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REVIEW

Managing risk for aging patients in long-term care: a narrative review of practices to support communication, documentation, and safe patient care practices

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Abstract: Resident safety and welfare in long-term care (LTC) is being redefined as the focus shifts to promoting an optimal quality of life especially in LTC. Achieving this requires contemporary practice to improve the organization and staff's ability in identifying, communicating, documenting, and managing the risks that arise from the choices a person makes in pursuit of a better quality of life. This article is a narrative realist style review examining the issues of how to manage risks for older residents living in LTC. The issues are examined in six stages: context, identifying, communicating, documenting, enacting, reviewing and reflecting on how choices are made and risks managed. It is important for individuals to be supported in making an informed choice – this requires identifying, providing, and communicating the available options and the potential consequences. Documenting consent, perhaps with formal risk agreements, provides clarity for all involved and assists in determining how and who is responsible for enacting choices. Reviewing and reflecting upon the decisions and actions to enact choices are familiar to prudent LTC managers who implement and monitor robust governance systems. Learning from these experiences is essential to better meet individual resident, staff, organizational, and community expectations. Improving practice at each of the six steps should reduce adverse professional and legal repercussions and enable the resident, families, and staff to better cope with respecting choices when a known harmful outcome eventuates.

Keywords: risk management, choice, long-term care, dignity of risk, quality of life, forensic gerontology

Introduction

The rapidly aging populations of high-income countries are accompanied by significant concerns about the quality of care and quality of life of older people.[1–5] These concerns also exist in the provision of long-term care (LTC), where the quality of care has a substantive impact on older persons' quality of life.[2] LTC usually refers to facilities that provide services, accommodation, and supervision or assistance to older persons with activities of daily living and are also often described as a nursing home, convalescent home, skilled nursing facility, social care, care home, rest home, or Residential Aged Care Service.[1,6]

Resident safety and welfare in LTC is being redefined as the focus shifts to promoting an optimal quality of life.[2,4,7] Achieving this requires applying contemporary knowledge of best practice for identifying, communicating, documenting, and managing the risks that arise from the choices made in pursuit of a better quality of life.

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Basic principles underpinning risk management, including communicating with persons involved and reviewing and monitoring the risk management process,[8] are applicable in LTC settings to ensure a comprehensive approach to risk management. To successfully implement an optimal program requires recognizing and addressing both the technical aspects and nontechnical aspects of managing risk.

The technical aspects involve adhering to science and law, ie, the principles of evidence-based practice, person-centered care, professional and legal duty of care, as well as respecting the rights of an individual. The nontechnical or humanistic aspects are equally important, as promoting an optimal quality of life often creates perceived and actual high-risk situations that are emotionally laden, ethically complex, and morally confronting.

Enacting decisions of older people is intended to improve quality of life and yet may lead to serious injury or death. This may be psychologically discordant and distressing for the carer, family, and health professional – who prioritize safety for the patient or resident. Managing the risks and consequences requires organizational and societal processes that support and promote confidence and illustrate a commitment to enacting the residents' choices.

Patient safety is defined by the WHO[9] as "the prevention of errors and adverse effects to patients associated with healthcare". While this definition was not directly intended for LTC, it has influenced health care professionals by reinforcing the view that no harm should ever occur due to errors of professional practice. This is detrimental to promoting and supporting the concept of "dignity of risk" (DoR). Ibrahim and Davis[10] proposed that the DoR concept refers to "an individual's personal dignity [being] manifested, in part, by their ability to remain autonomous,[11,12] and [this] engenders risk-taking…[13] with subsequent enhancement of personal growth and quality of life".[13,14]

Addressing this issue is gathering urgency as globally, by 2050 the number of people over the age of 80 years will triple from 137 million in 2017, to 425 million in 2050,[15] and a significant proportion will have dementia and impaired decision-making capacity.[16] This coincides with the growing emphasis on preventing elder abuse[17] and promoting the rights and choices of older people. This narrative review article examines how to manage risks for aging patients by focusing on the processes required to enact and support DoR for residents living in LTC.

We begin by examining the context or culture using an illustrative everyday scenario requiring risk management in LTC. Following on from this, the concepts of choice and risk are explored, explaining how risk could be managed while still facilitating an individual's choice. The third section considers the importance of communication in enabling safer risk-taking focusing on the role of consent and capacity. The fourth section examines the importance and nature of documentation to facilitate DoR for all persons involved. The fifth section addresses challenges and approaches for enacting choices with an emphasis on accepting or mitigating, rather than eliminating risk. The article concludes with a discussion on the importance of reviewing and reflecting upon the outcomes and consequences of enacting such choices.

Method

The literature search and narrative review were conducted using the approach best described as a realist review. The contributors are a multidisciplinary team with skills, knowledge, and experience in geriatric medicine, public health, nursing, injury prevention, risk management, resident safety, geriatric and gerontology research and law. A realist approach acknowledges the limitations of traditional systematic reviews for complex policy interventions.[18] Further, the virtual absence of empirical-based research in LTC, addressing the management of risk while promoting choice for residents, negates the application of a traditional systematic review.

The review consisted of a search strategy of published literature in the English language focused on identifying issues and approaches to communication, documentation, and decision-making surrounding risk-taking in the LTC setting. There were no restrictions on the year of publication, and the following databases were searched: MEDLINE, CINAHL, Embase, AgeLine, Cochrane Library, AustLII, and Google Scholar.

All study designs published in the English language including case studies were considered for the review. The focus was on LTC setting; however, when necessary, examples from other institutional settings were considered. Community style accommodations such as private homes, family homes, and private shared living were not included. We sought to identify concepts and principles pertinent to managing risk and enacting choice for each component of what we deemed a logical pathway for managers and the "point of care" practitioners to address.

Context

The context is perhaps more easily understood as whether the community and organization are ready to enact DoR, recognizing and accepting that there will be occasional adverse outcomes. Addressing these issues requires understanding the

medical, social, political, ethical, religious, economic, and legal aspects of the situation, as well as understanding the roles and responsibilities of each person and organization. Consider the following scenario:

Mary is 80 years old and has had a stroke causing swallowing difficulties and a loss of mobility being predominantly bed bound, with little financial support and limited manual dexterity. Mary wants to celebrate her birthday with champagne and strawberries to relive experiences of happier times.

Mary cannot leave the nursing home to obtain the champagne, does not have enough money to buy it, and needs help to drink it.

Mary's son leaves the money to cover the cost of the purchase, which is transacted by her grandson, who provides a magnum of French champagne and fresh strawberries to a colleague who is also a personal care worker. The personal care worker explains to the registered nurse that the champagne and fresh wild strawberries are on Mary's bedside table…

Outcome one

Before anything happens, Mary's daughter discovers the champagne and fresh wild strawberries. She becomes concerned that the alcohol will interact with medication and that Mary will choke on the strawberries and reports the incident to the nursing home manager, and nursing registration board, and seeks to revoke the son's legal standing as Mary's guardian.

Outcome two

The nurse pours the champagne into a glass flute with a strawberry at the bottom and assists Mary to have the drink. Mary finishes the drink and eats the strawberry with no untoward effects.

Outcome three

The nurse tells Mary she does not want to be involved and leaves the room. Mary manages to drink most of the magnum, becomes unwell, disorientated, gets out of bed, and slips on a strawberry breaking her hip, and she subsequently dies.

This scenario and the response to the different outcomes requires examining the steps in the process from 1) identifying to 2) communicating to 3) documenting to 4) enacting to 5) reviewing and reflecting on the choices and risk a person has the right to choose.

Identifying choices and risks

Identifying choices

Proactive management of risk requires identifying the hazards associated with a resident's choices that enhance their quality of life. Choice is defined as "an act or the possibility of choosing"[19] that is "to decide what you want from two or more things or possibilities".[19]

Many LTC residents are not provided with choices; instead, decisions are made for them. It is important not to assume that we know what a person wants. Identifying current choices requires asking and actively listening. Making assumptions based on previous experiences is not always valid. It is important to confirm each time a potentially hazardous activity is requested, that it is what the person wants.

Family members are often asked to make choices on behalf of a resident. This is not straightforward as they may have preconceptions that do not reflect their loved one's wishes. Personal preferences may also change because of the new social setting or a worsening in functional status due to disease progression. The resident may also have private or secret personal habits or preferences that may not be known to family, or newly desired activities that may generate disapproval.

Identifying risk

Risk is somewhat simplistically defined as "the possibility of something bad happening".[20] This reflects the common usage of the term, but fails to recognize that some risk-taking is positive and beneficial. To better understand this requires examining the distinction between "risk" and "hazard". A hazard is "something that is dangerous and likely to cause damage,"[21] eg, Mary wanting champagne and strawberries where the alcohol and the thin fluid or strawberry are the "hazard", while the "risk" is the chance of harm occurring (becoming inebriated and slowing reflexes leading to a fall or aspirating on the fluid or choking on a strawberry).

Identifying harm

Harm is an outcome that may result from taking or not taking a risk. The different types of harm include physical, psychological, financial, professional, reputational, and legal. Harm is caused in many different ways; most simply, it can be classified according to whether it occurred as a result of an omission or a commission. Generally, harm caused by commission is perceived or considered as "worse" than harm caused by omissions,[22] even where the outcome is the same. Harm can also be categorized according to whether an individual has "consented" to the harm, eg, choosing to take alcohol and bearing the consequences of any side effects (or legal repercussions), or whether the harm has been inflicted by an abuser (ie, without consent); for example, Mary's grandson buys a case of 12 bottles of champagne with Mary's money for his own personal use (financial abuse).

Harm is a necessary precursor for establishing abuse; however, not all harm occurs as a result of abuse.[23] If Mary wants to drink alcohol and unmodified food and consents to the risks associated, then any harmful consequences will not be as a result of abuse. Genuine consent to harm weighs against the likelihood of abuse.[24] Where there is no consent to harm to which another person has contributed, the presence of abuse may be indicated.

Approaches to risk management

Risk management in health care is defined as "the basis of preventing and reducing harms …"[25] Haddon's matrix provides an approach that examines the factors associated with the risk and how the risk can be eliminated or mitigated.[26] This may be a useful tool for identifying the potential consequences of a risk an LTC resident wishes to take, and how these consequences may be mitigated. A risk management matrix provides a similarly useful tool to examine the types of harm that may result from an activity and the likelihood of that harm occurring.[8] This is useful for generating an informed discussion toward determining which risks are considered acceptable and in supporting safer risk-taking.

Basic risk management approaches may be applied to the LTC setting, the Australian/New Zealand Standards[27] provide the following framework:

1. Identifying the context.
2. Identifying the risk, its sources, and potential consequences.
3. Analyzing the risk: considering causes/sources of risk; their positive and negative consequences; the likelihood that these consequences will occur; and what might alter the likelihood of consequences eventuating.
4. Evaluating the risk.
5. Managing or "treating" the risk.
6. Monitoring and reviewing the risk.

The approach to risk management is influenced by the perception of risk; this depends on an individual's personality, knowledge, and personal experiences. Perception of risk tends to become heightened after exposure to a hazard that has led to an adverse outcome.[10]

A human rights approach to risk management may also be useful in LTC – a breach of human rights should be considered a risk in and of itself.[28] Human rights are based upon the principles of dignity, equality, and freedom;[29] arguably, if residents in LTC do not have the opportunity to enact choice and take risk, they are denied these basic rights and this may cause greater harm than the risk itself.

Understanding consequences when taking risks

It is important for individuals to make an informed choice – they should be provided with all available options and the potential consequences before making a decision. Older people, especially those in LTC, are at a greater risk of harm as a consequence of their physical frailty, presence of multiple comorbidities, complex drug regimens, and the need for care coordination. It is unreasonable to expect this population to also be able to articulate the available risk management strategies. It is incumbent on family, staff, and society to provide the support to mitigate risk. It is implausible to eliminate all risk as doing so impinges on an individual's autonomy. Speculating or forecasting potential consequences is important to ensure that staff can devise mitigation strategies and "rescue plans" to minimize the chance of harm following an adverse event.

Communicating choices and risks

Principles of communication

Communication around choice, risk, and harm is complex. It is necessary to actively consider the purpose of communication and the nature of the parties involved. Communication about DoR choices are required as a minimum between 1) resident and family, 2) resident and staff, 3) incoming and outgoing shift staff, 4) internal LTC staff and any external health professionals responsible for the resident, and 5) resident and staff and management and staff.

Communicating effectively with a person with cognitive impairment is imperative in the equitable enactment of DoR in the LTC setting. Some relevant considerations proposed by Young and Manthorp[30] for communicating with a person with cognitive impairment include communicating in a suitable environment, body language, eye contact, empathy, listening, clarity, reducing anxiety, reinforcing concept, and checking understanding. It is important to consider not only how we communicate with residents, but also ensuring that we actively listen to residents. Without listening to what the resident wants, we cannot help them to enact genuine choices.

Capacity to consent

People are deemed to have capacity at 18 years of age;[31] this is accepted as the right to make decisions for yourself and does not consider whether the decision is right or wrong, sensible or foolish, healthy or unhealthy, and so forth. It does not also consider that individuals have differing levels of maturity and ability – capacity is arbitrarily assigned with

age. Older people have the same rights even though they may have impaired cognition. How decisions are made in the setting of cognitive impairment needs to be more carefully considered – the process of decision-making is important.

Under the Powers of Attorneys Act 2014 (Vic), a person has the capacity to make a decision about a matter if they are able to "understand the information relevant to the decision and the effect of the decision… use or weigh that information as part of the process of making the decision and communicate the decision …"[32,33]

If there are any concerns, capacity must be assessed according to the jurisdiction's laws and by appropriately qualified health and legal professionals – it is not a matter of staff/family opinion. It is critical to understand that impaired capacity to make one type of decision does not preclude capacity to make a decision about a different matter – capacity is decision-specific.[34] In some circumstances where capacity is impaired, a guardian or power of attorney may be appointed as a substitute decision-maker.[35]

The intricacies of the notion of capacity require multiple discussions and are perhaps best approached by a multidisciplinary team with the resident and family in a formal meeting to ensure everyone contributes their opinion and arrive at the same understanding of any decision. These types of meetings will be very familiar in LTC settings. The models and principles used in discussing end-of-life care[36,37] are worthy of consideration in the LTC setting. It is impractical to conduct such meetings whenever a decision is made. Meetings could be conducted at agreed intervals to discuss "everyday" choices involving risk (eg, every 6 months). It may also be timely to hold meetings when a resident wishes to undertake a "special activity" or if the resident's cognitive ability has significantly declined. Ultimately, it is up to the LTC facility, staff, family, and resident to determine the regularity of such meetings.

Key aspects to address within multidisciplinary team meetings are as follows:

- What is the choice being made? It is helpful to have a reason for the choice as it may assist others to accept the decision; however, it is essential to remember that a person does not need to explain or justify their choice.
- What are the potential consequences of this choice?
- What are different stakeholders views and why?
- Is a mitigation strategy possible? How will this be initiated?
- Who will enact the choice? If another person is required who should this be and how does it alter the conditions around the choice?
- What is the rescue and recovery plan?
- Assuming this proceeds, have the adverse outcomes been discussed and accepted?
- Who else needs to be informed?
- Documentation of choice, discussion is clear, comprehensive, and available to all parties?

Verbal consent

Consent needs to be informed and voluntary, and the resident needs to have capacity to consent. Challenges arise where a resident verbally expresses a desire to take a risk (or consents) to an individual staff member and this risk-taking results in death. In these circumstances, it is very difficult to determine whether the staff member was acting in accordance with the resident's wishes or if they were abusing their power. By documenting that verbal consent was obtained, staff members confirm that their actions are what the resident desired.

Documenting choices and risks

Documentation

Documenting consent for a person's choices provides an important means of protection both for the residents themselves and for the LTC facility and staff. Documenting consent protects residents by ensuring their voice is heard, their wishes are fulfilled, and that they are not exposed to unnecessary risks or activities to which they have not consented. Documentation protects the LTC facility management and staff by providing a record of consent and the process by which this was obtained, in case of an adverse event. Where errors are made or unnecessary risks are taken which result in adverse consequences, documentation is crucial in ensuring a proper investigation. Examining, rather than ignoring adverse events, also provides a useful learning tool for prevention.[38]

Written consent

What a legal court may consider as robust evidence of consent and the form that most likely to be accepted without challenge is written documentation of consent. The strongest form of documentation comprises consent that is 1) in writing, 2) signed, and 3) witnessed. Again, it is important that the consent is informed. In the absence of proof in writing, consent can be extremely challenging to prove as demonstrated by cases involving sexual offenses. Written consent may be more challenging to obtain where a risk arises spontaneously or is unplanned. It is unrealistic to expect that written consent should be obtained for every substantive risk.

Risk agreements

Risk agreements, or negotiated risk agreements, provide a way of setting out which risks a resident wishes to accept and in what circumstances,[39] and they should also outline how the LTC facility will provide support. An important part of entering and creating a risk agreement is an open discussion between the LTC facility, resident, and their family. The risk agreement needs to be tailored to the individual, as each resident will have differing preferences and values, degrees of risk they are willing to accept, and consequences they are willing to face.

The changing nature of risks provides a further complicating factor. When a resident's health deteriorates, a behavior that was previously safe may now pose a risk of harm. When deterioration in health is identified or a new diagnosis occurs, the existing risk agreement should be reassessed and modified if necessary.

Where an adverse event occurs, it is timely that the risk agreement is revisited. The LTC facility should assess why the adverse event occurred – was it due to chance, deterioration in the resident's condition, or a failure of LTC practice? The LTC facility should then implement any changes necessary to prevent recurrence, if possible, and reassess the risk agreement with the resident. The facility should also document the cause and incident to help prevent related incidents in the future.

Enacting choices, managing risks, and managing the consequences

Prudent managers and executives implement and monitor robust clinical governance systems that provide the multipronged approaches required to meet the expectations of the resident, staff, organizational, and community. Enacting residents' choices to enhance quality of life, while mitigating risks and managing adverse consequences, requires time, resources, knowledge, skills, and expertise.

Challenges to traditional views of best practice

In clinical care, best practice can be defined as "the 'best way' to identify, collect, evaluate, disseminate, and implement information about as well as to monitor the outcomes of health care interventions for patients/population groups and defined indications or conditions".[40] In the general community, best practice can apply to a wide range of industries and defined as "a working method or set of working methods that is officially accepted as being the best to use in a particular business or industry …".[41] Best practice in LTC needs to take a broader and more multifaceted approach to incorporate quality of life and DoR as important factors.

Enacting choices

Senior managers and executives are responsible for the quality of care provided to older people living in LTC and have joint responsibility in enabling the desired quality of life for residents. This requires establishing the policies, procedures, and protocols that recognize staff members as both providers of care and enactors of choices. This places staff members in a potentially invidious position as they owe a "duty of care" to residents which may conflict with their role as "enactors of choice". Legal protection may be necessary to ensure that staff can assist in enacting decisions without being reprimanded; however, due to the conflicting duties, this is an incredibly challenging and contentious area. The role and the responsibilities of staff must be viewed on a continuum, rather than as absolute or discrete categories.

Awful things do happen. Not only may the resident suffer serious harm or death but many others are also impacted. Vicarious trauma is recognized as occurring in suicide and mental illness, and is another reason to discuss and document the procedures when making the initial decisions.

LTC staff have the moral right not to enact a decision if it is contrary to their beliefs or places them in a position of causing physical or psychological harm. This is a potential deterrent to the whole principle of DoR and has received virtually no consideration. Those who work with people in LTC will understand the personal trauma which is rarely articulated in policy or human rights documents. Support needs to be provided to staff when they are involved in adverse events to mitigate the potential impact on their mental health.

The more steps and people involved in realizing a resident's choice, the more complex the situation becomes. Consider the following circumstances:

1. Enacting the choice is possible with passive support and impacts only the resident who made the choice (eg, Mary drinks alcohol by herself).
2. Enacting the choice is possible with passive support but impacts on others (either other residents or staff; eg, Mary drinks champagne by herself but assaults staff by becoming disinhibited in reaction to the alcohol).
3. Enacting choice requires active assistance and impacts only the resident who made the choice (eg, Mary requires the assistance of another person to drink alcohol and eat the strawberry, and she aspirates on the champagne and chokes on the strawberry).

4. Enacting the choice requires active assistance and impacts on the resident and others (eg, Mary requires the assistance of another person to drink the alcohol and eat the strawberries, then slips and falls fracturing her hip. The staff who attempt to prevent the fall are both injured and psychologically traumatized due to her death).

This scenario demonstrates the need to have a process and level of documentation that respects the rights of the residents, describes mutual responsibilities, and protects staff who assist and act appropriately. If staff are blamed or suffer psychologically from assisting a resident to enact a choice with an adverse outcome, they will become increasingly reluctant to render assistance in the future and this in turn will impinge upon DoR. Providing support will not only help the staff to recover but may also help ensure that they are not unnecessarily reluctant to assist in resident risk-taking in the future.

Reviewing and reflecting on enacting choices

As with all clinical and age care initiatives, revision and reflection are important to optimize outcomes for future practice. A culture of learning from mistakes and adverse events is important. Adverse events need to be acknowledged and examined to determine the following:

1. What went wrong?
2. Why did it go wrong?
3. How could it have been prevented?
4. What further support/training might our staff need?

The impact of an adverse event and how this is managed post event will influence on future willingness to support DoR. Poorly managed, this will have a sustained impact on the people, facility, and the core values of respect for an individual.

Currently, reviewing choices occurs only when a choice goes awry and a resident or staff member is harmed or if a complaint is made. Keeping comprehensive documentation will assist in reflecting upon factors that influence the safe enactment of choices. The presentation and framing of investigation reports and recommendations, as well as the remedial actions to follow will also influence whether or not DoR will be well supported.

The clinical governance of LTC must expand to incorporate DoR and quality of life, as well as the traditional evidence-based practice; accountability for quality of care; monitoring of clinical activity; and professional development.[42]

Without the support of the families of residents in LTC, it will be extremely difficult to effectively enact DoR. Family support for risk-taking is important; however, the resident's wishes should take priority. For new residents, policies surrounding risk-taking/management should be discussed both with the resident and their family before entering LTC.

It is difficult to estimate how long it will take for these concepts to become embedded in practice. The major limitation we identified is the lack of robust empirical research studies that describe policy, practice, or evaluation of programs. Promoting greater risk-taking for quality of life remains as a concept widely supported in principle but with little to guide practice.

Aged care practitioners and policy makers continue to advocate for this principle, encouraging and promoting understanding and support from across the community and importantly demonstrating the need to generate empirical evidence to assist in determining the efficacious approaches to managing risk and respecting choice.

The information in this article identifies that enacting these strategies begins first with education – not only for health care professionals but also for residents, family members, and the general community, as they all play important roles in enacting DoR. Next, a shift in policy needs to occur – it is important to note that it is not a matter of a single change and will involve a series of changes over an extended time period.

Conclusion

Most high-income countries have regulatory or accreditation standards that LTC services must meet to continue operating. Failure to meet the standards may lead to consequences including sanctions on conditions or operation, economic penalties, or even closure or revocation of operating licences.

Understanding how to manage risk in LTC with the appropriate support for communication, documentation, and practice should improve the lives of older persons and restore family and community confidence.

Documentation provides a means for residents to have their voice heard by setting out their needs and wishes in an agreement. It means that staff members can easily identify which risks a resident would like to take, and that they have consented to it in writing.

Documentation can also be utilized to set out ways to minimize the chance of harm, eg, risk management plans. This will help allow the resident to take risks in a safer and supported manner.

Improved practice should also reduce adverse professional and legal repercussions and enable resident, families, and staff to better cope with respecting choices when a known harmful outcome eventuates.

Injury and physical harm prevention are often prioritized as a component of best practice in LTC, whereas the quality of life and happiness of residents are often subservient to those goals. Changing the focus to incorporate safety and quality of life should improve the overall health of older people. To put this framework into practice will require substantial changes in policy to ensure that staff, LTC facilities, and families are fully supported in assisting residents to make informed choices that will improve their quality of life.

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