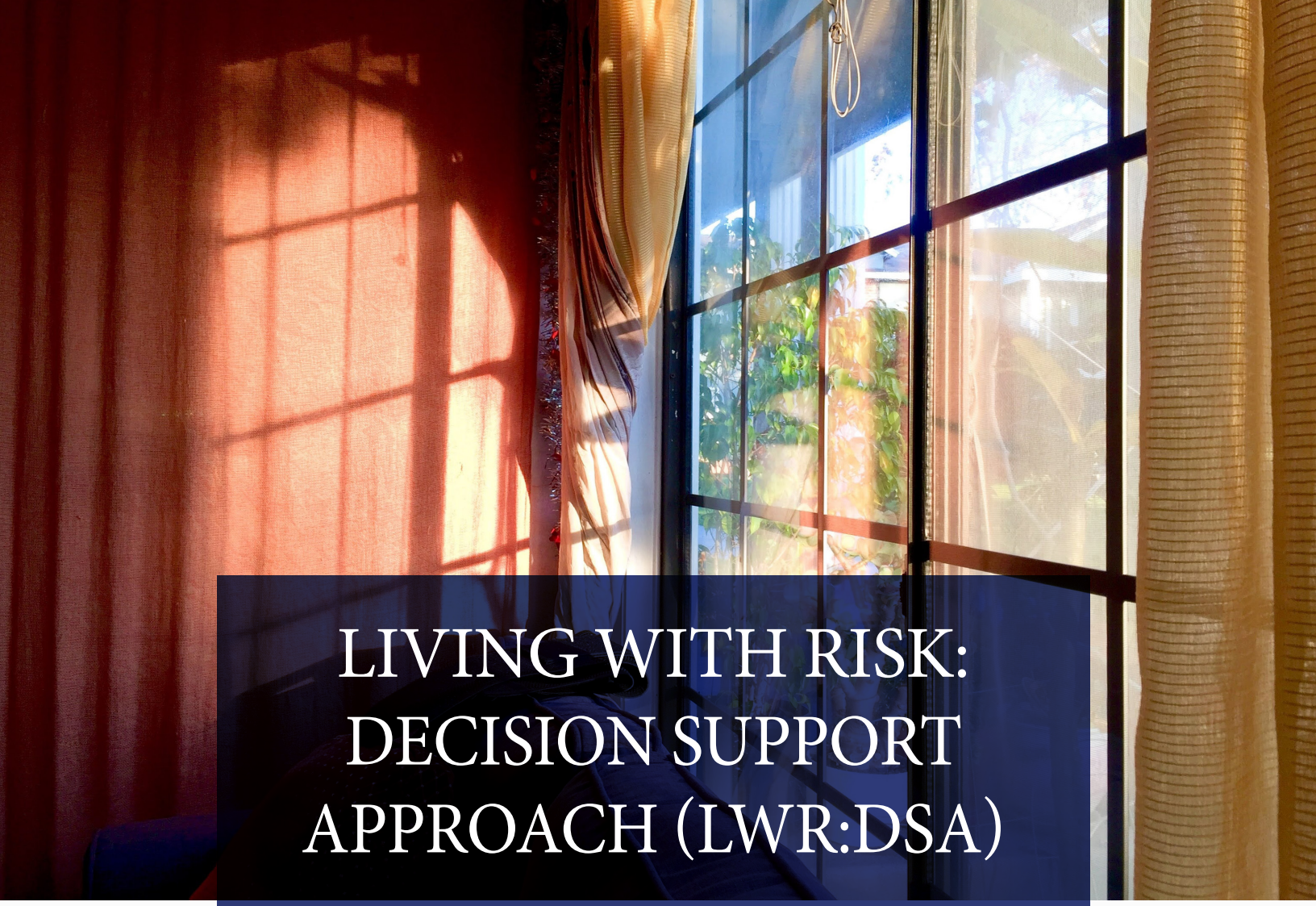

LIVING WITH RISK: DECISION SUPPORT APPROACH (LWR:DSA)

INSTRUCTION GUIDE FOR CLINICIANS WORKING WITH OLDER ADULTS

LIVING WITH RISK: DECISION SUPPORT APPROACH RESEARCH GROUP

JANUARY 2024

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What the LWR:DSA is NOT...

LWR:DSA :

- does NOT replace clinical judgment; the information collected by the clinicians using this approach needs to be analyzed while taking into account the global context of the situation;
- does NOT predict outcomes with certainty;
- does NOT result in an overall score.

TABLE OF CONTENTS

What is the LWR:DSA?

The *Living with Risk: Decision Support Approach* (LWR:DSA) is a process that encourages clinicians to:

- collect and organize information stemming from concerns related to the older adult's safety;
- evaluate the situation in a structured manner to recognize and support the valued outcomes of informed risk taking, and minimize the negative consequences of risk through optimizing health and function, leveraging strengths and adapting environments;
- support a balanced problem-solving process that prevents overestimation or underestimation of an older adult's possible exposure to the risk of harm.

How can the LWR:DSA help?

This approach supports a **holistic and structured review of an older adult's risk status** by identifying potential strategies that acknowledge older adult choices and decision-making.

This is a **reflective** approach designed to help with care plan discussions by:

- ensuring that a wide variety of potential risk categories are addressed;
- supporting a balanced problem-solving process that includes input from the older adult and caregivers.

When used by a team, this approach can also help

- outline accountability for who will address each issue and follow up on the care plans;
- encourage a collaborative team process, especially during the discharge planning discussions.

Why, when and how to use the LWR:DSA

WHY USE THE LWR:DSA?

The LWR:DSA can be used to strengthen

- **clinical thinking for decision-making;** used individually or as a team, to gather comprehensive information about the older adult's context for informing decision-making related to goal-based person-centred treatment plans that optimize the health, function, safety and quality of life of older adults.
- **communication for decision-making:**
    - between the older adult, caregiver and the clinician to identify areas of concern, the rationale for the concern and justifications for the proposed recommendations;
    - between clinicians working with the older adult on identified safety-related concerns.

WHEN IS THE LWR:DSA MOST USEFUL?

The LWR:DSA may be useful when the goals of care and/or discharge plans differ

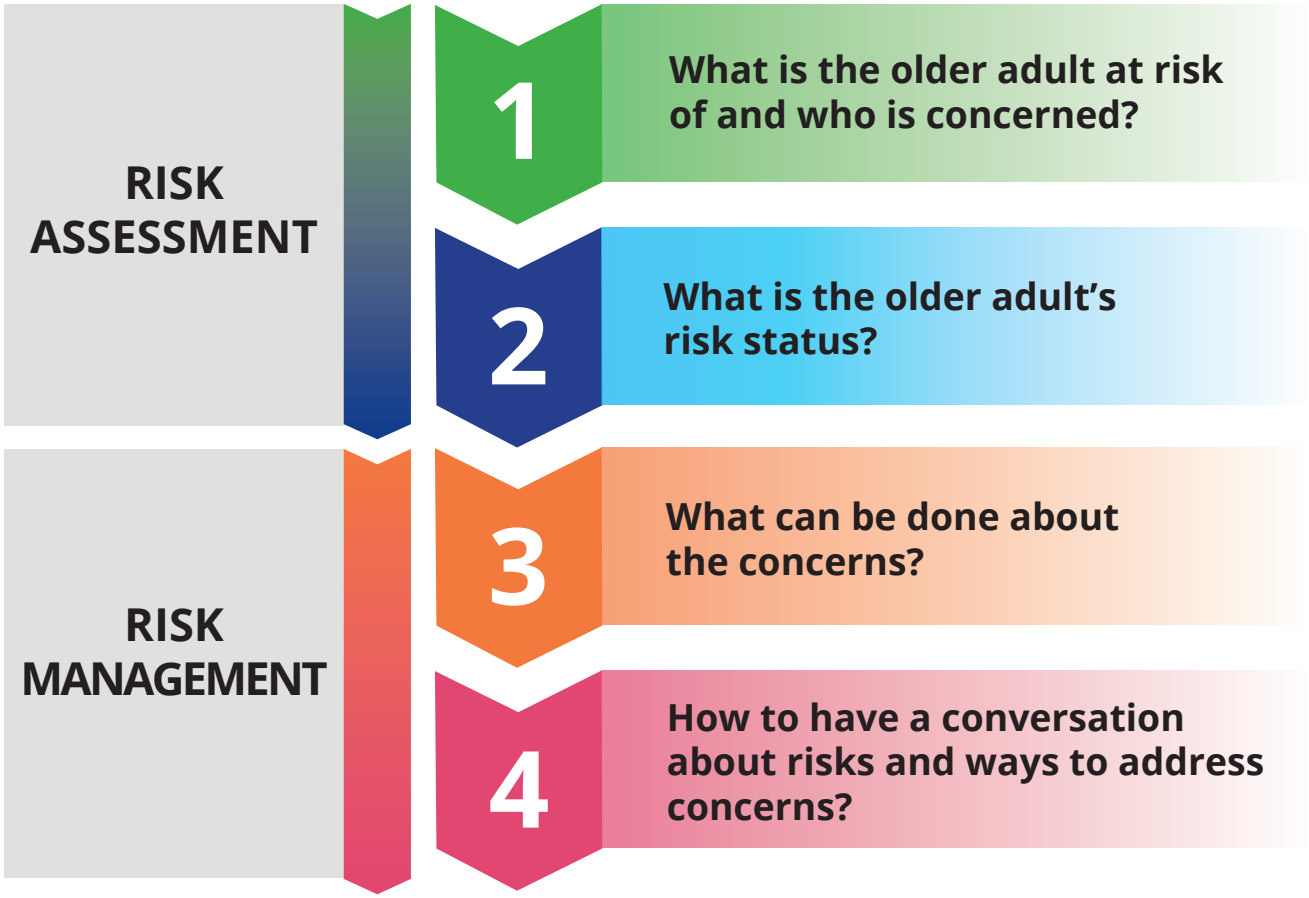
- between clinicians;
- between the older adult and their caregiver, and/or;
- between clinicians and the older adult and/or caregiver.

HOW TO USE THE LWR:DSA?

The LWR:DSA is the four questions listed on page 3 and explained on pages 4-14. These questions are meant to help guide a systematic review of the older adult's risk status.

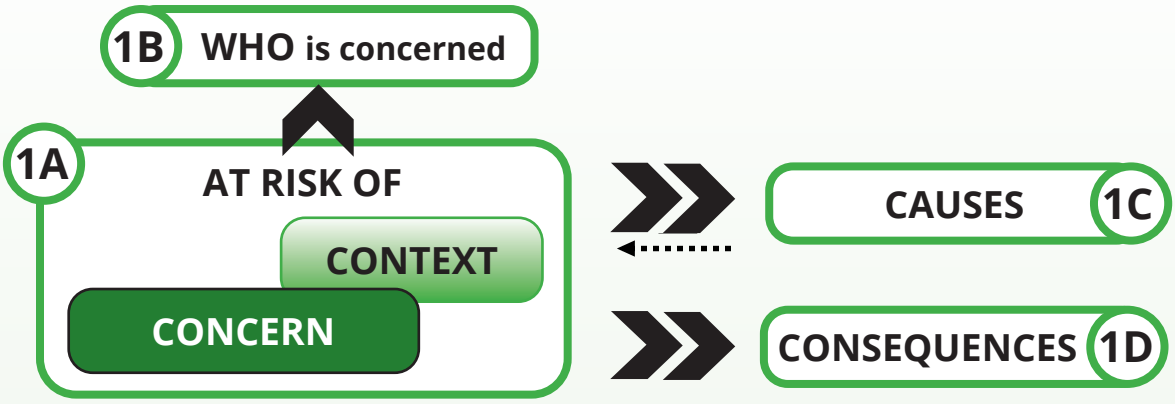
Worksheets have been developed as a practical format for using and documenting the process involved in reviewing the 4 questions. They are optional and can be amended to suit the clinical need. Complete the worksheets in the manner that is most clinically relevant and useful for you, your team and the older adult. The LWR:DSA is to be used to guide your decision-making and communication to the older adult and caregiver and between each other. Examples of how to use the approach in real situations are depicted in **videos**. The worksheets and videos are accessible on the LWR:DSA website.
https://lwrdsa-vivreaveclesrisques.recherche.usherbrooke.ca

A 4-STEP PROCESS



1 Risk assessment

What is the older adult at risk of and who is concerned?



1A **Clearly state what you, the older adult, their caregiver and the health care team are saying the older adult is at risk of.**

Worries about risk are driven by concerns that something bad will happen. It is important to clearly identify the **safety concern** and whether it occurs in a particular **context** so that it can be accurately and thoroughly analyzed. Not all concerns happen in a specific context, but contextual considerations could include understanding if the safety concern happens at a certain time of day, in a specific location (physical environment), with a specific activity, or due to changes in formal or informal supports (social environment).

EXAMPLES :

CONCERNS

- **Falls**
- **Malnutrition**
- **Fires**
- **Wayfinding**
- **Motor Vehicle Collision**
- **Medication mismanagement**
- **Financial mismanagement**
- **Abuse** (Physical, Financial, Emotional, Neglect, Sexual)
- **Suicide/homicide**

CONTEXTS
(time, place, activity, support)

- **Living alone** (no immediate supports)
- **Using the stove to prepare meals** (activity)
- **Falling when up at night** (timing)
- **Falling outside** (location)

Determine onset and progression:

If this is not NEW or DIFFERENT, has this been addressed before?

- If not, are these choices the older adult has been making?
- If so, are there new factors that can be addressed?

1 Risk assessment

What is the older adult at risk of and who is concerned?

1B WHO is concerned by what the older adult is at risk of?

- Yourself, another clinician, the health care team?
- The older adult?
- A caregiver?

Understand differences of opinions:

- Take into account the older adult's values, beliefs, goals and right to self-determination.
- Understand cause of caregivers' concerns.
- Understand if your values/discomforts are impacting the decision-making.

1C Determine the CAUSE(S):

- Is there a **change in:**
  - Physical, cognitive or mental health?
  - Medical stability?
  - Medications?
  - Contexts, i.e. physical (e.g., unkempt living environment) or social environment (e.g., spouse passes away)?
- Is this related to the person's values, beliefs and/or choices?
- Is the cause treatable or reversible?

1D Determine the positive and negative CONSEQUENCE(S) for the older adult:

- What are the consequences of the concerns? For example,
  - Related to their **health** (hospitalization, harm to themselves or others, emotional well being).
  - Related to **quality of life** (functional decline, financial issues, eviction or relocation to a different living environment, over-protection, resilience, engagement in meaningful activities, happiness, sense of belonging).

Living with Risk: Decision Support Approach
RISK ANALYSIS WORKSHEET

1. What is the older adult at risk of and who is concerned?

At risk of **(example)**

1A **Concern** *Falls*

Context(s) *Getting up at night to void*

1B **WHO is concerned + level of risk**

✓	Clinician		Older Adult	✓	Caregiver

1C **Cause(s) of the concern**

Balance issues
Decreased vision
Polypharmacy

1D **Potential consequence(s) of this concern**

Hip fracture

Recommendations to reduce the concern, its causes and its consequences	Older adult in agreement: YES	MAYBE	NO	Options/ alternatives

Older adult's perspective

Additional Comments

2 Risk assessment

What is the older adult's risk status?

RISK STATUS DECISION TREE

Evaluate the older adult's risk status

Step 2 of the LWR:DSA process is determining the older adult's risk status. Is the situation low ●, medium ▼, or high ■ risk? As clinicians, we tend to overestimate risk and assume the potential for extreme harm. Step 2 provides a structured approach to ensure risk is not over-or underestimated. **The Risk Status Decision Tree** (next page) provides a visual depiction of the questions to consider for step 2.

LIKELIHOOD :

- Determine how **likely** it is for the safety concern and/or its consequences to happen.

AND

SEVERITY :

- Determine the **severity of the consequences** for all situations.

- Then, plot your likelihood and severity ratings into the **Risk Status Matrix** (next page, below the Risk Status Decision Tree)

- Lastly, for medium or high risk ratings, review the following **additional considerations** that may increase or decrease the individual's risk status:
  - o If the safety concern is happening now, determine how **frequently** it is happening. If the safety concern is rarely occurring, this may lower the risk compared to if it is happening frequently, this may raise the level of risk.
  - o How **imminent** are the consequences of the concern? For example, the consequences of malnutrition take longer to take effect compared to the immediate effects of a fire or falls. If there is time to take action to prevent the effects of the consequences, this may reduce the overall risk status.
  - o Does the older adult have reliable, **consistent support** in place? If so, this may reduce the level of risk.
  - o Are there **other concerns**? If so, they might increase the level of risk.

2 Risk assessment

What is the older adult's risk status?

RISK STATUS DECISION TREE

LIKELIHOOD

How likely is the safety concern to happen?

- Unlikely
- Moderately likely
- Highly likely

SEVERITY

How severe are the consequences?

- Minimal
- Moderate
- Severe

RISK STATUS MATRIX

LIKELIHOOD	SEVERITY: Minimal	SEVERITY: Moderate	SEVERITY: Severe
Unlikely	LOW	LOW	MEDIUM 🔍
Moderately likely	LOW	MEDIUM 🔍	HIGH 🔍
Highly likely	MEDIUM 🔍	HIGH 🔍	HIGH 🔍

🔍 **ADDITIONAL CONSIDERATIONS IF MEDIUM OR HIGH RISK**

- How **frequently** is the safety concern happening?
- How **imminent** are the consequences of the concern?
- Does the person have reliable, consistent **support** in place?
- Are there **other concerns** occurring?

RISK ANALYSIS WORKSHEET

2. What is the older adult's risk status?

At risk of **(example)**

Concern *Falls*

Context(s) *Getting up at night to void*

2 → **WHO is concerned + level of risk** ● ▼ ■

✓ Clinician	Older Adult	✓ Caregiver
■	●	▼

Cause(s) of the concern

Balance issues
Decreased vision
Polypharmacy

Potential consequence(s) of this concern

Hip fracture

Recommendations to reduce the concern, its causes and its consequences	Older adult in agreement: YES	MAYBE	NO	Options/ alternatives

Older adult's perspective

Additional Comments

3 Risk management

What can be done about the concerns?

What does the older adult want?

- What matters most to the older adult – what "makes life worth living"?
- What are the benefits for the older adult?
- What was the older adult's past habits, choices and desires?
- Acknowledge the power imbalance that exists among clinicians, older adults and their caregivers and how this might influence your recommendations to the older adult.

What can be done about the contexts?

- Adapt activities;
- Adapt physical environments (such as reducing trip hazards);
- Augment social environments (such as increasing formal and informal support and/or services).

What can be done about the causes?

- Optimize impairments and enhance strengths. For example:
    - o improve the older adult's cognitive impairment by supporting physical, social and cognitive activity and addressing vascular risk factors;
    - o improve the older adult's physical impairments by recommending increasing strength and balance

What can be done about the consequences?

- Minimize the negative consequences, highlight the positive consequences, weigh the emotional and physical consequences, weigh the consequences of remaining in hospital versus being discharged home.

3 Risk management
What can be done about the concerns?

What protective factors can be optimized? For example:

- leverage the older adult's motivation to return home by recommending participation in meaningful activities for them (ex: gardening, taking their bath);
- leverage the older adult's habitual memory by using familiar objects or environments;
- expand caregiver support to more members.

What can be done based on the risk status?

- **Low risk** 
  - What treatment and/or recommendations can be offered to ***prevent*** the concerns from happening or the potential negative consequences?

- **Medium risk**
  - What treatment and/or recommendations can be offered to ***reduce*** the risk status from medium to low?

- **High risk** 
  - What treatment and/or recommendations need to be ***urgently*** put in place to reduce the risk status from high to medium or low?

What can be done based on resource availability?

- **Accessibility**
  - Does the older adult meet the resource eligibility criteria to access services and equipment?

- **Timing**
  - What are the wait times for resources, equipment and/or home modifications?

- **Finances**
  - Can the older adult afford the services or equipment?

RISK ANALYSIS WORKSHEET

3. What can be done about the concerns?

At risk of **(example)**

Concern *Falls*

Context(s) *Getting up at night to void*

WHO is concerned + level of risk

✓ Clinician	Older Adult	✓ Caregiver
■	●	▼

Cause(s) of the concern

Balance issues
Decreased vision
Polypharmacy

Potential consequence(s) of this concern

Hip fracture

3 → Recommendations to reduce the concern, its causes and its consequences

Recommendations to reduce the concern, its causes and its consequences	Older adult in agreement: YES	MAYBE	NO	Options/ alternatives
Install night-lights				
Use a walker for mobility at night				
Wear glasses for mobility at night				

Older adult's perspective

Additional Comments

4 Risk management

How to have a conversation about risks and ways to address concerns?

Communicating risk status

- Based on the risk status for each concern (refer to the *Living with Risk: Decision Support Approach* worksheets) discuss with the older adult, caregivers (with the older adults' permission) and team members:
  - The rationale used for the risk status determination (low ●, medium ▼, high ■).
  - The recommendations suggested:
    - to reduce the frequency of the concerns and/or negative consequences;
    - to maximize older adult autonomy and the benefits of taking the risk.

When the concerns and the risk status are in agreement amongst the older adult, caregiver and clinician/team:

- Support the establishment of priorities.

When the concerns and the risk status are in disagreement amongst the older adult, caregiver and clinician/team:

- Support discussions to better understand the reasons and rationale for the divergence;
- Support discussions to see if the recommendations are acceptable.
  - If the older adult is in disagreement with the proposed recommendations, what can make them more acceptable?
  - Suggest more acceptable recommendations by offering or modifying the current recommendations to increase their alignment with the older adult's preferences;
  - Document all the proposed recommendations so that the older adult can consult at a later date.

RISK ANALYSIS WORKSHEET

4. How to have a conversation about risks and ways to address concerns?

At risk of **(example)**

Concern *Falls*

Context(s) *Getting up at night to void*

WHO is concerned + level of risk ● ▼ ■

✓ Clinician	Older Adult	✓ Caregiver
■	●	▼

Cause(s) of the concern

Balance issues
Decreased vision
Polypharmacy

Potential consequence(s) of this concern

Hip fracture

Recommendations to reduce the concern, its causes and its consequences	Older adult in agreement: YES	MAYBE	NO	Options/ alternatives (4)
Install night-lights	✓			
Use a walker for mobility at night		✓		*Use a cane*
Wear glasses for mobility at night	✓			

Older adult's perspective *Finds a walker too cumbersome.*

Additional Comments

Foundational Supporting Concepts

The LWR:DSA is based on the following definition of risk.

Risk

Risk is "the effect of uncertainty on objectives where the consequences could vary from loss and detriment to gain and benefit (p882)"[2].

The LWR:DSA was developed based on the following concepts:

Comprehensive Geriatric Assessment (CGA)

The CGA is considered the gold standard of care for the older adult living with frailty[3]. It is a holistic review of an individual's physical, cognitive, mental, medical health and environmental factors with the goal of optimizing their health, safety and function. It is also a holistic approach to care of these older adult in providing interdisciplinary patient-focused screening, assessment and risk identification for the provision of goal-based care planning and intervention. A recent Cochrane review showed that those who underwent a CGA on an inpatient ward had a 30% higher chance of being alive and being in their own home at 6 months[4].

Dignity of Risk

The dignity of risk is the principle of allowing an individual the dignity afforded by risk-taking that results in the enhancement of personal growth and quality of life[5].

Therapeutic Risk

Therapeutic risk is the positive health and well-being outcomes that can arise from risk taking[6]. For instance, resilience is a positive by-product of taking risks and only comes about by taking a risk or overcoming a challenge[7]. High resilience later in life has been associated with reduced depression and mortality risk, better self-perceptions of aging successfully, increased quality of life and improved lifestyle behaviours[8].

Person-centred positive risk-taking framework

A person-centred positive risk-taking framework is a 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[9].

Person-centred care

Person-centred care considers the older adult's cultural traditions, their personal preferences and values, their family situations and their lifestyles and ensures that patients are an integral part of the care team who collaborate with clinicians in making clinical decisions[10].

Shared decision-making

Shared decision-making occurs when clinicians and older adults work together to make decisions about treatments and care plans based on clinical evidence that balances potential negative consequences and expected outcomes with the older adult's preferences and values[11]. Additionally, "information is shared clearly to promote informed choice, patients' capabilities and strengths are drawn on, and the outcomes of a decision are managed by effective assessment and collaborative planning (p.81)"[12].

"I think that it [LWR:DSA] *helps to organize ideas and concerns, and facilitates collaborative problem-solving around risk. [...] I think the tool and the worksheets help to consolidate information and, in the end, save time for everyone."*
(Kris, healthcare professional)

"Well, what I like about it [LWR:DSA] *is, it's sort of a summary of probably a number of* ***conversations*** *that have happened over a period of time, and perhaps a client like me wouldn't remember necessarily. So it's really helpful to* ***have it all in one place****, and* ***have it really reviewed****, because I think* ***that would help me to agree*** *with what perhaps is being suggested, because it's there."*
(Barbara, older adult)

Additional guidance for each step of the LWR:DSA

1 Risk assessment

What is the older adult at risk of and who is concerned?

Reflection on perceiving risk differently

Older adults, caregivers and clinicians perceive risks differently[25]. Additionally, patient goals are often misaligned with caregiver and clinician goals when safety is identified as a concern[26].

- **Older Adults**
  - relate to the biographical domains of risk such as a loss of identity[27];
  - are sometimes concerned about risk from outside themselves, for instance strangers who may be trying to access their home, or criminal activity in their neighbourhoods[28].
- **Caregivers**
  - emphasize the present and focus on the interpersonal impacts of risk[27];
  - evaluate risk along an acceptable to non-acceptable continuum suggesting that everyone has a tipping point which results when the risk in their evaluation becomes unacceptable to them[28].
- **Clinicians have a tendency to**
  - overestimate risk[27];
  - focus on extreme harm rather than risks associated with daily living[12];
  - emphasize the future and focus on the negative and physical consequences of risk[27, 29, 30];
  - focus on the fear of physical harm during discharge decision making[31];
  - be paternalistic[12] and risk averse[5];
  - be reluctant to allow people to make risky choices[32].
- **Clinicians are better able to support increased risk when they**
  - focus on the older adult's goals[29, 33];
  - are supported by their organization and not worried about litigation[15, 29];
  - receive feedback from community partners;
  - are able to reflect on their practice and debrief with their colleagues[29];
  - become more experienced and closer to being an older adult[29, 33];
  - are able to gather comprehensive information about the client (i.e. holistic assessment) comprehensively (i.e. from multiple sources, client, caregiver, friends, home environment)[29];
  - are able to work with the older adult over time or arrange for further involvement with other clinicians[29].

Personal Reflection

- **How does your mental models impact on your approach to risk assessment?**
  - What are your personal and professional beliefs about risk taking?
  - Do you value safety over autonomy?
  - Do you have a tendency towards overprotection, or have you become desensitized?
  - Are you making recommendations that favor decreasing your discomfort?
  - What are your professional beliefs about shared decision making even with older adults with cognitive impairments?
  - Do you approach risk assessment in a binary, finite way (i.e., safe or not safe) instead of a continuum of safe to unsafe?
  - Do you go into the decision-making process with a predetermination of what you believe or want to happen and then only see the answers that confirm this belief? A broadened approach to risk assessment requires an infinite mindset. By not being immediately dichotomous, it allows for more creativity in problem-solving.
- **How does your clinical setting impact on your approach to risk assessment?**
  - Do you feel supported by your organization, or do you fear litigation should bad outcomes occur?
  - Is there a pressure to discharge your client prior to the assessment being completed and /or the services put in place?

2 Risk assessment

What is the older adult's risk status?

- **Likelihood :** Consider risk factors (i.e. poor balance) and context (i.e. physical environment) to determine the likelihood of concern (i.e. falls).

- **Severity :** Consider factors such as medical history (i.e. osteoporosis) and context (i.e. living alone and no medical alarm system) to determine the severity of harm. Also consider if the consequences are temporary or permanent. Clinicians rated the situation as higher risk when the consequences affected others (i.e. driving safety issues, fires in an apartment building)[1].

3 Risk management

What can be done about the concerns?

- Clinicians felt they were better able to support their clients to live with risk when they were able to access colleagues for debriefing, problem solving, validation and a different perspective[29].
- Clinicians prefer to manage safety concerns by informing the client and by collaborating with the client and caregiver[29]. As guided by most provincial legislation, clinicians can only override a client's wish when they are at imminent risk to themselves or others.

4 Risk management

How to have a conversation about risks and ways to address concerns?

Clinicians, older adults and caregivers have acknowledged the benefit of the LWR:DSA for supporting and guiding conversations around safety concerns. The LWR:DSA can be used to support a safe environment to have and hold conversations especially when there are differences in perspectives.

- **Risk Communication Best Practices including for people living with dementia**
  - **Work towards a shared understanding and not a shared agreement**[35,36]
    - Risk is contextual and has multiple meanings across different stakeholders[35]. Work with the older adult and caregiver on a shared understanding of the concerns, negative consequences and the approach towards the risk of harm[36].
    - Understand the acceptable thresholds and the tipping points for the older adult and/or caregivers[35].
    - Provide the rationale for the concerns and recommendations[37].
  - **Know the person**
    - Work to understand the older adult's values, preferences, goals in order to suggest creative and person-centered approaches to reducing the risk of the negative consequences[38].
    - Understand the needs or values that the 'risky' activity is meeting in order to suggest another activity that would still meet this need and/or value[39,40].
  - **Acknowledge the older adult's and caregiver's fears, feelings and belief systems**[38]
  - **Acknowledge quality of life**
    - Older adults may value quality of life over safety[37]
  - **Encourage active decision making**[36]
    - Involve the person living with dementia in ways that they can participate and decisions that they can make[36]
    - Focus on solutions and on what can be done [36,37]
  - **Support time**
    - Provide the time to process the information, make choices and adapt to changes, as often risk assessment and management is happening in a time of crisis (change in health or functional skills, withdrawal of support, accumulation of further risk factors)[35,36]
  - **Provide information in written format**
    - To help process the information, to refer back to at a later date, for and/or future consideration[37].

Frequently Asked Questions

How was the LWR:DSA developed and how is it being adapted, validated, tested and implemented?

- The LWR:DSA was **developed** from the literature including a qualitative research study on how clinicians perceived, identified, assessed and treated risk while trying to negotiate safety and autonomy when working with community-dwelling older adults who were labelled as living at risk[1].

- The LWR:DSA was **adapted** to the hospital context and **validated** and **pre-tested** in both the community and hospital setting by the LWR:DSA Research Group: MacLeod, H., Provencher, V., Klein, J., Veillette, N., Kergoat, M.J., Giroux, D., Delli-Colli, N., Gingrich, S., Egan, M and with financial support from the Canadian Frailty Network.

Canadian Frailty Network
This research is funded by Canadian Frailty Network (Technology Evaluation in the Elderly Network), which is supported by the Government of Canada through the Networks of Centres of Excellence (NCE) program.

- The LWR:DSA was **tested** and **implemented** by clinicians in hospital and community settings by the LWR:DSA Research Group: MacLeod, H., Provencher, V., Kessler, D., Klein, J., Veillette, N., Kergoat, M.J., Giroux, D., Delli-Colli, N., Egan, M , Lewis, K and with financial support from the Canadian Institutes of Health Research.

CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

Psychometrics

- **Has the LWR:DSA's inter-rater reliability been tested?**
  - No, as this is an approach to care and not a tool, the inter-rater reliability has not been determined.

- **Can this approach reliably predict whether a frail older adult can be discharged home or remain at home?**
  - Given that individual contexts are highly variable, the LWR:DSA does not predict outcomes such as remaining at home or being discharged home without negative consequences.

References

[1] MacLeod, H., & Stadnyk, R.L. (2015). Risk: 'I know it when I see it': how health and social practitioners defined and evaluated living at risk among community-dwelling older adults. *Health, Risk & Society,* 17(1): 46-63.

[2] Purdy, G. (2010). ISO 31000:2009. Setting a new standard for risk management. *Risk Analysis,* 30(6): 881-892. Doi:10.1111/j.1539-6924.2010.01442.x

[3] British Geriatrics Society (2017). *Fit for Frailty: Consensus Best Practice Guidance for the Care of Older People Living in Community and Outpatient Settings.* British Geriatrics Society: London, England.

[4] Ellis, G., Gardner, M., Tsiachristas, A., Langhorne, P., Burke, O., Harwood, R.H., Conroy, S.P., Kircher, T., Somme, D., Saltvedt, I., Wald, H., O'Neill, D., Robinson, D., & Shepperd, S. (2017). Comprehensive geriatric assessment for older adults admitted to hospital. Cochrane Database of Systematic Reviews, (9): CD006211. DOI:10.1002/14651858.CD006211.pub3.

[5] Ibrahim, J.E., & Davis, M.C. (2013). Policy and practices updates: Impediments to applying the 'dignity of risk' principle in residential aged care services. *Australasian Journal on Ageing*, 32(3): 188-193.

[6] Marsh, P., & Kelly, L. (2018). Dignity of risk in the community: a review of and reflections on the literature. *Health, Risk & Society,* 20(5-6): 297-311.

[7] Resnick, B. (2014). Resilience in Older Adults. *Topics in Geriatric Rehabilitation,* 30(3): 155-163.

[8] MacLeod, S., Musich, S., Hawkins, K., Alsgaard, K., & Wicker, E.R. (2016). The impact of resilience among older adults. *Geriatric Nursing,* 37(4): 266-272.

[9] Titterton, M. (2005). Risk and risk taking in health and social welfare. London: Jessica Kingsley Publishers

[10] Alberta Health Services. (2015). The Patient First Strategy. Retrieved from https://www.albertahealthservices.ca/assets/info/pf/first/if-pf-1-pf-strategy.pdf

[11] Hoffmann, T.C., Légaré, F., Simmons, M.B., McNamara, K., McCaffery, K., Trevena, L.J., Hudson, B., Glasziou, P.P., & Del Mar, C.B. (2014). Shared decision making: what do clinicians need to know and why should they bother? *Medical Journal of Australia*, 201(1): 35-39.

[12] Felton, A., Wright, N., & Stacey, G. (2017). Therapeutic risk-taking: A justifiable choice. *British Journal Psychological Advances*, 23(2): 81-88.

[13] Canadian Mortgage and Housing Corporation. (2008). *Impacts of the aging of the Canadian population on housing and communities. Ottawa, ON: CMHC.*

[14] Cooney Jr, L. M., Kennedy, G., Hawkins, K., & Balch Hurme, S. (2004). Who can stay at home? Assessing the capacity to choose to live in the community. *Archives of Internal Medicine,* 164: 357-360.

[15] Bowles, K.H., Hanlon, A., Holland, D., Potashnik, S.L., & Topaz, M. (2014). Impact of discharge planning decision support on time to readmission among older adult medical personne aînées. *Professional Case Management,* 19(1): 29-38.

[16] Douglas, A., Letts, L., Eva, K. & Richardson, J. (2012). Measurement of Harm Outcomes in Older Adults after Hospital Discharge: Reliability and Validity. *Journal of Aging Research,* 2012: 2090-2204.

[17] Greenwald, J.L., Denham, C.R., & Jack, B.W. (2007). The hospital discharge: A review of a high-risk care transition with highlights of a reengineered discharge process. *Journal of Personne aînée Safety,* 3(2): 97-106.

[18] Wu, H.Y., Sahadevan, S., & Ding, Y.Y. (2006). Factors associated with functional decline of hospitalised older persons following discharge from an acute geriatric unit. *Annual Academy of Medicine Singapore,* 35(1): 17-23.

[19] Depalma, G., Xu, H., Covinsky, K.E., Craig, B.A., Stallard, E., Thomas, J.R., & Sands, L.P. (2013). Hospital readmission among older adults who return home with unmet need for ADL disability. *Gerontologist,* 53: 454-61.

[20] Romagnoli, K.M., Handler, S.M., Ligons, F.M., & Hochheiser, H. (2013). Home-care nurses' perceptions of unmet information needs and communication difficulties of older patients in the immediate post-hospital discharge period. *British Medical Journal of Quality and Safety,* 22(4),324-332.

[21] Boockvar, K.S., Litke, A., Penrod, J. D., Halm, E.A., Morrison, R.S., Silberzweig, S.B., Magaziner, J., Koval, K., & Siu, A.L. (2004). Patient relocation in the 6 months after hip fracture: risk factors for fragmented care. *Journal of the American Geriatric Society,* 52(11): 1826-31.

[22] He, S., Craig, B.A., Xu, H., Covinsky, K.E., Stallard, E., Thomas, J., Hass, Z., & Sands, L.P. (2015). Unmet Need for ADL: assistance is associated with mortality among older adults with mild disability. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences,* 70(9): 1128-32.

[23] Canadian Institute for Health Information (2017). Seniors in transition: *Exploring pathways across the care continuum.* Retrieved from https://www.cihi.ca/en/infographic-seniors-needs-and-care-settings-improving-alignment

[24] Donnelly, S.M., Carter-Anand, J., Cahill, S., Gilligan, R., Mehigan, B., & O'Neill, D. (2013). Multiprofessional views on older patients' participation in care planning meetings in a hospital context. Practice: Social Work in Action, 25(2): 121-138.

[25] Provencher, V., D'Amours, M., Viscogliosi, C., Guay, M., Giroux, D., Dubé, V., Delli-Colli, N., Corriveau, H., & Egan, M. (2019). Risks perceived by frail male patients, family caregivers and clinicians in hospital: Do they change after discharge? A multiple case study. *International Journal of Integrated Care*, 19(1): 4.

[26] Kuluski, K., Gill, A., Naganathan, G., Upshur, R., Jaakimainen, R.L., & Wodchis, W.P. (2013). A qualitative descriptive study on the alignment of care goals between older persons with multi-morbidities, their family physicians and informal caregivers. *BMC Family Practice,* 14: 133.

[27] Clarke, C. (2000). Risk: Constructing care and care environments in dementia. *Health, Risk Society,* 2(1): 83-93.

[28] Cott, C., & Tierney, M.C. (2013). Vulnerability and risk across the life course. *Health Risk & Society,* 15(5): 402-415.

[29] MacLeod, H. (2013) Understanding risk: Health professionals' decision making with frail community-dwelling older adults. Halifax, Nova Scotia: Dalhousie University.

[30] Alaszewski, A., & Alaszewski, H. (2002). Towards the creative management of risk: Perceptions, practices and policies. *British Journal of Learning Disabilities,* 30: 56-62.

[31] Mukherjee, D. (2015). Discharge decisions and the dignity of risk. *Hastings Center Report,* 45(3): 7-8.

[32] Bailey, C., Clarke, C.L., Gibb, C., Haining, S., Wilkinson, H., & Tiplady, S. (2013). Risky and resilient life with dementia: review and reflections on the literature. *Health, Risk & Society,* 15(5): 390-401.

[33] Gunstone, S. (2003). Risk assessment and management of patients whom self-neglect: A 'grey area' for mental health workers. *Journal of Psychiatric and Mental Health Nursing,* 10: 28-296.

[34] Giroux, D., & Stibre, D. (2015). Validation de l'Outil d'Évaluation de l'Aptitude (PÉA) : Une étude Delphi. *Canadian Journal on Aging,* 34(4), 1-8.

[35] Stevenson, McDowell, M. E., & Taylor, B. J. (2018). Concepts for communication about risk in dementia care: A review of the literature. Dementia (London, England), 17(3), 359–390. https://doi.org/10.1177/1471301216647542

[36] Stevenson, M., Savage, B., & Taylor, B. J. (2019). Perception and Communication of Risk in Decision Making by Persons with Dementia. Dementia (London, England), 18(3), 1108–1127. https://doi.org/10.1177/1471301217704119

[37] MacLeod, H., Provencher, V., Klein, J., Veillette, N., Kergoat, M.J., Giroux, D., Delli-Colli, N., Gingrich, S., Egan, M. (2019-2021) An innovative decision tool to optimize hospital discharge in frail older patients living with risk. Canadian Frailty Network Funding - 70 000$ (unpublished results).

[38] Stevenson, M & Taylor, B. J. (2017). Risk Communication in Dementia Care: Professional Perspectives on Consequences, Likelihood, Words and Numbers. The British Journal of Social Work, 47(7), 1940–1958. https://doi.org/10.1093/bjsw/bcw161

[39] Lee, L., Hillier, L., Lu, S., Martin, S., Pritchard, S., Janzen, J., & Slonim, K. (2019). Person-centered risk assessment framework: assessing and managing risk in older adults living with dementia. Neurodegenerative Disease Management, 9(1), 47–57. https://doi.org/10.2217/nmt-2018-0031

[40] Bedin, M.G., Kuhne, N., & Droz Mendelzweig, M. (2020). Volition to risk taking in the ordinary activities of daily life of older people living at home alone. A study using explicitation interviews. Health, Risk & Society, 22(7-8), 421–436. https://doi.org/10.1080/13698575.2020.1861223