Guidance on Nurses' Roles in Medical Assistance in Dying

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College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario
THE STANDARD OF CARE.

Table of Contents

Introduction

This document provides nurses[1] with guidance about their accountabilities related to medical assistance in dying.[2] Nurses are also accountable for complying with other College of Nurses of Ontario (CNO) standards and guidelines as applicable. They are available at www.cno.org/standards. If you have questions or concerns about how the legislation applies to your practice or about liabilities, please talk to your organization or seek legal advice.

Medical assistance in dying (MAID), as defined in the *Criminal Code*, refers to when:

- A Nurse Practitioner (NP) or physician provides assistance by administering a medication to a patient, at their request, that causes their death (i.e. practitioner-assisted medical assistance in dying) or
- An NP or physician prescribes or provides a medication to a patient, at their request, so that they may self-administer the medication, and in doing so, cause their own death (i.e. patient self-administered medical assistance in dying).

Key legislative changes

The *Criminal Code* provisions that relate to medical assistance in dying first came into effect on June 17, 2016 through Bill C-14. The Bill allowed eligible people to receive medical assistance in dying. It establishes safeguards for patients and offers protection to health professionals who provide medical assistance in dying, along with people who assist in the process in keeping with the law. Medical assistance in dying must be provided with reasonable knowledge, care and skill, and in accordance with any applicable laws, rules or standards. Nurses who fail to comply with legal requirements may be convicted of a criminal offence.

Truchon V Canada (AG) decision

On Sept. 11, 2019, the Superior Court of Québec, in its *Truchon v Canada* (AG) decision, declared that it is unconstitutional for the federal medical assistance in dying legislation to require that natural death must be reasonably foreseeable to be eligible for Medical assistance in dying. Also, the "end of life" eligibility criterion contained in Quebec's *Act Respecting End-of-Life Care* was declared unconstitutional.

[1] RNs, RPNs and NPs

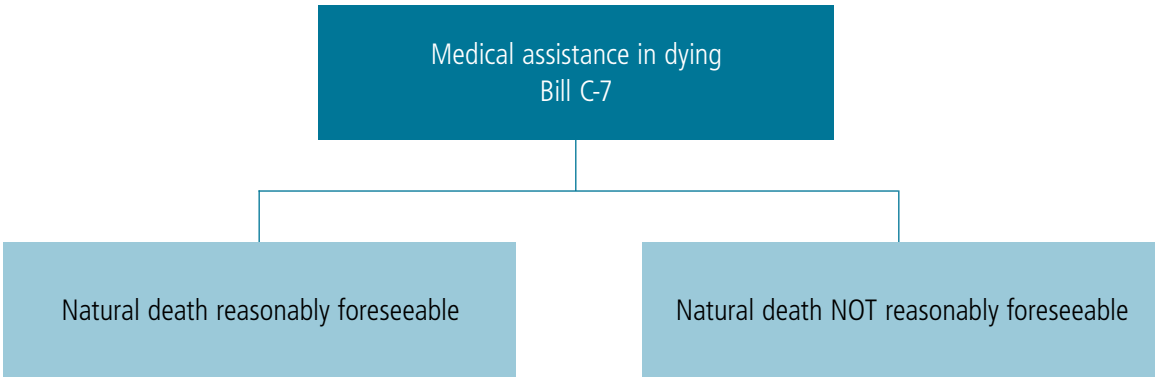
[2] This document is based on *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*: https://laws-lois.justice.gc.ca/eng/acts/C-46/page-53.html#docCont.

Bill C-7

Bill C-7, which took effect Mar. 17, 2021 is the Government of Canada's legislative response to the *Truchon* decision.

Bill C-7 made the following amendments to the *Criminal Code*:

- **Eligibility criteria**
  Removed the "reasonably foreseeable natural death" criterion and excluded cases where mental illness is the sole underlying medical condition. This exclusion remains in effect until Mar. 17, 2023. The government will review this criterion with an expert panel.
- **Safeguards**
  Created a two-track approach to procedural safeguards for practitioners to follow – one set of eased safeguards for people whose natural death is reasonably foreseeable, and a second set of new and clarified safeguards for people whose natural death is not reasonably foreseeable.



- **Advanced consent**
  Permitted the administration of medical assistance in dying on the basis of advanced consent. In other words, the requirement for final consent at the time of the medical assistance in dying procedure would be waived by operation of law:
  - for patients whose natural death is reasonably foreseeable and who have been assessed and approved for medical assistance in dying, if they lose capacity to consent before their preferred date for medical assistance in dying and have a written arrangement with a practitioner[3]
  - to permit advanced consent to the administration of medical assistance in dying by a practitioner in cases of failed self-administration

- **Monitoring regime**
  Enhanced the reporting requirements based on experiences with the federal medical assistance in dying monitoring regime to date.

[3] In this document, practitioner refers to an NP or physician.

Providing medical assistance in dying

General nursing accountabilities

Medical assistance in dying requires the involvement of an NP or a physician. An NP can provide an eligible patient with medical assistance in dying provided it is done in accordance with the federal law, as well as any applicable provincial laws, rules or standards. Registered Nurses (RNs) and Registered Practical Nurses (RPNs) can participate by providing nursing care and supporting an NP or physician who is providing medical assistance in dying, according to the law.

NP students can participate in providing nursing care in current capacity as an RN but they cannot perform eligibility assessments for medical assistance in dying. Only physicians and NPs have this authority. NP students can, however, learn about the eligibility assessment process through observation and discussion with their mentors.

When a patient chooses practitioner-assisted medical assistance in dying, the law allows only NPs and physicians to administer medications to cause the death of the patient. No other health care providers, including RNs and RPNs, are legally permitted to administer medication for medical assistance in dying.

When any nurse is assisting an NP or a physician with providing medical assistance in dying in accordance with the law, they may perform activities such as (but not limited to):

- educating patients, providing support and comfort to patients and family
- inserting an intravenous line (with an order) that will be used to administer medications that will cause the death of a patient
- acting as an independent witness

Nurses who give information to patients about the lawful provision of medical assistance in dying must ensure they do not encourage or pressure the patient to choose medical assistance in dying.

Conscientious objection

CNO recognizes a nurse's freedom of conscience. A nurse may have beliefs and values that differ from those of a patient and may not be comfortable providing or participating in medical assistance in dying. The law does not compel an individual to provide or assist in providing medical assistance in dying. Therefore, a nurse may conscientiously object. However, conscientious objection must not be directly conveyed to the patient and no moral judgments about the beliefs, lifestyle, identity or characteristics of the patient should be expressed. Nurses who conscientiously object must transfer the care of the patient to another nurse or health care provider who will address the patient's needs. Nurses can work with their employers to identify an appropriate alternative care provider. Until a replacement caregiver is found, the nurse must continue to provide other nursing care, as per the patient's care plan that is not related to activities associated with medical assistance in dying.

Practitioners who conscientiously object to providing medical assistance in dying can either make a referral using their own professional networks or institutional policies, or they may contact the Ministry of Health and Long-Term Care's Care Coordination Service.

A Nurse Practitioner's role in medical assistance in dying

The law allows NPs to provide the following to patients who have requested medical assistance in dying:

- administering a medication to the patient, at their request, that will cause the patient's death (i.e., practitioner-assisted medical assistance in dying) and
- prescribing or providing a medication to the patient to self-administer, and in doing so, cause their own death (i.e., patient self-administered medical assistance in dying).

NPs have reporting requirements that occur at various stages during the process of medical assistance in dying. The most obvious is the report to the Office of the Chief Coroner at the end of medical assistance in dying. However, NPs are also required to report to Health Canada under certain conditions (See the Reporting Requirements section on page 14)

In addition, an NP may provide an independent second opinion on a patient's eligibility to receive medical assistance in dying. NPs should consider their ability to provide these services early in the process to support timely access to care.

NPs who do not provide medical assistance in dying must refer the patient who requests this to another NP or physician who provides this service.

Stages in medical assistance in dying

The following stages are involved whether a patient's natural death is reasonably foreseeable or not:

Stage 1: Determine eligibility
Stage 2: Ensure safeguards are met
Stage 3: Obtain consent
Stage 4: Provide Medical assistance in dying – either by the NP or physician, or self-administered by the patient

NPs who may be providing medical assistance in dying (and RNs and RPNs who may be supporting this process) must have a comprehensive understanding of these stages, including the risks, eligibility criteria, safeguards, and processes.

Stage 1: Determine eligibility

The criteria for determining eligibility applies whether natural death is reasonably foreseeable or not. NPs who provide medical assistance in dying are responsible for establishing the patient's eligibility for the procedure.

Eligibility criteria

The law states that to be eligible for medical assistance in dying, the patient must meet the following criteria:

- be at least 18 years of age
- be capable of making decisions about their health
- have a grievous and irremediable medical condition
- voluntarily request medical assistance in dying (in particular, not as a result of external pressure)
- give informed consent to receive medical assistance in dying after they were informed of treatments available to relieve their suffering, including palliative care
- be eligible to receive health services funded by a government in Canada.

The law defines a patient as having a grievous and irremediable medical condition only if:

- they have a serious and incurable illness, disease or disability
- they are in an advanced state of irreversible decline in capability
- that illness, disease, disability or state of decline causes them enduring physical or psychological suffering that is intolerable to them and cannot be relieved under conditions that they consider acceptable.

Medical assistance in dying excludes cases where mental illness is the ***sole*** underlying medical condition. This exclusion remains in effect until Mar. 17, 2023. The government will review this criterion with an expert panel.

The remainder of this document will guide nurses through stages 2 to 4 and explain what must be done before providing medical assistance in dying:

- When a patient's natural death is reasonably foreseeable (See page 8)
- When a patient's natural death is NOT reasonably foreseeable (See page 12)

When a patient's natural death is reasonably foreseeable

What is a reasonably foreseeable natural death?

Each patient who is seeking medical assistance in dying is assessed on a case-by-case basis to determine if their natural death is reasonably foreseeable. Anticipating how long a patient has left to live is challenging. Reasonably foreseeable natural death is not defined by a maximum or minimum prognosis, but it does require a connection to death where the patient is approaching the end of their life in the near future.

The NP or physician who assesses the patient must consider the whole individual and their unique medical circumstances. This stream is not limited to those who have an illness that is known to cause death but can result from multiple factors.

Stage 2: Ensure safeguards are met

The following are safeguards that must be in place when providing medical assistance in dying for a patient with a reasonably foreseeable natural death:

- patient's written request signed by one independent witness
- confirmation of patient's eligibility provided by two independent practitioners (NP or physician)
- patient is informed that they can withdraw consent at any time (unless the patient has an "advanced consent agreement," they must be given an opportunity to withdraw their consent and give express consent again immediately before medical assistance in dying is provided)
- all necessary measures are taken to provide a reliable means for patients with difficulty communicating to understand and communicate their decision.
- immediately before providing medical assistance in dying, the patient is given an opportunity to withdraw their request and ensure that the patient gives express consent to receive medical assistance in dying (this verification of final consent can be waived in certain circumstances, see section on Consent on page 10).

Written request

The law requires the patient to make a written request for medical assistance in dying.

The request must be signed and dated by the patient after they have been assessed as eligible by a physician or NP. If the patient is unable to sign and date the request, another individual may do so in the patient's presence and under the patient's express direction. The person who signs on the patient's behalf must meet the following criteria:

- be at least 18 years of age
- understand the nature of the request for medical assistance in dying
- not know or believe that they are a beneficiary under the patient's will and
- not know or believe that they are a recipient, in any other way, of a financial or other material benefit resulting from the patient's death.

Independent witness

The law requires that the NP must be satisfied that the patient's written request for medical assistance in dying was signed and dated by the patient (or a person on their behalf) before one independent witness who is also required to sign and date the request.

The law requires that witnesses must be at least 18 years of age and understand the nature of medical assistance in dying. Witnesses must **not**:

- know or believe that they are a beneficiary under the patient's will
- know or believe that they are a recipient, in any other way, of a financial or other material benefit resulting from the patient's death
- be an owner or operator of a health care facility where the patient is being treated, or any facility in which the patient resides.

RNs and RPNs involved in the medical assistance in dying process may be asked to be an independent witness. Bill C-7 allows nurses to act as a witness if the provision of care is their primary occupation and they are paid to provide that care. NPs providing medical assistance in dying or NPs providing the eligibility assessment cannot act as a witness.

Accountabilities of the practitioner who provides second written opinion on eligibility

The law requires that an NP who provides a patient with medical assistance in dying must ensure that there has been a second written opinion from another NP or physician confirming that the patient meets all the eligibility criteria listed above.

The law requires that the NP or physician who provides the second opinion must be independent from the NP or physician who provides medical assistance in dying. Specifically, the two providers must not be:

- in a mentoring or supervisory relationship with one another
- connected in any other way that would affect their objectivity.

Furthermore, the two providers must not know or believe that they are:

- a beneficiary under the patient's will
- a recipient, in any other way, of a financial or other material benefit resulting from the patient's death or
- connected to the patient in any other way that would affect their objectivity.

If the second NP or physician concludes that the patient does not meet the criteria for medical assistance in dying, the NP cannot proceed with providing medical assistance in dying. The patient could have another NP or physician assess them against the criteria.

Supporting patient's communication needs

The law requires that, if a patient has difficulty communicating, NPs and physicians should take all necessary measures to provide a reliable means by which the patient can understand the information provided to them and communicate their decision with respect to medical assistance in dying.

Virtual assessments

Practitioners are permitted to use virtual means to assess a patient's request for medical assistance in dying, as long as any care provided through virtual means meets the requirements set out in law as well as all of the standards and expectations that apply to care provided to a patient (See CNO's *Telepractice* Guideline).

Stage 3: Consent

As with any nursing intervention, procedure or activity, NPs are accountable for obtaining informed consent. Here are the different types of consent to consider in medical assistance in dying (each will apply depending the patient's wishes):

- general consent
- advanced consent
- express consent (final)

For more information about the different types of consent, read the *Consent* practice guideline.

General Consent

Under the *Health Care Consent Act, 1996*, a patient is capable of making decisions about their health if they are able to understand the information that is relevant to making the decision and appreciate the reasonably foreseeable consequences of a decision or lack of decision.

Advanced consent agreements

An "advanced consent agreement" allows patients whose natural death is reasonably foreseeable to retain their ability to receive medical assistance in dying if they should happen to lose capacity to consent after they have been approved, but before it is provided.

Advanced consent waives the requirement for final consent if the following conditions are met:

- Before the person loses the capacity to consent:
  - the patient's natural death is reasonably foreseeable
  - the patient has been assessed and approved for medical assistance in dying in accordance with all applicable safeguards
  - they have indicated in their written arrangement their preferred date to receive medical assistance in dying
  - they have been informed by their practitioner that they are at risk of losing the capacity to consent to medical assistance in dying before their preferred date, and
  - the patient has a written arrangement giving advance consent to their practitioner to receive medical assistance in dying on their preferred date if they no longer have the capacity to give final consent on that date, and the practitioner agrees to provide medical assistance in dying on that date if the patient has in fact lost the capacity to consent at that time. They may also agree that the practitioner will provide medical assistance in dying earlier than the preferred date, upon loss of capacity, if so desired.
- The person has lost capacity to consent to medical assistance in dying.
- The person neither demonstrates, by words, sounds or gestures, refusal or resistance to the administration of the substance.
- The substance is administered in accordance with the terms of the arrangement.

Practitioners must not implement the advanced consent for medical assistance in dying in cases where the patient demonstrates, by words, sounds or gestures, refusal or resistance to the administration of the substance to cause their death. A demonstration of resistance would make the advanced consent arrangement invalid going forward. If the patient regains capacity at a later date, they could consent to receiving medical assistance in dying at that time (as long as they continue to meet all eligibility criteria) or they could draft a new advanced consent arrangement with their practitioner.

Bill C-7 clarifies that involuntary bodily actions, such as twitching or physical recoiling from contact or insertion of needles, for instance, do not equate to resistance or refusal.

Express consent (final)

The law requires the NP to ensure that the patient gives express consent to receive medical assistance in dying immediately before administering medication to cause death or providing a prescription for a medication for the patient to self-administer. The law also requires that NPs give the patient an opportunity to withdraw their request. The exceptions to this are outlined below.

Exception to final consent to medical assistance in dying

A patient who has chosen to self-administer medical assistance in dying can create a back-up plan in case self-administration fails to produce death within a specified time and causes the patient to lose capacity. This applies whether natural death is reasonably foreseeable or not. The patient would need to have entered into an agreement with the practitioner that will be present at the time of self-administration, who will administer a second substance to cause the person's death if the patient loses capacity to consent and has not died within a specified time.

When a patient's natural death is NOT reasonably foreseeable

Stage 2: Ensure safeguards are met

The following safeguards must be in place when providing medical assistance in dying for a patient whose natural death is **NOT** reasonably foreseeable:

- patient's written request signed by one independent witness
- a 90-day assessment period is observed – the law requires at least 90 clear days between the day on which the first assessment begins and the day medical assistance in dying is provided. If the assessments have been completed and both of the practitioners are of the opinion that the loss of the patient's capacity to provide consent is imminent, the NP or physician who will provide medical assistance in dying can consider a shorter period that is appropriate in the circumstances.
- confirmation of patient's eligibility provided by two independent practitioners:
  - A second physician or NP must provide a written opinion confirming that the patient meets the criteria.
  - One practitioner must have expertise in the condition that is causing suffering. If neither physician nor NP has expertise in the condition causing the patient's suffering, a third physician or NP with such expertise must be consulted.
- the patient is informed that they can withdraw consent at any time
- the patient is informed about the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care. The patient must have been offered consultations with relevant professionals who provide those services. The practitioners must agree that the patient has seriously considered these available services.

- all necessary measures are taken to provide a reliable means for the patient to understand and communicate their decision if the patient has difficulty communicating

- immediately before providing medical assistance in dying, the patient is given an opportunity to withdraw their request and the practitioner makes sure the patient gives express consent to receive medical assistance in dying (this verification of final consent can be waived in certain circumstances, though it is more limited compared to when natural death is reasonably foreseeable. See section on Consent on page 13).

Stage 3: Consent

Here are the different types of consent to consider in medical assistance in dying when death is **NOT** reasonably foreseeable:

- general consent
- express consent (final)

Similar to the guidance provided for patients whose death is reasonably foreseeable, the *Health Care Consent Act, 1996*, still applies. The patient must be capable of making decisions about their health, be able to understand the information that is relevant to making the decision and appreciate the reasonably foreseeable consequences of a decision or lack of decision.

For more information about the different types of consent, read the *Consent* practice guideline.

Exception to final consent to medical assistance in dying

There is an exception to final consent to medical assistance in dying, which applies whether natural death is reasonably foreseeable or not. This allows a patient who has chosen to self-administer medical assistance in dying to create a back-up plan in case self-administration fails to produce death within a specified period of time but results in a loss of capacity. The patient would need to enter into an agreement with the practitioner that will be present at the time of self-administration, who will administer medical assistance in dying if the patient loses capacity.

Stage 4: Provide medical assistance in dying

Prescribing, providing or administering medications that cause death

This section applies for reasonably foreseeable natural death and death that is not reasonably foreseeable.

Immediately before providing medical assistance in dying, give the patient an opportunity to withdraw their request and ensure that the patient gives express consent to receive medical assistance in dying (this verification of final consent can be waived in certain circumstances, see section on Consent on page 10).

NPs use evidence and consider each patient's unique situation to inform decisions about which medications to use when providing the patient with medical assistance in dying. They are accountable for following the standards for therapeutic management and prescribing outlined in the Nurse Practitioner practice standard.

NPs ensure the safe disposal of unused medication after providing medical assistance in dying. If prescribing medication for a patient to self-administer at a later time, NPs should work with the patient to develop a plan for the safe storage of medication and safe disposal of unused medication.

We encourage NPs to work with their broader health care teams, including pharmacy professionals, to support the safe disposal and storage of medications for medical assistance in dying.

Reporting requirements

Reporting is required, and may occur, at different stages of medical assistance in dying.

In Ontario, a hybrid model is being used to monitor medical assistance in dying reports. This approach captures information where medical assistance in dying deaths have occurred. It also captures written requests for medical assistance in dying where deaths have not occurred.

Reporting to the Coroner

In accordance with the *Coroner's Act, 1990*, NPs must report all deaths from medical assistance in dying to the Office of the Chief Coroner. As part of the consent process, NPs should inform the patient about the requirement to notify the coroner. Where a patient chooses to self-administer medical assistance in dying, NPs should collaborate with the patient to develop a plan for how the coroner will be notified. NPs must be available to provide information to the coroner after providing medical assistance in dying. The coroner will inform the NP if an investigation will be conducted into the medically assisted death, and if a medical certificate of death will be subsequently issued. Otherwise, NPs can complete the medical certificate of death if the conditions under which NPs can complete medical certificates of death are met. These conditions are outlined in the Handbook of Medical Certification of Death.

More information about issuing medical certificates of death, and access to the *Handbook on Medical Certification of Death*, can be found in the Practice Resources section at www.cno.org/np.

Reporting to Health Canada

In cases where a request was made, but a medically assisted death has not occurred, NPs are required to report to Health Canada using the MAID Data Collection Portal. This includes any case in which an assessment takes place, not only cases in which a written request has been submitted to the physician or NP. This also includes cases where:

- an NP has provided a prescription for self-administered medical assistance in dying but a medically assisted death has not occurred
- the patient is ineligible for medical assistance in dying
- the patient withdraws their request
- the patient dies from another cause

Bill C-7 has introduced new reporting requirements, which includes the elements considered in the course of the assessments and information about the race, indigenous identity and/or disability of a person who requests or receives medical assistance in dying, if the person consents to providing the information.

Other considerations

Considering the practice setting

Practice settings play an important role when nurses perform a procedure or activity, including medical assistance in dying. Nurses should consider the practice supports and consultation resources that would help them in clinical decision-making.

Debriefing after medical assistance in dying is provided

CNO recognizes the emotional impact that providing medical assistance in dying has on health care providers. Providing medical assistance in dying may pose a risk of increased moral distress, burnout, and trauma. To address these risks, it is important for health care providers to have debriefings with their broader health care team to have a safe space to talk about medical assistance in dying, the patient and the perspectives and feelings of the team. We encourage you to debrief with your teams to reflect on your experiences.

The importance of self-care

Lastly, it is also important to take care of yourselves. Research shows that physical and emotional fatigue can reduce brain function and affect decision-making, memory and attention. Our personal and professional lives will have ups and downs. Take a step back and reflect on whether you feel your physical or mental health is impacting the care you are providing. If it is, it might be time to self-care or to seek help. For more information, read Supporting Nurses in Self-Care Webpage and the Self-Care Fact Sheet. Also, consider any other resources that may be available through your employer.

CNO will continue to monitor any changes that will impact this guidance and modify this information as required. Please see www.cno.org for updates.

Glossary

Capacity: A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision[4].

Conscientious Objection: The health care provider's right to refuse participation in the provision of medical assistance in dying[5].

Practitioner: A person who under the laws of the province is entitled to practice medicine (physician) or as a nurse practitioner (NP)[6] .

Safeguards: Measures taken to ensure the lawful provision of medical assistance in dying.

[4] Definition from *Health Care Consent Act*.

[5] Definition from Royal College of Physicians and Surgeons of Canada (n.d.) from: Conscientious Objection to Medical Assistance in Dying (MAiD) : The Royal College of Physicians and Surgeons of Canada

[6] Definition from Criminal Code

Resources

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