AdvantAge Ontario
Advancing Senior Care

Feedback Submission on the Draft Health Standards Organization (HSO) Palliative Care Services National Standard of Canada

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Overview

HSO is developing a new edition of CAN/HSO 13001 Palliative Care Services National Standards of Canada. As more people live longer with serious illnesses, expanding and adapting palliative care services is essential to meet diverse needs and respect individual goals and preferences.

This new draft edition of the standard provides evidence-informed guidance for delivering safe, equitable, comprehensive, people-centred, and high-quality palliative care and end-of-life services to people of all ages with serious illness. The target audience includes organizational leaders and teams within health and social service organizations providing palliative care and end-of-life services.

These standards are developed at the federal level and intended to provide evidence-informed guidance, as currently there is no funding to implement the guidelines nor are these guidelines mandatory through provincial legislation.

Please note that this submission was completed directly within a survey platform. Responses will be entered under each corresponding question rather than provided as a standalone document. The 7 survey questions and responses are outlined below.

In preparation of this submission, we conducted consultations with members representing both rural and urban settings who have experience and knowledge of palliative care services in long-term care and the community (i.e., assisted living, community paramedicine program). The responses below reflect the perspectives shared during those discussions and highlight areas of support on the draft standard, implementation considerations, and opportunities to strengthen the standard from the diverse group of members we serve.

Question 1: Based on your experience and expertise, do you believe the draft standard adequately addresses the most important issues?

Answer: *Yes.*

General Comment:

AdvantAge Ontario has been the trusted voice for senior care for over 100 years. We are the only provincial association that represents the full spectrum of the seniors' care continuum and our over 530 members include 88% of all not-for-profit and charitable long-term care homes, 82% of the hospital-affiliated long-term care homes and 96% of all municipal long-term care homes. Over 160 of our members represent social housing, independent living, supportive housing, life lease, non-profit retirement homes, and developing members.

We appreciate the opportunity to provide feedback on the HSO draft Palliative Care Services standard. Overall, we believe the draft standard addresses many of the key issues relevant to the delivery of high-quality palliative care services. We commend the HSO for the comprehensive

and thoughtful co-design approach taken in developing the standard. The proposed framework reflects an important commitment to strengthening palliative care services and promoting safe, reliable, and consistent person-centered care. Our members highlighted that many of the principles and practices reflected in the HSO draft standard are consistent with existing legislative requirements and provincial guidelines in Ontario, particularly within the long-term care sector, including the *Fixing Long-Term Care Act, 2021* (FLTCA, 2021) and the Palliative Care Quality Standards developed by Health Quality Ontario.

The most important issues adequately addressed in the standard include the encouragement for development of both formal and informal partnerships in the delivery of palliative care, the progression of palliative care services from implementation to ongoing continuous quality improvement, the holistic approach to addressing resident needs, expectations for regular documentation, and an ongoing review of residents' values, goals, and wishes. The standard also outlines implementing a team-based approach, which recognizes the contributions of an interdisciplinary team and the value of designating a lead while involving all members of the organization. These are all aspects of palliative care services our members currently implement and find important in delivering safe, high-quality care.

Question 2: Do you feel there are any gaps in the standard that should be addressed?

Answer: *Yes.*

Comment #1:

To further strengthen the standard, HSO could consider incorporating additional contextual guidance to help organizations understand how expectations may be adapted when resources and workforce capacity are limited. The draft standard notes its intended use across geographic contexts, including rural and remote settings. However, some expectations outlined in the standard, such as providing culturally responsive supports and ensuring access to interdisciplinary care, may be more challenging to implement in rural and remote communities where access to the full range of specialized supports is limited.

For example, the standard could encourage providers to work closely with clients and families to identify and prioritize the support that is most meaningful and feasible within their local context. The standard could also more explicitly recognize the role of collaboration with local providers and community organizations in rural settings, where creative and locally tailored approaches may be necessary to deliver comprehensive palliative care services. Additional feedback on specific sections of the standard that could benefit from greater rural context is provided in Question 3.

Comment #2:

The draft standard provides valuable guidance on palliative care implementation across a range of care settings, including hospitals and long-term care homes. However, it is less clear how these guidelines on palliative care implementation should be delivered within community settings.

In many communities, older adults continue to live independently or in supportive housing environments, such as assisted or retirement living. These individuals may not have consistent access to coordinated palliative care supports until they transition into more formal care settings, such as long-term care. In Ontario, this issue is exacerbated by the fact that many Ontarians do not have access to a family doctor, thereby removing yet another avenue for access to palliative care services in the community. As a result, palliative care services may be introduced later in the course of illness, likely upon hospitalization, which can impact quality of life and overall health outcomes. Additional guidance on early identification of palliative care needs, such as suggested triggers based on functional decline, frequent hospitalizations, or advancing chronic illness, could help support earlier and more equitable access to palliative care services across long-term care and community settings.

While community-based services, such as community paramedicine programs, community hospice, and palliative home care may incorporate elements of palliative care support, these programs often operate with limited capacity and are not positioned to meet the full range of palliative care needs in the community. Additional guidance for organizational leaders and teams in community-based settings could be helpful in clarifying how palliative care services can be accessed and coordinated for individuals who remain in the community for much of their care journey. Guidance on a broader system of coordination across all care settings within a community may also help with overall access to palliative care services for older adults. Further clarification on accountability for care coordination across settings, particularly where individuals move between community, supportive housing, and long-term care, could help reduce fragmentation and improve continuity of care.

Question 3: Please provide any specific feedback, including the section number and comment.

Comment #1:

Section 3.3.5: The emphasis on virtual care options is a positive element of the standard. However, additional guidance on how virtual consultation, outreach services, and regional specialist support could be used to build local capacity in rural communities to further support implementation could be beneficial.

Comment #2:

Section 5.1.3: The reference to collaborative care approaches involving paramedicine, palliative teams, and local providers is a valuable inclusion. Expanding how these partnerships can be

operationalized beyond service agreements or referral pathways may help organizations better understand how to implement coordinated care models, particularly those in rural settings.

Comment #3:

Section 8: We express strong support for this section addressing continuous quality improvement. The elements described in this section reflect practices that are commonly implemented within well-developed palliative care programs and align with approaches that support reflective practice, team learning, and ongoing improvement in care delivery. Emphasis on sharing learnings from improvement cycles with all care team members through focused mechanisms is helpful. Example prompts or guiding questions to facilitate structured reflection and discussion during quality improvement activities could be an additional consideration (e.g., What changes have been observed since implementing this improvement? What feedback have clients, families, or team members shared about these changes? What additional adjustments could be considered moving forward? What opportunities exist to further improve care or address emerging needs?). This would also help to guide specific metrics that care providers could use toward continuous quality improvement.

Question 4: Please provide any general feedback on the draft standard such as language and ease of use.

General Comment:

The clear distinction between defining palliative care and end-of-life care was viewed as particularly valuable. Members noted that these concepts are often conflated in practice, with palliative care frequently assumed to refer only to end-of-life care. Providing clear definitions within the standard helps support a more accurate understanding of palliative care as an approach that can be introduced earlier in an individual's care trajectory.

We also appreciate the emphasis on organization-wide engagement in palliative care. Recognizing that individuals across the organization may contribute to palliative care in different ways and ensuing that staff have at least a foundational understanding of palliative care principles, is viewed as an important element in strengthening care delivery.

The inclusion of strong senior leadership engagement was also seen as a key strength. Leadership support is critical in providing the time, resources, and organizational commitment needed to advance palliative care initiatives.

The emphasis on interdisciplinary collaboration and shared responsibility aligns well with current practices in many settings. Team-based approaches help distribute responsibilities and support the implementation of palliative care guidelines. In some organizations, this has included the development of dedicated teams responsible for reviewing training materials and

supporting staff education, an approach that could be further supported through the implementation of these standards.

We do want to note that factors including limited access to specialists and hospice beds in rural and remote communities can create barriers to the timely access of services and may contribute to individuals entering the palliative care trajectory later in the course of their illness. This can affect health outcomes and place additional strain on long-term care and community providers. Additionally, implementation of some expectations may be constrained by workforce availability and skill mix, particularly in settings where regulated clinical staff or specialized palliative expertise are limited or shared across multiple sites. These issues reflect bigger healthcare system-level challenges, and while the standard should still set a basic level of care that everyone deserves and that the system can support, it is important to acknowledge the real limitations that exist within Ontario's healthcare system.

Question 5: Are there any sections of the standard where the language is unclear or ambiguous?

Answer: *No.*

Question 6: Is the terminology used in the standard easily understood?

Answer: *Yes.*

Additional Feedback:

The terminology used in the standard reflects similar language used in other standards and legislation in long-term care (e.g., *Fixing Long-Term Care Act, 2021*). This helps to provide a wide array of guidelines for implementation.

Question 7: Does the draft standard reflect the RUMBA principles? Please share any observations or examples that support your assessment.

Answer: *Yes.*

General Comment:

Relevant: The content is aligned well with the scope of palliative care services and reflects key components of high-quality care. The expectations outlined are aligned with current practices and established guidance in palliative care and appear to be supported by evidence and best practices.

Understandable: The standard is written in clear, concise language that is accessible to a broad range of audiences involved in the delivery of palliative care services. The structure and terminology used throughout the document help ensure that expectations are understandable for staff across different roles, which support consistent interpretation and implementation.

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Measurable: Overall, the guidelines described throughout the standard can be verified through documentation, observation, and/or discussion. However, as noted in Question 3, there could be room for improvement on specific example prompts or guiding questions to facilitate structured reflection and discussion during quality improvement activities. While measurement and documentation are important, ensuring expectations are proportionate and aligned with existing documentation processes would help minimize administrative burden and support sustainability.

Beneficial: The standard does meaningfully contribute to improving quality care and safety. Some examples include, 1) clear definitions and scope of palliative care and end-of-life care, promoting timely access to appropriate supports can improve symptom management, care planning, and overall quality of life, 2) emphasis on interdisciplinary collaboration helps ensure that individuals receiving palliative care benefit from a range of professional perspectives and expertise, 3) the focus on engaging clients and care partners in care planning was also viewed as a key strength to help ensure that care decisions align with the wishes and values of the individual and their family, and 4) emphasis on continuous quality improvement is an important mechanism for strengthening palliative care services over time.

Actionable: We generally agree that the expectations outlined in the standard are actionable and reflect practices that can meaningfully support the delivery of high-quality palliative care services. At the same time, implementation may be influenced by broader system constraints. For example, timely access to palliative care services can be challenging in some regions, particularly in rural and remote communities with limited access to specialized care and services. These factors can make it more difficult for organizations to fully operationalize certain elements of the standard. Palliative care initiatives can sometimes compete with other priorities within the health system. Limited funding across the health sector, including within long-term care, may create challenges for organizations seeking to dedicate resources to training and capacity-building in areas such as advance care planning and symptom management. Given these constraints, implementation of the guidelines outlined in the standard may require additional resources and funding. We would also like to take this opportunity to acknowledge considerations related to accessibility of the standard itself. As access to the full standard involves a cost, this may present a barrier for some organizations seeking to engage with and implement the guidance. Ensuring that HSO standards are broadly accessible may help support wider adoption and implementation.

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