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# Guidelines for Decisions regarding end of life care (Allow for Natural Death).

Saint John of God Kerry Services

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| Title: | Allow for Natural Death |
| Document Reference: | Kerry49 |
| Revision Date: | Sep 2023 |
| Revision Number: | 00 |
| Pages, incl. cover & signature: | 10 |
| Approved By: | PPP Group |

# Policy and Procedure

St John of God Kerry Services is committed to ensuring that end of life care is offered under the values of the St John of God Ministries. End of Life Care is concerned with helping people to live well until the end of life and includes care in the final year of life for people with any end stage illness in any setting. (Gold Standards Framework)

## Purpose

The purpose of this document is to guide staff in offering the optimum care to people who are approaching the end of their life.

## Scope

All staff employed in St John of God Kerry Services.

## End of Life Wishes

St John of God Kerry Services also has a My Final Wishes document which gathers information in relation to an individual's preferences around their end of life wishes, this should not be confused with the End of Life Care Plan described below. However the Glancing Back Planning Forward (SJOG30 End of Life Procedure Appendix 2), if completed, should inform part of the development of an End of Life Plan of Care.

## Management Plans

Cardiopulmonary resuscitation can be attempted on any individual in whom cardiac or respiratory function ceases. Whilst a primary aim of care is to improve and maintain a state of health, it is recognised that in certain circumstances, in order to allow for death with dignity, there should be no interference in the natural process of death.
If cardiac or respiratory arrest is an expected part of the dying process and CPR will not be successful, making and recording an advance decision not to attempt CPR will help to ensure that the person can die in a dignified and peaceful manner.
It may also help to ensure that the persons last hours or days are spent in their preferred place of care by, for example, avoiding emergency admission from a community setting to hospital.
These management plans are called Do Not Attempt CPR (DNACPR) orders, or Do Not Attempt Resuscitation or Allow Natural Death decisions. (GMC 2010)

Allow Natural Death Decisions also provide clarity and direction for staff; specifying that staff:
Administer oxygen as required, position for comfort, splint or immobilise, control bleeding, provide pain medication, provide emotional support, and contact other appropriate health care providers and palliative care team.

**MUST NOT** administer chest compressions, insert an artificial airway, administer resuscitative drugs, defibrillate or cardiovert, provide respiratory assistance (other than administering oxygen), initiate resuscitative IV, or initiate cardiac monitoring.

## End of Life Plan

When a person is approaching the end of their life, a comprehensive person centred end of life care plan should be devised; and all other relevant care plans should be reviewed to reflect the resident's changing needs.
Circumstances where an individual may require an end of life care plan include, a life limiting illness, a terminal diagnosis or a dementia diagnosis, but this list is not exhaustive.
A meeting must be held to develop a plan for each individual and may include family members/independent advocates as appropriate, the GP/consultant, MDT members involved in the person's care, a representative of the palliative care team and nursing and care staff.
The individual should also be involved at this stage of planning; but this will vary on an individual basis.
It may not always be possible for GP/Consultant to attend this meeting, in this event; the plan does not become valid until the GP/Consultant signs off on it. Family members present at the meeting should be made aware of this.
In the absence of the General Practitioner/Consultant attending an end of life meeting, advance discussion should take place with the GP/Consultant and a copy of the minutes and agreed recommendations from the meeting must be forwarded to the GP/Consultant for approval and signature.
The agreed plan is an evolving plan, being continuously reviewed in line with the changing conditions of the resident, and it should include but is not limited to the following:

- Agreed Medical directives
- Treatment
- Conditions for transfer to Acute services
- Emotional support
- Spiritual support
- Physical environment

The plan should ensure that everything possible is being done so that people at the end of their life:

- Are treated as individuals with dignity and respect
- Receive appropriate pain and symptom management
- Are in the company of family, friends, and those who know them.

## Discussion process relating to Allow for Natural Death (AND)

Allowing a natural death simply means not interfering with the natural dying process while providing care directed at keeping the resident as comfortable as possible.
Consideration may be given by the GP to an 'Allow for Natural Death' (AND) decision in the following circumstances:

- If the resident's condition indicates that CPR is unlikely to be successful.

• If the quality of life for the resident, following attempts to resuscitate, is likely to be severely adversely affected.

All relevant reports and information relating to the residents history and current condition must be obtained to inform the decision making process.

When it is possible to consult the resident, his or her refusal of an AND decision must be respected.
Otherwise, the final decision to AND lies with the general physician or Consultant, though family members and other members of the MDT should be involved in the process.
The HSE National Consent Policy (Part Four) on when to and when not to attempt resuscitation provides guidance on the decisions about CPR, noting:
*Decisions about CPR must always be made on the basis of an individual assessment of each case and not, for example, on the basis of age, disability, the subjective views of healthcare professionals regarding the individual's quality of life or whether he/she lives in the community or in long-term care. The individual's own views and values are centrally important..... it is also necessary to consider the likelihood of CPR being successful as well as balancing the benefits and risks involved.*

The policy goes on to state
*If a person has decision-making capacity then his/her family or friends should only be involved in discussions regarding his/her treatment and care with that individual's consent. If the individual is unable to participate in discussions due to his/her physical or cognitive condition, those with a close, on-going, personal relationship with the individual may have insight into his/her previously expressed preferences, wishes and beliefs....*
*However, the role of those close to the individual is not to make the final decision regarding CPR, but rather to help the healthcare professional to make the most appropriate decision. Where CPR is judged inappropriate, it is good practice to inform those close to the resident, but there is no need to seek their 'permission' not to perform CPR in these circumstance*
Relatives should be informed that they cannot legally give consent to, or refuse treatment on a resident's behalf, and that they will not be asked to make a decision on resuscitation. However, they do have a role in helping to determine the resident's best interests for their end of life care, so their views must be carefully considered.
If family members have not been present at any meeting they should be notified regarding the agreed outcome(s) and this must recorded in residents personal plan.

A copy of the minutes is maintained in the resident's IPP.
If consensus cannot be achieved within the team, including family members, an external, second neutral medical opinion must be sought.
If consensus is still not reached, the circumstances must be referred to the Director of Nursing, Care and Support or Director of Care and Support, and the Regional Director who will seek advice (including legal advice) on how best to proceed.

## Procedure for completion of an Allow for Natural Death (AND) decision

The entry in the medical records should clearly document and date, the **AND** decision and the reasons for it, and should be made by the most senior member of the medical team available. This person should ensure that the decision is communicated effectively to other relevant health professionals. Any information pertaining to **AND** decisions for residents must be communicated to all staff at staff change over, team meetings and during induction.
The minutes of the meeting at which the decision to apply an **AND** decision must be signed by the medical practitioner and maintained in the 'End of Life' section of the personal plan using the template for recording End of Life Meeting Minutes/Decisions (Appendix 1). This document should also include the signatures of all present at the meeting. Where there is a time delay in receipt of the minutes, the decision documented in the medical records must be followed.
The document must be signed by all staff members to verify that they are aware of it.
If an accidental incident, not related to the terminal condition occurs, usual first aid interventions should be employed. At the time of the **AND** decision, consideration must be given to its application under these circumstances.
In the absence of a clear documented decision not to resuscitate, resuscitation must be attempted.

## Review

Frequency of a full MDT review of an **AND** decision will vary with each individual, but must be carried out at least **three monthly**, and may also be considered if there is a substantial change in the resident's condition. Where any review of the decisions takes place this must be documented in the review section of the end of life meeting (Appendix 1) .The Review of decisions MUST be stored in at the front of the minutes.

## Bibliography

British Medical Association (2007), *Decisions relating to Cardiopulmonary Resuscitation: A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing.* http://www.bma.org.uk/ethics/cardiopulmonary_resuscitation/CPRDecisions07.jsp *accessed 8/4/2010*

Cleveland Clinic Department of Bioethics (2004), *Policy on Do Not Resuscitate, , www.clevelandclinic.org/bioethics/policies/dnr.html, accessed 28.9/06*

General Medical Council (2010) Treatment and care towards the end of life: good practice in decision making. GMC, Manchester.

Guidelines in relation to obtaining consent to clinical treatment in an acute hospital setting (2006) HSE NE, Kells

HSE(2013) National Consent Policy V1.3

HSE (2020) Guidance on End of Life Care in social care led disability residential centres during COVID-19

McGinn P. (2002), Do not resuscitate, *World of Irish Nursing,* 10 (3).

McNamee J. & O'Keefe S (2004) Documentation of do-not-rescusitate orders in an Irish hospital. *Irish Journal of Medical Science* 173 (2) 99-101

Nambi (2003) Who Decides and How? People with Intellectual Disabilities – Legal Capacity and Decision-Making.

# Appendix 1

## End of Life Meeting

**Name:** **Date of Birth:**
**Address:**

**Date of Meeting:**
**Present:**

**Apologies:**

| **Review of Decisions**<br>*(including Resuscitation, Transfer, Palliative Care)* | |
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| **Please record all reviews and note any amendments to original decisions.** | Date |
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| **Decisions Arising from Meeting**<br>Date:<br>*(including Resuscitation, Transfer, Palliative Care)* | |
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| **Decision** | **Person Responsible** |
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**Meeting Participants:**

| Print Name | Signature | Date |
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**House/Unit staff members**

| I have read and understand the decisions made at this End of Life Meeting. | | |
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| Print Name | Signature | Date |
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SIGNATURE PAGE

I have read, understand and agree to adhere to the attached Policy and Procedure:

| **Print Name** | **Signature** | **Area of Work** | **Date** |
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