High Risk Screening Tool

Seniors living in the community can find it difficult to get the services and care they need to stay at home. Seniors can experience being lonely, helpless, fearless and at time feel unsafe.

Adapting to changes in their health, social need, and care becomes more difficult as seniors age, making them more at risk for poor outcomes that can lead to trips to Emergency Department for non-emergency issues. It is also common for identifying “at risk” seniors earlier and providing them with the appropriate care and services will aid in support, safety and the ability to connect with their care team when they don’t feel well or scared.

Every South East LHIN acute care hospital will be screening “at risk” seniors when they arrive for non-emergency care. The hospital care team will talk with their community care team to assess the client and links them with appropriate services and care upon their discharge home. For “at risk” seniors who are to be admitted for in-hospital care, the hospital team will know about the high risk and provide care suitable for preventing physical weakness and confusion. When the patient is ready to return home after their hospital stay, they will be connected with the community team. The patient will receive the right care to help the senior’s health and desired needs.

Within a year of identifying the “at risk” seniors, over 1,000 clients have been identified as high-risk, with most of these seniors receiving supports and care at home. The senior’s care team work together to make sure all team member and patient are aware of service and care plan.
This high risk identification tool will be shared for use in family physician office with their care teams and post-acute care hospital over the next three years.