

QUALITY STANDARDS

Frailty in Adults

Care in All Settings

MONTH 2026

DRAFT

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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 frailty or who are at risk of frailty, 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 with frailty and 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 falls 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](#), 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](#). 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 Health⁷
- The [Senior Friendly Care](#) initiative from the Regional Geriatric Program of Toronto⁸
- 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 Alliance⁹

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 focus on areas identified as having the greatest potential to improve care for older adults with or at risk of frailty.

A Note on Terminology

While the term *frailty* is regularly used in clinical practice and research, Ontario Health acknowledges that this term is neither consistently defined nor popular among older adults.¹⁰ In this quality standard, *frailty* is used to describe a state of health complexity and increased vulnerability arising from the interaction of complex health conditions, typically related to declines in physical, cognitive, mental, and social health. *Frailty* describes a constellation of complex health and social conditions; it is not a diagnosis, and it is not meant to be used as a label for people. Frailty can also be framed as “having complex health needs” or “experiencing complex health conditions.” The symptoms of frailty can often be improved; as such, a positive framing such as “enhancing vitality” or “increasing resilience” is encouraged.

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

Frailty is a complex syndrome involving multiple body systems that predominately affects people aged 65 years and older.¹⁻³ Older adults are at higher risk than younger adults of experiencing signs and symptoms of frailty owing to an accumulation of age-related or disease-associated physical, cognitive, mental, and social decline.^{2,11} Approximately 13.8% of adults aged 66 years and older in Ontario experience frailty, and the prevalence of frailty is expected to rise with the province's aging demographic.¹² Women in Ontario account for about 60% of identified cases of frailty, but men with frailty are at greater risk of mortality.¹³ Among older adults, those with frailty have higher health service use, including higher rates of physician visits, hospitalizations, and emergency department, home care, and long-term care use.¹² In 2019, the Canadian Institute for Health Information found that, compared with those not identified as at risk, older adults at risk of frailty were 3 time more likely to be hospitalized for 30 days or more and twice as likely to be readmitted within 30 days.¹⁴

Frailty has an earlier onset among people from underrepresented racial and ethnic groups and those with lower socioeconomic status, compared with those of European descent and with higher socioeconomic status, respectively.¹⁵⁻¹⁷ Indigenous peoples also experience earlier onset compared with other populations owing to institutional and systemic barriers in the health care system.⁵

The burden of frailty is further complicated by comorbidities that are more commonly experienced in older adults than in younger ones.¹⁸ Compared with the broader population of older adults, those with frailty more often experience multiple coexisting medical and psychiatric conditions, and frailty is associated with adverse outcomes such as falls, fractures, impaired mobility, and depression.^{11,19} Frailty is also associated with cognitive disorders such as dementia and delirium.²⁰ Owing to these compounded vulnerabilities, people with frailty are at a significantly higher risk of mortality than those without frailty.^{11,19} Further, early signs of frailty are often subtle and thus frequently missed during health care visits – and even when frailty is identified, approaches to care are inconsistent and lack proper integration across health care settings.²¹

Quality Statements to Improve Care

These quality statements describe what high-quality care looks like for adults who have frailty or who are at risk of frailty.

Quality Statement 1: Identification and Assessment of Frailty

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.

Quality Statement 2: Comprehensive Assessment

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 comprehensive assessment is based on frailty severity and completed collaboratively with the person and their care partners. The assessment informs the person's care plan.

Quality Statement 3: Individualized Care Plan

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.

Quality Statement 4: Multicomponent Exercise Program

People with or at risk of frailty are supported to participate in individualized multicomponent exercise programs. 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.

Quality Statement 5: Coordination of Care

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.

Quality Statement 1: Identification and Assessment of Frailty

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.

Sources: International Conference of Frailty and Sarcopenia Research, 2019²² | National Institute for Health and Care Excellence, 2016²³ | Ontario Health, 2021²⁴ | Ontario Health, 2022²⁵

Definitions

At risk of frailty: Risk factors for frailty include being aged 65 years or older¹⁶ and the presence of any of the following¹⁹:

- Multimorbidity or geriatric syndromes²³
- A history of falls^{11,20}
- Polypharmacy^{16,20,23}
- Functional decline (e.g., psychosocial concerns, cognitive or mental health concerns)^{16,20,23}
- Being at risk of losing or having lost social function and communication^{22,26}
- Poor nutrition or weight loss^{16,20,23}
- Increased use of health and social services²⁰
- Admitted to a hospital

Frailty: A dynamic and progressive health state characterized by increased vulnerability to internal and external stressors, such as illness or injury, resulting from cumulative declines across physical, cognitive, psychological, and social domains.^{20,27,28} Social frailty is characterized by reduced social resources and limited social participation, resulting in the diminished ability to meet one's social needs.^{29,30} Social frailty correlates with psychological well-being and interacts with the other domains to increase both vulnerability and the risk of frailty.^{22,29,30} The severity of frailty can be managed to slow progression and improve function through early identification and the delivery of appropriate interventions.^{22,16,19,20,23,28}

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Identified at every opportunity: Includes routine primary care visits, hospital admission assessments (regardless of presenting concern), and encounters related to major changes in health status.^{22,23} At these encounters, clinicians use their clinical judgment to identify risk factors (e.g., gait problems).²² Those who are identified as having frailty or being at risk of frailty are followed up with a detailed assessment. Identification and assessment are conducted alongside a proactive standardized review of electronic health records and patient charts.²³

Validated instruments: Standardized tools that are suitable to and available in the care setting in which a person is receiving care. In hospital settings, this includes tools to assess and monitor changes in a person’s functional status (e.g., compared with functional status 2 weeks before hospitalization). Tools are used to identify and assess a person’s risk of frailty before a comprehensive geriatric or multidomain assessment is completed. Physical performance tests are not used for people who are acutely unwell.^{22,23}

Examples of standardized identification and assessment tools include:

- [The Rockwood Clinical Frailty Scale \(CFS\)](#)³¹
- [The Pictorial Fit-Frail Scale \(PFFS\)](#)³²
- [The FRAIL Scale](#) (which assesses fatigue, resistance, aerobic capacity, illnesses, and loss of weight)
- [The Edmonton Frail Scale](#) (EFS)

The CFS, PFFS, and FRAIL Scale can be used across health care settings, whereas the EFS is designed for use in community settings.²²

Instruments to systematically identify frailty include²³:

- Predicting Emergency Admissions Over the Next Year (PEONY)
- [QAdmissions](#)

Rationale

Frailty affects approximately 13.8% of adults aged 66 years and older in Ontario.¹³ Although frailty is a progressive condition, it can be managed through early identification, assessment, and the proactive management of risk factors. Despite this, frailty remains underreported and inconsistently identified across care settings, highlighting the need for timely and standardized approaches to identifying people with or at risk of frailty.^{33,34}

Quality Statement 2: Comprehensive Assessment

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 comprehensive assessment is based on frailty severity and completed collaboratively with the person and their care partners. The assessment informs the person's care plan.

Sources: International Conference of Frailty and Sarcopenia Research, 2019²² | National Institute for Health and Care Excellence, 2016²³ | Ontario Health, 2021²⁴ | Ontario Health, 2022²⁵

Definitions

Timely: For people receiving care in the community, the comprehensive multidomain or geriatric assessment is conducted within 8 weeks of initial identification (advisory committee consensus). For people being hospitalized, it is conducted upon admission.²³ However, time to assessment is also informed by the person's frailty status, contributing risk factors, and symptom severity (advisory committee consensus).

Comprehensive multidomain assessment: A structured assessment that builds from the initial identification and considers the person's health history and changes across physical (e.g., unintentional weight loss, gait), cognitive, functional, and/or psychosocial domains based on their needs, as well as the person's goals of care and current concerns.^{22,24,25} A person is referred to specialized geriatric services when changes are identified that indicate the need for further detailed assessment and specialized care.

Comprehensive geriatric assessment: A detailed review across multiple domains of health that is completed by an interprofessional care team. The assessment may be conducted using a phased approach in which priority areas of the assessment are completed first, based on the person's needs (e.g., if cognition is identified as the most important domain of assessment, that could be assessed first, and the other domains could be assessed later) (advisory committee consensus).

A comprehensive geriatric assessment evaluates the following domains:

- Cognition (including delirium risk)
- Function (e.g., functional decline, change in social function and engagement, change in daily activities)

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- Mobility and falls risk (e.g., gait)
- Mood

Additional components of a comprehensive geriatric assessment are completed as indicated. The person is reassessed as needed over time according to changes in their health priorities, health status, goals of care, or care needs. Additional components include:

- Bowel and bladder function (e.g., continence)
- Dysphagia, nutrition, and hydration
- Pain
- Polypharmacy
- Skin integrity
- Sleep

Based on frailty severity:

- People identified as being *at risk of frailty* or as having *mild frailty* receive a comprehensive multidomain assessment, which can be completed by members of a primary health care team, community care providers, or home care providers (advisory committee consensus).
- People identified with *mild to moderate frailty* or *moderate to severe frailty* are referred to specialized geriatric services to receive a comprehensive geriatric assessment in alignment with their goals of care (advisory committee consensus). People with *severe frailty* (e.g., a CFS score of 7 or higher) are also referred for an assessment of their palliative care needs if that aligns with their goals of care.²⁰ As part of advance care planning, people with severe frailty identify their future substitute decision-maker and engage in ongoing communication with this person about their wishes for care, values, and beliefs.
 - For further information on care for people requiring palliative care, see Ontario Health’s [Palliative Care](#) quality standard.⁵

Rationale

For people identified with frailty or as being at risk of frailty, multiple contributing factors – such as age, multimorbidity, and other chronic conditions – are often involved.¹⁴ In 2023–2024, more than 46% of hospitalized older adults in Canada were at risk of frailty.¹⁴ However, it has been demonstrated that timely comprehensive assessments delivered by interprofessional teams can reduce emergency department visits by nearly 50%, resulting in more efficient assessments and improved treatment decisions and referrals.³⁵

Quality Statement 3: Individualized Care Plan

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.

Sources: Canadian Frailty Network, 2021³⁶ | International Conference of Frailty and Sarcopenia Research, 2019³ | National Institute for Health and Care Excellence, 2015³⁷ | Ontario Health, 2022¹ | World Health Organization, 2017³⁸

Definitions

Individualized care plan: A documented plan of care informed by an assessment of a person’s frailty status and their needs and preferences. The plan is based on the person’s physical, cognitive, and psychosocial health needs and their current level of functioning and capabilities.^{14,19,28,37} It is flexible and accessible enough to accommodate changes in the person’s evolving health needs, and it is coordinated across all health care settings and services used by the person.^{14,19,28,37} The care plan aligns with the person’s goals of care, values, and preferences and is reviewed and updated every 9 to 12 months (or sooner if deterioration is rapid), following a reassessment of their functional status (advisory committee consensus).

Targeted interventions: A set of interventions informed by a person’s comprehensive assessment and guided by the person’s frailty severity. Interventions may be phased and are tailored to the person’s evolving needs, preferences, physical and cognitive capabilities, and circumstances. Interventions address both medical and rehabilitative care. Examples include:

- Encouraging healthy behaviours and lifestyle changes (e.g., smoking cessation, limiting alcohol consumption, improving diet)^{3,36-38}
- Education about how to reduce frailty risk for people receiving care and their care partners³⁶⁻³⁸
- Falls prevention and management
 - For further information on care for people who have experienced a fall or who are at risk of falls, see Ontario Health’s [Falls in Adults](#) quality standard.³⁹
- Optimizing nutrition with protein-fortified foods and supplements^{3,36-38}

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- Addressing food intake and the impact of dysphagia, early satiety, and mood-related factors on oral intake^{3,36-38}
- Addressing comorbidities (e.g., cognitive impairment, vision loss, hearing loss)^{3,36-38}
- A multicomponent exercise program based on the person’s level of functioning and capabilities (see quality statement 4)^{3,36-38}
- Individualized management of other symptoms of aging and complications associated with geriatric conditions^{20,37}
- Physiotherapy and occupational therapy⁹
- Speech language pathology services⁹
- Wound care and preventive wound care⁹
 - For further information on care for people who require wound care, see Ontario Health’s [Diabetic Foot Ulcers](#),⁴⁰ [Pressure Injuries](#),⁴¹ and [Venous Leg Ulcers](#)⁴² quality standards.
- Bowel and bladder (e.g., continence) care⁹
- A structured medication review, medication reconciliation, and an assessment of postdischarge medication adherence⁹
- Pain management⁹
- Case management⁹
- Mental health care⁹
- Support for families and care partners (e.g., respite care)⁹
- Self-management strategies
- Traditional healing practices⁹
- Providing palliative care support in alignment with the person’s goals of care, addressing pain and symptom management and providing psychosocial and spiritual support^{20,37}
 - For further information on care for people requiring palliative care, see Ontario Health’s [Palliative Care](#) quality standard.⁵

Interprofessional care team: At minimum, the team includes 2 or more clinicians with expertise in 1 or more domains of frailty. Other team members may include community paramedics, geriatric emergency management nurses, kinesiologists, social workers, home and community care case managers, physiotherapists, occupational therapists, pharmacists, behavioural support clinicians, or geriatric specialist clinicians.^{3,36-38}

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.⁹

Rationale

Compared with people without frailty, those with frailty have higher rates of health care use, including more frequent emergency department visits, hospital admissions, outpatient service use, and long-term care residency.⁴³⁻⁴⁵ About 56% of people with frailty in Ontario have visited an emergency department, and more than half require home care services.^{46,47} Multicomponent interventions for frailty and individualized management have been shown to improve patient outcomes and should be integrated in health planning and when planning transitions.⁴⁸⁻⁵⁰

Quality Statement 4: Multicomponent Exercise Program

People with or at risk of frailty are supported to participate in individualized multicomponent exercise programs. 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.

Sources: Canadian Frailty Network, 2021³⁶ | International Conference of Frailty and Sarcopenia Research, 2019²² | World Health Organization, 2017³⁸

Definitions

Multicomponent exercise program: A combination of planned, structured, and repetitive sets of physical activities combining (1) resistance, aerobic, and balance training to address frailty, and (2) exercises to prevent falls risk.^{22,36,38} Exercise programs are personalized and progressive and designed to optimize or restore the functional ability and mobility of a person with or at risk of frailty.⁹ Exercise programs are provided by a trained professional, such as a certified exercise physiologist, registered kinesiologist, or registered physical or occupational therapist (advisory committee consensus). Exercises are safe and meaningful to the person, culturally appropriate, and aligned with the person’s goals of care and preferences.^{22,36,38}

For further information on care for people who have experienced a fall or who are at risk of falls, see Ontario Health’s [Falls in Adults](#) quality standard.³⁹

Frequency: To improve adherence and optimize outcomes, the frequency of the exercise program is established collaboratively with the person receiving care and their care partners.^{51,52} All older adults are recommended to engage in (1) progressive balance-challenging exercises; bone and muscle strengthening exercises at least twice a week; and (3) moderate vigorous aerobic activity totaling at least at least 150 minutes per week.^{22,53,54}

Progressive: Exercises can be initiated at low intensity for people new to exercising.³⁶ Exercises are reviewed frequently and progressed in intensity to maintain an optimal level of challenge for the person receiving care while ensuring their safety.^{20,22}

Rationale

Muscle strength declines by approximately 12% to 15% per decade after the age of 50 years.⁵⁵ Frailty is strongly associated with progressive reductions in strength, functional capacity, balance, and mobility.^{36,45} Structured exercise interventions have been shown to improve frailty status, including by enhancing function, slowing muscle deterioration, and improving bone health and joint mobility.^{55,56}

Quality Statement 5: Coordination of Care

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.

Sources: International Conference of Frailty and Sarcopenia Research, 2019²² | Ontario Health, 2021²⁴ | Ontario Health, 2022²⁵

Definition

Coordinated access to health and social services: Care is coordinated across all domains of frailty management, with interprofessional care team members working together to support the needs, goals, and preferences of the person receiving care. Elements of coordinated care include:

- Developing, maintaining, and communicating a shared care plan across the health and social care services the person is receiving. The care plan is shared with the person and their care partners in accessible formats to support understanding, self-management, and informed decision-making
- Clearly outlining expectations, accountability, roles, and responsibilities for coordinating care across health and social care services, including the identification of a most responsible clinician, case manager, or designated team member to support follow-up, continuity of services, and effective transfer of information across settings
- Managing follow-up and transitions of services across the continuum of care
- Ensuring continuity of care by establishing clear processes to connect the person to appropriate preventive, rehabilitative, specialized geriatric, community, and social services and by acknowledging and addressing systemic barriers (e.g., access constraints)
- Helping the person navigate the health care system, including by providing self-management support
- Coordinating palliative care supports as needed, including timely and seamless transitions across health care services for people with severe frailty and providing support and ongoing communication with people with severe frailty and their substitute decision-makers
 - For further information on care for people transitioning from hospital to home, see Ontario Health’s [Transitions Between Hospital and Home](#) quality standard.⁶
 - For further information on palliative care, see Ontario Health’s [Palliative Care](#) quality standard.⁵

Rationale

Compared with the broader adult population, adults with frailty typically have multiple coexisting health needs. An estimated 72% of people with frailty have multimorbidity and use multiple health services.⁵⁷ As a result, they frequently interact with various parts of the health care system, highlighting the need for coordinated care among interprofessional care teams and services.^{14,49,58}

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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.

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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.

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