



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

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

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

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

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

Each of the geriatric syndromes includes the following two sections:

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

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Compendium of Evidence-Based Assessments and Interventions to Support the Management of the Geriatric Syndromes within In-Home Rehabilitative Care

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<p><u>Delirium Standardized Assessment</u></p> <p><u>RNAO - Screening for Dementia, Delirium and Depression</u></p> <p><u>CCSMH – The Assessment and Treatment of Delirium</u></p> <p><u>SFH - Screening and Detecting Delirium</u></p>	<ul style="list-style-type: none"> • A high index of suspicion should be maintained for delirium, dementia and depression in the older adult (B)¹. • Clients should be screened for changes in cognition, function, behaviour and/or mood, based on ongoing observations of the client and/or concerns expressed by the client, family and/or interdisciplinary team, including other specialty physicians (C)¹. • There are differences in the clinical features of delirium, dementia and depression and a structured assessment method should be used to facilitate this process (C)¹. • All clinicians working with older persons should be aware that the symptoms of delirium may be superficially similar to those of a dementia and that the two conditions frequently co-exist. Clinicians should be aware of the features that can help differentiate delirium from dementia (C)². • Objective assessments of cognitive changes should be completed by using one or more standardized tools in order to substantiate clinical observations (A)¹. • Factors such as sensory impairment and physical disability should be assessed and considered in the selection of mental status tests (B)¹. • Prevention efforts should be targeted to the older person’s individual risk factors for delirium [D].² • Delirium can be detected more easily when a structured and routine process to screen for delirium and cognitive function during hospitalization is established, using standardized instruments where possible. This facilitates detection of delirium and also helps to differentiate its symptoms from chronic or slower onset syndromes like dementia or depression. Tools include³: <ul style="list-style-type: none"> ○ Confusion Assessment Method (CAM). ○ Delirium Observation Screening (DOS) Scale
<p><u>Delirium Standardized Intervention</u></p> <p><u>CCSMH - The Assessment and Treatment of Delirium</u></p> <p><u>SFH - Preventing and Managing Delirium</u></p>	<ul style="list-style-type: none"> • Delirium is a medical emergency and requires urgent intervention. Treatment of all potentially correctable contributing causes of the delirium should be done in a timely, effective manner [D].² • Interventions to prevent delirium should be interdisciplinary.[A]² • Prevention efforts should be targeted to the older person’s individual risk factors for delirium [D].² • Older persons with delirium are at risk for micronutrient deficiencies (e.g., thiamine), especially if alcoholic and/or have evidence of malnutrition. A daily multivitamin should be considered [D].² • Strive to maintain a normal elimination pattern. Aim for regular of voiding during the day and a bowel movement at least every two days [D].² • Urinary retention and fecal impaction should be actively looked for and dealt with if discovered [D].² • Multicomponent interventions targeting multiple risk factors should be implemented in older persons who have intermediate to high risk for developing delirium [A].² • Older persons with impairments of vision should be provided with their visual aids and/or other adaptive equipment [B].² • Older persons with impairments of hearing should be evaluated for reversible causes and provided with hearing aid(s) and/or other amplifying devices [B].² • Older persons with evidence of dehydration should be encouraged to increase their oral fluid intake. Other measures may be required depending on the severity of the dehydration and the patient’s response to efforts to increase their oral intake [B].² • Environmental risk factors should be modified, if possible including the following: [D]² <ul style="list-style-type: none"> ○ Sensory deprivation (e.g., windowless room, single room), Sensory overload (e.g., too much noise and activity), Isolation from family/friends (or familiar objects), frequent room changes, absence of orientating devices (e.g., watch, clock or calendar), absence of visual/hearing aids, use of

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restraints.

- Where available, proactive consultations to a geriatrician, geriatric or general psychiatrist, or to a general internist should be considered for older persons undergoing emergency surgery to minimize the risk of post-operative delirium [B].²
- Prevention, early detection, and treatment of postoperative complications in older persons are important in preventing delirium. These would include (but are not limited to) the following: myocardial ischemia, arrhythmias, pneumonia, exacerbations of Chronic Obstructive Pulmonary Disease, pulmonary emboli, and urinary tract infections [B].²
- Educational interventions directed to hospital staff dealing with delirium and its prevention should be implemented.²
- All clinicians working with older persons should be alert to the possibility of delirium developing after surgical procedures (especially cardiopulmonary bypass and surgical repair of a hip fracture), with acute medical conditions (e.g., infections) and/or during exacerbations of chronic medical conditions (e.g., Congestive Heart Failure)[C].²
- All clinicians working with older persons should be aware that delirium can show a fluctuating course with periods of lucidity during which the person's mental/cognitive status can appear unremarkable. Therefore, repeated screening and looking for diurnal variation is recommended [C].²
- Due to the fluctuating course of delirium and since many older persons will not be able to provide an accurate history, collateral information should be sought [C].²
- All clinicians working with older persons should be aware that intact functional status does not rule out delirium [C].²
- All clinicians working with older persons should be vigilant of recent-onset lethargy and unexplained somnolence (i.e., sleepiness, or the state of feeling drowsy), which might indicate the development of the hypoactive-hypo alert sub-type of delirium [C].²
- All clinicians working with older persons should recognize that while symptoms of delirium typically develop abruptly, an insidious onset can occur (e.g., irritability, restlessness, anxiety, or sleep disturbance) [C].²
- Delirium should be considered as a potential cause of any abrupt change in the cognition, functional abilities, and/or behaviour of an older person seen in an ambulatory clinic, primary care, or long term care setting [C].²
- The evaluation of an older person for the possibility of delirium should include a review of their prior cognitive functioning (e.g., over the previous six months) [C].²
- Any clinician noticing changes in the mental status or alertness of an older hospitalized person should bring this to the attention of the nurse caring for the individual and/or the person's attending physician [C].²
- In response to either observations or reports of changes in mental status/alertness from members of the clinical team, the older person or members of their family, nurses caring for the older person should initiate an assessment searching for evidence of delirium [C].²
- The physician responsible for the older person should promptly review the delirium screening results and determine the need for further evaluation [C].²
- Older persons with complex presentations such as those with pre-existing neurocognitive decline, cerebrovascular disease and/or aphasia may require referral for assistance in the diagnostic work-up. The referral may be directed to a geriatrician, geriatric or general psychiatrist, neurologist, and/or neuropsychologist [C].²
- While clinicians use screening tools to identify persons with probable delirium in need of further evaluation and follow-up, the results from these tools must be interpreted within a clinical context and do not in themselves result in a diagnosis of delirium [D].²
- Ratings on the CAM should be informed by an objective mental status examination [C].²

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- Serial cognitive and functional measurements should be done. They will help in monitoring the older person’s progress and their need for care [D].²
- When the care of an older person with delirium is transferred to another practitioner or service, the receiving practitioner or service must be informed of the presence of the delirium, its current status and how it is being treated [D].²
- The implementation of intensive rehabilitation that requires sustained attention or learning from the delirious older person is not likely to be beneficial and may increase agitation. It should be delayed until the older person is able to benefit from the intervention [D].²
- Given difficulties in sustaining attention, when communicating with a delirious older person ensure that instructions and explanations are clear, slow-paced, short, simple, and repeated. The older person should be addressed face-to-face [C].²
- Avoid abstract language/ideas and do not insist that the older person appreciate the information that is being given.²
- Do not engage in discussions that the older person cannot appreciate [C].²
- Discuss topics that are familiar and/or of interest, such as hobbies and occupation, with the older person [D].²
- Routinely provide orienting information in the context of care. For example, frequently use the older person’s name and convey identifying information (e.g., “I’m your physiotherapist”) [D].²
- When providing care, routinely explain what you are about to do. This is to reduce the likelihood of misinterpretation [D].²
- Keep your hands in sight whenever possible and avoid gestures or rapid movements that might be misinterpreted as aggressive. Try to avoid touching the older person in an attempt to redirect him/her [D].²
- Encourage independence in activities of daily living³
- Manage pain and discomfort³
- Use interpreters/communication aids as necessary³
- Provide information about delirium to family and caregivers³

Cognitive Impairment Standardized Assessment

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

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

- The Mini-Cog™ is a simple screening tool that can be used to detect cognitive impairment quickly during both routine visits and hospitalizations. The Clock Drawing Test (CDT) component of the Mini-Cog™ allows clinicians to quickly assess numerous cognitive domains including cognitive function, memory, language comprehension, visual-motor skills, and executive function and provides a visible record of both normal and impaired performance that can be tracked over time⁴.
- Administration:
 1. Instruct the patient to listen carefully to and remember 3 unrelated words and then to repeat the words. The same 3 words may be repeated to the patient up to 3 tries to register all 3 words.
 2. Instruct the patient to draw the face of a clock, either on a blank sheet of paper or on a sheet with the clock circle already drawn on the page. After the patient puts the numbers on the clock face, ask him or her to draw the hands of the clock to read a specific time. The time 11:10 has demonstrated increased sensitivity.
 3. Ask the patient to repeat the 3 previously stated words.
- Scoring (out of 5)
 - Give 1 point for each recalled word after the CDT distractor. Recall is scored 0-3.
 - The CDT distractor is scored 2 if normal and 0 if abnormal. (Note: The CDT is considered normal if all number are present in the correct sequence and position, and the hands readably display the requester time. Length of hands is not considered in the score.)
- Interpretation

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<p><u>SFH Toolkit: Cognitive Assessment</u></p> <p><u>Hartford Institute: The Mini-Cog™</u></p>	<ul style="list-style-type: none"> ▪ 0-2: Positive <u>screen</u> for cognitive impairment ▪ 3-5: Negative <u>screen</u> for cognitive impairment <ul style="list-style-type: none"> • Montreal Cognitive Assessment (MoCA)⁵ <ul style="list-style-type: none"> • A cognitive <u>screening</u> tool for detection of MCI • 30-point scale • Many more domains than MMSE (good for AD and non AD) – comprehensive • Minor adjustments for education (add 1 point if grade 12 or less) • MCI = MoCA score of 26 or less • Using a cut-off score ,26 provides sensitivity of 80% and specificity of 91% to distinguish MCI • Mini Mental State Examination⁵ <ul style="list-style-type: none"> • 30-point scale • Focus on memory/orientation (16/30 points) • Good for AD, poor for non-Alzheimer’s dementias • Poor at upper end at discrimination between normal (especially highly educated) and MCI • Poor with those < grade 5 education (cut off = 20 for 80y/o, 19 for 85 y/o) • If MMSE is 26 or more and functional problems related to cognition, preferable to complete assessment with MoCA (due to enhanced sensitivity for detecting MCI.)
<p><u>Cognitive Impairment</u></p> <p><u>Standardized Intervention</u></p> <p><u>RNAO - Caregiving Strategies for Older Adults with Delirium, Dementia, and Depression</u></p>	<ul style="list-style-type: none"> • Clinicians should have knowledge of the most common presenting symptoms of : Alzheimer’s Disease, Vascular Dementia, Frontotemporal Lobe Dementia, Lewy Body Dementia, and be aware that there are mixed dementias (IV).⁶ • Clinicians should contribute to comprehensive standardized assessments to rule out or support the identification and monitoring of dementia based on their ongoing observations and expressed concerns from the client, family, and interdisciplinary team (IIa).⁶ • Clinicians should create partnerships with family members or significant others in the care of clients. This is true for clients who live in either the community or in healthcare facilities (III).⁶ • Clinicians should recognized their clients retained abilities, understand the impact of the environment, and relate effectively when tailoring and implementing their caregiving strategies (III).⁶ • Clinicians caring for clients with dementia should be knowledgeable about pain assessment and management in this population to promote physical and emotional well-being (IV).⁶ • Clinicians caring for clients with dementia should be knowledgeable about non-pharmacological interventions for managing behaviour to promote physical and psychological well-being (III).⁶ <ul style="list-style-type: none"> ○ Non-pharmacological interventions should focus on the stimulus initiating the behavioural symptoms when considering treatment. Techniques employed should be client-sensitive and this individualized approach should maintain the “person” as the centre of care. Occupational activities, environmental modifications, validation therapy, reminiscence and sensory stimulation are interventions that can be considered. • Clinicians caring for clients with dementia should be knowledgeable about pharmacological interventions and should advocate for medications that have fewer side effects (Ia).⁶

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- Clinicians should avoid physical and chemical restraints as first line care strategies for older adults with delirium, dementia, and depression (III).⁶

Polypharmacy

Standardized Assessment

[AGS - 2012 Beers Criteria](#)

[IPET - Guidelines](#)

[RGP GiiC Toolkit: Polypharmacy](#)

- The “AGS 2012 Beers Criteria” is available as a guide for identifying medications for which the risks of use in older adults outweigh the benefits. The criteria are not applicable in all circumstances (e.g., patient’s receiving palliative and hospice care)⁷.
- Canadian guidelines have been developed and adapted into a quickly administered screening tool called “Improved Prescribing in the Elderly Tool” (IPET)⁸.
- Physical signs that should arouse suspicion of an adverse drug reaction include:⁹
 - Fatigue , constipation, diarrhea, incontinence, weight loss, weakness, tremors, falls, drowsiness, dizziness, confusion, depression, agitation, anxiety, decreased sexual behaviour
- A high level of suspicion for an adverse drug effect should be maintained if the problem develops shortly after a medication is started or increased.⁹
- In addition to being aware of the side effect profile of the drug in question, the onset of these signs should be considered in the context of the patient’s medical comorbidities, risk factors for illness, and previous response to this or other interacting medications.⁹
- Changes in health status, such as the ongoing evolution of an existing chronic condition, can affect a patient’s sensitivity to a drug they may have tolerated previously for a long time.⁹
- The following tools/resources are available through the GiiC toolkit to support the identification/prevention of ADE in the elderly:⁹
 - Common drug classes and adverse reactions
 - Common drug-drug interactions
 - Drugs and over-the-counter or herbal remedy interactions
 - Drugs and food/beverages interactions

Polypharmacy

Standardized Intervention

[RNAO: Prevention of Falls and Fall Injuries in the Older Adult](#)

[RGP GiiC Toolkit: Polypharmacy Medication Review](#)

[Osteoporosis Canada: Clinical Practice Guidelines](#)

- Patients should adhere to a single medication prescriber if possible. If not, clear communication is necessary to ensure fidelity of the patient’s drug treatment program as a whole.⁹
- Patients should be encouraged to use a single pharmacy and a relationship should be developed with their pharmacist, who can assist with providing accurate medication records, assist in patient education, and help identify risky potential drug interactions.⁹
- A thorough medication review is recommended every 6-12 months and after events which alter a patient’s medication regimen (e.g., hospitalization)¹⁰
- Ask the patient about any adverse effects experienced when taking any of their medications.¹⁰
- Screen for adherence; ask the patient whether they are taking all their medications how often they miss a dose. Consider a pill count or a review of prescription refills.¹⁰
- Factors to consider when reviewing medications:¹⁰
 - Is the medication still indicated?
 - Is this medication the safest and most effective of the alternatives available?
 - Is the dose correct (taking into account renal function and body weight?)
 - Are there duplications with other drugs (e.g., in the same class?) Are simplifications possible?
 - Are there drugs prescribed for an adverse reaction? Can they be withdrawn?
 - Are there drug-drug interactions or drug-illness interactions that are of concern?
 - Are the dosing schedule, administration instructions, and cost feasible for this patient?

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Pharmacotherapy for fracture prevention¹⁵

- Pharmacotherapy should be offered to patients at high risk (>20% probability for major osteoporotic fracture over 10 years).
- Fragility fracture of the hip or vertebra, or more than one fragility fracture event, constitutes a high risk for future fracture and such individuals should be offered pharmacologic therapy.
- For those at moderate risk (10% - 20% probability for major osteoporotic fracture over 10 years), lateral radiographs or vertebral fracture assessment (VFA) of the thoracolumbar spine is recommended for further risk stratification and to aid in clinical decision-making regarding pharmacologic interventions.
- For those at moderate fracture risk, patient preference and clinical risk factors that are not already incorporated in the risk assessment system should be used to guide pharmacologic interventions.
- For those at moderate fracture risk, patient preference and clinical risk factors that are not already incorporated in the risk assessment system should be used to guide pharmacologic management decisions.
- Clinicians should avoid prescribing more than one anti-resorptive agent concurrently for fracture reduction.
- Individuals at high risk for fracture should continue osteoporosis therapy without a drug holiday.
- Potential benefits and risks of the prescribed agent should be discussed with each patient prior to initiating therapy to support informed decision-making.

Falls/Mobility

Standardized Assessment

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

Integrated Provincial Falls Prevention Framework & Toolkit

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

SFH: Screening and Detection of Functional Decline

- Risk Screening is an effective method for identifying fall-prone individuals. The tool used must be appropriate for the setting and for the specific client population. Therefore, it is essential to assess the patient population in order to select a tool most appropriate for the setting. Recommended tools include:¹¹
 - STRATIFY Risk Assessment Tool
 - Morse Fall Scale
 - Hendrich II Fall Risk Model
- For additional consideration when selecting a clinical tool appropriate for the patient population/setting, a list of clinical tools to assess falls risk is available from the Senior's Friendly Hospital Toolkit (including, but not limited to):¹²
 - Timed Up and Go
 - Tinetti Balance Scale
 - Gait Speed and Gait Abnormality
 - Functional Reach
 - Berg Balance Scale
- Screening and assessment is the first step in determining the most appropriate individualized intervention.¹³
- Seniors in the low risk category should be offered a simple assessment that may even be a self-assessment.¹³
- A more comprehensive assessment should be completed for seniors at the high risk level, and are best conducted by a multi-disciplinary health care team including a physician, physiotherapist (PT), or occupational therapist (OT), registered nurse (RN)/registered practical nurse (RPN), pharmacist and other health care professional as deemed necessary.¹³
- Comprehensive risk assessments would include all or some of the following: assessment of the home for any environmental hazards; thorough assessment of current medications; a full medical assessment, assessment of gait and balance; assessment of equipment such as walkers and wheelchairs; and assessment of underlying addictions or recreational use of non-prescription drugs and/or alcohol.¹³
- All older individuals should be asked whether they have fallen (in the past year).¹⁴

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Osteoporosis Canada: Clinical Practice Guidelines

- An older person who reports a fall should be asked about the frequency and circumstances of the fall(s).¹⁴
 - Older individuals should be asked if they experience difficulties with walking or balance.¹⁴
 - Older persons who present for medical attention because of a fall, report recurrent falls in the past year, or report difficulties in walking or balance (with or without activity curtailment) should have a multifactorial fall risk assessment).¹⁴
 - Older persons presenting with a single fall should be evaluated for gait and balance.¹⁴
 - Older persons who have fallen should have an assessment of gait and balance using one of the available evaluations.¹⁴
 - Older persons who cannot perform, have difficulty, demonstrate unsteadiness, or perform poorly on a standardized gait and balance test should be given a multifactorial fall risk assessment.¹⁴
 - The multifactorial fall risk assessment should be performed by a clinician (or clinicians) with appropriate skills and training.¹⁴
 - The multifactorial fall risk assessment should include the following:¹⁴
 - Focused History
 - History of falls: Detailed description of the circumstances of the fall(s), frequency, symptoms at time of fall, injuries, other consequences
 - Medication review: All prescribed and over-the-counter medications with dosages
 - History of relevant risk factors: Acute or chronic medical problems (e.g., osteoporosis, urinary incontinence, cardiovascular disease).
 - Physical Examinations
 - Detailed assessment of gait, balance, mobility levels and lower extremity joint function.
 - Neurological function: Cognitive evaluation, lower extremity peripheral nerves, proprioception, reflexes, tests of cortical, extrapyramidal and cerebellar function.
 - Muscle strength (lower extremities)
 - Cardiovascular status: Heart rate and rhythm, postural pulse, blood pressure, and, if appropriate, heart rate and blood pressure responses to carotid sinus stimulation.
 - Assessment of visual acuity
 - Examination of the feet and footwear
 - Functional Assessment
 - Assessment of activities of daily living (ADL) skills including of adaptive equipment and mobility aids, as appropriate
 - Assessment of the individual's perceived functional ability and fear related to falling (Assessment of current activity levels with attention to the extent to which concerns about falling are protective [i.e., appropriate given abilities] or contributing to deconditioning and/or compromised quality of life [i.e., individual is curtailing involvement in activities he or she is safely able to perform due to fear of falling]).
 - Environmental Assessment
 - Environmental assessment including home safety.
- Fracture Risk Assessment/Osteoporosis – Recommendations¹⁵
- Individuals 50 years and older who have experienced a fragility fracture should be assessed for osteoporosis and considered for treatment.
 - Recommended elements in the history and physical examination of fracture risk/osteoporosis:
 - Identify risk factors for low BMD, future fractures and falls
 - Inquire about falls in the previous 12 months and inquire about gait and balance
 - Accurate height and weight measurement
 - Get-Up-and-Go-Test

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	<ul style="list-style-type: none"> ○ In selected patients based on clinical assessment: additional biochemical testing to rule out secondary causes of osteoporosis. ○ If clinical evidence is suggestive of a vertebral fracture: lateral thoracic and lumbar spine radiographs. ● Initiation of pharmacologic treatment for osteoporosis should be based on an assessment of ten-year absolute fracture risk using a validated fracture prediction tool that incorporates BMD and clinical risk factors. <ul style="list-style-type: none"> ○ The Canadian WHO Fracture Risk Assessment Tool (FRAX) and the Canadian Association of Radiologist and Osteoporosis Canada (CAROC) risk assessment systems can be used in Canada at the present time, since they have been validated in a Canadian population. <ul style="list-style-type: none"> ▪ For purposes of BMD reporting, CAROC is the preferred national risk assessment system at the present time ▪ For BMD in these systems, only the femoral neck T-score should be used. ○ All individuals with a T-score of the spine or hip ≤ -2.5 should be considered as having at least moderate risk of osteoporotic fractures.
<p>Falls/Mobility Standardized Intervention</p> <p>RNAO: Prevention of Falls and Fall Injuries in the Older Adult</p> <p>SFH: Preventing Functional Decline</p> <p>AGS/BGS Clinical Practice Guidelines: Prevention of Falls in Older Adults</p> <p>Osteoporosis Canada: Clinical Practice Guidelines</p>	<ul style="list-style-type: none"> ● The multifactorial fall risk assessment should be followed by direct interventions tailored to the identified risk factors, coupled with an appropriate exercise program. [A]¹⁴ ● A strategy to reduce the risk of falls should include multifactorial assessment of known fall risk factors and management of the risk factors identified. [A]¹⁴ ● The components most commonly included in efficacious interventions were:¹⁴ <ul style="list-style-type: none"> ○ Adaptation or modification of home environment [A] ○ Withdrawal or minimization of psychoactive medications [B] ○ Withdrawal or minimization of other medications [C] ○ Management of postural hypotension [C] ○ Management of foot problems and footwear [C] ○ Exercise, particularly balance, strength, and gait training [A] ● All older adults, who are at risk of falling, should be offered an exercise program incorporating balance, gait, and strength training. Flexibility and endurance training should also be offered, but not as sole components of the program. [A]¹⁴ ● Multifactorial/multicomponent intervention should include an education component complementing and addressing issues specific to the intervention being provided, tailored to individual cognitive function and language. [C]¹⁴ ● The health professional or team conducting the fall risk assessment should directly implement the interventions or should assure that the interventions are carried out by other qualified healthcare professionals. [A]¹⁴ ● Psychoactive medications (including sedative hypnotics, anxiolytics, antidepressants) and antipsychotics (including new antidepressants or antipsychotics) should be minimized or withdrawn, with appropriate tapering if indicated. [B]¹⁴ ● A reduction in the total number of medications or dose of individual medications should be pursued. All medications should be reviewed, and minimized or withdrawn. [B]¹⁴ ● Exercise should be included as a component of multifactorial interventions for fall prevention in community-residing older persons. [A]¹⁴ ● An exercise program that targets strength gait and balance, such as Tai Chi or physical therapy, is recommended as an effective intervention to reduce falls. [A]¹⁴ ● Exercise may be performed in groups or as individual (home) exercises, as both are effective in preventing falls. [B]¹⁴ ● Exercise programs should take into account the physical capabilities and health profile of the older person, (i.e., be tailored) and be prescribed by qualified health professionals or fitness instructors. [I]¹⁴

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- The exercise program should include regular review, progression and adjustment of the exercise prescription as appropriate [I] ¹⁴
 - In older women in whom cataract surgery is indicated, surgery should be expedited as it reduces the risk of falling. ¹⁴
 - Assessment and treatment of postural hypotension should be included as components of multifactorial interventions to prevent falls in older persons. [B] ¹⁴
 - Dual chamber cardiac pacing should be considered for older persons with cardioinhibitory carotid sinus hypersensitivity who experience unexplained recurrent falls. [B] ¹⁴
 - Identification of foot problems and appropriate treatment should be included in multifactorial fall risk assessments and interventions for older persons living in the community. [C] ¹⁴
 - Older people should be advised that walking with shoes of low heel height high surface contact area may reduce the risk of falls. [C] ¹⁴
 - Home environment assessment and intervention carried out by a health care professional should be included in a multifactorial assessment and intervention for older persons who have fallen or who have risk factors for falling. [A] ¹⁴
 - The intervention should include mitigation of identified hazards in the home, and evaluation and interventions to promote the safe performance of daily activities. [A] ¹⁴
 - Education and information programs should be considered part of a multifactorial intervention (should not be provided as a single intervention) for older persons living in the community. [C] ¹⁴
 - Provide clients with information on the benefits of vitamin D supplementation in relation to reducing fall risk. In addition, information on dietary, life style and treatment choice for the prevention of osteoporosis is relevant in relation to reducing the risk of fracture. (IV) ¹¹
- Strategies for Fracture Prevention ¹⁵
- Vitamin D and Calcium
 - Adequate vitamin D status, in addition to calcium from diet and supplements, is essential for the prevention and treatment of osteoporosis.
 - Other non-pharmacologic therapies
 - For those with or at risk for osteoporosis: appropriate resistance training and/or weight-bearing aerobic exercise.
 - For those with vertebral fractures; directed core stability exercises.
 - For those at risk of falls: exercises that focus on balance (e.g., Tai chi, balance and/or gait training)

Depression Standardized Assessment

RNAO - Screening for
Dementia, Delirium
and Depression

CCSMH – The
Assessment and
Treatment of
Depression

- A high index of suspicion should be maintained for delirium, dementia and depression in the older adult (B). ¹
- Patients should be screened for changes in cognition, function, behaviour and/or mood, based on the ongoing observations of the patients and/or concerns expressed by the patient, family and/or interdisciplinary team, including other specialty physicians (C). ¹
- There are differences in the clinical features of delirium, dementia and depression and a structured assessment method should be used to facilitate this process (C). ¹
- Health care providers should be familiar with the physical, psychological, and social risk factors for depressive disorders in older adults and include a screening for depression for their clients/patients who present with some of these risk factors [D]. ¹⁶
- Appropriate depression screening tools for elderly persons without significant cognitive impairment in general medical or geriatric settings include the self-rating Geriatric Depression Scale (GDS), the SELFCARE self-rating scale, and the Brief Assessment Schedule Depression Cards (BASDEC) for hospitalized patients [B]. ¹⁶
- For patients with moderate to severe cognitive impairment, an observer-rated instrument, such as the Cornell Scale for Depression in Dementia is

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<p><u>RGP GiiC Toolkit: Late Life Depression</u></p>	<p>recommended instead of the GDS [B].¹⁶</p> <ul style="list-style-type: none"> • Clinicians should always assess the risk of suicide in patients with suspected depression by directly asking patients (as well as their caregivers and family) about suicidal ideation, intent and plan. Those at high risk for suicide should be referred to a specialized mental health professional and/or service as a priority for further assessment, treatment, and suicide prevention strategies [D].¹⁶ • Patients who have had strokes should be monitored closely for the possible development of depression as a common complication of stroke, even in those who do not report depressed mood.¹⁶ • The following tools are used in community care to assess for dementia in older adults¹⁷: <ul style="list-style-type: none"> ○ Geriatric Depression Scale (GDS) ○ CAGE (Cut;Annoyed;Guilty;Eye opener) ○ Cornell Scale for Depression in Dementia (CSDD) – for patients with moderate to severe dementia • Following a positive screen for depression, a complete bio-psycho-social assessment should be conducted, including;¹⁶ <ul style="list-style-type: none"> ○ A review of diagnostic criteria outlined in DSM IV-TR or ICD 10 diagnostic manuals ○ An estimate of severity, including the presence of psychotic or catatonic symptoms. ○ Risk assessment for suicide ○ Personal and family history of mood disorder ○ Review of medication use and substance use ○ Review of current stresses and life situation ○ Level of functioning and/or disability ○ Family situation, social integration/support and personal strengths ○ Mental status examination, including assessment of cognitive functions ○ Physical examination and laboratory investigations looking for evidence of medical problems that could contribute to or mimic depressive symptoms. (D) • Depression should not be diagnosed in the context of an acute delirium, but reassessment for depressive symptoms should be done after delirium has cleared significantly.²
<p>Depression Standardized Intervention</p> <p><u>RGP GiiC Toolkit: Late Life Depression</u></p> <p><u>CCSMH – The Assessment and Treatment of Depression</u></p>	<ul style="list-style-type: none"> • Health care professionals and organizations should implement a model of care that promotes continuity of care as older adults appear to respond better to consistent care providers.¹⁷ • For severe depression (GDS score 11 or greater), refer for psychiatric evaluation.¹⁷ • For less severe depression (GDS score 6 or greater), refer to mental health services for psychotherapy/counseling. Consider resources such as psychiatric liaison nurses, geropsychiatric advanced practice nurses, social workers, psychologists, and other community- and institution-specific mental health services.¹⁷ • If suicidal thoughts, psychosis, or comorbid substance abuse are present, a referral for a comprehensive psychiatric evaluation should always be made.¹⁷ • Psychosocial treatment should be part of the treatment of depression co-existing with dementia. This treatment should be flexible to account for the decline in functioning as well as multifaceted to provide help with the diversity of problems facing the patient and caregiver. It should be delivered by clinicians sensitized to the vulnerabilities and frailties of older adults with dementia. This treatment should include helping caregivers deal with the disease in a skill-oriented manner [A].¹⁶

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<p>RNAO - Caregiving Strategies for Older Adults with Delirium, Dementia, and Depression</p>	<ul style="list-style-type: none"> • Health care professionals and organizations should implement a model of care that addresses the physical/functional as well as the psychosocial needs of older depressed adults. Given the complex care needs of older adults, these are most likely to require interdisciplinary involvement in care [B].¹⁶ • Both cardiovascular (aerobic) activities resistance training (nonaerobic) can help reduce depressive symptoms, but the results appear to be more consistent for cardiovascular exercise.¹⁷ • Older patients have a response rate with antidepressant therapy similar to younger adults. Clinicians should approach elderly depressed individuals with therapeutic optimism (A).¹⁶ • Antidepressants should be used when indicated, even in patients with multiple co-morbidities and serious illnesses, as they have similar efficacy rates compared with use in the well elderly. Adverse events in patients with multiple co-morbidities can be minimized by careful selection of drugs that are not likely to worsen or complicate patient-specific medical problems (B).¹⁶ • Co-morbid psychiatric disorders, particularly generalized anxiety disorders and substance abuse, should be identified and appropriately treated as they will adversely influence the outcome of depression. Clinicians should avoid the use of benzodiazepines for treatment of depressive symptoms with elderly patients (B).¹⁶ • Clinicians should choose an antidepressant with the lowest risk of drug-drug interactions when patients are taking multiple medications (C).¹⁶
<p><u>Incontinence Standardized Assessment</u></p> <p>Canadian Continence Foundation: Incontinence – A Canadian Perspective</p> <p>RNAO: Promoting Continence Using Prompted Voiding</p> <p>RGP GiiC Toolkit: Incontinence</p>	<ul style="list-style-type: none"> • To detect and manage UI:¹⁹ <ul style="list-style-type: none"> ○ Ask Individuals “Do you have any problems with involuntary loss of urine” ○ Know the risk factors for developing UI and the associated conditions ○ Reassure individuals with UI that there are effective treatments to resolve, improve, or control the condition. • Comprehensive evaluation of women considering surgery to treat urinary incontinence is essential to rule out causes of incontinence that may not be amenable to surgical treatment. Simplifying the evaluation minimizes the discomfort and embarrassment potentially experienced by women. Thorough evaluation of each woman is essential to determine the underlying etiology of the urinary incontinence and to guide management.¹⁹ • Elderly patients presenting symptoms of urinary incontinence should have the following completed:¹⁹ <ul style="list-style-type: none"> ○ General History Assessment (with caregiver if applicable) <ul style="list-style-type: none"> ▪ Goals and expectations of treatment ▪ Medications ▪ Previous medical history ▪ Chronic conditions ▪ Focusing on environmental/functional factors, polypharmacy, drug interactions, comorbidity, constipation/fecal impaction. ○ Focused Incontinence History <ul style="list-style-type: none"> ▪ Environmental/functional assessment ▪ Quantification of urine loss ▪ Qualification of urine loss ▪ Fluid intake (amount/type) ▪ Feeling of prolapse (women) ▪ Bowel function/fecal incontinence ▪ Sexual function

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- Impact on quality of life
- Physical Exam
 - General assessment (abdominal exam)
 - Specific assessment
 - Vaginal inspection (W)
 - Pelvic exam (W)
 - Assessment of pelvic floor strength (W)
 - Genital exam (M)
 - Rectal Exam (M)
 - Physical examinations should focus on functional/neurological/musculoskeletal/gait
 - Pelvic inspection/exam (atrophic vaginitis, discharge)
- Investigate Urinalysis & Culture/Sensitivity
 - Voiding diary
 - Post-void residual
 - Assess for depression & cognitive function
- Clinicians should consider using the following tools when assessing and evaluating urinary incontinence in the frail elderly population, including:¹⁸
 - Incontinence Patient Information Form (Patient completed form that outlines patient’s goals for treatment, and history of incontinence).
 - Patient Incontinence Impact Questionnaire (Patient completed form that identifies how incontinence affects the patients activities, relationships, and feelings).
 - Bladder Diary (to assist patient and health care provider in assessing needs and tacking progress).
 - Algorithm to guide the initial management of UI in women, men and frail elderly.
 - Urinary Incontinence Evaluation (comprehensive evaluation form for physician use)
 - Contributors to Transient Incontinence (List of contributing factors to transient incontinence by condition and the mechanism to identify condition (delirium, drug side effects, retention of feces, restricted mobility, urinary infection, inflammation, polyuria, and psychogenic).

Incontinence **Standardized Intervention**

[RNAO: Promoting
Continence Using
Prompted Voiding](#)

[Canadian Continence
Foundation:
Incontinence – A
Canadian Perspective](#)

- The Canadian Continence Foundation recommends conservative (behavioural –non-drug, non-surgical) treatment as the first response to managing UI.¹⁹
- Conservative management includes behaviour training, education, scheduled voiding, positive reinforcement and pelvic muscle exercises with various techniques to help control urinary incontinence.¹⁹
 - Bladder retraining combines education on healthy bladder behaviours with positive reinforcement and a scheduled voiding routine.
 - Healthy bladder behaviours include:
 - Limiting or avoiding caffeine/alcohol.
 - Drinking non-caffeinated fluids – up to six to eight cups (1.5 – 2.0 litres) per day
 - Trying to avoid getting up more than twice a night
 - Not “pushing” when urinating
 - Maintaining a healthy weight
 - Not smoking. The chronic cough associated with smoking is a risk factor for incontinence
 - Eating more fibre to avoid constipation, which strains and weakens pelvic floor

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<p><u>RGP GiIC Toolkit:</u> <u>Incontinence</u></p>	<ul style="list-style-type: none"> ○ Pelvic Floor Retraining Exercise Example: <ul style="list-style-type: none"> ▪ Sit on a firm chair so you can feel your buttocks. Keep feet flat on the floor. ▪ Pretend you need to stop gas from passing and squeeze those rectal muscles – by pulling in. ▪ Try not to tighten your abdominal and buttock muscles. ▪ Hold for three counts, relax for three counts. Remember to breathe. ▪ You should feel a tweaking at the front of the pubic bone when you are holding ▪ Repeat this squeezing exercise ten times. This equals one set. Do one set five times per day. ● If UI persists following conservative management interventions, consider referral to other team members for medical, pharmacological, mechanical, or surgical interventions.¹⁹ ● The Geriatrics Interprofessional Interorganizational Collaboration developed the following handouts to educate patients on treating and self-managing urinary incontinence:¹⁸ <ul style="list-style-type: none"> ○ Urinary Incontinence and its Treatment (handout educating clients on the different types of UI, and an overview of possible treatments). ○ Daily Habits and Urinary Incontinence (Information on the effects of daily habits on the bladder, including: Fluid Intake, Toileting Habits, Bladder Irritants, Caffeine, Smoking, Chronic Cough, Chronic Constipation, and Obesity). ○ Bladder Training for Urinary Incontinence (information on the goals and benefits of a bladder training schedule, and a bladder urge control procedure). ○ Pelvic Muscle Exercises – Kegels (information on the types of exercises to be completed, frequency to be completed, and the benefits). ○ Urge Incontinence: Diagnosis and Treatment (information on the symptoms, causes, and diagnosis, and treatments of Urge Incontinence) ○ Drug Treatment for Urge Incontinence (information on the goals and types of drugs used to treat urge incontinence, as well as tips for self-care). ○ Urodynamics (information on the purpose of urodynamic testing, as well as the procedure details and risks). ○ Biofeedback for Urinary Incontinence (information on the goals and technique for using biofeedback to treat urinary incontinence). ○ Simple Cystometrics (information on the cystometrics procedure and what to expect) ○ Surgical Treatment for Urinary Incontinence in Women (information on how the need for surgery is diagnosed, and instructions for patient preparation) ○ Radical Prostatectomy (Information on the function of the prostate gland, and instructions for patient preparation and expectations).
<p><u>Nutrition</u> <u>Status</u> <u>Standardized</u> <u>Assessment</u></p> <p><u>Nestle Nutrition</u> <u>Institute: MNA-SF</u></p> <p><u>CMTF: Nutrition Risk</u> <u>Screening Tool</u></p>	<ul style="list-style-type: none"> ● Clinicians can screen for malnutrition using the MNA-SF annually for patients within the community or whenever a change in clinical condition occurs.²⁰ <ul style="list-style-type: none"> ○ Clinicians will need to gather the following patient information in order to complete the MNA-SF form: <ul style="list-style-type: none"> ▪ Name, Gender, Age ▪ Weight (kg): to obtain an accurate weight, remove shoes and heavy outer clothing. Use a calibrated and reliable set of scale. Pounds must be converted to kilograms. ▪ Height (cm): measure height without shoes using a standiometer (height gauge). If the patient is bedridden, measure height by demispan, half-arm span, or knee height. Inches must be converted to centimeters. ● Clinicians should be familiar with administering the MNA-SF and determining patient’s screening score.²⁰ ● The MNA-SF tool allows standardized, reproducible, and reliable determination of nutritional status.²⁰ ● Follow up: Refer results of assessments and re-assessments to doctor/dietitian and record in medical record.²⁰

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	<ul style="list-style-type: none"> • Clinicians can also use the Canadian Malnutrition Task Force (CMTF) Nutrition Risk Screening Tool to identify patients who are either malnourished or at risk for malnutrition.²¹ • Patients should be flagged for assessment if they are eating 50% or less of their meals.²¹
<p style="text-align: center;"><u>Nutrition Status Standardized Intervention</u></p> <p>Nestle Nutrition Institute: MNA-SF User Guide</p> <p>CMTF: Nutrition Risk Screening Tool</p>	<ul style="list-style-type: none"> • The following strategies can be used to support adequate food intake:²¹ <ul style="list-style-type: none"> ○ Clarify why the patient is not eating and find solutions to overcome these problems ○ Determine if the patient has pain, is depressed, anxious or in need of medication and social support • Based on the results of the 14 point MNA-SF Screening tool, the following interventions are recommended:²⁰ • Normal Nutritional Status (12-14 Points): Rescreen: <ul style="list-style-type: none"> ○ After acute event or illness ○ Every 3 months in institutionalized patients • At Risk of Malnutrition (8-11 Points) AND No Weight Loss: Monitor: <ul style="list-style-type: none"> ○ Close weight monitoring ○ Rescreen every 3 months • At Risk of Malnutrition (8-11 points) AND Weight Loss: Treat: <ul style="list-style-type: none"> ○ Nutrition Intervention <ul style="list-style-type: none"> ▪ Diet Enhancement ▪ Oral nutritional supplementation (400kcal/d) ○ Close weight monitoring ○ Further in-depth nutrition assessment • Malnourished (0-7 Points): Treat: <ul style="list-style-type: none"> ○ Nutrition Intervention <ul style="list-style-type: none"> ▪ Oral nutritional supplementation (400-600 kcal/d) ▪ Diet enhancement ○ Close weight monitoring ○ Further in-depth nutrition assessment
<p style="text-align: center;"><u>Pain Management Standardized Assessment</u></p> <p>RNAO: Assessment and Management of Pain in the Elderly</p>	<ul style="list-style-type: none"> • On initial presentation or admission of any older person to any healthcare service, a healthcare professional should assess the patient for evidence of persistent pain (IIb)²². • Any persistent pain that has an impact on physical function, psychosocial function, or other aspects of quality of life should be recognized as a significant problem (IIa).²² • All patients with persistent pain that may affect physical function, psychosocial function, or other aspects of quality of life should undergo a comprehensive pain assessment, with the goal of identifying all potentially remediable factors. Assessment should focus on recording a sequence of events that led to the present pain complaint, and on establishing a diagnosis, a plan of care, and likely prognosis (IIIb):²³ <ul style="list-style-type: none"> ○ History <ul style="list-style-type: none"> ▪ Initial evaluation of present pain complaint should include pain characteristics, such as intensity, character, frequency (or pattern, or both) location, duration, and precipitating and relieving factors. ▪ Initial evaluation should include a description of pain (from the individual’s perspective) in relation to impairments in physical and social function (e.g., ADLs, IADLS, sleep appetite, energy, exercise, mood, cognitive function, interpersonal and intimacy issues, social and leisure

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AGS: Management of Persistent Pain in Older Persons

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

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	<p>they should also be observed for verbal and nonverbal pain-related behaviours and changes in normal functioning.</p> <ul style="list-style-type: none"> ▪ Patients can also be asked about their worst pain experience over the past week. ▪ With mild to moderate cognitive impairment, assessment questions should be framed in the present tense because patients are likely to have impaired recall. <ul style="list-style-type: none"> • The following tools have established validity to assess the intensity of pain: ²³ <ul style="list-style-type: none"> ○ Visual Analogue Scale (VAS) ○ Numeric Rating Scale (NRS) ○ Verbal Scale ○ Faces Scale ○ Behavioural Scale • Additionally, the “Checklist of Non-Verbal Pain Indicators” can be used to assess pain in non-communicative adults. ²³ • For the older adult with moderate to severe dementia or who is nonverbal, the practitioner should attempt to assess pain via direct observation or history from caregivers. ²³ <ul style="list-style-type: none"> ○ Patients should be observed for evidence of pain-related behaviours during movement (e.g., walking, morning care, transfers). ○ Unusual behaviour in a patient with severe dementia should trigger assessment for pain as a potential cause. • The risks and benefits of various assessment and treatment options should be discussed with patients and family. With consideration for patient and family preferences in the design of any assessment or treatment strategy. ²³ • Patients with persistent pain should be reassessed regularly for improvement, deterioration, or complications. ²³ <ul style="list-style-type: none"> ○ The use of a pain log or diary with regular entries for pain intensity, medication use, mood, response to treatment, and associated activities should be considered. ○ The same quantitative pain assessment scales should be used to initial and follow-up assessments. ○ Reassessment should include evaluation of analgesic and nonpharmacologic interventions, side effects, and compliance issues. ○ Reassessment should consider patient preferences in assessment and treatment revisions.
<p style="text-align: center;"><u>Pain Management</u> Standardized Intervention</p> <p><u>RNAO: Assessment and Management of Pain in the Elderly</u></p> <p><u>AGS: Management of Persistent Pain in Older Persons</u></p>	<ul style="list-style-type: none"> • Nonpharmacologic Intervention Recommendations ²³: <ul style="list-style-type: none"> ○ A physical activity program should be considered for all older patients. <ul style="list-style-type: none"> ▪ Physical activities should be individualized to meet the needs and preferences of each patient. ▪ For some older adults with severe physical impairments, a trial of supervised rehabilitation therapy is appropriate, with goals to improve joint range of motion and to reverse specific muscle weakness or other physical impairments associated with persistent pain. ▪ For health individuals who are currently sedentary or deconditioned, referral should be made to a group exercise program (e.g., YMCA classes) for a moderate program of physical activity. ▪ For those who are incapable of strenuous training, initial training should be conducted over 8 to 12 weeks and should be supervised by a professional with knowledge of the special needs of older adults. ○ Moderate levels of physical activity (leisure-time or utilitarian) should be maintained. ○ Any physical activity program for older patients should include exercises that improve flexibility, strength, and endurance. ○ Patient education programs are integral components of the management of persistent pain syndromes. <ul style="list-style-type: none"> ▪ Content should include information about self-help techniques (e.g., relaxation, distraction), the known causes of their pain, the goals of treatment, treatment options, expectations of pain management, and analgesic drug use.

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	<ul style="list-style-type: none"> ▪ Educational content and the patient’s self-help efforts should be reinforced during every patient encounter. ▪ Focused patient education should be provided prior to special treatments or procedures. ▪ Patients should be encouraged to educate themselves by using available local resources (e.g., local hospitals, support groups, and disease-specific organizations). ○ Formal cognitive-behavioural therapies are helpful for many older adults with persistent pain. <ul style="list-style-type: none"> ▪ Cognitive-behavioural therapy conducted by a professional should be applied as a structured program that includes education, a rationale for therapy, training in cognitive and behavioural pain coping skills, methods to generalize coping skills, and relapse prevention. ▪ Plans for coping with pain exacerbations should be a part of this therapy to prevent self-defeating behaviour during such episodes. ▪ Spouses or other partners can be involved in cognitive-behavioural therapy. ○ Other modalities (e.g., heat, cold, massage, liniments, chiropractic, acupuncture, and transcutaneous electrical nerve stimulation) often offer temporary relief and can be used as adjunctive therapies. ● Clinicians/pharmacists should consider the following factors when selecting opioids: ²³ <ul style="list-style-type: none"> ○ Pain pattern ○ Presence of renal, gastrointestinal or cognitive dysfunction ○ Lifestyle ○ Existing medications ○ Specific type of pain ● Ambulatory care facilities, hospitals, nursing homes, assisted-living facilities, and home-care agencies should routinely conduct quality assurance and quality improvement (QA and QI) activities in pain management. ²² <ul style="list-style-type: none"> ○ QA and QI activities should include appropriate structure and process indicators of pain assessment and treatment activities. ○ Benchmarks for quality improvement should be established internally and should include quantifiable pain outcomes, which may include, but should not be limited to, patient satisfaction.
<p>Pressure Ulcers</p> <p>Standardized Assessment</p> <p><u>RNAO: Risk Assessment and Prevention of Pressure Ulcers</u></p>	<ul style="list-style-type: none"> ● A head-to-toe skin assessment should be carried out with all clients at admission, and daily thereafter for those identified at risk for skin breakdown. Particular attention should be paid to vulnerable areas, especially over bony prominences (IV) ²⁴. ● The client’s risk for pressure ulcer development is determined by the combination of clinical judgment and the use of a reliable risk assessment tool. The use of a tool that has been tested for validity and reliability, such as the <i>Braden Scale for Predicting Pressure Sore Risk</i>, is recommended. Interventions should be based on identified intrinsic and extrinsic risk factors and those identified by a risk assessment tool, such as Braden’s categories of sensory perception, mobility, activity, moisture, nutrition, friction and shear (IV). ²⁴ ● Clients who are restricted to bed and/or chair, or those experiencing surgical intervention, should be assessed for pressure, friction and shear in all positions and during lifting, turning and repositioning (IV). ²⁴ ● All pressure ulcers are identified and staged using the National Pressure Ulcer Advisory Panel (NPUAP) criteria (IV). ²⁴ ● If pressure ulcers are identified, utilization of the RNAO best practice guideline <i>Assessment and Management of Stage I to IV Pressure Ulcers</i> is recommended (IV). ²⁴ ● All data should be documented at the time of assessment and reassessment (IV). ²⁴

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Pressure Ulcers

Standardized Intervention

RNAO: Risk Assessment and Prevention of Pressure Ulcers

- Protect skin from excessive moistures and incontinence: (IV)²⁴
 - Assess and manage excessive moisture related to body fluids (e.g., urine, feces, perspiration, wound exudate, saliva, etc).
 - Gently cleanse skin at time of soiling. Avoid friction during care with the use of a spray perineal cleanser or soft wipe.
 - Minimize skin exposure to excess moisture. When moisture cannot be controlled, use absorbent pads, dressings or briefs that wick moisture away from the skin. Replace pads and linens when damp.
 - Use topical agents that provide protective barriers to moisture.
 - If unresolved skin irritation exists in a moist area, consult with the physician for evaluation and topical treatment.
 - Establish a bowel and bladder program.
- A nutritional assessment with appropriate interventions should be implemented on entry to any new health care environment and when the client's condition changes. If a nutritional deficit is suspected:²⁴
 - Consult with a registered dietitian (IV)
 - Investigate factors that compromise an apparently well-nourished individual's dietary intake (especially protein or calories) and offer him or her support with eating (IV)
 - Plan and implement a nutritional support and/or supplementation program for nutritionally compromised individuals (IV)
 - If dietary intake remains inadequate, consider alternative nutritional interventions (IV)
 - Nutritional supplementation for critically ill older clients should be considered (Ib)
- For individuals restricted to chair: (IV)²⁴
 - Utilize an interdisciplinary approach to plan care.
 - Have the client shift weight every 15 minutes, if able.
 - Reposition at least every hour if unable to shift weight.
 - Use pressure-reducing devices for seating surfaces.
 - Do not use donut type devices or products that localize pressure to other areas.
 - Consider postural alignment, distribution of weight, balance, stability, support of feet and pressure reduction when positioning individuals in chairs or wheelchairs.
 - Refer to Occupational Therapy/Physiotherapy (OT/PT) for seating assessment and adaptations for special needs.
- Institute a rehabilitation program, if consistent with the overall goals of care and the potential exists for improving the individual's mobility and activity status. Consult the care team regarding a rehabilitation program. (IV)²⁴

Frailty

Standardized Assessment

RGP GiiC Toolkit: Frailty

- Individually developed care plans, which address modifiable biological and psychosocial factors while integrating individual disease factors that impede the health goals of patients should be completed for elderly patients who are frail or at risk of frailty. The approach of developing patient-centered care plans is grounded in the philosophy that frailty may be preventable or delayed and that patients can improve their function and quality of life through rehabilitation²⁵.
- Clinicians should consider each visit with a patient as an opportunity to engage the patient in individualized care planning, and to identify any follow-up needs.²⁶
- Once a patient is identified as being at risk of frailty, or frail, the Canadian Study on Health and Aging (CSHA) Clinical Frailty Scale should be used to categorize the needs of the patient. The scaled is based largely on an individual's function for ADLs and IADLs).²⁷
- The CSHA Clinical Frailty Scale includes 7 levels of Frailty:²⁷
 1. **Very Fit** – robust, active, energetic, well-motivated and fit; these people commonly exercise regularly and are in the most fit group for their

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CMAJ: A global measure of fitness and frailty in elderly people

BC Guidelines: Frailty in Older Adults

- age
2. **Well** – without active disease, but less fit than people in category
 3. **Well, with treated comorbid disease** – disease symptoms are well controlled compared with those in category.
 4. **Apparently vulnerable** – although not frankly dependent, these people commonly complain of being “slowed up” or have disease symptoms.
 5. **Mildly Frail** – with limited dependence on others for instrumental activities of daily living.
 6. **Moderately Frail** – help is needed with both instrumental and non-instrumental activities of daily living.
 7. **Severely Frail** – Completely dependent on others for the activities of daily living, or terminally ill.
- Patients with identified frailty (CHSA Scale, Level 4 and greater [e.g., 4-7]) require additional assessment in order to support the development or refinement of a Care Plan.²⁷
 - Ideally, the physician and other health professionals will work collaboratively to complete assessments, in order to create one comprehensive Care Plan that is used by the patient and all health professionals involved in the patient’s care (example, if community case managers have completed their comprehensive initial assessment using the Minimal Data Set – Home Care problem areas identified by that assessment could help to further inform the physician assessment and Care Plan.²⁸
 - In addition to the collection of information on underlying chronic conditions, some practical areas to pursue in assessing older patients are as follows:²⁸
 - Weight change
 - Reduced physical activity levels and endurance
 - Impaired balance and mobility
 - Increase number and frequency of falls or first fall if not with cause
 - Declining functional status
 - Difficulties due to polypharmacy and psychoactive medications
 - Impaired vision/hearing
 - Increased alcohol consumption
 - Driving competency
 - Difficulty maintaining continence
 - Change in sleep patterns
 - Frequent/increased pain
 - Responsive behaviour
 - Social isolation
 - Transition in living circumstances
 - Change in family/caregiver support
 - Advanced caregiver stress
 - Irrational fears/concerns
 - Altered mental health status, including presentation of delirium, depression, and/or dementia.

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Frailty Standardized Intervention

RGP GiIC Toolkit:
Frailty

CMAJ: A global
measure of fitness
and frailty in elderly
people

BC Guidelines: Frailty
in Older Adults

CSHA: Clinical Frailty
Scale

- Effective interventions to prevent and/or reverse frailty include:²⁹
 - Medication review
 - Exercise (aerobic and strength training)
 - Nutritional advice
 - Social support
 - Optimize environmental support
 - Tobacco cessation
 - Screen for geriatric syndromes
 - Safe driving counselling when appropriate
 - Vaccinations
- The first step in establishing a functional care plan for seniors who are frail or at risk of frailty is to develop a shared understanding of desired care with the patient and family/caregiver (i.e Collaborative Goal Setting), which will inform the development and implementation of a functional care plan. Collaborative goal setting can be achieved by combining the physician's problem list with the patient and family/caregiver concerns and preferences for care:²⁵
 - What are the patient's or family/caregiver's concerns
 - What are the physician's concerns?
 - What are the patient's priorities for their care when considering both the physician's concerns and their own concerns?
 - What does the patient or family/caregiver hope to achieve from medical treatment?
 - Incorporate and document discussion of advance care planning.
- The Care Plan is generated from the collaborative goals established in step 1. First note the most bothersome complaint, as voiced by the patient, and proceed with consideration for:²⁸
 - Patient rehabilitation potential.
 - Appropriate prevention activities for the patient
 - Self-management support for the patient and family/caregiver(s).
- Within the complex frail population of older adults, it is recommended that the Care Plan also include:²⁸
 - A Medication Review
 - Advance Care Planning
 - Goals associated with significant health and safety risks (eg. falls, living alone)
 - Plans to manage significant co-morbidities in relation to patient goals
 - Expected outcomes
 - Names and contact information of other providers involved in the care of the patient (i.e for case conferencing as required).
 - Plans for follow-up
- A scheduled care plan review should include input from the patient, family/caregiver(s), and other involved health care providers. The review should be undertaken as scheduled, at the request of the patient, or when there is a transition (planned or unplanned), such as:²⁸
 - Significant change in patient's health status
 - Transition across care locations (e.g. into and out of the emergency room and/or hospital, into assisted living or a care facility, etc.); and
 - Change in patient's caregiver support

In-Home Rehabilitative Care	
<p>Activities of Daily Living Standardized Assessment</p> <p><u>SFH: Screening and Detection of Functional Decline</u></p> <p><u>CSHA: Clinical Frailty Scale</u></p>	<ul style="list-style-type: none"> ○ Help facilitate shared understanding within a multi-disciplinary approach, the Care Plan could be given to the patient (and/or caregiver) to carry as they become involved with other care providers and as they transition across care settings. ● Functional Status includes the patient’s performance in mobility, basic ADLs (e.g., bathing, dressing, toileting), and instrumental ADLs (e.g., medication administration, shopping, finances).¹² ● There are many tools used to measure mobility and ADL performance. No single instrument appears to adequately measure all dimensions of mobility and ADL performance over the wide range of functional abilities of older patients. The choice of tool may depend on its applicability to the patient population and its feasibility of use within the institution. Recommended tools include:¹² <ul style="list-style-type: none"> ○ Barthel Index ○ Lawton Brody IADL ○ Older Americans Resources Services (OARS) ADL & IADL scales ○ Katz Index ● For additional consideration when selecting a clinical tool appropriate for the patient population/setting, RNAO also recommends the FIM®.¹ ● Activities required to live in the community (IADL):²⁷ <ul style="list-style-type: none"> ○ Meal preparation ○ Ordinary housework ○ Managing finances ○ Managing medications ○ Phone use ○ Shopping ○ Transportation ● Non-instrumental activities of daily living; related to personal care (ADL):²⁷ <ul style="list-style-type: none"> ○ Mobility in bed ○ Transfers ○ Locomotion inside and outside the home ○ Dressing upper and lower body ○ Eating ○ Toilet use ○ Personal hygiene ○ Bathing
<p>Activities of Daily Living Standardized Intervention</p> <p><u>SFH: Preventing Functional Decline</u></p>	<p><i>Best practice recommendations identifying interventions for various geriatrics syndromes (Delirium, Cognitive Impairments, Pain, Depression, Falls/Mobility, Frailty, etc.) address the patient’s functional performance of ADLs/IADLS. Please refer to the intervention sections of the Compendium (based on the appropriate geriatric syndrome) for additional standardized interventions.</i></p> <ul style="list-style-type: none"> ● Optimize nutrition and hydration¹² ● Initiate functional goal setting and discharge planning with patient and family.¹² ● Maximize patients’ own participation in ADLs.¹² ● Encourage and assist with regular daily mobility where appropriate; early referral to physiotherapy and occupational therapy for complex patients.¹²

In-Home Rehabilitative Care

- Optimize sleep using non-pharmacologic protocols.¹²
- Assess and manage depression.¹²
- Assess and treat pain appropriately.¹²
- Provide education to the inter-professional team on function-focused interventions.¹²
- Maximize social engagement – encourage patient and family/caregiver visits and participation with care, volunteer visits.¹²

Appendix A – Glossary of Acronyms

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

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