E.20 Responding to deterioration in client health

1.0 INTRODUCTION/BACKGROUND

Some of the people Mercy Services assist are the frail aged and people with long-term health issues. In some cases a client's condition may either progressively or suddenly deteriorate. Mercy Services does not specifically provide palliative or high level aged care however Mercy Services clients may need assistance in preparing for these services.

Mercy Services Policy[1] strongly supports the primacy of clients having control over the care provided to them. The philosophy of Mercy Services also requires that we assist clients with more than just their physical health needs in that we*: "recognise and honour the whole person: body, mind, heart and spirit."*[2] In keeping with this holistic framework Mercy Services may need to inform and support clients, and their carers/advocates, make plans and actions relating to their health care, decision making capacity, end of life and meaning of life issues.

The following are some of the plans/actions that a client may want to address:

a) **An Advance Care Directive** (also called a Health Care Directive or a Living Will) is a document that set out a person's wishes in relation to future medical treatment in the event that the person cannot make or communicate their wishes.
http://www.seniorsinfo.nsw.gov.au/__data/assets/pdf_file/0009/79425/SIS_FS5B_Planning_ahead_wills.pdf

b) **A Will** is a document where a person states how they want their assets distributed when they die. A person can prepare their own Will, but the legal profession urges people to have their Will checked by a lawyer or community legal centre to ensure it is valid. If a person does not make a Will the court will appoint an administrator and distribute their assets according to a formula set out in law.
http://www.seniorsinfo.nsw.gov.au/__data/assets/pdf_file/0009/79425/SIS_FS5B_Planning_ahead_wills.pdf

c) **A Centrelink Nominee** is a person authorised by the recipient of a Centrelink payment to receive the payment and deal with Centrelink and on their behalf.

d) **Power of Attorney** is when a person appoints someone (s) as their attorney (delegate) with the power to do anything legally or financially on their behalf *(e.g. pay bills, buy and sell real estate, open and operate bank accounts, enter nursing home and hostel contracts).*
http://www.seniorsinfo.nsw.gov.au/__data/assets/pdf_file/0009/79425/SIS_FS5B_Planning_ahead_wills.pdf

e) **Enduring Power of Attorney** This power of attorney that stays in effect if the person who has appointed the attorney then loses their mental capacity after making the appointment.
http://www.seniorsinfo.nsw.gov.au/__data/assets/pdf_file/0009/79425/SIS_FS5B_Planning_ahead_wills.pdf

[1] E.01 Service Guarantee
[2] A.1 Mission and Philosophy 3.a. page 1

f) **A Guardian** is a person legally appointed by the NSW Guardianship Tribunal or the Supreme Court. The Guardian can legally make important decisions on behalf of another person. That other person must be over the age of 16 and have a disability that affects their capacity, or ability, to make their own decisions. The Guardianship order will detail the extent of decisions the guardian can make decisions such as where the person will live or what services will support them, or to provide medical consent on behalf of a person under guardianship.
http://www.ncat.nsw.gov.au/Pages/guardianship/gt_matter_about/matter_guardianship.aspx

g) **A person responsible** is the person who knows the patient well and is able to give consent for basic medical treatment if the patient is not capable of consenting to their own treatment.
http://www.publicguardian.justice.nsw.gov.au/Documents/fs2_person_responsible_jan2014.pdf

h) **Enduring Guardianship** is where a person appoints another as their Enduring Guardian in the event that they are unable to make their own decisions (e.g., due to illness, disability, accident) on issues such as where they will live, what services they will receive, what health care they will receive and consent to medical and dental treatment on their behalf.
http://www.ncat.nsw.gov.au/Pages/guardianship/gt_matter_about/enduring_guardianship.aspx

i) **Palliative Care** is the specialised, multi-disciplinary and holistic care of someone living with a terminal illness so this person can maximize their quality of life. Palliative care can be provided in the person's home, a hospice or other residential facility.
http://www.palliativecarensw.org.au/about.php

j) ***Distinction between euthanasia/assisted suicide and lawful limitation***
Euthanasia and assisted suicide are illegal in NSW. It is legal for health professionals to withhold or withdraw life-sustaining treatment in accordance with good medical practice and the client's wishes. When treatment is withheld or withdrawn in these circumstances, and a patient subsequently dies, the law classifies the cause of death as the patient's underlying condition and not the actions of others. Following through on a client's request not to resuscitate her/him is an example of a lawful limitation.
http://www.cena.org.au/nsw/end_of_life_guidelines.pdf

k) **Pastoral Care** means acknowledging and nurturing the whole person - their values, spirituality, interests, strengths, humour and aspirations. Pastoral Care can be expressed through:

- providing non-judgemental support and encouragement of each person in his/her religious tradition and/or personal belief system;
- assisting the person in their efforts to find meaning and hope – sometimes with rituals and resources;
- not seeking to change people, but offering them opportunities where, if they wish to, they can make the review and modify the elements of their life; and
- listening to a person as they try to understand and express their thoughts, feelings and experience and providing options for specialist assistance if these are desired by the person.

M:\Shared\POLICY\A. Values Policies\A.6._Pastoral_Care_Policy

l) **High level Aged Care** could refer to any of the range of care options providing more assistance than Mercy Services provides e.g., residential aged care, Home Care Package (levels 3 or 4).
http://www.myagedcare.gov.au/

2.0 SCOPE

The scope of this policy is to provide guidance to Mercy Services staff when a client's health is deteriorating especially when this brings forward complex issues such as: preparation for end of life, client's declining decision making capacity, transition to residential care or death.

3.0 POLICY STATEMENT

Mercy Services staff will strive to provide clients, and people significant in their lives, with the practical, emotional and spiritual support they need to respond to a deterioration of their health.

Mercy Services staff will actively facilitate a client's (and where applicable their carer/advocate) plan/preparation for the possibility of their condition deteriorating.

Mercy Services aims to provide staff and volunteers with the training, information and support they need to cope with deterioration in a client's health or a client's death.

4.0 PROCEDURES

4.a Identifying the planned approach

1. Low level care/low expectation of deterioration

When Mercy Services commences a person with only low level care (e.g. home maintenance, volunteer transport) the person would see it as alarmist and inappropriate for the Mercy Services to suggest they plan for deterioration in their health.

However it would be appropriate for the Mercy Services Coordinator to engage in a discussion on the possibility of deterioration in the client's health when:

- The client's Care/Service Plan is being reviewed (initial, scheduled or due to concerns);
- The client specifically raises concerns about their death/deterioration;
- The client asks for information on Guardianship on similar roles; and/or
- The client's response gives the Coordinator the impression that the clients may have a cognitive or physical decline that needs clarifying with their family/emergency contact person.

2. High level care/high expectation of deterioration

The Coordinator at the point of developing/reviewing a Care/Service Plan (initial, scheduled or due to concerns) will assess:

- Indications that the client's capacity to make decisions may be impaired;
- Whether the client has an Advance Care Plan/Directive and what it states (when a client doesn't have an Advance Care Plan/Directive the Coordinator will explain the benefits and leave a one with the client);
- The degree of family/other support people who will assist the client address a decline in their decision making capacity - including seeking Power of Attorney or Guardianship. (If the Coordinator has concerns about the adequacy of external support for the client then the Coordinator will offer to assist the client review the adequacy of their financial, legal, housing and health decision-making options should their health suddenly deteriorate.)

Where a client has an Advance Care Plan/Directive the Coordinator will ensure that relevant details of this will be made known to staff via the job sheet (roster) and on the client database (e.g., emergency summary, contact details).

Client/carer/advocate will be made aware that Mercy Services has a limited role in providing emergency, clinical and end of life care and does not offer or guarantee 24 hours a day service to a sudden deterioration in client health. In most cases an ambulance or family member will need to provide such support.

The Coordinator will tactfully address the issue if s/he identifies that additional care may be required in the near future or that client plans are inadequate. The Coordinator will provide the client with information on their care options and encourage them (and their carers/advocates) make a decision on these options.

4.b Joint plans between providers where possible/appropriate

Where possible and appropriate, Mercy Services will be a party to a joint plan with other service providers who are assisting the client.

4.c Ensuring capacity to consent

Where Mercy Services staff have concerns with respect to a client's capacity to make informed decisions it is the Coordinator's responsibility to check whether the client's nominated Enduring Guardian/Enduring Attorney is now acting on behalf of the client.

If the client did not appoint an Enduring Guardian/Enduring Attorney the Coordinator will encourage the client's family to make contact with the Guardianship and Management of Property Tribunal to review whether an application for a Guardianship Order may be required. If the client has no family or the family are unwilling to proceed the Coordinator will consult Mercy Services Management before contacting the Guardianship and Management of Property Tribunal.

The client's family/Coordinator may consider contacting the Mental Health Tribunal where the person has a mental illness or mental dysfunction and there are risks associated with non-compliance with the recommended mental health care plan.

The Office of the Community Advocate is also available to discuss options with respect to emergency or long-term guardianship on 6207 0707.

4.d Flags of sudden deterioration

A review of the client's health/abilities by a medical practitioner, Mercy Services, or another service may determine if any deterioration has taken place or is likely to take place. Alternatively, the investigation of an incident may uncover deterioration in the client's health/abilities.

Deterioration in the client's health/ability will require changes to the client's Care Plan. The deterioration may be such that the Mercy Services service needs to bring in additional services. If Mercy Services cannot safely or adequately meet the client's needs the Coordinator will discuss with the client/carer/advocate the process for referring the client elsewhere.

If the client has a sudden cognitive deterioration it will be addressed as per 4.c above.

4.e Assisting with the transition to higher level care

When Mercy Services becomes aware that a client needs a higher level of care than Mercy Services can provide the Coordinator will phone the client/carer/advocate to arrange a meeting to discuss the situation and the client's options. If the client/carer/advocate refuses to participate in such a meeting or at the end of the meeting refuses a transition plan to higher care services the Coordinator will offer them two working days to reconsider.

If the client/carer/advocate still refuses a transition plan to higher care the Coordinator will inform the client/carer/advocate that Mercy Services will not allow its staff or the client to be put at risk of harm and will withdraw services after one month. The Coordinator will inform the client of the reasons for this decision, the client's options for service and the complaints procedure the client/carer/advocate can pursue if they want to appeal this decision. The Coordinator will follow up this discussion with a letter containing the above information (see Appendix one: sample client transition to higher care letter).

Mercy Services will ensure that adequate support is in place while a client awaits high level care.

Mercy Services will encourage prolonged hospitalisation if that be safer and more appropriate than the client returning to her/his home.

4.f Sudden deterioration in client health

When a client has a sudden deterioration of health her/his care preferences will be clarified by the Coordinator. If the client has appointed an Enduring Guardian that person will be contacted by the Coordinator.

Mercy Services will provide additional assistance to the extent that resources and safety considerations allow. If Mercy Services cannot provide the level of assistance required by the client the Coordinator will consult the client/Enduring Guardian about moving to other options.

4.g Preparing clients for end of life

If it becomes apparent that a Mercy Services client is dying the relevant Coordinator will ensure that the client and her/his family/support network are aware of available Pastoral Care and Palliative Care options. If necessary the Coordinator will assist the client and her/his family/support network connect with these services.

4.h Responding to death of a client

If a person dies while still a Mercy Services client the Mercy Services Safe Work Practice Responding to a Client Death will be implemented.

4.i Staff training

Mercy Services Coordinators who are likely to have clients with deteriorating health will seek out any education/training they need to appropriately support clients. This may include education/training in:

1. Pastoral Care;
2. Supporting staff;
3. Awareness of legalities; and/or
4. Awareness of service options.

Mercy Services Coordinators will ensure their staff are adequately prepared for any likely deterioration in client health.

4.j Compliance

Compliance with this policy is being measured by:

a) Manager to check adequacy of service/records to clients with deteriorating health when conducting client file audits.

4.k Evaluation

The performance indicators for the evaluation of this policy are:

a) 90% average satisfaction from clients in the biennial Client Satisfaction Survey.

5.0 REFERENCES

1. Current issues	None identified
2. Australian Standards	None identified
3. Legislation	a) Work Health and Safety Act 2012 (NSW) b) Work Health and Safety Regulations, 2011 (NSW)
4. Professional guidelines	None identified
5. Codes of Practice	None identified
6. Codes of Ethics	a) Australian Association of Social Workers Code of Ethics http://www.aasw.asn.au/document/item/1201 b) Australian Psychological Association Code of Ethics http://www.psychology.org.au/Assets/Files/Code_Ethics_2007.pdf c) The Nursing and Midwifery Board of Australia. Registration Requirements

	http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx d) Integrity in the Service of the Church https://www.catholic.org.au/media-centre/media-releases/cat_view/10-organisations/38-national-committee-for-professional-standards e) Mercy Services Code of Conduct
7. Evidence	a) NSW Health Policy (2010) Recognition and Management of Patients Who Are Clinically Deteriorating http://www.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_026.pdf b) NSW Health (2005) Guidelines- *End-of-Life Care and Decision-Making* GL2005_057 http://www.health.nsw.gov.au/policies/gl/2005/GL2005_057.html c) NSW Office of the Public Guardian (2005) Enduring Guardianship in New South Wales: your way to plan ahead http://www.lawlink.nsw.gov.au/lawlink/opg/ll_opg.nsf/pages/opg_yourwaytoplanahead d) Benevolent Society & Legal Aid NSW (2001) Speaking For Myself http://www.bensoc.org.au/uploads/documents/Speaking-for-myself-2011.pdf
8. Mercy Services Values	Justice, Respect, Care, Unity, Service

6.0 OTHER RELATED POLICIES AND PROCEDURES

- A.01 Mission and Philosophy
- A.03 Code of Conduct (staff and volunteers)
- A.05 Reconciliation
- C.04 Program Performance & Monitoring
- C.05 Quality Improvement
- E.01 Principles of Service Delivery
- E.02 Service Guarantee
- E.03 Meeting Individual Needs
- E.05 Client Participation, Decision Making & Advocacy
- E.06 Involvement of Families and Friends
- E.07 Behaviour Support
- E.08 Complaints
- E.09 Client Records
- E.10 Nursing Care
- E.11 Coordination with other services
- E.13 Cultural Awareness
- E.14 Duty of Care
- E.15 Privacy Policy
- E.16 Protection of Vulnerable adults from Abuse and Neglect
- E.18 Falls Prevention
- E.19 No Response From Client
- G.06 Safe Home Visiting

7.0 RELATIONSHIP WITH STANDARDS

Aged Care Accreditation Standards	***Home Care Standards***	***Disability Standards***	***EQuIP Standards***
1.8, 2.6, 3.5, 3.6, 3.9, 4.5, 4.6	*1.4, 1.6, 2.2, 2.3, 2.4, 2.5, 3.5*	*1.1, 1.2, 1.3, 1.4, 1.4, 1.7, 1.8, 1.9, 2.1, 3.1, 4.5, 5.1,*	*1.1.1, 1.1.4, 1.1.5, 1.2.2*

8.0 DOCUMENT CHANGES RECORD

Dates of change	*Section altered*	*Natures of changes made*
12/08/2011	All	First record of document
14/11/2011	a) Various b) 4.a c) 4.d	a) Include advocate as well as carer b) Changes to nature of Coordinator's assessment and that staff are informed of relevant Advance Care Directive details via job sheet – not Care Plan. c) Added response to sudden cognitive decline
12/12/2011	a) 4.a.1 b) 4j c) 5.0 Referennces d) Appendix Two	a) New section added b) Requirement that compliance be as per Appendix Two c) New WHS Laws and Current Issues added d) New section added
27/11/2012	All Sections	Organisation name updated
29/09/2015	a) 1.0 Introduction b) 3.0 Policy statement c) 4.0 Procedures d) 4.j Compliance and 4.k Evaluation e) 5.0 references f) 6.0 Other related policies g) 7.0 Relationship to Standards h) Appendix 1 i) Appendix 2	a) Update references and web addresses b) Minor changes in words not meaning c) Minor changes to wording to improve clarity d) Completely changed e) Update: Codes of Practice and Evidence f) Update g) Added Aged Care and updated Disability Standards h) Updated i) Deleted
Review due 29/09/2018		

Appendix one: sample client transition to higher care letter

service name

21 August 2015

Dear <client>

I am writing to confirm the conclusion of our conversation on……. that as of <date> we will no longer be providing you with our .... service.

The reason being that:

<quote relevant section of CDC Home Care Package Agreement or NDIA Agreement Booklet or Home Support Program Client Information Booklet).

In the recent meeting you had with me I explained that I am happy to assist you move to alternative care by..... You can also contact the ……. for information on options available to you.

If your situation changes we are happy to look again at whether we can provide you with a service.

If you are not satisfied and want to appeal my decision you can contact me and I will arrange a meeting for you with my Manager. You are welcome to bring an advocate or support person to this meeting.

Please feel free to contact me if you are unclear about your options or if you want more information.

Yours sincerely,

<name>
Coordinator