

Individualized Summary – Frequently Asked Questions

Questions Related to the Individualized Summary – “The PoET Form”

The **Individualized Summary (IS)** is a tool used as part of the PoET project, and is an Accreditation Canada Leading Practice. The IS is used to document resident’s wishes, values and beliefs related to their care. It also summarizes aspects of the current treatment plan related to transfer for acute care, and code status.

Question	Answer	Notes
What sort of wishes should be documented on the IS?	The IS should be used to document the resident’s wishes about care (including end-of-life care), if they have any to share. The IS should include a <i>summary</i> of the resident’s wishes, and details about the discussion should be included in the health care provider’s documentation.	If the resident has expressed their wishes in writing, a copy of the document can be attached to the completed IS.
Should wishes and information about funeral arrangements be included on the IS?	If a resident chooses to discuss wishes about funeral arrangements, then it may be appropriate to record it on the IS; however, it is not recommended that the health care provider ask about funeral arrangements when completing the IS.	Funeral arrangement details are probably better recorded in progress notes or wherever the home usually records this information.
Can the IS be filled out if the resident is incapable ?	Yes. The IS can be completed for all residents, whether or not they are capable of decision-making or communication at the time. If there is nothing known about wishes, values, and beliefs it is appropriate to write “none known.”	If information is shared about wishes, values, and beliefs at a later time (by the resident, or by the substitute decision maker, or another trusted source), the IS can be updated. Keep in mind, however, that nobody else can express <i>new</i> wishes, values, or beliefs on behalf of the resident.
Does the IS need to be updated regularly ?	The IS needs to be updated whenever there are changes related to: (1) aspects of the treatment plan that are related to transfer for acute care, (2) code status, or (3) the resident’s wishes, values or beliefs.	Homes can verify the information on the IS as part of the resident’s annual care conference, if they choose – but verifying does not mean that any of the information needs to be changed.
Is there an IS for “ end of life ”?	Yes , there are two versions of the IS. One version is appropriate for situations in which an “end of life”(or what is sometimes called “palliative”) treatment plan is put in place either because it was proposed and consented to, or the capable resident states that they want an end-of-life plan put in place. This version of the IS states, in part, “The current plan includes death in the home. Death is expected and won’t be treated as an emergency.”	The default version of the IS (which would be in place for most residents most of the time during their stay at the home) states: “If transfer to hospital is proposed by the physician or Nurse Practitioner, obtain consent for the capable resident, or the incapable resident’s substitute decision maker.. If it is an emergency (suffering, potential serious harm) transfer to hospital immediately and then notify physician and substitute decision maker”.
Who writes on the IS?	A health care provider should complete the IS and write their name at the bottom.	The IS should not be completed by a resident or a family member.
Does the IS replace the DNR-C form ?	No . The IS is designed to be <i>consistent</i> with the MOHLTC’s DNR-C form.	The DNR-C form is the only form that paramedics and firefighters can accept.

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The Basis for the Individualized Summary - the Health Care Consent Act

The *Health Care Consent Act* is an Ontario law that deals with consent, capacity, and substitute decision making. The PoET (Prevention of Error-Based Transfers) project's aim is to help long term care homes align practices and habits as closely to the *Health Care Consent Act* as possible. Becoming in line with the *Health Care Consent Act* allows residents to receive the care they want and can benefit from and can reduce errors in transfers.

Question	Answer	Additional Information
Who provides consent for treatment decisions in LTC?	Consent must be obtained from residents whenever they are able to understand and appreciate what is being proposed.	If a resident is not able to understand information and/or appreciate benefits or risks related to what's being proposed, then their substitute decision maker would have to be asked for consent. Capacity can come and go; so does the role of the substitute decision maker.
What is capacity ?	Capacity refers to two things: 1) the ability to understand information about what is being proposed, and 2) the ability to appreciate benefits and risks related to the decision. A person must have both abilities to be capable.	Capacity changes over time, and is always related to a specific decision. This means that health care providers must evaluate for every new decision at the time it is proposed.
Who proposes treatment?	The health care provider. In long-term care, this will usually be a physician or nurse practitioner.	Residents and family cannot propose treatment or treatment plans.
What is the difference between a Substitute Decision Maker and someone named in a Power of Attorney for Personal Care?	Both are substitute decision makers filling in to make a decision when a resident is found to be incapable. A POAPC (Power of Attorney for Personal Care) must be appointed by the resident by using a formal document.	The <i>Health Care Consent Act</i> provides an ordered list of substitute decision makers that health care providers must use. Whoever is ranked highest on this list, and is also willing, capable and available is the Substitute Decision Maker.

MAKE TREATMENT DECISIONS

- At the time
- Based on the resident's current situation
- With the resident first
- Starting with the physician's proposal

Still have questions?
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