

Senior Friendly 7



DELIRIUM



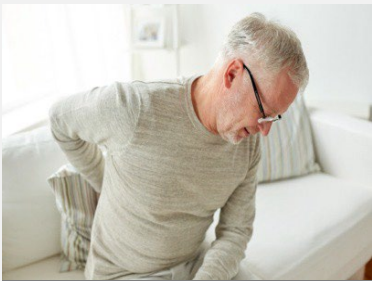
MOBILITY



CONTINENCE



NUTRITION



PAIN



POLYPHARMACY



SOCIAL ENGAGEMENT



SF7 TOOLKIT

THE SF7 TOOLKIT V4 2024

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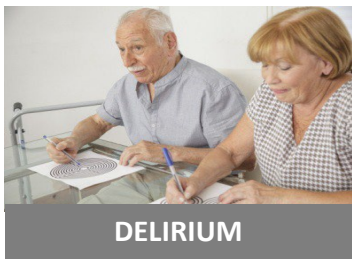
About this toolkit

The SF7 Toolkit is a Senior Friendly Care (sfCare) resource that supports clinical best practices for healthcare providers across the sectors of care and includes self-management tools for older adults and their caregivers. Senior Friendly 7 focuses on seven clinical areas that support resilience, independence, and quality of life.

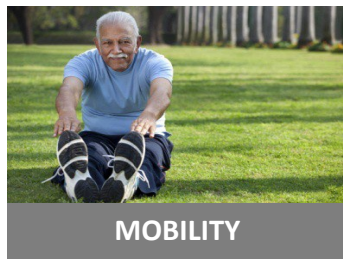


You will see this logo throughout the toolkit which is intended as a reminder to reflect on health equity. We have included practical tips to help providers get started with putting equity into practice.

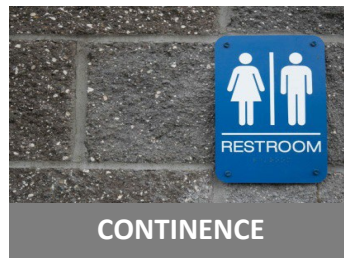
which is intended as a reminder to reflect on health equity. We have included practical tips to help providers get started with putting equity into practice.



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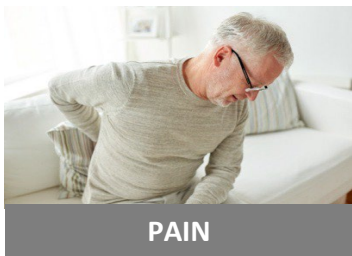
MOBILITY



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SF7 TOOLKIT

Use of this toolkit

The content for older adults and their family or caregivers is not intended to replace the advice of a physician or other qualified healthcare providers.

The toolkit provides a common practice framework that complements the unique skills and practices of the various care providers helping older adults. The content is provided for guidance, and is not intended to be exhaustive.

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Senior Friendly 7



DELIRIUM TOOLKIT



**REGIONAL GERIATRIC
PROGRAM OF TORONTO**

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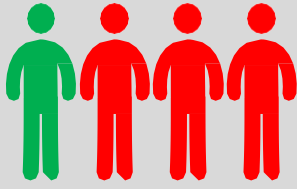
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What is delirium and how common is it?

Delirium is a **SUDDEN change** in a person's memory, thinking, and behaviour.

Delirium requires prompt medical attention!

More **COMMON** than you might think!



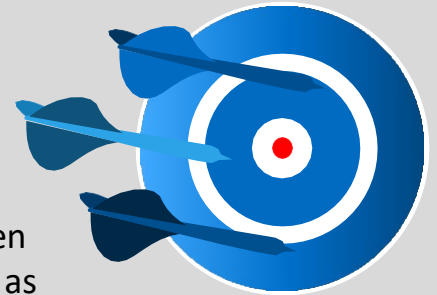
Up to 75%

Up to 75% of older adults experience delirium after acute illness or surgery.^[1]

Often **MISDIAGNOSED** or **NOT DETECTED!**

Sometimes mistaken for or documented as

- Dementia
- Depression
- Normal aging



Know the signs and symptoms. They often **fluctuate** throughout the day, and there may be periods of no symptoms. Primary signs and symptoms^[2] include changes in:

Perception of the environment such as:

- Lack of concentration and getting distracted easily.
- Not being able to respond to a question by getting stuck on a thought or an opinion.

Thinking skills such as:

- Poor recent memory
- Being disoriented to time and place
- Difficulty in comprehending speech, readings, and writings

Behaviour such as:

- Hallucination (seeing things that do not exist)
- Delayed response and movement
- Significant changes in sleep habits

Emotion such as:

- Rapid and unpredictable mood changes
- Feeling depressed or euphoric without reason



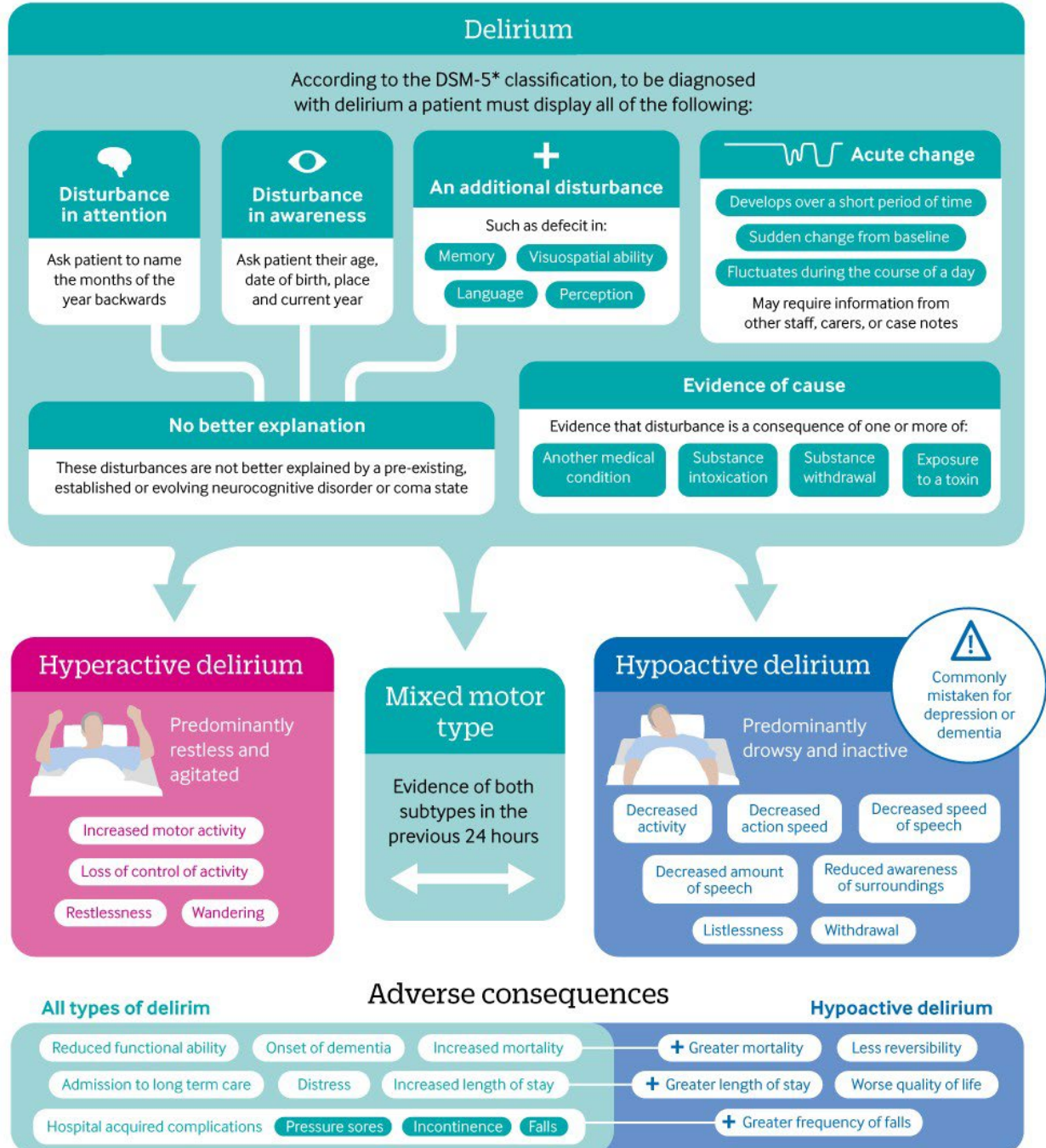
Do you have biases about “normal aging” or about dementia that might be influencing your assessment of an older adult? When in doubt, check them out.

Identifying delirium and understanding consequences

Visual summary

Quietly delirious

Hypoactive delirium can be more difficult to recognise than hyperactive delirium, and is associated with worse outcomes. This infographic summarises the main differences between the two forms of delirium.



* DSM-5 = Diagnostic and Statistical Manual of Mental Disorders (fifth edition)

thebmj Read the full article online <http://bmj.co/delirium>

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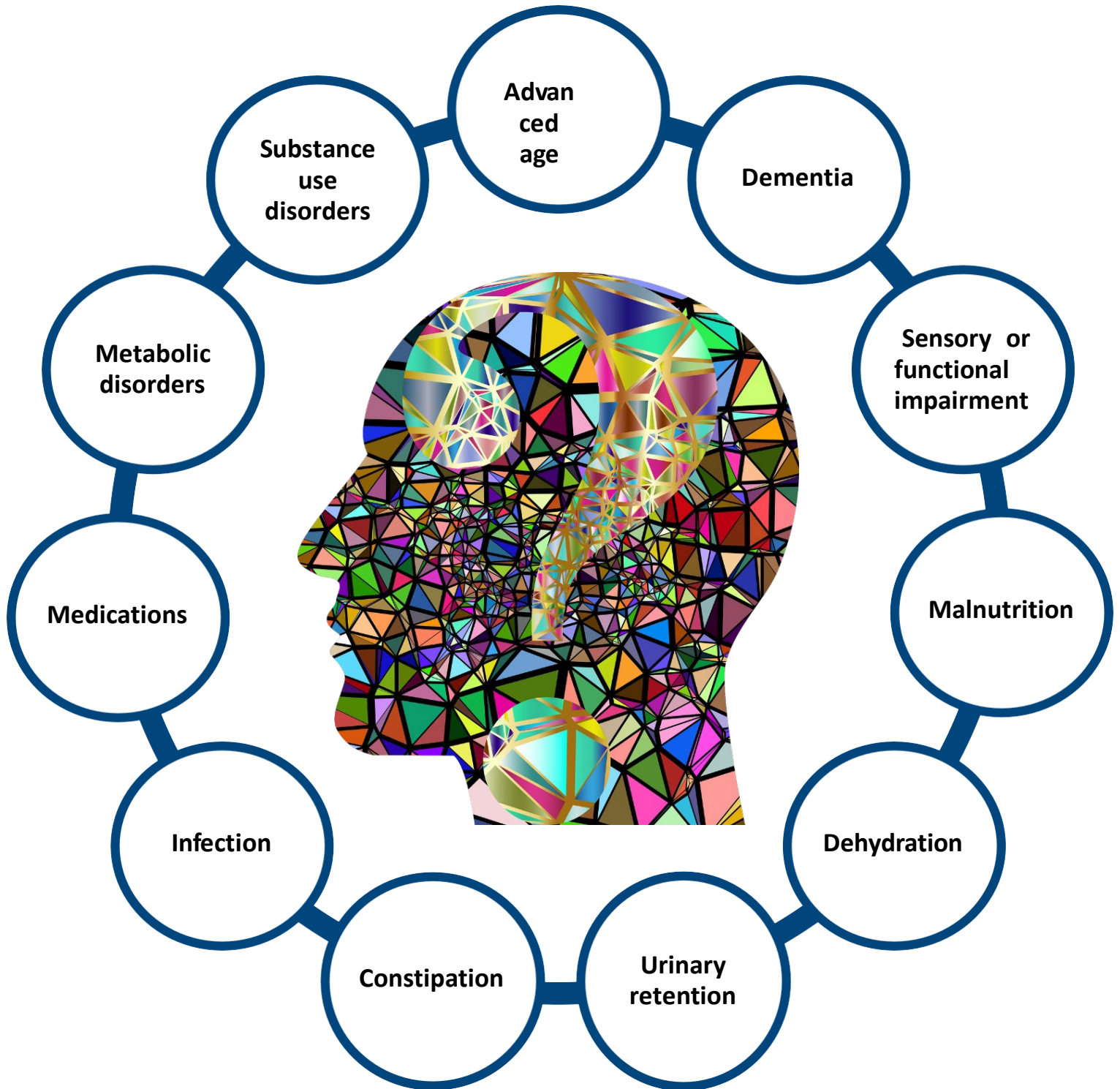
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Factors influencing delirium in older adults

Awareness of risk factors is a key to prevention and diagnosis.

Some of the factors which can predispose someone to delirium or precipitate delirium include:



[For more information, see the Assessment and Management in Delirium Patients Quick Reference Card](#) (Canadian Coalition for Seniors' Mental Health, 2010)

6 PROVEN STRATEGIES TO PREVENT DELIRIUM IN OLDER ADULTS



*Adapted with permission from: A Multicomponent Intervention to Prevent Delirium in Hospitalized Older Patients (Inouye et al., 1999)

Delirium information for older adults + family

Delirium requires prompt medical attention!

Prompt recognition and treatment may reduce the likelihood of long-term complications.

If you or your family member notice sudden changes in thinking, memory or personality you should report your concerns to a doctor or nurse immediately so that they can fully assess.

You may want to use this Delirium Detection Questionnaire for Caregivers (Trillium Health Partners, 2014)^[3] which highlights **7 changes which may help identify delirium**. It can be used to help communicate your concerns to a doctor or nurse.

Delirium Detection Questionnaire for Caregivers

During your interaction with the person today, have you observed any of the following?

			YES	NO
1	Altered level of awareness to the environment in any way different than being normally awake.		<input type="text" value="3"/>	<input type="text" value="0"/>
2	Reduced attentiveness; inability to focus on you during the interaction.		<input type="text" value="4"/>	<input type="text" value="0"/>
3	Fluctuation in awareness and attentiveness such as drifting in and out during an interaction or through the day.		<input type="text" value="3"/>	<input type="text" value="0"/>
4	Disordered thinking; the response (whether verbal or action) is unrelated to the question or request.		<input type="text" value="3"/>	<input type="text" value="0"/>
5	Disorganized behaviour; purposeless, irrational, under-responsive or over-responsive to requests.		<input type="text" value="2"/>	<input type="text" value="0"/>
6	Unexplained impaired eating or drinking (excluding appetite); unable to perform the actions to feed oneself.		<input type="text" value="2"/>	<input type="text" value="0"/>
7	Unexplained difficulty with mobility or movement.		<input type="text" value="1"/>	<input type="text" value="0"/>
Score	Predictive	Value Description		TOTAL
4	89%	Possible delirium: evaluate potential medical causes, medications, substances, etc.	<input type="text"/>	
9	100%	Delirium: immediate medical evaluation required.		

Learn more about delirium in the pamphlet [Delirium Prevention and Care with Older Adults](#) (Canadian Coalition for Seniors' Mental Health, 2016) or [the Changes in Thinking and Behaviour \(Delirium\) chapter](#) (Provincial Geriatrics Leadership Ontario, 2019)

Delirium in home and community care

ASSESS



- If you notice sudden changes in thinking, memory or personality consider using The Delirium Detection Questionnaire for Caregivers (*page 10*). This tool looks at 7 changes which may help identify delirium, and can be used to help communicate your concerns to a doctor or nurse.
- OR
- If you are a clinician who is familiar with the [CAM](#) (Confusion Assessment Method) (*Hospital Elder Life Program, 2003*) use this tool as part of an initial assessment.

MANAGE



- For all older adults, use proven strategies to prevent delirium (*page 9*).
- If the CAM is positive, this should prompt immediate assessment by a physician or nurse.

COMMUNICATE



- Communicate findings within the circle of care (healthcare team).
- Support older adult and their family. Consider providing written information about delirium, such as [the Delirium Prevention and Care with Older Adults handout](#) (*Canadian Coalition for Seniors' Mental Health, 2016*) or [the Changes in Thinking and Behaviour \(Delirium\) chapter](#) (*Provincial Geriatrics Leadership Ontario, 2019*)

Learn more about preventing, identifying or supporting an older adult in the community who has or is at risk of delirium: [Delirium Micro-Learning Modules for the Community](#)

Delirium in primary care

ASSESS



- When an older adult presents with a change in their condition, be aware that this may trigger a delirium
- Consider using the [CAM](#) (Confusion Assessment Method) (Hospital Elder Life Program, 2003) or the [4 AT Assessment Test](#) for delirium & cognitive impairment (MacLulich A., Ryan T., Cash H., 2011) as a screening tool.
- Consider asking families or homecare providers to complete The Delirium Detection Questionnaire for Caregivers (page 10) or the [FAM CAM](#) (Family Confusion Assessment Method) tool.
- If the older adult screens positive for delirium, search for a cause, using the [Delirium Assessment and Treatment for Older Adults – Clinician’s Pocket Card](#) (Canadian Coalition for Seniors' Mental Health, 2024)

MANAGE



- For all older adults, use proven strategies to prevent delirium (page 9).
- Provide treatment for underlying causes and supportive care for delirium symptoms or refer to an emergency department as needed. For more information on the prevention and management of delirium:
 - [Delirium Quality Standard](#) (Ontario Health, 2021)
 - [Canadian Coalition for Seniors' Mental Health](#)
 - [Hospital Elder Life Program \(HELP\)](#) for the prevention of delirium

COMMUNICATE



- Communicate findings within the circle of care (healthcare team).
- Support the older adult and their family. Consider providing written information about delirium, such as [the Delirium Prevention and Care with Older Adults handout](#) (Canadian Coalition for Seniors' Mental Health, 2016) or [the Changes in Thinking and Behaviour \(Delirium\) chapter](#) (Provincial Geriatrics Leadership Ontario, 2019)
- For planned admission to hospital, communicate previous incidence of delirium or suspected risk of delirium.

Delirium in hospital

ASSESS



- Screen for delirium daily using the [CAM](#) (Confusion Assessment Method) (Hospital Elder Life Program, 2003) or the [4 AT Assessment Test](#) for delirium & cognitive impairment (MacLulich A., Ryan T., Cash H., 2011) as a screening tool.
- If the older adult screens positive for delirium, search for a cause, using [the Delirium Assessment and Treatment for Older Adults – Clinician’s Pocket Card](#) (Canadian Coalition for Seniors’ Mental Health, 2010)

MANAGE



- For all older adults, use proven strategies to prevent delirium (page 9).
- Provide treatment for underlying causes and supportive care for delirium symptoms or refer to an emergency department as needed. For more information on the prevention and management of delirium:
 - [Delirium Quality Standard](#) (Ontario Health, 2021)
 - [Canadian Coalition for Seniors’ Mental Health](#)
 - [Hospital Elder Life Program \(HELP\)](#) for the prevention of delirium
- For planned surgical procedures, there are several tools available for delirium risk screening: [The Delirium Prediction Based on hospital Information \(Delphi\) in general surgery patients](#) (Kim MY., Park UJ., Kim HT., Cho WH., 2016), The European System for Cardiac Operative Risk Evaluation (EuroSCORE) <http://www.euroscore.org/> (EuroSCORE study group, 2011) and [The Delirium Elderly At Risk \(DEAR\)](#) (Freter, SH. Copyright © 2004-2010 by Dalhousie University) tool for orthopedic surgery.

COMMUNICATE



- Support the older adult and their family. Consider providing written information about delirium, such as [the Delirium Prevention and Care with Older Adults handout](#) (Canadian Coalition for Seniors’ Mental Health, 2016) or [the Changes in Thinking and Behaviour \(Delirium\) chapter](#) (Provincial Geriatrics Leadership Ontario, 2019)
- For older adults who experienced delirium in hospital, include recommendations related to follow up care in discharge plans.

Learn more about preventing, identifying or supporting an older adult who has or is at risk of delirium in hospital: [Delirium Micro-Learning Modules for Acute Care](#)

Delirium in long-term care

ASSESS



- Know the signs of delirium, and look for changes in the older adult's condition.
- Consider using the [CAM](#) (Confusion Assessment Method) (Hospital Elder Life Program, 2003) or the [4 AT Assessment Test](#) for delirium & cognitive impairment (MacLulich A., Ryan T., Cash H., 2011) as a screening tool.
- Consider asking families or homecare providers to complete The Delirium Detection Questionnaire for Caregivers (page 10) .
- If the older adult screens positive for delirium, search for a cause, using [the Delirium Assessment and Treatment for Older Adults – Clinician's Pocket Card](#) (Canadian Coalition for Seniors' Mental Health, 2010)

MANAGE



- For all older adults, use proven strategies to prevent delirium (page 9).
- Provide treatment for underlying causes and supportive care for delirium symptoms or refer to an emergency department as needed. For more information on the prevention and management of delirium:
 - [Delirium Quality Standard](#) (Ontario Health, 2021)
 - [Canadian Coalition for Seniors' Mental Health](#)
 - [Hospital Elder Life Program \(HELP\)](#) for the prevention of delirium

COMMUNICATE



- Communicate findings within the circle of care (healthcare team).
- Support the older adult and their family. Consider providing written [information about delirium, such as the Delirium Prevention and Care with Older Adults handout](#) (Canadian Coalition for Seniors' Mental Health, 2016) or [the Changes in Thinking and Behaviour \(Delirium\) chapter](#) (Provincial Geriatrics Leadership Ontario, 2019)

References

1. Inouye SK, Westendorp RG, Saczynski JS, Kimchi EY, Cleinman AA. Delirium in elderly people--authors'reply. *Lancet*. 2014;383(9934):2045.
2. Clinic M. Delirium Webpage Mayo Clinic 2018 [cited 2018 September 14]. Available from: mayoclinic.org/diseases-conditions/delirium/symptoms-causes/syc-20371386?p=1.
3. Shulman RW, (THP). THP. Additional file 1: of Validation of the Sour Seven Questionnaire for screening delirium in hospitalized seniors by informal caregivers and untrained nurses *BMC Geriatrics*: Copyright ©2014 [Available from: <https://pubmed.ncbi.nlm.nih.gov/26879927/>]
4. CCSMH. Assessment and Management of Delirium in Older Adults Canadian Coalition for Seniors' Mental Health 2010 : [Available from: ccsmh.ca/projects/delirium/].
5. CCSMH. Delirium Prevention and Care with Older Adults 2017. [Available from: ccsmh.ca/wp-content/uploads/2017/06/CCSMH-8.5-x-11-Delirium-R1-1.pdf]
6. Inouye SK. *Hospital Elder Life Program (HELP) for Prevention of Delirium HELP1999* [Available from: help.agscocare.org/]
7. Morandi A, Solberg LM, Habermann R, Cleeton P, Peterson E, Ely EW, et al. Documentation and management of words associated with delirium among elderly patients in postacute care: a pilot investigation. *J Am Med Dir Assoc*. 2009;10(5):330-4.
8. Voyer P, Richard S, Doucet L, Carmichael PH. Predisposing factors associated with delirium among demented long-term care residents. *Clin Nurs Res*. 2009;18(2):153-71.
9. Pam B. Hallucinations in Hospital Pose Risk to Elderly. *New York Times*. 2010.
10. Voyer P, Richard S, Doucet L, Cyr N, Carmichael PH. Examination of the Multifactorial Model of Delirium Among Long-Term Care Residents with Dementia. *Geriatric Nursing*. 2010;31(2):105-14.
11. Chan P. Clarifying the confusion about confusion: Current practices in managing geriatric delirium. *BCM J*. 2011;53(8):409-15.
12. Nashef SAM, Roques F, Michel M, Goldstone T. European System for Cardiac Operative Risk Evaluation (EuroSCORE) 2011 [Available from: euroscore.org/]
13. MacLulich A, Ryan T, Cash H. 4AT rapid clinical test for delirium www.the4AT.com 2011, updated 2014. [updated (Edinburgh Delirium Research Group, University of Edinburgh, Scotland). Available from: the4at.com/].
14. Cage L, Hogan D. 2014 CCSMH Guideline Update: The Assessment and Treatment of Delirium.: Toronto: Canadian Coalition for Senior's Mental Health (CCSMH); 2014 [Available from: ccsmh.ca].
15. CHSAH. Overview for Delirium in the Long-Term Care Setting sagelink.ca 2014.
16. Davis D, Barnes L, Stephan B, MacLulich A, Meagher D, Copeland J, et al. The descriptive epidemiology of delirium symptoms in a large population-based cohort study: results from the Medical Research Council Cognitive Function and Ageing Study (MRC CFAS). *BMC Geriatrics*. 2014;14(87).
17. Bush S, Lawlor P. Five things to know about delirium. *CMAJ*. 2015;187(2):129.
18. Mikhailovich A. The American Geriatrics Society/National Institute on Aging Bedside-to-Bench Conference: Research Agenda on Delirium in Older Adults. *Journal of the American Geriatrics Society*. 2015;63(5):843-52.
19. Canadian Coalition for Seniors' Mental Health. Delirium Prevention and Care with Older Adults [https://ccsmh.ca](http://ccsmh.ca)
20. Freter S, Dunbar M, Koller K, MacKnight C, Rockwood K. Risk of Pre-and Post-Operative Delirium and the Delirium Elderly At Risk (DEAR) Tool in Hip Fracture Patients 2016. 212-6 p.
21. Shulman RW, Kalra S, Jiang JZ. Validation of the Sour Seven Questionnaire for screening delirium in hospitalized seniors by informal caregivers and untrained nurses. *BMC Geriatrics*. 2016;16:44.
22. Visual Summary Quietly Delirious [Internet]. *The BMJ*. 2017. [Available from: bmj.com/content/357/bmj.j2047]
23. Wong CL, Holroyd-Leduc J, Simel DL, Straus SE. Does this patient have delirium?: value of bedside instruments. *Jama*. 2010;304(7):779-86.
24. Inouye SK. Delirium-A Framework to Improve Acute Care for Older Persons. *Journal of the American Geriatrics Society*. 2018;66(3):446-51.
25. Shenkin SD, Fox C, Godfrey M, Siddiqi N, Goodacre S, Young J, et al. Protocol for validation of the 4AT, a rapid screening tool for delirium: a multicentre prospective diagnostic test accuracy study. *BMJ Open*. 2018;8(2):e015572.
26. Kim MY, Park UJ, Kim HT, Cho WH. Delirium prediction based on hospital information (Delphi) in general surgery patients. *Medicine (United States)*. *PubMed Central*® 2016.;95 (12) (nopagination)(e3072).

Senior Friendly 7



MOBILITY TOOLKIT



**REGIONAL GERIATRIC
PROGRAM OF TORONTO**

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The many benefits of mobilization

Mobilizing is one of the most important ways to maximize function and independence!

Skin

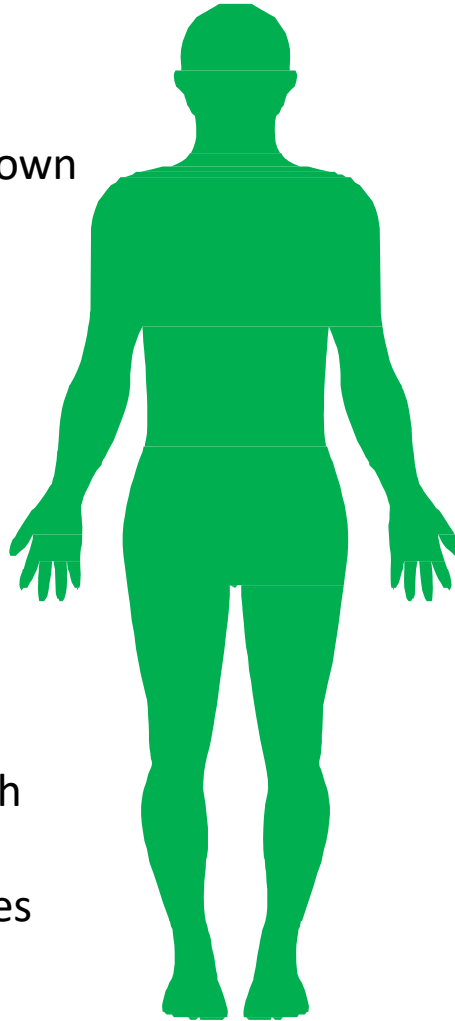
Prevents skin breakdown

Nutrition

- Improves appetite
- Lowers choking risk when eating

Muscles/Bones

- Improves strength
- Improves pain
- Strengthens bones



Memory/Mood

- Improves sleep and mood
- Decreases risk of confusion

Heart

Improves blood pressure and circulation

Lungs

- Improves breathing
- Helps to clear lungs
- Helps to fight infection



Benefits are achieved with even small amounts of activity!

Adapted from MOVEON movescanada.ca



PREVALENCE AND OUTCOMES OF IMMOBILIZATION IN OLDER ADULTS

In Hospital



Up to **83%** of time in hospital is spent **in bed** (Brown, 2009)



- Almost **35%** of **patients 70+** decline **in function** after a hospital admission.
- Immobility **increases length of stay** and **decreases rate of return home**

In the Community



Only **14%** of older adults **aged 65–79** are meeting the Canadian **physical activity** guidelines of 150 minutes of moderate-to-vigorous physical activity per week in bouts of 10 minutes or more. (Statistics Canada, 2014/15)



- Immobility **shortens lifespan**
- Immobility **doubles the risk of functional disability** (Hubbard, Parsons, Neilson & Carey, 2009)
- Immobility **increases risk of falling**
- Immobility **increases level of assistance needed** for daily living

In Long-Term Care



75% of **awake time** in LTCHs is **sedentary** (De Souto Barreto, 2016)



- Immobility **increases level of assistance needed** for daily living

Onset of **complications** can occur **within 24 hours** of bed rest!

Assessing mobility level

Mobilization is possible in all care settings - even in critical care!

Simplified Mobility Assessment Algorithm



This algorithm can be used by all staff to determine mobility level

- | | | | |
|---|---|----------|--------------------------|
| 1. Able to respond to verbal stimuli? | } | C | Cannot stand to transfer |
| 2. Able to roll side to side? | | | |
| 3. Able to sit at edge of the bed? | | | |
| 4. Able to straighten one or both legs? | | | |
| 5. Able to stand? | | | |
| 6. Able to transfer to a chair? | } | B | Bed to chair transfers |
| 7. Able to walk a short distance? | } | A | Ambulates |

Develop individualized mobility care plan

The level of mobility can be used to guide an individualized mobility care plan that is tolerated, safe, and (ideally) fun! This may involve a specific program or just making a habit of incorporating mobilization into daily activities and socializing.

movescanada.ca



EVERYONE can use support to help them move more. Ask yourself “Will I help ALL of the older patients in my care move more today?”

Creating a mobility care plan

A personalized mobility care plan should be based on the older adult's level of mobility. It should incorporate core activities as well natural opportunities for mobilization in every day activities based on the older adult's preference.



Mobility level		Core mobilization activities	Natural opportunities for mobilization
A1	Ambulates independently		<ul style="list-style-type: none"> • Participate in personal care • Use the bathroom for toileting
A2	Ambulates with assistance	Ambulate 3x/day or more, with or without a gait aid	<ul style="list-style-type: none"> • Eat meals sitting in chair/wheelchair • Active range of motion exercises
B	Bed to chair transfers	Up to chair or wheelchair 3x/day or more	<ul style="list-style-type: none"> • Participate in personal care • Bathroom (BR)/commode chair for toileting • Eat meals sitting in chair/wheelchair • Self-propel wheelchair • Active range of motion exercises
C	Cannot stand to transfer	<ul style="list-style-type: none"> • Mechanical lift to chair/wheelchair • Active/passive repositioning every 2 hours 	<ul style="list-style-type: none"> • Participating in personal care • Upright/side of bed/chair for meals • Standing with assistance • Active/passive range of motion exercises 3x/day and/or self-propel
Other opportunities for mobilization		Participating in personal care, toileting, up for meals, range of motion exercises	

movescanada.ca

Mobility information for older adults + family

General Guidelines

If your mobility is not limited, aim for 2.5 hours of moderate level physical activity weekly, in sessions of at least 10 minutes.

TIP – moderate level physical activities raise your heart rate and make you sweat a little and breathe a little faster. You should be able to talk but not be able to sing during the activity.

If your mobility is limited or you require assistance, aim to be as physically active as your abilities or condition allows, and do muscle strengthening at least twice a week.

Resources to help you get active

- [The Canadian Physical Activity Toolkit for Older Adults](#) (*Participation, 2018*) includes Canadian physical activity guidelines, tips on fun ways to stay active, a movement log, an 8-week walking program, and helpful tips for staying active with various health conditions.
- [Stretch, Lift or Tap \(SLoT\) program](#) (*RGP of Toronto 2021*) includes resources to help older adults move more with their daily activities.
- To find activities in your community, visit: ontario.ca/page/seniors-connect-your-community

Build movement into daily activities. Some examples include:

- Walking to nearby stores
- Walking to the post box
- Getting off the bus one stop early
- Slow bouncing on toes while dishwashing
- Moving arms and legs even when you're sitting down or lying in bed.
- Picking hobbies for their movement potential e.g. swimming, dancing, or hiking



Speak with your healthcare provider about the kind of physical activity that is recommended for you.

Mobility in home and community care

ASSESS



- Assess level of mobility using the Simplified Mobility Assessment Algorithm (page 20).
- Identify changes in the status in the older adult's mobility.
- Identify barriers to mobilization (e.g. physical, social, emotional, and cognitive).
- Identify the older adult's interests to help tailor activities appropriately.

MANAGE



- In general, most older adults should be encouraged to mobilize 2.5 hours per week in sessions of at least 10 minutes long.
- Use the activities suggested for each level of mobility (page 21) as a starting point for developing an activity plan.
- Encourage older adults to mobilize as much as possible during their daily activities (such as walking to bathroom, lifting their arms, [shrugging their shoulders, etc.](#)). Use the [Stretch, Lift or Tap \(SLoT\) program](#) (RGP of Toronto 2021) includes resources to help older adults move more with their daily activities
- Think about how to overcome any barriers that have been identified.

COMMUNICATE



- Try different approaches when encouraging older adults to mobilize. Some older adults may be motivated by the term “exercise”, while others may prefer to talk about being “more active” or “sitting less”.
- Identify and make referrals as needed to community programs for older adults – [click here for the Ontario Guide to Programs and Services for Seniors](#).
- Share information on your assessment of mobility levels and changes in mobility status within the circle of care (healthcare team).
- Provide printed information on physical activity, such as the [Canadian Physical Activity Toolkit for Older Adults](#) (Participation, 2018) and the [Stretch, Lift or Tap \(SLoT\) program](#) (RGP of Toronto 2021).

Mobility in primary care

ASSESS



- History should include:
 - ✓ Current and baseline ability in walking, balance, and function
 - ✓ Past mobility problems and interventions
 - ✓ Functional needs and preferences
- Mobility can be monitored in ambulatory patients using the [Timed Up & Go](#).
- Older adults can self-assess their physical activity periodically using the [RAPA Tool](#) and bring it with them on their next appointment.

MANAGE



- In general, most older adults should be encouraged to mobilize 2.5 hours per week in sessions of at least 10 minutes long.
- Recommend ways to build mobilization into the activities of daily living. Suggest the [Stretch, Lift or Tap \(SLoT\) program](#) (RGP of Toronto 2021) which includes resources to help older adults move more with their daily activities.
- Remember that bed- or chair-dependent older adults also benefit from appropriate activity.
- Use the activities suggested for each level of mobility (page 21) as a starting point for developing an activity plan.

COMMUNICATE



- Try different approaches when encouraging older adults to mobilize. Some older adults may be motivated by the term “exercise”, while others may prefer to talk about being “more active” or “sitting less”
- Consider referrals such as:
 - Community programs for older adults. [Click here for the Ontario Guide to Programs and Services for Seniors](#).
 - Specialized Geriatric Services (SGS). [Click here to search Healthline for SGS close to the older adult’s home](#).
- Document and communicate mobility level and any concerns within the circle of care (healthcare team).
- Provide printed information on physical activity, such as [the Canadian Physical Activity Toolkit for Older Adults](#) (Participation, 2018) and the [Stretch, Lift or Tap \(SLoT\) program](#) (RGP of Toronto 2021).

Mobility in hospital

ASSESS



- Ask about mobility level prior to admission to hospital.
- Assess level of mobility within 24 hours of admission using the Simplified Mobility Assessment Algorithm (page 20).
- Assess functional level on admission and discharge using [the Barthel Index](#).
- Refer to a physiotherapist and/or occupational therapist for further assessment when complex mobility issues are identified.
- Reassess mobility level daily, with the aim of progressing mobility.

MANAGE



- Encourage the older adult to mobilize at least 3 times per day.
- Use the activities suggested for each level of mobility (page 21) as a starting point for developing an activity plan.
- Ensure that there is a family member or staff available to assist if mobility risks are identified.

COMMUNICATE



- Try different approaches when encouraging older adults to mobilize. Some older adults may be motivated by the term “exercise”, while others may prefer to talk about being “more active” or “sitting less”.
- Throughout hospitalization, communicate the older adult’s mobility level to the team so that they can promote mobilization.
- On discharge, emphasize the importance of mobilization, and consider referrals such as:
 - Community programs for older adults – [click here for the Ontario Guide to Programs and Services for Seniors](#)
 - Specialized Geriatric Services (SGS). [Click here to search Healthline for SGS close to the older adult’s home](#)
- Provide printed information on physical activity, such [as the Canadian Physical Activity Toolkit for Older Adults](#) (Participation, 2018) and [the Stretch, Lift or Tap \(SLOT\) program](#) (RGP of Toronto 2021).
- Communicate mobility level and any concerns within the circle of care (healthcare team).

Resource: [MovesCanada](#) provides a set of resources to implement a mobility program in hospitals.

Mobility in long-term care

ASSESS



- Assess level of mobility using the Simplified Mobility Assessment Algorithm (page 20).
- Consider that motivation and pleasure are key elements to drive mobility/activity – activities should be enjoyable for the older adult.
- Review medications and health conditions that may be impacting mobility.

MANAGE



- Maximize the older adult's participation in activity programs and social events according to their preferences.
- Use the activities suggested for each level of mobility (page 21) as a starting point for developing an activity plan.
- Look for natural opportunities to incorporate mobilization in usual care activities (e.g. walking to bathroom or dining room, assisting with dressing or bathing, pet visits).
- Adopt strategies to break up sedentary time (e.g. stretch breaks) several times per day.
- Identify and make referrals for further assessment and intervention as needed, particularly if an older adult's mobility changes (e.g. refer to physiotherapist or occupational therapist).

COMMUNICATE



- Try different approaches when encouraging older adults to mobilize. Some older adults may be motivated by the term “exercise”, while others may prefer to talk about being “more active” or “sitting less”.
- Engage family members to support mobilization during visits and to encourage their loved one to participate in activity programs.
- Document and communicate mobility level within the circle of care (healthcare team), including during transitions or transfer of accountability.

Resource: [Maintaining & Improving Mobility in Ontario LTC Homes Webinar - Caitlin McArthur](#) (Schlegel – University of Waterloo Research Institute for Aging, Feb 2018)

References

1. Regional Geriatric Programs of Ontario, Geriatrics Interprofessional Interorganizational Collaboration (GiiC). Falls, Frailty e-learning modules RGP of Ontario. [cited 2018 September 14]. Available from: geriatricessentialslearning.ca/
2. Mahoney F, Barthel D. Functional Evaluation: the Barthel Index www.strokecenter.org: The Internet Stroke Center, by National Institute of Neurological Disorders and Stroke & UT Southwestern Medical Center.; 1965]. Available from: sralab.org/rehabilitation-measures/barthel-index
3. Covinsky KE, Palmer RM, Fortinsky RH, Counsell SR, Stewart AL, Kresevic D, et al. Loss of independence in activities of daily living in older adults hospitalized with medical illnesses: increased vulnerability with age. *J Am Geriatr Soc*. 2003;51(4):451-8.
4. HPRC. Rapid Assessment of Physical Activity (RAPA) © 2018 HPRC: Health Promotion Research Center, University of Washington; 2006 [Available from: depts.washington.edu/hprc/resources/products-tools/rapa/].
5. World Health Organization. Age-friendly primary health care centres toolkit: WHO; 2008 [Available from: emro.who.int/elderly-health/age-friendly-phc-centres/].
6. Brown CJ, Redden DT, Flood KL, Allman RM. The underrecognized epidemic of low mobility during hospitalization of older adults. *J Am Geriatr Soc*. 2009;57(9):1660-5.
7. Hubbard IJ, Parsons MW, Neilson C, Carey LM. Task-specific training: evidence for and translation to clinical practice. *Occup Ther Int*. 2009;16(3-4):175-89.
8. Canadian Society for Exercise Physiology. Tips to get active Physical Activity Tips for Older Adults (65 years and older): Government of Canada; 2011 [Available from: publications.gc.ca/collections/collection_2011/aspc-phac/HP10-16-4-2011-eng.pdf].
9. Regional Geriatric Program of Toronto. The Ontario Senior Friendly Hospital Strategy Delirium and Functional Decline Indicators: www.rgptoronto.ca; 2012 [Available from: rgptoronto.ca/wp-content/uploads/2017/12/SFH_Delirium_and_Functional_Decline_Indicators.pdf]
10. Statistics Canada. The Canadian Health Measures Survey 2007/2008 to 2012/2013. 2013 [Available from: statcan.gc.ca/eng/about/er/chmser].
11. Garriguet D, Colley R. A comparison of self-reported leisure time physical activity and measured moderate-to-vigorous physical activity in adolescents and adults: Statistics Canada; 2014 [cited 2018 September 4]. Available from: www150.statcan.gc.ca/n1/en/pub/82-003-x/2014007/article/14038-eng.pdf?st=CE6QXfEc.
12. American College of Rheumatology. Timed Up and Go (TUG): © 2018 American College of Rheumatology.; 2015 Available from: https://www.cdc.gov/m-steady/pdf/TUG_test-print.pdf
13. Liu B, Straus S, Holroyd-Leduc J, Moore J, Khan S, Harris C. the MOVE Program. © 2015 MOVE Canada. All Rights Reserved. [Available from: movescanada.ca]
14. de Souto Barreto P, Morley JE, Chodzko-Zajko W, K HP, Weening-Dijksterhuis E, Rodriguez-Manas L, et al. Recommendations on Physical Activity and Exercise for Older Adults Living in Long-Term Care Facilities: A Taskforce Report. *J Am Med Dir Assoc*. 2016;17(5):381-92.
15. Government of Ontario. Seniors: connect with your community 2017 [Available from: ontario.ca/page/seniors-connect-your-community].
16. Government of Canada. A Common Vision for increasing physical activity and reducing sedentary living in Canada: *Let's Get Moving 2018* [Available from: canada.ca/en/public-health/services/publications/healthy-living/lets-get-moving.html].
17. McArthur C. Maintaining & Improving Mobility in Ontario Long-Term Care Homes webinar with Caitlin McArthur: Schlegel-UW Research Institute for Aging; 2018 [Available from: youtube.com/watch?v=Yo3vJaO0w4k].
18. ParticipACTION, Recreation Newfoundland and Labrador, Government of Newfoundland and Labrador. Physical Activity Toolkit for Older Adults 2018 [Available from: seniorsnl.ca/app/uploads/2018/05/Older-Adult-Physical-Activity-Toolkit.pdf].
19. The Ministry of Seniors Affairs. A Guide to programs and services for seniors in Ontario: Service Ontario Publications; 2022 [Available from: <https://files.ontario.ca/msaa-guide-to-programs-services-for-seniors-fall-en-2023-01-26.pdf>]
20. Thehealthline.ca. The health line: Find local health and community services across Ontario: © 2018, thehealthline.ca 2018 [Available from: thehealthline.ca/].

Senior Friendly 7



URINARY CONTINENCE TOOLKIT

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Prevalence and outcomes of urinary incontinence



Urinary incontinence is defined as **involuntary loss of bladder control causing the release of urine.**

Urinary incontinence is under-reported.

Older adults may not want to discuss the issue and healthcare providers may not ask.

Men and women of all ages



Urinary incontinence can occur in adults of all ages. Approximately **5% of men and 7% of women** experience daily urinary incontinence.^[1]

>84 years of age



The prevalence of urinary incontinence increases with age. After age 84, approximately **15% of men and 24% of women** are reported to have urinary incontinence.^[1]

Older adults in institutions



The prevalence of urinary incontinence for older adults in institutions (such as long term-care homes or hospitals) is approximately **37% for both men and women.**^[1]

Urinary incontinence can have a significant impact on quality of life including:

- X** depression
- X** falls
- X** loss of sexual intimacy
- X** social isolation
- X** pressure sores
- X** financial burden

Assessing urinary incontinence

Assessing for urinary incontinence can be challenging due to:

- Embarrassment, stigma or the misconception that urinary incontinence is a normal part of aging. This may prevent older adults from recognizing or discussing their symptoms.
- Misunderstanding of what urinary incontinence is due to different definitions and terminology used.
- No validated screening tools. However, **these 3 questions may be helpful to initiate a conversation about urinary incontinence** in a non-judgmental way:



- Does your bladder cause you concern or embarrassment?
- Do you leak urine before getting to the toilet? How often does this happen? Has this happened today?
- Are you rushing to the toilet or looking for a toilet frequently?

Adapted from: "Identifying Continence Issues" health.vic State Government of Victoria, Australia, 2017. www2.health.vic.gov.au/hospitals-and-health-services/patient-care/older-people/continence@ Copyright State of Victoria 2018.



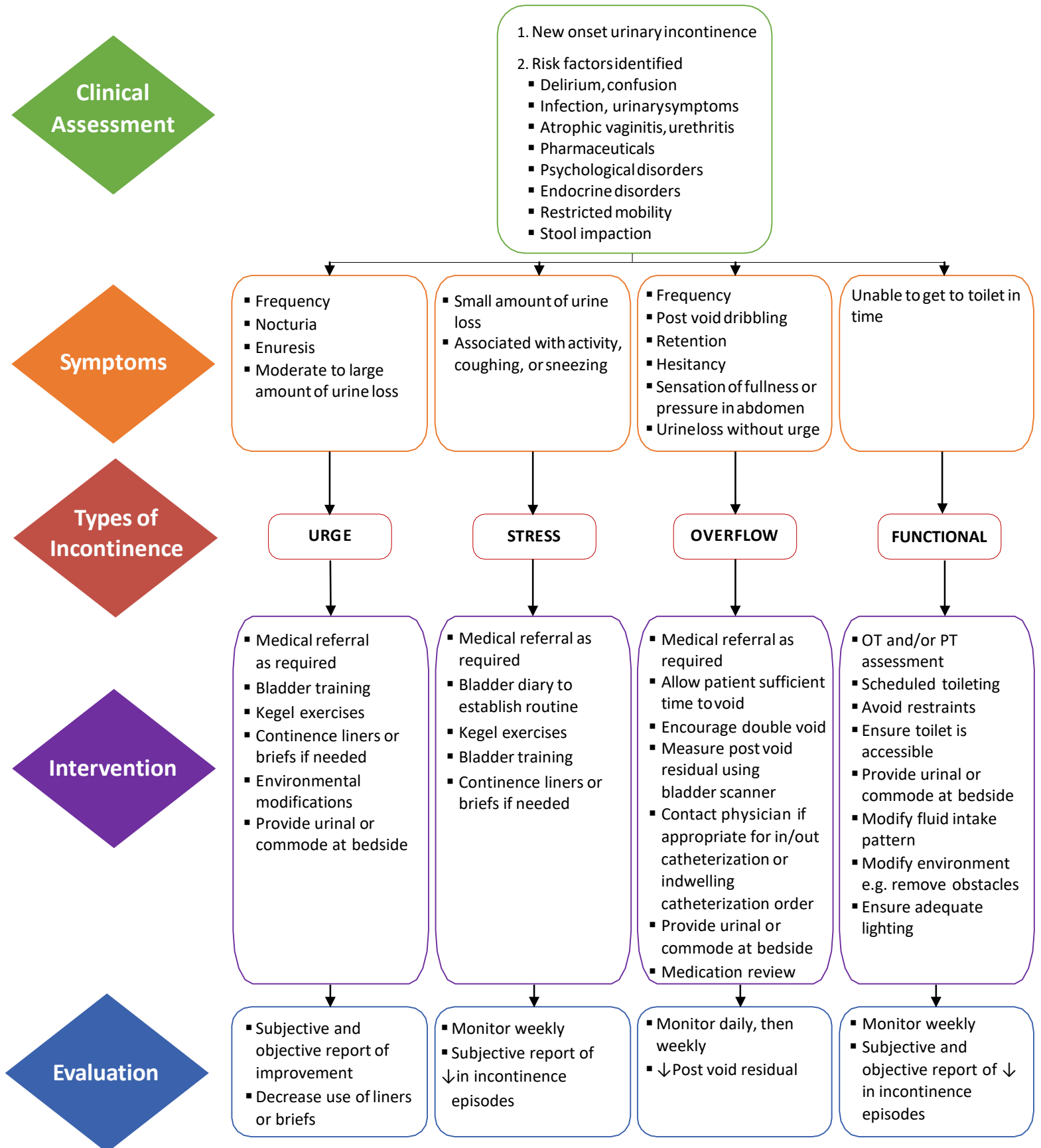
Do you have biases about “normal aging”? Urinary incontinence is not a normal part of aging. It is often a symptom of an underlying health problem. It can be treated or managed. Address incontinence as a health issue just as you would for adults of all ages.

Types of urinary incontinence

Functional incontinence	Not being able to get to the toilet in time due to an issue outside the urinary system (e.g. mobility issues, cognition, medications).
Transient incontinence	Caused by reversible factors and can resolve or improve if the cause is treated. Eight reversible factors of urinary incontinence are: <ol style="list-style-type: none">1) Delirium2) Infection (urinary, symptomatic)3) Atrophic urethritis and vaginitis4) Pharmaceuticals5) Psychological disorders, especially depression6) Excessive urine output (e.g. from heart failure)7) Mobility8) Constipation
Stress incontinence	Leakage of small amounts of urine due to increased intra-abdominal pressure sometimes associated with sudden exertion (e.g. sneezing) and muscle weakness in the urinary system.
Urge incontinence	An inability to delay urination due to sudden bladder contractions causing uncontrollable urges, frequently at night; also referred to as unstable or overactive bladder.
Overflow incontinence	Dribbling of urine associated with a distended bladder causing difficulty with voluntary voiding possibly caused by blockage or neurologic conditions.
Total incontinence	Due to the complete absence of urinary control which may cause continuous leakage or periodic, uncontrolled emptying.

Adapted from: "Different Types of Urinary Incontinence". canadiancontinence.ca Copyright © 2018 The Canadian Continence Foundation

Urinary incontinence care decision tree for healthcare providers



Adapted with permission. "Urinary Incontinence Care Decision Tree", Donna Ruffo, RN(EC), 2018

Urinary continence information for older adults + family

Understand your urinary patterns and symptoms



Consider using the following tools to better understand your urinary patterns and symptoms:

- [The Continence Symptom checklist](#) (*The Canadian Continence Foundation*) is a quick questionnaire that will help you to identify the symptoms that you may be experiencing.
- [The Bladder Diary](#) (*The Canadian Continence Foundation*) helps you document your daily bladder routine over a few days.

These two tools provide valuable information for your care provider to help assess and manage your symptoms.

Speak to a healthcare provider



- While you may be embarrassed to discuss your urinary symptoms, your primary healthcare provider can help you manage this health condition by determining the cause of your symptoms and creating a care plan.

Maintain healthy bladder habits



Consider the following healthy bladder habits:

- Drink at least 6-8 cups of non-caffeinated fluids per day because concentrated urine can be more irritating to the bladder
- Reduce caffeine intake including: coffee, tea, or cola.
- Avoid or limit alcohol.
- Eat more fiber to avoid constipation.
- Avoid pushing when urinating.
- Empty your bladder completely every 3-4 hours during the day and before going to sleep whether you feel the urge to go or not.
- Maintain a healthy weight.
- Stay physically active.
- Avoid smoking.

Learn more about urinary incontinence



- You can learn a lot about continence and how to manage it in this comprehensive guide: [The Source – Your guide to better bladder control](#) (*Canadian Continence Foundation, 2018*).
- You may find it useful to download this app on your phone [Go Here Washroom Locator](#) which offers assistance with finding public washrooms across Canada.

Urinary continence in home and community care

ASSESS



Older adults may be reluctant to discuss symptoms of urinary incontinence, so it is important for healthcare providers to broach the subject as a routine part of their care.

- Be aware of signs that an older adult may be having bladder problems such as the smell of urine in the room, or soiled bed linens or undergarments.
- Screen for urinary incontinence periodically even if no signs are present (*page 31*).

MANAGE



- If the answer to any of the screening questions is yes, encourage and assist the older adult with:
 - completing a [Bladder Diary](#) and/or
 - completing [The Continence Symptom checklist](#) and
 - making an appointment to discuss symptoms with their primary care provider.
- Reinforce and encourage healthy bladder habits (*page 34*).

COMMUNICATE



- Communicate bladder concerns within the circle of care (healthcare team).
- Provide educational materials to older adults such as [The Source – Your guide to better bladder control](#) (*Canadian Continence Foundation, 2018*).
- Encourage the older adult to discuss their symptoms with their primary care provider. You may also want to let them know about Nurse Continence Advisors (NCAs), [available through the Canadian Continence Foundation](#). NCAs are registered nurses with specialty certification who can assess, diagnose and treat people with urinary and/or fecal incontinence (some may provide services in the home).

Urinary continence in primary care

ASSESS



Older adults may be reluctant to discuss symptoms of urinary incontinence, so it is important for healthcare providers to broach the subject as a routine part of their care.

- Be aware of signs that an older adult may be having bladder problems such as the smell of urine.
- Screen for urinary incontinence periodically even if no signs are present. (page 31).
- If incontinence is present, consider using the Urinary Continence Decision Tree to assess type (page 33).

MANAGE



- If the answer to any of the screening questions is yes, encourage the older adult to complete a [Bladder Diary and/or The Continence Symptom checklist](#).
- If incontinence is present, consider using the Urinary Continence Decision Tree to inform the care plan (page 33).
- Consider referral to a Nurse Continence Advisors (NCAs) available through the [Canadian Continence Foundation](#). NCAs are registered nurses with specialty certification who can assess, diagnose and treat people with urinary and/or fecal incontinence (some may provide services in the home).

COMMUNICATE



- Communicate bladder concerns and continence care plan within the circle of care (healthcare team).
- Provide educational materials to older adults such as [The Source – Your guide to better bladder control](#) (Canadian Continence Foundation, 2018).

Urinary continence in hospital

ASSESS



- On admission, establish the older adult's baseline for continence. Consider using urinary incontinence screening questions (*page 31*).
- If incontinence is present, consider using the Urinary Continence Decision Tree to assess type (*page 7*).

MANAGE



- If incontinence is present, consider using the Urinary Continence Decision Tree to inform the care plan (*page 33*).
- Assess for and proactively manage factors that can cause previously continent older adults to become incontinent such as:
 - Physical barriers - catheters, IV poles, monitors, height of hospital bed, bed rails being up.
 - Treatment / consequences of treatments - medications (such as diuretics, opioids, sedatives), IV fluids, surgery, catheter-associated urinary tract infection.
- Establish an appropriate toileting plan with the older adult which supports their baseline bladder control, and maximizes their independence with using the toilet (or bed pan / urinal / commode). All plans should include maximizing mobility (mobilizing at least 3 times per day), and reducing use of indwelling catheters.
 - For patients with dementia or delirium consider that the need for toileting can be a cause of responsive behaviours. As part of their toileting plan, consider using prompted voiding – an evidence-based behavioural technique using verbal and physical cues for toileting. [See Nursing Best Practice Guidelines - A Proactive Approach to Bladder and Bowel Management in Adults](#) (RNAO, 2020), prompted voiding protocol (*page 139*).

COMMUNICATE



- Include a continence care plan in discharge plans and in communications within the circle of care (healthcare team).
- Optimize continence support for the older adult on discharge by providing resources such as: [the Continence Symptom Checklist](#), [Bladder Diary](#) and [The Source – Your guide to better bladder control](#) (*all from Canadian Continence Foundation*). Encourage the older adult to follow up with their primary care provider. You may also want to let them know about Nurse Continence Advisors (NCAs) available through the [Canadian Continence Foundation](#). NCAs are registered nurses with specialty certification who can assess, diagnose and treat people with urinary and/or fecal incontinence (some may provide services in the home).

Urinary continence in long-term care

ASSESS



- On admission, establish the older adult's baseline for continence. Consider using urinary incontinence screening questions (*page 5*).
- If incontinence is present, consider using the Urinary Continence Decision Tree to assess type (*page 33*).

MANAGE



- If incontinence is present, consider using the Urinary Continence Decision Tree to inform the care plan (*page 33*).
- Establish an appropriate toileting plan with the older adult which supports their baseline bladder control, and maximizes their independence with using the toilet (or bed pan / urinal / commode). All plans should include maximizing mobility (mobilizing at least 3 times per day), and reducing use of indwelling catheters.
 - For patients with dementia or delirium consider that the need for toileting can be a cause of responsive behaviours. As part of their toileting plan, consider using prompted voiding – an evidence-based behavioural technique using verbal and physical cues for toileting. [See Nursing Best Practice Guidelines - A Proactive Approach to Bladder and Bowel Management in Adults](#) (RNAO, 2020), prompted voiding protocol (*page 139*).
- Encourage and support the older adult in maintaining healthy bladder habits.

COMMUNICATE



- Communicate bladder concerns and continence care plan within the circle of care (healthcare team).
- Encourage the older adult to discuss their symptoms.

References

1. The Canadian Continence Foundation. The impact of incontinence in Canada a briefing document for policy-makers. Cameron Institute; 2014 [cited 2018 September 20]. Available from: canadiancontinence.ca/pdfs/en-impact-of-incontinence-in-canada-2014.pdf
2. RGP of Ontario, Geriatrics Interprofessional Interorganizational Collaboration (GiiC). Incontinence - Frailty eLearning Module [Available from: geriatricessentialslearning.ca/].
3. The Canadian Continence Foundation. Specialized Management of Urinary Incontinence, Health Care Professionals - Patient Resources: Copyright © 2001; [Available from: canadiancontinence.ca/images/chart-specialized-management-of-ui.gif].
4. RNAO. Nursing Best Practice Guidelines - A Proactive Approach to Bladder and Bowel Management in Adults: Registered Nurses' Association Of Ontario; 2020. Available from: rnao.ca/bpg/guidelines/proactive-approach-bladder-and-bowel-management-adults.
5. Irwin DE, Milsom I, Hunskaar S, Reilly K, Kopp Z, Herschorn S, et al. Population-Based Survey of Urinary Incontinence, Overactive Bladder, and Other Lower Urinary Tract Symptoms in Five Countries: Results of the EPIC Study. *European Urology*. 2006;50(6):1306-15.
6. Herschorn S, Gajewski J, Schulz J, Corcos J. A population-based study of urinary symptoms and incontinence: the Canadian Urinary Bladder Survey. *BJU Int*. 2008;101(1):52-8.
7. Ramage-Morin PL, Gilmour H. Urinary incontinence and loneliness in Canadian seniors. *Health Rep*. 2013;24(10):3-10.
8. health.vic State Government of Victoria A. Identifying continence issues © Copyright State of Victoria 2018.; 2018 [October 31,]. Available from: www2.health.vic.gov.au/hospitals-and-health-services/patient-care/older-people/continence.
9. The Canadian Continence Foundation. The Source - Your guide to better bladder control Copyright © 2018 [Available from: www.canadiancontinence.ca/pdfs/Source-2018/The-Source-2018-English.pdf].
10. The Canadian Continence Foundation. Different Types of Urinary Incontinence Copyright © 2018 [Available from: www.canadiancontinence.ca/EN/types-of-urinary-incontinence.php].
11. The Canadian Continence Foundation. Bladder Diary Copyright © 2018 [Available from: www.canadiancontinence.ca/pdfs/Bladder-Diary.pdf].
12. The Canadian Continence Foundation. Symptom checklist Copyright © 2018 [Available from: www.canadiancontinence.ca/pdfs/Symptom-Checklist.pdf].

Senior Friendly 7



NUTRITION TOOLKIT

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Nutrition risk in older adults

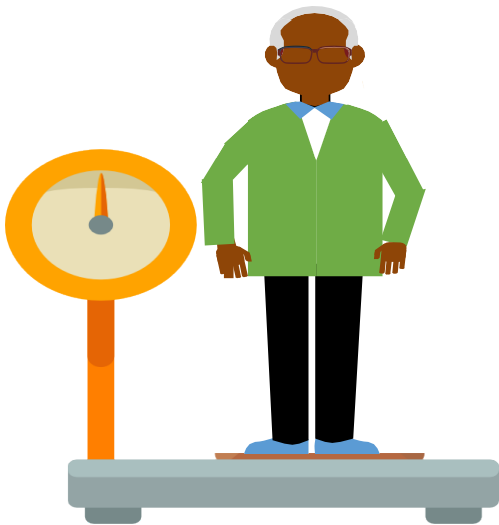
Malnutrition is preventable and treatable!

Good nutrition is an important aspect of a healthy lifestyle. If an older adult's diet is insufficient in vitamins or minerals, macronutrients, or energy to meet their body's requirements they may be at **nutrition risk**.^[1]

Malnutrition is defined as a state resulting from lack of intake or uptake of nutrition that leads to altered body composition and function.^[1]

Any imbalance between the nutrients that older adults need and those that they receive can result in **two kinds of malnutrition**:

1. **Overnutrition** comes from consuming too many calories or too much of any nutrient—protein, fat, carbohydrate, vitamin, mineral, or dietary supplement.
2. **Undernutrition** results from not consuming enough calories, protein, or nutrients. (Merck Manual, 2021)



- Nutrition risk increases at older ages^[2]
- About **34%** of community-dwelling Canadian older adults aged 65 and over are at nutrition risk. (Health Reports, 2017)
- Malnutrition prevalence rates range from **12% to 85%** in institutionalized older adults.^[3,4,5]



Do you have biases about “normal aging”? Do not dismiss weight loss and poor appetite as a normal part of aging. Malnutrition is preventable and treatable. When in doubt, check them out!

The many benefits of good nutrition

Memory/Mood

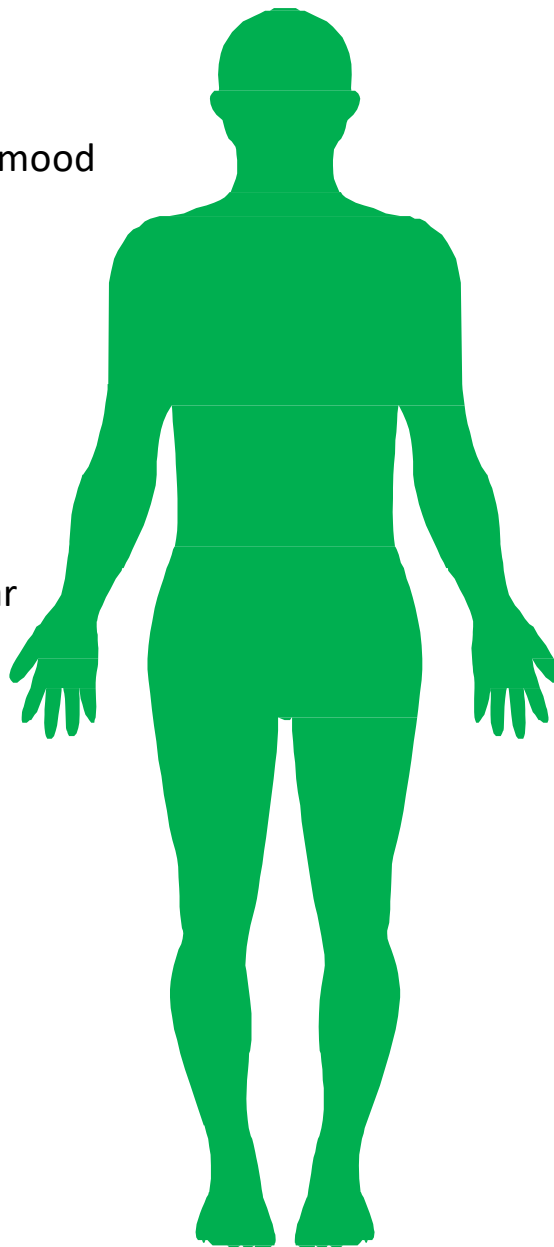
- Improves sleep and mood
- Decreases risk of confusion

Gastrointestinal

- Supports gut health and digestion
- Supports blood sugar

Muscles/Bones

- Improves strength
- Strengthens bones
- Supports weight management



Heart

- Supports blood pressure and cardiovascular health

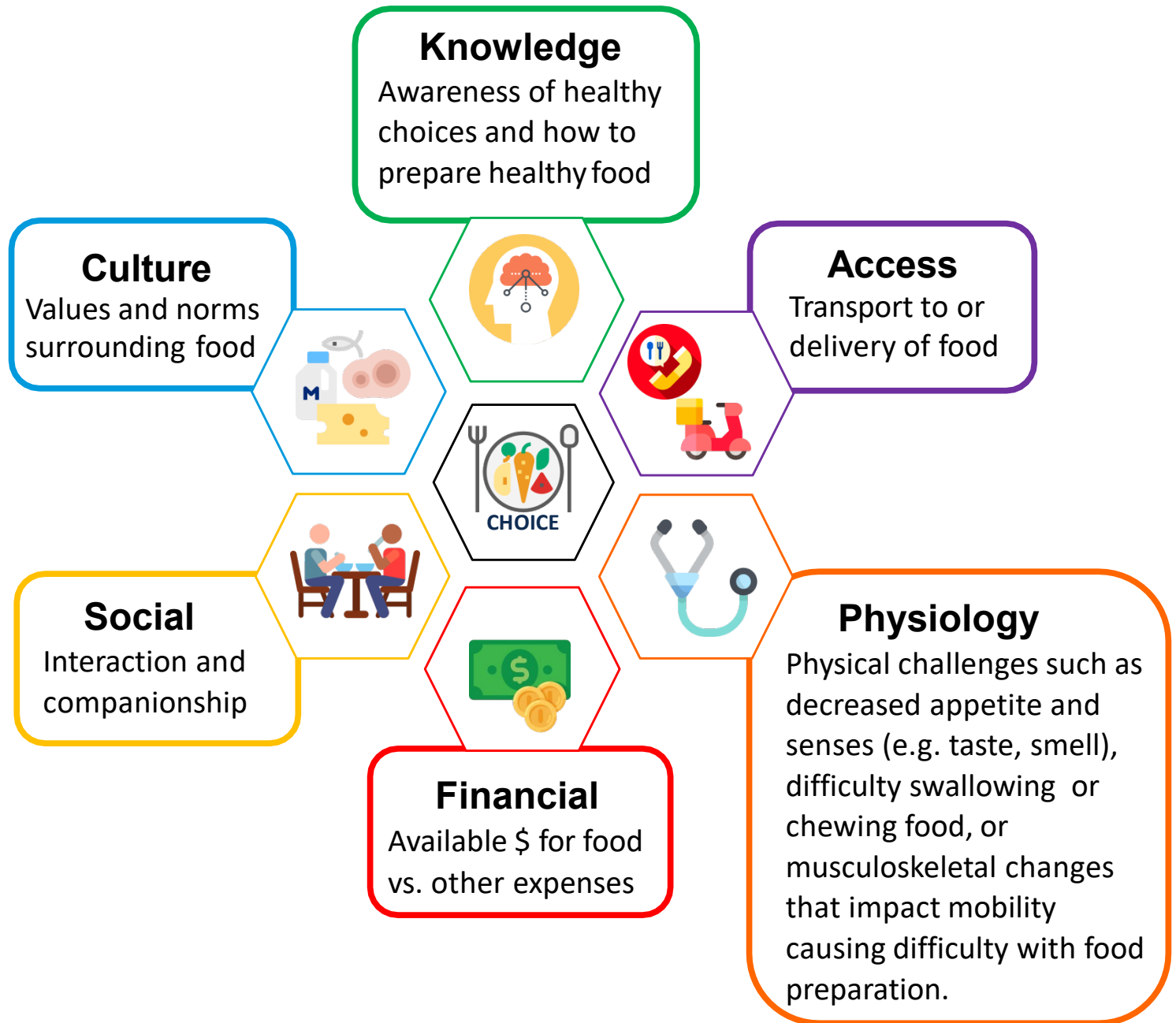
Immunity

- Decreases risk of infections
- Helps prevent or manage osteoporosis, diabetes, heart disease and some cancers
- Improves ability to heal from illness or injury
- Improves drug metabolism
- Supports wound healing

Adapted from: White Paper: “Opportunities to Improve Nutrition for Older Adults and Reduce Risk of Poor Health Outcomes” by Tilly, J. 2017. *The National Resource Center on Nutrition & Aging* ^[6]

Many factors influence nutrition in older adults

Health conditions, social determinants, psychosocial factors, and food choices influence nutritional status in older adults. Considerations for an older adult's food choices may include:



Don't assume that someone has adequate food available to them – ask them. Ask if finances or transport/delivery are barriers. The inability to access adequate nutrition is an equity issue and needs to be addressed. It may require creative solutions! Call 211 for supports.

Nutrition information for older adults + family

Understand your eating habits



- You can assess your eating habits by using a tool such as [Seniors in the Community Risk Evaluation for Eating and Nutrition – SCREEN-14](#) (*©2019, H.H.Keller*). This tool consists of 14 questions that cover aspects such as weight change, appetite, how often you eat, servings from food groups, motivation to cook, and ability to shop and prepare food.

Discuss with a healthcare professional



- Speak with your primary care provider about your food and nutrition concerns or questions so that they can provide the nutritional guidance that is right for you

Improving your nutritional status



- [Healthy eating tip sheets and recipes for older adults.](#) (*2019, H.H.Keller*).
- **Nutritional programs, meal delivery services and congregate dining** thehealthline.ca/ (after selecting your region, enter the search term “meals”).
- **Support from a dietitian** through individual counselling or nutrition programs and workshops. To find a local dietitian: members.dietitians.ca/DCMember/s/find-dietitian (there may be a fee) or:
 - Check with Public Health Units and Community Health Centres (CHC)
 - Ask your primary care provider if he or she is part of a Family Health Team that provides dietitian services.
 - If you receive homecare services, ask your case manager if a qualified dietitian is available for house calls.
 - Check with your local grocery store to see if they offer appointments with dietitians.

Nutrition in home and community care

ASSESS



- Include nutritional screening as part of routine assessment using a standardized and valid tool such as: [Seniors in the Community Risk Evaluation for Eating and Nutrition - SCREEN](#) (*©2019, H.H.Keller*). which consists of 14 questions that cover aspects such as, weight change, appetite, the frequency of eating, servings from food groups, motivation to cook, ability to shop and prepare food. Also available in abbreviated versions of 8 or 3 questions.
- Assess food on each visit for freshness, quantity, and variety.
- Consider factors affecting food choices (*page 44*).

MANAGE



- Assist by offering to:
 - Read food labels.
 - Identify ‘out-of-date’ food and offer to remove it.
 - Help with grocery shopping.
 - Coordinate visits to assist with meals as required.
 - Eat together if appropriate.
 - Find food-related community support like Meals on Wheels, Congregate Dining, Seniors Centres, and grocery delivery or transportation services: www.thehealthline.ca/
- For further assessment and management, consider referrals as appropriate, which may include:
 - A Dietitian dietitians.ca/find
 - [Specialized Geriatric Services](#) which are a range of healthcare services that use a comprehensive geriatric assessment to diagnose, treat and rehabilitate frail older adults (or those at risk of becoming frail).

COMMUNICATE



- Share findings within the circle of care, such as nutritional issues, weight changes, and observations from the food assessment.
- Recommend resources, such as [healthy eating tip sheets and recipes for older adults](#) (*2019, H.H.Keller*).

Nutrition in primary care

ASSESS



- Include nutrition screening in periodic assessments of older adults using standardized tools such as:
 - [Seniors in the Community Risk Evaluation for Eating and Nutrition - SCREEN](#) (@2019, H.H.Keller) which consists of 8 questions that cover aspects such as weight change, appetite, the frequency of eating, intake of fruits and vegetables, motivation to cook, ability to shop and prepare food.
 - [Mini Nutritional Assessment \(MNA\)](#) (Nestle Nutrition Institute, 2009) which is appropriate for use in older adults with mild cognitive impairment. It assesses aspects such as decline in food intake, weight loss in the last three months, mobility level, the presence of psychosocial stress and neuropsychological problems, Body Mass Index (BMI), and calf circumference.
- Evaluate the impact of medications on nutritional status.
- Evaluate the factors that influence food intake and nutritional status (page 44) and involve other team members.

MANAGE



- Discuss screening results with older adults and engage them in the development of the care plan.
- For further assessments and management, consider referrals as appropriate, which may include:
 - A Dietitian within a Family Health Team, or through dietitians.ca/find
 - [Specialized Geriatric Services](#) which are a range of health care services that use a comprehensive geriatric assessment to diagnose, treat and rehabilitate frail older adults (or those at risk of becoming frail).
- If difficulty accessing food is identified, recommend community based nutrition support services such as meal delivery services and congregate dining <http://www.thehealthline.ca/>.
- Optimize prescribing to align with nutrition goals.

COMMUNICATE



- Share nutritional care plan within the circle of care (healthcare team)
- Recommend resources, such as [healthy eating tip sheets and recipes for older adults](#) (2019, H.H.Keller).

Nutrition in hospital

ASSESS



- Include nutrition screening in older adults on admission using a standardized tool such as [the Canadian Nutrition Screening Tool \(CNST\)](#) (*Canadian Malnutrition Task Force & Canadian Nutrition Society, 2014*) which consists of two items: unintentional weight loss over the past six months and low appetite.
- Consider using [the Integrated Nutrition Pathway for Acute Care \(INPAC\) Implementation Toolkit](#) (*Canadian Malnutrition Task Force, 2017*) which provides information on how to improve nutrition care practices in hospitals, including: screening, assessing, and managing and preventing malnutrition.

MANAGE



- Create a nutritional care plan
- Encourage meal consumption by removing obstacles (e.g. unwrapping food, tray placement) and involving family and volunteers.
- Encourage family members to visit at mealtimes, and to bring food from home as appropriate.
- Optimize social interaction at mealtimes (e.g. patients who can be mobilized out of the ward to the hospital's cafeteria with families and other patients).

COMMUNICATE



- Share nutritional care plan within the circle of care (healthcare team)
- On discharge, include referrals or information on how to access community supports such as:
 - A dietitian [dietitians.ca/find](https://www.dietitians.ca/find)
 - Meals on Wheels, Congregate Dining, Seniors Centers, and grocery delivery or transportation services: [thehealthline.ca/](https://www.thehealthline.ca/)
 - [Specialized Geriatric Services](#) which are a range of health care services that use a comprehensive geriatric assessment to diagnose, treat and rehabilitate frail older adults (or those at risk of becoming frail).
- Provide the older adult with a written summary (use min. font size 12) of nutritional needs and care plan. Considering using a template such as [From Hospital to Home](#) (*Canadian Malnutrition TaskForce*).
- Recommend resources, such as [healthy eating tip sheets and recipes for older adults.](#) (2019, H.H.Keller).

Nutrition in long-term care

ASSESS



- Include nutrition screening at least quarterly using a standardized tool such as [Mini Nutritional Assessment \(MNA\)](#) (Nestle Nutrition Institute, 2009) which is appropriate for use in older adults with mild cognitive impairment. It assesses aspects such as decline in food intake, weight loss in the last three months, mobility level, the presence of psychosocial stress and neuropsychological problems, Body Mass Index (BMI), and calf circumference (CC).
- If patients are identified at risk for malnutrition, make a referral to a dietitian to provide a comprehensive nutritional assessment.
- Consider using the following guideline [Best Practices for Nutrition, Food Service and Dining in LTC Homes](#) (Dietitians of Canada, 2019) which includes information on nutrition, hydration, meal service, and pleasurable dining.
- Collect information from the older adult, their family, and other care providers to create an appropriate nutritional care plan including allergies or intolerances, food texture needs, assistive devices, and food preferences.

MANAGE



- Discuss the nutritional care plan with the older adult and their family.
- Provide assistance according to the care plan, including:
 - Seating and positioning.
 - Use of assistive devices.
 - Eating assistance as needed with the goal of maximizing self feeding skills.
 - Adapting meal times and dining environment as needed.
 - Encourage meal consumption by removing obstacles.
 - Optimizing social interaction at mealtimes.
 - Encourage family members to visit at mealtimes and to bring food from home, as appropriate.

COMMUNICATE



- Share the nutritional care plan within the circle of care (healthcare team) when transferring to an acute care facility.

References

1. Keller H, Laur C. Making the Case for Nutrition Screening in Older Adults in Primary Care. *Nutrition Today*. 2017;52(3):129-36.
2. Dietitians of Canada. Best Practices for Nutrition, Food Service and Dining in Long-Term Care Homes A Working Paper 2013 [Available from: dietitians.ca/Dietitians-Views/Health-Care-System/Long-Term-Care.aspx].
3. Nestle. Mini Nutritional Assessment (MNA) Nestle Nutrition Institute 1994 [updated 2009; cited 2018 September 14]. Available from: mna-elderly.com.
4. Allard JP, Keller H, Jeejeebhoy KN, Laporte M, Duerksen DR, Gramlich L, et al. Malnutrition at Hospital Admission - Contributors and Effect on Length of Stay: A Prospective Cohort Study From the Canadian Malnutrition Task Force. *Journal of Parenteral and Enteral Nutrition*. 2014;40(4):487-97.
5. Rahman A, Wu T, Bricknell R, Muqtadir Z, Armstrong D. Malnutrition Matters in Canadian Hospitalized Patients: Malnutrition Risk in Hospitalized Patients in a Tertiary Care Center Using the Malnutrition Universal Screening Tool. *Nutrition in Clinical Practice*. 2015;30(5):709-13.
6. Tilly J. White Paper: Opportunities to Improve Nutrition for Older Adults and Reduce Risk of Poor Health Outcomes: The National Resource Center on Nutrition & Aging; 2017 [cited 2018 February]. Available from: <https://acl.gov/sites/default/files/nutrition/Malnutrition-Issue-Brief-ACL2017.pdf>
7. Shatenstein B, Kergoat MJ, Nadon S. Weight change, nutritional risk and its determinants among cognitively intact and demented elderly Canadians. *Can J Public Health*. 2001;92(2):143-9.
8. Allard JP, Aghdassi E, McArthur M, McGeer A, Simor A, Abdoell M, et al. Nutrition risk factors for survival in the elderly living in Canadian long-term care facilities. *Journal of the American Geriatrics Society*. 2004;52(1):59-65.
9. Payette H. Nutrition as a determinant of functional autonomy and quality of life in aging: A research program. *Canadian Journal of Physiology and Pharmacology*. 2005;83(11):1061-70.
10. Silver HJ. Oral strategies to supplement older adults' dietary intakes: Comparing the evidence. *Nutrition Reviews*. 2009;67(1):21-31.
11. Keller, H. SCREEN tools. 2019; Available from: <https://olderadultnutritionscreening.com/screen-tools/>
12. Ramage-Morin PL, Garriguet D. Nutritional risk among older Canadians. *Health Rep*. 2013;24(3):3-13.
13. Malnutrition Task Force; 2014 [Available from: nutritioncareinCanada.ca/sites/default/uploads/files/CNST.pdf].
14. Keller H, Allard J, Vesnaver E, Laporte M, Gramlich L, Bernier P, et al. Barriers to food intake in acute care hospitals: a report of the Canadian Malnutrition Task Force. *J Hum Nutr Diet*. 2015;28(6):546-57.
15. Keller, H. Integrated Nutrition Pathway for Acute Care (INPAC) Implementation Toolkit Canadian Nutritional Task Force 2017 [Available from: m2e.nutritioncareinCanada.ca/sites/default/uploads/files/INPAC-Toolkit-FINAL-June2-2017.pdf].
16. Keller H, Laporte M, Payette H, Allard J, Bernier P, Duerksen D, et al. Prevalence and predictors of weight change post discharge from hospital: a study of the Canadian Malnutrition Task Force. *European Journal of Clinical Nutrition*. 2017;71(6):766-72.
17. Keller HH, Carrier N, Slaughter SE, Lengyel C, Steele CM, Duizer L, et al. Prevalence and Determinants of Poor Food Intake of Residents Living in Long-Term Care. *J Am Med Dir Assoc*. 2017;18(11):941-7.
18. Ramage-Morin PL, Gilmour H, Rotermann M. Nutritional risk, hospitalization and mortality among community-dwelling Canadians aged 65 or older. *Health Rep*. 2017;28(9):17-27.
19. CMTF. From Hospital to Home. 2018 Canadian Malnutrition Task Force. [Available from: nutritioncareinCanada.ca/sites/default/uploads/files/CMW2017/CMW-2017-Checklist/CMTF005%20-%20Food%20is%20Medicine%20-%20Checklist_Debranded.pdf].
20. Morley JE. Undernutrition: © 2021 Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc., Kenilworth, NJ, USA; 2021 [Available from: merckmanuals.com/en-ca/home/disorders-of-nutrition/undernutrition/undernutrition].
21. Victoria (Australia) State Government. Nutrition and Hydration: health.vic Victoria's hub for health services & business 2015 [Available from: www2.health.vic.gov.au/hospitals-and-health-services/patient-care/older-people/nutrition-swallowing/nutrition-and-hydration].
22. RGP of Ontario, Geriatrics Interprofessional Interorganizational Collaboration (GiiC). Nutrition- Frailty eLearning Module [Available from: geriatricessentialslearning.ca/].

Senior Friendly 7



PAIN TOOLKIT



**REGIONAL GERIATRIC
PROGRAM OF TORONTO**

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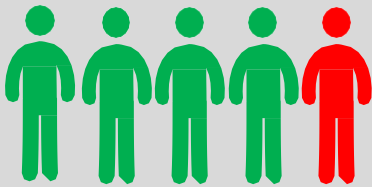
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Prevalence and impact of pain in older adults

Pain is a common experience for older adults and it is often under-reported. Chronic pain is associated with a lower quality of life compared with other chronic conditions^[1], and is one of the most frequent causes of visits to the emergency department (ED) and hospital admissions.

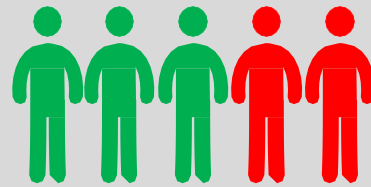
The prevalence of pain increases with age^[2,3,4,5,6]

1 in 5 Canadians
experience chronic pain^[2,3,5,6]



Up to 20%

2 in 5 older Canadians
experience chronic pain^[1,2,3,4,5,6]



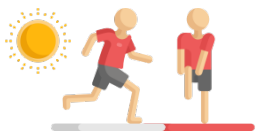
Up to 40%

The following can be improved if pain is identified and appropriately managed:



Quality of Sleep

Improvement in pain can promote a more restful and uninterrupted sleep.



Mobility

Well-controlled pain increases older adults' ability to participate in physical activities.



Mood

Reducing pain can have a positive impact on the happiness and self-perceived health of older adults.^[7]



Social engagement

Older adults may be more willing to participate in social activities.



Quality of life

Older adults may experience a better quality of life if their pain is adequately assessed and controlled.^[7]

Types of pain

Acute Pain	An unpleasant sensory and emotional experience associated with tissue damage or recognizable disease process.
Chronic Pain	Prolonged pain lasting at least 3 months beyond the time of acute tissue damage or recognizable disease process.
Allodynia	Sensation of pain in response to a stimulus that does not normally produce pain (e.g. sheets touching feet may cause pain).
Breakthrough Pain	Pain that continues despite treatment or emerges before the next treatment is implemented.
Neuropathic Pain	Acute or chronic pain that is primarily caused by dysfunction in the nervous system.
Nociceptive Pain	Acute or chronic pain caused by injury to joints, bones, connective tissue, muscles, or internal organs.
Referred Pain	Acute or chronic pain that is felt at a location other than the site of injury.
Refractory Pain	Pain that is resistant to usual treatment approaches.

Adapted from : [“Pain-Assessment Terminology”, by The University of Iowa © 2018 geriatricpain.org/pain-assessment-terminology](#) and the [“Acute Pain Service Handbook”, by McCartney C. et al, 2010.](#)

Understanding pain from the older adult’s perspective

Explore attitudes and beliefs about pain with older adults.



Asking about pain

These 7 questions can help to engage older adults in conversations about the presence of pain:



Note: Further assessment might be needed according to the intensity and disability caused by pain.

- Are you feeling any aching/soreness/or pain now?
- Do you hurt anywhere?
- Are you having any discomfort?
- Have you taken any medications for pain? (including acetaminophen or other over-the-counter products)?
- Are you having any aching or soreness that keeps you up at night?
- Have you had any trouble with any of your usual day-to-day activities?
- How intense is your pain?

Adapted from: "Assessment and Management of Pain (3rd ed.)", Registered Nurses' Association of Ontario (2013).

Pain assessment and management strategies

- All older adults with chronic pain, or those who report new pain, should have a comprehensive geriatric pain assessment.
- A comprehensive assessment can guide selection of treatments most likely to benefit the patient and identify potential targets for intervention.
- It is important to provide information and education to clarify any misunderstandings about pain and its treatment.
- A holistic approach that includes both drug and non-drug strategies for pain is recommended.
- Involve and engage family members and caregivers and seek out other resources that can help to reinforce adherence to treatment and maintain gains from treatment.

Adapted from: "Management of Chronic Pain in Older Adults" by Reid M.C., Eccleston C., Pillemer K. 2015 Bmj. 2015;350:h532.



Don't assume that someone can access recommended approaches for pain control. Ask if finances or transportation are barriers. The inability to access recommended treatment is an equity issue and needs to be addressed. It may require creative solutions! Call 211 for supports.

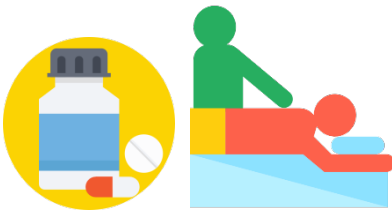
Pain information for older adults + family

Understanding your pain pattern and symptoms



- For older adults: If you are experiencing pain, you can use a daily [Pain Diary](https://www.geriatricpain.org) (*geriatricpain.org*, 2019) to record the intensity of your pain and what you did to manage it.
- This information can help your care provider better understand your pain experience.
- For families: Use this [One-Minute Pain Assessment](https://www.geriatricpain.org) (*geriatricpain.org*, 2022) which can help you to identify the presence of pain and communicate your findings to your family member's care provider. If you suspect pain but your family member is unable to talk about it, you can look for physical indicators of pain such as, facial expressions, verbal expressions and body posturing (e.g. grimacing, being unusually quiet, yelling) or any other new behaviours.

Pain Management Strategies



- Regularly monitoring pain can have treatment value in itself.
- Consider non-pharmacological approaches to help with pain (*page 8*).
- Information regarding the safe use of common pain medications and the possible side effects is available in this pamphlet: [Managing your pain effectively using over the counter medicines](#) (*British Pain Society, 2010*).
- If pain is increasing despite treatment see your primary care provider for further assessment.

Sharing your pain experience



- Make sure that your care providers know that you are experiencing pain.
- Share your pain assessment with your primary care provider.
- Tell your care providers about any over-the-counter medications that you are taking (e.g. nonprescription medications such as acetaminophen).

Non-pharmacological approaches to help with pain

Focus on Mind

Redirecting attention

When you are in pain, your attention may become focused on the pain. Redirecting attention away from pain can reduce the unpleasant experience (e.g. listening to music, watching movies, spending time with animals).

Cognitive Behavioral Therapy (CBT)

When your attention is focused on pain you may become preoccupied with thinking about it. Cognitive Behavioral Therapy (CBT) is a form of talk therapy that helps you to identify the way you might be inadvertently paying attention to pain and making it worse. Redirecting these thoughts can reduce feelings of pain.

Meditation

Meditation can be thought of as a form of CBT. [For example: meditainment.com/pain-management-meditation](https://www.meditainment.com/pain-management-meditation)

Mindfulness

Mindfulness can be thought of as a form of CBT. For example: Mindfulness-Based Chronic Pain Management (MBCPM™) [neuronovacentre.com/](https://www.neuronovacentre.com/)

Relaxation Methods

Relaxation methods such as breathing exercises and repeating the same word over and over, can reduce your stress and muscle tension and alleviate the feeling of pain. For example: [youtube.com/watch?v=ihO02wUzgkc](https://www.youtube.com/watch?v=ihO02wUzgkc)

[Resource: Low-Risk Pain Treatments: Benefits, Risks, Tips](#) (geriatricpain.org, 2022)

Focus on Body

Cold or Heat

Cold packs (e.g. frozen gel packs or cold cloth) and heat packs (e.g. heated gel packs or warm cloths) can help you manage pain based on your preferences. It is wise to place a layer between your skin and the pack, not to place them on an open wound, and to stop using them if the pain becomes worse.

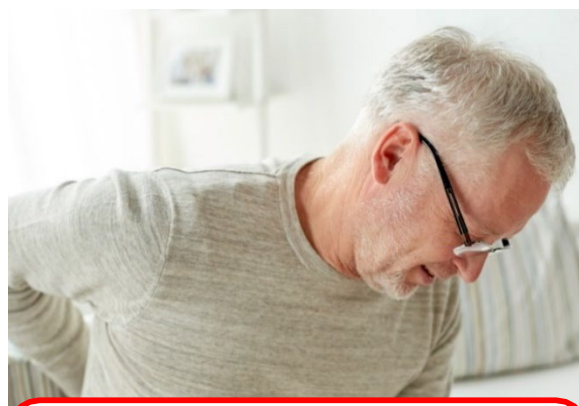
Positioning and Massage

Using pillows and support to optimize comfortable positioning can be helpful along with massage therapy. Massage devices can help too.

Acupuncture

Acupuncture is a component of traditional Chinese medicine (TCM). Acupuncture involves the insertion of fine needles into the body. This facilitates the body's self-healing system, which can assist with the management of pain.

Adapted from [geriatricpain.org/](https://www.geriatricpain.org/)



Speak with your healthcare provider about pain management approaches that you could try.

Pain in home and community care

ASSESS



- Ask about the presence of pain (*page 55*).
- Where possible, assess pain intensity by using a patient self-reporting tool such as [the Iowa Pain Thermometer – Revised](#) (*geriatricpain.org - University of Iowa*). Research indicates this tool is the best choice for most older adults.
- For older adults who are living with advanced dementia, and are unable to report the severity of pain, consider using [the Pain Assessment in Advanced Dementia \(PAINAD\)](#) (*geriatricpain.org - University of Iowa*) which is based on observation of breathing, vocalization, facial expression, body language and consolability.
- Ask family members or other care providers if there is any change in the older adult’s usual behaviour (e.g. grimacing, unusually quiet, yelling) as this change might indicate pain. Look for physical root causes of pain such as constipation or pressure ulcers.

MANAGE



- Consider non-pharmacological approaches to help with pain (*page 57*).
- Information regarding the safe use of common pain medications and the possible side effects for older adults is available here: [Low-Risk Pain Treatments: Benefits, Risks, Tips](#) (*geriatricpain.org - University of Iowa*, 2022)
- If requested to do so, assist with taking pain medications by reminding when they are due, reviewing instructions, and opening bottles and blister packs and pouring liquid medications in appropriate dosages.

COMMUNICATE



- Share your observations about the older adult’s pain within the circle of care (healthcare team).
- Let the older adult’s primary care provider know if the older adult or their family members are considering going to the emergency department because of pain.

Pain in primary care

ASSESS



- Ask about the presence of pain (*page 55*).
- Where possible, assess pain intensity by using a patient self-reporting tool such as [the Iowa Pain Thermometer – Revised](#) (*geriatricpain.org - University of Iowa*). Research indicates this tool is the best choice for most older adults.
- For older adults who are living with advanced dementia, and are unable to report the severity of pain, consider using [the Pain Assessment in Advanced Dementia \(PAINAD\)](#) (*geriatricpain.org - University of Iowa*) which is based on observation of breathing, vocalization, facial expression, body language and consolability.
- Ask family members or other care providers if there is any change in the older adult’s usual behaviour (e.g. grimacing, unusually quiet, yelling) as this change might indicate pain. Look for physical root causes of pain such as constipation or pressure ulcers.

MANAGE



- Discuss non-pharmacological approaches to help with pain (*page 57*).
- When prescribing new pain medications, be mindful of the patient’s medication history, current medications, and the potential side effects of prescribed medications. The following resources may be helpful:
 - [Treatment Guidelines for the Pharmacological Management of Pain in Older Persons](#) (*American Academy of Pain Medicine, 2012*) provides information on special considerations for non-opioid analgesics, opioid analgesics, and adjuvant drugs used to treat moderate to severe pain in older adults.
 - There is lack of evidence to guide the use of cannabis in older adults; however, [the Simplified Guideline for Prescribing Medical Cannabinoids](#) (*Allan M. et al., 2018*) provides a medical cannabinoid prescribing algorithm to offer help in decision making for the use of cannabinoids in general population.

COMMUNICATE



- Verify that the older adult and family understand the pain management plan.
- Share the pain management plan within the circle of care (healthcare team).

Pain in hospital

ASSESS



- Ask about the presence of pain (*page 55*).
- Where possible, assess pain intensity by using a patient self-reporting tool such as [the Iowa Pain Thermometer – Revised](#) (*geriatricpain.org - University of Iowa*). Research indicates this tool is the best choice for most older adults.
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MANAGE



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COMMUNICATE



- Discuss pain during rounds and in shift reports.
- If the older adult is being discharged with a new pain management plan, ensure that it is shared within the circle of care (healthcare team).

Pain in long-term care

ASSESS



- Ask about the presence of pain (*page 55*).
- Where possible, assess pain intensity by using a patient self-reporting tool such as [the Iowa Pain Thermometer – Revised](#) (*geriatricpain.org - University of Iowa*). Research indicates this tool is the best choice for most older adults.
- For older adults who are living with advanced dementia, and are unable to report the severity of pain, consider using [the Pain Assessment in Advanced Dementia \(PAINAD\)](#) (*geriatricpain.org - University of Iowa*) which is based on observation of breathing, vocalization, facial expression, body language and consolability.
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MANAGE



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COMMUNICATE



- Share the pain management plan within the circle of care (healthcare team).
- Provide education for the older adult and family.

Resource: [Assessment and Management of Pain in the Elderly – self-directed learning package for nurses in long term care \(RNAO, 2007\).](#)

References

1. Lynch ME. The need for a Canadian pain strategy. *Pain Research and Management*. 2011;16(2):77-80.
2. Moulin DE, Clark AJ, Speechley M, Morley-Forster PK. Chronic pain in Canada - Prevalence, treatment, impact and the role of opioid analgesia. *Pain Research and Management*. 2002;7(4):179-84.
3. Boulanger A, Clark AJ, Squire P, Cui E, Horbay GL. Chronic pain in Canada: have we improved our management of chronic noncancer pain? *Pain Research & Management*. 2007;12(1):39-47.
4. Choiniere M, Dion D, Peng P, Banner R, Barton PM, Boulanger A, et al. The Canadian STOP-PAIN project - Part 1: Who are the patients on the waitlists of multidisciplinary pain treatment facilities? *Can J Anaesth*. 2010;57(6):539-48.
5. Schopflocher D, Taenzer P, Jovey R. The prevalence of chronic pain in Canada. *Pain Research & Management*. 2011;16(6):445-50.
6. Reitsma ML, Tranmer JE, Buchanan DM, VanDenKerkhof EG. The epidemiology of chronic pain in Canadian men and women between 1994 and 2007: Results from the longitudinal component of the National Population Health Survey. *Pain Research and Management*. 2012;17(3):166-72.
7. Ramage-Morin PL. Chronic pain in Canadian seniors. *Health Rep*. 2008;19(1):37-52.
8. Hadjistavropoulos T, Herr K, Turk DC, Fine PG, Dworkin RH, Helme R, et al. An interdisciplinary expert consensus statement on assessment of pain in older persons. *Clinical Journal of Pain*. 2007;23(SUPPL. 1):S1-S43.
9. Schofield P. Pain in Older Adults: Epidemiology, Impact and Barriers to Management. *Reviews in Pain*. 2007;1(1):12-4.
10. Breivik H, Borchgrevink PC, Allen SM, Rosseland LA, Romundstad L, Breivik Hals EK, et al. Assessment of pain. *BJA: British Journal of Anesthesia*. 2008;101(1):17-24.
11. University of Alberta. Observing and Reporting Pain Behaviours <https://www.ualberta.ca/2008>
12. Perry G. Fine, MD, Treatment Guidelines for the Pharmacological Management of Pain in Older Persons, *Pain Medicine*, Volume 13, Issue suppl_2, April 2012, Pages S57–S66, <https://doi.org/10.1111/j.1526-4637.2011.01307.x>
13. Hadjistavropoulos T, Fitzgerald TD, Marchildon GP. Practice Guidelines for Assessing Pain in Older Persons with Dementia Residing in Long-Term Care Facilities. *Physiotherapy Canada*. 2010;62(2):104-13.
14. Kashin B, Sawhney M, Riazi S. *Acute Pain Service Handbook* 2010.
15. Kaye AD, Baluch A, Scott JT. Pain management in the elderly population: A review. *Ochsner Journal*. 2010;10(3):179-87.
16. Damsgard E, Dewar A, Roe C, Hamran T. Staying active despite pain: pain beliefs and experiences with activity-related pain in patients with chronic musculoskeletal pain. *Scand J Caring Sci*. 2011;25(1):108-16
17. RNAO. *Assessment and Management of Pain Third Edition* Toronto, ON. 2013 [cited 2018 September 28]. Available from: rnao.ca/bpg/guidelines/assessment-and-management-pain.
18. Nahin RL. Estimates of pain prevalence and severity in adults: United States, 2012. *J Pain*. 2015;16(8):769-80.
19. Reid MC, Eccleston C, Pillemer K. Management of chronic pain in older adults. *Bmj*. 2015;350:h532.
20. Wilson MG, Lavis JN, Ellen ME. Supporting chronic pain management across provincial and territorial health systems in Canada: Findings from two stakeholder dialogues. *Pain Research and Management*. 2015;20(5):269-79.
21. Fillingim RB, Loeser JD, Baron R, Edwards RR. Assessment of Chronic Pain: Domains, Methods, and Mechanisms. *J Pain*. 2016;17(9 Suppl):T10-20.
22. Busse JW, Craigie S, Juurlink DN, Buckley DN, Wang L, Couban RJ, et al. Guideline for opioid therapy and chronic noncancer pain. *Cmaj*. 2017;189(18):E659-E66.
23. Jones J, Sim TF, Hughes J. Pain Assessment of Elderly Patients with Cognitive Impairment in the Emergency Department: Implications for Pain Management—A Narrative Review of Current Practices. *Pharmacy*. 2017;5(2).
24. Allan GM, Ramji J, Perry D, Ton J, Beahm NP, Crisp N, et al. Simplified guideline for prescribing medical cannabinoids in primary care. *Canadian Family Physician*. 2018;64(2):111-20+e64-e75.
26. geriatricpain.org. Pain Assessment in Cognitively Impaired Older Adults. © The University of Iowa, 2018. [Available from: geriatricpain.org/assessment/pain-assessment-cognitively-impaired-older-adults].
27. geriatricpain.org. Pain Assessment in Cognitively Intact Older Adults. © The University of Iowa, 2018. [Available from: geriatricpain.org/assessment/pain-assessment-cognitively-intact-older-adults].
28. geriatricpain.org. Pain Assessment Terminology. © The University of Iowa, 2018. [Available from: geriatricpain.org/assessment/pain-assessment-terminology].

References (continued)

29. RGP of Ontario, Geriatrics Interprofessional Interorganizational Collaboration (GiiC). Pain- Frailty eLearning Module [Available from: geriatricessentialslearning.ca/].
30. RNAO. Assessment and Management of Pain in the Elderly – self-directed learning package for nurses in long term care. Toronto, ON.2007 [cited 2022 August 15].
[Available from: rnao.ca/sites/rnao-ca/files/Assessment and Management of Pain in the Elderly - Learning Package for LTC.pdf](http://rnao.ca/sites/rnao-ca/files/Assessment_and_Management_of_Pain_in_the_Elderly_-_Learning_Package_for_LTC.pdf).

Senior Friendly 7



POLYPHARMACY TOOLKIT



**REGIONAL GERIATRIC
PROGRAM OF TORONTO**

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Understanding polypharmacy

How many is too many?

Polypharmacy or multiple medications may be clinically appropriate, but it is **important to identify when the medications used by older adults may be inappropriate and may place the person at increased risk of adverse events and poor health outcomes.**^[1]

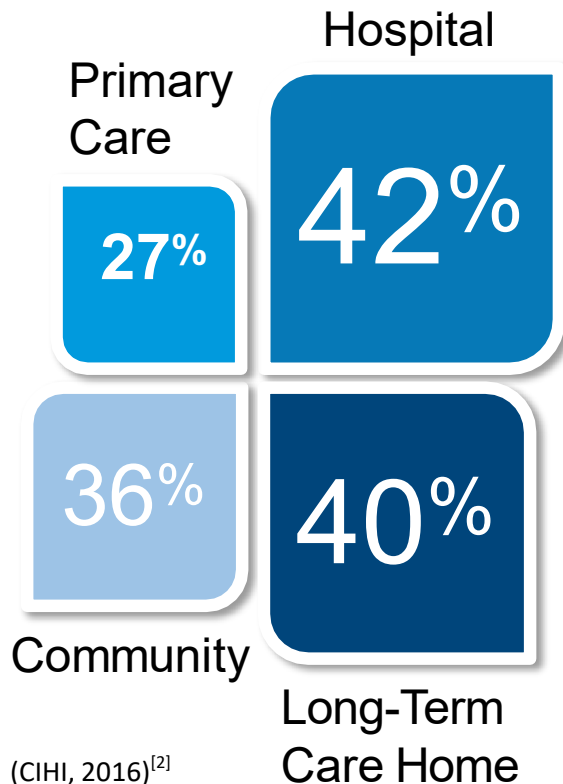


- >5 medications
- >12 doses a day
- or medications prescribed by multiple healthcare providers



Increased risk of adverse events

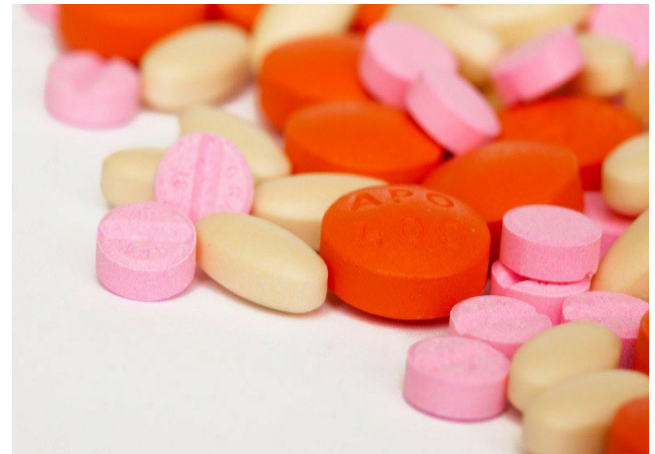
Polypharmacy prevalence



How many medications are older adults taking?

66% take 5+
27% take 10+

(CIHI, 2016)^[2]



45%







of community-dwelling patients have 1+ medication discrepancies requiring the attention of a physician.

51%

of home care clients have medication discrepancies following discharge from hospital.

(Health Reports, 2014)^[3]

Risk factors for adverse drug reactions (ADRs) in older adults

	Recent change in medications	Recent changes in medication leading to a functional decline (e.g. low blood pressure, falls because of the medication change).
	Polypharmacy	Taking more than 5 medications, and/or more than 12 doses a day increases the risk of adverse events and poor health outcomes.
	Age-related changes	<p>Older adults experience physical changes that affect the way the body processes medications, such as a decrease in kidney and liver function, a decrease in total body water, and a higher proportion of body fat, leading to altered medication effects.</p> <p>Visual impairment can make it hard for older adults to read medication labels.</p>
	Ethnicity, gender	Certain drugs or combinations of drugs may cause adverse drug reactions depending on a person's ethnicity or gender.
	Health conditions	<p>Older people are more likely to have multiple chronic conditions, requiring more medications to treat them.</p> <p>Asthma, COPD, stroke, hip fracture, kidney failure, incontinence, and cognitive impairment are associated with increased ADRs. Frailty or damage to the heart, lung or kidney caused by disease or conditions such as diabetes can increase the risk of ADRs.</p> <p>An acute change in health (e.g. acute illness, dehydration) can result in intolerance of exiting medication.</p>
	Social habits	<p>Alcohol can add to the sedative effects of medications that cause sedation.</p> <p>Alcohol and smoking can affect the way the body processes medications.</p>

Adapted from: "Adverse drug reactions in special populations - the elderly" by *Davies, EA. and O'Mahony, MS.* British Journal of Clinical Pharmacology. 2015;80(4):796-807.

Medication reconciliation

Ensure that accurate and complete medication information is available. This is especially important when there is a transition in care such as being admitted to or discharged from hospital.



Medication reconciliation (“Med Rec”)

is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care.



A **Best Possible Medication History (BPMH)** is created as part of the “Med Rec” process to verify all of a patient’s medication use (**prescription, over-the-counter, supplements, and herbal remedies**). The history is created using 2 sources of information:

1. interviewing the person and/or family and
2. confirming with at least one other reliable source of information (such as medication containers, pharmacist, or primary care provider).

Adapted from The Institute for Safe Medication Practices Canada (ISMP)



Do you have biases about “normal aging”? Symptoms such as confusion, falls, functional decline or memory loss are not a normal part of aging. They may be ADRs – even if no recent medication changes have been made. Review appropriateness of medications for ALL patients regularly and when there’s a change in health to optimize medication effectiveness and ensure patient goals are being met.

13 Recommendations

The following **13 recommendations** should be taken into consideration **when prescribing for older adults with frailty.**

1. Use the **least possible number of medications** and the simplest possible dosing regimen to improve adherence and avoid drug interactions.
2. **Avoid medications known to be potentially harmful** in older adults as per [Beers Criteria](#) (*the American Geriatrics Society, 2023*)
 - Especially medications with anticholinergic effects which can cause toxicity such as, central nervous system (CNS) confusion, urinary retention, constipation, dry mouth and eyes, and blurred vision.
3. Use extra **caution when prescribing high alert drugs**: digoxin, calcium channel blockers (CCB), opioids, warfarin, theophylline, oral hypoglycemics, lithium, selective serotonin reuptake inhibitors (SSRIs), monoamine oxidase inhibitors (MAOIs), anticonvulsants, antimicrobials (macrolides, quinolones, antivirals, antifungals).
 - Organ dysfunction or drug interactions can result in toxicity.
4. Are the **benefits worth the risks?** Is the problem self-limiting or only a minor inconvenience?
5. **Avoid overestimating renal function** based on serum creatinine that is in normal range.
 - Note that creatinine clearance declines by 10% per decade after age 40.
 - Calculate creatinine clearance (to account for age and weight) and adjust doses of renally cleared medication accordingly.
6. Start at the **lowest drug dose and titrate up slowly** (except for antibiotics) so as to avoid:
 - The occurrence of excessive pharmacologic effects or adverse drug reactions that result in harm or refusal to take the medication.
7. **Avoid the prescribing cascade** - adding a medication to combat the side effects of another one.
 - This may occur because of failure to attribute current signs and symptoms to drug effects. (In some circumstances a prescribing cascade may be appropriate.)

13 Recommendations

8. Rule out medication side effects as a cause of new symptoms such as confusion, falls, functional decline or memory loss.

- Drug accumulation can occur after several weeks or months, or with declining renal function.
- Drug adverse effects (especially falls, incontinence, confusion) may be incorrectly attributed to normal aging.
- Older adults may not tolerate their usual medications when acutely ill, requiring dose reduction or temporary discontinuation.
- Older adults with type 2 diabetes may need to hold medications on sick days (**SADMANS** –Sulfonylureas, ACE-inhibitors, Diuretics, direct renin inhibitors, Metformin, Angiotensin Receptor Blockers, Non-Steroidal Anti-Inflammatory Drugs and SGLT2 inhibitors).

9. Avoid making simultaneous changes in medications.

10. The moment of prescribing is an opportunity to review the current medication list.

- Is each drug indicated? —Stop unnecessary, outdated or duplicate medications [STOPP-START Criteria for Potentially Inappropriate Prescribing in Older People](#) (NHS Cumbria Clinical Commissioning Group, 2023).
- Is a drug required? — START guideline-recommended therapy as appropriate
- Do current prescription label instructions match the person's drug taking practice?
- Forced compliance of outdated instructions can cause problems.
- Consider potential interactions with caffeine, cigarette smoking, OTCs, or herbals.

11. Write a time-limited prescription.

12. Encourage older adults to understand the importance of each of their medications and to have a **system to remember doses.**

- Dose organizers (blister pack, dosette box), reminders, education.

13. Encourage older adults to use one pharmacy so that drug interactions can be identified quickly, medication-taking problems can be addressed, and periodic medication reviews can be conducted.

- Older adults over 65 years of age should obtain a [MedsCheck](#) (a program of The Ministry of Health and Long-Term Care) at their pharmacy and bring their medication list to appointments with their primary care provider.

Lawrence Jackson BScPhm, CTD, RGP's Geriatric Emergency Management (GEM) Network Conference (Sept 2016)

5 QUESTIONS TO ASK ABOUT YOUR MEDICATIONS when you see your doctor, nurse, or pharmacist.

1. CHANGES?

Have any medications been added, stopped or changed, and why?

2. CONTINUE?

What medications do I need to keep taking, and why?

3. PROPER USE?

How do I take my medications, and for how long?

4. MONITOR?

How will I know if my medication is working, and what side effects do I watch for?

5. FOLLOW-UP?

Do I need any tests and when do I book my next visit?



Keep your medication record up to date.

Remember to include:

- ✓ drug allergies
- ✓ vitamins and minerals
- ✓ herbal/natural products
- ✓ all medications including non-prescription products

Ask your doctor, nurse or pharmacist to review all your medications to see if any can be stopped or reduced.

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Société canadienne des pharmaciens d'hôpitaux



CANADIAN PHARMACISTS ASSOCIATION ASSOCIATION DES PHARMACIENS DU CANADA

SafeMedicationUse.ca



Visit safemedicationuse.ca for more information.

This tool is reproduced with permission by ISIMP. [Click here](#) to download a printable copy of this poster.

Ask your pharmacist to do a [MedsCheck](#) covered by Ontario health benefits.

Polypharmacy in home and community care

ASSESS



- Ensure that accurate and complete medication information is available by conducting medication reconciliation (“Med Rec”), especially when there has been a transition in care. The “Med Rec” process in home and community care comprises 4 steps:

1. Collect – the Best Possible Medication History (BPMH)
2. Compare – identify discrepancies
3. Correct – resolve discrepancies
4. Communicate – the reconciled medication list

Consider the following tools (Canadian Safety Patient Institute & ISMP Canada) to assist in the “Med Rec” process:

- [Medication Reconciliation in Home Care Getting Started Kit](#) (v4, 2019)
- [BPMH Interview Guide](#)

MANAGE



- Help older adults to be aware of signs and symptoms of adverse drug reactions (ADRs).
- Offer to identify out-of-date medications and dispose of them.
- If requested to do so, assist with taking medications by reminding when they are due, reviewing instructions, and opening bottles and blister packs and pouring liquid medications in appropriate dosages.
- Assess whether the older adult can easily open the medication packaging. If not, explore options with the pharmacist.

COMMUNICATE



- Contact the primary care provider if discrepancies are found during the “Med Rec” process, and communicate the reconciled medication list within the circle of care (healthcare team).
- Communicate any issues related to medication adherence or skipped doses and suspected ADRs with the primary care provider and others in the circle of care (including family if permitted by the older adult).
- Encourage use of the Ministry of Health and Long-Term Care’s [MedsCheck](#) program (medication review at a pharmacy or in home).

Polypharmacy in primary care

ASSESS



- Ensure that accurate and complete medication information is available by conducting medication reconciliation (“Med Rec”), especially when there has been a transition in care. The “Med Rec” process in primary care comprises 4 steps:
 1. Collect – the Best Possible Medication History (BPMH)
 2. Compare – identify discrepancies
 3. Correct – resolve discrepancies
 4. Communicate – ensure continuity of medication information

Consider the following tools (*Canadian Safety Patient Institute & ISMP Canada, 2015*) to assist in the “Med Rec” process:

- [Ontario Primary Care Medication Reconciliation Guide](#)
- [BPMH Interview Guide](#)
- Assess the appropriateness of medications guided by [Beers Criteria](#) (*the American Geriatrics Society, 2023*) or [STOPP-START Criteria for Potentially Inappropriate Prescribing in Older People](#) (*NHS Cumbria Clinical Commissioning Group, 2023*).

MANAGE



- Review prescribing tips in older adults (*pages 69-70*).
- Identify opportunities for de-prescribing using guidelines, pamphlets, and resources from:
 - [Deprescribing.org](#) or
 - [Polypharmacy: Guidance for Prescribing](#) - includes key considerations for prescribing for older adults with frailty. (*All Wales Therapeutics & Toxicology Centre, 2014*)
- Involve older adults in prescribing decisions to ensure that the plan of care meets their goals and preferences. Confirm patient understanding of their medications. Clarify patient preference for family involvement in medication discussions.

COMMUNICATE



- Share concerns arising from the “Med Rec” process within the circle of care (healthcare team).
- Communicate up-to-date medication lists and actual or potential adverse drug reactions (ADRs) for monitoring by providers within the circle of care.
- Provide older adults with clearly written medication summaries and instructions, including how to monitor for ADRs (use a min. font size of 12).
- Provide older adults with information on self-management of their conditions and encourage them to take an active role in medication safety.
- Encourage use of the Ministry of Health and Long-Term Care’s [MedsCheck](#) program (medication review at a pharmacy or in home).

Polypharmacy in hospital

ASSESS



- Ensure that accurate and complete medication information is available from admission through discharge. Consider the following tools (*Canadian Safety Patient Institute & ISMP Canada, 2017*) to assist in the “Med Rec” process:
 - [Medication Reconciliation in Acute Care Getting Started Kit](#) (v4, 2019)
 - [Medication Reconciliation in Acute Care Poster](#)
 - [BPMH Interview Guide](#)
- Assess the appropriateness of medications guided by [Beers Criteria](#) (*the American Geriatrics Society, 2023*) or [STOPP-START Criteria for Potentially Inappropriate Prescribing in Older People](#) (*NHS Cumbria Clinical Commissioning Group, 2023*).

MANAGE



- Review prescribing tips in older adults (*pages 69-70*).
- Identify opportunities for de-prescribing using guidelines, pamphlets, and resources from:
 - [Deprescribing.org](#) or
 - [Polypharmacy: Guidance for Prescribing](#) - includes key considerations for prescribing for older adults with frailty. (*All Wales Therapeutics & Toxicology Centre, 2014*)
- Identify if medications could be the cause of hospital admission.
- Involve older adults in prescribing decisions to ensure that the plan of care meets their goals and preferences. Confirm patient understanding of their medications. Clarify patient preference for family involvement in medication discussions.

COMMUNICATE



- Share concerns arising from the “Med Rec” process within the circle of care (healthcare team).
- Discuss anticipated changes to long-standing medication regimens with primary care providers.
- Communicate up-to-date medication lists and actual or potential adverse drug reactions (ADRs) for monitoring by providers within the circle of care.
- Provide older adults with clearly written medication summaries and instructions, including how to monitor for ADRs (use a min. font size of 12).
- Provide older adults with information on self-management of their conditions and encourage them to take an active role in medication safety.
- Encourage use of the Ministry of Health and Long-Term Care’s [MedsCheck](#) program (medication review at a pharmacy or in home).

Polypharmacy in long-term care

ASSESS



- Ensure that accurate and complete medication information is available by conducting medication reconciliation (“Med Rec”), especially when there has been a transition in care. Consider the following tools (*Canadian Safety Patient Institute & ISMP Canada, 2017*) to assist in the “Med Rec” process:
 - [Medication Reconciliation in Long Term Care Getting Started Kit](#) (v3, 2019)
 - [Medication Reconciliation in Long Term Care Poster](#)
 - [BPMH Interview Guide](#)
- Assess the appropriateness of medications guided by [Beers Criteria](#) (*the American Geriatrics Society, 2023*) or [STOPP-START Criteria for Potentially Inappropriate Prescribing in Older People](#) (*NHS Cumbria Clinical Commissioning Group, 2023*).

MANAGE



- Review prescribing tips in older adults (*pages 69-70*).
- Conduct regular medication reviews to determine the appropriateness of each medication.
- Consider the following resources to identify opportunities for de-prescribing:
 - [Deprescribing in Ontario LTC Framework](#) (*deprescribing.org, 2019*) or
 - [Polypharmacy: Guidance for Prescribing](#) - includes key considerations for prescribing for older adults with frailty. (*All Wales Therapeutics & Toxicology Centre, 2014*)
- Involve older adults or their substitute decision makers in prescribing decisions to ensure that the plan of care meets their goals and preferences. Confirm understanding of their medications. Clarify preference for family involvement in medication discussions.

COMMUNICATE



- Share concerns arising from the “Med Rec” process within the circle of care (healthcare team).
- Communicate up-to-date medication lists and actual or potential adverse drug reactions (ADRs) for monitoring by providers within the circle of care.
- Provide staff and older adults or substitute decision makers with clearly written medication summaries and instructions, including how to monitor for ADRs (use a min. font size of 12).
- Provide medication information to staff and older adults or their substitute decision makers to encourage them to take an active role in medication safety.

References

1. Masnoon N, Shakib S, Kalisch-Ellett L, Caughey GE. What is polypharmacy? A systematic review of definitions. *BMC Geriatrics*. 2017;17:230.
2. CIHI. Drug Use Among Seniors in Canada Canadian Institute for Health Information 2016 [cited 2018 September 28]. Available from: cihi.ca/en.
3. Rotermann M, Sanmartin C, Hennessy D, Arthur M. Prescription medication use by Canadians aged 6 to 79: Statistics Canada; 2014 [cited 2018 September 14]. Available from: www150.statcan.gc.ca/n1/pub/82-003-x/2014006/article/14032-eng.htm
4. Payne RA, Avery AJ. Polypharmacy: One of the greatest prescribing challenges in general practice. *British Journal of General Practice*. 2011;61(583):83-4.
5. Reeve E, Wiese MD, Hendrix I, Roberts MS, Shakib S. People's attitudes, beliefs, and experiences regarding polypharmacy and willingness to Deprescribe. *J Am Geriatr Soc*. 2013;61(9):1508-14.
6. All Wales Therapeutics & Toxicology Centre. Polypharmacy: Guidance for Prescribing: AWTTTC; 2014 [Available from: patientsafetyinstitute.ca/en/toolsResources/Pages/Med-Rec-resources-getting-started-kit.aspx..
7. College of Physicians and Surgeons of Alberta. Medication reviews in long-term care and supportive living: a physician's perspective 2014
8. Emanuel L, Taylor L, Hain A, Combes J, Hatlie M, Karsh B, et al. The Patient Safety Education Program Module 14: Medication Reconciliation: Canadian Patient Safety Institute (CPSI); 2014 [cited 2022 August 17]. Available from: patientsafetyinstitute.ca/en/education/PatientSafetyEducationProgram/PatientSafetyEducationCurriculum/Pages/Module-14-Medication-Reconciliation.aspx.
9. Maher RL, Hanlon JT, Hajjar ER. Clinical Consequences of Polypharmacy in Elderly. Expert opinion on drug safety. 2014;13(1):10.1517/14740338.2013.827660.
10. AGS. American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults. *J Am Geriatr Soc*. doi:[10.1111/jgs.15767](https://doi.org/10.1111/jgs.15767)
11. Davies EA, O'Mahony MS. Adverse drug reactions in special populations - the elderly. *British journal of clinical pharmacology*. 2015;80(4):796-807.
12. ISMP. Ontario Primary Care Medication Reconciliation Guide Institute for Safe Medication Practices 2015 [Available from: ismp-canada.org/download/PrimaryCareMedRecGuide_EN.pdf.
1. ISMP. Best Possible Medication Interview Guide Institute for Safe Medication Practices Canada; 2015 [Available from: ismp-canada.org/download/MedRec/SHN_medcard_09_EN.pdf
2. ISPM, CPSI. Medication Reconciliation in Home Care Getting Started Kit Version 4: Institute for Safe Medication Practices Canada & Canadian Patient Safety Institute 2019 [Available from: patientsafetyinstitute.ca/en/toolsResources/Pages/Med-Rec-resources-getting-started-kit.aspx
3. O'Mahony D, O'Sullivan D, Byrne S, O'Connor MN, Ryan C, Gallagher P. STOPP/START criteria for potentially inappropriate prescribing in older people: version 2. Age and ageing. 2015;44(2):213-8.
4. The North of England Commissioning Support (NECS). STOPP START Toolkit 3 Cumbria. 2016 [Version 2: [Available from: https://static-content.springer.com/esm/art%3A10.1007%2Fs41999-023-00777-y/MediaObjects/41999_2023_777_MOESM1_ESM.pdf
5. ISPM, CPSI. Medication Reconciliation in Long-Term Care Getting Started Kit version 3 Institute for Safe Medication Practices Canada & Canadian Patient Safety Institute 2019 [Available from: patientsafetyinstitute.ca/en/toolsResources/Pages/Med-Rec-resources-getting-started-kit.aspx
6. ISPM, CPSI. Medication Reconciliation in Acute Care Getting Started Kit Version 4 Institute for Safe Medication Practices Canada & Canadian Patient Safety Institute 2017 [Available from: patientsafetyinstitute.ca/en/toolsResources/Pages/Med-Rec-resources-getting-started-kit.aspx
7. Sirois C, Ouellet N, Reeve E. Community-dwelling older people's attitudes towards deprescribing in Canada. *Res Social Adm Pharm*. 2017;13(4):864-70.
8. Bruyère Research Institute. Deprescribing Guidelines and Algorithms: Copyright © 2018 Bruyere.; 2018 [Available from: deprescribing.org/resources/deprescribing-guidelines-algorithms/.
9. RGP of Ontario, Geriatrics Interprofessional Interorganizational Collaboration (GiiC). Medication Review Frailty eLearning Module [Available from: geriatricessentialslearning.ca/.

Senior Friendly 7



SOCIAL ENGAGEMENT TOOLKIT



**REGIONAL GERIATRIC
PROGRAM OF TORONTO**

Contents

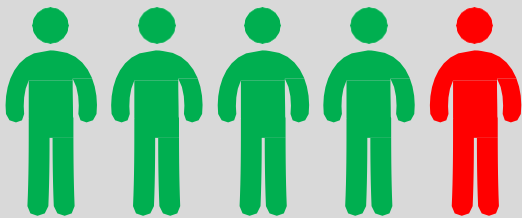
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Understanding loneliness and social engagement

Loneliness

A disconnect between a person's desired and actual social relationships, which results in a complex emotional and physical response.^[1]

We have all felt lonely at times, but it becomes a problem when it occurs frequently or even chronically, negatively impacting health and functioning.



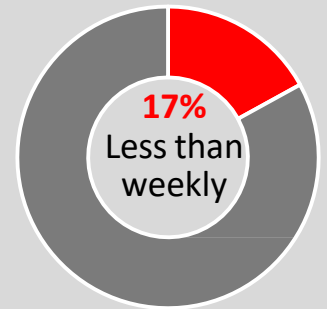
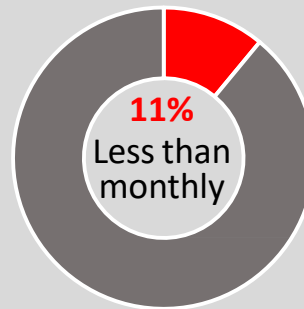
One in five Canadians, mainly older adults, **experience some degree of loneliness**. In those **over 85** years, the rate of loneliness is as high as **25%**.^[2]

Social Isolation

Results from situations where a person has few people to interact with.

Although closely related, loneliness and social isolation are not the same. A person can be socially isolated but not feel lonely, whereas an individual with a seemingly large social network can still experience loneliness. Individuals may be lonely in a crowd or socially contented while alone.

How often do older adults have contact with family, friends, or neighbours?^[3]



Social engagement

Involvement in meaningful activities with others and maintaining close, fulfilling relationships.^[1]

Social engagement can lessen loneliness.



The potential impact of loneliness

Loneliness has a similar impact on mortality as smoking and alcohol misuse. It exceeds the risk associated with obesity and inactivity.^[4]

Can affect physical health

- Early mortality
- Stroke
- Elevated blood pressure
- Malnutrition

Can affect mental health

- Depression
- Risk of suicide
- Substance misuse

Can cause functional decline

- Physical and/or cognitive deterioration



Social isolation can be a contributing factor to loneliness. Risk factors for social isolation include:



Psychological
Personality or mental health issues



Living alone
Widowhood, divorce or never married



Health status
Health problems, physical challenges or disability



Sensory Impairment
Chronic or recent changes



No children




Major life events
Loss and bereavement, change in living arrangements



Do you have biases about “normal aging”? Loneliness is not a normal part of aging. It can have a serious impact to health outcomes, and needs to be addressed as a health issue, just as you would for adults of all ages. The inability to access social support is an equity issue. It may require creative solutions! Call 211 for supports.

Assessing loneliness



Older adults who experience loneliness may be less likely to visit a primary care provider, and may avoid talking about loneliness with others.

Here are questions you can ask to explore loneliness. The Three-Item Loneliness Scale is a simple, validated assessment for loneliness. It can be used by any care provider.

The Three-Item Loneliness Scale

These questions are about how you feel about different aspects of your life. For each question, answer how often you feel that way.

	Hardly Ever	Some of the Time	Often
How often do you feel that you lack companionship?	1	2	3
How often do you feel left out?	1	2	3
How often do you feel isolated from others?	1	2	3

The Score: the sum of all items.

Score range: 3-9. 3-5 is considered “not lonely” and 6-9 is considered “lonely”

Adapted from: “A Short Scale for Measuring Loneliness in Large Surveys: Results from Two Population-Based Studies” by Hughes ME, Waite LJ, Hawkey LC, Cacioppo JT, 2004. *Research on Aging*.26(6):655-72.

Social engagement for older adults + family

Think inside and outside of the home - how can you increase your social engagement?

There are different types of social opportunities. It is important to find out what works best for you based on your interests and preferences. Options may include:



Group activities



Family interactions



Informal relationships



Programs via phone



Social media and online platforms

To find activities in your community, visit: ontario.ca/page/seniors-connect-your-community

Practical tips for families on social engagement

- When social engagement opportunities are regularly scheduled and controlled by the older adult, it offers reassuring predictability.
- Do not be hurt if your loved one prefers reminiscing with someone other than yourself.
- If desired, help your family member find ways to connect with friends.
- Conversation can be enhanced by:
 - Listening actively
 - Responding positively
 - Following-up actively
 - Allowing time for silence and reflection

If you or your loved one have expressed the wish for more company, feel left out or isolated – share this information with a member of your circle of care (healthcare team).

Social engagement in home and community care

ASSESS



- Be alert to statements suggesting that the older adult wants more company, feels left out or feels isolated.
- Having an understanding of the older adult's social network, culture, and personality style can be helpful.
- If you suspect that an older adult is suffering from loneliness, consider using the Three-item Loneliness Scale (*page 81*). A score of more than 6 suggests that the person is very socially isolated and this needs to be addressed.

MANAGE



- Consider all visits as an opportunity for social engagement.
- Control and predictability improve the positive impact of visits on social engagement.
- Conversation can be enhanced by:
 - Starting with open-ended questions such as: "How are you doing today?"
 - Listening actively
 - Responding positively
 - Following-up actively
 - Allowing time for silence and reflection
- Reminiscence can be a healthy part of conversation. There are different types and [functions of reminiscence](#).
- Identify opportunities for the older person to connect with friends or family, or join social groups in the community, and offer assistance with these connections.

COMMUNICATE



- Communicate concerns of loneliness within the circle of care (healthcare team).
- Consider the older adult's relationships and preferences before discussing with family members, and if appropriate, share information on ways to promote social engagement.

Social engagement in primary care

ASSESS



- Be alert to statements suggesting that the older adult wants more company, feels left out or feels isolated.
- Having an understanding of the older adult's social network, culture, and personality style can be helpful.
- If you suspect that an older adult is suffering from loneliness, consider using the Three-item Loneliness Scale (page 6 of this toolkit). A score of more than 6 suggests that the person is very socially isolated and this needs to be addressed.

MANAGE



- Consider writing a social prescription using [the sfCare social prescription template which may include things like:](#)
 - Seniors active living centres
 - Community recreation centres
 - Libraries
 - Volunteering and community engagement
 - See ontario.ca/page/seniors-connect-your-community for more options
- Ensure that the older adult collaborates on the social prescription.
- For some older adults, medical appointments may be their main form of social engagement.
- Sometimes just talking and listening can offer therapeutic benefit.
- Persistent loneliness despite access to social opportunities may indicate the need for more specialized assessment and intervention.

COMMUNICATE



- Communicate concerns about loneliness and recommendations within the circle of care (healthcare team).
- Consider the older adult's relationships and preferences before discussing with family members, and if appropriate, share information on ways to promote social engagement.

Social engagement in hospital

ASSESS



- Consider whether social isolation was a risk factor that contributed to seeking hospital care.
- Having an understanding of the older adult's social network, culture, and personality style is important in making this assessment.
- If you suspect that an older adult is suffering from loneliness, consider using the Three-Item Loneliness Scale (page 6 of this toolkit). A score of more than 6 suggests that the person is very socially isolated and needs to be addressed.

MANAGE



- Consider writing a social prescription using [the sfCare social prescription template which may include things like:](#)
 - Seniors active living centres
 - Community recreation centres
 - Libraries
 - Volunteering and community engagement
 - See ontario.ca/page/seniors-connect-your-community for more options
- Ensure that the older adult collaborates on the social prescription.
- Conversation can be enhanced by:
 - Starting with open-ended questions such as: "How are you doing today?"
 - Listening actively
 - Responding positively
 - Following-up actively
 - Allowing time for silence and reflection
- Reminiscence can be a healthy part of conversation. There are different types and [functions of reminiscence](#).

COMMUNICATE



- Include concerns and recommendations related to loneliness in discharge plans.
- Consider the older adult's relationships and preferences before discussing with family members, and if appropriate, share information on ways to promote social engagement.

Social engagement in long-term care

ASSESS



- Be alert to statements suggesting that the older adult wants more company, feels left out or feels isolated from life.
- Having an understanding of the older adult's social network, culture, and personality style is important in making this assessment.
- Assess whether physical or mental health issues such as incontinence, vision, hearing, or mobility are having an impact on the older adult's level of social engagement.
- If you suspect that an older adult is suffering from loneliness, consider using the Three-Item Loneliness Scale (page 6 of this toolkit). A score of more than 6 suggests that the person is very socially isolated and needs to be addressed.

MANAGE



- Consider writing a social prescription using [the sfCare social prescription template which may include things like:](#)
 - Seniors active living centres
 - Community recreation centres
 - Libraries
 - Volunteering and community engagement
 - See ontario.ca/page/seniors-connect-your-community for more options.
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 - Following-up actively
 - Allowing time for silence and reflection
- Reminiscence can be a healthy part of conversation. There are different types and [functions of reminiscence](#).

COMMUNICATE



- Communicate concerns and recommendations related to loneliness within the circle of care (healthcare team).
- Consider the older adult's relationships and preferences before discussing with family members, and if appropriate, share information on ways to promote social engagement.

References

1. Masi CM, Chen HY, Hawkley LC, Cacioppo JT. A meta-analysis of interventions to reduce loneliness. *Personality and Social Psychology Review*. 2011;15(3):219-66.
2. Gilmour H. Social participation and the health and well-being of Canadian seniors. *Health Rep*. 2012;23(4):23-32.
3. Victor, C., Scambler, S., Bond, J., & Bowling, A. (2000). Being alone in later life: Loneliness, social isolation and living alone. *Reviews in Clinical Gerontology*, 10(4), 407-417. doi:10.1017/S0959259800104101. <https://www.cambridge.org/core/journals/reviews-in-clinical-gerontology/article/abs/being-alone-in-later-life-loneliness-social-isolation-and-living-alone/5B070D099EC989DF39F6114F071E9EDC>
4. Holt-Lunstad J, Smith TB, Layton JB. Social relationships and mortality risk: a meta-analytic review. *PLoS Med*. 2010;7(7):e1000316.
5. Wong PT, Watt LM. What types of reminiscence are associated with successful aging? *Psychol Aging*. 1991;6(2):272-9.
6. Hughes ME, Waite LJ, Hawkley LC, Cacioppo JT. A short scale for measuring loneliness in large surveys: Results from two population-based studies. *Research on Aging*. 2004;26(6):655-72.
7. Cattan M, White M, Bond J. Preventing social isolation and loneliness among older people: a systematic review of health promotion intervention. *Database of Abstracts of Reviews of Effects (DARE): Quality-assessed Reviews [Internet]*. 2005;25:41-67.
8. Hartwell S.W., P.R. B. Social Integration: A Conceptual Overview and Two Case Studies. Pescosolido B.A. (eds) *Mental Health, Social Mirror*: Springer, Boston, MA; 2007.
9. Klever S. Reminiscence therapy: finding meaning in memories. *Nursing*. 2013;43(4):36-7.
10. Birtwhistle R, Grad R, Bell NR, Thombs BD, Dickinson JA. Periodic preventive health visits: A more appropriate approach to delivering preventive services: From the Canadian task force on preventive health care. *Canadian Family Physician*. 2017;63(11):824-6 and e449-e51.

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