

Dignity of risk in residential aged care: a call to reframe understandings of risk

The Royal Commission into Aged Care Quality and Safety sent a powerful message to the community that older Australians deserve to be treated with dignity and respect, and affirmed a government commitment to completely transform the aged care system. As a consequence of this reform agenda, the focus in residential aged care has acquired a rights-based lens.^{1,2} This includes the right for individuals to make their own decisions, including choices that involve risk. Dignity of risk is the “principle of allowing an individual the dignity afforded by risk taking”,³ encouraging providers to balance the harms and benefits of paternalism and examine the justifiability of protective measures. The *Aged Care Act 2024* sets out a Statement of Rights and Principles, and compliance obligations to strengthened Quality Standards and the Code of Conduct for Aged Care, which facilitate autonomy, choice, and independent decision making.^{2,4,5} Dignity of risk is respected when risk-based choices are supported — decisions such as the refusal of mobility assistance in the context of heightened falls risk, choice of food texture despite choking hazard or aspiration risk, or engagement in activities that risk injury or unexplained absence. Duty of care is often referenced to justify actions or behaviours that inhibit risk taking, but this mostly sits within the narrow view of preserving physical safety. This can lead to a paternalism grounded in care that ultimately deprives residents of opportunities to take and accept risks to live a dignified life. Repositioning risk as having both positive and negative outcomes, and necessary to quality of life and dignity in aged care, is an essential step towards realising person-centred care (Box 1 and Box 2).

Robert Perske was the first to connect the concept of dignity with taking of risks. Perske claimed the denial of persons with intellectual disabilities “exposure to normal risks commensurate with their functioning tends to have a deleterious effect on both their sense of human dignity and their personal development”.⁶ Perske argued that the real world is not always safe and predictable, every day yielding the possibility of risk, and that individuals are enabled to thrive through risk taking.⁶ Perske claimed human dignity in risk, and dehumanising indignity in overprotection. This early notion of dignity through risk taking, and recognition of a need to shift away from paternalism, has subsequently played a similar role in the context of aged care, mental illness, hospice care, and rehabilitation.⁷⁻⁹

It is a human reality that risks are present in everyday life, and risk can be seen as either a threat to be managed, or a positive opportunity for growth.^{6-8,10,11} Older adults who take risks experience a range of dignity-enhancing benefits: increased social interaction, independence, hope, empowerment, self-esteem, self-worth and respect,

and self-determination.^{10,12-14} Hence, implementing risk-averse strategies in residential care potentially denies residents the benefits of positive risk taking and can affect wellbeing. Older adults are sometimes so protected from risk that these protective measures themselves become a source of harm.¹⁵ Dignity can be violated, for example, when an individual at risk of falling is constrained from independent mobility due to alarm sensor mats, or excluded from community activities and denied socialisation because of wandering risk.

Historically, especially in health care contexts, a paternalistic approach towards risk has been adopted. The framing of risk has shifted towards something to be avoided, minimised, or controlled, generally for assurance of physical safety.¹² In aged care, the resident experience is often that undesired actions or behaviours are deemed “too risky” as the explanation for discouragement, even though community-dwelling older adults might be freely doing the same thing. Refusals to accept staff recommendations about care commonly see residents labelled non-compliant

1 Dignity of risk case example in Australian residential aged care*

George is in his 80s and living in residential aged care. He expresses a strong preference for swallowing his medications whole, despite significant swallowing difficulties. The facility's speech pathologist has recommended George's tablets be crushed to allow for easier medication administration and to reduce the risk of choking, and possibly death. George declines to comply with this recommendation. He sees swallowing his tablets intact as a matter of choice and control, and these values are important to him. George feels he should have the right to decide how he lives his life.

Although the residential aged care facility is supportive of George, the staff still struggle to reconcile his preference with their own apprehensions. The carers report feeling distressed whenever he ingests his medications. They witness him experience severe discomfort and near-choking episodes, as each tablet can take some time and require multiple attempts to swallow. The fear of George choking when they are in attendance is ever-present. The provider is concerned about the psychological wellbeing of the staff and conscious of their duty to manage workplace risks to psychological health and safety. Duty of care obligations to George, and the legal and regulatory consequences of an adverse health outcome are also considerations.

A meeting is facilitated involving George and his daughters, the general practitioner, and the multidisciplinary team. George's decision-making capacity is assessed by his general practitioner; George can comprehend, retain, and weigh up the information provided to support his decision, and he freely and voluntarily gives informed consent.

George signs a written agreement with the facility indicating that he understands the potential consequences of his choice and is accepting of the risks. Nonetheless, George considers independence with his medication management, including the right to take risks, as integral to his dignity and quality of life in residential aged care.

*This case is based on composite real-world experience and does not represent an actual resident. ♦

Maria Foundas^{1,2,3}

¹ St John of God Midland Public and Private Hospitals, Perth, WA.

² University of Notre Dame Australia, Fremantle, WA.

³ Bethanie Group, Perth, WA.

maria.foundas@sjog.org.au

2 A case study approach applying dignity of risk in residential aged care: resolving dilemmas by adopting a positive view of risk taking

Looking at “dignity of risk” through the restricted lens of autonomy and informed consent, George should be supported to swallow his medications whole. Risk taking gives him a dignity based on respect for his autonomy and George’s personal values of choice and control. But George is not the only stakeholder, and he (and others) might experience real harms. George may experience a major health care complication or die. It is clear that swallowing his tablets crushed would protect George from physical harm, the caregivers from psychological harm, and the health care professionals and provider from potential regulatory or legal consequence. Therefore, this presents a dilemma. The provider also has competing legislative and regulatory obligations. They have to ensure the delivery of safe, high quality care to residents, a psychologically safe workplace for staff, and respect George’s right to make decisions that involve risk. George’s doctor must also balance the delivery of person-centred, rights-based, quality clinical care, alongside legal obligations to duty of care and informed consent, and commitment to their own professional standards and ethics.

The evaluation of George’s case therefore requires access to an expanded suite of considerations relevant to residential aged care, including dignity of risk. All stakeholders should be engaged to explore their own, often values-based, narratives. George, influenced by his own values and lived experience, will hold his own beliefs around what constitutes an acceptable risk to live the life of his choosing. This will undoubtedly be different for the general practitioner, caregivers and provider who will likely place a higher value on physical safety and perceive a duty of care to protect George from harm. The benefits of risk taking, beyond perceptions of harm, and best interest considerations that extend beyond the medical or physical perspective should be richly explored.

Incorporating dignity of risk into a broader, narrative-based analysis may alter the framing of benefits and burdens, and create a deeper, more descriptive assessment of the situation. There should be enhanced appreciation for how George might wish to live his life, in its final stages. The provider and health care professionals should seek to manage George’s risks in the least restrictive way, and balance his rights and preferences against his safety, and the wellbeing of the other caregivers. Effective risk management principles require that providers identify, manage and continuously review risks to aged care consumers.

Implementing dignity of risk in practice requires understanding of the important role of positive risk taking and acceptance from providers, caregivers and families that residents may wish to take risks in their daily life. Supporting stakeholders to see that there is a dignity given to George when he is supported to take risks may change the priority focus from protection to enablement when all the relevant factors are considered.

or high risk. Yet outside this context they may be viewed as confident or brave.¹⁶ Sometimes, the risk outcome affects more than the individual decision maker, often with very different interests at stake.¹⁷ Unlike the community, where the risk consequence is borne largely by the risk taker, providers have legal obligations to external regulatory bodies and their staff, and a duty of care obligation to ensure resident safety and wellbeing. Other residents may also be affected by the risk outcome; for example, the resident choosing to drive a mobility scooter despite safety concerns to others. The legislation recognises that providers must balance individual rights with competing or conflicting rights and other legislative compliances.² Doctors may experience competing obligations when resident rights conflict with quality

care delivery, with common law and local statutes also governing duty of care, capacity and consent. Codified standards and professional ethics further guide practice. Families expect health care practitioners and providers to act with care to avoid their loved one experiencing harm.

Woolford and colleagues¹⁸ qualitatively explored with policy makers and guardians the meaning, barriers and facilitators to applying dignity of risk in the aged and disability sectors. All participants acknowledged that taking risks is an important aspect of human life and central to dignity of risk. It was generally understood that maintaining a life according to a resident’s values inevitably includes risk, and that implementing risk-averse strategies will likely affect wellbeing. However, risk was universally perceived negatively and generally associated with adverse consequences, especially the potential for physical harm and need for safety and protection. In practice, risk-reduction strategies are prioritised over the promotion of independence.^{12,18} There is often limited appreciation of the positive benefits of risk and no counter strategy for risk enhancement. Bailey and colleagues⁸ reflected on the complex area of risk in dementia care and found a competing narrative of protection and vulnerability, and concern for litigation, undermining a positive approach to risk. Regulation and compliance, and adherence to duty of care, is often action guiding for caregivers and providers. This can result in a restricted appetite for supporting risk taking in residential care due to concerns about adverse clinical outcomes and the regulatory consequences of non-compliance. Resource constraints present a practical barrier, especially when adequate staffing or a changed physical environment is required to support the risk.

Putting dignity of risk into practice does not mean the resident-centric view should always prevail, especially with multiple stakeholders, competing obligations, and possible individual and/or third-party harms.¹⁹ Providers should instead be challenged to balance the delivery of person-centred care, where residents are enabled to express preferences and goals, make choices, and take risks, within a risk management framework that attempts to mitigate the potential risks (and harms) arising from those choices.^{4,18,20} Balancing risk and safety, or benefits and burdens, needs a values-driven narrative to incorporate the equally important, but often divergent, perspectives of residents, caregivers and providers. This might mean reconsidering, reframing, or questioning opposing viewpoints about risk and safety, and probing what is really in a resident’s best interests. Conceptions of “risk” and “safety” are likely to be vastly different, yet are central to the conflict.^{13,16}

Providers and caregivers should be encouraged to consider the positive benefits of risk taking, and explore beyond the medical or physical perspective when considering best interests and possible harms.¹² Duty of care obligations should extend to supporting risk-taking opportunities, not just to prevent harms. When the positive benefits of risk taking are appreciated alongside potential harms, this supports reaching

a conclusion that genuinely honours and respects a resident's dignity of risk. This means providers and caregivers are thinking less about protecting residents and avoiding risks and instead determining which risks are reasonable to support, and meaningful enough to the resident, so the resident remains "safe enough". Aged care residents are especially vulnerable to dignity violations and sometimes need protection from harms. But dignity-enhancing opportunities for risk taking are a fragile right too and providers have a duty to nurture and safeguard these. Consider a resident with dysphagia who declines thickened fluids, because their sole pleasure is a cup of tea. They might accept thickened fluids if tea is the agreed exception, with caregivers ensuring correct positioning and a suitable drinking vessel. When staff understand the dignity-enhancing benefits to the resident, this can change perceptions of harm.

The implementation of dignity of risk in real-world contexts has been challenging for aged care providers who have struggled to reconcile the many competing tensions.^{1,3,18,20} It has been difficult to operationalise, especially as the number of residents, many with cognitive impairment, continues to increase.²¹ Providers are expected to ensure residents understand the risks, work with the resident to manage the risks, and respect residents' decisions. This means that dignity of risk is often collapsed into autonomy and informed consent. However, respect for autonomy provides far less ethical guidance when an individual's decisions might cause them harm or affect other residents or staff. Hence, there is a call for practical guidance to support both providers and residents.^{1,3,18} Choice and dignity need to be deeply embedded in the daily care of residents, and risk-based decisions should be supported by effective organisational policies. Stakeholders must develop a shared language around risk: why it is important to the resident, how it enhances the dignity of the resident, and what harms might result (and to whom) if the risk is supported. Through acknowledging the positive benefits of risk taking, and supporting residents to make choices and take chances, providers, caregivers and residents can become authentic partners in person-centred care.

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