Rehabilitative Care for Older Adults Living With/ At Risk of Frailty

From Frailty to Resilience

Rehabilitative Care Alliance

Provincial Geriatrics Leadership Ontario

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INTRODUCTION

The number of older adults in Ontario continues to grow.[1] While the majority of older adults live well and independently, a growing proportion live with frailty, a medical condition of reduced function and health.[2] Inactivity, poor nutrition, social isolation or loneliness, and polypharmacy contribute to frailty, in which minor stressors may trigger rapid and dramatic deterioration.[2] More than 600,000 Ontarians currently live with frailty, and that number is projected to increase to more than 1.1 million by 2040.[3] There is also growing concern and early evidence that this number will increase further due to the effects of COVID-19 infection among older adults and the unintended effects of infection control protocols (e.g., social isolation).[4 5 6 7 8]

About this Document

Numerous documents describe best practice care for older adults and older adults living with frailty. However, no single framework provides a standardized approach to **rehabilitative care** across the continuum for older adults living with/at risk of frailty. This document addresses that gap.

Rehabilitative Care for Older Adults Living With/At Risk of Frailty: From Frailty to Resilience provides a best practice framework (the Framework) for use by:

- Rehabilitative care professionals and other clinicians across all locations of care who deliver care as part of the rehabilitative care team
- Operational leaders responsible for health care program development and performance that includes rehabilitative care

The Framework outlines best practices and the required components of rehabilitative care for older adults living with/at risk of frailty in order to:

- Enable standardized best practice rehabilitative care[i] across Ontario for older adults living with/at risk of frailty
- Inform and improve rehabilitative care for older adults across all locations of care

Implementation of the Framework will enable the provision of optimal senior friendly care, as defined in the Regional Geriatric Program (RGP) of Toronto's Senior Friendly Care (sfCare) Framework, and improve outcomes for older adults receiving rehabilitative care services.

The Framework was developed by the Rehabilitative Care Alliance (RCA) and Provincial Geriatrics Leadership Ontario (PGLO).

The Language of Frailty

The term "frailty" is used throughout this document, but with an important caveat. Those with lived experience emphasize that their frailty does not define them and should not be used as a reason to limit treatments or "give up" on them.

We share that view. Evidence shows that rehabilitative care strategies can mitigate the impact of frailty and foster resilience among older adults living with complex health and social conditions. By adopting these strategies, providers can improve outcomes for older adults living with frailty and support their journey from frailty to resilience.

[i] Identification and development of best practice recommendations for inclusion in the Framework were based on the following guiding principles: a) be person-centred, b) address the rehabilitative care needs for the majority of older adults and, where possible, identify considerations for those with more complex needs, c) be evidence-based whenever possible; in the absence of high-quality evidence, make recommendations based on expert consensus, and d) provide care that is accessible and equitable to diverse populations of older adults living with/at risk of frailty.

REHABILITATIVE CARE FOR OLDER ADULTS LIVING WITH/AT RISK OF FRAILTY

Older adults living with/at risk of frailty 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.[9]

Such individuals may live with multiple, complex and often interacting health conditions that require unique approaches to care. These individuals also represent a wide diversity of race, ethnicity, religion, spirituality, language, ability, gender identity, gender expression, sexual orientation and socio-economic status. In order to provide optimum care, care providers must take into account this diversity and the impact of social determinants of health (e.g., geographic location, income, education, housing, etc.) in addition to medical and psychological health factors.[10]

Evidence demonstrates that older adults who have restorative potential will benefit from rehabilitative care (i.e., rehabilitative care is likely to improve or maintain their function), especially those living with/at risk of frailty.[11] Rehabilitative care for this population should follow the principles of senior friendly care and include a comprehensive geriatric assessment (CGA) and care planning. It should treat the presenting injury or illness, while addressing prevention and management of underlying symptoms and functional decline.

Changes in function in an older adult, with or without a specific injury or illness, may signal the need for rehabilitative care. The nature of required rehabilitative interventions will vary according to the presentation of an individual's needs across their care journey.

Rehabilitative care designed for the needs of older adults with/at risk of frailty is a tailored, progressive, dynamic, goal-oriented process that enables individuals to reach or maintain their optimal level of physical, cognitive, communicative, emotional and social function. It is directed by the goals of the older adult, their care partner/s and/or substitute decision-maker and uses diagnostic and therapeutic interventions to restore functional ability or enhance residual functional capability.

Rehabilitative care for older adults living with frailty/at risk of frailty aims to:

- Promote healthy aging through prevention of functional decline
- Reverse or stabilize a decline in health status
- Achieve and maintain functional improvements, quality of life and self-management
- Maximize recovery and return to previous level of function when possible, and
- Reduce care partner burden.[12] [13] [14]

Key Resources for Care of Older Adults

This Framework builds on the best practice recommendations from the RCA's Frail Seniors Guidance on Best Practice Rehabilitative Care in the Context of COVID-19, and aligns closely with the RGP's Senior Friendly Care (sfCare) Framework, PGLO's (formerly the RGPs of Ontario) Competency Framework for Interprofessional Comprehensive Geriatric Assessment, Ontario Ministry of Health's Assess & Restore Guideline, PGLO's Designing Integrated Care for Older Adults Living with Complex and Chronic Health Needs and Ontario Health's Alternate Level of Care (ALC) Leading Practices Guide & Self-Assessment Tool.

RCA Frail Seniors Guidance on Best Practice Care in the Context of COVID-19

- Provides a brief summary of evidence-based best practice rehabilitative care for older adults living with/at risk of frailty
- Offers considerations for the provision of rehabilitative care for seniors living with/at risk of frailty in light of restrictions due to the COVID-19 pandemic
- Developed by the Rehabilitative Care Alliance

Regional Geriatric Program of Toronto Senior Friendly Care (sfCare) Framework and Resources

- Provides guiding principles and defining statements for sfCare
- Provides a foundation for achieving the best possible outcomes for **all** older adults (not only older adults with frailty)
- *sfCare Getting Started Toolkit*, *Senior Friendly 7 Toolkit*, *sfCare Learning Series* and *sfCare Self-Assessment Tool* provide actionable recommendations and practical implementation resources
- Developed by the RGP of Toronto

PGLO A Competency Framework for Interprofessional Comprehensive Geriatric Assessment (CGA)

- Describes practice expectations of members of the interprofessional team participating in the CGA, the gold standard of care for older adults living with complex health concerns
- Developed by the RGPs of Ontario (now Provincial Geriatrics Leadership Ontario)

Ministry of Health Assess & Restore Guideline

- Defines the elements of an Assess & Restore approach to care
- Outlines expectations and defines the roles and responsibilities of organizations and care providers in delivering interventions across five areas: screening, assessment, navigation and placement, care delivery and transitions home
- Developed by the Ontario Ministry of Health

PGLO Designing Integrated Care for Older Adults Living with Complex and Chronic Health Needs

- Synthesizes the literature to highlight core design elements for integrated care for older adults that can assist in health system design work
- Leverages experience of the specialized geriatric services clinical community to describe approaches to implementing 13 evidence-based design elements of integrated care
- Developed by Provincial Geriatrics Leadership Ontario

Ontario Health ALC Leading Practices Guide and Self-Assessment Tool

- Identifies evidence-based care strategies for proactive management of hospitalized older adults at risk of delayed transition to an appropriate setting
- Provides organizations with an approach to defining current state and identifying opportunities for quality improvement
- In development by the Ontario Health ALC Leading Practices Working Group

BEST PRACTICE FRAMEWORK

Rehabilitative Care for Older Adults Living With/At Risk of Frailty: From Frailty to Resilience is organized in three distinct and inter-related sections. The first two sections present the essential core elements and processes of care required when providing rehabilitative care to older adults living with/at risk of frailty, along with recommended best practices. The third section provides guidance on how to implement these best practices within specific domains of care.

THE THREE SECTIONS ARE AS FOLLOWS:

Core Elements of Care

- Older Adult & Care Partner Engagement
- Equitable & Culturally Appropriate Care
- Interprofessional Team Approach
- Specialized Geriatric Expertise
- Comprehensive Geriatric Assessment
- Performance Evaluation

Processes of Care

Identify Rehabilitative Care Needs

- Identify Risk for Functional Decline
- Determine Restorative Potential
- Co-Develop Rehabilitative Care Goals

Deliver Evidence-Based Rehabilitative Care

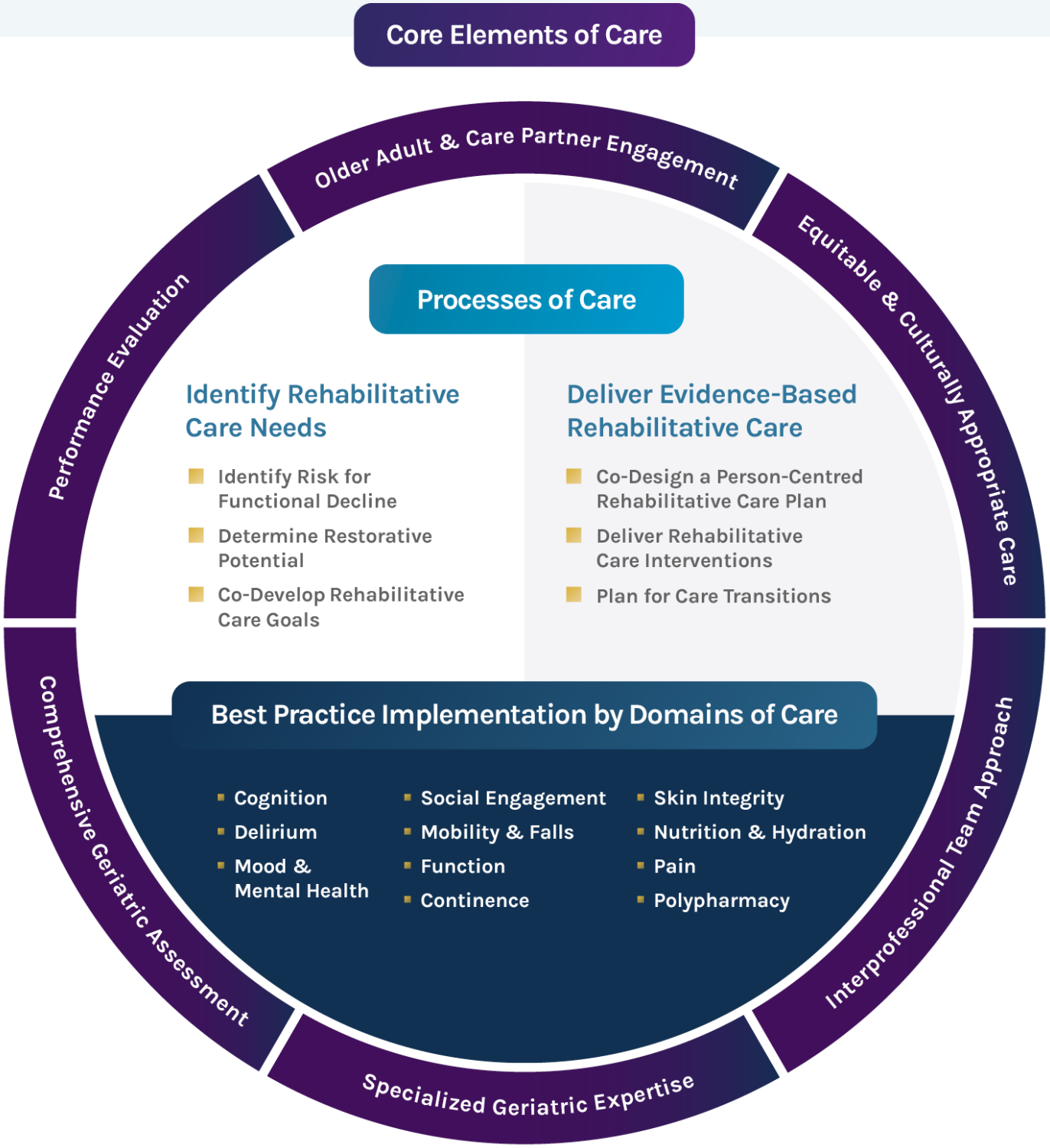
- Co-Design a Person-Centred Rehabilitative Care Plan
- Deliver Rehabilitative Care Interventions
- Plan for Care Transitions

Best Practices Implementation by Domains of Care

- Cognition
- Delirium
- Mood & Mental Health
- Social Engagement
- Mobility & Falls
- Function
- Continence
- Skin Integrity
- Nutrition & Hydration
- Pain
- Polypharmacy

Figure 1

Best Practice Framework for Rehabilitative Care for Older Adults Living With/At Risk of Frailty



Core Elements of Care

The core elements of this Framework form the foundation of rehabilitative care best practices for older adults living with/at risk of frailty regardless of the location at which they access the health system.

This section outlines the six core elements, including recommended best practices, that describe the standard of care required for this population.

Note: *Recommendations that align with the RGP sfCare Self-Assessment Tool are identified by "sf"; those that align with the Ontario Health ALC Leading Practices Guide and Self-Assessment Tool are identified by "ALC".*

Relevance for Clinicians

Clinicians must integrate these core elements into the rehabilitative care that they provide for all older adults living with/at risk of frailty.

Relevance for Operational Leaders

Operational leaders must understand these core elements in order to provide the structure, resources and education that will allow clinicians to provide the best practice rehabilitative care presented in this Framework.

1. Older Adult & Care Partner Engagement

Older adults living with/at risk of frailty and their care partner/s must be included as part of the circle of care.[15] Comprehensive, team-based geriatric care and the formulation of collaborative care plans with the individual and their care partner/s are essential aspects of rehabilitative care for older adults.[16]

Recommended Best Practices	
1.1	Older adults living with/at risk of frailty and their care partner/s must be included in the circle of care communication and care planning. (sf, ALC)
1.2	Older adults living with/at risk of frailty and their care partner/s must be invited to play an active role in carrying out rehabilitative care. (sf, ALC)
1.3	Designated care partners who provide care to maintain the older adult's mental and physical health and who advocate on the person's behalf must be considered essential to rehabilitation and transition care planning. (sf, ALC)
1.4	Health equity demographic data should be collected to inform an individualized rehabilitative care plan and treatment options, e.g., to ensure care is culturally appropriate, to make recommendations for assistive devices that are within an individual's financial reach, etc.
1.5	Multi-modal education should be provided to older adults and their care partner/s. Materials must be tailored to an individual's preferences, experiences and learning style; consider the individual's level of health literacy and language; and be compliant with the *Accessibility for Ontarians with Disabilities Act (AODA)* requirements for accessibility.[17] [18] [19] (sf)

Resources

- *RGP-PGLO-CGS Family Presence in Older Adult Care*
- *Caregiving Strategies Handbook*
- *Design Elements of Integrated Care for Older Adults Living with Complex and Chronic Health Needs*
- *Canadian Foundation for Healthcare Improvement Essential Together Tool*
- *CFHI Policy Guidance for the Reintegration of Caregivers as Essential Care Partners*
- *BSO Recommendations to Enhance the use of Personhood Tools*
- *Accessibility for Ontarians with Disabilities Act*
- *Senior Friendly Care Framework*

2. Equitable & Culturally Appropriate Care

Equity does not require that everyone receive the same rehabilitative care interventions; it requires fairness and justice in the processes of care and patient outcomes. Differential treatment and resource distribution must be provided to achieve comparable outcomes among all older adults living with/at risk of frailty; redistribution recognizes and addresses barriers to opportunities that could prevent achievement of their rehabilitative care goals.[20] This individualized approach to care enables consideration of the social determinants of health unique to each older adult.

An anti-racism approach is a systematic method of analysis and a proactive course of action that recognizes the existence of racism, including systemic racism, and actively seeks to identify, reduce and remove the racially inequitable outcomes and power imbalance between groups and the structures that sustain these inequities.[20] Action is needed to respond to embedded historical and current injustices through an anti-oppressive approach, by proactively understanding the role that health and other systems may play in marginalization (in the past and today).[21]

Rehabilitative care for older adults living with/at risk of frailty should use an inclusive and affirming approach and be conducted in a culturally appropriate, inclusive environment.[22] [23] Inclusion recognizes and embraces diversity. Diversity refers to the visible and invisible qualities, experiences and identities that shape a person's individuality, uniqueness and how they are perceived.[20] Dimensions of diversity include race, ethnicity, gender, gender identity, sexual orientation, socioeconomic status, age, physical or mental abilities, religious or spiritual beliefs, and political ideology.[20]

Rehabilitative care for older adults living with/at risk of frailty should be based on the intersectionality framework which considers the intersecting experiences of marginalization and the needs of the whole person. For example, a Black gay man may face racism inside the LGBTQ2S (Lesbian, Gay, Bisexual, Transgender, Queer and Two-Spirit) community and homophobia in the Black community.[20] [22]

Recommended Best Practices

2.1 An approach of trust, respect and accommodation should be recognized as essential to the provision of equitable and culturally appropriate rehabilitative care.[24]

2.2 The existence of oppression and racism and its impact on the health and well-being of marginalized Canadians must be acknowledged. Discriminatory practices and processes in all forms must be identified and addressed at all levels using targeted approaches, such as ensuring inclusive rehabilitative care policies and procedures.[20] [22] [25]

2.3 Rehabilitative care providers must learn about the health beliefs, practices and values of the cultural groups they serve and develop culturally responsive knowledge, skills and attitudes.[24]

2.4 Rehabilitative care providers must ensure a safe, inclusive space to provide rehabilitative care with consideration for the older adult's intersecting identities, health beliefs, practices and values.[22] [24]

2.5 Rehabilitative care providers must use culturally appropriate language and a person-centred, history-taking approach, such as asking open-ended questions and ensuring privacy and confidentiality during interactions with all older adults.[22] [24]

Resources

- *Black Health Alliance*
- *Ne'likaanigaana Toolkit*
- *Ontario CLRI Embracing Diversity: A Toolkit for Supporting Inclusion in Senior Living*
- *Ontario Health's Equity Inclusion, Diversity and Anti-Racism Framework*
- *RNAO Promoting 2SLGBTQI+ Health Equity*

3. Interprofessional Team Approach

Rehabilitative care for older adults living with/at risk of frailty must be provided using an interprofessional approach.[16 26 27] Older adults living with/at risk of frailty may receive rehabilitative care across settings or services, and team members may vary depending on the setting, the person's rehabilitation needs and local resources.[28] Team members work jointly to deliver person-centred care where there is opportunity to move beyond discipline and sector-specific approaches.[29] Members of the interprofessional team should work together with the older adult living with/at risk of frailty, their care partner/s and other cross-sector partners, as needed. Additionally, team members should engage in professional development on approaches to ensure equitable access to and delivery of equitable care.

Recommended Best Practices

3.1 Rehabilitative care for older adults living with/at risk of frailty must be provided through an interprofessional approach.[9 30 31] (sf, ALC)

3.2 Medical care and rehabilitation of older adults living with/at risk of frailty must be managed by or in collaboration with a physician/advanced practice practitioner (APP) with specialized geriatric expertise (e.g., geriatric medicine, care of the elderly).[30] (sf, ALC)

3.3 The interprofessional team must have secure access to the older adult's health record, including their health equity demographic data, to inform person-centred clinical interventions and treatment options.

3.4 The interprofessional team should include, but not be limited to, the following:

- *Nurse*
- *Social worker*
- *Occupational therapist (OT)*
- *Physiotherapist (PT)*
- *Speech language pathologist (SLP)*
- *Clinical pharmacist*
- *Dietitian*
- *Kinesiologist*
- *Psychologist*
- *Communication liaison (to assist with care transitions)*
- *Unregulated health care providers (e.g., personal support worker, therapeutic recreationist, OT/PT/communicative disorders assistant)*
- *Specialist physician/APP with expertise in geriatrics (e.g., geriatric medicine, care of the elderly, geriatric psychiatry, neurology, physiatry and others)[11 27 28 29] (sf, ALC)*
- *Traditional healer[32]*

3.5 Team members should engage in professional development on approaches to ensure access to and delivery of equitable care, including strategies to recognize and overcome unconscious bias in care. This includes strategies addressing anti-racism, anti-oppression and Indigenous cultural safety, and training to support the LGBTQ2S population.

Resources

- RCA Rehab Care Standards for Rehabilitative Care (*bedded levels of care* and *community-based*)
- *A Competency Framework for Interprofessional Comprehensive Geriatric Assessment*

4. Specialized Geriatric Expertise

A senior friendly approach is foundational to best practice rehabilitative care for older adults living with/at risk of frailty. Members of the interprofessional team delivering rehabilitative care should have expertise in geriatric care.[27] In addition, specialists with expertise in the care of older persons (e.g., geriatricians, geriatric psychiatrists, care of the elderly physicians) are essential collaborative partners within the circle of care.[29] The role of specialists can include providing direct care and/or training members of the interprofessional team or other practitioners without expertise in geriatrics who are providing care.[29]

Recommended Best Practices	Resources
4.1 Members of the interprofessional team must have expertise in geriatric and rehabilitative care (see Competency Framework for Interprofessional Comprehensive Geriatric Assessment).[9] (sf, ALC)	• *Senior Friendly Care Framework* • *Senior Friendly 7 Toolkit* • *Senior Friendly Care Learning Series* • *A Competency Framework for Interprofessional Comprehensive Geriatric Assessment*
4.2 Capacity/contingency plans must be developed to ensure that interprofessional teams with skill and knowledge in geriatrics are available to deliver care across the continuum. (sf, ALC)	

5. Comprehensive Geriatric Assessment

Comprehensive Geriatric Assessment (CGA) is the standard of care for the assessment and treatment of older adults living with/at risk of frailty.[12 13 26 33] CGA guides a multidimensional, specialized geriatric team approach to care that determines an older person's biomedical, psychosocial, functional and environmental needs, and identifies an appropriate treatment and follow-up plan.[34] Through use of the multi-dimensional CGA, specialized geriatric services are able to incorporate consideration of the broader social determinants of health in care planning and treatment decisions.

CGA is delivered in a person-centred, interprofessional collaborative practice model. Teams that provide CGA integrate with primary care, specialists and other providers to ensure a person-centred approach for older adults; integration of health and social care processes is critical to improved services and outcomes for older adults.[34 35] Clinicians with geriatric and rehabilitative care expertise should be involved to optimize assessment and treatment of the older adult living with/at risk of frailty.

An essential component of the CGA is advance care planning, a process of guiding the older adult to reflect on their values and wishes to help them identify what kind of health and personal care they would want in the future if they are unable to speak for themselves.[36 37]

Recommended Best Practices	Resources
5.1 CGA should be used in assessment and treatment planning to determine an older person's biomedical, psychological, socio-cultural and environmental needs.[30] (sf, ALC)	• *A Competency Framework for Interprofessional Comprehensive Geriatric Assessment*

5.2 Screening should be done for all CGA domains and where problems are identified, specific domains assessed. (sf, ALC)	• *CGA Self-Assessment Tool (Interprofessional)* • *Advance Care Planning Canada*
5.3 The health care team should determine whether the older adult has an advance care plan. Discussions with an older adult about advance care planning may help them to: • Plan for a time when they cannot make their own health care decisions • Think about their goals of care and personal beliefs • Name a substitute decision-maker • Record and write down their wishes[38]	

6. Performance Evaluation

Patient and provider experience and outcomes should be measured using standardized and validated tools. Processes should be developed to collect and analyze the outcomes data and measure the presence and effectiveness of the integrated care processes outlined in this Framework.[29] Indicators that reflect program and system performance should also be identified, and data collected and analyzed.

Data should be used to enhance models of rehabilitative care for older adults living with/at risk of frailty and to inform program, policy and funding decisions.

Recommended Best Practices	Resources
6.1 Evaluation should include micro-level indicators of relevance to older adults living with/at risk of frailty and their care partner/s (e.g., experience, pre/post frailty, function and perceived sense of well-being). (sf, ALC)	• *Design Elements of Integrated Care for Older Adults Living with Complex and Chronic Health Needs*
6.2 Evaluation should include meso-level indicators reflecting program performance (e.g., achievement of rehabilitative goals, appropriate prescription of medications, cultural and community linkages, self-management support). (sf, ALC)	
6.3 Evaluation should include macro-level indicators (e.g., health care utilization; cost savings; population health outcomes that include measures of effective equity, anti-oppression and culturally appropriate practices). (sf, ALC)	
6.4 Organizational and leadership time should be dedicated to the review and analysis of collected performance measures and their inclusion in business and program development processes. (sf, ALC)	

Processes of Care

This section outlines six best practice processes of care, including recommended best practices that are essential to identify the rehabilitative care needs of an older adult living with/at risk of frailty and deliver evidence-based rehabilitative care.

Relevance for Clinicians

Clinicians must utilize these recommended best practices to focus their work, inform how they provide care and determine the trajectory of care. Sufficient time must be built into the care plan to address these processes of care.

Relevance for Operational Leaders

Operational leaders must understand the need for the resources, time, team consultation and coordination required to apply the processes of care.

Identify Rehabilitative Care Needs

1. Identify Risk for Functional Decline

All older adults who are at risk of functional decline should be screened for changes from baseline levels of function to identify risk for or loss of independence related to functional impairment/decline.[27] Functional decline refers to a diminishing ability to maintain independence in daily life and encompasses physical, cognitive and social functioning.[39]

When caring for older adults who experience functional decline, knowledge of an individual's baseline functional status is key to:

- Understanding an individual's degree of frailty, the extent to which it is modifiable and its impact on treatment and care plan design
- Identifying changes to current level of function, cognition, mood, mobility and social relationships (e.g., as a result of an acute illness)
- Flagging the need for rehabilitative care and the development of a rehabilitative care plan that can slow, prevent or reverse decline[26 40]

This applies regardless of their entry point into the health care system.

Recommended Best Practices

1.1 Older adults should be screened for the risk, possible presence and degree of functional decline. (sf, ALC)

1.2 Screening for functional decline should include the determination of an individual's baseline functional status:

- *Two weeks prior to illness/injury onset, and*
- *Within (at a minimum) the domains of mobility, function (Activities of Daily Living and Instrumental Activities of Daily Living – ADLs/IADLs) and cognition.* [9 11 12 16 27 33 39 41 42 43 44 45] *(sf, ALC)*

1.3 Functional decline should be identified by determining if there has been a change in function relative to baseline. (sf, ALC)

Resources

- *Clinical Frailty Scale (CFS) 2.0*
- *CFS Guidance*
- *Pictorial-Fit-Frail-Scale*
- *BC Guidelines – Frailty Identification*
- *NESGC Baseline Function*

2. Determine Restorative Potential

Older adults experiencing functional decline can benefit from rehabilitative care to optimize a return to/recovery toward their baseline level of function. This can mitigate frailty and preserve independence. Individuals are considered to have restorative potential if there is reason to believe that rehabilitative care will provide benefits and lead to functional improvement or maintenance of function.

Determining restorative potential is a process which involves complex clinical judgement and prognosis on the projected benefits of undertaking a targeted program of rehabilitation.[46] Cognitive impairment, delirium, depression, discharge destination or age do not preclude an older adult from benefiting from interventions that offer the potential to improve or maintain function and should not be used in isolation to influence a determination of restorative potential.[11] The best way to determine if someone has the potential to regain function is to undertake a period of functional rehabilitation and then assess if any progress has been made.[28] Rehabilitative care with a restorative approach should be the default.

The degree of potential benefit that can be expected from rehabilitative care must take into account the following[28]:

- Baseline functional and psychological status (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?)
- Medical stability (i.e., can the individual participate in rehabilitative care?)
- Availability of care partner supports
- Identified rehabilitative care goals that are culturally appropriate, person-centred, specific, measurable, realistic and timely

CGA is the standard of care for determining the restorative potential of older adults who have experienced functional decline (see Core Element #5).

Recommended Best Practices

2.1 For the older adult who has experienced functional decline, the nature and degree of the change compared with baseline functional status should be identified by:

- Determining what has changed and the degree of change within (at a minimum) the domains of mobility, function (ADL and IADL) and cognition
- Identifying the timeline for the change in function
- Exploring why the change occurred
- Exploring if the change is potentially modifiable or reversible (sf, ALC)

**Ideally, CGA is completed to address all domains and determine restorative potential – see Core Element #5.*

2.2 Cognitive impairment, delirium, depression, discharge destination or age must not be used in isolation to influence a determination of restorative potential.[11] (sf)

Resources

- *NESGC Baseline Function*

3. Co-Develop Rehabilitative Care Goals

Individual goal setting, completed together with the older adult living with/at risk of frailty and their care partner/s, is an essential aspect of rehabilitative care.[47] [48] There are many benefits to setting clear and concise goals; without goals, the rehabilitation process can lack purpose, resulting in decreased motivation from both staff and the individual involved.[28] Older adults have their own desired outcomes for the rehabilitation process, which may relate to their health status, cultural beliefs, lifestyle and environment.[48] Goals are developed based on an individual's priorities and are informed by the presenting need for rehabilitative care (e.g., primary prevention, post-injury/illness, progressive/chronic condition, maintenance) and within the context of the individual's community/environment.

The purpose of goal setting is to assist older adults to return to their baseline level of function where possible. If a return to a previous level of function is not feasible due to the nature of the presenting illness/injury, then the focus should be on returning or progressing to the highest possible level of function achievable for that individual.[28] Rehabilitative goals are part of the overall context of goal-based care and advance care planning and help to guide the work of health professionals.

The nature of rehabilitative interventions required to address person-centred goals will vary according to an individual's needs across their trajectory. Multiple goals are often required to address an individual's complex medical, social and functional requirements.[26]

Recommended Best Practices

3.1 Rehabilitative care goals that are based on individual needs and priorities must be developed in partnership with the older adult living with/at risk of frailty and their care partner/s. (sf, ALC)

3.2 The next steps for rehabilitative care (most appropriate provider, setting and types of intervention) should be determined, recognizing that needs may fluctuate along the course of the recovery trajectory. (sf, ALC)

Resources

- The *RCA Referral Decision Tree for Rehabilitative Care* and Rehab Care Standards Frameworks (*bedded levels of care* and *community based*)

Deliver Evidence-Based Rehabilitative Care

4. Co-Design a Person-Centered Rehabilitative Care Plan

Older adults living with/at risk of frailty, their care partner/s and the rehabilitative care team must develop a person-centred, culturally appropriate, goal-oriented and individualized rehabilitative care plan that is enabled through shared decision-making.[15] This plan should consider the social determinants of health and address modifiable biopsychosocial factors and consider medical diagnosis/prognosis and co-morbidities that impact the health goals of older adults.[49] The rehabilitative care plan should be aligned with assessed domains of the CGA, be initiated prior to or as soon as possible following the onset of illness or injury[28] and have an identified time frame.[13]

Recommended Best Practices	Resources
4.1 The rehabilitative care plan must be developed in partnership with the older adult living with/at risk of frailty, their designated care partner/s and relevant community partners to address the older adult's care needs. (sf, ALC)	• Ontario Health *ALC Leading Practices Guide* and *Self-Assessment Tool* • RCA Rehab Care Standards for Rehabilitative Care (*bedded levels of care* and *community-based*) • *A Competency Framework for Interprofessional Comprehensive Geriatric Assessment*
4.2 The rehabilitative care plan should be aligned with and address the assessed domains of CGA.[13]	
4.3 Prevention of functional decline and health promotion should be a key focus of interventions in the development of the rehabilitative care plan. (sf ALC)	
4.4 The rehabilitative care plan should be goal-oriented and have an identified time frame. (sf, ALC)	
4.5 A process should be in place to regularly review the rehabilitative care plan: (sf, ALC) • With the older adult and their care partner/s • Within the interprofessional team, e.g., during rounds • Using patient experience and clinical outcome measures	

5. Deliver Rehabilitative Care Interventions

Rehabilitative care interventions should be delivered within a dedicated, coordinated and integrated model of care. These interventions should be carried out jointly and seamlessly by an interprofessional team. The interventions should include protocols for services such as[15 27]:

- Physiotherapy, occupational therapy and speech language pathology services delivered directly by a regulated health professional (RHP) or a person acting under the direct supervision of an RHP
- Wound care and preventative wound care
- Continence care
- Medication reconciliation and management
- Pain management

- Diet/nutrition/hydration management
- Case management
- Psychosocial/behavioural support/seniors' mental health
- Caregiver support
- Traditional healing practices[32]

Information, skills and resources/tools should be provided to older adults living with/at risk of frailty and their care partner/s to build their capacity to actively manage health conditions and prevent health complications in languages and at literacy levels accessible to the older adult and their care partner/s. Self-management support should be provided on a formal, ongoing basis.[15]

Where appropriate, virtual care technologies can be integrated into rehabilitative care service delivery and treatment processes to support older adults to maintain functional abilities and promote independence.[15] Attention should be paid to potential barriers to access with virtual care and accommodated. See Appendix B.

Recommended Best Practices	Resources
5.1 Rehabilitative care for older adults living with/at risk of frailty should accommodate differing levels of activity tolerance. As the individual's activity tolerance level changes, services should be adjusted accordingly to achieve their goals.[11] (sf, ALC)	• *Ontario Health ALC Leading Practices Guide and Self-Assessment Tool* • *Senior Friendly 7 Toolkit* • *Senior Friendly Care Learning Series* • *Providing Geriatric Virtual Care across the South West* • *RGP Toronto Virtual Care Resources*
5.2 Where virtual care technologies are integrated to support the delivery of rehabilitative care interventions, ensure the older adult has adequate support and access to technology and internet connectivity.	
5.3 Interventions should be designed to actively support older adults and care partner/s to self-manage rehabilitation and everyday health concerns. (sf, ALC)	
5.4 Where best practice recommendations are out of scope for providers or not feasible within existing resources, providers should refer elsewhere (where services are available) to ensure the older adult has the opportunity to receive best practice care and culturally appropriate supports. (e.g., A single-service physiotherapy provider should refer to other community services, where appropriate, to address potential depression.)	

6. Plan for Care Transitions

The interprofessional rehabilitative care team should develop transition plans in partnership with older adults living with/at risk of frailty, their care partner/s and cross-sector partners at each transition point throughout the continuum of care. These plans should be tailored to the older adult's unique circumstances and identity (e.g., ethno-racial identity, language preferences). A communication liaison with training in the culturally appropriate care of older adults should be designated as part of the circle of care.

Transitions are complex, multi-step processes that require integrated communication, collaboration and coordination among the older adult living with/at risk of frailty, their care partner/s, the interprofessional team and frequently, cross-sector partners. The transition process may include:

- Preparing care partners for discharge
- Communicating the person's care plan to the health care providers taking over the person's care
- Performing medication reconciliation and checking post-discharge medication adherence
- Arranging for transportation and equipment needs (including equipment for virtual technology, if appropriate)
- Coordinating appropriate follow-up care
- Evaluating and adjusting the effectiveness of treatment and care plans[50]

Recommended Best Practices

6.1 Transition plans must be developed and agreed upon in partnership with the older adult living with/at risk of frailty, their care partner/s and the circle of care involved at each point of transition. A communication liaison should be designated as part of the circle of care. (sf, ALC)

6.2 Shared responsibility for continuity of care should be determined among cross-sectoral partners in advance of transfers. (sf, ALC)

6.3 Care partners must be recognized as providing essential support to coordinate care at all times, including times of major transition. (sf, ALC)

6.4 Before transitioning, older adults living with/at risk of frailty and their care partner/s should be offered education and training to help them manage health care needs, including guidance on community-based resources, medications and medical equipment. (sf, ALC)

Resources

- *OHQ - Transitions in Care Quality Standard*
- *Design Elements of Integrated Care for Older Adults Living with Complex and Chronic Health Needs*
- *RNAO Care Transitions Best Practice Guideline*
- *BSO Guiding Checklist: Supporting Transitions from Acute/Community into LTC*

Best Practices Implementation by Domains of Care

This section provides guidance on how to implement the recommended rehabilitative care best practices outlined in the previous sections within specific domains of care. The guidance is grouped according to the two categories of processes of care: identifying rehabilitative care needs and delivering evidence-based rehabilitative care.

It is recognized that where and how rehabilitation is delivered differs locally, but older adults living with/at risk of frailty should receive the same standard of care regardless of location or setting. Most recommendations are appropriate in any location of care; however, where applicable, location-specific considerations are identified.

Relevance for Clinicians

Clinicians must be provided with guidance on how to implement recommended rehabilitative care best practices within each domain of care.

Relevance for Operational Leaders

Operational leaders must understand the need for the resources, time, team consultation, training and coordination required to provide best practice care across the domains of care.

Cognition

Cognitive Impairment (CI) does not preclude the older adult living with/at risk of frailty from functional improvement, and the presence of CI must not be used in isolation to influence a determination of restorative potential.[11] CI does not usually occur in isolation and should be addressed in the context of other geriatric syndromes and co-morbidities.[51]

Identify Rehabilitative Care Needs	• The baseline level of cognitive function of the older adult living with/at risk of frailty and their ability to participate in and benefit from rehabilitative care within the context of their specific functional goals should be considered in the determination of their restorative potential.[11] • The presence of cognitive impairment must not be used in isolation to influence a determination of restorative potential.[11] • A thorough history from the older adult, care partner/s, substitute decision maker, and any friends or relatives should be taken.[28] • Older adults should be screened for CI. If screening identifies issues, further assessment is required. The interprofessional team should conduct a detailed assessment, in collaboration with appropriate physician/specialist input that informs accurate diagnosis and the rehabilitative care plan.[52]

Resources

Cognitive Impairment Screening:

- *One Size Does Not Fit All: Choosing Practical Cognitive Screening Tools for Your Practice: https://doi.org/10.1111/jgs.16713*

CGA:

- *Competency Framework for Interprofessional Comprehensive Geriatric Assessment*

	• Functional cognition – the ability of an individual to utilize and integrate their thinking and processing skills to accomplish everyday activities in clinical and community living environments – should be assessed to determine whether and how a client safely and effectively participates in essential activities of daily living (ADLs).[28]
	• Assessment should include performance-based testing, such as the Canadian Occupational Performance Measure (COPM), Independent Living Scales (ILS) and Cognitive Performance Test (CPT).
	• Because capacity can fluctuate, capacity should be assessed only when the individual is at their best. If they are unwell, then they should be given the time to recover. Similarly, if there are barriers to demonstrating capacity (e.g., no hearing aid, or difficulty with speech), these should be addressed where possible to enable accurate assessment.[28]
	• Rehabilitation teams should understand how brain health can affect mental capacity and should be alert to fluctuations. It is important to recognize that individuals should be supported as much as possible to express their wishes and preferences, and that these should be central to the rehabilitation process.[28]
	• Development of rehabilitative goals with the older adult living with CI should:
	  ○ Be individualized, reflecting cultural values and personal beliefs
	  ○ Take psychosocial and environmental factors into account
	  ○ Be undertaken collaboratively with the individual living with CI and their care partner/s
	  ○ Be based on comprehensive assessment of the individual's cognitive and behavioural functioning, their psychological adjustment and coping styles and available support[51 53 54]
	Dementia
	• Practitioners should be aware of the likelihood of encountering undiagnosed dementia during rehabilitation.[28]
	• Dementia should not be seen as a barrier to rehabilitation.[28]
		• *CGA Self-Assessment Tool*
		Functional Cognitive Outcome Measures:
		• *Canadian Occupational Performance Measure (COPM)*
		• *Independent Living Scale (ILS)*
		Care Partner Strategies:
		• *RGPO Caregiving Strategies Handbook*
		• *Canadian Foundation for Healthcare Improvement Essential Together Tool*

Deliver Evidence-Based Rehabilitative Care	• Practitioners must provide care as part of an interprofessional team approach. In ambulatory, in-home and primary care settings, this may require inter-organizational communication and partnerships within the older adult's circle of care. • Based on the results of a CGA and goals developed with the older adult and care partner/s, older adults living with CI should have a multicomponent rehabilitative care plan to address the causes of functional decline and manage symptoms.[51] • Cognitive rehabilitation is a highly individualized interprofessional approach and should be centered around the identification of and focus on personally meaningful goals related to everyday activities.[54]	

- Serial cognitive and functional measurements should be conducted. They will help in monitoring the older person's progress and their need for care.[42]
- Older adults must be provided with information in a manner that they understand. They should also be given time to absorb the information, and support should be provided by an advocate if needed.[28]
- Involvement of care partners in rehabilitative care should be encouraged. Care partners can help to identify areas of functional impact as these are often activities or tasks where they have to provide additional support.[54] [55] [56]

Dementia

- A flexible and innovative approach should be taken when working with people living with dementia. For example, if individuals are unable to sustain attention during sessions, one longer session can be replaced by a number of shorter sessions distributed throughout the day.[57]
- Risk enablement or a positive risk management approach for people living with dementia should be considered. The positive benefit of taking risks is balanced against the negative effects of attempting to avoid risk altogether, e.g., the risk of an individual living with CI falling when mobilizing without a walking aid may be balanced against the difficulties generated by preventing the individual from mobilizing and the resulting deconditioning.[28]

Transitions

- Recognize that transitions in care can be challenging for older adults living with CI and their care partner/s. Relevant information, including the rehabilitative care plan, should be given to older adults living with CI and their care partner/s at transitions in care. This information is communicated to those involved in the person's circle of care.[49]
- One or more named providers in the interprofessional circle of care should serve as a point of contact to facilitate care coordination and transitions across settings.[58]

Location Specific Considerations

Facility-Based Rehabilitation:

- For older adults living with CI in a facility-based setting, the prevalence of behavioural symptoms, cognitive and functional decline and delirium may increase due to a change in environmental context and the potential for unmet needs causing distress. Higher functioning in their usual environment with familiar supports is often observed. [59]
- Care partners should be encouraged to bring in personal and familiar objects.[56]
- Team member lack of confidence in working with people living with dementia should not lead to an older adult being excluded from referral or acceptance by rehabilitative care programs.[28] [54]

Delirium

The presence of delirium should not be used in isolation to influence a determination of restorative potential.[11]

Identify Rehabilitative Care Needs

- Delirium may manifest in various ways. Rehabilitation professionals must recognize potential indicators of delirium and anticipate how these may impact an individual's participation in rehabilitative care, e.g., cognitive function, physical function, perception, social behavior, etc.[51]
- Recognizing and differentiating between delirium and dementia must occur as it is of paramount importance to the direction of the plan of care.
- Delirium is a medical emergency and is both treatable and preventable.[28]
- Older adults living with/at risk for frailty should be assessed for the following risk factors for delirium on initial contact with the health care system:
  - Age 65 years or older
  - Cognitive impairment and/or dementia
  - Current hip fracture
  - Severe illness
  - Previous delirium
  - Problematic alcohol or substance use[58]
- Older adults living with/at risk of frailty should be screened early and routinely for delirium using standardized, validated tools.[30]
- A clinician who is familiar with the *CAM (Confusion Assessment Method)* should use this tool as part of an initial assessment.[60]
- Sudden changes in thinking, memory or personality, should prompt health professionals to consider working with care partners to complete the *Delirium Detection Questionnaire for Caregivers*. This tool looks at seven changes which may help identify delirium and can be used to help communicate concerns to a physician or nurse.[60]
- If delirium screening is positive, this should prompt immediate assessment by a physician or nurse.

Deliver Evidence-Based Rehabilitative Care

- All members of the interprofessional team should provide multicomponent interventions for the prevention of delirium tailored to the person's individual needs and care setting. These interventions should be based on an assessment for clinical factors that may contribute to the development of delirium.[58] In ambulatory, in-home and primary care settings, this may require inter-organizational communication and partnerships within the older adult's circle of care. Strategies to prevent and manage delirium may include:
  - Reorienting the person to current day, month, year
  - Ensuring hearing and visual aids and dentures are available and in use

Resources

Delirium Screening:

- *Delirium Detection Questionnaire for Caregivers*
- *The CAM (Confusion Assessment Method)*
- *The 4 AT Assessment Test*
- *FAM CAM (Family Confusion Assessment Method)*

Delirium:

- *Canadian Coalition for Seniors' Mental Health*
- *Delirium Quality Standard*
- *Delirium Quality Standard Practical Implementation Guide*
- *Senior Friendly 7 - Delirium Toolkit*
- *Senior Friendly Care Learning Series*
- *RNAO Delirium, Dementia, and Depression in Older Adults: Assessment and Care, Second Edition*
- *Ontario Health Quality Delirium Aware Safer Healthcare (DASH)*

- Ensuring adequate food intake and hydration
- Encouraging physical activity
- Providing appropriate lighting
- Introducing cognitively stimulating activity
- Establishing a toileting routine and avoiding unnecessary urinary catheterization
- Reducing noise during sleep periods
- Reviewing pain management
- Identifying and treating infections
- Conducting medication review
- Avoiding physical restraints[58]

- Results of delirium screening and management findings should be communicated within the circle of care.
- Support for the older adult and their care partner/s should be provided. Consider providing written information about delirium, such as Delirium Prevention and Care with Older Adults.
- One or more named providers in the interprofessional circle of care should serve as a point of contact to facilitate care coordination and transitions across settings.[58]

Older Adult & Family Materials:

- *Delirium Prevention and Care with Older Adults*
- *Caregiving Strategies: Changes in Thinking and Behaviour (Delirium)*

Mood & Mental Health

Depression is the most common mental health problem among older adults; older adults are at greater risk of depression, especially after an acute illness and hospital stay.[28] [61] Both anxiety and depression can have profound effects on rehabilitation and the progress people make; severity of depressive symptoms is a predictor of poorer rehabilitation participation resulting in negative functional outcomes.[28] [62] However, there is a growing body of evidence that physical activity and engagement in meaningful activities can be beneficial in aiding recovery from depression, and daily cardiovascular (aerobic) activities and resistance training (nonaerobic) can help reduce depressive symptoms.[63] [64] A holistic interprofessional approach that addresses issues of mental health augmented by high quality interprofessional work and flexible treatment frequency and duration provides an opportunity for improved rehabilitation outcomes.[28] [63] Depression should not be used in isolation to influence a determination of restorative potential.[11]

Resources

Depression Screening:

- *Geriatric Depression Scale (GDS)*
- *Patient Health Questionnaire-9 (PHQ-9)*
- *Cornell Scale for Depression in Dementia*

Identify Rehabilitative Care Needs

- Older adults living with/at risk of frailty should be screened for depression and/or apathy. Those with suspected depression should be screened for risk of suicide by asking older adults and their care partner/s about suicidal ideation, intent and plan.[63]

	• If concerns were noted upon screening:
	  ○ A thorough mental health history should be obtained from the older adult, care partner/s and any friends or relatives.[28]
	  ○ Referral to primary care and/or mental health services for a comprehensive assessment should be completed. [61] [63]
	  ○ For concerns of severe depression (GDS score of 11 or greater), or if there is concern of self-harm or suicidal thoughts, health professionals must immediately refer for comprehensive psychiatric evaluation.[61] [63]
	• Mental health issues can arise over time, therefore screening should occur on an ongoing basis. In particular, older adults who have had a stroke should be monitored closely for the possible development of depression, even in those who do not report depressed mood.[63]
	• In a rehabilitation setting, health care professionals should have a "high index of suspicion" to aid in reliably recognizing depression and anxiety, particularly among older adults who are struggling to progress with rehabilitation.[28]
	• Health professionals should recognize that depression and dementia often co-exist in older adults.[64]
	• Depression should not be diagnosed in the context of an acute delirium. Reassessment for depressive symptoms should be done after delirium has cleared significantly.[63]
	• Care partners may experience stress that can impact their health. Health professionals should help care partners identify common warning signs of stress and link them with supports.[65]
		Depression Assessment & Intervention:
		• *Canadian Guidelines on Prevention, Assessment and Treatment of Depression Among Older Adults*
		• *RNAO Delirium, Dementia, and Depression in Older Adults: Assessment and Care, Second Edition*
		
		CGA:
		• *Competency Framework for Interprofessional Comprehensive Geriatric Assessment*
		• *CGA Self-Assessment Tool*
		
		Caregiver Resources:
		• *RGPO Caregiving Strategies Handbook*
		• *Caregiving Strategies Course*

Deliver Evidence-Based Rehabilitative Care	• Psychosocial treatment should be part of the treatment of depression for older adults living with/at risk of frailty. This treatment should be flexible to account for the decline in functioning as well as multifaceted to provide help with the challenges facing the older adult experiencing depression and their care partner/s.[63] • Older adults and their care partner/s should have access to culturally appropriate psychosocial and/or supportive care services to manage issues such as coping with a diagnosis and side effects, decision-making and functional decline, among others. • Care partner/s should be a part of rehabilitative care interventions and given strategies to address the sequelae of depression in the older adult's day-to-day life.[63] • Information regarding depression should be given to older adults experiencing depression and their care partner/s at transitions in care. This information should be communicated to those involved in the person's circle of care. • One or more named providers in the interprofessional circle of care should serve as a point of contact to facilitate care coordination and transitions across settings.	

Location Specific Considerations

Community-Based Rehabilitation:

- Treatment for depression and other mood disorders in ambulatory, in-home and primary care settings should be enabled through inter-organizational communication and partnerships within the older adult's circle of care.

Social Engagement

Loneliness and social isolation can adversely affect physical health (leading to early mortality, stroke, elevated blood pressure, malnutrition) and mental health (resulting in depression, risk of suicide, substance misuse). It can also cause functional decline (physical and/or cognitive deterioration) .[60] A holistic approach that accommodates opportunities for social engagement provides an opportunity for improved rehabilitation outcomes, when augmented by high quality interprofessional work, and flexible treatment frequency and duration.[28]

Identify Rehabilitative Care Needs

- The older adult and their care partner/s should be screened for social isolation risk factors, including:
  - psychological, personality or mental health issues
  - living alone
  - disconnection from community/cultural groups
  - health problems
  - physical challenges or disability;
  - sensory impairment
  - no children
  - major life events such as loss and bereavement.[60]
- If there is suspicion that an older adult is experiencing loneliness, health care providers should consider using the *Three-Item Loneliness Scale*.[60]

Deliver Evidence-Based Rehabilitative Care

- Clinicians should ensure opportunities for conversation with older adults, including telephone or virtual care options where feasible.[60]
- Older adults should control the type and duration of social activity. Finding ways to optimize predictability of social activity is especially important.[66]
- Health care providers should support the social engagement of older adults by:
  - Discussing re-establishing connections and relationships that may have been lost during a time of injury/illness (e.g., cultural organizations and community groups)

Resources

Loneliness Screening:

- *Three Item Loneliness Scale*

CGA:

- *Competency Framework for Interprofessional Comprehensive Geriatric Assessment*
- *CGA Self-Assessment Tool*

Social Engagement Assessment & Intervention:

- *Senior Friendly 7 – Social Engagement Toolkit*
- *Senior Friendly Care Learning Series*
- *Caregiving Strategies: Social Engagement*

Advance Care Planning:

- *Advance Care Planning Canada*

- Exploring options for social activities and environments within their abilities (e.g., hobbies and interests)
- Fostering a therapeutic relationship with the older adult to allow them to feel comfortable talking openly about personal goals related to their sexuality and intimacy
- Concerns and recommendations related to social engagement should be included in transition care planning.[60]

- Where appropriate, referral to culturally appropriate community social programs, counseling or psychotherapy should be considered.[66]
- One or more named providers in the interprofessional circle of care should serve as a point of contact to facilitate care coordination and transitions across settings.

Mobility & Falls

Rehabilitation has a well-established role in treating and preventing falls, syncope and dizziness. Rehabilitation is effective for improving or maintaining functional ability and physical performance and may improve bone density, reducing the risk of fall-related fractures.[28]

Identify Rehabilitative Care Needs

Mobility

- Level of mobility should be assessed using the Simplified Mobility Assessment Algorithm.[60]
- Changes in the mobility of older adults living with/at risk of frailty should be identified.[60]
- Barriers to mobilization (e.g., physical, social, emotional and cognitive) should be identified.[60]
- The older adult's interests should be identified to help tailor activities appropriately.[60]

Falls

- Falls are common in the rehabilitation setting, where older adults tend to have difficulty with both mobility and transfers.[28] Older adults in contact with rehabilitative care professionals should be asked routinely whether they have fallen or had a near fall in the past year and asked about the frequency, context and characteristics of the fall/s.[67]
- Older people reporting a fall or who are considered at risk of falling should be observed for balance and gait deficits.[67]
- If concerns regarding falls are identified, a multifactorial fall risk assessment should be completed.[14] [68]

Resources

Mobility assessment tools:

- *Simplified Mobility Assessment Algorithm*

Fall Risk Screening Tools:

- *Stay on Your Feet Falls Risk Checklist*

Fracture Risk Screening Tools:

- *FRAX*

Balance & Gait Assessments Tools:

- *Timed Up and Go*
- *Tinetti Gait & Balance Scale*
- *Gait Speed and Gait Abnormality*
- *Functional Reach*

Location Specific Considerations

Facility-Based Rehabilitation:

- Fracture risk scales (FRS) have been developed for the MDS RAI in long term care and should be utilized. These tools were developed to identify hip fracture risk within the next year. When embedded in routine assessments, the tools allow the risk level to be calculated without bone mineral density testing and have significant potential to improve fracture risk assessment and prevention for this vulnerable population.

Community-Based Rehabilitation:

- Fracture risk scales (FRS) have been developed for the MDS RAI in home care and are pending approval.

Deliver Evidence-Based Rehabilitative Care

Mobility

- A personalized mobility care plan should be based on the older adult's level of mobility. It should incorporate core activities, as well natural opportunities for mobilization in everyday activities based on the older adult's preference.[60]
- In general, older adults should be encouraged to be active 150 minutes per week in sessions that are at least ten minutes long.[60 69]
- The older adult should be encouraged to mobilize at least three times per day and strategies used to break up sedentary time several times per day (e.g., stretch breaks).[60]
- The older adult's participation in activity programs and social events should be maximized according to their preferences.[60]
- Exercises provided should challenge the older adult at the appropriate level.
- A variety of approaches should be considered 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."[60]
- Care partners should be educated and engaged to support mobilization as per the rehabilitative care plan.
- Appropriate referrals should be identified and made to community programs for older adults.
- Information about the assessment of mobility levels and changes in mobility status should be shared within the circle of care.[60]
- Printed information on physical activity, such as the *Canadian Physical Activity Toolkit for Older Adults* should be provided.[60]

- *Berg Balance Scale*

CGA:

- *Competency Framework for Interprofessional Comprehensive Geriatric Assessment*
- *CGA Self-Assessment Tool*

Mobility & Falls Intervention:

- *Senior Friendly 7 - Mobility Toolkit*
- *RCA Primary Care Post-Fall Pathway*
- *RCA Post-Fall Pathway Pilot Report*
- *RNAO Preventing and Reducing Injury from Falls*
- *AGS/BGS Clinical Practice Guideline for Prevention of Falls in Older Persons*
- *NICE Falls in older people guideline*
- *Frailty eLearning Modules - Falls*
- *World Health Organization Prevention Operational Definitions*
- *Caregiving Strategies: Staying Active*
- *World Falls Guidelines*

Falls

- Standardized care for older adults with/at risk of frailty who present with a fall should include the integration of rehabilitative care services. Secondary fall prevention pathways are essential to mitigate functional decline and improve outcomes.[68]
- Rehabilitative care strategies, including primary, secondary and tertiary prevention, should be implemented to mitigate risk of falls:[70]
    - Primary prevention of fall-related injuries involves reducing the occurrence of falls
    - Secondary prevention of fall-related injuries involves preventing injuries when falls occur. Secondary prevention aims to reduce the impact of a disease or injury that has already occurred
    - Tertiary prevention aims to soften the impact of a fall after it has happened and preventing future falls.
- Interventions are based on the identification of reversible risk factors.[71] Common interventions should include:
    - Strength and balance training
    - Home hazard assessment & intervention
    - Vision assessment and rehabilitation
    - Medication review with modification/withdrawal
    - Fall prevention programs, including education and exercise [72]
- Care should include osteoporosis management and fracture prevention interventions related to rehabilitation and exercise that are based on the *Clinical practice guideline for management of osteoporosis and fracture prevention in Canada: 2023 update*.[73]

Fracture Prevention & Assessment:

- *Bonefit™*
- *Clinical practice guideline for management of osteoporosis and fracture prevention in Canada: 2023 update*
- *Osteoporosis Exercise Recommendations*
- *Ontario Osteoporosis Strategy Clinical Practice Resources*

Information for Older Adults:

- *Physical Activity Toolkit for Older Adults*
- *Canadian 24-Hour Movement Guidelines*

Function

Rehabilitation for older adults living with/at risk of frailty extends their functional independence and reduces care partner burden.[74]

This section includes physical function pertaining to ADLs, mobility and IADLs. (Please see cognition section for information on functional cognition.)

Resources

Activities of Daily Living (ADL) and Instrumental ADL (IADL) assessment tools:

- *NESGC Baseline Function: Barthel Index*
- *Lawton Brody IADL*
- *Older Americans Resources Services (OARS) Functional*

Identify Rehabilitative Care Needs

- All older adults living with/at risk of frailty should be assessed for risk of functional decline.
- Functional decline refers to any change in an individual's functional status as compared to their baseline level of function. Functional status describes the abilities necessary to maintain independence in daily life and encompasses physical, cognitive and social functioning.39 Baseline functional status is defined as the individual's ability to perform basic and instrumental ADLs two weeks prior to onset of the current illness/presenting complaint.

	This time duration should be used in order to eliminate the possibility that effects of the illness are causing a change in function.[75]
	• Measures of functional status should include ADLs, mobility, IADLs and cognition.
	• Development of rehabilitative goals with the older adult should be:
	  ○ Individualized
	  ○ Undertaken collaboratively with the older adult and their care partner/s
	  ○ Reflect the unique circumstances of each older adult, including relevant social determinants of health and personal beliefs
	• Goals may relate to cognition, activity (mobility, basic ADLs, IADLs and leisure activities), behavior, emotion, physical symptoms (e.g., pain) or communication.
	• Goals should be operationalized based on a careful understanding of the individual's abilities, to ensure that the aims are achievable, realistic and meaningful.
		Assessment Questionnaire
		• *Katz Index*
		• *Functional Improvement Measure (FIM™)*
		CGA:
		• *Competency Framework for Interprofessional Comprehensive Geriatric Assessment*
		• *CGA Self-Assessment Tool*
		Assessment & Intervention:
		• *Senior Friendly Care Learning Series*
		• *RCA Rehab Care Standards for Rehabilitative Care (community-based)*

Deliver Evidence-Based Rehabilitative Care	• The rehabilitative care plan should be based on the results of the comprehensive geriatric assessment, and older adults living with/at risk of frailty and their care partner/s should participate in its development. • Based on the results of the CGA, rehabilitative care strategies should be implemented to mitigate risk of functional decline and maintain or improve the individual's level of independence in their home and community relative to their baseline.[27] • Culturally appropriate education and support should be provided to older adults and their care partner/s to facilitate a return to baseline level of function. • Involvement of care partners in rehabilitative care should be encouraged.[56] For example, care partners may provide supervision for the older adult to mobilize, if mobility risks are identified.[60] • It is important for older adults and their care partner/s to understand that changes in cognition, changes in medication and reduced physical function can increase the risk of motor vehicle collisions among older adult drivers. Any member of an interprofessional team might be the first to identify a driving safety issue. Currently in Ontario, the Ministry of Transportation can only process reports regarding driving safety that are completed by a physician, nurse practitioner, optometrist or an occupational therapist who is specifically affiliated with a Driving Rehabilitation Fitness Centre. Interprofessional health care professionals who do not have a legal obligation to report should consider their ethical obligation to inform the individual's physician of driving-related concerns identified through assessment and intervention.[76]	

Transitions

- Robust processes should be in place for anticipating the transitional care needs of older adults and their care partner/s to promote continuity of care and reduce duplication of assessments.[27]
- Individualized transition plans should be developed in collaboration with the team, older adult and their care partner/s and should be shared within the circle of care.[27]

Location Specific Considerations

Community-Based Rehabilitation:

- An interprofessional team approach must be used to provide care. In ambulatory, in-home and primary care settings, providing care as part of an interprofessional team may require inter-organizational communication and partnerships within the older adult's circle of care.

Continence

Incontinence is not an inevitable consequence of aging. Incontinence may be embarrassing to the older adult and may create dependence; gaining independence in toileting means gaining control.[77] Management of continence is often a barrier to older adults transitioning home successfully or participating in meaningful roles; care partners often identify that they cannot manage incontinence at home.[78] Constipation is increasingly common in later life and can exacerbate urinary incontinence; maintenance of mobility and hydration and avoidance of precipitating medications are key interventions in management.[28 79]

Identify Rehabilitative Care Needs

- Older adults may be reluctant to discuss symptoms of urinary incontinence. Health care providers should broach the subject as a routine part of their care.
- Health care providers should be aware of signs that an older adult may be having bladder problems, such as the smell of urine in the room or soiled bed linens or undergarments.[60]
- Health care providers should screen for urinary incontinence periodically via history and observation, even if no signs are present.[60 78 80]
- If the answer to any of the screening questions is "yes," the older adult should be encouraged and assisted with:
  - Completing a bladder diary and/or
  - Completing the continence symptom checklist, and
  - Making an appointment to discuss symptoms with their primary care provider[60]

Resources

CGA:

- *Competency Framework for Interprofessional Comprehensive Geriatric Assessment*
- *CGA Self-Assessment Tool*

Assessment & Intervention:

- *Senior Friendly 7 – Urinary Continence Toolkit*
- *Senior Friendly Care Learning Series*
- *Canadian Continence Foundation*
- *Caregiving Strategies: Bladder Health*

Deliver Evidence-Based Rehabilitative Care	• Rehabilitative care goals should be developed in collaboration with the older adult and their care partner/s to return to baseline level of function for toileting and continence.
	• A rehabilitative care plan related to incontinence should include toileting behaviour training, education, scheduled voiding, positive reinforcement and pelvic muscle exercises.[78]
	• All plans should include maximizing mobility (mobilizing at least three times per day), reducing use of indwelling catheters and utilizing conservative treatments as the first response.[60]
	• If incontinence persists following conservative management interventions, the health care provider should consider referral to other team members for medical, pharmacological, mechanical or surgical interventions.[80]
	• Additionally, health care providers should:
	  ○ Reinforce and encourage healthy bladder habits
	  ○ Communicate bladder concerns and pressure injury risk management within the circle of care
	  ○ Provide educational materials to older adults such as *The Source – Your guide to better bladder control*[60]
	  ○ Encourage the older adult to discuss their symptoms with their primary care provider
	  ○ Consider referral to nurse continence advisors (NCAs), who are available through the Canadian Continence Foundation, or to nurses specialized in wound, ostomy and continence (NSWOCs), who are available through Nurses Specialized in Wound, Ostomy and Continence Canada. NCAs/NSWOCs are registered nurses with specialty certification who can assess, diagnose and treat people with urinary and/or fecal incontinence. Some may provide services in the home.[60 81]
	  ○ If incontinence is due to pelvic floor dysfunction, continence physiotherapists can provide first line treatment, such as functional retraining to improve pelvic floor muscle strength, endurance, power and relaxation.[82 83]	

Skin Integrity

Pressure injuries are caused by unrelieved pressure (due to compression of soft tissue between a bony prominence and a hard surface), shear forces, friction or a moist environment.[61]

Identify Rehabilitative Care Needs	• A head-to-toe skin assessment should be carried out with all older adults on initial presentation and routinely thereafter for those who are identified at risk for skin breakdown.[84]	**Resources** **CGA:** • *Competency Framework for Interprofessional Comprehensive Geriatric Assessment*

	• A risk assessment tool that has been tested for validity and reliability should be used. The *Braden Scale for Predicting Pressure Sore Risk* is recommended.[84] • Prevention is better than cure; all older adults who are at risk of sustaining pressure damage should be assessed and provided with appropriate pressure-reducing strategies.[85] • All pressure injuries should be identified and staged using the National Pressure Injury Advisory Panel criteria.[84]	• *CGA Self-Assessment Tool* **Pressure Injury Risk Screening Tool:** • *Braden Scale for Predicting Pressure Sore Risk*
Deliver Evidence-Based Rehabilitative Care	• Older adults and their care partner/s should participate in the development of a rehabilitative care plan based on intrinsic and extrinsic risk factors identified by a pressure injury risk assessment tool. This plan might include a repositioning schedule, reduction/management of moisture, nutritional intake and hydration. Where lifestyle modifications are required, this individualized approach may enhance adherence to the plan.[14 73] • Occupational therapy and physiotherapy should consult regarding transfer and positioning techniques, devices to reduce friction and shear, pressure relief surfaces and seating adaptation.[14] • Training should be provided to the older adult on independent transfers, weight shifting or repositioning.[85] • Older adults at risk of pressure damage, or those who have had pressure damage in the past, should be monitored daily to check for early signs of recurrence.[85]	**Pressure Injury Assessment & Prevention:** • *RNAO Risk Assessment & Prevention of Pressure Ulcers* • *BMJ Best Practice Pressure Ulcer* • *NICE Guidance: Pressure Ulcers: Prevention and Management* • *National Pressure Injury Advisory Panel (NPIAP) Stages*

Nutrition & Hydration

An association has been identified between malnutrition, low physical function and reduced effectiveness of rehabilitation.[86] Many factors cause poor appetite during rehabilitation, and these should be systematically identified and managed.[28] To ensure adequate food intake and hydration for the older adult, it is essential to recognize the social and cultural aspects of food intake and the older adult's preferences, and to include care partners in goal setting and meal planning. Nutritional care has shown a number of benefits including improved muscle mass, muscle strength, physical function and quality of life, as well as reduced re-hospitalization.[86] Drinking liquids throughout the day is also especially important for older adults. Dehydration can lead to dizziness, fainting and low blood pressure which may put older adults at risk for falls. Dehydration may also make constipation worse.[87]

Resources

Nutrition Screening Tools:

- *The Mini Nutritional Assessment – Short Form (MNA-SF) ™*

Identify Rehabilitative Care Needs	• Nutritional screening should be included as part of routine assessment using a standardized and valid tool.
	• If concerns are identified, the interprofessional team should assess the following:
	  ○ Amount of unintentional weight loss or gain in the past six months
	  ○ Reduced food and quality of food intake (and for how long)
	  ○ Hydration
	  ○ Swallowing[14]
	• For further assessment and management, health care providers should consider referrals as appropriate, which may include a dietitian for a food assessment.[60]
		• *The Malnutrition Universal Screening Tool (MUST)*
		• *The Seniors in the Community Risk Evaluation for Eating and Nutrition (SCREEN II©)*
		• *PEN: The Global Resource for Nutrition Practice*
		• *Nutrition Screening Tools for Community-Dwelling Older Adults*
		• *Canadian Nutrition Screening Tool (CNST)*

Deliver Evidence-Based Rehabilitative Care	• Nutrition, hydration and swallowing should be included as a core component of goal-setting with older adults and their care partner/s and in team discussions/rounds.
	• Strategies to support adequate food intake and hydration should be implemented,[88] including strategies that consider social and cultural aspects of food intake and that help to increase appetite. These could include:
	  ○ Providing a comfortable place to eat
	  ○ Making mealtimes an event, an opportunity to engage care partners, family and/or friends, to engage in rehabilitation and to socialize
	  ○ Adding familiar cultural foods and flavours to meal options
	  ○ Determining if medications are causing appetite or taste problems
	  ○ Ensuring that food is accessible, e.g., opening containers, assisting individuals with visual limitations to scan their meal[28 88]
	  ○ Promoting physical activity and exercise
	• To meet fluid needs throughout the day, offer water most often. Other fluids like milk, coffee, tea and juice also count towards daily fluid intake. Avoid soft drinks and limit drinks with caffeine to three cups per day.[87]
	• All team members, including care partners should offer drinks when interacting with older adults. To ensure proper hydration, older adults may require a continence plan, including the help of care partner/s, to successfully manage the necessary intake and subsequent voiding.
	• Older adults with potential dysphagia should receive education on swallowing, prevention of aspiration, feeding recommendations and oral hygiene.[89]
		Swallowing Screening & Assessment Tools:
		• *Canadian Stroke Best Practice Recommendations Suggested Tools*
		
		CGA:
		• *Competency Framework for Interprofessional Comprehensive Geriatric Assessment*
		• *CGA Self-Assessment Tool*
		
		Assessment & Intervention:
		• *Senior Friendly 7 - Nutrition Toolkit*

- If there are concerns with swallowing, health care providers should refer to:
  - Speech-language pathologist for swallowing assessment and follow-up
  - Dietitian for recommendations on meeting nutritional and fluid needs while supporting alterations in food texture and fluid consistency or enteral nutritional support, when necessary.[89]
- Findings from the nutritional screening and strategies to manage them should be shared within the circle of care, including nutritional issues, weight changes, observations from the food assessment and successful approaches to food intake and hydration.

Location Specific Considerations

Facility-Based Rehabilitation:

- In hospital, include nutrition screening for older adults on admission using a standardized tool such as the *Canadian Nutrition Screening Tool (CNST)*.[60]
- Consider using the *Integrated Nutrition Pathway for Acute Care (INPAC) Implementation Toolkit*, which provides information on how to improve nutrition care practices in hospitals.[60]
- In long-term care, include nutrition screening at least quarterly using a standardized tool such as the *Mini Nutritional Assessment (MNA*), which is appropriate for use in older adults with mild cognitive impairment.[60]

Community-Based Rehabilitation:

- Nutritional screening should be included as part of routine assessment using a standardized and valid tool such as *Seniors in the Community Risk Evaluation for Eating and Nutrition (SCREEN II©)*.
- Health care providers may assist older adults with nutrition by offering to:
  - Read food labels
  - Identify 'out-of-date" food and offer to remove it
  - Help with grocery shopping
  - Coordinate visits to assist with meals as required
  - Eat together if appropriate
  - Find food-related community support like Meals on Wheels, congregate dining, seniors centres, and grocery delivery or transportation services: http://www.thehealthline.ca/[60]

- *Senior Friendly Care Learning Series*

Information for Older Adults:

- *Unlock Food.ca: Seniors Nutrition*
- *Healthy eating for seniors*
- *thehealthline.ca*
- *Caregiving Strategies: Nutrition*

Pain

It is important that pain is well-managed to promote and support participation in rehabilitation.[28] In the rehabilitative care environment, the older adult living with/at risk of frailty may experience both chronic and acute pain depending on pre-existing co-morbidities as well as any new injury.[28] Pain in older adults living with dementia is under-recognized, as individuals may not be able to inform staff when they require pain medication.[28]

Identify Rehabilitative Care Needs

- On initial presentation of any older adult, a rehabilitative care professional should assess the individual for evidence of persistent pain.[90]
- Pain should never be considered a natural part of the ageing process; however, pain perception appears to change with age.[28] These changes include decreased sensitivity for pain of low intensity and increased pain threshold, but aging does not have a strong effect on pain tolerance.[91]
- For the older adult living with moderate to severe dementia or who is nonverbal, the practitioner should attempt to assess pain via direct observation or history from care partners. Individuals should be observed for evidence of pain-related behaviours during movement (e.g., walking, morning care, transfers).[90]
- Unusual behaviour in an older adult living with severe dementia should trigger assessment for pain as a potential cause.[90]
- Pain assessment should be addressed in an interdisciplinary manner.[28]
- All older adults experiencing 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.[92]
- 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.[92]
- The same quantitative pain assessment scales should be used at initial and follow-up assessments.[92]

Deliver Evidence-Based Rehabilitative Care

- The risks and benefits of various assessment and treatment options should be discussed with the older adult and their care partner/s.[92]
- The older adult, their care partner/s and the interprofessional rehabilitative care team should collaborate on the design of any assessment or treatment strategy.[92]
- Each person's pain experience will be unique. The older adult, care partner/s and team should work together to develop goals for pain management and to facilitate participation in the rehabilitative care plan.
- All interprofessional team members should understand the potential impact of pain on an individual's ability to participate in and/or benefit from rehabilitative care interventions.

Resources

Patient Reported Outcome Measures for Pain:

- *Visual Analogue Scale (VAS)*
- *Numeric Rating Scale (NRS)*
- *Checklist of Non-Verbal Pain Indicators*

CGA:

- *Competency Framework for Interprofessional Comprehensive Geriatric Assessment*
- *CGA Self-Assessment Tool*

Pain Assessment & Intervention:

- *Senior Friendly 7 – Pain Toolkit*
- *Senior Friendly Care Learning Series*
- *RNAO Assessment and Management of Pain in the Elderly*
- *Caregiving Strategies: Pain*

- Consider strategic use of PRN pain medications (i.e., 30-45 minutes prior to assessment/treatment) to maximize participation and improve rehabilitative benefit[93]
- Patient education programs are integral components of the management of persistent pain syndromes. Content should include information about:
  - Self-help techniques (e.g., relaxation, distraction)
  - Known causes of pain
  - Goals of treatment
  - Treatment options
  - Expectations of pain management, and
  - Analgesic drug use[92]
- In discussion with the older adult, both pharmacological and non-pharmacological pain management strategies should be utilized as part of the plan to facilitate rehabilitative care interventions. For example, in combination with pharmacological pain management, formal cognitive-behavioral therapies are helpful for many older adults with persistent pain, depending on their cognitive status. Other modalities (e.g., heat, cold, massage, chiropractic, acupuncture and transcutaneous electrical nerve stimulation) often offer temporary relief.[92]
- The pain management plan should be shared with the older adult, care partner/s and within the circle of care.

Polypharmacy

Older adults who take more than five medications, more than 12 doses/day and/or receive prescriptions from multiple health care providers are at increased risk of adverse events.[60] Medication reconciliation (Med Rec) is a formal process in which health care providers work together with older adults and their care partner/s to ensure accurate and comprehensive medication information is communicated consistently across transitions of care.[60] The interprofessional team plays an important role in monitoring, supporting, counselling and educating the older adult and their care partner/s in their medication use and possible side effects.

Identify Rehabilitative Care Needs

- A thorough medication review that includes prescription drugs, over-the-counter drugs, alcohol intake and cannabis should be conducted every 6-12 months and after events which alter an individual's medication regimen (e.g., hospitalization).[94]
- Observed physical signs of adverse drug reactions should be shared with the interprofessional team, including the pharmacist and most responsible physician. These signs may include fatigue, constipation, diarrhea, incontinence, weight loss, weakness, tremors, falls, drowsiness, dizziness, confusion, depression, agitation, anxiety and decreased sexual behaviour.[60]

Resources

Medications Assessment & Intervention:

- *Senior Friendly 7 – Polypharmacy Toolkit*
- *Senior Friendly Care Learning Series*
- *AGS Updated Beers Criteria: https://doi.org/10.1111/jgs.18372*
- *deprescribing.org*
- *Caregiving Strategies: Medication Management*

	• Health care providers should:
	  ○ Identify if medications could be the cause of hospital admission
	  ○ Assess the appropriateness of medications guided by the *Beers Criteria*[94]
	  ○ Identify opportunities for de-prescribing using guidelines, pamphlets and resources from *deprescribing.org*. De-prescribing is the planned and supervised process of dose reduction or stopping of medication that might be causing harm, or that is no longer of benefit.[95]	

Deliver Evidence-Based Rehabilitative Care	• All interprofessional team members should understand the potential impact of polypharmacy on an individual's ability to participate in and/or benefit from rehabilitative care interventions. • Older adults and their care partner/s should be taught strategies to manage multiple medications. • The following should be shared with the older adult, care partner/s and providers within the circle of care: concerns arising from the medication reconciliation process, up-to-date medication lists, and actual or potential adverse drug reactions that require monitoring.[60]	

APPENDIX A: GLOSSARY

Baseline functional status is defined as an individual's functional ability within (at a minimum) the domains of basic activities of daily living (ADLs), instrumental activities of daily living (IADLs) and cognition two weeks prior to onset of the current illness/presenting complaint. This time duration is used in order to eliminate the possibility that effects of the illness are causing a change in function.[75]

Care partners are essential and are key in many settings to the provision of care. Care partners are defined by the older adult and are often family members or friends. They serve as a liaison between older adults and clinicians, and are essential for day-to-day decision-making, care delivery, transition care planning and system navigation.[96 97]

Care transitions occur when older adults transfer between different care settings (e.g., hospital, primary care, long-term care, home and community care) and between different health care providers during the course of an acute or chronic illness.[50]

Circle of Care is the group of health care providers and care partners providing care to a patient who need information to provide that care. Consent to share information with providers and care partners within the circle of care is generally implied.[98]

Co-designed, person-centred rehabilitative care plan is a goal-oriented and individualized rehabilitative care plan that is enabled through the shared decision-making of the older adult, their care partner/s and the interprofessional rehabilitative care team.[15]

Co-developed, rehabilitative care goals are developed in partnership with the older adult and their care partner/s based on their individual priorities and are informed by the presenting need for rehabilitative care.

Communication liaison is a named health care professional on the interprofessional team who is responsible for timely transition planning, coordination and communication to ensure an effective transfer of transition plans and information related to the older adult's care.[50]

Comprehensive geriatric assessment (CGA) involves an interprofessional team approach that determines an older person's biomedical, psychosocial and environmental needs so that an appropriate treatment and follow-up plan can be initiated.[26]

Frailty is a medical condition of reduced function and health in older individuals resulting in the inability of the older adult to cope with minor stressors, which may trigger rapid and dramatic deterioration.[2]

Functional decline refers to any change in an individual's functional status as compared to their baseline level of function. Functional status describes the behaviours necessary to maintain independence in daily life and encompasses physical, cognitive and social functioning.[39] Measures of functional status can include ADLs, mobility, IADLs and cognition.

Geriatric care is provided by health care professionals who specialize in the care of older adults (e.g., geriatricians, geriatric psychiatrists, care of the elderly physicians and members of the interprofessional geriatric team). Geriatric specialists use a comprehensive geriatric assessment to diagnose, treat and rehabilitate older adults living with/at risk of frailty with complex and multiple medical, functional and psychosocial issues.

Geriatric syndromes are multifactorial health conditions that occur when the accumulated effects of impairments in multiple systems render an older adult vulnerable to situational challenges.[99]

Health equity refers to an optimal state, where no matter who the person is, their background, where they live, or their personal resources, they are able to access and receive high quality care that is suited to their needs and helps them achieve their best health possible.[100]

Interprofessional team approach involves multiple health disciplines with diverse knowledge and skills who share an integrated set of goals and who utilize interdependent collaboration that involves communication, sharing of knowledge and coordination of services to provide services to older adults living with/at risk of frailty and/or their care partner/s.[101]

Rehabilitative care – is a care approach that focuses on maintaining or restoring functionality or developing adaptive capacity. Rehabilitative care for older adults aligns with Senior Friendly Care (sfCare) and is part of an interprofessional approach to care. It is delivered by geriatric specialists and health care providers who have the knowledge and skill in the provision of sfCare.

Rehabilitative care plan is a written record that includes the following:

- Clinical priorities identified by the comprehensive geriatric assessment
- Individualized rehabilitative care goals associated with significant health and safety risks
- Plans to manage significant comorbidities in relation to the older adult's goals
- Appropriate prevention activities for the older adult, and
- Self-management support for the older adult and care partner/s.[49]

Restorative potential means that there is reason to believe (based on clinical assessment and expertise and evidence in the literature where available) that the older adult's condition is likely to undergo functional improvement and benefit from rehabilitative care.[11]

Senior friendly care is evidence-based, preventive and proactive care for the unique needs of older adults. It is not an add-on to care; it is essential care that should be provided at all times. Senior friendly processes of care include: delirium, mobilization, social engagement, nutrition, pain, polypharmacy and urinary incontinence.

Social determinants of health refer to factors such as income, social status, social support networks, education, employment/working conditions, social environments, physical environments, personal health practices and coping skills, gender, sexual orientation and culture, which influence people's health outcomes and quality of life.[100]

APPENDIX B: VIRTUAL CARE

Virtual care is defined as "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."[102] Each of the regulated health professional colleges have statements and guidelines regarding the use of virtual care as an alternate mode of service delivery to traditional rehabilitation services. Health professionals must be able to maintain appropriate rehabilitative and regulatory standards of care.

Implementation of virtual care requires the following:

- Organizations should ensure that front line providers have access to the supports required to deliver effective virtual care, (e.g., technology, training, etc.).[103]
- Decisions to utilize virtual care must take into consideration the feasibility of delivering the specific therapy needs, as well as the older person's characteristics, (e.g., access to technology, care partner supports, individual preference, clinical condition etc.).[102]
- Prior to providing virtual care, detailed information should be made available to the individual and their care partner/s regarding what virtual care is and how to access it, the potential privacy/security risks and the scope of care provision. Verbal consent to provide care using virtual care electronic communication tools should be obtained and documented in the patient chart.[104]

Virtual care may be utilized for many aspects of care, including the following:

- Interview with the older adult
- Physical assessments that do not require palpation or auscultation[105]
- Some diagnosis, treatment, maintenance, consultation and education and training
- Follow-up assessment of physical conditions for individuals who have previously been seen face-to-face and have already received the key pieces of physical examination

However, virtual care is not appropriate for all rehabilitative or older adult care needs and should be considered on a case-by-case basis. The following factors should be taken into account when considering virtual care delivery of rehabilitation interventions:

- An older adult's access to technology and internet and other practical limitations, (e.g., communication abilities)[106]
- Potential safety issues. Engage and train care partners to provide assistance for both the safety of tasks during intervention and/or technical support.[106 107]
- Difficulty with hearing and vision or language barriers and the impact this will have on the older adult's ability to participate[106]
- Cognitive ability and how it may impact an individual's safety and their ability to complete a self-directed program and the carry-over advice that is provided[106]

- Confidentiality issues. Individuals may be at home with many other people or in a virtual group therapy session, 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.[104]
- Need for flexible hours to accommodate the needs of individuals and their care partner/s. Allow for extra time to build rapport and trust and for potential technical issues.[106]
- 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, and apps; and remote sensor monitoring.[102]

As with any health care decision, choosing to provide virtual or in-person rehabilitative care will have consequences that range from positive to negative. These consequences may impact the older adult and their care partner/s, the clinician, the organization or health care system or all of the above.

Table 1: Potential harms and benefits of both in-person and virtual care[105]

	Virtual Care	In-Person Care
Potential Harms	■ Uncertain accuracy of standardized assessment results ■ May be confusing for some patients with cognitive decline ■ Unable to complete hands-on physical assessment ■ Lack of confidence/comfort with virtual care for provider and/or patient ■ Equity concerns related to affordability of equipment/devices and internet service	■ Longer wait times for some services; cost and stress related to travel, parking, time off work ■ Increased risk of infection, especially during outbreaks (e.g., influenza, COVID-19) ■ Increased anxiety for some, due to associations with health care environments ■ Not accessible for all, e.g., rural or remote living and/or access to transportation ■ Increased travel time for staff; decreased efficiency
Potential Benefits	■ Quicker access to care; decreased stress related to travel, mobility risks ■ No cost associated with travel, parking, time off work ■ Decreased anxiety for some/more comfortable in-home environment ■ Opportunity to include additional family/friend caregivers or health team members ■ Minimize risk of infection, especially during outbreaks (e.g., influenza, COVID-19) ■ Reduced staff travel time; increased efficiencies	■ Ability to complete hands-on assessment; ability to observe patient ■ Standardized application of assessments ■ Increased provider confidence in assessment results/findings ■ Potential for enhanced rapport-building

Decisions regarding the mode of care delivery should take into consideration the potential harms and benefits of both virtual and in-person approaches, according to the unique circumstances and clinical needs of each older adult and their care partner/s. Often there will be competing harms and benefits associated with each.[105]

Hybrid models which include both in-person and virtual care may also be considered, (e.g., virtual assessment with in-person follow up, if required). Health care providers may wish to leverage virtual strategies to improve processes and engagement (e.g., to gather history and explain care processes prior to in-person visits, thus allowing additional in- person time to build rapport, or to engage multiple caregivers, thus ensuring a common understanding of an older adult's needs and situations).[105]

Table 2: Interventions and clinical activities to consider delivering in a virtual capacity

Interventions and Clinical Activities
■ Intake/history assessment
■ Goal-setting with the older adult and care partner/s to maximize function and develop a specific plan of care. Discuss the individual's and care partners' expectations during this episode of care. Identify and address older adult/care partner concerns.
■ Review of educational materials
■ Observation of home setting, including home equipment and safety check[108]
■ Multifactorial fall risk assessment based on observation and report of the older adult and care partner/s
■ Osteoporosis management and fracture prevention interventions related to rehabilitation and exercise according to the Clinical practice guideline for management of osteoporosis and fracture prevention in Canada: 2023 update.[73 109]
■ Observation and provision of feedback for functional tasks, exercises and range of motion[108]
■ Provision of rehabilitative care programs with regulated rehabilitative care professional supervision that are matched to the older adult's needs[108]
■ Administration of outcome measures, assessment and screening tools:
• Cognitive assessment (copy of the tool to be sent to the older adult before the assessment).[110] Note: Available evidence suggests scores for cognitive screening completed virtually need to be interpreted cautiously.[111] Considerations for choosing an appropriate tool can be found in *Choosing a Cognitive Screening Tool*
• Depression screening, such as:[63 112]
○ Geriatric Depression Scale (GDS)
○ SelfCARE(D) self-rating scale
○ Patient Health Questionnaire – 9 (PHQ-9)
• Performance outcome measures, such as:
○ 30 Second Chair Stand Test[113]
○ Timed Up and Go
• Patient Reported Outcome measures, such as:
○ EQ-5D-5L™
○ Pain Visual Analogue Scale (VAS)/Numeric Pain Rating Scale (NPRS)

Table 3: Clinical needs or interventions requiring in-person assessment and/or treatment

Clinical Needs or Interventions
■ Cognitive, perceptual or emotional difficulties that limit independence and/or there is no care partner available to assist[106]
■ Change in status requiring in-person visits to assess and treat[106]
■ Hands-on therapy, as required
■ Assessment and intervention for skin integrity, mobility, balance and falls where older adult safety is a concern
■ Hands-on care partner teaching where required to support rehabilitation goals

Table 4: Clinical needs or interventions for which virtual care may not be appropriate

Clinical Needs or Interventions
■ Older adults experiencing new onset symptoms indicative of medical emergency (neurological symptoms, shortness of breath, chest pain)
■ Undifferentiated acute problems or unstable mental health conditions
■ Situations in which the older adult may not be able to secure a private space in which to comfortably share confidential information
■ Situations in which there are language barriers that could negatively impact the virtual visit[105]
■ Sharing bad news or a significant diagnosis
■ Providing new prescriptions for narcotics, benzodiazepines or stimulants

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- RCA Geriatric Rehab Care Task Group
- RCA Patient & Caregiver Advisory Group
- PGLO Specialized Geriatric Services Administrators Group
- PGLO Older Adults & Care Partners Advisory Council
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ENDNOTE

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