Provincial PoET Program
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PoET Goals Information Page

This information page is intended to outline some of the goals related to consent, capacity, and substitute decision making that PoET supports Ontario long term care homes to prioritize, select from, and achieve over time.

All PoET Goals relate to decision making: some directly to the requirements of the Health Care Consent Act and related college obligations, and others to practical steps that can be taken to meet those requirements.

The list included here is not exhaustive, so please let us know if there are other goals that your home would like to achieve.

At All Times

- Inform staff of treatment and therapies available in the home, or have information readily accessible
- Obtain treatment plan proposals from physician or nurse practitioner
- Obtain informed consent at the time treatment is being proposed
- Obtain informed consent from the resident, if the resident is capable
    - Document discussion and decision
- If the resident is not capable of making a consent decision at the time
    - Document discussion and finding of incapacity
    - Inform resident of finding of incapacity, in line with professional requirements
    - Use the Health Care Consent Act hierarchy to determine the substitute decision maker
    - Seek consent from substitute decision maker
        - Document discussion and decision
            - Recognize resident's right to withdraw consent upon return of capacity
- Have an identified place to record resident's wishes and update as appropriate
- Have an understanding of dispute resolution mechanisms available, and how and when to access them
- Regulated staff and physicians respect their relative roles related to treatment proposals and consent
    - Regulated staff and physicians respect and meet their professional obligations related to consent

On admission

- Document resident's wishes if they have any to share
- Provide resident with information about decision making
- Provide substitute decision makers with information on their role
- Reassess DNR-C (Do Not Resuscitate Confirmation) forms
- Establish code status through resident's capable wishes, or consent process related to physician's or nurse practitioner's

At care conferences

- Invite all residents to attend their own care conferences
- Ensure care conferences occur in a space accessible to residents, and at a time that is good for them
- Ensure resident has what they need to communicate and participate in the care conference
- Ask residents in advance if they would like family members or others to attend
- Invite physicians to attend residents' care conference
- Invite physicians to make treatment proposal, if appropriate
- Communicate changes in condition to physician or nurse practitioner