Rehabilitative Care Alliance

Updated July 2026

# Pathway to rehabilitative care for older adults living with frailty in the community presenting to Emergency Department post-fall and not requiring acute hospitalization

**Emergency Department**

Older Adult 65+ years

**Older adult reports fall(s) or presents immediately following a fall**

Definition: A fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.
World Health Organization

Older adults who experience a fall are likely to have multiple conditions and complex health needs. Preventing functional decline and further falls among high risk older adults requires an integrated, coordinated approach to care.

Preliminary Evaluation

2 or more falls in the last year? N

Difficulties with walking and/or balance? N

**Community Intervention** (See Below)

Y

Suggest secondary prompt. Example: Have you had a "Near Fall"?

Y

High Risk for Functional Decline

**Immediately following a fall:**
- ❑ Assess severity of injury
- ❑ Rule out acute medical conditions
- ❑ Injuries may be occult or present atypically

**Multifactorial Evaluation**
- ❑ Determine risk factors for secondary fall
- ❑ Assess level of frailty: e.g., Clinical Frailty Scale (CFS)*
- ❑ If time & capacity, complete functional assessment: e.g., Barthel Index ǂ
- ❑ Use interdisciplinary team approach. Refer to GEM Nurse, PT, OT, SW, RD as appropriate

**Multiple fall risk factors, including:**
- ❑ Alcohol Intake
- ❑ Cognition
- ❑ Feet/Foot Wear
- ❑ Hearing
- ❑ Home Hazards
- ❑ Inactivity/sedentary
- ❑ Incontinence
- ❑ Medical History
- ❑ Mobility/Balance
- ❑ Mood
- ❑ Nutrition & Hydration
- ❑ Orthostatic Hypotension
- ❑ Polypharmacy
- ❑ Vestibular Conditions
- ❑ Vision

**~All domains are assessed together to inform a comprehensive plan of care**

- Not frail
- eg. CFS 1-3
- Few fall risk factors
- Not medically complex

- Mild to moderate frailty, eg. CFS 4-6
- Multiple fall risk factors
- Reasonably mobile
- May be medically/ psychosocially complex

- Moderate to severe frailty, eg. CFS 6-7
- Multiple fall risk factors and/or medically complex
- Requires nursing care and support over and above what can be provided in the local community setting, i.e., no other reasonable means of rehabilitative care

Assessment and Intervention

**Community Intervention**

**Outpatient Community Clinic/ In Home Care/ Specialized Geriatric Services**

**Explore Direct Access to Inpatient Rehabilitative Care**

**Pathway Development:** Complete asset mapping of local rehab services for older adults. Enter services and referral processes in the appropriate boxes below.

**Enter prevention programs such as fall prevention and exercise classes here**

**Publicly funded rehabilitative care service listing:**
www.rehabcareontario.ca

**Enter Rehab Services here**

OHaH Rehab Services for older adults who are homebound

Outpatient Community Clinics/Services

Specialized Geriatric Rehab Services

**Publicly funded rehabilitative care service listing:**
www.rehabcareontario.ca

**Enter**
**Inpatient Rehabilitative Care Program here**
Align the older adult's goal, functional trajectory, target population and functional characteristics to a program that has the resources to safely manage the medical needs.

Refer to the *RCA Framework for Bedded Levels of Rehabilitative Care*

*Clinical Frailty Scale

ǂBarthel Index

**MONITORING & FOLLOW-UP IN PRIMARY CARE:** Communicate results of preliminary evaluation and referral pathway to primary care provider. Recommend Fracture Risk Assessment