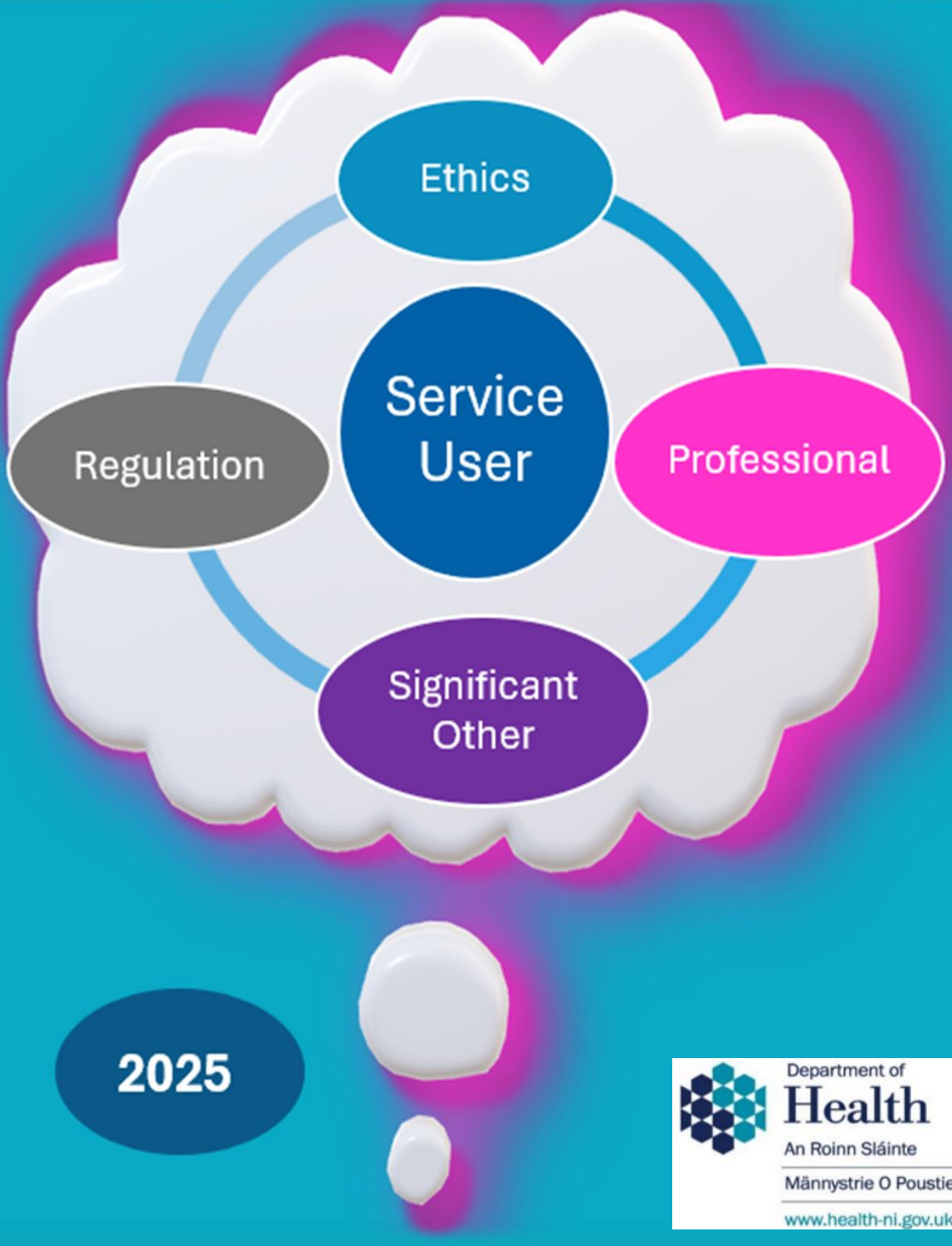
‘DECISION’

An Ethical Decision-Making Framework for Allied Health Professions in Northern Ireland



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Foreword

In the ever-evolving landscape of healthcare, Allied Health Professionals play a critical role in shaping patient experiences and outcomes. From Physiotherapists and Paramedics to Occupational Therapists and Dietitians, these professionals bring unique expertise and perspectives to multidisciplinary care. Yet, alongside the privilege of their role comes a profound ethical responsibility - to ensure that every decision is guided by the principles of compassion, equity, professionalism, and respect for the dignity of all individuals. This ethical decision-making framework is both a guide and a call to action. It invites Allied Health Professionals to pause and reflect amidst the complexities of clinical practice, where competing priorities, resource limitations, and diverse cultural and individual needs often challenge clear cut solutions. Ethical dilemmas are not just intellectual puzzles; they are deeply human challenges that demand courage, humility, and unwavering commitment to the values that underpin our professions.

This framework provides a structured yet flexible approach to navigating such dilemmas. It is designed to empower professionals to engage in thoughtful analysis, foster collaborative dialogue, and arrive at decisions that align with both ethical principles and evidence-based practice. By incorporating real world scenarios and practical tools, it seeks to bridge theory and practice in a way that resonates with everyday clinical experiences. The framework however is not just for moments of ethical crisis but is a resource for cultivating an ethical mindset in all aspects of practice. It encourages Allied Health Professionals to be proactive in considering the broader implications of their actions and to build cultures of accountability and transparency within their teams and organisations.

As we move forward in a world of increasing complexity and interdependence, this framework will stand as a testament to the integrity and dedication of Allied Health Professionals who strive not just to do what is effective, but to do what is right. It is my hope that this resource will serve as both a compass and a source of inspiration for practitioners who seek to navigate their responsibilities with wisdom, empathy, and fairness. Together, let us champion a healthcare system where ethical decision making is not an obligation but a shared commitment to the betterment of humanity.

Professor Michelle Tennyson
Chief Allied Health Professions Officer

Definition of Allied Health Professions

The Allied Health Professions (AHPs) represent the second-largest clinical workforce in Health and Social Care in Northern Ireland (NI). There are currently 14 registerable titles for AHPs and all are regulated by the Health and Care Professions Council (HCPC) : Dietitians, Occupational Therapists, Orthoptists, Paramedics, Physiotherapists, Podiatrists, Speech and Language Therapists, Diagnostic Radiographers, Therapeutic Radiographers, Art Therapists/Art Psychotherapists, Dramatherapists, Music Therapists, Orthotists and Prosthetists.

AHPs play a vital role across primary and secondary care, encompassing prevention, assessment, diagnosis, treatment, and intervention. They work both as independent practitioners and as key members of multidisciplinary teams, striving to achieve the best outcomes for service users.

AHPs are degree-level professionals, with many holding Masters level qualifications and possessing advanced skills and knowledge that enable them to undertake extended roles and responsibilities. They provide system-wide care across Health and Social Care services, as well as roles in Housing, Education, Justice, and the Independent and Voluntary sectors. Their holistic approach supports care throughout the life course, from birth to palliative and end of life care. AHPs focus is on prevention and improvement of health and wellbeing to maximise the potential for individuals to live full and active lives within their family circles and social networks. They also have invaluable roles in health improvement within education, training, and workplace settings.

Each AHP profession operates autonomously, with the ability to assess, treat, diagnose, and discharge patients. Their expertise and adaptability are crucial to transforming and modernising healthcare services.

Purpose and Context

> "Do what is right, not what is easy nor what is popular."
>
> *Roy T Bennett (Author)*

Purpose:

This framework was collaboratively developed by all stakeholders to provide a consistent and well-considered approach to ethical decision making for Allied Health Professionals (AHPs). AHPs frequently encounter ethical dilemmas and challenging decisions in today's complex healthcare environment, where increasing care needs and limited resources often create difficult situations. Many of these dilemmas involve ethical considerations with potential implications for professional practice.

In September 2024, the Health and Care Professions Council (HCPC), the regulator for AHPs, updated its 'Standards of Conduct, Performance and Ethics'. These updated standards emphasise equality, diversity, inclusion, communication, and the duty of candour. While healthcare professionals are expected to perform their duties in a moral and ethical manner and with an understanding of the law, it is important to recognise that moral standards are influenced by culture and experience, while professional standards shape ethical and legal responsibilities. By renewing their HCPC registration annually, AHPs reaffirm their commitment to uphold these standards.

Ethical decision-making however requires more than simply adhering to a code of ethics. While professional codes serve as important reference points, effective ethical responses are shaped by clinical experience, values, and a comprehensive understanding of the context. Decision-making processes whilst influenced by lived experiences and cultural dimensions, are also affected by therapeutic relationships, and interpersonal interactions. To support AHPs in navigating the complexities of modern healthcare, it is essential to understand the factors that impact ethical decision-making across different professional contexts and levels.

The framework has been developed to ensure that decisions are guided by core ethical principles such as, respect for autonomy, beneficence, non-maleficence, justice, confidentiality and accountability, whilst also aligning with professional standards, legal obligations, and incorporating cultural and resource considerations.

By fostering consistency and transparency, the framework supports AHPs in:

- Critically evaluating relevant laws, policies, guidelines, ethical principles, and professional values to uphold professional integrity.
- Prioritising the best interests and well-being of service users and their significant others.
- Promoting discussion of ethically relevant considerations with all stakeholders.

- Striving for solutions that balance ethical considerations with the best outcomes for service users.
- Ensure decision-making rationale is clear and comprehensive and promotes fairness and consistency.
- Collaboratively developing ethically appropriate plans that consider all implications.

The 'DECISION' framework empowers Allied Health Professionals to make informed, compassionate, and ethically sound decisions in complex healthcare environments.

Designed to enhance objectivity and consistency, the framework provides a systematic thought-provoking process to guide decision-making and a means to document decisions made in practice that support our commitment to serve and protect service users' best interests. When confronted with an ethical issue or dilemma, AHPs should systematically work through the steps outlined in the framework.

While this framework enhances ethical decision-making, it does not provide a definitive set of instructions for resolving every ethical dilemma. Rather, it serves as a guide and resource to support constructive conversations and inspire engagement in the pursuit of ethical solutions.

Context:

AHPs in Northern Ireland play a vital role in delivering safe, effective, and ethical care. As frontline practitioners, they frequently encounter complex ethical dilemmas due to the increasing complexity of care needs and resource constraints. Ethical decision-making requires sound judgment, professional integrity, and adherence to ethical principles.

September 2024 saw the Health and Care Professions Council (HCPC) update their published 'Standards of Conduct, Performance, and Ethics', which AHPs affirm to uphold by annually renewing their registration with the regulator. These updated standards and profession specific 'Standards of Proficiency' from the HCPC both recognise the importance of practicing within the legal and ethical boundaries of their profession.

Key Ethical Challenges for AHPs

AHPs must navigate ethical complexities in areas such as:

- Resource Allocation - Balancing service user needs and expectations, with service and resource limitations.
- Informed Consent and Autonomy - Supporting decision-making, using a shared decision-making approach and advocating for service users.
- Confidentiality and Data Protection - Managing information in line with General Data Protection Regulation (GDPR) and organisational policies.
- Interprofessional Collaboration - Working within multidisciplinary teams while respecting diverse perspectives.

- Equity and Access to Care - Addressing healthcare disparities and ensuring equity of access to care.

Developing the Ethical Decision-making Framework

The framework was developed as a Policy Fellowship project within the Chief Allied Health Professions Officer (CAHPO) team.

The first step was the design of a questionnaire survey which started from the identification of relevant items from literature searches and existing ethical- decision making frameworks from other medical professions. A thorough review of relevant literature was conducted to understand the concept of ethical decision making, ethical principles and medical law. This review included research articles, case studies and guidelines from healthcare professional bodies. They were analysed to identify key themes, principles, and obligations in relation to ethical law, decision making and human rights. The analysis also helped to identify key characteristics of principles and their practical application, to inform an ethical decision-making framework. The survey received a response from 259 AHPs across NI, with 85% reporting frequent ethical decision-making within their roles and 99% seeing the need for an ethical decision-making framework for AHPs (Appendix 2).

Subsequently the data from the survey was used to draft framework templates for discussion within focus groups. The purpose of the focus groups was to gather insights and perspectives on the content of the framework and envision its practical application in healthcare settings. These focus groups provided valuable information on the challenges faced in upholding these principles and how a framework to guide the process would be a helpful tool in addressing solutions. Two types of focus groups were held to work through the drafts. One type of focus group had representation from different AHP professions, specialities and Health and Social Care Trusts, the other from Public and Patient Involvement (PPI) groups, service user, carer, and voluntary organisations. Stakeholder engagement with AHPs, Public Health Agency (PHA), professional bodies, HCPC regulator, and AHP leaders was conducted. Working groups of AHPs used the framework to complete worked examples of ethical dilemmas that had been faced by AHPs in NI, gathered from the initial survey. This gives real world examples of the framework's application in practice (Appendix 5). Following this multifaceted process, that combined literature review, legal document analysis, surveys, stakeholder engagement, focus groups and working groups, this framework provides a comprehensive understanding. This process ensures that the framework has representative validity and reliability, and that it has been adapted to the social, cultural, and medico-legal specificity of Northern Ireland.

Aligning with Policy, Strategy & Professional Standards

This framework aligns with:

- The 'NI Health Minister's 3-Year Strategic Plan', which builds on the NI Executive's 'Making Life Better', highlighting the need to address wider health determinants, improve outcomes, and reduce inequalities: https://www.health-ni.gov.uk/publications/health-and-social-care-ni-three-year-plan
- The CAHPOs IMPACT Vision for AHPs, promoting trust, equity, advocacy and timely access to care: AHP IMPACT VISION (health-ni.gov.uk)
- HCPC standards, ensuring AHPs work within their legal and ethical boundaries.
- The 'Regional HSC Being Open Framework', supporting and enabling an open culture: Consultation on 'Being Open' Framework and Duty of Candour launched | Department of Health
- The proposed 'Hillsborough Law', Public Advocate and Accountability Bill, which emphasises transparency, candour, and public accountability for actions and decisions whilst following a code of ethics.
- The 'UK Allied Health Professions Public Health Strategic Framework 2025-2030', empowering individuals to make informed health choices.

The framework also enables AHPs to articulate and raise concerns and to seek resolution ensuring that the right decision is made first time. Prompting consideration of the impact of their proposed decision.

AHPs and Ethical Decision-Making: A Structured Approach

The framework provides a clear, practical guide to ethical decision-making that is:

- Patient-Centred - Prioritising service user rights, needs, and well-being.
- Evidence-Based - Grounded in ethical principles and legal standards.
- Reflective and Inclusive - Encouraging diverse perspectives and shared decision-making.
- Supportive and Practical - Offering structured guidance for real-world challenges.

By integrating ethical decision-making into daily practice, AHPs can uphold professional standards, maintain public trust, and contribute to a fair, effective, and transparent healthcare system in Northern Ireland.

> "Ethics is knowing the difference between what you have a right to do and what is right to do"
>
> *Potter Stewart (Associate of Justice US Supreme Court)*

Ethical Approaches

Allied health professionals practice is guided by ethical approaches, fundamental principles, and professional values that ensure safe, fair, and respectful care. Ethical decision-making is crucial, as AHPs navigate complex situations involving service user rights, professional responsibilities, and system constraints.

Ethical decision-making can be guided by different ethical theories or approaches:

1. Deontological Ethics (Duty-Based Approach): This approach focuses on following moral rules and professional duties, regardless of the consequences. These are the ethics of obligation, where 'no harm is permitted' even if it resulted in favourable outcomes. Choices based on these principles may be appropriate for an individual but do not benefit society as a whole.

2.Consequentialism: This approach emphasises the outcomes of actions. **Utilitarianism** is a type of consequentialism, where the best decision is the one that results in the greatest benefit for the most people. For example, if using this approach, a healthcare professional may prioritise resources for service users who have the best chance of recovery.

3.Virtue Ethics: This approach focuses on the moral character of the professional rather than rules or consequences. Professionals are encouraged to cultivate virtues such as compassion, honesty, and integrity.

4.Relational Ethics: This widely used approach relies on fundamental ethical principles (beneficence, non-maleficence, autonomy, justice, and confidentiality) to guide decision-making. This approach has been used to develop this ethical decision-making framework. This framework considers the interplay between ethical approaches, principles and values.

'DECISION' Framework

D

DILEMMA
- Is it an ethical issue and what is it?
- What are the key facts and who are the key stakeholders?
- Is the ethical dilemma complicated by a 'conflict of values': organisational, personal, professional, societal?
- Contextual factors : social, economic, cultural, legal i.e. urgency, resources, accessibilty, availability?

E

EVIDENCE
- Gather all relevant information: applicable legislation, policies, guidelines or resources that need considered?
- What does HCPC 'Standards of conduct, performance and ethics' say about this situation?
- Take account of Ethical Principles: Autonomy, Beneficence, Non-Maleficence, Justice, Confidentiality, and Accountability.
- What are service user and their significant others preferences and expectations?

C

CHOICES
- Evaluate possible resolutions or alternative actions that respect the autonomy of the service user.
- Co-produce a range of options (3 if possible): consider strengths / limitations or risks / benefits of each.
- Other opinions from e.g. colleagues / supervisor /multidisciplinary team /professional body?
- Considerations regarding dignity, quality of life, safeguarding?

I

INCLUSIVE
- Reasoned decision considering all options.
- Shared decision-making.
- Equal opportunity of access to healthcare.
- Respect for individual needs, fair and non-discriminatory.

S

SOLUTION
- Consent: Informed /Voluntary /Capacity /Acting in best interests /Mental Capacity Act /Advanced Care Plan.
- Select option that supports the best outcome for service user, aligns with ethics and professional standards.
- Document the rationale for your decision for transparency and accountability.
- Contemplate the impact / implications for significant others and service resources.

I

IMPLEMENT
- Support the service user throughout the whole process and with the implementation of the solution.
- Support their significant others throughout, particularly with the impact / implications of the solution upon them.
- Implement decisions taking consideration of possible challenges and duty of candour.
- Bear scrutiny: would others consider it ethical or appropriate?

O

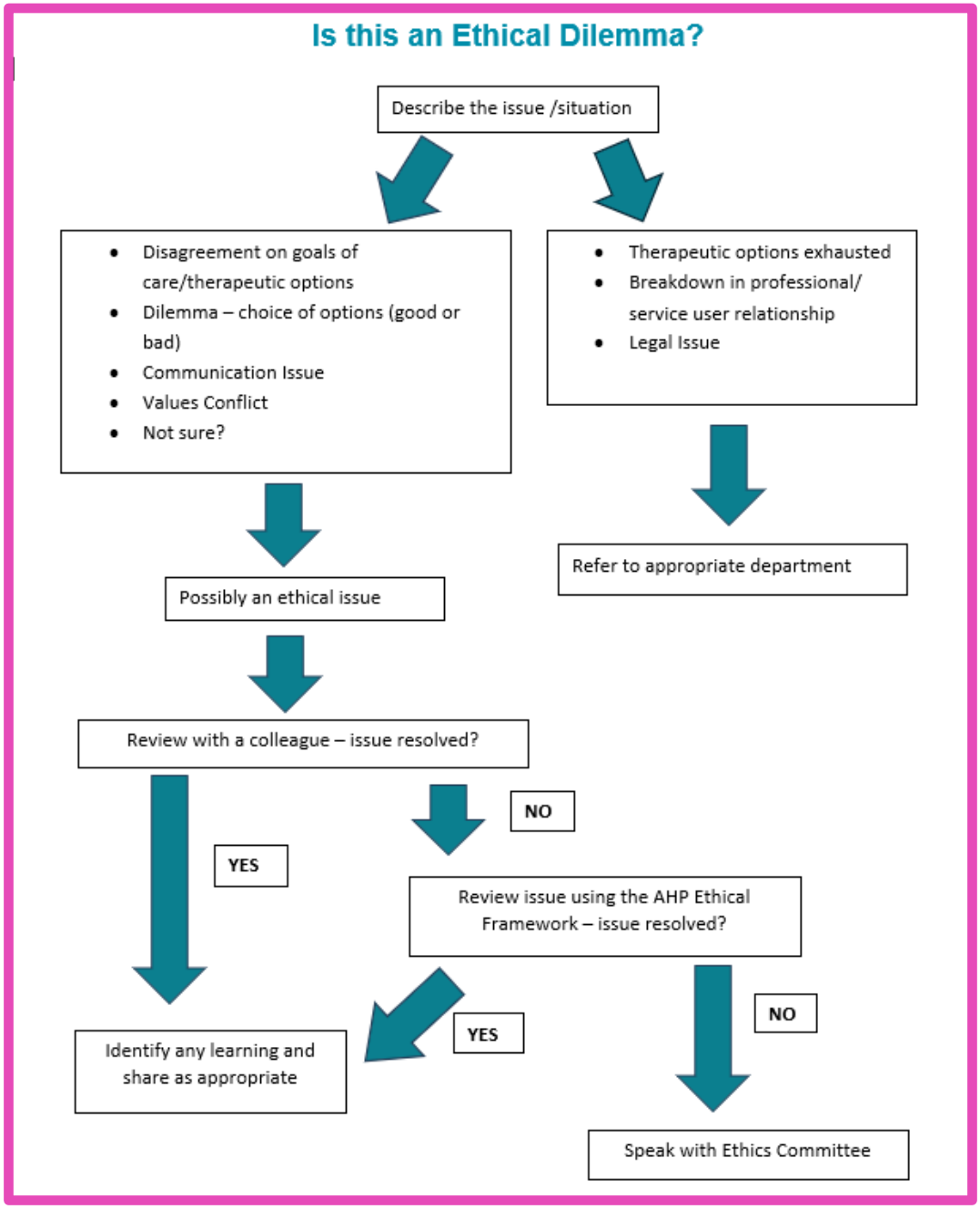
OUTCOME
- Review solution as required and reflect on the outcome for service user and their significant others.
- What might you have done differently to produce a better outcome?
- Implications for individual AHP, team, profession, policy?
- Be considered an example of good practice for future decisions i.e. would it be appropriate for others to do this now?

N

NEXT STEPS...
- De-brief, reflection, supervision, team discussion.
- Support colleagues / team with process, learning and reflection.
- Moral distress – support for individual AHP; Health and Well-being resources / Counselling.
- Share any learning; disseminate as appropriate with team, profession, organisation.

Step 1: Dilemma

Is it an ethical issue and what is it? Step one is to decide is this actually an ethical dilemma, or could it be a breakdown in the therapeutic relationship or a legal issue? By using the flowchart below AHPs can discuss the issue with a colleague and decide if it constitutes an ethical dilemma, and hence whether working through the steps of the 'DECISION' framework is required. If an AHP identifies ethical issues that causes them concern about the impact and that they cannot resolve individually, or in discussion with colleagues, by identifying solutions within existing guidelines and codes of practice then these should be escalated within their structures for discussion and resolution.



What are the key facts and who are the key stakeholders? Note the key facts in relation to this specific issue and identify all key stakeholders.

Conflict of values: ORGANISATIONAL, PERSONAL, PROFESSIONAL AND SOCIETAL factors. Is the dilemma complicated by a conflict in these values/factors?

Contextual factors: Circumstances in each situation can vary considerably. Each profession and setting have their own unique challenges. It is important to include the environmental circumstances at the time decisions are made, alongside the key facts. These can include social, economic, cultural or legal factors. Should a query or complaint be received at a later date, decisions relating to conduct will be made in the context of the prevailing conditions at the time. Such conditions may include urgency/time available to make decision, needs of other service users, availability of services, access to services, access to other specialist colleagues, time at work, availability of rest/meal breaks, availability of resources, indicative competing demands (including personal circumstances if relevant), service user cultural or religious beliefs and staffing ratios. Whether cost should be a factor in clinical ethical decision making can intensify as resources become scarcer.

Step 2: Evidence

Relevant information: The second step of the framework requires gathering of all relevant information, such as, applicable legislation, policies, guidelines or professional resources, that relate to this specific issue.

Regulators standards: Consider the issue with regard to AHP regulators the Health and Care Professions Council (HCPC) "Standards of conduct, performance and ethics": The Health and Care Professions Council

Ethical principles: Key Principles of medical law and ethical principles of, Autonomy, Beneficence, Non-maleficence, Justice, and Confidentiality, influence ethical and legal guidelines for AHPs. AHPs need an awareness of the legal liabilities and the importance of obtaining voluntary, informed consent. Both service users and professionals, benefit from AHPs understanding the principles of law and their significance in protecting the rights and well-being of patients.

Autonomy: This principle emphasises the importance of the service user's right to make decisions about their own health. It establishes that service users have the right to refuse or accept treatment and that their decisions should be respected if they have had the opportunity to make an informed choice.

Beneficence: This principle requires AHPs to act in the best interests of the service user and promote their well-being. It emphasises the responsibility of the AHP to provide the best possible care to the service user.

Non-Maleficence: This principle requires AHPs to do no harm to service users. This principle requires a duty to not cause any unnecessary harm and to minimize risks.

Justice: This principle emphasises fairness and equity in the distribution of health care resources. It determines the equitable distribution of health care resources and services based on need and availability, without discrimination or prejudice.

Confidentiality: This principle emphasises the importance of maintaining and protecting service user's confidentiality and information. AHPs are required to maintain confidentiality of service user information unless disclosure is required by law or necessary for care.

Service user and significant other preferences and expectations: It is important to ascertain and document the service users wishes, preferences and expectations of your service. Person-centred care means understanding patient preferences and incorporating them where practicable, it does not mean all service user demands must be met. When they cannot be met, it is important to manage patient expectations.

Step 3: Choices

AHPs need to take the time to ask questions, gather information, and consult resources, as these steps will enable consideration of a variety of meaningful solutions. What is the goal? Ideally, the goal is to resolve the situation and prevent future similar problems. AHPs then need to co-produce up to three possible options, examining the strengths/benefits and weaknesses/limitations of each. Service users and their significant others are active participants in any decision, this is autonomy. This autonomy requires service user wishes to be upheld, as far as is reasonably possible and achievable, whilst balancing all other aspects of the decision-making process.

Links to the AHP professional bodies can be found below for professional opinions:

www.BAPO.com

www.sor.org

www.rcpod.org.uk

www.rcot.co.uk

www.rcslt.org

www.collegeofparamedics.co.uk

www.orthoptics.org.uk

www.baat.org

www.bamt.org

www.badth.org.uk

www.csp.org.uk

www.bda.uk.com

Dignity: The principle of respect for human dignity and human rights forms the duty of a healthcare professional and helps to determine the service users trust in their service. However broad this principle may be, it is the standard that creates trust in the therapeutic relationship. It helps to prevent depersonalisation in the AHP / service user relationship and promotes respect for individualised care.

Quality of life: Enhancing quality of life is as important as any other healthcare measure and impact upon it should always be considered when discussing options.

Safeguarding: Safeguarding covers a broad range of activities and is an integral part of care. Duties to safeguard service users are required by professional regulators, service regulators and supported in law. It is important to document any safeguarding measures in place and raise any concerns if suspected.

Step 4: Inclusive

Shared Decision Making (SDM) is a collaborative process where service users, carers, and healthcare professionals make informed choices together. This approach improves health services and outcomes both personally and strategically. In May 2022, the Department of Health formally endorsed SDM through a Policy Circular, requiring Health and Social Care Trusts to implement new NICE Clinical Guidelines. The Public Health Agency (PHA) and the Strategic Planning and Performance Group (SPPG) oversee regional implementation.

Benefits of SDM

- Ensures people understand treatment options, including benefits and risks.
- Empowers individuals to make informed decisions, including opting for no treatment.
- Respects varying levels of engagement in decision-making.

Impact of SDM: Research shows SDM helps people:

- Understand decisions and consider what matters most.
- Feel supported and confident in managing care.
- Follow agreed treatment plans and improve health behaviours.
- Make the best use of available services.

NICE SDM Resources: To support SDM, NICE provides:

- SDM Baselining Tool for HSC organizations.
- Patient Decision Aids (PDAs) to help individuals align choices with personal values.
- SDM Standards Framework to assess PDA quality.

For more information, visit the Engage website available on the engage website. Further information on the NICE Clinical Guideline for SDM can be found on Shared decision making | NICE guidelines | NICE guidance | Our programmes | What we do | About | NICE

Non-discriminatory: It is important to note that when considering direct and indirect discrimination, that all service users, irrespective of background matter equally. However, that does not necessarily mean that all will be treated the same. Particular care should be given to ensuring that individuals are not discriminated against especially during decisions about treatment options, including availability or allocation. Decisions pertaining to protected characteristics that have no evidenced implication on likely survival/ “capacity to benefit quickly” such as age, religious views, disability including mental or learning difficulties are likely to be unlawful.

Step 5: Solution

Consent: Informed consent, the process of providing all necessary information to patients so they can make decisions about their medical care, is a fundamental aspect of service user autonomy. It is a general legal and ethical principle that valid consent must be obtained before commencing an examination, starting treatment or physical investigation, or providing personal care. This principle reflects the right of individuals to determine what happens to their own bodies and is a fundamental part of good practice. An AHP who does not respect this principle may be liable both to legal action by the person and action by their regulatory body.

Mental Capacity Act: In the United Kingdom (UK) the Mental Capacity Act (MCA) of 2005, sets out the legal framework for making decisions on behalf of individuals who lack the capacity to do so themselves. This act highlights the importance of respecting service user autonomy and ensuring that decisions are made in the best interests of the individual, adhering to the principles of beneficence and non-maleficence.

Advanced Care Planning: Advance Care Planning (ACP) is a process that emphasises reflection, choice and communication. Advance Care Planning is an umbrella term covering personal, legal, clinical, and financial planning. It enables a person to think about what is important to them and plan for their future. It is a voluntary process and helps a person to make known what their wishes, feelings, beliefs and values are, and to make choices that reflect these. It should be an important part of life for all adults. It needs to be encouraged by those providing care, support or treatment, to ensure that people have the opportunity to have timely, realistic and practical conversations.

Select the option: that supports the best outcome for the services user and aligns with ethics and professional standards. Document rationale for selection (Appendix 3). Contemplate the implications and impact of the decision for the service user, significant others and service resources.

GDPR: The European Union (EU) General Data Protection Regulation (GDPR) is a comprehensive data protection law that applies to the processing of personal data in healthcare settings. This protects an individual's right to privacy and confidentiality. This regulation promotes confidentiality, privacy, and justice in medical law.

Resources: Time and resources do not allow every person to have the 'best possible' treatment or service. People in similar situations should normally have access to similar health care. When deciding for one, we need to consider the effect that will have on others. Limited resources, and the legal obligation to stay within budgets, mean that AHPs need to have an approach that strikes the right balance between the use of resources that meets population need and taking account of the differing requirements of service users. AHPs must ensure that resources are used to provide the greatest benefit to the largest number of people. Our organisations cannot fund all types of healthcare that might be requested for our population and, as a result, difficult decisions must be taken to determine priorities.

Step 6: Implement

Ensure that you support the service user, significant others throughout the entire decision-making process and through the implementation of the solution. Particularly in regard to implications and impacts of the decision on both them and others.

Duty of candour: This value is described as a commitment to "being open and honest with each other and acting with integrity and candour": guidance and resources on candour and being open for health and social care staff and for service users, their families and carers in other jurisdictions

A core purpose of being open is to encourage learning from mistakes and develop better systems that help improve patient safety and quality of care. Alongside the possibility of the introduction of statutory instruments to require candour within HSC, there is the recognition that staff and organisations need support and direction to develop an open, just and learning culture. The NI HSC currently have a consultation on a "Being Open Framework" which will provide guidance in this area: Being Open Framework consultation | Department of Health

Clear and open to scrutiny? Decisions and the way they are made should be transparent, consistent, and easy to understand, and open to public scrutiny.

Step 7: Outcome

Review the solution as required and reflect on the outcome for all stakeholders. What might you have done differently to produce a better outcome?

What an AHP chooses to do, or not to do, has implications and consequences not only for that individual but also their profession and AHPs as a whole. Prior experiences of service users have the potential to heavily influence a service users view of both the individual profession and AHPs in general.

Would this solution be considered as an example of good practice? Would this be appropriate for others within your profession or other AHPs to do this now? Does this solution and the decision-making process used have implications for health care policy?

Step 8: Next Steps…

Debrief / Reflection: Experiencing ethical dilemmas has been linked to moral distress and burnout. A template for de-brief and reflection is included in Appendix 4.

Moral Distress: AHPs are not immune to the challenges of healthcare and must prioritize their own well-being and that of their colleagues. Stress management techniques such as mindfulness, debriefing, and psychological support; through discussions with colleagues, managers, or professional and spiritual resources; can help mitigate risk. Sustained high workloads, fatigue, and emotional strain can impact decision-making quality, making mental wellness and seeking support essential, especially in high-pressure or crisis situations. AHPs must be able to stand by their decisions, and using an evidence-based, systematic approach like the Ethical Decision-Making Framework can support both well-being and professional integrity. Healthcare organizations offer various resources to assist employees (Appendix 9).

Moral Injury: For AHPs occurs when they experience profound psychological distress after witnessing, participating in, or being unable to prevent actions that conflict with their ethical or professional values. Unlike moral distress, which arises from external constraints that prevent ethical action, moral injury involves a deeper sense of guilt, shame, or betrayal; either by oneself, colleagues, or the healthcare system.

For AHPs, moral injury can result from:

- Being forced to prioritise resource allocation over patient needs.
- Witnessing substandard care due to systemic failures.
- Feeling unsupported in ethically challenging situations.
- Experiencing burnout or compassion fatigue while trying to uphold standards.

Left unaddressed, moral injury can lead to emotional exhaustion, disengagement, and even long-term psychological effects such as PTSD, anxiety, or depression. Support strategies include reflective practice, peer discussions, professional supervision, and access to mental health resources. A debriefing template resource is included in this document (Appendix 4), as well as some health and wellbeing resources.

Health and Well-being Resources

Staff can access their organisations intranet site to be signposted to a number of health and wellbeing resources or can seek a referral to Occupational Health services.

HSC Staff working in an organisation with access to the **INSPIRE** Employee Assistant Programme can contact Inspire 24/7 via their Helpline on **0808 800 0002** for telephone support or referral into structured telephone video e-counselling.

LIFELINE for anyone who is in crisis and experiencing distress or despair can call the Northern Ireland crisis response helpline on **0808 808 8000**.

MINDING YOUR HEAD has information, advice and support to help people in Northern Ireland look after and improve their mental health and wellbeing: http://www.mindingyourhead.info/

British Association for Counselling Website - Provides local information on counselling organizations and individuals who are accredited: BACP Register of Counsellors and Psychotherapists

HSENI website contains a list of counselling and support services contact details: support-services

Conclusion

Ethical decision-making is a critical skill for allied health professionals, ensuring they provide safe, fair, and patient-centred care. The welcoming of the 'DECISION' framework by the Health and Care Professions Council (HCPC) represents a significant step towards embedding ethical decision-making into the practice of Allied Health Professionals (AHPs) at all stages of their careers.

Integrating ethical education at both pre-registration and post-registration stages will equip AHPs with the tools to navigate the complexities they face and ensure that their decisions are grounded in ethical principles and professional integrity. Early exposure to an ethical decision-making framework will help to foster a culture of accountability and patient advocacy within their clinical practice.

Collaboration between the CAHPO team, the University of Ulster, HSC Trusts and the Clinical Education Centre to provide this education and training to AHPs will mean that AHPs will receive continuous ethical training. This approach will foster critical thinking, reflective practice and give AHPs the tools to manage ethical situations and moral distress. By developing local training and integrating ethical decision-making within interdisciplinary studies, AHPs are investing in a future where ethical practice is the norm, not the exception.Embedding ethical decision-making education throughout an allied health professional's career has the potential to improve patient outcomes, reduce ethical conflicts, and strengthen public trust and improve the culture within the professions.

Alongside the framework other tools to assist the implementation have been developed to enhance its practical application, ensuring that AHPs can apply ethical principles with confidence and consistency in real-world settings. A documentation template, the 'DECIDE' documentation, (Appendix 3) has been produced and is available in digital versions for Encompass and other electronic systems. A template guiding reflection and debrief is also available (Appendix 4). Creation of a 'FutureNHS' platform for NI AHPs could facilitate the sharing of best practices and learning, creating a dynamic environment for collaboration and growth. The framework has the adaptability be applied and support ethical decisions in individual cases, profession-wide issues, and even on a strategic level.

Ultimately, embedding ethical decision-making throughout an AHPs career has the potential to elevate patient care, reduce ethical conflicts, and foster a culture of trust and accountability, in keeping with the framework's strategic drivers. With this comprehensive approach to implementing the 'DECISION' framework, AHPs can continue to demonstrate their commitment to not only providing high-quality care but also advancing the ethical standards that underpin a compassionate and sustainable healthcare.

Glossary

Accountability: Being answerable and responsible for the actions and decisions you make. It is an essential part of providing safe, effective, and trustworthy care services.

ACP: Advanced Care Planning, offers people the opportunity to plan their future care and support, including medical treatment, while they have the capacity to do so.

Autonomy: The principle that actions are ethically right if they comply with a person's self-determined choice.

Confidentiality: The principle of keeping sensitive information private and ensuring it is only shared on a need-to-know basis.

Beneficence: 'Doing good.' Obligation to help someone in need, treat people autonomously and contribute to their welfare.

Bias: A frame-of-mind, perspective, point of view, or inclination. This can be affected by a person's beliefs, values, educational or social background, assumptions, demographic characteristics, and life experiences. Bias is important to recognise and acknowledge because it affects one's opinions and views on what is right and wrong and is highly influential in decision-making.

Capacity: The ability to understand information relevant to a decision and to appreciate the foreseeable consequences of choosing to act or not to act. Capacity is specific to each decision and capacity can change over time.

Consent: A person's agreement to, or permission for, a proposed action, particularly any form of examination, care, treatment, or support.

Dignity: How people feel, think, and behave in relation to the worth or value that they place on themselves and others. To treat someone with dignity is to treat them as being of worth and respecting them as a valued person, taking account of their individual views and beliefs.

Dilemma: A problem that arises when there is a choice to be made, with no obvious reason to prefer one option over the other; a choice between two or more conflicting options, or a choice between two options that cannot both be carried out.

Duty of Candour: statutory requirement of healthcare providers, such as the NHS, to be open and honest with a service user and/or their significant others when an incident causes or has the potential to cause harm.

Ethical conflict: Tension that arises when there is a choice to be made, especially when two (or more) values must be weighed and ranked, and a decision made on which is most important in the situation.

Ethics: The study of morality and moral life; a system for deciding what is right and what is wrong. A systematic way of evaluating values and actions.

Informed consent: Voluntary agreement reached by a capable client based on information about foreseeable risks and benefits associated with the agreement.

Justice: Obligation to provide equitable access to care and ensure fairness in resource allocation.

MCA: Mental Capacity Act (2005), provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

Moral distress: The negative feelings that occur when one knows the right thing to do; but is prevented from doing it through some barrier or constraint. This leads to the sense that one has compromised their integrity and can cause significant personal emotional reactions.

Non-Maleficence: 'Doing no harm.' Obligation to prioritise patient safety.

Principles: Rules or norms that guide behaviour; often a starting point for considering ethical problems and may lead to more specific rules of conduct in some contexts.

Stakeholder: Diverse individuals, groups, or organisations that have an interest in the services provided by AHPs and their outcomes e.g. AHPs, service users, healthcare managers, regulators.

Service user: A person, family, group of persons, client, patient, association, or community on whose behalf an AHP provides or agrees to provide a service.

Significant Other: Carer, relative, partner, neighbour or friend who looks after the service user, they provide care and support that is unpaid.

Uncertainty: Indecision, lack of clarity, when one is unsure of what the ethical problem actually is, and/or which values or principles apply in a situation. This often arises as a sense of something not being quite right, and there may not be anything concrete to suggest what it might be.

Values: A person's individual perspective, opinions, beliefs, and views about what is important. Values guide actions by suggesting what is most important when decisions are made. Values are highly individual, and ethical conflicts often arise when values must be ranked in importance in order to decide the right thing to do.

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This framework has been produced by Bernie McGreevy on behalf of the Chief Allied Health Professions Officer, Department of Health as part of the CAHPO Policy Fellowship Programme.

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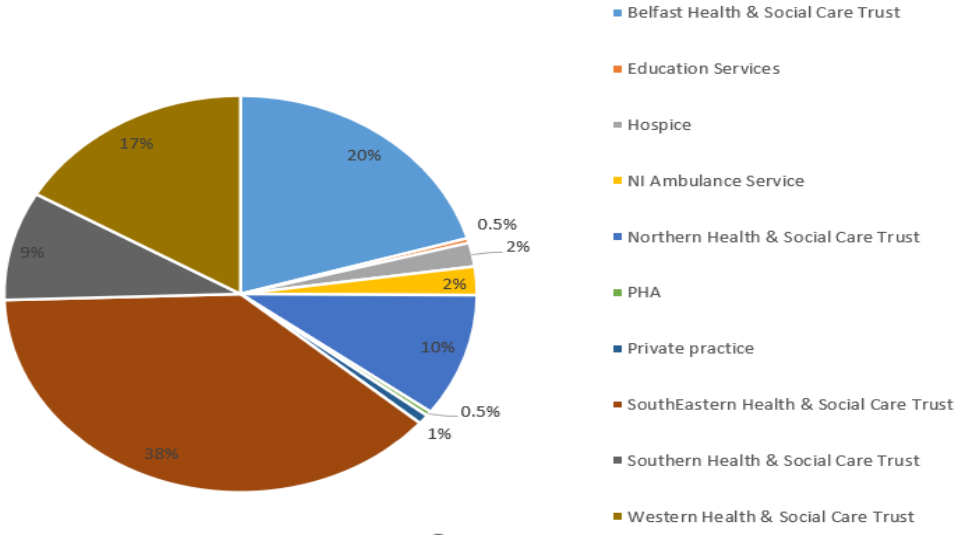
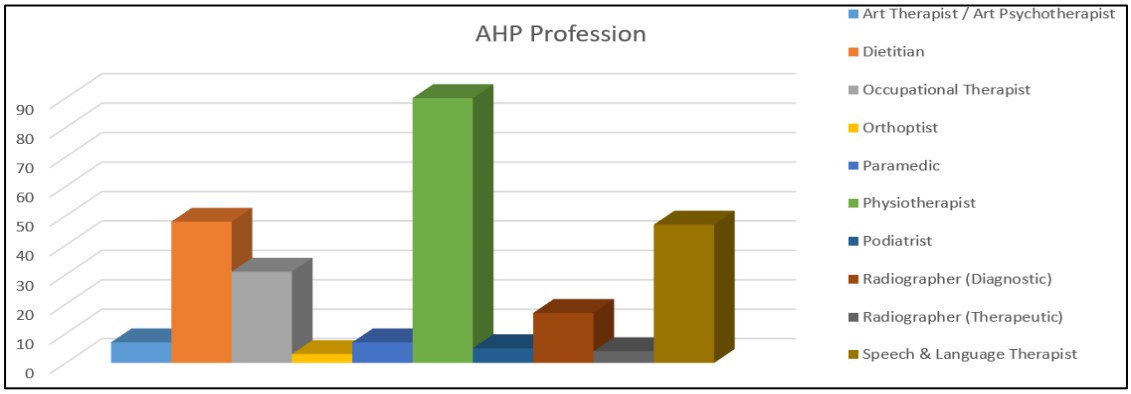
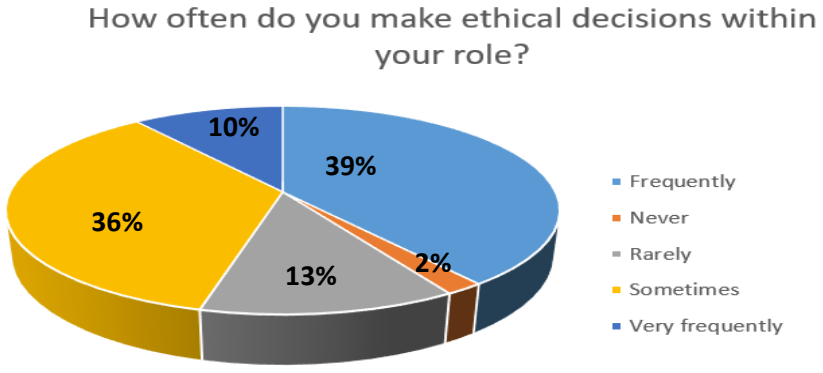
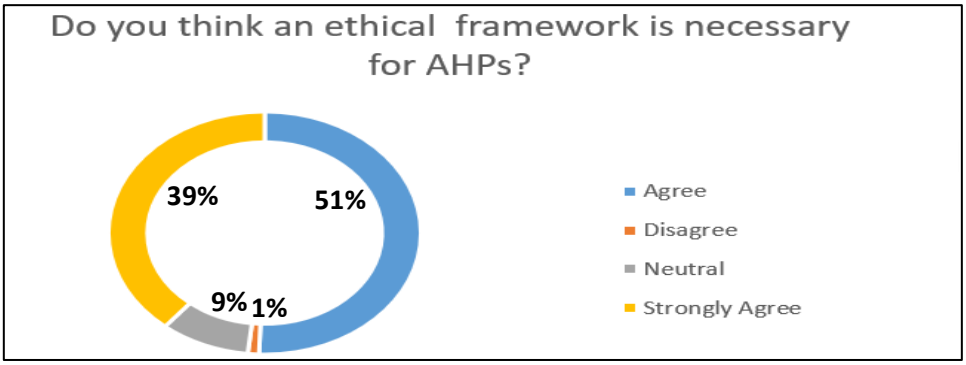
Appendix 2: AHP NI Survey results summary

Where is your AHP role based?









Appendix 3: 'DECISION' Documentation template

'DECIDES' Steps	Date:

DILEMMA	(Detail: issue, key facts, conflict of values, stakeholders, context)
EVIDENCE	(HCPC standards, policies, guidelines, legislation, ethical principles, preferences – both service user and significant others)
CHOICES:	(Consider 3 options: risks / benefits, strengths/limitations, opinions, dignity, quality of life, safeguarding) **1.** **2.** **3.**
INCLUSIVE	(Shared-decision, equal access, individual needs, impact, implications)
DECISION	(Consent, explain how decision supports best outcome for service user, implications for service user and significant others)
EVALUATION	(Review and reflect on outcome, support given to service user and significant other)

Appendix 4: 'DECISION' Reflection / Debrief template

'DECISION' Framework Reflection / Debrief

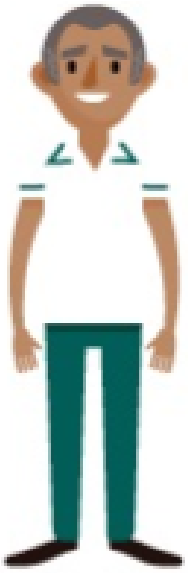
Date of situation:
Name / Role / Organisation:
Brief description of situation:
How has this impacted you, your thoughts / feelings?
List / describe what went well?
List / describe what did NOT go well?
What else could have been done / done differently?
Recommendations for improvement for future similar situations:
Signed / Dated:

Appendix 5: 'DECISION' Worked Examples

'DECIDE' steps WORKED EXAMPLE ONE

DILEMMA	Client A is a 20-year-old young man with Global Developmental Delay (GDD), Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD) and Epilepsy. Recently transitioned to Adult LD service – lives with foster mum. Options being explored for placement but will be shared care. Can mobilise independently for short distances with an unsteady gait. AFO's and Piedro boots in place. Sensory processing difficulties identified - vestibular, proprioception, visual, auditory and tactile. Positive Behaviour Support Plan (PBSP) in place. He finds loud and high-pitched noises difficult and this can result in exhibiting behaviours that challenge. Other triggers for behaviours that challenge include, demands being placed on him, hunger, people in his personal space, sensory aversions, frustration, constipation, and waiting. Escalation of behaviours without warning signs and escalate quickly. Physical aggression: Biting, nipping, scratching and pushing. Self-injurious behaviour: Throwing self to floor/onto wheelchair, head-banging (low level), biting his own hand (has broken skin), hitting himself on the head, 'thrashing' in wheelchair. Environmental damage: Swiping items off surfaces, throwing items (including food) and overturning items in his proximity. OT involved re: safely accessing the community and appropriate wheelchair prescription to meet needs of Client A and caregiver. Conflict of values identified – harm to client if triggered, injury to care giver, limiting social opportunities, prescription of powered wheelchair may be considered restrictive and over prescription. Stakeholders: Client A, Care giver, OT, OT and wheelchair services, MDT
EVIDENCE	Restrictive Practice Policy Three Steps to Positive Practice Eligibility Criteria and clinical guidelines for the provision of wheelchairs NI. 'Equal Lives' Review of Policy and Services for People with LD in NI. Human Rights Legislation HCPC Standards Client A: Acting in best interests Care giver: Anxious about social settings but also poor quality of life if restricted activities.
CHOICES	1. Has standard manual wheelchair prescription with power pack operation for attendant. Option to continue with this arrangement, however issues raised: Risk of injury to Client A or caregiver due to rocking behaviour, risk of tipping wheelchair as not robust. Limitations - Caregiver anxiety about above therefore reducing opportunity for social outings for Client A means decreased quality of life. 2. Explore option for attendant powered wheelchair. Is this an over prescription when looking at eligibility criteria? Client A is still mobile, therefore consider thresholds for acts of restraint, apply best interest principles and collaborate with MDT. Is this reasonable and proportionate? Attendant powered wheelchair range will provide heavy duty options, therefore more robust. Will alleviate physical burden on caregiver as not required to lift heavy power pack on/off for transport. Ultimately will increase opportunity for safe community

	outings with caregiver if trial successful, therefore improving quality of life. Will require careful risk assessment and management and continual review under restrictive practice guidelines.
INCLUSIVE	MDT discussion, collaboration and agreement that prescription of attendant powered wheelchair in best interests of Client A and due diligence undertaken around restrictive practice. Impact: Will result in increased community outings, improved quality of life, integration into local community, and caregiver is supported to continue caregiver role. Caregiver consulted throughout process and wishes taken into consideration and presented to MDT.
DECISION	Need agreement by OT governance panel and MDT to explore trial of attendant powered wheelchair. Taking into consideration best interests and restrictive practice principles. Decision will support caregiver to continue caregiver role and will improve quality of life for Client A to ensure that he has continued opportunity to safely access his local community and social outings. Resource cost implications for service considered but outweighed by quality-of-life benefits for Client A and for care giver.
EVALUATION	Need agreed by OT governance panel and MDT to explore trial of attendant powered wheelchair, taking into consideration best interests and restrictive practice principles. Decision will support caregiver to continue caregiver role and will improve QoL for Client A to ensure that he has continued opportunity to safely access his local community.



'DECIDE' steps WORKED EXAMPLE TWO

DILEMMA	Miss P is 16-year-old with diagnosis of dysphagia. She has been having recurrent chest infections from aspirating her food and fluids. She is keen to continue eating without any modifications. Her parents are struggling with keeping her well and upholding her wishes. She has been referred to speech and language therapy (SLT) for assessment. Legal implications for providing food that is known to be incompatible with SLT recommendations (although Miss P is 16 her parents will be doing shopping/meal planning/meal preparation). Potential for harm to parents if anything happens to Miss P as a result of the decisions made. Stakeholders: Miss P, her parents, SLT and others from multidisciplinary team involved in care.
EVIDENCE	RCSLT position paper on EDAR, regional and national guidance NI EDAR resource Age Majority Act legislation, 16-year-old can consent to medical care if competent Clinical evidence from detailed assessment of swallow and highlight risks of aspiration for SDM (e.g. severity, frequency, long term implications), may include instrumental swallow assessment Autonomy: respect Miss P's wishes, provided she understands risks Beneficence: Acting in Miss P's best interests, highlight implications on health and possible legal consequences for parents of not following recommendations. Non-Maleficence: Avoiding aspirations and their complications, harm to parents legally. Justice: Equitable access – to assessment and MDT for Shared Decision Making (SDM)
CHOICES	1. EDAR on regular diet, thin fluids -in line with Miss P's wishes. Plan for managing complications. Benefits: Respects autonomy, maintain enjoyment and QoL. Risks: High risk of aspiration, chest infections, hospital admissions, mortality. Morally challenging for parents to support as potential to become unwell and possible legal implications for parents if something happens to Miss P due to not following SLT recommendations. 2. Fully modified diet or non-oral feeding options. Benefits: potential better health outcomes, in line with SLT recommendations, no legal ramifications for parents as following recommendations. Limitations: Not respecting autonomy, parents not supporting wishes, reduced or no oral intake, reduced EDS skills, negative QoL impact, compliance if against wishes. 3. Mixture of modified diet and fluids / alternate feeding and normal diet and fluids. Benefits: allows flexibility, potentially improves QoL, normal in social settings, potentially reduced chest infections and complications, not completely against wishes of Miss P or parents. Limitations: Compromise, restrictions on diet, not fully in keeping with wishes.
INCLUSIVE	SDM to discuss reasons for disliking modifications, compromise options, free water protocol outside of mealtimes, focus on mouthcare, naturally thick fluids. See food unmodified form first then modify to make safer. Education of Miss P and parents on aspirations and benefits of modification. Full consideration on Miss P's and parents' wishes using SDM approach. Discussion on impact on health, align goals of treatment and expectations. SLT open and transparent that unable to quantify level of risk for options so all have *potential* harm. Facilitate open discussion in safe environment to reach consensus.
DECISION	If Miss P selects Choice 3 – compromise considering all opinions using SDM process. Patient centred whilst protecting health and considering all stakeholders wishes Miss P is primary decision maker, her autonomy and QoL are central. Her parents have a vested interest in her health. SLT responsible for providing clear, unbiased advice, informing decisions and minimising harm. Clearly document assessment, recommendations and discussions of SDM process and agreed plan. Include contingencies for revisiting decisions if changes in health or circumstances
EVALUATION	Review of swallow, recommendations, and plan. Linking with MDT and GP e.g. input for management of aspirations, chest infections or possible hospital admissions.

'DECIDE' steps WORKED EXAMPLE THREE

DILEMMA	Mr A is 78-year-old gentleman who lives alone, with the support of a carer twice a day. The carer placed a '999' call at 19:30 reporting that Mr A appeared unwell and unsteady on mobilising. On assessment, it is deemed that Mr A is showing clinical signs of a low-grade infection. Whilst requiring further assessment and treatment, the condition does not warrant conveyance to ED at this time. Mr A makes it clear that he does not wish to leave his home and wants people to go, stating that he will be fine if he can just be assisted into bed. Mr A is adamant that he does not want his son to be contacted. Paramedic concerned as there is a potential for the condition to worsen and is unsure of Mr A's ability to manage safely, including his ability to escalate, if necessary. Paramedic not content to leave Mr A alone without giving a full explanation of concerns and risks involved. Paramedic needs to ensure Mr A has the capacity to make a reasoned decision regarding his care. Context: Choices are based on the presenting acuity and accuracy of information available at that time from Mr A, Carer, care notes. Stakeholders: Mr A, carer, son, paramedics, GP
EVIDENCE	History from Mr. A & carer - with consent. Mr A lives alone- low grade Infection but already having effects on mobility- considerations for worsening during night- ability to maintain own safety and summon further help if necessary. Consideration also if Mr A has any pre-existing conditions/co-morbidities and that Mr A does not consent to family, friends (significant others) being contacted. **Mental Capacity Act Northern Ireland 2016** – reasoned, formal assessment of capacity **HCPC Standards of Conduct Performance & Ethics** - considerations of standards- 1,2,3,5,6,7,9,10. **HCPC Standards of Proficiency (Paramedics)** - consideration of standards- 1,2,4,5,6,7,8,9,10,12,13,14,15. **Joint Royal Colleges Ambulance Liaison Committee Guidelines** - Medical Emergencies in Adults +/- Sepsis Guideline. **NICE Clinical Knowledge Summary** - sepsis. **Safeguarding Referral / Policy** - consider criteria. **Ethical Principles** -Autonomy, Beneficence, Non-Maleficence: conflict with respecting Mr A's autonomy knowing that his decision risks him coming to harm.
CHOICES	Consent (to contact family to assist in shared decision making?) Complete formal, reasoned assessment of capacity prior to considering options – finds Mr A has capacity. Hospital at home services – further option, if criteria met. Consideration to discuss/review Mr A's case and potential choices. with someone from the Integrated Clinical Hub. Choices below are in order of clinician preference, to promote safety of Mr A. (N.B. Choices 1 & 2 could be blended.) 1. Reassure Mr A that will respect autonomy and not enforce any decision without his consent. Engage Mr A to discuss further. Clearly outline the concerns for his wellbeing and safety and gain consent to have some input/advice from GPOOH on his behalf. *Risks*- Mr A may still refuse. *Benefits*- allows discussion with GPOOH re: concerns for Mr A. *Strengths*- supports Mr A's dignity & autonomy *Limitations*- GPOOH may not be willing/able to visit/input into Mr A's care. GPOOH may advise transport to ED contrary to Mr A's wishes. 2. Gain consent to contact family, friend or significant other, to provide some help/assistance during night. *Risks*- Mr A may still refuse. *Benefits*- allows discussion with NOK outlining clinician's concerns for Mr A.

	Strengths- supports Mr A's dignity & autonomy. Potentially allows further fact finding providing a holistic overview of Mr A's medical and social history to help inform decisions about his ability to safely care for himself given his current clinical presentation. *Limitations*- Family/significant other/s may not be willing/able to visit/input into Mr A's care. Family/significant other/s may insist on transport to ED contrary to Mr A's wishes. 3. Respect Mr A's autonomy and leave. Provide and document worsening care advice (to include contacting GPOOH and family) and any relevant contact numbers. *Risks* - lives alone, may become more clinically unwell, more unsteady/confused. Will have no further contact from anyone until carer comes again in the morning. *Benefits/Strengths* - respects Mr A's opinion and supports his dignity & autonomy regarding decisions made about his care *Limitations* - no system exists that would allow follow up or checking in with Mr A, unless further 999 call is placed.
INCLUSIVE	Shared decision making, ensure choices are mindful of consent / co-production / collaboration with Mr. A. and, if consented, his family or significant other/s. Providing appropriate information will better empower and enable Mr A to be involved in decisions about his care. Educate Mr A on impact and implications if condition deteriorates and he is unable or unwilling to contact for help.
DECISION	All choices respect Mr A's wishes and autonomy about his care. Choice 3 acknowledges that although Mr A may make a decision which could result in a poor outcome, it doesn't mean that he does not have the capacity to make that decision. Importance of clearly outlining all relevant concerns and options to ensure Mr A has all the information he needs to support his decision making. Communication should be free from medical jargon and in a language that Mr A will understand. Implications: Mr A: - may recover fully with no further issues - may still deteriorate. There is also the potential for Mr A to fall/ sustain a traumatic injury or endure a 'long lie' which may further complicate his condition. The outcome of these complications may also lead to longer term changes in how Mr A manages in general or perhaps his ability to continue to live independently. Significant others may disagree with Mr A's decision. Worsening of his condition may cause distress for them. Any changes to his long-term management may require more help/input from significant others impacting on their lives also.
EVALUATION	On scene time with Mr A may be considerably more that 'normal' to facilitate review and discussion of presenting condition and to explore options for care and calls to stakeholders. Supporting the carer with any distress. Benefits of longer time on scene, allows ongoing review of clinical observations, assessment of needs/mobility/safety and building a rapport with Mr A to encourage engagement. Difficulty for clinician to 'walk away' from Mr A knowing that this may not be a good outcome- moral injury? Dealing with this type of situation is always a lot more challenging 'out of hours' when many services/options are not available. This situation may result in a complaint from GP or significant other. Potential for an adverse incident investigation. Decision for non-conveyance may not stand up to public scrutiny.

'DECIDE' steps WORKED EXAMPLE FOUR

DILEMMA	Mr A 78-year-old gentleman with end stage Parkinson's disease is admitted to hospital with community acquired pneumonia and his condition has deteriorated despite active management. He is now for end-of-life care. Family and staff are very distressed by noisy respiratory secretions and ring the on-call Physiotherapist. On your arrival he is not responsive to voice and showing no signs of distress, the family are asking you "to do something", staff are requesting you suction the patient.
EVIDENCE	HCPC standards of conduct, performance and ethics – 1,2,6,9,10 Consent guidelines, acting in best interests – patient unable to express current desires or wishes. Any advanced directives or advanced care plans in place? Has invasive interventions been previously discussed with patient/family/team. Ethical Principles – Beneficence: professional opinion, not likely to benefit patient. Non-maleficence: may cause trauma to soft tissues as invasive technique. Professional judgement – not likely to benefit patient with suctioning but want to maintain dignity and comfort, avoid further distress to significant others. If no advanced directive or care plan then acting in patients' best interests. Significant others and staff finding noise distressing. Stakeholders: Mr A, family, staff caring for Mr A, physiotherapist on-call
CHOICES	1. No suction – request medications for secretions e.g. glycopyrronium or hyoscine hydrobromide. Good mouthcare and positioning. Provide education/support for significant others and staff on why there are noisy secretions at end of life and how Mr A is not showing any signs of distress. Strengths – beneficence and non-maleficence, managing Mr A's symptoms with no risk or harm from invasive technique, explanation for secretions to family and staff to alleviate their distress. Weakness - may not have a significant change in noise. 2. Suction Mr A – strengths – may reduce noisy breathing temporarily, relieving distress for family, fulfils staff request. Weakness – may cause harm or distress to Mr A and provide no or temporary benefit. Ward staff unable to perform further suction when physiotherapist not available. Not in keeping with principles of beneficence and non-maleficence.
INCLUSIVE	If no ACP/ directive in place then acting in Mr A's best interests the physiotherapist should educate the family and staff on the reason for noisy secretions at end of life and that although they are hard to listen to, they are not distressing Mr A. The medications for secretions should be prescribed and administered and good mouthcare and positioning carried out. Impact: Explain that noise may not reduce and if Mr A does shows signs of distress the situation will be reviewed.
DECISION	Acting in best interests. Decision not to suction – choice 1 is most appropriate. Reassure significant others that Mr A is under constant review, can be reassessed if appropriate or situation changes.
EVALUATION	Family and staff aware that they can ask for reassessment as required. Look at training and education for staff on normal dying and symptom management at end of life. Introduce and encourage advanced care planning to those with palliative conditions and their families to help alleviate these types of distressing situations.

DECIDE' steps WORKED EXAMPLE FIVE

DILEMMA	Mr B is a 45-year-old gentleman. Married with 2 young children. Diagnosis of pancreatic cancer. Had Whipple's procedure 12 months previously and had seemed to be improving so had been discharged from Dietetics services. Now been referred for nutritional support following recurrence. Mr B does not wish to have any nutritional support as he feels it would prolong his suffering, as he has been told that his time is short. His wife disagrees with his decision to refuse nutritional support and is trying to give him more food thinking it will 'build him up', improve his strength allowing him to be able to do more with her and his children and improve his prognosis. Stakeholders: Mr B, his wife and children, dietitian, his healthcare team.
EVIDENCE	Mr's B personal choice to refuse input – principle of autonomy. Wife's wishes to have nutritional support. Professional opinion: Nutritional support is not compulsory, considered to be a treatment that can be given, withdrawn or stopped by patient themselves HCPC standards: 1,2,6,9,10. Evidence based practice Regional and local nutritional support recommendations, policies and guidelines
CHOICES:	1. No nutritional support Benefit: autonomy, wishes are taken into account and carried through. Limitation: loses weight, becomes less well, increase in fatigue, not able to interact with kids. Relationship with his wife may deteriorate; may shorten prognosis. 2. Limited nutritional support e.g. which could be a small additional snack Benefit: may not lose as much weight therefore may be not as fatigued, may mean he can interact more with children and wife. Hopefully would help wife in the situation and therefore relationship would remain intact; Limitation: compromise on his wishes, prognosis may not change. 3. Use shared decision-making approach and advanced communication skills to address the issue, explore thoughts and feelings. Benefit: Using this approach may change one of the other's viewpoints. Improved relationship and QOL. Chance to explore advanced care planning. Limitations: discussions may not change outcome but relationship hopefully will improve and they will both have information to understand each other's perspective.
INCLUSIVE	Shared decision-making process. Discussing implications for all involved of each of the 3 options. Chance to explore advanced care planning Holistic care, able to refer to others in the team to support Mr B and his significant others
DECISION	Has capacity, informed consent, explore consequences of decisions Select his choice to not have nutritional support Explore impact of choice on all stakeholders Opportunity for Advanced care planning
EVALUATION	(Review and reflect on outcome, support given to service user and significant other) Review Mr B even if refusal of nutritional support, to assess any change in situation. Support Mr B and his significant others Referral with consent, to other members of Palliative Care team as required e.g. SPC Social worker for supporting young children, counselling services

‘DECIDE’ steps WORKED EXAMPLE SIX

DILEMMA	Mrs W is 71 years old. She presents with a painful condition that will require further intervention. The condition is starting to impact on her quality of life and function. Interventions that your service can currently offer will be of little benefit. Routine waiting lists for further intervention are very lengthy. You are concerned her condition will deteriorate whilst she waits. Mrs W and her family are requesting that you prioritise her referral as urgent but she does not currently meet urgent criteria. Stakeholders: Mrs W, her family, onward service, your service
EVIDENCE	HCPC standards: 1, 2, 3, 5, 6, 9, 10 Integrated Elective Access Protocol DoH Criteria for services, guidelines, Trust policies, NICE guidelines on specific condition Any other services she can be signposted to, other care pathways? IMPACT vision for AHPs: Advocacy for access – provide information to support and empower people on waiting lists. Expectations and wishes of service user / significant other
CHOICES	Explanation of criteria, provide self-management and conservative measures, discuss case with onward team for advice, consider referral to other services/support – waiting well initiatives. Contact details if any change in circumstances. Apply for short notice / cancellation lists. 1. Unable to change priority – Risks: service users condition deteriorates and further impacts QoL and family life implications of increasing care needs. 2. Triage panel / MDT discussion– opinions of team re: service eligibility and prioritisation, risk assessment, safety implications, functional implications. 3. Consider referral to private options if available and affordable.
INCLUSIVE	Clear communication, open and transparent about criteria and eligibility. Provide as much support and advice as possible. Acknowledge criteria are in place to allow equity of services based on need, ethically cannot change priority on request to prevent waiting if criteria have been fairly applied. Risk assessment and clinical reasoning for prioritisation. Decision based on evidence and individualised on need. Case discussion if required.
DECISION	Advise service user and their significant others, cannot expedite referral on request against urgent criteria not being met. Empathise and address symptoms within scope of practice. Refer to other support/services, waiting well initiatives, as appropriate. Link with MDT re: condition and circumstances, providing contact details if any change that could lead to re-prioritisation. Re-assessment if required for change in status or following further request to expediate appointment.
EVALUATION	Support, advice and signposting, advocating for service user. Linking with MDT, GP and other services. Use communication skills.

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