



October 15, 2009

Ms. Colleen Sonnenberg
Ministry of Health and Long-Term Care
Health System Strategy Division – LTCHA Regulation Project
9th Floor, 56 Wellesley Street West
Toronto, Ontario
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Dear Ms. Sonnenberg,

The Ontario Society of Occupational Therapists (OSOT) is pleased to forward comments on Part 2 of the proposed initial draft regulations made under the *Long-Term Care Homes Act, 2007*. With our comments we extend our profession's commitment to contribute constructively to the evolution of regulations that will bring to life the full commitments and protections offered to residents in long-term care homes in Ontario.

The Society represents over 3000 occupational therapists in the province. Occupational therapists believe that people live life to the fullest through meaningful occupations – the day to day skills, activities, interactions and experiences that engage us with our environment, our community and the people around us. Our ability to participate in occupations that are important to us promotes health and well being. Occupational therapists (OTs) work with their clients to help them identify barriers to meaningful occupations and to then change or remove these barriers. The goal of occupational therapy is to positively influence people's health by enabling occupation.

Occupational therapists have applauded the commitments of the *Long-Term Care Homes Act, 2007* to engage a "home" environment for residents. The fundamental principle around which the Act has been crafted speaks with much congruence to the core values, theory and practice of the profession of occupational therapy.

The fundamental principle to be applied in the interpretation of this Act and anything required or permitted under this Act is that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met. 2007, c. 8, s. 1.

Further, both the Residents' Bill of Rights and the requirement that an interdisciplinary program with a restorative care philosophy be provided that promotes and maximizes independence (Section 3. (1) and Section 9. (1)) make

commitments to ensure long-term care homes are resident-focused and provide for a quality of life that enables individuals to function to their maximum potential.

We have used the legislative commitments of the fundamental principle, the Residents' Bill of Rights and the commitment to programs and services as cornerstones for our review of the draft regulations. We view the draft regulations as an expression of the Ministry's commitment to bring the principles and requirements of the Act to life. While we recognize the importance of all of the regulations we will limit our comments to those of most relevance to OT, the regulations relating to the provision of restorative care.

1. A Central Commitment to Restorative Care – integrating Restorative Care into Programs

While the Act provides general direction and definition of a Restorative Care Program, requiring that it be interdisciplinary in nature and that a focus be maximizing independence, the proposed regulation provides further guidance by requiring that homes ensure that;

- a) restorative care approaches are integrated into the care that is provided to all residents and
- b) the restorative care approaches are coordinated to ensure that each resident is able to maintain or improve his or her functional and cognitive capacities in all aspects of daily living to the extent of his or her abilities.

The Residents' Bill of Rights provides for residents to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

While occupational therapists support these descriptors, members report that there is variable comfort and understanding of restorative care approaches and philosophy in the long-term care home sector. We are thoughtful that the regulations make reference to staffing requirements and training to support the Restorative Care Program but assert that it will become critical to engage shifts in thinking and approach to care across all staff in LTC Homes to ensure a consistent, collaborative and ultimately effective interpretation and practice of a restorative care philosophy. A restorative care program that works in isolation of organizational support or clear organizational direction, or that lacks staff participation in its programming across the organization, will be compromised in its potential. Historically, many LTC Homes have been well staffed with individuals that are focused on "caring for" or "doing for" residents. Caring *about* residents remains paramount but a restorative care approach requires a commitment to enabling residents to do for themselves as much as they are safely able to do.

Recommendation: We believe the regulations could be strengthened with content that speaks to directing LTC Home licensees to ensure that orientation programs for all staff include education, support for and communication of performance expectations relating to practice of a restorative care philosophy. This more specific direction supports the direction of Section 36 which requires licensees to ensure that restorative care approaches are integrated into the care provided to all residents. In this way the regulations will more effectively direct implementation of the spirit of the legislation.

Occupational therapists could assist the Ministry or Long-Term Care Homes to develop orientation resources for these purposes.

2. Therapy Services

The Society recognizes, appreciates and deems important the inclusion of occupational therapy (OT) and speech language therapy (SLP) as required therapy services in LTC Homes. We have positioned that these are critical services to direct safe and comprehensive restorative care approaches in homes. Current practice in Ontario homes has clearly identified that unless OT and SLP are required services, they are unlikely to be provided. Section 37 provides clear direction that is complimentary to and supports the fundamental principle around which the Act has been developed.

Occupational therapists have much to offer the Long-Term Care Home. While our primary concern is to meet the needs, support function and promote quality of life of the resident, the engagement of OT services in homes will, we believe, have more far-reaching impacts by supporting nursing staff, contributing to all staff education, informing restraints policy implementation, consulting re seating and positioning practices, etc.

It is not clear what is meant by *Section 37 (c) other therapies* and we would suggest that this section provides inadequate direction as a regulation to guide service provision under restorative care programs. The inclusion of the word "other" causes one to question how a licensee is to be held accountable to this section. How can they provide "other" therapies unless they are listed?

At the same, time, it is important to ensure that the provision of other therapies is based on identified needs for those therapies and not as substitutes for PT, OT or SLP. Interdisciplinary restorative care that engages all team members in the identification of resident goals and needs is the desired outcome. This ensures that the most appropriate therapy is provided for each resident through their care plan.

Recommendation: That Section 37 be amended to achieve greater clarity with one of the following options;

- ***" the licensee shall ensure that there are therapy services in the home that include physiotherapy, occupational therapy and speech-language therapy services. It is recommended that "other therapies" be offered based on identified need." or***
- ***"the licensee shall ensure that there are therapy services in the home that must include, but may not be limited to, physiotherapy, occupational therapy and speech-language therapy."***

3. Provision of "on-site" therapy services

The Society is concerned and unclear about the distinction of "on-site" services for physiotherapy but not for OT and SLP. Indeed, we find use of the word "on-site" confusing. Does this speak to services being provided "in the home" as opposed to outside the home? Does this refer to having PTs hired onsite (i.e. employed by the

home)? What are the implications for OT and SLP when this wording is not related to their service provision?

OSOT advocates that it is critical that access to OT services provided on-site (in the Home) be directed by the regulation. Although some residents may be suitable to receive services in the community, the vast majority of LTC Home residents are not. OT services, indeed restorative care, needs to be provided in the context of the aging individual's "home" and in collaboration with other interdisciplinary team members engaged with the residents' care. We are aware that new LTC regulations enable CCACs to deliver OT services in group or congregate settings. While this is a valuable option of flexibility for some community clients, we are concerned that this not be seen to be an option for residents of long-term care. For example, the notion of an elder with multiple physical and/or cognitive impairments attending, by some means of transportation, an unfamiliar clinic setting with unfamiliar people, to be assessed for seating & mobility needs, is unsupportable.

Consultation with the Ministry to clarify this point identified that the distinction of "on-site" physiotherapy services was related to the fact that the Ministry currently provides for and funds physiotherapy services in LTC Homes. It is unclear how this related to the term "on-site".

Occupational therapists have concern about the details of this wording because we would position that;

- Occupational therapy services must be provided in the LTC Home where the client is in the context of their "home" environment
- Occupational therapy services must be integrated into the interdisciplinary team approach to restorative care. This requires the presence and interaction of a consistent OT Team member with others in the home. Whether OT services are provided on a full time or part time basis we would assert that it is critical that the therapist(s) providing these services is consistent. Only in this way can an OT realistically contribute as a team member, get to know the staff, policies, challenges and issues of the home and be a true value add to the organization in addition to the residents they serve. Residents, nursing staff, support personnel and the Restorative Program lead are all best served when consistent professional staff are assessing, developing care plans and treating residents, delivering staff education and support and are available to contribute to program development, evaluation and improvement.
- Use of the MDS classification system has created the need for expertise in the area of ADL retraining which includes individualized treatment planning, program development, implementation and evidence-based evaluation and ongoing staff education/support. We believe that access to an on-site OT is a strategic investment for homes in this regard.
- It is inadequate to simply have provision that OT services be accessed as needed through the Community Care Access Centre. Although this has been a model to access minimal OT services in some LHINs, it is fraught with problems. CCAC funding and client care demands often result in unforeseen or planned cutbacks. In fact few CCACs provide any services to LTC Homes currently. Furthermore, CCAC provided services do not assure engagement of the same therapist or provider agency for all residents in a home. This

results in a consultative model that is limited in its capacity to contribute to interdisciplinary decision-making and care. The time bounded nature of CCAC visits limits the capacity of OTs to contribute to follow-up or to provide ongoing supervision to support personnel. Out-sourcing OT services serves to minimize the potential for benefits of an additional team perspective, flexible attention to emerging trends or issues relating to resident care or safety, etc.

- It is important that the regulations provide sufficient protection for the conditions of access to therapy services to ensure that unauthorized practices are not inadvertently supported. Occupational therapists are keenly aware of current trends of designated physiotherapy clinics offering to provide homes with OT services without charge. This has resulted in lost OT jobs, previously funded by the homes, but may also represent a misuse of government funds designated for PT services.

Recommendation: We propose that the regulations be clarified to direct that;

- ***PT, OT and SLP services will be provided in(on-site) the long-term care home***
- ***Employment of therapy providers or service contracts to engage therapy services will provide for a consistent therapist(s) to participate as a team member(s) in the homes restorative care program***
- ***therapy service provision be driven by the needs of the home***
- ***Funding for OT and SLP services be a responsibility and commitment of the long-term care home's operating program budget.***

4. Standards for provision of OT Services

The regulation provides for homes to provide access to OT services but no guidance or requirement related to service standards. How will the service standards be established and who will make this decision? We express concern that without clearer guidance there may be vast variability amongst homes resulting in inequitable access to services. The absence of any clarity in this regard, leaves therapists nervous that an expectation will be that services are accessed solely on a prn basis from the CCAC. We have noted how inadequate this service has been and how vulnerable homes are to the service demand changes experienced by CCACs. We make assumption that Local Health Integration Networks will be involved in funding services but are unclear how they will be guided without any service standards.

Recommendation: That service standards for therapy services be addressed or referenced for future development in the regulation and that guidance regarding the process for access to OT services be clarified. The Ontario Society of Occupational Therapists would be pleased to discuss service and funding standards to effect greater clarity and direction in the regulations.

5. Section 38 - Space and Supplies

The Society supports and appreciates the requirement to provide both space and equipment and supplies for therapy services. This suggests a partnership and ownership that therapy is an essential part of the life in a LTC home and will ensure

that there is a budget for therapy equipment. This is critical to effective service delivery. Therapy supplies and equipment isn't just exercise. It can be bed surfaces/cushions which relate to skin management, wheelchair parts/accessories including seat belts and trays which relate to the application of restraints, bed/chair alarms for fall prevention, transfer poles/raised toilet seats etc. for transfers, adaptive aids/assistive devices used to promote independence with ADL's. Not only do the homes have to acquire and store the equipment, they need someone to manage, allocate and track the items to render them useful, monitor maintenance needs and effectively protect the investment of the home.

6. Therapy Services Staff Qualifications – Section 39

OSOT supports the requirement that OT services be provided by registered occupational therapists or by support personnel supervised by registered OTs. While we support the use of support personnel to increase cost efficiencies in service delivery we assert that this happens most effectively when there is a designated, consistent employed or contracted OT(s) working in a home. This assures service efficiency as support personnel cannot assess residents, establish treatment goals and develop or modify programs/interventions independently. They must work under the direct supervision of a therapist.

We are concerned about the qualifications of support personnel as designated in the regulations. We would wish the regulations to clearly allow for an Occupational Therapist Assistant to be support personnel of choice for OT services. We believe our colleagues in physiotherapy would support the use of PTAs in a similar way. These workers have focused education and training in OT and working with diverse populations including the aging, those with disabilities, cognitive deficits or mental illness. We offer this suggestion as an additional option to the requirement that support personnel have completed or are enrolled in a training program in restorative care or participate in a program delivered by the licensee, designed and supervised by an OT. We are aware that Restorative Care training courses are typically offered as a 1 – 2 day course. Support personnel with only this basic level of training will not possess the knowledge base or problem solving skills necessary to successfully deliver the varied and diverse components of a Restorative Care program. This speaks more fully to the previously raised point that it is essential to have an on-site OT who is available to provide ongoing general education/training sessions to staff of the LTC home and also to work on a 1:1 basis with support personnel and PSWs to ensure that resident's achieve the maximum level of functional independence. This is what OTs are trained to do.

Recommendation: That Section 39 (1) (b) be amended to include provisions for support personnel to be Occupational Therapist Assistants or Physiotherapist Assistants. That the regulations stipulate the need for access to occupational therapy services delivered in the home in order to enable an effective service delivery model utilizing support personnel.

7. Designated Lead – Section 42

The Regulation requires that a designated lead be established for therapy and social work programs that may be either a regulated health professional or member of college of social workers or have a post secondary diploma or degree in recreation and leisure studies, recreation therapy, kinesiology or a related field.

OSOT would assert that the program lead is a critical role related to bringing the spirit of the LTCHA's commitment to restorative care approaches to life. Not only will this individual direct the Restorative Care program but they will also function as a link to leadership of other programs and services within the home. As the commitment of the Act assures a delivery of a restorative care philosophy in all care and services provided to a resident, we would position that this lead has an important role to facilitate true collaboration across all program areas. As such, we feel that the qualifications for the lead should be driven by skills and competence in restorative care. As defined in the Act, restorative care approaches will be coordinated to ensure that each resident is able to maintain or improve his or her functional and cognitive capacities in all aspects of daily living to the extent of his or her abilities. We position that a regulated health professional (PT, OT, SLP) brings the best qualification for this role – a professional focus on promotion of function and an educational background in disease, disability and/or dysfunction and rehabilitation. OSOT positions that OTs are ideal candidates to be program leads as they bring backgrounds in physical function, cognition and mental health and bring a unique focus of attention to an individual's capacity to participate in all aspects of occupational performance – self care, productivity and leisure. We note the increasing attention the MDS classification system brings attention to the area of ADL retraining and position that it would be a strategic advantage for a home to have an OT in a leadership role for the restorative care program.

As written, we perceive that the regulation allows that the Designated lead for Recreational and Social Activities may also be the lead for Restorative Care but not vice versa. It is not clear whether this is the intent of the Ministry but it would appear contrary to the strong principle of restorative care that the Act speaks to, to have this program not have strong and unique leadership. While we might surmise that the intent is to allow smaller homes to consolidate their leadership teams, we would assert that if the two roles were to be combined, then the leadership should come from the restorative care program as this lead might well have an increased capacity to promote the restorative care philosophy through all recreation and social programming as well.

We believe the regulation could be stronger in this section by requiring that the designated lead must act in accordance with the directions provided by the regulated health professional. Otherwise, this undermines the contributions of regulated professionals in the restorative care program. This is particularly concerning if the lead is not a therapy professional or social worker and at very least speaks to the need to have on-site therapy providers who are consistently available in the home in order to be able to meet, consult to and report to the program lead. Our vision would be that the lead is regularly consulting with all providers covered by sections 36 – 42 to ensure that they have an understanding of the potential contributions that each discipline can offer and represents this effectively and collaboratively at a management level.

Recommendation: That Section 42 (2) (a) read "must have a current general certificate of registration with the appropriate college of a regulated health profession" and that 42 (2) (b) be deleted.

8. Section 118 – Additional Training

We note that the regulations provide for a requirement that homes provide additional training to all direct care staff on topics that include;

- Falls prevention and management
- Skin and wound care
- Pain management
- Responsive behaviour
- Safe and correct use of therapeutic equipment and adaptive aids
- Application, use and potential dangers of physical devices used to restrain residents or personal assistance support devices

Furthermore, homes are required to provide training to enable all direct staff to provide support and assistance to residents to promote independence. Occupational therapists have significant contributions to lend to each of the above topics and OTs employed or contracted by a home should be engaged in the development and delivery of such training programs as well as one on one education, sharing of best practice and support to staff to help them best assist the residents to reach their maximum potential.

9. Section 165 – Reports re Key Personnel

OSOT notes with interest that licensees are required to report to the Director the name and contact information of key personnel including Medical Director, Nurse Practitioners, Administrator, Director of Nursing and Personal Care, Nutrition Manager, all Dietitians, designated lead for housekeeping, laundry and maintenance. We query why a lead of a program that has such importance in the Act such as Restorative Care is not identified on the list of key personnel. We trust this does not relay a lack of profile or commitment to the importance of Restorative Care as key driver in the organization.

Recommendation: That the Restorative Care Lead be identified on the list of Key Personnel to be reported to the Director by the licensee. (Section 165)

The Ontario Society of Occupational Therapists reiterates our commitment to work collaboratively with government, long-term care homes and local health integration networks to bring the *Long-Term Care Act, 2007* and its promises to Ontarians to successful realization.

Please do not hesitate to contact us if we can provide clarification of any of our messaging or could contribute constructively in other ways to the regulation development process.

Sincerely,



Christie Brenchley
Executive Director

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