QUALITY STANDARDS

New Falls and Frailty Quality Standards

Ontario Collaborative for Aging Well Discussion Forum

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Ontario Health

Falls and Frailty Quality Standards

Background & Objectives

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Objectives

- Introduce Ontario Health's new *Falls in Adults* and *Frailty in Adults* quality standards and their role in defining high-quality care for older adults
- Explore the top 5 areas of focus for each quality standard and discuss the opportunities to support quality improvement across care settings in Ontario
- Provide an opportunity to ask questions about the quality standards

Quality Standards Program

Quality standards define high-quality care for conditions where significant variations or gaps exist. They are grounded in clinical evidence and lived experience.

1 Data-driven **2 Patient-centred** **3 Equity-focused**

Program vision

A blueprint for a better-functioning health system with smooth transitions and consistent care:

- Empower patients and care partners to advocate for their care
- Guide clinicians with evidence-based quality statements
- Enable organizations to measure and improve care quality
- Ensure consistent care across the province

Progress to date

44 quality standards available, updated every 5 years. Focus has shifted to *implementation* and demonstration of impact:

- Priority upstream areas: chronic conditions, mental health, addictions, transitions, women's health
- Reducing unwarranted variation and inequitable access across populations and regions
- Mainpro+ credits for physicians via the "Understanding Quality Standards in Primary Care" program
- Successful implementation of Schizophrenia and Hip Fracture quality standards with hospital partners

Definitions

Fall:

- An unexpected event that results in a person inadvertently coming to rest on the ground or a lower surface, with or without injury.
- People at risk of falls include all adults who self-report fear of falling, have a history of falls or near falls, have certain comorbidities, or have impairments to gait, balance, or mobility.

Frailty:

- A state of health complexity and increased vulnerability arising from the interaction of complex health conditions, typically related to declines in physical, cognitive, mental, and social health.
- *Frailty* describes a constellation of complex health and social conditions; it is not a diagnosis, and it is not meant to be used as a label for people.

Why Falls and Frailty Matter

About 1 in 5

Canadians older than 65 years have frailty.[1]

Frailty is associated with higher rates of emergency department visits, hospitalizations, home care use, and long-term care home admission.[1]

About 20%–30%

of Canadians older than 65 years experience 1 or more fall each year.[2]

Falls are a leading cause of preventable injury-related hospitalization in older adults. [2]

1. Gilmour H, Ramage-Morin PL. Association of frailty and pre-frailty with increased risk of mortality among older Canadians. Health Rep. 2021 Apr 21;32(4):15-26.
2. Ontario Fall Prevention Collaborative. An integrated approach to preventing fall-related injuries among older adults in Ontario [Internet]. Toronto (ON): Ontario Neurotrauma Foundation; 2019. Available from: https://geriatricsontario.ca/wp-content/uploads/2021/03/OntarioFallPreventionCollaborative_positionpaper_final_11-06.pdf

The Impact of Frailty

Frailty is widespread among older adults in Ontario, and the prevalence is anticipated to grow.[1]

13.8%
of adults aged ≥ 66 years experience frailty.[2]

About 314,000
older adults in Ontario live with significant frailty.[2]

60%
of people identified with frailty are women,[2] but men face a higher mortality risk.[1]

Because of Ontario's aging population, identifying frailty early is a system-level priority, requiring robust screening and follow-up.[1]

Note: These prevalence figures are drawn from frailty signals in clinical administrative data across multiple care settings but reflect a floor estimate that may underdetect frailty compared to clinical assessments.

1. Gilmour H, Ramage-Morin PL. Association of frailty and pre-frailty with increased risk of mortality among older Canadians. Health Rep. 2021;32(4):15-26.
2. Seitz D. A population-based study of older adults in Ontario: dementia, frailty and utilization of physician specialist services [Internet]. Hamilton (ON): Provincial Geriatrics Leadership Office of Ontario; 2019 [cited 2026 Jul 13]. Available from: geriatricsontario.ca/wp-content/uploads/2019/08/PGLO-report-May15r.pdf. Based on the population of Ontario aged ≥ 66 years as of April 2018. Frailty was identified in administrative data based on records of long-term care, palliative care, or 2 or more frailty-related conditions.

The Impact of Falls

Falls are the leading cause of preventable injury-related hospitalizations among older adults in Canada, accounting for 85% of cases.[1]

Each year, **20% to 30%** of older adults in Canada report a fall, but the **real toll is higher** since many people don't report a fall unless it causes serious injury.[2-3]

The prevalence of falls among older adults increases with age. In 2017/18, 9.6% of adults aged ≥ 85 years reported a fall-related injury – nearly **double the rate** among those aged 65 to 69 years (5.5%).[4]

People with frailty are **far more likely to be hospitalized for a fall** than those without frailty; the greater the frailty severity, the higher the fall risk.[5]

1. Public Health Agency of Canada. Seniors' falls in Canada: second report [Internet]. Ottawa (ON): The Agency; 2014 [cited 2026 May]. Available from: canada.ca/content/dam/phac-aspc/migration/phac-aspc/seniors-aines/publications/public/injury-blessure/seniors_falls-chutes_aines/assets/pdf/seniors_falls-chutes_aines-eng.pdf
2. Public Health Ontario. Prioritization of older adult fall prevention indicators in Ontario [Internet]. Toronto (ON): King's Printer for Ontario; 2022 [cited 2026 Apr]. Available from: publichealthontario.ca/-/media/Documents/P/2022/prioritization-older-adult-fall-prevention-indicators-ontario.pdf?sc_lang=en&rev=e415b96bfa5245659f87af3787d59115&hash=7BC0127F81F26DCC70C75FDA3E9C869C
3. Montero-Odasso M et al. World guidelines for falls prevention and management for older adults: a global initiative. Age Ageing. 2022;51(9):afac205.
4. Public Health Agency of Canada. Surveillance report on falls among older adults in Canada [Internet]. Ottawa (ON): The Agency; 2022 [cited 2026 Jul 13]. Available from: https://www.canada.ca/en/public-health/services/publications/healthy-living/surveillance-report-falls-older-adults-canada.html (based on 2017/18 data from the Canadian Community Health Survey).
5. Hatcher VH et al. Association of clinical frailty scores with hospital readmission for falls after index admission for trauma-related injury. JAMA Netw Open. 2019;2.

Falls and Frailty Quality Standards

Inside the Quality Standards

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Scope

- The *Falls in Adults* and *Frailty in Adults* quality standards address care for adults aged 18 years and older who have experienced a fall, who are at risk of falling, who have frailty, or who are at risk of frailty.
- Focus on older adults, aged 65 years and older, and their care partners.
- Care provided in all health care settings, including acute care, emergency, primary care, regional geriatric program, long-term care, palliative care, and other home and community care settings, as well as referral to specialized care.

Key Inputs for Quality Standard Development

Evidence, clinical expertise, patient experience, and public input drive quality standard development.

INPUTS

1. **Clinical practice guidelines & HTAs**
2. **Data analytics**
3. **Engagement with key audiences**
4. **Public feedback**

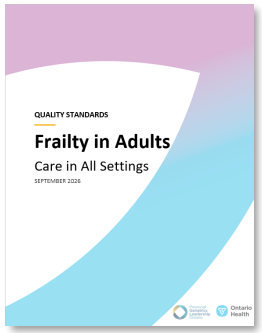
SYNTHESIS & PRIORITIZATION

Quality Standard Advisory Committee

reviews and interprets the evidence and feedback

Topic prioritization

OUTPUT



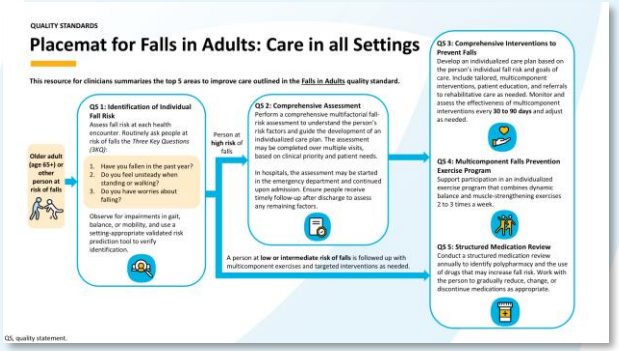
Quality standard

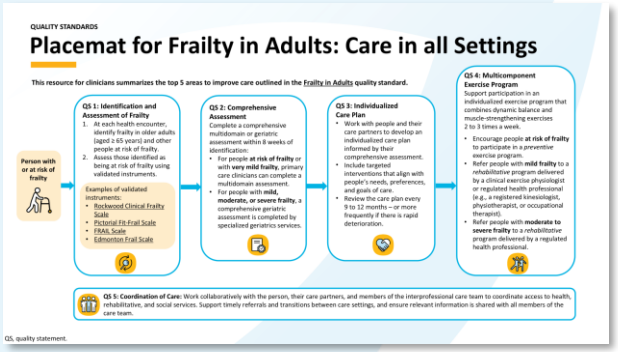
Clear statements describing what high-quality care looks like

Quality Standard Resources

Quality Standards

Patient Guides





Care Pathways and Placemats

QR code for the *Falls* quality standard and resources

QR code for the *Frailty* quality standard and resources

Falls and Frailty in Adults: Topic Areas

Falls	Frailty
1 Identification of individual fall risk	1 Identification and assessment of frailty
2 Comprehensive assessment	2 Comprehensive assessment
3 Comprehensive interventions to prevent falls	3 Individualized care plan
4 Multicomponent falls prevention exercise program	4 Multicomponent exercise program
5 Structured medication review	5 Coordination of care

What is inside the quality standards?

Quality Statement

Quality Statement 1: Identification of Individual Fall Risk

Older adults and other people at risk of falls have their individual fall risk identified routinely during health care encounters.

Sources: National Institute for Health and Care Excellence, 2025[24] | Registered Nurses' Association of Ontario, 2017[25] | World Guidelines for Falls Prevention and Management for Older Adults, 2022[19]

Audience Statements

What This Quality Statement Means

For Clinicians

Ask all older adults and other people at risk of falls about any falls, near falls, slips, or fear of falling within the past 12 months at least once a year during routine appointments and if there have been any changes in health status. For those who report falling, feeling unsteady when standing or walking, or having a fear of falling, observe for impairments in gait, balance, or mobility, and use clinical judgment to identify individual fall risk. A fall-risk assessment using a setting-appropriate validated risk prediction tool that is in your scope of practice can also be considered. For people identified as being at high risk of falls, perform a comprehensive multifactorial fall-risk assessment (see quality statement 2).

Definitions

Definitions

Older adults: Adults aged 65 years and older.

At risk of falls: Includes all adults who self-report fear of falling, have a history of falls or near falls, have certain comorbidities, or have impairments to gait, balance, or mobility.[19,24,25]

Some people with disabilities may also be at risk of falls. If it is determined that a person with a disability is at risk of falls or has fallen, it is imperative that they receive tailored care plans with appropriate accommodations.

Identified routinely: People at risk of falls have their individual fall risk identified at least once a year and after any major change in health status. The standardized identification of individual fall risk is completed by a clinician and includes the following:

NEW! Guidance to Support Implementation

Guidance to Support Implementation

Organizations can use the following resources – as relevant to their care setting, population, and local context – to identify opportunities for quality improvement and select change ideas to implement:

- ALC Leading Practices Guide: Preventing Hospitalization and Extended Stays for Older Adults:
  - Organizational Leadership & Support: Leading Practices A.5, A.6, A.12
  - Early Identification & Assessment: Leading Practices B.1, C.4.a
  - Care Plan Development & Ongoing Reassessment: Leading Practices B.5, C.9
  - Intervention/Senior-Friendly Care: Leading Practice B.6
- Leading Practices in Community-Based Early Identification, Assessment & Transition: Preventing Alternate Level of Care:
  - Early Identification & Assessment: Leading Practices 2, 3
- Home First Operational Direction: Directions A1, B1, C1

Further information about planning, implementing, measuring, and sustaining local quality improvement initiatives can be found in Ontario Health's Getting Started Guide: Putting Quality Standards Into Practice and the North East Specialized Geriatric Centre's NESGC Implementation Playbook.

QS 2: Comprehensive Assessment – *Falls*

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

QS, quality statement.

QS 2: Comprehensive Assessment – *Frailty*

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

QS, quality statement.

Register for the Provincial Webinar!

- **Join us Friday, October 29, at 9:30–10:30 a.m.**
- Introducing the Ontario Health *Falls in Adults* and *Frailty in Adults* quality standards and resources to support evidence-based care
- Click here or scan the QR code to register!

Falls and Frailty Quality Standards

Implementation

Zil Nasir

Building on Existing Guidance

Each quality statement is mapped to ALC Leading Practices and the Home First Operational Direction, reinforcing provincial guidance rather than competing with it.

Start with the quality standard

Each quality statement laid out one at a time.

Quality Statement 1: Identification of Individual Fall Risk

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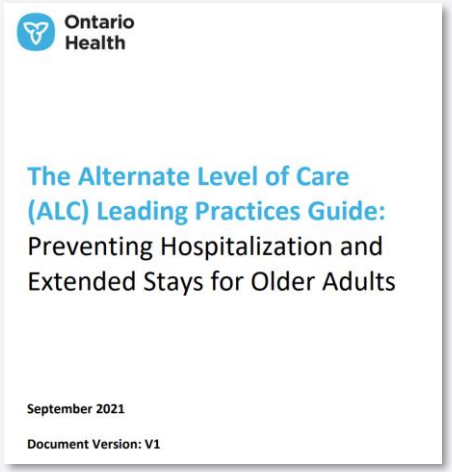
Sources: National Institute for Health and Care Excellence, 2025[24] | Registered Nurses' Association of Ontario, 2017[25] | World Guidelines for Falls Prevention and Management for Older Adults, 2022[19]

Map and align with SMEs

We worked with SMEs to match each statement to relevant ALC Leading Practices and Home First Operational Directions, ensuring that intent and wording aligned.



Ontario Health

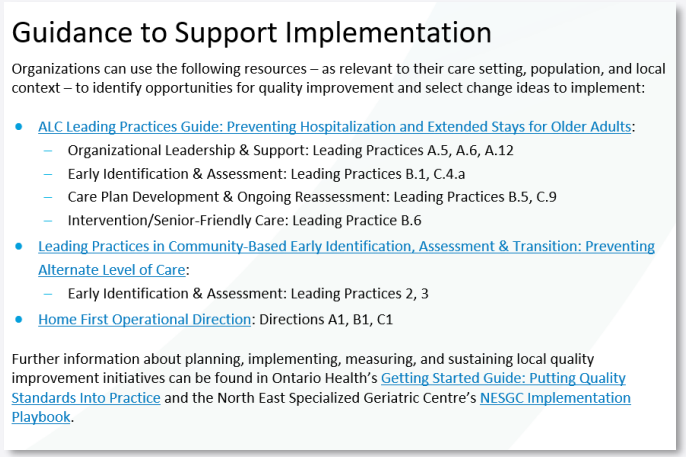
The Alternate Level of Care (ALC) Leading Practices Guide: Preventing Hospitalization and Extended Stays for Older Adults

September 2021

Document Version: V1

Build it into the standard

Each quality statement is linked to relevant ALC Leading Practices and Home First Operational Directions, supported by the *NESGC Implementation Playbook*.



Guidance to Support Implementation

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  - Organizational Leadership & Support: Leading Practices A.5, A.6, A.12
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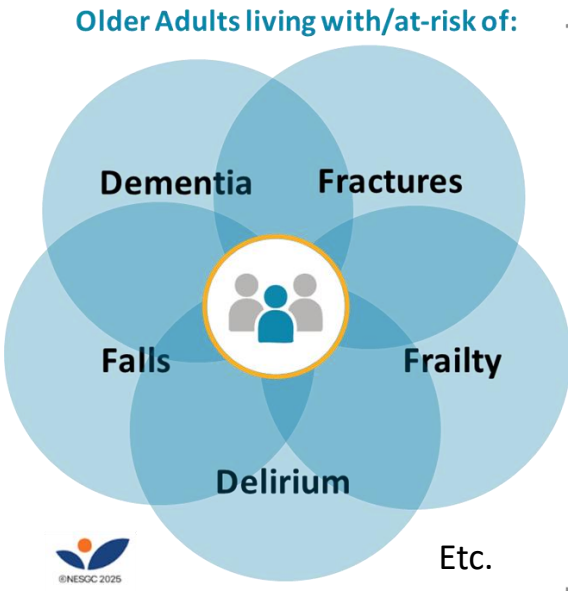
  - Intervention/Senior-Friendly Care: Leading Practice B.6
- Leading Practices in Community-Based Early Identification, Assessment & Transition: Preventing Alternate Level of Care:
  - Early Identification & Assessment: Leading Practices 2, 3
- Home First Operational Direction: Directions A1, B1, C1

Further information about planning, implementing, measuring, and sustaining local quality improvement initiatives can be found in Ontario Health's Getting Started Guide: Putting Quality Standards Into Practice and the North East Specialized Geriatric Centre's NESGC Implementation Playbook.

ALC, alternate level of care; NESGC, North East Specialized Geriatric Centre; SME, subject matter expert.

Older Adults: One Population Across Provincial Priorities

One population with overlapping clinical presentations and needs.



Ontario has developed numerous provincial quality standards, clinical guidelines, and operational approaches to support older adults with or at risk of frailty.

Same population

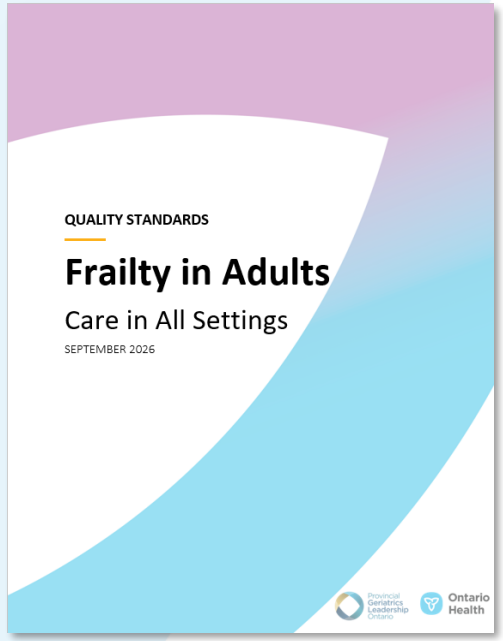
Quality Standards:

- Behavioural Symptoms of Dementia
- Dementia: Care in the Community
- Delirium: Care for Adults
- Hip Fracture
- Transitions Between Hospital and Home
- Palliative Care
- Etc.

Provincial Clinical Guidance:

- ALC Leading Practices Guide
- Home First Operational Direction
- Senior Friendly Care
- Rehab Best Practice Framework
- Etc.

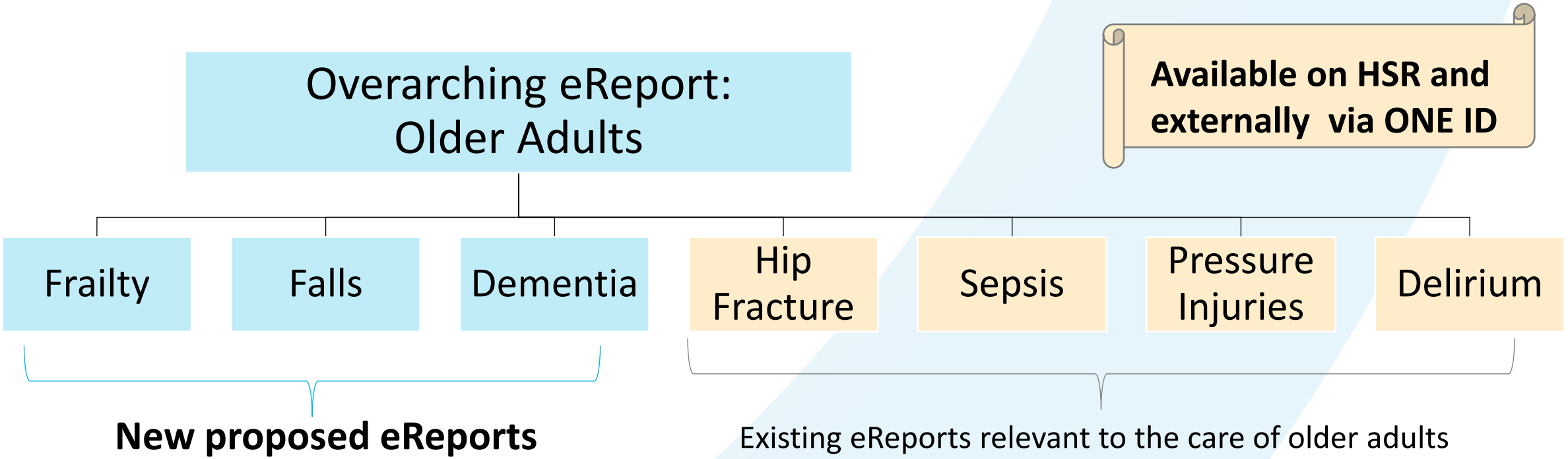
The *Frailty* quality standard aligns with and builds on these existing provincial guidelines for the same population.



Aligning approaches to support improved care for older adults across care settings

Quality eReport Ecosystem for Older Adults

An integrated suite of eReports will bring together data on geriatric syndromes, strengthening the implementation and impact of quality standards. The indicators will be hospital-focused, giving clinicians and system leaders a cohesive view of care and outcomes for older adults, covering conservable bed days and patient safety.



HSR, Health System Report.

Falls and Frailty Quality Standards

Acknowledgements

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