7.11 Responding to the Death of an Individual Receiving Services

Purpose

To ensure that employees take the appropriate actions following the death (expected and unexpected) of an individual supported by our agency.

Policy

The Burnaby Association for Community Inclusion (BACI) is responsible for ensuring that individuals we support receive skilled and compassionate care. This is particularly vital when their support needs involve illness(es) or injury(ies) which are deemed critical and/or terminal, or co-morbidities associated with long term, complex and chronic conditions (e.g. chronic dysphagia), which could potentially result in an expected death. In providing this care, employees may encounter an unexpected death of an individual they support. In these circumstances, they are expected to be familiar with, and adhere to, the reporting, documentation and review procedures related to this policy.

Late Life and End of Life Planning are an integral part of the supports and responsibilities which are provided to individuals we serve. These planning processes are part of our commitment to proactively plan throughout an individual's lifespan, so that their wishes are known.

All employees are expected to be familiar with any plans in place that can help guide them in their response to either the expected or unexpected death of an individual.

Definitions

B.C. Coroners Service: Refers to an agency within the Ministry of Justice governed by the *B.C. Coroner's Act*. The agency investigates unnatural, sudden, unexpected, unexplained, or unattended deaths, and has the legal authority to compel the production of records and attendance of witnesses to assist with their responsibilities.

End of Life Care: Refers to the supportive and compassionate care provided for people who are dying and for members of their support network. End of life may include a diagnosis of a terminal illness (e.g., end-stage cancer) or a progressive disease which has become palliative in nature. End of life care is not strictly limited to the immediate moments prior to death but can occur over a period of days, weeks, and even months depending upon the unique circumstances for the individual. Care can encompass emotional, physical/health, psychological, and spiritual supports and focuses on comfort and symptom management.

End of Life Plan: Describes and defines the responsibilities associated with supporting an individual regarding at home end of life care. End of life care plans are complementary to the directions provided in a Health Care Plan.

Late Life Planning: Refers to planning ahead for later life. It considers all aspects of a person's quality of life – health and health care, legal and financial matters, work/community life and retirement, psychological issues, and social roles and resources (Adapted from the American Psychological Association, 2018).

Advance Care Plan: An Advance Care Plan is a written summary of an adult's wishes or instructions to guide a substitute decision-maker if that person is asked by a physician or other health care provider to make a health care treatment decision on behalf of the adult.

No Cardiopulmonary Resuscitation Decision (No CPR) – Medical Order: Refers to an order that instructs people such as first responders, paramedics, and health care providers, not to start CPR on a person's behalf at home or in the community. No CPR is a choice that can be made regarding whether or not cardiopulmonary resuscitation will be initiated in the event of a respiratory and/or cardiac arrest. Individuals who have independent decision-making capacity may request this. A Medical Order form will be required. This should be done after discussions with their doctor or nurse practitioner.

Medical Orders for Scope of Treatment (MOST): The Medical Order for Scope of Treatment (or "MOST") form helps care providers honour what is important to the person. MOST are official documents (Medical Orders). Physicians and other health care professionals use the MOST to relay the treatment wishes and decisions regarding a person's care to others who may be part of the integrated care team. It is a doctor's or nurse practitioner's order based on advance care planning conversations that explore the person's values, goals, and the range of beneficial treatments. Once decisions are made, the doctor will record this on the MOST form.

Personal Support Network: Refers to friends, family and/or community members who provide personal support, advocacy, and/or who help with monitoring services, and who have reciprocal relationships with an individual.

Legal Representative: A person or persons who are legally authorized to make decisions on behalf of the individual (e.g. Committee, Representative, Temporary Substitute Decision Maker). There are legal parameters regarding what kind of decisions can be made by different Legal Representatives and their role and responsibilities in carrying out these duties.

Linking Policies:

1.1 Vision & Mission Statements
1.2 Guiding Principles

1.3 Quality Assurance Policy
1.8 Code of Ethics
2.1 Accessibility Policy
2.2 Access to Service Policy
3.1 General Health & Safety Policy
6.1 Outcomes Management Policy
7.1 Individual Support Planning Policy
7.2. Personal Service Planning Policy
7.3. Individual Support Plans (Care Plans) Policy
7.4 Service Transition Policy
7.5 Adult & Youth Service Evaluation Policy
7.6 Personal Assistance Policy
7.9 Late Life Planning Policy
7.10 End of Life Care Policy
8.1 Privacy Protection for Individuals Policy
9.1. Rights & Responsibilities of People with Disabilities Policy
9.5 Involvement in Decision-Making Policy