UNDERSTANDING RISK: HEALTH PROFESSIONALS' DECISION MAKING

WITH FRAIL COMMUNITY-DWELLING OLDER ADULTS

by

Heather MacLeod

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Dedication Page

I would like to dedicate this research to my older adult clients from whom we can learn

about taking a risk and resilience.

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Abstract

This qualitative research study addressed the gap in the literature and lack of clinical guidelines and frameworks for health professionals as they assess and manage risk when balancing the safety and autonomy of community-dwelling older adults. Twelve health professionals were asked in individual interviews how they perceive, identify, assess and treat risk and how they negotiate the safety and autonomy of their clients. Informed by grounded theory methodology, the findings revealed what kinds of decisions health professionals made and how they made them within this clinical context. These findings from the perspective of the health professional contributed to the development of a definition of living at risk, a safety continuum and a conceptual/practice framework to help health professionals, including occupational therapists, make sound clinical decisions as they balance the autonomy and safety of their community-dwelling older adult clients.

my parents who instilled in me from a very early age the notion that with hard work I can do anything. This attitude helped me put one foot in front of the other during moments of emotional and mental exhaustion from working full-time and doing this research part-time. Lastly, to my dad who instilled in me a passion for life-long learning and who serendipitously in the 11th hour provided a key reflection during a 15-minute car ride to a book reading that enhanced my analysis.

Chapter 1: Introduction

About 85% of Canadians over the age of 55 plan to remain in their present home for as long as possible, even if there are changes in their health (Canadian Mortgage and Housing Corporation, 2008). With increasing age, disability and illness can affect an adult's independence and increase their health and safety risks (Dyer, Pickens & Burnett, 2007). A decrease in independence and health status may activate a community health response by involving a variety of health professionals who are asked to evaluate individuals whose mental status, patterns of self-care, judgment and decisions in financial and personal matters raise concerns about their safety and ability to live alone (Cooney, Kennedy, Hawkins, & Balch Hurme, 2004). In order to support the older adult who is experiencing a decline in health affecting function and prefers to remain at home, the health professional must know how to evaluate risk when safety is a concern. While the literature provides a variety of information on defining, identifying, perceiving, assessing and managing risk, the breadth of and inconsistencies in the literature suggest it difficult for health professionals to apply it to the clinical context of community dwelling older adults (Clarke, 2000; Gunstone, 2003; MacCourt & Tuokko, 2010; Moats, 2007; Patterson & Rosenthal, 1997; Purdy, 2010).

More specifically, occupational therapists are among the many health professionals who play a key role in supporting functional independence in the home for older adults (Clark Green, 2002). Occupational therapists are encouraged to employ a client-centered approach to care which means that the client's views, experiences, interests and safety are central to the process of assessment and intervention (Townsend et al., 2007) in contrast to a paternalistic approach to health care where the client's wishes

might be overturned or overridden for the sake of their safety. The Canadian

occupational therapy practice guidelines suggest that the "aim in occupational therapy is

to enable safe engagement in just-right risk-taking" (Townsend et al., 2007, p. 101),

however, they offer no specific framework on how to do this. Additionally, health care

professionals lack guidelines about how to proceed with clinical decision making, when

the client's capacity to make their decisions is questioned and has not been formally

determined (MacCourt & Tuokko, 2010). Respecting the client's goals in client-centered

care is relatively straightforward when the client is assessed as either competent or

incompetent to make decisions, but becomes more difficult when the client falls in the

grey area of marginal competence (MacCourt & Tuokko, 2010; Moats, 2007).

Some research has been conducted on the complex decision-making processes of

occupational therapists working on inpatient hospital wards in preparing for safe

discharges home (Crennan & MacRae, 2010; Moats, 2007; Reich, Eastwood, Tilling &

Hopper, 1998), but there is a lack of research about the complex decision-making

required by community occupational therapists to support older adults to continue to live

at home safely. Both the Canadian Association of Occupational Therapists (CAOT)

(2011) and Lang and Edwards (2006) acknowledge the need for more evidence on client

safety issues in the home.

The goal of this qualitative research study was to address this gap in the literature

and lack of clinical guidelines and frameworks for health professionals as they assess and

manage risk when making decisions around balancing the safety and autonomy of their

community-dwelling older adult clients. Twelve health professionals were asked how

they perceive, identify, assess and treat risk and how they negotiate the safety and

autonomy of their clients. The findings, from the perspective of the clinician, revealed what kinds of decisions health professionals made and how they made them within this clinical context. These findings contributed to the development of a conceptual/practice framework to help health professionals, including occupational therapists, make sound clinical decisions as they balance the autonomy and safety of their community-dwelling older adult clients.

This thesis is organized in the following way: I will first, in Chapter 2, review the literature on risk and clinical decision making, highlighting the persistent gaps; then in Chapter 3, I will review the details of the methodology used for this research study. Chapter 4 will highlight the findings that emerged from the interviews with the health professionals while Chapter 5 will discuss how these findings, from the perspective of the clinician, might inform a conceptual/ practice framework on risk and clinical decision making.

Chapter 2: Literature Review

The specific research question posed in this study is "*How do health professionals working with community-dwelling older adults, perceive, identify, assess and manage the client's risk?*" In order to understand how health professionals make clinical decisions around identifying, assessing and treating risk when trying to balance safety and autonomy, a general understanding of the concepts of risk and clinical decision making is needed. As the clinical context of this research study involves health professionals working with community-dwelling older adults, a specific understanding of the characteristics of this clientele and how they raise particular concerns regarding risk and decision making is also beneficial.

This chapter provides a review of the current literature on risk and health professionals' clinical decision making, and how these two concepts apply to older adults and more specifically to those who live in the community. This chapter will summarize the literature on these concepts and comment on the gaps as they relate to this research study. The chapter will begin with a review of the search strategy used to find relevant literature and then review the terms used to define this sub-set of older adults and then proceed into a review of risk. Finally, the chapter will review the literature on clinical reasoning and decision making.

Search Strategy

The literature for the foundational knowledge to support this research project was found in a number of ways. Both CINAHL and PubMed were used to search the following terms: aging-in-place, risk, risk assessment, risk management, risk perceptions, home safety, patient safety, balancing safety and autonomy, autonomy and older adults,

occupational therapy, home assessment, capacity, clinical decision making, clinical reasoning with limiters of community-dwelling older adults, vulnerable, age 65+ when the output of the search was large. The terms were searched individually when the output was small and in combinations when the output was large. Results from these searches provided secondary references. Other literature was found from the reference list of primary references. The authors Alaszewski, Titterton, Naik were searched separately in CINAHL as they are all prominent researchers in this field. This led to some recent articles in addition to some book references. The table of content of recent issues of Health, Risk and Society were perused for relevant articles. Google was used to search the term risk and this led to British government documents on risk within the health and social service departments. The reference list in these documents also provided additional articles.

Older adult users of community and specialized geriatric services.

The majority of older adults age well and are not in need of specialized community geriatric services and health care. However, when older adults start to experience changes to their physical health, mental health and/or functional status to the point that it impacts on quality of life, independent living and safety, they typically require specialized health care and in-home services. The research on older adults utilizing these services either does not define this specific subset of older adults who are not aging well or labels them as frail or vulnerable. Self-neglecter is an additional term used in the risk assessment and risk management literature involving community-dwelling older adults. All these terms are nebulous at best and may not be all encompassing. Having an understanding of frailty, vulnerability and self-neglect helps

health professionals understand the health care and service needs of this subset of older adults and helps them interpret how the findings of the research studies generalize to their clientele.

Frailty. Frailty is a term commonly used amongst health professionals within specialized geriatric services. Frailty is a concept that has a variety of definitions but "in most models of frailty, frailty is presented as a state of vulnerability or decreased capacity to respond to environmental demands, which in turn predisposes the individual to increased risk for adverse health outcomes"(Aminzadeh, Dalziel, & Molnar, 2002, p.83). The specific definition of frailty that is most applicable to the specialized geriatric services population is "a co-occurrence of complex bio-psychological and functional difficulties sufficient to compromise quality of life and threaten the capacity for independent living" (Ryan & Esbaugh, 2008, p.108). The term frailty is preferred by specialized geriatric services as it removes age from the defining characteristic of this clientele and focuses on the biological, psychological or functional reasons for which clients are typically referred to geriatric services (Ryan & Esbaugh, 2008). Therefore it is a term that describes older adults who are not only experiencing a decline in their health that is having an impact on their ability to live independently but a decline that is also predisposing them to future adverse health outcomes.

Vulnerability. Vulnerable in its general sense is "derived from the Latin verb, vulnerare, meaning, "to wound" (Aday, 1994, as cited in Alberta Health Services, 2011, p.2). The Alberta Health Services (2011) defines vulnerable populations as those, which have "increased susceptibility to adverse health outcomes as a result of disparities in access to the resources needed to handle risks to health" (p. 3) that all people experience.

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The vulnerable are susceptible to or at risk of harm, damage, loss, injury or victimization (College and Association of Registered Nurses of Alberta, 2005).

Within the literature on older adults, vulnerability is defined generically as being "65 years or older at increased risk of death or functional decline (Saliba et al., 2001, p. 1691)" or more specifically as "the failure to engage in acts of self-care that adequately regulate safe and independent living, or to take actions to prevent conditions or situations that adversely affect personal health and safety (Naik, Kunik, Cassidy, Nair, & Coverdale, 2010, pp. 614-615)". These authors further suggest that being vulnerable puts older adults at risk for neglect, exploitation, safety hazards, functional impairment, medical morbidity and death. However, these authors do not suggest that the older adult's vulnerability is as a result of a lack of access to resources.

Self-neglect. Naik and colleagues' (2010) definition of vulnerability is similar to the definition of self-neglect amongst older adults in the literature. Pavlik, Hyman, Festa and Dyer (2001) define self-neglect as "the failure to provide for one's self the goods and services which are necessary to avoid physical harm and mental anguish (p. 46)", while Tierney and colleagues (2004) define self-neglect as

> "the result of an adult's inability due to diminished capacity to perform essential self-care tasks such as providing essential food, clothing, shelter and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being and general safety and/or manage financial affairs (p. 1437)".

It is not surprising that these three terms are all used in the literature on risk assessment and risk management with older adults, as all three states (vulnerability, frailty, self-neglect) are considered to potentially lead to adverse outcomes, including, at the very least, dependent living. However, there are important differences in the way in

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which these terms are used, with respect to the underlying causes of the adverse outcomes envisaged and the term's focus. The cause of frailty and self-neglect resides within the individual while the cause of vulnerability resides outside of the individual due to a lack of access to resources. Frailty appears to focus on the impairments leading to a decline in function, whereas as self-neglect is a terminology used to describe both a process and an overt outcome of a decline in independent living. Vulnerability on the other hand focuses on a probability of increased susceptibility to some adverse outcome.

As all three terms describe either a state of increased risk for adverse health outcomes and/or functional impairment, it is also not surprising that they would be characteristics of the older adult sub-set, who are not aging well for whichever reason (lack of access to resources or health impairments) and who are the users of specialized geriatric health and community care. Rockwood's Clinical Frailty Scale[1] (Rockwood et al., 2005) shows the range of health states of older adults from very fit (stage 1) to terminally ill (stage 9). Based on this scales' description, the sub-set of community-dwelling older adults who use specialized geriatric health services and community care would most likely be categorized as vulnerable or mildly frail to severely frail. When the term older adult is used in this document, it is referring to the subset of older adults who may face increased susceptibility to adverse outcomes, who are 'vulnerable' to 'severely frail', and who may be self-neglecting.

Risk

What is risk? The Merriam-Webster online dictionary (2013) defines 'risk' as "the possibility of loss or injury", defines 'to risk' as "to expose to hazard or danger" and

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[1] For a version of the Clinical Frailty Scale please refer to
http://geriatricresearch.medicine.dal.ca/pdf/Clinical%20Faily%20Scale.pdf

defines 'at risk' as being "in a state or condition marked by a high level of risk or susceptibility". However, Carson and Bain (2008) highlight that risk is a commonly used complex term that does not have a consistent definition in the literature. They argue that the dictionary definitions, which focus on harm, likelihood and uncertainty, are inadequate for the clinical context of working with people in health and social care and criminal justice. This narrow focus on harm or hazards contributes to a safety first approach to risk which neglects the appreciation of the positive outcomes of risk (Aleszewski & Aleszewski, 2002; Carson & Bain, 2008; Titterton, 2005). These authors advocate for a broader definition where both the positive and negative outcomes of risk are equally considered. Carson and Bain's (2008) suggested broader definition of risk describes risk as an occasion when either beneficial or harmful consequences may occur under uncertain conditions where the number and the extent of the consequences and their likelihood is unknown. The business literature provides an even more succinct definition of risk: "risk is the effect of uncertainty on objectives where the consequences could vary from loss and detriment to gain and benefit (Purdy, 2010, p882)".

Generally, risk is a complicated concept as social and cultural factors influence risk perceptions (Titterton, 2011; Zinn & Taylor-Gooby, 2006); as risk has the potential for diametrically opposed (positive and negative) outcomes (Titterton, 2011); and as risk has a subjective experiential dimension (Titterton, 2011). Carson and Bain (2008) encourage a systems approach to understanding risk. These authors indicate that risk can exist along a micro-macro continuum and the concept of risk and corresponding risk assessment and risk management strategies differs depending on what focus is taken.

These authors report that if the focus of risk assessment and risk management is on the *person*, then this micro perspective suggests that people, things or circumstances are risky. Risk assessment then is targeted at gathering information about the person and risk management is about avoiding or preventing potential harms. Focusing on the person is consistent with the medical model. If the focus is on the *context* in which the risk occurs, then this suggests that the social setting in which the individual lives and interacts can be dangerous so the risk assessment and management interventions are focused on and within the social setting. This perspective is in line with a social work model. If the focus is on the *people who make or take the decision*, such as the front line staff, then it is the decisions that they make with or for their clients, which are considered potentially dangerous. This perspective suggests that risk taking is a skill that involves judgment and highlights that successful decision making occurs when the benefits of the risk are achieved and the harms are avoided. If the focus is on *dangerous management* then it suggests that the risk is caused by or made worse by decisions made by managers. For instance this could include management providing policies and procedures that support positive risk taking. Or this could include management creating a risk adverse or blaming culture, where the individual health professional might not feel supported by management and may make their clinical decisions to avoid litigation. Lastly if the focus is on *dangerous systems* it suggests that it is the systems and organizations, which make the situation risky. Here the authors are referring to the multiple organizations that can be involved with the client when risk is concerned. Each organization has a different mandate and perspective and can make a situation more risky if they are not able to all

work together on a common goal. For instance, the multiple social and health care organizations involved with community-dwelling older adults.

In summary, risk is a complex term that has a multitude of meanings dependent on its political, social and cultural construction and micro or macro focus of the user. For this reason, it is important to explore and understand the concept of risk as it pertains to health care and older adults.

How is risk perceived within health care? How risk is identified, assessed and managed is contingent upon how it is perceived. The literature acknowledges that we have become a risk-preoccupied society, seeing events through the lens of risk (Heyman, 2010). Heyman and Titterton (2010) acknowledge that risk thinking has also permeated health care but not because the world has become more dangerous from a health perspective. They suggest that a risk can only be acknowledged if the observer is looking through the lens of risk and that a risk never exists independently of the health professional's knowledge, beliefs and values in contrast to disease, pain and death which exist regardless (Heyman & Titterton, 2010). Titterton (2005) adds that risk within health care also exists due to health professionals' propensity to place a priority on safety due to a concern for the client and a fear of being seen as 'bad workers' should the person become injured under their care. In other words, health professionals may over-see risk in order to protect themselves and their clients from harm.

There are varying perceptions of risk between and among health care professionals, caregivers, and older adults. Given this, in order to appropriately identify, analyze and evaluate risk, health professionals need to be aware of their own perspectives and biases with respect to risk and must understand the client's and family caregivers'

perspectives as well. Deciding on what is risky behaviour, what is the likelihood of harm to occur, what is acceptable risk, and what is the potential severity of the harm are all subjective and based on personal values, beliefs and knowledge base. Therefore it is not surprising that clients, family members, and health professionals may all have different perspectives (Alaszewski & Alaszewski, 2002; Baker, Campton, Gillis, Kristjansson, & Scott, 2008; Clarke, 2000) especially as risk perceptions differ across generations (Alaszewski, 2010).

Health professionals have a general tendency to emphasize the physical domains of risk identification due to a knowledge base arising from past experiences and education in medical pathology (Clarke, 2000; Mitchell & Glendinning, 2007). However, it is possible that training in a specific discipline may also play a role in how risk is perceived and acted on. For instance, Clemens and Hayes (1997) concluded that since nurses are trained to be task oriented they were more apt to make snap decisions with regards to risk management compared to the social workers who are professionally trained to be process oriented were more apt to agonize over a risk decision. At the same time, individual beliefs, values and attitudes affect the decisions made by health professionals and influence their tolerance of degrees of risk (Clarke, 2000; Gunstone, 2003; Patterson & Rosenthal 1997). Woman health professionals were found to be more cautious and perceived risk to be greater (Gale et al., 2002; Ryan, 1998). Gunstone (2003) found that community mental health worker's tolerance for risk varied over time due to their personal and professional experiences.

The literature also highlighted that professional judgments of risk are also influenced by organization affiliation (McDermott, 2010), organizational management

(Alaszewski & Manthorpe, 1998) and organizational size (Mitchell & Glendinning, 2007). For example, professionals working in health-focused organizations were more concerned with the client's risk resulting from self-neglect while housing and other community-based organizations were more concerned with the client's risk associated with squalor (McDermott, 2010). Additionally, mental health nurses viewed risk as a hazard, nurses working in the field of learning disabilities saw risk as potentially empowering and nurses working with older people saw risk as a dilemma (Alaszewski & Manthorpe, 1998 as cited in Mitchell & Glendinning, 2007).

Family caregivers on the other hand emphasize the present and focus on the interpersonal impacts of risk, while health professionals emphasize the future and focus on the physical consequences of risk (Clarke, 2000). Family caregivers and health professionals both perceive risk as being within the older person but family caregivers evaluate risk along an acceptable to non-acceptable continuum (Cott & Tierney, 2013).

Meanwhile clients relate to the biographical domains of risk such as a loss of identity (Clarke, 2000) and make risk management decisions based on a sense of obligation while health professionals make decisions based on safety (MacCourt & Tuokko, 2010). Clients also perceive risk as being outside of themselves and their homes, for instance, not letting strangers in (Cott & Tierney, 2013).

Understanding the different perspectives helps to optimize the working relationship between the person, their family members and the health care practitioners to develop an intervention that successfully supports the older adult's goal of living in their own home while minimizing risk.

Which risks pertain to community-dwelling older adults? Carson and Bain

(2008) summarized that "we take many risks everyday" since "risks are everywhere" (p.

14). Walking across the street entails risk of being hit by a vehicle, falling, or going in the

wrong direction. When working with community-dwelling older adults to assist them in

remaining in their own home as they age, it is important to have an understanding of the

types of risk that these older adults may face – risks that are common though not

inevitable with aging. The majority of the literature on risk with community-dwelling

older adults either does not define risk (Ceci & Purkis, 2009; McDermott, 2010; Reich et

al., 1998), references risk as being a perilous event/hazard (MacCourt & Tuokko, 2010;

Taylor, 2006) or infers the consequences of the event as the risk (Gilbert, Adams &

Buckingham, 2011; Ryan, 1998; Tanner, 2003; Tierney et al., 2004). These various

references to risk show that the concept of risk is used in different and often inconsistent

ways in the literature. The majority of the literature on the risks pertaining to this

population describes risk as events that have the potential to cause negative

consequences, which as indicated above by Carson and Bain (2008) is in line with the

medical model. These risks include inappropriate nutritional intake, inappropriate

medication use, falls, fires, inability to access help, financial abuse, suicide, wandering

and automobile accidents (Anemaet & Moffa-Trotter, 1999; Gilmour, 2004; Nikolova,

Carignan, Moscovitz & Demers, 2004; Patterson & Rosenthal, 1997; Pavlik et al., 2001;

Poulin de Courval et al., 2006;Tanner, 2003). While the literature is consistent on the

types of risk that frail older adults potentially face, the prevalence of these risks with this

population compared to the general older adult population is not clear.

What are people at risk of? Not only do health professionals need to be clear on their definition of risk and what risks pertain to older adults but they also need to be clear on what their client is at risk of. Are they at risk of poor health, injury, hospitalization, death, reduced quality of life, decline in function, decline in independence, relocation or exploitation? Naik and colleagues (2010) list their potential outcomes of risks for community-dwelling older adults as including: neglect, exploitation, numerous safety hazards, functional impairment, medical morbidity and death, which are all understood to occur more commonly among frail elders.

How is risk assessed? Health professionals are typically working with their community dwelling older adult clients for either health care or in the case of occupational therapists, occupational performance related reasons, however, when safety concerns are identified, a risk assessment becomes part of the general assessment. Therefore the purpose of risk assessment is not only for the purpose of determining appropriate level of care, support and treatment but also to reduce the ambiguity that occurs when health care professionals try to balance the client's safety and autonomy (Gunstone, 2003). More specifically risk assessment involves collecting sufficient information about the consequences and the likelihood of the risk in addition to assessing the reliability of that information in order to make a decision (Carson & Bain, 2008). Sufficient information includes details not only about the risk but also aspects about the client's health and social situation, which may either, minimize or increase the client's risk (McDermott, 2010). When time permits, the risk assessment data gathering process can be comprehensive with health care professionals gathering information from interviews, medical records, assessment tools, observations and from caregivers

(Gunstone, 2003). The risk assessment is completed by working with the client to assess needs, strengths and weaknesses, recent events and past history and to determine if the concerns observed are either an active or passive decision (Gunstone, 2003).

In response to health care professionals' tendencies to focus on the negative and physical consequences of risk, Titterton (2005) has proposed a person-centred positive risk taking framework. This framework encourages health and social care professionals to adopt a more balanced risk assessment approach by not only making judgments about the individual's capabilities but also their coping resources, not only acknowledging the possible disadvantages and harms but also the gains for the individual's physical, psychological and emotional well being. This model also acknowledges not only the values placed on the outcomes but the consequences for the individual of not going ahead with the risky activity (Titterton, 2005). Despite, health professionals being comprehensive in the acquisition of client data (Gunstone, 2003), there does not appear to be any evidence that this positive risk taking framework is being used.

How is risk managed? Risk management refers to the way in which the decision arrived at through risk assessment is best implemented (Carson & Bain, 2008). There is a current tendency in health care to minimize or avoid risks due to a 'safety first' focus (Clarke, et al. 2011; Heyman, & Titterton, 2010; Taylor, 2006). Risk management specifically with older adults also involves seeking certainty while identifying and meeting needs, making judgments while balancing benefits and harms, working as a team, managing complexity, accounting for resources and priorities and being aware of potential litigation (Clarke et al., 2011; Taylor, 2006).

The 'safety first model' is the traditional model that focuses on the client's physical health, disabilities, danger, control and what the risk assessor thinks is right (Titterton, 2005). However there is growing advocacy for a focus on the positive aspects of risk taking. This approach involves a purposeful process between the health professional and the client seeking a mutually acceptable and reasonable informed decision (Titterton, 2011). It focuses on the individual and their needs. It considers the individual's physical, psychological and emotional well-being, their rights and responsibilities, their abilities and disabilities, their choices and opportunities and the involvement of individuals and family caregivers (Titterton, 2005). Risk management in this case involves not only reducing the likelihood and/or the consequences of the harm but also maximizing the likelihood of the benefits (Carson & Bain, 2008, Titterton, 2005). The risk management process for businesses offers a more comprehensive framework with six possible outcomes that take into account negative and positive outcomes of risk taking: (a) avoid the risk, (b) increase the risk, (c) remove the source of the risk, (d) change the likelihood or consequences of the risk, (e) share the risk with another party or (f) retain the risk by informed decisions (Purdy, 2010).

Although there appears to be a difference in approaches to managing risk within health care and business, Carson and Bain (2008) acknowledge that the differences can also be personal in nature. These authors indicate that there is a tendency for the health professional to focus on the benefits of risk taking in one's personal capacity versus a focus on the harms or what might go wrong in one's professional context. In other words health professionals feel more responsibility for the client's safety and well-being causing

them to preferentially err on the side of caution compared to when they are taking risk decisions for themselves.

As indicated above, risk in general is considered a complex concept but the literature on risk in health care is equally complex as it is still affected by personal, social, cultural and political factors. However, there is consistency in the literature that health professionals perceive risk as negative, which consequently translates into a tendency to manage risk by avoiding it or eliminating it. To overcome this there is a movement in the UK's health and social care system to broaden the perspective of risk by acknowledging and incorporating the potentially beneficial outcomes of risk (United Kingdom Department of Health, 2007). Despite this general literature on risk and health care, there remains a gap in the literature on the concept of risk as it pertains to community-dwelling older adults. In order to understand the kinds of clinical decisions the participants in this research made to balance the safety and autonomy of their community-dwelling older adults and to address the knowledge gap in this clinical context, it is important to ascertain how they define risk, what they perceive to be risk and how they assess and manage risk. It is also important to understand how health professionals make decisions. This is discussed in the next section.

Clinical Decision Making

What health professionals perceive, identify, assess and treat as risk is not only dependent on their beliefs about risk but also on their clinical reasoning skills. Since the goal of this research study is to understand health professionals' decision making with community-dwelling frail older adult clients, when safety is a concern, an understanding of risk and clinical decision making is needed. An overview of the general literature on

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clinical reasoning and clinical decision making is below and this chapter then concludes with a review of the literature on clinical decision making with older adults.

Clinical reasoning. At its simplest, clinical reasoning involves a thinking component that informs an action component referred to as clinical decision making (Boyt Schell & Schell, 2008; Hooper, 2008; Wainright, Sheppard, Harman, & Stephens, 2011). Clinical reasoning skills are involved in all stages of the therapeutic process: referral, assessment, intervention planning, intervention and discharge to help the health professional plan, direct, perform and reflect on client care (Moyers 1999, as cited in Carrier, Levasseur, Bedard, & Desrosiers, 2010; Schell 2003, as cited in Boyt Schell & Schell, 2008, p. 5). The process of clinical reasoning involves *gathering* and *processing* information to make treatment decisions to help the client attain their clinical goals (Rogers 1983, as cited in Kuipers & Grice, 2009). This process is conceptualized as a thinking, decision, action cycle (Smith, Higgs, & Ellis, 2008).

Types of clinical reasoning. The health professional needs to gather specific information in order to reason about it. The types of reasoning describe the kinds of information that the health professional *gathers*. The health professional literature is inconsistent in the names given to the types of reasoning that clinicians use. Mattingly and Fleming (1994) were instrumental in first describing Occupational Therapists' clinical thought processes (Boyt Schell & Schell, 2008; Chapparo & Ranka, 2008). They found that Occupational Therapists worked with a three-track mind: they reasoned about the client's diagnosis (procedural track), they focused on the client as a person (interactive narrative track) and they created an image of the client that was provisional and holistic but dependent on the client's participation (conditional track) (Chapparo &

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Ranka, 2008). Boyt Schell and Schell (2008) refer to these three types of reasoning as scientific, narrative and conditional reasoning respectively and added three more types of reasoning; pragmatic, ethical and interactive. These authors describe these latter three types of reasoning as pertaining to the impact of the social and physical work environment, reasoning around ethical dilemmas and reasoning around the client-therapist interaction respectively. Scientific, narrative, ethical and conditional reasoning will be explained in more detail below, as they are most referred to in the literature of risk amongst older adults. Pragmatic reasoning and interactive reasoning are discussed later in this chapter as conditions that impact on the therapeutic relationship and decision making, rather than being labeled as a type of reasoning.

Scientific reasoning involves "a systematic approach to creating, testing and using knowledge to make decisions" (Tomlin, 2008, p. 92) by using a deductive, inductive probabilistic and/or statistical process. Scientific reasoning also includes diagnostic reasoning, which is the thinking about the causes of the conditions requiring occupational therapy involvement and procedural reasoning, which is the thinking around choosing interventions that best suit the occupational dysfunction (Tomlin, 2008).

Narrative reasoning occurs when the practitioner is paying attention to the stories that clients are telling to describe their life circumstances (Hamilton, 2008). This type of reasoning helps the practitioner better understand the client with regards to their values, beliefs and skills and their social, cultural and physical contexts in order to better meet the needs of the client (Hamilton, 2008).

Ethical reasoning involves the thinking about dilemmas that occur around the ethical principles that exist within health care namely autonomy, beneficence,

nonmaleficence and justice (Beauchamp & Childress, 2009; Kanny & Slater, 2008). Ethical principles that are critical for establishing trustful client-therapist relationship include telling the truth (veracity), keeping promises (fidelity), keeping client's information confidential (confidentiality) and keeping client's personal information private (privacy) (Beauchamp & Childress, 2009; Kanny & Slater, 2008).

Conditional reasoning involves the thoughts that health professionals have when projecting an imagined future for the client based on their participation (Chapparo & Ranka, 2008). It is the thinking used when they anticipate possible clinical outcomes for their client based on the current situation (Boyt Schell, 2008).

Types of information processing. Once the therapist gathers the information, the information is *processed* through cognitive processes and termed by some authors as "clinical reasoning capacity" (Christensen, Jones, Higgs, & Edwards, 2008). The literature is consistent in supporting an analytic approach to process information but differs in its acceptance of other ways in which clinicians process information, namely through intuition and reflection.

The analytic type of information processing is also referred to as critical thinking or hypothetico-deduction and is characterized by a slow, deductive, rational, rule based linear process low in emotional investment (Stanovich, 2005, as cited in Croskerry & Norman, 2008). Decision trees and decision aids are examples of structured approaches that are occasionally used to facilitate analytic thinking (Bonner, 2001).

Intuition on the other hand is described as a fast, inductive information processing system that uses mental short cuts, associations and is set off by an affective system (Hammond, 1990, as cited in Croskerry & Norman, 2008). Therapists not only need to

understand their emotions to access intuition but they need to trust this affective reaction in order to use it in decision making (Chaffer, Unsworth, & Fossey, 2010, as cited in Chaffer, Unsworth, & Fossey, 2012). It is typically accessed without a conscious awareness and is considered a sixth sense (Chaffer et al., 2010 as cited in Chaffer et al., 2012). Intuition is typically associated with expert health professionals as it requires the health professional to draw on past clinical experiences and quickly link them to an anticipated future for their current client (Shraeder & Fischer, 1987, as cited in Cioffi, 1997).

Intuition is a debated concept as it is poorly understood due to its difficultly in being researched (Nyatanga & de Vocht, 2010). The difficulty in quantifying intuition has also resulted in its intermittent popularity over the years. It was renounced when positivist thinking became popular and reintroduced when experience and practice became valued (Cioffi, 1997).

Reflective thinking is a cognitive process that can occur in the midst of therapy "reflection in action" or the thinking that occurs after therapy "reflection on action" (Schon, 1983 as cited in Christensen et al., 2008). It involves organizing the information about the professional experience and using it to inform future action whether that future action is in the moment or at a later time (Forneris, 2004 as cited in Christensen et al., 2008).

It has been suggested that analytic thought combined with intuitive judgments provides an optimal process to support complex decision making (Blum, 2010; Croskerry & Norman, 2008) but a multidimensional model of clinical decision making (O'Neil, 1997 cited in Banning, 2007) using the benefits of both the analytic approach and the

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pattern recognition (intuition) approach has not been evaluated in a clinical situation (Banning, 2007).

All of these clinical reasoning processes are in play when a health professional is working with a frail older adult. Specifically, the gathering and then processing of information by health professionals are two necessary steps before they are able to make clinical decisions. These processes occur in all therapeutic environments, including the environment community and home environments of community-dwelling older adults. For instance, when working with community-dwelling older adults, health professionals gather and think about information related to the client's diagnoses (scientific reasoning), the client's life and preferences (narrative reasoning) and the ethical dilemma of safety and autonomy (ethical reasoning). They then process this information using analytic, intuitive and reflective processes in order to make clinical decisions around risk assessment and risk management and balancing safety and autonomy.

Clinical decision making. Once the different types of information are gathered and processed they are used for action, namely decision making. As Smith and colleagues (2008) stated, clinical decision making is "both an outcome and a component of clinical reasoning" (p.89). Carrier and colleagues (2010) distinguished the two processes of clinical reasoning as problem solving (cognitive processes) and decision making, which involves evaluating the solutions to the problem and making choices.

The client has an effect on the multitude of decisions that are made throughout the therapeutic process. As health professions continue to adopt a client-centred approach, it is being advocated that client participation in both aspects (thinking and action) of the clinical reasoning process be increased (Atkins & Ersser, 2008). The different types of

decision making defined below are characterized by the kind of involvement with the client.

Types of decision-making. The literature describes three main decision-making models as it pertains to clinical treatment decisions. The paternalistic approach had been the traditional decision-making model of choice until the emergence of client centered practice and increased access to health information, which encouraged the shift towards an informed choice/consumerist decision-making model (Brody, 2005; Whitney et al., 2008). The shared decision making model was brought forth as a middle ground model to address the apparent downfalls, as described below, of both the paternalistic and consumerist/informed choice models (Brody, 2005; Cribb & Entwistle, 2011; Joosten et al., 2008; Makoul & Clayman, 2006; Whitney et al., 2008).

Beauchamp and Childress' (2009) definition of paternalism within a health care perspective suggests that it is an intentional action by the health professional to override the client's preferences with the goal of achieving a beneficial outcome by either preventing or mitigating harm. In simplest terms it suggests that the health professional knows best and makes the decision without deliberating with the client (Cribb & Entwistle, 2011; Joosten et al., 2008). Cribb and Entwistle (2011) suggest that this overriding action neglects to respect clients' autonomy and clients' responsibility.

At the other end of the spectrum, the consumerist/informed consent model supports client autonomy but neglects to respect the health professional's autonomy, expertise, responsibilities and accountability (Cribb & Entwistle, 2011). In the consumerist model of decision making the health professional plays a passive role by only providing information and options, but refraining from voicing specific

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recommendations (Joosten et al., 2008). In this model, the interaction is unidirectional from clinician to client as the client receives the information from the clinician but deliberates on it and makes the final decision on his or her own (Cribb & Entwistle, 2011; Joosten et al., 2008).

The shared decision making model was thus proposed as a way to respect the autonomy and responsibility of both the client and the health professional (Cribb & Entwistle, 2011). This model also supports the notion that not only do the client and the health professional both play an active role in health care decision making but they both possess equally valuable knowledge; the health care professional has the health expertise and the client has the personal context expertise (Makoul & Clayman, 2006; Moreau et al., 2012). Makoul and Clayman (2006) acknowledge that although the literature discusses three distinct models of decision making with shared decision making seen as the middle ground, decision making realistically exists on a continuum.

Clinical decision making with older adults. The literature discussed to date provides a general synthesis of the concept of risk and the processes involved in clinical decision making. How these concepts apply to the clinical context of working with older adults will now be discussed with regards to specific client, environmental, practitioner and decision attributes which are said to influence the clinical reasoning process (Higgs & Jones, 2008; Smith et al., 2008). These factors are discussed below as they relate to the clinical context of working with community-dwelling older adults.

Impact of the client. There are many client-specific factors that have an impact on the clinical reasoning process, namely client beliefs, values, expectations, health care needs and problems that exist within their personal, social and physical environments

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(Higgs & Jones, 2008). For instance, older adult decision making is compounded by fluctuating mental status, inability to test decision-making capacity, concerns about safety, and complexity of the decisions (Collopy, 1998, Gamroth, Semradek, & Tornquist, 1995, Kane & Wilson, 2001 as cited in Oakes, 2011). One client factor that impacts on the clinical reasoning process when working with community-dwelling older adults is the client's decision-making capacity. This will be discussed below.

According to the College of Occupational Therapists of Ontario, the principles of good practice include client-centred practice and respect for autonomy (College of Occupational Therapists of Ontario, June 2012). This means that practice is focused on the client's "needs, wishes and abilities, in the context of their priorities, supports and resources", that the client can make "their own decisions about their own life, within legal limits" and that they are presumed capable until proven otherwise (College of Occupational Therapists of Ontario, June 2012, p.3). However, when the client's decision-making capacity is questioned their capacity for that decision must be assessed so that if a client is deemed incapable of making the treatment decision, a substitute decision maker is engaged in the process.

There is some controversy in the literature with regards to assessing the capacity of community-dwelling older adults. Naik, Lai, Kunik and Dyer (2008) suggest that the concept of autonomy was developed within an acute care setting and does not work well with the kinds of decisions made by older adults living in the community. For instance, to ensure safe and independent living the older adult needs to make decisions around any of the following five areas of self-care and self protection: personal needs and hygiene, condition of the home, activities for independent living, medical self-care, and financial

affairs and estate (Naik et al., 2008; Naik, Dyer, Kunik, & McCullough 2009). Contrary

to the majority of the literature on assessment of the client's decision making capacity

(Beauchamp & Childress, 2009; Brody, 2005; Jones & Holden, 2004), Naik and

colleagues (2008) suggest that these health care decisions around safe and independent

living are different than the medical care decisions that are made in acute care. In the

acute care setting the client is authorizing health decisions for the team to follow through

on, which explains why a client only requires decisional capacity. In contrast, the

decisions older adults make around remaining in their home require the client not only to

make decisions but also be able to follow-through on these decisions (Naik et al., 2009).

It is for this reason, Naik and colleagues (2008) are suggesting that older adults not only

need *decisional capacity* but also *executive capacity*. They define *executive capacity* as

the ability to execute on decisions whether it is by implementing these decisions or

arranging for services when their physical or mental health prevents them from being able

to follow-through on their decisions through their own actions.

This is an important concept for this research study as the majority of the clients

of the participants in this study do have some kind of cognitive impairment which often

puts them in a questionable zone of decision making capacity. This concept of executive

capacity is new and not widely known but applies directly to the kinds of decisions that

the participants are wondering if the client is capable of making. How the participants

handle decision making and capacity affects how they are able to balance risk, safety and

autonomy.

   Impact of the practice environment. Boyt Schell (2008) describes pragmatic

reasoning as "the thinking that is focused on the everyday realities that affect the delivery

of service" (Schell & Cervelo, 1993 as cited in Boyt Schell, 2008a, p.170) and is a type of reasoning related to the practice environment. It encompasses both practice and therapist personal contextual factors that inhibit or facilitate therapy (Boyt Schell, 2008a).

Personal contextual factors include the therapist's attitude, motivation, perceived behavioural control and personal norms and are discussed below as practitioner influencing factors (Boyt Schell, 2008a). The contextual factors related to practice consist of issues such as organizational norms and policies about caseload, treatment space and duration and availability of supplies (Boyt Schell, 2008a). There are a number of practice environments within occupational therapy; the ones most applicable to community-dwelling older adults include the hospital environment and the community environment.

Moats' (2007) study on the institutional factors influencing discharge accommodation decision-making with older people found that the practice environment influenced what type of decision making process occurred. The length and amount of involvement with the client on longer-stay rehabilitation settings supported a more informed choice decision making process; this process was also facilitated by a clientele without significant cognitive impairment. A shorter length of stay with more medically fragile and cognitive impaired clients on specialized geriatric wards led to a blending of informed choice, paternalistic and shared decision making models. The medically dominated acute care wards forced a paternalistic decision making model due to the time constraints where fast decisions were made based on limited assessments and on clients who were still recovering and whose functional status had not been optimized. Another study found that institutional pressures impacted on how the health professional made decisions (Clemens & Hayes, 1997). Inpatient workers were more apt to make decisions

quickly while community health professionals took their time to make decisions (Clemens & Hayes, 1997).

It has been suggested that the power relationship in community-based decisions favours the client (Moats, 2007) but this is not always the case. In at least two studies, the clients did not feel like an active participant in the decision making process (Hicks, Sims-Gould, Byrne, Kahn & Stolee, 2012; Janlov, Hallberg & Petersson, 2006). The health professional's expertise about the health care system and available services tilted the power relationship towards the health professional leaving the clients to be reluctant and resigned accepters of health care decisions and health care services. Additionally, the lack of real options for the clients in the community in both of these studies further contributed to the clients' feelings of hopelessness (Hicks et al, 2012; Janlov et al., 2006). This lack of real options challenges the common narrative 'the case manager offers alternatives; the client makes choices' (Ceci & Purkis, 2009). Studies in community care have shown that clients in fact do not have a plethora of options (Hicks et al., 2012).

Impact of the practitioner. There is broad agreement that health professionals bring personal and professional values and beliefs in addition to professional knowledge and skills to the clinical reasoning process (Carrier et al., 2010; Higgs & Jones, 2008; Smith et al., 2008). With regards to personal values, two studies found a gender correlation with women health professionals being more cautious of risk or perceiving risk to be greater (Gale et al., 2002; Ryan, 1998). With regards to professional values impacting on decision making, the literature shows some inconsistency. Some studies showed a difference in risk management by health discipline (Clemens & Hayes, 1997, Montandon & Harding, 1984 as cited in Gale, et al., 2002; Ryan, 1998) while other

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studies show no difference between health professionals (Gale et al., 2002). Studies on expert and novice therapists show how their clinical reasoning skills differ with regard to what types of information they use and how they process information (Wainright et al., 2011). It is suggested that experts are able to process information faster by being able to utilize the intuitive model of practice (Carr & Shotwell, 2008).

Attributes of the decision. Smith and colleagues (2008) highlight ten attributes of decisions that influence the clinical reasoning process. These include the decision's uniqueness, certainty, importance, stability, urgency, complexity, relevance, riskiness, familiarity and congruency. Decisions are easily made when the decision is familiar, has limited variables, the consequences involve low risk, the environment is stable, the information is certain, and the factors related to the decisions are in agreement with each other. Conversely, decisions are harder to make when the guidelines or the amount of information is uncertain, where the decision and its outcome are unfamiliar, where the practice conditions are changing, where there are multiple conflicting variables and where there is a high likelihood of an adverse event occurring as a result of the decision (Smith et al., 2008).

Impact of ethical dilemmas. Difficult decisions also typically involve an ethical and emotional component (Smith et al., 2008). Ethical dilemmas are complex problems that cause ethical distress that typically occur in situations where there is not one best course of action or when the problem involves conflicting ethical values and responsibilities (Horowitz, 2002).

The Ontario regulatory body for occupational therapists recognizes that challenging and complex practice issues occur which might elicit moral unease, moral

distress or a moral dilemma (College of Occupational Therapists of Ontario, June 2012).

They mandate that even when most ethical action is not initially clear the therapist still

must uphold principles of good practice by a thoughtful and conscious decision (College

of Occupational Therapists of Ontario, June 2012). Although the College acknowledges

that some decisions are habitual and some decision making processes are invisible, in

order to facilitate good practice within an ethical dilemma, therapists should use a

systematic decision making process to ensure that the therapist reaches an ethically

defensible decision (College of Occupational Therapists of Ontario, June 2012). To

support this request, the College of Occupational Therapists of Ontario (June 2012)

proposed the use of an 8-step conscious decision-making framework for ethical dilemmas

to facilitate this process to ensure that the therapist completes a sufficient level of

consciousness to arrive at the ultimate decision. The 8-steps are

Step 1: Describe the situation

Step 2: Identify the principles related to the situation

Step 3: Identify the relevant resources to assist with the decision making

Step 4: Consider if you need further information or clarification

Step 5: Identify the options

Step 6: Choose the best option

Step 7: Take action

Step 8: Evaluation the decision

This generic decision making framework highlights the lack of guidance in the

literature that is required for health professionals to work through an ethical dilemma

such as when balancing a client's safety and autonomy. It lacks the weighing of the facts and possible outcomes.

As Beauchamp and Childress (2009) indicate, the resolution of an ethical dilemma involves optimal balancing of all principles. Although the principle of autonomy is valued in Western society, it does not necessarily always trump all other principles. As the College of Occupational Therapists of Ontario (September 2012) suggests that a thorough examination of all the facts should be taken into account to resolve a dilemma. Since balancing risk, safety and autonomy involves the two ethical principles of beneficence and autonomy, decisions around intervention with older community-dwelling adults, where risk is entailed, would likely involve an ethical dilemma.

The literature reviewed on clinical decision making highlights the complexities involved in making decisions during a therapeutic interaction. None of the literature reviewed considered all aspects of the clinical reasoning process (the thinking component and the action component) with sufficient detail to provide a comprehensive practice framework to apply to the clinical context of working with community-dwelling older adults with regards to balancing safety and autonomy. The literature reviewed on community-dwelling older adults revealed that there is also a lack of literature on how elements of the client, the practitioner, the practice environment and attributes of the decisions that are made within this clinical context impact on decision making. This research project on understanding how health professionals perceive, identify, assess and treat risk in this clinical context provides findings that contribute to a conceptual/practice framework on how to balance safety and autonomy. This framework considers all aspects of the clinical reasoning process (thinking and action) and considers a variety of factors

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(client, practitioner and practice environment factors, decision attributes) that impact on

decision making to help support health professionals to better balance safety and

autonomy.

Chapter 3: Methods

Research Design

The goal of research in a health care discipline is to support practice by "generating foundational knowledge, by providing evidence about the need for occupational therapy services, by developing and testing theory that underlines practice or by generating findings about the process and outcomes of therapy" (Kielhofner, 2006a, p. 4). The purpose of my research was to generate foundational knowledge of the concept of risk as perceived by health professionals working with community-dwelling frail older adults to better understand how they balance the client's safety on the one hand and their goal to remain in their own home on the other. The research question used to elicit this foundational knowledge was "*How do health professionals working with frail community-dwelling older adults, perceive, identify, assess and manage the client's risk?*" As the literature currently lacks specific information on how community health practitioners make decisions – or should make decisions – within the clinical context of older adults and risk, a second goal of the research was to analyze the knowledge gained from this project to develop a conceptual/ practice framework.

In order to know more about how health professionals perceive, identify, assess and manage risk when working with frail older adults labeled as living at risk, a qualitative research methodology was chosen. Qualitative research is used when an understanding of the inner experiences of a participant and/or the meaning of a concept are the desired outcome, which is the purpose of this research study (Corbin & Strauss, 2008).

This chapter will begin with an outline of the methodology of this research study and provide justifications for specific decisions made about the research design and implementation. The chapter will proceed with a review of the strategies used to enhance the rigour of the data and will end with a discussion about the strategies used to address the ethical considerations raised by the research topic, research design and research implementation.

Methodology – Grounded Theory

As the goal of this research study was to contribute to the development of a conceptual/ practice framework on how health professionals balance risk, safety and autonomy when working with community-dwelling frail older adults, the grounded theory approach to qualitative research was best suited to facilitate this process. The goal of qualitative grounded theory research is to not only gain insight into various meanings, perspectives and interpretations that people ascribe to a particular phenomenon (Merriam, 2009; Lysack, Luborsky, & Dillaway, 2006), but also construct a theory grounded in the data (Charmaz, 2006). It is considered a useful method to develop clinical conclusions in areas in which there has been limited research such as the current clinical context of this research project (Kreiger, Ashbury, Cotterchio, & Macey, 2001). The grounded theory approach is an inductive approach of obtaining data that is used to inform a theory about a particular life situation (Stanley & Cheek, 2003). Grounded theory is based on the symbolic interactionist perspective that proposes that human beings socially construct their world and make sense of it through the process of social interaction (Stanley & Cheek, 2003).

Grounded theory methodology has specific requirements for sample selection, data collection and data analysis. These will be discussed below with regards to this research study in which the data was collected via individual in-depth interviews.

Sample Selection and Recruitment

Population and Sample. Purposeful sample selection is well suited to qualitative research as it allows a deliberate selection of individuals who can best offer insights about the research questions (Dickerson, 2006). Morse and Field (1995, as cited in Dickerson, 2006) identify appropriateness and adequacy as two principles that guide qualitative purposeful sampling and Seidman (2006) adds sufficiency and saturation as two complimentary principles. Appropriateness refers to the type of participant who should be chosen for the research study and adequacy, sufficiency and saturation refers to characteristics of the sample size. Grounded theory adds the extra sampling criteria of "theoretical" to the concepts of appropriateness, adequacy, sufficiency and saturation (Cutcliffe, 2000; Stanley & Cheek, 2003).

An appropriate sample suggests that the participants should be chosen for their ability to provide insights about the research question (Dickerson, 2006) and ability to contribute further data to the emerging theoretical constructs (Stanley & Cheek, 2003). An adequate sample means that enough data has been gathered to provide depth and richness to the point of saturation, which is a point where no new information is discovered with subsequent data collection (Dickerson, 2006; Merriam, 2009; Seidman, 2006). Grounded theory methodology suggests that participants are added one by one and purposefully chosen based on what they can add to the data that has already been collected and analyzed. An adequate grounded theory sample occurs when theoretical

saturation is reached, when the constructed theory is rich and detailed (Charmaz, 2006). Seidman (2006) adds that the sample should be sufficient to ensure a form of generalizability. He stated that there should be "sufficient numbers to reflect the range of participants and sites that make up the population so that others outside of the sample might have a chance to connect the experiences" (p.55). Whalley Hammell (2002) described the latter concept as representiveness while Malterud (2001) described this concept as transferability.

My sample was chosen based on the concepts of appropriateness, adequacy, sufficiency and saturation. Health professionals were recruited from each of the following three community organizations within the City of Ottawa: Geriatric Psychiatry Community Services of Ottawa, Geriatric Assessment Outreach Team and Community Care Access Centre. They are the three main organizations in Ottawa offering specialized geriatric psychiatry services, specialized geriatric medicine services and services in the home within the City of Ottawa respectively. Thus their staff would all be appropriate participants to be able to provide meaningful insights about how they perceive, identify, assess and manage community-dwelling older adult clients' risk.

These health professionals were homogeneous in that (1) they all worked with frail older adults living alone at home, (2) they all worked in a multi-disciplinary role (i.e. geriatric assessor, case manager or case worker) rather than a discipline specific role and (3) they all worked within the same political health care environment of the City of Ottawa. Having a homogenous sample increased rigour with triangulation across sites and increased transferability of findings to similar populations.

The literature reviewed indicated that health professionals' judgments about risk

differ amongst different professions and are influenced by organization affiliations (McDermott, 2010). An attempt was made to recruit a variety of health discipline backgrounds including occupational therapy, physiotherapy, nursing and social work to meet the criteria of sufficiency by offering a range of potential health professionals across a range of participant sites. The multiple sites and disciplines increased the rigor of the study by providing triangulation of data sources but it also increased heterogeneity within the sample, casting doubt on the ability to reach saturation with a sample of 12.

Grounded theory methodology suggests that the researcher must continue interviewing until no new information about the concept is provided to avoid developing a weak theory that has too many unexplained exceptions (Charmaz, 2006; Corbin & Strauss, 2008; Dickerson, 2006; Seidman, 2006). It is difficult to determine when saturation will occur but qualitative research studies have reported achieving saturation with sample sizes as small as 10-20 participants (Miles & Huberman, 1994; Morse, 1994, as cited in Kreiger et al., 2001). For this research study, it was anticipated that saturation would occur within a sample size of 10-15. The upper limit of 15 was established due to financial and time constraints. It was hoped that an equal amount of participants from each organization would be obtained.

As the potential informants spend a majority of their time in the community, email is the most commonly used form of communication within these organizations and the most effective tool to advertise the research opportunity in a timely manner. Each program director was asked to send out the recruitment letter (see Appendix A) which outlined (1) the goal of the research, (2) the process of the interviews (60-90 minutes in length conducted at their work site in a confidential room), (3) the risks (potential

psychological trauma of discussing stressful cases) and the (4) benefits (possible presentation of the results). It clearly stated that their participation was completely voluntary and did not have any bearing on their work performance/evaluation as their participation was confidential. They were invited to contact the principal researcher directly for more information and when they did the telephone script (Appendix B) was used to provide more detail. Thus, the program directors did not know which staff members chose to obtain more information or to participate. The recruitment email was sent out by each program director in a staggered manner to allow time for the simultaneous data collection and analysis that is required in the grounded theory methodology (Charmaz, 2006). When the first email did not elicit enough participants for each program, the director was asked to send out a second recruitment email.

A total of 12 health care professionals were interviewed. All respondents met the inclusion criteria of (1) being able to complete the interview in English, (2) being from any of the following health professionals: occupational therapists, physiotherapists, nurses and social workers, and (3) working in a generalist position, either geriatric assessor or case manager in the City of Ottawa in one of the following three organizations: Geriatric Assessment Outreach Team, Geriatric Psychiatry Community Services of Ottawa and the Champlain District Community Care Access Centre with any number of years of experience. Because of the number of respondents from the Geriatric Assessment Outreach team exceeded the number needed, the participants from that setting were purposively sampled for years of experience and health professional background. The purpose of doing this was to ensure that a variety of perspectives and language about risk were included, given that perception of risk may be informed in part

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by one's professional background (McDermott, 2010).

Data Collection

There are many ways to gather data within a qualitative research paradigm including participation, observation, in-depth interviews and analysis of documents and objects (Lysack et al., 2006). The grounded theory approach recommends in-depth interview or participant observations (Stanley & Cheek, 2003). The individual in-depth interview was chosen as the method to gather the data instead of observations as the goal of this research study was to capture the health professional's understanding of risk and how they balanced risk safety and autonomy. The in-depth interview technique is used in situations when the desired information of feelings, thoughts and intentions cannot be observed (Merriam, 2009). More specifically, the individual in-depth interview allows for topics to be explored in significant depth and allows for the co-creation of meaning between interviewer and the interviewee (DiCicco & Crabtree, 2006). The individual in-depth interview allows for optimal depth of the topic, flexibility in the exploration of ideas and confidentiality in comparison to the group interview (Lysack et al., 2006).

The in-depth individual interview was best suited for this research question as it allowed me to solicit information from participants on their feelings, thoughts, beliefs and assumptions that are not easily observed. It also provided a way to gain insight into the multiple realities and practices that exist amongst health professionals working with older adults living at risk in their homes alone. The in-depth interview also provided the time needed to explore in detail the beliefs, values and attitudes that affect the decisions made by health professionals and influence their tolerance of degrees of risk (Gunstone, 2003; Clarke, 2000; Patterson & Rosenthal, 1997). Choosing an individual interview over the

group interview format allowed more time to delve into the depth needed to explore this topic but it also allowed the flexibility to adjust the questions in situations when unexpected responses emerged. The individual format also allowed the participant to feel comfortable sharing their specific experiences in the case where the perspectives of nurses, physiotherapist, occupational therapist and social workers may have been different. It also provided the participants with privacy to discuss the details of any cases that involved ethical dilemmas. Doing individual in-depth interviews in addition to observation visits would have added depth to the data and ultimately the analysis however; time constraints prevented this data collection method.

With the support of the three program directors, the interviews were scheduled during work time. All 12 were fully informed about study details and indicated their agreement to participate in this study by providing their signature on the study participant consent form (Appendix C). Ten out of the twelve interviews took place at the participant's worksite in a conference room away from the clinical areas to ensure confidentiality. Two participants acknowledged the importance of confidentiality but made an informed decision to forfeit confidentiality by having the interview in their office with the door closed. Each interview was audio-recorded using a digital audio recorder and lasted between 43 minutes to 124 minutes. Interviews were transcribed by a professional transcriber who indicated her agreement to confidentiality by signing the transcriber consent form (Appendix D). Only one recording out of the 12 interviews was lost due to technical malfunction. The results of this interview were typed up immediately following the interview based on notes taken during the interview and from memory.

Tool. In-depth interviews range from unstructured to structured (Lysack et al., 2006). The semi-structured interview guide was the tool chosen to gather data for this research project. The semi-structured interview provides some structure to the interview process by asking questions about pre-determined topics (Lysack et al., 2006). This allows for modest researcher control over the design and sequence of the research questions, which ultimately allows for some control over the topics covered during the interview (Lysack et al., 2006). As there is a multitude of information that health professionals can provide on working with frail older adults living at risk, a semi-structured interview can help the participants' discussions stay focused on how they perceive, assess and manage client risk. The semi-structured format can also allow some flexibility to explore participants' emerging responses as needed, in contrast to the inflexibility of structured interviews (Merriam, 2009).

Please refer to Appendix E for the semi-structured interview guide developed for this research project. Based on recommendations of Lysack and colleagues (2006), Merriam (2009), Seidman (2006) and Whalley Hammell (2002), the wording of the actual questions was developed in order to make sense to the participant and reflect their worldview. The questions on risk perception, risk identification, risk assessment, risk management and organizational and demographic influences, were developed in order to effectively solicit information on participants' perspectives on risk based on themes derived from the literature (Baker et al., 2008; Clarke, 2000; McDermott, 2010; Purdy, 2010).

One disadvantage of the semi-structured interview guide is that the questions may be too directive for the participant. For this reason, I was administered the interview first

as a pilot to ensure the clarity of the questions and the appropriateness of the answers in addressing the overall research question. This is recommended by Merriam (2009). No questions were changed after this pilot.

Seidman (2006) recommends a range of 5-10 questions to allow enough depth to be covered for each interview. The number of questions in this research study exceeded this number. A paper copy of the interview guide was provided to 10 of the 12 participants at the interview. This was done so that they could refer to the questions throughout the interview as the first two participants asked to have many of the questions repeated. The paper copy appeared to help the participants remember the question and helped them to focus their thoughts.

Data Analysis

The research study was based on the grounded theory methodology, which has specific requirements not only for data collection but data analysis. The grounded theory methodology involves the following seven components

1.   Simultaneous involvement in data collection and analysis

2.   Constructing analytic codes and categories from data, not pre-conceived logically deduced hypotheses

3.   Using constant comparative method, which involves making comparisons during each stage of analysis

4.   Advancing theory development during each step of data collection and analysis

5.   Memo writing to elaborate categories, specify their properties, define relationships between categories and identify gaps

6.   Sampling aimed toward theory construction, not for population

       representativeness

7.   Conducting the literature review after developing an independent analysis

       (Glaser & Strauss 1967, as stated in Charmaz, 2006, p. 5)

This research study attempted to utilize these seven steps. Initially it was hoped

that two interviews would be conducted every other week to allow for the interview to be

transcribed and imported into Atlas.ti within the same week to facilitate enough time for

analysis to be completed on the following week. This would have allowed for the data to

be collected and analyzed simultaneously, which is encouraged so that the questions can

be adapted to ensure saturation of ideas. However, due to research participant availability,

interviews were booked when it was convenient for the participant and not all fell within

the pattern of two interviews every two weeks. Also the transcriber was not always able

to transcribe the interviews in time for the interviews to be fully coded prior to the next

dyad of interviews.

       The data was analyzed utilizing the three phases of grounded theory techniques

outlined in Charmaz (2006) and analyzed using the qualitative data analysis software

program Atlas.ti version 6 and 7. The first phase of coding is called initial coding and

consists of studying fragments of data (words, lines, segments and incidents). The

researcher reviews the data with the following questions in mind: Which theoretical

categories might these statements indicate? What is happening in the data? What does

this mean? What is the data a study of? What does this data suggest? And from whose

point of view? Based on the answers to these questions, the researcher then codes these

fragments of data in the form of an action to prevent making conceptual leaps (Charmaz,

2006). It was hoped that the first phase of analysis, initial coding, would have been completed on each transcript prior to the next dyad of interviews. However as described above participant and transcript availability did not also occur with enough time for this phase of analysis. All transcripts were read in their entirety and analyzed on a global level for general trends, patterns and gaps in knowledge. This general analysis led to probing in different areas in future interviews, which is the purpose of simultaneous data collection and analysis.

Once the interview has been initially coded, the researcher returns to the data for the second phase of coding: focused coding (Charmaz, 2006). This phase consists of selecting the most useful initial codes and utilizing the constant comparative method, where data is compared to data, then data is compared to codes, then codes are compared against categories and finally categories are compared against themes. The goal at this second phase is to sort, synthesize, integrate and organize the data (Charmaz, 2006). After all the interviews were initially coded, the codes were analyzed for possible themes and patterns. Categories were developed with sub-theme headings to explain the data. All the codes were then re-organized under these themes and categories and in some instances re-named or collapsed under these new headings. All the interviews were then re-analyzed with the new headings and every quotation for each code was re-read to ensure that it still belonged under the new heading.

The goal of the third phase, axial coding, is to bring the data back together to specify the properties and the dimensions of each category (Strauss and Corbin, 1990, as cited in Charmaz, 2006). Axial coding focuses on describing the relationships of the data between categories on a conceptual level by answering the following questions: when,

where, why, who, how and with what consequences for each category (Corbin & Strauss, 2008). During this phase of the coding, the category headings were placed in an order to try and explain how health professionals perceive, identify, assess and treat risk as they attempt to balance risk, safety and autonomy. The category headings were analysed for patterns and meanings and organized as a way to explain the relationships among headings. The codes and quotes under these headings were then re-analyzed to ensure that they explained the proposed processes.

Theory development is the hallmark aspiration of the grounded theory methodology and is created during the data collection by choosing participants who can contribute to the development of the emerging theory, by asking the participants more probing questions based on the gaps in the emerging theory and by developing theoretical concepts through all phases of the coding. Memo writing is used as a technique to capture initial ideas, theoretical concepts and potential information gaps that occur during the interview but also during the coding and analysis phase in order to facilitate theory development.

Brief memos were written after each interview was conducted, after each interview was read for the first time and after they were analyzed for the first time. Memo writing at this stage involved commenting on the overall sentiment and message of each interview and more specifically about the meaning of the codes in order to develop appropriate category headings. Memos were also written during the development of the categories and themes and then during the final stage of analysis of the overall proposed framework. Memo writing at this later stage involved commenting on how the categories

and themes related to each other. Understanding these relationships helped develop the clinical framework.

The last component of grounded theory is to return to the literature after the development of the theoretical frame work to see if the literature supports or contradicts the findings. I conducted a second literature review after all the interviews were coded and analysed, and integrated the findings into the literature review presented in Chapter 2.

Rigor. Rigour is a characteristic of research that distinguishes it from ordinary searching of knowledge to encourage confidence in the information generated by research (Kielhofner, 2006c). Rigour refers to how well the research results, their interpretations and their use are valid, reliable and trustworthy (Dellinger & Leech, 2007). The techniques to improve rigour in my qualitative research included triangulation, peer review, member checking, memoing and reflexivity (Johnson & Waterfield, 2004; Klopper, 2008; Whalley Hammell, 2002).

Triangulation is a technique used at the data collection stage to provide rigour in the collected data. Triangulation can be done by data or sources, by time, space or person, by methods or by theories (Whalley Hammell, 2002). The goal of the data collection phase is to provide rich meaningful data. Triangulation on the one hand enhances rigour through credibility and dependability when findings are consistent and confirmed across sites, persons, methods, theories (Johnson & Waterfield, 2004) but on the other hand enhances rigour by identifying rival accounts (Whalley Hammell, 2002). Whalley Hammell (2002) and Johnson and Waterfield (2004) both indicate that contradictions and a diversity of perspectives allow for deeper reflection and analysis of the data, ultimately producing richer and more comprehensive data. This research study attempted to achieve

rich data by triangulating across health disciplines and triangulating across three different health care sites.

Peer review is a technique used at the data analysis stage to enhance rigour by validating the findings. A peer reviews the robustness and completeness of the emerging themes (Johnson & Waterfield, 2004). A peer can also help to search for contradictory themes (Barbour 2001 as cited in Johnson & Waterfield, 2004) which according to Murphy and colleagues (1998, as cited in Johnson & Waterfield, 2004) is a sign of rigourous analysis. This research study enlisted a peer to review the data analysis to ensure that the themes were clearly and logically emerging from the data rather than being forced onto the data (Walker & Myrick, 2006). I used my supervisor for peer review due to her qualifications as a qualitative researcher in older adult health care. The supervisor reviewed the analysis and provided feedback at each of the three phases; initial, focused and axial coding in addition to the global analysis done after each interview.

Member checking which refers to having participants verify the analysis derived from their interviews typically occurs after data analysis (Cohen & Crabtree, 2008; Conneeley, 2002; Johnson & Waterfield, 2004; Whalley Hammell, 2002). As the goal of qualitative research is to understand the participant's subjective experience of a phenomenon (Whalley Hammell, 2002), a rigourous study must prove that the analysis truly represents the participants' experience. Corbin and Strauss (2008) highlight the importance of participants feeling that the findings fit with their experience and that they can "see" themselves in the study results. Dependability of the data and credibility of the findings is ensured if they are given to the participants to confirm or challenge the results

(Johnson & Waterfield, 2004). However, member checking can cause some differences in perspectives as the participants can change their mind over time, the participants can have poor recall, the participants can have new experiences in the meantime that change their thoughts and the participants and the researcher have different agendas (Johnson & Waterfield 2004). The participants in this research study were asked to indicate on the consent form if they wanted to review the transcript for accuracy of their responses. Those who indicated in the positive were sent their transcript by their indicated preference of either email or mail and asked to respond back with any changes. Only one participant responded with changes and these were incorporated into the analysis.

Memoing throughout the data collection and analysis is a key component of the grounded theory methodology (Charmaz, 2006; Corbin & Strauss, 2008) but it also contributes to the rigour of the study by providing an audit trail of the theoretical, methodological and analytic decisions made throughout the entire research process (Johnson & Waterfield, 2004; Whalley Hammell, 2002). This enhances reliability and dependability as it allows the reader to understand how and why decisions were made (Koch 1994, as cited in Johnson & Waterfield, 2004). As indicated earlier memos were written through all phases of the research including during the interview and during each of the three phases of analysis.

In order to provide additional rigour, I reflected on how my own life experiences and perceptions of risk impacted the research at all stages. As knowledge gained from qualitative research methodology is co-constructed and negotiated between researcher and participant (Cohen & Crabtree, 2008; Krauss, 2005), and because the researcher is the instrument of analysis, the values, beliefs, experiences and knowledge of the

researcher have an impact on the research process and findings (Starks & Trinidad, 2007). The researcher must clearly examine and state how their biographical positioning and their philosophical positioning impacts on all parts of the research process (Whalley Hammell, 2002). Subjectivity is a resource rather than a source of error or bias and it can make the research meaningful (Johnson & Waterfield, 2004).

The literature on risk states that reflexivity (attention to the impact of the researcher) in the research is extremely important due to the socio-cultural construction of risk as it not only affects the perspectives of the participant but also of the researcher. Henwood and colleagues (2008) indicated that the risk researcher needs to consider the framing of risk at all three stages of the research process: constructing the research topic, introducing the research to participants and interpreting meanings of data. The authors advocate for a degree of self-reflexivity on the part of researchers so that they are aware of their own risk framing in order to be sensitive about the possibilities and consequences of imposing them on the participant. Reflexivity will not only address the concerns brought forth by Henwood and colleagues (2008) when researching the concept of risk but it will also serve as another strategy to increase the rigour of this study (Whalley Hammell, 2002). For this research, prior to conducting interviews I was administered the interview by a peer who would not be participating in the research study, so that my ideas and biases were documented and acknowledged prior to data collection and analysis. Being both the researcher and a health professional in one of the organizations recruited for this study, it became even more important to document my biases.

As a result of being a geriatric assessor with the Geriatric Assessment Outreach Team, one of the organizations recruited for this study, for the past 14 years I had

frustrating conversations with family caregivers about family members who they labeled as living at risk. I often found I disagreed with this label and what they considered risk so I sought to find research on how to deal with this dissonance. This is when the lack of literature on risk and community-dwelling older adults became apparent and is what led me to want to conduct a research study on the meaning of risk from the perspective of the client, family caregivers and health professionals. These risks became identified through our comprehensive multi-dimensional assessment using both standardized and non-standardized assessments. Although I personally feel that the majority of the clients who I see who would be labeled as living at risk and would be safer in a more supportive environment, my occupational therapy perspective allows me to be more risk tolerant in supporting their choice to continue to live at home. Experience of over 14 years within this position has also allowed me to become more tolerant of risk even extending to occasional times of desensitization, as acknowledged by Gunstone (2003). I suspect that the health professionals in all three organizations would agree on the types of risk prevalent in this population (listed in Appendix B) but may rank the importance of them differently due to the mandates of their organizations and their professional backgrounds. Prior to the research study I anticipated that the participants from Geriatric Psychiatry Community Services would demonstrate the most tolerance for risk as they are dealing with the most difficult situations compared to the two other organizations and they have the most time to work with the clients compared to member of the two other organizations.

Ethical Considerations. All research has ethical considerations but the intimate nature of the researcher and participant interaction and the flexibility during the interview

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process introduces special ethical and moral considerations within qualitative research (Morse & Field, 1996 as cited in Klopper, 2008). It is the responsibility of the researcher to clearly identify the possible risks in addition to the probability of the risks occurring to the participant and to ensure that every effort is made to mitigate the risk (Office of Research Ethics Administration, 2007). Klopper (2008) argues that the researcher must ensure protection of the following participant rights through all aspects of the research process: "the right to self-determination, the right to privacy, the right to autonomy and confidentiality, the right to fair treatment and the right to protection from discomfort and harm" (p. 71).

This current research study used multiple strategies to protect the participant's rights. The right to self-determination was protected by the statement in the recruitment email and in the consent form that they can opt out of the study at any time during the interview. None of the participants elected for this.

Having the interview in a separate conference room with a closed door protected the participant's right to privacy. The room was always on-site to facilitate ease of participation but away from the clinical areas, to promote privacy. As indicated above, two of the 12 participants elected to forfeit the right to privacy of participation in the study by electing to have the interview in their own office with the door closed. The right to confidentiality was outlined in the recruitment email but also in the consent form. The participant was informed that all data obtained from the interview (interviewer notes and audio recording) was kept in a locked manner during transport (to and from the interview) and kept in a locked room in the offices of the East Geriatric Assessment Outreach Team and will be kept for five years post publication as indicated by the

University Policy on Scholarly integrity (Office of Research Ethics Administration, 2007). It was clearly stated that no significant identifying information would be outlined on the audio-recording as it only contained minor identifying information, such as health professional background, place of employment and years of experience. Three of the 12 interview participants asked to have the audiotape turned off during the provision of sensitive information but agreed to have it turned back on to talk about their answer in a very general way. This also improved confidentiality during transcription. The participants were also asked for permission on the consent form to utilize non-identifying quotes that would be represented by a number for presentations, journal articles and the thesis write-up. Access to any participant information required a password; this included the digital audio recordings, the transcripts and analysis in Atlas.ti and the transcripts, analysis and written documents in Word.

The right to fair treatment was protected by the fact that participants were treated with dignity and respect during the interview process. The researcher is a skilled interviewer who as a practicing health professional currently utilizes strategies to ensure respect and dignity with clients and fellow health professionals. It was clearly stated at the beginning of the interview that all perspectives were welcome as no right answers exist. Participants were also given the opportunity to provide any addition comments during member checking.

Duty to report is another ethical consideration that is relevant to this research study as the participants are describing how they provide assessment and treatment to clients. It was clearly stated in the consent form that the researcher had a duty to report to the proper authorities if any information disclosed during the interview could be

considered elder abuse or professional misconduct. This did not occur.

As with any research project, there are always risks involved in participating (DiCicco-Bloom, 2006; Seidman, 2006). A potential risk in participating in this research project was that the participant's discussion of cases of clients living at risk, might cause them to reflect back on the meaning of their experiences and cause emotional or psychological distress (Conneeley, 2002). In order to mitigate this risk, it was clearly stated in the consent form and clearly explained at the beginning of the interview that the interview could be terminated at any time. Also during the interview if any non-verbal communication arose that suggested distress or discomfort, the participant would have been asked if they wanted to continue. Any participants who showed signs of distress at any stage of the interview or in post-reflection of the interview would have been encouraged to seek professional counseling and would have been reminded of the availability of their work's EAP program. None of the 12 participants showed any distressed or remarked about any distress before, during or after the interview.

Another ethical consideration that is a factor in this research was the consequences to the participants of being interviewed by a peer with whom they may have regular contact. Some of the interview participants might have had daily in-person contact with the researcher, some might have had monthly in-person contact with the researcher and some participants might have had yearly contact by telephone with the researcher dependent on their organization affiliation. There are pros and cons of being interviewed by a peer (Chew-Graham, May, & Perry, 2002; Coar & Sim, 2006). Being interviewed by a peer can create an atmosphere that encourages the disclosure of rich data due to prior understanding of the issue being studied, and feelings of professional

cooperation and solidarity (Coar & Sim, 2006). However, being interviewed by a peer can also stifle responses due to a reluctance to share information if the participant feels that their clinical decision-making is being judged, if they feel that there is one right answer or if they feel frail being audio recorded (Chew-Graham et al., 2002; Coar & Sim, 2006). As indicated above, the consent form indicated to the participants that there was no right answer to the questions, that their responses could not be linked back to their employer and that there would be no identifying information on the audiotape or quotations. This was reiterated at the beginning of the interview. There was one participant who asked to have the audio-recorder turned off on a number of occasions while she shared specific insights and after some reassurance that this was a legitimate response worthy of inclusion, the participant allowed for the audio-recorder to be turned back on. Another participant was nervous about being audio-recorded but her anxiety was eased once the interview began and the audio-recorder was put away from direct view. The Dalhousie Ethics Review Board approved this research design, as the estimated probability of these listed risks occurring was considered low. This low rating was due to the fact that the participants were health professionals who are trained in the understanding of confidential situations and would be fully capable of saying no to participating in the study in addition to being fully in control of what they felt comfortable sharing. Additionally, risk being the topic of this study is considered a benign topic that is already a part of ongoing discussions amongst health professionals and therefore it was anticipated that the participants would not feel uncomfortable discussing this topic.

In summary, this research study conducted individual in-depth interviews using a

semi-structured interview guide with health professionals from different health disciplines within three different health organizations about their experiences working with community-dwelling older adults living at risk. Interview findings were used to develop a risk assessment and management practice framework that would assist health professionals in providing care that will help older adults maintain their autonomy and safety. Chapter four summarizes the analyses of the rich descriptive data that was collected and Chapter five highlights the three significant findings that contribute to a clinical framework to help health professionals better balance risk safety and autonomy.

Chapter 4: Findings

In order to 'enable safe engagement in just right-risk taking' (Townsend et al., 2007, p.101), health professionals must know how to assess and manage risk as they support community-dwelling older adults choosing to remain at home. Furthermore, risk assessment and risk management are based on personal perceptions, which in turn affects one's definition of risk and one's abilities to identify risk. Additionally, risk's potential consequences force the health professional to balance the ethical values of autonomy and beneficence: in this case, the client's wishes to remain at home and their safety there. Therefore, in order to develop a conceptual/practice framework to help health professionals balance safety and autonomy, it is critical to understand not only how health professionals define, perceive, assess and manage risk but also how they balance safety and autonomy to make decisions.

As the participants in this research study were health professionals, they were able to provide a wealth of information for this clinical context from their perspective of being a clinician. Firstly, their interviews described how health professionals working with community-dwelling older adults defined, perceived, assessed and managed their clients' risk. Secondly, the results that emerged from this study illustrated how personal aspects of the health professional and aspects of their work environment impacted on their clinical decisions as they tried to balance safety and autonomy of their community-dwelling older adult clients. Lastly, the findings described conditions under which balancing safety and autonomy worked well.

This chapter begins with a demographic description of the participants so that the results can be understood within this context. It then presents the findings. Quotes are

used to illustrate the findings that emerged from the data. The quotes are referenced according to the randomly assigned number from 1-15 that was provided to the participant as an identifier. As a total of 15 participants were anticipated prior to the recruitment of the participants, the assigned numbers were randomly assigned from 15, even though only 12 participants in the end were recruited. This explains why there are participants labeled Participant 13, 14 and 15 but no participants labeled 2, 4, and 12.

The findings from this research were obtained from 12 individual in-depth interviews with female health professionals working as geriatric assessors or case managers within three different organizations whose mandates are to optimize the health, safety and function of their clients by providing health care and/or services to community dwelling older adults. The participants included four social workers, four occupational therapists, three nurses and one physiotherapist. The health professionals' work experience within their specific organization, ranged from 6 months to 30 years with an average of 11 years.

Six participants came from the Geriatric Assessment Outreach Team, whose role is to provide assessment and recommendations for older adults with mental health or physical health diagnoses. Five participants worked with the Geriatric Psychiatry Community Services of Ottawa, whose role is to provide case management for older adults with mental health diagnoses. One participant came from the third organization, the Community Care Access Centre whose role is to provide case coordination for in-home services and community linkages for older adults with either physical or mental health diagnoses. In the first organization, the clinicians only see the client once and provide health recommendations and access to further specialized geriatric or community

services whereas clinicians in the other two organizations have the ability to work with the client over multiple visits as needed.

Although the 12 participants were not equally representative of the three different organizations or of the four health disciplines, they were equally split between health professionals who see the client once and health professionals who are involved with the client over time. As all the organizations offer different services, it is possible that all three organizations could potentially be involved with the same client at the same time suggesting homogeneity in the types of clients and their corresponding concerns that these health professionals work with. Thus, a range of perspectives was obtained from differing health care disciplines (nursing, occupational therapy and social work) and differing time involvement with clients. However, the perspective of physiotherapists working in a generic position and the perspective of case managers from CCAC were not well represented.

The findings regarding how these health professionals defined, perceived, assessed and managed risk are now discussed.

Defining Risk

How participants understood risk and living at risk varied significantly as evidenced by the lack of consistency in their definitions. When asked to define risk and living at risk within this clinical context, the participants referred to four different elements: impairments, environments, events and consequences. This variety in definitions points to the complexity of this concept. No single participant used all elements, but all used at least one of them in their responses. These elements are summarized in Table 1 and are discussed below.

Table 1   Elements of living at risk

Impairments	Environments	Perilous Events	Consequences
Impairments Cognitive Physical Mental Health Health Medical illnesses	**Physical** Home (disrepair, lack of adaptive aids or equipment, scatter rugs, infestation, etc) Unsafe Neighbourhood **Social** Family support **Economic** Financial support	**Immediate** Falls Unsafe medication use Abuse (physical, mental, financial) Fires Malnourishment Unsafe driving Wandering Financial mismanagement Suicide **Longer term** ↓ health maintenance ↓ house maintenance	**Health Related** Death Hospitalization Injury/harm ↓Physical health ↓Mental health Harm to others **Life related** Functional decline Financial decline Eviction Relocation to LTC Quality of life Being over protected
Treatment Options: Optimize treatment Enhance strengths	Adapt the environments Change the context	Prevent the events	Minimize the consequences

The majority of the participants defined risk or described elements of a risky situation as being something that was related to either an impairment or a perilous event. However, some also referred to the physical environment that the client was living in as being associated with risk. Although it was rare for the participants to spontaneously discuss the consequences of the risky situation, with probing, the participants were able to provide some consequences, all being negative consequences.

Based on the various definitions provided by the participants, a collaborative and comprehensive definition for living at risk within this clinical context is proposed. How it emerged is discussed below.

*Living at risk is: A judgment about a client's **impairment** within an **environment** that can cause an **event** that has the potential for a **negative consequence**.*

Impairments. The participants who defined risk with regards to impairment were suggesting a relationship between impairment and risk. Some participants suggested it

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was a causal relationship. The following participant describes how a client's depression could not only cause a decline in their function but also their safety.

> *So, are they so severely depressed for instance that they don't want to get out of bed, they don't feed themselves, don't want to clean themselves. They're at risk then of physical infections, etc., if they're not caring for themselves (participant 6).*

Similar examples were raised concerning the potential for dementia or visual impairment leading to eating spoiled food. Participants argued that any number of physical or mental health impairments can cause a perilous event to occur that may result in negative consequences for the client.

Some participants described a less causal but contributory relationship, where the impairment makes situations riskier.

> *So you can have someone with a medical issue like shortness of breath, okay. There is a medical issue that is an active problem that's not being addressed, they're getting shortness of breath, it's not causing them a significant level of risk. It may cause them some risk in that they have to make sure they have the walker with them so that they can sit down so they're not getting so far down the road and then getting breathless and not able to foresee (participant 10).*

Here the participant sees the clients' impairment as likely to increase their risk for negative consequences related to walking if they do not use walkers.

Participants also described two other elements of the client that increased their overall risk status. Participants indicated that risk was reduced when clients acknowledged the risk and accepted services that would either prevent the risk from occurring or minimize the severity of the consequences, and increased when they declined services. As one participant said,

> *[it's easier] when they're willing to let services be put in place to help minimize risks. For example, help from CCAC, a dosette, Meals on Wheels; to let other health professionals in from community resource centres, primary care outreach, geriatric psychiatry [etc] (participant 15).*

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Here the participant lists a range of the services that could be offered to the client to reduce a perilous event from occurring or to reduce potential negative consequences from occurring.

Another participant described how complex the impairment and negative consequence relationship can be:

> *It might be that they have mobility issues and their risk would be that they're not remembering to use their walkers or the tools available to them or choosing not to use those tools. So, those kind of jump out at me for physical risks (participant 6).*

In this quote, the participant describes the complex effect of multiple impairments on risk. Although the client's mobility is the reason for risk of a potential fall, it is actually the client's cognitive impairment that is causing the increase in his physical risk. For example, as long as the client remembers to use his walker, he decreases his chance of having a fall, thus decreasing his chance for physical injury. However, if the client never had any mobility impairments, the risk for a fall would be low.

The participants also indicated that physical or mental health impairments made client situations riskier across a continuum, depending on the level of impairment, with greater impairment meaning greater risk.

Cognitive impairment was the impairment that was most often referred to in the participants' discussions about their definitions of living at risk. As one participant indicated: *"it's pretty widely understood that people living with cognitive impairment are living at risk (participant 8)."* This participant like many indicated that you could not talk about people with cognitive impairment without talking about risk, however a couple of participants also acknowledged that risk could exist within an environment of

safety. "***Any client that has a dementia or memory impairment is living at risk by degree depending [on] how severe, that doesn't mean they're unsafe (participant 5).***" If risk and safety can co-exist then this suggests that risk and safety are not opposite concepts.

The fact that participants acknowledged that impairments and risk exist along continua, suggests that impairments and risk do not automatically make a situation unsafe. This then suggests there exists a threshold below which safety occurs, and that a tipping point could switch a safe situation over to an unsafe situation. This was acknowledged by one participant;

> ***we think [she had] chronic schizophrenia but had never been diagnosed… and there were a variety of issues throughout her lifetime that were problematic….but nothing was unmanageable until layered on top of that we got some dementia developing (participant 6).***

This quote describes a client with a chronic mental illness who was marginally managing until she developed dementia. It was the dementia that became the tipping point of the client being able to manage safe and independent living, causing some extreme risks. Knowing that there is an impairment tipping point suggests that interventions could be targeted to compensate for or remediate the client's impairments where possible and/or focus on their strengths to maintain the client's risk status below the tipping point towards unsafety.

Environments. The participants who defined risk or described living at risk with regards to the environment were mostly referring to elements of the client's physical environment that were considered risky, but occasionally the client's social and economic environments were also implicated.

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The physical environment was acknowledged in two ways. It was described as a contributor to a perilous event (for example, scatter rugs causing falls) or as proof of an event occurring (for example, burn marks from fire, moldy food from not eating). For example:

He has scatter mats all over the place and he's done a few weird things. He's put little placemats down on the floor almost like a little pathway. Like stepping stones from his living room to his little front apartment door, but they're just little plastic placemats. So, the risk there of him stepping on one of those and just slipping or tripping, it's there (participant 14).

Here, the client's presence of scatter mats and plastic mats on the floor put him at increased risk for falls.

On the other hand, the physical environment can provide evidence that a perilous event has already occurred or has a high likelihood of occurring. For example:

His only family was his 86-year-old sister who lived out of town and she was very, very concerned about him. He was actually forgetting pots on the stove quite often and the fire alarm was going off often. In the fridge there was rotting food and when I asked if I could throw it out, he refused to let me throw it out. Like the pork chops they were growing things (participant 15).

Here the environment provides evidence that person is living at risk, and in fact perilous events may have already occurred.

The client's social environment was identified as having an impact on the chance of a risk occurring or the severity of the consequences. Social environments that were lacking in formal or informal support or had poor quality support were considered by participants to be higher risk situations. Living with family was usually seen as lessening risk:

I think you're living at risk when you have minimal social support, be it formal or informal. Like, if you have minimal family or friends or neighbours that are checking in on you. Or no access to service, you know, or not being aware of

what services are out there. That can place you at risk because then you're doing things that you're not necessarily safe to do anymore (participant 14).

However, when family (usually a spouse) also had health issues this caused safety concerns for both of them. In some instances poor quality family support was seen to heighten risk:

It was the son living with mom again. He wasn't a junkie, but he had junkie friends and the friends would be high on drugs and she was repetitive and she was always coming in, "Do you want supper now?" and she couldn't cook. And this would irritate the junkie friends so they would turn around and tell her, 'If you don't shut the f--- up, your son's going to put you in a long-term care. Lock you away somewhere' (participant 5).

This quote also shows the complexity of risk where both the client's likely cognitive impairment and unsafe social environment makes the situation riskier.

The economic environment was discussed as being a protective factor against risk when the client had money to pay for services or relocate to a more supportive environment or as being a factor that increased the client's risk when finances were minimal.

Events. Some participants defined living at risk as an occurrence of specific perilous events. Similar to impairment levels, the participants indicated that these events existed along a continuum. In this case the participants referred to three continua: the occurrence continuum, the frequency continuum and the multiplicity continuum. The occurrence continuum ranged from immediate to long-term. The participants indicated that some events had the possibility of occurring immediately such as falls, unsafe medication use, abuse, fires, unsafe driving, wandering and financial mismanagement. For instance: *"It's falling, or being abused, or not eating properly, or not taking their medication or taking too many; driving they're unsafe, burning themselves, leaving the*

stove on (participant 3)." While other events occur over long periods of time before the negative consequences transpire, such as a decline in health maintenance and a decline in house maintenance. This is illustrated in the following quote: *"Sometimes that's imminent harm and sometimes it's more general, so, they may not be at risk right now, but in the long run they're putting their health and themselves at risk, their safety at risk (participant 15)."*

The frequency continuum referred to how often the event occurred from not often to often and the multiplicity continuum referred to how many events was occurring at once ranging from one event to multiple events. The following quote lists examples of both immediate and long-term events but the quote also highlights the concept of the multiplicity continuum:

> *He was not taking his medication. There was absolutely no food in the fridge. He was driving. He was generally unkempt, the apartment was unkempt, but that's not what's putting him at risk. It was really he's not taking care of his health. He's not eating. And he was driving and he had serious cognitive issues (participant 15).*

This quote suggests that events do not automatically create an unsafe environment but like impairments they can occur along a continuum of safe to unsafe. The participant in this quote seems to suggest that it is the number of events that are occurring makes a higher risk situation.

Consequences. Participants had to be specifically asked what clients were at risk of, when they were defining living at risk. They acknowledged that the concept of consequences also existed along a continuum. In this case, it was a continuum of severity ranging from minimal to catastrophic. The examples provided by the participants ranged from being over protected on the minimal end (*"they are at risk of people overprotecting*

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them (participant 5)") to death on the catastrophic end (*"at risk for dying and having horrible consequences (participant 9)"*).

Consequences could vary in terms of the kind of effect. Possible kinds of effects included negative effects on clients' health (mental, physical, injury) their living arrangements (eviction, relocation, hospitalization) their finances (financial decline) and/or their functional ability (functional decline). For example, one participant described, *"a gentleman unable to organize himself to get himself some help. [He was] at risk of eviction because of the state of the apartment (participant 15)."*

The participants also acknowledged that the consequences could vary from affecting only the client to also affecting others. A participant described the importance of considering who is affected:

> *We see a lot of falls and falls can be catastrophic because you can hit your head and have a bleed. There's catastrophic consequences to every one of these [events], but to me, without a doubt, as I say, anything that affects someone other than themselves is definitely, as I say, I have the least tolerance for (participant 10).*

Many participants were prepared to support the individual to live at risk if the consequences were solely self-affecting, however, when there was the potential for harm to others and thereby public safety, the participants felt a need to intervene even if it meant against the client's wishes. This specifically occurred in situations where the client lived alone in an apartment building as illustrated by one participant:

> *If they're living in an apartment or a house as opposed to a shelter or a YMCA. That's different risks. And, also, putting other people at risk. If you live in a single family home or a single dwelling, it's different than if you're living in an apartment and potentially putting other people at risk for fire for example (participant 15).*

In summary, the participants defined risk and living at risk as a multi-dimensional concept. They described it as an event that is caused by a health impairment or a hazard in the client's physical, social and/or economic environments, that leads to a variety of consequences whose severity exists along a continuum where depending upon the severity, the proof of its occurrence can be found on the person or in the client's home environment.

Additionally, the definition uses the word judgment. Some participants acknowledged that labeling a client living at risk becomes an interpretation and ultimate judgment call on behalf of the observer, which in this case is themselves as the health professional. This idea is captured in the following quote:

> ***Well it means to me that from a societal perspective we're looking from the outside at them saying that in our eyes, they are not safe where they are in the conditions that they're living in, that they're choosing to live in based on our experience and our concerns for their safety. So it's a very subjective impression (participant 6).***

Here the participant is highlighting the idea that determining a client's risk and safety status is highly subjective as it is based on the health professional's personal ideas about these concepts that ultimately get projected onto the client.

Perceiving risk

While the participants varied in their definitions of risk, they were more consistent in their understanding of the construction of risk. They were in line with the literature as they acknowledged that perceptions of risk are socially, personally and culturally constructed. The participants recognized the influence of current social expectations on what we perceive as risk by remarking that we are living in an overprotective society:

"***We're [an] overprotective society, we see risk and hazard everywhere and I think a lot***

of it is coming from the media (participant 5)." Participants highlighted that personal

origins and past and current work experience contributed to how people perceived risk

personally: "*It [perception] totally depends, in my experience, where you come from*

and where you're working or what your experience has been (participant 8)." They also

acknowledged that their personal beliefs of risk differed from their professional beliefs.

The majority of the participants described themselves as being personally risk averse but

professionally risk tolerant suggesting that the participants were prepared to go against

their personal beliefs about risk to support clients: *"I have a higher tolerance for risk in*

my professional practice than I do in my personal life (participant 10)." One participant

was concerned that her professional tolerance for risk was so high that it could bias her to

support a client in more risk than would normally be acceptable.

Some participants acknowledged that their perceptions of risk could also be

culturally constructed. While cultural construction could include several factors, the

participants only spoke about the influence of age on perceptions of risk. Participants

described two different ways age could affect the perception of risk. The first centred on

the fact that the age of the client should not be an influencing factor on how risk is

perceived and the second centered on the idea that having an increased understanding of

the client's life stage helped the participant understand risk from the client's perspective.

The participants who discussed the impact of age were emphatic that risk occurred at all

ages and that one's judgment about risk should not be influenced by the age of the client:

> *I can't ... think that the way I think is the way they should think. If they want to*
> *live at risk, some people have lived at risk all their lives, why would that change*
> *because they're 85 or they're a certain age (participant 15)?*

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Three participants also acknowledged that the more familiar they were with the client's life stage, the more they understood the client's perception of risk. One participant indicated that this increased understanding developed from having parents or in-laws that were in this age group, from being closer in age to this age group, or just understanding what this cohort went through. As one participant said, "***As I've gotten older and closer to the age we're dealing with, I have an understanding why people make certain decisions and they have a right to (participant 3).***" It is possible that as this participant gets closer to the age of her clients she is reflecting on how she would like to be treated if she were a client and uses this empathy to guide her clinical decisions. Lastly, one participant found that understanding history helped her understand her clients' point of view:

> ***It's a general premise of why do we study history; because to understand where we are now, you've got to understand how we got there. And these are people that we're dealing with, so in order to try and get them to buy in, we have to respect and understand where they've come from. And it might be a compromise (participant 10).***

Another participant described how understanding the client's generational experiences helps put the concept of risk in context:

> ***The perception of risk in the generation as a whole that we deal with typically is a lot-their tolerance is a lot higher…. Especially with the generation we're dealing with right now. Case in point, this lady lived through the Blitz in London all those years and we've got people who have been through concentration camps and we come in and go, 'Well, you're a little wobbly on your feet. And you've had a couple of falls.' They're looking at you going, 'Really? I've survived all of this' (participant 10)***.

Perceptions of risk among colleagues. Participants indicated that for the most part they perceived risk similarly to their immediate co-workers as evidenced during formal and informal discussions. The following participant acknowledged that although

her colleagues may have different personal tolerances for risk, they share the same

perception of risk for clients:

> *For the most part we all have varying degrees of acceptance of risk and there are times when maybe some of my colleagues-there may be some variations, but I think for the most part, we have a good understanding of risk and are on the same page in terms of risk and what that means for our clientele (participant 1).*

One participant thought the similarities in perception amongst colleagues seemed to occur

as a result of in-house training: *"the specific geriatric training (participant 14)"*.

Another participant thought risk perceptions became reinforced through the ongoing

consultations colleagues had with each other during their workday: *"When we do case*

conferencing, if I'm presenting a situation, I get validation from my peers that, 'Yep,

yep that's a problem' or 'Yeah, no, that can slide' that kind of thing (participant 8)."

Regardless of length of time in a workplace, participants highly valued their ability to

debrief and problem solve with colleagues about their difficult cases which likely had a

homogenizing effect on risk perceptions and risk management strategies.

Perceiving risk differently from colleagues seemed to occur most often across

organizations. Though differences arose between acute and community settings,

participants thought differences were most evident between them and referral sources:

> *Different organizations or maybe staff in different positions will perceive risk differently than others and I can give you an example. When we receive referrals some family doctors will want us to go see the client urgently because they really believe that the client is living at high risk and when we probe, for us, with our lens, they might be living at risk, but how we weight the risk might be differently (participant 15).*

The participant indicates that there is something about her expertise, whether

professional background, expertise in the care of the elderly or program affiliation, that

has her perceiving and weighing risk differently just based on the answers from the referral source prior to even seeing the client.

Similarly, participants found their perceptions of risk differed form referral sources once they saw clients in their home environments. For example:

> *Sometimes for instance we'll get referrals from an assessment service that say*, *'This person should move to a retirement home as soon as possible', in fairly strong terms that they need to be out of their home. And I've gone in and been rather surprised and since I decided that it's probably more for legal or insurance purposes that they need to make that kind of statement, I don't know, but when I go into their home I really don't see that it's that urgent. And I've certainly worked with people a year or two years after that point where they have been able to stay in their home that much further and they have been able to prepare and the family's been able to prepare for the next steps (participant 6).*

Although in this particular quote the health professional highlights that risk perception can be politically driven, the quote also shows that this participant has developed her perception of risk by comparing current clients to past client success. The participants felt that the ability to assess the client comprehensively in their home environment helped to really understand the complexity of the situation and either confirm or challenge perceptions of risk.

Perceptions of risk: health professionals and families. Participants found that their perception of risk did not always match the perception of risk held by family members for a number of reasons. Some participants felt that their perceptions differed for practical reasons:

> *I think sometimes family members live in denial, and so I think sometimes, and maybe I'd go so far as to say a good deal of times, maybe because of caregiver burden, caregivers don't always want to see the risk because it means they have to do something about it (participant 14).*

Some participants suspected that family members did not admit to potential risks as it would mean that they would have to provide more physical support. For example, participants explained the reluctance of family caregivers to admit their concerns about driving as it would mean that they would have to chauffeur their family member whose license was revoked. Participants acknowledged that family members' willingness to see risk connected complexly with the family members' own geographical, employment, financial, emotional and cognitive states. For example, family members who live at a distance may see changes more dramatically, and have more fear about their own inability to respond quickly in crises. One participant noted there are different perspectives and different agendas when considering risk: "***We're highlighting risks that they don't see, or are they highlighting risks that we can't act on (participant 3)?***"

Risk Perceptions and Clients. Participants felt that their perceptions of risk differed from their clients' perspectives as the client rarely acknowledged that they were living at risk: "***No. Clients never say it (participant 9).***" One participant acknowledged that her perception of risk is likely different from her clients': "***What I identify as a risk and what a client identifies as a risk are probably two different things (participant 10).***" This participant suggested generational differences might be a cause: "***I think the perception of risk in the generation as a whole that we deal with typically is a lot--their tolerance is a lot higher (participant 10).***" Another participant felt that the differences could be due to differences in values:

> ***It's a values issue, right, so my values and my risk tolerance might not be the same as my clients'. For some people, the opportunity to live on their own is so important they might take risks that I would not be comfortable with if it was my own self (participant 8).***

Similarly, a client might value independence more than reducing risk: ***"I think a lot of caregivers and families have a greater sensitivity to risk and our clients minimize risk because they equate risk with loss of independence which is what they fear (participant 10)."***

As risk is personally, socially and culturally constructed it is not surprising that the participants found that their beliefs about personal and professional risk differed; that their perceptions of risk were similar to their colleagues within their organization but occasionally different as compared to colleagues from other organizations; and that their perceptions of risk were different as compared to families and clients. This highlights the need for health professionals to approach the therapeutic relationship with a clear understanding of their definition of risk and their perception of risk, knowing that these may differ from both the client and their family caregiver. Knowing why their perceptions are different can help pave the way for a more empathetic relationship and productive therapeutic interaction with the client as less time would be spent on potential miscommunications.

Assessing Risk

The participants in this study identified risk through an iterative process of gathering and interpreting the data in order to build an impression of the client's risk status. In order to understand the participant's responses, quotes from the participants on their organizations' role and how they assess risk is discussed first.

The following quote describes the assessment process by one of the geriatric assessors:

> ***We receive referrals from a variety of sources, triage those referrals to see if there's urgency regarding the people we're seeing whether from the emergency***

room, of if there is a risk that person might be at risk of harm in any way. Then we visit people in their homes with their consent to a complete a comprehensive geriatric assessment about their life there, and to make recommendations and triage them to appropriate services and determine if the client is willing to take up those recommendations and receive further assessment or services in their home or referrals to different agencies such as geriatric psychiatry, CCAC, day hospitals. If we can give them any further support to help them stay safe and independent in their environment. So it's comprehensive and quite complex (participant 3).

The geriatric assessors from the Geriatric Assessment Outreach Team only see a client once in a two-hour assessment and refer the client to other appropriate services. Although it is not indicated with this quote, the geriatric assessors only see clients over the age of 65 who are living at home who could have either physical health or mental health diagnoses.

The case managers from the Geriatric Psychiatry Community Services of Ottawa team have long-term involvement with their clients. Their role is described as follows:

The goal of our work is to try to keep people living at home for as long as possible and as safely as possible and to provide support to individuals and their families in relation to whatever's going on. So the bulk of our work is with people who have some memory impairment or dementia, but we also see people who struggle with mood issues, sometimes psychosis or other psychiatric illnesses (participant 13).

The participant clarifies that their clientele is over the age of 65 and must either have a dementia or a psychiatric illness.

Lastly, the case manager participant from the Community Care Access Centre who also is involved with her clients long term described her role as follows:

I do get a referral with specific request of assessment. It could be for services for personal care, it could be for long-term care, determine the eligibility, but at the same time, while we're there, we do a general assessment. You know, we don't limit ourselves to strictly go in for long-term care assessment because we always start with the functional assessment which is the RAI tool. So this RAI tool sometimes will focus, of course, the objectives if the client and the family wants the long-term care application we'll go through the process but if we

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assess other needs we will offer whatever services or link with community organizations or any other person or organization or associations that can help them. That's part of our work. So information, counseling, education, link (participant 11).

Here the participant summarizes that the goal of their assessment is to determine the client's functional status through a provincially mandated assessment tool called the 'RAI' and determine what type of services the client needs and whether the client is eligible for the long-term care application process. Although this participant could see clients of any adult age, the majority of clients are over the age of 65.

Gathering data. The participants described how they gathered the information and what kind of information they gathered. All participants described that they gathered comprehensive information in a comprehensive way. All the participants felt that their assessment was comprehensive as it involved gathering information about the client's physical and mental health, their functional abilities, their social supports, and their environment. Following are two examples illustrating different aspects of comprehensive assessment:

If there's not services, why not? Should there be? If there's not family involved, why not? Is there a way we can get them re-involved, if that's a possibility? You know, or friends or whoever we can get to kind of support that person (participant 14) and

I'm looking in the fridge, I'm looking in the bathroom, I'm watching a person ambulate, I'm listening to what they're saying, I'm asking for history (participant 6).

The participants completed the assessment and gathered the information in a number of ways. They used preconceived checklists of risk developed with experience, and preconceived checklists of medical diagnoses developed with increased medical knowledge. They used formal assessments when it came to assessing cognition and

mood. They used observations to gather information about the state of the home environment and how the client interacted in their environment. They used intuition to follow certain lines of questioning as they came up during the assessment. Lastly, all participants discussed the importance of obtaining obtain collateral information where possible, by talking to family, friends, or neighbours (with the client's agreement) to obtain information about the client's past and present abilities to be able to establish a comprehensive overview of the client.

Interpreting data. Once the comprehensive information was gathered, the participants interpreted this data by corroborating the information, by weighing the facts and by reflecting. Corroborating information was a way to ensure the comprehensiveness of the data but also to ensure validity. They were corroborating their own observations and impressions of the client and environment with the client's self-report, other health professionals' assessments and family members' concerns: ***"Probably because they see the client in all their situations, we do rely on the family to provide information about what might be going on behind the scenes, for sure (participant 3)."*** Some participants also corroborated their findings against the client's medical diagnosis as another way to confirm or contrast against their findings.

The participants found that at times the corroborations were synchronized with the client and others' and at other times their synopsis did not match. This further validated the need to collect as much information as possible in as many different ways as possible from as many different sources as possible. The following quote illustrates how the client's self-report does not corroborate with her environment.

> *I had a lady a couple of weeks ago, really well put together and quite the*
> *character and neat as a pin, like the studio cameras neat, neat, neat, neat. And*

then I asked her what she had to eat every day, like, what her meal plan was, and the flag was that she said to me, she said, 'I have two sandwiches for breakfast in the morning, ham or cheese. And then I have a sandwich or soup at lunch, and then I have fish and vegetables and potatoes.' Well, I'm sitting down, I'm going, 'This is just too good to be true.' Right? So, she goes in to get her medications into this little compact little kitchen and she said, 'Do you want to see my kitchen?' And I said, 'Oh, I'd love to see your kitchen.' So, we go in. 'Oh, this is a great little kitchen. I love these little apartment-size fridges and stoves. Can I have a look in?' So, I look in and there's of course, hardly anything in the fridge and hardly anything in the freezer. And so, again, the flag is there and she's potentially at risk (participant 10).

In this situation, the participant is highlighting how being able to look into the client's fridge and freezer to see if it coincides with the client's twenty-four hour food recall is invaluable in determining the presence or absence of risk. The client's self-report of what she eats on a daily basis sounds like enough to meet her daily energy requirements but this is not substantiated by what is seen in the client's home. The lack of food triggers a concern for the participant about the risk of malnutrition but it also triggers a concern about the client's cognitive abilities and potential lack of insight and whether this puts the client at increased risk for other perilous events.

The participants not only corroborated the facts when interpreting the data but they also weighed all the information that they gathered. The participants weighed the evidence in the home environment against the client's and the family member's comments to come up with not only an understanding but then a judgment about the situation. The participants had to determine if the data that they had gathered in multiple ways and from multiple sources was valid. They had to determine if one source of information should hold more weight than another. For instance if the score on a cognitive test is low and the client is self-reporting no concerns and the environment shows no evidence of functional impairment, how much weight should the cognitive test

hold? The participants' judgments about the state of the home environment when in disarray and in disrepair had to be weighed against a good understanding of the client; is this new behaviour or is this how the client has always lived? Participants were more willing to support the client in situations that were judged as higher risk if this was not new and different behaviour. The following quote illustrates the participants' effort to be understanding rather than judgmental in these situations:

> *That's the challenge with our job is not to bring our own definitions of these things. We've got to understand, is this a change or is this how someone has decided to live. So, it's very, very hard because this is very much a judgment (participant 10).*

The participants also arrived at an interpretation of the client's situation by reflection. The participants described general reflections on the concept of risk and specific reflections on practice. Although it was the specific reflections on practice that guided decision-making specific to the individual case, the participant's general reflections showed how pervasive the concept of risk is and how it has a general impact on a health professional's approach to a client interaction.

The participants reflected on numerous aspects of the concept of risk, which not only highlights the complexity of this concept, but also how potentially value-laden it is. They reflected on the definition of safety and on society's double standard for different risks. One participant questioned their goal and how safety is defined: *"Our goal is to help keep you independent, safe, and functional in your own surroundings. But is that really our goal and how do we define 'safe' (participant 9)?"* This same participant reflected on double standards concerning risk for older adults For instance, the health risks caused by smoking or inactivity are tolerated more by society than other risks such as falls, malnutrition, or medication misuse. Her musing is illustrated in the following

quote: ***"The three things for functional decline, the risk for functional decline is smoking, cardiac problems and physical activity. So you've got a smoker who is inactive. Should we report it (participant 9)?"*** This same participant also reflected on how she would want to be treated with regard to risk, suggesting that these personal reflections influence how she treats clients: "***I don't want other people stopping me now or later on, providing some discussion about whether or not they think I'm safe to do almost anything, live at home or drive the car (participant 9)."***

When participants reflected on their practice they reflected on the client's safety status. As an older adult's social support system and/or physical and mental health status can change, it is not surprising that a risky client situation can cause the health professional to continue to reflect on the client's risk status and on what to do next. One of the participants who works with clients over time acknowledged the importance of needing to continually re-assess the client's risks and how they impact on their safety due to client's changing health status:

> ***Things change often very gradually so you constantly have to be reflecting on your own practice and your own comfort with their safety and what you're seeing and what other people are seeing all along the way, so you're constantly reassessing in the process of working with this person therapeutically (participant 6).***

Another participant who worked with clients over time acknowledged that they were continuously evaluating if their strategies were working as a way of determining what to do next: ***"Especially if we have put in strategies for harm reduction and risk reduction and, yet, these things are still happening ... The red flags are up. When do we say, 'enough is enough' (participant 8)?"*** By using the terminology of red flags the participant is suggesting that knowing the tipping point between safe and unsafe risk

demands constant reflection. One participant described how reflection helped her become better at her job in the long term: ***"Just from clinical experience, right? You do something long enough and you reflect on it, then you get better at knowing what the issues are and the concerns are and the barriers and you can target them more quickly (participant 8).*"** Reflection appeared to be part of not only immediate interpretation of risk, but also the development of skill in risk interpretation.

Building an impression. Once the participants gathered comprehensive data and interpreted it through corroboration, weighing the facts and reflection, they used this information to determine the client's overall risk status. Building an impression of the client's overall risk status involved ranking the client in terms of risk. Analysis of the interviews identified seven safety continua that participants appeared to be using, to greater or lesser extents, to help them form an impression of lower to higher risk. This impression would then directly inform decision-making as it helped the participants determine what they did, how they did it and how fast they needed to intervene especially when the risk status was determined as being at either extreme; low risk or high risk. The participants also described tipping points, factors that they described as tipping the scales towards higher risk typically resulting in recommendations of relocation. The participants did not specifically describe how they made decisions in-between the two extremes, in the cases of medium risk. This could mean that the participants realistically worked in a dichotic paradigm, such as in the clinical scenarios of the client can drive or not drive or remain at home or relocate. In this situation decision making for medium risk would exist up until the high risk dichotomy such as in the clinical scenario of relocate or not drive.

The notion of seven safety continua emerged from the collective responses in the data and consisted of questions around capacity, occurrence, severity, imminence, frequency, support and complexity and is summarized in Figure 1. Similar to the definition of living at risk, not one participant discussed using all seven continua but most participants referred to at least one of the continua in their responses of how they made decisions around managing client's risk. All seven continua emerged from the data when the participants discussed their definitions of risk and how these concepts existed along a continuum. The imminence, frequency and complexity continua emerged from the data when the participants described their decisions around managing risk. The participants indicated that an imminent risk that was occurring frequently amidst other events, whose consequences impacted on others caused participants to engage faster acting interventions compared to taking the time to put forth long-term recommendations for single risks that were deemed not imminent and did not occur frequently.

The colour scheme for the continua (as illustrated in Figure 1) also emerged from the data when several participants described their role as going into the home looking for yellow flags (situations that had the potential to be risky) and red flags (situations that were already considered risky). For example:

> *"Yellow flag's a little warning sign, so you know, I guess, the easiest analogy is really trips and slips and when you're looking at potential fall risk, so that would be a yellow flag, I guess. Some falls can be a yellow flag, too and for the most part, I think the people that we see have actually had falls. It's a judgment thing as to if it was a catastrophic fall with an injury, then you'd probably say that's a red flag rather than a yellow... I would say red flags are things that really affect the safety of the client or the safety of the public (participant 10)."*

Another participant described how discovering red flags affects decision making:

"If there's no big red flags, then we want to try and keep them at home. It's when

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there's those big red flags when we're saying 'okay, we need to take steps right now'

(participant 13)." Here she is referring to steps to relocate the client to a more supervised

setting such as a retirement home or a long-term care facility. It is as if the participants

associated the colour of the continuum to correspond with the colour of the light

standards; green meaning safe to continue driving, yellow for caution and red for danger

or stop.

Figure 1: Safety Continua

1.	**Capacity Continuum**: *Is client capable to make this decision?*

Low	**Yes**	Medium	**Unsure**	High	**No**

2.	**Occurrence continuum**: *Is the perilous event occurring now?*

Low	**No**	Medium	Precursor Signs/Risk factors	High	**Yes**

3.	**Severity continuum**: *How severe is the consequence of the event?*

Low	Minimal	Medium	Moderate	High	Catastrophic

4.	**Immediacy continuum**: *How imminent is the event*?:

Low	Long-term	Medium	Moderate Term	High	Immediate

5.	**Frequency continuum**: *How often is this event happening*?

Low	Yearly	Medium	Monthly	High	Daily

6.	**Support Continuum**: *Does client have consistent reliable support in place?*

Low	Lots of support	Medium	Some Support	High	No Support

Low	Single risk	Medium	A couple of Risks	High	Many Risks

The capacity continuum consisted of the health professional asking themselves the question "Is the client capable to make this decision?" with an answer ranging from capable (lower risk) to not capable (higher risk). When capable, participants felt they had to accept the client's decisions: ***"Where they're capable, we have to err on the side of capacity if there's any doubt. So, where they're capable of making the decision we have to let them do that (participant 10)."*** When cognitive capacity was less evident, participants indicated that this magnified the client's risk status: "***…particularly if it's a person that's not capable, so I think that the risk is certainly magnified (participant 1).***"

The occurrence continuum consisted of the health professional asking themselves the question "Is the perilous event occurring now?" with an answer ranging from not occurring (lower risk) to a potential to occur (medium risk) to currently occurring (higher risk). Some participants saw the potential for an event to occur as an opportunity to provide preventive recommendations to prevent the risk of harm from progressing to actual harm. However, one participant saw potential to occur as something to leave alone:

> ***There are grades of risk you know because somebody might be at a potential risk of fall, I have to be really careful in how aggressively I want to help manage that risk because they're making some choices themselves…so potential of risk is less concerning than an obvious risk (participant 6).***

The discrepancy in how potential for a perilous event to occur is treated likely speaks to a philosophical difference about the concept of prevention. On the one hand participants felt that prevention was within their mandate towards supporting the client to remain in

their own home, whereas other participants felt that until an event occurs, intervention should be minimal:

> *My concern increases when what is a risk becomes things that are actually happening. You are falling. You are burning pots on the stove. You haven't eaten in three days. You haven't taken your medications in a week or more than three times in a week. It's when there's hard evidence that it's not just a potential as these things are happening, these behaviours are happening that we really have to have an important discussion around what can we do (participant 8).*

The severity continuum consisted of the health professional asking themselves the question "How severe are the consequences of this perilous event?" with the answers ranging from minimal (lower risk) to catastrophic (higher risk). Participants weighed the risks that had catastrophic consequences higher than those that had minimal consequences and ranked injury to others higher than injury to self; "***There's catastrophic consequences to every one of these [risks] but to me, without a doubt, as I say, anything that affects someone other than themselves is definitely as I say, I have the least tolerance for (participant 10).***"

The imminence continuum consisted of the health professional asking themselves the question "How imminent are the consequences of this event?" with answers ranging from long-term (lower risk) to immediate (higher risk). Imminence referred specifically to the temporal nature of the consequences of the event. For instance the negative consequences of malnutrition can take a longer time to develop compared to falls or fire whose consequences are immediate. Based on their assessment of the imminence of the risk, participants felt that there were some situations where they had to act right away such as fires rather than taking time to implement long-term strategies such as in the case of malnutrition. For example: ***"I guess the highest risks are the ones when they put***

themselves in imminent danger to themselves or others …the imminent risk would be

suicide or fire (participant 9)."

The frequency continuum consisted of the health professionals asking themselves the question "How frequently is this perilous event occurring?" with answers ranging from rarely such as yearly (lower risk) to often such as daily (higher risk). Participants dealt with perilous events that occurred frequently such as daily falls with more urgency than perilous events that occurred occasionally such as one fall in the past year. One participant described the increase in concern that occurs when the frequency of the perilous events increases:

> *There is an incident where the person goes out in the middle of the night. And it caused some stress but then everybody's saying 'it's okay, it's only happened once, nothing happened, he made it back, it's okay' and then maybe it happens again and it's like 'oh my god, how many more times does that have to happen?'(participant 6).*

When an increase in frequency of an event occurs it moves the event along the continuum from a chance occurrence that could happen to anyone to an established event where there is a high likelihood that this event will continue to occur.

The support continuum consisted of the health professionals asking themselves the question "How much stable support does the client have?" with answers ranging from stable reliable support (lower risk) to no support (higher risk). Participants felt that having a stable support system in place reduced the client's risk status:

> *If we have a well caregiver who can be there to monitor someone's behaviour, who can monitor whether someone's wandering, who can monitor someone's mood and someone's suicide risk, that's completely different than working with someone who's family or support system is completely burnt out and people are saying, we can't do it anymore (participant 13).*

This quote highlights some of the subtle ways that a caregiver is helpful in monitoring the risk, with the underlying suggestion that if the client's risk status increases, a well caregiver can intervene, can ask for help and/or arrange for assistance.

The complexity/multiplicity continuum consisted of the health professionals asking themselves the question "Is there more than one risk occurring?" with answers ranging from one risk (lower risk) to many risks (higher risk). Participants took situations where there were multiple risks occurring more seriously than situations where there was only one risk: ***"There were just so many risks that trying to put in supports just wasn't enough to bring her to a level that was safe (participant 1)."*** The participants also acknowledged that multiple risks could sometimes be a tipping point towards the more drastic measure of relocating a client out of their home.

The participants referred to tipping points when discussing the various continua through which to understand the client's risk status. The participants described a tipping point as something causing the client's situation to tip towards being unsafe as the continua tip towards higher risk. The participants described the tipping points as being either an increased impairment (particularly cognition) or increased hazards in the client's environment (particularly decreased social support). Although the participants hinted at the result of the tipping point as being relocation, they mostly described the unsafe situation as being the high-risk situations of the 7 continua, namely a client who was not capable with multiple risks that were occurring and occurring frequently. The following quote describes the tipping points that caused one participant to feel that relocation of the client to a more supportive environment might be needed.

> ***So, a tipping point for her would be suddenly I or the son went to the house and her exits are no longer clear, there's reason to believe that she's using the stove***

and there's potential-or there has been a fire, or she hurts herself. Or, you know, we go see her and it's clear she hasn't been eating. It could be a number of different things, right? If she was to get a delirium and she clearly couldn't get herself organized anymore to get her basic needs met (participant 13).

Managing Risk - Goals

The participants gathered data comprehensively, interpreted it by corroborating, weighing and reflecting in order to build an impression of the risk status so that they could make clinical decisions on what to manage, how to manage it and toward what goals. Below, the first section on managing risk provides the rationale behind the risk management goals. The participants in this study indicated that they were mainly trying to prevent, eliminate or minimize the client's risk, but they also discussed conditions under which the client's risk was increased, shared or accepted.

Managing risk by preventing risk. Some participants indicated that helping the client avoid risk was the main goal of their program. The following participant highlighted the benefits of a preventative approach:

We're looking for those things that are not causing too much of a problem now, so we're going to jump on them, address them so they don't turn into the red flag. From the way we practice in this particular role, I would say that absolutely, yellow flag is one that you see the potential for change to address it so that it does not progress or that you slow down that progression (participant 10).

The participants who believed in prevention felt that this was a perfect opportunity to support the client's goal of staying in their own home by preventing the occurrence of either the perilous event or the negative consequences from the event. However, one participant held the view that prevention was not an appropriate role: ***"You can't protect people from things that haven't happened and there's a great tendency to want to do that (participant 5)."*** The differences in approach appear to be philosophical in nature.

Preventive strategies included interventions aimed at preventing an event (for example falls, car crashes, medication mismanagement, fires) from occurring, sharing resource information, providing education to the caregiver on what to do if the risk progressed, helping the client and their family prepare for the future and providing medical advice. For example, when assessment of the client's health suggest impairments that diminish the client's ability to safely operate a motor vehicle, the participants are obligated to ask the client to voluntarily refrain from driving pending further assessment to prevent any injury to self or others:

> ***Really clear cut avoiding a risk altogether, what comes to mind is driving and sometimes we have to clearly say to somebody 'You're not safe to drive and in order to avoid harming yourself or harming others we're going to have to notify the Ministry of Transportation'(participant 14).***

In other circumstances participants might talk to caregivers about probable declines that might tip a situation from tolerable to intolerable risk.

The participants also prevented risk by making recommendations that removed the source of the risk to prevent a perilous event. The examples that the participants provided included recommending removal of outdated medications to avoid medication mismanagement, removal of scatter rugs or exposed cords to prevent falls, unplugging the stove to prevent fires, and recommending relocation when physical and financial abuse were a concern. For example:

> ***Mom or dad has left the stove on, on numerous occasions, that's a big red flag. Or, they've set fires so in those kinds of conditions we're going to put things in place to try to prevent risk. We might tell people to unplug the stove, get rid of the stove...that kind of thing (participant 13).***

Participants did not provide examples of recommendations that could prevent the negative consequences of the event from occurring but possible examples could include

hip protectors to prevent hip fractures or teaching clients how to prevent injury when they

fall.

Managing risk by eliminating risk. In contexts in which participants considered

that the event was already occurring, the participants indicated that eliminating the event

was a clinical goal for them, although they admitted that this was not always possible:

> *It can happen at any time, and we need to, with client consent, we need to try to make a plan with the client to decrease risk-eliminate is the goal, but at least to decrease with services linked to organizations…(participant 11).*

Some of the examples of the strategies that the participants provided as risk eliminators

were similar to preventing risk but the key difference in this case is that the event or the

consequences of the event had already occurred and the strategies had to eliminate the

possibility of the event occurring again. Examples include removing the fuses or

unplugging the stove for those individuals who had already had stove fires; having a

reliable caregiver administer medications for those individuals who were forgetting to

take their medications; and recommending to have the clients' license revoked and car

removed for those individuals who were getting lost while driving or who had had several

accidents.

Managing risk by minimizing consequences. Strategies aimed at minimizing

risk acknowledged that the perilous event was already occurring and attempts were made

to reduce the severity of the negative consequences of this event. One participant felt that

although eliminating the risk may be the main goal, minimizing/reducing the risk was a

more realistic outcome to achieve with the client since risk is part of everyone's life and

not amenable to being completely eliminated:

> *I think if we walk in there expecting to eliminate risk, we're going to be disappointed a lot of the time. I think if we can identify risk, that's one level of*

success. If we can minimize risk, that's another level. If we can eliminate it, that's another level, but all a success as long as someone understands that they are at risk, then our job is done (participant 10).

A strategy for minimizing the consequences of the event could include registering the

client with the Safely Home registry or notifying neighbours that the client wanders:

There's things like the Wandering Registry through the Alzheimer's Society, for example, often we'll encourage people to do that. Also, you know, get people to talk to their neighbours. Are there people who would be in the area where that person is most likely to wander? So talking to people, 'Have you seen my loved one out and about? Can you give so-and-so a call?' (participant 13).

Neither of these two strategies prevents the client from wandering but can prevent the

client from wandering for an indefinite period of time, decreasing the negative

consequences to the client.

Managing risk by increasing risk. The participants were not prepared to state

that they intentionally made recommendations that would increase the client's risk status

but they admitted that there were some situations in which this occasionally occurred. It

could occur in situations where withdrawing services increases the likelihood of an event

occurring or increases the severity of the consequences, however, one participant

indicated that it could also occur when services put in place to manage one risk increases

another risk. The following quote illustrates this situation:

For the moment we're making it worse by putting resources in. It's upsetting mom. It was making her.... She was saying she was going to kill herself. She didn't want people in her house. She was going to kill herself (participant 9).

Here the participant was referring to the personal care support services that were going in

to prevent the perilous events of malnutrition and a decline in personal hygiene by

providing assistance with showering and meal preparation, but this support was upsetting

the client mentally to the point that it was putting the client at risk of suicide.

One participant also felt that using an authoritarian approach could jeopardize the client's willingness to accept any services and thus increase the potential risk of the situation in the future:

> ***Well, I guess, on some occasions, though we don't want to admit it, we go in and we add fuel to the fire and increase the risk by the fact that someone's accepted us to be in, but the fact that we've gone in and addressed issues that they're very defensive about that they push back and then won't let anybody help them, so and in that scenario, we do increase the risk (participant 10).***

The example that this geriatric assessor is referring to is when a client is asked to refrain from driving after the completion of the assessment due to physical and/or mental health impairments. The participant then wants to arrange further follow-up to address these impairments and wants to organize other services to be involved to reduce the client's overall risk status but the client refuses all recommendations as they are upset about the driving recommendation. Leaving the client with untreated impairments puts the client at higher risk for the events to continue to occur.

Managing risk by sharing risk. The participants described situations where the risk was shared. This had multiple meanings. Participants described sharing risk as a concept that occurred when others (including themselves) became aware of the situation and more specifically when others were used to help minimize the risk: "***I think we share the risk a lot. You know, we diffuse it by sharing it with other agencies, with family and I suppose with the client themselves (participant 3).***" This participant suggests that sharing risk occurs often and can be successful at reducing the client's overall risk status. One participant felt that the more people who know about the risky situation the more that the risk was shared with the hope that this would ultimately keep the client safer.

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Managing risk by accepting risk. The participants described that there were times when they accepted the client's risk but that this would only occur under certain conditions. The participants had no difficulty accepting the client's decision to live at risk when they felt that the client fully understood the consequences of their actions after being presented with all the information. In these situations, the participants were able to accept withdrawal of their services and one participant indicated that if appropriate, they would leave the door open, should the client change their mind. One participant acknowledged that there were situations where acceptance still occurred even if the client might not be capable to make this decision. This tension was reconciled by documenting: "***If they don't have the insight, you know, in terms of that, I think we just make ourselves comfortable that we've said the right things and that we've documented everything… (participant 9).***" Here the participant describes situations where she questions the client's capacity due to a lack of insight, where there are likely events with negative consequences occurring and where the client is likely disagreeing with the recommendations to reduce the risk. This is a participant who only sees the client once so she reconciles the discomfort of having to walk away from a client with risk by documenting the client's refusal for further involvement or recommendations in the client's chart. This is done as legal protection for the health professional should anything happen to the client and legal action is taken.

The participants indicated that they would also feel better about accepting risk when the consequences of the event were not imminent nor serious or if the situation was in synchrony with their philosophy:

> ***Accepting risk, I think we accept risk all the time because, no matter what, it's just life. There's always going to be risks. We take a risk to drive to work every***

morning. I think that's just how it is. And, so, I think a lot of the time families accept a degree of risk, I guess, at the cost of not taking away someone's freedom or rights or maybe because they feel guilty-there are a lot of reasons why people accept risk, I think that there's a lot of that going on for sure (participant 13).

This quote shows how participants are better able to accept risk when they are able to acknowledge that risk exists in everyday life for everyone of any age. It also acknowledges that risks have costs that include not only the consequences of the event but freedoms and rights, and that families and clients are weighing all of these in complex formulations.

Managing Risk - Process

The participants managed risk with the main purpose of preventing, eliminating or minimizing risk but risk was also occasionally shared, accepted or increased. The participants described that they accomplished these goals by collaborating with the client, family and/or others, by informing the client, by delaying and waiting and/or by overriding the client's wishes.

By collaborating with client, family and others. Managing risk often involved a collaborative process between the participant and the client and was expanded to include family and others typically when cognitive impairment was a concern. Descriptions of their collaborations with clients mirrored aspects of client-centred care. The participants indicated collaborations with the client included being open and honest with the client, taking the time to understand the client, giving the client time to take ownership of the next steps of their life, providing information for involvement later and by leaving the door open. For example, one participant explained,

> *I might say something like, 'If you change your mind, or when you start thinking about this over time and if something changes, I want you to know you can call me back.' So I also leave the door open for that…(participant 14).*

Collaborations with the client also included encouraging the client to accept the recommendations and supporting the client's experiential learning: "*I think when sometimes people experience living at higher risk, it really sometimes forces them to make the really hard decisions that maybe didn't seem as imminent before (participant 13).*" This quote highlights the idea that in some situations, participants might support the client to live at a higher risk for the main purpose of helping them understand the consequences of the risk by experiencing them.

The participants also collaborated with families. This collaboration was often complex. Participants found that it could be both a help and a hindrance towards supporting the client's goal of remaining in their own home. Under positive conditions, this collaboration could involve actively providing treatment directly to families in the form of support, advice and education or it could involve using families as the intermediaries to follow-through on recommendations on behalf of the client. In these situations participants felt a sense of relief and found that their job was easier when family was involved:

> *Easier or satisfying-however you want to describe it-when families really start to appreciate the need for their increased involvement and we're able to actually help them help their parent and that's really satisfying and that makes my job easier too when I know that finally they get it (participant 6).*

Contrarily, participants acknowledged that family involvement could also be a hindrance to the therapeutic involvement. This occurred when family involvement increased risk by either being a cause of the risk, as in the case of suspected abuse or by magnifying the risk as in the case of caregiver burnout or caregiver ignorance. Families

also had a negative impact on the therapeutic interaction when they tried to push their

own agenda. This could occur when they wanted their family member relocated as

illustrated in the following quote:

> *Sometimes families get really frustrated and they're calling me and they're saying, 'Why can't we just put mom or dad in a retirement home? Why can't we?' And in our society we can't just take away people's rights just because we think there is a potential for risk and I think that is a really tough question to answer (participant 13).*

This quote highlights the frustration families have with their parents who they feel are

living at higher risk than what is comfortable for them. It also highlights the multiple

agendas that are at play in these clinical contexts, the client who wants to remain at home,

the health professional who wants to support this goal and protect individual's rights and

their safety, and the family who want the safest environment for their parent.

Participants described clinical situations where they also collaborated with others,

which might involve utilizing community services, mobilizing neighbours for support or

accessing medical or legal experts for advice and/or intervention. Participants

acknowledged that in order to provide the client with the widest variety of options and

support, collaborating with others was necessary:

> *Looking at what the person can do, what the family can do, what the community can do to help keep that person in their home safely as long as possible if that's where they want to be and it usually is (participant 6).*

However, participants did acknowledge some frustrations when collaboration with other

agencies was restricted by strict program criteria. This occurred with complicated

situations that did not meet the clear-cut criteria of organizations such as home care

(CCAC) or the Public Guardian and Trustee (PGT) offices.

By informing the client. Some of the participants felt that it was their role to provide the client with information and recommendations but then leave it up to the client to decide the next steps:

> *Risk is different things to different people so our role is not to go in and tell someone how to do something or how to change their lives in certain ways, it's to let them know what's available and what's out there, if they're interested and to facilitate that and if they're not, to respect that (participant 10).*

The majority of the participants felt that it was their professional responsibility to inform the client of the risks that they were concerned about and provide corresponding recommendations to minimize the risks but they were passionate about the client making the decisions even if it meant termination of the relationship after they presented the client with all the options.

By delaying and waiting. Other participants were willing to wait for the client to be ready for their recommendations thus acknowledging that interventions for risk could get delayed. This typically occurred with the participants in the two organizations who followed the client over time. They indicated that there were times when interventions were delayed on purpose, for instance while waiting for the natural course of life to occur:

> *I think that they really hoped that in putting it off as long as they did that something would just happen naturally and she'd be able to die in her own home and they'd never have to take away her rights or participate in taking away her rights and causing her so much distress, which they expected (participant 6).*

This quote highlights the difficulty family members have in relocating their parent to a more supervised setting when they know it's against their parent's wishes. Delay can mean never having to intervene directly.

Participants indicated that the implementation of longer-term recommendations

might be delayed while families and clients bought time by implementing short-term recommendations. This also occurred with relocation recommendations. Families and clients would agree to short-term services like Meals on Wheels, knowing that with a progressive illness like dementia, relocation would be inevitable:

> *If somebody's quite demented then you're having the conversation with the family about the next step which is going to be long-term care or retirement home to avoid, I would be saying then, this is just a stop-gap, this is just buying us some time with Meals on Wheels and this and that, this is just buying time, but we can't-this is a progressive disorder. It's going to continue to change. It's not like someone who's just come out of hospital and needs support for a while. This is ongoing. So to avoid, you know, more things happening, more dramatic things happening, we need to have a plan for [a] safer environment (participant 5).*

Some participants hinted that they experienced more frustration with family members who reject recommendations than with clients; participants were seemingly more readily able to accept client resistance.

Delaying risk interventions could also be at the request of the client. In these cases some participants were willing and able to leave the door open should clients reconsider the recommendations:

> *If there's just no agreement then I have to say, I accept your decision about this, and try to leave it on amicable terms, to leave a door open. And say, 'You know, just because you said, no, now, doesn't mean we couldn't come back again or see this again or maybe you'll change your mind' (participant 3).*

Here the participant discusses the importance of accepting the client's decision and perhaps this is easier to do since she has the flexibility to re-open the client's file in the future should they change their mind. One participant used the client's delaying of treatment to work on other issues:

> *If, you know, there's other issues then I'm going to keep working on other issues. And in this current job, I follow people over a fair length of time, so knowing that they might not be ready today when I think they'll come back in*

three months, then I'll revisit that at that point (participant 8).

This is again another benefit of being able to work with a client over time.

On the other hand, risk intervention might also get delayed until a crisis occurred:

> *Sometimes it takes the crisis, and I guess that's what living at risk is; whether we can intervene and change it or whether we have to sit back and wait for the crisis if those people are living at risk (participant 10).*

This quote is suggestive of a participant who has reconciled with the fact that some clients' decisions will result in a future crisis.

By overriding the client's wishes. Although the majority of the participants preferred to respect the client's wishes in situations where the client declined recommendations even if it differed from their professional judgments, there was one experienced participant who felt that some of her more junior colleagues used coercion to convince clients to accept their recommendations:

> *They [the client] may be reluctant to do that [accept services] and I'm going to back off then because I've given you the resources, I can't make you do it, and I find some staff are not comfortable with that, so there's a bit bordering on coercion, but you can't do that (participant 5).*

This participant had been 30 years in the job and found this coercive attitude among newer staff. She found that they had a lower tolerance for risk which led to trying to force interventions on clients.

However there were conditions under which the majority of participants felt they had to override the client's wishes to remain in their own home. These conditions included when there was significant harm to the client and the client was felt to be incapable to make this decision and/or when there was significant harm to others. Significant harm to the client could occur in situations when there was suspicion of a medical emergency:

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> *He was living in extreme risk and his sister had tried to bring him to the emergency department to have his health looked at and make sure that everything was okay, that it wasn't a delirium but he got agitated in the ER so he had to go back home and so, he was putting himself and others at risk, so we had to force him to go for the assessment (participant 15).*

This participant was concerned enough about the client's health that they activated the Form 1 process which involves a family physician completing a legal document granting police the legal authority to bring the client to the hospital against their will for medical assessment; the hospital can detain the client for up to 72 hours. Overriding a client's wishes also occurred when it affected the safety of others: "*We have to accept that we can't always change someone's willingness to live at risk themselves, but when it comes to the safety of others, we have to step up (participant 10).*"

Perceptions of significant harm to the client could also occur gradually over time. Participants who follow clients over time may wait until a subjective threshold is reached before they override the client's wishes:

> *I have many clients who we check on on a regular basis and we're just basically waiting for enough evidence to say this person is no longer safe to live at home because we have a right to continue to live in our own homes until there is a perceived degree of risks (participant 13).*

Participants spoke of legal authority to override client wishes, but also spoke of moral obligation, to ensure client safety. All such situations require substantial evidence of the client being at extreme imminent risk to themselves and/or others.

> *'Let's move her out then.' No. No you can't do that. You can't make those major changes unless you have the absolute evidence for it. Same as going for a Form 1. You've really got to lay that out (participant 5).*

Balancing Safety and Autonomy in the Context of Risk

Working with frail community-dwelling older adults who wish to remain at home even when their health changes invokes an ethical dilemma for health professionals in

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their desire to support the client's wishes on the one hand and support their safety on the other, whenever risk is a concern. The participants in this research study discussed the factors that affected this balancing act, the emotional toll involved in this balancing act and conditions under which this balancing act worked well. Participants felt that there were practitioner, work-environmental, legal and health care system, clinical environmental, therapeutic and client factors that had an impact on their decision making when balancing safety and autonomy. They acknowledged and provided examples of how the decision making process in this clinical context has an emotional toll on not only the client but the family caregivers and the health professional. The impact factors will now be discussed.

Impact of the practitioner. There are many personal factors of health professionals that can affect the types of clinical decisions made when assessing and managing risk, as they try to balance safety and autonomy when working with community-dwelling older adults. Clinical reasoning skills, medical content knowledge, knowledge about one's roles and responsibilities, life experiences, understandings, beliefs and perceptions of risk are all personal factors that the participants from this study found affected their ability to balance safety and autonomy. The participants revealed that when their understanding of risk increased, they were more comfortable in tolerating risk and when their clinical reasoning around risk improved, their job satisfaction improved. This quote reveals the participant's increased satisfaction with her abilities as she gained more experience and understanding about risk over time:

> [*I got better] at identifying risk for sure, and also building a frame work in my head of what I see as risky situations…, it wasn't clear to me at the beginning what I should be looking for or really, what, to me, I felt was a risk (participant 15).*

This participant felt that with improved skills she became a better clinician:

> *I've come up with this mental checklist which is not 100% complete but at least I feel more confident knowing what to look for and how I'm going to look for it…. I am a much happier, more balanced person and I think I can help people if I am in a better state (participant 15).*

Gradually developing confidence, efficiency in clinical reasoning, clearer boundaries around program mandates, and better knowledge of medical conditions and functional impacts all helped the clinician balance safety and autonomy: "*I'd say probably over the years, my experience led me to boiling things down faster and getting to the heart of an issue more quickly (participant 8)".*

Lastly, the participants acknowledged that their understandings of risk and perceptions of risk are personally driven which has an impact on their clinical decisions and how well they balance safety and autonomy. As one participant indicated "*We all bring to it our own issues too, which really blurs and colours our perception of risk depending on how that risk is going to affect us…. and that includes us professionally (participant 10).*" Here the participant acknowledges that factors at a personal level can influence professional decision making.

Having an increased understanding of risk and increased skills to manage risk helped the health professional better balance safety and autonomy by having a better understand of the perspectives of the client, family member and other health professionals.

Impact of the work and clinical environments. The research participants found that there were aspects of their work and clinical environments that both supported and hindered their ability to balance safety and autonomy. Supportive colleagues, supportive

safety policies, legislation and the health care system, working in the client's home and having flexible and extended involvement with the client were environmental factors that participants felt improved their ability to balance safety and autonomy. However, some participants acknowledged that working in the client's home can come at a cost. These environmental factors will be discussed below.

Work environment. All participants acknowledged that they worked in a supportive work environment. They all commented that being able to confer with their colleagues was critical to their success with clients. Some participants also felt supported by policies and procedures with regards to safety.

All workers accessed colleagues for support in both formal and informal situations. Formal support occurred during team meetings, while informal work support occurred during a regular work day. One participant alluded to unintended informal support that occurs "***They [the team] support me in a way maybe that they're not even aware (participant 6).***" Participants primarily sought support from colleagues who were in the same position as they were within their organization but they also occasionally accessed support from management, the program's physicians, or health professionals in other programs, depending on the need. The regulatory college was also mentioned as a clinical support: "***I spoke to the College. They told me very clearly that it was my responsibility to make the management of the building aware that this was happening and for them to deal with [it] (participant 10)".***

Participants also appreciated management supporting their judgment about pragmatic work logistics such as deciding how to manage their caseload and how much time to spend with a client. Policies around safety procedures were mentioned as another

support in the work environment such as bringing along a co-worker or calling police for an escort:

> ***If we know we're dealing with a particularly high risk situation we can have one of our colleagues come along with us, or [our] intake coordinator who's here on the phone all the time will call and say, 'Just checking in. How are you doing?' That kind of thing. Certainly we debrief without a doubt. There's lots of informal support from colleague to colleague. We'll often come back and go, 'Wow, I was just in a really tough home visit. Do you mind if I just bounce this off of you?' To me that's the main thing. And that really makes a difference (participant 14).***

Supportive colleagues and supportive policies were presented as key work environmental factors that helped the participants better balance safety and autonomy by allowing them to access more expertise and feel safe while working in potentially unknown home environments, respectively.

Legal and health care system. The frustrations associated with navigating the health care system and the lack of legislation were two work environment factors that made balancing safety and autonomy difficult. Participants found it easier when their clients fit the criteria of programs needed to support them at home, *versus* those clients with atypical needs that fell outside of the program criteria. Trying to arrange piece meal support for the client was not only difficult for the participant but also confusing for the client.

Legislation also helped and hindered the balancing act for participants. Clear legislation around driving privileges made the difficult recommendation of driving cessation easier compared to the difficult recommendation of relocation in situations of elder abuse and self neglect where there is minimal legislation.

Clinical environment. Elements of the clinical environment that had an impact on the participant's ability to help their client to remain in their own home even if risk was

identified included the location of the clinical intervention, the length of the clinical involvement and the kinds of decisions that are made in this clinical context. Being in the client's home, being able to work with clients over time and the attributes of the decisions had an impact on the kinds of decisions that the participants made around risk assessment and risk management.

All study participants' clinical involvement occurred in the client's home and they all stressed the importance of being able to work in the client's home environment for its ability to reduce risk. As one participant indicated, it is critical when working with older adults around risk management: ***"By going and meeting them in their own homes, in their own environment, I think that is a reducer of risk right there. It's a strategy to reduce risk and geriatrics should always exist for that reason (participant 14)."***

However, the participants also acknowledged that working alone in the community occasionally put them in a clinically, physically and/or legally vulnerable position. Participants felt clinically vulnerable with respect to working in isolation and having no medical backup especially in times of client medical instability. In a hospital, health professionals can access physicians and emergency tests, while in the community; they only have telephone access to the client's family physician if available or 911. Participants also felt clinically vulnerable when they had a lack of detailed information about the client compared to copious amounts of clinical information that one has access to in a client's hospital chart: "***We are going into some situations cold***, ***we don't always know what we're going into (participant 14).***" Participants acknowledged feeling physically vulnerable when working alone in the community, but if concerns were indicated ahead of time they could decrease this risk by activating their safety protocol:

"*We can call the police just for an escort, just 'cause we're not sure what the situation's going to be (participant 5).*"

Participants also felt legally vulnerable when working alone with community-dwelling older adults especially if things went wrong as illustrated by this participant's comment:

> *Because we're very autonomous and we're out in the community, no one's there with us, no one sees or hears what we're seeing or hearing, so there are situations when, I mean a family might decide that what was done isn't to their liking and so there can be consequences about that, so that's difficult (participant 3).*

One participant indicated that using documentation as one strategy to protect against litigation is not always foolproof: **"*There is a lot of focus on documentation when the reality is that just makes us feel safe and that's false safety (participant 9).*"**

The participants indicated that the length of involvement they had with the client had an impact on decision making. Being able to work with clients over time allowed the study participants to meet the client where they were at, which meant they had the time to gather the necessary information and work on the client's priorities at a pace that worked for the client:

> *You need to find your own rhythm, what works for you, what your comfort zone is. Your comfort zone maybe making three or four visits with a new client until you feel you've got a feel that you've got all the information (participant 5).*

Being able to work with a client over time allowed the participant to monitor changes over time and adjust treatment recommendations as needed.

This was in contrast to only seeing a client once, where a participant had to gather all the information and provide recommendations for all the concerns, whether a priority

to the client or not, in one session. The latter could be overwhelming for the client but also clinically frustrating for the health professional:

> *We get these snapshots which may or may not even be accurate. We make decisions which are clearly on unvalidated tools and then hope someone else takes the monkey off our back, at least the family physician and who they're just not prepared to do that. We've had family physicians call and say, 'We're not case managers.' Neither are we (participant 9).*

Here a participant who only sees clients once, questions the accuracy of the information that can be obtained during a single visit, and the challenge of assessing risk when she will not be working with the client through these issues. Elsewhere in the interview she notes that the more practical goal is developing enough trust for the client to buy into the next step of intervention with another program. She acknowledges that problem identification is a necessary part of the process in helping older adults remain safe and independent at home. Nonetheless, the lack of follow-up on identified problems was frustrating for her. Other participants who see clients only once had come to terms with any potential frustration by accepting their program boundaries:

> *We are not there to be able to solve all the problems. We're there to identify what the problems are and then get them the help that they need... And, the bottom line is, if I feel I need to see someone again, I see them (participant 10).*

When trying to balance a client's safety and autonomy, certain clinical decisions were made. Specific attributes of these decisions had an influence on the clinical reasoning process and impacted on how easy it was for the health professional to balance safety and autonomy. The participants directly discussed the impact that the seriousness, the uncertainty and the consequences of the decisions had on their clinical involvement with the client.

Participants found the balancing act more difficult when the decisions that had to be made had a serious impact on the client. Uprooting the client with relocation recommendations or causing increased dependence and potential isolation with driving cessation recommendations, were the two most serious clinical decisions that the participants had to make. One participant described the responsibility associated with some of these serious decisions:

> *It's a huge feeling of responsibility and, I guess, the thing that helps me with that is that, I guess if I was a 20-year-old [health professional] just coming out of school, it would be pretty devastating to try to make those decisions on behalf of anybody else. And the stage I am in my life, I have to look at it like what would I want for my mother or for my loved one? And I think that I can step back just a little bit and it helps me make that decision (participant 6).*

Participants also found making decisions related to balancing safety and autonomy difficult as the outcomes for a lot of the decisions are uncertain. Due to the uniqueness of clients and their situations, one is never sure which recommendations are going to work well. One participant elaborated on this concept of trial and error: *"That's what I think is so difficult about risk is there's generally speaking not just one strategy that works for every person. Sometimes, what works for one person doesn't work for another (participant 13)."*

Lastly, participants acknowledged that if the client's decisions affected public safety it made the balancing act of safety and autonomy easier. Participants felt better about overriding the client's wishes when the client's risk decisions could affect public safety. This mostly occurred around the event of fires when the client lived in an apartment building, knowing that not intervening for fire risk could not only injure the client but could also cause injury to fellow tenants. Unsafe driving was the other event where participants felt that they had to intervene at any cost to the client to prevent the

public from being seriously harmed. This next quote not only illustrates the focus on public safety but also shows the participant's need to prevent injury to the client:

> ***Well, I think it's when we know that we might have saved this person, or we've prevented them from harming themselves, or being really injured themselves, or hurting some other people or killing other people if it is regarding driving, or that they could have more quality in life down the road… (participant 3).***

Despite the costs of working in the client's home environment with respect to clinical, physical and legal vulnerabilities as indicated above, all participants found that it was critical in developing a comprehensive knowledge of the client and an understanding of their concerns. As indicated previously, observations about the home environment can help confirm or deny suspected concerns and serves to be a powerful collaborator of client and family concerns, which in turn, helps provide the health professional with a more comprehensive foundation from which to build a more realistic treatment plan. Working with a client over time helps the health professional build a more client-centred treatment plan by allowing the time to know the client, to gain trust from the client and to address more than one issue, which is commonly needed when working with frail community-dwelling older adults. There are many clinical decisions that the participants had to make when working in this clinical context. Participants definitely found it easier to make the decisions needed to balance safety and autonomy, when there was enough information to be able to make a certain decision, when the risk was minimal enough that the decisions were not serious or when the risk was significant enough to affect public safety.

Impact of the therapeutic relationship. The participants found that they were successful with balancing safety and autonomy when they had a good therapeutic

relationship with the client. They acknowledged that this involved basic tenets of client-centred care and having a philosophy that agreed with client-centred care.

The client-centred care factors that the participants acknowledged included: assessing with the client's consent, addressing the needs of the client, developing trust, developing a plan that aligned with the client's goals, giving the client time to take ownership of the intervention plan, listening actively, being upfront and honest with the client, ensuring that the client understands, helping the client make an informed decision, and taking the time that is needed to work with the client. One participant highlighted the importance of respecting but not necessarily liking the client's decisions to ensure a successful client interaction:

> *I think we do support the risk as-is. If they don't accept any of the recommendations then you are left to provide them with the information, but ultimately it's up to them to decide whether they make those changes or not. So I wouldn't say that I'm supporting the risk, but I'm respecting their decision to live at risk. Because I can't say that I would support and encourage risk, but I would respect their decision to live at risk (participant 1).*

Participants found it easier when their philosophical beliefs were in sync with the client's choices around living with risk: *"Whatever can be done to maintain someone's autonomy in their own home is what the goal is of our assessment and the goal of our involvement, so I philosophically believe that so it makes that part easier (participant 1)."*

Impact of client factors. The participants described two client factors that impacted on their ability to balance safety and autonomy. These included the cognitive capacity of the client and social support.

The balancing act was harder when the client had some cognitive impairment. This lead the participants to question the client's capacity to make decisions:

Yeah, what to do, but you know, getting to that point and figuring out when somebody is capable or incapable is really tough and that's when I would call on someone if I really wasn't sure, I'd call on a colleague and just go over it (participant 6).

Participants had no difficulty supporting the client's decisions to continue to live at home even when negative consequences of risks were occurring if they felt that the client was making an informed decision. Questionable decision making capacity made it harder for the participant to determine if the client was able to make an informed choice and thus whether they should respect these decisions or override them. This grey zone of decisional capacity affects the health professionals' clinical decision making:

They're not so impaired that they can't make choices for themselves, but they have some impairment that impacts on the quality of the choices that they make and I think, inherently, does increase their risk because their impairment is not so overt (participant 1).

Participants found it difficult to balance safety and autonomy when the client did not have family support and found it easier when there was support:

I guess, easier or satisfying-however you want to describe it-when families really start to appreciate the need for their increased involvement and we're able to actually help them help their parent and that's really satisfying and that makes my job easier too when I know that finally they get it. Or the spouse gets it. Or the son or the daughter gets it and they are going to step up to the plate and they are going to help (participant 6).

As indicated previously, having family support made the balancing act easier for the participant because they could be used as a strategy to either eliminate or decrease the risk. It comforted participants knowing that family members would follow up the recommendations. Family support meant that the client would have regular contact and monitoring which would help to ensure professional re-involvement with any changes in the client's health, function or safety status. It also meant that the client had a personal advocate, which proves helpful in not only navigating the health care system but also

ensuring that they get to their medical appointments.

Reacting emotionally. The participants described the emotional toll that the clinical decision making process involved in balancing safety and autonomy had on families, themselves as health professionals, and clients. Participants acknowledged that the decision-making process was stressful for family members:

> *The daughter was rather tortured with these decisions that she was having to make. First of all, having to make in terms of at what point is the risk too great and when do I have the right to make that decision on her behalf just in her own mind, I guess (participant 6).*

One participant highlighted the shared stress, acknowledging that family members are often relieved when others, such as health professionals, make tough decisions for them. For example: *"Often in my experiences, families feel a huge burden lifted off their shoulders if they know that someone else is dealing with telling someone they can't drive anymore (participant 13)."* Participants also felt that stress caused family members to delay making decisions due to a fear of making a 'wrong' decision and consequently may extend negative situations longer. Participants acknowledged that family members also delayed making decisions due to feeling overwhelmed by the seriousness of the decisions. One participant was prepared to be the 'bad cop' in decision-making to preserve the familial relationship: "*The mom could be mad at me, and could be mad at the paramedics and police, but it would be better if the daughter distanced herself (participant 6)."*

The participants described a variety of emotions that they experienced while trying to balance safety and autonomy. The participants described feelings of discomfort, stress, potential burnout and angst. For one participant, when she starts thinking about

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work situations at home or they are surfacing in nightmares she knows that she is close to

the tipping point of no longer being able to support the client in his/her home:

> ***The struggle for me is when I'm feeling very uncomfortable and maybe it's even affecting me personally, like they're coming up in my nightmares or I'm thinking about them on the weekend when I'm at home something like that where the risk has then got to a point where I'm feeling some real discomfort because I'm looking at it from the outside and then I know that the next step is going to be something that my client is not going to be happy with (participant 6).***

Several participants mentioned sleepless nights. Some said revoking driving rights, a

legal obligation, felt far from their role in a helping profession, led to feelings of burn out.

Participants also acknowledged the difficulties that their clients' experienced

during this balancing act. One participant described the emotions that a client felt in

reaction to some difficult news:

> ***I can think of times when I've had to tell someone, I don't think that they should drive right away, and it's really as if they've been struck. They've been physically struck in the chest and you can see it and it's almost like, 'Oh, I'm worried they're going to have a heart attack, or they're just going to give up.' That's powerful. And, yet, it's something that's needed because for some reason there's been a determination of possible harm. So, I find that that can be stressful (participant 3).***

Clearly the strong emotional reactions evoked in clients also contribute to the emotions

experienced by health professionals. Driving was often mentioned as the source of the

stress for the health professional and the feeling of anguish for the client.

Summary

Health professionals working with community-dwelling older adults face the

difficult challenge of balancing the client's safety and autonomy when trying to support

their goal to remain at home as they age. In order to make the clinical decisions that are

required for this balancing act, a health professional needs to have a good understanding

of risk. The participants in this research study, who were practicing clinicians provided a wealth of information on risk and how to balance safety and autonomy with community-dwelling older adults. Their knowledge in this clinical context helped develop a collaborative definition of living at risk that can support clearer communication about risk with other health professionals, clients and family members. Their definition highlights the fact that living at risk is a complex concept that is comprised of four elements; impairments, environments, perilous events and consequences.

The participants clarified how risk is perceived from the perspective of a clinician and how these perceptions have an effect on how risk is assessed and managed. They described the importance of assessing risk comprehensively by gathering detailed information in a variety of methods from a variety of sources in order to avoid jumping to the wrong conclusions. The participants also described a comprehensive interpretive process that they used to build an impression about their older adult client's risk status, which ultimately informed decision making about managing risk. The safety continua emerged from the participants' descriptions of this process. The safety continua involves ranking the client's safety from low risk to high risk for seven continua; client's decision making capacity, event occurrence, event imminence, event frequency, consequence severity, multiple events and type of support. Determining the client's risk status on these seven continua informed the risk management strategy. Participants indicated that their strategies for risk management mainly focused on preventing, eliminating, minimizing or sharing risk. However, they did describe contexts under which risk was accepted or increased. The participants described that they managed risk by collaborating with client

and others, by informing the client, by delaying and waiting or by overriding the client's wishes.

The participants acknowledged that balancing safety and autonomy was difficult and had an emotional toll on the client, the family and the health professional. However, they described factors of the health professional, their work environment, the therapeutic relationship and the client that could be optimized to better balance safety and autonomy.

Chapter 5: Discussion and Conclusions

The goal of this research project was to address gaps in the literature as to how health professionals make clinical decisions when working with their community-dwelling older adults when risk is identified as a concern. This clinical dilemma typically invokes a need for the health professional to consider not only the client's goal to remain at home but also their safety. In order to understand the kinds of decisions the health professional makes in this clinical context, this research study asked community practicing health professionals how they perceive, identify, assess and manage their clients' risk. The findings from this research project have contributed to filling this literature gap by generating a definition of living at risk from the perspective of the health professional, by detailing the decision making processes throughout risk assessment and risk management and by elucidating factors that affect a health professional's ability to balance safety and autonomy.

The analysis showed how the participants respectively perceived risk and how these perceptions were at times similar but also different to their colleagues, other health professionals and family's perceptions of risk. The health professional participants identified risk by gathering a wide range of information in order for assessment and interpretation to occur. The results demonstrated how risk management did not occur until the information was interpreted by a comprehensive process of corroboration of the information, weighing of the facts and reflection.

Once this initial interpretation phase was completed an additional enhanced step occurred. This involved building an impression about the client's situation by determining the risk status. This was done by evaluating seven different factors about the

client, the event and the consequences of the event on a continuum scale of low risk to high risk. This risk status often determined how the risks were managed and for what purpose. Managing risk primarily involved interventions which prevented or eliminated the risk and/or minimized the consequences of the event, but the participants also described clinical scenarios where risk was accepted or shared. It was only under specific clinical conditions where the participants acknowledged that they would willingly allow their clinical interventions to increase the client's risk.

The participants managed the risk by either collaborating with the client, family and/or others, by informing the client, by delaying and waiting or in extreme situations of high risk, by overriding the client's wishes. The participants reiterated that balancing the client's safety and autonomy could be a challenging clinical task. They described factors about themselves, the work environment, the client and the therapeutic relationship that tipped the scales towards autonomy and other factors that favoured safety. It is these factors that informed the development of a practice framework for balancing client's safety and autonomy.

This chapter will explore the three major findings of defining, deciding about and balancing risk from the perspective of the health professional. First, the collaborative definition of 'living at risk' that evolved from the participants descriptions will be discussed. Specific definitions of 'risk' in the literature are either absent or highly variable; therefore articulating a conceptualization of 'living at risk' not only provides a concrete addition to the literature but also to clinical practice. Second, I will demonstrate how understanding how the participants made their decisions throughout the risk assessment and risk management process substantiates and extends the current

knowledge on clinical decision making in the literature by showing how it unfolds in this clinical context. Finally, I will show how understanding the participants' process of perceiving, identifying, assessing and managing their clients' risk contributes to a clinical and practical framework for how to balance client safety and autonomy. Although the Canadian occupational therapy practice guidelines suggest that the "aim in occupational therapy is to enable safe engagement in just-right risk-taking" (Townsend et al., 2007, p. 101), they offer no specific suggestions on how to do this. It is hoped that this risk assessment and risk management framework developed on the basis of this research can address this gap in the literature.

Defining Living at Risk: I know it when I see it

The participants had little difficulty detailing clinical scenarios about risk and describing clients who they labeled as living at risk, but they were unable to provide a universal definition of either concept. Their lack of a consistent definition is not surprising given that the literature clearly states that risk is a commonly used but rarely defined concept (Carson & Bain, 2008). The inconsistent discourse on risk is also reinforced by the lack of definitions of risk or references to risk in journal articles describing studies about risk. For instance some studies did not define risk (Ceci & Purkis, 2009; McDermott, 2010; Reich et al., 1998), some studies inferred the consequences of an event as the risk (Gilbert et al., 2011; Ryan, 1998; Tanner, 2003; Tierney et al., 2004) and other studies referenced risk as being a perilous event/hazard (MacCourt & Tuokko, 2010; Taylor, 2006). This debate naively assumes that risk is a clearly understood, straightforward concept that does not need defining. However, the results of this study prove otherwise as the participants' descriptions of 'living at risk'

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contained four different elements: impairments, environments, events and/or

consequences as illustrated in Table 1 on page 60. Based on the various

conceptualizations of risk by the health professional participants, the following definition

of living at risk is proposed: "***Living at risk*** *is a judgment about an* ***impairment*** *within*

an ***environment*** *that can cause an* ***event*** *that has the potential for a* ***negative***

consequence". Two main observations result from this definition, firstly, living at risk is

complex and multi-dimensional and secondly, the participants defined risk with a

negative focus. These are discussed in turn below.

      Living at risk as a multidimensional concept. Having a concept made up of

four elements can complicate its understanding and lead to miscommunication on the one

hand but can provide more opportunities for treatment on the other hand.

      Having a concept comprised of four elements shows how easily

miscommunication about risk amongst and between health professionals, families and

clients can occur. As risk is personally, socially and culturally constructed, it is not

surprising that health professionals see risk from a different perspective than families or

clients. The literature has shown that professional socialization, organizational mandate

and location of the clinical intervention contributes to how a health professional assesses

and manages risk therefore it is highly likely that these factors could have an affect on

which element the health professionals uses to define risk and living at risk. For instance,

among health professionals whose role is to provide treatment or arrange for treatment for

the client's impairments, for example physicians or in the case of this study, geriatric

assessors, it would not be surprising if they identified living at risk from an impairment

perspective. Those health professionals who work for an organization who see older

adults as a result of either an event or a consequence of an event, in the case of an emergency room or a falls clinic, might define risk according to events. Lastly, those health professionals who work in the client's home and see their physical environment may relate to the concept of living at risk as a visual representation based on evidence that they see on a daily basis in the clients' home.

Due to the comprehensive role of geriatric assessors and case managers, they would be referred clients for either a decline in the client's physical and/or mental health or after an event and they all see the client in the home. This would explain why they might use any one of the elements to define living at risk, but does not explain why they used one particular element over another to define living at risk. The health professionals in this study differed in terms of their professional socialization and organizational mandate but were similar in the location of client intervention as they all worked in the client's home. The results revealed that the health professionals did not use these elements in consistent ways and there was not a clear pattern to this inconsistency that would validate the importance of these contextual factors. It is possible that there was not enough saturation of the data with regards to this concept to show clear relationships between how the elements were used and the contextual factors influencing their use.

An advantage of defining the four elements of risk is that it provides opportunities for four different treatment options as indicated in Table 1. Although the participants in the study were not consistent in the elements they used to define living at risk, they consistently used the four different treatment options based on these elements. A health professional can ensure that the client's strengths are enhanced and that all possible treatment for their impairments has been tried rather than relegated to being caused by

aging. The health professional can make recommendations to adapt the client's physical environment and enhance their social support. They can also make recommendations to prevent perilous events from occurring and they can make suggestions to minimize the consequences of any events, when elimination of a risk is not possible. This finding has implications for teaching health professionals a logical way to define and address risk.

Defining risk with a negative focus. While the health professionals in this research study were inconsistent in their definition of living at risk, they were consistent in their focus on the physical and negative aspects of risk. They also attributed risk as belonging to the person or their environment, rather than to the provider or others. This supports the findings in the existing literature which show that health professionals are known to primarily focus on the negative outcomes (Carson & Bain, 2008; Taylor-Gooby & Zinn, 2006; Titterton, 2005), on the physical consequences of risk (Clarke, 2000; Mitchell & Glendinning, 2007) and on risk pertaining to the individual (Cott & Tierney, 2013). Societal reasons include a presence of the blame culture (Carson and Bain, 2008) and a general notion that risks are feared (Taylor-Gooby & Zinn, 2006). It is also a result of the socialization of health professionals (Clarke, 2000). Individual reasons include health professionals' focus on patient safety, their fear of being seen as a negligent worker if an injury occurs and their fear of litigation (Titterton, 2005). Titterton (2005; 2010) advocates that both social and health care professionals should adopt a positive risk taking approach for the benefit of their clients. Although Titterton's first step in his 10-step Person-Centred Positive Risk Assessment and Management Systems (PRAMS) framework is ensuring positive risk-taking policies at the organizational level, being able to appreciate the potential positive outcomes of risk would seem like another key first

step. Adopting a neutral definition of risk can facilitate this broadening of the health professional's appreciation of risk by acknowledging both the positive and negative outcomes of risk-taking. Purdy's (2010) definition: "risk is the effect of uncertainty on objectives where the consequences could vary from loss and detriment to gain and benefit" (Purdy, 2010, p. 882) is being proposed as a useful definition for health professionals to adopt when working with community-dwelling older adults. Also broadening the proposed definition of living at risk to not only include both the positive and negative consequences of an event but also the physical and social consequences of an event would help the health professional to be able to adopt a more positive risk-taking approach.

A health professional's understanding about risk provides the foundation to how he/she assesses and manages risk, which ultimately affects how he/she balances the client's autonomy and safety. The participants' negative focus explained why their risk management strategies were primarily aimed at preventing, eliminating or minimizing risk.

Surprisingly, the inconsistency in the participant's definitions from an element standpoint did not seem to have an effect on the risk assessment and risk management process. Therefore there is something about the term risk that makes it difficult to define but easy to recognize when one sees it. Regardless, having a specific definition of 'living at risk' can facilitate clearer communication amongst health professionals and between health professionals, clients and family members. Additionally, adopting a neutral definition of risk and living at risk can facilitate a broadening of the health professional's view of risk to acknowledge both the positive and negative consequences. This broadened

view is also discussed later in this chapter as a way for the health professional to more easily balance the client's safety and autonomy.

Reductionist approach. Breaking down the definition of living at risk into four components is suggestive of a reductionist approach. The reductionist approach has experienced a resurgence with the popularity of the evidence based practice movement (Taylor, 2000 as cited in Chapparo & Ranka, 2008). This approach suggests that risk can be objectively measured (Henwood et al., 2008 as cited in Cott & Tierney, 2013) and that people make rational decisions (Ceci & Purkis, 2009; Zinn, 2008 as cited in Cott & Tierney, 2013). The critique of this approach suggests that people instead make decisions using non-rational techniques such as hope or in-between strategies that rely on intuition, feelings and past experiences (Zinn, 2008, as cited in Cott & Tierney, 2013). Having an understanding of the non-rational decision making strategies that people use would help health professionals relate to how and why their clients and the family members make certain decisions. However, considering that health regulatory colleges require their members to be rational, competent and conscious decisions makers to ensure that they are making defensible decisions (College of Occupational Therapists of Ontario, September 2012; Baker & Wilkinson, 2011), proposing a framework that uses a reductionist approach is still warranted.

Making decisions: Being comprehensive to reduce uncertainty

Clinical reasoning involves a process of thinking, decision, action cycles throughout all stages of the therapeutic process (Higgs & Jones, 2008; Smith et al., 2008). The thinking phase involves decisions about what kind of data gets gathered and how it is processed. Scientific, narrative, ethical, conditional and pragmatic are types of clinical

reasoning processes that dictate what kind of information is paid attention to for clinical decisions (Boyt Schell and Schell, 2008; Chapparo & Ranka, 2008). This information is then processed cognitively via analytic, intuitive or reflexive techniques providing the necessary foundation for the action phase characterized by either paternalistic, informed or shared decision making. The risk assessment and risk management literature has yet to specify the thinking, decision, action cycles used by community-practicing health professionals with their older adult clients. The findings from this study adds to the risk assessment and risk management literature by describing the specific thinking, decision, action cycles the participants used to reduce the uncertainty that exists when trying to balance the safety and autonomy of one's client. The clinical reasoning processes used by the participants in this study are now described with regards to how they assessed and then managed risk.

Assessing Risk Comprehensively. Risk assessment consists of gathering sufficient information to coordinate the most appropriate level of care, support and treatment for the client but it is also the process used to gather sufficient information to reduce the uncertainty or ambiguity surrounding the management of the clients' safety and autonomy (Gunstone, 2003). Carson and Bain (2008) suggest that risk assessment specifically requires that the health professional collects and evaluates information about the outcomes and likelihood of the risk.

The participants were committed to gathering comprehensive information about the client in a variety of different ways, which was similar to the participants in Gunstone's (2003) study on mental health workers' risk assessment and risk management with people who self-neglect. The literature lacked any studies highlighting the clinical

reasoning process used during risk assessment. The participants in this study used the process described by Fleming's "three track mind" (Fleming, 1984 as cited in Chapparo & Ranka, 2008) to gather and process information about the client in order to inform decision making. This three track mind consists of the therapist reasoning about the client's diagnosis (procedural track), the therapist focusing on the client as a person (narrative track) and the therapist creating an image of the client that is provisional, holistic and conditional on participation (conditional track). These tracts are now more commonly referred to as scientific diagnostic reasoning, narrative reasoning and conditional reasoning respectively.

The research showed that participants used scientific diagnostic reasoning when they gathered information about their clients' mental and physical health status and sought to understand how this impacted on their function and safety. The participants tended to use narrative reasoning to gather more intimate information about the client. This type of information included specific information about risk, such as their client's beliefs about risk and their risk tolerance but also included more general information such as the client's goals, their functional status, their social support network and ideas about ageing in place.

The research also showed that conditional reasoning, which is defined as projecting an imagined future for the client (Chapparo & Ranka, 2008), occurred in two ways:(1) when the participants tried to predict the client's illness trajectory especially for those individuals with dementia and (2) when the participants tried to determine the client's risk status. The participants from the geriatric psychiatry outreach team who worked with clients diagnosed with a dementia and their family over time found that their

expertise about the dementia trajectory helped the families understand what to expect so that they could plan for the future. Conditional reasoning was also used when the participants tried to predict the projected risk status of the client. Traditionally determining risk status also referred to as risk estimation or risk evaluation (Titterton, 2005) is detailed in the literature as predicting the likelihood of the risk occurring and its consequences (Carson & Bain, 2008; Monk et al., 2006, Titterton, 2005). The results from this study expanded this two -factor evaluation to include six other criteria as outlined in Figure 1 on page 83. This further supports the participants' desire to be comprehensive not only while gathering the information but when processing the information in order to determine the risk status. Although these seven criteria emerged from the data as being important considerations when determining risk status, not all seven criteria were described by all participants. While participants considered the consequences of the risk as recommended in the literature, they did not discuss the likelihood of the risk occurring. Instead they were more concrete in their evaluation of the occurrence. The participants assessed whether this event was occurring or not occurring and whether it had the potential to occur but not what was the likelihood or the probability of the risk occurring. It is surprising that the health professionals did not discuss the prevalence of the risks that they are working on with the client or the probability of these risks occurring. Neglecting to factor the likelihood or the probability of the risk occurring in their risk evaluation causes the health professional to work on issues that may not be relevant. For instance if a health professional determines that the risk has a low likelihood of occurring then, providing strategies to minimize the risk would not be a good use of health care resources. It is not clear why the participants did

not consider the likelihood of the risk, despite documented prevalence, but it is possible that ageism may have been a factor. It is possible that the real or imagined frailty of their clientele lead the participant to feel that all of their clients have a likelihood of any risk and therefore evaluating the likelihood is a moot point or non-contributing factor to the risk status determination process. It may also be an indication of the risk society where any risk is not acceptable, whether it is prevalent or not.

The participants also determined risk status by commenting on the client's capacity, by acknowledging the amount of support they had, by determining the imminence of the event, the frequency of the event, and this was all weighed against how many events were presently occurring. Answers to these questions led the participant to determine if the client's situation was low, medium or high risk and this led not only to the types of decisions the participants made but how they made them. The participants' need to use a combination of seven factors for their risk evaluation rather than the traditional two factors points to the seriousness to which the participants took this process.

The emergence of the seven risk evaluation factors from this research also sheds new light on the complexity of decision making involved in the risk assessment and risk management process. It provides health professionals with another concrete clinical tool to use when working with their community-dwelling older adults which supports a rational, competent and conscious decision making process.

Managing Risk Comprehensively. Once information is gathered using a type of reasoning (in the case of this study, scientific, narrative and conditional reasoning), information gets cognitively processed in order for decisions and actions to occur.

Clinical information is typically processed analytically, intuitively and/or reflectively. The participants used all three types of processing but were most consistent on using an analytic and reflective approach to make their decisions. The analytic approach was most noticeable in how comprehensive the participants were in the amount of data they gathered, the variety of data sources they used and the number of criteria they used to determine risk status. All this data was processed carefully and analytically, in conjunction with reflection during the therapeutic involvement and after. This finding supports the College of Occupational Therapists of Ontario (September 2012) expectations that occupational therapists should be consciously competent decision makers as the public expects and deserves accountability. The College defines a consciously competent practitioner as someone who knows their strengths and limits, knows the standards, guidelines and rules and the values behind them, makes good choices consciously and deliberately and is able to explain why he or she took a particular course of action (College of Occupational Therapists of Ontario, September 2012). The latter two requirements can be met by an analytic and reflective approach. Some of the participants in this study described clinical situations when they acted intuitively but the intuitive approach was never used alone. One participant remarked that although she felt she could trust her gut she always wanted to corroborate these intuitive thoughts and never use them on their own. This again points to the desire for the participants to be comprehensive. The participants in this study were consistent in using the analytic and reflective approaches regardless of their respective organization or professional discipline. This contrasts with Clemens and Hayes' (1997) findings where they found that decision making was influenced by these two factors. They found that nurses and those

working in discharge planning roles were more apt to make "snap" or intuitive decisions compared to social workers or those working in the community who were labeled as "agonizers" as they took their time to process information before making their decisions. The latter is indicative of an analytic approach. The differences in organization and professional discipline might have been more noticeable in Clemens and Hayes' study as the differences in these two factors, were more extreme. For instance they compared inpatient workers to community workers compared to this study, which compared different health organizations within the community. Clemens and Hayes' health professionals were also working in their own discipline compared to the health professionals in this study who were working in a generic role and not their discipline. Suggesting that organizational context might arguably be more important than discipline.

Once the information is gathered and processed, decisions are then made. Clinicians have to decide what kinds of decisions to make and how they will make them. The health professionals in this study made risk management decisions of preventing, minimizing or eliminating the risk by methods of collaborating, informing, overriding or delaying.

As the health professionals in this study held a negative view of risk is it not surprising that their primary risk management strategy focus was on preventing, minimizing or eliminating this risk. This finding is in line with previous research (Clarke et al., 2011; Gunstone, 2003, Taylor, 2006). It was only in specific circumstances where the health professionals accepted, shared or increased the risk. Accepting the risk occurred when the health professional felt that the client was capable to make these choices and harm to others was not a concern, which was consistent with the health

professionals in McDermott's (2010) study. However, the health professionals in McDermott's study also did not intervene if they determined that the client's were making a lifestyle choice. This was not specifically discussed in this current study. It is possible that lifestyle choice was not discussed in this study as risk for the majority of the participants' clients resulted from a decline in function due to a decline in impairments rather than risk arising from lifestyle choices.

The methods in which the risk management decisions were made whether by collaborating, informing or overriding were indicative of the three common types of clinical decision making, namely shared, informed and paternalistic decision making respectively. This study showed that delaying was a fourth type of decision making technique used by the health professionals that has not been discussed in the literature. Which method was chosen was dependent on two main factors: risk status and temporality.

In general, when risk status was determined as high and a collaborative approach was not successful at minimizing the consequences, the participants used the overriding method. When risk status was low then the participants were able to use the collaborative or informing methods.

More specifically the collaborative decision making strategy was used by those health professionals who had the time to collaborate due to program mandate and the risk status was ranked as low-moderate. Participants described the range of collaborating from client only, to client and family, to family only.

Informed decision making was used by all participants but it was the decision making strategy most used by those health professionals who only saw the client once. It

was characterized by a unidirectional involvement, whereby the health professional provided recommendations for services, strategies or education to the client and/or family members. Providing sufficient information for the client to make an informed decision was considered a very important step by the health professionals in their clinical involvement with the client. However, informed decision making has it critiques. As indicated above, all participants were advocates of providing their clients with sufficient information to make an informed decision and sufficient options for them to make choices. Ceci and Purkis (2009) and Hicks and colleagues (2011) caution that this common narrative 'the case manager offers alternatives, the client make choices' does not accurately reflect current practice due to a lack of viable options for the client and due to covert pressure from health professionals. Ceci and Purkis (2009) state that the client's ability to execute autonomous decision making is limited by age, economic status, diagnoses and available resources. The participants in this study frequently stated that their clients have a right to live at risk yet Ceci and Purkis (2009) comment that this right to live at risk "often means the right to live in reduced circumstances, in conditions of frailty or decline without societal support (p.212)" due to the lack of true resources available. The participants in this study stated that they respected the client's decisions by offering recommendations and walking away, yet Hicks and colleagues (2011) found that their clients nonetheless felt covert pressure to accept recommendations from health care providers. This literature highlights the complex nuances that occur during clinical decision making both on the side of the health professional and the client. Having an understanding that informed decision making is limited by the resources available to the

client but also influenced by health professional power helps the health professional be a conscious competent decision making about the clinical decisions made with the client.

As indicated above overriding the client/paternalistic decision making was used when the consequences or the risk were high for the client, when the consequences affected public safety, when there was no social support that could minimize the risk, and when the imminency of the consequences provided no time to work through a collaborative process. Overriding the client's wishes also occurred with passive assent from the client. This meant that the family or the client was not happy with the decision but 'went along with it'.

Delaying and waiting occurred in a variety of clinical situations and was initiated by the client, the client's family or the health professional. Clients delayed intervention when they were not ready to work on the issues but did not close the door for clinical involvement. Families delayed decision making due to the seriousness of the decisions. Health professionals delayed decision making when the client was not interested in clinical involvement but they weren't prepared to walk away. Instead the health professionals delayed decision making while they could gather enough evidence to override the client's wishes or while they waited for a crisis to happen with the hope that then either the family or client would be more amenable to intervention.

The clinical reasoning processes used by health professionals when assessing and managing risk have not been documented in the literature. The data from this study highlighted the thinking, decision action cycles used by the health professionals in this study as they assessed and managed risk. They used scientific, narrative and conditional reasoning to gather the information and analytical and reflective methods to process

information. Decisions were made collaboratively when there was enough time and the risk status was low to moderate otherwise when risk status was high participants felt a need to make decisions that overrode the client's wishes. Informing the client of recommendations and delaying and waiting were two other decision making strategies that were used dependent on the mandate of the organization or on the clinical situation.

Balancing Safety and Autonomy: **Easier said than done**

The health professionals in this study acknowledged the importance of respecting the client's autonomy. However, there are critiques of such a focus. Hicks and colleagues (2011) feel that focusing on individual autonomy precludes our ability to fully understanding the complexity that exists within health care decision making. These authors stated that this type of decision making takes place in a multisystem arena and should be considered at both the individual and societal level. The present research study provides some insight on factors that influence decision making from a practitioner's point of view and should be considered in conjunction with the client's point of view and societal factors. Additionally, Beauchamp and Childress (2009) state that holding autonomy higher than other principles is an American bias and cautions health practitioners from neglecting social responsibilities in the autonomy debate or from neglecting other bioethic principles such as nonmaleficence, beneficence and justice. These authors instead recommend a balanced review of principles. This perspective helps to inform the present proposal of balancing both the client's safety and autonomy.

Balancing the client's safety and autonomy is a typical practice dilemma encountered by health professionals working with community-dwelling older adults when risk is a concern for which several different approaches in the literature are provided.

Client-centred care forces the health professional to favour the client's autonomy whereas bioethical clinical principles of beneficence ('do good' and 'prevent harm") and nonmaleficence ('do no harm') force health professionals to favour client safety. Heyman, Griffiths and Taylor (2002) notion of the risk escalator supports this dichotomous conceptualization of safety and autonomy as an "either/or" relationship by positioning safety and autonomy at opposite ends of a continuum. Interventions are then aimed at moving the client "upwards" on the escalator towards safety or "downwards" towards autonomy. Family caregivers on the other hand performed this balancing act by considering risk along a continuum of acceptable to unacceptable risk (Cott & Tierney, 2013).

This study's participants also did not see safety and autonomy on a continuum scale with safety on one end and the client's autonomy on the other. Instead the health professionals considered the client's risk along a safety continuum from safe to unsafe. As the participants evaluated risk by determining the client's risk status as either low, medium or high risk, they translated this evaluation onto a safety scale from safe to unsafe. Here the participants balanced their client's safety and autonomy by supporting their clients in their own home along a continuum of safety up until a tipping point. This tipping point was a circumstance at which the client's situation had become unsafe to the point that the participants felt they had to override the client's autonomy. This typically occurred when the client had to be relocated against their will or asked to stop driving against their wishes. This conceptualization of a safe-unsafe continuum highlights several important differences from the Heyman and colleagues (2002) and Cott and Tierney (2013)'s results.

Firstly, it suggests that the participants recognize that risk can exist within an environment of safety. Therefore the participants are acknowledging that the presence of risk does not automatically make a situation unsafe. Secondly, their preference to utilize a safety scale reinforces the well-documented focus of health professionals on client safety. While the positive risk-taking approach (Titterton, 2011) suggests that a safety-first approach prevents health professionals from supporting risk taking, this focus on safety indicates otherwise as they acknowledge that risk and safety co-exist. This safety focus also prevents the health professional from making a judgment call on what is "acceptable" or "unacceptable" risk as per the family caregiving participants in Cott and Tierney's (2013) study. Instead, they are making a judgment on what they feel is safe and not safe, which may be in the participant's mind more scientific and less judgmental. Most importantly, balancing safety and autonomy along a safety scale allows for both autonomy and safety to co-exist.

This finding is in line with the concept of polarity management. Polarity management is a tool for managing competing dilemmas (Keenan, Hurst, & Olnhausen, 1993). It allows for the positive outcomes of both poles, in this case safety and autonomy, to be taken into account in the balancing act rather than having to choose one pole or outcome over the other. Managing polarities involves trying to maximize the positive outcomes of both poles while at the same time of minimizing the negative outcomes of both poles. In this case, creating a situation where the client is able to remain in his/her home while his/her safety is maximized. Polarity management acknowledges that conditions are active, dynamic and ever changing which is more indicative of this clinical context compared to a problem solving approach which implies a cause and effect

relationship suggesting that once the problem is solved no further intervention is needed (Keenan et al., 1993). The risks associated with the situations of the community-dwelling older adult are ever changing due to potential changes in the client's impairments or environments. For example, the client's social support can decline which can increase the client's risk or the client can decide to accept services in the home, which would decrease the client's overall risk status.

The participants in this study provided a wealth of information about the factors impacting on this balancing act of supporting both the client's safety and autonomy. Knowing about these factors and how they interrelate provides the basis for developing a conceptual/practice framework that can help guide health professionals to make conscious and defendable decisions around supporting their client's desire to age in their home while at the same time maximizing their safety. The five factors that impact on the balancing act of the client's safety and autonomy provided by the health professionals in this study expand on the literature on factors influencing risk management. These five factors are considered typical factors that influence clinical decision making although Chapparo and Ranka (2008) referred to these factors as the therapy context, the client situation and identity of the therapist. These factors that have been discussed in Chapter 4 are visualized in Figure 2 and expanded on below.

Figure 2: Factors Influencing Balancing Safety and Autonomy
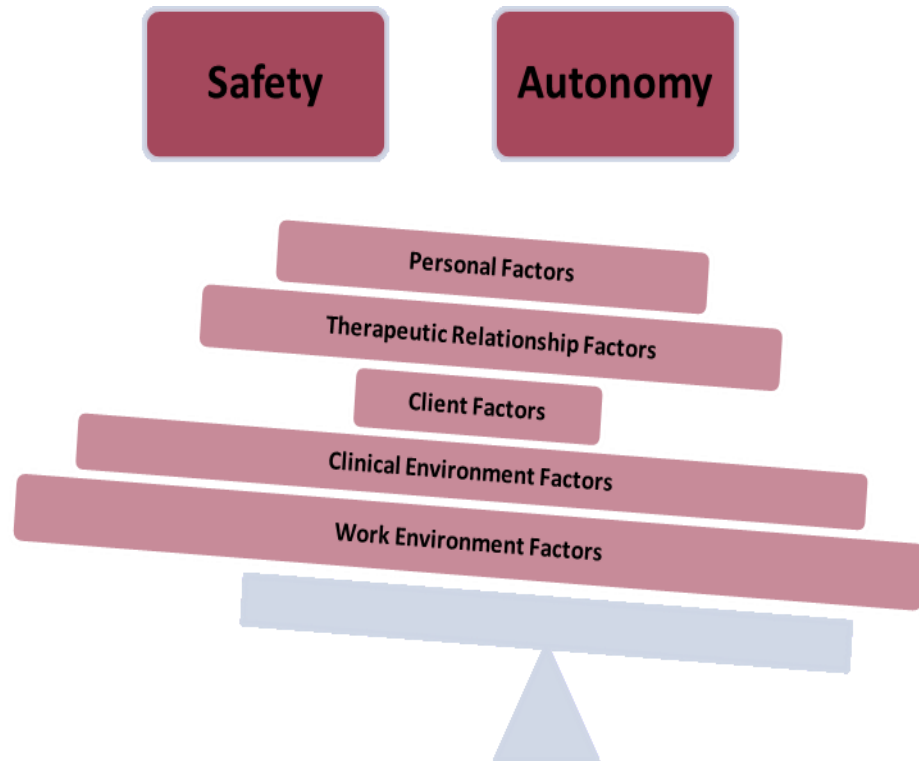
Personal Factors. The health professional brings elements of their personal and

professional selves to the clinical decision making process (Higgs & Jones, 2008). These

elements range from attitudes, values, beliefs and assumptions (Hooper, 2008) to clinical

skills (Boyt Schell, 2008a). Within the clinical context of risk assessment and risk

management, the literature provided a variety of personal factors that influence decision

making. For instance, personal and professional experiences, gender and professional

background were found to influence the risk assessment and risk management process.

With more personal and professional experiences, workers were found to be more risk

tolerant (Gunstone, 2003). Women were found to be more cautious (Gale et al., 2002)

and perceive the risk as greater (Ryan, 1998). Some studies found professional

socialization to impact on decision making (Clemens & Hayes, 1997; Ryan, 1998) while

another study found no differences between health professionals (Gale et al., 2002). The findings from this study supported the influencing factors of personal and professional experience. The participants found that as their attitudes, values, beliefs and assumptions of risk were clearer to them and were more tilted to being risk tolerant and as their clinical skills around risk assessment and risk management improved, they felt better able to balance the client's safety and autonomy. No differences were noted between professional disciplines; however, this could have been due to insufficient numbers of participants. As all the participants were female, a gender difference was not explored.

Another influencing professional and personal factor is the fact that the health professionals defined risk with a negative focus as discussed above in the defining living at risk section. A negative focus on risk influences the focus of the interventions to be on minimizing the risk (Ryan, 1998). Titterton (2005) states that this is common perspective for health professionals due to a feeling of personal responsibility of ensuring the client's safety. He suggests that this is born out of the safety first approach that has emerged from the patient safety movement within the hospital environment. Titterton (2005) criticizes this traditional approach for focusing on the client's physical health and disabilities. He indicates that this approach sees risk as a danger and is based solely on what the health practitioner thinks is right neglecting the perspective of the client. He proposes that as long as health practitioners value the client's safety and/or their physical health over the client's mental health and their right to make choices, then they will continue to favour safety over autonomy. Titterton (2005) advocates for health professionals to consider a positive risk taking approach as a more balanced approach to working with risk with one's client. This approach promotes choice and autonomy for the individual, celebrates

taking risks as a way of enhancing people's lives, recognizes the importance of psychological and emotional needs as well as physical needs and accepts that there will may be conflict between individual and their caregivers. It is also possible that if the health professional enters the therapeutic relationship with an occupational first focus rather than a safety first focus, the client's occupational goals will be considered equally important as the client's safety, another way of supporting a more balanced approach.

Therapeutic Relationship Factors. Respecting the client's desire to remain at home was always the goal of the therapeutic involvement for the health participants in this study. These health professionals found that when they were able to be client-centred, they were more able to balance the client's safety and autonomy. It was only in situations of high risk such as when the client was incapable to make these decisions or when the consequences affected public safety that the health professionals had to override their client's goal. This finding was supported by the literature. Gunstone's (2003) mental health workers went to great lengths to protect their clients against 'unnecessary interference' and McDermott's (2010) and Taylor's (2006) health professionals only intervened or intervened against the client's wishes when the client was deemed incapable of making decisions.

Client Factors. The client factors that impacted on the study participant's ability to balance safety and autonomy was the client's capacity to make decisions and their social support. It was important to the health professionals in this study to provide enough information about the risk and the consequences of the risk so that the client could make an informed decision but the client's capacity occasionally prevented this from happening. As indicated above it is well documented in the literature that the

client's decision-making capacity impacts on the clinical decisions made in the risk assessment and risk management process (Gunstone, 2003; McDermott, 2010; Naik et al., 2010; Skelton et al., 2010; Taylor, 2006). The literature did not specifically talk about social support as being a factor affecting the balancing act of safety and autonomy.

Clinical Environment Factors. The clinical environmental factors that influenced the decision making of the participants in this study were the location and length of the clinical involvement and the attributes of the decisions that had to be made. With regards to location of the clinical involvement, all participants worked in the client's home. This allowed for the participants to be comprehensive in the data collection and data interpretation phases, which helped in reducing uncertainty. During data collection, the participants used the environment not only to gather data in but also gather data from. The environment was used as way to corroborate the information provided by the client but also to weigh the facts that would either deny or confirm if the risks were occurring. This substantiates the general occupational therapy literature that supports the value of home assessments (Anemaet & Moff-Trotter, 1999; Crennan & MacRea, 2010; Robnett, Hopkins, & Kimball, 2002). The risk assessment and risk management literature found a difference in decision making between inpatient and community workers but described the difference as the way in which the decisions were made (Clemens & Hayes, 1997). They found that inpatient workers were more likely to make snap decisions compared to the community workers who were labeled as agonizer decision makers. Use of the term agonizer suggests that the health professional used time to agonize over a decision as they could not decide what to do, versus the health professionals in this study used time to be comprehensive in their decision making.

The literature on the decisions made by health professionals as they balance safety and autonomy described actions aimed at increasing clarity and certainty. Being comprehensive during the risk assessment described in this study was also a strategy used by the health professionals in Gunstone's (2003) study and Clarke and colleagues' (2011) study. Involvement over time was another strategy used to increase clarity and certainty and deemed necessary to manage the complexities of risk management (Clarke et al., 2011; Naik et al., 2010). The participants in this study also found that being able to work with the client over time allowed them to be more comprehensive in their data gathering and data interpretation but it also allowed them to be more collaborative during the risk management phase.

As detailed in Chapter 2, Smith and colleagues (2008) described a number of different general attributes of a decision (listed in italics in this paragraph) that impact on decision making. The findings from this research study not only substantiated this concept but also expanded on it by providing specific risk management decision attributes as detailed in the safety continua questions outlined in Figure 1. Both the general and specific decision attributes all factored into the decisions the participants in this study made while balancing safety and autonomy. The participants managed *uniqueness* and *uncertainty* by being comprehensive. However, they were also comprehensive due to the *importance* of the decision that had to be made, when the decision involved relocation. As the health professionals in this study worked with clients whose health was changing whether due to the progression of a dementia or a decline in the frail client's medical status, there were some situations when the client's health became *unstable* which prompted immediate and often paternalistic management by the

health professional. *Incongruency* of goals between the health professional, client and/or family also impacted what decisions were made and how they made them. This often led to an informing type of decision making and an acceptance of the risk the client and/or family were taking. *Data relevance* and *complexity* of the situation could also impact on what type of decisions the health professionals made and how they made them. As indicated above a high risk situation was deemed as being *urgent* and led the health professional to be paternalistic in their decision making. The health professionals wanted to gather a variety of information from a variety of sources before making a decision. Smith and colleagues (2008) suggested that if this isn't possible then making the necessary decisions is more difficult.

The specific decision attributes related to risk management were discussed in Chapter 4 under determining risk status. As discussed above, the participants indicated that the client's capacity and social support were client factors impacting on decision making. However, the risk frequency, occurrence, imminency, complexity and seriousness of the consequences were the specific attributes of the risk management decisions that impacted on what kinds of decisions the participants made and how they made them.

Work Environment Factors. The findings from this study indicated that the work environmental factors that impacted on their ability to balance safety and autonomy were supportive colleagues, legislation and the health care system. This was supported in the literature. All participants found that being able to debrief and problem solve with colleagues was crucial in being able to balance safety and autonomy. Team support, team decision making, team collaboration were the variations of this theme found in the

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literature as being crucial to managing risk and balancing safety and autonomy (Clark et al., 2011; Crennan & MacRea, 2010; Gunstone, 2003). The participants found that legislation specifically related to driving and forming a client provided the necessary support to override the client's wishes of wanting to remain at home. Only three participants in this study mentioned that the fear of litigation influenced their decision making compared to this being a major theme 'wariness of lurking conflicts' in Taylor's (2006) study. Lastly, the health professionals were frustrated when the health care system could not support the client and were elated when they could. This tension existed amongst the health professional's in Taylor's (2006) study.

Summary

A health professional is more able to balance the client's autonomy of remaining in their home and their safety when they can maximize personal practitioner factors, therapeutic relationship factors, client factors and work environmental factors, and clinical environmental factors:

- When they philosophically believe in autonomy, they believe that risk exists everywhere at all times, they understand the client's medical diagnoses, they understand their client's risk preferences, they acknowledge the positive and negative consequences of risk and both the physical and emotional consequences of risk and they have worked with client's living at risk in the past (*Personal Factors*).

- When they work in an organization that supports positive risk-taking, supports education, backs the health professional during litigious action and provides opportunities for collegial debriefing and group problem-solving. (*Work Environmental Factors*).

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- When they work in or are able to arrange for an assessment in the client's home and are able to work with the client over time or arrange for further follow-up. The health professionals are better able to balance safety and autonomy when they can gather comprehensive information from a number of different sources in a number of different ways in order to build an impression about the client's risk status (*Clinical Environmental Factors*).

- When they are able to be client centred (*Therapeutic Relationship Factors*).

- When the client is capable to make these specific decisions about safe and independent living and when the client has stable, reliable support (*Client factors*).

Limitations

There are several limitations to the study. Although some of the questions were changed or different probing was done based on global missing pieces from previous interviews, further analysis prior to each subsequent interview would have enriched the data. There were a few topics such as fear of litigation and evaluating clinical involvement that were not fully developed due to a lack of saturation amongst all the participants. Interviewing more participants from each health discipline would have been interesting to see if discipline-specific professionalization exists when health professionals work in a generic role.

These findings may be of interest to a more global audience but it must be acknowledged that the data is a reflection of an urban setting within the province of Ontario within a community practice of health professionals who work in a generic role and are English speaking. Extrapolating the data beyond this clinical context should be done with caution as risk is personally, socially and culturally constructed.

These findings only reflect the perspective of the health care professional. Future explorations of risk and decision-making would benefit from being understood within a paradigm that includes both the perspective of the client as well as the perspective of family caregivers, in diverse practice contexts.

Implications for Future Research

Further research in this area is needed. A similar study with client and family caregivers for their perspective would be beneficial in providing a holistic understanding of this clinical context and could only enhance the health professional's ability to better balance safety and autonomy. The health professionals in this study valued the impact that working in the client's home environment had on their clinical reasoning and decision making, therefore it would be interesting to do a study comparing understandings of risk and decision making between community health professionals and inpatient hospital health professionals (who no longer do home visits). Titterton (2010) postulates that risk is needed in order to develop more diverse forms of resilience and suggests that more attention should be paid towards understanding fostering resilience in older adults. A study examining the relationship between risk, resilience and vulnerability would be interesting to elucidate the conditions under which resilience occurs.

Conclusions

The literature on how to balance a community-dwelling older adult's safety and autonomy was lacking. Health professionals were left without specific guidelines on how to support the older adults wishes to remain at home as they age while at the same time maximizing their safety. The findings from this study of knowing how health

professionals perceive, identify, assess and manage their clients' risk has led to clinical framework based on three significant findings.

Firstly, the findings revealed a practical definition of living at risk that has not existed to date in the literature. Utilizing a common definition, not only contributes to clearer communication between health professionals but also between the client, the health professional and family caregivers. A practical definition also provides a clearer foundation from which risk assessment and risk management decision making can be based on.

Secondly, the findings detailed the clinical reasoning processes used by the health professional as they made decisions during the risk assessment and risk management processes. This has also not been documented in the literature. In order to manage the uncertainty surrounding risk, the health professionals used a comprehensive process to gather information for risk assessment and risk management through scientific, narrative, conditional and ethical reasoning and processed this information comprehensively mainly through analytic and reflective processes but occasionally intuition was also used. The health professionals also used a variety of decision making strategies dependent on client and situation factors. The health professionals managed risk typically using collaborative or informed decision making but occasionally they had to override the client's wishes and occasionally they waited and delayed decision making. Understanding how a health professional gathers information, processes information and makes clinical decisions with regards to risk management, provides the health professional with a clear guideline on how to clinically reason within this clinical context.

Lastly, the findings provided details on how to balance a client's safety and autonomy. It suggested that a clinical framework that when adopted under a polarity management strategy, maximizes the clinical environment so that the health professional can support both the client's safety and their autonomy. The clinical framework suggests that personal practitioner, therapeutic relationship, client, work environment and clinical environment factors all influence the balancing act of safety and autonomy. Having a good understanding of these factors helps a health professional try to enhance the factors that make the balancing act easier.

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You are invited to participate in a qualitative research study on "Understanding risk, autonomy and safety: Health professionals decision-making amongst older adults living alone".

This is a study being conducted by Heather MacLeod, Geriatric Assessor with the East Geriatric Assessment Outreach Team as a requirement of her Master of Science (post-professional - Occupational Therapy) degree.

Purpose:
To gather information about the current practice of health professionals who work with older adults living alone. It is hoped that the information collected from this study can contribute to the development of a clinical framework that would be of benefit for health professionals working in this clinical context.

Who can participate?:
Any health professional working with older adults living alone who are working as either a case manager or a geriatric assessor with one of these programs: Geriatric Psychiatry Community Services of Ottawa, Geriatric Assessment Outreach Team or Champlain District Community Care Access Centre (City of Ottawa only).

Time Commitment:
You would be required to take part in a 60-90 minute in-person interview that would take place at a time and location that is convenient for you. Within one-month of your interview, you would also be asked to review the typed transcript of your interview to ensure accuracy.

Risks and Benefits:
The risks involved in participating in this research study are minimal if any. A possible risk includes emotional distress when reflecting on any clinical case. There are no direct benefits in participating in this research study but your valued opinion would be helpful in developing a clinical framework for working with this population.

Participation:
All participation is completely voluntary and has no bearing on your current work status. Any participant can withdraw from the study at any time.

If interested in participating or if you have more questions:
Please contact Heather MacLeod directly by telephone: 613-562-6262 x1257.

Thank you for expressing interest in the qualitative research study: "Understanding risk, safety and autonomy: Health professionals decision-making amongst older adults living alone".

Purpose:
The purpose of this study is to gather information about the current practice of health professionals who work with older adults living alone. It is hoped that the information collected from this study can contribute to the development of a clinical framework that would be of benefit for health professionals working in this clinical context.

Inclusion Criteria:
What is your health professional discipline?, What is your position?, Who do you work for?

Time Commitment:
You would be required to take part in a 60-90 minute in-person interview that would take place at a time and location that is convenient for you. Within one month of your interview, you would also be asked to review the typed transcript of your interview to ensure accuracy.

Risks and Benefits:
The risks involved in participating in this research study are minimal if any. A possible risk includes emotional distress when reflecting on any clinical case. There are no direct benefits in participating in this research study but your valued opinion would be helpful in developing a clinical framework for working with this population.

Participation:
All participation is completely voluntary and has no bearing on your current work status. Any participant can withdraw from the study at any time.

Confidentiality:
Confidentiality is taken seriously and all efforts will be made to ensure your anonymity of participation and the confidentiality of your input.

Questions:
Do you have any questions?

Interest:
Would you be interested in being put on the participant interview waiting list?

Contact:
If selected I will contact you by phone within the next three months to schedule an interview at a time and location that is convenient for you.

(on Dalhousie letterhead)

Consent Form for the following study:

Understanding risk, safety and autonomy: Health professionals decision-making amongst older adults living alone

Contact Person:
Heather MacLeod OT Reg. (Ont.)
Geriatric Assessor
East Geriatric Assessment Outreach Team
Bruyere Continuing Care
43 Bruyere St.
Ottawa, ON K1N 5C8
613-562-6262 x1257
hmacleod@bruyere.org
heathermacleod@dal.ca

Researcher:
Principal Investigator
Heather MacLeod Masters of Science (Post-Professional Occupational Therapy) Candidate

Supervisor:
Robin Stadnyk
School of Occupational Therapy
Dalhousie University
902-494-8434
rstadnyk@dal.ca

We invite you to take part in a research study being conducted by Heather MacLeod who is a graduate student at Dalhousie University as part of her Masters of Science (post-professional Occupational Therapy) degree. Your participation in this study is voluntary and you may withdraw from the study at any time. Your work performance evaluation will not be affected by whether or not you participate. The study is described below. This description tells you about the risks, inconvenience, or discomfort that you might experience. Participating in the study might not benefit you, but we might learn things that will benefit others. You should discuss any questions you have about this study with Heather MacLeod.

Purpose

The purpose of this study is to gather information about the current practice of health professionals who work with older adults living alone. It is hoped that this understanding can contribute to a framework that would be of benefit to health professionals working in this area.

Study Design

I will be conducting in person interviews with 10 to 15 people. Your interview will be held at a time and location that is convenient for you. During the interview you will be asked questions about how you currently work with older adults living alone.

Who can Participate in the Study?

You may participate in this study if you are a health professional working with older adults living alone employed by one of the following two programs: Specialized Geriatric Services (which includes geriatric assessors from Regional Geriatric Assessment Program of Eastern Ontario - Geriatric Assessment Outreach Team, and case managers from the Geriatric Psychiatry Community Services of Ottawa) and case managers from the Champlain District Community Care Access Centre working within the City of Ottawa. You may participate if you are a health professional working in a generalist role (i.e. geriatric assessor or case manager) with educational training in one of the following disciplines (nursing, social work, physiotherapy or occupational therapy).

Who will be Conducting the Research?

Heather MacLeod will be booking and conducting all of the interviews and remains your point of contact should you have any questions.

What will you be asked to do?

You will be asked to participate in one 60-90 minute interview at a time and location that is convenient for you. You may be contacted by telephone after the interview for possible clarifications. Within one month of your interview, you will be asked to review a transcript of your interview to make sure that it is accurate. This typed transcript will be sent to you by email. If you choose not to respond, I will assume that you agree with the accuracy of the transcript. Any feedback that you provide will be considered relevant and subject to analysis.

What are the possible risks of participating in this study?

There are four possible risks to participating in this study. Firstly, reflecting back on your practice during the interview may make you feel uncomfortable sharing your opinions with a peer. To minimize this risk, you have the right to take a break, refuse to answer any questions or stop the interview. If you experience any emotional distress from the interview you will be encouraged to contact your Employee Assistance Program (EAP). Secondly, you may feel uncomfortable discussing your current practice with a peer. This risk will be minimized by highlighting that there are no right answers and that your responses will not be shared with your employer. Thirdly, there is a risk that you could be identified as a participant in this study if you are seen in a meeting with the researcher. To minimize this risk, all efforts will be made to arrange the interview at a time and location that is convenient for you away from any clinical areas. Lastly, sharing information about your practice that suggests professional misconduct, such as neglect of an older adult, will result in the researcher notifying your professional regulatory college and/or the local authorities. To minimize this risk, you are encouraged only to share information that you are comfortable discussing.

What are the possible benefits of participation?

There are no anticipated direct benefits for you by participating in this study. However, it is hoped that the information you share will contribute to a clinical framework that health professionals working with older adults living alone could benefit from.

Is there any compensation?

There is no compensation provided for participating in this study.

Confidentiality and Anonymity

All efforts will be made to ensure the anonymity of all participants and the confidentiality of all the information provided. In this study your anonymity will be ensured by conducting your interview in a closed door environment. With your permission, the interview will be taped but all identifying information will removed and would only be accessed by the researcher and transcriber. All identifying information will also be removed from direct quotes from your interview which may be used in report, article or presentation format.

Confidentiality will be ensured by storing all collected information on a secured server. The information will be analysed on a password protected computer. Any information in paper format will be kept in a secure location. All information will be kept for 7 years from the date of any reports or publications in a secure location and can only be accessed by the principal researcher. At the end of the seven-year term all information will be shredded or physically destroyed.

Confidentiality can be broken if during the course of the interview, information is shared about your practice that suggests professional misconduct, such as neglect of an older adult. This will result in the researcher notifying your professional regulatory college and/or the local authorities.

What do I do if I have questions?

Please contact Heather MacLeod at 613-562-6262 x1257 if you have questions about the study at any time.

Withdrawal

Your participation in this interview is completely voluntary. You may withdraw at any time by telling me during the interview, or by contacting me after the interview by phone (613-562-6262 x1257). You may also choose not to answer any of the questions or ask to have the interviewed re-scheduled or completed at a more convenient time. Please let me know if you experience any discomfort during the interview so that we can take a break or reschedule.

By signing below I acknowledge that I have read this form and have been informed of the following:

- My participation is completely voluntary and I can choose to not answer any questions and I can withdraw from the interview at any time.
- There are no direct benefits to me for participating in this study.
- The potential risks of participating in this study include emotional distress from reflecting on clinical scenarios involving older adults living alone or loss of anonymity if being seen by participating in the individual interview.
- All information I provide will be kept confidential. All identifying information will be removed from the data.
- This research study is being conducted as a requirement of the Master of Science (Occupational Therapy – post professional) program at Dalhousie University.
- If I have any questions about this research study, I can contact Heather MacLeod at 613-562-6262 x1257.
- If I have any concerns about this research study, I can contact Catherine Connors, Director of Dalhousie University's Office of Human Research Ethics Administration at 902-494-1462.
- I will keep a copy of this consent form for my records.

[]   I consent to having this interview audio-recorded

[]   I consent to the use of my quotes in a summary report, presentation or journal article provided that I am not identified in any way.

[]   I would like to receive a summary of the results.
         Please forward to me by email:
         Please forward to me by post:

Signature of Participant   Date

Signature of Researcher   Date

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. However, I realize that my participation is voluntary and that I am free to withdraw from the study at any time.

Problems or Concerns
If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Catherine Connors, Director of Dalhousie University's Office of Human Research Ethics Administration, for assistance (902) 494-1462, catherine.connors@dal.ca

Appendix D - Transcriber Consent Form

Pledge of Confidentiality
Regarding Protection of Research Data

The purpose of this document is to ensure ethical behaviour in research through informed agreement to comply with the measures for privacy and confidentiality set out in the research protocol for this project.

I agree to protect the confidentiality of the information provided to me.

I will use the information accessed only as needed to do my job, which in this case is transcription of a digital file to a data file.

I will pick up the digital file from Dalhousie University's file exchange and return the digital file and the data file back to the password-protected Dalhousie University's file exchange.

I will temporarily save the data file on a password-protected computer only during the act of transcription. Once both the data and digital file have been returned to Dalhousie University's file exchange, the temporary data file will be erased.

By signing this document, I agree that I have read, understood and will comply with this agreement. I am aware that if a breach of confidentiality occurs my services will be terminated immediately and I am obligated to return all information related to this project back to Dalhousie's file exchange.

_____   _____
Name   Date

_____
Signature

Appendix E – Interview Guide

1. Tell me about your work in relation to older adults living at home.
2. How do you define risk in the context of working with older adults labeled as "living at risk"?
3. What does it mean to you, when a client is labeled "living at risk"?
   a. What makes this situation risky?
   b. What are the behaviours or actions that you consider risk?
4. What are the typical situations in which "living at risk" occurs?
5. Please describe a clinical situation of working with an older adult who you would consider "living at risk".
   a. Why would you call this situation risky?
   b. How do you identify risk?
6. In working with older adults living at risk what causes the most struggle in terms of balancing safety and autonomy?
7. In working with older adults living at risk what are the easiest parts when balancing safety and autonomy?
8. There exists amongst the general public a whole range of tolerances of risk and this is not always the same personally and professionally.
   a. How you would you characterize your personal and professional tolerances?
   b. Do your understandings of risk match others that you work with?
   c. How do you handle situations when your understandings of risk is in conflict with your other team members?
9. Once you identify a risky behaviour or situation what do you do about it?
   a. Are you able to be consistent in your practice when working with older adults living alone?
   b. How has your practice changed over time with regards to working with older adults living alone?
   c. What contributed to these changes?
10. In what way does your work support you when working in these situations?
    a. In what way does your work hinder your ability to work in these situations?
11. Is there any information from your experiences of working with vulnerable older adults living at risk in their home alone that you haven't discussed and you would like to add?
12. Is there any questions you thought I would ask that I didn't?