POLICY DOCUMENT

Policy Title:	Withdrawal of Clinically Assisted Nutrition and Hydration (CANH)
Policy Group:	Clinical
Policy Owner:	Director of Clinical Services
Issue Date:	October 2020
Review Period:	2 years
Next Review Due	October 2022
Author:	Rasheed Meeran
Cross References:	Health records policy Consent policy Information Management Policy Neuropalliative care guidelines Advanced decision to refuse treatment policy
Evidence:	Mental Capacity Act 2005 – Code of Practice CANH and adults who lack capacity (2018) RCP DOC guidelines (2019) BMA Guidance on CANH and adults who lack capacity (20180
How implementation will be monitored:	Health records audit Training MDT meetings Medical Advisory and Ethics Committee meetings
Sanctions to apply for breach:	Further training and support
Computer File Ref.	O: risk management: policies: clinical
Policy Accepted by MT	MAC 27 October 2020
Sign-off by CEO	

STATEMENT OF PURPOSE

This policy sets out standards and procedures related to withdrawal of Clinically Assisted Nutrition and Hydration (CANH), which aim to provide staff employed by Holy Cross Hospital with a clear understanding of the relevant issues.

1. POLICY STATEMENT

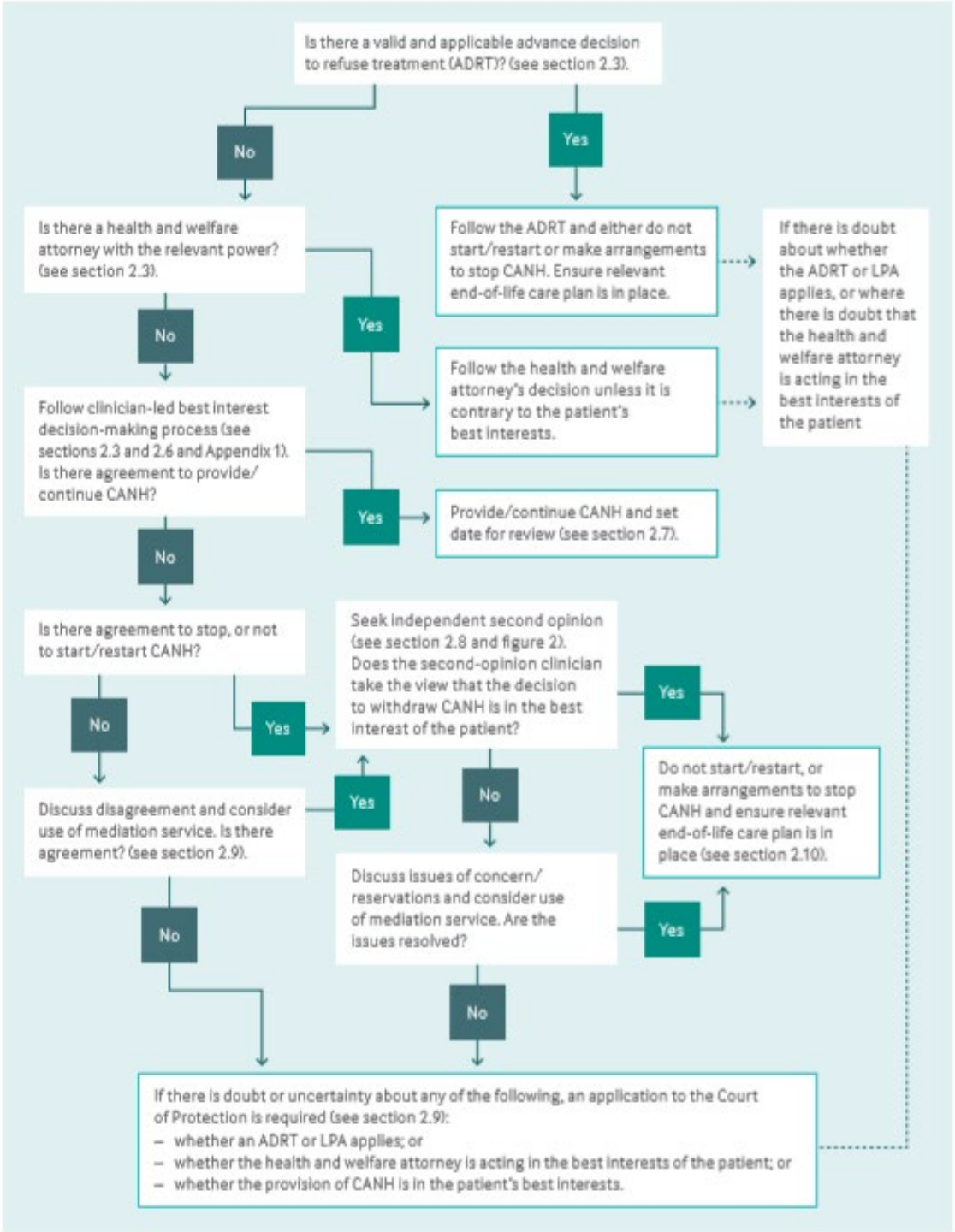
Holy Cross Hospital complies with the legal rights of adults under the Mental Capacity Act 2005 and provides training to relevant staff in all aspects of the Act. Clinical staff will make reasonable efforts to locate a verbal or written advance decision to refuse treatment if there are grounds to believe one exists. Advance decisions to refuse treatment will be included in discussions regarding treatment options if appropriate.

All patients requiring CANH will be reviewed on a regular basis and a decision made to ensure they continue to receive CANH in their best interest. When patients families request withdrawal of CANH, the process recommended by the British Medical Association (2018) and the Royal College of Physicians (2019) will be followed, (please see below)

CANH (Clinically-assisted nutrition and hydration)

BMA

The decision-making process



2. INTRODUCTION

The Mental Capacity Act 2005 formalised previously known advanced directives (living wills) which were part of Common Law. Clearer arrangements were put in place. The Act states:

- Under the Mental Capacity Act 2005 a person over the age of eighteen years who has capacity has a legal right to refuse treatment in advance
- Refusal can be verbal or in writing
- Refusal of life sustaining treatment must be in writing
- Refusal takes affect when the person no longer has capacity unless treatment is for a mental disorder under the Mental Health Act 1983

Advance decisions must be both valid and applicable and relate only to refusal of treatment **not** to a request for treatment.

2.1 Withdrawal of CANH:

The withdrawal of CANH applies to patients who lack mental capacity and is followed in line with the British Medical Associations guidelines published in 2018. CANH refers to all forms of tube-feeding (e.g. via nasogastric tube, percutaneous endoscopic gastrostomy (PEG) or parenteral nutrition). It does not cover oral feeding, by cup, spoon, or any other method for delivering food or nutritional supplements into the patient's mouth. This guidance covers decisions to start, re-start, continue or stop CANH in adult patients in England and Wales who lack the capacity to make the decision for themselves. The Hospital does not perform withdrawal of CANH on site and will transfer the patient to an appropriate provider in Consultation with the patient's family or friends.

3. RESPONSIBILITIES

Healthcare professionals should be aware a patient may have made an advance decision to refuse treatment when they had capacity. Prior to admission, every effort will be made to locate the existence of such a decision including making enquiries to the discharging clinical team.

3.1 Responsibilities of the Clinical Managers:

- Ensure there is no ADRT in place at Holy Cross Hospital
- Senior Clinical staff to ascertain diagnosis using a battery of tests (CRS-R, WHIM etc) in line with the RCP PDOC Guidelines.
- Discuss with the MDT to confirm prognosis for the patient
- Identify, in liaison with Consultant in Rehabilitation, a second Consultant to provide second opinion and a palliative care team who will provide end of life care.
- Inform patient's GP and confirm the presence of ADRT
- Keep CCG informed of all discussions and decisions from the early stages

3.2 Responsibilities related to withdrawal of CANH

3.2.1 Decision Maker: At Holy Cross Hospital, the Consultant in Rehabilitation Medicine assumes responsibility of the decision maker. All CANH withdrawal discussions will be discussed at the Medical Advisory Committee and the Management Team meetings.

3.2.2 Best Interest meetings: The Director of Clinical Services will arrange the Best Interest meetings involving

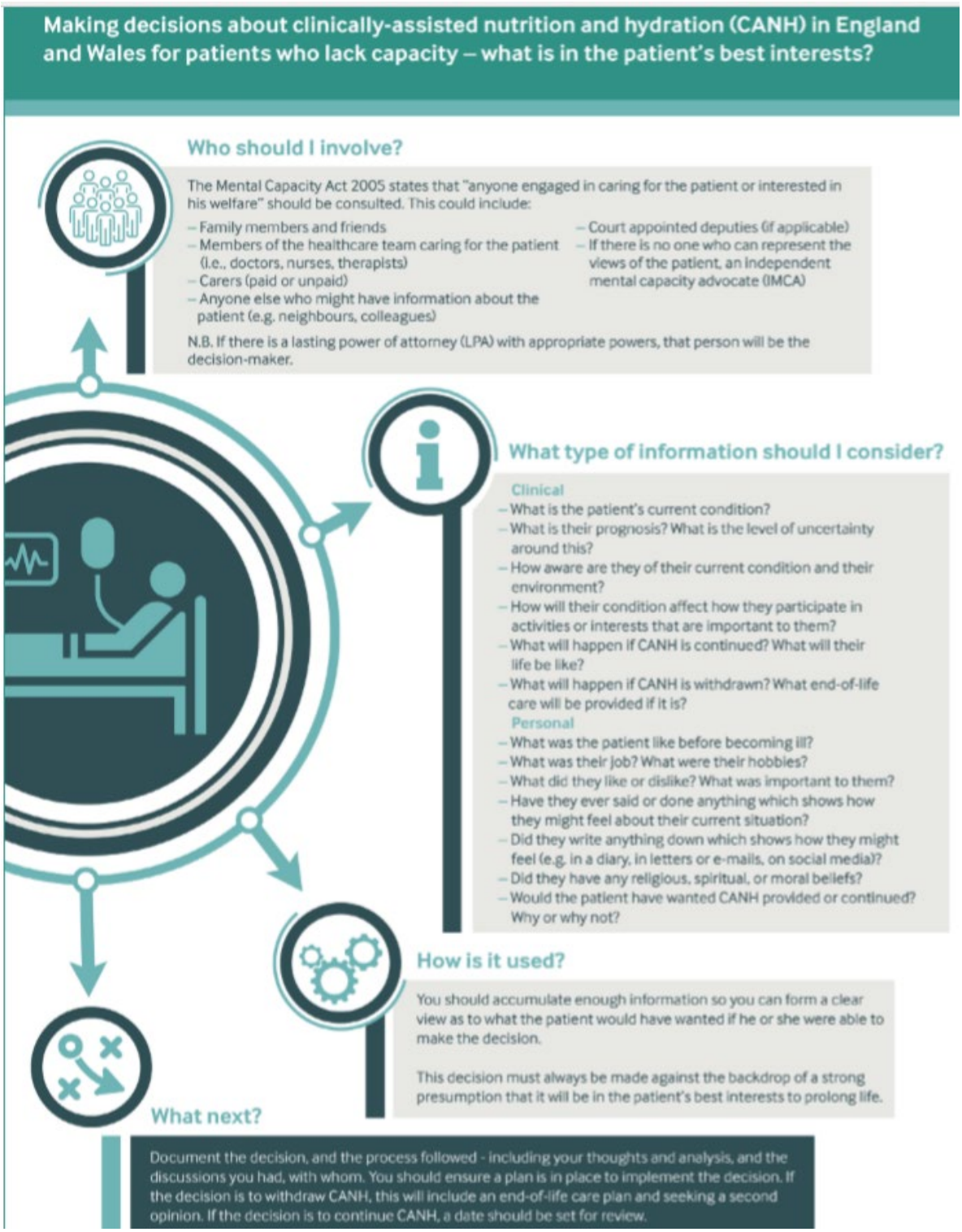
1. Anyone named by the patient as someone to be consulted on such matters;
2. Those 'engaged in caring for the patient or interested in his or her welfare'; This includes the Hospital's MDT, any key external clinicians or case managers involved, the patients relatives and/ or friends
3. A court-appointed deputy (if there is one);
4. An IMCA if nobody fits the above criteria and
5. The patients funding authority i.e. CCG, Social services, Solicitors
6. Family members and significant friends
7. Representative from the Hospital's ethics committee

Legally, family members cannot give consent to or refuse treatment on the patient's behalf unless they have been formally appointed as a health and welfare attorney. Although not the decision-maker, they do have a crucial role in providing information about the patient as part of the best interest assessment (BMA Guidance, 2018). Please see below for best interest decision-making process.

3.2.3 Discharge planning: A suitable discharge destination, most likely a Hospice, will be identified in liaison with the family prior to the best interest meeting. The multidisciplinary team from the discharge destination will be requested to attend the best interest meeting and share the end of life care plan to ensure the family, friends and other professionals involved in the decision making are fully aware of the plans and risks. This will also be an opportunity for the Hospice team to explain the support available for the family and friends.

3.2.3 Ethical considerations: A representative from the Hospital's Medical advisory and Ethics committee will attend the best interest meeting. The notes of the meeting will be shared with the committee to keep them informed of the planned process on a case-by-case basis.

In situations where the Hospital's MDT or Management have unresolved ethical concerns, external support from appropriate professionals or contacts will be sought. This could be from the religious order or from the authors of the BMA or RCP Guidelines.



3.3 Managing uncertainty and disagreement

3.3.1 Where there is uncertainty or disagreement about whether CANH is in the patient's best interests, various informal conflict resolution options should be explored – for example, the involvement of an independent advocate, obtaining a further clinical opinion, holding a case conference, or the use of medical mediation services.

3.3.2 Where those close to the patient disagree with the decision made, they should be provided with clear information about the process to follow to challenge the decision and directed to sources of help or support.

3.3.3 Where there is disagreement about the patient's best interests, or the decision is finely balanced (i.e. there is ongoing uncertainty), and this is unresolved by seeking a further opinion or mediation, the Court of Protection should be asked to resolve the matter.

4. SECOND OPINIONS AND COURT INVOLVEMENT

The Court of Protection should be contacted for advice in cases where it is unclear whether an advance decision is valid and/or applicable.

4.1 Involving the courts in relation to withdrawal of CANH:

4.1.1 Court of Protection proceedings should be initiated and funded by the relevant CCG/ social services responsible for commissioning or providing the patient's care (RCP PDOC Guidelines, 2019).

4.1.2 The family should be kept informed at all stages and every effort should be made to avoid any unnecessary delays, but they should not be responsible for initiating or funding the proceedings. The Director of Clinical Services or the Director of Nursing Services will be nominated to manage this communication effectively.

4.1.3 Applications should clearly set out the treatment that is currently being provided and any decisions that have already been made about ceilings of treatment or intervention.

4.1.4 If an immediate decision is needed about whether or not to re-start CANH, if the feeding tube becomes blocked or dislodged, whilst a case is under consideration by the court, an urgent application should be made to the court, out of hours if necessary. The clinical managers need to ensure appropriate discussions have taken place with the Consultant/ MDT and the court professionals contact details are available in the ward.

4.2 Second opinions related to withdrawal of CANH:

The Consultant in Rehabilitation Medicine will recommend the external Consultant who will carry out the second opinion assessments in line with the BMA guidance i.e. A Consultant who has not been involved in this patients care in the past and an expert in PDOC if relevant.

5 Review

This policy has been reviewed for overt or implied discrimination within the scope of the Hospital's policies on equality and diversity and none was found.

The policy will be reviewed every two years to ensure that the system described continues to provide an effective framework for making decisions to manage withdrawal of Clinically Assisted Nutrition and Hydration.