Risk... what makes a difference?

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What potential factors make these photos appear as risky behaviours?
Risk... what is it?

• A probability or threat of a damage, injury, liability, loss or other negative occurrence that is caused by external or internal vulnerabilities, and that may be neutralized through preemptive action (Lumley, 2002).

• Risk is very individual, therefore it is very variable between what is deemed acceptable by the client, family, health care clinicians and society (Nay, 2002).
Risk… what is it?

- Dignity of risk - a term used to describe the right of individuals to choose to take some risk in engaging in life experiences (Nay, 2002; Parson, 2008).
- Right to failure (Nay, 2002).
Risk… what is it?

- Autonomy - The right of patients to make decisions about their medical care without their health care provider trying to influence the decision. Patient autonomy does allow for health care providers to educate the patient but does not allow the health care provider to make the decision for the patient (Nay, 2002).
Risk… what is it?

• Client centred practice – where the client is the central focus of assessment and intervention.

• Requires information gathering to determine what is important and meaningful to the client.

• Shift from traditional impairment based approach to top down approach (Moats, 2007; Stark, Landsbaum, Palmer, Somerville, & Morris, 2009).
Risk… what is it?

Client centred practice cont.
• Engages the assistance and support of the therapist to facilitate the client’s problem solving and goal achievement.

• Joint partnership, sharing of knowledge and mutual respect between the client and the therapist.

• Can include significant others (Moats, 2007; Stark, Landsbaum, Palmer, Somerville, & Morris, 2009).
Mrs D – Case Study

Background

- 91 year old lady
- Previously home alone
- Daughter interstate
- Son in Melbourne who visits for a week every 3 weeks
- Nil formal services
Mrs D – Case Study

Background cont.

• Previously independent with all transfers and mobility with nil aid, personal care tasks, light cleaning, basic meal prep, and gardening.

• Son assisted with heavy cleaning, cooked larger meals which he froze, finances and some community tasks.

• Neighbours would take Mrs D to the hairdresser each Friday and would assist with small grocery shops.
Mrs D – Case Study

Background cont.

- Admitted to Ballarat Base Hospital 22/10/11 with R) tibial fracture, surgical intervention ORIF - LISS plate.
- Mobility slow to progress and home environment not conducive for PUF use.
- Transferred to Inpatient Complex Care 3/11/11 for slow stream rehab and discharge planning.
Mrs D – Case Study

Background cont.

- ICC admission 3/11/11 – 7/12/11
- Progressed to independent with 2WF ~40m
- Independent with transfers
- Unable to complete steps whilst on ICC due to 2WF use (has 4 x steps at home- therefore home ax unable to be completed)
- Family Mtg completed 23/11/11 – Plan for ACAS Ax for TCP and LTC
Mrs D – Case Study

Background cont.
• Planned admission to TCP bed based for 7/12/11
• D/C Information/Goals for TCP

Social Work:
• Family investigating LTC options in Ballarat and Melbourne
• Family to attend appointment with residential services officer
• Nil previous formal services
Mrs D – Case Study

Background cont.

Physio:
- Currently independent with 2WF
- Goal to optimise gait and determine long term gait aid (?2WF or 4WF)
- If returning home progress towards mobility within home environment
- 4 x steps to access home
- Accessing garden
Mrs D – Case Study

Background cont.

Occupational Therapy:

- Increase independence with mobility and increase WBg in R) leg
- Increase independence and initiation in personal care tasks
- Pt likely to transition to LTC in either Ballarat, Melbourne or interstate near her daughter

- Family and treating team concerned about Mrs D’s cognition (MMSE 22/30) and ability to return home safely
- Mrs D wanting to return home
Mrs D – Case Study

So let’s reflect on what we know so far…

What are your thoughts about the proposed plan for LTC at this point for this patient?

Is TCP an appropriate discharge plan from the ward?
Person, Environment, Occupation Model (PEO)

(Moats, 2007)
Mrs D and the PEO Model

(Moats, 2007)
Evidence Based Identified Issues within Current Clinical Practice

• Decision making is often taken away from the client within hospital (Lumley, 2002)

• Family opinion/wishes are valued higher than the client’s (Moats, & Doble, 2006)

• Hospital based assessments are not truly reflective of capabilities of clients (Provencher, 2009)
Evidence Based Identified Issues within Current Clinical Practice

• Poor communication between team members and with the client’s family (Crennan, & MacRae, 2010; Nay, 2002)

• Competency ruling influencing discharge planning and team members involvement (Moats, 2007)

• Do no harm approach not conducive with human nature (Moats & Doble, 2006)
Evidence Based Identified Issues within Current Clinical Practice

- Persuasion and cohersion used as a tool by clinicians to make self feel better with overall decision making (Moats, & Doble, 2006)

- Inexperience/lack of exposure to patients post discharge for inpatient clinicians (Crennan, & MacRae, 2010)

- Decisions regarding LTC can be pre-emptive (Provencher, 2007)
Identify issues with clinical practice related to Mrs D

Difficult to fully ascertain given we are not the original treating team, however could include:

• Client’s wish was to return home, however daughter’s wish was for her to go into LTC
• Decreased involvement of client in D/C plan
• Long term plan for D/C destination pre-determined whilst still an inpatient – plan for LTC
• Incomplete assessment of Mrs D’s function and home environment
So what does the evidence say to improve clinical practice?

• Removing the right to take risks removes autonomy and control from clients (Nay, 2002).

• Clinicians should be advocating for client’s wishes separately to acknowledgement of family concerns (Nay, 2002).

• Clinicians should be utilising their skills for the best outcome for the client, placing less emphasis on their own conscience/needs (Nay, 2002)
So what does the evidence say to improve clinical practice?

- Allowing opportunity for risk and potential failure with community based support on discharge (Parson, 2008)

- Safety and risk taking need to be balanced with autonomy promotion (Moats, & Doble, 2006)
So what does the evidence say to improve clinical practice?

- Engage client’s in meaningful and purposeful occupation within a familiar environment for assessment purposes (Buettner, & Voelkl, 2006; Provencher, 2007)

- Interdisciplinary approach with clear lines of communication most effective (Buettner, & Voelkl)
New models to guide clinical practice…

Figure 1. Negotiated Model of Decision-making for a Client with Mild Cognitive Impairment and Minimal Reliance on Family.

(Moats, 2007)
So what happened with Mrs D?

TCP Admission 7/12/11 – 10/4/12 (Extension Approved)

• Mrs D was continuing to voice her desire to return home
• Improvements in mobility noted. Client independent with 2WF 100-200m and independent with 4WW also.
• Client independent with steps with rail/gait aid.
So what happened to Mrs D?

- Home assessment completed and consent gained from client to have rail installed at side access steps (main access) to increase safety.
- Discussed with PT possibility of 2 x frames (one inside and one outside).
- Outdoor area around the garden flat and frame accessible.
- Mrs D independent with preparing cup of tea at home.
So what happened to Mrs D?

- Daughter still voicing concerns of Mrs D returning home. Son open to LTC or return home with support.
- Daughter requesting meeting with OT and CM
- Developed a plan of graded staggered leave to determine long term discharge plan from TCP for Mrs D.
- 2 hrs one day, then 4 hrs another day (with MOW for lunch), 9.30am – 2.30pm next day, overnight leave 2.30pm – 1.30pm the next day (with MOW, medications and nursing checks).
So what happened to Mrs D?

- Transitioned home with TDS visits.
- AM: Hygiene and Med prompt
- Lunch/Tea: Med prompt and observe eating meals.
- MOWs 7/7 and HH 1/14
- Arranged a locked box for medications so Mrs D wouldn’t get confused with her meds
- Mrs D cancelled her MOWs after 3-4 weeks, and recommenced cooking her meals. Was also baking and gardening.
- H/O to Linkages for CACPs
Was the TCP team evidence based in their practice and was Mrs D the central focus?

Do you still think that Mrs D should have gone into LTC?

Has this changed your view on discharge planning?
Food for thought…

OH, COME ON — YOU ONLY LIVE ONCE!


Thank you.