QUALITY STANDARDS

Falls in Adults

Care in All Settings

MONTH 2026

Provincial Geriatrics Leadership Ontario

Ontario Health

Table of Contents

What Is a Quality Standard?

Scope of This Quality Standard

Building On Existing Provincial Guidance

A Note on Terminology

Why This Quality Standard Is Needed

Quality Statements to Improve Care

Quality Statement 1: Identification of Individual Fall Risk

Quality Statement 2: Comprehensive Assessment

Quality Statement 3: Comprehensive Interventions to Prevent Falls

Quality Statement 4: Multicomponent Falls Prevention Exercise Program

Quality Statement 5: Structured Medication Review

Acknowledgements

References

About Us

About Provincial Geriatrics Leadership Ontario

What Is a Quality Standard?

Quality standards outline what high-quality care looks like for conditions or processes where there are large variations in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive. They help:

- Patients, families, and care partners know what to ask for in their care
- Clinicians know what care they should offer, based on the best available evidence and expert consensus
- Health care organizations measure, assess, and improve their performance in caring for patients
- Health services planners create the environment for clinicians and health care organizations to deliver high-quality care

Quality standards and their accompanying patient guides are developed by Ontario Health in collaboration with patients, clinicians, and care partners across Ontario.

For more information, contact QualityStandards@OntarioHealth.ca.

For more information on our program, please see About Quality Standards.

Scope of This Quality Standard

This quality standard addresses care for adults aged 18 years and older who have experienced a fall or who are at risk of falling, with a focus on older adults, aged 65 years and older, and their care partners. It addresses care provided in all health care settings, including acute care, emergency, primary care, regional geriatric program, long-term care, palliative care, and other home and community care settings, as well as referral to specialized care. Some statements may also apply to care provided in rehabilitation, behavioural support, or specialized geriatric settings.

This quality standard does not address the treatment of comorbidities. However, it can be used alongside existing Ontario Health quality standards to address the needs of people who have experienced a fall or are at risk of falling and have comorbidities such as dementia (experienced in hospitals and long-term care homes[1] or in the community[2]), delirium,[3] or hip fracture,[4] as well as the needs of those requiring palliative care[5] or transitioning between hospital and home.[6]

A separate quality standard addressing frailty is in development.

Building On Existing Provincial Guidance

This quality standard is informed by the Ontario Alternate Level of Care (ALC) Leading Practices Working Group's 2021 guide, The Alternate Level of Care (ALC) Leading Practices Guide: Preventing Hospitalization and Extended Stays for Older Adults,[7] and by Provincial Geriatrics Leadership Ontario's 2022 guide, Supporting Ontario Health Teams to Influence Alternate Level of Care: Leading Practices in Community-Based Early Identification, Assessment and Transition.[8] The quality statements align with ALC leading practices to avoid unnecessary ALC designation and prevent delayed transitions to an appropriate care setting, as well as with ALC leading practices for care provided in community settings.

The quality standard also complements and builds on existing Ontario guidance on care for older adults, including the following:

- The Home First approach from Ontario Health[9]
- The Senior Friendly Care initiative from the Regional Geriatric Program of Toronto[10]
- The Rehabilitative Care for Older Adults Living With/At Risk of Frailty: From Frailty to Resilience best practice framework from Provincial Geriatrics Leadership Ontario and the Rehabilitative Care Alliance[11]

These guidance sources support a coordinated and integrated approach to improving care, experiences, and outcomes for older adults and their care partners. They also reinforce the notion that effective care for older adults requires alignment across multiple care pathways and settings rather than a single service stream or sector. Consistent with this approach, the quality statements in this quality standard focus on areas identified as having the greatest potential to improve care for people who have experienced a fall or who are at risk of falling.

A Note on Terminology

This quality standard uses the term *care partner* to describe an unpaid person identified by the person at risk of falls who provides care and support in a nonprofessional capacity, such as a family member, friend, or another trusted person. Although people at risk of falls may have various people in their lives who care for them, it is important not to assume that a person at risk of falls always has a care partner available to support them.

When actively involved in a person's care, a care partner may participate in care planning and decision-making in alignment with the person's goals of care; however, their availability, capacity, and ability to provide support may vary over time owing to personal circumstances. The health care system is responsible for ensuring that appropriate supports are in place as needed so that neither the person receiving care nor their care partners are expected to compensate for gaps in services.

Why This Quality Standard Is Needed

A fall is an unexpected event that results in a person inadvertently coming to rest on the ground or a lower surface, with or without injury.[1] The prevalence of falls increases with age and is the leading cause of preventable injury-related hospitalizations (85% of cases) among older adults (aged 65 years and older) in Canada; falls are also the leading cause of unintentional injury-related deaths globally.[1-3] Approximately 20% to 30% of older adults in Canada report falling yearly[12,13]; however, falls are likely underreported as many older adults do not disclose falls to their clinicians unless they result in serious injury.[14]

In Ontario in 2024, the rate of emergency department visits for falls in older adults was nearly 6,000 falls per 100,000 people, and the hospitalization rate was almost 1,500 per 100,000 people.[15] The average length of hospital stay for older adults who have had a fall is 4 to 5 days longer than for those hospitalized for injuries due to any cause.[16] People with frailty are more likely to present to hospital as a result of a fall than those without frailty, and frailty severity is an important predictor of fall risk.[17]

Falls among older adults are most often the result of a complex interaction of biological, behavioural, environmental, and socioeconomic factors.[14] Falls in older adults resulting in serious injury typically result from interactions among long-term age-related factors – such as functional declines in neural networks and sensory, cognitive, or musculoskeletal structures – and short-term factors – such as tripping, acute illness, or adverse reactions to medications.[14]

In addition to advanced age, the risk of falls is higher among people with a history of falls, female sex, and comorbidities such as incontinence, Parkinson's disease, arthritis, diabetes, and chronic pain.[16] Falls are associated with negative health outcomes such as loss of autonomy, isolation, reduced cognition and mobility, and depression.[18]

Quality Statements to Improve Care

These quality statements describe what high-quality care looks like for people who have experienced a fall or who are at risk of falling.

Quality Statement 1: Identification of Individual Fall Risk

People at risk of falls have their individual fall risk identified at regular intervals during health care encounters.

Quality Statement 2: Comprehensive Assessment

People at high risk of falls, including all hospitalized older adults, are offered a comprehensive multifactorial assessment. The assessment is completed by an interprofessional care team and informs the development of an individualized care plan.

Quality Statement 3: Comprehensive Interventions to Prevent Falls

People at risk of falls are supported with tailored, multicomponent interventions. An individualized care plan is developed collaboratively and shared with the person, their care partners, and their interprofessional care team. The plan addresses the fall risk identified in the comprehensive assessment. It also includes education about falls prevention, interventions to prevent injuries and fractures, and referrals to the appropriate levels of rehabilitative supports as needed.

Quality Statement 4: Multicomponent Falls Prevention Exercise Program

People at risk of falls are supported to participate in an individualized, multicomponent falls prevention exercise program. The frequency of the program is determined collaboratively with the person and their care partners. Exercises are progressive and guided by the person's individual fall risk, goals of care, capabilities, and functioning.

Quality Statement 5: Structured Medication Review

People at risk of falls receive a structured medication review to identify polypharmacy and the use of fall risk–increasing drugs. The benefits and risks of each medication are evaluated and discussed with the person and their care partners. A shared decision is made to gradually reduce, change, or discontinue medications as appropriate.

Quality Statement 1: Identification of Individual Fall Risk

People at risk of falls have their individual fall risk identified at regular intervals during health care encounters.

Sources: National Institute for Health and Care Excellence, 2025[19] | Registered Nurses' Association of Ontario, 2017[20] | World Guidelines for Falls Prevention and Management for Older Adults, 2022[14]

Definitions

At risk of falls: Includes all adults aged 65 years and older, as well as those who self-report fear of falling, have a history of falls or near falls, or have impairments to gait, balance, or mobility.[14,19,20]

Individual fall risk: People are identified as being at low, intermediate, or high risk of falls based on the following factors:

- Low risk: no history of falls *or* a single nonsevere fall not resulting in injury or impairment to gait or balance[14]
- Intermediate risk: a history of a single nonsevere fall not resulting in injury but causing gait or balance impairment[14]
- High risk: Underlying frailty[14,20]; *or* a history of 2 or more falls within the past 12 months and gait speed below 0.8 m/s[14], poor balance, or impaired mobility[14]; *or* meeting any 1 or more of the following criteria:
  - Presenting to hospital with a fall-related injury or needing medical or surgical treatment for a fall[14,20]
  - Self-reported fear of falling or a change in behaviour due to fear of falling (e.g., avoiding certain activities) [14]
  - Previous experience of being unable to get up after a fall without help for at least 1 hour[14]
  - Syncope or previous experience of losing consciousness after a fall[14,19,20]
  - Currently hospitalized (e.g., an older adult presenting to hospital for a severe fall or with acute illness, delirium, or dementia)[14]
  - Multimorbidity (e.g., cognitive impairment)[14,19,20]
  - Living in a long-term care home[14]
  - Previous fractures[14,19,20]

Risk prediction tools such as the Timed Up and Go (TUG) test can be used to assess fall risk.[14]

People identified as being at *high risk* should receive a comprehensive assessment (see quality statement 2).

Identified: Involves clinicians asking people whether they have experienced a fall within the past 12 months, the use of clinical judgment, and risk stratification (see definition of *individual fall risk*).[14,19,20] Any clinician may conduct the identification.

Regular intervals: At least once a year and after any major change in health status.[14,19]

Health care encounters: Includes intake and routine primary care and home care visits, emergency department visit and hospital admission assessments (regardless of presenting issue), and encounters related to a major change in health status or social changes.[14,19,20]

Rationale

Approximately 20% to 30% of people aged 65 years and older living in Canada experience at least 1 fall each year.[13] The risk of falling and being seriously injured as a result increases with age.[13] Because falls are likely underreported by older adults, clinicians should identify people who may be at risk of falls at every opportunity and provide appropriate supports as needed.[14,19,20]

Quality Statement 2: Comprehensive Assessment

People at high risk of falls, including all hospitalized older adults, are offered a comprehensive multifactorial assessment. The assessment is completed by an interprofessional care team and informs the development of an individualized care plan.

Sources: National Institute for Health and Care Excellence, 2025[19] | Registered Nurses' Association of Ontario, 2017[20] | World Guidelines for Falls Prevention and Management for Older Adults, 2022[14]

Definitions

High risk of falls: See definition in quality statement 1.

Comprehensive multifactorial assessment: A structured evaluation of a person's modifiable and nonmodifiable risk factors across multiple domains to understand the mechanisms of previous falls and the current fall and to prevent future falls.[14] The comprehensive assessment may be phased and completed by the most appropriate clinician, an interprofessional care team, or specialized geriatric services, depending on the domains assessed (advisory committee consensus).

The domains of a comprehensive multifactorial assessment include:

- An assessment of the circumstances of the most recently reported fall (e.g., falling during routine activity)[14,20]
- An assessment of physical (i.e., mobility, balance, gait, muscle strength, foot problems), sensory (e.g., dizziness, vision, hearing), cognitive, autonomic, and psychological function[14,20]
- A structured medication review (see quality statement 5)[14,19,20]
- An assessment of perceptions and fear of falling via a validated tool such as the Falls Efficacy Scale–International (FES-I) or the Short FES-I[14]
- An assessment of the presence of long-term health conditions such as arthritis, dementia, diabetes, osteoporosis, or Parkinson's disease[14,19,20]
  - For further information on care for people with arthritis (specifically osteoarthritis), dementia, or diabetes, see Ontario Health's Osteoarthritis,[21] Dementia,[2] Type 1 Diabetes,[22] or Type 2 Diabetes[23] quality standards.
- An assessment of the presence of other comorbid conditions such as cardiovascular disease or neurocognitive disorders[14,19,20]

- An assessment of the presence of any relevant environmental hazards[14,19,20]
- An assessment of relevant lifestyle and social factors, including diet, protein and nutrient intake, and vitamin D supplementation[14,19,20]
- An assessment of fracture risk, previous hip or spine fracture, and bone health[14,20]
  - For further information on care for people with hip fracture, see Ontario Health's Hip Fracture quality standard.[4]

Interprofessional care team: At minimum, the team includes more than 1 clinician with expertise in falls management or geriatric care. Other team members may include nurses and geriatric emergency management nurses, kinesiologists, registered dietitians, social workers, home and community care case managers, paramedicine professionals, physiotherapists, occupational therapists, pharmacists, behavioural support clinicians, and clinicians with speciality in care for older adults.[3,24-26]

Individualized care plan: A plan developed collaboratively with the person receiving care and their care partners. It is based on the results of a comprehensive multifactorial assessment and the person's frailty status. The plan is tailored to the care setting; reflects the person's goals, preferences, circumstances, needs, and capabilities; and is made accessible to the person receiving care and their care partners. It is reviewed and updated regularly, with repeated follow-up every 6 months, or sooner if there is rapid deterioration, and after any major change in health status. Elements of the care plan may include:

- A structured medication review (see quality statement 5) [14,19,20]
- An assessment of home safety and the provision of guidance about how to eliminate hazards at home[14,19,20]
- Education on falls prevention strategies (see quality statement 4)[14,19,20]
- Recommendations regarding the use of devices such as hip protectors as appropriate[20]
- Exercises tailored to the person's needs, preferences, and capabilities (see quality statement 4)[14,19,20]
- Assessment of nutrition and lifestyle[14,20]

For further information on care for people with or at risk of frailty, see Ontario Health's Frailty quality standard.[27]

Rationale

In Ontario, falls account for 67% of injury-related hospitalizations among adults aged 65 to 74 years and 81% of such hospitalizations among those aged 75 years and older.[13] Although common, falls are largely preventable and stem from multiple interacting risk factors, such as coexisting frailty and other comorbid conditions, nutrition and lifestyle, bone and muscular health, and sensory impairments.[14,19,20] Recurring falls (2 or more within 12 months)[14] accelerate functional decline and increase mortality, highlighting the importance of identifying and mitigating fall risk factors.[28]

Quality Statement 3: Comprehensive Interventions to Prevent Falls

People at risk of falls are supported with tailored, multicomponent interventions. An individualized care plan is developed collaboratively and shared with the person, their care partners, and their interprofessional care team. The plan addresses the fall risk identified in the comprehensive assessment. It also includes education about falls prevention, interventions to prevent injuries and fractures, and referrals to the appropriate levels of rehabilitative supports as needed.

Sources: National Institute for Health and Care Excellence, 2025[19] | Registered Nurses' Association of Ontario, 2017[20] | World Guidelines for Falls Prevention and Management for Older Adults, 2022[14] | World Health Organization, 2017[26]

Definitions

Multicomponent interventions: A combination of 2 or more interventions that target a person's fall risk factors and are delivered by an interprofessional care team.[14] Interventions are based on the person's health status, goals of care, and the health care setting. Examples include:

- Interventions to manage frailty
  - For further information on care for people with or at risk of frailty, see Ontario Health's Frailty quality standard.[27]
- Exercises to maintain or improve physical function, muscular strength, balance, and bone health, including home and community exercise programs (see quality statement 4)[14,19,20,26]
- A structured medication review and the deprescribing of medication where appropriate (see quality statement 5)[14,19,20,26]
- Home and environmental safety modifications[14,19,20,26]
- Vision and hearing support as needed[14,19]
- Addressing underlying comorbidities (e.g., appropriate management of vestibular disorders)[1-3]
- Assessing the need for mobility aids and assistive devices, including proper fitting and education and training on their safe use[14,19,20]

- An individualized nutrition care plan, which may include[29]:
  - Calcium intake and vitamin D supplementation for bone health[14,19]
  - Dietary changes (e.g., Mediterranean diet to manage both frailty and risk of falls[30,31])
  - Lifestyle changes including reducing alcohol consumption[14,19]
- Providing self-management supports (e.g., ways to minimize fall risk, empowering the person to be actively involved in decisions regarding their health)
- Referrals to appropriate community rehabilitative supports and services
- For people with complex needs, referrals to appropriate specialists, including specialized geriatric services as needed[14]

Interventions are made accessible to the person receiving care. They are reassessed every 30 to 90 days – or more frequently, depending on the person's health status – to evaluate their effectiveness and make adjustments as needed.

Individualized care plan: See definition in quality statement 2.

Interprofessional care team: See definition in quality statement 2.

Education: All people at risk of falls receive education about preventing falls in combination with interventions to prevent falls. The educational content is based on the person's health status, goals of care, needs, preferences, and care setting. It is delivered in various formats, including oral, written, and electronic.[20] Topics may include:

- Personal fall risk factors and self-management strategies[1-3]
- Lifestyle changes in areas such as exercise and wellness, appropriate nutrition, vitamin D supplementation, and reducing risky behaviors[1-3]
- Home safety, including how to identify and eliminate home hazards, how to reduce the likelihood of injuries from falls, and what to do after a fall to reduce harm[14,19,26]
- Medication usage and side effects of medications that may increase the risk of falls
- Supports for care partners

Interventions to prevent injuries and fractures: Interventions may include:

- Management of osteoporosis based on risk assessment[20]
- Dietary interventions and other strategies to maintain and optimize bone health[20]
- Hip protectors for adults at high risk of hip fracture, if aligned with the person's goals of care[20]
- Progressive multicomponent exercise program (see quality statement 4)[20]

Levels of rehabilitative supports: Tailored and progressive supports based on the person's goals of care and current level of functioning to maintain or restore their optimal level of physical, cognitive, emotional, and social function.[11]

Rationale

The identification of a person's individual fall risk combined with the timely delivery of tailored multicomponent interventions can reduce the risk of falls and fall-related injuries.[32] Evidence from systematic reviews shows that multicomponent interventions to prevent falls are associated with a lower rate of falls across community and long-term care settings compared with settings that do not implement such interventions.[33,34]

Quality Statement 4: Multicomponent Falls Prevention Exercise Program

People at risk of falls are supported to participate in an individualized, multicomponent falls prevention exercise program. The frequency of the program is determined collaboratively with the person and their care partners. Exercises are progressive and guided by the person's individual fall risk, goals of care, capabilities, and functioning.

Sources: National Institute for Health and Care Excellence, 2025[19] | Registered Nurses' Association of Ontario, 2017[20] | World Guidelines for Falls Prevention and Management for Older Adults, 2022[14] | World Health Organization, 2017[26]

Definitions

Individualized, multicomponent falls prevention exercise program: A combination of planned, structured, and repetitive sets of physical activities combining (1) strength and balance training for falls prevention and (2) aerobic and functional training to address underlying frailty.[14] The exercise program is designed to reduce a person's risk of falls, support recovery after a fall, and address comorbidities such as underlying frailty.[14,20] It is provided by a trained professional, such as a certified exercise physiologist, registered kinesiologist, or registered physical or occupational therapist (advisory committee consensus). Examples of exercises for falls prevention include tai-chi and progressive resistance training targeting lower limb strength and balance.[14] Exercises are safe and meaningful to the person, culturally appropriate, and aligned with the person's goals of care and preferences.[20]

Frequency: To improve adherence and optimize outcomes, the frequency of exercise program sessions is established collaboratively with the person receiving care and their care partners.[35,36] For people at high-risk of falls, this includes sessions offered three or more times a week focusing on balance challenging and functional exercises.[14]

All older adults are recommended to engage in (1) progressive balance-challenging and functional exercises; (2) bone and muscle strengthening exercises at least twice a week; and (3) moderate vigorous aerobic activity totaling at least 150 minutes per week.[37,38]

Progressive: Exercises can be initiated at low intensity for people new to exercising. Exercises are reviewed frequently and progressed in intensity to maintain an optimal level of challenge for the person receiving care while ensuring their safety.[14,20]

Individual fall risk: People are identified as being at low, intermediate, or high risk as defined in quality statement 1. Exercise programs are tailored to individual fall risk as follows:

- *All people at risk of falls* receive education about the importance of exercise and are supported to participate in falls prevention exercises and functional training to maintain or improve balance and bone and muscle strength.[14]
- People at *intermediate risk* are supported to participate in interprofessional rehabilitation programs. They receive a comprehensive management plan that includes a targeted exercise program, or they are referred to physiotherapy to improve balance and muscle strength.[14]
- People at *high risk* are supported to participate in interprofessional rehabilitation programs. They receive a comprehensive management plan that includes a tailored, supervised exercise program that addresses their specific risks; this program is delivered by a certified exercise professional (e.g., physical therapist, occupational therapist, exercise kinesiologist).[14]
  - Caution is applied when recommending exercises to people at high risk of fracture. (For information on care for people with hip fracture, see Ontario Health's Hip Fracture quality standard.[4])

Rationale

Multicomponent exercise programs designed to maintain or improve balance, strength, and function significantly reduce the rate of falls among at-risk adults.[39] Exercise interventions can also improve overall confidence and independence and reduce fear of falling.[39] However, results from the 2023 Canadian Community Health Survey show that physical activity decreases with age and that only about 40% of older adults participate in the recommended amount of weekly exercise.[40]

Quality Statement 5: Structured Medication Review

People at risk of falls receive a structured medication review to identify polypharmacy and the use of fall risk–increasing drugs. The benefits and risks of each medication are evaluated and discussed with the person and their care partners. A shared decision is made to gradually reduce, change, or discontinue medications as appropriate.

Sources: National Institute for Health and Care Excellence, 2025[19] | Registered Nurses' Association of Ontario, 2017[20] | World Guidelines for Falls Prevention and Management for Older Adults, 2022[14] | World Health Organization, 2017[26]

Definitions

Structured medication review: Clinicians use a validated, structured assessment tool and approach to complete a medication history and to proactively identify and adjust any inappropriately prescribed or inappropriate over-the-counter medications that may increase a person's fall risk.[19,41] This review is completed annually, when prescribing new medications, and after any major change in health status.[19,41] The medication review should be completed by a clinician with the appropriate training in medication usage or referred to a pharmacist or specialized geriatric services. Clinicians caring for people living in long-term care homes conduct rational deprescribing of fall risk–increasing drugs (FRIDs) with their patients.[14]

Examples of structured medication review tools include STOPPFall (Screening Tool of Older Persons Prescriptions in Older Adults with High Fall Risk) and STEADI (Stopping Elderly Accidents, Deaths & Injuries).[14]

Polypharmacy: The concurrent use of multiple medications.

Fall risk–increasing drugs (FRIDs): Medications that increase the likelihood of falls in older adults.[42] These medications typically affect the cardiovascular or central nervous system. Common classes of FRIDs include:

- Anticonvulsants and antiepileptics[42]
- Antidepressants[14,42]
- Cardiovascular medications (e.g., antiarrhythmics, antihypertensives, diuretics)[14,42]
- Opioids and analgesics[14,42]
- Psychotropic medications (e.g., benzodiazepines, sedative-hypnotics)[14,42]

Benefits and risks of each medication: In addition to a consideration of the preferences of the person receiving care, the benefits and risks of medications are carefully evaluated before initiating new or adjusting the dosage of existing medications.[41] The risks associated with FRIDs are discussed with the person receiving care, including whether dose reduction or discontinuation is appropriate. Medications whose benefits outweigh the risk of falls should not be discontinued.[41]

Rationale

The use of multiple medications is associated with an increased risk of fall-related injury in both community and hospital settings.[43,42] A 2024 study found that up to 84% of adults hospitalized after a fall used multiple medications – including at least 1 FRID among 92% of those patients.[44] Accordingly, the use of medications is a major modifiable risk factor for people at risk of falls, and structured medication reviews are key to substantially reducing this risk.[43,42]

Acknowledgements

Advisory Committee

Ontario Health and Provincial Geriatrics Leadership Ontario thank the following individuals for their generous, voluntary contributions of time and expertise to help create this quality standard:

Jo-Anne Clarke (co-chair)
Medical Director, North East Specialized Geriatric Centre

Sid Feldman (co-chair)
Associate Professor and Head, Division of Care of the Elderly, University of Toronto; Chief, Family and Community Medicine, Baycrest Health Sciences; Chair, Members' Interest Group in Care of the Elderly, College of Family Physicians of Canada

Manuel Montero-Odasso (co-chair)
Professor, Epidemiology and Biostatistics, Western University; Director, Gait and Brain Lab, Parkwood Institute

Priyank Bhatnagar
Physician and Emergency Medicine Lead, Older Person Care, North York General Hospital

Kathy Borthwick
Lived Experience Advisor

Veronique Boscart
Chief Scientific Officer, William Osler Health System

Eric Brown
Associate Chief, Geriatric Psychiatry, Centre for Addiction and Mental Health

William Eastway
Lived Experience Advisor

Sabeen Ehsan
Director, Quality and Planning, Seniors Care Network

Pamela Fuselli
President and Chief Executive Officer, Parachute

Nicole Gallagher
Regional Clinical Quality Lead, North East Specialized Geriatric Centre

Lora Giangregorio
Schlegel Research Chair in Mobility and Aging, Schlegel-UW Research Institute for Aging; Professor, Department of Kinesiology, University of Waterloo

George Heckman
Schlegel Research Chair in Geriatric Medicine, Schlegel-UW Research Institute for Aging; Associate Professor, Department of Health Studies and Gerontology, University of Waterloo

Allen Huang
Geriatric Medicine Specialist, The Ottawa Hospital; Professor of Medicine, University of Ottawa; Medical Director, Regional Geriatric Program of Eastern Ontario

Annika Kalviainen
Geriatric Assessor, St. Joseph's Continuing Care Centre

Heather Keller
Schlegel Research Chair in Nutrition and Aging, Schlegel-UW Research Institute for Aging; Professor, Department of Kinesiology and Health Sciences, University of Waterloo;

Hans Kreder
Professor, Orthopedic Surgery and Health Policy, Management and Evaluation, University of Toronto; Scientist, Evaluative Clinical Sciences, Sunnybrook Health Sciences Centre

Robert Lam
Family Physician, Care of the Elderly, Carefirst Geriatric Assessment and Intervention Network Clinic

Barbara Liu
Geriatrician, Sunnybrook Health Sciences Centre; Executive Director, Regional Geriatric Program of Toronto

Stuart Lord
Lived Experience Advisor

Avril Mansfield
Senior Scientist, KITE Research Institute; Kinesiologist, University Health Network

Jacqueline Minezes
Patient Care Manager, Sunnybrook Health Sciences Centre

Mary Anne Monahan
Staff Physician, Care of the Elderly, Bruyere Health

Alexandra Papaioannou
Geriatric Medicine Specialist; Executive Director, GERAS Centre for Aging Research, Hamilton Health Sciences; Professor of Medicine, McMaster University

Tejal Patel
Schlegel Specialist in Medication Management and Aging, Schlegel-UW Research Institute for Aging; Clinical Associate Professor, School of Pharmacy, University of Waterloo

Danielle Petruccelli
Director, Regional Geriatric Program Central

Marion Quigley
Lived Experience Advisor

Benoit Robert
Attending Physician, Primary Care, Greenboro Family Medicine Centre

Gabrielle Sadler
Project Manager and Physiotherapist, Rehab Care Alliance

Christina Stergiou-Dayment
Chief, Programs and Clinical Operations, Alzheimer Society of Ontario

Shirin Vellani
Chief, Professional Practice and Quality (Nurse Practitioner), Yee Hong Centre for Geriatrics

Jennifer Watt
Scientist, University Health Network; Geriatrician, St. Michael's Hospital; Adjunct Scientist, Institute for Clinical Evaluative Sciences; Assistant Professor, Department of Medicine, University of Toronto

We also thank the following individuals for their contributions to the development of this quality standard:

Dana Corsi
Secondee, Sector Capacity and Performance, Ontario Health

Carrie Heer
Nurse Practitioner, Brant Community Healthcare System, Nurse Practitioners' Association of Ontario

Katie Hood
Lead, Capacity, Access and Flow, Ontario Health

Kelly Kay
Executive Director, Provincial Geriatrics Leadership Ontario

Heather MacLeod
Director, Programs and Partnerships, Provincial Geriatrics Leadership Ontario

Emily Norcliffe
Nurse Practitioner, Geriatric Medicine, Halton Healthcare; Doctor of Nursing Student, University of Toronto

Cindy Payne
Director, Home and Community Care, Ontario Health atHome

Candice Tam
Manager, ALC and HCC Information Programs, Sector Capacity and Performance, Ontario Health

Lora VanBerlo
Director, Palliative Care Provincial
Programs – II, Ontario Health

Ontario Health also thanks everyone who provided input during the public feedback phase of this quality standard.

References

(1) Ontario Health. Behavioural symptoms of dementia: care for people in hospitals and long-term care homes [Internet]. Toronto (ON): King's Printer for Ontario; 2024 [cited 2026 Apr]. Available from: https://ontariohealth.ca/clinical/quality-standards/qs-details?cf=behavioural-symptoms-dementia

(2) Ontario Health. Dementia: care for people living in the community [Internet]. Toronto (ON): King's Printer for Ontario; 2024 [cited 2026 Apr 14]. Available from: https://ontariohealth.ca/clinical/quality-standards/qs-details?cf=dementia

(3) Ontario Health. Delirium: care for adults [Internet]. Toronto (ON): Queen's Printer for Ontario; 2021 [cited 2026 Apr]. Available from: https://ontariohealth.ca/clinical/quality-standards/qs-details?cf=delerium

(4) Ontario Health. Hip fracture: care for people with fragility fractures [Internet]. Toronto (ON): King's Printer for Ontario; 2024 [cited 2026 Apr 14]. Available from: https://www.ontariohealth.ca/clinical/quality-standards/qs-details?cf=hip-fracture

(5) Ontario Health. Palliative care: care for adults with a serious illness [Internet]. Toronto (ON): King's Printer for Ontario; 2024 [cited 2026 Apr]. Available from: https://ontariohealth.ca/clinical/quality-standards/qs-details?cf=palliative-care

(6) Ontario Health. Transitions between hospital and home: care for people of all ages [Internet]. Toronto (ON): King's Printer for Ontario; 2026 [cited 2026 Apr]. Available from: https://ontariohealth.ca/clinical/quality-standards/qs-details?cf=transitions-hospital-home

(7) Ontario Health. The alternate level of care (ALC) leading practices guide: preventing hospitalization and extended stays for older adults [Internet]. Toronto (ON): Queen's Printer for Ontario; 2021 [cited 2025 Nov 13]. Available from: https://www.ontariohealth.ca/content/dam/ontariohealth/documents/alc-leading-practices-guide.pdf

(8) Provincial Geriatrics Leadership Ontario. Supporting Ontario Health Teams to influence alternate level of care: leading practices in community-based early identification, assessment and transition [Internet]. Hamilton (ON): Provincial Geriatrics Leadership Ontario; 2022 [cited 2026 Apr]. Available from: https://geriatricsontario.ca/wp-content/uploads/2023/06/2022-April-1-ALC-Community-_-FINAL.pdf

(9) Ontario Health. Operational direction: Home First [Internet]. Toronto (ON): King's Printer for Ontario; 2025 [cited 2026 Apr]. Available from: https://www.ontariohealth.ca/news/operational-direction-home-first

(10) Provincial Geriatrics Leadership Ontario. Senior friendly care (sfCare): provincial initiative [Internet]. Hamilton (ON): Provincial Geriatrics Leadership Ontario; n.d. [cited 2026 Apr]. Available from: https://geriatricsontario.ca/initiatives/sfcare/

(11) Provincial Geriatrics Leadership Ontario, Rehabilitative Care Alliance. Rehabilitative care for older adults living with/at risk of frailty: from frailty to resilience [Internet]. Hamilton (ON): Provincial Geriatrics Leadership Ontario and Rehabilitative Care Alliance; 2021 [last updated 2024] [cited 2026 Apr]. Available from: https://rehabcarealliance.ca/wp-content/uploads/2022/10/Rehab_for_Older_Adults_Living_with_Frailty_Framework.pdf

(12) World Health Organization. Falls [Internet]. Geneva: The Organization; 2021 [cited 2025 Oct]. Available from: https://www.who.int/news-room/fact-sheets/detail/falls/

(13) Public Health Ontario. Prioritization of older adult fall prevention indicators in Ontario [Internet]. Toronto (ON): King's Printer for Ontario; 2022 [cited 2026 Apr]. Available from: https://www.publichealthontario.ca/-/media/Documents/P/2022/prioritization-older-adult-fall-prevention-indicators-ontario.pdf?sc_lang=en&rev=e415b96bfa5245659f87af3787d59115&hash=7BC0127F81F26DCC70C75FDA3E9C869C

(14) Montero-Odasso M, Van Der Velde N, Martin FC, Petrovic M, Tan MP, Ryg J, et al. World guidelines for falls prevention and management for older adults: a global initiative. Age Ageing. 2022;51(9):afac205.

(15) Ontario Agency for Health Protection and Promotion (Public Health Ontario). Hospitalizations for injuries snapshot (2011-2019) [Internet]. Toronto (ON): Queen's Printer for Ontario; 2022 Mar 31 [cited 2026 Jan]. Available from: https://www.publichealthontario.ca/en/Data-and-Analysis/Injuries-Data/Injury-Hospitalization

(16) Public Health Agency of Canada. Surveillance report on falls among older adults in Canada [Internet]. Ottawa (ON): The Agency; 2024 [cited 2026 Apr]. Available from: https://www.canada.ca/en/public-health/services/publications/healthy-living/surveillance-report-falls-older-adults-canada.html

(17) Hatcher VH, Galet C, Lilienthal M, Skeete DA, Romanowski KS. Association of clinical frailty scores with hospital readmission for falls after index admission for trauma-related injury. JAMA Netw Open. 2019;2(10):e1912409.

(18) Public Health Agency of Canada. Seniors' falls in Canada: second report [Internet]. Ottawa (ON): The Agency; 2014 [cited 2025 Oct]. Available from: https://www.canada.ca/en/public-health/services/publications/healthy-living/seniors-falls-canada-second-report.html

(19) National Institute for Health and Care Excellence. Falls: assessment and prevention in older people and in people 50 and over at higher risk [Internet]. London: The Institute; 2025 [cited 2025 Oct 3]. Available from: https://www.nice.org.uk/guidance/ng249/resources/falls-assessment-and-prevention-in-older-people-and-in-people-50-and-over-at-higher-risk-pdf-66143964997573

(20) Registered Nurses' Association of Ontario. Preventing falls and reducing injury from falls [Internet]. Toronto (ON): The Association; 2017 [cited 2025 Oct 16]. Available from: https://rnao.ca/bpg/guidelines/prevention-falls-and-fall-injuries

(21) Ontario Health. Osteoarthritis: care for adults with osteoarthritis of the knee, hip, hand, or shoulder [Internet]. Toronto (ON): King's Printer for Ontario; 2024 [cited 2026 Apr 14]. Available from: https://ontariohealth.ca/clinical/quality-standards/qs-details?cf=osteoarthritis

(22) Ontario Health. Type 1 diabetes: care for people of all ages [Internet]. Toronto (ON): Queen's Printer for Ontario; 2021 [cited 2026 Apr 14]. Available from: https://ontariohealth.ca/clinical/quality-standards/qs-details?cf=type-1-diabetes--care-for-people-of-all-ages

(23) Ontario Health. Prediabetes and type 2 diabetes: care for people of all ages [Internet]. Toronto (ON): Queen's Printer for Ontario; 2021 [cited 2026 Apr 14]. Available from: https://ontariohealth.ca/clinical/quality-standards/qs-details?cf=prediabetes-type-2-diabetes

(24) Lorbergs AL, Prorok JC, Holroyd-Leduc J, Bouchard DR, Giguere A, Gramlich L, et al. Nutrition and physical activity clinical practice guidelines for older adults living with frailty. J Frailty Aging. 2022;11(1):3-11.
(25) National Institute for Health and Care Excellence. Dementia, disability and frailty in later life: mid-life approaches to delay or prevent onset [Internet]. London: The Institute; 2015 [cited 2026 Apr]. Available from: https://www.nice.org.uk/guidance/ng16/resources/dementia-disability-and-frailty-in-later-life-midlife-approaches-to-delay-or-prevent-onset-pdf-1837274790085
(26) World Health Organization. Integrated care for older people: guidelines on community-level interventions to manage declines in intrinsic capacity [Internet]. Geneva: The Organization; 2017 [cited 2026 Apr]. Available from: https://www.who.int/publications/i/item/9789241550109
(27) Ontario Health. Frailty in adults: care in all settings [Internet]. Toronto (ON): King's Printer for Ontario; 2026 [cited 2026 Mon XX]. Available from: TBD
(28) Jehu DA, Davis JC, Falck RS, Bennett KJ, Tai D, Souza MF, et al. Risk factors for recurrent falls in older adults: a systematic review with meta-analysis. Maturitas. 2021;144:23-8.
(29) Canadian Malnutrition Task Force. Primary care nutrition pathways [Internet]. Ottawa (ON): Canadian Nutrition Society 2026 [cited 2026 Apr 1]. Available from: https://nutritioncareincanada.ca/resource-library/primary-community-care/malnutrition-toolkit/toolkit-pathways
(30) Kojima G, Avgerinou C, Iliffe S, Walters K. Adherence to Mediterranean diet reduces incident frailty risk: systematic review and meta-analysis. J Am Geriatr Soc. 2018;66(4):783-8.
(31) Fa-Binefa M, Clara A, Lamas C, Elosua R. Mediterranean diet and risk of hip fracture: a systematic review and dose-response meta-analysis. Nutr Rev. 2024;83(6):1133-43.
(32) Karlsson MK, Magnusson H, von Schewelov T, Rosengren BE. Prevention of falls in the elderly—a review. Osteoporos Int. 2013;24(3):747-62.
(33) Hopewell S, Copsey B, Nicolson P, Adedire B, Boniface G, Lamb S. Multifactorial interventions for preventing falls in older people living in the community: a systematic review and meta-analysis of 41 trials and almost 20 000 participants. Br J Sports Med. 2020;54(22):1340-50.
(34) Suen J, Kneale D, Sutcliffe K, Kwok W, Cameron ID, Crotty M, et al. Critical features of multifactorial interventions for effective falls reduction in residential aged care: a systematic review, intervention component analysis and qualitative comparative analysis. Age Ageing. 2023;52(11).
(35) Liu CK, Fielding RA. Exercise as an intervention for frailty. Clin Geriatr Med. 2011;27(1):101-10.
(36) Geraedts HA, Zijlstra W, Zhang W, Bulstra S, Stevens M. Adherence to and effectiveness of an individually tailored home-based exercise program for frail older adults, driven by mobility monitoring: design of a prospective cohort study. BMC Public Health. 2014;14(1):570.
(37) Ross R, Chaput J-P, Giangregorio LM, Janssen I, Saunders TJ, Kho ME, et al. Canadian 24-hour movement guidelines for adults aged 18–64 years and adults aged 65 years or older: an integration of physical activity, sedentary behaviour, and sleep. Appl Physiol Nutr Metab. 2020;45(10):S57-S102.
(38) Canadian Society for Exercise Physiology. Canadian 24-hour movement guidelines for adults aged 65 years and older: an integration of physical activity, sedentary behaviour, and sleep [Internet]. Ottawa (ON): The Society; 2022 [cited 2026 Mar 3]. Available from: https://csepguidelines.ca/guidelines/adults-65/

(39) Sherrington C, Fairhall NJ, Wallbank GK, Tiedemann A, Michaleff ZA, Howard K, et al. Exercise for preventing falls in older people living in the community. Cochrane Database Syst Rev. 2019(1).

(40) Statistics Canada. Canadian community health survey [Internet]. Ottawa (ON): Statistics Canada; 2023 [cited 2025 Dec 22]. Available from: https://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&Id=1496481

(41) National Institute for Health and Care Excellence. Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes [Internet]. London: The Institute; 2015 [cited 2026 Apr]. Available from: https://www.nice.org.uk/guidance/ng5

(42) Lee J, Negm A, Peters R, Wong EKC, Holbrook A. Deprescribing fall-risk increasing drugs (FRIDs) for the prevention of falls and fall-related complications: a systematic review and meta-analysis. BMJ Open. 2021;11(2):e035978.

(43) Xue L, Boudreau RM, Donohue JM, Zgibor JC, Marcum ZA, Costacou T, et al. Persistent polypharmacy and fall injury risk: the Health, Aging and Body Composition Study. BMC Geriatr. 2021;21(1):710.

(44) Ashraf M, Boland Y, Mello S. Identification and modification of fall-risk-increasing drugs following fall-related hospitalization in older adults. Age Ageing. 2024;53(Suppl 4):afae178.232.

About Us

We are an agency created by the Government of Ontario to connect, coordinate, and modernize our province's health care system. We work with partners, providers, and patients to make the health system more efficient so everyone in Ontario has an opportunity for better health and well-being.

Equity, Inclusion, Diversity, and Anti-Racism

Ontario Health is committed to advancing equity, inclusion and diversity and addressing racism in the health care system. As part of this work, Ontario Health has developed an Equity, Inclusion, Diversity and Anti-Racism Framework, which builds on existing legislated commitments and relationships and recognizes the need for an intersectional approach.

Unlike the notion of equality, equity is not about sameness of treatment. It denotes fairness and justice in process and in results. Equitable outcomes often require differential treatment and resource redistribution to achieve a level playing field among all individuals and communities. This requires recognizing and addressing barriers to opportunities for all to thrive in our society.

For more information about Ontario Health, visit OntarioHealth.ca.

About Provincial Geriatrics Leadership Ontario

Provincial Geriatrics Leadership Ontario coordinates specialized geriatrics services and seniors' mental health services to advance integrated care for older adults living with complex health conditions, including dementia, frailty and mental health conditions, and their care partners, in Ontario.

Looking for More Information?

Visit OntarioHealth.ca or contact us at QualityStandards@OntarioHealth.ca if you have any questions or feedback about this quality standard.

Ontario Health
500–525 University Avenue
Toronto, Ontario
M5G 2L3

Toll Free: 1-877-280-8538
TTY: 1-800-855-0511
Email: QualityStandards@OntarioHealth.ca
Website: OntarioHealth.ca

Need this information in an accessible format? 1-877-280-8538, TTY 1-800-855-0511, info@OntarioHealth.ca

Document disponible en français en contactant info@OntarioHealth.ca

ISBN TBD (PDF)