative outcomes when abuser is partner, or family member.

• People with a disability reluctant to disclose abuse - interpreted as them being incapable of living independently (Faulkner, 2012).

• Poor mental health and anxiety can stop people seeking help and impact on their ability to process information and advice provided (Improving ASP participation Project Team, 2013).

• The way that decisions are framed, and by whom, may also have a significant impact on how such information is processed and used by decision-makers (Hedberg et al., 2007; Donnelly et al. 2013).
MAKING SAFEGUARDING PERSONAL (MSP) Participation of adult at risk and wider society (Lawson, 2014)

In all jurisdictions, the participation of the ‘adult at risk’ is a central principle of the safeguarding process.

MSP centres on engaging with people about the outcomes they want at the beginning, working with the person to achieve these outcomes, recording outcomes in their own words.

Person felt more empowered and in control of their safeguarding experience.

Greater professional discretion. Enhanced discussions. Greater expertise, more extensive managerial support, and time needed.

Social worker involved was more positive about their role as an advocate and the outcomes for the client.

MSP enabled staff to have more open discussions with adults at risk which helped the safeguarding process to be more effective.
BARRIERS AND ENABLERS OF ASSISTED DECISION-MAKING FOR OLDER PEOPLE IN ACUTE CARE HOSPITALS:
A MULTI-STAKEHOLDER INQUIRY

PROMOTING ASSISTED DECISION MAKING IN ACUTE CARE SETTINGS FOR THE PURPOSES OF CARE PLANNING WITH OLDER PEOPLE (PADMACS)
“Without close attention to the mechanics of how supported decision-making is implemented, there is a risk that it will become another tick box exercise, more to serve a bureaucratic purpose than to provide genuine choice and control for people with disability”  Disability expert Dr Anna Arstein-Kerslake
PHASE 1 PMACs:
RAPID REALIST REVIEW

PHASE 2:
PRIMARY DATA COLLECTION
Engaging knowledge user’s perspective Practice informed evidence will help to re-fine the PT for care of older people in the acute healthcare setting.

Phase 2: Primary data collection (interviews n=40)

- Two acute care hospital sites.
- Doctors n=10
- Allied Health n=13
- Nurses n=3

Healthcare professionals

- Experience of recent acute care admission.
- Older people n=5
- Older people with a diagnosis of dementia n=4

Older people

- Experience as a family carer of an acute care admission of a person they care for.
- n=5

Family carers

The interviews were based on experiences of decision making with older people in the acute health care setting.

Content Analysis using the Programme theory from the RRR
Unfavourable climate for ADM

‘Well for me hospitals are frightening places. They are disabling places. And my own personal experience of public hospital has not been very good. I think for me the reason I have come to the conclusion that it hasn’t been very good … is that I was not just being listened to because of a diagnosis with early onset Alzheimers but to understand that I could make decisions for myself’.

Person with dementia

Favourable climate for ADM

‘They were so supportive; they were kind they were friendly they answered my questions. If I had my questions ten times over …they would give me the support. And they were very supportive of my family as well’.

Older person with dementia

‘She had a hearing impairment, so we had to get a very quiet room to help ensure that she absolutely understood everything’.

HSCP

Key characteristics : Favourable climate for ADM

✓ Strong shared vision driven by patient needs.
✓ The patient feeling empowered and remaining central in all decision-making practice.
✓ Taking time to get to know the person.
✓ Active engagement in providing the supports needed to assist decision making and care planning.

Guiding Principle1:
Practice that is informed by a shared commitment to person-centred care and shared decision making.
Guiding Principle 2

ADM is fostered in an acute care setting that operates strong interprofessional accountability and shared responsibility for patient care that is guided by a clear policy process.

Unfavourable climate for ADM

‘I suppose we (healthcare professionals) have all got different agendas you know’.

Allied HCP

‘the team the famous magical team you know … you can talk to any nurses and they say you have to talk to the doctor and team’.

Older Person

‘there were so many involved in decision making…..her primary team was orthopaedics; the renal team were involved too because of her on dialysis. So we said we would step back maybe, but we still were not able to evaluate her wishes… and they were never documented’.

Doctor – Team for Older Person

Favourable climate for ADM

I feel that we are under pressure here that it is hard to think to remember the patient’s kind of wishes as well. But I think we are good at that in general. But I guess that us where the team working comes in’.

Allied HCP

‘I think everybody was involved… I think from the patient perspective everybody was involved at the appropriate time’.

Doctor

Key characteristics: Favourable climate for ADM

✓ Interprofessional team-based approach.

✓ Shared understanding of roles and responsibilities.

✓ Distributed accountability & shared responsibility (collective expertise).

✓ Standardised approaches that are flexible and adaptable.
Unfavourable climate for ADM

I think probably in retrospect we had too many people..... And I think she became a little bit defensive, because you know the son and his wife were a bit emotional. …

And with all the people I think we probably overwhelmed her a little bit. And the conversation shut down from her side. She didn’t engage with the conversation at all. And we had to end it you know ....with no decision at that time.

Doctor

Favourable climate for ADM

After reflection and action plan (MDT meeting)

So then we had a couple of more discussions that we did on a more one to one level and left everyone else out of the room.....so it was a mixture of the medical social worker met with her a couple of times. I met with her a couple of times with the consultant. And then the case worker from the community came into meet her as well.

(We) took a different approach and I suppose different people bringing different perspectives. And giving her different bits of information and making sure she could digest the bits she was getting.

Outcome:
So we concluded that she had capacity to make the decision and she went home.
BARRIERS TO ASSISTED DECISION-MAKING IN ACUTE HOSPITALS (PADCAMCS, 2019)

- Medical jargon, discipline-specific or technical language
- ‘Best Interests’ or ‘Professional knows best’ approach for PWD
- No private/quiet space to have discussions
- Time and Timing
- Family vs Patient voice
- Environment
- Cognitive assessments
- Lack of recognition of skills and expertise of MDT
- Fluctuating capacity
- Lack of resources in the community
ENABLERs TO ASSISTED DECISION-MAKING IN ACUTE HOSPITALS (PADMACS, 2019)

• Supporting will and preference of the patient
• Information provision and opportunity to ask questions
• Time to build therapeutic relationship and trust
• Uninterrupted, private places for discussions
• Awareness and utilisation of skills of specialist MDT therapists to build capacity
• Slow stream rehabilitation for patient’s capacity to be fully maximised
• Continually reassess patient’s need for communication support or decision-supporter
SUPPORT FOR DECISION MAKING: A PRACTICE FRAMEWORK (BIGBY & DOUGLAS, 2016)

**Attention to communication**
Pitching information and communication at the right level – awareness of verbal and behavioural clues – checking back for understanding

**Education about consequences and practicalities**
Making it understandable, doing the research – presenting the options and pros and cons – explaining consequences of decisions and that priorities can be undermined by small decisions

**Listening and engaging to ensure all options are considered**
Attentiveness to will and preference – taking the time – using others as sounding boards

**Creating opportunities**
Active reframing that invites participation – providing a sounding board – acknowledging low expectations and building confidence – testing options – introducing and nurturing the seeds of ideas – bringing in others to trial a situation – creating distance to enable greater autonomy

**Breaking things down**
Breaking into smaller components that are shared across the person and supporter – teaching and shaping skills
Donnelly & O’Brien
Forthcoming (2019)

Falling Through the Cracks

THE CASE FOR CHANGE, KEY DEVELOPMENTS AND
NEXT STEPS FOR ADULT SAFEGUARDING IN IRELAND
CARE PLANNING MEETINGS/FAMILY MEETINGS

All people should be given the option to participate.

CPM’s should be used in a proactive way so that issues are anticipated and addressed before they reach a crisis level.

Use simple, clear language and avoid medical/technical (discipline specific) language.

Strive to maintain a conversational style/dialogue format that is two-way.

Tailor Information!

Consider number of people attending CPM.

Use the 'teach back method'.

Avoid usage of the third person grammatical.

Maintain good eye contact and turn to face the person when you are speaking to them.

Pre-Meeting Preparation

Skilled facilitator
CONCLUSIONS

• A social work value has little value unless it can be translated into ethical practice. Only to know about the Code of Ethics does not make one an ethical practitioner (Perlman, 1975).

• Critical role of Supervision. Focus needs to move beyond Case Management and to an opportunity to ‘reflect on and learn from mistakes’ (Banks, 2009; 39).

• Ethical Decision-Making Tools can help enable a more systematic, rigorous decision-making process.

• A person always enters the ethical decision-making process in midstream, influenced by his or her past experience . . . the ideal goal is to come to an ethical decision through a personal equilibrium in which emotion and reason are both activated and in accord (Callahan, 1988, p. 91).
Thank you for listening
Any Questions?