



The provincial Rehabilitative Care Alliance is working with the Ministry of Health to support the development of an Assess and Restore philosophy across the continuum of the health care system. As such, the Frail Senior/Medically Complex (FS/MC) Task Group of the Alliance has developed a FS/MC “Compendium”.

The purpose of the RCA Frail Senior/Medically Complex Compendium is to:

- Provide a concise summary from gold standard literature of best practices regarding the assessment and treatment of geriatric syndromes
- Increase awareness of the geriatric syndromes that contribute to frailty
- Increase capability amongst rehabilitative care professionals to assess and treat geriatric syndromes.

NOTE: The following gold standard documents were endorsed by the FS/MC Task Group to be included in the development of the Compendium:

- o Registered Nurses Association Of Ontario (RNAO)
- o Canadian Coalition for Seniors’ Mental Health (CCSMH)
- o Senior Friendly Hospital (SFH) Toolkit (2012)
- o Regional Geriatric Programs (RGP) GiiC Toolkit

Each of the geriatric syndromes includes the following two sections:

- o **Standardized Assessment**
 - Standardized, cross-continuum (where available) and/or sector specific assessment tools and leading practices for use in combination with clinical judgment and functional trajectory by rehabilitative care providers to support the assessment of high-risk adults with restorative potential in the context of each of the geriatric syndromes.
- o **Standardized/Evidence-Based Interventions**
 - Existing evidence-based interventions and clinical practices that are effective for use by rehabilitative care providers to support the care needs of high-risk older adults who have restorative potential in the context of ‘Geriatric Syndromes’ and other considerations.

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Compendium of Evidence-Based Assessments and Interventions to Support the Management of the Geriatric Syndromes in Long Term Complex Medical Management & Long Term Care Homes

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Delirium Standardized Assessment

[RNAO - Screening for Dementia, Delirium and Depression](#)

[CCSMH – The Assessment and Treatment of Delirium](#)

[SFH - Screening and Detecting Delirium](#)

- A high index of suspicion should be maintained for delirium, dementia and depression in the older adult (B)¹.
- Clients should be screened for changes in cognition, function, behaviour and/or mood, based on ongoing observations of the client and/or concerns expressed by the client, family and/or interdisciplinary team, including other specialty physicians (C)¹.
- There are differences in the clinical features of delirium, dementia and depression and a structured assessment method should be used to facilitate this process (C)¹.
- All clinicians working with older persons should be aware that the symptoms of delirium may be superficially similar to those of a dementia and that the two conditions frequently co-exist. Clinicians should be aware of the features that can help differentiate delirium from dementia (C)².
- Objective assessments of cognitive changes should be completed by using one or more standardized tools in order to substantiate clinical observations (A)¹.
- Factors such as sensory impairment and physical and disability should be assessed and considered in the selection of mental status tests (B)¹.
- Prevention efforts should be targeted to the older person’s individual risk factors for delirium[D]².
- Delirium can be detected more easily when a structured and routine process to screen for delirium and cognitive function during hospitalization is established, using standardized instruments where possible. This facilitates detection of delirium and also helps to differentiate its symptoms from chronic or slower onset syndromes like dementia or depression. Tools include³:
 - Confusion Assessment Method (CAM).
 - Delirium Observation Screening (DOS) Scale
- All clinicians working with older persons should be aware that delirium can show a fluctuating course with periods of lucidity during which the person’s mental/cognitive status can appear unremarkable. Therefore, repeated screening and looking for diurnal variation is recommended [C]²
- The evaluation of an older person for the possibility of delirium should include a review of their prior cognitive functioning (e.g., over the previous six months) [C]².
- In response to either observations or reports of changes in mental status/alertness from members of the clinical team, the older person or members of their family, an assessment should be initiated to search for evidence of delirium [C]².
- While clinicians use screening tools to identify persons with probable delirium in need of further evaluation and follow-up, the results from these tools must be interpreted within a clinical context and do not in themselves result in a diagnosis of delirium [D]².
- Delirium should be considered as a potential cause of any abrupt change in the cognition, functional abilities, and/or behaviour of an older person seen in an ambulatory clinic, primary care, or long term care setting [C].²
- Due to the fluctuating course of delirium and since many older persons will not be able to provide an accurate history, collateral information should be sought [C].²
- All clinicians working with older persons should be aware that intact functional status does not rule out delirium[C].²
- All clinicians working with older persons should be vigilant of recent-onset lethargy and unexplained somnolence, which might indicate the development of the hypoactive-hypoalert sub-type of delirium [C].²
- All clinicians working with older persons should recognize that while symptoms of delirium typically develop abruptly, an insidious onset can occur [C].²
- Older persons with complex presentations such as those with pre-existing neurocognitive decline, cerebrovascular disease and/or aphasia may require referral for assistance in the diagnostic work-up. The referral may be directed to a geriatrician, geriatric or general psychiatrist, neurologist,

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	<p>and/or neuropsychologist²</p> <ul style="list-style-type: none"> • Serial cognitive and functional measurements should be done. They will help in monitoring the older person’s progress and their need for care [D].² • When the care of an older person with delirium is transferred to another practitioner or service, the receiving practitioner or service must be informed of the presence of the delirium, its current status and how it is being treated [D].² • Strive to maintain and improve (where appropriate) the older person’s self-care abilities, mobility and activity pattern. Allow free movement (provided the older person is safe) and encourage self-care and other personal activities to reinforce competence and to enhance self-esteem [D].²
<p style="text-align: center;"><u>Delirium</u> Standardized Intervention</p> <p style="text-align: center;"><u>CCSMH - The Assessment and Treatment of Delirium</u></p> <p style="text-align: center;"><u>SFH - Preventing and Managing Delirium</u></p>	<ul style="list-style-type: none"> • Delirium is a medical emergency and requires urgent intervention. Treatment of all potentially correctable contributing causes of the delirium should be done in a timely, effective manner [D].² • Interventions to prevent delirium should be interdisciplinary². [A] • Older persons with delirium are at risk for micronutrient deficiencies (e.g., thiamine), especially if alcoholic and/or have evidence of malnutrition. A daily multivitamin should be considered [D].² • Strive to maintain a normal elimination pattern. Aim for regular of voiding during the day and a bowel movement at least every two days [D].² • Urinary retention and fecal impaction should be actively looked for and dealt with if discovered [D].² • Multicomponent interventions targeting multiple risk factors should be implemented in older persons who have intermediate to high risk for developing delirium². [A] • Older persons with impairments of vision should be provided with their visual aids and/or other adaptive equipment². [B] • Older persons with impairments of hearing should be evaluated for reversible causes and provided with hearing aid(s) and/or other amplifying devices². [B] • Older persons with evidence of dehydration should be encouraged to increase their oral fluid intake. Other measures may be required depending on the severity of the dehydration and the patient’s response to efforts to increase their oral intake². [B] • Environmental risk factors should be modified, if possible, including the following:² [D] <ul style="list-style-type: none"> ○ Sensory deprivation (e.g., windowless room, single room), Sensory overload (e.g., too much noise and activity), Isolation from family/friends (or familiar objects), frequent room changes, absence of orientating devices (e.g., watch, clock or calendar), absence of visual/hearing aids, use of restraints. • Where available, proactive consultations to a geriatrician, geriatric or general psychiatrist, or to a general internist should be considered for older persons undergoing emergency surgery to minimize the risk of post-operative delirium². [B] • Prevention, early detection, and treatment of postoperative complications in older persons are important in preventing delirium. These would include (but are not limited to) the following: myocardial ischemia, arrhythmias, pneumonia, exacerbations of COPD, pulmonary emboli, and UTIs². [B]. • All clinicians working with older persons should be alert to the possibility of delirium developing after surgical procedures (especially cardiopulmonary bypass and surgical repair of a hip fracture), with acute medical conditions (e.g., infections) and/or during exacerbations of chronic medical conditions (e.g., Congestive Heart Failure)². [C] • All clinicians working with older persons should be aware that delirium can show a fluctuating course with periods of lucidity during which the person’s mental/cognitive status can appear unremarkable. Therefore, repeated screening and looking for diurnal variation is recommended². [C] • Due to the fluctuating course of delirium and since many older persons will not be able to provide an accurate history, collateral information should

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- be sought². [C]
- All clinicians working with older persons should be aware that intact functional status does not rule out delirium². [C]
- All clinicians working with older persons should be vigilant of recent-onset lethargy and unexplained somnolence (i.e., sleepiness, or the state of feeling drowsy), which might indicate the development of the hypoactive-hypo alert sub-type of delirium². [C]
- All clinicians working with older persons should recognize that while symptoms of delirium typically develop abruptly, an insidious onset can occur² (e.g., irritability, restlessness, anxiety, or sleep disturbance). [C]
- Delirium should be considered as a potential cause of any abrupt change in the cognition, functional abilities, and/or behaviour of an older person seen in an ambulatory clinic, primary care, or long term care setting². [C]
- The evaluation of an older person for the possibility of delirium should include a review of their prior cognitive functioning (e.g., over the previous six months)². [C]
- In response to either observations or reports of changes in mental status/alertness from members of the clinical team, the older person or members of their family, nurses caring for the older person should initiate an assessment searching for evidence of delirium². [C]
- The physician responsible for the older person should promptly review the delirium screening results and determine the need for further evaluation². [C]
- Older persons with complex presentations such as those with pre-existing neurocognitive decline, cerebrovascular disease and/or aphasia may require referral for assistance in the diagnostic work-up. The referral may be directed to a geriatrician, geriatric or general psychiatrist, neurologist, and/or neuropsychologist². (C)
- While clinicians use screening tools to identify persons with probable delirium in need of further evaluation and follow-up, the results from these tools must be interpreted within a clinical context and do not in themselves result in a diagnosis of delirium². [D]
- It is recommended that clinicians use the Confusion Assessment Method (CAM) for screening and as an aid in the assessment/diagnosis of delirium occurring in older persons on acute medical/surgical units and in EDs². [C]
- Ratings on the CAM should be informed by an objective mental status examination². [C]
- Serial cognitive and functional measurements should be done. They will help in monitoring the older person's progress and their need for care². [D]
- When the care of an older person with delirium is transferred to another practitioner or service, the receiving practitioner or service must be informed of the presence of the delirium, its current status and how it is being treated². [D]
- Strive to maintain and improve (where appropriate) the older person's self-care abilities, mobility and activity pattern. Allow free movement (provided the older person is safe) and encourage self-care and other personal activities to reinforce competence and to enhance self-esteem². [D]
- The implementation of intensive rehabilitation that requires sustained attention or learning from the delirious older person is not likely to be beneficial and may increase agitation. It should be delayed until the older person is able to benefit from the intervention². [D]
- Given difficulties in sustaining attention, when communicating with a delirious older person ensure that instructions and explanations are clear, slow-paced, short, simple, and repeated. The older person should be addressed face-to-face². [C]
- Avoid abstract language/ideas and do not insist that the older person appreciate the information that is being given².
- Do not engage in discussions that the older person cannot appreciate². [C]
- Discuss topics that are familiar and/or of interest, such as hobbies and occupation, with the older person². [D]
- Routinely provide orienting information in the context of care. For example, frequently use the older person's name and convey identifying

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- information (e.g., “I’m your physiotherapist”)². [D]
- When providing care, routinely explain what you are about to do. This is to reduce the likelihood of misinterpretation². [D]
 - Keep your hands in sight whenever possible and avoid gestures or rapid movements that might be misinterpreted as aggressive. Try to avoid touching the older person in an attempt to redirect him/her². [D]
 - Avoid both sensory deprivation (e.g., windowless room) and sensory overload (e.g., too much noise and activity). The older person’s room should be quiet with adequate lighting. Over-stimulation is a common antecedent of agitation². [C]
 - Implement unit-wide noise-reduction strategies at night (e.g., silent pill crushers, vibrating beepers, quiet hallways) in an effort to enhance sleep². [C]
 - Check if the older person wants a radio or television for familiar background stimulation and arrange for it, if requested and possible. Allow delirious older persons to listen to music of their choice. If it is felt that these devices are distracting, disorientating and/or disturbing to the older person when used, they should be removed from the room². [C]
 - Ensure that the older person’s room has a clock, calendar and/or chart of the day’s schedule. Give the older person frequent verbal reminders of the time, day and place². [C]
 - Attempt to keep the older person in the same surroundings².
 - Avoid unnecessary room changes². [C]
 - Obtain familiar possessions from home, particularly family pictures, sleepwear and objects from the bedside, to help orient and calm the older person². [D]
 - It is generally not recommended to put older persons with delirium (especially if hyperactive-hyperalert) in the same room. Agitation tends to be reinforced by the presence of agitation in other individuals. The exception to this would be if delirious persons are being congregated in order to provide enhanced care². [D]
 - Routinely screen for delirium and changes in cognitive function³
 - Encourage or provide assistance with eating and drinking to ensure adequate intake, including use of dentures, proper positioning, nutrition supplements as needed³
 - Provide regular bowel routines to avoid constipation³
 - Minimize use of indwelling catheters³
 - Provide oxygen therapy and chest physiotherapy as needed³
 - Ensure availability and use of vision and hearing aids³
 - Avoid use of physical restraints³
 - Encourage or assist with regular mobilization, physiotherapist/occupational therapist involvement as needed³
 - Encourage independence in ADLs (Activities of Daily Living)³
 - Screen and treat infections appropriately and judiciously³
 - Obtain Best Possible Medication History (BPMH), reconcile, review, and optimize medications³
 - Correct fluid and electrolyte imbalances – serum sodium, potassium, and glucose; monitor and treat dehydration or fluid overload³
 - Promote relaxation and sleep – e.g. regular mobilization during the day, encourage wakefulness during the day, massage and/or warm drink prior to sleep, schedule medications/procedures to allow sleep³

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- Manage pain and discomfort³
- Provide orienting information, including name and role of staff members³
- Use interpreters/communication aids as necessary³
- Provide information about delirium to family and caregivers³
- Encourage family/caregiver visits and involvement in care³
- Encourage the family/caregiver to bring in patient’s personal and familiar objects³

Cognitive Impairment Standardized Assessment

[RNAO - Screening for Dementia, Delirium and Depression](#)

[RGP GiiC Toolkit: Dementia Screening & Assessment](#)

[SFH Toolkit: Cognitive Assessment](#)

[Hartford Institute: The Mini-Cog™](#)

- The Mini-Cog™ is a simple screening tool that can be used to detect cognitive impairment quickly during both routine visits and hospitalizations. The Clock Drawing Test (CDT) component of the Mini-Cog™ allows clinicians to quickly assess numerous cognitive domains including cognitive function, memory, language comprehension, visual-motor skills, and executive function and provides a visible record of both normal and impaired performance that can be tracked over time⁴.
- Administration:
 1. Instruct the patient to listen carefully to and remember 3 unrelated words and then to repeat the words. The same 3 words may be repeated to the patient up to 3 tries to register all 3 words.
 2. Instruct the patient to draw the face of a clock, either on a blank sheet of paper or on a sheet with the clock circle already drawn on the page. After the patient puts the numbers on the clock face, ask him or her to draw the hands of the clock to read a specific time. The time 11:10 has demonstrated increased sensitivity.
 3. Ask the patient to repeat the 3 previously stated words.
- Scoring (out of 5)
 - Give 1 point for each recalled word after the CDT distractor. Recall is scored 0-3.
 - The CDT distractor is scored 2 if normal and 0 if abnormal. (Note: The CDT is considered normal if all number are present in the correct sequence and position, and the hands readably display the requester time. Length of hands is not considered in the score.)
- Interpretation
 - 0-2: Positive screen for cognitive impairment
 - 3-5: Negative screen for cognitive impairment
- Montreal Cognitive Assessment (MoCA)⁵
 - A cognitive screening tool for detection of MCI
 - 30-point scale
 - Many more domains than MMSE (good for AD and non AD) – comprehensive
 - Minor adjustments for education (add 1 point if grade 12 or less)
 - MCI = MoCA score of 26 or less
 - Using a cut-off score ,26 provides sensitivity of 80% and specificity of 91% to distinguish MCI
- Mini Mental State Examination⁵
 - 30-point scale
 - Focus on memory/orientation (16/30 points)
 - Good for AD, poor for non-Alzheimer’s dementias

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	<ul style="list-style-type: none"> • Poor at upper end at discrimination between normal (especially highly educated) and MCI • Poor with those < grade 5 education (cut off = 20 for 80y/o, 19 for 85 y/o) • If MMSE is 26 or more and functional problems related to cognition, preferable to complete assessment with MoCA (due to enhanced sensitivity for detecting MCI.)
<p style="text-align: center;"><u>Cognitive Impairment Standardized Intervention</u></p> <p><u>RNAO - Caregiving Strategies for Older Adults with Delirium, Dementia, and Depression</u></p>	<ul style="list-style-type: none"> • Clinicians should have knowledge of the most common presenting symptoms of: Alzheimer’s Disease, Vascular Dementia, Frontotemporal Lobe Dementia, Lewy Body Dementia, and be aware that there are mixed dementias (IV).⁶ • Clinicians should contribute to comprehensive standardized assessments to rule out or support the identification and monitoring of dementia based on their ongoing observations and expressed concerns from the client, family, and interdisciplinary team (IIa).⁶ • Clinicians should create partnerships with family members or significant others in the care of clients. This is true for clients who live in either the community or in healthcare facilities (III).⁶ • Clinicians should recognized their clients retained abilities, understand the impact of the environment, and relate effectively when tailoring and implementing their caregiving strategies (III).⁶ • Clinicians caring for clients with dementia should be knowledgeable about pain assessment and management in this population to promote physical and emotional well-being (IV).⁶ • Clinicians caring for clients with dementia should be knowledgeable about non-pharmacological interventions for managing behaviour to promote physical and psychological well-being (III).⁶ <ul style="list-style-type: none"> ○ Non-pharmacological interventions should focus on the stimulus initiating the behavioural symptoms when considering treatment. Techniques employed should be client-sensitive and this individualized approach should maintain the “person” as the centre of care. Occupational activities, environmental modifications, validation therapy, reminiscence and sensory stimulation are interventions that can be considered. • Clinicians caring for clients with dementia should be knowledgeable about pharmacological interventions and should advocate for medications that have fewer side effects (Ia).⁶ • Clinicians should avoid physical and chemical restraints as first line care strategies for older adults with delirium, dementia, and depression (III).⁶
<p style="text-align: center;"><u>Polypharmacy Standardized Assessment</u></p> <p><u>AGS - 2012 Beers Criteria</u></p> <p><u>IPET - Guidelines</u></p> <p><u>RGP GiiC Toolkit: Polypharmacy</u></p>	<ul style="list-style-type: none"> • The “AGS 2012 Beers Criteria” is available as a guide for identifying medications for which the risks of use in older adults outweigh the benefits. The criteria are not applicable in all circumstances (e.g., patient’s receiving palliative and hospice care)⁷. • Canadian guidelines have been developed and adapted into a quickly administered screening tool called “Improved Prescribing in the Elderly Tool” (IPET)⁸. • Physical signs that should arouse suspicion of an adverse drug reaction include:⁹ <ul style="list-style-type: none"> ○ Fatigue , constipation, diarrhea, incontinence, weight loss, weakness, tremors, falls, drowsiness, dizziness, confusion, depression, agitation, anxiety, decreased sexual behaviour • A high level of suspicion for an adverse drug effect should be maintained if the problem develops shortly after a medication is started or increased.⁹ • In addition to being aware of the side effect profile of the drug in question, the onset of these signs should be considered in the context of the patient’s medical comorbidities, risk factors for illness, and previous response to this or other interacting medications.⁹ • Changes in health status, such as the ongoing evolution of an existing chronic condition, can affect a patient’s sensitivity to a drug they may have tolerated previously for a long time.⁹ • The following tools/resources are available through the GiiC toolkit to support the identification/prevention of ADE in the elderly:⁹ <ul style="list-style-type: none"> ○ Common drug classes and adverse reactions

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	<ul style="list-style-type: none"> ○ Common drug-drug interactions ○ Drugs and over-the-counter or herbal remedy interactions ○ Drugs and food/beverages interactions
<p>Polypharmacy Standardized Intervention</p> <p>RNAO: Prevention of Falls and Fall Injuries in the Older Adult</p> <p>RGP GiiC Toolkit: Polypharmacy Medication Review</p> <p>Osteoporosis Canada: Clinical Practice Guidelines</p>	<ul style="list-style-type: none"> ● Nurses, in consultation with the health care team, conduct periodic medication reviews to prevent falls among elderly in health care settings. Clients taking benzodiazepines, tricyclic antidepressants, selective serotonin-reuptake inhibitors, trazodone, or more than five medications should be identified as high risk for falls. There is fair evidence that medication review be conducted periodically throughout the institutional stay. (IIb)¹¹ ● A thorough medication review is recommended every 6-12 months and after events which alter a patient’s medication regimen (e.g., hospitalization)¹⁰ ● Ask the patient about any adverse effects experienced when taking any of their medications.¹⁰ ● Factors to consider when reviewing medications:¹⁰ <ul style="list-style-type: none"> ○ Is the medication still indicated? ○ Is this medication the safest and most effective of the alternatives available? ○ Is the dose correct (taking into account renal function and body weight?) ○ Are there duplications with other drugs (e.g., in the same class?) Are simplifications possible? ○ Are there drugs prescribed for an adverse reaction? Can they be withdrawn? ○ Are there drug-drug interactions or drug-illness interactions that are of concern? ○ Are the dosing schedule, administration instructions, and cost feasible for this patient? <p>Pharmacotherapy for fracture prevention¹³</p> <ul style="list-style-type: none"> ● Pharmacotherapy should be offered to patients at high risk (>20% probability for major osteoporotic fracture over 10 years). ● Fragility fracture of the hip or vertebra, or more than one fragility fracture event, constitutes a high risk for future fracture and such individuals should be offered pharmacologic therapy. ● For those at moderate risk (10% - 20% probability for major osteoporotic fracture over 10 years), lateral radiographs or vertebral fracture assessment (VFA) of the thoracolumbar spine is recommended for further risk stratification and to aid in clinical decision-making regarding pharmacologic interventions. ● For those at moderate fracture risk, patient preference and clinical risk factors that are not already incorporated in the risk assessment system should be used to guide pharmacologic interventions. ● For those at moderate fracture risk, patient preference and clinical risk factors that are not already incorporated in the risk assessment system should be used to guide pharmacologic management decisions. ● Clinicians should avoid prescribing more than one anti-resorptive agent concurrently for fracture reduction. ● Individuals at high risk for fracture should continue osteoporosis therapy without a drug holiday. ● Potential benefits and risks of the prescribed agent should be discussed with each patient prior to initiating therapy to support informed decision-making.
<p>Falls/Mobility Standardized Assessment</p>	<ul style="list-style-type: none"> ● Assess fall risk on admission (Ib), and after a fall (Ib)¹¹ ● Screening assessment tools should identify which reversible risk factors to base the choice of intervention.¹² ● Risk Screening is an effective method for identifying fall-prone individuals. The tool used must be appropriate for the setting and for the specific client population. Therefore, it is essential to assess the patient population in order to select a tool most appropriate for the setting. Recommended tools include:¹¹

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RNAO: Prevention of Falls and Fall Injuries in the Older Adult

AGS/BGS Clinical Practice Guidelines: Prevention of Falls in Older Adults

SFH: Screening and Detection of Functional Decline

Osteoporosis Canada: Clinical Practice Guidelines

- STRATIFY Risk Assessment Tool
- Morse Fall Scale
- Hendrich II Fall Risk Model
- For additional consideration when selecting a clinical tool appropriate for the patient population/setting, a list of clinical tools to assess falls risk is available from the Senior’s Friendly Hospital Toolkit (including, but not limited to):¹⁴
 - Timed Up and Go
 - Tinetti Balance Scale
 - Gait Speed and Gait Abnormality
 - Functional Reach
 - Berg Balance Scale
- Fracture Risk Assessment/Osteoporosis – Recommendations¹³
 - Individuals 50 years and older who have experienced a fragility fracture should be assessed for osteoporosis and considered for treatment.
 - Recommended elements in the history and physical examination of fracture risk/osteoporosis:
 - Identify risk factors for low BMD, future fractures and falls
 - Inquire about falls in the previous 12 months and inquire about gait and balance
 - Accurate height and weight measurement
 - Get-Up-and-Go-Test
 - In selected patients based on clinical assessment: additional biochemical testing to rule out secondary causes of osteoporosis.
 - If clinical evidence is suggestive of a vertebral fracture: lateral thoracic and lumbar spine radiographs.
 - Initiation of pharmacologic treatment for osteoporosis should be based on an assessment of ten-year absolute fracture risk using a validated fracture prediction tool that incorporates BMD and clinical risk factors.
 - The Canadian WHO Fracture Risk Assessment Tool (FRAX) and the Canadian Association of Radiologist and Osteoporosis Canada (CAROC) risk assessment systems can be used in Canada at the present time, since they have been validated in a Canadian population.
 - For purposes of BMD reporting, CAROC is the preferred national risk assessment system at the present time
 - For BMD in these systems, only the femoral neck T-score should be used.
 - All individuals with a T-score of the spine or hip ≤ -2.5 should be considered as having at least moderate risk of osteoporotic fractures.

Falls/Mobility Standardized Intervention

RNAO: Prevention of

- Use strength training as a component of multi-factorial fall interventions; however, there is insufficient evidence to recommend it as a stand-alone intervention (1b).¹
- The multidisciplinary team should implement multi-factorial fall prevention interventions to prevent future falls (1b)¹.
- Consider the use of hip protectors to reduce hip fractures among those clients considered at high risk of fractures associated with falls; however, there is no evidence to support universal use of hip protectors among the elderly in health care settings (1b)¹.
- Minimize bed rest orders, and consider daily mobility/out-of-bed orders.¹⁴
- Minimize use of physical restraints and of mobility restricting devices such as indwelling catheters and intravenous lines/poles – when used, review daily.¹⁴
- Optimize nutrition and hydration – provide easy access to water and fluids, provide diets consistent with patient preferences, daily review of NPO (no food by mouth) orders.¹⁴
- Optimize sleep using non-pharmacologic protocols.¹⁴

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Falls and Fall Injuries in the Older Adult

SFH: Preventing Functional Decline

Osteoporosis Canada: Clinical Practice Guidelines

- Assess and manage depression.¹⁴
 - Assess and treat pain appropriately.¹⁴
 - Provide education to the inter-professional team on function-focused interventions.¹⁴
 - Maximize social engagement – encourage patient and family/caregiver visits and participation with care, volunteer visits.¹⁴
 - Exercise programs should be considered to reduce falls in older persons living in long-term care settings with caution regarding risk of injury in frail persons. [C]¹¹
 - Noise prevention measures – reduced use of overhead pagers, acoustical room treatments, headphones, earplugs.¹⁴
 - Furniture and equipment –low beds with rails down, bedside chairs, assistive mobility aids, access to vision and hearing aids, commodes and raised toilet seats, seating in showers.¹⁴
- Strategies for Fracture Prevention¹³
- Vitamin D and Calcium
 - Adequate vitamin D status, in addition to calcium from diet and supplements, is essential for the prevention and treatment of osteoporosis.
 - Other non-pharmacologic therapies
 - For those with or at risk for osteoporosis: appropriate resistance training and/or weight-bearing aerobic exercise.
 - For those with vertebral fractures; directed core stability exercises.
 - For those at risk of falls: exercises that focus on balance (e.g., Tai chi, balance and/or gait training)

Depression Standardized Assessment

RNAO - Screening for Dementia, Delirium and Depression

CCSMH – The Assessment and Treatment of Depression

- LTC homes’ assessment protocols should specify that screening for depressive and behavioural symptoms will occur both in the early post-admission phase and subsequently, at regular intervals, as well as in response to significant change.¹⁵
- Health care providers should be familiar with the physical, psychological, and social risk factors for depressive disorders in older adults and include a screening for depression for their clients/patients who present with some of these risk factors [D].¹⁵
- Appropriate depression screening tools for elderly persons without significant cognitive impairment in general medical or geriatric settings include the self-rating Geriatric Depression Scale (GDS), the SELFCARE self-rating scale, and the Brief Assessment Schedule Depression Cards (BASDEC) for hospitalized patients [B].¹⁵
- For patients with moderate to severe cognitive impairment, an observer-rated instrument, such as the Cornell Scale for Depression in Dementia is recommended instead of the GDS [B].¹⁵
- Clinicians should always assess the risk of suicide in patients with suspected depression by directly asking patients (as well as caregivers and family) about suicidal ideation, intent and plan. Those at high risk for suicide should be referred to a specialized mental health professional and/or service as a priority for further assessment, treatment, and suicide prevention strategies [D].¹⁵
- Patients who have had strokes should be monitored closely for the possible development of depression as a common complication of stroke, even in those who do not report depressed mood¹⁵.
- Following a positive screen for depression, a complete bio-psycho-social assessment should be conducted, including;¹⁵
 - A review of diagnostic criteria outlined in DSM IV-TR or ICD 10 diagnostic manuals
 - An estimate of severity, including the presence of psychotic or catatonic symptoms.
 - Risk assessment for suicide
 - Personal and family history of mood disorder
 - Review of medication use and substance use

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	<ul style="list-style-type: none"> ○ Review of current stresses and life situation ○ Level of functioning and/or disability ○ Family situation, social integration/support and personal strengths ○ Mental status examination, including assessment of cognitive functions ○ Physical examination and laboratory investigations looking for evidence of medical problems that could contribute to or mimic depressive symptoms. (D) <ul style="list-style-type: none"> ● Depression should not be diagnosed in the context of an acute delirium, but reassessment for depressive symptoms should be done after delirium has cleared significantly.²
<p><u>Depression</u> Standardized Intervention</p> <p><u>RGP GiiC Toolkit: Late Life Depression</u></p> <p><u>CCSMH – The Assessment and Treatment of Depression</u></p>	<ul style="list-style-type: none"> ● For severe depression (GDS score 11 or greater), refer for psychiatric evaluation.¹⁶ ● For less severe depression (GDS score 6 or greater), refer to mental health services for psychotherapy/counseling. Consider resources such as psychiatric liaison nurses, geropsychiatric advanced practice nurses, social workers, psychologists, and other community- and institution-specific mental health services.¹⁶ ● If suicidal thoughts, psychosis, or comorbid substance abuse are present, a referral for a comprehensive psychiatric evaluation should always be made.¹⁶ ● Psychosocial treatment should be part of the treatment of depression co-existing with dementia. This treatment should be flexible to account for the decline in functioning as well as multifaceted to provide help with the diversity of problems facing the patient and caregiver. It should be delivered by clinicians sensitized to the vulnerabilities and frailties of older adults with dementia. This treatment should include helping caregivers deal with the disease in a skill-oriented manner [A].¹⁵ ● Health care professionals and organizations should implement a model of care that addresses the physical/functional as well as the psychosocial needs of older depressed adults. Given the complex care needs of older adults, these are most likely to require interdisciplinary involvement in care [B].¹⁵ ● Both cardiovascular (aerobic) activities resistance training (nonaerobic) can help reduce depressive symptoms, but the results appear to be more consistent for cardiovascular exercise.¹⁶ ● Health care professionals and organizations should implement a model of care that promotes continuity of care as older adults appear to respond better to consistent care providers.¹⁵ ● Older patients have a response rate with antidepressant therapy similar to younger adults. Clinicians should approach elderly depressed individuals with therapeutic optimism (A).¹⁵ ● Antidepressants should be used when indicated, even in patients with multiple co-morbidities and serious illnesses, as they have similar efficacy rates compared with use in the well elderly. Adverse events in patients with multiple co-morbidities can be minimized by careful selection of drugs that are not likely to worsen or complicate patient-specific medical problems (B).¹⁵ ● Co-morbid psychiatric disorders, particularly generalized anxiety disorders and substance abuse, should be identified and appropriately treated as they will adversely influence the outcome of depression. Clinicians should avoid the use of benzodiazepines for treatment of depressive symptoms with elderly patients (B).¹⁵ ● Clinicians should choose an antidepressant with the lowest risk of drug-drug interactions when patients are taking multiple medications (C).¹⁵
	<ul style="list-style-type: none"> ● Obtain a history of the client’s incontinence (IV).¹⁷ <ul style="list-style-type: none"> ○ Assessment for a history of incontinence includes the following:

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<p><u>Incontinence</u> Standardized Assessment</p> <p><u>RNAO: Promoting Continence Using Prompted Voiding</u></p>	<ul style="list-style-type: none"> ▪ Frequency and pattern of incontinence. ▪ Client’s awareness of the urge to void, and behaviours exhibited when needing to void. ▪ Motivation to be continent. ▪ Fluid intake. ▪ Frequency of bowel movement. ▪ Medical/surgical history. ▪ Medications. ▪ Functional ability. ▪ Environmental barriers. ▪ Presence of urinary tract infection (UTI). ▪ History of UTIs. ▪ Identification of client goals/motivation. <ul style="list-style-type: none"> • Gather information on (IV):¹⁷ <ul style="list-style-type: none"> ○ The amount, type and time of daily fluid intake, paying particular attention to the intake amount of caffeine and alcohol. ○ The frequency, nature and consistency of bowel movements. ○ Any relevant medical or surgical history which may be related to the incontinence problem, such as but not limited to diabetes, stroke, Parkinson’s disease, heart failure, recurrent UTIs or previous bladder surgery. • Identify the client’s functional and cognitive ability (III).¹⁷ • Identify attitudinal and environmental barriers to successful toileting. Barriers include(III)¹⁷: <ul style="list-style-type: none"> ○ Proximity and availability of the nearest bathroom; ○ Accessibility of commode; ○ Satisfactory lighting; ○ Use of restraints; ○ Staff expectation that incontinence is an inevitable consequence of aging; and ○ Staff belief that few interventions exist to promote continence. • Check urine to determine if infection is present (IV).¹⁷ • Determine how the client perceives their urinary incontinence and if they will benefit from prompted voiding. Before initiating prompted voiding, identify the client’s pattern of incontinence using a 3-day voiding record (III).¹⁷
<p><u>Incontinence</u> Standardized Intervention</p> <p><u>RNAO: Promoting Continence Using</u></p>	<ul style="list-style-type: none"> • Ensure an adequate level of fluid intake (1500-200 ml per day), and minimize the use of caffeinated and alcoholic beverages where possible (III).¹⁷ • Initiate an individualized prompted voiding schedule based on the client’s toileting needs, and as determined by a 3-day voiding record (1a). Successful implementation of prompted voiding requires (IV):¹⁷ <ul style="list-style-type: none"> • Management support; • Opportunities for education and training; • Active involvement of key clinical staff; • Gradual implementation of the prompted voiding schedule; • Collection of baseline information about clients, resources and existing knowledge;

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Prompted Voiding

Canadian Continence Foundation: Incontinence – A Canadian Perspective

- Interpretation of this data and identification of problems;
- Development of implementation strategy; and
- Monitoring of the program.
- Initiate a 3-day voiding record, a minimum of 3 weeks and a maximum of 8 weeks, after the prompted voiding schedule (IV).¹⁷
- Implement an educational program on promoting continence using prompted voiding. The program should include information on (IV):¹⁷
 - Myths related to incontinence and aging
 - Definition of continence and incontinence
 - Continence assessment
 - Prompted voiding
 - Individualized toileting
 - The impact of cognitive impairment on ability to be continent and strategies to manage aggressive behaviours
 - Relation of bowel hygiene care to healthy bladder functioning; and
 - Use of a voiding record with individualized toileting
- **Stress UI:**¹⁷
 - Teach pelvic floor muscle exercises (PFMEs)
 - Provide toileting assistance and bladder training PRN (whenever necessary)
 - Consider referral to other team members if pharmacological or surgical therapies are warranted.
- **Urge UI and OAB:**¹⁷
 - Implement bladder training (retraining)
 - If patient is cognitively intact and is motivated, provide information on urge inhibition.
 - Teach PFMEs to be used in conjunction with bladder training, and instruct in urge inhibition strategies
 - Collaborate with prescribing team members if pharmacologic therapy is warranted.
 - Initiate referrals for those patients who do not respond to the previous steps.
- **Overflow UI:**¹⁷
 - Allow sufficient time for voiding.
 - Discuss with interdisciplinary team the need for determining a post-void residual (PVR)
 - Instruct patients in double voiding and Crede's maneuver
 - If catheterization is necessary, sterile intermittent is preferred over indwelling catheterization PRN.
 - Initiate referrals to other team members for those patients requiring pharmacological or surgical intervention.
- **Functional UI:**¹⁷
 - Provide individualized, scheduled toileting, timed voiding, or prompted voiding
 - Provide adequate fluid intake.
 - Refer for physical and occupational therapy PRN.
 - Modify environment to maximize independence with continence
- **Follow up Monitoring:**¹⁷
 - Provide patient / caregiver discharge teaching regarding outpatient referral and management.
- The Canadian Continence Foundation recommends conservative (behavioural –non-drug, non-surgical) treatment as the first response to managing

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<p>UI.¹⁸</p> <ul style="list-style-type: none"> • Conservative management includes behaviour training, education, scheduled voiding, positive reinforcement and pelvic muscle exercises with various techniques to help control urinary incontinence.¹⁸ <ul style="list-style-type: none"> ○ Bladder retraining combines education on healthy bladder behaviours with positive reinforcement and a scheduled voiding routine. ○ Healthy bladder behaviours include: <ul style="list-style-type: none"> ▪ Limiting or avoiding caffeine/alcohol. ▪ Drinking non-caffeinated fluids – up to six to eight cups (1.5 – 2.0 litres) per day ▪ Trying to avoid getting up more than twice a night ▪ Not “pushing” when urinating ▪ Maintaining a healthy weight ▪ Not smoking. The chronic cough associated with smoking is a risk factor for incontinence ▪ Eating more fibre to avoid constipation, which strains and weakens pelvic floor ○ Pelvic Floor Retraining Exercise Example: <ul style="list-style-type: none"> ▪ Sit on a firm chair so you can feel your buttocks. Keep feet flat on the floor. ▪ Pretend you need to stop gas from passing and squeeze those rectal muscles – by pulling in. ▪ Try not to tighten your abdominal and buttock muscles. ▪ Hold for three counts, relax for three counts. Remember to breathe. ▪ You should feel a tweaking at the front of the pubic bone when you are holding ▪ Repeat this squeezing exercise ten times. This equals one set. Do one set five times per day. • If UI persists following conservative management interventions, consider referral to other team members for medical, pharmaceutical, mechanical, or surgical interventions.¹⁸ 	
<p>Nutrition Status Standardized Assessment</p> <p><u>Nestle Nutrition Institute: MNA-SF</u></p> <p><u>CMTF: Nutrition Risk Screening Tool</u></p>	<ul style="list-style-type: none"> • Clinicians can screen for malnutrition using the MNA-SF every 3 months for patients in the hospital or long-term care setting or whenever a change in clinical condition occurs.¹⁹ <ul style="list-style-type: none"> ○ Clinicians will need to gather the following patient information in order to complete the MNA-SF form: <ul style="list-style-type: none"> ▪ Name, Gender, Age ▪ Weight (kg): to obtain an accurate weight, remove shoes and heavy outer clothing. Use a calibrated and reliable set of scale. Pounds must be converted to kilograms. ▪ Height (cm): measure height without shoes using a stadiometer (height gauge). If the patient is bedridden, measure height by demispan, half-arm span, or knee height. Inches must be converted to centimeters. • Clinicians should be familiar with administering the MNA-SF and determining patient’s screening score.¹⁹ • The MNA-SF tool allows standardized, reproducible, and reliable determination of nutritional status.¹⁹ • Follow up: Refer results of assessments and re-assessments to doctor/dietitian and record in medical record.¹⁹ • Clinicians can also use the Canadian Malnutrition Task Force (CMTF) Nutrition Risk Screening Tool to identify patients who are either malnourished or at risk for malnutrition.²⁰ • Patients should be flagged for assessment if they are eating 50% or less of their meals.²⁰
	<ul style="list-style-type: none"> • The following strategies can be used to support adequate food intake:²⁰ <ul style="list-style-type: none"> ○ Position patients properly for eating

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<p><u>Nutrition Status</u> Standardized Intervention</p> <p>Nestle Nutrition Institute: MNA-SF User Guide</p> <p>CMTF: Nutrition Risk Screening Tool</p>	<ul style="list-style-type: none"> ○ Assist patients in opening packages and containers ○ Avoid scheduling tests or examinations during meal times ○ Consider in-between meal snacks and supplements to support intake ○ Clarify why the patient is not eating and find solutions to overcome these problems ○ Determine if the patient has pain, is depressed, anxious or in need of medication and social support ● Based on the results of the 14 point MNA-SF Screening tool, the following interventions are recommended:¹⁹ ● Normal Nutritional Status (12-14 Points): Rescreen: <ul style="list-style-type: none"> ○ After acute event or illness ○ Every 3 months in institutionalized patients ● At Risk of Malnutrition (8-11 Points) AND No Weight Loss: Monitor: <ul style="list-style-type: none"> ○ Close weight monitoring ○ Rescreen every 3 months ● At Risk of Malnutrition (8-11 points) AND Weight Loss: Treat: <ul style="list-style-type: none"> ○ Nutrition Intervention <ul style="list-style-type: none"> ▪ Diet Enhancement ▪ Oral nutritional supplementation (400kcal/d) ○ Close weight monitoring ○ Further in-depth nutrition assessment ● Malnourished (0-7 Points): Treat: <ul style="list-style-type: none"> ○ Nutrition Intervention <ul style="list-style-type: none"> ▪ Oral nutritional supplementation (400-600 kcal/d) ▪ Diet enhancement ○ Close weight monitoring ○ Further in-depth nutrition assessment
<p><u>Pain Management</u> Standardized Assessment</p> <p>RNAO: Assessment and Management of Pain in the Elderly</p> <p>AGS: Management of Persistent Pain in Older Persons</p>	<ul style="list-style-type: none"> ● On initial presentation or admission of any older person to any healthcare service, a healthcare professional should assess the patient for evidence of persistent pain (IIb)²¹. ● Any persistent pain that has an impact on physical function, psychosocial function, or other aspects of quality of life should be recognized as a significant problem (IIa)²¹. ● All patients with persistent pain that may affect physical function, psychosocial function, or other aspects of quality of life should undergo a comprehensive pain assessment, with the goal of identifying all potentially remediable factors. Assessment should focus on recording a sequence of events that led to the present pain complaint, and on establishing a diagnosis, a plan of care, and likely prognosis (IIIb)²²: <ul style="list-style-type: none"> ○ History <ul style="list-style-type: none"> ▪ Initial evaluation of present pain complaint should include pain characteristics, such as intensity, character, frequency (or pattern, or both) location, duration, and precipitating and relieving factors. ▪ Initial evaluation should include a description of pain (from the individual's perspective) in relation to impairments in physical and social function (e.g., ADLs, IADLS, sleep appetite, energy, exercise, mood, cognitive function, interpersonal and intimacy issues, social and leisure activities, and overall quality of life).

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- Initial evaluation should include a thorough analgesic history, including current and previously used prescription medications, over-the-counter medications, complementary or alternative remedies, and alcohol use or abuse. The effectiveness and any side effects of current and previously used medications should be recorded.
- The patient’s attitudes and beliefs regarding pain and its management, as well as knowledge of pain management strategies, should be assessed.
- Effectiveness of past pain-relieving treatments (both traditional and complementary or alternative) should be evaluated.
- The patient’s satisfaction with current pain treatment or health should be determined and concerns should be identified.
- Physical Examination:
 - Physical examination should include careful examination of the site of reported pain, common sites for pain referral, and common sites of pain in older adults
 - Physical examination should focus on the musculoskeletal (e.g., myofascial pain, fibromyalgia, inflammation, deformity, contractures posture, leg length discrepancy). Practitioners skilled in musculoskeletal examination should be considered for consultation (e.g., physical therapy, occupation therapy, physiatry).
 - Physical examination should focus on the neurologic system (e.g., search for weakness, hyperalgesia, hyperathia, allodynia, numbness, paresthesia, other neurologic impairments).
 - Initial assessment should include observation of physical function (e.g., measures of ADLs, performance measures such as range of motion, get-up-and-go test, or others)
- Comprehensive pain assessment should include results of pertinent laboratory and other diagnostic tests. Tests should not be ordered unless their results will affect decisions about treatment.
- Initial assessment should include evaluation of psychologic function, including mood (e.g., depression anxiety), self-efficacy, pain coping skills, helplessness, and pain-related fears.
- Initial assessment should include evaluation of social support, caregivers, family relationships, work history, cultural environments, spirituality, and healthcare accessibility.
- Cognitive function should be evaluated for new or worsening confusion.
- For the older adult who is cognitively intact or who has mild to moderate dementia, the practitioner should attempt to assess pain by directly querying the patient.
 - Quantitative estimates of pain based on clinical impressions or surrogate reports should not be used as a substitute for self-report unless the patient is unable to reliably communicate his or her pain.
 - A variety of terms synonymous with pain should be used to screen older patients. (e.g., burning, discomfort, aching, soreness, heaviness, tightness).
 - A quantitative assessment of pain should be recorded by the use of a standard pain scale that is sensitive cognitive, language, and sensory impairments (e.g., scales adapted for visual, hearing, foreign language, or other handicaps common in elderly persons). A variety of verbal descriptor scales, pain thermometers, numeric rating scales, and facial pain scales have acceptable validity and are acceptable for many older adults.
 - Elderly persons with limited attention span or impaired cognition should receive repeated instructions and be given adequate time to respond. Assessment may be done in several steps; it may require assistance from family or caregivers, and planning in advance of the visit.
 - Patients should be queried about symptoms and signs that may indicate pain, including recent changes in activities and functional status; they should also be observed for verbal and nonverbal pain-related behaviours and changes in normal functioning.

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<p style="text-align: center;">Pain Management Standardized Intervention</p> <p>RNAO: Assessment and Management of Pain in the Elderly</p> <p>AGS: Management of Persistent Pain in Older Persons</p>	<ul style="list-style-type: none"> ▪ Patients can also be asked about their worst pain experience over the past week. ▪ With mild to moderate cognitive impairment, assessment questions should be framed in the present tense because patients are likely to have impaired recall. • The following tools have established validity to assess the intensity of pain:²² <ul style="list-style-type: none"> ○ Visual Analogue Scale (VAS) ○ Numeric Rating Scale (NRS) ○ Verbal Scale ○ Faces Scale ○ Behavioural Scale • Additionally, the “Checklist of Non-Verbal Pain Indicators” can be used to assess pain in non-communicative adults.²² • For the older adult with moderate to severe dementia or who is nonverbal, the practitioner should attempt to assess pain via direct observation or history from caregivers.²¹ <ul style="list-style-type: none"> ○ Patients should be observed for evidence of pain-related behaviours during movement (e.g., walking, morning care, transfers). ○ Unusual behaviour in a patient with severe dementia should trigger assessment for pain as a potential cause. • The risks and benefits of various assessment and treatment options should be discussed with patients and family. With consideration for patient and family preferences in the design of any assessment or treatment strategy.²² • Patients with persistent pain should be reassessed regularly for improvement, deterioration, or complications.²² <ul style="list-style-type: none"> ○ The use of a pain log or diary with regular entries for pain intensity, medication use, mood, response to treatment, and associated activities should be considered. ○ The same quantitative pain assessment scales should be used to initial and follow-up assessments. ○ Reassessment should include evaluation of analgesic and nonpharmacologic interventions, side effects, and compliance issues. ○ Reassessment should consider patient preferences in assessment and treatment revisions.
<p style="text-align: center;">Pain Management Standardized Intervention</p> <p>RNAO: Assessment and Management of Pain in the Elderly</p> <p>AGS: Management of Persistent Pain in Older Persons</p>	<ul style="list-style-type: none"> • Nonpharmacologic Intervention Recommendations:²² <ul style="list-style-type: none"> ○ A physical activity program should be considered for all older patients. <ul style="list-style-type: none"> ▪ Physical activities should be individualized to meet the needs and preferences of each patient. ▪ For some older adults with severe physical impairments, a trial of supervised rehabilitation therapy is appropriate, with goals to improve joint range of motion and to reverse specific muscle weakness or other physical impairments associated with persistent pain. ▪ For health individuals who are currently sedentary or deconditioned, referral should be made to a group exercise program (e.g., YMCA classes) for a moderate program of physical activity. ▪ For those who are incapable of strenuous training, initial training should be conducted over 8 to 12 weeks and should be supervised by a professional with knowledge of the special needs of older adults. ○ Moderate levels of physical activity (leisure-time or utilitarian) should be maintained. ○ Any physical activity program for older patients should include exercises that improve flexibility, strength, and endurance. ○ Patient education programs are integral components of the management of persistent pain syndromes. <ul style="list-style-type: none"> ▪ Content should include information about self-help techniques (e.g., relaxation, distraction), the known causes of their pain, the goals of treatment, treatment options, expectations of pain management, and analgesic drug use. ▪ Educational content and the patient’s self-help efforts should be reinforced during every patient encounter.

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	<ul style="list-style-type: none"> ▪ Focused patient education should be provided prior to special treatments or procedures. ▪ Patients should be encouraged to educate themselves by using available local resources (e.g., local hospitals, support groups, and disease-specific organizations). ○ Formal cognitive-behavioural therapies are helpful for many older adults with persistent pain. <ul style="list-style-type: none"> ▪ Cognitive-behavioural therapy conducted by a professional should be applied as a structured program that includes education, a rationale for therapy, training in cognitive and behavioural pain coping skills, methods to generalize coping skills, and relapse prevention. ▪ Plans for coping with pain exacerbations should be a part of this therapy to prevent self-defeating behaviour during such episodes. ▪ Spouses or other partners can be involved in cognitive-behavioural therapy. ○ Other modalities (e.g., heat, cold, massage, liniments, chiropractic, acupuncture, and transcutaneous electrical nerve stimulation) often offer temporary relief and can be used as adjunctive therapies. ● Clinicians/pharmacists should consider the following factors when selecting opioids: ²² <ul style="list-style-type: none"> ○ Pain pattern ○ Presence of renal, gastrointestinal or cognitive dysfunction ○ Lifestyle ○ Existing medications ○ Specific type of pain ● Ambulatory care facilities, hospitals, nursing homes, assisted-living facilities, and home-care agencies should routinely conduct quality assurance and quality improvement (QA and QI) activities in pain management. ²¹ <ul style="list-style-type: none"> ○ QA and QI activities should include appropriate structure and process indicators of pain assessment and treatment activities. ○ Benchmarks for quality improvement should be established internally and should include quantifiable pain outcomes, which may include, but should not be limited to, patient satisfaction.
<p>Pressure Ulcers</p> <p>Standardized Assessment</p> <p>RNAO: Risk Assessment and Prevention of Pressure Ulcers</p>	<ul style="list-style-type: none"> ● A head-to-toe skin assessment should be carried out with all clients at admission, and daily thereafter for those identified at risk for skin breakdown. Particular attention should be paid to vulnerable areas, especially over bony prominences (IV) ²³. ● The client’s risk for pressure ulcer development is determined by the combination of clinical judgment and the use of a reliable risk assessment tool. The use of a tool that has been tested for validity and reliability, such as the <i>Braden Scale for Predicting Pressure Sore Risk</i>, is recommended. Interventions should be based on identified intrinsic and extrinsic risk factors and those identified by a risk assessment tool, such as Braden’s categories of sensory perception, mobility, activity, moisture, nutrition, friction and shear (IV). ²³ ● Clients who are restricted to bed and/or chair, or those experiencing surgical intervention, should be assessed for pressure, friction and shear in all positions and during lifting, turning and repositioning (IV). ²³ ● All pressure ulcers are identified and staged using the National Pressure Ulcer Advisory Panel (NPUAP) criteria (IV). ²³ ● All data should be documented at the time of assessment and reassessment (IV). ²³
<p>Pressure Ulcers</p> <p>Standardized Intervention</p>	<ul style="list-style-type: none"> ● For clients with an identified risk for pressure ulcer development, minimize pressure through the immediate use of a positioning schedule (IV). ²³ ● Use proper positioning, transferring, and turning techniques. Consult Occupational Therapy/Physiotherapy (OT/PT) regarding transfer and positioning techniques and devices to reduce friction and shear and to optimize client independence (IV). ²³ ● Consider the impact of pain. Pain may decrease mobility and activity. Pain control measures may include effective medication, therapeutic

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RNAO: Risk Assessment and Prevention of Pressure Ulcers

- positioning, support surfaces, and other non-pharmacological interventions. Monitor level of pain on an on-going basis, using a valid pain assessment tool (IV).²³
- Consider the clients risk for skin breakdown related to the loss of protective sensation or the ability to perceive pain and to respond in an effective manner (e.g., impact on analgesics, sedatives, neuropathy, etc.) (IV).²³
 - Consider the impact of pain on local tissue perfusion (IV).²³
 - Avoid massage over bony prominences (IIb).²³
 - Clients at risk of developing a pressure ulcer should not remain on a standard mattress. A replacement mattress with low interface pressure, such as high-density foam, should be used (Ia).²³
 - For high risk clients experiencing surgical intervention, the use of pressure-relieving surfaces intraoperatively should be considered (Ia).²³
 - For individuals restricted to bed: (IV)²³
 - Utilize an interdisciplinary approach to plan care.
 - Assess for the use of pressure-relieving surfaces.
 - Use devices to enable independent positioning, lifting and transfers (e.g. trapeze, transfer board, bed rails).
 - Reposition at least every 2 hours or sooner if at high risk.
 - Use pillows or foam wedges to avoid contact between bony prominences.
 - Use devices to totally relieve pressure on the heels and bony prominences of the feet.
 - A 30° turn to either side is recommended to avoid positioning directly on the trochanter.
 - Reduce shearing forces by maintaining the head of the bed at the lowest elevation consistent with medical conditions and restrictions. A 30° elevation or lower is recommended.
 - Use lifting devices to avoid dragging clients during transfer and position changes.
 - Do not use donut type devices or products that localize pressure to other areas.
 - For individuals restricted to chair: (IV)²³
 - Utilize an interdisciplinary approach to plan care.
 - Have the client shift weight every 15 minutes, if able.
 - Reposition at least every hour if unable to shift weight.
 - Use pressure-reducing devices for seating surfaces.
 - Do not use donut type devices or products that localize pressure to other areas.
 - Consider postural alignment, distribution of weight, balance, stability, support of feet and pressure reduction when positioning individuals in chairs or wheelchairs.
 - Refer to Occupational Therapy/Physiotherapy (OT/PT) for seating assessment and adaptations for special needs.
 - Protect and promote skin integrity: (IV)²³
 - Ensure hydration through adequate fluid intake.
 - Individualize the bathing schedule.
 - Avoid hot water and use a pH balanced, non-sensitizing skin cleanser.
 - Minimize force and friction on the skin during cleansing.
 - Maintain skin hydration by applying non-sensitizing, pH balanced, lubricating moisturizers and creams with minimal alcohol content.
 - Use protective barriers (e.g., liquid barrier films, transparent films, hydrocolloids) or protective padding to reduce friction injuries.

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	<ul style="list-style-type: none"> • Protect skin from excessive moistures and incontinence: (IV)²³ <ul style="list-style-type: none"> ○ Assess and manage excessive moisture related to body fluids (e.g., urine, feces, perspiration, wound exudate, saliva, etc). ○ Gently cleanse skin at time of soiling. Avoid friction during care with the use of a spray perineal cleanser or soft wipe. ○ Minimize skin exposure to excess moisture. When moisture cannot be controlled, use absorbent pads, dressings or briefs that wick moisture away from the skin. Replace pads and linens when damp. ○ Use topical agents that provide protective barriers to moisture. ○ If unresolved skin irritation exists in a moist area, consult with the physician for evaluation and topical treatment. ○ Establish a bowel and bladder program. • A nutritional assessment with appropriate interventions should be implemented on entry to any new health care environment and when the client’s condition changes. Any resident with altered skin integrity is to be referred to the Registered Dietitian (LTC Regulations 79/10). If a nutritional deficit is suspected^{23, 23}: <ul style="list-style-type: none"> ○ Consult with a registered dietitian (IV) ○ Investigate factors that compromise an apparently well nourished individual’s dietary intake (especially protein or calories) and offer him or her support with eating (IV) ○ Plan and implement a nutritional support and/or supplementation program for nutritionally compromised individuals (IV) ○ If dietary intake remains inadequate, consider alternative nutritional interventions (IV) ○ Nutritional supplementation for critically ill older clients should be considered (Ib) ○ Institute a rehabilitation program, if consistent with the overall goals of care and the potential exists for improving the individual’s mobility and activity status. Consult the care team regarding a rehabilitation program. (IV)
<p style="text-align: center;">Frailty Standardized Assessment</p> <p style="text-align: center;"><u>RGP GiiC Toolkit:</u> <u>Frailty</u></p> <p style="text-align: center;"><u>CMAJ: A global</u> <u>measure of fitness</u> <u>and frailty in elderly</u> <u>people</u></p> <p style="text-align: center;"><u>BC Guidelines: Frailty</u> <u>in Older Adults</u></p>	<ul style="list-style-type: none"> • Individually developed care plans, which address modifiable biological and psychosocial factors while integrating individual disease factors that impede the health goals of patients should be completed for elderly patients who are frail or at risk of frailty. The approach of developing patient-centered care plans is grounded in the philosophy that frailty may be preventable or delayed and that patients can improve their function and quality of life through rehabilitation.²⁴ • Clinicians should consider each visit with a patient as an opportunity to engage the patient in individualized care planning, and to identify any follow-up needs.²⁵ • Once a patient is identified as being at risk of frailty, or frail, the Canadian Study on Health and Aging (CSHA) Clinical Frailty Scale should be used to categorize the needs of the patient. The scaled is based largely on an individual’s function for ADLs and IADLs).²⁶ • The CSHA Clinical Frailty Scale includes 7 levels of Frailty:²⁶ <ol style="list-style-type: none"> 1. Very Fit – robust, active, energetic, well-motivated and fit; these people commonly exercise regularly and are in the most fit group for their age 2. Well – without active disease, but less fit than people in category 3. Well, with treated comorbid disease – disease symptoms are well controlled compared with those in category. 4. Apparently vulnerable – although not frankly dependent, these people commonly complain of being “slowed up” or have disease symptoms. 5. Mildly Frail – with limited dependence on others for instrumental activities of daily living. 6. Moderately Frail – help is needed with both instrumental and non-instrumental activities of daily living. 7. Severely Frail – Completely dependent on others for the activities of daily living, or terminally ill. • Patients with identified frailty (CHSA Scale, Level 4 and greater [i.e., 4-7]) require additional assessment in order to support the development or

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	<p>refinement of a Care Plan.²⁶</p> <ul style="list-style-type: none"> • Ideally, the physician and other health professionals will work collaboratively to complete assessments, in order to create one comprehensive Care Plan that is used by the patient and all health professionals involved in the patient’s care (example, if community case managers have completed their comprehensive initial assessment using the Minimal Data Set – Home Care problem areas identified by that assessment could help to further inform the physician assessment and Care Plan.²⁷ • In addition to the collection of information on underlying chronic conditions, some practical areas to pursue in assessing older patients are as follows:²⁷ <ul style="list-style-type: none"> ○ Weight change ○ Reduced physical activity levels and endurance ○ Impaired balance and mobility ○ Increase number and frequency of falls or first fall if not with cause ○ Declining functional status ○ Difficulties due to polypharmacy and psychoactive medications ○ Impaired vision/hearing ○ Increased alcohol consumption ○ Driving competency ○ Difficulty maintaining continence ○ Change in sleep patterns ○ Frequent/increased pain ○ Responsive behaviours ○ Social isolation ○ Transition in living circumstances ○ Change in family/caregiver support ○ Advanced caregiver stress ○ Irrational fears/concerns ○ Altered mental health status, including presentation of delirium, depression, and/or dementia.
<p>Frailty Standardized Intervention</p> <p><u>RGP GiiC Toolkit:</u> <u>Frailty</u></p> <p><u>CMAJ: A global</u> <u>measure of fitness</u></p>	<ul style="list-style-type: none"> • Effective interventions to prevent and/or reverse frailty include:²⁸ <ul style="list-style-type: none"> ○ Medication review ○ Exercise (aerobic and strength training) ○ Nutritional advice ○ Social support ○ Optimize environmental support ○ Tobacco cessation ○ Screen for geriatric syndromes ○ Safe driving counselling when appropriate ○ Vaccinations • The first step in establishing a functional care plan for seniors who are frail or at risk of frailty is to develop a shared understanding of desired care

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<p><u>and frailty in elderly people</u></p> <p><u>BC Guidelines: Frailty in Older Adults</u></p> <p><u>CSHA: Clinical Frailty Scale</u></p>	<p>with the patient and family/caregiver (i.e Collaborative Goal Setting), which will inform the development and implementation of a functional care plan. Collaborative goal setting can be achieved by combining the physician’s problem list with the patient and family/caregiver concerns and preferences for care:²⁷</p> <ul style="list-style-type: none"> ○ What are the patient’s or family/caregiver’s concerns ○ What are the physician’s concerns? ○ What are the patient’s priorities for their care when considering both the physician’s concerns and their own concerns? ○ What does the patient or family/caregiver hope to achieve from medical treatment? ○ Incorporate and document discussion of advance care planning. <ul style="list-style-type: none"> ● The Care Plan is generated from the collaborative goals established in step 1. First note the most bothersome complaint, as voiced by the patient, and proceed with consideration for:²⁷ <ul style="list-style-type: none"> ○ Patient rehabilitation potential. ○ Appropriate prevention activities for the patient ○ Self-management support for the patient and family/caregiver(s). ● Within the complex frail population of older adults, it is recommended that the Care Plan also include:²⁷ <ul style="list-style-type: none"> ○ A Medication Review ○ Advance Care Planning ○ Goals associated with significant health and safety risks (eg. falls, living alone) ○ Plans to manage significant co-morbidities in relation to patient goals ○ Expected outcomes ○ Names and contact information of other providers involved in the care of the patient (i.e for case conferencing as required). ○ Plans for follow-up ● A scheduled care plan review should include input from the patient, family/caregiver(s), and other involved health care providers. The review should be undertaken as scheduled, at the request of the patient, or when there is a transition (planned or unplanned), such as:²⁷ <ul style="list-style-type: none"> ○ Significant change in patient’s health status ○ Transition across care locations (e.g. into and out of the emergency room and/or hospital, into assisted living or a care facility, etc); and ○ Change in patient’s caregiver support ○ Help facilitate shared understanding within a multi-disciplinary approach, the Care Plan could be given to the patient (and/or caregiver) to carry as they become involved with other care providers and as they transition across care settings.
<p>Activities of Daily Living Standardized Assessment</p>	<ul style="list-style-type: none"> ● Functional Status includes the patient’s performance in mobility, basic ADLs (e.g., bathing, dressing, toileting), and instrumental ADLs (e.g., medication administration, shopping, finances).¹⁴ ● There are many tools used to measure mobility and ADL performance. No single instrument appears to adequately measure all dimensions of mobility and ADL performance over the wide range of functional abilities of older patients. The choice of tool may depend on its applicability to the patient population and its feasibility of use within the institution. Recommended tools include:¹⁴ <ul style="list-style-type: none"> ○ Barthel Index

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<p><u>SFH: Screening and Detection of Functional Decline</u></p> <p><u>CSHA: Clinical Frailty Scale</u></p>	<ul style="list-style-type: none"> ○ Lawton Brody IADL ○ Older Americans Resources Services (OARS) ADL & IADL scales ○ Katz Index ● For additional consideration when selecting a clinical tool appropriate for the patient population/setting, RNAO also recommends the FIM®. 1 ● Activities required to live in the community (IADL):²⁶ <ul style="list-style-type: none"> ○ Meal preparation ○ Ordinary housework ○ Managing finances ○ Managing medications ○ Phone use ○ Shopping ○ Transportation ● Non-instrumental activities of daily living; related to personal care (ADL):²⁶ <ul style="list-style-type: none"> ○ Mobility in bed ○ Transfers ○ Locomotion inside and outside the home ○ Dressing upper and lower body ○ Eating ○ Toilet use ○ Personal hygiene ○ Bathing
<p>Activities of Daily Living Standardized Intervention</p> <p><u>SFH: Preventing Functional Decline</u></p>	<p><i>Best practice recommendations identifying interventions for various geriatrics syndromes (Delirium, Cognitive Impairments, Pain, Depression, Falls/Mobility, Frailty, etc.) address the patient’s functional performance of ADLs/IADLS. Please refer to the intervention sections of the Compendium (based on the appropriate geriatric syndrome) for additional standardized interventions.</i></p> <ul style="list-style-type: none"> ● Minimize bed rest orders, and consider daily mobility/out-of-bed orders.¹⁴ ● Minimize use of physical restraints and of mobility restricting devices such as indwelling catheters and intravenous lines/poles – when used, review daily.¹⁴ ● Optimize nutrition and hydration – provide easy access to water and fluids, provide diets consistent with patient preferences, daily review of NPO (no food by mouth) orders.¹⁴ ● Initiate early functional goal setting and discharge planning with patient and family.¹⁴ ● Maximize patients’ own participation in ADLs while in hospital.¹⁴ ● Encourage and assist with regular daily mobility where appropriate; early referral to physiotherapy and occupational therapy for complex patients.¹⁴ ● Optimize sleep using non-pharmacologic protocols.¹⁴ ● Assess and manage depression.¹⁴ ● Assess and treat pain appropriately.¹⁴ ● Provide education to the inter-professional team on function-focused interventions.¹⁴

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	<ul style="list-style-type: none"> • Maximize social engagement – encourage patient and family/caregiver visits and participation with care, volunteer visits.¹⁴ • Initiate early discharge planning focusing on patient and family goals.¹⁴ • Environmental modifications – floors with a non-glare finish, lighting to match time of day, large clock and calendar in patient rooms for orientation, grab bars where necessary, wide doorways, clutter reduction.¹⁴

Appendix A – Glossary of Acronyms

ACE	Aid to Capacity Evaluation	Mac CAT – T	MacArthur Competence Assessment Tool
ACED	Assessment of Capacity for Everyday Decision Making	MCI	Mild Cognitive Impairment
AD	Alzheimer’s Disease	MMSE	Mini Mental State Examination
ADE	Adverse Drug Effect	MNA – SF	Mini Nutritional Assessment – Short Form
ADLs	Activities of Daily Living	MoCA	Montreal Cognitive Assessment
AGS	The American Geriatrics Society	Non-AD	Non-Alzheimer’s Dementia
BASDEC	Brief Assessment Schedule Depression Cards	NPO	Nil Per Os (nothing by mouth)
BMD	Bone Mineral Density	NPUAP	National Pressure Ulcer Advisory Panel
BPMH	Best Possible Medication History	OAB	Overactive Bladder
CAM	Confusion Assessment Method	OARS	Older Americans Resource Services
CAM - ICU	Confusion Assessment Method – Intensive Care Unit	OT	Occupational Therapy
CAROC	Canadian Association of Radiologists and Osteoporosis Canada	PFMEs	Pelvic Floor Muscle Exercises
CAT	Capacity Assessment Toolkit	POA	Power of Attorney
CDT	Clock Drawing Test	PRN	Pro Re Nata (when necessary)
CHSA	Canadian Study on Health and Aging	PT	Physiotherapy
CMTF	Canadian Malnutrition Task Force	PVR	Post Void Residual
COPD	Chronic Obstructive Pulmonary Disorder	RNAO	Registered Nurses Association of Ontario
DOS Scale	Delirium Observation Screening Scale	SFH	Senior Friendly Hospital
ED(s)	Emergency Department(s)	TUG	Timed Up and Go Test
FRAX	Fracture Risk Assessment Tool	UI	Urinary Incontinence
GDS	Geriatric Depression Scale	UTI	Urinary Tract Infection
GiiC	Geriatrics interprofessional interorganizational Collaborative	UTI(s)	Urinary Tract Infection(s)
IADL	Instrumental Activities of Daily Living	VFA	Vertebral Fracture Assessment
ICDSC	Intensive Care Delirium Screening Checklist	WHO	World Health Organization
IPET	Improved Prescribing in the Elderly Tool		
IU	International Units (Measurement of Drugs and Vitamins)		
LTC	Long-Term Care		

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