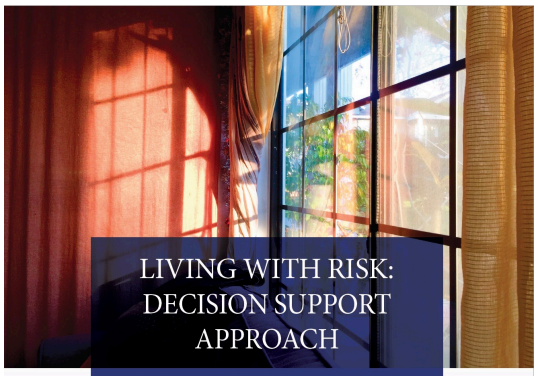

Implementation Study Launch Webinar

UDS Université de Sherbrooke

Centre de recherche sur le vieillissement Research Centre on Aging

Queen's University

CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

1

WELCOME

2

OBJECTIVES

- Brief Risk Primer
- The 4-Step Approach
- The Study Protocol

3

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LIVING WITH RISK

4

WHAT WE KNOW

- HOME is where 85% of Canadians over the age of 55 want to remain for as long as possible even if their health changes[1].
- HOME is also where the majority of older adults want to be discharged to following hospitalization[2].

5

WHAT WE KNOW... Clinicians

Define	risk negatively[3]
Define	living at risk negatively[4]
Define	living at risk differently[4]
Focus	on the negative consequences[3]
Focus	on the physical consequences[5]
Assess	risk comprehensively - 8 factors[4]

6

THE SOLUTIONS

Broaden — YOUR DEFINITIONS
- Risk
- Living at risk

Clarify — YOUR DEFINITIONS
- Risk
- Living at risk

Broaden — YOUR APPROACH
- Balanced
- Shared decision making

7

Negative → Neutral

Negative

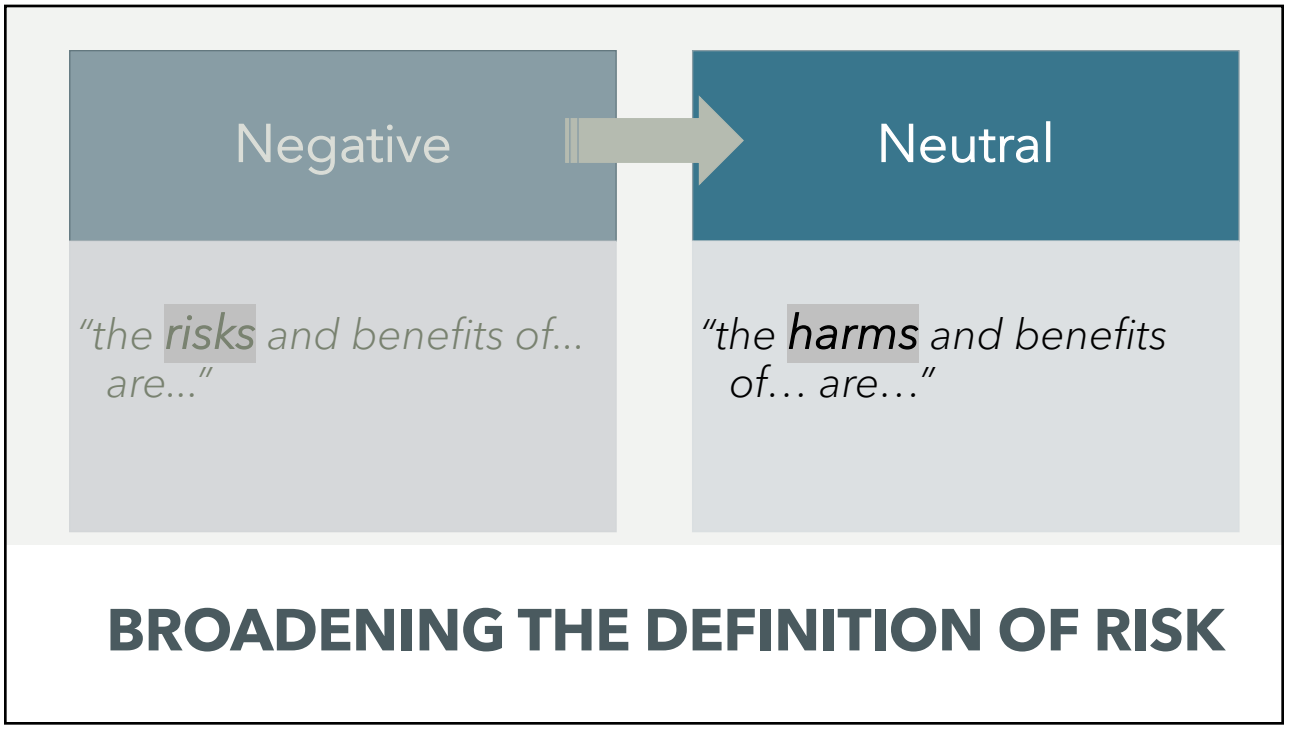
"the **possibility** that something **unpleasant** or unwelcome will happen; A situation involving **exposure to danger**" [7].

Neutral

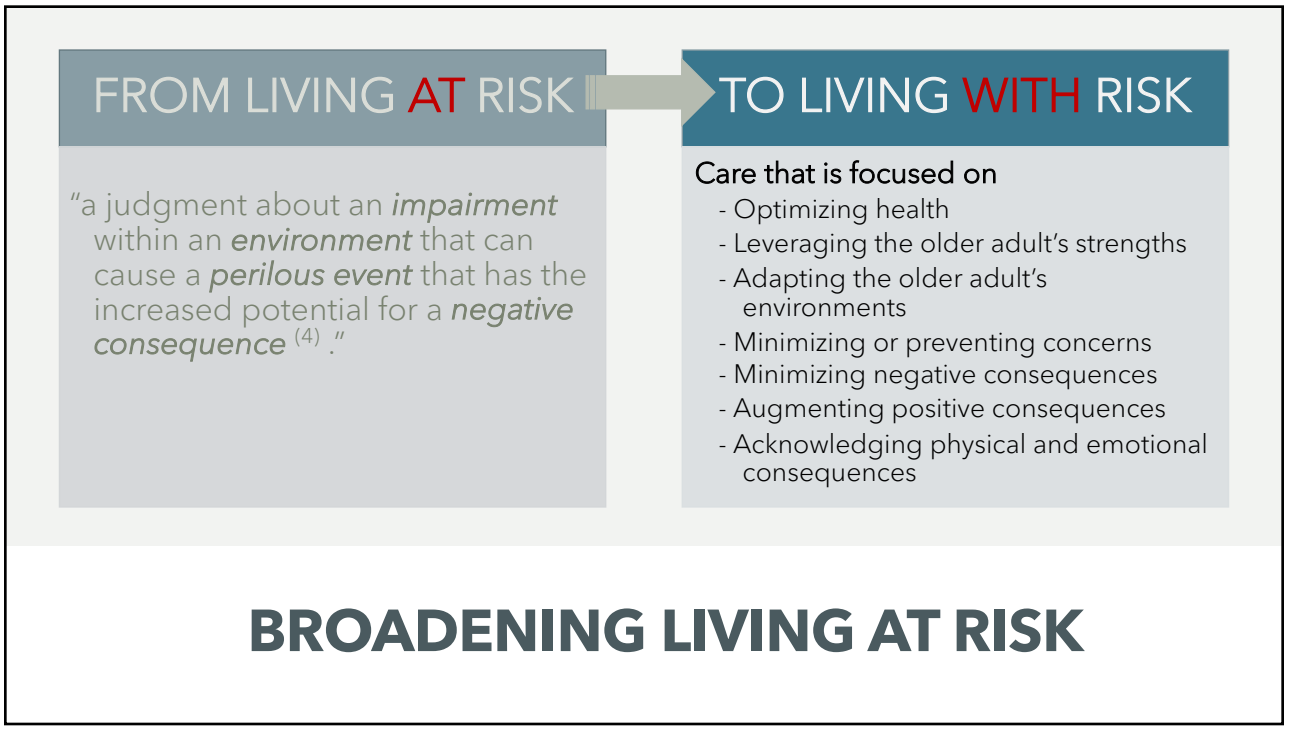
"risk is the effect of **uncertainty** on objectives where the consequences could vary from **loss** and detriment **to gain** and benefit "[8].

BROADENING THE DEFINITION OF RISK

8


Negative
Neutral
"the risks and benefits of... are..."
"the harms and benefits of… are…"
BROADENING THE DEFINITION OF RISK

9


FROM LIVING AT RISK
TO LIVING WITH RISK
"a judgment about an impairment within an environment that can cause a perilous event that has the increased potential for a negative consequence (4) ."
Care that is focused on
- Optimizing health
- Leveraging the older adult's strengths
- Adapting the older adult's environments
- Minimizing or preventing concerns
- Minimizing negative consequences
- Augmenting positive consequences
- Acknowledging physical and emotional consequences
BROADENING LIVING AT RISK

10

CAUSES		CONCERNS	CONTEXT	CONSEQUENCES
Impairments & Personality	Environments			
Impairments Cognitive Physical Mental Health Medical **Personality** Personality factors	**Physical** Home Neighbourhood **Social** Paid/unpaid support **Economic** Financial resources	Falls Unsafe med use Abuse Fires Malnourishment Unsafe Driving Wandering Suicide ↓Health Maintenance ↓House Maintenance	Activities Location Timing	**Health Related** Death Hospitalization Injury/harm Harm to others **Life Related** Functional decline Financial decline Eviction Relocation to LTC Being over protected **Positive** Quality of life Resilience Meaningful Activity

CLARIFYING RISK(4)

11

BROADENING RISK ASSESSMENT

12

THE BENEFITS OF RISK TAKING...

RESILIENCE

Comes about by **taking a risk** or overcoming a challenge [9]

A process by which people bounce back from adversity, reintegrate and ideally **grow from the experience** [9]

High resilience later in life has been associated with

reduced depression
decreased mortality risk
increased quality of life[10]

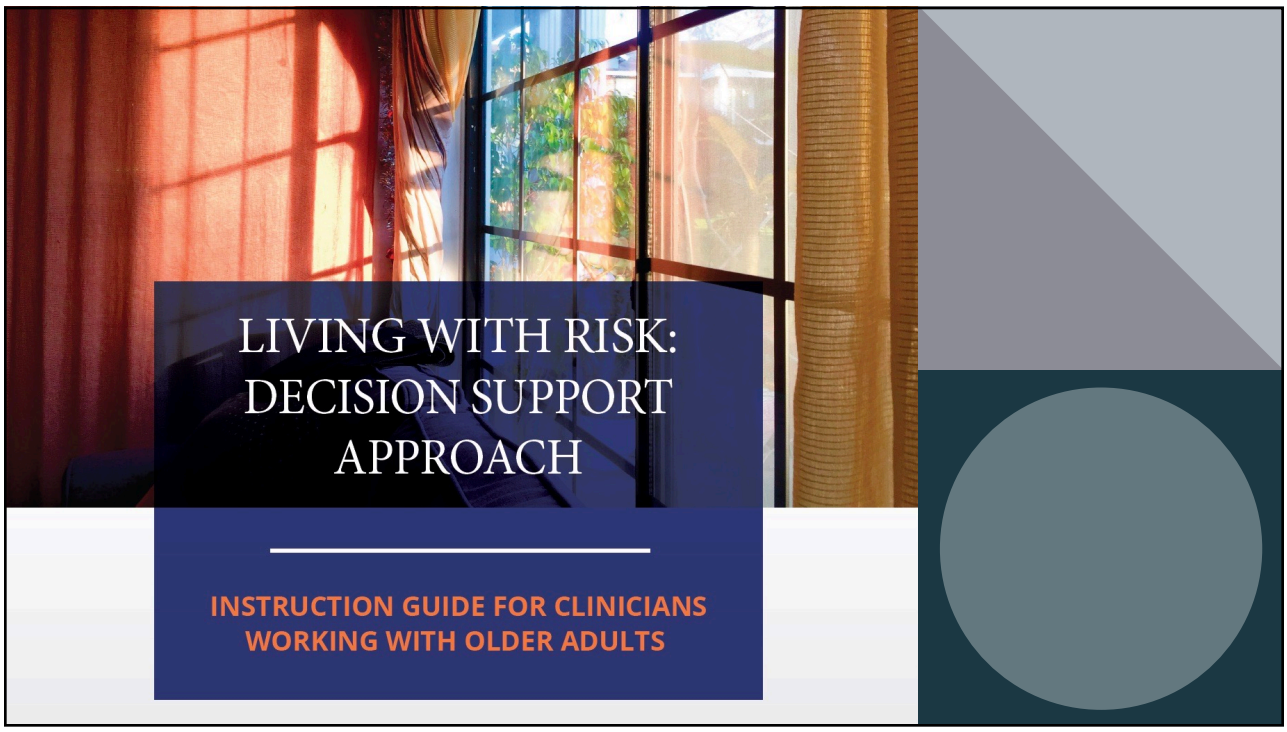
13

SHARED DECISION MAKING

Expert in life, value, beliefs, goals, dreams, reward, positive consequences

Experts in illness, disease, causes, resources, adaptations, negative consequences

14



15

Living with Risk: Decision Support Approach

- Broadened approach to risk assessment
- Holistic, structured, systematic review of an older adult's risk status
- Identifies potential strategies that
  - decrease negative consequences,
  - augment positive consequences of the risk,
  - address impairments, leverage their strengths and adapt their environments
- Acknowledges the older adult's decisions and choices

16

Living with Risk: Decision Support Approach

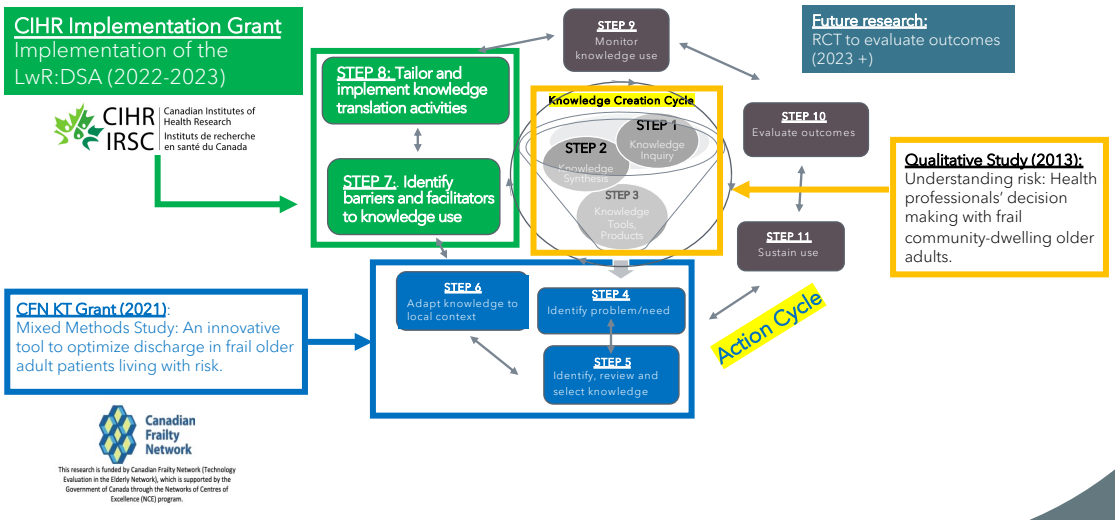
Objective approach to help with discharge and care plan discussions by:

- **framing** information clinicians are already gathering
- ensuring a wide **variety of risk** categories are addressed
- supporting a **balanced problem-solving** approach by providing a consistent process which includes participation from the older adult and their caregiver
- encouraging a **collaborative** team approach
- outlining **accountability** for whose job it is to address each risk when using within a team

17

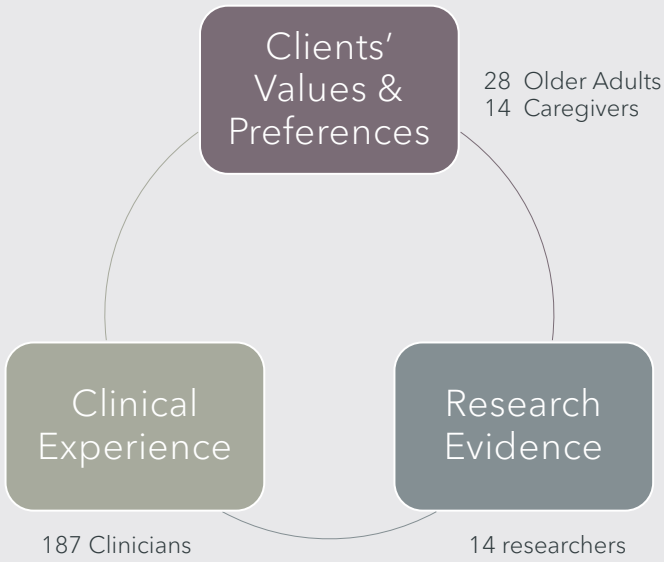
Living with Risk: Decision Support Approach

Applied to the Knowledge to Action Model (Health Canada, 2017 adapted from Graham, et al. 2006)



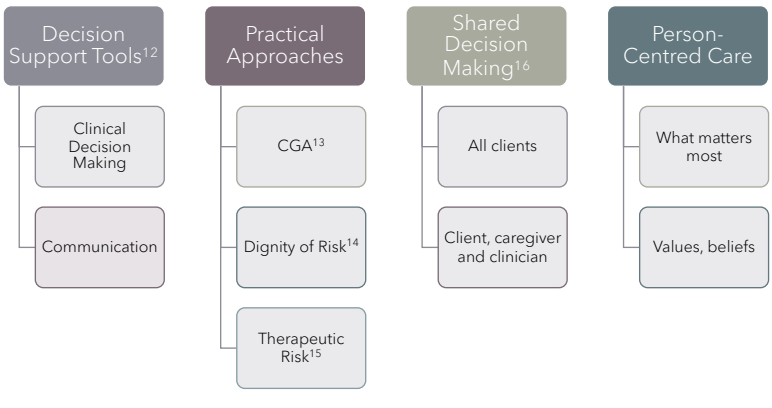
18

EVIDENCE INFORMED PRACTICE



"Evidence-based practice is the integration of clinical expertise with the best available external evidence from systematic research and patients' preferences and goals" (11)

19

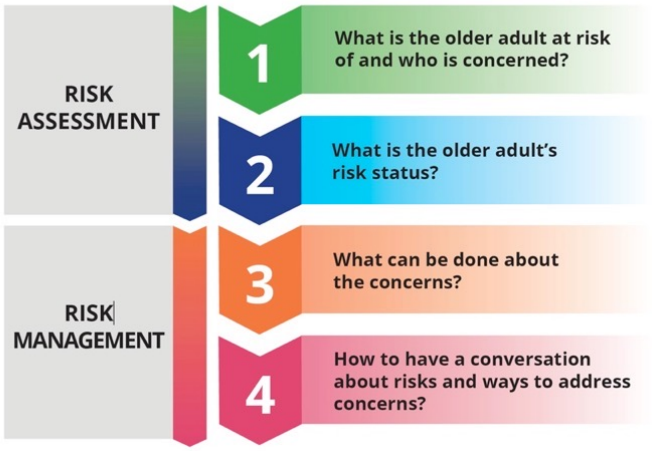


LWR:DSA Guiding principles

20

LIVING WITH RISK: DECISION SUPPORT APPROACH

A 4 STEP APPROACH



21

4 WORKSHEETS

- Information Sheet
- Risk Analysis Sheet
- Summary Table
- Safety Continuum

22

INFORMATION SHEET

Living with Risk: Decision Support Approach
4-STEP PROCESS

1) What is the older adult at risk of and who is concerned?

- What are the older adult, the caregiver and the clinicien concerned about?
- Understand differences of opinions, and if present, power imbalances
- Determine onset, context, progression, cause and consequences

2) What is the older adult's risk status?

- Evaluate the older adult's risk status
- Consider the following factors for each concern to determine if risk is low ●, medium ▼ or high ■
  - **Capacity :** Is the older adult capable to make this health care decision?
  - **Occurrence :** Is the concern occurring now?
  - **Frequency :** If yes, how often does this concern happen?
  - **Likelihood:** How likely is this concern to occur?
- If occurring now or likely to occur:
  - **Likelihood :** How likely are the consequences to occur?
  - **Severity :** How severe would the consequences be?
  - **Immediacy :** How imminent are the consequences of this concern?
  - **Support :** Does the older adult have consistent reliable support in place?
  - **Complexity :** Are there other concerns occurring?

3) What can be done about the concerns?

- What are the wishes and goals of the older adult?
- What can be done about
  - **The concerns :** Prevent or decrease the frequency and modify or adapt the context.
  - **The causes :** Optimize the older adult's health, minimize impairments, leverage their strengths and adapt or modify their environments.
  - **The consequences :** Minimize the negative consequences, leverage the positive consequences, consider both the emotional & physical consequences.

4) How to have a conversation about risks and ways to address concerns?

- Communicate perceived risk status
- Discuss areas of agreement and disagreement
- Support priorities

27 | INSTRUCTION GUIDE LWR:DSA

1

23

RISK ANALYSIS WORKSHEET

At risk of

Concern	
Context(s)	

WHO is concerned + level of risk ● ▼ ■	✓ Clinician	✓ Older Adult	✓ Caregiver

Cause(s) of the concern	
Potential consequence(s) of this concern	

Recommendations to reduce the concern, its causes and its consequences	Older adult in agreement YES	NO	Options/ alternatives

Older adult's perspective	

2

24

SUMMARY TABLE

What is the older adult at risk of? (concern + context)	Who is concerned? What is the risk status? (low ● /medium ▼ /high ■)[1]			Causes	Consequences	Recommendations to minimize concerns, causes and consequences	Older adult in agree-ment? (yes/no)	Alternatives
	Clinician	Older adult	Caregiver					

3

25

SAFETY CONTINUA

1. Capacity Continuum: Is the older adult capable to make this health care decision?

LOW Yes | MEDIUM Unsure | HIGH No

2. Occurrence continuum: Is the concern occurring now?

LOW No | MEDIUM Risk factors | HIGH Yes

3. Frequency continuum: How often is this concern occurring?

LOW Yearly | MEDIUM Monthly | HIGH Daily

4. Likelihood continuum: How likely is the concern and/or consequences to occur?

LOW Unlikely | MEDIUM Moderate | HIGH Highly

5. Severity continuum: How severe would the consequences be?

LOW Minimal | MEDIUM Moderate | HIGH Catastrophic

6. Imminency continuum: How imminent are the consequences?

LOW Long-term | MEDIUM Short-term | HIGH Immediate

7. Support Continuum: Does the older adult have consistent reliable support in place?

LOW Lots | MEDIUM Some | HIGH None

8. Complexity Continuum: Are there other concerns occurring?

LOW Single | MEDIUM Some | HIGH Many

Adapted from MacLeod & Stadnyk, 2015[1]

4

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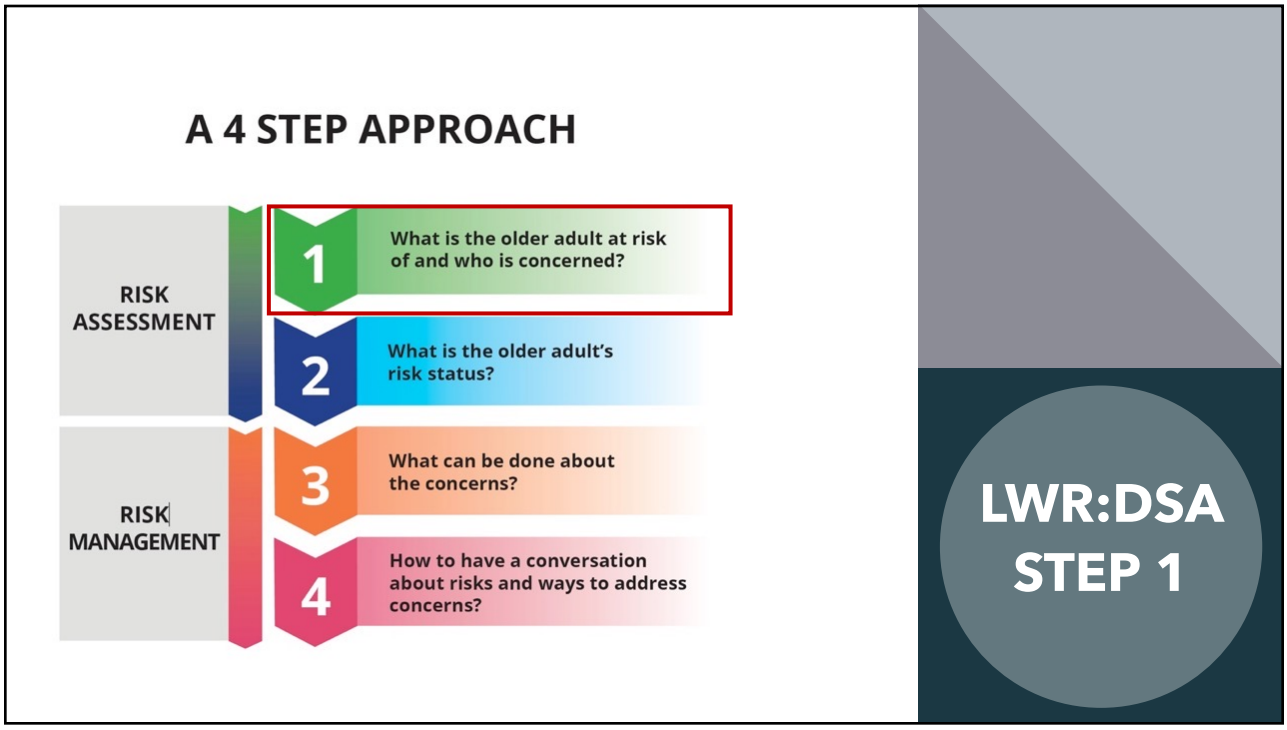
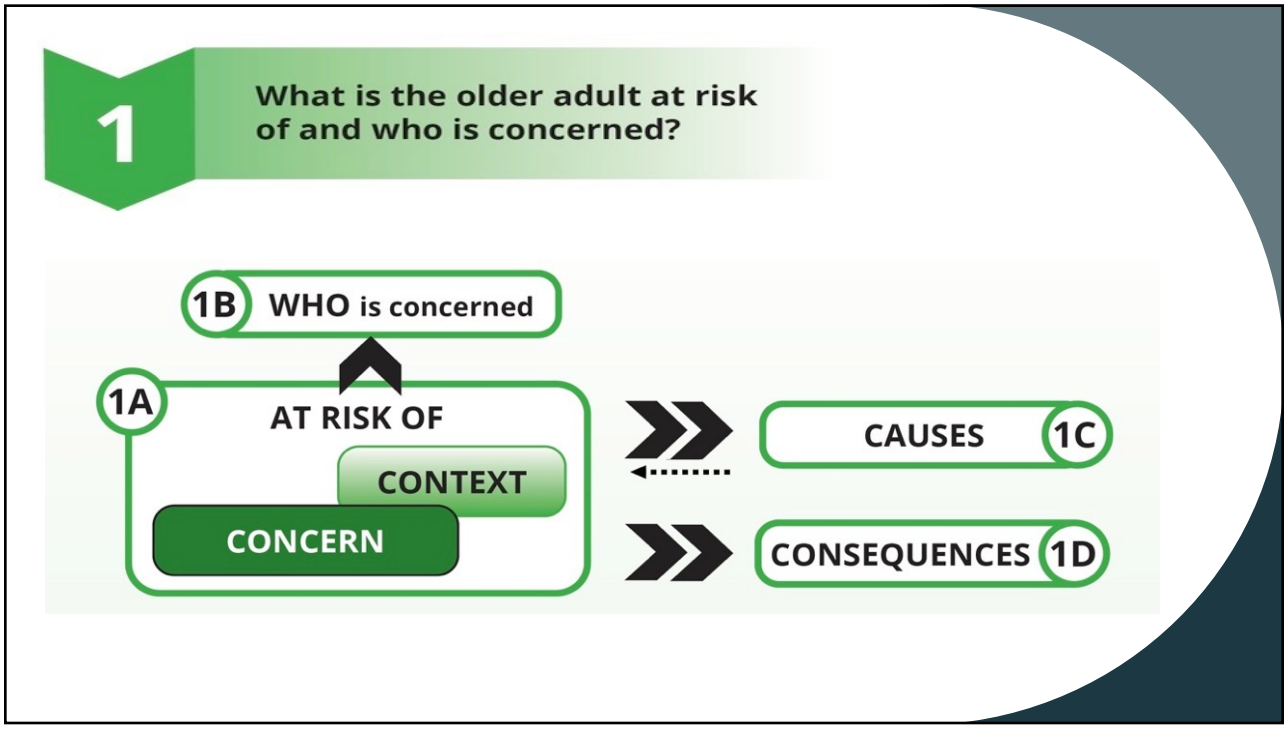
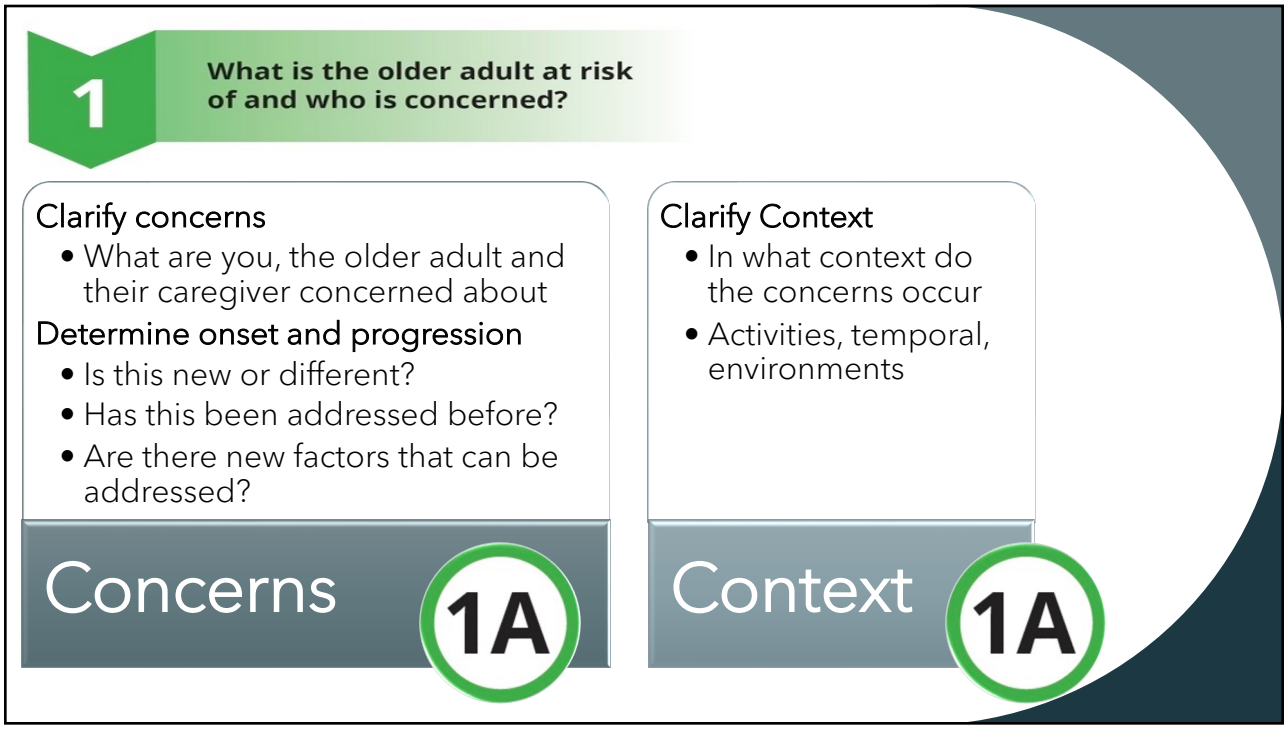

A 4 STEP APPROACH
RISK ASSESSMENT
RISK MANAGEMENT
1
What is the older adult at risk of and who is concerned?
2
What is the older adult's risk status?
3
What can be done about the concerns?
4
How to have a conversation about risks and ways to address concerns?
LWR:DSA STEP 1

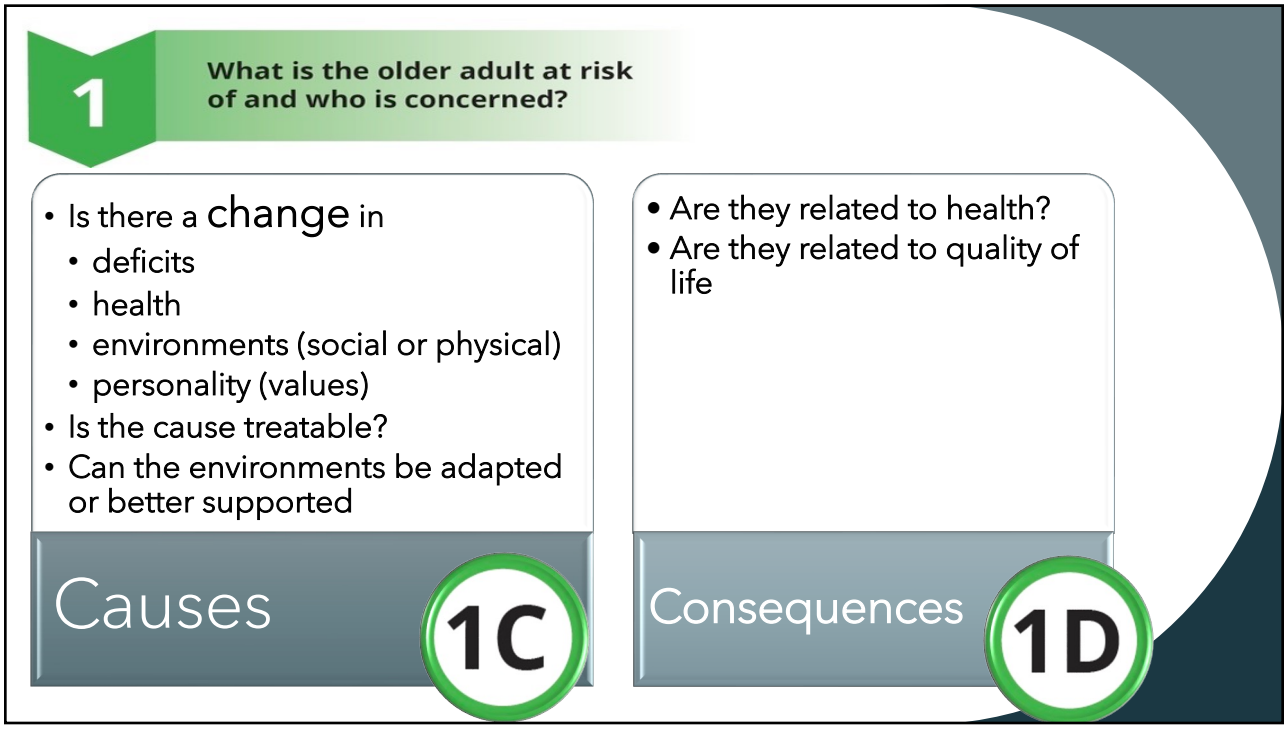
27


1
What is the older adult at risk of and who is concerned?
1B WHO is concerned
1A
AT RISK OF
CONTEXT
CONCERN
CAUSES 1C
CONSEQUENCES 1D

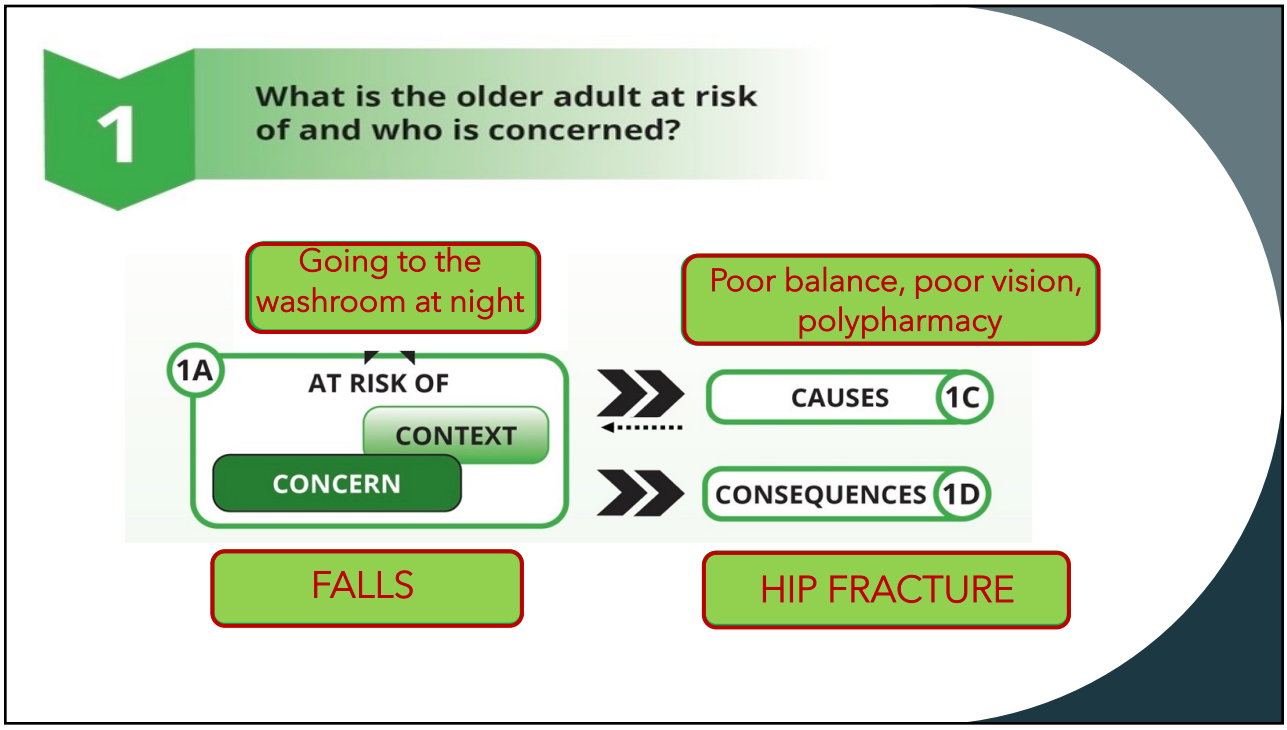
28


1
What is the older adult at risk of and who is concerned?
Clarify concerns
• What are you, the older adult and their caregiver concerned about
Determine onset and progression
• Is this new or different?
• Has this been addressed before?
• Are there new factors that can be addressed?
Concerns
1A
Clarify Context
• In what context do the concerns occur
• Activities, temporal, environments
Context
1A

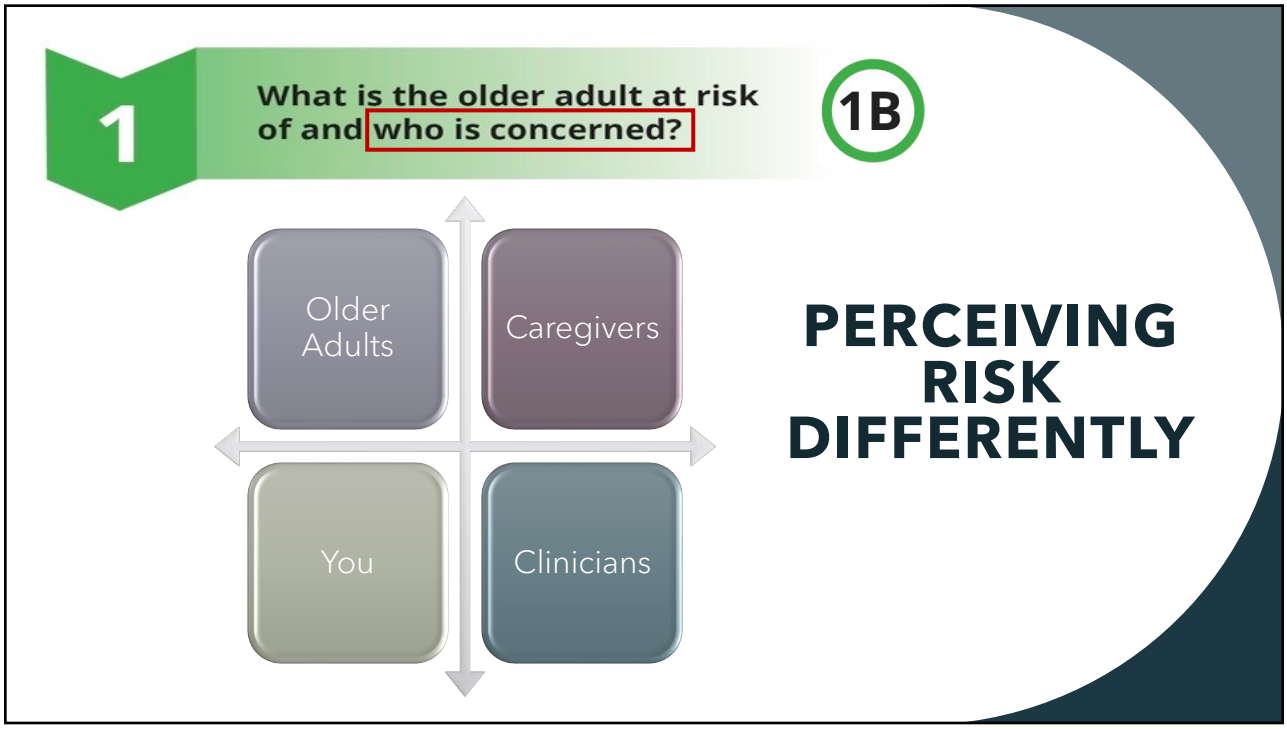
29


1
What is the older adult at risk of and who is concerned?
• Is there a change in
• deficits
• health
• environments (social or physical)
• personality (values)
• Is the cause treatable?
• Can the environments be adapted or better supported
Causes
1C
• Are they related to health?
• Are they related to quality of life
Consequences
1D

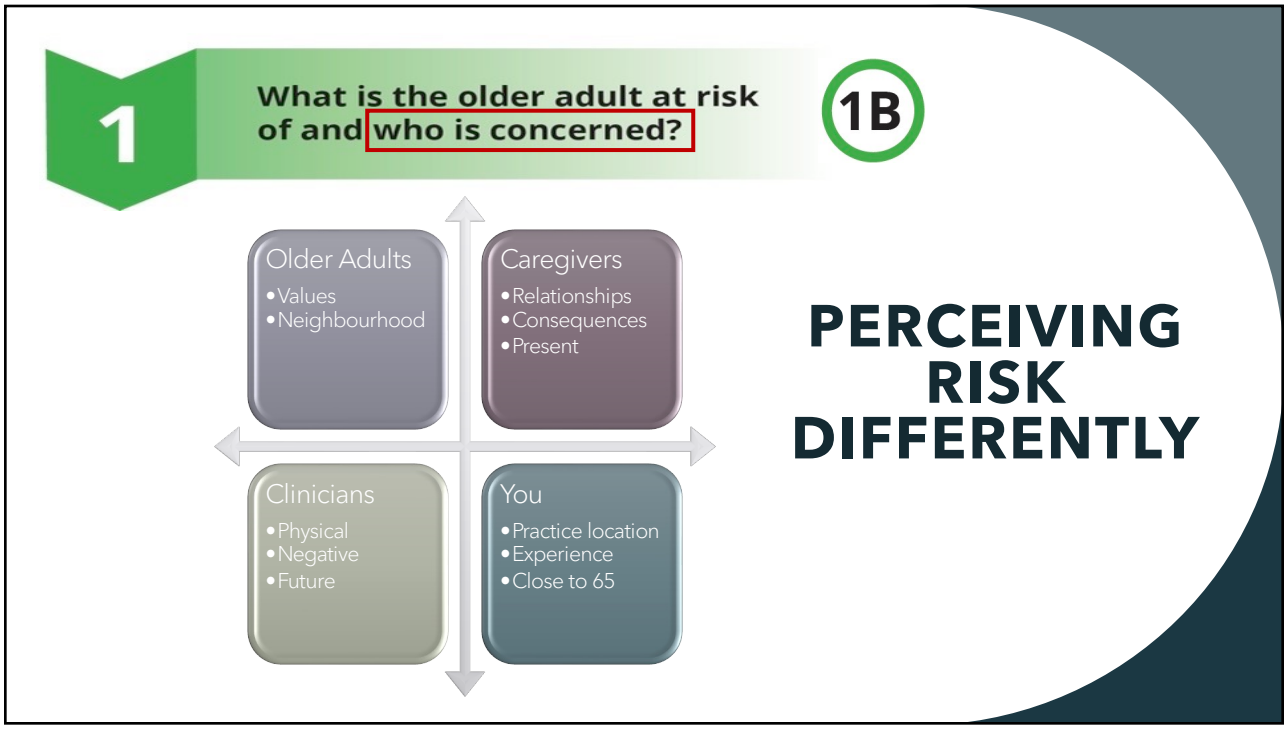
30


1
What is the older adult at risk of and who is concerned?
Going to the washroom at night
Poor balance, poor vision, polypharmacy
1A
AT RISK OF
CONTEXT
CONCERN
CAUSES
1C
CONSEQUENCES
1D
FALLS
HIP FRACTURE

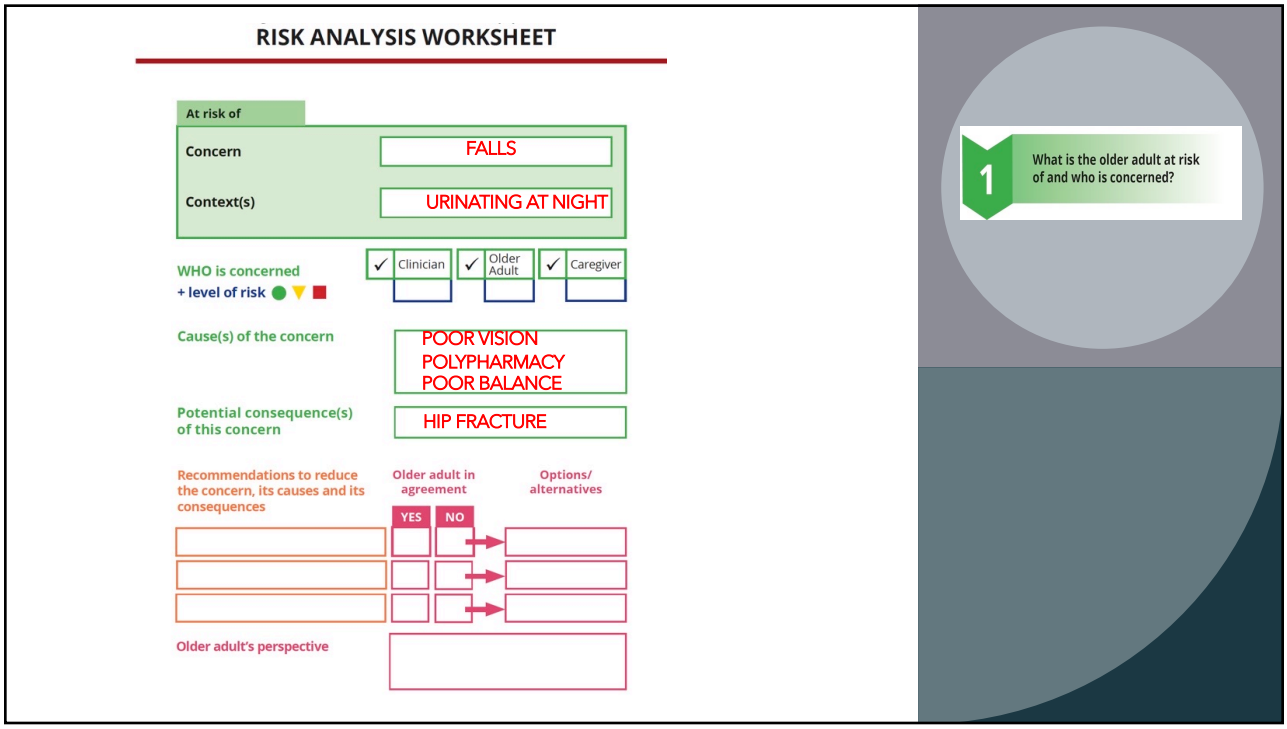
31


1
What is the older adult at risk of and who is concerned?
1B
Older Adults
Caregivers
You
Clinicians
PERCEIVING RISK DIFFERENTLY

32


1
What is the older adult at risk of and who is concerned?
1B
Older Adults
• Values
• Neighbourhood
Caregivers
• Relationships
• Consequences
• Present
Clinicians
• Physical
• Negative
• Future
You
• Practice location
• Experience
• Close to 65
PERCEIVING RISK DIFFERENTLY

33


RISK ANALYSIS WORKSHEET
At risk of
Concern
FALLS
Context(s)
URINATING AT NIGHT
WHO is concerned
+ level of risk
✓ Clinician
✓ Older Adult
✓ Caregiver
Cause(s) of the concern
POOR VISION
POLYPHARMACY
POOR BALANCE
Potential consequence(s) of this concern
HIP FRACTURE
Recommendations to reduce the concern, its causes and its consequences
Older adult in agreement
YES
NO
Options/ alternatives
Older adult's perspective
1
What is the older adult at risk of and who is concerned?

34

A 4 STEP APPROACH

RISK ASSESSMENT

1. What is the older adult at risk of and who is concerned?
2. What is the older adult's risk status?

RISK MANAGEMENT

3. What can be done about the concerns?
4. How to have a conversation about risks and ways to address concerns?

LWR:DSA STEP 2

35

2 What is the older adult's risk status?

Is this a low, medium or high-risk situation?

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Business

Likelihood x Severity

Likelihood severity occurs	Potential Severity Rating: Minor	Moderate	Significant	Catastrophic
Very Likely	Moderate	High	Extreme	Extreme
Likely	Low	Moderate	High	Extreme
Unlikely	Very Low	Low	Moderate	High
Rare	Very Low	Very Low	Low	Moderate

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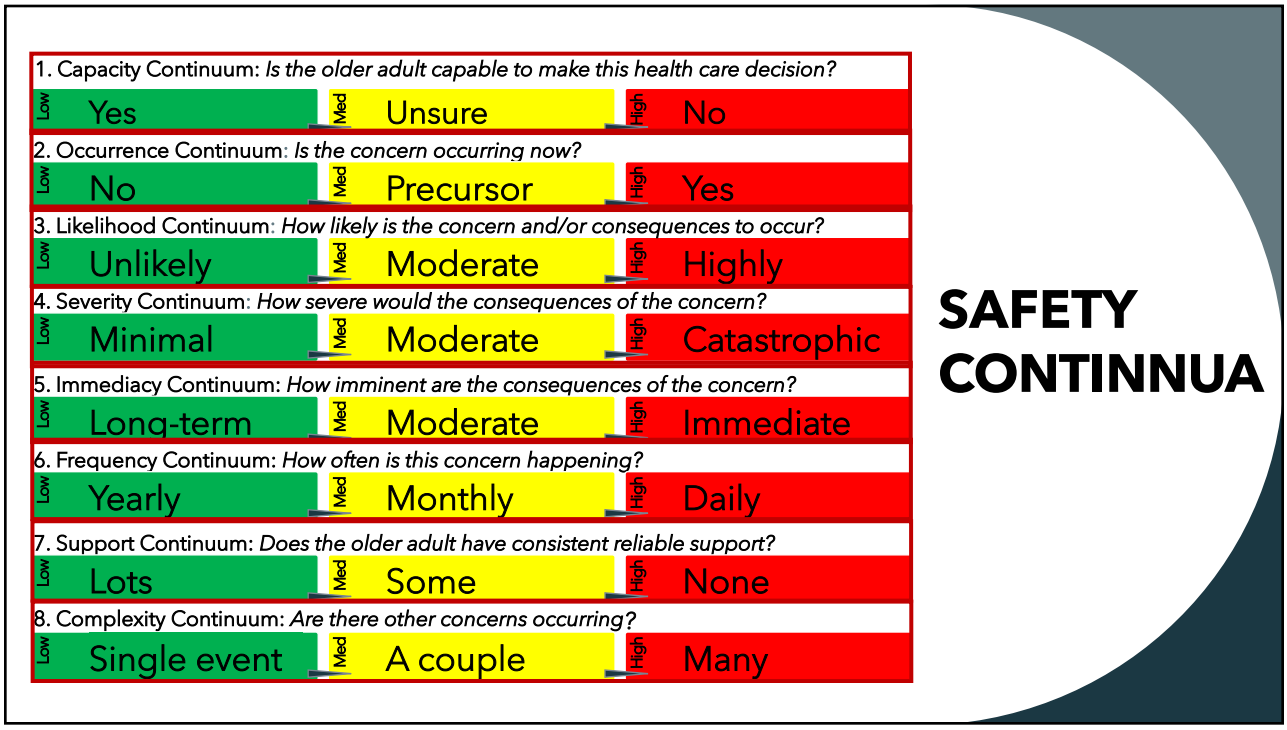
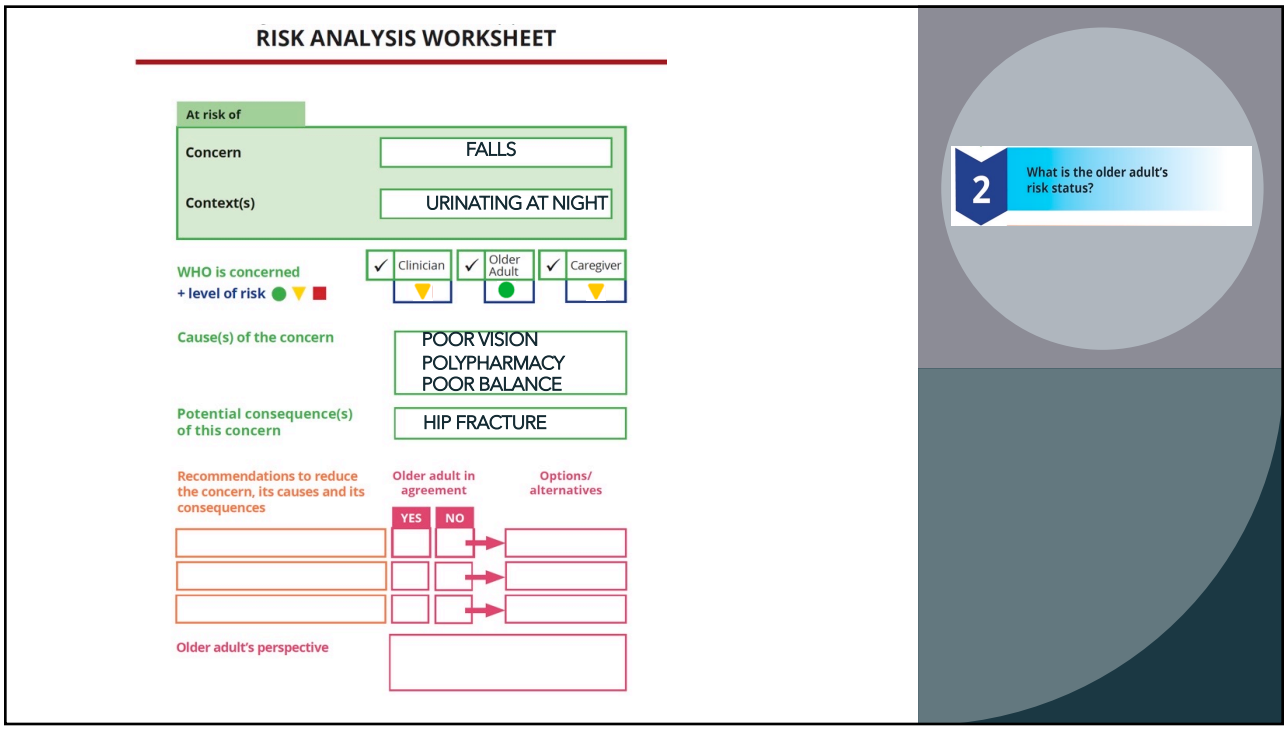
36


1. Capacity Continuum: Is the older adult capable to make this health care decision?
Low Yes
Med Unsure
High No
2. Occurrence Continuum: Is the concern occurring now?
Low No
Med Precursor
High Yes
3. Likelihood Continuum: How likely is the concern and/or consequences to occur?
Low Unlikely
Med Moderate
High Highly
4. Severity Continuum: How severe would the consequences of the concern?
Low Minimal
Med Moderate
High Catastrophic
5. Immediacy Continuum: How imminent are the consequences of the concern?
Low Long-term
Med Moderate
High Immediate
6. Frequency Continuum: How often is this concern happening?
Low Yearly
Med Monthly
High Daily
7. Support Continuum: Does the older adult have consistent reliable support?
Low Lots
Med Some
High None
8. Complexity Continuum: Are there other concerns occurring?
Low Single event
Med A couple
High Many
SAFETY CONTINNUA

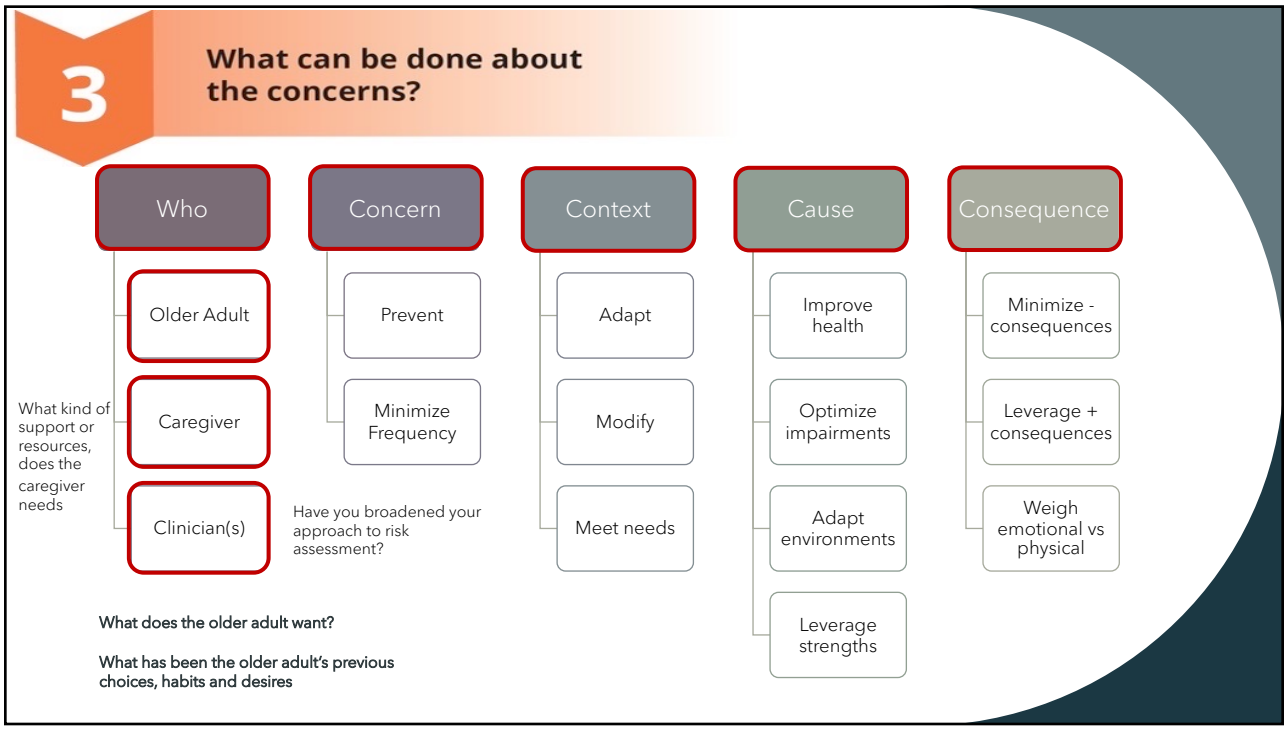
37


RISK ANALYSIS WORKSHEET
At risk of
Concern
FALLS
Context(s)
URINATING AT NIGHT
WHO is concerned
+ level of risk
Clinician
Older Adult
Caregiver
Cause(s) of the concern
POOR VISION
POLYPHARMACY
POOR BALANCE
Potential consequence(s) of this concern
HIP FRACTURE
Recommendations to reduce the concern, its causes and its consequences
Older adult in agreement
YES
NO
Options/ alternatives
Older adult's perspective
2
What is the older adult's risk status?

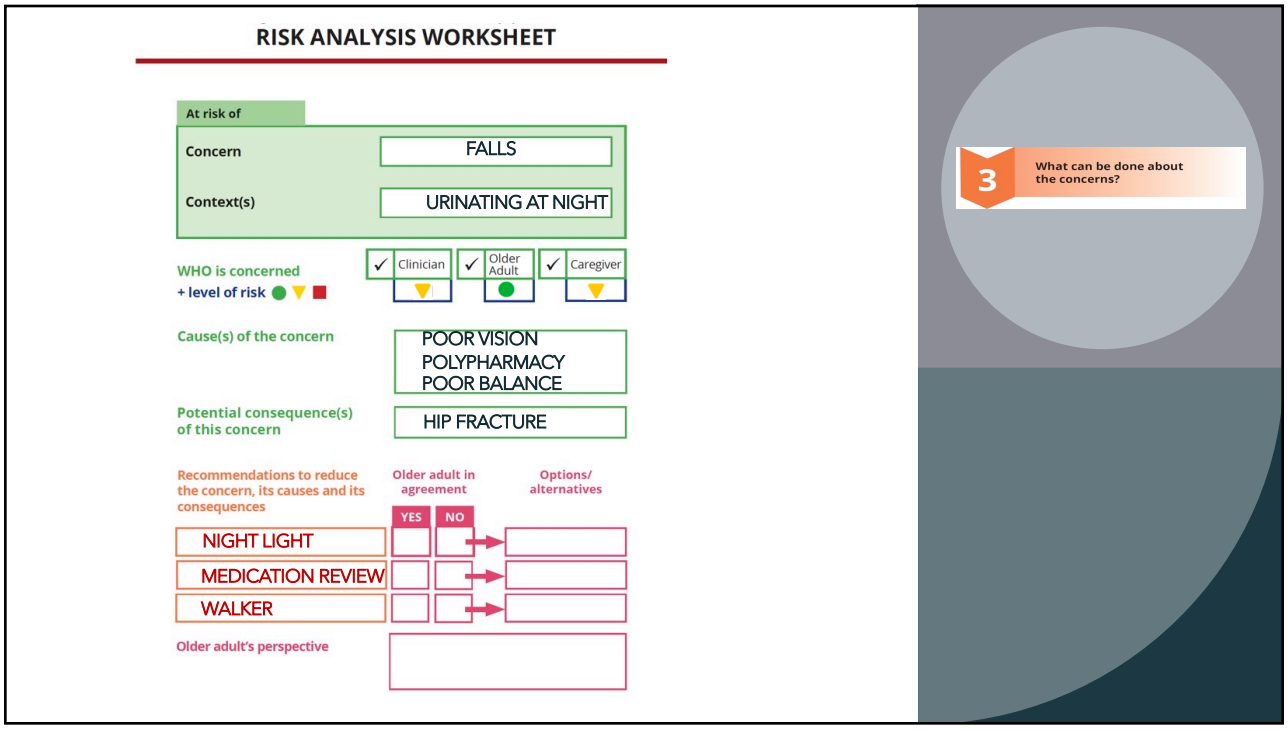
38


A 4 STEP APPROACH
RISK ASSESSMENT
RISK MANAGEMENT
1
What is the older adult at risk of and who is concerned?
2
What is the older adult's risk status?
3
What can be done about the concerns?
4
How to have a conversation about risks and ways to address concerns?
LWR:DSA STEP 3

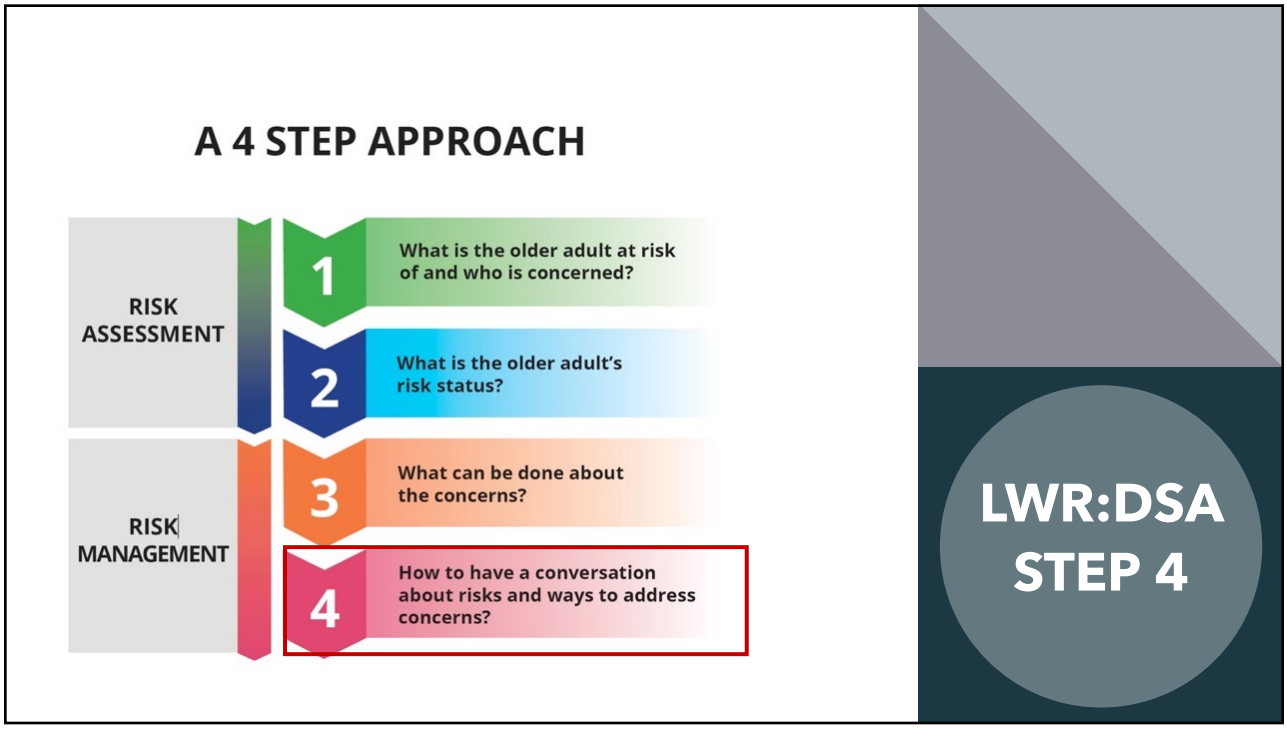
39


3
What can be done about the concerns?
Who
Concern
Context
Cause
Consequence
Older Adult
Caregiver
Clinician(s)
What kind of support or resources, does the caregiver needs
Prevent
Minimize Frequency
Have you broadened your approach to risk assessment?
Adapt
Modify
Meet needs
Improve health
Optimize impairments
Adapt environments
Leverage strengths
Minimize - consequences
Leverage + consequences
Weigh emotional vs physical
What does the older adult want?
What has been the older adult's previous choices, habits and desires

40


RISK ANALYSIS WORKSHEET
At risk of
Concern
FALLS
Context(s)
URINATING AT NIGHT
WHO is concerned
+ level of risk
Clinician
Older Adult
Caregiver
Cause(s) of the concern
POOR VISION
POLYPHARMACY
POOR BALANCE
Potential consequence(s) of this concern
HIP FRACTURE
Recommendations to reduce the concern, its causes and its consequences
Older adult in agreement
YES
NO
Options/ alternatives
NIGHT LIGHT
MEDICATION REVIEW
WALKER
Older adult's perspective
3
What can be done about the concerns?

41


A 4 STEP APPROACH
RISK ASSESSMENT
RISK MANAGEMENT
1
What is the older adult at risk of and who is concerned?
2
What is the older adult's risk status?
3
What can be done about the concerns?
4
How to have a conversation about risks and ways to address concerns?
LWR:DSA STEP 4

42

4 How to have a conversation about risks and ways to address concerns?

FOCUS ON WHAT MATTERS MOST

ESTABLISH PRIORITIES

SUPPORT DISCUSSIONS

UNDERSTAND DIFFERENCES OF OPINIONS

43

4 How to have a conversation about risks and ways to address concerns?

OLDER ADULTS

QUALITY OF LIFE OVER SAFETY

FOCUS ON WHAT CAN BE DONE

SHARED DECISION-MAKING

UNDERSTANDING THE RATIONALES

44

RISK COMMUNICATION AND COGNITIVE IMPAIRMENT[17-20]

Reach a shared understanding
- Concerns and negative consequences
- Approach to the risk of harm
- Acceptable thresholds/ The tipping points

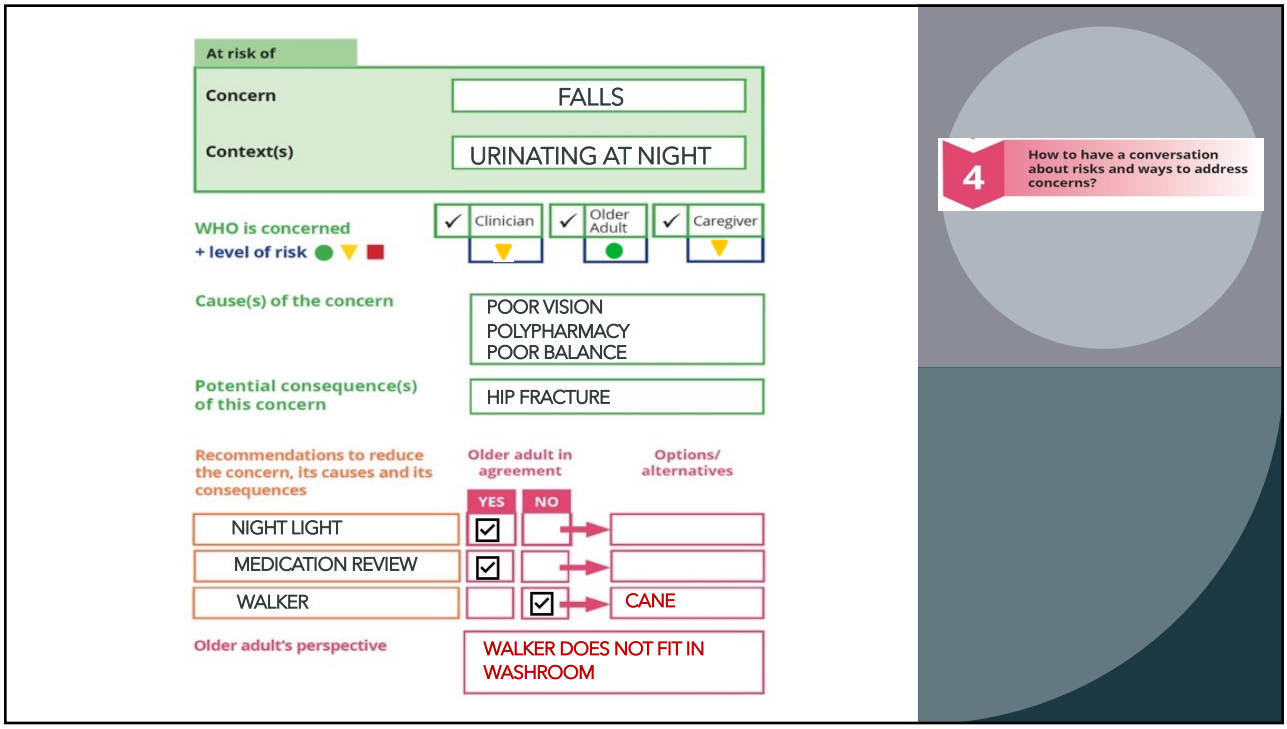
Know the person
- For creative and person-centered approaches

Acknowledge the caregivers'
- Fears, feelings and belief systems

Active decision making
- That focuses on solutions

Support time
- To process, make choices, adapt to changes

45



46

4 How to have a conversation about risks and ways to address concerns?

SUMMARY TABLE

What is the older adult at risk of? (concern + context)	Who is concerned? What is the risk status? (low ● /medium ▼ /high ■)[1]			Causes	Consequences	Recommendations to minimize concerns, causes and consequences	Older adult in agree-ment? (yes/no)	Alternatives
	Clinician	Older adult	Caregiver					
Falls	▼	●	▼	Poor vision Polypharmacy Poor balance	Hip Fracture	Night Light	Yes	
						Med Review	Yes	
						Walker	No	Cane

47

STUDY PROTOCOL

- Study Question
- Objectives
- Timeline
- Data Collections
- Study Ethics - consent, voluntary participation, confidentiality
- Contacts

48

Study Methods – Research Questions

What are the characteristics that are either barriers or facilitators to using the LwR:DSA in practice?

- clinicians
- the LwR:DSA
- the implementation strategies, and
- the clinicians' practice settings

What changes need to be made to to improve uptake into practice?

- the LwR:DSA and/or
- the implementation strategies

49

Study Methods – Research Objectives

Implementation Outcome Measurement - Adoption

- To measure the **implementation outcome of adoption** of the LwR:DSA into practice.

Exploratory – Barriers and Facilitators

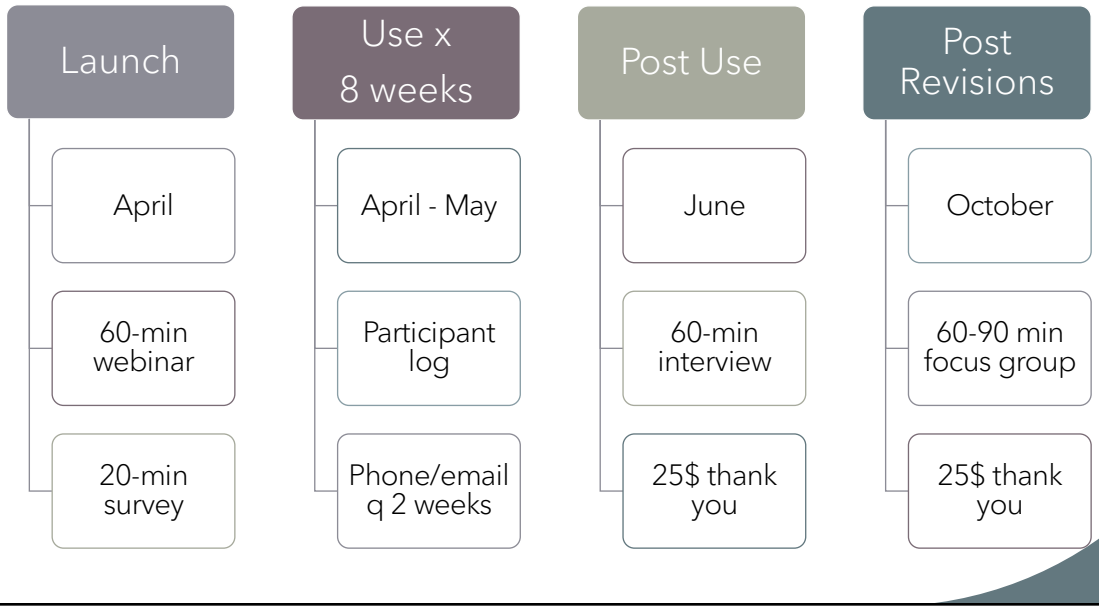
- To identify and understand the **characteristics of the LwR: DST, implementation strategies, the clinician and their practice environments** that may facilitate or hinder the use of the LwR:DSA.

Outputs

- To **enhance, adapt or develop** features of the LwR:DSA and implementation strategies to improve adoption of the LwR:DSA into practice.
- To **develop implementation guidelines** that support adoption of the tool across a variety of clinical health settings.

50

TIMELINES



51

LWR:DSA USE X 2 MONTHS (8 WEEKS)

Using the LWR:DSA

- in usual care
- LWR:DSA – 4 Step Approach

Supports for use

- Worksheets
- Training Videos – short videos per step
- Twice monthly phone calls set up by email

Data Collection

- Complete log weekly

52

USE – DATA COLLECTION LOG

Date	Gender* and ethnicity* of each patient used	LwR:DSA Use		Implementation Strategies					Questions
		# of client used with + reasons	# of clients could have but did not use + reasons	Instruction Manual (#)	Videos (# and which ones)	Worksheets (#)			
						Risk Analysis (#)	Summary Table (#)	Safety continua (#)	
Week 1 Example	Pt 1 – F/White Pt 2 – M/Filipino PT 3 – F/Arab Pt 4 – F/South Asian Pt 5 – M/Latin Ameri Pt 6 – F/Chinese Pt 7 – M/did not identify	7 clients - Worried about d/c home	6 clients - No time - Client declined - Gender or ethnicity?	Reviewed full guide 1x	watched step 1 and step 3	1	1	0	
Week 2									Check in
Week 3									
Week 4									Check in
Week 5									
Week 6									Check in
Week 7									
Week 8									Check in and book interview

*CIHR takes gender, race and ethnicity health inequities very seriously requiring most health research to identify gender and ethnicity of the participants. Ethnicity is a multi-dimensional concept referring to community belonging and a shared cultural group membership. It is related to socio-demographic characteristics, including language, religion, geographic origin, nationality, cultural traditions, ancestry and migration history, among others.[21]

53

USE – DATA COLLECTION

- **Bi-weekly touch-points**

  Questions and review of log

  By phone calls or email

- **Submit de-identified worksheets**

  Upload to Research Website (or Fax)

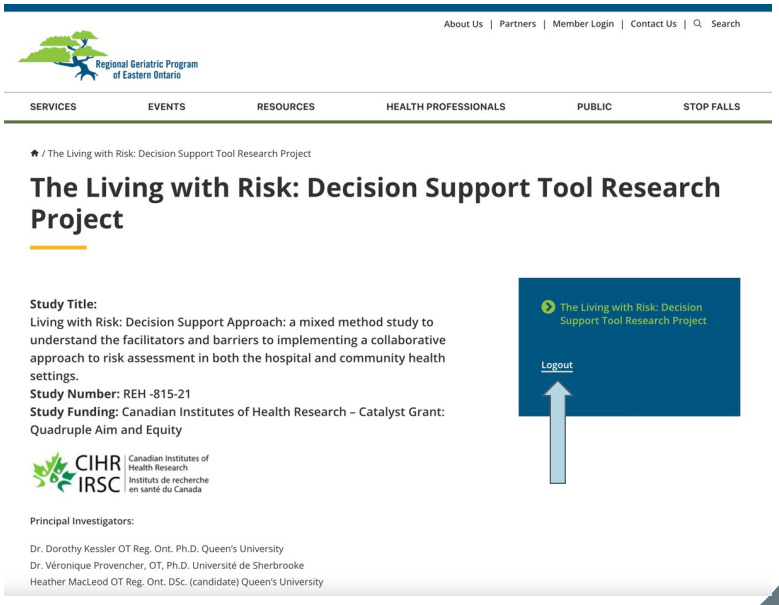
  After completed

- **Submit research log**

  Upload to Research Website at end of 8 weeks

54

RESEARCH WEBSITE



55

RESEARCH WEBSITE

56

INTERVIEWS AND FOCUS GROUPS

Semi-Structured Interviews

- After use x 8 weeks
- Time that is convenient for you
- Questions around use, the LWR:DSA and the implementation strategies

Focus Groups – October 2022

- Time that is convenient for you – so may be an interview
- Questions about revisions made to LWR:DSA and implementation strategies and aspects of the implementation guide

57

STUDY PROTOCOLS – CONSENT

Consent

- Obtained at beginning of study for all phases

Voluntary Participation

- Participation in this study is voluntary and you can withdraw at any time

Harms of Participation

- Increase time to your workload
- Emotional distress related to recalling patients that you used the approach with
- Encouraged to contact your Employee Assistance Program, and/or your primary care provider

Benefits

- No specific benefits but goal is to develop a clinically useful approach

58

STUDY PROTOCOLS – CONFIDENTIALITY

- Confidentiality
  - Will be protected to the extent permitted
  - The file linking your Study ID to your name/email will be stored securely and destroyed after five years
  - All data between phases will be linked by your study ID
  - Any quotes used will be devoid of any identifying data

59

QUESTIONS AND SUPPORT

- Ethical Concerns
  - Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board (HSREB)
  - Approval : TRAQ #: 6034411 Department Code: REH-815-21
  - 1-844-535-2988 (Toll free in North America)
  - hsreb@queensu.ca

- Study Questions and/or Concerns
  - Heather MacLeod: heather.macleod@queensu.ca
  - Supervisor and Co-PI: Dr. Dorothy Kessler: dk75@queensu.ca or 613-533-6551
  - Co-Pi: Dr. Véronique Provencher: veronique.provencher@usherbrooke.ca

60

NEXT STEPS

- Complete Consent Form Survey: survey link sent by email
- Complete Survey 2: survey link sent by email
- Use tool for 8 weeks
- Complete research log weekly – upload at end to Research Website
- Heather will contact you every two weeks for questions and review of research log. Notify heather.macleod@queensu.ca of start date for 8 weeks ONLY if you don't start the week after completing consent
- Send in de-identified worksheets to Research Website

61

Project Role	Individual	Affiliation
Principal Applicant		
Principal Applicant	Véronique Provencher	Université de Sherbrooke
Principal Applicant	Dorothy Kessler	Queen's University, Kingston
Co-Investigators:		
Knowledge User	Heather MacLeod	KT Specialist in Geriatrics, Regional Geriatric Program of Eastern Ontario, Ottawa
Researcher	Krystina Lewis	University of Ottawa
Researcher	Nathalie Delli-Colli	Université de Sherbrooke
Researcher	Mary Egan	University of Ottawa
Researcher	D. Giroux	Université Laval
Researcher	Nathalie Veillette	Université de Montréal
Research & Knowledge User	MJ Kergoat	Geriatrician, Université de Montréal
Knowledge User	Jennifer Klein	Healthcare Improvement Specialist, Glenrose Rehabilitation Hospital, Edmonton, Alberta
Collaborators:	Shaen Gingrich	Knowledge Translator – North East Specialized Geriatric Centre, Sudbruy, Ontario
	Chantal Foidart	Geriatric Assessor, Geriatric Assessment Outreach Team, Ottawa
	Jenn Cavanagh	Geriatric Psychiatry Community Services of Ottawa, Ottawa
	Frédérick Roy	Coordinator – CHUS Patients' Committee Centre intégré universitaire de santé & de services soc de l'Estrie - CHUS
	Christine Allard	Gestionnaire - Centre intégré universitaire santé&serv.sociaux Capitale Nationale (Québec)

Research Team

CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

62

63

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64