



DEPARTMENT OF COMMUNITY SERVICES

Disability Support Program

Planning for End of Life Care Policy and Procedures

Effective: May 2014

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1.0 POLICY STATEMENT

This policy applies to Disability Support Program (DSP) adult participants being supported in DSP licensed homes, or through the Independent Living Support (ILS) or Alternative Family Support (AFS) programs.

The *Planning for End of Life Care Policy and Procedures* replaces the May 28, 2001 *Resuscitation/Supportive Care Policy*.

2.0 POLICY OBJECTIVE

Planning for End of Life Care Policy and Procedures provides that respectful end of life care will be available to a DSP participant, who is diagnosed with a life limiting medical condition, until their death, when appropriate.

3.0 DEFINITIONS

Delegate

The person named in a Personal Directive to make decisions on behalf of the individual, when they are not capable of making personal and health care decisions for themselves.

Do Not Resuscitate (DNR) Order

A directive signed by an attending physician stating that when the heart stops or breathing ceases, no attempts at resuscitation will occur.

End of Life Care/Palliative Care

Active and compassionate care focused on the relief of suffering and the provision of comfort while improving the quality of life and dying for participants with life limiting illnesses.

End of Life Care Plan

A person directed plan which sets out the wishes of a participant for the support and care they would like to receive when diagnosed by their physician with a life limiting medical condition.

Personal Directive

A document which allows an individual to direct how personal care decisions, including health care decisions, are to be made for them if they become incapable of making those decisions for themselves. The personal directive is only in effect when a person is alive and incapable of speaking for themself.

4.0 PLANNING FOR END OF LIFE CARE

When a participant has been diagnosed by their physician with a life limiting medical condition, and they wish to remain in their support option until their death, the autonomy of the participant shall be respected including the participant's right to knowingly accept or refuse a service.

End of life care will be considered when the following apply:

- a) the participant has access to medical services, and a health care resource that can provide ongoing professional assessment and oversight as necessary, such as, but not limited to: an end of life care/palliative care resource, family physician, nurse practitioner, registered nurse or licensed practical nurse;
- b) the participant, service provider, care coordinator, attending physician and an end of life care/palliative care resource all agree that the type of care and support required by the participant can be appropriately provided in their support option;
- c) the service provider is able to provide end of life care within their existing resources or with the augmentation of natural supports and standard community resources;
- d) the service provider's staff can be reasonably expected to have the skills and knowledge necessary, within the scope of their role, to deliver the required care and support needs as determined by the physician or end of life care/palliative care resource;
- e) at any time, should the assessed care needs of the participant exceed the available resources, or if the participant, service provider, care coordinator, attending physician or the end of life care/palliative care resource do not agree that the appropriate services can be provided in the participant's support option until death occurs, plans will be made for a hospital admission for the participant;
- f) other residents in the support option must be considered at all times. The provision of end of life care shall not adversely affect other residents in the home to the extent that they cannot be supported by staff.

5.0 PROCEDURES FOR DEVELOPING AN END OF LIFE CARE PLAN

5.1 As part of the development of an end of life care plan, the following must occur:

- a) the service provider must advise the care coordinator that the

participant has been diagnosed with a life limiting medical condition;

- b) the service provider and care coordinator must confirm that the participant does, or does not, have a personal directive.

5.2 When the participant has an existing personal directive:

- a) the service provider and care coordinator will respect the wishes for end of life care expressed in the personal directive;
- b) if a delegate is named, the service provider and care coordinator will respect the direction for end of life care given by the delegate.

5.3 When the participant does not have a pre-existing personal directive:

- a) the service provider and care coordinator shall make every effort to ensure the participant is provided with all information necessary to make the decisions required to develop an end of life care plan. This may require the involvement of others (family, spiritual advisors, physician, other health care providers, etc.) of the participant's choosing;
- b) the care coordinator will provide input and oversight to the development of the end of life care plan in their role as case manager. This includes approving associated costs according to DSP policy and monitoring the plan's effectiveness in achieving the identified outcomes;
- c) if the participant does not wish to be resuscitated in the event their heart stops beating or they stop breathing, this must be included in their end of life care plan and signed by the participant's attending physician as a do not resuscitate order. Copies of this order will be kept in the participant's support option and in their Department of Community Services file;
- d) upon the wishes of the participant, the end of life care plan may be amended or discontinued at any time;
- e) all supports required as part of this plan shall be available within the capacity of the service provider's resources and approved staffing complement, or with the augmentation of natural supports and standard community resources;
- f) the end of life care plan becomes part of the participant's Individual Support Plan;
- g) details of the end of life care plan will be kept on the participant's file in their support option and on the participants electronic file, maintained

by the care coordinator;

- h) the participant, service provider, and care coordinator will review the end of life care plan as necessary, and at a minimum of annually. Reassessments shall occur at any time when:
 - i) the participant expresses that they would like to review or revise their end of life care plan;
 - ii) there is a change in the participant's health condition that results in a need to amend the end of life care plan.

6.0 APPLICATION

Planning for End of Life Care Policy and Procedures applies to all funded Adult Residential homes, Independent Living Support and Alternative Family Support Service Providers under the mandate of the Department of Community Services, Disability Support Program.

7.0 ACCOUNTABILITY

7.1 Department of Community Services

The Director, Disability Support Program is responsible for ensuring that the DSP achieves the objectives for which it was created, and is delivered within a fiscally sustainable manner.

Regional Administrators are responsible for implementing this Policy and ensuring compliance within their respective areas of responsibility, and that resources are made available.

Managers and supervisors are responsible for complying with this Policy within their respective areas of responsibility and adequately preparing their employees to carry out their respective functions.

Care Coordinators are responsible for complying with the procedures outlined in this Policy.

7.2 Department of Community Services Funded Residential Service Provider Accountability

Service Providers are responsible for complying with this Policy.

8.0 MONITORING

The Director, Disability Support Program is responsible for implementing appropriate mechanisms to ensure monitoring and compliance with this Policy.

Regional Administrators are responsible for regularly monitoring and reporting on compliance with this Policy.

Regional management teams have a role in supporting and providing oversight of this Policy and consulting with the Coordinator of Assessment, as required.

Care Coordinators shall act in collaboration with the participant, the Service Provider and local palliative care resources to monitor alignment with this Policy.