Risk in Occupational Therapy Practice

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Abstract

Occupational therapists working with older adults in discharge planning are often working with patients who have multiple co-morbidities and complex social needs impacting on functional abilities. The combination of a national policy to reduce hospital stays and admission to long term care, combined with family anxiety, and health professionals who are not trained to manage risk taking has created pressures and uncertainties around discharge planning for older people. The aim of this research was to explore how occupational therapists understand and negotiate risk taking in discharge planning with older adults and their families.

This research was positioned within social constructionist epistemology and used a qualitative descriptive methodology. Participants were occupational therapists working in acute settings who are regularly involved with patient discharges. Data collection included focus groups and follow-up interviews with key informants. Data analysis utilised an inductive approach to produce three primary themes: acknowledging risk, looking into how risk is a part of occupational therapy practice; working with the risky discharge, looking at the unique tools occupational therapists have, the impact of discharge pressures, risks for therapists and working with a team; and patients, families and risk, looking at the barriers occupational therapists face in discharge planning with families, and the sharing of knowledge to reduce fears.

One of the key findings was that risk is a part of everyday life, but that it impacts on people in different ways depending on their previous experiences, knowledge and its current social context. This makes risk an undeniable part of occupational therapy practice. Working in discharge planning for older adults involves consideration of not only the patient’s wishes, but understanding how they view risk and whether the potential benefits in the patient’s view outweighs the potential for an adverse event. Acute services for older adults is an area of practice that is often construed as suitable for new graduate therapists. However, this study identified that new graduates do not necessarily identify real risks and support should be provided specifically in relation to identifying and discussing risk and risk viewpoints with patients and their families. This research further suggests that there is potential for occupational therapists not only to recognise but to make use of the positive aspects of risk and its potential positive impact on quality of life.
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Chapter One: Introduction

New Zealand’s population is aging. By 2021, around 2.3 percent of the population will be aged 85 and over (Ministry of Health, 2006), many of whom will have multiple medical conditions placing increased demand on health services (Cox & Hope, 2006). This projected increase in the aged population has signalled an impending deficit in the provision of health care for older people, which is being addressed in policy with a focus on maintaining independence for longer and increasing the availability of health care and social support in the community. This focus has also included an emphasis on shorter lengths of stay in tertiary health care services, changes in the way patients are assessed as suitable for rest home care, and an attendant increasing level of scrutiny around clinical decisions that result in lengthy hospital stays. Although an older person may want to move into long term residential care, simply supporting their decision is now not enough, and occupational therapists among other health professionals must complete assessments of functional needs (Ashton, 2000).

It has become clear from the literature (Blaga & Robertson, 2008; Craig, Robertson, & Milligan, 2004) and from my own clinical experience as an occupational therapist that occupational therapy practice in acute hospital services tends to focus on prompt discharge to home. This is achieved by prioritising patients’ purely medical needs, particularly symptom control, and by relying increasingly on the family’s willingness to be involved in a practical way in the support or even care of the older family members.

Discharge planning for older patients in this environment is a complex endeavour that involves the patient, the family, and a multi-disciplinary team (MDT) comprising of medical, nursing, and allied staff. The occupational therapy role in the multi-disciplinary team often involves conducting, evaluating, and reporting back assessment of the skills, abilities, and risks involved in a patient living independently at home. This responsibility can see occupational therapists in conflict with the patient, the family, or the other health professionals in the care team. Conflict, in my own practice experience, is particularly prevalent where there are differing understandings of the nature of the risk being faced by the patient and by each person’s willingness or ability to accept or avoid the risks.

This thesis reports the findings from a research project that explored risk in occupational therapy practice in relation to the discharge planning of older people.
Background to the research question

I am a registered occupational therapist, with just over ten years of clinical experience working in various practice areas in New Zealand and the United Kingdom. The most unorthodox position I have held was working in a private charitable organisation that provided ‘adventure therapy’ (Beringer, 2004), primarily for adolescents or young to mid-life adults who had spinal cord injury. Participants would attend a week long course which, depending on the season, could involve skiing with adaptive equipment, or scuba diving, tramping and abseiling leading up to an overnight kayaking journey down white water. Within this setting risk was a sought after experience which was accessed through adventure activities, often by young men who were wheelchair bound, and wanted to have ‘real’ experiences. In this environment risk was viewed as therapeutic and positive, with personal gains such as increased confidence being made by participants: if they were able to abseil in their wheelchair down a rock face, or tramp through the bush, they could believe in their ability to navigate roadside curbs without the help of a caregiver. The risks involved in adventure therapy were numerous and required careful management from the charities’ outdoor instructors, all of whom were trained in the support of people with physical disabilities. Although many of the risks were similar to those the instructors would have to manage with able bodied people such as exposure, injury in the outdoors and safety associated with ropes and height, there were additional, very serious considerations such as participants not being able to feel cold or injury on their lower limbs, or being unable to roll onto their back in water should a kayak capsize. The occupational therapy role in this specific adventure therapy context was referred to as a course co-ordinator. It involved general setup of courses (managing catering and care staff), assessment of potential clients, goal setting and communication with funders. A large part of the role revolved around long term goal setting that would encourage participants to consider the impact that the week long course could have on other areas of their life.

This study specifically considers risk taking in an acute hospital context, however these adventure experiences and witnessing firsthand the gains that can be made in the face of challenges and risk have informed my thoughts about risk, leading to a conviction that risk is a part of personal growth. This in turn has led to my desire to complete this research and has influenced the formulation of this question.
My journey as an occupational therapist has led me now to a senior position in a small acute neurology ward where I provide assessment and treatment for people with neurological conditions such as stroke, multiple sclerosis and Parkinson’s disease in addition to general medical conditions. This ward is one of fifteen in the region’s primary hospital, which currently offers 400 inpatient beds and employs approximately 20 inpatient occupational therapists. Assessment of safety for discharge alongside the MDT as well as assessment of impairment following a neurological diagnosis is a big part of the role. Common occupational therapy assessments within this setting also include initial information gathering, personal care and kitchen assessments, cognitive assessments and home visits, with the therapist involved relying on clinical skills and knowledge to decide which assessments should be completed.

This position also involves, among other responsibilities, the supervision and teaching clinical skills to one junior therapist working over two general medical wards and another on the neurology ward, both working primarily with adults over the age of 65. Throughout my practice I have been lucky to work within supportive occupational therapy teams, and it has been through this peer support (both support by myself to others and often from others for me) and informal discussions in the office that the notion of occupational therapists having to manage risk first arose. There have been a number of practice stories, involving junior and senior therapists worrying about the safety of their patients’ post-discharge that led to the idea that the topic of risk was one that was significantly present within occupational therapy practice even if we are not outdoors traversing rock faces. It was also apparent that experiences and concern are shared by a number of therapists, and is therefore one that deserves research attention.

Throughout the thesis I have chosen to illustrate some points by providing practice-based case studies. This first true case study, although simplified, is one that illustrates a number of points that led to the decision to pursue this topic further. Any identifying information regarding this patient has been omitted, her diagnosis details are purposely vague and names have been changed. Both from my experiences described above and from conversing with professional colleagues about this research, the case study presents a story that I feel a number of therapists empathise with.

Mrs Smith is a 76 year old woman with progressing short term memory loss. She was admitted to hospital following a fall that resulted to injury to her back, which unfortunately revealed an existing medical condition affecting her spinal cord and
reducing sensation and strength in her legs. Prior to her fall she was living independently at home, managing both domestic and personal activities of daily living with no formal support. Her family who did not live locally expressed concerns regarding her poor memory and felt that she wasn’t coping at home prior to the fall.

Mrs Smith was transferred to a short stay rehabilitation ward, unable to walk, but determined to return to her own home. Her therapy goals revolved around independent wheelchair mobility, independent and safe transfers into and out of the wheelchair to a variety of places (including her bed and the toilet) and independent management of lower limb dressing to enable her to complete activities of daily living at times when carers may not be available to assist.

During her longer-than-usual admission the MDT and her family continued to express concerns about her memory and the impact this was having on her ability to recall safe transfer techniques. The ward charge nurse in particular expressed concern about the length of stay, considering that ‘she would just have to go to a rest home anyway’. A number of home visits were completed to practice techniques in her own home, as her ability to generalise skills learnt in hospital to her home environment appeared limited. Throughout family meetings, planning for care at home, therapy sessions and these home visits Mrs Smith continued to clearly and loudly advise those around her that she was going to return home.

An unusually complex package of care was put in place to provide assistance with showering, meals, housework, groceries and medication management with the aim of continuing rehabilitation at home. Despite this significant formal support her family remained concerned about Mrs Smith going home, understandably worrying in particular about managing on her own at night, when no care was available. This concern was only somewhat alleviated when Mrs Smith agreed to a medical alarm, and that on discharge from hospital she had achieved her goals detailed above. As her family were unable to support her in person because of work commitments, a friend of Mrs Smiths agreed to stay with her on her first night home.

Mrs Smith was admitted to the emergency department (ED) the next morning having fallen during the night attempting to transfer from her bedside commode back to bed. Rather than calling out to her friend asleep in the spare room Mrs Smith decided to wait until the morning, and after pulling her blanket and pillow down onto the floor
went back to sleep. She was found to have no injuries from her fall, however her friend, who had discovered Mrs Smith on the floor and had had to call an ambulance was horrified that she might return home again. Her occupational therapist received a phone call from a very stressed and upset son wondering how we could let this happen and stating that she could not be allowed to go home after this incident and had to go into a rest home. Mrs Smith declined, and after determining that there were no changes to her function, and that the company providing her carers were happy to continue, she was discharged home from ED.

This story has elements that seem to be more and more frequently experienced by therapists: potential risks for their patient on discharge (falls, injury, limited formal care availability); pressure for a shorter length of stay; family members concerned for the safety of their loved one; an older patient with multiple medical conditions and declining cognition; conflict for the therapist planning the discharge because that’s what the patient wanted; and limited resources available. Not immediately apparent in this story is the anxiety experienced by the occupational therapist, who had numerous informal office conversations about whether she was doing the right thing, particularly at the point when Mrs Smith was readmitted with a ‘failed discharge’ after only one night home.

It is the experiences of the occupational therapist in situations such as the one involving Mrs Smith that are the focus for this research.

**Rationale**

In New Zealand there are 20 District Health Boards (DHBs) responsible for the provision of health and disability services within an allocated geographical area with around 29 major hospitals that vary in size and demand for services. This DHB structure provides local areas with their own planning and funding control, giving direct responsibility for their respective communities (Ministry of Health, 2014). For the purposes of this research, references to acute care refer to settings where a person has been admitted into inpatient hospital care. Attempts to reduce health care expenditure and manage increased pressure on resources has led to attention focused on preventing hospital admissions through provision of primary health care in the community and importantly for this research, reducing the length of stay in hospital for patients (Malcolm, 2007). Hospital beds are an important and costly resource for all healthcare
systems; between 1988/89 and 2005/06 the average length of stay in hospital dropped by nearly 50% from an average of 6.67 days to just 3.9 days (Malcolm, 2007). This significant reduction in the length of stay in hospital highlights the importance of engaging with discharge planning within relatively short time frames.

The clinical context of health care for older people throughout New Zealand has developed in the last decade to focus on living independently, also known as ‘ageing in place’ or more recently ‘ageing in community’ (Ashton, 2000; OECD, 1994). The underpinning reasons for ageing in community, primary health care initiatives and shorter stays in hospital include such varied motivations as self-sufficiency for the older person, reducing the medicalisation of old age and the effective management of limited health resources (Davey, 2006; Malcolm, 2007). These reasons may seem obvious to the health professional, however, the families of patients who are faced with the prospect of an apparently risky discharge may struggle to accept that their loved one can return home, and they may also require time and support to adapt to the changes in family relationships that accompany taking on a caring role (Coffey & McCarthy, 2012). The reduced length of hospital stays can mean that families do not get the time they need to adjust.

Regardless of any potential concerns from healthcare professionals or family members, the patient themselves has the right within New Zealand’s healthcare system to make their own choices, even if these may expose them to risk (Health and Disability Commissioner, 1996). The right to make their own choices is not readily overridden from either a legal or an ethical perspective, so negotiations among the patient, family and health care team are necessarily multifaceted and intricate. The occupational therapists’ role in such negotiations is often pivotal, as this is the health professional who has assessed the patient in hospital as well as in their own home and therefore has a valuable perspective.

Inherent in the ageing in community direction is the need for an awareness and subsequent management of risk, however there is little recognition of this in literature from occupational therapy, older people’s care, or national policy. The combination of a national aim to reduce hospital length of stays and long term care, family anxiety and/or lack of preparation for their changed roles, and health professionals who are not equipped to manage risk has created pressures and uncertainties around the discharge planning for older people.
Given the ageing population, this scenario is likely to become more frequent. Occupational therapists are at the forefront of discharge planning for older people, and decisions made by the multi-disciplinary team about the timing and place of discharge in my clinical experience often rest on assessments and recommendations made by the therapist. The ability of the occupational therapist to recognise the types and levels of risk, and the context in which risk is taken or avoided is therefore a key part of the discharge planning process.

There is a significant body of occupational therapy knowledge that considers clinical reasoning in relation to decision making in practice, which is discussed in the literature review chapter. Rather than addressing the issue of clinical reasoning about risk, this thesis is located within the clinical reasoning process as it considers what beliefs occupational therapists have about risk and how they recognise and negotiate it in their practice. This level of knowledge is fundamental to understanding how occupational therapists engage with clinical reasoning around risk and is explored further in the discussion chapter.

**Research question**

This research seeks to understand how occupational therapists understand and negotiate risk taking in discharge with the older adult patient and their families.

The research approach is positioned within a social constructionist epistemology, which locates knowledge as constructed by the social environment, particularly language. This is discussed in more detail in chapter three. Social constructionism reflects the social interactions, conversations, and shared experiences that inform occupational therapy practice within a busy acute hospital. The research methodology utilised focus groups and follow-up interviews. Participants were recruited for focus groups from therapists working in acute hospital settings, with the follow-up interviews completed with participants from the focus groups in order to address gaps in the findings and gain further depth of information. Analysis was completed utilising an inductive thematic approach, resulting in three key themes: acknowledging risk, looking into how risk is a part of occupational therapy practice; working with the risky discharge, looking at the unique tools occupational therapists have, the impact of discharge pressures, risks for therapists and working with a team; and patients, families and risk, looking at the barriers occupational therapists face in discharge planning with families, and the
sharing of knowledge to reduce fears. Recommendations and implications for practice are described within the discussion chapter.

Risk

The concept of risk is a complex one that differs according to its context. As can be seen from the background section above, even within a single health profession such as occupational therapy there can exist several ways of experiencing and managing risk. It is important to recognise the potential for adverse events arising from risk, as well as the more positive consequences that include personal growth and satisfaction. In my experience, occupational therapists work with both aspects of risk.

While a simple definition of risk could be useful at this point prior to delving into the research, there is no definition that fits all contexts. Providing a definition here could potentially narrow the focus of the research rather than allowing the fullness of the concept to emerge from the research. Therefore, I have instead chosen to delay a definition so that the topic of risk can be explored and developed more fully as the thesis progresses.

Structure of the thesis

Chapter one has introduced the research topic and provided some insight into how the research question was developed and its importance to the body of knowledge for occupational therapy.

Chapter two presents a review of the literature. Topics related to the ageing population, the policy environment of the care of older people, occupational therapy practice, and risk are covered.

Chapter three comprises of the methodology and method of this qualitative research project. Ethical considerations are also included here.

Chapter four contains the findings from the focus groups and interviews, presented with rich detail from the participants.

Chapter five discusses the findings, makes recommendations for occupational therapy practice and identifies areas where further research is needed.

Chapter six concludes the thesis.
Conclusion

This chapter outlined the background to the research question and has examined my professional background and current work as a part of the rationale for the research question. It has identified that in different practice areas risk can be understood as potentially adverse but also as creating the possibility for personal growth and satisfaction.

Occupational therapists are increasingly working with complex risks when they are planning the discharge of older people. This research project aims to understand how occupational therapists understand and negotiate risk taking in the older persons’ care context. The next chapter provides a literature review of the topics associated with risk, discharge planning and occupational therapy.
Chapter Two: Literature review

This literature review comprises of information from a variety of sources. It aims to frame the research by examining older adults within a New Zealand context alongside the health and social policies related to them. It will provide background regarding the working environment and culture for the occupational therapists involved, the concept of risk, and how this all fits together to impact discharge planning from acute hospital services.

Search strategies included:

1. Search of electronic databases with a combination of key words into CINHAL, ProQuest and google scholar. Combinations included risk and occupational ther* (>2000 results), risk and occupational ther* and older adults/older people/elderly (between 63-88 results) risk and occupational ther* and discharge planning (22 hits, many involving pre-discharge home visits)
2. Search of Ministry of Health and government websites for relevant documents
3. Manual searching of reference lists and skimming of journal indexes

Because of the broad nature of risk and the multitude of potential definitions dependant on context, it was important to set parameters for this literature review. Literature from a range of healthcare disciplines (primarily nursing, physiotherapy and occupational therapy accessed via CINHAL and ProQuest databases) based in physical healthcare environments were included, with all studies involving an <65 age group excluded. The age of literature was considered, although with the limited results relevant to this study it was decided that research from 1994 onwards would be included, up to the planned thesis submission of early 2014 giving a parameter of 20 years.

As described above in the introduction chapter, my previous experiences of risk in outdoor adventure played a significant part in the development and context of this research. As such, outdoor adventure literature was specifically sought in order to enrich descriptions of risk and provide some comparison to those provided by healthcare literature.

Older Adults in New Zealand

Older adults make up the highest proportion of admissions to hospital compared with any other age group, and also in general experience a longer length of hospital stay due
to complex, multi-factorial problems (Cox & Hope, 2006; New Zealand Health Technology Assessment, 1998). General health and the capacity for independent living reduces from age 85 (Haslam, 2008), with the 85+ age group accounting for more health expenditure per capita than any other group (Cox & Hope, 2006). Added to this is the fact that in the 2030’s people aged 65 and over are expected to make up more than 25% of New Zealand’s population, compared with only 8% in 1960 (Dunstan & Thomson, 2006a). These statistics alone make this growing population an important topic for ongoing research in healthcare.

While men’s and women’s advancing life expectancy is a contributor to the aging population of New Zealand, the growth of both proportion and number of older people is more the result of ‘demographic transition’: movement from high mortality and fertility rates to low mortality and fertility rates (Boddington, 2003; Davey, de Joux, Nana, & Arcus, 2004; Hale, Barrett, & Gauld, 2010; Statistics New Zealand, 2007). Those in this over 65 age group are increasingly diverse with a potentially significant age difference in addition to the cultural diversity that exists throughout the New Zealand population as a whole (Dunstan & Thomson, 2006a). Haslam (2008) illustrates this difference in age by explaining that New Zealand’s population over 65 covers at least two generations, with the oldest people alive today born in the first decade of the 20th century, whereas those in their 60s were born in the 1940s and could easily be the children of the oldest. Due to internal migration overall population ageing is more pronounced in the South Island than the North Island, with Auckland projected to be the only region with a median age still under 40 in 2026 (Dunstan & Thomson, 2006b; Statistics New Zealand, 2007). Another demographic feature of the 65+ group is that women outnumber men by a sizeable margin. At the 2006 Census, there were 221,142 men and 274,461 women in the 65+ age group, although the mortality rate differences between men and women are slowly narrowing (Dunstan & Thomson, 2006a; Statistics New Zealand, 2007). Ethnic diversity within the over 65 age group is expected to increase, although those identifying as having European descendency are still expected to remain a majority. Maori and Pacific Island ethnic groups have higher fertility and mortality rates than European and Asian groups, therefore the population remains younger (Dunstan & Thomson, 2006a). There is variable use of age bands in the literature with terms such as young-old, middle-old, old-old or oldest-old used (Haslam, 2008).
As a consequence of the New Zealand population growing older, it is expected that the attitudes to what constitutes ‘old’ will evolve. In her theoretical article Ann Wilcock suggests that age is not chronological, and that we should consider viewing people according to their ‘felt age’, she offers the example of an 81 year old woman who feels 8 when she is playing soccer with her grandson, or 40 when she is talking with her daughter (Wilcock, 2007). Haslam (2008) had similar thoughts, and as such investigated the occupations of people aged 85+. Her findings showed that despite the specific chronological age (considered in the old-old age band), there is substantial variety in the occupations undertaken e.g. leisure, social activities, personal maintenance, and activities of daily living. She described a number of personal factors that can contribute to ‘felt age’ or ability to participate in occupations, including health, physical and cognitive functioning influenced the abilities of participants. Notions of ‘felt age’ are important to this research because they permit insight into the beliefs that can underpin a patient’s desire to return to independent living despite multiple medical issues and apparent frailty.

**Frailty and Caregiving**

Daniels, van Rossum, de Witte, and van den Heuvel (2008) attribute a decline in the health of older adults to increased frailty, particularly in the old-old. The authors of this discussion paper state that there is controversy on how to define frailty; however the main consequence is greater risk of adverse health-related outcomes. As touched on above frailty as a concept isn’t necessarily associated directly with chronological age but can be multi-factorial, combining reduced reserves and physical, psychological, social or environmental difficulties (Hale et al., 2010; Markle-Reid & Browne, 2003). Physical and psychosocial frailty can be as a result of a sudden event, or a slower process of cumulative loss such as the sudden loss of a spouse, or a long-term worsening illness (Hale et al., 2010).

Throughout life there are recognized stages/life events such as graduations, employment, marriage and becoming a parent. These transitions do not stop as a result of frailty, but continue into retirement, bereavement, and can in fact include transition from health and independence into supported living (Hale et al., 2010). Transitions have a wider impact on the social environment, which can be particularly important for older adults. Hale et al (2010) suggest that the transition into frailty and potentially disability naturally has an impact on a person’s relationships, including family
dynamics where children or spouses take on a carer role. They argue that there is a point, often after an event, where family members recognize that their relationship has changed, and that now they aren’t just wife, daughter or grandson, but carer.

Family carers are often expected to assume responsibility for making decisions or taking on the physical burden of care, and taking on this role can result in physical, emotional and financial stress for the caregiver (Ryan, McCann, & McKenna, 2009). Despite the clear recognition of these expectations Hale et al (2010) state that many carers report that they are excluded from decision making for their loved one, and that there is little consideration of the intimate knowledge that family carers have of the recipient’s situation. The involvement of family in the discharge planning process for older adults will be specifically discussed below. Within the concepts of frailty and changing social roles also sits comments and attitudes that could be labeled as ageism, where difficult questions often arise about patient autonomy, the allocation of resources, and overall why a person of 75 may be treated differently to one who is 60 (Klein & Liu, 2010). Within a study looking specifically at occupational therapists experiences of ageism in practice, it was found that ageism is present both in the attitudes of the general public, within the healthcare system, and at times in the self-derogatory remarks or low expectations of the older person themselves (Klein & Liu, 2010). These authors reinforce the idea that frailty is not necessarily linked purely with age. In a body of research looking into communication of risk to older adults, Finucane (2008) reports that emotion, affect and cognition play important roles in risk perception. She states that we do in fact go through changes in decision-making processes throughout life, and as a result older and younger adults respond differently to risk messages. Increasing age may come with increasing reliance on affective or emotive information. Finucane (2008) reports that this can at times be attributed to older adults forgetting specifics of message details such as dates or complex treatment details, relying instead on automatic processes, expert knowledge or how they feel about the message to determine choices. This suggests that despite concerns that do exist about ageism, treating older adults differently with regards to communication may in fact be necessary.
Policy

Having described some of the characteristics of the ageing population, it is timely to examine the national policy environment that seeks to manage the current and future demands on resources and the quality of life of New Zealand’s oldest citizens.

New Zealand’s health care system is based on several key strategies, including the New Zealand Health Strategy (Ministry of Health, 2000), Disability Strategy (Ministry of Health, 2001), He Korowai Oranga (Ministry of Health, 2002a) and the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (Health and Disability Commissioner, 1996). These strategies all emphasise patient autonomy within the provision of quality health services, clearly outlining that respect for patient’s choices is essential and expected for any healthcare professional. The impact of the ageing population on healthcare services is also considered as the use of health services is known to increase with age (Cornwall & Davey, 2004). There is particular concern both in New Zealand and worldwide that current healthcare systems and long-term residential care facilities are projected to be inadequate to meet population needs in the coming years (Cornwall & Davey, 2004).

The New Zealand Positive Ageing Strategy (Dalzeil, 2001) was created by the Ministry of Social Development to provide an overarching framework for developing and understanding policy with implications for older people. It outlines ten priority goals and actions to achieve these, under the premise that it is in everyone’s best interests that older people are encouraged and supported to remain self-reliant. Particularly relevant to this project is the fifth goal, for older people to feel safe and secure and age in place (defined as offering people the opportunity to continue to live safely in their community). Although a review in 2008 changed the phrase Ageing in Place to Ageing in Community, the goal and actions remain the same, including developing services that support ageing in community, developing policy options that facilitate ageing in community, and improving delivery of information about services that enable older people to age in community. Worth noting however, is that in addition to raising spending on home based care services to support ageing in place, the dependency level at which a person is eligible for government subsidised residential care has also been raised and requires the person to have a formal assessment (Ashton, 2000). The impact of this is that older people who feel they need the additional support provided by long-term care facilities, or who wish to make this choice as a lifestyle option but do not
meet the level determined by a formal needs assessment have to fully fund placement (Ashton, 2000).

Davey and Glasgow (2006) provided a critique of the Positive Ageing Strategy, and comparison of this document to its equivalent in the UK and Australia. They conclude that while promoting the image of ageing as a positive is beneficial to those who are able to or chose to participate in the community, the document may isolate those older people who are affected by illness or injury and are therefore unable to remain self-reliant.

Developed from the Positive Ageing Strategy (2001) and specific to the older person is the Health of Older Persons Strategy (Ministry of Health, 2002b). The strategy identifies itself as a government priority and has a vision of older people participating to their fullest ability in family, whanau and community life, and also in decisions about their own health and wellbeing. It specifically states that older people are to be supported in this participation by co-ordinated and responsive health and disability support programmes.

Lastly, the Health of Older People Information Strategic Plan: Directions to 2010 and beyond (Ministry of Health, 2006) was published to support implementation of The Health of Older People Strategy (2002). This document focuses on seamless assessment as an essential tool for improving health outcomes in vulnerable people.

**Occupational Therapy**

“Our understanding and perception of old age influences our therapeutic approach and service provision as occupational therapists. Our practice is also influenced by our professional philosophical belief that health and wellbeing is enabled through occupation.” (McIntyre, 2013, p. 16)

The World Federation of Occupational Therapy (WFOT) asserts that occupational therapy is a client-centred health profession, with a primary emphasis on the importance of occupation in health and well-being (World Federation of Occupational Therapy, 2012). Occupational therapists focus on enabling people to participate in the activities of everyday life by working with individuals, families and communities to “enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement” (World Federation of Occupational Therapy, 2012,
The term ‘occupation’ in this context refers to everyday activities that people do as individuals to occupy time, bringing meaning and purpose to life (World Federation of Occupational Therapy, 2012).

Occupational therapists in New Zealand are guided in their practice by the New Zealand Association of Occupational Therapy and the Occupational Therapy Board of New Zealand (OTBNZ) (Occupational Therapy Board of New Zealand, 2013), particularly the code of ethics and competencies for registration. Occupational therapists work in a variety of settings including hospital inpatient acute and rehabilitation wards, within the community in people’s homes, in schools or day units, with children, adults or older adults for physical or mental health. Client-centred practice is a large part of the occupational therapy philosophy, with the OTBNZ itself recommending that occupational therapists strive to practice in a client-centred manner (Occupational Therapy Board of New Zealand, 2004a, 2004b). Client-centred practice in all settings means that clients are actively involved in the processes of assessment, intervention and evaluation (World Federation of Occupational Therapy, 2012), with the therapist listening to and respecting the client’s values and needs throughout (Sumsion, 2000). Although patient/client autonomy is well recognised within occupational therapy practice, it is also well recognised that maintaining this partnership with the patient in acute medical settings when considering intervention or discharge for older adults can be difficult due to increased frailty, cognitive impairment or lack of competency (Lane, 2000; Moats, 2007).

Within New Zealand new graduate occupational therapists are expected to enter the workforce with the ability to perform within the seven competencies for registration prescribed by the OTBNZ (Occupational Therapy Board of New Zealand, 2004b). These are implementation of occupational therapy, safe, ethical, legal practice, culturally safe practice, communication, management of self and people, management of environment and resource, and continuing professional development.

Last year Nayar, Gray, and Blijlevens (2013) studied the competency-based strengths and weaknesses of new graduate occupational therapists in New Zealand. Through a mixed method study including a survey and focus groups they reported that the competency areas of ‘implementation of occupational therapy’ and ‘management of self and resources’ were areas of difficulty for new graduate therapists. Overall new graduate therapists are meeting the OTBNZ competencies for registration, however
their individual abilities are often perceived as variable by those more experienced therapists who work alongside the new graduates. The authors conclude that occupational therapy is a diverse profession in terms of population and scope of practice, which provides challenges for new graduates entering practice and recommend that time and support is provided to new graduates in addition to further research into the area of preparedness for practice.

Once working, occupational therapists are required by the OTBNZ to take responsibility for maintaining these competencies. Recently there has been increased research into maintaining ‘professional currency’ where keeping current in a complex and changing work environment requires constant shifts in knowledge, skills, ways of thinking about work and practice (Murray & Lawry, 2011).

The development of skills and knowledge from entry into the workforce as a new graduate to professional establishment as an expert is often framed within occupational therapy literature as development of clinical or professional reasoning. The key difference in the clinical reasoning of new graduate (novice) and experienced (expert) therapists is a larger knowledge and experience base. This allows them to compare a current problem to their experience of past cases (Unsworth, 2001). There is diverse literature on the topic of clinical reasoning. Of particular relevance to this research is the idea that both personal schemas and interpretation of context are important to clinical reasoning, and underpin decision making (Robertson & Griffiths, 2012). With regards to novice therapists, it is suggested that assessment and treatment is more likely to be driven by medical priorities, while experts have a wider knowledge base to consider the patients’ subjective experience of the illness and their goals for the future (Mattingly & Fleming, 1994). In a 2001 Australian study on the nature of occupational therapy practice in acute care settings, one of the findings was that newer occupational therapists experienced more concern than more experienced therapists about not being able to do more for their patients. The study recommended that support and mentoring be provided to less experienced therapists to address this (Griffin & McConnell, 2001). The differences in practice between new graduate and experienced occupational therapists may also be important, particularly in relation to their recognition and management of risk. It is therefore necessary to explore the concept of risk in more depth.
Risk

Risk in the health care setting may be referred to as patient safety, or risk management in the reduction and/or elimination of adverse events (O'Byrne, 2008). Due to a multitude of factors including co-morbidities, frailty and/or long term conditions risks are often identified more readily for older people than those in other age groups (Clarke, 2009; Moats, 2006). Adverse events with significant consequences can include recurrent admissions with reduced mobility, increased possibility of falls, and cognitive changes as a result of illness. The possibility of an adverse event occurring is inherent in the notion of risk, so it is important to note that it is not only the definition of risk that is subjective, but recognising an event as adverse is also subject to differing interpretations (Clarke, 2000). The recognition of risk is also affected by professional context, with healthcare professionals instinctively rejecting that which is risky in favour of a level of safety they feel is acceptable (O’Byrne (2008).

Risk is not always seen as something to be avoided, but as a controllable factor that can add meaning to an experience (Dickson & Dolnicar, 2004; New Zealand Mountain Safety Council, 2004). Within outdoor adventure literature there is evidence of participants of adventure activities actively seeking risk as part of an experience in order to gain insights or personal growth (Bentley, Page, & Laird, 2001). It is also suggested that the absence of risk can actually decrease participant satisfaction, leaving adventure operators with the problem of attracting people to adventure activities that can still be perceived by the layperson as risky, without actually having high probability of an adverse event occurring (Dickson & Dolnicar, 2004). Haddock (1993) explains this in more detail when considering risk in terms of adventure tourism and suggests that there are three types of risk: absolute risk or the uppermost limit of the risk inherent in a situation with no safety controls present; real risk or the amount of risk which actually exists at a given moment in time (absolute risk adjusted by safety controls such as experience or equipment); and perceived risk, an individual’s subjective assessment of the real risk present at any time. In the following example the different types of risk are highlighted: A young woman attempts rock climbing for the first time outdoors (absolute risk), she attends a course with a group of friends, is taught how to use climbing equipment, her belayer is supervised by the course instructor and she climbs an established low grade route (safety controls limiting the absolute risk). On her first climb she is unsure of herself, resulting in some anxiety and high perceived
risk. Over the period of the day and more climbs her confidence in herself and the
equipment increases, reducing her perceived risk.

Haddock’s definitions however, still rely on agreement of absolute risk as a starting
point and seem to consider only physical risks posed by outdoor adventure activities. In
addition to this physical risk, there may also be a potential risk for the participant to
their self-image should they not succeed. Risk has also been descriptively defined in
outdoor literature as ‘the potential to lose something of value’, where the adverse event
could be the potential of a physical injury or the possibility of financial, social or
spiritual loss (Priest, 1991, p 115). Haddock (1993) takes this a step further, suggesting
that if there is the potential to lose something of value, there must also be the potential
to gain something of value which could be a personal gain or a peak experience. An
experience involving risk is likely to be one where someone is performing to their
physical and sensory potential. ‘Risk takers’ can include a newly married couple
deciding to start a family, a person who gives up a full time job to become self-
employed, a runner who fundraises for charity by completing their first marathon, a
woman in her 60’s taking up playwriting, a young person having unprotected sex, or an
older person deciding to return home to live independently following a fall (Dickson,
Chapman, & Hurrell, 2000).

Outside of the outdoor adventure context, there is little mention in the literature of risk
as a positive notion. Risk taking is often viewed as irrational or, in the case of the
layperson, resulting from insufficient knowledge and experience (Lupton & Tulloch,
2002). Various studies around voluntary risk taking such as sky-divers and surfers,
young male criminals and female boxers have concluded that benefits can include
facing and conquering fear, displaying courage, seeking excitement and thrills and
achieving a sense of personal achievement and actualisation (Lupton & Tulloch, 2002).

Although not discussing risk in an entirely positive light, Clarke (2009) does suggest
that in attempting to remove risk, healthcare professionals may remove components of
life that are valued and therefore compromise quality of life. This occurs in the
following example:

“A daughter caring for her elderly father who has dementia declines
recommendations from healthcare professionals of pharmaceutical restraint, as
she feels that this poses a risk of loss of self – a much more adverse event for
both father and daughter than events that may occur if he chooses to wander from the house” (Clarke, 2000, p. 87).

More important than an accurate, fixed definition of risk for healthcare professionals is the understanding and facilitation of an environment where different views are able to be discussed and conflicting views of risk are resolved or accommodated (Huby, Stewart, Tierney, & Rogers, 2004). Although their study is based within a research context rather than healthcare, Henwood, Pidgeon, Sarre, Simmons, and Smith (2008) suggest that making explicit reference to risk can help to open up an exploration of its meaning for participants. They explain that this explicit reference to risk also has the benefits of allowing participants to voice their reactions to issues and makes it legitimate for participants to integrate their own understandings of risk within stories.

The concept of risk is complex and broad, and one that many authors admit is a subjective notion whose definition is entirely dependent on epistemological underpinnings (Dennhardt & Laliberte Rudman, 2012; Slovic, 1999). While risk can be viewed from wider contexts such as socioeconomic or political, this project will consider risk in a specific healthcare context (old age) from a social constructionist perspective, where knowledge of risk is influenced by social and cultural processes, and what is viewed as risk is influenced by a group’s social structure (Dennhardt & Laliberte Rudman, 2012; Huby et al., 2004; Kelman, 2003; Lupton & Tulloch, 2002). From an occupational therapist perspective, those group influences include other therapists and the training and practice context, the multi-disciplinary team context including the organisational culture, the patient, and their family.

Even within similar theoretical perspectives there can be conflict between ‘experts’ and ‘laypersons’ who may have different ways of understanding risk (Slovic, 1999). This thesis, working within the social construction framework, questions the absolute nature of terms such as ‘expert’ and ‘layperson’, noting that the layperson may be a family caregiver who has known the patient for decades, while the expert may be a junior health professional with no specialist or personal knowledge of the situation. As the thesis progresses, social constructionist as a theoretical perspective will be used as a critical lens through which risk and risk taking are examined.
Occupational Therapy, Risk and Discharge Planning

Planning discharge from hospital involves assessment of a patient’s needs, wishes, current abilities and resources available to them (including family members, formal care or equipment) when leaving hospital to return home (Durocher & Gibson, 2010). For many older people hospital admission as a result of illness can intensify difficulties in functional ability or pre-existing conditions, making discharge planning a complex issue which requires communication and collaboration between the multi-disciplinary team, community services, family and patient (Crennan & MacRae, 2010). In addition discharge planning often occurs within a short time frame, and in a setting where the length of hospital stay is closely monitored (Bauer, Fitzgerald, Haesler, & Manfrin, 2009; Welch & Lowes, 2005), as extended admissions are not only costly, but can carry additional complications of increased chance of infection, reduction in independence and mobility as well as confidence (Crennan & MacRae, 2010). Patients can be labeled as ‘medically stable’ when a course of medical treatment is completed and tests are within normal range, so from the purely medical perspective this medically stable patient no longer needs to be in hospital. The term ‘fit for discharge’ however, involves not only this medical stability but emotional, cognitive and psychosocial readiness for the patient and the caregivers (Connolly et al., 2009).

Popejoy, Galambos, Moylan and Madsen (2012) identified high hospital readmission rates in Missouri, America as a concern following discharge for older adults. Within their survey of health care professionals in Missouri they found that accessing post-acute care (for example care for patients with ongoing wound needs or for those with ventilators) was the greatest challenge facing those planning discharge from hospital. Although the authors stated that this research was intended to be multidisciplinary the sample included only one ‘physical or occupational therapist’ (0.27% of the respondents) compared with 84 physicians and 63 nurses.

One recent UK study explored occupational therapists’ and physiotherapists’ perceptions of risks with older adults in acute care setting (Atwal, Wigget, & McIntyre, 2011). The study used reflective journals to identify the self-reported risk taking behaviours of six occupational therapists and two physiotherapists. Findings suggested that support from the multi-disciplinary team and clinical confidence was important in managing risks. It was indicated that increasing patients’ quality of life and meeting patient goals of being discharged home were both rationales for risk taking behaviour.
(Atwal et al., 2011). These authors concluded that support and guidance was needed to “enable positive risk taking” (p. 417) to occur in practice, however make no reference as to what positive risk taking may involve.

Occupational therapists assess patient’s occupational performance and use this assessment information in the hopes of facilitating a timely, safe and successful discharge (Crennan & MacRae, 2010). A New Zealand study by Craig, Robertson and Milligan (2004) surveyed occupational therapists from three large New Zealand hospitals and found that occupational therapists in acute care felt that their role was primarily in ensuring safe discharge home with resources (such as compensatory equipment or community services) in place. The authors report that to achieve this safe discharge for patients, occupational therapists had to assess and problem solve in a time-pressured environment. Welch and Lowes (2005) agree, concluding that within hospital services the rapid pace of discharge planning has led to assessments focusing only on the essentials to enable patients to return home. New Zealand therapists in a 2002 study addressing the occupational therapy role in acute care agreed that their main role was to assess and plan for safe discharge (Blaga & Robertson, 2008). Their study found that the main focus of occupational therapists was to increase independence and safety post-discharge, and similar to the studies above found that therapists had to use knowledge of a range of medical conditions to make fast clinical judgments.

Although occupational therapy literature acknowledges that there are elements of uncertainty and risk with discharge from hospital (Huby et al., 2004; Reich, Eastwood, Tilling, & Hopper, 1998), research to date focuses primarily on the decision making process, with few available sources that explore how discharge is managed by occupational therapists when there is risk involved. Moats (2006) identified the increasingly complex discharge decisions that occupational therapists are faced with, including involvement in assessing a patient’s capacity to remain living in their own homes. She conducted semi-structured interviews with occupational therapists, and found that the biomedical model obviously predominates in hospital settings, and pressure for fast decisions in acute settings impeded client-centred practice. The therapists aimed to be client-centered, however Moats (2007) identified that the competing issues of safety and client autonomy when considering discharge decisions made this difficult.
Reich et al (1998) suggest that little is known about the processes involved in risk taking. Their work focuses on complex decision making on acute medical wards where they studied the differences in decision making between student occupational therapists and qualified occupational therapists. Four hypothetical patient cases requiring decision making were presented to each group. They found that qualified OT’s are less likely than student therapists to recommend discharge to a residential or nursing home when this is contrary to the patient’s wishes, suggesting that more experienced therapists may have a greater capacity to deal with risk as a concept.

This is also supported by Holm and Mu (2012) who reported that experienced clinicians are more effective in discharge planning as they have previous experience to draw on. Other authors suggest this prior experience gives expert therapists a base from which to be responsive and adapt therapy/plans more readily (Mattingly & Fleming, 1994).

Huby et al. (2004) explored older patients’ participation in discharge decision making through ward based observation and interviews. Their findings suggest that the formal systems of cognitive and functional assessment left little opportunity for patients to express their views, hampering the active discussion of risk and, as a consequence, safe decision making. Huby et al (2004) also discuss the concept of trust, which involves an active decision to delegate or share responsibility for one’s own welfare to someone else such as a health care professional in situations of uncertainty or risk. This has particular relevance to this study as the occupational therapist is often the key health professional providing information about the older person’s ability to independently carry out the tasks of daily living, and therefore occupies a position of trust with the older person, their family and also the hospital care team.

Discharge planning can not only involve the patient themselves, but also their families, especially adult children who often bridge the gap between what community services can provide and what patients may need (Bauer et al., 2009; Jenkins, 2000). Chippendale and Bear-Lehman (2010) describe social support as one of the most important factors in occupational function at home and Dwyer, Gray and Renwick (2000) acknowledge that family support and care is a significant factor in determining whether or not an older person continues to live independently. Connolly et al. (2009) report during their study on discharge planning that their focus group participants felt that relatives at times were highly uncooperative and hindered the smooth running of
discharge planning. They concluded that balancing the needs and safety of the patient while involving and supporting the caregivers required a high level of expertise.

Conclusion

The Health and Disability Commission’s Code of Health and Disability Services Consumers' Rights (Health and Disability Commissioner, 1996) asserts that all patients have the right to take responsibility and control for their lives even when certain choices may expose them to considerable risks. The increasing pressure to keep older adults out of residential homes and in their own homes for positive health, empowerment and self-identity outcomes (Davey, 2006; Molony, 2010) and increasing pressures for quick discharge from acute services reinforces the idea that clinical decisions are more complex than ever before.

The patient and their family also bring highly individual needs and perceptions to the discharge planning process. The occupational therapist working in such complex settings is challenged to balance the risks associated with discharge with the risks of potentially reinforcing frailty and dependence in the patient.

This chapter has used literature from a variety of sources to frame the research question. It examined the demographics of older adults within a New Zealand context alongside the health and social policies related to them. Background information regarding the working environment and culture for the occupational therapists involved was outlined. The concept of risk with its broad and variable definitions, and finally how these areas all fit together to impact discharge planning from acute hospital services were explored. The next chapters of this thesis engage with the research process. Chapter three describes the theoretical, methodological and practical aspects of the research.
Chapter Three: Methodology

The development of a theoretical and practical basis for this research involved a careful examination of the multiple contexts occupied by the concept of risk. As discussed in the previous chapters, the definition of risk can change according to the time and context in which it is being considered, and the person who is considering it. Throughout this thesis I argue that the experience and understanding of risk is tightly linked to the time and place of the therapists’ practice.

A qualitative descriptive methodology has been chosen as the methodology, situated within the frame of social constructionism and utilising focus groups and subsequent interviews as methods for data collection. In itself qualitative descriptive methodology does not align itself to any particular theoretical position making it all the more important to clearly state the links from an overarching methodological position through to the more practical methods considerations involved in data collection and analysis (Sandelowski, 2000, 2010; Stanley & Nayar, 2014). In this chapter I describe these theoretical positions, the participant sample, and the data collection and analysis processes. I also discuss the ethical issues associated with the research.

Theoretical underpinning

Social constructionism

This research was framed from a social constructionism paradigm, wherein researchers seek to interpret the meanings that others make of the world in which they live and work (Creswell, 2007). Social constructionism assumes that meaning is created as people engage with the world around them, and is therefore interested in the shared understanding of concepts that emerge through lived experiences and interaction with others in conversation (Andrews, 2012). This theoretical position is consistent with the discussion in the previous chapters which identifies risk as being highly contextual and the conversational nature of occupational therapy practice. Social constructionism furthermore is consistent with the use of focus groups as a means for the therapist participants to define and explore the concept of risk from within their own social context because of the conversational nature of the ideas that are developed during the groups.

Social constructionism and social constructivism are closely connected and are sometimes used interchangeably. Young and Collin (2004) identify the key difference
as one of focus; constructivism focuses on the way the individual’s knowledge is shaped by their social environment, while constructionism focuses on the product (artifact) that is created through the social environment. In this research the product is occupational therapy practice and a professional understanding of risk, so although there is some content related to how the therapists have developed their knowledge the primary theoretical position remains that of social constructionism, or how the therapists have developed their practice in relation to risk.

**Qualitative descriptive methodology**

Qualitative methodology is useful for issues that are not already well understood, and for generating new ways of understanding phenomena; it is particularly useful for research that seeks to gain insight into people’s behaviour and attitudes because it focuses on why and how something happens, not simply where and when (Denzin & Lincoln, 2011). Rather than identifying a hypothesis, and developing a project with the assumption that the hypothesis can be tested, a qualitative descriptive approach enables the researcher to identify an area or phenomena to be studied and any hypotheses are allowed to emerge from the data. Therefore, a qualitative approach enables this research to explore the beliefs of the occupational therapist participants about risk, shaped by their culture and experiences, and to closely examine this area of practice that is not yet fully understood.

Qualitative description as a research methodology aims to offer a comprehensive description of a phenomena viewing “language as a vehicle of communication” (Sandelowski, 2000, p. 334) and encouraging the use of everyday terms of the participants in the presentation of data (Sandelowski, 2000). Qualitative description involves the collection of rich data from participants who are involved in the phenomena under investigation, generally though individual face to face interviews. Data are presented as ‘findings’ and include many participant quotes to enable the richness of the data to be fully appreciated by the reader. Data are analysed using codes and categories, with the emergent themes providing new descriptive information.

**Focus group methodology**

This research has purposely made mention of the focus group methodology as an overtone, or a secondary methodology influencing the primary methodology of qualitative description. Sandelowski (2000) describes “hues, tones and textures” (p.
where any individual qualitative approach can have aspects of other approaches, and encourages the naming of these (Sandelowski, 2000, 2010). Although more frequently used as a method of data collection within a qualitative methodology, the focus group approach arguably has its own assumptions, forms of methodological criteria and research procedures. Focus groups not only obtain data regarding the ideas, attitudes, understanding and perceptions, but do so in a way that allows participants to use their own language when talking about the research topic (Plummer-D’Amato, 2008a). Part of what makes focus groups special and worth mentioning as a methodological influence and not just a method of data collection is that they allow participants to develop, refine and justify ideas and thoughts through interaction with others, leading to the construction of new knowledge, or the articulation of previously unspoken or inferred knowledge (Ivanoff & Hultber, 2006). This social interaction has influences on data analysis and reporting, which is specifically discussed in the analysis section below. The ability to recognize these influences situates focus group methodology and method well within a social constructionist framework (Ivanoff & Hultber, 2006).

**Rigour**

Rigour is an essential aspect of any qualitative research requiring a fit between the research question, methodology, methods and data analysis (Stanley & Nayar, 2014). As qualitative research aims to give a voice to the perspectives of research participants, central to the quality of this research is whether participants’ perspectives have been authentically represented and their experiences fully and accurately illuminated (Creswell, 2007; Fossey, Harvey, McDermott, & Davidson, 2002). Rigour involves both methodological rigour (good practice in conduct of research itself), and interpretative rigour (trustworthiness within interpretation of information gathered) to ensure results resonate with participants (Fossey et al., 2002). Stanley and Nayar (2014) advise that researchers be selective in their strategies to demonstrate rigour, aiming to avoid a multitude of strategies that may only superficially address the issue of rigour.

Techniques specifically considered and employed throughout this research process to ensure methodological rigour include the employment of two different forms of data collection (focus groups and interviews), member checking, and transparency or signposting. Techniques employed to increase interpretive rigour included peer review and signposting to indicate influences and decision making (Koch, 2006; Plummer-
D’Amato, 2008b; Stanley & Nayar, 2014). In addition to this essential outline of how rigour was addressed in this research, also embedded in sections below are specifics relevant to different areas. For example the recommendations of Plummer-D’Amato (2008b) to increase reliability in data collection by having more than one focus group, and the decision trail and supervisor review specific to increasing analytical rigour.

**Member checking**

Member checking is a check on the understanding of the data by the people involved, to provide the opportunity for participants to change mistakes they feel they might have made and to assess the researchers’ understanding and interpretation of the data. This can be done by repeating or paraphrasing participants words verbally or in writing, and can be done immediately or following initial review of information (Holloway & Wheeler, 2010). Within focus groups data collection member checking is recognised as difficult because ideas are developed and refined through group interaction, meaning that paraphrasing could include a number of participants’ contributions, not just one (Plummer-D’Amato, 2008b). Carey and Asbury (2012) suggest that this can be somewhat addressed within groups by the facilitator clarifying inconsistencies as they arise and by the facilitator checking with participants that the main ideas were captured.

In this project, while immediate and obvious inconsistencies or unclear information were certainly checked during the groups (often by other group members in addition to the facilitator), inconsistencies in information became more apparent following close reading of transcripts, rather than when immersed in the group. This is a recognised difficulty in focus group data collection (Plummer-D’Amato, 2008b) which, in hindsight, could have been addressed by including a second facilitator specifically to identify inconsistencies and support their resolution. In addition, in both focus groups my attempts to check main ideas by paraphrasing at the end of the sessions were somewhat difficult as this acted as stimulation for further elaboration and conversation.

An intentional benefit of having the interviews following focus groups, and the interviewees participating in both, is that this allows for another form of member checking. The follow-up interviews, described in more detail in the data collection section below, took place after close reading of the focus group transcripts and were planned in order to allow the initial ideas and potential themes from the focus groups to be discussed and verified during the interviews (Holloway & Wheeler, 2010; Thomas, 2003). A second form of member checking was also employed whereby a presentation
of initial findings was given to the occupational therapy department during internal training time after all data collection was completed. Attendees of this included a number of participants from the focus groups. Initial thoughts and feelings on the findings were specifically sought during and at the completion of the presentation, with the aim of ensuring that the findings resonated with the therapists present. The participants verified that they recognised the content of the presentation, and that the initial findings were consistent with their experiences of both the focus groups and of their own clinical practice. The presentation to the occupational therapy department also partially met the requirements for peer review because of the level of occupational therapy expertise among the audience.

**Peer review**

Academic peer review is the involvement of another person, competent in qualitative research, who can review raw data and discuss each stage of the analysis, enabling them to detect potential problems with data interpretation, confirm the ideas arising during analysis and ensure plausibility (Holloway & Wheeler, 2010). The academic supervisor fulfilled this peer review role throughout all stages of research planning, data collection and data analysis, the details of which are outlined below.

As mentioned above, occupational therapy experts were also involved in peer review of the research. This took place in two ways. The first was an implied verification of the worth of the research itself through the participants’ willingness to put their personal time and effort into attending the focus groups and engaging in the discussion. This suggested that they found the research question clinically relevant, and that the focus group methodology was consistent with their expectations about how a project should be conducted. The second type of peer review occurred in a much more obvious way when the occupational therapists attended a presentation and engaged in further discussion about the relevance of the initial findings to their practice.

**Transparency**

Transparency is the openness with which research is conducted and is involved in both methodological and interpretive rigour. It includes the concept of signposting, or acknowledging research decisions and influences so that the reader can see why choices were made (Koch, 2006). Transparency in this research was considered carefully, not only in the reporting of findings but also during data collection as the researcher is a
part of the District Health Board (DHB) that data was collected from. Right from the moment of participant recruitment the history of the researcher and points leading up to the decision to complete research into this topic were outlined, including the case study used within the introduction chapter. It was made clear to participants at the beginning of each focus group that the researcher was taking on the role of group moderator.

The different aspects of rigour in qualitative research are closely linked, so an additional feature of transparency in data analysis has been signposted by demonstrating techniques such as peer review and by the comprehensive and vivid recording of information.

The intended audiences for this research are drawn from academia and clinical practice, so the successful accomplishment of transparency for both groups was an important consideration. Transparency and signposting in the presentation of this thesis has been achieved through the inclusion of many direct quotes from the focus groups and interviews. An additional technique has been purposefully included in the thesis; that of including both real and hypothetical case studies to illustrate key points. The case studies signal a departure from the purely academic nature of some research, and a move into the kind of reporting that may resonate with occupational therapists in all levels of clinical practice.

**Ethics**

Ethics approval for this research was sought from Otago Polytechnic Ethics Committee, and granted prior to any contact with potential participants (see appendix 1). Approval to conduct research within the DHB was sought via the DHB Research Committee. They were provided with a copy of the research proposal and provisional ethics approval in addition to a formal application. Please see appendix 2 for a copy of the supporting letter.

This research was considered low risk, as all participants were a part of the occupational therapy workforce, meaning that they belonged to a registered profession and it can be assumed they were all fit to practice within New Zealand and receiving formal supervision (Occupational Therapy Board of New Zealand, 2004b).

Local iwi were accessed via Maori Health Services, who have an established relationship with the DHB Research Committee. Please refer to appendix 3 for a copy of the supporting letter. A copy of the full research proposal was provided for
discussion in the Maori Health Services team monthly meeting in addition to a one on
one discussion regarding the proposed research with the team leader and iwi
representative. Through this contact the offer was made for cultural supervision for
both Maori and Pakeha therapists (including the researcher) should they wish to discuss
any issues that arose during discussion in the focus groups or interviews. This offer was
made explicit to the participants during the recruitment presentation and at the
beginning of each group.

Methods

Within the framework of qualitative description, the specific methods of focus groups
and semi-structured interviews were employed. Both of these methods have their own
research procedures.

The focus group method uses a process of guided conversation to collect data about
how a collective group (occupational therapists) understand their common, shared
experience of understanding and negotiating risk in discharging older adults (Ivanoff &
Hultber, 2006). Focus groups generate an in-depth understanding of participants’
experiences and beliefs through moderated group processes which help participants to
develop and refine their ideas (Carey & Asbury, 2012; Morgan, 1998; Plummer-
D’Amato, 2008a). The focus group approach is particularly suitable for examining how
clinicians think and talk about a specific issue because, as mentioned above, the group
interaction can reveal more about the clinical problem and reasoning than is possible at
an individual level through commonality, shared experiences and reflection (Ivanoff &
Hultber, 2006). These advantages to utilising focus groups were demonstrated in this
research, with the participants engaging in insightful and dynamic conversations. Ideas
presented by one member of the focus group tended to generate opinions, different
perspectives, and practice stories by the wider group, resulting in consensus or
disagreements that provided a broader and deeper understanding of the topic than could
have been generated within individual interviews.

Individual semi-structured interviews are commonly used in qualitative research
(Creswell, 2007), and are a useful adjunct to focus groups both to verify information
and to follow-up on interesting points of discussion identified following initial data
review (Morgan, 1998). As a data collection method they utilise open questions
designed to elicit the participants’ personal experiences, beliefs and understanding of a
phenomena. In this research, the semi-structured interviews are supplementary, following the focus groups with the aim of further examining the ideas raised by the focus group participants and exploring the individual participants’ specific opinions and experiences in more depth. Further information regarding focus group moderation and the semi-structured interviews is provided in the data collection section below.

**Recruitment**

Participants were recruited from one DHB, where the researcher was able to complete a ten minute presentation to the occupational therapy team. This technique for recruitment is recommended by Shaha, Wenzel, and Hill (2011) as the presentation allows the researcher to provide information about the research to a large group and hand out information sheets (see appendix 4), giving participants the opportunity to thoroughly consider information and time to ask questions. Potential participants were asked to approach the researcher either in person or via email if they were interested or had further questions. In order to ensure participants were able to volunteer without coercion or follow-up from the researcher, in a subsequent meeting the department professional advisor reminded therapists of the need for volunteers.

**Sample**

Purposive sampling was employed for both focus groups and interviews, meaning that participants who would be appropriate to the research question itself were approached through their workplace, rather than taking the more wide-ranging approach utilised by researchers seeking randomization (Creswell, 2007). The focus groups were planned to take place outside of working hours, which qualified the participants as those who would be interested and engaged participants of the focus groups (Plummer-D’Amato, 2008a; Sandelowski, 2000; Taylor, 2007).

There does not seem to be a consensus in literature regarding the ideal number of participants for a focus group, however Ivanhoff and Hultberg (2006) recommend no more than six in each group as larger numbers may hinder full participation, while very small numbers will naturally limit discussion. They suggest that the quality of the data gathered depends more on the involvement of the participants in the topic than on the actual number of participants. Carey and Asbury (2012) suggest that smaller group numbers (in addition to the skill of the moderator) can assist in limiting the effects of having more dominant members of the group, as there is increased time for quieter
therapists to be encouraged to participate. Five occupational therapists participated in each focus group (n=10). This number enabled each participant to speak, and also meant that voices in the audiotapes were able to be identified, which may not have been the case with a larger group.

It is generally recommended that when planning focus groups researchers consider common backgrounds and experiences of participants to ensure as much as possible that participants feel comfortable expressing their views (Ivanoff & Hultber, 2006; Kitzinger, 1995). For this particular research consideration of homogeneity was not required in depth, as participants were already known to each other and a part of one working group. There is support for homogeneity in the use of pre-existing groups, such as work place colleagues, as they are more likely to relate each other’s stories and there is increased likelihood of rapport. This in turn offers increased opportunities to become fully involved in the topic and increases the depth of data gathered (Kitzinger, 1995). While the overall homogeneity of profession, patient population, and institutional workplace was acceptable for this project, there was some attempt to create diversity in the focus groups in terms of practice experience. Participants were asked if they would prefer one of the two specific time slots set for the focus groups. Those who were flexible were purposely placed in groups in an effort to create a mixture of levels of experience and work areas. Focus group literature cautions that hierarchy within the group can impact on data, or serve to silence some members of the group (Kitzinger, 1995; Plummer-D’Amato, 2008b). Despite this I felt for this project that having separate ‘senior’ and ‘junior’ groups could potentially affect the data collected in each group, and that in fact having a mix of experience could open up positive discussion opportunities. In considering how to facilitate open discussion for the more junior therapists, it was specifically considered when preparing for the groups how to manage more dominant participants, with smaller group sizes to ensure time for all to participate and techniques such as setting group boundaries and using eye contact and specific questioning to encourage involvement (Carey & Asbury, 2012). This approach worked well for this project, with all participants engaging in the discussion and with a wide ranging discussion that included the perspectives of therapists at varying levels of clinical experience and knowledge.

The number of focus groups completed should depend on the research being undertaken (Ivanoff & Hultber, 2006; Plummer-D’Amato, 2008a). In the case of this
project two smaller groups were completed to increase the reliability of data gathered (Plummer-D’Amato, 2008b). The use of follow-up interviews complemented this and ensured that any questions arising could be elucidated in more depth.

The inclusion of participants from other parts of the DHB or other organisations would have enabled further focus groups to be held. However, it was important to maintain the scope of the current project, and to have enough data to undertake a robust analysis without being overwhelmed with data that could only be superficially analysed within the timeframe and word limit of a Masters project. The resultant findings from this research provide insight into a relatively new area of investigation, but more data from a wider variety of participants is required before the findings can be translated into other settings.

Eleven therapists responded to the requests for volunteers, with one withdrawing because of other time commitments. All indicated on their consent forms (appendix 5) that they were happy to be contacted for follow-up interviews. The participants were therefore registered occupational therapists who had worked or were currently working in areas involving discharge planning for older adult patients. This included general medical and surgical wards, orthopaedics, acute neurology and rehabilitation. None of the therapists participating identified as Maori, and no specific references to Maori patients were made during the research. This could be an important area for future research considering the health inequalities currently facing New Zealand’s Maori population (Ministry of Health, 2002a). The table below offers a breakdown of the participants’ demographic details.

<table>
<thead>
<tr>
<th></th>
<th>Focus Group 1</th>
<th>Focus Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of participants</td>
<td>5 (all female)</td>
<td>5 (all female)</td>
</tr>
<tr>
<td>Years post-graduate</td>
<td>2 participants &gt;10 years</td>
<td>1 participant &gt;10 years</td>
</tr>
<tr>
<td></td>
<td>1 participant &gt;5 years</td>
<td>1 participant &gt;5 years</td>
</tr>
<tr>
<td></td>
<td>2 participants &lt;2 years</td>
<td>3 participants &lt;2 years</td>
</tr>
<tr>
<td>Areas of practice</td>
<td>Rehabilitation</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td></td>
<td>Orthopaedics</td>
<td>Orthopaedics</td>
</tr>
<tr>
<td></td>
<td>Acute neurology</td>
<td>Acute neurology</td>
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<tr>
<td></td>
<td>General medical</td>
<td>Surgical</td>
</tr>
<tr>
<td></td>
<td>Acute assessment</td>
<td></td>
</tr>
</tbody>
</table>
Following completion of the focus groups and initial close reading of the transcripts two therapists were selected to participate in follow-up interviews; these key informants were chosen following initial reflection on the focus group information and following discussion and sharing of the focus group recordings with the academic supervisor. Both therapists came from the same focus group, however both had raised and participated in different discussions of interest including risk taking by new graduate therapists, and risk-taking to help patients continue to make progress in their physical and social needs. These points of interest are signposted in the findings chapter to ensure transparency in this decision making process.

One interviewee had more than ten years of post-graduate experience and worked within a rehabilitation area, while the other had less than two years of post-graduate experience and worked within orthopaedic services. While consideration was made of the make-up of both groups as detailed above, it is acknowledged that there was still the potential for dominance by more senior staff, or even just for junior therapists to be more hesitant in vocalizing thoughts. Therefore it was important for one of the interviews to be completed with a less experienced therapist to prevent gaps in the findings.

The choice of two therapists working within different practice areas also offered a depth of data that may have not been available if both worked within orthopaedics for example. Although the rehabilitation unit is considered short stay, within this particular DHB it still offers therapists more time with their patients, potentially impacting on views of discharge planning.

**Data collection**

The data collection for this research involved two focus groups with five participants in each. These were completed two weeks apart, and follow-up supplementary individual semi-structured interviews were completed three weeks later. Within qualitative research, it is common for interim data analysis and reflection on the quality of data being received to take place almost alongside data collection allowing for shaping and refining of questions (Pope, Ziebland, & Mays, 2000). The gap between focus groups and again between the groups and follow-up interviews was deliberate to allow time for reflection and to ensure that appropriate and useful information was being gathered. Taking into account my status as a novice researcher, this timeframe had the added
benefit of allowing for review of the recordings by the academic supervisor to increase rigour and provide feedback on group moderation techniques.

Both groups and interviews were recorded with two devices, a digital and analogue recorder, to safeguard against technical errors. Recordings were transcribed verbatim by a medical transcriber and thoroughly checked by the researcher as soon as possible after data collection. All recordings and transcripts were sent to the academic supervisor to allow review of decision making and audit of data analysis.

The focus groups were moderated by myself. Although there is suggestion in some focus group literature that having an uninvolved moderator or facilitator can be advantageous to limit bias and unintentional moderator participation (Shaha et al., 2011), there is also support for the researcher completing the group moderation as this offers more insight into the research and allows for more responsive moderating during data collection (Ivanoff & Hultber, 2006). As the researcher and the moderator of the groups there was additional value for me ‘being an insider’ in terms of being acceptable to the participants and not needing additional time to establish rapport, understanding jargon and not hindering the conversation by needing to have processes or participants’ roles explained to me. For example, a brief point of discussion that did not need to be clarified was the reference of a participant to convalescent funding within the orthopaedic service. As an insider I was aware that this was reference to a specific pool of funding that is available to provide temporary rest home care should an orthopaedic condition prevent discharge home or restrict a patients’ ability to participate in rehabilitation. As mentioned above, however, there was a disadvantage to being the only facilitator when I became fully involved in the group process and did not always notice inconsistencies or only partially developed discussions until I was reviewing the transcripts. This could have been remedied with the inclusion of a second facilitator.

For both focus groups a brief question route was devised (appendix 7), with consideration of broad, opening questions that would encourage involvement from all participants, followed by transition or general questions to encourage the participants to begin to focus on the research topic, and culminating in specific key questions that were vital to the research (Ivanoff & Hultber, 2006; Plummer-D’Amato, 2008a). Focus group literature cautions against the use of too many pre-prepared questions, and emphasises encouragement of discussion rather than ‘interviewing’ by the moderator (Ivanoff & Hultber, 2006). The time between each group allowed for consideration of
the usefulness of the questions, but no changes were required. Differences between the two focus groups naturally occurred as the facilitation or moderation of these groups was purposefully minimal and followed the discussion of the participants.

As mentioned previously the semi-structured interviews were completed after brief initial data analysis of the focus groups, to identify both potential gaps in the research and areas of interest that required further exploration. Both interviews were approximately one hour long, and aimed to expand on and add to information already initially indicated within the focus groups. Interview questions (as seen in appendix 8) were therefore established after the focus groups were completed and the first close reading of the transcripts was finished. During the semi-structured interviews a number of quotes were used from the focus groups to prompt conversation and questions were not rigidly adhered to but instead offered a guide and reminder of points to cover. A lot of time was spent in the focus groups developing the idea that risk is a part of the occupational therapy role, something that is discussed in depth as the thesis progresses. The primary areas of focus for the interviews therefore was on moving past this then established idea and discussing instead how risk is manifested, how the therapists felt about risk and how they supported each other.

As a data collection method these interviews also served to provide a form of member checking, something that is difficult to achieve with focus groups because of the interaction of the group (Plummer-D’Amato, 2008b). Each interviewee confirmed that the follow-up questions were based on their recollection of the content of the focus group they attended.

**Data analysis**

This research utilised Thomas’s general inductive approach for data analysis (2003), where the purpose is to “allow research findings to emerge from the frequent, dominant or significant themes inherent in raw data” (Thomas, 2003, p. 2). This approach fits well within both a qualitative descriptive and focus group methodology as it allows for use of the language of the research participants, without imposing restrictions or technical data analysis procedures. Using this specific approach not only offers a clear process, but also has the added benefit of negating concerns expressed by some authors that qualitative description as a methodology may be used as an excuse for minimal analysis (Sandelowski, 2010). Further, the general inductive approach to analysing
focus group data enables the explication of how the knowledge within each focus group was developed, including the silence of some participants around particular topics. This has been particularly useful in understanding how the more junior therapists responded to discussions of the positive aspects of risk. Thus the general inductive approach is consistent with interpreting data from a social constructionist perspective.

Analysis and reporting of focus group data itself presents specific challenges that do not exist in other data collection methods, as it needs to take into consideration the interaction of the group, which is integral to focus groups as a data collection method (Plummer-D’Amato, 2008b; Webb & Kevern, 2001). This interaction is not only taken into account in establishing themes as discussed below, but is also reflected in the findings by reporting segments of conversation together if it adds to a contextual understanding. This was somewhat difficult to achieve, but is presented in the text as short conversations with pseudonyms given to each participant followed by the identification of the focus group. For example:

Claire: “Life is risky”

Marjorie: “it is, you could get run over crossing the road tomorrow, that is a risk” (FG1)

Consensus or disagreement among the therapists, or if an idea stimulated significant discussion, was considered within the analysis itself and is clearly visible in the initial creating of categories (appendix 9). Carey and Asbury (2012) urge researchers using a focus group method to consider the circumstances within which information is disclosed and group interaction, but not to privilege this component over actual words spoken and vice versa. Within analysis of focus group data, they also caution researchers to be aware of issues such as conformity which can at times be difficult to differentiate from simple refinement of thoughts or feelings. My insider status with these participants was helpful in this regard, because I had previous knowledge about how each person tended to communicate outside of the research context. This information was brought into the data analysis process as a nuanced understanding of topics and times when conformity, silencing, and deference to more experienced therapists occurred. This level of analysis is clearly signposted in the findings and discussion chapters where it has been utilised.
Thomas (2003) suggests five procedures for analysis, with an overall goal of three to eight summary categories which capture key aspects of the data; preparation of the raw data, close reading of the text, creation of categories, overlapping coding and uncoded text, and finally continuing revision and refinement of the category system. The two procedures that are emphasised within these processes are the importance of close reading to ensure the researcher is completely familiar with the data, and the continuing refinement of the categories. While working with this data I found that I paused several times during the refinement of the categories to reread and reflect on the raw data and its relationship to the categories that were emerging.

The process I used to develop the categories involved highlighting and colour coding on the hard copies of the transcripts, noting potential areas of interest from each of the four transcripts, note taking in the margins, frequent discussion with peers and finally the creation of an electronic table that allowed for cutting and pasting sections of text together.

Thomas (2003) suggests that more than eight major themes is incomplete and requires further refinement while acknowledging that decisions need to be made by the researcher about which themes or categories are the most important. Appendix 9 shows an extract from the table initially used to create categories, while appendix 10 depicts photos of the category refinement process and demonstrates how progress and decision making was communicated to the academic supervisor.

Three main themes or summary categories were identified, with specific sub-themes within these.

**Conclusion**

This chapter has presented the theoretical underpinnings, methodology and methods used in this research project. The thread of social constructionism is woven through all aspects of the research, and has informed the selection of focus groups as the key methodology and follow up interviews as the means of enriching the data, filling gaps, and member checking. Findings from this research are outlined in rich detail in the next chapter.
Chapter Four: Findings

The findings from this study have been organised into the following themes: acknowledging risk; working with the risky discharge; and patients, families and risk. Smaller sub-themes within each of these are outlined below.

Verbatim quotes from transcripts have been included to illustrate themes and categories, from numbered focus groups (FG1 or FG2) or interviews (I1 or I2). Some focus group quotes contain discussion between group members in order to give an accurate picture of agreement or dissention. Where appropriate, additional notes have been made to signpost the possible conformity by junior staff or the dominance of senior staff within the groups. Pseudonyms have been used throughout for the privacy of the participants.

Acknowledging Risk

When first asked what they think when they think about risk all participants of both focus groups engaged in a discussion in agreement that risk was a part of everyday life. The therapists described risk as having an impact on everyone regardless of age or circumstances. Risk was discussed in terms of everyday people, patients and therapists.

Everybody has risks, no matter what, we all have risks (I2)
Claire: “Life is risky”
Marjorie: “it is, you could get run over crossing the road tomorrow, that is a risk” (FG1)

Participants also identified that risk was a part of day to day work within a hospital setting, choosing to illustrate this point with examples of risk associated with everyday activities.

I think even getting someone out of bed, that is a risk (I1)
Really, the first time you stand a patient you’ve got risk (FG2, Cathy)

Within the conversations about risk being part of everyday life, discussion arose that choosing to do nothing at all also involved considerable risk.

If we leave [the patient] in bed, what are the risks to her function overall if we don’t get her out of bed? So we just have to try (FG1, Claire)
They also all agreed that as part of life, risk is also a part of the occupational therapy role.

*I think if you accept there is always going to be a risk then you can prepare... It is huge, every day we are doing it, and it is taking risks putting somebody like in a new wheelchair and taking risks trying out a bit of equipment with somebody and it is everything you do is a risk, but yeah, we don’t talk about it. I think it is a natural part of our job that we just take for granted and it is all part of our job (I2)*

*Claire: “I think what Marjorie said, we get used to taking risk”*

*Marjorie: “Well, it’s so linked to function. We are about enabling people to do meaningful occupations, so therefore there is an element of risk in doing tasks, in doing things. That is what life is about. All of us take risks” (FG1)*

As the discussion developed, the participants acknowledged that patients have a choice about the level of risk that they are prepared to take, and that some patients choose to take more risks than others.

*Yeah, I suppose some people are willing to take the risk, and say ‘yep, I’d rather go home and risk being all these things but at least I’m home’ (FG2, Katie)*

**Changes with experience**

Throughout both focus groups and the subsequent interviews it emerged that with clinical experience there are changes in views of risk taking. Therapists initially identified that as new graduates they were more prone to avoiding risk, or allowing themselves to be swayed in their decisions about risk.

*As a new grad I definitely find myself staying on the very very safe side sometimes, but I kind of know that I’m like that and that’s ok (FG2, Elise)*

*As a new grad I would definitely have been more cautious (FG1, Claire)*

*You’re [now] more confident in your ability as well. When you first start out [you] don’t take those risks... (FG2, Katie)*
If you’re not confident [other people] can influence when you take that risk and how much risk you take (FG2, Katie)

They expanded on this idea, stating that their willingness to take calculated risk increased as their confidence in their practice and in their clinical reasoning increased.

Marjorie: “I take more risks now”

Paula: “Yeah, as you get more experienced you take more risks” (FG1)

It’s kind of more educated risk taking I guess (FG2, Cathy)

Rebecca: “More confident in your clinical reasoning”

Katie: “Yeah, plus you’ve also got experience…” (FG2)

It also emerged during the groups that at the same time as avoiding risks, conversely, participants also reported taking more risks as novice therapists, although these were unintentional and tended to stem from a lack of knowledge and awareness.

Maybe it comes from experience and I look back now at the people I took home 10 years ago from ED, who I would never take home now, because I know better (FG1, Claire)

Yeah, and you know how you were saying before the more experienced you get the more risks you take... there’s another side to that as I well, because I remember I was probably just 7 months out – and sometimes it’s not identifying the risk. Like I went into this room with this lady who was really, really demented, and her physical ability fluctuated quite a bit... just to practice a simple bed transfer across to the chair, and it started off alright... and next minute she’s kind of grabbing onto everything trying to drag me down and I’m trying to support so she’s not falling, and I can’t get to the nurses bell, and there’s no one else in the room, and I’m like... oh my god, this persons going to fall and hurt themselves, and also I felt completely out of my depth... I’ve got this woman... and I’m like “help, help” (FG2, Rachel)

Unsurprisingly these ideas were voiced by more experienced therapists. None of the newer therapists disagreed with these statements, and on initial close reading of the transcripts this point about unintentional risk taking based on lack of knowledge, was considered to be appropriate to follow-up. A one on one interview was planned to gain
a clearer viewpoint from a novice therapist in a setting without the constraints imposed by more experienced therapists.

When discussing this in a follow up interview with a therapist who had only two years postgraduate experience she discussed her naivety as a new graduate who didn’t want to take risks, and in fact wanted to completely eliminate risks for her patients.

> When I first started I would have thought more that the OT role was to eliminate the risk and that is almost a naivety. As a new grad you kind of think I am here and I have given them a shower stool and I have given them a transfer bench and they won't step over the bath and I am going to take away all that risk and it is going to fine (I1)

These perspectives on risk taking during different moments in their career highlighted a conflict of ideas. Limited awareness of risks as a new graduate therapist leads to unintentional risk taking. This unintentional risk taking reduces as experience in occupational therapy practice increases. In complete opposition to this, participants also identified that willingness to take calculated risks also increases as experience does. The participants of the focus groups and interviews all agreed with these ideas, without seeming to recognize the contradictions. This will be discussed in further detail in the next chapter.

**Acknowledging risk in order to ‘progress’ patients**

An extension of the acknowledgement that risk is a part of the occupational therapy role was the discussion around needing to take risks to make progress. This part of the discussion related to the functional abilities of patients preparing to go home from hospital. This idea was discussed much more easily by the more experienced therapists, as would be expected from the conversations above, and this was another point that was chosen to be discussed in more detail in an interview with a more junior therapist.

> I think if we didn’t take risks half our patients’ would still be in AT&R (FG2, Katie)

> But, I think if you don’t take enough or you take too much that is when you get a risk because you are not going to see the results in your therapy if you don’t take enough and you are going to have incidents if you take it too far, so it really is finding that line...You see the people that really shelter their patients and their patients move slower because
they don’t give them the opportunities to take those big leaps forwards (II)

There was also the suggestion that choosing to take risks could be a therapy tool, acting to increase the confidence of the patient or to provide opportunities for education.

Sometimes they need that push from a professional, and seeing that person has got that confidence in me, I should have some confidence in myself to go (II)

And this sounds really bad but sometimes you’re letting people take that sort of risk in a supported area, so if they do fail, it’s good to use it to give them that insight, to be like ‘well you did nearly trip there’ or ‘you did nearly burn yourself’ so it’s kind of exposing people to that risk, you know, as a tool as well (FG2, Katie)

In this section risk has been acknowledged as an everyday part of life, which extends then to the role of occupational therapy within a hospital setting. Therapists identified how risk could be used to progress patients, and that if they didn’t take risks there would be a struggle to discharge patients at all. Therapists felt that as new graduates they took less intentional risk, but also more unintentional risk. This is an important point, and will be explored in greater detail in the discussion chapter.

**Working with the risky discharge**

Some therapists talked about the feelings of concern and worry they experience when a patient they have been working closely with is discharged.

There have been so many times where I’ve worried about patients and thought “am I going to go in tomorrow and they’re going to be back?” or you hear that the person such-and-such is back on the ward and you feel sick, you run through everything... you know that maybe it wasn’t the best discharge but we’ve put everything in place, and we’ve done everything we can do, and the person knows the risk and they’re willing to take them... I’ve lain awake at nights thinking “did we do everything?” (FG2, Katie)

Only one therapist disagreed with this, stating that she used to worry about patients, but that with twenty plus years of experience now she no longer does.
I used to get so worried as a new grad about my patients who went home and I thought they were unsafe. I used to worry and stress. Now I’m older I don’t lose sleep at night generally... I have done my best and they made their choice, so I don’t take it on board the way I used to.

(FG1, Claire)

**Occupational therapists have unique tools**

Mentioned earlier was the idea that risk is a part of day to day life and therefore part of occupational therapy practice. The participants of the focus groups also felt that within the hospital setting occupational therapists have a unique, holistic outlook that allows for greater consideration of risk than other professions.

*I think OTs enable people to take risks a lot more than other systems* (FG1, Marjorie)

*...risk is such a holistic thing, because as OT’s we look at everything, then that’s what makes us good at identifying the risks because we are looking at all that stuff and not just one thing in isolation* (FG2, Katie)

The usefulness of home visits as a tool specific to occupational therapy came up. Therapists reported using these visits to assess and manage risk for discharge, with all participants agreeing that if they have any concerns about patients they will consider a home visit as a valuable assessment option in getting a thorough picture of the patient in their own environment. This consensus was present in both focus groups and interviews. There was no mention at all of time or staffing restrictions preventing home visits.

*...a home visit is a really good way of assessing risk. If I have any really serious doubts, and I think actually a home visit is going to give me a lot more information than what I can see on the ward and I think it’s really important* (FG1, Paula)

Yeah, I always opt for a home visit when in doubt and I’m not quite sure what is going on here. I always find once they are back into their own home it gives you a much clearer picture of how this person is going to manage or not (FG1, Marjorie)
You can get such a better idea of someone’s function at home, like they could be a massive risk in the hospital but when they know where everything is they can be fantastic (FG2, Cathy)

**The impact of discharge pressures**

As discussed in previous chapters, hospital lengths of stay are shortening. Hospital beds are a finite number, and occupational therapists play a role in facilitating discharge. The participants in focus group one in particular had a lengthy conversation about how the expectations on therapists to discharge patients quickly regardless of risk can change from season to season at times when the hospital is experiencing high numbers of admissions. Participants in focus group two agreed, although the topic didn't elicit as much conversation with this group.

Paula: “the support can change depending on the bed pressures as well. I notice in winter we get a lot of pressure to get people home, because there are so many people coming in needing those acute beds”

Claire: “Actually, I think that is probably a good point. The risk that the hospital in general is prepared to accept shifts, depending on the pressure on beds, so a patient who is admitted one day from ED would not be admitted the next day under exactly the same circumstances because there are no beds, suddenly that risk is ok to accept and send them home” (FG1)

We still had to discharge her because there was a push for beds (FG2, Julie)

These pressures had an impact on the therapists, and on their practice.

...we don’t have a lot of control over that. As OTs that puts more pressure on you having to make more rapid decisions about discharge... you push people out faster than you would have done... (FG1, Marjorie)

The pressure to get people out that is really hard because you want people to have the best when they go home, you want them to have the right package, you want them to have the right equipment, you want them to have the right support (II)
I think you probably do. I think if you’re given that deadline, that persons got to be out, then you probably do take more risks, yeah, definitely (FG2, Katie)

The impact of this external pressure is one that was acknowledged as present by all participants in both focus groups. It appeared to have a significant impact on the risk that an occupational therapist will choose to take during discharge planning. This will be discussed further in the next chapter.

**Risks for therapists**

The idea was brought up in focus group one that having patients discharging home when there was high risk of adverse events occurring resulted in not only the obvious risk for the patient, but also risk for the therapist. Risks mentioned by the participants included damage to the reputation of the therapist, and the risk of investigation or disciplinary action by the occupational therapy board. Both groups talked about the importance of documentation in medical records as a way of protecting themselves.

Risk would be completely changed if we were prosecuted, if we were, like in the [United] States and I think that if you know there is going to be a law case against you... (FG1, Marjorie)

But what Natalie was saying about the risk to us, as professionals, I think that documentation is really important and the good clinical reasoning and the good, you know, getting that initial assessment information is important (FG1, Paula)

You know what, the more I perceive the risk the more documentation. So the lady I was talking about before who I thought was highly unsafe for me and the physio to get up, I wrote a page and a half on what it was like to get her from lying to sitting and on to the shower commode chair (FG1, Claire)

They also discussed using documentation as being important to have a record of the patients’ choices, particularly those against the recommendations of the therapist or that might result in adverse events.

*If they’ve taken on board my recommendations but they’ve declined it, I’ll just document (FG2, Rebecca)*
People that in your head you think right, these people are more of a risk, they’re going to be a little more difficult, your documentation is so much better (FG2, Katie)

Interview one explored covered this in more depth, with a particular focus on how it feels to be "at risk" professionally.

As a professional you are one encouraging it and you are one who is meant to be qualified to make sure that it doesn’t get out of hand, so I do think there is always a risk, that if you are the OT and you told someone to do something, and it didn’t work or you didn’t support them as you should have, there is going to be consequences to that (I1)

I do often find myself thinking about how will this affect me if I don’t sort this out appropriately... I guess you are always in the back of your mind thinking about, it sounds awful, but thinking about yourself... It is your career, you don’t really want to do something that is going to put that in jeopardy or put a big black mark on your name (I1)

Working with a team

One way of managing patient discharges when there is risk involved is using different versions of peer support. Therapists talked about utilising the multi-disciplinary team for support in more complex discharge decision making.

I think it is probably people, like the support you get from the team as well, seeing everybody on the same page and you know people are identifying the same things that it makes a lot easier to handle it (I2)

Having others involved also served as a protective measure to reduce the risks to the occupational therapist alone.

I think the really tricky ones become more team oriented for decision-making. If I’m really unsure I will talk to the physio, social worker, and say this is what I’m thinking, what do you think? (FG1, Cathy)

When you get the really complex high risk people I think it’s really important too as an OT not to have that sitting on your shoulders entirely (FG1, Paula)
It is really important to have everyone involved and especially if it is someone who is really, really complex (FG1, Paula)

On the other hand, focus group two in particular raised examples of occupational therapists needing to advocate for the patient in opposition to the multi-disciplinary team. They described having different views of risk to others, and the need for not only good clinical reasoning but also the ability to clearly verbalize this reasoning.

Speech and language therapists and consultants are very adamant that this person can’t manage at home because they can’t communicate and you know, that risk, but for me, you know, you can’t just put someone in a rest home because of that. And that’s where you have to work as a team, and communicate how you can minimise those risks (FG2, Katie)

When you’re working with an MDT and you’ve got quite strong personalities and someone saying to you “this person has got to go” and you’re like, well, no, there’s a risk... You can probably find yourself being railroaded into something, and you’re thinking, ‘wait a minute’ (FG2, Katie)

And nurses were talking about a failed discharge and saying the joke was when he will be back not if he will be back (FG1, Megan)

One therapist talked specifically about a disagreement with a consultant regarding a recommendation for discharge.

I had a situation a couple of weeks ago where the doctor came right up and was right in my face, “so why did you think this” and I was like... well, I got my point across (FG2, Rebecca)

Further exploration and conversation from the group and Rebecca elicited the idea that disagreeing with others in the team is unpleasant, but sometimes necessary when risk is involved.

That’s really what it felt like, like my head was on the chopping block, but yeah, I was doing that for the client, because I could have said nothing (FG2, Rebecca)

As a part of working within a team the participants of both focus groups touched on using informal peer discussions and formal supervision as a way of gaining support and
increasing confidence around discharge planning. This idea was explored in more depth with both interviews where both therapists talked about supporting others involved in risky discharges.

_Talking through your own experience and your own knowledge and just having a little bit of a forum. Often it’s not necessarily that someone needs to be told what to do, it is just to talk about what they are doing and know that it is okay (I1)_

_I think that supervision is a big thing as well.... actually being able to bring things to supervision and talk it through and kind of think about, almost like brainstorming you know.... Giving people the opportunity to talk through their case or talk through what they are doing with everybody (I2)_

... because you do get the same sorts of things that come around all the time, and people do ask what should I do and it is good to say well I did this last time. But just speaking to others about the different sorts of risk (I2)

This theme outlines different elements involved for therapists in discharge planning. Participants reported experiencing fluctuating pressure to discharge patients quickly in response to the hospitals need for beds. They felt that the multi-disciplinary team often provided them with support, particularly in the discharge of more risky or complex patients. However, they also reported disagreements with members of the team about what is risky and what isn’t. A valuable resource for occupational therapists working with risky discharges was supervision and informal peer support to utilise others experiences. Given the thoughts of these therapists that risk is a part of the occupational therapy role, further exploration of the ideas around support for this will be outlined in the next chapter.

**Patients, families and risk**

There was a consensus in both groups and interviews that the ideal occupational therapists hold is that the patient, at the centre of practice is the person who makes decisions about how much risk they are prepared to take. This ideal process of decision making involves the therapist recognising their patient’s values and beliefs, their
individual circumstances and offers therapy input to support the patient with these in mind.

Marjorie: “very much individually based on the presentation of the case”

Claire: “as soon as you start making generalisations you get it wrong” (FG1)

And it is ultimately their choice (FG1, Marjorie)

Again, it is just making sure that they know that they are quite aware of all the risks and that you just put everything in place that you can and at the end of the day it is peoples’ call” (I2)

If they are able to get help appropriately, then to me yes, there is a risk, but that is really coming down to personal choice and values and what that person wants (FG1, Claire)

Part of me thought he was so motivated and so determined to get home, his wife really wanted him home... and I thought we just have to give it a go. We have to honour his wishes (FG1, Megan)

As discussed earlier in this chapter, throughout the whole of the data collection there was the understanding that risk exists, and that life in general is risky. Therapists in both groups identified that completely eliminating all risk would result in reduced quality of life, linking closely to the idea that their work needs to address what is important to the patient.

Giving the people the opportunities to take risks and I guess it is almost empowering for some people to take risks, so you are actually giving that person something back by allowing them to take the risk” (I1)

Elise: “Better quality of life, with a bit of risk”

Katie: “Exactly, yeah” (FG2)

She just wants to stay at home and enjoy her environment and be as independent as she can be, and she still gets down and scrubs the floor. She’s not supposed to, so there’s always this risk in sending her home,
and probably everyone knows she’s probably going to be back soon, but sending her to a rest home won’t solve the situation (FG2, Julie)

I think you have got to let patients take the risk, that’s the big thing, because it is a quality of life and that is why we do our home visits and day leave and all that stuff, because you are exposing them to those risks a little bit every time and we do that. (I2)

The participants talked about managing risks in terms of minimising them, having come to a consensus that completely eliminating risk was not what they were aiming for as occupational therapists. Minimising risk for the patient generally seemed to involve supports in the home or devices such as a medical alarm.

Cathy: “And I guess there are ways to manage it to, if she had a personal alarm she could push a button and the ambulance will be there in 5mins you know”

Katie: “It’s minimising them”

Julie: “Yeah, exactly, and she gets like 4 carers a day” (FG 2)

Participants of both groups and the interviews identified that the values and beliefs of the patient were important to them, and that by minimising risks too much, or giving the patient no choice they would be negatively affecting their quality of life. This idea will be explored in further detail in the next chapter.

Alongside the ideal of supporting a patient’s autonomy, there was a lot of discussion around the idea that difficulties presented themselves when there were other factors impacting on the patient’s ability to be fully involved, such as cognitive impairment or when the patient chooses not to participate in therapy.

I think it’s often patients with dementia, because they haven’t got that insight (FG2, Julie)

When they can’t participate or they choose not to participate, it is a huge risk (FG1, Paula)

If someone is unable to get help appropriately, if they are going to be lying on the ground for hours forgetting and not using a pendant alarm, then that changes the risk for me. You start to add in lots of other risks, like incontinence, pressure areas, long lies, all the risk factors that come
Within the discussion about factors that impact on risk with patients, was the idea that risk is multi-faceted, with factors like cognition not only impacting on patients’ ability to participate in therapy, but on risk.

*Risk is such a holistic thing... We are looking at all that stuff and not just one thing in isolation (FG2, Katie)*

*Because most of the research around falls is saying it’s a multi-faceted issue, so you’ve got your muscles and your bone weaknesses, and you potentially might also have your cognition, and you’ve got anxiety and the home environment and things like that so it makes sense that risk in general will be multi-faceted (FG2, Rebecca)*

The important part that families play in supporting older adults to age in community is discussed earlier in this thesis, and was specifically mentioned in the focus groups. The participants acknowledged the importance of support, however this topic sparked different avenues of conversation within both groups.

*I think the families are a huge influence on the amount of risk that we take in sending somebody home. I think they influence it, support is always a factor (I2)*

*Families, that helps me handle the risk for somebody to be discharged as I said before with the family on board (I2)*

This family involvement can not only be a positive support in the discharge planning process, but also a negative. Therapists described families who wanted the patient to be discharged to a rest home as they believed the risks in discharge home (often alone) were too great and outweighed the potential value.

*Julie: “There was a lot of pressure from her [the patients] family, her son was very concerned because she lived alone... even though she had a lot of supports like her friends and her carers... she really wanted to go home, but the more her son spoke to her the more she got anxious and she said ‘oh I don’t want to burden my family”*
Katie: “You hear that situation a lot... I want to go home but I don’t want to be a burden on my family... the family do influence that (FG2)

On the other side of this, one participant in particular raised experiences of families who were supportive of the patient being discharged home, but with limited understanding of what the concerns were, potentially creating more risk for all involved.

You have the opposite of that when you have families that say go into a rest home, but then you have the families who take the patients home that are a huge risk and they just don’t have an understanding of how much of a risk they are, so say, ‘we’ll take Mum home, she’ll be fine’... their understanding of risk is completely different (FG2, Katie)

Sharing knowledge

When talking about preparing patients for discharge the term "minimising the risk" frequently came up. The most common ways discussed for management of the difficult situations with families described above was clear communication and provision of education to patients and families. This included increasing awareness about the establishment of community supports such as personal carers or medical alarms.

...communicating with the patient, communicating with the family throughout your interactions with them, why you are doing it and how you are going to manage it if something does go wrong (I1)

Talking through clinical reasoning and things like that and kind of sharing of information and knowledge... when you are communicating with a patient or a patient’s family you are giving them your knowledge (I1)

Getting them to a level where they are safe as we can get them and then that education about the risk and then support around it for family and carers (I2)

Therapists seemed to be indicating that families frequently expressed concerns about the level of risk for their loved one, and often wanted to completely eliminate risk.

Minimise, minimise is always a good one and I always say that to patients and their families. You know, we are not going to be able to
totally eliminate the risk of you falling. Families always get worried about falling, so I always put it that we can minimise the risk, in terms of environment, support and that” (FG1, Paula)

I think when you are talking with respect to family, they are concerned about risk. A good explanation, good reasoning, good evidence in terms of what we have done to help minimise risk and giving that communication with the patient and the family is really important (FG1, Paula)

An idea that came out of discussion around families in focus group 2 was that potentially the barriers from families to discharge people home came from fear for the patient, and a differing opinion from the patient or family about the risk. It was suggested that this fear came from limited knowledge or experiences.

That’s it, it’s just that everyone has a different opinion of what is risky and what’s not (FG2, Katie)

With a lot of the risk and fear is around unfamiliarity as well isn’t it? (FG2, Rebecca)

First of all you want to clarify what the fear is... why can’t she [the patient] go home? (FG1, Claire)

So they need to build their own knowledge to be comfortable with the risk you are putting them in (I1)

The participants in focus group one also discussed that there is often the expectation from families for the therapist to take control and enforce recommendations, and often education is required for families and carers about the rights of the patient to make informed decisions.

There is a common theme I find where the children of an older person want to make them do something, like make mum do this, or make dad do that... People are sometimes shocked that you even want to support the patient to do what they want to do and that their personal autonomy actually overrides what the son or daughter wants from them, or needs them to do... We still advocate for the patient to make that decision themselves (FG1, Claire)
But, you know if someone has a falls history, you might say okay, you’re right, she might fall. We can put all these things in place to minimise the risk. Whether your Mum chooses to follow that advice and use that equipment is another thing... (FG1, Claire)

It emerged that patient autonomy was an important part of discharge planning, although there were barriers to this including the patient’s own participation and factors that might limit this such as poor cognition. Although families were often supportive of discharge home and often made this easier on the therapist, participants also identified that families who were not supportive created another barrier, both from expecting therapists to enforce recommendations and from preferring patients to be discharged into rest home care. This potential barrier to discharge will be discussed further in the discussion chapter.

Conclusion

Three primary themes were identified from two focus groups and two follow-up interviews; acknowledging risk; working with the risky discharge; and patients, families and risk. Throughout the two focus groups and two follow on interviews, it was notable that although a number of topics elicited significant conversation, there was very minimal disagreement between participants.

It was interesting that therapists identified that risk is a part of everyday life and part of occupational therapy practice. They acknowledged that as therapists, although at times they might like to, they are unable to completely eliminate risks for the patient, and moreover they simultaneously identified that they do not want to as this would have a negative impact on the patients’ quality of life. Further conflicting information was provided about how views of risk change with increased experience. It was identified that new graduates avoided risk, and took more risks at the same time, while more experienced therapists were able to take more calculated risks based on previous knowledge. When describing risk in practice they generally referred to both specific physical risk such a falls to the patient in discharge planning, and professional risk to the occupational therapist should something go wrong. Participants identified that as occupational therapists they relied on the support of peers and their own documentation to justify risks that they did take, or that the patient chose to take. Participants also felt that at times they experienced opposition from the multi-disciplinary team and that they
had pressures from the hospital to discharge patients quickly if bed numbers were high. Participants identified that occupational therapists as a profession have unique tools that allow them to consider risk from different perspectives and that risk requires a holistic view that occupational therapists are able to provide.

Participants focused heavily on the minimisation of risk through recommendations of community support such as that provided by community carers, family, friends and social organisations. They identified clearly that they work to incorporate patient autonomy into their discharge planning, but that often there were barriers such as poor cognition that prevented full patient participation. Families play an important part in support of patients for discharge, however it was identified that families also provided negative input. It was felt by participants that in part this family opposition was due to fear or limited experiences, and that education and clear communication was required to ensure families knew what was in place to minimize risks for their loved ones.

In the following chapter the key issues from these findings that will be explored in more depth include: risk taking by new graduate therapists and supports required; the impact of discharge pressures on risk taking in discharge; the impact on quality of life of attempting to eliminate risk for patients; and the involvement of families in discharge planning.
Chapter Five: Discussion

Marlin: I promised I'd never let anything happen to him.

Dory: Hmm. That's a funny thing to promise.

Marlin: What?

Dory: Well, you can't never let anything happen to him. Then nothing would ever happen to him. Not much fun for little Harpo

Finding Nemo (Stanton & Unkrich, 2003)

The aim of this research was to explore how occupational therapists understand and negotiate risk taking for the older adult patient and their families. As discussed in the methodology chapter, the research is based on a social constructionist epistemology, which views knowledge as subjective and constructed, and assumes that meaning is created as people engage in the world around them (Andrews, 2012; Grbich, 2013). Continuing from this, a central point that will be portrayed throughout this discussion is that risk is an idea that has a definition that is socially constructed, shaped by social and cultural norms with the potential to change dramatically with time and situation (Lupton & Tulloch, 2002).

During the focus groups and interviews no exploration was undertaken into a theoretical or academic definition of risk, but at the beginning of each interaction the participants were asked what they thought of when we mention the word risk. This was to assess for a common understanding prior to progressing with data collection. The therapists showed an awareness of how different individual perceptions could be at different points in the patient journey and the therapists’ careers, and relating to different aspects of discharge. Risk was described as being present in everyday activities, as having an impact on the patient and on the therapist, and as an idea that means different things to different people. It is therefore appropriate that further findings and recommendations be discussed with an awareness of the social construction of risk as a foundational point.

Alongside this foundation is a key finding, explored further below, that occupational therapists recognise that risk is a part of everyday life, and as a result believe that risk is a fundamental part of occupational therapy practice.
“We are about enabling people to do meaningful occupations... there is an element of risk in doing tasks, in doing things. That is what life is all about”
(FG1, Marjorie)

This chapter will draw on the research findings presented in the last chapter and relevant literature to examine how occupational therapists understand and work with risk. Recognising that risk is a fundamental part of occupational therapy practice, this discussion will ask questions about how occupational therapists understand risk, how they learn to work with risk, and what impact it has on discharge from hospital for older adult patients and their families. When faced with making decisions, the way therapists work with and understand risk is viewed as an underpinning foundation that informs clinical reasoning. Recommendations and implications for practice are made at the end of the chapter.

Life is risky/occupations are risky

That risk is an inescapable part of life and the day to day activities we choose was a key finding from this research which needs to be explored before any other topics can be considered. Participants in the focus groups and interviews reflected on the perception that although life is risky, to do nothing is also risky. In doing nothing risk is created – for example a participant identified the uncertainty when assisting a new patient to get up out of bed. There is a risk that the patient may fluctuate in their abilities following illness and could fall or experience a medical problem; it therefore could be decided that leaving the patient in bed is much safer, for the therapist and for the patient. However, by doing nothing this patient now has the risk of further reduction in strength and function, the risk of pressure areas, of chest infection and the risk in general of not regaining the functional abilities they need.

“...if we didn’t take risks half our patients would still be in AT&R” (FG2, Katie)

Similarly, this research also identified that occupational therapists acknowledge the necessity of taking risks to progress or discharge patients. In the same way that to do nothing can create risks for the patient, completing only therapy that is entirely safe will not assist patients to progress in a timely manner or to quickly and safely leave hospital. These considerations of risk as an everyday, necessary part of life have ongoing
implications for the role of occupational therapy that the participants were very clear about.

The notion that occupational therapists engage with risk in various ways as part of professional practice has been thoroughly addressed in the literature (Atwal et al., 2011; Huby et al., 2004; Moats, 2006, 2007; Reich et al., 1998). Of particular relevance to this study is the work done by Moats (2006, 2007) wherein the competing issues of safety and client autonomy are identified. Although her findings do not extend to the location of risk as an inherent and necessary part of occupational therapy practice, she nonetheless acknowledges that risk can appear differently depending on the time and context of the patient and therapist. This current study extends Moats’ findings with the emergent concept of risk being present in some way regardless of the actions a therapist may take. This study asserts that recognising the presence of risk and its dynamic, context bound nature is an essential part of occupational therapy practice.

**The impact on quality of life in attempting to eliminate risk for patients**

“Life is risky” (FG1, Claire)

The findings of this research indicated that along with awareness that risk and managing risk is a fundamental part of the occupational therapy role, attempting to completely eliminate all risk for patients is not only impossible, but will have a negative impact on patients’ quality of life. Clarke (2009), who has written on the subject of risk for older people with dementia, discusses this clearly in an editorial. She states that “removing risk results in removing also components of life that are valued and so compromises quality of life.” (p. 299). She contends that with the risk averse approach of health service providers, moving beyond the idea of removing all risk is challenging in health provision, although she does not offer any recommendations to address this issue. Although older people in New Zealand (65+) are higher users of healthcare resources than any other age group, it is important to be aware that ageing does not necessarily go hand in hand with frailty or chronic disease, and that ongoing participation in activities can have a positive impact on their mental, social and physical well-being (Wilcock, 2007). The nature of occupational therapy practice in acute care may heavily focus on safety post-discharge (Blaga & Robertson, 2008), however this research showed that occupational therapists believe that a focus on safety and minimising risk by reducing activities of daily living can have a negative impact on the
patient. Further research into the patients’ and families’ perspectives is needed to confirm this finding.

**Social construction of positive and negative risk taking**

This research has highlighted the differences in how risk can be constructed by patients, families, and occupational therapists. These differences extend to include the timing of assessing for risk, and the experiences, knowledge, and priorities of the person who is defining the risk. It is important to note that what is central to the patient who is being discharged may not be what is considered “safest” by the multi-disciplinary team (Clarke, 2000). Health professionals may place an emphasis on keeping the patient physically safe by reducing the risk of falling or minimising the risks associated with symptoms of a medical condition, while patients may well be considering risks such as the loss of meaningful activities and roles, or a meaningful place.

One participant illustrated this well, describing her input with an older patient who was admitted to hospital with seizures. The patient was at high risk of falls, and needed to use equipment such as walking aids to minimise this risk. It was very important to her patient, however, to maintain a tidy home as she had all her life, and a clean kitchen floor was a big part of this. The risk constructed by the occupational therapist working in an acute medical environment was the high level of physical risk associated with the difficulty of cleaning a floor while following the recommendation of using a walking frame, and the possible adverse events such as fracturing a hip falling onto the floor. The risk constructed by the patient however, was not being able to independently keep her house to her own high standards; a loss of part of her identity. We can extend this to include timing in the overall context; when the patient is medically unwell and not at her usual level of function the act of cleaning the floors becomes much riskier than two months earlier, when she was well and at her usual level of function. When applying an experiential lens to the therapist’s risk assessment, other more experienced participants noted that they would have categorized falls as the lesser risk, as long as the patient was carefully prepared to manage her floor cleaning and provided with additional support and resources to achieve her goals. If this scenario is viewed through the lens of outdoor adventure (Haddock, 1993), the more experienced therapists would be mitigating the highest or absolute risk though education and resourcing, in order to meet the patient’s need. Within this framework the patient herself appeared to have identified a relatively low perceived risk associated with the cleaning activity.
Earlier in this thesis the notion of risk as something positive was raised. Outdoor adventure literature was drawn on, where risk is used as a tool to enhance experience and promote personal growth. A specific idea stated was that if risk involves the potential to lose something of value, then there must also be the potential to gain something (Haddock, 1993). Although the therapists in this study clearly stated that risk was a part of their job, that to do nothing was to create more risk and that risk taking in the right way can be used to progress patients, the overall connotation was that risk is negative and is to be avoided. While risk was identified as a patient’s choice and therapists reported not wanting to eliminate all risk for the patient, the stories that even the more experienced therapists told about failed discharges and the worry over patients strongly suggests that their construction of risk is a negative one with negative implications. From the sociology literature, Lupton and Tulloch (2002) report that avoiding risk is often described as rational behavior, while risk taking is represented as “irrational or stemming from lack of knowledge or faulty perception” (p 114). It could therefore be concluded that there is nothing wrong with avoiding risk and viewing risk as negative. However, if the novice occupational therapist in the practice story described above was encouraged to think of her patient cleaning the kitchen floors as a positive risk, as having a positive impact on other areas of the patient’s life, and simply as valued by the patient and not related to faulty perception, would it have been easier for her to problem solve with the patient and be a part of making this meaningful occupation more accessible?

There is potential for occupational therapists working with older adults in discharge situations to consider not only what the potential losses for the patient may be, but to incorporate a more positive view of risk and consider what the potential gains might be. Atwal et al. (2011) noted that positive risk taking needs to occur in practice, however made no reference to positive risk taking in the article’s findings or discussion. Neither Atwal et al. (2011) nor Clarke (2000) referenced above, made recommendations for how to change views of risk. This research suggests that to be able to view risk as something with the potential to provide gains for patients, occupational therapists need to recognise more explicitly that they have their own view of risk, informed by their work culture, their background and experiences. Importantly, this recognition should build on an awareness that their view of risk is different to the risk constructed by the
patient, and that theirs is not necessarily the expert view and the patient’s is not necessarily irrational or based on faulty perception.

**Learning to work with risk**

The findings from this research highlighted that occupational therapists have different perspectives on risk taking during different moments in their career. In particular the participants reported taking both less and more risks as new graduates in their first year of clinical practice. The less experienced therapists reported that they are less willing to take risks when discharging patients and that they ‘played it safe’. One participant in particular described herself as naïve when as a new graduate she would attempt to eliminate all risk for her patients. In apparent contrast to this, the more experienced therapists reported making choices as new graduates that they never would with the additional experiences they have now. Several participants characterised this as ‘unintentional risk taking’. One possible explanation of this apparent dichotomy of more and less risk is that new graduate or early career therapists simply do not have the experience to recognise certain types of risk. This is not well addressed in the occupational therapy literature, where research into risk taking is generally subsumed into the subject area of practice errors.

Research looking into the practice errors of occupational therapists have found that lack of experience and lack of knowledge are two of the top five causes of errors (Lohman, Scheirton, Mu, Cochran, & Kunzweiler, 2008; K Mu, Lohman, & Scheirton, 2006). Both of these causes of practice errors are true for the new graduate therapists who participated in this study, with one participant recounting an incident where her lack of experience together with lack of knowledge regarding a medical condition resulted in a ‘near miss’\(^1\) with an older patient. Also congruent with reports from participants in this research, Mu et al (2006) state that following practice errors therapists become more vigilant and modify their future practice to prevent errors from re-occurring. This modification following an experience is a valuable part of therapists’ construction of risk. This research also found that therapists provide support to their peers through the use of formal supervision and informal discussion, feeling that sharing knowledge can

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\(^1\) Near-miss is defined as an unplanned event that did not result in injury, illness or damage – but had the potential to do so. [http://en.wikipedia.org/wiki/Near_miss_%28safety%29](http://en.wikipedia.org/wiki/Near_miss_%28safety%29)
help to alleviate concerns or worries and increase the confidence of less experienced therapists to take risks or help their patients to take risk.

“... because you so get the same sorts of things that come around all the time.... It is good to say “well I did this last time” (I2)

The combination of a modifying practice experience and discussions with peers, whether formally or informally, is a powerful demonstration of the process of the social construction of risk, culminating in a change in perception for the therapist.

This study, combined with the literature, suggests that there is a gap in professional knowledge around the risk-taking behaviours of new and early career therapists. When taking into account the complexities of discharge planning established in previous chapters in conjunction with unintentional risk taking, it is not unreasonable to question the appropriateness of new graduates working alone in fast paced acute practice settings.

Sharing knowledge, peer support, and the impact this potentially has on risk construction will be explored in more detail later in this discussion in relation to families.

The impact of discharge pressures on risk taking

As a profession, occupational therapists in acute settings are experiencing increasing pressure to discharge patients quickly (Crennan & MacRae, 2010; Welch & Lowes, 2005). Unsurprisingly, an Australian study found that the most valued attributes for occupational therapists working within the cost containment setting of acute care were time management skills, and the ability to make quick clinical decisions (Griffin & McConnell, 2001). The participants in this current research identified that this is particularly true when the hospital is experiencing high numbers of admissions. This increased pressure in turn has an impact on the amount of risk they and their patients are expected to take. The participants stated that at times when beds are full they are expected to discharge patients home, when perhaps at a different time when the hospital wasn’t so full the patient would have been given more time as an inpatient to recover from illness and the subsequent functional implications. This need to empty beds for more admissions leaves occupational therapists either taking more risks with patients than they usually would at quieter times, or having to advocate for the patient to remain in hospital, sometimes against other members of the multi-disciplinary team.
“When you’re working with an MDT... and someone saying to you “this person has got to go”... you can probably find yourself being railroaded into something” (FG2, Katie)

These findings have clear implications for therapists’ construction of risk, adding further external factors that are related to the time of the assessment and which fluctuate with the demands of an acute hospital system. Additional concerns include how less experienced therapists manage changes to the expectations on them, taking into account the discussion on practice errors and further highlighting the lack of evidence based knowledge about the risk-taking behaviours of new graduate therapists.

The conclusion arising from this is that therapists working in acute settings need to have the skills to respond in a consistent way to fluctuating pressure, ensuring that their practice doesn’t change unnecessarily, or in a way that is unsafe for their older adult patients.

**The influence of family in discharge planning**

Participants in this study agreed that family support makes discharge easier and has a positive influence on their perceptions of the overall risks faced by their patients. This is not a new idea, and is well supported in literature, with a general awareness that family caregivers play a role in making decisions about discharge and play an increasing part in post discharge care (Bauer et al., 2009; Bull, Hansen, & Gross, 2000). It is generally acknowledged in the literature that increasing numbers of early discharges for older people have resulted in a significant burden of care for family members, as patients may be perceived as being medically stable for discharge home, but may still be struggling with fatigue and reduced functional ability while recovering from serious illness (Coffey & McCarthy, 2012).

While acknowledging that families are an important part of enabling the discharge of older patients, the participants of this study felt more strongly that in their experiences families create difficulties for therapists planning discharge. Examples included families wanting patients to be discharged into rest home care against the patients’ wishes, supporting discharge home with a limited understanding of the associated risks, or expecting therapists to somehow enforce the family’s recommendations. Despite a high level of agreement among the participants and the topic eliciting significant conversation, the idea of families creating barriers to discharge is not well represented
in current literature, with the majority of studies focusing on the role of family in supporting discharge. Bauer et al (2009) recommends that clinical interventions should support family inclusion and education. They address the subject of communication with families, however acknowledge that despite good communication from therapists, families still often reject discharge plans, blaming this on lack of information. Bauer and colleagues’ findings are consistent with the results of this research, in which participants identified sharing knowledge and communication with families as important. These participants reported that they are communicating well with their patient’s families, but the families are still creating barriers, seemingly unnecessarily. However it is important to note that all the discussion and descriptions about communication depicted one-way communication only, from the therapist to the family, rather than being inclusive of communication flowing the other way, from the family to the therapist. The therapists apparently perceived the concerns of the families as barriers, although this was not overtly discussed in the focus groups.

The participants did suggest that concerns and barriers from families about patients being discharged home potentially arose from fear of adverse events and limited knowledge of the physical and emotional needs of the patient. The therapists felt that families were limited in their understanding of both how identified risks were being managed, and the responsibility of the therapist to uphold the autonomy of the patient themselves.

The social construction of risk in focus here is that of the patients’ family and caregivers. Therapists acknowledged, in their words, that everyone has a different opinion of what is risky and what is not, however they still appeared to view themselves as the experts, and agreed that sharing their knowledge was important to reducing barriers to discharge. This quote from one of the interviews illustrates well the subtle expert vs. layperson culture, where risk is something that the therapist is ‘allowing’.

“Giving the people the opportunities to take risks and I guess it is almost empowering for some people to take risks, so you are actually giving that person something back by allowing them to take the risk” (II)
Lupton and Tulloch (2002) are referenced earlier in this discussion, reporting that risk-taking behaviour is represented in literature as stemming from lack of knowledge. In this situation, families being risk averse has been linked by research participants with lack of knowledge, suggesting that potentially it is any disagreement with the ‘expert’ that is related to irrational behaviour. Slovic (1999) discusses risk as a social construction, making specific mention to the terms ‘expert’ and ‘layperson’ and stating that “whoever controls the definition of risk, controls the rational solution to the problem at hand (p. 689)”. Occupational therapy as a profession is proud of the underpinning philosophy of client-centred practice (Whalley Hammell, 2013), which that was touched on briefly in the literature review. When considering risk within a client-centred practice context the implication is that occupational therapists are putting their patients, as experts, in the centre of their practice. However, this does not in turn acknowledge the occupational therapist as the layperson in the patients’ construction. Whalley Hammell (2013) offer a recent critical reflection of client-centred practice that appears to fit well within a discussion of expert and layperson. This author points out that for a profession that values client-centred practice, remarkably little research has been done that seeks out the clients’ view of this practice. Looking into the research that has been done, she reports back that clients identify client-centred practice as that which aims to “seek and respect clients’ experience and knowledge” (p. 175). This is pertinent to this research, where to gain an understanding of families’ construction of risk, therapists need to recognise that it is not only our knowledge that we are sharing that is vital, but the knowledge that the patient and the family have to share with us. This knowledge includes the details about their home, their roles, their previous experiences of hospital admissions, how the patient deals with illness and importantly, their construction of potential adverse events.

Participants of this study identified that one of the best ways of dealing with different understandings of risk was for therapists to share their knowledge. This research in combination with literature about risk suggests that sharing our knowledge about discharge planning and resources available is important, but that being aware of how a patient and their family has constructed risk and what knowledge they have to share is equally important. This awareness could potentially open communication that will reduce the barriers that the participants identified as coming from families.
Several questions have arisen from the research findings and discussion above relating to how occupational therapists understand and negotiate risk taking in discharge planning with older adults and their families. Pertinent questions include how to support new graduate therapists who may be taking unintentional risks working in the complex area of discharge planning with older adults, how therapists can take a more positive stance on risk taking, and how we can communicate successfully with patients and their families about their views of risk.

**Implications for practice: a practical exposition**

This thesis is located within the clinical reasoning process as it considers what beliefs occupational therapists have about risk that inform their reasoning, and how they negotiate it in their practice. This knowledge is fundamental to understanding how occupational therapists engage with clinical reasoning around risk. This section aims to take the recommendations made and use a theoretical scenario to apply them to occupational therapy practice. A practice story from one of the focus group participants has been used above. Elements of this story will be used again here to demonstrate how occupational therapy input might look based on a particular social construction of risk.

For the purposes of this scenario I will make this therapist a very new graduate in her first six months of practice, and her patient an older woman admitted after pressing her medical alarm following her 3rd fall in two days, who was subsequently diagnosed with a urinary tract infection. This older patient was assessed as being at high risk of falls during her 4 day admission for IV antibiotics, therefore it was recommended by the ward physiotherapist that she should use a walking frame to minimize this risk. The occupational therapist received a referral because this patient was refusing a package of care that other members of the MDT felt she needed. While the patient was happy to use the frame most of the time, it was very important to her to maintain a tidy home as she had all her life, and a clean kitchen floor was a big part of this. She had tried having home help in the past, however didn’t feel they did a good enough job and did not particularly want the additional help again.

The new graduate therapist became involved on the second day of admission. Within her various assessments she explored the roles of the patient and discovered that she had lived in the same home for over 60 years. The kitchen designed for her by her late husband was the hub of her home and was where she felt her children always came
back to. The therapist acknowledged how important maintaining her home was to her patients’ identity, however her input following assessments centred around education for her patient on the risks of falls and serious injury if she chose not to use her walking frame and tried to independently clean her kitchen floor. Using the previous experiences and knowledge she had, the therapist prioritized removing the risks associated with cleaning the kitchen floor by strongly recommending that the patient trial home help again.

If we then substitute this new graduate therapist with a senior therapist who has years of experience in acute care, the input provided changes. This senior therapist came into her interactions with the patient already taking into account that the patient did not want a package of care. She made the same exploration into the roles and values of the patient, but also took into account the patients’ construction of risk. Prior to her illness she had had only one fall a year ago with no hospital admission required, and felt that when she was well again falls would not be an issue. They delved into the patients’ routines further, and discussed that she would usually mop the floor once a week, sweeping as needed. The senior occupational therapist postulated that this chore may not be needed this week as no one had been in the house, that the patient was recovering quickly from an acute medical illness rather than a long term condition, and wondered if perhaps a family member would be able to help the patient lift the kitchen chairs and be present initially while the patient cleaned. She provided education on the causes of falls and suggested the patient take into account factors such as fatigue, particularly following her illness. She provided the contact numbers for the provider who could assist with an assessment for home help, should the patient not recover as expected and change her mind. This therapists’ construction of risk involved greater knowledge of medical conditions and more experiences in discharge planning, therefore allowing her to participate in problem solving with the patients’ construction of risk in mind. She was able to acknowledge the patient as the expert, and therefore that the risk and the potential impacts of the risk of falling was not as important as the potential impact of not being able to return to her roles and routine.

Changes to this scenario could also be made in the context of time, with the new graduate therapist seeing the patient on the last day of her admission, following four days of medical treatment rather than day two. It is very possible that with this additional time for the patients’ infection to resolve she would have less reliance on the
walking frame and would perform differently in functional assessments. Additional experiences that could contribute to a change in the new graduate’s construction of risk could include her own grandmother being very fit and active, with strong feelings about maintaining independence, or the opposite – a frail grandmother who had numerous falls resulting in serious injury.

With a greater understanding of risk and how it can be socially constructed, there is potential for the new graduate therapist in this scenario to become aware of the impact that her construction can have on her clinical reasoning in practice. In the scenario above she has missed the positive impact that maintaining a valued activity can have for a patient. With support from more experienced clinicians to reflect and make these leaps in thinking, the new graduate therapist can more actively take into consideration the construction of risk that the patient is presenting.

**Recommendations**

Risk, both positive and negative, is a fundamental part of occupational therapy. By overtly acknowledging this in occupational therapy foundations as ‘just is’ rather than something we need to change, reduce, minimize or view in a certain light there are a number of potential benefits. Unsurprisingly, given the epistemological underpinning outlined early on and followed throughout this thesis, key recommendations addressing many of the above questions will also follow a social constructionist viewpoint. The body of literature specific to risk rather than to healthcare recognises the difficulty in defining risk, and the effects that culture, time, experiences and knowledge all have. This research therefore recommends the purposeful adoption of a social constructionist view of risk into occupational therapy language and knowledge. Specific recommendations for different contexts are elucidated below to begin answering some of the questions arising from this research. The implications of this research for clinical practice also follow.

**We are all experts**

By accepting and taking on board the notion of risk as socially constructed, we can take ownership of our own risk construction and acknowledge that of the people around us, including patients and their families. This leads to the possibility of eliminating the concept of expert and layperson in a way that does not involve sharing of power, the act of which naturally assumes an unequal relationship. Everyone is an expert within their
own construction of risk. This can include the new graduate therapist who may not have the same extensive knowledge of a long term condition that the older person living with it does, but whose construction of risk includes how current discharge pressures may impact on their discharge plans. It can also include the older adult patient who has had frequent hospital admissions and knows what kind of supports they need to manage safely at home while recovering. In this way the expertise of families can also be genuinely acknowledged by recognizing that the family has also constructed their own concept of risk based on their expertise, which may include the understandable desire to protect their loved one from harm.

Recommendation 1: Engage in dialogue that elicits expertise of junior therapists, families and patients when engaging in discharge planning

*Risk construction is relative to time, place, and person*

Occupational therapists need to be thinking and reflecting not only about our own, personal and professional construction of risk, but acknowledging it as fluid and changing with each new experience, each opportunity for professional development, each successful or unsuccessful discharge of a complex patient or even an informal conversation in the office.

There are numerous suggestions that new graduate or early career therapists require support when working in acute care, particularly with older adults who can present with complex discharge needs (Atwal et al., 2011; Keli Mu et al., 2011; Nayar et al., 2013). The increased risk taking in response to discharge pressures, in conjunction with the increasing complexity of balancing patient and family needs suggests that as a profession, we do need to look more into the types of supports that are offered and available to junior therapists. There is the potential to suggest here that acute care is not the best place for less experienced therapists to be working, however, changing an area of practice does not necessarily lead to better identification of risk or fewer practice errors. Instead, we can support less experienced therapists by encouraging them to become aware of and develop their own social construction of risk and to recognise the impact of its construction on others. Participants in this research already appeared to acknowledge how sharing of experiences, either informally or formally in supervision can impact on new graduate therapists’ confidence.
Recommendation 2: Support junior and new graduate therapists to articulate their own construction of risk and to recognise the impact it can have on others

*Discussions about risk can open possibilities*

It has been suggested in risk literature, again outside of healthcare, that explicit reference to risk acknowledges it as a legitimate, important topic and allows others to voice their thoughts (Henwood et al., 2008). If, as a profession, we have an established base from which to talk about risk between ourselves, with colleagues, or with patients and their families, we also give ourselves a chance of discussing the positive aspects of risk. By using a social construction view of risk we are not trying to define risks as negative or positive, but to understand them from the wider context of the patient, their family, our own professional perspective, and the culture of the organisation in which care is being provided. A new graduate therapist may have every reason to view discharge in certain circumstances as risky and likely to result in an adverse event occurring if they have had this experience before. This narrative style of communication is recommended within literature that incorporates the changes in information processing over a persons’ lifespan, and acknowledges that avoiding portraying risk in purely factual terms may assist older adults in making informed decisions (Finucane, 2008). By encouraging a dialogue about what has informed their construction of risk, and sharing good experiences, not just negative ones we could be taking the first steps to thinking about risk in a different way.

Recommendation 3: Open a professional dialogue about how risk is constructed and its positive and negative aspects within the occupational therapy practice and education literature

*Further research*

This research should be replicated within larger or different occupational therapy groups. This will allow findings to be applied to other occupational therapy practices and potentially other patient age groups. The participants of this research were coincidentally all of New Zealand European ethnicity. It is therefore important to reproduce this research with other ethnicities. With ethnicity in mind, worth further research is also addressing the question of whether therapists have different experiences in managing risk for those from other cultures, including Maori and Pacific Island.
Identified within this project was the lack of information available on the risk-taking behaviours of new graduate or early career therapists. The recommendations above strongly suggest that specific research into new graduate therapists working with complex and fast discharges from hospital with a range of patients would be valuable.

A final gap in literature that is deserving of further research is the view and opinions of older patients and their families about the risks around discharge planning. It would be particularly valuable and would add not only to this research but to a rapidly expanding area of occupational therapy practice to explore the thoughts of older adults on risk avoidance, and the potential impact on their quality of life.

**Limitations of the study**

Qualitative research does not aim to make generalizations about large populations, but to explore how individuals understand a phenomena (Creswell, 2007). Within this study, although the sample size was appropriate and the aim was not to generalise findings across occupational therapy as a whole, all participants were sourced from one hospital setting within a DHB. This offers limitations in fully assessing the perspectives of risk as the occupational therapy culture may differ in other acute areas throughout New Zealand. It also results in limitations in terms of the small study size and subsequently a smaller research report.

The position of the researcher as an occupational therapist and part of the DHB within which participants were sourced from has been clearly identified throughout the research process. It offers many potential benefits, which have been discussed above, however also lends some potential bias to the research that is acknowledged. My own experiences and interest leading to the formulation of this question also provided a bias in the direction for the focus groups and subsequent interviews.

**Conclusion**

This chapter has explored the research findings in greater depth, particularly in relation to understanding the consequences of risk as a social construction. The implications for practice were presented as an exposition in order to clearly demonstrate the potential for changes to occupational therapy practice. Recommendations were also provided including the acknowledgement of patients and families as experts, and the importance of recognizing and reflecting on risk construction related to different contexts. The following chapter provides a summary of the research, concluding this thesis.
Chapter Six: Conclusion

This research aimed to explore how occupational therapists understand and negotiate risk taking in discharge planning with the older adult and their family. The research question was prompted by my clinical experiences both in adventure therapy, where risk was something positive and sought after, and acute care, where risk is often avoided as much as possible and patient safety is paramount. The ageing population of New Zealand is well recognised, as is the impact that this is expected to have on health care services. This, combined with my own experiences of the complexity of discharge planning for older adults, the similar experiences and concern shared by my colleagues and the limited research into how occupational therapists understand and manage risk illustrated that the area of risk was one deserving of research attention. Many studies addressing risk focus heavily on the decision making process involved in discharge planning, while numerous articles addressing definitions of risk clearly conclude that risk is a very complex idea, whose definition is dependent on the knowledge and experiences of the person defining it. This thesis is therefore positioned within clinical reasoning, by aiming to explore how occupational therapists understand risk in the contexts of their older patients and discharge planning. This foundational understanding is essential before considering the decision making process itself.

A descriptive qualitative methodology was used, with special mention of the influences of focus group methodology, positioned within the framework of a social constructionist epistemology. The assumptions that knowledge is subjective and constructed, and meaning is created as people engage in the world around them allowed for exploration and reflection of the social interactions, conversations and experiences that shape occupational therapy practice. By using focus groups with follow-up interviews, data collection followed seamlessly from the research’s overarching framework. Focus groups not only obtain data regarding the ideas, attitudes, understandings and perceptions, but do so in a way that allows participants to develop and refine ideas through interaction with each other. Ethics approval for this research was received from the Otago Polytechnic Ethics Committee. Rigour was considered through the employment of techniques specific to qualitative research, such as member checking, peer review and transparency. My position as an occupational therapist working within the same DHB as participants was clearly stated both initially to participants during recruitment and throughout this thesis, and has been recognised as
both a strength in allowing increased depth in data analysis and within the limitations of this study as a potential bias. Data analysis was completed using a recognised approach of inductive analysis, thereby alleviating some concerns around qualitative description methodology sometimes resulting in a minimalist approach to analysis.

Three primary themes were drawn out, acknowledging risk, working with the risky discharge, and patients, families and risk. These themes formed the basis of a discussion that recognised that risk is a part of everyday life and as such a part of the occupations that we choose and occupational therapy practice as a whole. The discussion questioned the concepts of expert and layperson within occupational therapy practice and outlined the suggestion that risk itself is an idea that is socially constructed. From this, the recommendation was made that occupational therapy overtly acknowledge risk as part of our practice and purposefully adopt a social constructionist understanding of risk. Support of less experienced therapists working within fast paced acute care with complex discharges would include education on this social construction, and encouragement to reflect on how experiences and knowledge, or lack of, are influencing each person’s own social construction of risk. The implications for practice notably include recognition of the patient as the outright expert within their construction of risk, thereby enhancing client-centred practice and reducing instances of the occupational therapist ‘owning’ the risk, and the view that risk is something we allow patients to take. Implications also include an increased comfort with the idea of risk, and therefore creating the potential to have open conversations with patients, families and colleagues, including, importantly, the potential gains that can be made for patients in choosing to take risk.

Mrs Smith, a real patient introduced at the beginning of this thesis, is a remarkable woman. As a group invested in ageing in community, the nurse manager of the agency providing cares and supports to people living in their own home is quite frequently involved in other discharges from my clinical practice area and is keen to keep me updated about Mrs Smith’s progress. Finishing with her story at the conclusion of this thesis serves the dual purpose of encapsulating a patients’ expertise in her own construction of risk through sheer determination to choose her own life, and illustrating for a final time how taking risk can lead to significant gains.

_Three years on from her admission to the rehabilitation ward, Mrs Smith remains happily living in her own home with her serious medical conditions, high risk of falls_
and progressive short term memory loss. While she still has her wheelchair for longer distances, she now mobilises indoors with a walking stick and down to her letterbox with a walking frame. Not only is she able to manage her own showering and personal care tasks, but taxis independently to the supermarket and does her own cooking. She has had falls at home, but jokes that her short term memory loss is a good thing, as she doesn’t remember to be afraid. The risks she determinedly faced when discharging home, particularly following her second discharge from the emergency department, seem very small in comparison to the gains she has made and quality of life she is now experiencing.

As with all research projects, this one does not end with the completion of this thesis. The findings from my research have already made a difference in my professional practice, and of those junior therapists I support and mentor. It is my hope that the dialogue I have begun in this document and among my academic and practice colleagues will continue to thrive.
References


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Appendices

Appendix 1: Ethics approval

Research Ethics Committee
Private Bag 1910
Dunedin 9054
Phone +64 3 477 3014
Fax +64 3 471 6861

2 April 2012
Tracy Murphy
Occupational Therapy
Assessment, Treatment and Rehabilitation Unit
Hastings Memorial Hospital

Dear Tracy,

Ethics 511: “How do occupational therapists understand and negotiate risk taking in discharge planning with the older adult patient and their family?

Thank you for forwarding to the ethics committee the revised consent form, and the result of your conversations with the Maori health services.

We are happy with your revised consent form, and give you permission to proceed with your research.

We are pleased that you have had useful conversations with Mr Ratapu: this process of consultation will assist you should there be issues that arise during your data collection that have particular relevance, either for therapists who identify as Maori or their concerns about clients who identify as Maori. It was not our intention that you should expand significantly the shape or focus of your research; however, neither is it appropriate for you to exclude (consciously or unconsciously) issues that relate to Maori, in research based within the New Zealand health care system. We hope that you will be alert to therapists’ issues, concerns, curiosity, observations, anxieties, ignorance, comfortableness and or competence around discharge planning for Maori, however it is raised.

We wish you well with your research and look forward to receiving your eventual report to the ethics committee

Sincerely,

Linda H Wilson
Chair - Ethics committee
Appendix 2: Hawke’s Bay District Health Board approval for research
Appendix 3: Letter of support from Maori Health Services
Appendix 4: Participant information sheet

Participant Information

Project title
How do occupational therapists understand and negotiate risk taking in discharge planning with the older adult patient and their family?

Researcher
My name is Tracy Murphy, I am a Master of Occupational Therapy student and this research is being undertaken as a part of my programme of study with the Occupational Therapy Department at Otago Polytechnic. My academic supervisor is Dr Mary Butler with Otago Polytechnic.

General introduction
Occupational therapists in New Zealand hospitals are integral to the process of assessment and subsequent recommendations for the discharge of older patients. Discharge often inherently carries risk from a range of medical conditions, impaired function and decreased reserves. These risks have to be carefully balanced with the value of home and its link with sense of identity, empowerment and control, and the fears of patient’s families. Both my own practice and discussions with other therapists has lead to the conclusion that these tensions are commonly experienced on a day to day basis regardless of experience or seniority.

This research aims to find out how we as a profession manage such potentially difficult and stressful situations; how we portray risk to our patients and their families, how we navigate the demands of clinical practicalities, and how do we aim for timely discharge and achieve a good outcome for our patients.

This study is aiming to recruit registered occupational therapists from all levels of experience and seniority working within the hospital in areas where discharge facilitation occurs.

What will my participation involve?
Those who agree to take part in this project will be asked to participate in a 1-1½ hour focus group with other members of the occupational therapy team on the xxx or xxx of February. The focus groups will be digitally recorded for transcription, which will be offered to the group for checking. The focus groups will be an opportunity to discuss with colleagues the issues associated with risk and discharge planning.

Following the focus groups I intend to complete two to four individual interviews in order to follow up key ideas in more depth. Like the focus groups these will also be digitally recorded and transcripts of these interviews will be offered for checking.

How will confidentiality and/or anonymity be protected?
During transcription of the focus groups and interviews all participants will be de-identified by issue of codenames. Within any published articles no reference will be made to identifiable information such as place of work. While I will be asking for participants to draw on their clinical experiences, no patient names or identifying information should be used.

What data or information will be collected and how will it be used?
Results of this project may be published but any data included will in no way be linked to any specific participant without prior consent. The primary use of this research will be in the production of a Masters Thesis.

You may request a copy of the results of the project. The final thesis will be available through the Bill Robertson Library.

Data Storage

The data collected will be securely stored in such a way that only the researcher and supervisor will have access to it. The electronic data will be password protected, while hard copies will be stored in a locked cabinet. At the end of the project any personal information will be destroyed and any raw data on which the results are based will be retained in secure storage for a period of five years, after which it will be destroyed.

Can participants change their minds and withdraw from the project?

You can decline to participate without any disadvantage to yourself of any kind. If you choose to participate, you can stop participating in the project at any time, without having to give any reasons. You can refuse to answer any particular question within both the focus groups and interviews, and ask for the recorder to be turned off at any stage. You can request to withdraw any information given during the interviews, however as focus groups rely on discussion, reflection and interaction between participants removal of a participants contribution following the group could potentially have an impact on the understanding and context of the rest of the transcript.

What if participants have any questions?

If you have any questions about the project, either now or in the future, please feel free to contact either:

Researcher: Tracy Murphy

Tracy.murphy@hawkesbaydhb.govt.nz
(06) 878 8109 ext 2936

Or Supervisor: Dr Mary Butler

Mary.butler@op.ac.nz
0800 762 786
Appendix 5: Focus group participant consent form
Participant Consent Form

Project Title: How do occupational therapists understand and negotiate risk taking in discharge with the older adult patient and their family?

I have read the information sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:

- My participation in the project is entirely voluntary and I am free to refuse to answer any particular question.
- I will have the opportunity to check transcripts from the focus group/interview and to make specific alterations related to accuracy.
- I can choose to withdraw from the project without giving reasons and without any disadvantage.
- I am aware that information supplied during the focus group cannot be withdrawn without significantly altering the context of information that others have provided. However, this does not effect my right to refuse to answer any question or to make specific alterations related to accuracy.
- Any raw data on which the results of the project depend will be retained in secure storage for five years after which it will be destroyed. If it is to be kept longer than five years my permission will be sought.
- The results of the project may be published and will be used in presentation to the OT team and other masters students but my anonymity / confidentiality will be preserved.
- The researcher will advise the occupational therapy team should any published data arise from the research.
- I will receive a summary of the research findings.

I agree to take part in this project under the conditions set out in the Information Sheet.

............................................................... (name of participant)
............................................................... (signature of participant)
............................................................... (date)
............................................................... (signature of researcher)

This project has been reviewed and approved by the Otago Polytechnic Research Ethics Committee.
Appendix 6: Interview participant consent form
Interview Participant Consent Form

Project Title: How do occupational therapists understand and negotiate risk taking in discharge with the older adult patient and their family?

I have read the information sheet provided prior to my participation in the focus group and that provided about the interviews. I understand what the research project is about and all my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:
- My participation in the project is entirely voluntary and I am free to refuse to answer any particular question or to stop the interview at any time without giving reasons and without any disadvantage
- I will be provided with a transcript of the interview for member checking and will have the opportunity to request changes up to 10 days after being provided with the transcript
- Any raw data on which the results of the project depend will be retained in secure storage at Otago Polytechnic for seven years, after which it will be destroyed.
- The results of the project may be published and presented at a conference, and will be used in presentation to the OT team and other Masters students but my anonymity / confidentiality will be preserved.
- The researcher will advise the occupational therapy team should any published data arise from the research.

I wish/do not wish to receive a summary of the research findings (please circle one option)

I agree to take part in this project under the conditions set out in the Information Sheet.

............................................................... (name of participant)
............................................................... (signature of participant)
............................................................... (date)
............................................................... (signature of researcher)

This project has been reviewed and approved by the Otago Polytechnic Research Ethics Committee
Appendix 7: Focus group and interview question route
Focus Group Prompts

**Broad opening questions**
What does the word 'risk' initially bring to mind? *Do you think of risk differently when you think of yourself or younger people and when you think of older people?*
Could risk be a good thing?
What does risk mean to you in terms of discharge with older adult patients?

**Transition questions**
How does the input from families impact discharge? *How do families manage risk when it comes to older members? What influences their perspective of risk?*
What impact does patient participation have on discharge and the level of risk? *What factors about the patient impact on our perception of risk?*
What level of responsibility do we have? How is risk shared amongst the team?

**Key questions**
How does the idea of potential risk for our patients make us feel?
What do we do if we think there is risk?
How do you feel you portray risk to patients?
- To their families?
- To the rest of the team?

**Semi-structured Interview Prompts**
In the focus group you mentioned.... could you tell me more about that experience/the patient/the outcome you achieved?

Have these experiences changed your clinical practice?

Is there anything in the focus groups or interview that you would have expected me to ask that I haven’t or that you would like to cover?
Appendix 8: Follow-up interview prompts
How do OTs understand and negotiate risk taking in discharge planning with the older adult patient and their family?

Interviews

“I think if we didn’t take risk half our patients would still be in AT&R”

“Therapeutic risk giving, sometimes for them to get there you’ve got to”

“If we leave her in bed, what are the risks to her function? ...we just have to try”

“It’s hard I suppose to see the person’s risk not attached to your own risk.... if they’re taking risks you’re linked to that”

“I don’t think we can ever totally eliminate risk”

The focus for this interview is on the idea that when we (OTs) discharge someone and there is an element of risk associated with the discharge, or their family or the MDT THINK there’s a risk, that there is also a risk to the OT.

• Do you think that OTs support/encourage/enable people to take risks? (One of the quotes from the focus group was about ‘therapeutic risk giving’)

• Is that a part of the role?

• What do you think of the idea that there is a risk to the OT in ‘giving risk’ or enabling/supporting someone to take a risk?

• Are OTs in general supported and expected to take risks?

• How do you handle the risk?

• How do you help others handle the risk?

• What makes handling risk easier/harder?
  o Eg MDT support, family support, personal experience with successful risk taking, personal values about how life should be lived, DHB and national policy about aging in place, professional knowledge (reads research etc.)
Appendix 9: Extract from data analysis table
<table>
<thead>
<tr>
<th>Theme or idea or concept (use descriptive language, even if it’s lengthy – we’ll tidy it up later). Use te reo with translation if that’s what was used in the data</th>
<th>Is it a primary/frequent theme, or a secondary/less frequent theme?</th>
<th>Thoughts, comments and questions that come up during analysis</th>
<th>Good quotes to illustrate the theme</th>
<th>Location in transcript</th>
</tr>
</thead>
<tbody>
<tr>
<td>You can’t eliminate risk, only work with patients to minimise it</td>
<td>Primary</td>
<td>How do we discuss this with patients and families? Do we all have the same idea of what is risky or might be risky? Do people have an expectation that we will eliminate risk before discharge? Full agreement by everyone in both groups, second group fully understood what ‘minimise risks’ meant.</td>
<td>“Minimise, I don’t think we can ever totally eliminate risk” C: “Life is risky” M: “it is, you could get run over crossing the road tomorrow, that is a risk, but we still encourage people to cross the road” “Minimise, minimise is always a good one and I always say that to patients and their families. You know, we are not going to be able to totally eliminate the risk of you falling. Families always get worried about falling, so I always put it that we can minimise the risk, in terms of environment, support and that” C: “And I guess there are ways to manage it to, if she had a personal</td>
<td>Focus group 1 Page 4 Focus group 1 Pg5 Focus group 2 Pg 15</td>
</tr>
</tbody>
</table>
alarm she could push a button and the ambulance will be there in 5mins you know” K: “It’s minimising them” D: “Yeah, exactly, and she gets like 4 carers a day”

“When I first started I would have thought more that the OT role was to eliminate the risk and that is almost a naivety. As a new grad you kind of think I am here and I can given them a shower stool and I have given them a transfer bench and they won’t step over the bath and I am going to take away all that risk and it is going to fine”

“ours is so much patient centred and is their beliefs in everything and if that person is willing to take the risk why shouldn’t we, also putting as much in place as we can to eliminate that, but I think if you accept there is always going to be a risk then you can prepare”

“everybody has risks, no matter
| We have to try – risk is an essential part of our job | Primary | There is risk everywhere in life – runs over into OT practice
OTs look at function more than just risk | “I think if we didn’t take risks half our patient’s would still be in AT&R”
“Really, the first time you stand a patient you’ve got risk”
“I think OTs all people to take risks a lot more than other systems”
“It is going to be really hard and then the other risk is if we leave her in bed | Focus group 2
Page 13
Focus group 2
Pg 13
Focus group 1
Pg 9
Focus group 1
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Appendix 10: Photos of the category refinement process