Living at risk– Lecture guide

Living at Risk: The (usual) conflict

- The health-care team / provider has concerns about the patient's safety, or their best interests, and this might be in conflict with the patient's choice, where that choice is riskier than the team/provider thinks is best.
- Challenging is that there is no standardized definition or understanding of what constitutes "living at risk"; being alive is inherently "risky".
- Health-care teams must consider the degree of risk and the probability of harm.

How we understand "risk"

To help understand concerns about risk for patients, consider the following questions:

- Are the rights and behaviours of older adults questioned in ways that would never be acceptable if they were younger adults?
- What is more concerning, a competent 85-year-old person at risk of falling wanting to stay home or a 16-year-old learning to drive or a 50-year-old who decides to have a baby?
- Are the rights and behaviours of mental health or substance use and addiction patients questioned in ways that would not be for other patient populations?

When patients choose to live at risk, many challenges exist

- Potentially paternalistic views of the health-care team - "We know best"
- Cultural factors and language barriers
- Pressure to discharge
- Lack of consistent direction

When decisions to live at risk are made…

Ideally:

- We enhance and respect autonomy
- We practice patient-centered care
- Patients and families agree and adhere with the treatment or discharge plan
- We ensure continuity of care and available resources to facilitate transitions and minimize risks

In reality:

- Disagreement with patients' choices and/or with treatment or discharge plans
- There are limited resources and increasing pressures
- Our health-care system can be fragmented and silo-ed
- There may be a "rescue culture" where staff are trained to let go or allow patients to take ++risks.

***Check:* What does living at risk look like in your environment/practice?

Is there a living at risk culture?
Does your organization have a policy?

Consent & Capacity

- Consent & capacity are key to this ethical debate
- Why?
    - Individuals have the right to choose how to live
    - A "foolish" decision ≠ incapacity
    - Before thinking about risk, we must assess if the individual is capable or incapable of making a particular decision
    - Capacity assessors in Ontario operate under the Substitute Decisions Act (SDA)

Components of Consent: Refresh

- 1. Full Disclosure/Informed – the provision of all relevant information and the comprehension of this information by the patient
- 2. Capable- the patient's ability to understand information and appreciate potential consequences of their decision. They have "decision-making capacity."
- 3. Voluntary- the patient's right to come to a decision freely (without force, coercion or manipulation)
- *Definition*: A person is **capable** if he or she has…
- the **ability** to **understand** information relevant to the decision

AND

- the **ability** to **appreciate** the reasonably foreseeable consequences of giving or refusing consent

Remember:

- Capacity is presumed.
- Choosing "risk" does not necessarily indicate incapacity.
- Capacity can fluctuate over time, and is decision specific.

Our Ethical Dilemma

- Tension between respecting choice and minimizing risks
- Questions of liability and professional responsibility
- Lack of consistent guidance or practice standards
- Challenging situations for staff and management

Are we asking the right questions?

What tends to be asked:	What we ought to ask:
Can they live alone?	Do they have the capacity for this decision?
Can they manage?	What are the patient's preferences?
Are they safe?	Can we make the home, or discharge, safer?
Is the home suitable?	How can we maximize safety, functioning, and well-being?
What does the family want?	What is "Acceptable" Risk?

What is acceptable risk?

- **Risk**: Uncertainty of outcome, whether positive opportunity or negative threat.
- **Acceptable risk**: The level of risk that an organization **will** support
    - To be determined by the organization using evidence-based indicators and a rigorous review of options (e.g. falls risk)
    - Refer to previous experiences, look to past cases as precedent
- What is "Unacceptable" Risk?
- **Unacceptable risk**: The level of risk that the organization **will not** support
- Includes, but is not limited to…
    - any action that violates legal requirements (e.g., request to live close to an individual with a restraining order)
    - any action that requires resources beyond what is mandated
    - serious concerns that supporting the patient to live at risk will not meet the patient's needs (e.g., inappropriate treatment request)
    - the patient is in immediate danger

- the patient's choice to live at risk poses imminent harm to others (e.g., exposure to violence)

What should we do?

To help decide what we should do, we can refer to the **IDEA framework** we discussed previously.

Step 1: Identify the Facts Identify what is known versus what is not known. ● Medical Indications ● Client Preferences ● Quality of Life, and ● Contextual Features, Users of the framework should take into account all of the relevant considerations and stakeholders; this often includes facts that may not be known initially.	**Step 2: Determine Ethical Principles in Conflict** Identifying the ethical principles in conflict will not provide solutions; however, this step will assist in further clarifying and articulating the issues. Common ethical principles to consider might include, but are not limited to: ● Autonomy ● Beneficence (or doing good) ● Non-maleficence (or doing no harm) or ● Justice
Step 3: Explore Options The intent of this section is to brainstorm different alternatives and to consider the potential outcomes and impacts of each one (e.g., evaluate the potential positive and negative considerations of each option). Do the options fit with the patient's preferences? Do the options comply with corporate policy, regulations, and the law?	**Step 4: Act and Evaluate** Develop and document the action plan in the patient's chart and obtain consent. Evaluate the plan. Were the intended results obtained, or is additional follow-up and/ or action required? Ongoing documentation and communication of the evaluation is necessary. Self-evaluate your decision. What have you learned?

Case

- Mrs. Going Home: 82 yr female who lives with her son who has physical limitations. Mrs. Home is an amputee. She is mildly demented and is bed bound without assistance of mechanical lift in the hospital.
- Son wishes to take Mom home "I can do it, this is how we live and Mom will do better at home." The son refuses a mechanical lift in the home, as well as home care/Personal Support Worker supports
- Mother constantly looks to son for answers, however, when asked she says she wishes to go home with her son. Physician/Social Work/Health-care team feel Mrs. Home will be at great risk of falls, bedsores, and deterioration of health if she is discharged home. The health-care team feel that the son is not acting in Mom's best interest as her substitute decision-maker.
- As a member of the health-care team, what should you do?

References

Bowman K, et al. (2010). *The Ethical Considerations in Discharge Planning*. Presentation at Mount Sinai Hospital, Toronto, ON.