

QUALITY STANDARDS

Frailty

A guide for people
who have frailty or
who are at risk
of frailty

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Ontario Health is committed to improving the quality of health care in the province in partnership with patients, clinicians, and other organizations.

To do that, Ontario Health develops quality standards. These are documents that outline what high-quality care looks like for conditions or processes where there are large differences in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive. These quality standards set out important steps to improve care. They are based on current evidence and input from an expert committee that includes patients, care partners, clinicians, and researchers.

This guide is for people who have frailty or who are at risk of frailty and their active and participating care partners, if available. It accompanies the quality standard on [frailty in adults](#). It outlines the top 5 areas where health care teams can take steps to improve care for people who have frailty or who are at risk of frailty. The patient guide also includes suggestions on what to discuss with your health care team, as well as links to helpful resources.

DID YOU KNOW?

Clinicians are health care professionals who provide care to patients, including doctors, geriatric specialists, kinesiologists, nurses, nurse practitioners, occupational therapists, pharmacists, physiotherapists, psychologists, registered dietitians, and social workers.

A **health care team** is a group of clinicians, as well as people in unregulated professions, such as administrative staff, behavioural support workers, community care case managers, patient transport staff, personal support workers, recreational staff, spiritual care staff, and volunteers.

DID YOU KNOW?

The word *frailty* is commonly used in health care settings, but we know that not everyone is comfortable with this term. In this guide, we use *frailty* to describe a health condition that makes it harder for a person's body to recover from illnesses and injuries.

Frailty can occur when people have complex health needs and are more affected by changes in their health than they used to be. Because of this, they may need extra support. And with this extra support, the symptoms of frailty can improve.

Frailty describes a health condition, not a person.

Top 5 areas to improve care for people with or at risk of frailty



Quality Statement 1: Identification and Assessment of Frailty

What the standard says

People at risk of frailty are identified at every opportunity using approaches that are appropriate for the care setting. Those identified as at risk or with frailty are assessed to verify the initial identification using validated instruments.

What this means for you

Whenever you see your clinician or a member of your health care team, they should watch out for any signs that you might have complex health needs, sometimes also called frailty. If they notice anything, they should examine you and ask you questions about how you have been feeling.

If they decide that you might need more care, they should write this down for you. They should also share this information with all other members of your health care team. This will help everyone involved in your care understand your needs and give you the right care and support.

WHAT IS FRAILTY?

Frailty is a condition that makes it harder for your body to recover from minor illnesses and injuries. Frailty develops from small changes in your health that build up over time. These changes include things like:

- Feeling weaker than usual or having trouble moving around
- Finding it harder to do everyday activities, like dressing, bathing, or cooking
- Having little energy or feeling tired most of the day
- Having trouble with balance or feeling unsteady on your feet
- Losing weight without trying or not being as hungry as usual
- Feeling more forgetful or confused than usual
- Feeling irritable, down, or sad
- Spending less time with others or feeling lonely

If you notice any changes like this, let your clinician or health care team know. Getting care for frailty early can help you stay active and independent.



Quality Statement 2: Comprehensive Assessment

What the standard says

People with or at risk of frailty receive a timely comprehensive multidomain or geriatric assessment following initial identification and verification of their frailty status. The assessment is based on frailty severity and completed collaboratively with the person and their care partners. The assessment informs the person's care plan.

What this means for you

If you have frailty or you are at risk of developing frailty, your clinician or health care team should examine you thoroughly. They should ask you about things like:

- Your physical health
- If you have had any falls
- If you have any pain
- If you have any trouble moving around
- Your mental health, including things like feeling sad or worried a lot of the time
- If you feel lonely or isolated from your friends or family
- If you are having any trouble with your memory
- If you ever feel confused
- Your diet
- What medications you take
- How you are sleeping
- How you spend your time



Quality Statement 3: Individualized Care Plan

What the standard says

People with frailty have an individualized care plan consisting of targeted interventions informed by their comprehensive assessment. The plan is developed collaboratively with the person, their care partners, and an interprofessional care team. People are supported with timely access to health and social services, including appropriate levels of rehabilitative care.

What this means for you

Your clinician or health care team should work with you and your care partners to create a plan for the care you need. This plan should fit your needs, preferences, and the goals you have for your care. Your care plan should be shared with all members of your health care team so that everyone has the information they need to give you the best care.

Your care plan might include information about:

- How to stay active and build muscle strength
- How to prevent falls or reduce the risk of being injured if you fall
- How to manage pain
- How to manage other health conditions you might have
- Your medications and how to take them
- How to stay connected with your friends and your community
- How to get help for any mental health concerns you might have
- Healthy eating
- Any other supportive care or services you might need



Quality Statement 4: Multicomponent Exercise Program

What the standard says

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

What this means for you

Your clinician or health care team should help you participate in an exercise program to build your strength. They should work with you and your care partners to decide on a schedule for your exercise sessions that works for you. Your exercise program should be led by a trained professional – this might be an exercise physiologist, a physiotherapist, a kinesiologist, or an occupational therapist.

Your exercise program should be safe, and it should be designed to meet your needs, preferences, and goals. Your exercises should start at a level that feels comfortable for you and gradually get more challenging as you gain strength over time.

DID YOU KNOW?

Most older people benefit from exercising 2 to 3 times a week.

An exercise program will help you:

- Build muscle strength and function
- Improve your balance and coordination
- Maintain mobility (your ability to move around)
- Improve your endurance for daily activities (your ability to remain active for longer periods of time)



Quality Statement 5: Coordination of Care

What the standard says

People with or at risk of frailty are supported with coordinated access to health and social services across the continuum of care. Expectations of and accountability for the person responsible for coordinating care are clearly defined, and information is transferred effectively across care settings.

What this means for you

Your health care team members should work with each other – and with you and your care partners – to make sure you get the health care services you need when you need them. Your health care team members should share information about your care with each other – and with you and your care partners – regularly to make sure everyone has the most up-to-date information they need to understand your needs and make sure you get the best care.

Suggestions on what to discuss with your health care team

Ask your health care team:

- What health changes should I watch out for?
- Who will be involved in my assessment, and what will they do?
- What can I do to stay active, strong, and independent for as long as possible?
- What options are available to help manage my pain?
- What supports are available to help with my mental or emotional well-being?
- How can I stay socially connected in my community?
- If I start a new medication, what side effects should I watch out for?
- How can my family or care partners be involved in my care if I would like them to be?

Share with your health care team:

- Any changes in your muscle strength, balance, walking, or mobility (your ability to move around)
- Any changes in your memory, thinking, or ability to concentrate
- Any changes in your mood, such as feeling low, anxious, or irritable
- If you are feeling more tired or have less energy than usual
- If you are having trouble with everyday activities like dressing, bathing, cooking, or shopping
- If you have been losing weight without meaning to
- If you don't feel hungry or if you have trouble eating
- If you have had a fall or almost had a fall, or if you are afraid of falling
- If you are feeling lonely or isolated from your community

If you are a care partner

You might have your own questions. It can help to identify yourself as the patient's care partner to their health care team. This will make sure they know and respect your questions and concerns.

- Let them know what your role will be in helping the patient manage their frailty
- Let them know if you need help
- Let them know if you need community support or resources to help you as a care partner

Learn more

The [Canadian Frailty Network](#) offers [information and resources](#) for people with frailty and their care partners.

[Provincial Geriatrics Leadership Ontario](#) provides an [interactive map](#) to help people find specialized geriatric care close to home.

The [Senior Friendly 7 Toolkit](#) includes self-management tools for older adults and their care partners that support resilience, independence, and quality of life.

The [Regional Geriatric Program](#) provides [resources and services](#) for older adults with frailty living in the Hamilton, Niagara, Haldimand, Norfolk, Brant, Burlington, Waterloo, and Wellington regions.

[Frailty: Every Step You Take Matters!](#) is a short video about preventing and managing frailty from the Centre of Research Excellence in Frailty and Healthy Ageing.

Provincial Geriatrics Leadership Ontario provides [Caregiving Strategies](#), a collection of educational resources for care partners of people with frailty.

The Ontario Caregiver Organization's [I Am a Caregiver Toolkit](#) provides information to support new or long-term care partners.

Ontario Health has developed other quality standards and patient guides on conditions related to frailty that may be useful, including:

- [Behavioural Symptoms of Dementia](#)
- [Chronic Pain](#)
- [Delirium](#)
- [Dementia: Care for People Living in the Community](#)
- [Falls](#)
- [Hip Fracture](#)
- [Medication Safety](#)
- [Palliative Care](#)
- [Transitions Between Hospital and Home](#)

DID YOU KNOW?

You can make a complaint if you have experienced racism or discrimination when getting health care. Making a complaint can be difficult, but you do not have to do it alone. Ask someone you trust to help you.

- **Start with the health care organization:** The first step is to file a complaint with the health care organization where the experience happened. Use their complaint process to let them know what happened. This helps them understand the problem and gives them a chance to make it better.
- **Contact the Patient Ombudsman:** The Patient Ombudsman is an independent office created by the Ontario government to help resolve complaints about health care experiences. If you are not happy with how the health care organization responds to your complaint, or if you do not feel that the issue has been resolved, the Patient Ombudsman may be able to help. They can also help if you do not feel comfortable reporting your experience to the health care organization. For more information, you can contact the Patient Ombudsman by phone at 1-888-321-0339, or you can visit the [Patient Ombudsman's website](#).

Need more information?

If you have any questions or feedback about this guide, please contact us at QualityStandards@OntarioHealth.ca or 1-877-280-8538 (TTY: 1-800-855-0511).

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

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