SAHTU HEALTH AND SOCIAL SERVICE AUTHORITY
Policy

TOPIC:

END OF LIFE CARE PLANNING

INDEX:	CC.100
CANCELS & SUPERCEDES:	
EFFECTIVE DATE:	01 November 2007
DISTRIBUTION:	All Manuals
RECOMMENDED BY:	Senior Management

POLICY:

In cases of terminal illness or other natural end of life processes, an end of life care plan must be discussed with patients and their families. End of life care will include: ongoing physical care with emotional and spiritual comforting, appropriate intervention to alleviate pain, and any actions necessary to promote dignity and enhance the quality of the time remaining.

PURPOSE

The SHSSA recognizes the need to assist and direct staff when faced with decisions on end of life care. This policy aims to protect the interests of patients, their families, and SHSSA staff while pursuing a human collaborative course of action

RESPONSIBILITIES

A: When a person's condition is such that an end of life care plan is being considered, the patient's prognosis and decision making competence must be assessed by a physician in collaboration with the primary community care team, the patient, and the patient's family. Where the patient is determined to be incompetent to make decisions in his or her best interests, the plan must be fully discussed with the individual's family members and/or significant others and/or substitute decision-makers. This may include the Public Guardian.

A person who is determined to be competent to make decisions in his or her best interests has the right to:

Make decisions about his or her care including acceptance or rejection of care, including end of life care plan and make decisions about who else will be consulted about the end of life care plan.

A person who is determined NOT to be competent to make decisions in his or her best interests will be protected:

Family members, and/or significant others and/or substitute decision-makers have the right to make decisions about the person's end of life care plan taking into account any previously expressed wishes of the individual who is now incompetent.

In the absence of substitute decision makers willing or able to act in the patient's best interests, the Office of the Public Guardian must be notified.

B: The competent patient's decisions about his or her care take priority in cases where family members and/or significant others disagree.

NOTE:
Definition of family: For the purposes of this policy, family includes: spouse, parents and immediate relatives such as children, brother, sisters, aunts, uncles and grand-parents. Biologically related, or adoptive relatives are given family status in accordance with the patient's wishes.

Approved by:
Chad Fehr, CEO

End of Life Care Plan: Procedures

DOCUMENTATION

A: The end of life care plan must be completed by the attending physician on the person's health record, using the End of Life Care Plan Form; Appendix A.

B: Discussions with the person, family members and/or significant others and/or substitute decision-makers as well as the members of the primary community care team should also be recorded on the health record.

C: Physician consultants must record their opinions on the health record as consultant's notes. When appropriate, a second physician shall be consulted.

D: The primary community care team involved in the care of the person should be informed when an end of life care plan exists.

E: Patients are encouraged to advise their family members and/or significant others and/or substitute decision-maker of their decisions in their end of life care plan. A Living Will, or Advance Directive may also be completed.

F: A regular review of the end of life care plan should be established and carried out every 3 – 6 months or as indicated by the patient's condition.

SUSPENSION of the End of Life Care Plan

A: A request by a competent person to rescind the end of life care plan is implemented immediately and a clinical reassessment is conducted.

B: A request by the authorized substitute decision-maker of an incompetent person to rescind the end of life care plan is implemented immediately and a clinical reassessment is conducted.

C: Based on clinical changes in the person's condition, a nurse or physician may suspend implementation of the end of life care plan until there has been a clinical assessment of the person's condition by the physician. The patient and family shall be consulted and kept informed.

END OF LIFE CARE PLAN

It is the Sahtu Health and Social Services Authority's Policy to respect the patient and families wishes on End of Life Care.

(please print)

Date: ____________________

______________________________________ has been diagnosed as having
(Patient's name in full)
a terminal illness, or is considered to be near the natural end of their life.

The Diagnosis:

____

____

☐ I, ____________________________ have discussed the course, the
(Patient's attending physician)
treatment options that are available and the possible outcomes of his/her prognosis with the individual and/or his/her next of kin. These are the patient's wishes:

____

____

____

☐ ***The patient is not mentally competent at this time.*** I,

__________________________ have discussed the course, the
(Patient's attending physician)

treatment options that are available and the possible outcomes of his/her prognosis with his/her next of kin. These are the next of kin's wishes:

____

____

____

	YES	NO
Patient has a Personal Healthcare Directive indicating End of Life Wishes:	☐	☐
Copy on patient's chart:	☐	☐
Date copy left in the Individuals home:	________	

Patient/Next of Kin Signature: ______________________________

Physician's Signature: ______________________________

Attending Nurse/Witness Signature: ______________________________