North Simcoe Muskoka
Specialized Geriatric Services

Early Identification Toolkit

A resource prepared to support the upstream identification of older adults at risk and implementation of Home First Initiatives

Version 2 June 2026

North Simcoe Muskoka
Specialized Geriatric Services

Purpose of this Toolkit

While numerous high-quality resources exist that address best practices for the screening and identification of falls, delirium, dementia, care partner distress, and frailty, there is currently no single, consolidated source that compiles this information comprehensively. This document aims to fill that gap by synthesizing insights from over 200 provincial, national, and international guidelines, academic articles, self-screening tools, and patient education materials.

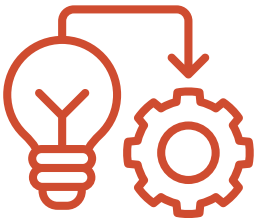
This toolkit is toolkit is also shaped by the generous feedback and perspectives of those with lived experience. By bringing these diverse resources together, this document serves as a practical, evidence-informed reference to support implementation and continuous quality improvement of consistent, effective early identification processes and practices across the region. Thank you for consulting this document.

Are you using this document?

We'd like to hear from you. **CLICK HERE**

Find a dead link, typo or other correction, please provide feedback.

Implementation Support from NSMSGS is available



This document is not intended to be read in its entirety. Readers are encouraged to use the table of contents to navigate directly to sections relevant to their clinical practice or organization.

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Appendices

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Acknowledgements

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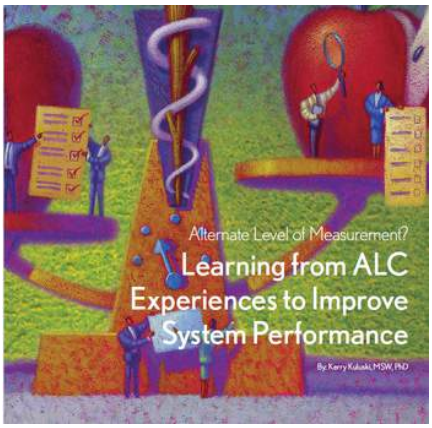
North Simcoe Muskoka Specialized Geriatric Services Program

Introduction and Background

Early identification of individuals at risk for entering Alternate Level of Care (ALC) status is essential to prevent hospitalization and extended stays, improve health outcomes for patients and care partners, and preserve healthcare system capacity in Ontario.

When individuals have not received the right care at the right time, there have been missed opportunities to intervene including discussion of their goals and wishes. Through proactive early identification, we can drive system improvements that improve both healthy and social service capacity and individual outcomes.

Collaboration between sectors with integrated patient-centred early identification is an essential component of addressing delayed discharge. [1]



Informative Reading: **Alternate Level of Measurement? Learning from ALC Experiences to Improve System Performance** (Kuluski et al, 2018)

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Early identification of risk

By proactively recognizing factors in community, primary care, and emergency departments, teams can engage in linking patients to the right care at the right time, comprehensive assessment and planning appropriate transitions, and initiate home- or community-based interventions. Investing in ALC reduction not only reduces delayed transitions and extended stays and associated costs, but also has the potential to address the patient safety concerns associated with ALC; hospital-acquired harm such as infections, delirium, and loss of independence for older adults, and ensuring acute care beds remain available to those who need them most.[2] For these reasons, integrating structured early identification and assessment into care pathways is a vital aspect to enhance outcomes for older adults and system efficiency in North Simcoe Muskoka.

The goal of early identification is much more than making a diagnosis, it's about finding ways to engage with older adults and care partners using integrated approach to foster better understanding, better support and better care.

By 2030 it is **estimated that** approximately 43400 individuals will be living with frailty in Simcoe and Muskoka, and 58200 by 2040. As emerging evidence suggests, early identification of Dementia, Delirium, Falls and Care Partner are the primary circumstances associated with ALC. Early identification can lead to earlier assessment and more timely intervention.[3] While frailty is not necessarily a primary indicator, understanding frailty helps to identify those most at risk and connect individuals to timely support.

Definitions and Acronyms

Definitions, defined acronyms and notes on language

Alternate Level of Care (ALC): Defined by the Canadian Institute for Health Information as a description used in hospitals to refer to patients who occupy a bed but do not require the intensity of services provided in that care setting. These individuals are at risk of experiencing adverse events during admission – functional decline, delirium, falls, social isolation.[4] Insight into ALC rates nationally and by province can be found **here**. Local data is also available.

ALC infographic snapshot (Canada's Drug Agency)

Patient(s): In this guideline, the term "patient" is used to describe older adults receiving health care or support services. The use of this term is intended for consistency with clinical and policy language and does not detract from a person-centred approach to care. The guideline recognizes that older adults are individuals with unique life experiences, preferences, and goals, and it fully supports approaches that promote dignity, autonomy, and partnership in decision-making.

Care Partner: Care partners are essential and are key in many settings to the provision of care. Care partners are defined by the patient and are often family members or friends. They serve as a liaison between older adults, clinicians and care teams, and are essential for day-to-day decision making, care delivery, transition care planning and system navigation.[5] Integration of care partners in health care decision making has been shown to improve health outcomes.[6]

A note on Case finding vs Screening vs Assessment

- Case finding focuses on the population considered higher risk than average and enables targeting resources toward subgroups of people rather than whole populations.[7]
- Screening is a brief process to identify those at risk of experiencing the underlying condition. Screening can involve short questions plus observations and clinical judgement.[8]
- Assessment informs clinical practice and identifies potential causes and individualized treatment.

Effective screening requires a thorough understanding of the specific population being served, including the unique factors and risk indicators that should prompt the need for screening. Tailoring the approach to these factors ensures that screening is both relevant and impactful.

However, a caution: identification of problems without mechanisms for follow up and intervention does not necessarily result in improved outcomes. Screening must be embedded in systems for follow up to be effective.[9]

Early identification can take on multiple forms.

- Self-Screening and creating supportive environments for self-disclosure of concerns related to cognition, frailty, care partner stress and falls
- Case finding higher risk individuals within population served
- Using clinical judgement to identify risk factors
- Programs or management pathways
- Use of formal screening tools/tests – Detection of an underrecognized condition
- Triaging those screened at risk to the appropriate assessment
- Leveraging data and electronic health records to identify at risk individuals

Formal screening

- Conducted by a trained clinician or designate using standardized, validated tools. It follows specific procedures and produces results that can be used for diagnosis, referral, or further assessment

Examples MoCA test, Clinical Frailty Scale, Confusion Assessment Method

Self-report

- Involves individuals providing information about their symptoms, behaviors, or health history
- Usually through interviews or questionnaires, but the information is not collected through a structured or validated screening tool. It reflects the person's own perceptions and may be influenced by recall or understanding

Examples: Functional Activities Questionnaire (FAQ), Pictorial Fit to Frail, Zarit Burden Inventory

Self-Screening

- Occurs when individuals independently complete a standardized screening tool, often online or on paper, without a clinician administering it
- While it may help identify risk and encourage help-seeking, results are preliminary and not a substitute for a formal clinical evaluation

Examples: Groningen Frailty Index, **Delirium Detection Questionnaire** (can also be used as self-report)

Intersection of Social Determinants of Health

Frailty is a health equity issue! Approximately 1 in 2 First Nations People over the age of 65 are living with frailty in Canada – this is almost double the national average. (Canadian Frailty Network)[10]

Poverty is a major factor: Nearly 1 in 3 patients with an ALC designation (31%) come from neighbourhoods with residents with lower socioeconomic status, compared to just 13% from neighbourhoods with residents with higher socioeconomic status." (CDA-AMC Alternate Level of Care Dashboard)[11]

Strategies to Support Culturally Safer Screening

Cultural safety has been shown to be a risk-reducing factor for frailty.
The Centre for Effective Practice offers the following tips to support Culturally Safe and Patient-Centered Screening:

- "Build therapeutic relationships and adopt shared decision-making that considers patient values and preferences.
- Acknowledge the decision to screen does not need to be made on the spot or during one encounter.
- Encourage the involvement of supportive individuals from the patient's network.
- Consider frailty in balancing the benefits and harms of screening. Clinical Frailty Scale is a tool to screen for frailty and to broadly stratify degrees of fitness and frailty.
- Ensure that preventive screening is delivered in an equitable manner, recognizing that disadvantaged or marginalized groups are often under-screened, placing them at a higher risk for developing or exacerbating chronic conditions." [13] [14]

At SGS, we have heard through codesign sessions that due to the increased stigma surrounding dementia the topic of screening should be broached carefully. There may be instances where the patient or care partner prefers a one-on-one discussion. Clinicians should involve patients and care partners in decisions about who should be present at each appointment.

Although this resource is somewhat specific to the topic of diagnosis and not screening, there are helpful strategies discussed to engage in patient-centred discussions: **Dementia Guidelines, Communicating Diagnosis of Dementia, Alzheimer's Society of Canada**

Care Partner Inclusion in Early Identification

Through the co-design sessions that informed this project we heard from multiple care partners that one of the best mechanisms to inform early identification is the care partner's perspective. Regardless of the early identification approach selected, it is essential to have mechanisms to include the perspective of the care partner(s). Their insights provide valuable context, highlight subtle changes that may not be captured through clinical assessment alone, and ensure that support strategies are both realistic and responsive to real-world caregiving challenges.

It starts with a conversation.

It has been identified through ALC research that strengthening relationships between providers, older adults and care partners is a critical opportunity to identify and negotiate shared purpose and goals to reduce delayed discharge and hospitalization.[12] While there are many mechanisms to engage older adults and care partners in early identification it all begins with a meaningful conversation.

Building trust and creating safer space(s) for patients and care partners to share their concerns, values, and priorities sets the stage for optimal outcomes. By understanding what matters most to the individual, clinicians can more effectively recognize early signs of change and tailor support in a way that respects the person's goals and lived experience.

Advanced Care Planning and Goals of Care

Incorporating advance care planning and early goals-of-care discussions into the assessment and management of falls, delirium, dementia, and care partner stress supports proactive, person-centred decision-making and earlier identification of clinical and psychosocial risk factors. By clarifying individual values, functional priorities, and acceptable levels of risk, care teams can anticipate transitions, address cognitive and functional decline, and implement appropriate supports before crises occur. This approach enables timely intervention for delirium prevention, fall risk mitigation, and dementia-related needs, while also recognizing and addressing care partner stress. Proactive alignment of care with patient and family goals facilitates coordinated discharge planning, reduces avoidable hospitalizations, and decreases the likelihood of Alternate Level of Care (ALC) designations by ensuring that appropriate community supports and care pathways are in place earlier in the care trajectory.

Advanced Care Planning Resources

For Clinicians

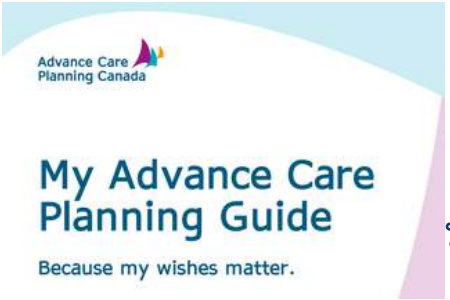
NSMHPCN
North Simcoe Muskoka Hospice Palliative Care Network

Advanced Care Planning for Providers Resource Page

JUST ASK: A Conversation Guide for Goals of Care Discussions

Time To Talk - Choosing Wisely Canada
Includes the Serious Illness Conversation Guide

For Older Adults and Care Partners



Ideas for using this toolkit

No more scouring the internet to find resources!

- Use the curated statistics for writing communications and briefings
- Share a topic per team meeting to optimize opportunities for microlearning
- Consult the list of recommended patient and care partner education resources and offer the resources in your setting/online
- Consult when establishing new pathways or screening programs
- A collection of resources for developing pathways for social prescribing

Health Teaching

For each domain, this document include talking points and recommended resources for health teaching and patient and care partner education which can be identified with icons as seen below:

Talking Points

Patient and Care Partner Education Resources

As a general guide:

- Let individuals know that they have not been singled out for this screening and discussion
- Patients should be informed of the risks and benefits of early identification
- Consider involving care partners in screening when appropriate and explain rationale for screening using talking points identified in the specific domains (frailty, delirium, dementia, falls, care partner stress)

Link the discussions to what matters to the patient (e.g. independence, activities, goals, involvement) [15 16]

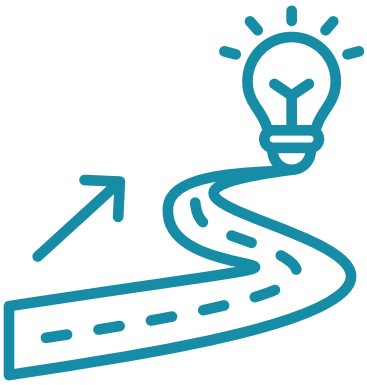
"How do you envision your health and/or living situation in the next few years?"
Linking screening discussions and health teaching to what matters most for the individual (activities, independence, values) assists in making proactive and informed decisions for future health planning.

Selecting an early identification strategy

Determining organizational needs involves evaluating capacity, priorities and previous screening initiatives. You will need to consider what you are trying to identify and how the screening will relate to early identification pathways. By comparing existing screening tools in the organization with the reference guide in the **Appendix G**, it is possible to evaluate which ALC risk factors are incorporated and where gaps may exist. For example, your organization may use the Identification of Seniors at Risk, however the domains covered in this screen do not include assessment of falls or delirium.

Once you have selected a focus area, the Seniors Care Network has recommended the following process for selecting a screening strategy:

1. Understand the population
2. Identify triggers for screening*
3. Select a screening tool*
4. Connect screening tool results to existing pathways of support

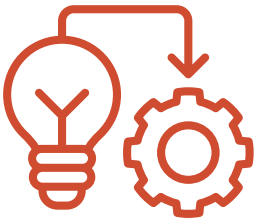


Understand the population

A review of administrative data sources such as the **PGLO Frailty Estimates** is recommended to understand the prevalence of frailty in your population and identify trends. Your organization may wish to review data or conduct a series of chart reviews prior to undertaking early identification. A sample, and customizable **Chart Review Form** is available.

*suggested triggers for Screening and Selecting a Tool are included in the subsequent focus areas

Implementation Support from NSMSGS is available



Conditions required for screening

There is extensive research on setting up effective screening programs for health conditions emerging from the initial work of Wilson and Junger. [17]
You may wish to consider the following criteria for effective screening as you establish your organization-specific processes:

1. There should be treatment(s) or intervention available
2. Individuals should be able to get follow-up assessment and care easily if they screen positive
3. There should be a suitable test or screening method. The test should be simple, safe, accurate, and acceptable to people
4. There should be a policy, pathway or guideline on who to treat
5. The cost of screening should be balanced against the benefits
6. Screening should be a continuous process, not a one-time effort

A successful screening strategy weighs multiple factors, including but not limited to:

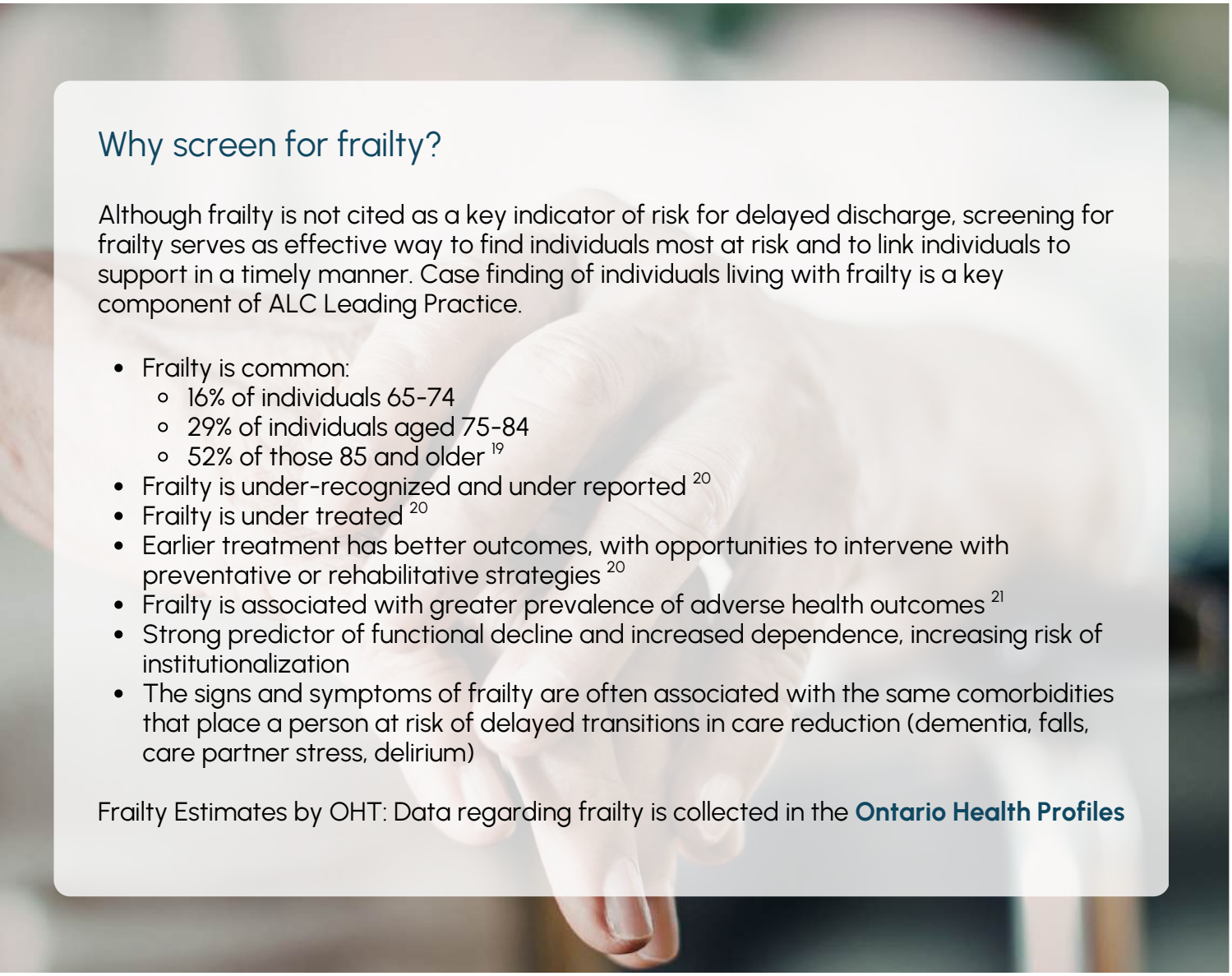
- The lived experience of patients and care partners
- The why - a clearly defined purpose
- Best available evidence
- Timing, frequency and documentation needs
- Time constraints and other realities in the clinical environment
- Mechanisms to link individuals to further assessment and support

Screening for Frailty

The **Ontario Collaborative for Aging Well**[18] recommends that concepts such as complexity and frailty, must include the physical, cognitive, mental, and social health of older adults and their care partners and the interaction and integration of these domains.

Understanding frailty in the context of other geriatric syndromes assists with risk stratification. Case Finding of older people living with frailty is a key component of linking to appropriate services in our region, and improving the health outcomes of older adults and is identified as a key component of ALC Leading Practice.

In Canada, frailty is defined by the Canadian Frailty Network (CFN) and the Ontario Collaborative for aging well as a state of increased vulnerability and functional decline across multiple body systems, leading to a reduced ability to cope with stressors, poor health outcomes like hospitalization, and a lower quality of life.[18]



Why screen for frailty?

Although frailty is not cited as a key indicator of risk for delayed discharge, screening for frailty serves as effective way to find individuals most at risk and to link individuals to support in a timely manner. Case finding of individuals living with frailty is a key component of ALC Leading Practice.

- Frailty is common:
  - 16% of individuals 65-74
  - 29% of individuals aged 75-84
  - 52% of those 85 and older [19]
- Frailty is under-recognized and under reported [20]
- Frailty is under treated [20]
- Earlier treatment has better outcomes, with opportunities to intervene with preventative or rehabilitative strategies [20]
- Frailty is associated with greater prevalence of adverse health outcomes [21]
- Strong predictor of functional decline and increased dependence, increasing risk of institutionalization
- The signs and symptoms of frailty are often associated with the same comorbidities that place a person at risk of delayed transitions in care reduction (dementia, falls, care partner stress, delirium)

Frailty Estimates by OHT: Data regarding frailty is collected in the **Ontario Health Profiles**

Warning Signs and Symptoms of Frailty [22]

The following may be used when considering what triggers screening and intervention for frailty or determining the target population.*indicates higher suspicion of frailty[22]

Mind
- delirium*
- cognitive impairment/dementia*
- depression
- irrational fears/concerns
- inappropriate behaviour
- irregular sleep patterns

Medication
- susceptibility to medication side effects*
- polypharmacy related issues
- increased alcohol consumption

Mobility
- declining functional status*
- immobility*
- recent fall(s)*, fear of falling
- impaired balance
- fatigue or loss of energy
- reduced physical activity/endurance

Multi Complexity
- unintentional weight loss*(esp. if ≥ 10lbs/4.5kg over past year)
- incontinence*
- loss of appetite
- loss of muscle/strength (sarcopenia)
- osteoporosis
- impaired vision/hearing
- chronic pain
- repeated ER visits/hospitalization

Social Matters
- social isolation
- transition in living circumstances
- change in family/caregiver support
- caregiver stress

Triggers for frailty screening

One or more of the following may trigger frailty screening
- Age 65 & older
- Presence of geriatric syndrome(s)
- Multi-morbidity
- Psycho-social concern

Implementation Tip

Given the high degree of multi-morbidity, to initially scale your project your team may wish to begin with a subset of your population such as those attending chronic disease clinics (i.e. COPD or CHF) in this population.

Frailty Screening Tools

Work with the Provincial Geriatrics Leadership Ontario and Seniors Care network has reviewed several frailty screening strategies and recommend 4 tools, with specific recommendations by sector included below.

The Clinical Frailty Scale, the Pictorial Fit-Frail Scale, and the Reported Edmonton Frail Scale are three tools that are comprehensive and cover all 4 domains of frailty. For a comparison of these tools see **Appendix C**.

Clinical Frailty Scale (CFS)

This is the most widely used in NSM SGS at this time. The CFS is validated, 9-point scale used to assess the overall fitness and vulnerability of older adults or patients with chronic illness. It ranges from 1 (Very Fit) to 9 (Terminally Ill), incorporating clinical judgment about a person's physical activity, comorbidities, cognition, and functional independence. The CFS helps guide clinical decision-making by predicting outcomes such as recovery potential, hospitalization risk, length of stay, and mortality.


Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing,

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** – Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

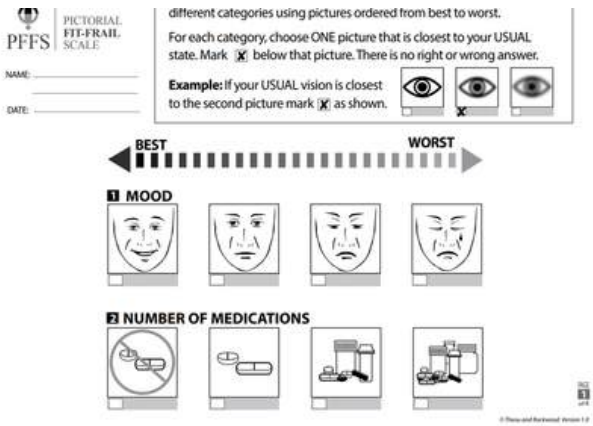
* 1. Canadian Study on Health & Aging. Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

DALHOUSIE UNIVERSITY

Top Tips to help you use the Clinical Frailty Scale

The Pictorial Fit-Frail Scale

A visual, easy-to-use assessment tool designed to measure frailty in older adults by using illustrated representations of function, mobility, cognition, and overall health status. It allows both clinicians and patients to identify the degree of frailty—from fit to severely frail—without requiring complex medical terminology, making it especially useful in diverse clinical settings and for individuals with communication or language barriers. A benefit is that it encourages patient involvement through self-report in their assessment of their own frailty status.


PFFS PICTORIAL FIT-FRAIL SCALE

NAME: _____

DATE: _____

different categories using pictures ordered from best to worst.

For each category, choose ONE picture that is closest to your USUAL state. Mark (X) below that picture. There is no right or wrong answer.

Example: If your USUAL vision is closest to the second picture mark (X) as shown.

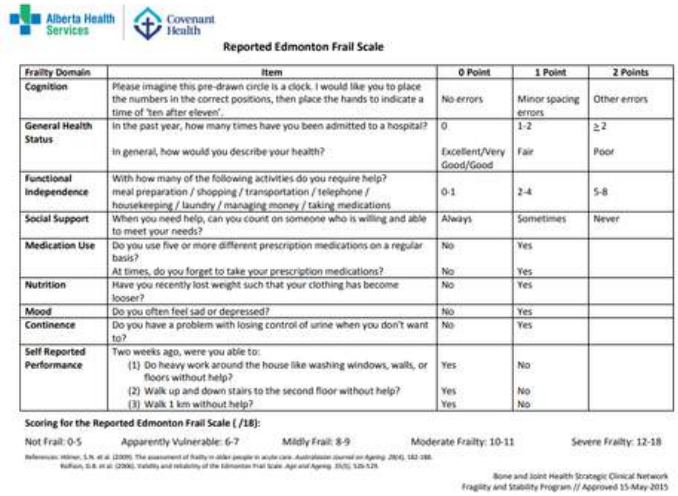
BEST WORST

1 MOOD

2 NUMBER OF MEDICATIONS

Edmonton Frailty Scale

Edmonton Frailty Scale is multidimensional tool used to assess frailty in older adults by evaluating 9 key domains such as cognition, general health status, functional independence, social support, medication use, nutrition, mood, continence, and balance/mobility. It consists of 11 items that generate a score reflecting the degree of frailty—from fit to severely frail. The EFS is quick to administer, requires minimal training, and provides a comprehensive overview of an individual's health and functional status, supporting clinical decision-making and care planning in various healthcare settings. A benefit of using the EFS is that it includes brief screening of other domains of concern for ALC risk (cognition, mobility, hospitalization).



Alberta Health Services | Covenant Health

Reported Edmonton Frail Scale

Frailty Domain	Item	0 Point	1 Point	2 Points
Cognition	Please imagine this pre-drawn circle is a clock. I would like you to place the numbers in the correct positions, then place the hands to indicate a time of 'ten after eleven'.	No errors	Minor spacing errors	Other errors
General Health Status	In the past year, how many times have you been admitted to a hospital?	0	1-2	≥ 2
	In general, how would you describe your health?	Excellent/Very Good/Good	Fair	Poor
Functional Independence	With how many of the following activities do you require help? meal preparation / shopping / transportation / telephone / housekeeping / laundry / managing money / taking medications	0-1	2-4	5-8
Social Support	When you need help, can you count on someone who is willing and able to meet your needs?	Always	Sometimes	Never
Medication Use	Do you use five or more different prescription medications on a regular basis?	No	Yes	
	At times, do you forget to take your prescription medications?	No	Yes	
Nutrition	Have you recently lost weight such that your clothing has become looser?	No	Yes	
Mood	Do you often feel sad or depressed?	No	Yes	
Continence	Do you have a problem with losing control of urine when you don't want to?	No	Yes	
Self Reported Performance	Two weeks ago, were you able to: (1) Do heavy work around the house like washing windows, walls, or floors without help?	Yes	No	
	(2) Walk up and down stairs to the second floor without help?	Yes	No	
	(3) Walk 1 km without help?	Yes	No	

Scoring for the Reported Edmonton Frail Scale (/18):

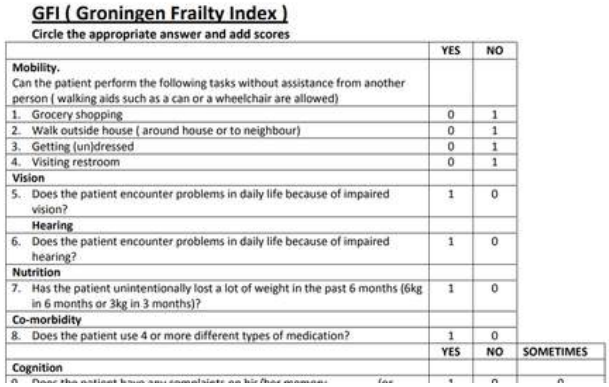
Not Frail: 0-5 Apparently Vulnerable: 6-7 Mildly Frail: 8-9 Moderate Frailty: 10-11 Severe Frailty: 12-18

References: Hilmer, S.N. et al. (2009). The assessment of frailty in older people in acute care. Australasian Journal on Ageing. 26(4), 182-188.
Rolfson, D.B. et al. (2006). Validity and reliability of the Edmonton Frail Scale. Age and Ageing. 35(5), 526-529.

Bone and Joint Health Strategic Clinical Network
Fragility and Stability Program // Approved 15-May-2015

Groningen Frailty Indicator

If considering a strategy whereby self-screening is desired, the Groningen Frailty Indicator is a 15-item questionnaire used to measure frailty by assessing four domains: physical, cognitive, psychological, and social. It is a self-administered tool, with a maximum score of 15 and a score of 4 or higher indicating moderate to severe frailty. This tool can be used to further discussion about frailty assessment and care planning and can be completed in advance of visits.



GFI (Groningen Frailty Index)

Circle the appropriate answer and add scores

	YES	NO
Mobility. Can the patient perform the following tasks without assistance from another person (walking aids such as a can or a wheelchair are allowed)		
1. Grocery shopping	0	1
2. Walk outside house (around house or to neighbour)	0	1
3. Getting (un)dressed	0	1
4. Visiting restroom	0	1
Vision		
5. Does the patient encounter problems in daily life because of impaired vision?	1	0
Hearing		
6. Does the patient encounter problems in daily life because of impaired hearing?	1	0
Nutrition		
7. Has the patient unintentionally lost a lot of weight in the past 6 months (6kg in 6 months or 3kg in 3 months)?	1	0
Co-morbidity		
8. Does the patient use 4 or more different types of medication?	1	0

	YES	NO	SOMETIMES
Cognition			

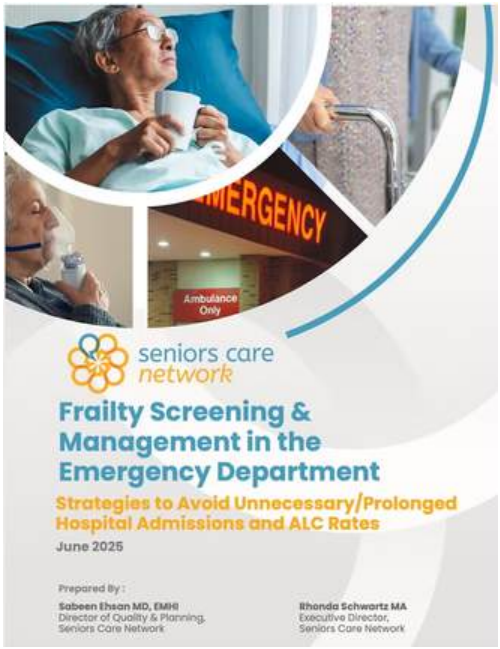
See **Appendix C** for more information on frailty screening tools

Proxy or Electronic Based Tools for Detecting Frailty

A Frailty Index (FI) is a way to measure how frail or vulnerable a person is by counting the number of health problems they have. It is a widely used tool in other jurisdictions such as the NHS. Frailty Indices can be designed to pull from existing data compiled in health records including but not limited to lab values, cognitive deficits, functional/mobility status, presence or absence of certain diseases, and symptoms such as dyspnea. Frailty indices are customizable. A properly constructed Frailty Index requires a minimum of 30 distinct variables. Frailty Indices are sensitive to change and accommodate for missing variables. There are guidelines for establishing a custom Frailty Index. [23]

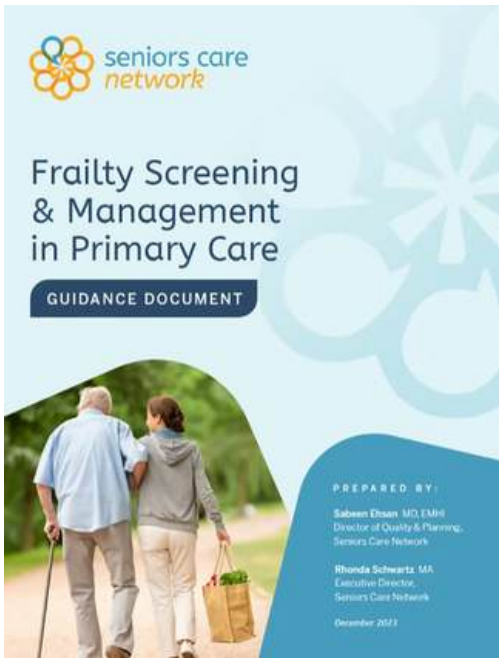
Sector Specific Frailty Screening

The following strategies include resources for understanding the population, determining the triggers for frailty screening, selecting tools and embedding identification within a pathway.



In Emergency Departments

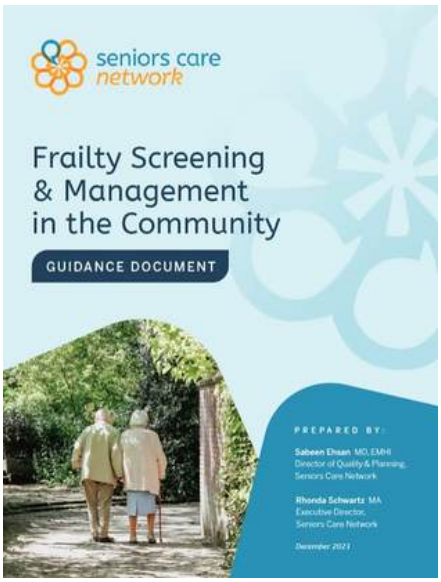
The Seniors Care Network has established **Strategies for Frailty Screening and Management in Emergency Departments**. This document references the CTAS: Canadian Triage and Acuity Scale frailty modifier, however more widely used across the NSM region are the Trauma risk screening tool (TRST) and or Identification of Seniors At Risk (ISAR). (See **Appendix C**) These tools remain useful in identifying those at risk of frailty who require further assessment.



In Primary Care

The Seniors Care Network has established **Strategies for Frailty Screening and Management in Primary Care**.

There are also resources specific to embedding **frailty screening in Chronic Disease Management**.



In Community Settings

The Seniors Care Network has established strategies for **Frailty Screening and Management in Community Settings.**

Implementation Support from NSMSGS is available

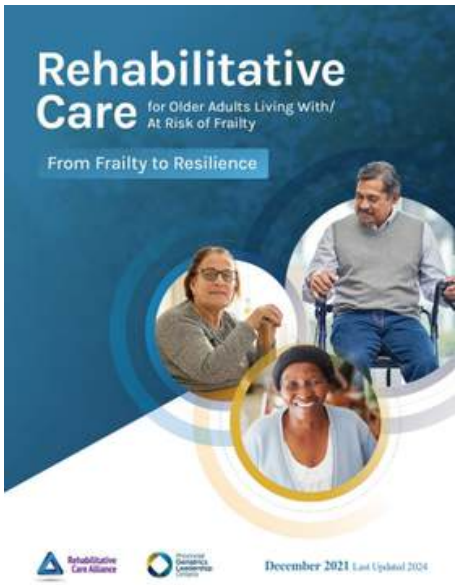
Health Teaching: A note on language

The language used to describe frailty can be a sensitive issue as some individuals may perceive it as stigmatizing or demoralizing. Not all older adults will resonate with the concepts of fit and frail and additional health teaching on the benefits of screening for frailty may be required. It has been shown that using the term frailty has the potential psychological impacts; including lower sense of self, lower expectations others have for them and expectations of themselves. Older adults have indicated that the term frailty is associated with health care professionals 'giving up on them'.[24, 25]

In other jurisdictions terms such as vitality and resilience are being used to help frame conversations around frailty. The Ontario Collaborative for Aging Well[25] suggests caution in the application of the term frailty and recommends that: person first language always be used (i.e. an older adult living with or experiencing complex health conditions); the dynamic nature of complexity or frailty be recognized; and that appropriate screening, assessment, diagnosis, treatments and interventions, and follow-up be offered to older individuals demonstrating changes in physical, cognitive, mental and social health.

Functional Decline and Rehabilitative Approaches

The Seniors Care Network has established strategies for **Frailty Screening and Management in Community Settings**.



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.

The Framework for Rehabilitative Care . Support from the Rehabiliative Care Alliance is available.

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 across Ontario for older adults living with/at risk of frailty
- Inform and improve rehabilitative care for older adults across all locations of care

Talking Points

Link clinical frailty screening to better health outcomes and reinforce that frailty is not an end or fixed state.

Frailty Management communication with older adults is a resource from the Seniors Care Network with tips for discussing screening, assessment and management of frailty with older adults and their care partners.

Link clinical frailty to what matters most for the older adult.

Patient and Care Partner Education Resources

What is Frailty? Link to Canadian Frailty Network

When appropriate, in the early stages of frailty, engage in health teaching using the **AVOID framework** (Canadian Frailty Network).

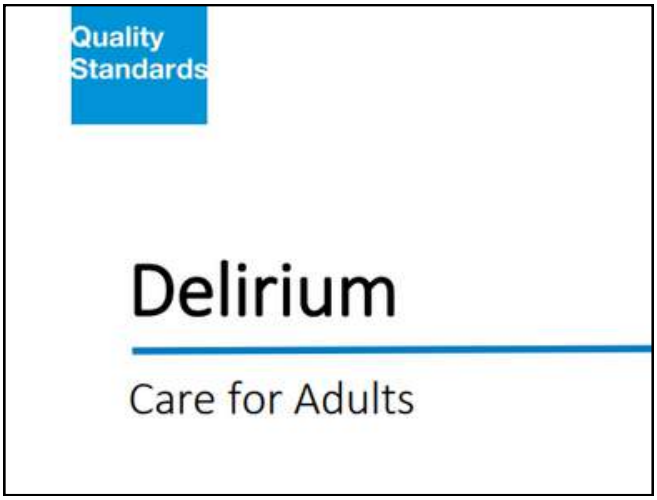
The **Senior Friendly 7 Toolkit** is a good well-rounded resource that covers many of the key factors involved in frailty.

Screening for Delirium

Delirium affects over 500 000 Canadians each year and remains the third most common hospital acquired harm in Ontario.

Delirium is burdensome, associated with 2x greater mortality, 12 days longer in hospital, approx. $20000 increased cost (unadjusted) in 1 year driven by increased hospital and community care needs. [26]

Significant work has been done across the region to ensure services meet the **Delirium Quality Standard,** continuing to advance early detection remains essential to improving patient outcomes.



Delirium is an acute disorder of attention, awareness, and altered mental status. It develops over a short period of time (usually hours to a few days) and tends to fluctuate in severity during the course of a day. (Delirium Quality Standard)

Delirium Quality Standards for Early Identification

Quality Statement 1: Identification of Risk Factors for Delirium

On initial contact with the health care system, people are assessed for risk factors for delirium, especially when they present to hospital or long-term care. Any risk factors for delirium are documented in their health record and at transitions in care, and are communicated to the person, their family and caregivers, and their health care team.

Quality Statement 3: Early Screening for Delirium

People presenting to hospital with any risk factors for delirium, or who have an acute change in behaviour or cognitive function during a hospital stay or in a long-term care home or in the community, are screened for delirium in a timely manner by a health care professional who is trained in screening for delirium using standardized, validated tools. The person and their family and caregivers are asked about any acute changes in the person's behaviour or cognitive function.

Quality Statement 4: Education for People with Delirium, Family and Caregivers

People who are at risk for delirium or who have delirium (as well as their family and caregivers) are offered education about delirium.

Identification of Risk Factors and Screening for Delirium

Quality Statement (QS)* 1: Identification of Risk Factors for Delirium

Assess people for **risk factors for delirium** on initial contact with the health care system, especially when they present to hospital or long-term care. This includes any of these **key** risk factors:

- Age 65 or older
- Cognitive impairment and/or dementia
- Current hip fracture (broken hip)
- Severe illness
- Previous delirium
- Problematic alcohol or substance use

Document any risk factors for delirium in the person's health record and communicate those risk factors to the health care team, the patient, and their family and caregivers.

*The quality statements are provided in full on page 2.

QS 3: Early Screening for Delirium

Evaluate people presenting to hospital who are at risk for delirium, or who have **acute changes in behaviour or cognitive function** during a hospital stay, in a long-term care home, or in the community.

Use a standardized, validated tool to screen for probable delirium:

- Delirium Triage Screen for emergency departments and inpatient hospital settings
- Confusion Assessment Method tools
- Arousal, Attention, Abbreviated Mental Test 4, Acute change (4AT)
- Intensive Care Delirium Screening Checklist

Conduct a detailed assessment to confirm delirium (e.g., *DSM-5*, *ICD-10*). If confirmed, discuss it with the person and their family and caregivers, communicate it to their care team, assess for underlying causes (see QS 5), and document it in their health record.

(Image from **Delirium Quality Standard**, Ontario Health)

Triggers for delirium screening

The following may be considered when determining the triggers for delirium screening:

- Any Individual or family member expressing a sudden change in cognitive status should cue delirium screening.
- Self, care partner or other informant reports sudden onset change in mental status
- Hypersomnolence or other new onset sleep disturbance

Clinicians should be particularly attentive to delirium in:

- Individuals over the age of 65
- Individuals with hip fracture(s)
- Individuals living with dementia
- Individuals with previous episodes of delirium
- Individuals with alcohol or substance use

Especially in cases in a person living with dementia, be attentive for phrases that express changes over short periods of time:
"This isn't my mom"
"He wasn't like this two days ago"
"Since the new medication she's sleeping all the time"

When documenting findings of delirium avoid ambiguous terms such as "altered mental status" or "confusion"

World Delirium Awareness Day (#WDAD)

NSM SGS has been a provincial leader in promoting #WDAD events and activities across the region since 2020. We engage partners across all sectors to participate with great annual success!

Validated Delirium Screening Tools - See also **Appendix D**

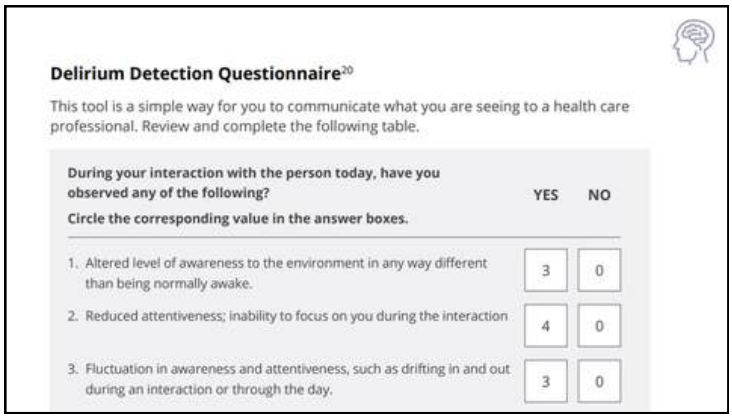
Delirium Triage Screen
Ultra brief (30 seconds) designed to rapidly rule out and increase delirium screening efficiency. This tool is used in some EDs in region. Brief screen of two components: level of consciousness (using Richmond Agitation-Sedation Scale) and attention. Better at ruling out delirium, than in. Reduces the number of formal delirium assessments needed by 50%

4AT
Designed to be used at first contact with the patient, and at any other time when delirium is suspected. Brief (under 2 minutes) bedside assessment tool used for the rapid initial detection of delirium. Consists of 4 items: Alertness, AMT4 (Abbreviated Mental Test - 4), Attention (Months Backwards test), and Acute change or fluctuating course.

Confusion Assessment Method (CAM)
Two versions available – short (serves as a diagnostic algorithm) and long (standard for identification of delirium). Cognitive testing is required (using any instrument) in addition to the rating in either version. Time includes 3-5 min. for cognitive testing, + 3 min. for rating in short form or 5 min. for rating in long form. Widely used.

Regardless of the delirium screen being used, attention must be formally assessed

Delirium Detection Questionnaire
Developed for caregivers or nurses without prior knowledge of the patient (including patients with dementia). Derived from the "Sour Seven" No questions are posed to the patient; rating is based on observation by caregiver only.



Delirium Detection Questionnaire[20]

This tool is a simple way for you to communicate what you are seeing to a health care professional. Review and complete the following table.

During your interaction with the person today, have you observed any of the following? Circle the corresponding value in the answer boxes.	YES	NO
1. Altered level of awareness to the environment in any way different than being normally awake.	3	0
2. Reduced attentiveness; inability to focus on you during the interaction	4	0
3. Fluctuation in awareness and attentiveness, such as drifting in and out during an interaction or through the day.	3	0

Sector Specific Delirium Screening

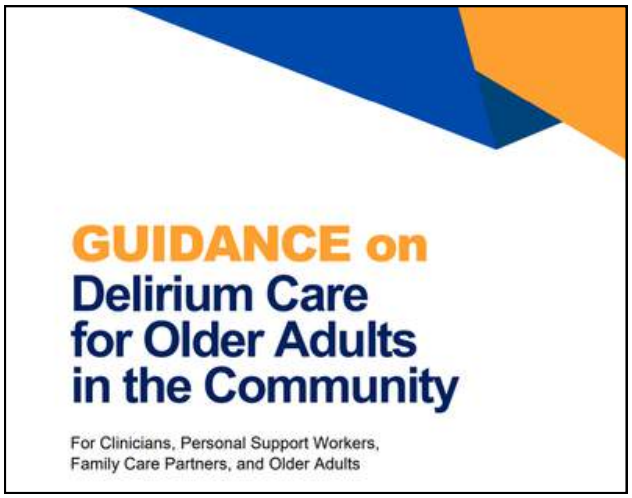
In Emergency Departments

Validated tools are available and currently in use across emergency departments in the region. A comparison of the tools available is found in **Appendix D**.

In Primary Care and Community Settings

In cases where there is concern of changes in mental status over relatively short periods or following a recent hospitalization in vulnerable older adult, a delirium screen is warranted. The CAM and 4AT have both been validated for use outside of acute care.

The Delirium Detection Questionnaire is useful in engaging an informant (formal or informal caregiver) when assessing for delirium in a person living with dementia.



See document **Guidance on Delirium Care for Older Adults in the Community** for more resources.

Implementation Support from NSMSGS is available

Talking Points

Patients who have had, or are at high risk for developing, delirium should be provided education on strategies to recognize and prevent delirium.

Where possible, involve care partners in the discussion regarding delirium.
"Delirium is a sudden change in thinking or awareness, often triggered by illness, medications, or hospital stays. It can be scary and confusing, but learning what to look for, like sudden confusion, trouble focusing, difficulties staying awake or changes in behavior—can help you or your caregivers act quickly." Provide and review handout below."

Individuals who have had delirium and their care partners should be counselled on warning signs and strategies to prevent recurrence.
"Having delirium means that you are more at risk to have it again should you become sick or hospitalized. It is important to understand what you can do to reduce your risk of delirium."

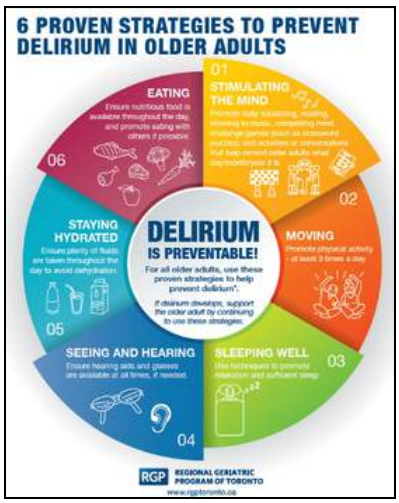
Care partners should be encouraged to use critical language in the critical situation when delirium is suspected
Orienting care partners to the Delirium Detection Questionnaire is designed to help support communicating delirium to health care providers, however the language used may not be accessible to all. See **Self Screening Tools.**

Patient and Care Partner Education Resources

Delirium Learning Video
Covers Prevention and detection of delirium with focus on empowering individuals and care partners to use critical language in critical situations. Based on Family Member's Guide to Delirium Below

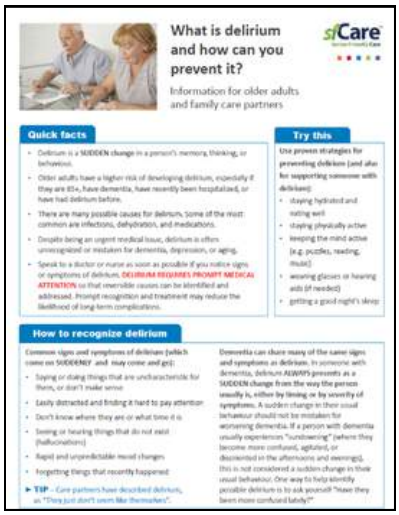
Health Quality Ontario
Family Member's Guide to Delirium

Patient and Care Partner Education Resources



6 Proven Strategies to Prevent Delirium in Older Adults
From RGP Toronto part of the Senior Friendly 7 Toolkit. Available in multiple languages.

Delirium Awareness Poster
From the RGP Toronto intended for display to stimulate conversation about delirium. Also available in French.

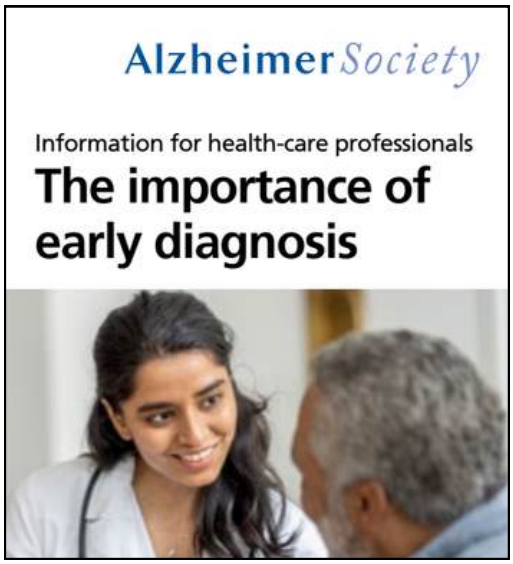


Delirium Caregiver Handout
Quick facts on how to recognize and prevent delirium for older adults and care partners.

Screening for Dementia

Early detection is a necessary step in reducing potentially preventable crises through proactive care. The most familiar type of crisis in dementia is caused by changes in emotions, behavior, and relationships that may occur as part of the disease process, strain family caregivers, and lead to disruptions in care. Less well considered, but important for the consideration of ALC prevention is the preventable health crises that can co-occur with dementia.[27]

Early detection of dementia provides an opportunity to adjust to the diagnosis and for individuals and care partners to actively participate in planning for the future, and with this proactive planning hospitalizations with delayed discharge can be avoided.[27]



Dementia, formally known as Major Neurocognitive Disorder is an acquired, persistent and progressive disease that causes deterioration in memory, intellect, and personality. It is not part of normal ageing and this deterioration tends to affect a person's everyday functioning.

Early diagnosis allows people with dementia and their families to receive timely practical information, advice and support. Early detection also gives individuals a chance to work with their primary care provider to optimize health conditions that may exacerbate cognitive decline. Social prescribing plays an important role in connecting individuals to strategies that can address modifiable risk factors.

When paired with appropriate interventions, early identification can be effective in supporting the individual's overall wellbeing, improving caregiver outcomes and assisting in proactive planning for avoiding hospitalization or delayed discharge and delaying or avoiding institutionalization.[27] [28]

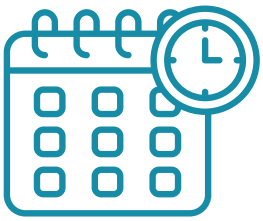
Triggers for Dementia Screening

Widespread screening for dementia should not be conducted in the absence of reported functional concerns.[29]

- Self or reported changes in cognition with gradual onset (for sudden onset, see delirium)
- "Individuals with memory concerns or other cognitive complaints. Non-memory triggers include personality change, depression, deterioration of chronic disease without explanation, and falls or balance issues
- Informant reports of cognitive impairment, with or without patient concurrence"[30]

Clinicians should be particularly attentive to:

- Missed appointments
- Individuals with history of delirium and falls
- Changes in medication or health management abilities
- Recent relocation to a supportive living environment (with kin, retirement home etc..)[8]
- Individuals with cerebrovascular disease[31]
- Deferring to a family member to respond to questions[31]
- Signs of self-neglect (or home neglect for community providers)[31]



Screening for Dementia/Cognitive Impairments

All health and social care providers involved in screening should receive training in the selection, administration, scoring, and interpretation of screening tools, as well as in how to communicate results and support individuals post-screening.[8]

The ideal setting for assessing cognitive impairment is in primary care, where providers have ongoing, trusted relationships with patients and can integrate cognitive screening into routine health evaluations, enabling early identification, timely intervention, and coordination of care within the broader healthcare system, however, concerns about cognitive health may be identified across the health system.[8]

Prior to initiating any cognitive or dementia screening, patients should be systematically screened for current or recent episodes of delirium.[31] As delirium is frequently underrecognized, patients should be asked about events of the hospitalization to rule out any suspected delirium. Clinicians should inquire specifically about recent hospitalizations, acute illnesses, medication changes, or changes in mental status (with particular attention paid to symptoms of hypoactive delirium), which may indicate a past or ongoing episode of delirium.

If delirium is suspected or confirmed, dementia screening should be deferred. Cognitive assessment during or shortly after delirium can yield misleading results. It is recommended to wait at least 3-6 months[32] after resolution of delirium symptoms before reassessing cognitive function, to allow for potential cognitive recovery and to avoid misdiagnosis.

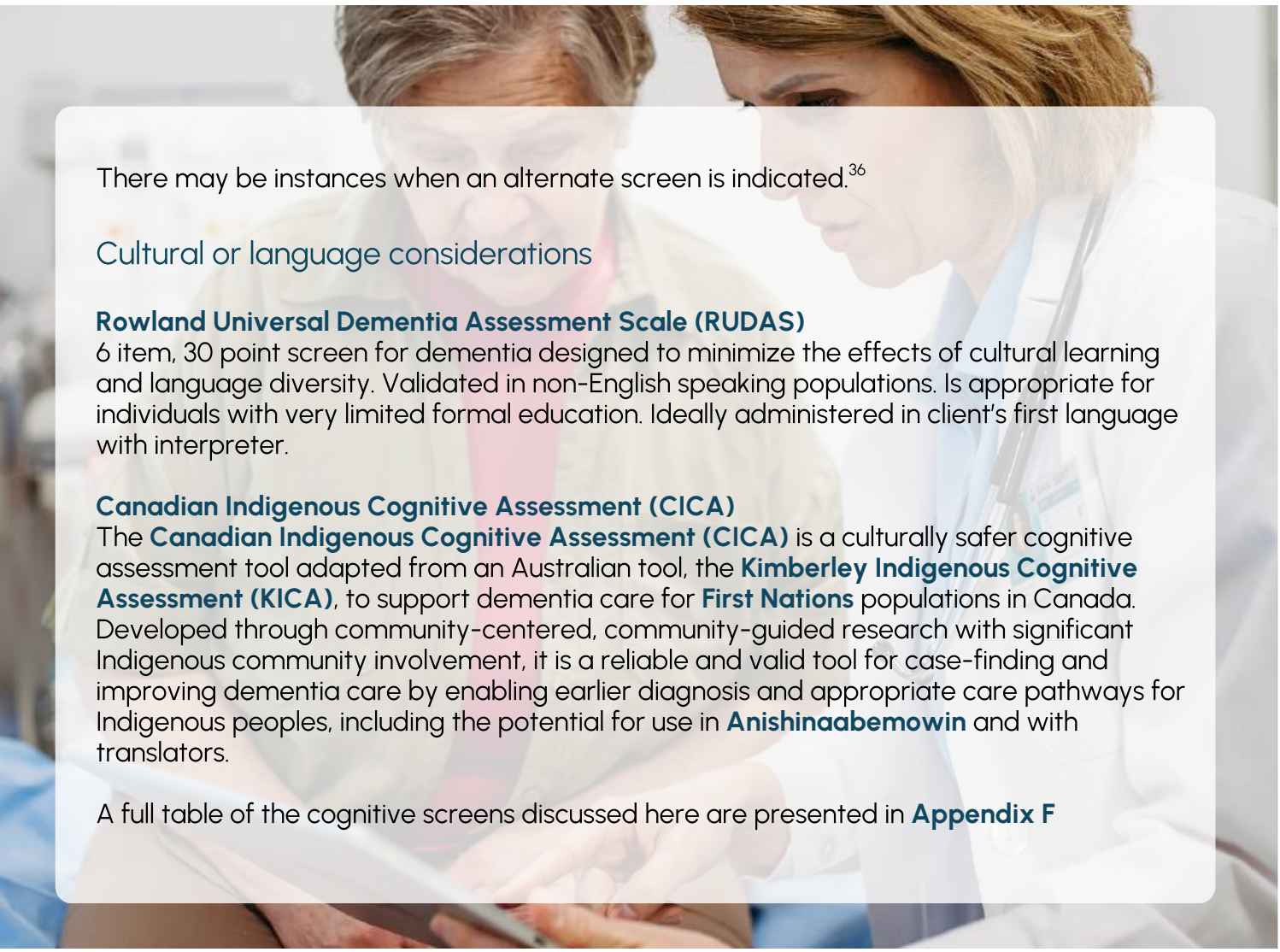
Depression should also be considered when there is evidence of cognitive impairments, especially in the context of somatic complaints.[31]

Dementia Screening Tools

The Mini-Cog is the recommended screening for primary care due to its brevity and relevance to common dementias.[35]

The Mini-Cog is a first-line cognitive screen for primary care, although it has not been evaluated as extensively as the MMSE or the Montreal Cognitive Assessment. The Mini-Cog combines the delayed three-word recall test and the clock-drawing test.
The Montreal Cognitive Assessment (MoCA) is widely used but may not be appropriate for all. Training is also required for administrators of the MoCA.

A full list of screening tools is found in **Appendix E**



There may be instances when an alternate screen is indicated.[36]

Cultural or language considerations

Rowland Universal Dementia Assessment Scale (RUDAS)
6 item, 30 point screen for dementia designed to minimize the effects of cultural learning and language diversity. Validated in non-English speaking populations. Is appropriate for individuals with very limited formal education. Ideally administered in client's first language with interpreter.

Canadian Indigenous Cognitive Assessment (CICA)
The **Canadian Indigenous Cognitive Assessment (CICA)** is a culturally safer cognitive assessment tool adapted from an Australian tool, the **Kimberley Indigenous Cognitive Assessment (KICA)**, to support dementia care for **First Nations** populations in Canada. Developed through community-centered, community-guided research with significant Indigenous community involvement, it is a reliable and valid tool for case-finding and improving dementia care by enabling earlier diagnosis and appropriate care pathways for Indigenous peoples, including the potential for use in **Anishinaabemowin** and with translators.

A full table of the cognitive screens discussed here are presented in **Appendix F**

Engaging Care Partners in Screening for Cognitive Impairment

Dementia can often be masked in a time-limited office visit.[31] Combining cognitive tests with functional screens and informant reports may improve case-finding in people with cognitive difficulties.[29]

Informants may be family, friends or care partners.

Informant and Functional Screens

8-Item Informant Interview (AD8)

The AD 8 was developed as a brief instrument to help discriminate between signs of normal aging and mild dementia. The AD8 contains eight items that test for memory, orientation, judgment, and function. Cut points are: normal cognition 0-1; impairment in cognition 2 or greater. The AD8 assesses intra-individual change across a variety of cognitive domains compared to previous levels of function and is sensitive to early signs of dementia regardless of etiology.

Quick Dementia Rating System (QRDS)

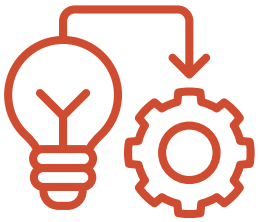
The QRDS is a simple 3-5 minute informant questionnaire that can be administered as an interview or self-administered. It is useful in staging the level of cognitive impairment. The tool can be completed in advance of a visit or by phone or video.

Functional Activities Questionnaire (FAQ)

A brief 1-3 minute tool to identify cognitive impairment based on independent activities of daily living (IADL). Limitation is that not IADL apply to all people (social, cultural factors).

Informant questionnaires are outlined in more detail in **Appendix F**

Implementation Support
from NSMSGS is available



Sector Specific Dementia Screening

In Emergency Departments

Given the high prevalence of cognitive impairment in the aging population and the increasing role of the ED as a point of care for complex geriatric patients and the prevalence of older adults who are not attached to primary care, brief and validated cognitive screening tools should be integrated into ED protocols as part of a specialized geriatric assessment (i.e. GEM nurse interventions). [33]

Screening for who requires comprehensive geriatric assessment can be done using the Trauma risk screening tool (TRST)[22] or Identification of Seniors At Risk (ISAR), in addition to opportunities and mechanisms for clinicians to refer to specialized geriatrics assessment based on judgement or heightened concerns.

There is some emerging evidence for using informant interviews in the ED care setting to screen for cognitive impairment, including the 8-item informant interview.[34] This would be especially valuable in situations were medical concerns and or delirium would limit an accurate cognitive screen.

When possible, Emergency Departments should develop mechanisms to facilitate primary care or geriatric follow up when concerns regarding cognition are identified, to increase the likelihood of a formal cognitive screen occurring in a lower-stress environment where providers have ongoing, trusted relationships with the at-risk individual.

In Primary Care

Primary Care is the ideal and recommended setting for cognitive screening as providers have developed trusted relationships.

Recommendations of the 5th Canadian Consensus conference on the diagnosis and treatment of dementia shares:
"Primary care health professionals should stay vigilant for potential early symptoms of cognitive disorders in older individuals who may be less likely to report due their lack of insight, social isolation, or sociocultural beliefs, and in older individuals with warning signs, including but not limited to: reported cognitive symptoms by the patient or an informant, otherwise unexplained decline in instrumental activities of living, missed appointments, showing up to appointments at the incorrect time or day, difficulty remembering or following instructions or taking medications, decrease in self-care, or new onset of later-life behavioral changes including new depression or anxiety (1C). If there is a clinical concern for a cognitive disorder (which may not always be shared by the patient due to their lack of insight) then validated assessments of cognition, activities of daily living, and neuropsychiatric symptoms are indicated (see subsequent sections for suggestions for valid tools). 1A (95%)"[29]

Talking Points

Preparing for cognitive screening is as important as screening itself. A comprehensive resource on **Pre-Screening Conversations** is available from the BOLD Public Health Centre of Excellence. This resource is highly recommended for clinicians who are new to engaging in preparing individuals for cognitive screening.

It is recommended to reframe Dementia Screening as cognitive or brain health screening.[27]
"Brain health is part of overall health. Changes with thinking can affect a person's ability to manage other health conditions."

Help individuals understand that cognitive changes are not a part of typical aging.
"memory loss or other changes with your thinking skills are not an expected part of growing older, so if you notice changes, let's talk about it"

Individuals may be reluctant to share information about cognitive impairments due to stigma or fear of losing independence, especially as it relates to driving. Link the discussions to what matters to the patient (e.g. independence, activities, goals, involvement)
"Screening for brain health helps identify issues in the earliest stages when interventions, lifestyle changes, and planning can be most effective. What's most important to you as you age?"
If you are a provider who communicates a diagnosis of dementia or shares concerns about your patient's cognitive health, consult the **National Dementia Guidelines**
Similarly, **Navigating Post-Screening Conversations** is also available.

Patient and Care Partner Education Resources

Talking to your doctor about dementia (Alzheimer Society)

Importance of Early Diagnosis of Dementia (Alzheimer Society)

My Memory and Thinking are Not What They Used to Be. Should I Be Concerned? (BOLD Public Health Centre of Excellence, Early Detection of Dementia)

Bringing Clarity to Dementia (McMaster Optimal Aging online learning)

Screening for Falls

Falls are the leading cause of injury-related morbidity and mortality among people aged 65 and older living in the community.[38] Injurious falls are one of the most common and serious factors impacting functional decline in older adults.[39] Most falls are preventable. As a crucial component of older adult care, healthcare providers can work in partnership with older adults to implement a variety of interventions to address and reduce their risks for falling.[40]

Clinical assessment by a healthcare provider with targeted interventions to address predisposing factors can decrease falls by approximately 25% among those at high risk.[41 42]

A fall is an unintentional change in position resulting in coming to rest on the ground, floor, or other lower level. (RNAO, 2017)

20-30% of ≥65 years of age experience a fall each year

85% of injury-related hospitalizations among older adults are caused by falls

50% of all falls causing hospitalization happen at home

95% of all hip fractures are caused by falls

(data compiled by Centre for Effective Practice)

Research in British Columbia has found that screening paired with targeted interventions to reduce falls in community-dwelling older adults at the primary care level is cost effective (estimated at $35,213 per Quality Adjusted Life Years).[43]

Triggers for Screening

- Annually screen all patients 65 years of age and older for falls risk
- Other opportunities for screening older adults include but are not limited to:
  - During or after hospitalization, ED visit or medical event (e.g., stroke, fracture, delirium, etc.)
  - After a bone mineral density test, decrease in bone density or diagnosis of osteoporosis
  - After a significant change in health status (e.g., weight gain or loss, increased frailty, dementia, etc.)
  - After a relevant medication change or addition (e.g., CNS medications or hypotensives) especially in individuals taking 5 or more medications
  - In cases of substance use (alcohol, benzodiazepine etc…)

North Simcoe Muskoka
Specialized Geriatric Services

APRIL 2020

Falls Risk Screening

When selecting a falls risk screening approach in your organization or practice, it may be helpful to review the publication on **Barriers and enablers for screening and assessing fall risk in older adults: an overview (2022)**. Several strategies to enable success of falls screening strategies are discussed.

A description and details of a variety of falls risk assessment tools can be found in the **Screening and Assessment Tools for Falls in Older Adults in Ontario**

When asking about falls history, ensure each patient understands what a fall means[44]

"A fall is when you accidentally end up on the ground, floor or other lower level including your knees. A fall is a fall with or without injury"

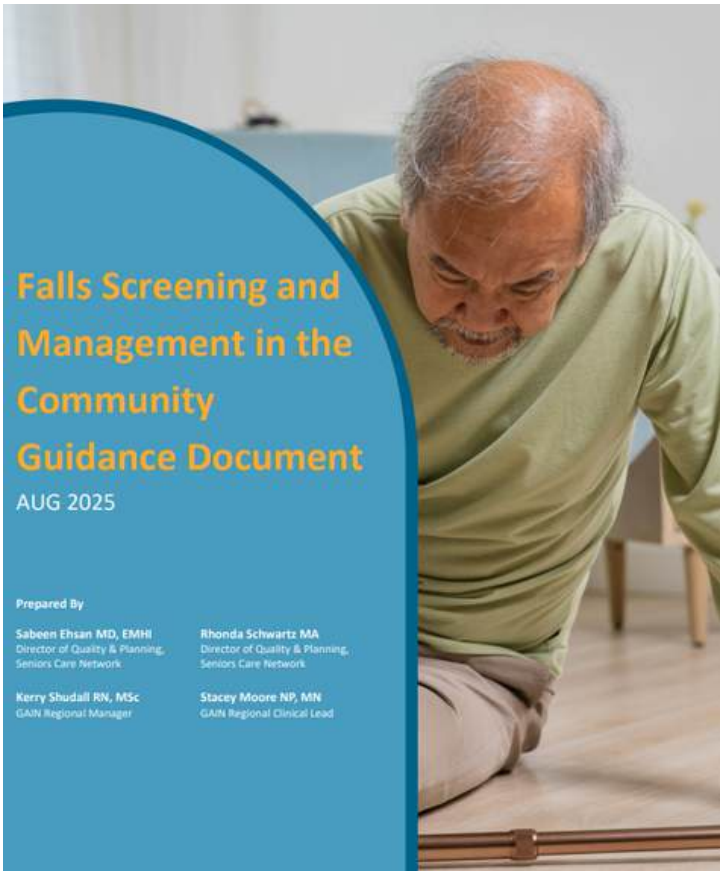
Implementation Support from NSMSGS is available

Sector Specific Falls Screening

In Emergency Department

All adults over the age of 65 should be screened for falls using either the Falls Risk Assessment Tool (FRAT) and/or **Morse Falls Risk tool**.[45]

Screening for falls should be used not only to prevent harm in the ED through implementation of universal and individualized falls prevention strategies but also be used to link individuals to appropriate follow up assessment and intervention to prevent falls at home and in the community.



In Community Settings

Screening for falls should be included during an admissions process[46] and at regular intervals and include identifying history of previous falls, gait, balance or mobility difficulties and use clinical judgement.[46]

Tools to support screening include: **Falls Screen and Management in the Community** produced by the Seniors Care Network applies to both community and primary care settings. This document helps provide screening strategies for identification, risk stratification and assessment approaches.

In Primary Care

A Three Question Approach is a quick one-minute screener to identify patients requiring a multifactorial risk assessment. [47]

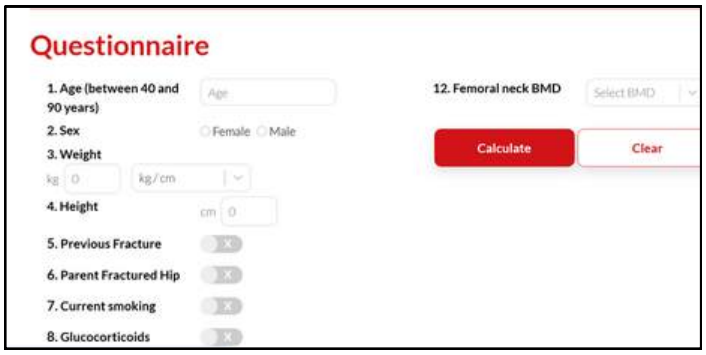
Ask the following questions:

1. Have you fallen in the past year? If so:
   - How many times?
   - Were you injured?
2. Do you ever feel unsteady when you stand or walk?
3. Do you worry about falling?

The **Centre for Effective Practice** offers primary care specific resources for falls screening and assessment.

The Timed up and Go (TUG) is a commonly used screening tool, however, should not be used in isolation to determine risk as it has poor predictive value for falls risk[48] (however has documented clinical utility for frailty identification).[49]

Fracture Risk Assessment Tool (FRAX)



Falls are not equivalent in their impact on alternate level of care risk. Injurious falls, particularly those resulting in fractures, are the key contributors. Fracture risk assessment is recommended to support early identification and prevention. The Fracture Risk Assessment is available to embed in primary care EHRs.

Leverage interprofessional teams and community supports to create a collaborative falls screening strategy

- Non clinician providers can be included in in the detection of those at risk for falls, including cueing clerical staff to observe for the mobility of individuals in waiting areas. Requiring extensive use of arm rests or struggling to rise from a chair is a good indicator of impaired mobility and indication for assessment for falls risk and prevention.[39]
- Involve interdisciplinary team members to engage in observing the patient's gait and mobility, collecting pre-screening documents or information, taking postural blood pressure[50]

Further assessment

Centre for Effective Practice recommends the following:

- "For adults at risk for falls, conduct a comprehensive assessment to identify factors contributing to risk and determine appropriate interventions. Use an approach and/or validated tool appropriate to the person and the health-care setting.
- Refer adults with recurrent falls, multiple risk factors, or complex needs to the appropriate clinician(s) or to the interprofessional team for further assessment and to identify appropriate interventions."[50]

Talking Points

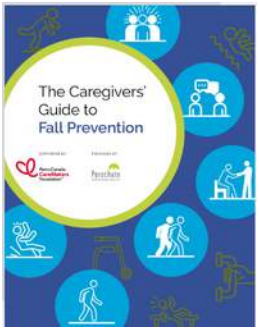
Older adults are unlikely to initiate a conversation about falls or falling. Older adults under report/recognize their risk of falls and role of self-management in prevention.[47]

Let patients know that they have not been singled out for this screening and discussion
"I ask all patients 65 and over about falls."

Link the discussions to what matters to the patient (e.g. independence, activities, goals, involvement)
"How do you envision your health and/or living situation in the next few years?"
Engage older adults at risk of falls in discussion about their perceptions of risk, motivation to address falls risk, and option and interventions to support self management to establish a collaborative plan of care. [46]

Patient and Care Partner Education Resources

Staying Active: Mobility and Fall Prevention
(Geriatrics Ontario)



Caregivers Guide to Fall Prevention
(Parachute Canada)

Walking Speed – Is it a New Vital Sign?
McMaster Optimal Aging Portal Online education

Appendix B also contains Self- Screening tools including the Staying Independent Checklist for Falls Prevention

Identify and Support Care Partners

Context and Background

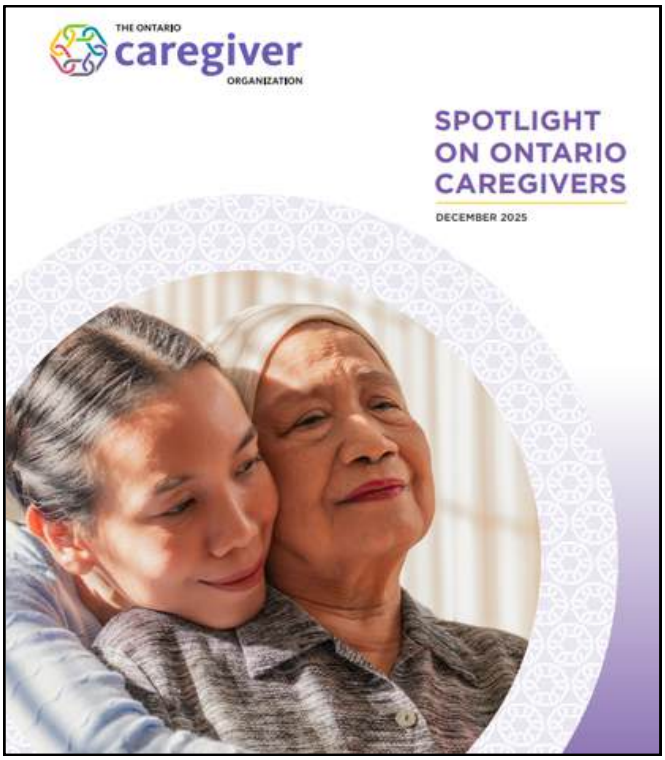
Initiating Conversations with Care Partners

Care Partner Stress Screening

Sector Specific Considerations

Health Teaching and Patient Education

The Ontario Caregiver Organization's Spotlight Report 2025 reveals a startling level of caregiver stress in Ontario: 68% of caregivers report they have reached their "breaking point" due to exhaustion and overwhelm from caregiving responsibilities. This widespread burnout isn't just momentary fatigue it signals a systemic crisis in the informal care infrastructure.

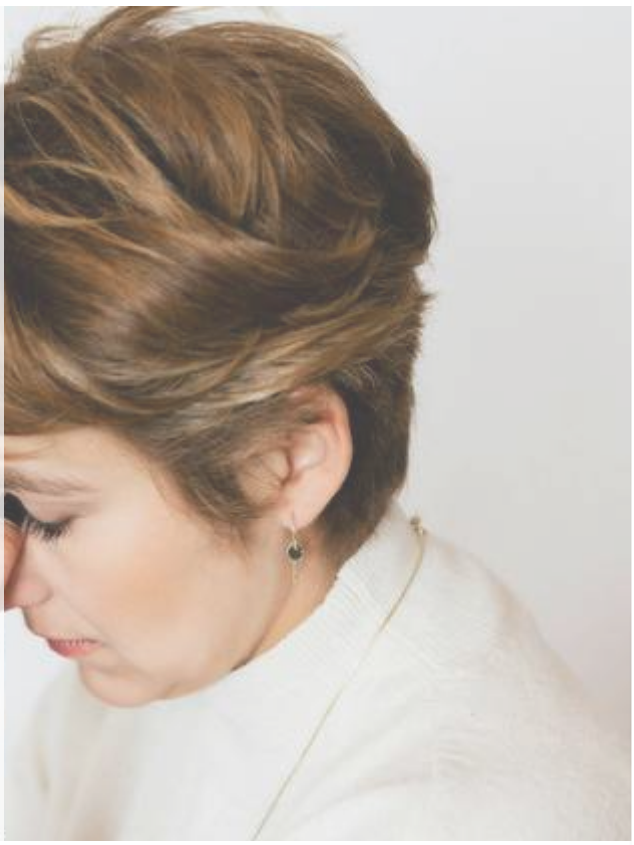


Care partner stress is the day-to- day physical, social, emotional, and financial demands of caregiving. Care partner burden or burnout occurs when stress and strain felt when the demands of caring for someone outweigh the caregiver's resources and support system.

72% of caregivers say they cannot maintain healthy behaviours because of their caregiving role (e.g., eating well, exercising, or attending to their own medical needs, OCO Spotlight Report 2025). This means the people providing essential care; physical, emotional, and cognitive, are themselves at elevated risk of long-term illness and mental health problems. When caregivers' health deteriorates, they are less able to sustain effective care, creating a doubly negative effect: worse outcomes for both care partner and care recipient.

When caregiver stress goes unrecognized:

- Many caregivers end up using hospital emergency departments as a form of respite because they have no other support options.
- A significant proportion of working caregivers either leave the workforce or consider doing so due to caregiving pressures.
- These outcomes increase system pressure in multiple ways:
- Higher acute care use not related to medical need but to caregiver burnout. 1.9M ED visits across Ontario in one year by caregivers who urgently needed a break
- Loss of workforce productivity and economic stability.
- Greater likelihood of premature, preventable long-term care placement for older adults

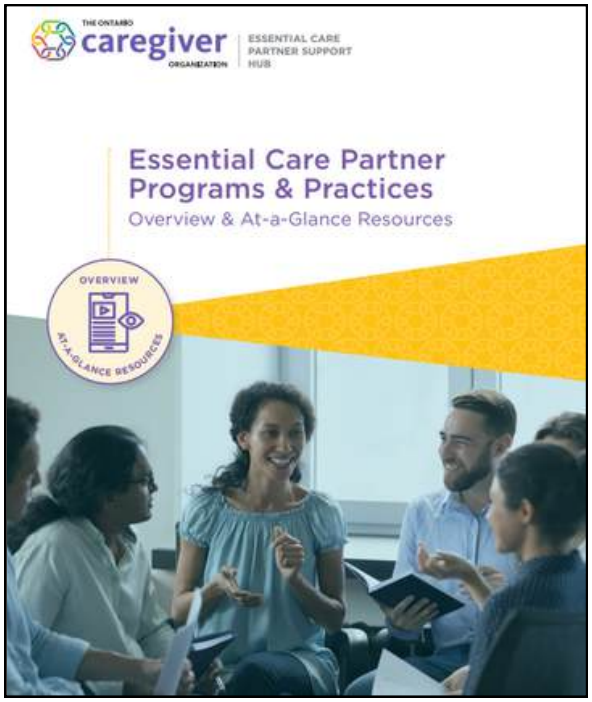


Ontario Caregiver Organization (OCO) provides a wealth of growing resources to support the identification of Care Partners Stress and associated interventions.

The evidence **for integrating caregivers as essential are partners across the care continuum** is overwhelmingly positive.

Ontario Caregiver Organization has curated and overview of the program and resources at a glance of the most referenced resources for organizations

Overview and At-a-Glance Resources



Links

Alzheimer Society Simcoe County

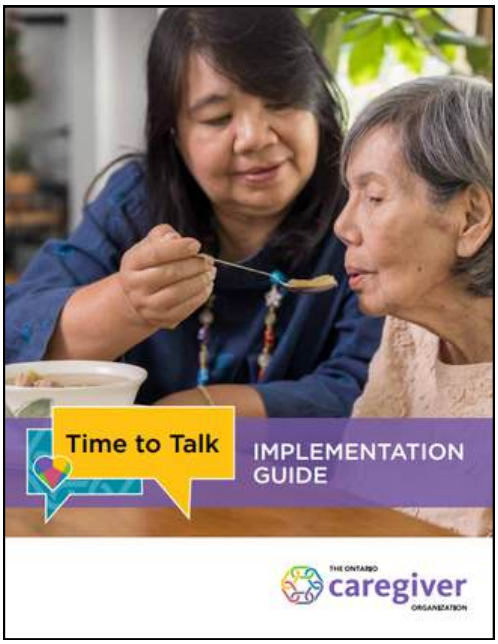
Alzheimer Society Muskoka

Implementation Tip

When building out referral pathways for caregivers, you may wish to consider the range of information, support, and community resources offered by the Alzheimer's Society and establishing direct referrals to the **First Link®** program.

Through focus groups and codesign sessions, clinicians have reported that they are often reluctant to ask care partners about levels of stress as they do not feel empowered to address issues that arise. There are resources to help empower individual providers and teams to address care partner stress.

The best way to mitigate that burnout is to reach caregivers early in their journey. Integrated support for care partners across health care sectors promotes shared care, mitigates the workload impact on individual clinicians, and reduces the likelihood of individuals presenting in crisis.



The **Time To Talk toolkit** supports implementation of caregiver strategies in organizations.

A **simple to use strategy for initiating conversations with caregivers** is available from OCO.

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Triggers for Screening for Care Partner Stress

While it may sound simple, the very first step in early identification of care partner stress is developing mechanisms to identify who the care partner is and finding a way to document this. This is a requirement to facilitate meaningful inclusion. Further, many care partners may not call themselves as such.

This Poster has been developed to help people self-identify as care partners

Suggested triggers to consider when setting up early identification for care partner stress include but are not limited to:

- New diagnosis impacting function/independence (e.g., patient is diagnosed with dementia, Parkinson's disease, etc.)
- Worsening of patient's condition/poor prognosis (e.g., advanced dementia, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, etc.)
- Patient screened 'frail' on a standardized tool (e.g., Clinical Frailty Scale, Pictorial Fit-Frail Scale, etc.)
- Evident/expressed caregiver distress
- Recent hospitalization(s)/repeat ED visits/multiple appointments with specialists

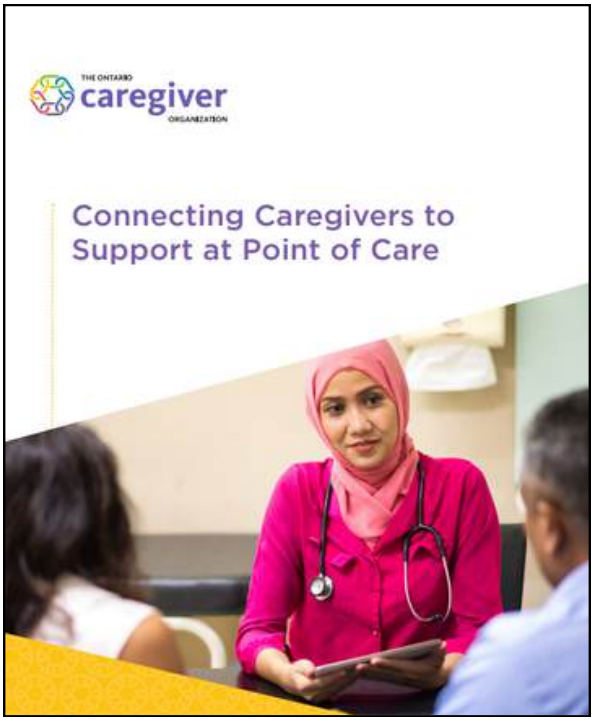
Sector Specific considerations for Identifying and Supporting Care Partners

In Emergency Department

Canadian Association of Emergency Physicians Position Statement: Care of Older People in Canadian Emergency Departments recommends "Emergency departments involve family members and caregivers in the care of older people during their ED stay."
Early identification of care partner stress involves first identifying, including and supporting essential care partners in the Emergency Department.

At present, there is not a current document outlining best practices for screening for care partner stress in emergency departments, however there are elements of the Acute Care document that apply to ED. Especially, strategies to identify care partners. Further, evidence supports that by including care partners in discharge planning reduces 6-month risk of readmission by 25%[51]

As part of the early identification project, we aim to trial and evaluate strategies in EDs. There are studies demonstrating the feasibility of administering the Zarit Burden Inventory in ED settings for target population with good effectiveness.[52]

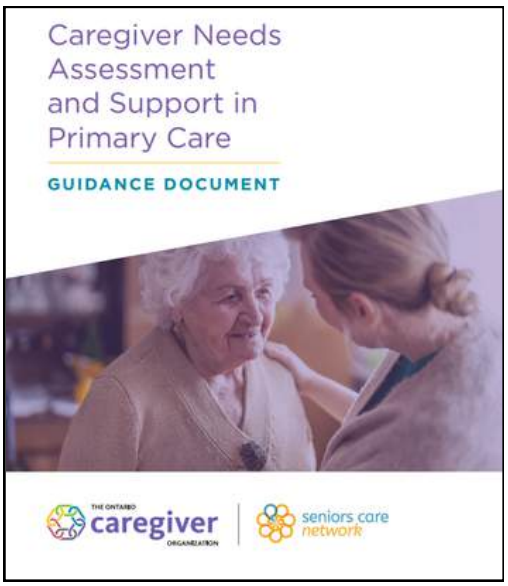


In Community Settings

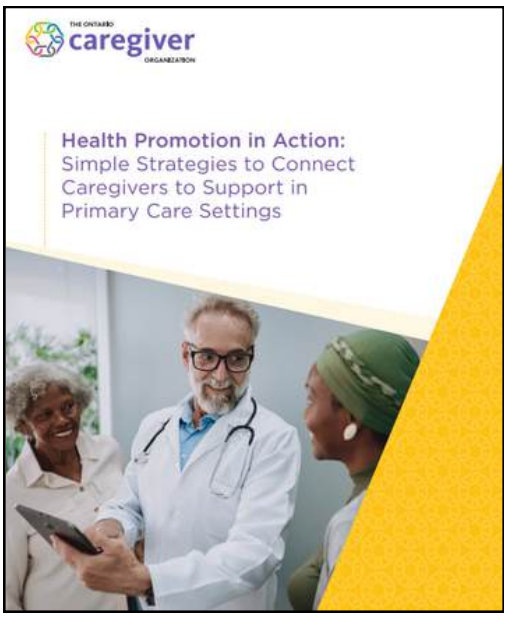
Care partners can be connected to support at any point of care, and seeing individuals in their home environment will likely paint the best picture of how care partners are coping.

Strategies to quickly identify and support care partners in the community **are available**.

In Primary Care



Caregiver Needs Assessment and Support in Primary Care
This guidance document is developed to facilitate primary care providers in assessing and supporting the needs of caregivers of older adults (including older adults living with frailty).



Health Promotion in Action
Provides actionable strategies for primary care to support caregiver wellbeing and better outcomes in primary care. Includes strategies for education, promotion of resources and including caregivers in quality improvement plans

Implementation Support from NSMSGS and OCO is available

Talking Points

Gain explicit consent to discuss with care partners when indicated. Let Patients and Care Partners know why you are asking:
"Each time a patient (insert trigger reason here i.e. returns from hospital, has a significant change in health status), I ask the people supporting them how they are doing."

Let patients and care partners know that involving care partners improves health outcomes.

Before initiating screening, ask caregivers how they're doing. This simple question can make a big difference.

Tips to initiate conversations with care partners [6]

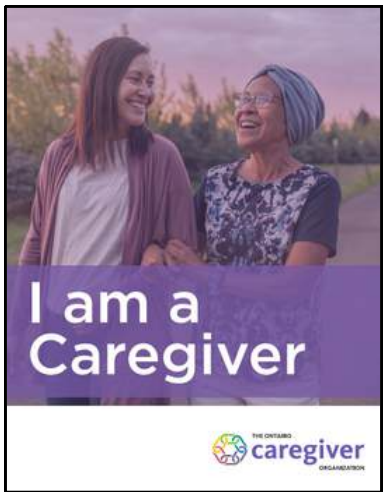
Navigating Consent

At a Glance: Understanding health privacy and consent in Ontario – For Caregivers

At a Glance: Understanding health privacy and consent in Ontario – for Care Providers

A softer and supportive approach can help you to avoid inviting a no response. Including the support of a caregiver can have a very positive effect on your recovery. You deserve to have this support. Have you thought of someone we can include in this conversation?

Patient and Care Partner Education Resources



I am a Caregiver (Ontario Caregiver Organization)

Available in Multiple languages

Unique versions are tailored to the needs of Indigenous, Black, Rural/Remote and 2SLGBTQIA+ caregivers

Understanding Grief in Dementia Caregiving

Why do I feel this way? If you're ever wondering why simple tasks feel so overwhelming, why you feel so isolated or why you experience anger or tears unexpectedly in [...]

Cultural Perspectives on Caregiving: Stories of Strength & Support

This webinar looks at how caregiving is experienced across different cultures. Hear first-hand from a caregiver in the Punjabi community about their personal

Ease the Journey: Advance Care Planning Tips for Caregivers

93% of Canadians believe it's important to talk about their wishes for their care with family and friends. Yet only 1 in 5 has a plan. As a caregiver, knowing [...]

Ontario Caregiver Organization offers webinars and learning series.

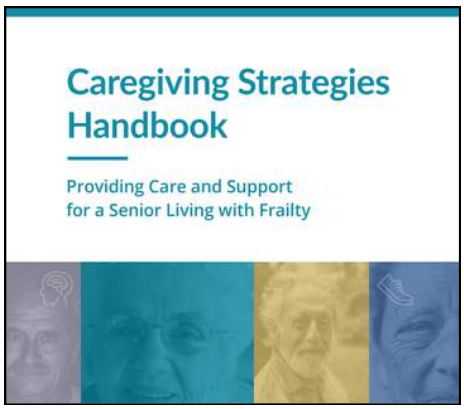
Subscribe to Newsletter or **Search in Resource Library**

Caregiver Checklist

Ontario Caregiver organization helps identify the tasks being performed by caregivers and facilitates discussions on getting help

Contingency and Emergency Planning for Caregivers

Ontario Caregiver Organization
Fillable documents to help develop a plan for when a caregiver is unavailable, or an emergency arises that affects their care duties



Caregiving Strategies Handbook (Geriatrics Ontario)

Caregiving Strategies Course
Provincial Geriatrics Leadership Ontario

I'm caring for a person living with dementia (Alzheimer Society)

Caregiver / Care Partner Support and Resources (Brain xchange)

Appendices

Appendix A - Tools Available for Integration in EHR

In primary care settings, tools are available to embed in EHR to assist in screening activities, these are presented for opportunity only.

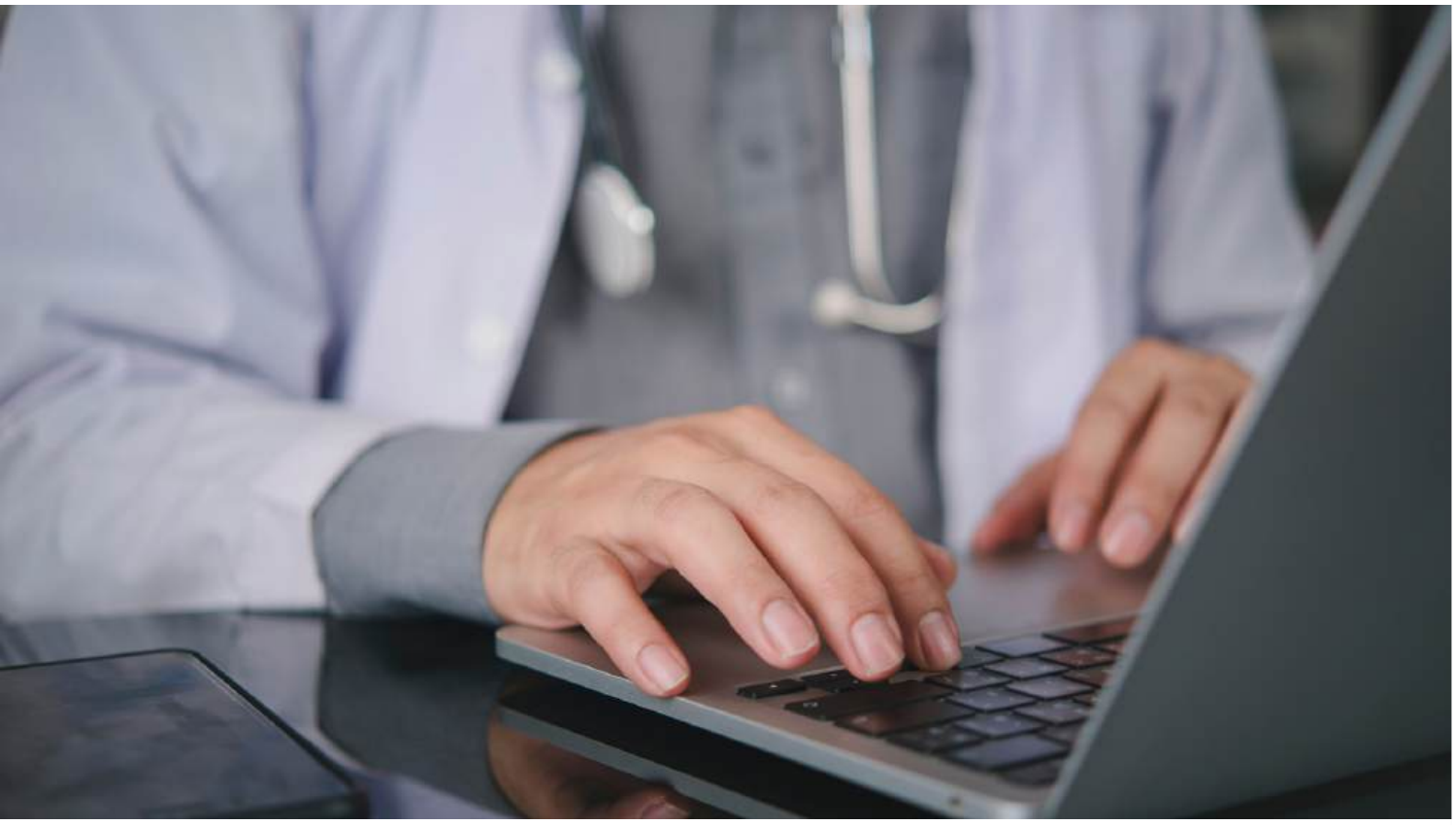
Centre for Effective Practice: Preventive Care for Older People (available to embed in PS Suite)

Developed by and for primary care providers. This tool can be tailored to your team and used by multiple providers/clinicians to facilitate a team approach. The tool can be completed in one or multiple sequential visits. This tool also features embedded clinical decision-making support. The Centre for Effective Practice updates and incorporates new guidelines in the tool as they become available, helping providers stay up to date.

A webinar about the implementation of the PCOP tool in primary care **is available.**

Clinical Frailty Scale

Georgian Bay Family Health team has done extensive work on embedding the CFS into PS Suite. Please reach out to NSM SGS if you would like to learn more about this initiative



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Appendix B - Self Screening Tools

Staying Independent Checklist

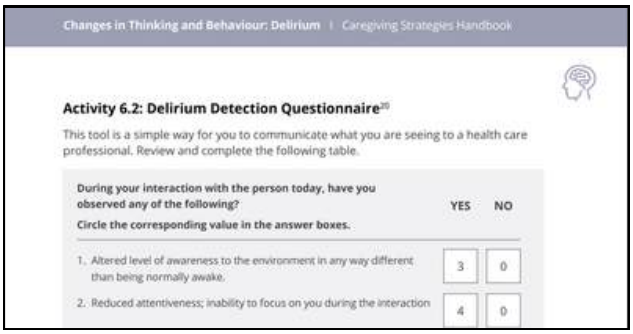
A checklist and guide to improve safety at home and reduce risk of falling.

Paper copies available for order from Simcoe Muskoka District Health Unit

Delirium: Urgency or Emergency

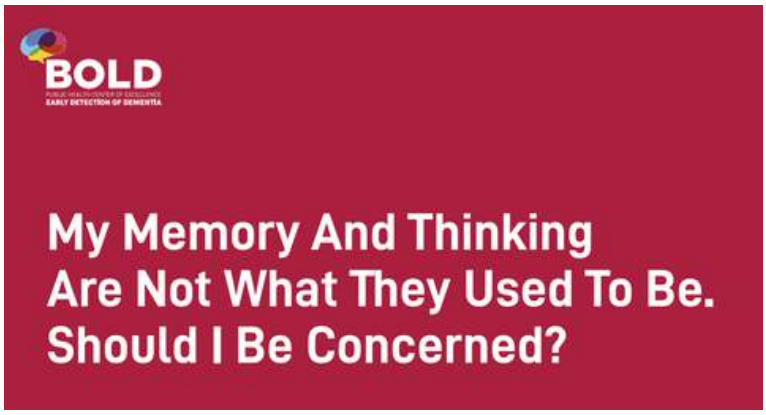
A quick reference for care partners outlining characteristics of delirium and helps individuals receive prompt medical attention.

Links to the **Delirium Detection Questionnaire**



Delirium Detection Questionnaire

Designed to help support communicating delirium to health care providers, however the language used may not be accessible to all. This is therefore not an ideal self screening tool, but one to be aware of as it is recommended by RGP and the PGLO Caregiver Training Course



My Memory and Thinking are Not What They Used to Be. Should I Be Concerned? (BOLD Public Health Centre of Excellence, Early Detection of Dementia)

It is noted that the recommended resource is based in the US Public Health whereas we have made best efforts to recommend resources with in provincial or national jurisdiction. Consultation with individuals who have lived experience of accessing a dementia or major neurocognitive disorder diagnosis indicates a preference for broader terminology, such as "brain health," rather than the use of "Alzheimer's" or Alzheimer's specific resources.

Links

Zarit Burden Interview can be administered as self screening with care and associated distribution of resources to link to help. Long and shorter forms are available

Groningen Frailty Indicator (see full description in Frailty Screening)

Am I at Risk of Falling? Good questionnaire and Associated Resources from Government of BC

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Appendix C - Frailty Screening Tools

Tool	Resources Considerations	Domains	Notes
Clinical Frailty Scale	Time to admin: 3 min Who can admin: Clinician skilled in geriatric assessment	Physical psychological, social, cognition	Judgement based tool Based on what the person was like two weeks ago(takes out the effect of acute reversible illness on functional state As it is dependent on clinician judgement, subject to bias (recency, central tendency etc..) Online training is available.
Reported Edmonton Frailty Scale	Time to admin: 10 minutes Who can admin: Clinician	Physical (balance/mobility, nutrition, medical history), psychological, social, cognition	Can be administered by non-specialists Adapted version of ethe EFS substitutes the timed up and go test for a report prior to current illness
The Pictorial Fit-Frail Scale	Can be filled in by general public and interpreted by clinician or clinician administered (approx. 5 mins)	Physical, psychological, social, cognition	Used for self or proxy assessment of a person's frailty state Evaluates 14 different domains Various versions available, copyrighted.
Groningen Frailty Scale	Filled in by general public and interpreted/revie wed by clinician	Physical (balance/mobility, activity, nutrition medical history, psychological (mood), social, cognition	Can be given in advance of visits for self-completion. 15-item questionnaire

Appendix D - Delirium Screening Tools

Screening Tool	Notes[53]	Sector	Rater	Training	# of Items	Sensitivity	Sensitivity
Confusion Assessment Method (CAM)	2 versions – short (serves as a diagnostic algorithm) and long (standard for identification of delirium). Cognitive testing is required (using any instrument) in addition to the rating in either version. Time includes 3-5 min. for cognitive testing, + 3 min. for rating in short form or 5 min. for rating in long form	All	Clinician 6-8 min	Yes	4 (short) 10 (long)	82%[54]	99%
CAM - ICU	Developed for use in non-verbal (i.e. mechanically ventilated) patients.	Hospital (ICU)	Clinician 1-2 min.	Yes	9	95% - 100%	93% - 98%
3D-CAM	A three-minute diagnostic interview requiring verbal responses. Includes skip patterns that can shorten the instrument further. Minimum training required.	All	Clinician <3min	Yes	20	95%	94%
4AT	Designed to be used at first contact with the patient, and at any other time when delirium is suspected.	All	Clinician ,2min	No	4	88%	88%
Delirium Triage Screen	Ultra brief (30 seconds) Designed to rapidly rule out and increase delirium screening efficiency Used in some EDs in region Has two components, level of consciousness and attention Better at ruling out delirium, than an reduce the number of formal delirium assessments needed by 50%	ED	Clinician <1min	Training manual and practice videos are available	2	98%	55%[55]
Delirium Detection Questionnaire (Formerly Sour Seven)	Developed for caregivers or nurses without prior knowledge of the patient (including patients with dementia). No questions are posed to the patient; rating is based on observation only.	Validated in hospital, promoted in all sectors	Clinician, Family, Caregiver	no	7	63.2% (with score of 9)[56]	100% (with score of 9)

Appendix E – A comparison of Cognitive Screening Tools

Instrument	Purpose/ Setting	Domains Assessed	Training and admin.	Strengths	Limitations Notes
Mini-Cog	Very brief dementia screening in primary care/community Time to administer: 3-5 minutes	Memory recall, clock drawing (executive function/visuospatial)	Brief training freely available Can be administered by non-clinicians with minimal training	Very quick, minimal training, less influenced by language/education	Less detailed, may miss subtle deficits Good, brief initial screening tool
Montreal Cognitive Assessment MoCA	Brief screening for mild cognitive impairment and dementia Time to administer 10-15 minutes	Executive function, attention, memory, language, visuospatial, orientation	Can be administered by variety of health care clinicians Requires training, available online	Sensitive to mild impairment, widely used	Requires training, influenced by education/language Popular for early detection
Mini Mental Status Examination	Brief screen used across settings	Orientation, registration, attention & calculation, recall, language, visuospatial skills	Minimal training; can be administered by healthcare professionals, 5-10 mins	Quick and easy to administer, widely used, standardized, useful for tracking cognitive changes	Influenced by education, language, and culture; limited sensitivity for mild cognitive impairment; copyright restrictions

Instrument	Purpose/Setting	Domains Assessed	Training and administration	Strengths	Limitations Notes
CICA Canadian Indigenous Cognitive Assessment	First Nations community-informed dementia case finding tool based on the Kimberly Indigenous Cognitive Assessment (KICA) from Australia.	Orientation recognition and naming, registration, verbal comprehension, verbal fluency, recall, visual naming, frontal/executive function, praxis	Community service providers and clinicians can administer provided they are trained in the use of the tool Orienting oneself to the cultural considers is essential Training videos freely available	Culturally sensitive, easy to administer. Training includes background information of First Nations ways of knowing about cognitive impairment	Not as widely known Anishinaabemowin version is available. Common objects are required to administer the tool including paper, spoon, matches, cup and water container. Modifications available for poor vision
Rowland Universal Dementia Assessment Scale (RUDAS)	Cross-cultural dementia screening in diverse older adults or those with lower literacy Time to administer: 10–15 minutes	Memory, concentration, praxis, judgment, language, orientation	Can be administered by trained clinicians Administration guidelines and training video freely available	Less influenced by culture, language, education; good in multicultural settings	While it can be helpful in detecting mild cognitive impairment, may miss very mild impairment, fewer norms in some groups Favorable for diverse population

Appendix F - Informant Interviews for Cognitive Screening

Tool	Purpose	Domains covered	Time to administer	Scoring	Notes
AD8 (8-Item informant Interview)	Early detection of cognitive changes informed by family or caregiver	Memory, problem-solving, orientation	3 minutes, can be given to respondent in advance of visit, requires respondent thinking time	2+ suggests cognitive impairment	Brief, easy to use, minimal training. Can be administered by non-clinical staff. Requires informant who has good knowledge of individual
Quick Dementia Rating System (QRDS)	Staging dementia severity across domains. Informed by family or caregiver	Memory, mood, behavior, language, function	10 items, takes 3-5 minutes, can be given to informant in advance of visit, requires respondent thinking time	Higher scores indicate greater severity	No training required to administer, high sensitivity and reliability, Broad, covers multiple domains, tracks cognitive change over time
Functional Activities Questionnaire (FAQ)	Assessing function/ impairment in daily tasks, informed by family or caregiver	Focus on real world function and daily tasks (finances, shopping, medication management)	10 items, approx. 1-3 mintues minutes, can be given to informant in advance of visit	Higher scores indicate greater functional decline	Assesses functional impact on cognitive loss. May not capture impairment in individuals able to mask impairment. High sensitivity and reliability, may be used to track or monitor change over time

*a limitation of each of these tools is that there are minimal studies to inform language or cultural adaptations to the tools. Often a literate, English-speaking informant is required, or translation assistance may be indicated.

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Appendix G - Inventory of other tools in use and how effectively they capture drivers of ALC (Sept 2025)

Tool	# of Items	Items Captured					Notes
		Dementia/ Cognitive Impairment	Delium	Falls	Caregiving Required	Caregiver Stress	
ISAR Step one of Two step intervention for seniors in ED Step two is SEISAR	6 item screener	Do you have serious problem with your memory?			Is someone needed to help on regular basis In last 24 hr have you needed more help than usual		
Blaylock Also called BRASS	10	x					Measures Behaviour which may capture elements of care partner burden or delirium. Does not ask about recent changes Likely more helpful for DC planning than predictive of ALC
MAPLe (Method for Assigning Priority Levels) Decision making tool to prioritize clients needing community or facility based services and plan allocation or resources	Uses RAI Data	X Captures CPS and worsening decision making Behaviour is captured					Identifies those at risk of hospitalization or LTC
CHESS Identify individuals at risk for serious health decline	RAI MDS outcome scale	Change in decision making only			Is someone needed to help on regular basis In last 24 hr have you needed more help than usual		MDS based

Appendix G - Inventory of other tools in use and how effectively they capture drivers of ALC (continued)

Tool	# of Items	Items Captured					Notes
		Dementia/ Cognitive Impairment	Delium	Falls	Caregiving Required	Caregiver Stress	
DIVERT				Falls frequency last 90 days			Can be pulled from RAI data
EQ-5D-5L Patient-reported Health related quality of life domains (mobility, self care, usual activities, pain and discomfort, anxiety/depression	5 item questionnaire						Numbers not summative, but describes health status snapshot of 5 health dimension.
Triage Risk Screening Tool (TRST)	5 items plus ADL ratings	Presence of cognitive impairment yes/no		Presence of gait disturbance or falls? Yes/no			Used in multiple EDs in region to determine who needs to be evaluated by GEM RNs
PRISMA 7	7 items			Presence or absence of gait aid	Do you need someone to help on a regular basis? Do you have problems that require you to stay home?		Brief and simple, sensitive in predicting frailty, not as widely used.

This table was informed by the inventory of screening tools cited in use across the NSM SGS region and compares to the leading ALC risk factors. For more specifics, please contact NSM SGS

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