

Losing Something of Value: An Exploration of Risk in Discharge Planning With Older People

Tracy Murphy, Mary Butler, and Jacquie Kidd

Abstract

Risk is an integral part of occupational therapy practice, particularly in relation to whether a patient is considered to be ready to be discharged home. This paper presents an exploratory qualitative study that examines the way a group of occupational therapists have conceptualised risk in relation to discharge planning with older adults. We found that although there are times when risks should be avoided, a wholly risk averse approach could result in patients losing something of value as they are prevented from growth experiences.

Key words

Ageing, acute care, positive risk, focus group

Reference

Murphy, T., Butler, M., & Kidd, J. (2018). Losing something of value: An exploration of risk in discharge planning with older people. *New Zealand Journal of Occupational Therapy*, 65(2), 13–19.

Planning for discharge from hospital involves the assessment of patients' needs, wishes, current abilities and the resources available to them when leaving hospital to return home (Durocher & Gibson, 2010). The management of current or potential risk within discharge planning is an explicit process of evaluating the physical, emotional and clinical consequences of discharge to the patient (O'Byrne, 2008). Examples include the risk of falls, social isolation, mismanaging or missing medication, poor hygiene, and lack of adequate food and fluid intake. Furthermore, for many older people hospital admission can intensify existing difficulties in their functional ability or can exacerbate pre-existing conditions that had not been previously problematic. The range of potential risks, and the interplay between the home and hospital environments can mean that discharge planning with the older patient is a complex process which requires collaboration between the multi-disciplinary team, community services, family and patient (Crennan & MacRae, 2010).

From a service perspective, discharge from hospital is carefully monitored because extended admissions are not only costly, they can also carry additional complications such as an increased chance of infection as well as reductions in

independence, mobility, and confidence (Bauer, Fitzgerald, Haesler, & Manfrin, 2009; Crennan & MacRae, 2010; Welch & Lowes, 2005).

New Zealand research has found that occupational therapists in acute care believe that their role is primarily to ensure safe discharge home, and to increase independence and safety post-discharge (Blaga & Robertson, 2008; Craig, Robertson, & Milligan, 2004). Similarly, an international literature review by Welch and Lowes (2005) noted that within hospital services the rapid pace of discharge planning has led to assessments focusing only managing risk to enable patients to return home.

This paper reports on a small exploratory qualitative research project, undertaken in a New Zealand hospital, to investigate occupational therapists' experiences and perceptions of risk when discharging older people. Ethics approval for the study was received from the Otago Polytechnic Ethics Committee. This included a letter of support from the participating District Health Board. The following anonymised scenario, taken from clinical practice, is used to contextualise the report.

Scenario: Mrs Smith, part one

Mrs Smith was a 76 year old woman who was admitted to hospital after a fall at home. She also had worsening short term memory loss. 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. During her three month admission to the rehabilitation ward she worked extremely hard within all therapy sessions. Occupational therapy goals included safe and independent transfers to and from her wheelchair, and independence with toileting tasks particularly overnight when no carers were available. Throughout the frequent family

Corresponding authors:

Tracy Murphy, NZROT, MOccTher
Hawke's Bay Hospital
Email: tracy.murphy@hawkesbaydhb.govt.nz

Mary Butler, NZROT, PhD
Otago Polytechnic

Jacquie Kidd, RN, PhD
University of Auckland

meetings, individual therapy sessions, and numerous home visits Mrs Smith continued to clearly articulate her intention to return home.

The morning after her discharge home Mrs Smith was re-admitted to the emergency department having fallen during the night while attempting to transfer from her bedside commode back to bed. She was found on the floor by a friend, and transferred back to hospital via ambulance. Although she had no injuries from her fall, her friend was horrified that Mrs Smith might be discharged home again. Mrs Smith's son contacted the occupational therapist to ask how she could have let this happen, stating that his mother should go into a rest home. When this suggestion was made to Mrs Smith she firmly declined, and after determining that there were no changes to her occupational performance, she was discharged home from the emergency department.

This story has challenges that are frequently faced 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; and limited resources available (Bauer et al., 2009; Crennan & MacRae, 2010; Welch & Lowes, 2005).

Literature review

While there are many available definitions of risk, the World Health Organization defined risk as "the probability that an incident will occur" (World Health Organization, 2011, p. 4) and an adverse event as "an incident in which a patient is harmed" (World Health Organization, 2011, p. 1). The World Health Organization conceptualised risk as something to be avoided, however Clarke (2009) suggested that in attempting to remove risk, healthcare professionals may also remove components of life that are valued and therefore comprise quality of life. For 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).

In addition to highlighting different perspectives of risk, this example also illustrates the conflict between expert and layperson. According to Clarke (2000) the expert is not necessarily the healthcare professional with experience in dementia care, but the patient's daughter, who has been caring for him for years and would traditionally be viewed as a layperson. Similarly, Moats (2006, 2007) observed that situations of patient-family-therapist conflict about the relative importance of patient safety and autonomy can highlight that perceptions of risk can be very different depending on the time and context of the person making the assessment.

There is a paucity of occupational therapy literature that recognises the potential impact of risk on quality of life, necessitating searches outside of healthcare where risk is not always seen as something to be avoided, but as a controllable factor that can add meaning to an experience (Dickson, Chapman, & Hurrell, 2000; Dickson & Dolnicar, 2004; New Zealand Mountain Safety Council, 2004). Outdoor education sources have conceptualised risk as the potential to lose something of value as a result of a physical injury or financial, social or spiritual damage (Priest, 1993). However

Haddock (1993) took 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.

The notion that occupational therapists engage with risk in various ways as part of professional practice has been addressed in the literature (Atwal, Wigget, & McIntyre, 2011; Huby, Stewart, Tierney, & Rogers, 2004; Moats, 2006, 2007; Reich, Eastwood, Tilling, & Hopper, 1998), however research to date focuses primarily on the decision making process, with few available sources that explore how risk is recognised and managed by occupational therapists. One small UK study used reflective journals to explore occupational therapists' and physiotherapists' rationale for risk taking behaviours with older adults in acute care setting (Atwal et al., 2011). Findings suggested that increasing patients' quality of life and meeting patient goals of being discharged home were viewed by the participants as important considerations.

Methods

A qualitative descriptive methodology was used for this research, with focus groups and key informant interviews as the methods of data collection. Qualitative description as a research methodology aims to offer a comprehensive description of a phenomena through the collection of rich data from participants who are involved in the phenomena under investigation. The use of participants everyday terms is encouraged in the presentation of data (Sandelowski, 2000, 2010).

Participants.

Convenience sampling (Creswell, 2007) was employed for both focus groups and interviews to ensure participants would be appropriate for the research being undertaken and would be readily accessible to the principal researcher. Occupational therapists from a regional hospital within one New Zealand district health board (DHB), working in inpatient services with older adults were approached to participate via an in-service presentation, allowing presentation of research information and information sheets to be shared with a large group. Eleven occupational therapists of a potential sixteen volunteered, although one withdrew due to time constraints. Participants were allocated to one of two focus groups, with the aim of creating as much diversity in practice area and experience within the groups as possible. The literature indicated that focus groups of five to eight participants would be enough to allow for each person to fully participate, and give the facilitator time to encourage individual participation from quieter members of the group (Carey & Asbury, 2012; Ivanoff & Hultber, 2006). Five participants took part in each focus group, and all took part in the discussion.

All participants indicated on their consent forms that they were happy to be contacted for follow-up interviews. On the basis of discussions that highlighted different perspectives from new and experienced therapists, two therapists were asked to participate in the interviews. One of the therapists had more than ten years post-graduate experience primarily in rehabilitation settings, while the other had less than two years' experience and was working within an orthopaedic service. These participants raised experience-related topics for discussion, and contributed based on their own practice related experiences.

While the make-up of the focus groups was taken into consideration, it is acknowledged that there was a potential for dominance by more senior staff, or for junior therapists

to be more hesitant in vocalising thoughts. Therefore it was beneficial for one of the interviews to be completed with a less experienced therapist to minimise gaps in findings. All participants were female, with practice experience ranging from less than two years (five participants) to more than ten years (three participants). Practice settings included rehabilitation, orthopaedics, acute neurology, general medical, surgical, and acute assessment.

Data collection

To obtain data regarding the participant's ideas, attitudes, understanding and perceptions a focus group was used for the first stage of data collection. This was done in a way that allowed participants to develop, refine and justify ideas and thoughts through interaction with others, thus leading to the construction of new knowledge, or the articulation of previously unspoken or inferred knowledge (Carey & Asbury, 2012; Ivanoff & Hultber, 2006). Individual interviews were used as an adjunct to the focus groups both to verify information and to follow-up on interesting points of discussion following initial data analysis.

Two focus groups involving five participants each, and two follow-up semi-structured interviews with a participant from each focus group were undertaken. For both focus groups a schedule of prompts was used (Ivanoff & Hultber, 2006; Plummer-D'Amato, 2008), starting with broad, opening questions about work experience and education in order to encourage involvement from all participants. This was followed by transition or general questions about the participants' understanding of risk in everyday life as well as in occupational therapy practice, before a final specific prompt for participants to discuss their own perceptions and experiences of risk taking when planning or undertaking a discharge from hospital.

The semi-structured interviews were completed after brief initial data analysis to identify potential gaps in the data and areas of interest that required further exploration. During the interviews a number of quotes were used from the focus groups to prompt conversation rather than developing new questions. As this was an exploratory study, the aim of the focus group and interview prompts was to remain non-prescriptive and allow data to emerge from conversations rather than drawing on pre-existing literature or expertise to frame specific questions (Carey & Asbury, 2012). The data gathered from both focus groups and interviews were recorded and transcribed verbatim by the principal researcher. Interview participants were provided with their transcripts and invited to edit or confirm the content. Neither of the interviewees changed their data.

Data analysis

This research utilised a general inductive approach for data analysis with an overall goal of summary categories that captured key aspects of the data (Thomas, 2006). The process of data analysis followed Thomas's (2006) structure: preparation of the raw data by transcribing and member checking the interviews; close reading of the text; creation of categories based on repeated words and phrases representing ideas or concepts; overlapping coding and uncoded text to allow for some text to be included in more than one category; and finally continuing revision and refinement of the category system until clear themes emerged. Data analysis was conducted by the principal researcher initially, but further analysis was conducted collaboratively between all authors via email and phone conversations over a four month period. While some

discussion took place, particularly in relation to a non-occupational therapist seeking understanding of some categories, all three researchers reached consensus without difficulty. Three main themes or summary categories were identified, with specific sub-themes within these.

Findings

The primary themes were drawn from the analysis of the focus groups and follow-on interviews; life is risky, working with the risky discharge, and patient-centred risk. These are presented below with the sub-themes outlined in each description.

Life is risky.

When first asked what comes to mind when they think of risk, all participants across both focus groups started with their personal thoughts and engaged in a discussion that risk was a part of everyday life, associated even with everyday activities such as crossing the road. This discussion extended to how the idea of risk in day-to-day life was reflected in their role as occupational therapists. *"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 about. All of us take risks."* (FG1)

Participants also identified that risk was a part of day to day work within a hospital setting, *"...really, the first time you stand a patient you've got risk"* (FG2), and discussing that even the most seemingly safe activities were risky. However, there was also a discussion around the idea that choosing to do nothing at all similarly involved considerable risk. Participants engaged in listing the consequences of leaving a patient in bed, and identified the risks of declining strength and functional abilities, pressure injuries or chest infection, and delayed discharge. This perspective is summed up by this quote: *"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) Having come to the conclusion that risks occur even when we are trying to avoid it, participants in the study agreed that risk is a part of the occupational therapy role. This idea was checked and elaborated on further in the individual interviews. For example:

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 like putting somebody 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. (Interview 2)

Understanding changes with experience.

This sub-theme emerged from both focus groups and the subsequent interviews, when it became clear that with clinical experience there are changes in views of risk taking. More experienced participants initially identified that as new graduates they were more prone to avoiding risk, which encouraged the less experienced therapists to comment: *"As a new grad I definitely find myself staying on the very, very safe side sometimes."* (FG1)

Both groups expanded on this idea, agreeing that their willingness to take calculated risk increased as their confidence in their practice and in their clinical reasoning increased. Conversely, the more experienced participants discussed how their risk taking had changed over time; they reported that with hindsight they could see that they actually took more risks as novice therapists, but they were

unintentional and tended to stem from a lack of knowledge and awareness. The ability to recognise risk, as well as the skill and self-awareness to manage it, are important facets of advancing occupational therapy practice.

Choosing risk to support patient progress.

The final sub-theme in the 'life is risky' theme relates to patients. Following the conversations about everyday life being risky, and that the occupational therapist role includes understanding risk, participants extended their discussion to include the connection between risk taking and patient progress. *"I think if we didn't take risks half our patients would still be in AT&R"* [Assessment, Treatment and Rehabilitation unit]. (FG 2) Both groups identified that risk was a part of everyday occupational therapy practice, and that the way they understood and worked with risk changed according to their professional experience and their goals for their patients. This led to the next theme, which focused on risk in discharge from hospital.

Working with the risky discharge.

In this theme the participants focused on how they relate the concept of risk to discharge planning. Each focus group talked about the feelings of concern and worry they experience when a patient they have been working with closely 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?' (FG 2)

There was general agreement with the sentiments expressed in this quote, however one very senior therapist asserted that she used to worry about patients, but that with twenty-plus years of experience she no longer does.

Working with a team.

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

"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)

I think it's 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 it a lot easier to handle it [risk]. (Interview 2)

As 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 in the interviews where both therapists talked about supporting others involved in risky discharges:

"Just speaking to others about different sorts of risk." (Interview 2).

Talking through your own experience and your own

knowledge...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. (Interview 1).

Patient-centred risk.

In the final theme the focus shifts to the position of the patient within the concept of risk. There was a consensus throughout the focus groups and interviews that participants felt that the patient themselves should be the person making decisions about how much risk they are prepared to take. Examples from the data included:

"...there is a risk, but that is really coming down to personal choice and values and what that person wants." (FG 1)

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 (Interview 2).

As with the discussion in the first theme 'life is risky', the participants talked about managing risks in terms of minimising them, unanimously agreeing that completely eliminating all risk for patients would result in reduced quality of life. However, they also identified that their work needs to address what is important to the patient, and that risk presents opportunities for building confidence and making progress. They noted that being in hospital can be disempowering and can make patients feel less able to cope when they leave. One participant said, *"I guess it's almost empowering for some people to take risks, so you're actually giving that person something back by allowing them to take the risk."* (Interview 1).

The important part that families play in supporting older adults to age in their community was specifically mentioned in the focus groups. The participants acknowledged the importance of support; however it was also clear that family involvement was sometimes at odds with the therapists' view in the discharge planning process. Therapists described families who wanted the patient to be discharged to a rest home as they believed that the risks involved in discharge home (often alone) were too great, they were unable to see any value in supporting discharge back home. Participants also noted that families often wanted to completely eliminate risk, focusing instead on their fear for the patient and thereby demonstrating a different understanding of risk from that of the patient and therapist. It was suggested that this fear came from limited knowledge or experience and that a part of the therapist role was to work with the family to reach consensus.

Discussion and practice implications

The three themes; life is risky, working with the risky discharge and patient-centred risk have described the participants' experiences and perceptions of risk when discharging older people. In addition to the patient's health needs and personal preferences, participants in this study identified their own experience and confidence, the multi-disciplinary team, and the family as being important influencers on decisions that relate to risk.

We are all experts.

Lupton and Tulloch (2002) stated that therapists' understanding of risk can be shaped by social and cultural norms and has the potential to change dramatically with time and situation. The findings of this research support this stance; a central point to this discussion is that the ways

occupational therapists understand risk and how they feel about managing it is shaped by the people around them and their previous experiences. This research suggests that occupational therapists need to recognise more explicitly that they have their own view of risk, informed by their work culture, background and experiences. Importantly, this recognition should build on awareness that their view of risk can be quite different to the risk constructed by the patient.

There can be significant tensions between 'experts' and 'laypersons' who may have different understandings of risk (Slovic, 1999) and people choosing to take risks can be viewed as irrational (Lupton & Tulloch, 2002). Being aware of how the construction of risk can vary depending on the context means that the therapists' view of discharge risks is not unequivocally the expert view while the patient's is not based on a faulty perception. The power of the occupational therapist to shape and communicate the meaning of risk for the patient and their family is an area of practice that warrants further exploration.

Recognising everyday risk.

It became clear throughout the research process that while participants believed that keeping patients safely in bed can appear at first glance the safer option, doing nothing at all is also risky. In the same way that doing nothing can create risks such as secondary complications for patients, participants felt that completing only therapy that is entirely safe will not assist patients to make progress in a timely manner so that they can quickly leave hospital. This current study confirms Moats' (2006; 2007) findings that occupational therapy practice is increasingly complex and contends with the competing imperatives of patient wishes, family anxiety, and organisational needs. The participants in this study and subsequent analysis suggests that in their view, risk is always present in some way regardless of the actions a therapist may take. Recognising the presence of risk and its dynamic, context bound nature should be an essential part of occupational therapy practice.

Choosing risk.

The participants in this research indicated that a focus on safety and minimising risk can also remove valued aspects of life. Although older people in New Zealand are higher users of healthcare resources than any other age group (Ministry of Health, 2016), it is important to be aware that ageing does not necessarily go hand in hand with frailty or chronic disease. Ongoing participation in activities can have a positive impact on people's mental, social and physical well-being (Wilcock, 2007). The notion that high levels of risk management may be associated with patients potentially losing things of value such as independence, confidence, resilience and pride is in contrast to the belief that occupational therapy in acute care focuses heavily on safety post-discharge (Blaga & Robertson, 2008). This study suggests that there is a role for occupational therapists to enable "risky activities" to increase quality of life.

Risk is relative to time, place and person.

The findings from this research highlighted that occupational therapists may have different perspectives on risk taking during different moments in their career. Participants reported that they take more unintentional risks and fewer deliberate risks as new practitioners, with more considered risks as their experience grows. Recognising risk as a new graduate therapist is not explicitly addressed in occupational

therapy literature, however there is research into the association of practice errors with lack of experience and lack of knowledge (Lohman, Scheirton, Mu, Cochran, & Kunzweiler, 2008; Mu, Lohman, & Scheirton, 2006). In line with this research, Mu et al (2006) noted that following practice errors, therapists become more vigilant and modify their future practice to prevent errors from re-occurring. These modifications following an experience are potentially valuable parts of therapists' construction of risk. This research also found that therapists provide support to peers through the use of formal supervision and informal discussion. Sharing knowledge can help to alleviate concerns or worries and increase the confidence of less experienced therapists to take risks or help their patients to take risk. The combination of a modifying practice experience and discussions with peers is a powerful demonstration of the process of the changing construction of risk, culminating in a change in the therapist's perception.

Limitations

This study was conducted within one regional hospital, and with a small number of participants who self-selected into the research, so a bias in the focus group sample is possible. The interviewees were selected on the basis of their contributions to the focus groups with the intention of expanding on their perspectives. Further, the wide range of experience among the participants may have affected how much the newer therapists felt able to contribute to the focus groups. These factors mean that this study is positioned as exploratory, and further research is required to confirm and expand on the findings.

Conclusion

Discharge planning for older adults from acute care is a growing area of practice for occupational therapists. It involves increasingly complex issues such as multiple comorbidities and limited resources. When working in acute care with frail older adults, occupational therapists often focus on minimising risk, struggling to identify the potential gains that choosing to take risk can provide. Although seemingly simple, risk is a concept that is dependent on the knowledge and experiences of each therapist. Occupational therapists need to acknowledge risk as part of practice and construct a professional understanding as a basis for future dialogue. Support of less experienced therapists could include education about the external factors that impact on the understanding of risk and encourage reflection on their own experiences. The implications for practice also include recognition of the patient as the expert on their acceptable levels of risk, thereby enhancing client-centred practice, reducing instances of the occupational therapist 'owning' the risk, and challenging the view that risk is something we should allow patients to take.

Finishing with Mrs Smith's story serves the dual purpose of capturing this patient's sheer determination to take her own risks. It also documents her right to take risks, and illustrates 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 living in her own home despite her serious medical conditions, high risk of falls and progressive short term memory loss. While she has her wheelchair for longer distances, she now mobilises indoors with a walking stick and 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.

Key points

1. A part of the occupational therapist role is to consider risk as something that can assist patient progress as well as something to be avoided.
2. Perceptions and understandings of risk change with experience.
3. Families and patients may have different perceptions of risk and these need to be considered in discharge planning.

Conflict of interest

The authors declared no potential conflicts of interest with respect to the research, authorship, or publication of this article. No funding was received for this research.

References

- Atwal, A., Wigget, C., & McIntyre, A. (2011). Risks with older adults in acute care settings: Occupational therapists' and physiotherapists' perceptions. *British Journal of Occupational Therapy, 74*(9), 412-418. doi:10.4276/030802211X13153015305510
- Bauer, M., Fitzgerald, L., Haesler, E., & Manfrin, M. (2009). Hospital discharge planning for frail older people and their family. Are we delivering best practice? A review of the evidence. *Journal of Clinical Nursing, 18*(18), 2539-2546. doi:10.1111/j.1365-2702.2008.02685.x.
- Blaga, L., & Robertson, L. (2008). The nature of occupational therapy practice in acute physical care settings. *New Zealand Journal of Occupational Therapy, 55*(2), 11-18.
- Carey, M. A., & Asbury, J. (2012). *Focus Group Research*. Walnut Creek, CA: Left Coast Press.
- Clarke, C. L. (2000). Risk: Constructing care and care environments in dementia. *Health, Risk & Society, 2*(1), 83-93. doi:10.1080/136985700111477
- Clarke, C. L. (2009). Risk and long-term conditions: The contradictions of self in society. *Health, Risk & Society, 11*(4), 297-302. doi:10.1080/13698570903045427
- Craig, G., Robertson, L., & Milligan, S. (2004). Occupational therapy practice in acute physical health care settings: A pilot study. *New Zealand Journal of Occupational Therapy, 51*(1), 5-13.
- Crennan, M., & MacRae, A. (2010). Occupational therapy discharge assessment of elderly patients from acute care hospitals. *Physical & Occupational Therapy in Geriatrics, 28*(1), 33-43. doi:10.3109/02703180903381060
- Creswell, J. W. (2007). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches* (2nd ed.). Thousand Oaks, California: Sage Publications, Inc.
- Dickson, T., Chapman, J., & Hurrell, M. (2000). Risk in outdoor activities: The perception, the appeal, the reality. *Australian Journal of Outdoor Education, 4*(2).
- Dickson, T., & Dolnicar, S. (2004). No risk, no fun: The role of perceived risk in adventure tourism. Retrieved from <http://ro.uow.edu.au/commpapers/246>
- Durocher, E., & Gibson, B. E. (2010). Navigating ethical discharge planning: A case study in older adult rehabilitation. *Australian Occupational Therapy Journal, 57*(1), 2-7. doi:10.1111/j.1440-1630.2009.00826.x
- Haddock, C. (1993). *Managing Risks in Outdoor Activities*. Wellington, New Zealand: New Zealand Mountain Safety Council.
- Huby, G., Stewart, J., Tierney, A., & Rogers, W. (2004). Planning older people's discharge from acute hospital care: Linking risk management and patient participation in decision-making. *Health, Risk & Society, 6*(2), 115-132. doi:10.1177/1054773810372990
- Ivanoff, S. D., & Hultber, J. (2006). Understanding the multiple realities of everyday life: Basic assumptions in focus-group methodology. *Scandinavian Journal of Occupational Therapy, 13*(2), 125-132. doi:10.1080/11038120600691082
- Lohman, H., Scheirton, L., Mu, K., Cochran, T., & Kunzweiler, J. (2008). Preventing practice errors and improving patient safety: An examination of case studies reflecting common errors in occupational therapy practice. *Journal of Allied Health, 37*(4), 242-247.
- Lupton, D., & Tulloch, J. (2002). 'Life would be pretty dull without risk': Voluntary risk-taking and its pleasures. *Health, Risk & Society, 4*(2), 113-124. doi:10.1080/13698570220137015
- Ministry of Health. (2016). DHB spending on services for older people. Retrieved from <https://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/older-peoples-health-data-and-stats/dhb-spending-services-older-people>
- Moats, G. (2006). Discharge decision-making with older people: The influence of the institutional environment. *Australian Occupational Therapy Journal, 53*(2), 107-116. doi:10.1111/j.1440-1630.2006.00568.x.
- Moats, G. (2007). Discharge decision making, enabling occupations, and client-centred practice. *Canadian Journal of Occupational Therapy, 74*(2), 91-101.
- Mu, K., Lohman, H., & Scheirton, L. (2006). Occupational therapist practice errors in physical rehabilitation and geriatrics settings: A national survey study. *American Journal of Occupational Therapy, 60*(3), 288-297. doi:10.5014/ajot.60.3.288
- New Zealand Mountain Safety Council. (2004). *Outdoor Safety: Risk Management for Outdoor Leaders*. Wellington, New Zealand: Author.
- O'Byrne, P. (2008). The dissection of risk: A conceptual analysis. *Nursing Inquiry, 15*(1), 30-39. doi:10.1111/j.1440-1800.2008.00372.x.
- Plummer-D'Amato, P. (2008). Focus group methodology part 1: Considerations for design. *International Journal of Therapy and Rehabilitation, 15*(2), 69-73.
- Priest, S. (1993). A new model for risk taking. *Journal of Experiential Education, 16*(1), 50-53. doi:10.1177/105382599301600111
- Reich, S., Eastwood, C., Tilling, K., & Hopper, A. (1998). Clinical decision making, risk and occupational therapy. *Health & Social Care in the Community, 6*(1), 47-54.
- Sandelowski, M. (2000). Focus on research methods: Whatever happened to qualitative description? *Research in Nursing & Health, 22*, 334-340.

- Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health*, 33, 77-84. doi:10.1002/nur.20362
- Slovic, P. (1999). Trust, emotion, sex, politics, and science: Surveying the risk-assessment battlefield. *Risk Analysis*, 19(4), 689-701. doi:10.1111/j.1539-6924.1999.tb00439.x
- Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, 27(2), 237-246. doi:10.1177/1098214005283748
- Welch, A., & Lowes, S. (2005). Home assessment visits within the acute setting: A discussion and literature review. *The British Journal of Occupational Therapy*, 68, 158-164. doi:10.1177/030802260506800403
- Wilcock, A. (2007). Active ageing: Dream or reality. *New Zealand Journal of Occupational Therapy*, 54(1), 15-20.
- World Health Organization. (2011). *Definitions of key concepts from the who patient safety curriculum guide*. Geneva: World Health Organization. Retrieved from http://www.who.int/patientsafety/education/curriculum/course1a_handout.pdf.