Rehabilitative Care Alliance

Frail Seniors

Guidance on Best Practice Rehabilitative Care in the Context of COVID-19

Please note:

This document predates *Rehabilitative Care for Older Adults Living With/At Risk of Frailty: From Frailty to Resilience*, a comprehensive best practice framework released by the RCA and Provincial Geriatrics Leadership Ontario in December 2021. While less detailed, this older document aligns with the new framework and provides specifics on providing care during the pandemic.

INTENT OF THIS GUIDANCE DOCUMENT

- Provide a brief summary of evidence-based best practice rehabilitative care for seniors living with frailty
- Offer considerations for the provision of rehabilitative care for seniors living with frailty in light of restrictions due to the COVID-19 pandemic

SECTION 1: CURRENT COVID-19 CONTEXT: THE NEED FOR REHABILITATIVE CARE

Although the COVID-19 pandemic is affecting individuals of all ages, the older adult population is at significant risk—particularly frail seniors.

In Ontario today, an estimated 628,642 older adults are living with frailty.[1] As a result of the pandemic, this already vulnerable population is at even higher risk due to

- social isolation and loss of engagement opportunities
- deconditioning
- reduction of medical and community support services
- challenges with participating in virtual care options
- fear-based refusal of services, and
- caregiver burnout.[2 3]

Equally concerning is the risk that significantly more older adults will ***become*** frail due to infection with COVID-19 and/or its wider system impacts.[3 4 5 6 7] In fact, Ontario must prepare for a "deconditioning pandemic" as months of reduced levels of activity among older adults result in reduced physical fitness, loss of cognitive and emotional wellbeing, increased risk of dementia, reduced quality of life and increased dependency.[8]

As Ontario gradually reopens services, rapid access to rehabilitative care that meets the needs of frail seniors will be essential to mitigate these effects. Rehabilitative care services are a core component of high value care that maximizes functional ability, psychological wellbeing and social integration.[3 7 9 10 11]

The provision of rehabilitative care will also be critical to support planning recommendations for the resumption of surgeries and procedures during COVID-19. Current plans are dependent on acute care hospitals maintaining occupancy at 90 per cent.[12] Because many patients undergoing surgery will be frail seniors, rehabilitative care best practices will be essential to achieve positive post-surgical outcomes and subsequent discharge.

SECTION 2: REHABILITATIVE CARE BEST PRACTICES FOR FRAIL SENIORS

The Rehabilitative Care Alliance (RCA) is currently developing evidence-based rehabilitative care best practice frameworks for frail seniors across the full continuum of care. The framework for bedded levels of care was released in June 2020; frameworks for other sectors will be released later this year.

However, the COVID-19 pandemic has created an urgent need for immediate best practice guidance. In response, the RCA has summarized key best practices below.

These best practices should guide rehabilitative care for frail seniors at all times, but are particularly important in the context of the COVID-19 pandemic when rehabilitative care will play a critical role in mitigating the detrimental impacts of social isolation, deconditioning and COVID-19, should infection occur. Considerations specific to COVID-19 are noted, where applicable.

1. Rehabilitative care for frail seniors

Evidence shows that older adults benefit from rehabilitative care, especially those living with frailty who have restorative potential.[13]

Frail seniors are individuals (typically over the age of 65) who experience increased vulnerability due to a combination of physical, cognitive, social and emotional factors that influence their ability to withstand life stressors.[14] Individuals are considered to have restorative potential if there is reason to believe that rehabilitative care will provide benefits and lead to functional improvement.[15]

Rehabilitative care for frail seniors aims to

- reverse or stabilize a decline in health status
- optimize medical conditions
- achieve and maintain functional improvements, quality of life and self-management
- maximize recovery and return to previous level of function when possible, and
- reduce caregiver burden.[1] [16] [17] [18]

Rehabilitative care is directed by the goals of the frail senior and their caregivers and uses diagnostic and therapeutic interventions to restore functional ability or enhance residual functional capability.

2. Processes of Care

Processes of care refer to evidence-based actions or interventions performed during the delivery of patient care.

2.1 Rehabilitative care for frail seniors should have an interdisciplinary approach. It is important that organizations and/or regions develop capacity/contingency plans to ensure that

interdisciplinary teams with skill and knowledge in geriatrics are available to deliver care across the continuum.[1 16 17 18 19 20]

2.2 The frail senior and their caregivers should be included as part of the team approach. In the context of COVID-19 restrictions, the integral role of caregivers and family members and their impact in providing physical, social, emotional and navigation of care has been crucial.[21]

2.3 Comprehensive Geriatric Assessment (CGA) is important for frail seniors with rehabilitative needs and should remain a priority. CGA includes interprofessional geriatric assessment data, physical assessment findings, analysis and synthesis of the clinical profile and development of a collaborative plan of care and follow up plans.[22]

2.4 Prevention and health promotion should be a key focus of care across all clinical areas.[23] During the COVID-19 pandemic in particular, rehabilitative care is essential to prevent functional decline and disability. Frail seniors should be supported to optimize their functional ability, engage in meaningful activity and maintain independence.[32]

2.5 Rehabilitative care for frail seniors should accommodate differing levels of tolerance. As the individual's tolerance level changes, services should be adjusted accordingly to achieve patient goals.[15]

2.6 The provider should determine the most appropriate level of rehabilitative care (prevention, stabilization, progression, and/or maintenance) based on individual patient need, recognizing that needs may fluctuate along the course of the functional/recovery trajectory. The *RCA Referral Decision Tree for Rehabilitative Care and Definitions Frameworks* (bedded levels of care and community based) provides guidance to support this determination.[15] This stratification of rehabilitation need will be necessary to prevent a particular rehab setting from being overwhelmed as the COVID-19 pandemic wave moves from acute to post-acute care.[3]

2.7 Multi-modal education should be provided to patients and caregivers. Materials should be tailored to an individual's preferences and experiences, consider the person's level of health literacy and be compliant with the Accessibility for Ontarians with Disabilities Act (AODA) requirements for accessibility.[24] In the context of COVID-19, these education materials should be in keeping with provincial pandemic restrictions, e.g., virtual care options.

2.8 Transition plans should be developed and agreed upon in partnership with the patient, any caregivers involved and the care team.[25] Caregivers provide essential support to coordinate care at major transition times. This is particularly the case during the COVID-19 pandemic, given potential reductions or changes in community-based health service delivery.[21]

3. Clinical Areas

Clinical areas refer to evidence-based domains of assessment and intervention.

*3.1 **Medical/Surgical History***

3.1.1 Medical/surgical history should be screened or scanned to determine whether more detailed assessment is needed to develop a full clinical profile of frailty.[22] Acute disease is often masked and expressed as functional impairment, falls, confusion or

reduced mobility. During this pandemic, atypical presentation of COVID-19 should be considered.[32]

3.2 Frailty

3.2.1 Clinicians should consider each interaction with frail seniors as an opportunity to engage them in individualized care planning and to identify any follow-up needs.[26]

3.2.2 Individually developed care plans should be completed for seniors who are frail or at risk of frailty. These plans should address modifiable biological and psychosocial factors while integrating individual disease factors that impede the health goals of patients.[27] In the context of COVID-19, care plans should include consideration of pandemic restrictions, such as physical distancing and isolation protocols.

3.3 Cognition & Mood/Mental Health

3.3.1 Clinicians should contribute to interdisciplinary comprehensive standardized assessments to rule out or support the identification and monitoring of dementia based on their ongoing observations and expressed concerns from the person, their family or the interdisciplinary team. Clinicians should recognize their client's retained abilities, understand the impact of the environment and effectively communicate tailored intervention strategies.[28]

During this time of pandemic, changes in environment (e.g., hospital admission), loss of familiar supports and difficulty communicating increase the risk of delirium in frail seniors with underlying dementia. It should be noted that people living with dementia might have difficulties in remembering safeguard procedures, such as wearing masks and social distancing.[32]

3.3.2 Older adults should be routinely screened for delirium. 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.[29]

Given that older adults with underlying COVID-19 may present with delirium, this routine assessment is vital. Special consideration must be given to how to manage people with delirium when they are in isolation and providers are wearing personal protective equipment (PPE), including communicating clearly, using body gestures, and providing reassurance and reorientation.[32]

3.3.3 Older adults should be screened for depression and/or apathy. Following a positive screen, a complete bio-psycho-social assessment should be conducted.[30] Consideration should be given to risk factors such as social isolation, disruption in normal schedule and reduced activity levels during the COVID-19 pandemic.

3.3.4 Consideration should be given to conditions that may impact changes in cognition or mood (e.g. stroke or post-COVID-19).

3.4 Pain

3.4.1 All frail seniors 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.[31]

3.5 Physical Assessment

3.5.1 If concerns are identified through a physical assessment, the following should be assessed: vital signs; orthostatic hypotension; vision; hearing; oral health; neurological, musculoskeletal (MSK), cardiovascular, respiratory and gastroenterology systems; feet; skin integrity; and fracture risk. Special consideration should be given to the following symptoms observed in older adults post-COVID-19: delirium, fatigue, oxygen desaturation, myopathy, anxiety, grief and low mood.[32]

3.6 Continence/Hydration & Nutrition

3.6.1 A history of incontinence should be obtained. Ensure adequate level of fluid intake and implement conservative treatment as the first response.[33] [34]

3.6.2 Frail seniors should be screened for risk of malnutrition and strategies to support adequate food intake should be implemented.[35] During this COVID-19 pandemic, there has been a reduction of services that provide meals and in-home services. Frail seniors and their caregivers need support to ensure proper nutrition and hydration.[36]

3.7 Falls & Function

3.7.1 All frail seniors should be assessed for risk of falls and functional decline (mobility, ADLs, iADLs). Rehabilitative care strategies should be implemented to mitigate risk.[37] [38] Of note, atypical presentation of COVID-19 in older adults includes postural instability or history of falls.[32]

3.8 Medication

3.8.1 A thorough medication review is recommended every 6-12 months and after events which alter a patient's medication regimen (e.g., hospitalization).[39] Medication management recommendations during the COVID-19 pandemic include discontinuing medications that provide no to minimal clinical benefit, reducing frequency of medication-associated monitoring and dose frequency, consolidating administration times and administering medications differently to reduce risks of COVID-19 transmission.[40]

3.9 Social History

3.9.1 Recognizing that loneliness and social isolation can affect physical health, mental health and functional decline, clinicians should implement strategies to enhance conversation with frail seniors, including telephone or virtual care options.[29] Loneliness and social isolation have been noted widely among the older adult population due to pandemic restrictions.

SECTION 3: ADDITIONAL PANDEMIC CONSIDERATIONS

Shorter-term

1. Timely access to rehabilitation programs and services for frail seniors (e.g., inpatient, outpatient, community-based, etc.) is essential. This will minimize adverse outcomes for vulnerable older adults and support those who have already begun to experience states of functional decline.[3]

2. Proactive case finding may be needed to identify frail seniors requiring rehabilitative care. Screening approaches, particularly in primary care and community settings, will be critical. There is substantial risk that older adults with impaired function will not present until a point of increased debility or illness, in part due to fear of COVID-19 transmission from interactions within health care facilities or through visits with health care providers. Furthermore, frail seniors will require post-acute care navigation to appropriate rehabilitative services. [3]

3. Community-based services available to older adults vary across Ontario. To ensure optimal care and longer-term management, liaise with local community services to determine the best model of care for the frail senior, such as primary care teams, home and community care or specialized geriatric services.[32]

4. Recognize that caregivers are essential to the care of frail seniors and are key in many settings to the provision of care.[41] Caregivers often serve as a liaison between patients and clinicians and are involved in day-to-day decision-making and care delivery.[42] They should therefore be included in the health care team's communication and care planning. Caregivers should also be given access to necessary resources. In the context of the current pandemic, caregivers will require personal protective equipment (PPE) with instruction in proper donning and doffing techniques.

5. Flexible models of delivery are needed in response to the COVID-19 pandemic. Tele-rehabilitation, also known as virtual care, is "any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies with the aim of facilitating or maximizing the quality and effectiveness of patient care."[43] This approach may be considered as a potential strategy to provide rehabilitative care for frail seniors.[3] [44] Tele-rehabilitation can often be utilized for all aspects of patient care, including the patient interview, physical assessment and diagnosis, treatment, maintenance activities, consultation, education and training. Each of the professional colleges have statements and guidelines regarding the use of tele-rehabilitation as an alternate mode of service delivery to traditional rehabilitation services. Professionals must be able to maintain appropriate rehabilitative and regulatory standards of care.

   Health care planners and clinicians involved in the provision of tele-rehabilitation should consider that the pandemic does not change the care needs of frail seniors, but changes the timing and mechanism of care delivery to control virus exposure.

   The following factors should be considered when considering virtual care delivery of rehabilitation interventions:

   - Older adult's access to technology and internet and other practical limitations (e.g., communication abilities).[32]
   - Potential safety issues. Engage informal caregivers to provide assistance for both the safety of tasks during intervention and/or technical support.[32]
   - Whether the older adult has difficulty with hearing or vision and the impact this will have on their ability to participate.[32]
   - Older adult's cognitive ability and how it may impact their safety, ability to complete a self-directed program and the carry-over advice that is provided.[32]
   - Confidentiality issues. Frail seniors may be at home with many other people, which can impact confidentiality. Additional sessions may be required for sensitive issues, e.g.,

phone call or private in-person visits. Clients may need to sign consents and/or paperwork where originals are required. Additional time for mailing may be needed.[45]
- Need for flexible hours to accommodate the needs of the frail senior and their caregivers. Allow for extra time to build rapport and trust and for potential technical issues.[32]
- Virtual care options for psychosocial support during in-hospital stay as a mode to enable social engagement and caregiver involvement.
- Virtual care is more than video or phone visits. It includes digital supports for self-care, online education and self-management tools, provider-to-provider and provider-to-patient supports via messaging, email, text, etc. and remote home monitoring.[43]

6. When the above considerations for virtual care cannot be met, frail seniors and their caregivers will need in-person assessment and intervention, i.e., outpatient ambulatory or in-home rehabilitation. Hybrid models which include both face-to-face and virtual care may also be considered (e.g., in-person assessment with virtual follow-up). In this case, health care providers will require the necessary equipment (PPE) and must maintain physical distancing as per the government of Ontario recommendations.

Longer-term

1. Stratification of rehabilitation need is one approach to prevent overwhelming any particular rehabilitation setting (e.g., inpatient rehabilitation) with an influx of referrals. Given anticipated increases in demand for rehabilitation, approaches to stratify rehabilitation levels of care for frail seniors should be considered within each local context. Matching rehabilitative care need with the right level of care allows for the right mix of skills to be deployed. For example, older adults at risk of falls may access community-based, instructor-led exercise programs, while those frail seniors with greater complexity may be managed by out-patient therapy services or within bedded rehabilitation settings.[3]

2. The anticipated increase in demand for rehabilitation will require an increase in capacity.[3] Alternate models of delivery may be needed to accommodate the influx of frail seniors who require inpatient rehabilitation, such as virtual rehabilitative care options or rehabilitation services offered in alternate infrastructures during recovery phases.[46]

3. A more diverse rehabilitation workforce may also be required to meet the scale of this challenge.[3][7] As staff-to-patient ratios potentially decrease due to reduction in group programming (notwithstanding virtual care options), increasing the capacity of the rehabilitative care workforce may be necessary.

4. There is opportunity to redesign rehabilitation pathways to better reflect integrated models of care.[47] Rehabilitative care for frail seniors needs to move beyond bedded rehabilitation settings to put services in primary care and the community in the forefront, and to engineer better collaboration with organizations across the continuum of care. Care will likely need to be delivered closer to home, and to be effective, teams must work across organizational boundaries and not in silos.[3]

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