Early Identification of Adverse Outcomes in Older Adults

Guidance for Emergency Departments

St. Joseph's Health Care London | Regional Geriatric Program of Southwestern Ontario | Ontario Health

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Acknowledgements

This guide was jointly developed by the Regional Geriatric Program of Southwestern Ontario (RGP SWO) and Ontario Health (OH) West, with expertise from valued Contributors across the West Region playing an essential role in the guide's development.

In response to questions raised by hospitals in the West Region, Contributors bringing expertise from emergency care, geriatric care, diverse geographic areas, and both suburban and urban hospital settings, worked together to compile practical strategies for identifying older adults at risk of delayed transition to an appropriate setting or other adverse outcomes presenting to the Emergency Department. Thank you to all Contributors for their time, insight, and dedication throughout the development of this guide.

Thank you for your commitment to early identification of older adults' needs in the Emergency Department. We hope this guide supports your implementation efforts and we welcome your feedback or suggested edits at oh-west-caf-team@ontariohealth.ca.

RGP SWO and OH West Leads

Bryson, Katrina
Researcher, Lawson Research Institute
St. Joseph's Health Care London (SJHCL)

Elliott, Dr. Jacobi
Director, Research and Strategy, St. Joseph's Health Care London (SJHCL)
Regional Geriatric Program of Southwestern Ontario (RGP SWO)

Heckman, Dr. George
Geriatrician, St. Joseph's Health Care London (SJHCL)
Regional Geriatric Program of Southwestern Ontario (RGP SWO)

Wilson, Samantha
Lead, Capacity Access and Flow, Acute Care and Alternate Level of Care
Ontario Health (OH) West

Contributors

Ashby, Brian
Consultant, Digital Transformation
Ontario Health (OH) West

Boyes, Maria
Waterloo Wellington (WW) Geriatric Emergency Management (GEM)
Resource Consultant, Cambridge Memorial Hospital (CMH)

Bradshaw, Sandra
Clinical Manager, Centre for Healthy Aging
Hamilton Health Sciences (HHS)

Kay, Dr. Kelly
Executive Director
Provincial Geriatrics Leadership Ontario (PGLO)

McKee, Amanda
Lead, Capacity Access and Flow, Acute Care and Alternate Level of Care
Ontario Health (OH) West

Morritt, Jennifer
Palliative Care Lead
Ontario Health (OH) West

Brar, Rashoo
Vice-President, Clinical Services
Erie Shores HealthCare (ESHC)

Buck, Mary
Lead, Capacity Access and Flow, Palliative Care
Ontario Health (OH) West

Cimek, Kelly
Director, Capacity Access and Flow
Ontario Health (OH) West

Clifford, Jenniffer
Lead, Specialized Geriatrics and Alternate Level of Care
Windsor-Essex Ontario Health Team (WE OHT)

Di Ruzza, Audriana
Geriatric Emergency Management (GEM) Nurse
Guelph General Hospital (GGH)

Elder, Janet
Palliative Care Lead
Ontario Health (OH) West

Ferguson, Dr. Alex
Emergency Medicine Lead
Ontario Health (OH) West

Folkl, Dr. Alex
Chief, Emergency Department
Guelph General Hospital (GGH)

Hanel, Dr. Erich
Emergency Medicine Lead
Ontario Health (OH) West

Janzen, Shannon
Lead, Capacity Access and Flow, Emergency Departments
Ontario Health (OH) West

Payne, Cindy
Director, Patient Services
Ontario Health (OH) atHome

Petruccelli, Danielle
Director, Geriatrics and Rehabilitation, Hamilton Health Sciences (HHS)
Regional Geriatrics Program Central (RGPc)

Reimer, Janine
Director, Alzheimer Society
Dementia, Resource, Education, Advocacy, Mentorship (DREAM) Team

Schitka, Jill
Director, Clinical Operations
Waterloo Regional Health Network (WRHN)

Scott, Kristen
Director, Emergency Services
Windsor Regional Hospital (WRH)

Shah, Dr. Amit
Emergency Medicine Lead
Ontario Health (OH) West

Sheridan, Laura
Palliative Care Lead
Ontario Health (OH) West

Turcotte, Dr. Luke
Assistant Professor, Department of Health Sciences
Brock University

Watson, Erin
Director, Clinical Programs and Operations, St. Joseph's Health Care London (SJHCL), Regional Geriatric Program of Southwestern Ontario (RGP SWO)

Wilband, Michelle
Lead, Capacity Access and Flow, Acute Care and Alternate Level of Care
Ontario Health (OH) West

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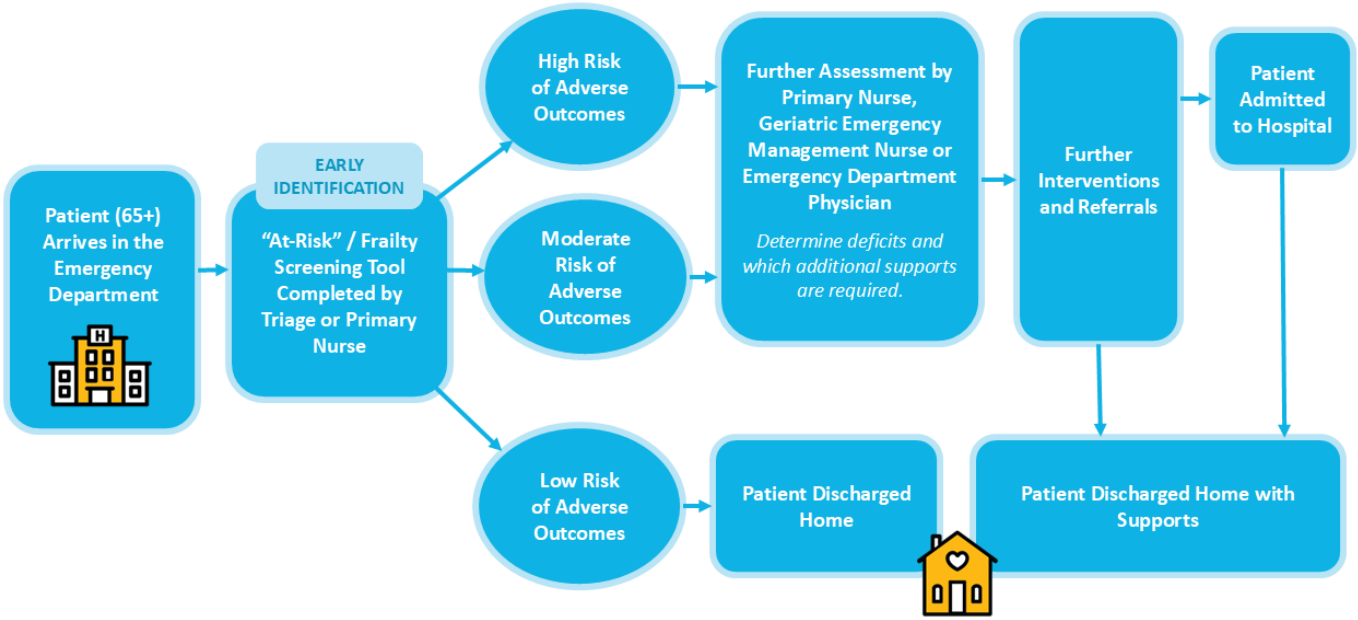
Executive Summary

The **Early Identification of Adverse Outcomes in Older Adults: Guidance for Emergency Departments** offers guidance to organizations seeking to implement screening processes in the Emergency Department to identify older adults, aged 65 years and older, at risk of adverse outcomes. Guidance in this document is consistent with and builds on the following previous guidance:

- The Alternate Level of Care (ALC) Leading Practices Guide: Preventing Hospitalization and Extended Stays for Older Adults[33]
- Operational Direction: Home First[34]

This guidance links the risk of adverse outcomes among older adults to the concept of frailty and compares risk and frailty screening tools appropriate for use in Emergency Departments (Table 1) to support choosing a screening tool. It also creates a common understanding of risk level, frailty level, and recommended next steps across tools (Table 3). Figure 1 depicts, in simple terms, the flow from early identification of individuals with or at risk of adverse outcomes and/or frailty, their stratification as low, moderate or high risk of adverse outcomes, and the subsequent interventions required to support their care.

Figure 1: Stratification of "At-Risk"/Frailty to Support Intervention



How to Navigate This Guide

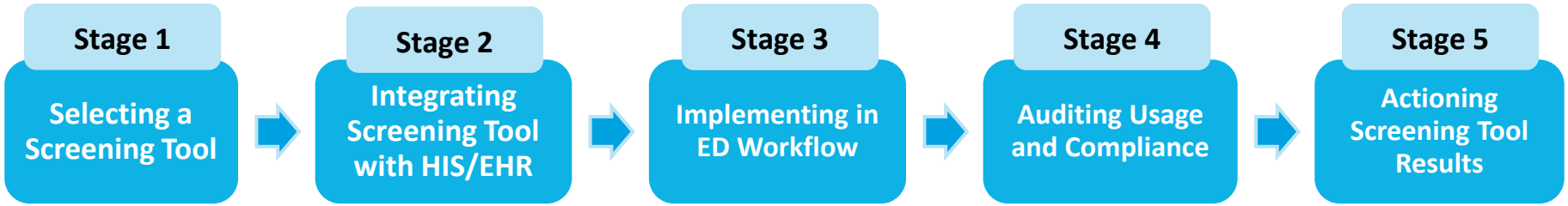
The **Early Identification of Adverse Outcomes in Older Adults: Guidance for Emergency Departments** aims to address questions linked to the Operational Direction: Home First[34] below:

> **OPERATIONAL DIRECTION: HOME FIRST**
>
> A. Direction for acute care hospitals:
>
> 2. All older adults (i.e., 65 years or older) in the Emergency Department are screened for early identification of "at-risk" adverse outcomes and ALC designation, and a follow-up plan is developed as needed.
>
> Compliance with the use of screening tools is audited quarterly by the Emergency Department management team and/or patient experience/quality team.

Based on the Home First Readiness Assessments submitted by OH West hospitals in November 2024:

- 49% of acute care hospitals reported screening all older adults in the Emergency Department to identify those at risk for delayed transition to an appropriate setting or other adverse outcomes (including potential ALC designation), using various screening tools and developing follow-up plans as needed
- 46% indicated they were developing quarterly audits to monitor staff compliance with these tools

Home First Reassessments, submitted in December 2025, highlighted progress and ongoing opportunities to meet the Operational Direction. Recognizing that Emergency Departments are at different stages of meeting the Operational Direction, the guide is organized into sections. This structure allows you to navigate directly to the section most relevant to your current stage of implementing the Operational Direction.



Identifying the Target Population

What Is Meant by "At-Risk"?

Adults aged 65 years and older presenting to the Emergency Department (ED) should be screened to support the **early identification of those at risk of adverse outcomes and delayed transitions in care, including designation as Alternate Level of Care (ALC)**. The goal of screening is to identify individuals who require further assessment, and enable timely, targeted interventions and appropriate care planning.

As defined in the The Alternate Level of Care (ALC) Leading Practices Guide: Preventing Hospitalization and Extended Stays for Older Adults[33], common characteristics of individuals "at-risk" of adverse outcomes and delayed transitions in care include:

- Age ≥65 years, with increasing risk among those ≥75
- Presenting or admitting diagnosis involving acute medical illness (e.g. infections), falls, or cognitive impairment
- Functional or cognitive impairments, and/or multiple comorbidities
- Occurrence of in-hospital adverse events (e.g. functional decline, delirium, falls, social isolation)
- Caregiver stress or limited social supports

For the purposes of this guide, the term "at-risk" will be used to refer to individuals at increased risk of the adverse outcomes described above.

What Is Frailty?

Older adults who are more likely to be considered at risk of adverse outcomes and prolonged hospitalization include individuals living with frailty. Frailty is a state of increased vulnerability to stressors resulting from age-related accumulation of impairments in multiple systems, with reduced physical reserve and loss of function across multiple body systems[3,6]. Frailty is multidimensional and covers the physical, cognitive, mental and social health of older adults and their care partner[30]. The interaction and integration across these domains predict death, heightened vulnerability, institutionalization, and reduced quality of life[6,30]. Frailty in older adults is also linked to increased risk of hospitalization, prolonged length of stays, deconditioning and loss of independence[4].

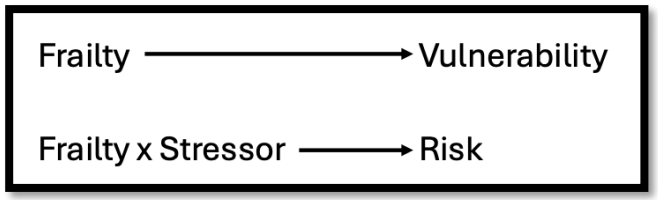
Identifying individuals living with frailty early through processes such as ED screening, helps to inform clinical decisions, identify pathways of care, and optimize outcomes for individuals living with or at risk of frailty[40,41]. In this way, frailty screening functions as a case-finding and segmentation strategy to stratify older adults into risk groups with similar needs and vulnerabilities, triggering focused and proportionate assessments and interventions. Importantly, frailty shapes how individuals present in the ED and how they respond to clinical stressors. Older adults living with frailty frequently present with non-specific symptoms (such as delirium, functional decline, weakness, falls, etc.) rather than

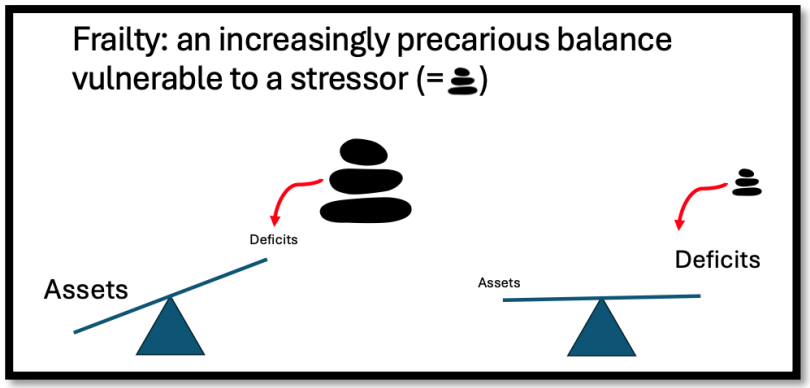
disease-specific signs. Recognizing these as manifestations of frailty allows for earlier identification and more accurate further assessment[6,11]. Once a presenting condition has been identified, the lens of frailty provides context for weighing the risks and benefits of proposed interventions. Frailty screening therefore signals the need for a more nuanced risk-benefit estimation to include functional outcomes, quality of life and alignment with patient goals and wishes.

Recognition of frailty prompts health care providers to look beyond the immediate episode and consider medium and longer-term needs including social vulnerability, caregiving supports and anticipated functional trajectory. When connected to clear pathways, screening can guide immediate and downstream care decisions, help prevent complications, and support timely referral to services. Frailty screening can also help to identify when an individual may benefit from a palliative approach to care. Early identification of a palliative approach to care provides an opportunity to explore advance care planning and clarify goals of care, ensuring interventions align with patient preferences and values. Frailty often follows a progressive illness trajectory characterized by decline in physical, cognitive, and functional abilities. Understanding illness trajectory through screening enables clinicians to recognize care needs and promote engagement with primary and community care services[11,44].

Understanding Frailty and Risk: A Patient Example

Frailty is not risk – it is a state of vulnerability to stressors including those related to illness, iatrogenic, or environmental stressors, often occurring in combination. Context determines the importance of frailty on risk[3].





Patient 1	Patient 2
Joe O. Screening • Clinical Frailty Scale (CFS) Score: 6 (Moderate Frailty) • Assessment Urgency Algorithm (AUA) Score: 4 (Moderate Risk) Social and Environmental Factors • Lives with his wife in a bungalow • Wife is healthy and supported by a son who lives nearby • Environmental scan: Fridge full of fresh food, tidy home, dosette up to date with medications • Reliable access to primary care	**Joe T.** Screening • Clinical Frailty Scale (CFS) Score: 6 (Moderate Frailty) • Assessment Urgency Algorithm (AUA) Score: 6* (High Risk) Social and Environmental Factors • Lives alone in a side-split • Wife recently passed away and only son lives out of town • Environmental scan: Empty fridge, untidy home (dirty dishes, piles of dirty laundry), disorganized medication bottles • Unreliable access to primary care (Family Doctor retired)

Although both Patient 1 (Joe O.) and Patient 2 (Joe T.) present with the same frailty score (6) on the CFS, Joe T. is at significantly higher risk for adverse outcomes due to the social and environmental stressors that increase vulnerability.

Joe T. lives alone, with no informal caregiver support following the passing of his wife. Environmental scans suggest some functional challenges with independent activities of daily living and potential issues with management of medication. Additionally, Joe T. lacks access to primary care following the retirement of his Family Doctor, increasing his risk for unmet needs and reliance on acute care services like the ED.

Altogether, these factors compound his frailty and place him at high risk for adverse outcomes. The AUA flagged Joe T. as higher risk (AUA score 6 vs. AUA score 4) by capturing these compounding social and environmental vulnerabilities, demonstrating the benefit of multidimensional screening tools to capture vulnerability rather than clinical presentation alone.

This patient example showcases the variability that can exist across screening focus and findings. In this example the AUA demonstrates stronger ability to identify and interpret the complexities involved. The use of multiple screening scores in this example is not to suggest using several screeners for each patient, but rather to showcase how different screeners may interpret scenarios differently.

Why Screening and Early Identification Matters

Recent data from the Canadian Institute for Health Information suggests that approximately 46% of hospitalized older adults, aged 65 years and older, had 6 or more deficits, placing them among the highest risk groups for frailty[8]. Given this prevalence, a focus on frailty screening in the ED is important, aligns with the Operational Direction: Home First[34], and can have significant impacts on both individuals and the health system.

According to the Geriatric ED Collaborative, an international collaborative of healthcare professionals, systems and organizations dedicated to the quality of care for older people in EDs[16], targeted interventions delivered in the ED can reduce downstream utilization of higher cost healthcare services and improve quality outcomes for older patients. Senior-friendly protocols and interprofessional team based-care focused on the needs of older adults in the ED can reduce the risk of hospital admission, reduce or delay admission to long-term care and lower overall costs[46].

The key to realizing these benefits is identifying which older patients are most likely to experience adverse outcomes and the risk of delayed hospital discharge at the earliest possible opportunity – upon or shortly after arrival to the ED. This necessitates a planned approach to **screening*** and assessment within the context of the ED. While the ED context may make introducing new processes challenging, the evidence for geriatric approaches in the ED is considerable, and such approaches can prevent unnecessary admissions and re-visits, help to prevent potentially life-threating conditions such as delirium, identify and appropriately support high-risk older adults (e.g. individuals with frailty, polypharmacy, dementia etc.) and connect older patients with the community resources needed to support aging in place.

***Note:** Throughout this document, we have used the term “screening” to refer to the process of case finding for older individuals living with frailty, and to allow for segmenting the identified population into levels of risk.

Introduction to Screening

The Need for Proactive and Targeted Screening for Older Adults

As Canada's population ages in both size and complexity, there continues to be increasing pressure on health systems to respond to the diverse needs of older adults. Older adults living with complex health conditions (e.g. dementia, frailty, mental health concerns, etc.) have high use of the ED overall, as well as increased urgent ED visitations, lengthier stays, and greater use of resources[25,27]. For some older adults the ED becomes the first, or only, point of access to care. Older adults frequently present to the ED with non-specific symptoms such as weakness, confusion, or decreased mobility. These may be early indicators of complex geriatric syndromes or functional decline, and may be complicated by other situations, such as precarious informal care support.

These complexities may remain unidentified during routine triage in EDs, which can lead to poorer outcomes, reduced quality of care for older adults, premature or uncoordinated discharges and can significantly influence the direction of subsequent care[15,20]. Therefore, there is a significant need for proactive and targeted screening of at-risk older adults who would benefit from additional assessments, supports, and resources in ED settings[26].

The ED presents a unique opportunity to screen large volumes of older adults and identify individuals who are at an elevated risk of adverse outcomes or delayed hospital discharge who may benefit from supportive interventions[14]. Early detection and intervention are essential in proactively addressing health concerns of older adults, with screening tools playing an important part of preventative and coordinated care that can improve wellbeing for older adults and caregivers[43]. Screening tools are an initial step in a response that combines clinical acumen and knowledge of the care of older adults that can lead to personalized care plans, improved social and medical outcomes, improved quality of life, and reduced healthcare costs[39,45].

Understanding Screening vs. Assessment

Although both screening and assessment play significant roles in the care of older adults, it is important to differentiate between screening and an assessment. Screening, as referred to in this document, is a case finding approach that asks, "is there a concern here?". An assessment is the next step, when screening identifies a concern, that asks, "what exactly is going on and what do we do next?"

Screening is for identifying individuals at risk of frailty while assessment is for diagnosing and planning care. Screening should be brief, accessible, and linked to action, while assessment is more in-depth and diagnostic, resulting in a plan for ongoing care and follow-up. Assessments must inform clinical decisions (immediate and potential), inform advance care planning and the benefits and risks of clinical management options

based on overall symptom burden. Drawing from chronic disease management literature - such as the Kaiser pyramid[36], population segmentation recognizes that the highest-need individuals represent a smaller proportion of the population but require more intensive interventions. Effective screening moves beyond a simple high/low risk binary and creates tiers or strata of risk which groups individuals with similar levels of vulnerabilities. Such segmentation helps guide the urgency and type of intervention required, and the system planning required to proactively address the needs of the population.

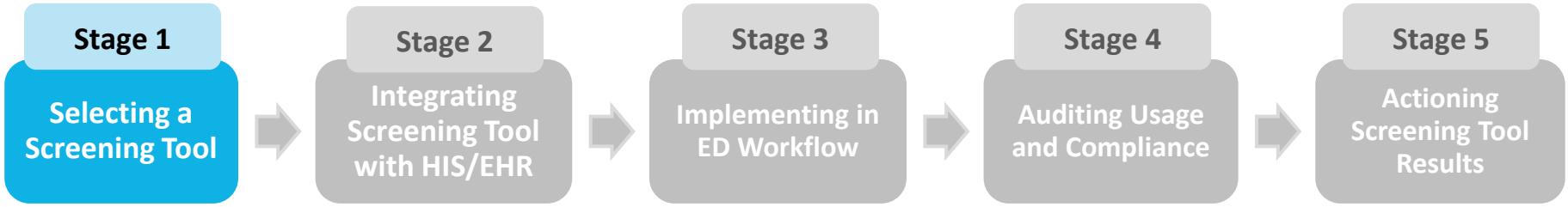
Screening: Identification of those at-risk or experiencing frailty[37].

- A brief process designed to be used by direct care staff to detect individuals who may be at risk of adverse outcomes
- Use validated tools, along with clinical acumen, to support screening activities that are typically short and easy to administer
- Screening tools can be self-administered or administered by frailty informed providers and clinicians
- Screening helps to identify areas or domains of concern and prioritize which patients would benefit from further and more comprehensive evaluations and assessments (e.g., interRAI Preliminary Screener or Identification of Seniors at Risk)

Assessment: Assessment is part of a process to characterize an individual's needs, strengths, and deficits to inform care planning and individualized treatment[38].

- Assessments are more detailed and focused processes that examine various domains of concern identified through screening (e.g. falls, function, cognition, mental health, pain, nutrition etc.) to determine contributing factors, underlying changes, or geriatric syndromes - assessments can also inform or support formal diagnoses
- Assessments rely on clinical acumen and may be supported in part by validated assessment instruments (e.g., InterRAI Contact Assessment or InterRAI Acute Care)

Stage 1: Selecting a Screening Tool



Promoting Efficiency in the Emergency Department with Screeners

We recognize that ED staff are facing heavy workloads and time constraints. Brief screening tools such as the interRAI Preliminary Screener, ISAR, TRST, and ER2 are designed to support efficiency, not add to the clinical workload[27]. By embedding screening tools within existing clinical workflows, staff can quickly identify at-risk older adults and streamline communication across care partners, including serious illness conversations to ensure interventions align with patient goals of care. This process can save time and effort for hospital staff, community providers, care partners and those receiving care. Proactive and targeted screening enables faster connection of high-risk patients to follow up supports, reducing the likelihood of repeat ED visits, and directing the use of specialized resources towards patients who are most likely to benefit from them[13,27].

A recent workflow study examining the use of geriatric screening tools in busy EDs found that brief tools can be administered quickly with very minimal disruption to nursing workflow. With many screeners adding a total of 3 – 5 minutes of work including documentation and interruptions[13]. This suggests that geriatric screening tools can be used without disturbing workflow and can even improve efficiency if duplicate or redundant processes are eliminated. Introducing a screener may provide opportunity to eliminate, replace or consolidate current processes including documentation[13]. For example, the interRAI Preliminary Screener is completed in under 2 minutes, making it highly feasible for implementation in dynamic and time-pressed emergency settings[26]. ED staff who have experienced the implementation of this screener have shared benefits to ED staff in improving efficiency of care planning[18].

Before Selecting a Tool

Prior to selecting a screening tool to implement, organizations should take time to assess their local context. This includes understanding current resources, existing workflows, and the specific needs of the population they serve. For further strategies, refer to the Ontario Health Emergency

Department Leading Practices Toolkit[35] section 2.6, 2.18 and 5.39. Additional consideration should be given to the setting, sector, size of hospital and available community resources. This includes reviewing internal and external factors that may impact how effectively a screening tool can be introduced and sustained within an ED. This process helps to ensure the chosen screening tool is feasible and aligned with an organization's capacity. Prior to selecting a tool an organization should consider the following:

Staffing Resources

- Who is available to administer the tool (e.g., Registration Clerk, Triage Nurse, Primary Nurse)?
- How will staff be trained on administering and interpreting the tool?
- Is there existing leadership who can support implementation?
- Workloads, time constraints, and skills

Technology Considerations

- Availability of technology to host the tool
- Which screeners could be incorporated into primary Health Information System/Electronic Health Record to avoid having to use multiple different programs/applications?
- Could data collected be used by hospitals for quality assurance or auditing purposes?
- If technology is not available, consider a hybrid, paper-based screening method

Integration into Workflow

- Where and when will the screening tool be administered (e.g., at registration, in triage, initial assessment, etc.)?
- How the tool can be integrated to enhance flow of ED

Current Local Practices

- Which tools are already being used by partners in the area? Can you align with these practices to promote consistency?
- Using tools compatible with others being used in your area to streamline processes and care transitions (e.g., the use of interRAI PS is increasing among Ontario Health Teams and in long term care settings)

Hospital Size and Capacity

- Size and capacity of a hospital (e.g., larger urban hospital vs. a smaller community or rural hospital) can influence scope and complexity of the ideal tool
- Using a phased approach, beginning with a patient population that is most prominent to pilot the new process and scale up

Follow-up Pathways

- What next steps will be triggered by screening results (refer to Stage 5)?

- Ensure there are actionable steps available for individuals identified as at-risk
- Caution: Identification of problems without a pathway to address them does not lead to improved outcomes

Sustainability Planning

- How can implementation be sustained and monitored over time?
- Who is responsible for ongoing oversight, management and auditing?
- Define clear success criteria for implementation and management (e.g., target outcomes, measurable impact on patient and system-level indicators, etc.)
- Plan for opportunities to refine screening processes in ED based on outcomes and feedback gathered

Table 1. Overview of Emergency Department Screening Tools

The screening tools identified below are appropriate for use in ED settings to support the rapid identification of vulnerability among older adults presenting in the ED who may be at risk of adverse outcomes such as functional decline, repeat ED use, hospitalization, or challenges following discharge. The recommended screening tools meet several key criteria, including brief administration time, demonstrated predictive ability, feasibility within the fast-paced ED environment, and the ability to support clinical decision making as standalone tools.

The screening tools referenced, linked, or described in this guide remain the intellectual property of their respective owners and must be used in accordance with each tool's published terms of use, licensing requirements, and disclaimers. It is the responsibility of each ED to review, validate, and ensure compliance with those terms prior to adoption or implementation. The RGP SWO and OH West do not assume responsibility for the misuse, misinterpretation, or improper application of any tools mentioned in this guide.

Recommended Screening Tools for ED Settings		
Tool	**Description**	**Key Considerations and Strengths**
Emergency Room Evaluation and Recommendation (ER^2) *Risk Tool*	A 6-item tool that stratifies risk (low, moderate, high) for adverse outcomes in older ED patients. Assesses key risk indicators including mobility aids, disorientation, polypharmacy, recent hospitalizations, and social supports[27].	✓ Short and easy to use ✓ Provides 3-level risk stratification to guide prioritization ✓ Captures clinical and social vulnerability indicators[2]
Identification of Seniors at Risk (ISAR) *Risk Tool*	Quickly screens for risk of functional decline, repeat ED use, and poor outcomes post discharge[23].	✓ Short and easy to use ✓ Widely used and well known ✓ Provides dichotomous cut off (2+ = at risk) ✓ Easy to administer, potentially limited predictive ability[28,42]

InterRAI Preliminary Screener (PS) *Risk Tool*	Identifies adults at risk of functional decline, repeat ED use, and poor post discharge outcomes[7]. PS collects standardized data and includes items required to generate an **Assessment Urgency Algorithm (AUA)*** Score. ***The AUA** is a decision-tree algorithm that integrates social vulnerability, functional status, and symptoms to determine urgency (1 = minimal to 6 = high) with which an older adult should receive a CGA.	✓ Captures functional, cognition, social domains ✓ Polychotomous score (1 – 6) for prioritization ✓ Short and easy to use (minutes to administer) ✓ Highly sensitive for detecting complex patients ✓ Well-tolerated by patients and providers ✓ Compatible across interRAI assessments that are used across sectors[26] ✓ Highly compatible with OH's new fully funded **Provincial Assessment Platform** to be launched in September 2026: • Phase I (Sept/Oct 2026): Available for hospitals to use the system to assess patients in ED using the interRAI PS, which will be shared with OH atHome • Phase II (post-Oct 2026): Integration of the Provincial Assessment Platform and hospital EMRs
PRISMA-7 *Frailty Tool*	Quickly identifies older adults with probable frailty who are likely to benefit from further assessment[24].	✓ Short and easy to use ✓ Aligned with community pathways X Identified as a frailty screener, and not a "risk screener" X May over-identify frailty; lower specificity[28]
Triage Risk Screening Tool (TRST) *Risk Tool*	Series of 6 questions that identifies older adults at risk for functional decline, ED revisit, and challenges post discharge[22].	✓ Short and easy to use (minutes to administer) X Uses yes/no flags instead of graded risk score X Limited predictive ability compared to other screening tools[12] X Limited alignment with other assessment tools across health sectors[21,42]

Note: Although the new Provincial Assessment Platform can build any of the screening tools mentioned above, the interRAI PS is already available. In terms of compatibility of assessments used across other sectors (including community support services, home care, complex continuing care, long term care, etc.), the interRAI PS supports a common, standardized approach that enhances continuity of information and care across sectors.

Table 2. Other Screening and Assessment Processes

In addition to the recommended tools in Table 1, several commonly used screening processes exist. While these entities may help to clarify an individual's current needs in certain scenarios, they are not specifically designed for measuring and identifying risk of adverse outcomes among older adults in the ED setting and instead are designed to complement broader clinical assessments and processes[27]. As a result, the commonly used processes below may be less suited to the fast-paced ED environment, where brief, validated tools are needed to rapidly identify individuals who may benefit from further assessment or targeted interventions. These tools can be highly valuable in other care settings or farther along in the patient journey for assessing needs and identifying concerns; however, may not be the most appropriate choice for efficient and accurate screening in the ED[27,40]. For this reason, it is recommended that ED teams utilize the independent screening tools listed in Table 1.

Assessment/Process	Description	Intended Use and Limitations in ED Screening
Blaylock Discharge Planning Risk Assessment Screen *Focus: Discharge Risk*	Identifies risks related to patient discharge including social, functional, and medical complexities. Captures psychosocial risks that may be missed and supports referrals and connection to supports[9].	Designed to support discharge planning, rather than rapid ED risk screening. • Most useful later in patient journey when planning transitions from hospital to home or community[9] • Requires a slightly longer administration time and generates a total summed score, rather than clear risk stratification, limiting its use in EDs[1,9]
Clinical Frailty Scale (CFS) *Focus: Frailty/Assessment*	Assesses severity of frailty including cognition and functional status to support triage. Designed to summarize results of Comprehensive Geriatric Assessment (CGA) [28].	Primarily a frailty severity measure. • Accurate scoring requires the knowledge of a patient's baseline functioning, which is often unavailable to ED staff • More useful in inpatient and longitudinal care settings where baseline can be determined[10,28]
The Canadian Triage and Acuity Scale (CTAS) Frailty Modifier *Focus: Frailty/Not Population-Specific*	A first-order modifier used in addition to the Canadian triage and Acuity Scale (CTAS) to adjust triage levels based on frailty. Identifies older adults whose frailty may increase urgency of care required and allows nurses to "up-triage" frail patients[5].	Useful as a triage support tool. • Functions as a modifier to the CTAS • Frailty modifier for all ages (inclusive of neonatal and persons with disabilities)

Additional Considerations to Increase Early Identification

This guidance document considers processes for implementing a particular screening tool into ED workflow, typically once the patient is in a bed. However, ED staff can also leverage information gathered at registration and triage to help identify patients at higher risk for adverse outcomes. Early recognition allows teams to proactively consider screening activities and assessment needs, mobilize resources, and begin care planning earlier in the ED visit. Many indicators of vulnerability are immediately visible or accessible at first point of contact through the EMR, patient presentation, or caregiver interaction. Utilizing these signals supports earlier clinical thinking, without adding burden or duplicating work in busy ED settings.

These are not diagnostic criteria but rather are early warning signals or flags that prompt consideration of more robust frailty-screening and next steps. Examples of high-risk flags may include:

Health System Utilization

- Recent or frequent ED visits (e.g., multiple visits in the past 30–90 days)
- Recent hospital admission or discharge
- Known involvement with home care

Presentation and Cognition

- Confusion, delirium, or altered mental status
- Difficulty providing history or answering questions

Caregiver and Social Context

- Caregiver present who appears overwhelmed, distressed, or unable to cope
- Concerns raised by family, paramedics, or accompanying supports

Living Situation and Transitions of Care

- Arrival from long-term care or retirement home
- Recent transition between care settings (i.e., hospital to long-term care)

While early flags at registration and triage are effective for identifying individuals with clear or high-risk, visible indicators, screening remains critical for patients who do not present with visible flags. Individuals at moderate risk often appear clinically stable and may not trigger concern based on utilization patterns, presentation, or social context alone. Without formal screening, this group is most likely to go unrecognized, despite having reduced reserves and increased vulnerability to adverse outcomes. Validated screening tools play a key role in systematically identifying this population and ensuring their needs are appropriately assessed and addressed.

Palliative Care Screening

Older adults living with serious illness and frailty often follow predictable patterns of illness progression, underscoring the importance of early palliative identification to guide coordinated, goal-aligned care. A palliative approach to care, introduced early in the trajectory of illness, is distinct from end-of-life care (focused on the final days to weeks of life).

A palliative approach to care integrates:

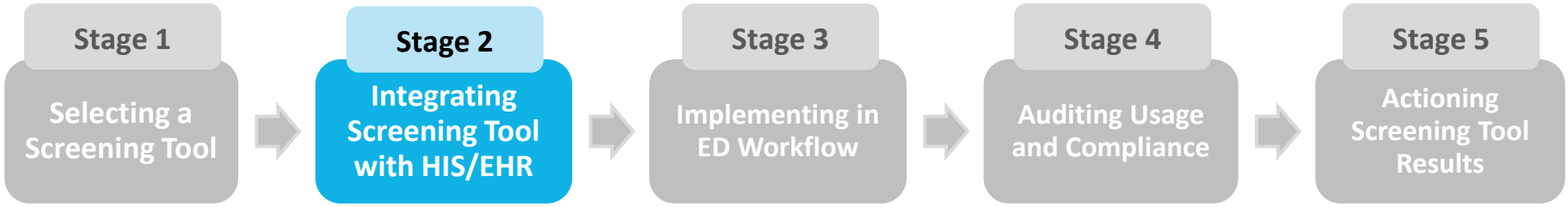
- Symptom management, quality of life supports, and advance care planning alongside restorative, curative, or disease modifying treatments, rather than only in the final days or weeks (initiated early in progressive or life-limiting illness)
- Enhances quality of life, supports symptom management, and facilitates proactive advance care planning

Benefits to early identification of palliative care approach in ED:

- Early recognition of palliative care needs, particularly for older adults whose frailty indicates increasing complexity, enables clinicians to initiate timely goals of care discussions
- Early integration of a palliative approach to care has consistently been shown to improve patients' quality of life, reduce symptom burden, increase satisfaction with care, and better support informed, goal-aligned decisions about treatment and future planning[29]
- Reduces caregiver strain and burnout, enhances communication
- Reduces clinician moral distress by ensuring that treatments are aligned with patient values and by minimizing non-beneficial interventions near the end of life, a recurring challenge in acute care settings
- Supports better coordination with primary care, home care, and community supports, enabling proactive planning based on predictable trajectories of frailty and serious illness
- Collectively, these benefits translate into reduced avoidable ED revisits, fewer preventable admissions, and decreased reliance on late-stage intensive interventions, easing organizational strain and improving patient flow while enabling more efficient discharge and transition processes across care settings

Palliative early identification is a practical mechanism that enables organizations to meet the Operational Direction: Home First[34]. It complements, but does not replace, frailty screening. Frailty reflects the cumulative impact of chronic, progressive illness and exists along a continuum, where small increases in frailty are associated with a 30–50% higher risk of mortality within two years, as well as increased hospitalization and system use. For populations identified through frailty screening, early identification of a palliative approach is essential to deliver the operational direction, enable proactive service planning, advance care planning, goal-concordant care and appropriate transitions. This integrated approach is reinforced across provincial standards, including the Health Quality Ontario Palliative Care Quality Standard[19], Palliative Care Health Services Delivery Framework: Recommendation for a Model of Care to Improve Palliative Care in Ontario[31], the Ontario Palliative Care Network: Tools to Support Earlier Identification for Palliative Care[32] and the Gold Standards Framework[17] (Identify–Assess–Plan).

Stage 2: Integrating Screening Tool with HIS/EHR



A screening tool has been selected, and the next step is to make it easy to find, simple to use, and consistently documented by integrating it into your Health Information System (HIS)/Electronic Health Record (EHR). Vendors offer collaborative communities where hospitals can share insights and request integration support. Communicate your needs to your IT team and your vendor early, as effective integration depends on keeping clinical priorities central. The more accessible the screening tool is, the more likely it will become routine in your ED. Begin by determining where it best fits in the workflow, then work with your IT team and vendor to explore integration options.

Key HIS/EHR Considerations

- Place the screening tool within existing workflows
  - E.g., Embed it in triage so it is completed early
- Ensure easy access
  - E.g., Add quick links or shortcuts on ED dashboards
- Reduce missed screenings
  - E.g., Use mandatory fields for essential indicators
- Automate where appropriate
  - E.g., Enable automatic scoring and high-risk flags to remove the need for manual calculation
- Consider cost implications
  - E.g., Assess licensing fees, subscription costs, technology upgrades, and staff training time required to implement digital tools or automated scoring features
- Review licensing requirements
  - E.g., Confirm whether the screening tool is free for clinical use, requires a paid license, or has restrictions on electronic integration, redistribution, or modification

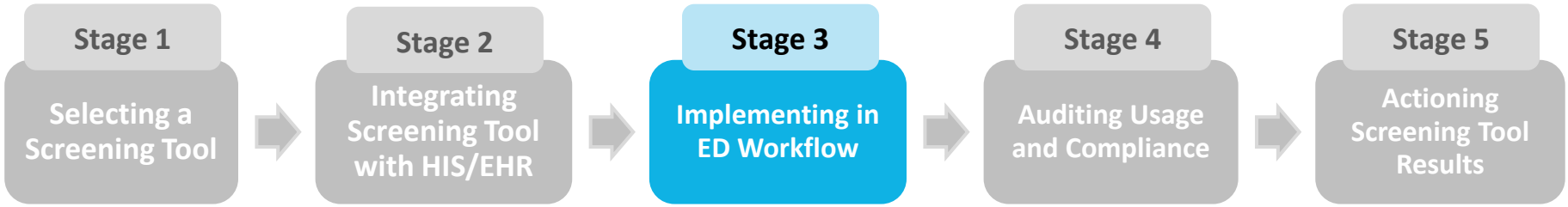
Vendor	Collaborative Details
Epic	• Open Epic • open@epic.com
MEDITECH	• Medical Users Software Exchange (MUSE) is a community of MEDITECH users and related professionals who interact to learn and share their knowledge and experience • Through MUSE, members network, solve problems, identify best practices, and improve performance for their organizations (info@museweb.org) • To connect with MEDITECH directly, contact your Client Service Support Representative
Oracle Health (Cerner)	• Collaborative Forum for Oracle Users • Contact your Client Service Support Representative for more information
Ontario Health's Civica Assessment Platform	• Ontario Health's provincial assessment platform is designed to facilitate completion of standardized assessments, including the interRAI Preliminary Screener • Once completed, assessments are automatically uploaded to the Integrated Assessment Record (IAR), Ontario's central provincial data repository

Considerations for Paper-Based Hospitals

Not all hospitals have transitioned to fully digital systems. Common challenges in paper-based environments include incomplete documentation and difficulties in tracking compliance. Below are practical strategies to support EDs that continue to rely on paper-based processes:

- Use a standardized paper form for screening and scoring
- Assign clear responsibility for completing the screening (e.g., Registration clerk, Triage Nurse or Primary Nurse)
- Implement a manual audit process to monitor compliance
- Consider hybrid options (e.g., Scan completed forms into the HIS or use tablets for quick data entry).

Stage 3: Implementing in ED Workflow



This section provides practical strategies for moving from *we chose a screening tool* to reliable, routine use in the ED by defining who does what, when, and what happens next.

Map the Moment of Use

- Place the screener where it naturally fits (e.g., registration, triage or first nurse assessment) so it is completed early, captured once, and visible to the whole team
- Use EMR prompts, mandatory fields for key indicators, and auto scoring/flags where available to reduce missed screens
- Reduce reliance on memory or manual processes

Keep It Brief and Reduce Extra Work

- Choose brief screeners already shown to add approximately 2–5 minutes (often less) when embedded into normal flow and remove redundant steps/documentation to offset that time
- Use auto-population and auto-flagging to minimize manual effort
- Frailty describes vulnerability, while other screening tools stratify urgent needs and downstream risk. Using both frailty and at-risk screening tools supports triage, care planning, and discharge readiness
- Do not launch a screener without a realistic referral/management pathway and capacity to respond

Make Scores Actionable

- A score must trigger a next step (referral, assessment, pathway, orders), otherwise it is merely static data in a chart
- Align your order sets, consult lists, and community referral pathways to the score cut-offs (refer to Stage 5)
- Clarify who receives the auto-flags and who is accountable for acting on them

Close the Loop

- Build feedback into daily operations
- Consider micro-audits, shift huddles, and regular reminders to maintain high compliance, even when dealing with turnover and volume pressures (refer to Stage 4)

Paper-Based Settings

- Use a standardized one-page form
- Assign clear responsibility (e.g., Registration Clerk, Triage Nurse or Primary Nurse), scan to the chart, and run simple manual audits until digital options are available
- Hybrid tablet entry can bridge the gap

Build Strong Referral Pathways

- Build (and approve) policy supported referral pathways that map screening tool scores to specific actions (e.g., further assessment, consults, order sets, community referrals, post-ED follow up)
- Use the Stage 5 tables to harmonize cut-offs across tools so staff do not need to memorize differences
- Consider who to engage to design and endorse pathways (e.g., ED leadership, GEM/Specialized Geriatric Service (SGS) teams, OT/PT, Social Work, Pharmacy, Medicine/Hospitalists, Mental Health, Discharge Planners/Home Care, and community partners like BSO, Alzheimer Society and OH atHome)
- Refer to the Ontario Health Emergency Department Leading Practices Toolkit[35] section 5.13 for further considerations

Screening Considerations When Resources Are Limited

- If screening *everyone 65 and over* is not immediately feasible, start where the benefit is highest
- Consider piloting with priority sub-groups (e.g., 80 and over, functional/cognitive change, social vulnerability, frequent ED use) and scale in phases - this strategy preserves intent while respecting resources

Keep the Purpose Clear

- Every screen should answer: “What do we do with this score today?”
- Normalize the expectation that a score is a call to action, not just informational, and use Stage 5’s pathways to define the exact referral or intervention that is most appropriate given your context and resources available

Role of Hospital Leadership in Building and Sustaining Workflows

Leaders operationalize reliability by:

- Hard-wiring the process: EMR/EHR placement, quick links, mandatory fields, and auto-scoring/flags (with vendor support) so the screener is easy to find, simple to use, and consistently documented (refer to Stage 2)

- Clarifying ownership: Who screens at triage vs. primary assessment, who receives auto-flags, and who is accountable for referrals
- Resourcing training and communication: Brief skill building for ED clinicians on frailty, delirium, dementia, and behavioural risk. Integrated into orientation, huddles, and refreshers
- Auditing and improvement cycles: Micro-audits and feedback loops to reduce variation by shift and site (refer to Stage 4)
- Engage staff regularly to gather feedback on whether the selected screening tool is the right fit and to ensure clinicians find the workflows clear, feasible, and valuable in practice

Considerations for Older Adults with Cognitive Deficits

For older adults with cognitive deficits or communication barriers, adapt your process by:

- Using collateral history (e.g., caregivers, family members, paid support staff, case managers, agency coordinators) to establish baseline function and recognize acute change
- Prioritizing non-pharmacological strategies and environment adjustments when behavioural risk is present (consider BSO)

Reinforce Auditing and Actioning

Implementation succeeds when use is measured and scores lead to care:

- Establish quarterly audits as per the Operational Direction: Home First[34]. Consider weekly micro-audits and ED dashboards to maintain compliance and detect gaps early
- Use the Actioning Screening Tool Results (Stage 5) so that *every* screen is scored and the appropriate action is taken (e.g., a referral, intervention, or plan that fits your ED's staffing and community resources)

High Volumes and Limited Specialty Coverage

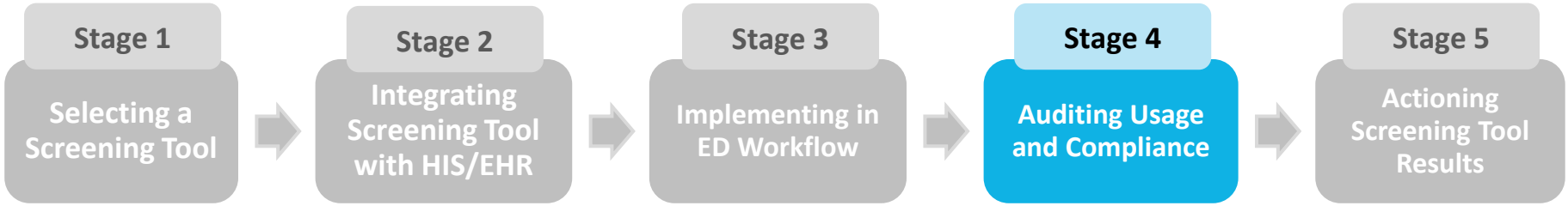
Even without onsite geriatric programs, EDs can deliver effective care, maximize internal capacity and provide after hours continuity by:

- Training core clinicians (e.g., nursing, OT/PT, pharmacy, SW, physicians) in senior friendly care approaches
- Embedding automatic triggers for consults and community referrals
- Coordinating with external partners (BSO, OH atHome, Alzheimer Society, LTC outreach)

Summary Checklist: Implementing in ED Workflow

- Implementing screening in the ED is supported by reliable routines - place the screening tool at the right moment, keep it brief, embed it in the EMR, and ensure every score changes care, then measure and iterate
- Screener location finalized in EMR/EHR with quick link and auto-flag
- Responsible roles named (e.g., Triage Nurse, Primary Nurse) and hand-off confirmed
- Referral pathways approved for each score tier (e.g., ED consults and community referrals)
- Paper/hybrid workflow defined (if required) with scanning and log for audits
- Education delivered (e.g., orientation, huddles, refreshers), materials posted in ED and audits/feedback loop to ED teams in place

Stage 4: Auditing Usage and Compliance



Quarterly audits are a foundational component of sustaining high quality early identification practices and a requirement of the Operational Direction: Home First[34]. This section provides practical strategies to ensure screening tools are used reliably and consistently in the ED.

Why Auditing Matters

Auditing verifies that screening tools are completed, documented, and acted upon, ensuring that early identification of at-risk older adults is not dependent on shift variation, site culture, or workflow pressures. Hospitals that have strong auditing processes demonstrate higher completion rates, stronger alignment between screening scores and follow up actions, improved reliability in how older adults move through ED pathways and better ability to identify system gaps early (e.g., screening drop off points, referral bottlenecks).

The Operational Direction: Home First[34] recommends quarterly audits conducted by ED management and/or quality/patient experience teams. Without structured monitoring, many hospitals experience screening inconsistencies, documentation gaps, lack of follow through on flagged patients and difficulty understanding population level trends due to missing or incomplete data. Track completion consistently, verify that documentation and follow-up are happening as intended, and use audit insights to strengthen workflows, close gaps, and strengthen early identification practices over time.

What to Audit

A reliable audit process typically includes the following components:

- Screening compliance, for example:
  - Percentage of older adults (65+) screened at triage
  - Percentage of screens completed correctly and fully documented
  - Percentage of high-risk screens with corresponding follow up

- Documentation quality, for example:
    - Whether scores are entered in the correct portion of the EMR/EHR
    - Whether auto flags or triage modifiers (where enabled) are firing correctly
    - Use of standardized paper forms in hybrid/paper-based departments
- Actioning of results, for example:
    - Whether moderate to high risk and moderate to severe frailty scores led to appropriate referrals
    - Whether referrals were completed in a timely manner
    - Whether interprofessional teams (e.g., GEM, OT/PT, SW) were engaged when indicated
    - Whether ED staff accessed community supports when internal specialty teams were unavailable
- Variation by shift, site, or staffing model
    - Differences in compliance between day vs. evening vs. night shifts
    - Impact of staff turnover, sick leave, and vacancies
    - Patterns indicating the need for refresher training or workflow redesign

When to Audit

Consider the use of multiple, layered strategies, in addition to quarterly audits, to review screening tool compliance including:

- Weekly micro-audits
    - Short, rapid sampling of 5–10 charts to identify real-time gaps
    - Prevent audit drift where compliance declines outside of quarterly cycles
- Audit dashboards and data visualization
    - Partner with your Decision Support team to build dashboards that show compliance rates, trends over time, high-risk population profiles, need for targeted support
- Embedding screening tool compliance monitoring in ED quality structures
    - Daily huddles
    - Weekly safety meetings
    - Performance scorecards
    - Staff newsletters and reminders
- Clear accountability channels
    - Assign explicit responsibility for completing the screening tool, entering the score, acting on the score, monitoring compliance and reporting results

Common Auditing Challenges and Potential Solutions

EDs face predictable challenges that reduce audit effectiveness. Common issues and solutions include:

Challenge	Description	Potential Solution
Inconsistent use of screening tools	Staff vary by shift or site in whether/when screening is done	Standardize screeners at triage; embed mandatory fields; use prompts/flags
Lack of clear ownership	Uncertainty around who screens, who follows up, who audits	Clarify role expectations; embed in job descriptions; reinforce in huddles
Weak or absent documentation	Scores not recorded or inconsistently entered	Use standardized digital or paper workflows; audit documentation quality
Audit fatigue	Audits decline over time without leadership support	Use dashboards, micro audits, and routine feedback loops
Lack of clear action	Scores do not translate to referrals or interventions	Reinforce pathways; review "score → action" alignment (refer to Stage 5)

Using Audit Findings to Drive Improvement

Audit results are most meaningful when they lead to visible improvements in ED practice:

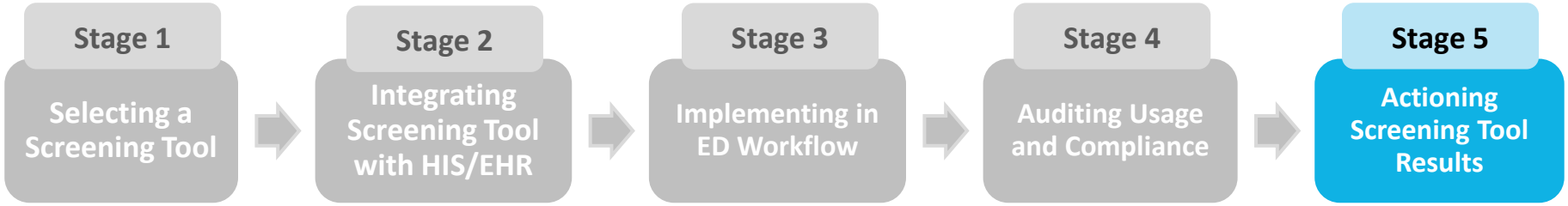
- Identify gaps and root causes: Use audit findings to identify breakdowns in workflow, knowledge, or system triggers
- Co-design solutions with frontline teams: Work with triage nurses, primary nurses, GEM, SW, OT/PT, pharmacy, and ED physicians to solve practical barriers
- Create action plans: Build quality improvement plans through ED and hospital QI structures, with timelines and accountability
- Reinforce success: Highlight improvements in team huddles, newsletters, and dashboards to maintain momentum and morale

Summary Checklist: Auditing Screening Tool Usage and Compliance

Auditing screening tool usage in the ED is about dependable practice.

- Quarterly audit completed and shared with ED leadership and quality structures; weekly micro audit process active
- Dashboard developed with Decision Support and reviewed monthly
- Clear ownership assigned for screening, documentation, and referral follow-up; documentation standards reviewed and reinforced
- Coaching and/or targeted education provided based on audit findings
- Screening pathways (refer to Stage 5) updated or clarified based on audit results
- Feedback loop to staff implemented (huddles, newsletters, debriefs)

Stage 5: Actioning Screening Tool Results



LET THE SCORE LEAD THE WAY

A screening score is a call to action. A scores value comes from identifying needs, initiating referrals, and guiding patients to the right pathway. Screening tools make a real difference only when their results spark the next clinical step. Screening results should never remain passive data. When a screening score sits untouched in the patient chart, it contributes nothing to patient care. Below are practical strategies to transform every score into meaningful action.

The Impact of Using Screening Tools to Streamline Care

Standardized use of frailty scores, risk scores and associated pathways, establishes a shared understanding and common language among ED staff, which can be applied across the hospital and with community partner organizations. This shared language supports continuity across care transitions and enables clearer communication of frailty and risk, including identification of changes from baseline at the time of ED presentation. The results of frailty screening should be evaluated to determine if the current ED presentation represents an acute change in functioning from baseline, a remediable condition, a chronic and long-standing condition, or a signal of the need to transition to palliative approaches to care. Acute changes to frailty should be documented and flagged for further assessment to identify potentially reversible causes. Clinical judgement should always be considered in addition to scores from validated tools, with the decision to refer patients for further frailty/geriatric assessment occurring independently of frailty screening tool scores. As part of your decision-making process, check ClinicalConnect to see recent admissions, diagnostics, specialist involvement, collateral information from community supports, and existing care plans. This additional information helps to validate screening results, uncover risks or supports not identified during the ED visit, and supports the choice of the most appropriate care pathway based on the patient's full care history.

Score Pathways

The results of screening along with clinical judgement should prompt referrals for further assessment and intervention from the ED, supported by organizational level policies. Referral pathways within the ED should be tailored to the specific resources and services available within the hospital and in the community for outpatient follow-up. When placing referrals, consideration should be given to the scope and clinical expertise of each service. In organizations with limited internal clinical support, processes should be in place to triage patients by degree of frailty, prioritizing further assessment during ED visit based on current risk of return visit, and potential barriers to discharge. For a 4-step Approach to Frailty Management in ED, including discharge vs. admission decisions, refer to the Seniors Care Network's Frailty Screening and Management in the Emergency Department: Strategies to Avoid Unnecessary/Prolonged Hospital Admissions and ALC Rates[40]

Intradepartmental Referral Considerations

Referrals to consider *within the department* based on clinical scope and expertise for further frailty assessment and intervention, as available:

Intradepartmental Referral	Primary Concern for ED Visit and/or Frailty
Alzheimer Society/Dementia Resources, Education, Advocacy, and Mentorship (DREAM) Team	• Suspected or known cognitive impairment requiring education, support, or access to community-based dementia resources (e.g., respite)
Geriatric Emergency Management (GEM) Nurse	• Complex, multifactorial frailty requiring comprehensive geriatric assessment and care planning
Geriatrician, Geriatric Nurse Practitioner	• Geriatric syndromes or medication-related concerns requiring specialized assessment, diagnosis, or optimization
Geriatric Psychiatry/Mental Health Teams	• Complex behavioural, cognitive, or psychiatric symptoms beyond the scope of general ED assessment and management
Home Care Case Manager (e.g., OH atHome, Integrated Palliative Care Team [IPCT], Hospital to Home [H2H])	• Decline in ability to function independently in the community requiring additional in-home supports and services
Occupational Therapy (OT)/Physiotherapy (PT)	• Mobility limitations, falls risk, or functional decline impacting safety and independence
Social Work (SW)	• Psychosocial concerns impacting health and discharge planning (e.g., housing instability, financial stressors, caregiver burden)

EDs where onsite geriatric mental health programs or geriatric specialists are not available can still effectively support older adults by maximizing internal capacity and enhancing after-hours coverage. Internal capacity among ED Clinicians can be enhanced by:

- Providing targeted education for nurses, pharmacists, OT, PT, SW, and physicians on frailty, frailty screening and interventions, delirium, dementia, pain management, goals of care and behavioural risk
- Encouraging discipline-specific assessments (PT, OT, pharmacy, SW) to identify functional, mobility, medication, pain, psychosocial, and cognitive concerns early
- Incorporating risk and frailty concepts into ED orientation, huddles, and ongoing professional development to build lasting internal capacity

In the absence of geriatric specific services (e.g., GEM Nurse, DREAM Team, Geriatric Psychiatrist, Geriatrician), core hospital clinicians collectively provide essential assessment and intervention:

- SW: Psychosocial assessment, caregiver input, crisis supports, linkage to community resources
- OT/PT: Functional decline, safe mobility, falls risk, cognition, pain, equipment needs
- Pharmacy: Polypharmacy review, anticholinergic load, deprescribing advice
- Mental Health/Crisis Teams: Behavioural assessment, de-escalation, risk evaluation
- Medicine/Hospitalists: Investigation and management of medical contributors to pain, functional decline, cognitive or behavioural change

Hospitals can further enhance care by coordinating with:

- Behavioural Supports Ontario (BSO), OH atHome, Long Term Care Outreach Teams, Alzheimer Society Programs

Community Referral Considerations

Consider referrals to *community-based services* for assessment, and intervention of frailty and frailty related syndromes, as available. For more information, consult Healthline, Health 811 and local Ontario Health Team websites.

Community Referral	Goal of Referral
Adult Day Programs	• Structured social engagement, therapeutic activities including meals in a group setting, and respite for caregivers
Alzheimer Society	• Education, support and system navigation for cognitive impairment and dementia

Assisted Living Services	• 24/7 scheduled and unscheduled Personal Support Worker (PSW) supports for adults who are living in the community but require assistance with personal care, homemaking, medication reminders and/or safety checks
BSO Teams	• Nonpharmacological support for behavioural and psychological symptoms of dementia
Canadian Mental Health Association (CMHA)	• Community or outpatient mental health supports
Community Paramedicine	• Programs to reduce ED visits and support hospital transitions by managing chronic conditions through home visits or remote monitoring and support for vulnerable populations through mobile clinics
Family Health Team/Community Health Centres	• Outreach teams, interdisciplinary support, primary care
Safety and Wellness Checks/Friendly Visiting	• Reduce social isolation and enhance emotional well-being for older adults living alone or with limited social supports • Friendly Visiting programs provide regular check-ins, companionship, and social engagement, helping to mitigate loneliness, support aging in place, and identify emerging concerns that may require follow-up or connection to additional community services
Home Care (e.g., OH atHome, IPCT, H2H, LEGHO)	• Care coordination • PSW, Nursing, Registered Dietitian, Speech Language Pathologist, SW, OT, PT, Palliative Care Supports
Homemaking	• Connecting individuals who need supports for homemaking activities such as light housekeeping, grocery shopping or meal preparation
Health Promotion and Wellness Programs	• Maintaining or promoting health and wellness through social and recreational activities based on group needs • Services within this category may include congregate dining and/or falls prevention and exercise programming
Caregiver Support and Respite Services	• Provides temporary in-home or overnight support that offers caregivers short-term relief while ensuring the person they care for remains safe and supported at home or in an overnight program setting • Provide information, education, training and therapeutic counseling for caregivers to reduce caregiver distress
Meals Delivery	• Ensure older adults living with frailty have reliable access to nutritious meals, reducing risks related to poor nutrition, functional decline, and unsafe meal preparation • Prevent avoidable ED return visits linked to malnutrition or inadequate food access

Transportation Services	• Ensure older adults living with frailty can safely access follow-up care and essential services after discharge, reducing risks of unmet needs and avoidable ED return visits • Accessible transportation may be available
SGS Medicine programs	• Geriatric medicine physician and team support
SGS Psychiatry program	• Geriatric psychiatry physician and team support

Table 3. Screening Tool Score Alignment and Recommended Actions

The table below was designed to support EDs by establishing a shared language around screening results and the follow-up actions they prompt. It emphasizes how results (e.g., scores) translate into appropriate next steps and care pathways, such as referrals to OH atHome, rather than the technical details of the tools themselves. Recognizing that staffing models, resource capacity, and service availability vary across EDs, the table incorporates context-aware considerations to guide decision-making that is both feasible and clinically appropriate. Ultimately, this table is intended to help ED providers answer the practical question: **"What do we do with this score?"** and to support the development of pathways that are meaningful, actionable, and aligned with each organization's staffing, capabilities, and community resources.

Recommended Screening Tools for ED Settings				
Tool	**Output**	**Low Risk**	**Moderate Risk**	**High Risk**
Emergency Room Evaluation and Recommendation (ER^2) *Risk Tool*	• Identifies those at higher risk of short-term undesirable outcomes • Sum of scores for 6 items • Generates a score from 0 to 14 • 3 levels of risk	0 – 3 *Low Risk*	4 – 5 *Moderate Risk*	6 – 14 *High Risk*
Identification of Seniors at Risk (ISAR) *Risk Tool*	• Risk of adverse health outcomes following an ED visit • Sum of scores for 6 items • Generates a score from 0 to 6 • 2 levels of risk	0 – 1 *No Clinical Concerns*	Not applicable	2 – 6 *Clinical Concerns*
InterRAI Preliminary Screener (PS) *Risk Tool*	• Decision tree • Identifies adults at risk of functional decline, repeat ED use, and poor post discharge outcomes (CIHI, 2022). PS collects standardized data and	1 – 2 Low risk	3 – 4 Moderate risk 3 self-sufficient 4 needs support	5 – 6 *High risk*

	includes items required to generate an Assessment Urgency Algorithm (AUA) Score generates a score from 1 – 6 • 6 levels of risk			
PRISMA-7 *Frailty Tool*	• Possible frailty • Generates a score from 0 to 7 • 2 levels of risk	0 – 2 *No Clinical Concerns*	4 – 5	6 – 7 *Clinical Concerns*
Triage Risk Screening Tool (TRST) *Risk Tool*	• Risk of ED revisit, hospitalization, or nursing home placement • 5 items	0 – 1	Not applicable	2+

Next Steps: Does the individual need further assessment (beyond presenting illness)?		
Low Risk	**Moderate Risk**	**High Risk**
Treat presenting illness No immediate need for further comprehensive assessment	Treat presenting illness Comprehensive assessment suggested, not urgent (e.g. OHaH, SGS)	Treat presenting illness Comprehensive assessment recommended and urgent (e.g. OHaH, SGS)

Potential Referrals and Interventions		
Low Risk	**Moderate Risk**	**High Risk**
• Education • Self-management support • Chronic disease management programs • Fall prevention programs • Fitness and exercise programs	**Depending on outcomes of additional assessment:** • OH atHome • Community Support Services • GEM Nurse (in ED) • DREAM Consultant (in ED) • Community memory clinic • Chronic disease management programs (e.g. diabetes) • Occupational Therapy • Physiotherapy • Clinical Pharmacist • Social Work • Community mental health services	**Moderate Risk Services +:** • Geriatric Medicine • Geriatric Psychiatrist • Specialized chronic disease programs (e.g. heart failure [HF], chronic obstructive pulmonary disease [COPD]) • Specialized geriatric services (e.g. outreach services, clinics) • Intensive Geriatric Services Worker • BSO

Final Reflections

This guide brings together the foundational elements needed for Emergency Departments to reliably identify older adults at risk of adverse outcomes. Each stage is designed to meet teams where they are, offering practical strategies that support consistent, senior friendly care aligned with the Operational Direction: Home First[34].

Across the West Region, Emergency Department staff encounter older adults with complex presentations, evolving needs, and varying levels of vulnerability. Effective early identification is not simply about completing a screening tool. It is about changing care, anticipating needs, preventing avoidable decline, supporting timely transitions, and connecting individuals with the right combination of supports. When screening is embedded at the right moment, interpreted with clinical judgement, tied to clear pathways, and reinforced through routine auditing, it becomes a dependable part of high-quality emergency care.

We thank you for your commitment to the early identification of older adults at risk for adverse outcomes, for contributing to and utilizing this guide. The strength of this work rests in a shared commitment to learn from one another, recognize vulnerability early, intervene with intention and provide care that is compassionate, coordinated, and aligned with the goals of older adults and their caregivers.

We leave you with the story of Joe T., a 79-year-old widow who arrived in the Emergency Department saying he *just felt a little weak*. Polite, quiet, and not wanting to be *a bother*, he looked like many older adults who come through the doors every day. But because all older adults aged 65 and over are screened at Emergency Department presentation, Joe T. received a brief frailty and risk screen the moment he was triaged.

Use of those screening tools changed everything. His screening revealed moderate frailty and high risk shaped by his social and environmental vulnerabilities, including his wife's recent passing, a son who lived hours away, an empty fridge, and missed medications. Screening allowed the team to see past his calm demeanor and recognize the loneliness, grief, functional decline and increasing risk of adverse health outcomes. Screening enabled the team to implement a plan to change Joe T.'s trajectory.

With this insight, the team mobilized, identifying risks in his safety, nutrition, medication management, and day to day functioning. Before Joe T. left, the Emergency Department team arranged OH atHome services, community physiotherapy, and connected him with the Alzheimer Society for ongoing support. Because compliance with screening tools is audited quarterly by Emergency Department leadership and quality teams, Joe T.'s experience was not a matter of luck. His experience reflected a reliable, monitored process that ensures older adults receive proactive, coordinated care. Joe T. went home safely, and in the weeks that followed, he did not need to return to the Emergency Department. With consistent check ins, help organizing medications, support for meals, and renewed peace of mind for his out-of-town son, Joe T. stabilized. Joe T.'s story reminds us that screening is not just another task. It is an act of noticing. It allows the Emergency Department to see the whole person, not just the presenting symptom, and for older adults like Joe T., that can change everything.

Additional Resources

BEHAVIOURAL SUPPORTS ONTARIO

- Erie St. Clair (ESC) BSO
- Hamilton Niagara Haldimand Brant (HNHB) BSO
- South West (SW) BSO
- Waterloo Wellington (WW) BSO

HEALTHCARE EXCELLENCE CANADA

- Hospitalised-Patient One-Year Mortality Risk (HOMR) Score Change Package

ONTARIO HEALTH

- Alternate Level of Care (ALC) Leading Practices Guide (Hospital)
- Alternate Level of Care (ALC) Leading Practices (Community)
- Clinical and Quality Standards
- Delirium: Care for Adults
- Delirium Aware Safer Healthcare (DASH)
- Emergency Department (ED) Leading Practices Toolkit
- Emergency Department (ED) Nursing Education, Retention and Workforce Program
- Emergency Department (ED) Peer-to-Peer Program
- Emergency Department (ED) Return Visit Quality Program
- Operational Direction: Home First (All Sectors)

ONTARIO HEALTH WEST

- Being a member of the OH_West_ALC_KES MS Team ensures you stay connected to Ontario Health West ALC partners and initiatives, including ALC Open Forums and Knowledge Exchange Sessions. If you are not already a member, please contact samantha.metler@ontariohealth.ca for access.

ONTARIO PALLIATIVE CARE NETWORK

- Tools to Support Earlier Identification for Palliative Care

PROVINCIAL GERIATRICS LEADERSHIP ONTARIO

- Defining Core Dementia Care Clinical Activities: Report of a Consultation on Dementia Care in Ontario
- Provincial Common Orientation to the Care of Older Adults
- Rehabilitative Care for Older Adults Living with or At Risk of Frailty

REGIONAL GERIATRIC PROGRAMS

- NESGC Implementation Playbook: Implementing the Standard of Care for Older Adults Living with or At-Risk of Frailty Across the North East
- Regional Geriatric Program Southwestern Ontario (RGP SWO)
- Regional Geriatric Program Central (RGPc)
- sfCare Self Assessment Tool
- The Senior Friendly Care (sfCare) Framework

SENIORS CARE NETWORK

- Customizable Templates for Frailty Screening and Management in the Emergency Department
- Frailty Screening and Management in the ED: Strategies to Avoid Unnecessary/Prolonged Hospital Admissions and ALC Rates
- Frailty Screening and Management in the Community: Guidance Document
- Frailty Screening and Management in Primary Care: Guidance Document
- Holistic Approach to Frailty Screening and Management in Community
- Integrating Frailty into Chronic Disease Management (CDM): Enhancing Care for Complex Older Adults

Appendix 1: Glossary

Term	Definition
Alternate Level of Care (ALC)	Defined by the Canadian Institute for Health Information as a description used in hospitals to refer to patients who occupy a bed but do not require the intensity of services provided in that care setting.
At-Risk	Older adults at risk of delayed transitions in care or adverse outcomes.
At-Risk Screening	Screening for the risk of adverse outcomes such as functional decline, delirium, hospitalization, high use of community services, death, etc. Completed by the triage clinician or the Most Responsible Nurse (MRN).
Assessment	Part of a process to characterize an individual's needs, strengths, and deficits to inform care planning and individualized treatment.
Comprehensive Geriatric Assessment (CGA)	A comprehensive, multidimensional evaluation of the medical, functional, cognitive, social, and environmental needs of an older adult, designed to improve quality of life, optimize independence, and guide coordinated care planning.
Dementia, Resource, Education, Advocacy, and Mentorship (DREAM) Program	A dementia focused Emergency Department intervention model that provides Dementia, Resource, Education, Advocacy, and Mentorship support to older adults and their care partners, with the goal of diverting non-acute dementia patients from unnecessary hospital admission and connecting them to timely, community-based supports.
Discharge Planning	An ongoing, iterative process that begins at admission and continues throughout the hospital stay to ensure a safe, effective, and timely transition from hospital to home or another care setting.
Early Identification (ID)	Early detection and intervention are essential in proactively addressing health concerns of older adults, with screening tools playing an important part of preventative and coordinated care that can improve wellbeing for older adults and caregivers.
Electronic Health Record (EHR)	Includes all Electronic Medical Record (EMR) functions but goes further by enabling interoperability and information sharing across multiple healthcare settings.
Electronic Medical Record (EMR)	A digital version of a patient's paper chart used within a single healthcare organization. It contains clinical information such as medical history, diagnoses, medications, and treatment documentation, but is not designed for easy sharing across different organizations.

Frailty	Frailty is a state of increased vulnerability to stressors resulting from age-related accumulation of impairments in multiple systems, with reduced physical reserve and loss of function across multiple body systems.
Frailty Screening	To identify if an individual is at risk of frailty or living with frailty (very mild, mild, moderate, severe).
Geriatric Care	Provided by health care professionals who specialize in the care of older adults (e.g. Geriatrician, GEM Nurse). Geriatric specialists use a comprehensive geriatric assessment to diagnose, treat and rehabilitate older adults with frailty (or those at risk of becoming frail) with complex and multiple medical, functional, and psychosocial issues.
Geriatric Emergency Management (GEM) Nurse	A Registered Nurse in the Emergency Department with specialized geriatric expertise that conducts focused assessments to identify frailty and geriatric syndromes, implement timely interventions, mitigate risk, and collaborate with interdisciplinary teams and community supports to promote safe discharge and continuity of care.
Geriatrician	A specialist medical doctor who is certified in Internal Medicine and Geriatric Medicine and provides comprehensive, specialized assessment and care for older adults with complex medical, cognitive, functional, and psychosocial needs.
Health Information System (HIS)	A broad, organization-wide digital ecosystem that includes the EHR/EMR plus administrative, financial, operational, and analytical systems. Examples include scheduling, billing, Human Resources, materials management, and enterprise reporting, covering the full spectrum of clinical, business, and operational functions in a healthcare organization.
Older Adult	Defined in the context of the sfCare Framework as someone who is 65 years or older.
Screening	Throughout this document, we have used the term screening to refer to the process of case finding for older individuals living with frailty, and to allow for segmenting the identified population into levels of risk.
Screening Tools	Evidence-based instruments, tests, or questionnaires used to identify individuals who may be at risk for a disease or condition, enabling earlier assessment, diagnosis, or preventive intervention.
Senior Friendly Care (sfCare)	Evidence-based, preventive and proactive care for the unique needs of older adults. It is not an add-on to care; it is essential care that should be provided at all times. Senior friendly processes of care include: delirium, mobilization, social engagement, nutrition, pain, polypharmacy, and urinary incontinence. The sfCare Framework provides the foundation for what sfCare looks like in an organization, including the need for all care providers to have the knowledge and skill required to provide sfCare.

Appendix 2: Screening Approaches Across the System

Several screening approaches can be used across the system to identify vulnerabilities in older adults and may be used in combination to provide a more complete picture:

Screening Approach	Description	Examples
At-Risk Screening	• Rapid scan for individuals more likely to be at risk of adverse outcomes (e.g., experiencing new change in cognition or function, socioeconomic instability, or requiring support for activities of daily living [ADLs] etc.). • This type of initial scanning aims to flag patients who are likely to experience adverse outcomes (e.g., functional decline, increased hospitalizations, high use of community services, death) during hospitalization or following discharge from hospital and who would benefit from additional supports and interventions. • This initial scanning, or flagging, is usually done as part of triage processes. • Once flagged, such individuals would be directed for further screening to confirm the presence or absence of additional risk factors (e.g. repeat hospitalizations, polypharmacy, nature of memory problems, rapid decline in function), or areas of concern in specific domains (e.g. falls, pain) to identify those individuals requiring more thorough assessment.	Identification of Seniors at Risk (ISAR) interRAI Preliminary Screener (PS) Triage Risk Screening Tool (TRST)
Caregiver Screening	• Among older adults living with frailty, many caregivers report distress. • Assessing and screening caregivers allows the health care team to recognize what caregivers need and support them in continuing their role of caring for older adults.	Zarit Burden Interview (ZBI) Caregiver Health Self Assessment Questionnaire Modified Caregiver Strain Index (MCSI)

Delirium Screening	• Ontario Health's Delirium Quality Standard recommends the screening of people for delirium on initial contact with the health care especially when they present to hospital. • This type of screening aims to detect confusion, disorientation, including sudden changes in cognition which are potentially reversible (e.g., infection).	4 'A's Test (4AT) Confusion Assessment Method for the Emergency Department (CAM-ED)
Falls Screening	• Across Ontario, 2.5% of older adults present with repeat ED visits due to falls, and 6.5% experience a hospitalization due to falls. • Falls screening is recommended for older adults living with frailty presenting to the ED, even if this is not the current presenting problem.	Morse Fall Scale (MFS) Staying Independent Checklist (SIC) World Falls Guideline Screen
Frailty Screening	• Identifies individuals who are at risk of frailty or are currently living with frailty, as well as the severity of frailty (very mild, mild, moderate, severe). • This type of screening aims to capture a baseline understanding of older adults' vulnerability, physical reserve and function, and health risks. This includes function across physical, cognitive, mental, and social health domains as well as the interaction across them. • For further guidance on proactive frailty screening and management, refer to the Seniors Care Network's Frailty Screening and Management in the Emergency Department: Strategies to Avoid Unnecessary/Prolonged Hospital Admissions and ALC Rates[40]	Frailty Index (FI) The Canadian Triage and Acuity Scale (CTAS) Frailty Modifier Clinical Frailty Scale (CFS) PRISMA-7
Problem Specific Screening	• Additional problem-specific screening may be required, particularly where highly prevalent conditions may be anticipated. • For further guidance on screening tools to use in specific domains or areas of concern, refer to the Rehabilitative Care Alliance and Provincial Geriatrics Leadership Ontario Framework for Rehabilitative Care for Older Adults Living with or At Risk of Frailty	

Appendix 3: Early ID of a Palliative Approach to Care

Tool	Description	Key Benefits/Considerations
GSF Prognostic Indicator Guidance (PIG)	• **Aim**: To identify patients in their last year of life who may benefit from palliative care • **Description:** A 3-step process multi-page tool that uses the surprise question, along with general and disease specific indicators of decline. Includes an assessment paradigm. • **Setting**: Applicable across care settings • **Disease States**: Not disease specific	• Extremely brief • Strong trigger for assessment and ACP discussions • Uses clinical indicators and the surprise question to recognize palliative needs early
HOMR	• **Aim**: To predict 12-month mortality • **Description**: An automated tool that uses administrative data (e.g., admitting service, arrival by ambulance, re-admission, Charlson Comorbidity index score, etc.) to calculate mortality risk at 12- months after an acute admission and sends a notification for patients whose risk exceeds a preset threshold • **Setting**: Applicable only in acute care settings • **Disease States**: Not disease specific	• **No added workload** • Fully automated • Recognized for Canadian excellence • Strong trigger for timely goals-of-care conversations • Healthcare Excellence Canada: HOMR Change Package
NECPAL	• **Aim**: To identify patients with limited life prognosis (less than 1 year) who may benefit from palliative care • **Description**: A 1-2 page checklist that starts with the surprise question and uses yes/no questions (patient or family request or need for PC; general clinical indicators of severity and progression, including co-morbidity, resource use; and disease-specific indicators). This may require some data that may not be readily available in all settings. • **Setting**: Applicable across care settings • **Disease States**: Not disease specific	• Captures symptom burden and psychosocial needs • Suited for interprofessional teams

RESPECT Risk Evaluation for Support: Prediction for Elder-life in the Community Tool	• **Aim:** To calculate life expectancy for the frail • **Description**: Online algorithm that uses patient demographics (age, gender, marital status), co-morbidities, functional and cognitive status, symptoms, and health care use. Can be used by clinicians, patients and caregivers. • **Setting**: Applicable across care settings but requires online access • **Disease States**: Not disease specific	• Supports earlier goals-of-care and care-planning conversations through a survival estimate based on function, cognition, symptoms, comorbidities, and health care use • Useful across community settings • Requires online access and should complement clinical judgment
SPICT	• **Aim**: To identify patients at risk of deteriorating and dying with a life-limiting illness who may benefit from palliative care • **Description**: A single page tool that includes general (e.g., weight loss, hospital admissions, etc.) and broad specific disease indicators (e.g., breathlessness at rest for heart and respiratory disease). Includes an assessment paradigm. • **Setting**: Applicable across care settings • **Disease States**: Not disease specific	• Simple to use • Effective across conditions • Aligns with the Gold Standards Framework[17] "Identify" step • Checklist identifying people with deteriorating health who may benefit from a palliative approach

References

(1) Alberta Health Services. (n.d.). *Blaylock discharge planning risk assessment screen.* https://www.albertahealthservices.ca/frm-09373.pdf

(2) Beauchet, O., Cooper-Brown, L. A., Lubov, J., Allali, G., Afilalo, M., & Launay, C. P. (2022). "Emergency Room Evaluation and Recommendations" (ER^2) tool for the screening of older adult emergency department visitors with major neurocognitive disorders: Results from the ER^2 database. *Frontiers in Neurology, 12*, 767285. https://doi.org/10.3389/fneur.2021.767285

(3) Bergman, H., Ferrucci, L., Guralnik, J., Hogan, D. B., Hummel, S., Karunananthan, S., & Wolfson, C. (2007). Frailty: An emerging research and clinical paradigm—Issues and controversies. *The Journals of Gerontology, Series A: Biological Sciences and Medical Sciences, 62*(7), 731–737. https://doi.org/10.1093/gerona/62.7.731

(4) Brennan, L., Bentley, K., Edge, L., Molamphy, A., Keane, B., Enright, A., & Keogan, F. (2024). Flagging frailty in the emergency department: A system to identify and visualize frailty. *Age and Ageing, 53*(Suppl. 4). https://doi.org/10.1093/ageing/afae178.151

(5) Bullard, M. J., Musgrave, E., Warren, D., Unger, B., Skeldon, T., Grierson, R., van der Linde, E., Swain, J., O'Brien, K., Holroyd, B., & Clemons, M. (2017). Revisions to the Canadian Emergency Department Triage and Acuity Scale (CTAS) Guidelines 2016. *Canadian Journal of Emergency Medicine, 19*(S2), S18–S27. https://doi.org/10.1017/cem.2017.365

(6) Canadian Frailty Network. (2023). *What is frailty?* https://www.cfn-nce.ca/frailty-matters/what-is-frailty/

(7) Canadian Institute for Health Information. (2022). *interRAI CA (IRRS): Using the assessment urgency algorithm as a decision-support tool* [Job aid]. https://www.cihi.ca/sites/default/files/document/interrai-ca-irrs-assessment-urgency-jobaid-en.pdf

(8) Canadian Institute for Health Information. (2026). *Hospitalized seniors at risk of frailty.* https://www.cihi.ca/en/indicators/hospitalized-seniors-at-risk-of-frailty

(9) Colognesi, S., Fagnani, C., Panceri, F., Ruggero, M., Di Florio, F., Passoni, C., Fantini, V., Boracchi, P., Orenti, A., Fumagalli, M. A., & Vergani, M. (2021). Hospital discharge: Testing the "Blaylock Risk Assessment Screening Score" in a surgical department. A*cta Bio-Medica: Atenei Parmensis*, 92(S2), e2021039. https://doi.org/10.23750/abm.v92iS2.10761

(10) Dalhousie University. (n.d.). *Clinical frailty scale (CFS).* Division of Geriatric Medicine. https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html

(11) DeGroot, L., Pavlovic, N., Perrin, N., Dy, S. M., Szanton, S., Gilotra, N., Denfield, Q., Miller, H., McIlvennan, C., Davidson, P., & Abshire, M. (2024). The impact of unmet palliative care needs and physical frailty on clinical outcomes: A prospective study of adults with heart failure. *Journal of Cardiac Failure, 30*(1), 129. https://doi.org/10.1016/j.cardfail.2023.10.032

(12) Duc, S., Fernandez, C., Moheb, B., Dang, V. M., Bloch, F., Videau, M. N., Tournier Louvel, S., Ducastaing, L., Couturier, P., & Salles, N. (2015). Triage Risk Screening Tool (TRST) in screening elderly patients requiring intervention of a mobile geriatric team: Results of a pilot study. *Geriatrics, Psychology and Neuropsychiatry of Aging,* 13(1), 55-62.

(13) Elder, N. M., Bambach, K. S., Gregory, M. E., Gulker, P., & Southerland, L. T. (2021). Are geriatric screening tools too time-consuming for the emergency department? A workflow time study. *Journal of Geriatric Emergency Medicine*, 2(6).

https://www.gedcollaborative.com/wp-content/uploads/2024/09/Are-Geriatric-Screening-Tools-Too-Time-Consuming-for-the-Emergency-Department-A-Workflow-Time-Study.pdf

(14) Elliott, J., Gregg, S., & Stolee, P. (2016). *Implementing and evaluating the Assessment Urgency Algorithm in primary care and an emergency department.* University of Waterloo.

(15) Furlong, K. R., O'Donnell, K., Farrell, A., Mercer, S., Norman, P., Parsons, M., & Patey, C. (2023). Older adults, the "social admission," and nonspecific complaints in the emergency department: Protocol for a scoping review. *JMIR Research Protocols, 12*, e38246. https://doi.org/10.2196/38246

(16) Geriatric Emergency Department Collaborative. (2025). *Home.* https://gedcollaborative.com/

(17) Gold Standards Framework Centre. (n.d.). *Free resources for professionals: The GSF proactive identification guidance (PIG).* https://www.goldstandardsframework.org.uk/training-accreditation/free-resources-professionals/

(18) Grand River Hospital. (2016). *New screening tool helps identify patients in Emergency Department who need additional supports.* https://www.grhosp.on.ca/news/2016/aua-emerg

(19) Health Quality Ontario. (2024). *Palliative care: Care for adults with a serious illness.* https://www.hqontario.ca/evidence-to-improve-care/quality-standards/view-all-quality-standards/palliative-care

(20) InterRAI. (2020). *The interRAI ED assessment system: Enabling rapid screening and assessment for older adults in the emergency department.* https://interrai.org/wp-content/uploads/2020/07/interrai-ed-a4.pdf

(21) Lalla, R., Sammy, I., Paul, J., Nunes, P., Ramcharitar-Maharaj, V., & Robertson, P. (2017). Assessing the validity of the Triage Risk Screening Tool in a third-world setting. *Journal of International Medical Research, 46*(2), 557–563. https://doi.org/10.1177/0300060517714935

(22) Loddo, S., Costaggiu, D., Palimodde, A., Cogoni, E., Putzu, S., Serchisu, L., Laconi, R., Scuteri, A., & Mandas, A. (2021). Emergency department: Risk stratification in the elderly. Journal of Gerontology and Geriatrics, 69, 164 – 170. https://doi.org/10.36150/2499-6564-N352

(23) McCusker, J. (2022). *Identification of Seniors at Risk (ISAR): Screening tool manual (Version 2).* St. Mary's Research Centre. https://www.mcgill.ca/cansmart/sites/cansmart/files/isar_-_manual_v2_en_2022-03-24.pdf

(24) Mohamed, A., McCormack, C., Sooknarine-Rajpatty, A., Barry, L., Gabr, A., Leahy, A., Carroll, I., Cunningham, N., Prendiville, T., Shanahan, E., Higginbotham, O., Hembrecht, S., Walsh, M., Barry, K., O'Connor, M., & Galvin, R. (2025). The diagnostic and predictive accuracy of the PRISMA-7 screening tool for frailty in older adults: A systematic review and meta-analysis. *BMC Geriatrics, 25*(1), 420. https://doi.org/10.1186/s12877-025-06094-2

(25) Mowbray, F. I., Brousseau, A., Mercier, E., Melady, D., Edmond, M., & Costa, A. P. (2020). Examining the relationship between triage acuity and frailty to inform the care of older emergency department patients. *Canadian Journal of Emergency Medicine, 22*(1), 74-81.

(26) Mowbray, F. I., Heckman, G., Hirdes, J. P., Costa, A. P., Beauchet, O., Eagles, D., Perry, J. J., Sinha, S., Archambault, P., Wang, H., Jantzi, M., & Herbert, P. (2023). Examining the utility and accuracy of the interRAI Emergency Department Screener in identifying high-risk older emergency department patients: A Canadian multiprovince prospective cohort study. *JACEP Open, 4*(1), e12876. https://doi.org/10.1002/emp2.12876

(27) Mowbray, F. I., Heckman, G. A., Costa, A. P., & Hirdes, J. P. (2023). Screening older adults in the emergency department: A narrative review of geriatric screening tools and recommendations for practice. *Canadian Journal of Emergency Medicine, 25*(2), 123–132.

(28) O'Caoimh, R., Costello, M., Small, C., Spooner, L., Flannery, A., O'Reilly, L., Heffernan, L., Mannion, E., Maughan, A., Joyce, A., Molloy, D. W., & O'Donnell, J. (2019). Comparison of frailty screening instruments in the emergency department. *International Journal of Environmental Research and Public Health, 16*(19), 3626. https://doi.org/10.3390/ijerph16193626

(29) Oncology Nursing Society. (2024). Early palliative care improves patient and caregiver quality of life. *Clinical Journal of Oncology Nursing, 28*(5), 496–501.

(30) Ontario Collaborative for Aging Well. (2022). *Consensus statement: Care for the older adult with complex health conditions—Reframing frailty in an Ontario context.* Provincial Geriatrics Leadership Ontario. https://geriatricsontario.ca/wp-content/uploads/2022/05/2022-June-2-Consensus-Statement-on-Frailty.pdf

(31) Ontario Health. (2019). *Palliative care health services delivery framework: Recommendations for a model of care to improve palliative care in Ontario.* https://www.ontariohealth.ca/content/dam/ontariohealth/documents/palliative-adult-care-community-setting.pdf

(32) Ontario Health. (2019). *Tools to support earlier identification for palliative care.* Ontario Palliative Care Network. https://ontariohealth.ca/content/dam/ontariohealth/documents/palliative-tools-support-earlier-identification.pdf

(33) Ontario Health. (2021). *The alternate level of care (ALC) leading practices guide: Preventing hospitalization and extended stays for older adults.* https://www.ontariohealth.ca/content/dam/ontariohealth/documents/alc-leading-practices%20guide.pdf

(34) Ontario Health. (2025). *Operational direction: Home First.* https://www.ontariohealth.ca/news/operational-direction-home-first

(35) Ontario Health. (2025). *Operational direction: Priorities for spring/summer 2025.* https://www.ontariohealth.ca/news/operational-direction-priorities-spring-summer-24-25

(36) Pan American Health Organization. (2012). *Improving chronic illness care through integrated health service delivery networks.* https://iris.paho.org/server/api/core/bitstreams/085589dd-5ce3-43f2-aad9-d1cafb6c7763/content

(37) Provincial Geriatrics Leadership Ontario. (2025). *Screening approaches and frailty pathways* [Presentation slides]. *The role of screening older adults: Alternate Level of Care (ALC) Knowledge Exchange Session.* Ontario Health West.

(38) Provincial Geriatrics Leadership Ontario. (2025). *Screening versus assessment and benefits of a screening program* [Presentation slides]. *Assessment and care planning for older adults: Alternate Level of Care (ALC) Knowledge Exchange Session.* Ontario Health West.

(39) Reid, L., Lahey, W., Livingstone, B., & McNally, M. (2018). Ethical and legal implications of frailty screening. *The Journal of Frailty & Aging, 7*(4), 224–232. https://doi.org/10.14283/jfa.2018.31

(40) Seniors Care Network. (2025). *Frailty screening & management in the emergency department: Strategies to avoid unnecessary/prolonged hospital admissions and ALC rates.* Seniors Care Network. https://fe1c8b0b-1f0b-4ee0-8fe1-153417952f4e.filesusr.com/ugd/d93231_07bd3e6e5d474f9a934ae1d006a4ef47.pdf

(41) Seniors Care Network. (2025). *Screening approaches, frailty, and frailty pathways* [Presentation slides]. *The role of screening older adults: Alternate Level of Care (ALC) Knowledge Exchange Session.* Ontario Health West.

(42) Sezik, S. (2023). A 30-day risk assessment of geriatric patients in the emergency department: A comparison of ISAR and TRST scores. Turkish Journal of Geriatrics, 26(1), 27-36. https://doi.org/10.29400/tjgeri.2023.328

(43) Stolee, P., Elliott, J., Giguere, A. M., Mallinson, S., Rockwood, K., Sims-Gould, J., Gregg, S., Brierley, M., Tarraf, R., Hastings, S., & Coudert, L. (2022). Improving the health outcomes of older adults living with frailty: Primary care implementation guide for providers in Ontario. Waterloo, ON: University of Waterloo.

(44) Stow, D., Spiers, G., Matthews, F. E., & Hanratty, B. (2019). What is the evidence that people with frailty have needs for palliative care at the end of life? A systematic review and narrative synthesis. *Palliative Medicine, 33*(4), 399–414. https://doi.org/10.1177/0269216319828650

(45) Walston, J., Buta, B., & Xue, Q. L. (2018). Frailty screening and interventions: Considerations for clinical practice. *Clinics in Geriatric Medicine, 34*(1), 25–38. https://doi.org/10.1016/j.cger.2017.09.004

(46) West Health Institute. (2024, March 22). *The gold standard in geriatric emergency department care: Gary and Mary West Senior Emergency Care Unit at UC San Diego Health.* https://westhealth.org/wp-content/uploads/2024/06/UCSD-Case-Brief_20240322_1453_FINAL.pdf