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OLTCC Response to the HSO draft LTC Standards
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Introduction

Ontario Long Term Care Clinicians represents physicians who work in long term care. Membership includes nurse practitioners, pharmacists, and other health care professionals in long term care. OLTCC's Vision is that all Ontarians in LTC will receive excellent care. The Mission is achieved through advocacy and education. Advocacy includes government relations and dialogue with many stakeholders. OLTCC sponsors the largest annual conference of long- term care physicians in Canada. The accredited Medical Director Course is now required for Ontario LTC Medical Directors. OLTCC also provides courses such as LTC Fundamentals and, with our partners, LEAP LTC palliative care and IDEAS quality improvement.

Physician Engagement and Oversight

"The organizational leaders ensure there is continuous and appropriate medical oversight and accountability for service delivery and care coordination within the LTC home." (8.1.3). Physicians are an integral member of the leadership and interprofessional team in long term care homes. To assure accountability and the best quality of care, the Medical Director should advise on the allocation of resources.

Education and Training

Recruitment and retention of all healthcare professions, including physicians and nurse practitioners, is an ongoing challenge in long term care. Standards should address the need to incorporate long term care in medical and nursing schools and continuing professional development. Medical leadership is an essential part of "organizational leaders". Ontario's new Long Term Care Act, Fixing Long Term Care Act (FLTCHA), will receive Royal Assent next month. The Regulations will require LTC Medical Directors to have completed the OLTCC Medical Director Course. The contents of the course and manual are extensive: in addition to resident centred care, topics include regulations, residents' rights, capacity, consent, documentation, preventing abuse, ethics, infection prevention and control, palliative approach to care, medical staff supervision, compliance, inspections, interdisciplinary teams, leadership, and more. Ontario's lead in trained medical leadership should be part of a national standard.

Information Technology

Information technology is loosely described as "technology (information, communication and/or equipment) improves working conditions for the LTC home's workforce and in turn contributes to the provision of high- quality care to residents" (9.5). With continued reliance on paper, fax machines and the digipen, a more powerful standard is needed for IT in LTC. Terms such as integrative, interoperability and knowledge engineering would elevate the standard. Interoperability allows for the expedient exchange of resident information with other platforms, such as hospitals and home care, to further support comprehensive and safe patient care. Knowledge-based systems integrate the resident's medical profile with prescribing, treatments, quality indicators, and other data. Such software is present in most hospitals and

many ambulatory settings. Modern information technology is essential to other standards such as evidence-informed survey instruments (5.2.1), medication management (7.1.1-7.1.3), order sets (7.1.7) and quality improvement (10.1).

Resident Centred Care

Long term care physicians have advocated for Resident Centred Care (RCC). RCC in the proposed Standards is defined as an "approach to care that consciously adopts the perspectives of residents as participants in, and beneficiaries of, trusted health and social services systems…[and] organized around the health needs and expectations of people rather than being organized around diseases." RCC ensures that an individual's preferences guide decision making. Section 7.1.7 states "The team uses standardized order sets that provide evidence-informed criteria to make decisions about diagnostic testing, and the initiation and choice of antibiotics for common infections." Standardized order sets may be contradictory to individual preferences and goals of care. Moreover, there is often an absence of applicable evidence related to the specialized clinical practice of caring for the frail elderly in long term care.

The Palliative Approach to Care

The Standards must make the distinction between palliative care and end-of-life care. "The team organizes timely access to palliative and end-of-life services based on the needs of the resident." (8.2.12). The World Health Organization defines palliative care as ""an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual." This approach to care begins on arrival to the LTC home or, preferably, before.

Advance Care Planning, Goals of Care

Section 2.2 addresses capacity and goals of care. This is advance care planning, an integral and dynamic process for all residents in long term care, which includes regular review of goals of care. The report refers to life experience, needs, and preferences. National resources (e.g., Pallium Canada, Advance Care Planning Canada) recognizes the individual's values, wishes and beliefs. The Standards should be more inclusive of the current language and application of advance care planning and goals of care.

Nothing About Us Without Us

The "team" is defined as including residents and designated support persons, presumably substitute decision makers. The voice of the resident should be assured in references to the team.

Respectfully submitted,

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