



**Rehabilitative
Care Alliance**

Frail Seniors Rehabilitative Care Best Practice Framework

Bedded Levels of Care

June 2020

Introduction

With the exponential growth of the older adult population in Ontario¹, capacity planning and best practice guidance for this population is becoming increasingly important. While the majority of older adults live well and independently, a growing proportion of older adults live with frailty. Frailty is a state of vulnerability to poor resolution of homeostasis after a stressor event and is a consequence of loss of reserve across multiple physiological systems, which occurs across a lifetime.² According to a report released by the Regional Geriatric Programs of Ontario in 2019 *Planning for Health Services for Older Adults Living with Frailty: Asset Mapping of Specialized Geriatric Services (SGS) in Ontario*, the estimated population living with frailty in Ontario was 628,642 in 2019 and is projected to increase to 922,252 in 2029³. There are numerous documents which describe best practices for frail seniors; however, there is no best practice framework to inform a standard approach to rehabilitative care for the frail senior population across the continuum. In addition to improving outcomes, quality of life and patient experience, implementation of a best practice rehabilitative care framework will support related system and organizational priorities such as: supporting community care organizations in ensuring they meet evidence-based quality standards for rehabilitation services; guiding implementation of rehabilitative care best practices and ensuring rehabilitative care for the frail senior population is both effective and efficient; and supporting continuous quality improvement by identifying practice changes that can improve care and optimize outcomes.

Development of the *RCA Frail Seniors Rehabilitative Care Best Practice Framework* was therefore undertaken by the Rehabilitative Care Alliance (RCA) to improve clarity on the key components of geriatric rehabilitative care across the continuum that can be used for program planning, to support implementation of senior friendly care and improve outcomes for older adults receiving rehabilitative care services.

Intent

The *RCA Frail Seniors Rehabilitative Care Best Practice Framework* (the Framework) is intended to:

- Influence frail seniors rehabilitative care best practice across the province;
- Provide a basis for informing and improving quality care for this population; and
- Provide a framework to support an approach to capacity planning that considers the optimal models/locations of rehabilitative care for older adults living with frailty.

¹ Ontario Population Projections, 2018-2046, Accessed:

<https://www.fin.gov.on.ca/en/economy/demographics/projections/>

² Clegg et al. (2013) Frailty in Older People. *Lancet*. 381(9868): 752-62. DOI:10.1016/S0140-6736(12)62167-9.

³ Regional Geriatric Programs of Ontario (2019) *Planning for Health Services for Older Adults Living with Frailty: Asset Mapping of Specialized Geriatric Services (SGS) in Ontario*. Accessed: <https://www.rgps.on.ca/wp-content/uploads/2019/05/Planning-for-Health-Services-for-Older-Adults-Living-with-Frailty-SGS-Asset-Mapping-Report-FINAL.pdf>

The Framework

Rehabilitative care best practices specific to frail seniors are described across the continuum of care under the following two categories:

1. **Processes of care** refer to evidence based actions or interventions performed during the delivery of patient care.
2. **Clinical areas** specific to the care of frail seniors are based on the domains of assessment described in the *Competency Framework for Interprofessional Comprehensive Geriatric Assessment*⁴ and the clinical areas described in the *Senior Friendly 7 Toolkit*⁵.

⁴ RGP of Ontario (2017). A Competency Framework for Interprofessional Comprehensive Geriatric Assessment. Accessed: <https://www.rgps.on.ca/wp-content/uploads/2019/03/A-Competency-Framework.pdf>

⁵ RGP of Toronto, SF7 Toolkit (v 2 2019). Accessed: <https://www.rgptoronto.ca/wp-content/uploads/2018/04/SF7-Toolkit.pdf>

The Framework Structure:

Frail Seniors Rehabilitative Care Best Practice Framework	Acute Care		Bedded Levels of Rehab			Primary Care	Out-patient Ambulatory		In Home	LTC
	ED	Inpatient Ex. Medical/ surgical units	Rehab Ex. General rehab Geriatric Rehab Unit	Restoration/ Activation Ex. Convalescent Care	Complex Medical Ex. Short & Long term complex medical	Ex. Family Health Team, Community Health Centre	Progression Ex. Community Physiotherapy Clinic, Specialty Clinics	Maintenance Ex. Fall prevention clinics	Ex. In home rehab, virtual care options	
Processes of Care										
Goals of care										
Target Population										
Prevention										
Assessment/Monitoring										
Treatment interventions										
Client & family perspective/education										
Transition care planning										
Clinical Areas										
Medical/surgical history										
Frailty										
Cognition & Mood/Mental Health										
Pain										
Physical Assessment										
Continence/Hydration & Nutrition										
Falls & Function										
Medication										
Social History										

Bedded Levels of Rehabilitative Care

Rehabilitative care best practices for the frail seniors population is described based on the levels of care defined in the *RCA Definitions Framework for Bedded Levels of Rehabilitative Care*⁶:

- Rehabilitation
- Activation/Restoration
- Short and Long Term Complex Medical

Each of the clinical areas include the following two sections:

- **Screening/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 older adults with restorative potential in the context of each of the clinical areas.
- **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 the clinical areas.

Restorative Potential⁶

Restorative Potential means that there is reason to believe (based on clinical assessment and expertise and evidence in the literature where available) that the patient's/client's condition is likely to undergo functional improvement and benefit from rehabilitative care. The degree of restorative potential and benefit from the rehabilitative care should take into consideration the patient's/client's:

- Premorbid level of functioning
- Medical diagnosis/prognosis and co-morbidities (i.e., is there a maximum level of functioning that can be expected owing to the medical diagnosis /prognosis?)
- Ability to participate in and benefit from rehabilitative care within the context of the patient's/client's specific functional goals and direction of care needs.

Note: Determination of whether a patient/client has restorative potential includes consideration of all three of the above factors. Cognitive impairment, depression, delirium or discharge destination should not be used in isolation to influence a determination of restorative potential.

⁶ Rehabilitative Care Alliance (updated 2017). Definitions Framework for Bedded Levels of Rehabilitative Care. Accessed: http://rehabcarealliance.ca/uploads/File/Toolbox/Definitions/Definitions_Framework_for_Bedded_Levels_of_Rehabilitative_Care_FINAL_Dec_2014_.pdf

Bedded Levels of Rehabilitative Care			
Frail Seniors Rehabilitative Care Best Practice Framework	Rehab Ex. General rehab Geriatric Rehab Unit	Activation/Restoration Ex. Convalescent Care	Complex Medical Ex. Short & Long term complex medical
Processes of Care			
Goals of care	<ul style="list-style-type: none"> To develop and provide a time limited coordinated, interprofessional rehabilitation plan of care ranging from low to high intensity through a combined and coordinated use of medical, nursing and allied health professional skills. Rehabilitation is focused on enabling, individuals with impairments and disabilities to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels.¹ Aims to counteract or stabilize decline in health status², optimize medical conditions^{3,4,5}, achieve sustainable improvements in functional status, quality of life and self management^{2,3,4}, maximize recovery & return to previous level of function, when possible^{6,7} and reduce caregiver burden.⁸ Provides short-term individualized multidisciplinary rehabilitation, assessment & treatment.⁵ 	<ul style="list-style-type: none"> To promote activity, increase strength, endurance, independence and ability to manage activities of daily living by providing access to therapies with a focus on restoring function. These include functional practice opportunities, wellness and self-care activities that support the return of patients to their previous living environment or other appropriate community environment¹, reduce caregiver burden and increase quality of life.⁸ 	<ul style="list-style-type: none"> To provide medically complex and specialized services to avoid further loss of function, increase activity tolerance and progress patient so that the patient may be able to go home OR may be able to be discharged to another level of (rehabilitative) care wherever possible OR “in the opinion of the attending physician, the patient requires chronic/complex continuing care and is, and will continue to be more or less a permanent resident in the hospital”¹
Target Population	<ul style="list-style-type: none"> Medically stable with significant functional impairments and who 	<ul style="list-style-type: none"> Medically stable and physically and cognitively able to 	<ul style="list-style-type: none"> Persons who require at least a moderate degree of active

	<p>require and are able to participate in a comprehensive interprofessional rehabilitation program at a low to high intensity to enhance functional and cognitive ability.¹</p> <ul style="list-style-type: none"> • May be at high risk of permanent loss of living independently in the community.¹ • Have identified goals for rehabilitation that are specific, measurable, attainable, realistic, and time-limited, which cannot otherwise be met in the community.¹ • Have no behavioural or mental health issues, which cannot be mitigated through the use of strategies, resources and/or environmental modifications, and which limit the patient's ability to participate.¹ • Achievement of goals requires daily interventions, frequent/daily re-assessment by regulated health professionals to update and progress the treatment plan, and a coordinated team approach by a dedicated/in-house interprofessional team of regulated health professionals.¹ • Although the patient's initial functional tolerance may fluctuate, the patient has the 	<p>participate in restorative activities designed to enable patients to return home by increasing their strength, endurance and ability to manage activities of daily living following an acute care hospital stay or admission from the community.¹</p> <ul style="list-style-type: none"> • Targeted individuals receiving interventions are expected to at least be capable of active participation in time-limited, low-intensity restorative care, but may lack the physical or cognitive capacity to participate in a rigorous rehabilitative care regimen.⁸ • Patients are expected to have a discharge location, typically home. Some patients could be preparing for active rehabilitation before returning home.¹ • Achievement of goals does not require daily access to a comprehensive, interprofessional rehabilitation team using a coordinated team approach. Goals are primarily addressed through exercise and recreational activities. • Although the patient's functional tolerance may fluctuate, the patient has the 	<p>medical management and, as a consequence, may possess a relatively low level of physical or cognitive ability to participate in rehabilitative care activities.⁸</p> <ul style="list-style-type: none"> • May be transitioning from acute medical treatment or surgery, require treatment for acute exacerbation of one or more chronic medical conditions, or a brief stabilization period to resolve medical issues, e.g. delirium or other symptoms related to poly-pharmacy.⁸ • Require a degree of active medical management that makes it unsafe or impractical to receive interventions on an in-home or ambulatory basis.⁸ • Are medically stable such that there is a clear diagnosis/prognosis; co-morbidities have been established; there are no undetermined acute medical issues; vital signs are stable; medication needs have been determined; and there is an established plan of care; however, some patients may experience temporary fluctuations in their medical status, which may require changes to medications/plan of care.¹
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	<p>cognitive ability and the physical tolerance to participate. Patients are expected to return to their previous living environment or other appropriate community environment following participation in rehabilitation^{1,8}</p> <ul style="list-style-type: none"> • Patients may present with physical disability, geriatric syndromes, frailty; and multimorbidity.⁹ • Many of these individuals may live in satellite communities where travel is a barrier to coming to clinic or day hospital frequently.⁵ • Patients are screened for rehabilitation potential before admission to a unit. Medical assessment should be an essential component of preadmission screening.⁴ • Assessing cognition, motivation and depression are important factors in determining rehabilitation potential.⁴ 	<p>cognitive ability and physical tolerance to participate.¹</p>	<ul style="list-style-type: none"> • Require skilled nursing and medical care that cannot be met on an ongoing basis in other levels of rehabilitative care • For whom it is anticipated their medical condition and tolerance improves, that they will be able to engage in limited rehabilitative activities¹
<p>Prevention/Health Promotion</p>	<ul style="list-style-type: none"> • As per the World Health Organization definitions¹⁰, primary prevention refers to actions aimed at avoiding the manifestation of a disease. Secondary prevention deals with early detection when this improves the chances for positive health outcomes. Health promotion is the process of empowering people to increase control over their health and its determinants through health literacy efforts and multisectoral action to increase healthy behaviors. • Health promotion usually addresses behavioral risk factors such as tobacco use, obesity, diet and physical inactivity, as well as the areas of mental health, fall & injury prevention, drug abuse control, alcohol control, health behavior related to HIV, and sexual health 		

Assessment/Monitoring	<ul style="list-style-type: none"> • Prevention and health promotion should be a key focus and inherent across all clinical areas/processes of care • Comprehensive Geriatric Assessment (CGA) is important for frail seniors with rehabilitation needs⁴ • <i>Health Care Professionals conducting a CGA should</i>¹⁵: • Understand physiological and biopsychosocial mechanisms of the aging processes, age-related changes to functioning, and the impact of frailty • Gather patient medical and social history and clinical data in sufficient depth to inform care planning and effective clinical decision making • Conduct accurate analysis of assessment findings and clinical information to develop a complete understanding of the patient’s story. Integrate assessment findings within and across domains to formulate a cohesive clinical impression. • With patients and their identified support network, formulate comprehensive, collaborative care plans focused on optimization of function and quality of life. Refer to appropriate community resources. Conduct iterative and ongoing review and revision of the care plan and adjust interventions and modify goals as needed. • Recognize and engage in inter-organizational collaboration through understanding of the roles of internal and external team members, and demonstrate the ability to identify appropriate opportunities to refer to collaborating teams/individuals. • Provide comprehensive, team based geriatric care. • Evaluate all 13 Domains of Assessment (Minimum areas of assessment required to accurately determine whether a more detailed assessment is needed.): Introduction, Social History, Medical/Surgical History, Medication, Falls, Continence/Hydration, Function, Cognition, Pain, Nutrition, Mood/Mental Health, Physical Assessment, Sleep • Establish and document goals with patient and family to maximize function and ensure a safe discharge to final destination, taking into consideration baseline cognitive and physical functioning¹¹ • Individual goal setting, done together with the patient is an essential aspect of geriatric rehabilitation^{12 13} • Often multiple goals based on the individual patient’s complex medical, social, and functional issues^{3 4} • Geriatric rehabilitative care is evidenced by the establishment of achievable treatment goals, the daily/frequent assessment and documentation of the functional status of patients and the occurrence of regular case discussion amongst treating practitioners.^{1 3 4 6 9 14} 		
	Interprofessional Treatment Interventions	<ul style="list-style-type: none"> • Physician assessment on admission 24/7 on-call physician. Access to daily physician or applicable alternate designate assessment is available if needed.¹ 	<ul style="list-style-type: none"> • Physician assessment on admission 24/7 on-call physician. Access to weekly physician follow-up/oversight.¹ • Requires nursing care ≤ 2 hours/day.¹

	<ul style="list-style-type: none"> • Medical care and rehabilitation should be managed by a physician and team with expertise in care of the elderly, including geriatrician, care of the elderly physician or geriatric nurse practitioner and team members who meet Comprehensive Geriatric Assessment Core Competencies.^{3 4 5 15} • Close medical supervision and concomitant treatment for comorbidities is important.⁴ • Patients with complex medication regimes who are returning to community living may benefit from a self-medication program.⁴ • Typically, requires up to 3 hours nursing care per day; however, some patients may require up to 4 hours per day¹ • Direct daily therapy (in alignment with treatment plan and patient tolerance) is provided/ supervised by regulated health professionals within a dedicated, interprofessional team model of care with expertise in rehabilitation populations.¹ • Geriatric rehabilitation should have an interdisciplinary team approach.^{2 3 4 5 7 9} 	<ul style="list-style-type: none"> • The rehabilitative plan of care is delivered largely by non-regulated health professionals, who may or may not be under the direction/supervision of a regulated health professional to provide programming for restoration/activation¹ • A significant amount of daily or near-daily activation, mobilization, strengthening, and other low-intensity rehabilitative activities⁸ • On-site therapy resources are limited to¹: • Physiotherapy (limited to providing an exercise program of 15 min/day on a 1:1 basis) • Non-regulated Activation / Recreational staff • Nursing • Social worker • Dietitian • Occupational Therapy and Speech Language Therapy may be available on a consultation basis. • Restorative activities may be provided in a group or 1:1 setting throughout the day (i.e. 30 minutes or up to 2 hours per day) 5 – 7 days per week¹ 	<p>follow-up/oversight. Up to 8 monitoring visits per month.¹</p> <ul style="list-style-type: none"> • Requires nursing care > 3 hours/day. Routine and regular daily scheduled nursing care¹; Skilled, technology-based care not available at home or in long-term care homes.⁸ • Regulated health professionals available to maintain and maximize cognitive, physical, emotional and functional abilities through limited rehabilitative activities, including geriatrician, care of the elderly physician or geriatric nurse practitioner and team members who meet Comprehensive Geriatric Assessment Core Competencies.^{1,5,15} • Up to 1 hour of rehabilitative activities per day as tolerated based on the patient’s medical condition/tolerance.¹ • Some daily rehabilitative therapy focused on restoration, adaptive skill acquisition, and mobilization, delivered or supervised by a regulated health professional⁸
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	<ul style="list-style-type: none"> • The interprofessional team should include: Clinical dietitian, discharge planner, nurse, occupational therapist, pharmacist, physiotherapist, psychiatrist and/or geriatrician, social worker, speech-language pathologist.¹ • Ideally, consultation is available from all of the following professionals: Chaplain/pastoral care provider, chiropractor, psychiatrist and/or geriatric psychiatrist, psychologist and/or neuropsychologist, recreation therapist, neurologist and wound care specialist.¹ • To accommodate differing levels of tolerance among patients on admission and increases in tolerance during the inpatient stay, the intensity of rehab may vary from low to high intensity (from at least 15 – 30 minutes of therapy 3x per day to 3 hours per day) up to 7 days per week.¹ • As a patient’s tolerance level improves to a level where s/he can participate in a higher intensity rehab program, the program should ideally be able to increase therapy hours as the patient’s tolerance increases to achieve all patient goals.¹ 		
Client & family perspective/education	<ul style="list-style-type: none"> • Health Care Professionals (HCP) orient patient and family to rehabilitative care by: <ul style="list-style-type: none"> ○ Discussing expectations for rehab stay^{11 15} 		

	<ul style="list-style-type: none"> ○ Orienting patient and family to patient specific care plan¹⁵ • Patient and family/caregiver education is best accomplished using a combination of methods. When education materials are provided, in addition to verbal communication, patient education is more effective.¹⁶ • Providing quality health information (accurate, accessible, and actionable) enables patients to better manage their health and wellbeing, and make fully informed decisions about their treatment and care.¹⁶ • Patient education materials should be developed using plain language as a key strategy for improving health literacy and be compliant with the Accessibility for Ontarians with Disabilities Act (AODA) requirements for accessibility.¹⁷ • Multi-modal education should be provided to patients, which can be tailored to individual preferences and experiences.¹⁶ • Engage patient/family through ongoing communication to review care and treatment program and discharge plan.¹⁸ • Identify and address patient/family concerns.¹⁸ • Consider patient and family’s level of health literacy, and ability to understand written or verbal information relating to their health and health care needs. Consider the person’s level of health literacy in the care and discharge plan(s).¹⁸ • Virtual care options for psychosocial support should be explored during inpatient stay as a mode to enable social engagement and caregiver involvement. 	
Transition care planning	<p><i>Discharge Indicator:</i> No longer requires ongoing nursing care and on-site access to MD. Identified rehab goals for bedded level of rehabilitative care have been met and additional progress can be achieved independently or with the assistance of a caregiver at home or through community-based rehabilitation.¹</p>	<p><i>Discharge Indicator:</i> Medical/functional recovery so as to allow patient to safely transition to the next level of rehabilitative care or an alternative level of care environment. Patients who are unable to transition to another level of care and require ongoing care will be considered for transition to a long-stay level of care.¹</p>
	<p><i>As per the Ontario Health (Quality) Transitions between Hospital and Home Quality Standard¹⁹:</i></p> <ul style="list-style-type: none"> • Hospital to share information about the admission with their primary care and home and community care providers, as well as any relevant specialist physicians, soon after admission. These providers in the community then share all relevant information with the admitting team in a timely manner. • Comprehensive assessment of current and evolving health care and social support needs is started early upon admission, and updated regularly throughout the hospital stay, to inform the transition plan and optimize the transition process. 	

	<ul style="list-style-type: none"> • Patients are involved in transition planning and developing a written transition plan. If people consent to include them in their circle of care, family members and caregivers are also involved. • Patients and their families and caregivers, have the information and support they need to manage their health care needs after the hospital stay. Education and training to manage their health care needs at home is offered, including guidance on community-based resources, medications, and medical equipment • Written transition plan, developed by and agreed upon in partnership with the patient, any involved caregivers, the hospital team, and primary care and home and community care providers before leaving hospital. Transition plans are shared with the person’s primary care and home and community care providers and any relevant specialist providers within 48 hours of discharge. • Named health care professional responsible for timely transition planning, coordination, and communication ensures an effective transfer of transition plans and information related to people’s care. • Medication reviews on admission, before returning home, and once they are home. These reviews include information regarding medication reconciliation, adherence, and optimization, as well as how to use their medications and how to access their medications in the community. People’s ability to afford out-of-pocket medication costs are considered, and options are provided for those unable to afford these costs. • Follow-up medical care with their primary care provider and/or a medical specialist coordinated and booked before leaving hospital. People with no primary care provider are provided with assistance to find one • Patients assessed for the type, amount, and appropriate timing of home care and community support services they and their caregivers need. When these services are needed, they are arranged before people leave hospital and are in place when they return home. • Ability to pay for any out-of-pocket health care costs considered by the health care team, and information and alternatives for unaffordable costs are included in transition plans. The health care team explains to people what publicly funded services are available to them and what services they will need to pay for.
Clinical Areas	
Medical/surgical history	<p>Screening/Assessment:</p> <ul style="list-style-type: none"> • Screen or scan the patient’s medical/surgical history to determine whether more detailed assessment is needed to develop a full clinical profile of frailty. If concerns are identified, assess the following¹⁵: <ul style="list-style-type: none"> ○ Past Medical History ○ Chronic Disease Management ○ Preventative Health Practices ○ Communication ○ Family history of relevant diseases (e.g. Dementia – with age of onset) • If concerns are identified with sleep, consider changes in sleep patterns and sleep apnea.¹⁵
Frailty	<p>Screening/Assessment:</p>

- 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.²⁰
- Once a patient is identified as being at risk of frailty, or frail, a scale such as the Canadian Study on Health and Aging (CSHA) Clinical Frailty Scale should be used to categorize the needs of the patient. Patients with identified frailty (CHSA Scale, Level 4 and greater) require additional assessment in order to support the development or refinement of a Care Plan.²¹
- 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.²²

Interventions:

- 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 rehabilitation²².
- Effective interventions to prevent and/or reverse frailty include²³:
 - 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 older adults who are frail or at risk of frailty is to develop a shared understanding of desired care 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 care²²:
 - 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?

	<ul style="list-style-type: none"> ○ What does the patient or family/caregiver hope to achieve from medical treatment? ○ Incorporate and document discussion of advance care planning. ● The Care Plan is generated from these collaborative goals. First note the most bothersome complaint, as voiced by the patient, and proceed with consideration for²²: <ul style="list-style-type: none"> ○ Rehabilitative 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 include²²: <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 ○ 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 as²²: <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.
Cognition & Mood/Mental Health	<p><u>Cognition:</u></p> <p><i>Screening/Assessment:</i></p> <ul style="list-style-type: none"> ● Screening tool that can be used to detect cognitive impairment quickly during hospitalizations include: <ul style="list-style-type: none"> ○ the Mini-Cog ^{TM24} ○ Montreal Cognitive Assessment (MoCA)²⁵ ○ Mini Mental State Examination (MMSE)²⁵ ● 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.²⁶

- 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 team²⁶.
- Be aware of the following considerations for potential delirium²⁷:
 - Intact functional status does not rule out delirium.
 - 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
 - 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 delirium.
 - While symptoms of delirium typically develop abruptly, an insidious onset can occur (e.g., irritability, restlessness, anxiety, or sleep disturbance).
- 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.²⁷
- 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).²⁷
- Any clinician noticing changes in the mental status or alertness of an older hospitalized person should bring this to the attention of the nurse caring for the individual and/or the person’s attending physician.²⁷
- Older persons should be routinely screened for delirium during their stay in hospital.^{27 28}
- 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 delirium²⁷.
- Screen for delirium daily using the CAM (Confusion Assessment Method) or the 4 AT Assessment Test for delirium & cognitive impairment.²⁸ Ratings on the CAM should be informed by an objective mental status examination.²⁷
- Serial cognitive and functional measurements should be done. They will help in monitoring the older person’s progress and their need for care.²⁷

Cognition:

Intervention:

- 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.²⁶
- Clinicians should recognize their clients retained abilities, understand the impact of the environment, and relate effectively when tailoring and implementing their caregiving strategies.²⁶
- Clinicians caring for clients with dementia should be knowledgeable about pain assessment and management in this population to promote physical and emotional well-being.²⁶

- Clinicians caring for clients with dementia should be knowledgeable about non-pharmacological interventions for managing behaviour to promote physical and psychological well-being.²⁶
 - 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.²⁶
- Clinicians should avoid physical and chemical restraints as first line care strategies for older adults with delirium, dementia, and depression.²⁶
- 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. Interventions to prevent delirium should be interdisciplinary^{27 28}.
- 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.²⁷
- Multicomponent interventions targeting multiple risk factors should be implemented in older persons who have intermediate to high risk for developing delirium²⁷
- 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.²⁷
- Strive to maintain a normal elimination pattern. Aim for regular voiding during the day and a bowel movement at least every two days. Urinary retention and fecal impaction should be actively looked for and dealt with if discovered. Minimize use of indwelling catheters.^{27 28 29}
- Older hospitalized persons with pre-existing cognitive impairment should be offered an orientation protocol and cognitively stimulating activities.²⁷
- Older hospitalized persons who are having problems sleeping should be offered non-pharmacologic sleep-enhancing approaches. Use of sedative-hypnotics should be minimized.^{27 28}
- Older hospitalized persons should be mobilized as quickly as possible. The use of immobilizing devices/equipment should be minimized. 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.^{27 28 29}
- Older persons with impairments of vision should be provided with their visual aids and/or other adaptive equipment.^{27 29}

- Older persons with impairments of hearing should be evaluated for reversible causes and provided with hearing aid(s) and/or other amplifying devices.^{27 28}
- 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 intake.^{27 28}
- 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-face.²⁷
- Avoid abstract language/ideas and do not insist that the older person appreciate the information that is being given. Do not engage in discussions that the older person cannot appreciate. Discuss topics that are familiar and/or of interest, such as hobbies and occupation, with the older person.²⁷
- Routinely provide orienting information in the context of care. For example, frequently use the older person's name and convey identifying information (e.g., "I'm your physiotherapist").²²
- When providing care, routinely explain what you are about to do. This is to reduce the likelihood of misinterpretation. 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/her.²⁷
- Environmental risk factors should be modified, if possible, including the following:²⁷
 - Avoid sensory deprivation (e.g., windowless room, single room)
 - Avoid sensory overload (e.g., too much noise and activity)
 - Avoid isolation from family/friends (or familiar objects)
 - Avoid frequent room changes, absence of orientating devices (e.g., watch, clock or calendar), absence of visual/hearing aids, use of restraints.
 - Implement unit-wide noise-reduction strategies at night (e.g., silent pill crushers, vibrating beepers, quiet hallways) in an effort to enhance sleep.
 - 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 room.
 - 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 place.
 - Attempt to keep the older person in the same surroundings.
 - Obtain familiar possessions from home, particularly family pictures, sleepwear and objects from the bedside, to help orient and calm the older person.

- 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 care.
- Consider the follow medical interventions²⁹:
 - Provide oxygen therapy and chest physiotherapy as needed
 - Screen and treat infections appropriately and judiciously
 - Obtain Best Possible Medication History (BPMH), reconcile, review, and optimize medications
 - Correct fluid and electrolyte imbalances – serum sodium, potassium, and glucose; monitor and treat dehydration or fluid overload
 - Manage pain and discomfort
- Provide information about delirium to family and caregivers. Encourage family/caregiver visits and involvement in care. Encourage the family/caregiver to bring in patient’s personal and familiar objects²⁹

Mood/Mental Health:

Screening/Assessment:

- 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.³⁰
- 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.³⁰
- Clinicians should always assess the risk of suicide in patients with suspected depression by directly asking patients (as well as their 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.³⁰
- Patients who have had strokes should be monitored closely for the possible development of depression, even in those who do not report depressed mood.³⁰
- Following a positive screen for depression, a complete bio-psycho-social assessment should be conducted, including³⁰:
 - 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
 - Review of current stresses and life situation
 - Level of functioning and/or disability
 - Family situation, social integration/support and personal strengths

	<ul style="list-style-type: none"> ○ 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. <p>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.²⁷</p> <p><u>Mood/Mental Health:</u></p> <p><i>Intervention:</i></p> <ul style="list-style-type: none"> ● For severe depression (GDS score 11 or greater), refer for psychiatric evaluation.³¹ ● 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.³¹ ● If suicidal thoughts, psychosis, or comorbid substance abuse are present, a referral for a comprehensive psychiatric evaluation should always be made.³¹ ● 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.³⁰ ● 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.³⁰ ● Both cardiovascular (aerobic) activities resistance training (nonaerobic) can help reduce depressive symptoms, but the results appear to be more consistent for cardiovascular exercise.³¹ ● 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.³⁰ ● Older patients have a response rate with antidepressant therapy similar to younger adults. Clinicians should approach elderly depressed individuals with therapeutic optimism.³¹
Pain	<p><i>Screening/Assessment:</i></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 pain³². ● 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.³² ● 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:³³

- History
 - 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).
 - 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, posture, leg length discrepancy). Practitioners skilled in musculoskeletal examination should be considered for consultation (e.g., physical therapy, occupational therapy, physiatry).
 - Physical examination should focus on the neurologic system (e.g., search for weakness, hyperalgesia, hyperaesthesia, 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 to 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.
 - The use of a multidimensional pain instrument that evaluates pain in relation to other domains (e.g., the Pain Disability Index or the Brief Pain Inventory) should be considered
 - 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.
 - 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: ³³
 - 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.³³
- 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.³²
 - Patients should be observed for evidence of pain-related behaviours during movement (e.g., walking, morning care, transfers).

	<ul style="list-style-type: none"> ○ 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.³³ ● Patients with persistent pain should be reassessed regularly for improvement, deterioration, or complications.³³ <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. <p>Reassessment should consider patient preferences in assessment and treatment revisions.</p>
	<p>Intervention:</p> <ul style="list-style-type: none"> ● Nonpharmacologic Intervention Recommendations:³³ <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. ▪ 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, chiropractic, acupuncture, and transcutaneous electrical nerve stimulation) often offer temporary relief and can be used as adjunctive therapies.
Physical Assessment	<p>Screening/Assessment:</p> <ul style="list-style-type: none"> • Upon physical assessment, if concerns are identified, assess the following¹⁵: <ul style="list-style-type: none"> ○ Vital signs ○ Orthostatic Hypotension ○ Vision ○ Hearing ○ Oral Health ○ Neurological ○ Musculoskeletal (MSK) ○ Cardiovascular ○ Respiratory ○ Gastroenterology ○ Foot ○ Skin/Nodes/ Thyroid ○ Labs/ Diagnostics <p>Fracture Risk Assessment/Osteoporosis – Recommendations³⁴</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ 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.

Pressure Ulcer Assessment:

- 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 prominences³⁵.
 - 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 been tested for validity and reliability, such as the *Braden Scale for Predicting Pressure Sore Risk*, 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.³⁵
 - 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.³⁵
 - All pressure ulcers are identified and staged using the National Pressure Ulcer Advisory Panel (NPUAP) criteria.³⁵
- All data should be documented at the time of assessment and reassessment.²²

Interventions:

Strategies for Fracture Prevention³⁴

- 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)

Pharmacotherapy for fracture prevention³⁴

- 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.

Pressure Ulcer Prevention:

- For clients with an identified risk for pressure ulcer development, minimize pressure through the immediate use of a positioning schedule.³⁵
- 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.³⁵
- Consider the impact of pain. Pain may decrease mobility and activity. Pain control measures may include effective medication, therapeutic positioning, support surfaces, and other non-pharmacological interventions. Monitor level of pain on an on-going basis, using a valid pain assessment tool.³⁵
- 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.).³⁵
- Avoid massage over bony prominences.³⁵
- Clients at risk of developing a pressure ulcer should not remain on a standard mattress. A replacement mattress with low interface pressure should be used.³⁵
- For high risk clients experiencing surgical intervention, the use of pressure-relieving surfaces intraoperatively should be considered.³⁵
- For individuals restricted to bed:³⁵
 - Utilize an interdisciplinary approach to plan care.
 - 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: ³⁵
 - 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: ³⁵
 - 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.
- Protect skin from excessive moistures and incontinence:³⁵
 - 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.

	<ul style="list-style-type: none"> ○ 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. If a nutritional deficit is suspected: ³⁵ <ul style="list-style-type: none"> ○ Consult with a registered dietitian ○ Investigate factors that compromise an apparently well-nourished individual’s dietary intake (especially protein or calories) and offer him or her support with eating ○ Plan and implement a nutritional support and/or supplementation program for nutritionally compromised individuals ○ If dietary intake remains inadequate, consider alternative nutritional interventions ○ Nutritional supplementation for critically ill older clients should be considered ● 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.³⁵
Continence/Hydration & Nutrition	<p><u>Continence:</u></p> <p><i>Screening/Assessment:</i></p> <ul style="list-style-type: none"> ● Obtain a history of the client’s incontinence.^{28 36} <ul style="list-style-type: none"> ○ Assessment for a history of incontinence includes the following: <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. ● Gather information on:³⁶ <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.³⁶
- Identify attitudinal and environmental barriers to successful toileting. Barriers include^{28 36}:
 - Proximity and availability of the nearest bathroom;
 - Accessibility of commode;
 - Satisfactory lighting;
 - Use of restraints;
 - Treatment / consequences of treatments - medications (such as diuretics, opioids, sedatives), IV fluids, surgery, catheter-associated urinary tract infection
 - 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.³⁶

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.³⁷

Continence:

Intervention:

- Ensure an adequate level of fluid intake (1500-200 ml per day), and minimize the use of caffeinated and alcoholic beverages where possible.³⁶
- Initiate an individualized prompted voiding schedule based on the client’s toileting needs, and as determined by a 3-day voiding record. Successful implementation of prompted voiding requires:³⁶
 - 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;
 - Interpretation of this data and identification of problems;
 - Development of implementation strategy; and
 - Monitoring of the program.
- Implement an educational program on promoting continence using prompted voiding. The program should include information on:³⁶
 - 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:**³⁶
 - 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:**³⁶
 - 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:**³⁶
 - 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:**³⁶
 - 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:**³⁶
 - 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 UI. ³⁷
- Conservative management includes behaviour training, education, scheduled voiding, positive reinforcement and pelvic muscle exercises with various techniques to help control urinary incontinence. ³⁷
- If UI persists following conservative management interventions, consider referral to other team members for medical, pharmacological, mechanical, or surgical interventions. ³⁷

Nutrition:

Screening/Assessment:

	<ul style="list-style-type: none"> • If concerns are identified, assess the following¹⁵: <ul style="list-style-type: none"> ○ Amount of Unintentional ○ Weight Loss in the Past 6 Months ○ Reduced Food Intake (how long?) ○ Hydration ○ Swallowing • Clinicians can screen for malnutrition using the Mini Nutritional Assessment – Short Form (MNA-SF)™ every 3 months for patients in the hospital or whenever a change in clinical condition occurs. Clinicians should be familiar with administering the MNA-SF and determining patient’s screening score. The MNA-SF tool allows standardized, reproducible, and reliable determination of nutritional status.³⁸ • Follow up: Refer results of assessments and re-assessments to doctor/registered dietitian and record in medical record.³⁸ • 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.^{28 39} <p>Patients should be flagged for assessment by a registered dietitian if they are eating 50% or less of their hospital meals.³⁹</p>
	<p><u>Nutrition:</u> <i>Intervention:</i></p> <ul style="list-style-type: none"> • The following strategies can be used to support adequate food intake:^{28 39} <ul style="list-style-type: none"> ○ Create a nutritional care plan and share within the circle of care ○ Position patients properly for eating ○ 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 ○ Encourage family members to visit at mealtimes, and to bring food from home as appropriate. ○ Optimize social interaction at mealtimes (e.g. patients who can be mobilized out of the ward to the hospital’s cafeteria with families and other patients).
<p>Falls & Function</p>	<p><u>Falls:</u> <i>Screening/Assessment:</i></p> <ul style="list-style-type: none"> • Assess fall risk on admission, and after a fall⁴⁰ • If concerns are identified, assess the following¹⁵: <ul style="list-style-type: none"> ○ History of Falls/Near Falls ○ Identification of Modifiable Risk Factors ○ Head Injury Risk

- Screening assessment tools should identify which reversible risk factors to base the choice of intervention.⁴¹
- 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:
 - STRATIFY Risk Assessment Tool
 - Morse Fall Scale
- 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 Toolkit⁴² (including, but not limited to):
 - Timed Up and Go
 - Tinetti Balance Scale
 - Gait Speed and Gait Abnormality
 - Functional Reach
 - Berg Balance Scale

Falls:

Intervention:

- Use strength training as a component of multi-factorial fall interventions; however, there is insufficient evidence to recommend it as a stand-alone intervention.⁴¹
- The multidisciplinary team should implement multi-factorial fall prevention interventions to prevent future falls⁴⁰.
- 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 settings⁴⁰.
- Provide clients with information on the benefits of vitamin D supplementation in relation to reducing fall risk. In addition, information on dietary, life style and treatment choice for the prevention of osteoporosis is relevant in relation to reducing the risk of fracture.⁴⁰
- Minimize bed rest orders, and consider daily mobility/out-of-bed orders⁴²
- Minimize use of physical restraints and of mobility restricting devices such as indwelling catheters and intravenous lines/poles – when used, review daily⁴².
- 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) orders⁴².
- Initiate early functional goal setting and discharge planning with patient and family⁴²
- Maximize patients' own participation in ADLs while in hospital⁴²
- Encourage and assist with regular daily mobility where appropriate; early referral to physiotherapy and occupational therapy for complex patients⁴²

- Optimize sleep using non-pharmacologic protocols⁴²
- Assess and manage depression⁴²
- Assess and treat pain appropriately⁴²
- Provide education to the inter-professional team on function-focused interventions⁴²
- Maximize social engagement – encourage patient and family/caregiver visits and participation with care, volunteer visits⁴²
- Initiate early discharge planning focusing on patient and family goals⁴².
- 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. ⁴¹
- Noise prevention measures – reduced use of overhead pagers, acoustical room treatments, headphones, earplugs⁴².
- 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 showers⁴².
- Nurses, in consultation with the health care team, conduct periodic medication reviews to prevent falls among elderly in health care settings.⁴¹

Function:

Screening/Assessment:

- A simplified mobility assessment algorithm is as follows²⁸:
 - C – Cannot stand
 - B – Bed to chair transfers
 - A – Ambulates
- This level of mobility can be used to guide an individualized mobility care plan, which may involve a specific program or making a habit of incorporating mobilization into daily activities and socializing.²⁸
- 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)²⁸.
- If concerns are identified, assess the following¹⁵:
 - Living Environment (Safety)
 - Equipment/Assistive Devices
 - Mobility/Transfers/Gait/Balance
 - Activities of Daily Living (ADLs)
 - Instrumental Activities of Daily Living (IADLs)
 - Driving/ Transportation
- 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

	<p>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:</p> <ul style="list-style-type: none"> ○ Barthel Index ○ Lawton Brody IADL ○ Older Americans Resources Services (OARS) ADL & IADL scales ○ Katz Index <ul style="list-style-type: none"> ● For additional consideration when selecting a clinical tool appropriate for the patient population/setting, RNAO also recommends the Functional Improvement Measure (FIM).⁴³
	<p>Function:</p> <p>Interventions:</p> <ul style="list-style-type: none"> ● Encourage the older adult to mobilize at least 3 times per day.²⁸ ● Ensure that there is a family member, or staff available to assist if mobility risks are identified.²⁸ ● Try different approaches when encouraging older adults to mobilize. Some older adults may be motivated by the term “exercise”, while others may prefer to talk about being “more active” or “sitting less”.²⁸ ● Throughout hospitalization, communicate the older adult’s mobility level to the team so that they can promote mobilization.²⁸ ● Activities required to live in the community (IADL):²² <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):²² <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
Medication	Screening/Assessment:

- Polypharmacy or multiple medications may be clinically appropriate, but it is important to identify when the medications used by older adults may be inappropriate and may place the person at increase risk of adverse events and poor health outcomes²⁸.
- Increased risk of adverse events²⁸:
 - >5 medications
 - >12 doses a day
 - Medications prescribed by multiple health care providers
- The “AGS Beers Criteria” (2019) 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)⁴⁴.
- Canadian guidelines have been developed and adapted into a quickly administered screening tool called “Improved Prescribing in the Elderly Tool” (IPET)⁴⁵.
- Risk factors for adverse drug reactions in older adults include²⁸:
 - Recent change in medications, polypharmacy, age-related changes, ethnicity, gender, health conditions, social habits
- Physical signs that should arouse suspicion of an adverse drug reaction include: ⁴⁶
 - 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.⁴⁶
- 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.⁴⁶
- 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.⁴⁶
- 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
- A thorough medication review is recommended every 6-12 months and after events which alter a patient’s medication regimen (e.g., hospitalization).⁴⁷ Medication reconciliation (“Med Rec”) is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care.²⁸
- If concerns are identified, assess the following¹⁵:
 - Allergies

	<ul style="list-style-type: none"> ○ Best Possible Medication History (BPMH) ○ Medication Adherence ○ Packaging and Administration ● Ensure that accurate and complete medication information is available from admission through discharge. Identify opportunities for de-prescribing (deprescribing.org). Identify if medications could be the cause of the admission.²⁸
Social History	<p>Interventions:</p> <ul style="list-style-type: none"> ● Involve older adults in prescribing decisions to ensure that the plan of care meets their needs and preferences. Confirm patient understanding of their medications. Clarify patient preference for family involvement in medication discussions. Provide older adults with clearly written medication summaries and instructions, including how to monitor for adverse drug reactions²⁸. ● Share concerns arising from the “Med Rec” process, up-to-date medication lists and actual or potential adverse drug reactions for monitoring by providers within the circle of care²⁸.
	<p>Screening/Assessment:</p> <ul style="list-style-type: none"> ● Loneliness and social isolation can affect physical health (early mortality, stroke, elevated blood pressure, malnutrition), mental health (depression, risk of suicide, substance misuse) and functional decline (physical and/or cognitive deterioration)²⁸ ● Social isolation risk factors include: psychological personality or mental health issues, living alone, health problems, physical challenges or disability, sensory impairment, no children and major life events such as loss and bereavement.²⁸ <p>Upon screening of social history, if concerns are identified, assess the following¹⁵:</p> <ul style="list-style-type: none"> ○ Gender/ Sexuality ○ Culture/language/Religion/Place of Birth ○ Family Demographic (marital status, children) ○ POA/SDM ○ Advance Care Directives ○ Caregiver Support/ Burden/Social & Community Supports ○ Current or Past Occupation ○ Financial Resources ○ Alcohol/Smoking/Recreational drugs ○ (past and present) ○ Abuse/Neglect (i.e. Financial/Physical/Emotional/Sexual) ○ Hobbies and interests <p>Interventions:</p>

- Enhance conversation with older adults by starting with open-ended questions, listening actively, responding positively, follow-up actively, allowing time for silence and reflection. Reminiscence can be a health part of conversation.²⁸
- Include concerns and recommendations related to loneliness in discharge plans²⁸
- Consider the older adult’s relationships and preferences before discussion with family members, and if appropriate, share information on ways to promote social engagement²⁸

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