

Alignment between Ontario's Palliative Care Standard and the PoET Project

Health Quality Ontario's (HQO) Quality Standards are designed to "inform clinicians and organizations about what high-quality health care looks like for aspects of care that have been deemed a priority for quality improvement in the province" (p.1).

The Palliative Care Quality Standard, which was developed with the Ontario Palliative Care Network (OPCN), identifies key features of high-quality palliative care for adults with a progressive, life-limiting illness.

The PoET (Prevention of Error-based Transfers) Project works with long-term care homes in Ontario to help align practices and policies related to consent, capacity, and substitute decision making with the *Health Care Consent Act*.

The PoET project aligns with the Palliative Care Quality Standard in the ways described below. Engaging in the PoET Project can help long-term care homes in Ontario meet these standards in order to provide high-quality palliative care.



Statements from the Palliative Care Standard

QUALITY STATEMENT 3: Advance Care Planning—Substitute Decision-Maker

People with a progressive, life-limiting illness know who their future substitute decision-maker is. They engage in ongoing communication with their substitute decision-maker about their wishes, values, and beliefs, so that the substitute decision-maker is empowered to participate in the health care consent process if required.



QUALITY STATEMENT 4: Goals of Care Discussions and Consent

People with identified palliative care needs or their substitute decision-makers have discussions with their interdisciplinary health care team about their goals of care to help inform their health care decisions. These values-based discussions focus on ensuring an accurate understanding of both the illness and treatment options so the person or their substitute decision-maker has the information they need to give or refuse consent to treatment.



QUALITY STATEMENT 5: Individualized, Person-Centred Care Plan

People with identified palliative care needs collaborate with their primary care provider and other health care professionals to develop an individualized, person-centred care plan that is reviewed and updated regularly.



QUALITY STATEMENT 10: Transitions in Care

People with identified palliative care needs experience seamless transitions in care that are coordinated effectively among settings and health care providers.



QUALITY STATEMENT 11: Setting of Care and Place of Death

People with identified palliative care needs, their substitute decision-maker, their family, and their caregivers have ongoing discussions with their health care professionals about their preferred setting of care and place of death.



How the PoET Project promotes alignment

The PoET Project encourages role clarity for everyone involved in decision making—residents, substitute decision makers, and health care providers. PoET tools are designed to help everyone know and understand their role in decision making; having this knowledge helps everyone to know what to expect from others.

PoET clarifies the relationship between Advance Care Planning and Ontario's consent process. PoET tools such as the Accreditation Canada Leading Practice *Individualized Summary*, and the *Treatment Plan Proposal Template* can help to ensure that everyone involved in decision making has the information that they need.

PoET changes and tools can help health care providers in long-term care obtain informed and voluntary consent to the specific treatment plans proposed the resident, or to his or her substitute decision maker.

PoET helps health care providers to understand how consent works within and across settings, and the roles of different health care providers and staff in developing a treatment plan and implementing it.

PoET provides health care providers with tools that help shape consent discussions so that residents (or their substitute decision makers) understand the connection between the proposal, treatment options, and location. These tools facilitate identification and documentation of preferred care setting whenever this is relevant to the resident.