Nova Scotia Health Frailty and Elder Care Network:

Dignity of Risk Program

INTERNATIONAL SYMPOSIUM ON DIGNITY OF RISK
APRIL 29, 2026

CATHERINE-ANNE MURRAY, DOR TEAM LEAD, OTREG(NS)

nova scotia health
Frailty and Elder Care Network

Presenter Disclosure

- No Conflict of Interest to declare

Dignity of Risk Program

01 **Frailty and Elder Care Network**
Dignity of Risk program

02 **DoR Education:**
via workshops and webinars

03 **DoR Implementation:**
via onsite pilot and
Clinical Frailty Scale (CFS) care plans

04 **NS Health resources**

05 **Future directions**

Frailty and Elder Care Network

Enhancing care for older adults living with frailty.

Centered on patients, focused on outcomes.

Become an older adult-friendly organization

Promote dignity and autonomy in aging by challenging ageism in healthcare

Adopt a system wide approach to frailty assessment and management

Advance frailty recognition, management and care across health systems and communities

Reduce unintentional hospital harm

Support older adults to stay independent, recover faster and return to the place they call home

Frailty ● **Dignity of Risk** ● **Early Mobility Program** ● **Seniors' Care Team** ● **Delirium**

nova scotia health
Frailty and Elder Care Network

www.nshealth.ca/frailty

Education 2024 - 2025

Total: ~200 sessions (1-3 hrs), in person workshop or virtual
over 2400 participants, province-wide

Topics: Frailty foundations, Clinical Frailty Scale (CFS)
DoR, Ageism, Overprotective attitudes, Fear of Liability, Hyperfocus on Safety
Broadened risk assessment and management, Coaching caregivers

Audience: Direct care staff, Leads, Physicians, IPPL, QIPS, Public

Findings: Surveys: Pre (n=685) Post (n=253) (Frailty/DoR workshops 2-3 hours)

DoR Workshop Findings

- Pre survey: Variable knowledge with DoR, but rated very important to incorporate into older adult care

- Post survey: -Increased confidence to implement DoR into practice
  -Increased confidence to have supportive risk conversations with caregivers

"Creating a positive risk culture means changing the language from safety to risk mitigation."

"Life is risky no matter what stage you're at or ability you have. ***Risk isn't a bad thing****."*

Post DoR Workshop Insights

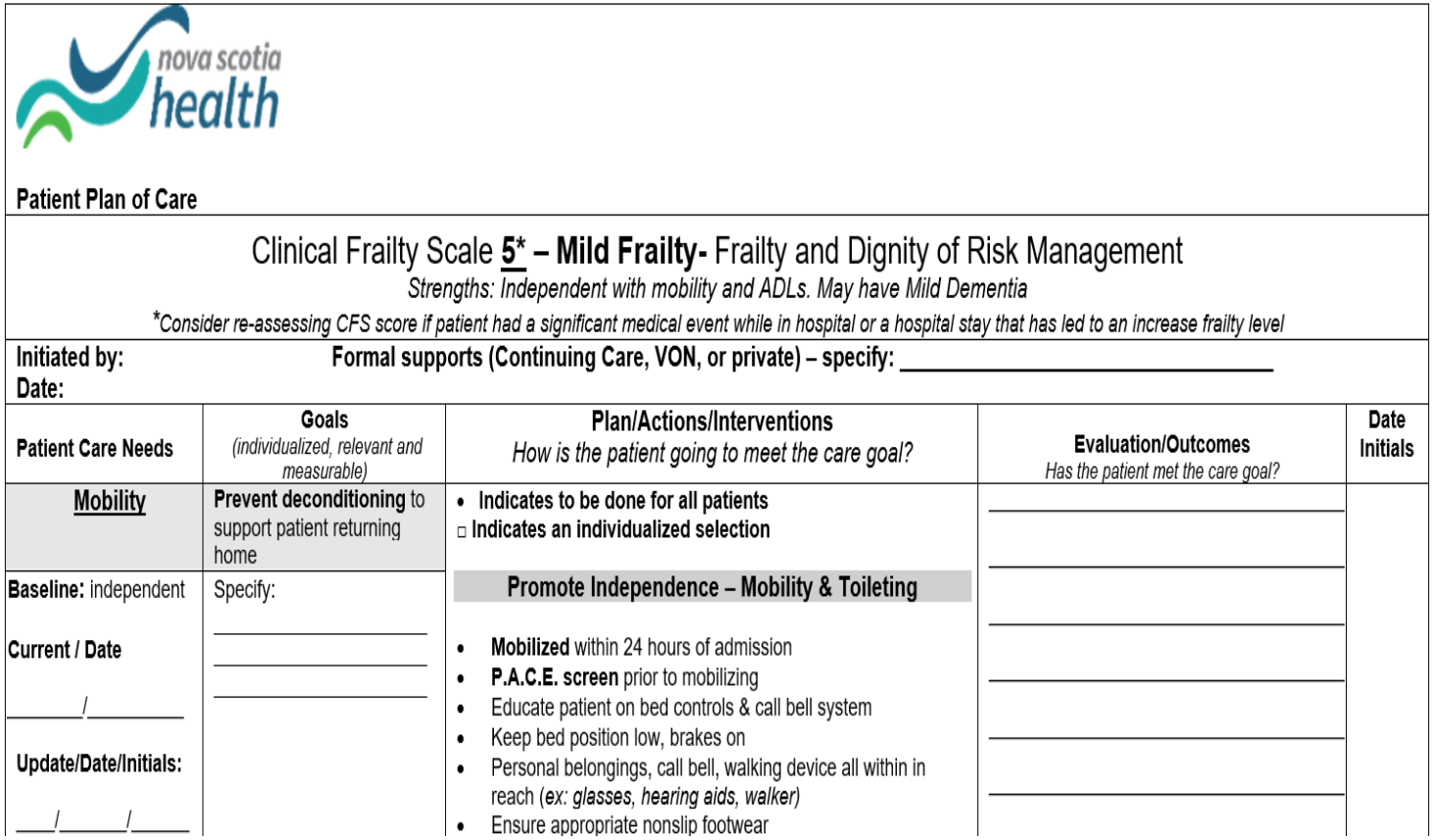
- Placing Greater Emphasis on Autonomy Over Absolute Safety
- More Confidence in Discussing and Documenting Risk
- Recognizing the Need for a Shift in Healthcare Culture
- Expanding System-Wide Education and Support
- Utilizing Tools Like the Clinical Frailty Scale (CFS)

"The great aim of education is not knowledge, but action."
— Herbert Spencer

Frailty and DoR Informed Care Pilot

- Urban general hospital, summer 2025
- **General medicine acute care unit** (>70% patients 65 years or older, CFS score obtained)
- Frailty and DoR workshop (2-3 hours) with 56% staff pre-pilot
- Two Network Leads (RN and OT) on site “at the elbow” x 6 wks
- **Developed and trialed CFS care plans** (CFS scores 3 - early 6)
- Implementation Science Team support (track changes, leader observations, provider surveys)

DoR at the point of care: CFS care plans (CFS scores 3-6)



nova scotia health

Patient Plan of Care

Clinical Frailty Scale **5*** **– Mild Frailty-** Frailty and Dignity of Risk Management

Strengths: Independent with mobility and ADLs. May have Mild Dementia

**Consider re-assessing CFS score if patient had a significant medical event while in hospital or a hospital stay that has led to an increase frailty level*

Initiated by: **Formal supports (Continuing Care, VON, or private) – specify:** _____

Date:

Patient Care Needs	**Goals** *(individualized, relevant and measurable)*	**Plan/Actions/Interventions** *How is the patient going to meet the care goal?*	**Evaluation/Outcomes** *Has the patient met the care goal?*	**Date Initials**
Mobility	**Prevent deconditioning** to support patient returning home	• **Indicates to be done for all patients** □ **Indicates an individualized selection** **Promote Independence – Mobility & Toileting** • **Mobilized** within 24 hours of admission • **P.A.C.E. screen** prior to mobilizing • Educate patient on bed controls & call bell system • Keep bed position low, brakes on • Personal belongings, call bell, walking device all within in reach (*ex: glasses, hearing aids, walker*) • Ensure appropriate nonslip footwear		
Baseline: independent **Current / Date** _____/_____ **Update/Date/Initials:** ___/_____/____	Specify: _____ _____ _____			

- **Replaces 7 care plans**

(mobility, falls, Braden, nutrition, pain, delirium, toileting)

- **PACE mobility screening** by nursing staff within 24 hours of admission
- Optimizes remaining strengths and abilities, **emphasis on mobility and toileting**, while **simultaneously managing multiple risks** to preserve independence and autonomy.
- Pt and family education/involvement: *Immobility, Falls & Dignity of Risk*
- Includes What Matters Most and aligns with discharge home initiatives such as Home First and SAFER-f

Pilot Findings

Provider checklist (completed early, mid, late pilot):

- Increase use of strength-based language

  *"**I used strength- and ability-based language, rather than deficit-focused language, in my care planning documentation**. (ex CFS 4/5 - was independent with toileting at home, avoid incontinence products and soaker pads in hospital)"*

- Increase implementation of Frailty and DoR Informed Care Plan

  *"**I actively implemented care plans that reflect patients goals, values, and capabilities** (ex CFS 5 - striving for independence in mobility and ADLs, remove restrictive devices such as bed alarms and bottom rails)"*

- Increase involvement of Care Partner in balanced risk conversations

  *"**I involved care partners/families in a way that supports-not overrides-patient autonomy**. (ex encouraging and coaching family to mobilize with patient)"*

Pilot Findings

3-Month post pilot provider survey:

- Modest Positive culture shift and buy-in for DoR and frailty-informed care

  "I have seen positive changes in how we approach patient autonomy since the pilot began. "

  "I spend more time documenting patient preferences or decisions in a way that improves care. "

- High Perceived Value, especially among less experienced staff

  "I spend more time communicating risk-benefit decisions with patients and families, and this feels like time well spent (e.g., immobility, pressure injuries, benefits of mobility)."

- Active facilitation and iterative adjustment appeared to support smoother implementation and stronger engagement

  The pilot suggests that translating DoR principles into everyday hospital practice can be facilitated by visible leadership, workflow-compatible tools, and regular reinforcement, rather than education alone.

NS Health Frailty and DoR Resources

- Library guide: Home - Frailty and Elder Care Network - LibGuides at Nova Scotia Health

DoR resources include:

- DoR train the trainer guide
- Mobility – “a positive risk worth supporting” facilitator activity
- Immobility, Falls, and DoR – patient/family education for acute care
- Language Dos and Don’t’s
- Documentation considerations

- CFS care plans (CFS scores 3-6)
- Implementation toolkit (Frailty and DoR Informed care pilot)

Current and Future Directions

- Primary Care – Frailty and DoR informed care with collaborative clinics
- Capacity and DoR - evidenced risk assessment and management first
- Quality Improvement partnerships:
  -Documentation considerations – DoR principles/balanced risk language
  -Serious Reportable Events (Falls, Pressure Injuries) incident reviews and recommendations
- Influence in policy, standards, and guidelines:
  -Frailty Network Strategic Plan 2025-2027
  -Falls prevention and Care Planning policies
  -Acute care standard of work – Frailty and DoR

Thank you

"the aging population should not be seen merely as a challenge or burden, but as a vital ***opportunity*** *to innovate our healthcare systems, improve quality of life, and harness the wisdom and experience that older adults bring to our communities."*
–Dr. Rockwood

nova scotia health
Frailty and Elder Care Network

dignityofrisk@nshealth.ca