Rehabilitative Care Alliance

Updated July 2026

Pathway to rehabilitative care for older adults living with frailty in the community presenting to Primary Care post-fall

Primary Care

Older Adult 65+ years

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

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

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

Preliminary Evaluation

2 or more falls in the last year? N

Difficulties with walking and/or balance? N

Community Intervention (See Below)

Y

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

Y

High Risk for Functional Decline

Immediately following a fall:

- ❑ Assess severity of injury
- ❑ Rule out acute medical conditions
- ❑ Injuries may be occult or present atypically

Initial visit:
Address immediate sequelae of fall

Secondary visit: Multifactorial Evaluation

- ❑ Determine risk factors for secondary fall
- ❑ Assess level of frailty: e.g., Clinical Frailty Scale (CFS)*
- ❑ Conduct fracture risk assessment
- ❑ If time & capacity, complete functional assessment: e.g., Barthel Index ǂ
- ❑ If available in your setting, use interdisciplinary team approach or telemedicine

Multiple fall risk factors, including:

- ❑ Alcohol Intake
- ❑ Cognition
- ❑ Feet/Foot Wear
- ❑ Hearing
- ❑ Home Hazards
- ❑ Inactivity/sedentary
- ❑ Incontinence
- ❑ Medical History
- ❑ Mobility/Balance
- ❑ Mood
- ❑ Nutrition & Hydration
- ❑ Orthostatic Hypotension
- ❑ Polypharmacy
- ❑ Vestibular Conditions
- ❑ Vision

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

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

- Mild frailty, eg. CFS 4-5
- Multiple fall risk factors
- Reasonably mobile

- Mild to moderate frailty, eg. CFS 5-6
- Multiple fall risk factors and/or medically/ psychosocially complex

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

Assessment and Intervention

Community Intervention

Outpatient Community Clinic/ In Home Care

Specialized Geriatric Services

Explore Direct Access to Inpatient Rehabilitation

Please note that some patients may require some or all of these services throughout their post-fall journey. The intent of this pathway is to depict the services initially required based on their preliminary evaluation.

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

Enter prevention programs such as fall prevention and exercise classes here

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

Enter Rehab Services here

OHaH Rehab Services for older adults who are homebound

Outpatient Community Clinics/Services

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

Enter Rehab Services here

Specialized Geriatric Rehab Services

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

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

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

*Clinical Frailty Scale

ǂBarthel Index

MONITORING & FOLLOW-UP IN PRIMARY CARE: Monitor progress against the care plan. Patient progress and reassessment results are communicated across care partners.