1. FOCUS

1.1 To provide a guided interprofessional care planning process in client situations that require a informed decision making and care planning related to assumed risk

1.2 To provide a framework and tool to guide care teams to identify, address and mitigate risk in the context of ethical decision making principles

1.3 To provide a process that will support the individual, family, and care providers who may be experiencing emotional and moral distress

1.4 To provide a standardized risk assessment process to determine tolerable and or intolerable risk for vulnerable adults who are presenting at risk in Fraser Health.

2. BACKGROUND

Adult Guardianship Legislation (AGL) protects the vulnerable adult's right to autonomy and choice to live at risk. Unless there has been adequate evidence gathered on the degree of intolerable risk when the person is at "baseline function" and in a stable condition, requesting an incapability assessment during recovery from an acute episodic event or acute exacerbation of chronic condition where the adult's cognition may be impaired temporarily and or their baseline function is disguised, can be considered unethical and highly intrusive. The intention is not to replace the Mental Health Act.

Link to the Adult Guardianship Act:
http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96006_01

Currently there is no standardized care team based risk assessment in the care planning process for vulnerable adults (as per definition on page 3) in Fraser Health. There are varying practices and standards in use. Without a standardized process for assessment or mitigation of risk, vulnerable adults are often assessed too early which may result in premature facility placement or an assumption of incapability. Due to a lack of a risk assessment process current patterns of practice have led to unnecessary incapability consult requests. (Dr. M. O. Agbayewa; Dr. P. O'Connor, 2010).

The declaration of incapability can have devastating consequences as it can potentially remove an individual's right to autonomous choice. There are both significant legal and financial implications in addition to emotional and moral distress for the individual, family and care providers. It should only be considered with significant discretion and apprehension.

Retrospective studies have revealed that families recognize signs of declining cognitive abilities approximately one year before seeking medical evaluation (Adapted Regional Geriatric Program (RGP) Ontario-Etchells et all 1996, Ganzani et al 2003, Ganzini et al 2005, Ministry of Attorney General 2005, Qualls & Smyer 2007).

These studies found that typically help is sought when personal safety is at risk and families have exhausted their own mitigation strategies.

Current evidence and best practice supports a least intrusive and ethical process related to assessing capability. Consideration must be given to how the vulnerable adult functions in the context of their own community, in their home environment, among whatever existing supports they may have. When a cognitive impairment is identified it may lead to be a major safety issue.

Decision-making ability and choosing to live at risk is not a test result or a diagnosis. There is no evidence that scores from standard tests of cognitive ability are a reliable indicator of capability or incapability. Most measures of cognitive status do not evaluate cognitive functions such as judgment and reasoning, which are relevant to capability and incapability. Questionable incapability is often reversible and illness can temporarily impair the adult's ability to make decisions. If a person appears incapable, the clinician should determine whether reversible factors are present (Primary Care, Capacity Assessment, Sept 2008, Regional Geriatric Program of Ontario). Some common reversible conditions are acute medical illness, exacerbation of chronic illness, delirium, depression, stress and sleep deprivation.

"No one is capable in every sphere of life. We all use prosthesis to assist us, e.g. an accountant to complete an Income Tax Return, Public Transit to get to work. In the same way, the inability to perform a function is not a reason to consider one incapable if the task can be performed by another. This prosthetic component of life should be considered in all situations where the assessment of incapability is considered" (Dr. Femi Agbayewa, Oct 2010)

The value of providing a standardized risk assessment framework that crosses the care continuum and all FH programs will be to provide a least intrusive ethical process which is essential to autonomy, quality of life and supports the individuals choice to live at risk.

The ultimate goal is to create and facilitate a respectful and dignified care plan that supports adults to live in the community for as long as safely possible

3. DEFINITIONS

Risk (Tolerable or Intolerable): "At risk" means there is a chance of suffering or injury and harm to self or others. (RGP Ontario Primary Care Toolkit –Capacity Assessment-Sept, 2008). Risk is a matter of degree: degree of harm and the probability of that harm eventuating (Browne et al, 2001).

Ability: The quality or state of being able; the power to perform, whether physical, moral intellectual, conventional or legal. (http://ardictionary.com)

Tolerable risk: Individualized risk factors that require no intervention based upon strengths, support system and environmental supports.. The individual chooses to engage in risky behavior despite being aware of potential consequences to self and others. Tolerance can vary depending on individual perspective. If the risk factor is not new-consistent with past behavior and is not causing harm it would be considered tolerable. Adults can be capable and choose to live at risk such as declining medications that are not imminently life threatening or getting "lost" when out of their home but able to return without incident (Adapted from VCH Risk Assessment Tool-1997).

Intolerable risk: Intolerable risk are considerations or factors that are potentially harmful to self and others. The best evidence of intolerable risk are indicators of a new behavior that is unprecedented or not consistent with past behavior and or the behavior is causing harm (Qualls & Smyer 2007 & Silberfield & Fish 1994) e.g: The adult is now withdrawing large amounts of cash and giving it away-in the past was scrupulous with banking and details of financial management with careful patterns of spending. Life limiting suffering or harm: must be within the context of the person's life story.

Level of Risk: Risk within a domain may be tolerable up to some point. (**Appendix B**)

Level of risk can be further defined, e.g Nutrition-the threshold for risk would increase if the adult was not eating versus not following the prescribed diet; Medication Compliance-the threshold for risk will increase if the adult is not taking diabetes medications versus their medications for osteoarthritis (OA)-although not taking their OA meds will increase pain and decrease mobility there is no imminent harm. Not taking antihypertensive meds will increase risk of stroke but there is greater risk if diabetes medications are not taken due to potential imminence of harm.

Capability: Under the Adult Guardianship Legislation (AGL), adults 19 years and older are presumed capable of making their own decisions unless deemed otherwise**.** In general, decisional capability is the ability to both understand information relevant to a decision and to appreciate the consequences of a decision (Etchells et al 1996, Gregory et al 2007, Ministry of the Attorney General 2005). According to the extensive literature review completed for the University of British Columbia (UBC) Care of Elder Incapability Module, there is no single definition of capability in British Columbia; rather the legal definition of capability depends on the type of decision made or the type of transaction involved in each case (Care for Elders, BC Incapacity Assessment Pre-reading Module November, 2009).

These decisions may affect daily life such as when to get up in the morning or when to go to the doctor. A person's ability to make decisions may also have legal consequences, such as providing consent for a medical treatment or making a will (Agbayewa, M.O. Dr., 2010 presentation "By Default, I am Competent until You Can Prove Otherwise").

Presumption of Capability-*Adult Guardianship Act Section 3(1):*
Until the contrary is demonstrated, every adult is presumed to be capable of making decisions about personal care, health care, legal matters or about the adult's financial affairs, business or assets

Vulnerable Adult: A person 19 years or older who has questionable decision making capability and presents with compromised function in his/her daily living that suggests the need for support and assistance in the opinion of a health professional. There is the possibility of or presence of significant risk, exploitation and /or harm to self or others (Silberfeld,. &. Fish 1994; Interior Health Adult Guardianship Practice Toolkit, October 2004-2005).

Incapability: A formal assessment /proof of inability to be capable is undertaken as a last resort usually when a change in the person impairs his/her ability to protect his/her self from harm and neglect (Agbayewa, M. 2010). Incapability suggests an individual is incapable to live at risk, it does not suggest the degree of risk unless it is determined the risk is intolerable (UBC Care of Elders: Incapability Pre-Reading Module, November 2009). Incapability is a legal term under Adult Guardianship. Similar terms

for example; incapacity, capacity, competency, incompetency are synonymous with the term incapability. However, Fraser Health will only use the term incapability.

Care team: All individuals involved in client/patient/residents care and care planning process. This includes the client/patient/resident and family whomever this may be to the client. This does include as appropriate in each unique situation and as involved: care aide; community health worker; client; clients support network and a variety of interprofessional team members.

4. EXPECTED OUTCOMES

1. 100% of care teams teams will use a standardized risk assessment process when assessing vulnerable adults **who are presenting at risk**.

2. 100 % increased awareness and understanding of the risk assessment process among FH staff through education and information sharing.

3. 100% of care teams will complete documentation of the care plan related to risk during care transitions between programs and health care settings and the completed documentation transitions with the client/patient/resident (**Appendix A** and care plan)

4. Decrease moral distress of the individual, family and care providers.

5. ASSESSMENT:

Risk Assessment Framework

5.1 Guiding Principles (adapted with permission Dr. M.O Agbayewa, 2010)

1. The vulnerable adult's quality of life is of paramount consideration
2. Team engages in culturally sensitive interventions
3. The autonomy of the vulnerable adult is upheld
4. Respect for the vulnerable adult's expressed choices/preferences
5. Previously established advance care plan (verbal or written) guides the teams interventions
6. Social network/caregiver are key partners

5.2 Ethical Considerations:
http://fhpulse/clinical_resources/ethics_services/Documents/Good%20Decision%20-%20Nov%203%202011%20-%20DRAFT.pdf

Care Teams: Consider these questions prior to completing the framework and/worksheets

1. What are the adult's values and beliefs?
2. Is the vulnerable adult experiencing risk of self harm or self-neglect?
3. Is the vulnerable adult experiencing risk from others?
4. Is the vulnerable adult a risk to others?
5. Is the level of risk experienced intolerable?
6. Are we legally required to intervene?
7. Are there any support services/caregivers involved?
8. What are the caregivers values and beliefs
9. What is the caregiver tolerance level for various risks
10. Is the vulnerable adult going to deteriorate further without intervention?
11. Is the intervention consistent with the vulnerable adult's attitudes, beliefs and preferences?

5.3 Steps within the Risk Assessment Framework:

(See Appendix A-Risk Assessment Framework)

(Optional-See Appendix B-Assessment Worksheets: Identifying Risk/Strengths)

1. Risk Assessment is a pre-requisite to considering a request for incapability assessment. If there is no risk of harm to self or others it does not matter if the individual is incapable

2. Documentation of a risk assessment and mitigation approach will be completed and incorporated into individual care plan

3. The Risk Assessment Framework does not replace and should follow each Program/Service or professional's discipline specific functional and or psycho-emotional social assessment

Questions to consider:

PART A

1. What is the presenting issue?

2. What has changed for the vulnerable adult that is triggering the need for a response/action?

3. What are the current risks?

4. Are the risks new, preexisting or worsening?

5. What are the consequences of the identified risks?
    a. To self?
    b. To others?
    c. Are they imminent or remote?
    d. Are they aware of consequences
    e. Are they choosing to live at risk voluntarily?

6. What has been tried to mitigate the risk?

7. What was the effectiveness of the mitigation interventions? How did the client respond to the interventions?

8. What is the adult's ability and willingness to use these supports?

9. What is the adult's understanding of the supports offered?

10. Is the new behavior causing harm despite mitigating interventions?
    a. Person has suffered actual harm (e.g. hypothermia from wandering outside)
    b. Exposes others to risk of harm (e.g. fire)
    c. Person engaging in risky behaviors they would normally avoid (e.g. driving through stop signs)
    d. Significant caregiver burden (e.g. caregiver depression, multiple stressors)
    e. Other (e.g. exposing self in public)

11. Is there a medical condition that may impact decision making ability?
    a. Is the condition reversible?
    b. Is the condition permanent? (e.g. severe paralysis)

12. Is there a psycho-emotional/social condition that may impact decision making?
    a. Is the condition reversible? (e.g. depression)

b. Is the condition permanent? (e.g. loss of spouse who was primary decision maker)

13. What current/new interventions are recommended to address the risks identified? What is the expected outcome of the interventions?

14. Were the risks mitigated successfully with the current interventions? If yes- monitor and modify interventions as necessary. If No proceed to Part B.

PART B

15. What evidence suggests the need to assess their capability to make decisions based on answers to questions thus far?
    a. Is a formal incapability assessment necessary?

16. Will a formal incapability assessment help solve the problem?

17. Are there informal support and assistance options available? If so, what are they?

18. Is the adult willing to accept support and assistance regardless of risk or questionable capability status?

19. Whose interest is being served should a formal incapability assessment be suggested?

20. What could the person lose?

21. Is there an ethically and legally recognized substitute decision-maker?

If the answer to any one of the intolerable risks is yes (Appendix A/ question # 10), then completing Identifying Risks/Strengths Worksheet (Appendix B)to assess degree of risks is recommended .

It would only be appropriate to move forward with a formal assessment if the risk is intolerable and there is a requirement to assess capability and an incapability determination will lead to an improvement in the adult's situation.

Whenever there are changes to the vulnerable adult's situation or condition the risk assessment would be repeated.

6. INTERVENTIONS

1. Use Risk Assessment Framework to identify current risks. Ensure all involved care team members are represented to complete the risk assessment.

2. Develop an care plan which identifies and mitigates risks and provides support and assistance to address the risks. **Create a care plan consistent with the person's values, beliefs, preferences and culture.**

3. Monitor the outcomes and evaluate your plan.

7. DOCUMENTATION

1. Risk Assessment Framework: Identifying Tolerable & Intolerable Risk Factors (Appendix A)
2. Assessment worksheet: Identification of Risks /Strengths (optional- Appendix B)
3. Care plan as per each professions standards of practice
4. Documentation of Risk Assessment Framework will move with the client/patient/resident as they transition to home, acute or residential/AL.(Appendix A will be in Form Imprint)

8. EDUCATION

Program and Profession

1. Education toolkit: Power point overview of purpose and guideline; case studies and facilitator guide ; risk assessment framework and identification of risk worksheet; and clinical practice guideline.

2. Regional education series to all programs clinicial leaders to introduce guideline, tools, education toolkit, resources as per reference list. SWT as a resource who will provide initial 3 sessions across region in 2011-2012.

3.Implementation process- Communication and awareness campaign in Sept 2011. The SWT will introduce via regional education sessions in 3 areas in the fall of 2011. SWT will act as a resource/support to programs as required. Programs/professions will determine program specific education and implementation as per program priorities.

4.Sustainability Plan-programs and professions will incorporate into clinical practice as an expected competency and introduce to their care teams in orientation.

9. EVALUATION

Testing Phase of Clinical Practice Guideline: Quality improvement process-testing of application of CPG and documentation completed Dec-Jan 2011. Testing included a diversity of settings in Abbotsford & Tri-Cities-Acute Care for the Elderly, Geriatric Emergency Nurse, Specialized Seniors Clinic, Home Health Case Manager and Mental Health Case Manager, Quick Response Case Manager. ReACT curriculum Module-education roll out –tool tested in education Dec 2011

Expected outcomes measurement:

a. Education: Pre and post survey of understanding of risk assessment and least intrusive process-use Likert scale.

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b. Survey 6 months post implementation : Does risk assessment process decrease moral distress for care providers, families, and individuals?

10. MONITORING

Evaluation

Sustainability plan-Regular education support by the programs incorporating into program specific and regional orientation

11. REFERENCES

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12. APPENDICES

Appendix A: Risk Assessment Framework

Appendix B: Assessment Worksheets: Identifying Risks /Strengths

Form imprint Name:_____

APPENDIX A: RISK ASSESSMENT FRAMEWORK: IDENTIFYING TOLERABLE & INTOLERABLE RISK FACTORS

PART A: IS THERE A CHANGE THAT MIGHT AFFECT DECISION MAKING ABILITY? ☐ No – STOP! ☐ Yes
WHAT CHANGED?

What are the actual current risks?	Pre-existing/ New?	What have been the consequences?	What has been tried to mitigate the risk?	Previous assistance effective? Y/N
	☐ Pre-Existing ☐ New ☐ Worse ☐ Aware			
	☐ Pre-Existing ☐ New ☐ Worse ☐ Aware			
	☐ Pre-Existing ☐ New ☐ Worse ☐ Aware			
	☐ Pre-Existing ☐ New ☐ Worse ☐ Aware			

Is the overall risk intolerable? ☐ No ☐ Yes (check all that apply):

☐ Adult has suffered actual harm-to whom (team, adult, family)
☐ Exposes others to risk of harm
☐ Adult engaging in risky behavior they would normally have avoided

To whom: (team, adult, family)_____

Explain:

ARE THERE MEDICAL CONDITIONS THAT MAY IMPACT DECISION MAKING ABILITY? ☐ No ☐ Yes (explain):

_____

ARE THERE PSYCHOSOCIAL CONDITIONS THAT MAY IMPACT DECISION MAKING ABILITY? ☐ No ☐ Yes (explain):

_____

WHAT CURRENT/NEW INTERVENTIONS ARE RECOMMENDED TO MITIGATE THE RISK? INSERT EXPECTED OUTCOME OF INTERVENTIONS

- _____
- _____
- _____

WERE THE RISKS MITIGATED SUCCESSFULLY WITH THE CURRENT INTERVENTIONS? No ☐ Yes ☐ If no proceed to PART B

PART B: ARE YOU CONSIDERING A FORMAL INCAPABILITY ASSESSMENT**? ☐ No ☐ Yes IF SO, WHY**

EXPECTED RESULTS:

WHOSE INTERESTS ARE BEING SERVED?

Adult's _____

Caregivers: _____

Others (Substitute Decision Maker/family/friend): _____

Care Team: _____

Name and Signature of Team and Program:_____ Date: _____

Adapted March 2011 from Dr. Karen Fruetel, Geriatrician, Regional Geriatric Program, LHSC, London

APPENDIX B: ASSESSMENT WORKSHEETS: IDENTIFYING ACTUAL RISKS/STRENGTHS

Key:

N/A – skill is not required to manage personal care requirements
S - Satisfactory: fully independent or compensates for personal limitations (Appreciates need and accepts assistance)
M - Marginal: could be a problem depending on availability
U - Unsatisfactory: no assistance available, resulting in unmet need
D - Does not accept assistance resulting in an unmet need

Personal Care

A. Nutrition	**Self report**	**Informant (if there is no neighbour, adult children/physician, significant other please indicate and draw a line)**	**Behavioral evidence**
Able to store, prepare food			
Able to arrange for purchase of food			
Able to eat unassisted			
Knowledge of special dietary needs/restrictions			
Knows what to eat/has knowledge of nutrition I.e.: Canada food guide			
Other:			
B. Clothing	**Self report**	**Informant**	**Behavioral evidence**
Able to dress/undress			
Clothes are adequate for weather			
Other:			
C. Hygiene	**Self report**	**Informant**	**Behavioral evidence**
Able to wash/bathe			
Able to use bathroom			
Manages with incontinence			
Keeps clothes clean			
Keeps living environment clean			
Personal grooming: teeth, hair, shaves			
Oral Health			
Other:			
D. Safety	**Self report**	**Informant**	**Behavioral evidence**
Sufficient mobility to meet needs/ Circumstances			
Does not exhibit life-threatening behavior (wandering, driving recklessly, provoking others? , medication abuse or misuse)			
Able to recognize and avoid hazards (handles cigarettes carefully, remembers to turn off stove, manages meds, oxygen use appropriate)			
Able to handle emergencies (notification & evacuation, medical, fire, break-ins)			
Recognizes when others present a danger & takes precautions (careful when out alone at night, does not carry large sums, appropriate responses to solicitation of money)			
Other:			

E. Shelter	=Self report	Informant	Behavioral evidence
Able to find shelter that meets minimum personal needs			
Type of shelter is appropriate to needs (manages steps, locks, has running water in bathroom and fridge for perishable food)			
Adequate temperature regulation /sanitation maintained within shelter			
Unsafe neighborhood/condition of shelter (i.e.: hoarding)			
Other:			
F. Health Care	**Self report**	**Informant**	**Behavioral evidence**
Manages routine health problems			
Can follow medical treatment plan and manage meds (this can be with support services/network)			
Seeks medical care when needed			
Recognizes and alerts others to serious health problems			
Knows primary medical diagnosis and need for treatment			
Can communicate symptoms of illness			
Appropriate medication use and adherence			
Other:			

Financial –Money Management

A. Basic money management	Self report	Informant	Behavioral evidence
Pay bills, pay for services:			
Manage income			
Other:.			

IF there is an Informant identified please describe the duration/nature of Contact (i.e. family, caregiver, physician, etc):

- _____
- _____
- _____

Adapted with permission from Regional Geriatric Program of Ontario (RGP) July 2011

Originally adapted by RGP from: Ministry of the Attorney General, Capacity Assessment Office, Guidelines for Conducting Assessments of Capacity, May 2005
Reprinted with permission.

For Financial Management-cross reference to Clinical Procedure Financial Incapability Assessment Process & / Obtaining Certificate of Incapability Under Patient's Property Act (Draft Aug 2010)