

Admissions

The Teresa Dellar Palliative Care Residence has a total of 23 beds, providing compassionate care and thus allowing the terminally ill to die in comfort and with dignity in a warm, home-like environment, close to their family and in their community. It is a non-profit organization that relies on community support. The Residence's team of physicians, nurses, supportive care workers and volunteers come together to address the needs of our patients and their families.

To be eligible for admission:

- ❖ have a terminal diagnosis
 - ❖ not be undergoing any current life-sustaining or prolonging forms of treatments
 - ❖ have a less than three (3) month prognosis
 - ❖ residing or have been treated in the CIUSSS West Island territory
- or
- ❖ primary caregiver resides in the CIUSSS West Island Territory
 - ❖ Completed application
 - Medical information provided by a healthcare team
 - Consent form
 - Understood and signed by the patient, if capable or natural caregiver.

Despite receiving all required documentation, there may be a delay in admission due to bed availability at that particular time. Please be aware that admissions take place Monday through Friday, except during statutory holidays. Not everyone who is dying requires specialized palliative care, as our beds are limited; people who suffer from uncomfortable symptoms take priority.

The out-of-pocket expenses for the patient and/or family are:

- the portion of medications not covered by their drug insurance (including RAMQ)
- any specialized medical supplies (specialized dressings, ostomy supplies etc.)
- toiletries (including incontinent products)
- transportation costs if incurred (extra-ordinary circumstances)

All of our rooms:

- | | | |
|----------------------|------------------------------------|---------------------------------|
| ❖ private | ❖ mini fridge | ❖ no rigid visiting hours |
| ❖ adjoining bathroom | ❖ WIFI accessibility | ❖ option of a visitor overnight |
| ❖ hospital bed | ❖ computer station | ❖ child friendly |
| ❖ telephone | ❖ natural light from large windows | ❖ pet friendly |
| ❖ television | | |

For questions or concerns, you may visit our website www.palliativecareresidence.ca or contact the admissions team directly at (514) 693-1718, ext. 260



265 André-Brunet, Kirkland, QC, H9H 3R4

Admission: (514) 693-1718 ext. 260 Fax: (514) 693-0374

| | | |
|--|---|--------------------------------|
| Name: | DOB: | Age: |
| RAMQ: | Exp: | Civil status: |
| Address: | Tel.: | |
| Language: | | |
| Main caregiver: | Relationship: | Tel.: |
| Patient is at: home <input type="checkbox"/> (lives alone? Yes / No) | Hospital <input type="checkbox"/> specify | Other <input type="checkbox"/> |
| Known to CLSC <input type="checkbox"/> specify | NOVA <input type="checkbox"/> | |
| Referring person: | Tel.: | |
| Case manager: | Tel.: | |

Reason for Application: End of Life Care Urgent Non-urgent Future admission
Is the patient aware of admission request? Yes No If no, why not? _____

Medical History

Primary illness: _____

Date of initial diagnosis: _____ Where was the diagnosis made: _____

Metastases:

Liver Lung Brain Bone
Lymph nodes Pleural Adrenal Peritoneal
Other: _____

Presence of complications:

Lymphedema Pleural effusion Spinal cord compression Bowel obstruction
Ascites Seizure Aspiration pneumonia Psychological distress
Hemorrhage Hypercalcemia Hematological abnormalities Anorexia/Cachexia

Wounds/Ulcers: _____

Other: _____

Treatments received:

Surgery Procedure/date: _____

Chemotherapy Drug/date of last dose: _____

Immunotherapy Type/date of last dose: _____

Radiation Location/date: _____

Current symptoms: Underline symptom is not well controlled

Pain Location(s): _____

Dyspnea Dyspnea at rest Cough Edema Pruritus Weight loss

Dry mouth Dysphagia Nausea Vomiting Constipation Diarrhea

Thrush Depression Anxiety Agitation Delirium Insomnia

Urinary incontinence Fecal incontinence

Presence of infection:

MRSA VRE C-Diff CRO Other: _____

| | |
|------------------------------------|------------------------------------|
| Physician's signature: _____ | Date: _____ |
| Prognosis: | |
| <input type="checkbox"/> ≤ 2 weeks | <input type="checkbox"/> ≤ 6 weeks |
| <input type="checkbox"/> ≤ 3month | <input type="checkbox"/> ≥ 3months |



Pertinent medical history: _____

Allergies: _____

Nursing Care: **Fall Risk**

| | | | |
|----------------------|--------------------------------------|--|---|
| <i>Mobilization:</i> | Independent <input type="checkbox"/> | Assistance <input type="checkbox"/> | (cane <input type="checkbox"/> walker <input type="checkbox"/> Assist from: 1 person <input type="checkbox"/> 2 people <input type="checkbox"/> |
| | Normal <input type="checkbox"/> | Reduced <input type="checkbox"/> | Mainly sits/lies <input type="checkbox"/> Mainly in bed <input type="checkbox"/> Bedbound <input type="checkbox"/> |
| <i>Care:</i> | Independent <input type="checkbox"/> | Assistance (Occasional <input type="checkbox"/> Significant <input type="checkbox"/> Total care <input type="checkbox"/> | |
| <i>Intake:</i> | Normal <input type="checkbox"/> | Reduce <input type="checkbox"/> | Sips only <input type="checkbox"/> Mouth care only <input type="checkbox"/> |
| <i>Alertness:</i> | Normal <input type="checkbox"/> | Somnolent <input type="checkbox"/> | Unresponsive <input type="checkbox"/> |

Specific care requirements: (Protocols and supplies will be required, and may be at the cost of patient)

Colostomy Ileostomy Urostomy Nephrostomy (Left Right Tracheostomy

PleurX Frequency: _____ Date/Amount last drained: _____

Pigtail Frequency: _____ Date/Amount last drained: _____

Pacemaker Implantable Cardioverter-Defibrillator (ICD) Anticoagulants specify _____

Gastric suction Nasogastric tube (NGT) Oxygen _____ L/min

Foley catheter: _____ French date inserted: ____/____/____ reason: _____

Enteral nutrition specify _____

Pressure injury Location: _____ Include Treatment Plan

Family/Psychosocial:

Place of birth: _____

Family composition: Partner Parents Siblings # _____ Children # _____

Name: _____ Relationship: _____ Tel.: _____ Name: _____

_____ Relationship: _____ Tel.: _____ Name: _____

_____ Relationship: _____ Tel.: _____ Pertinent

information: _____

Patient aware of diagnosis/prognosis yes no why not? _____

Family aware of diagnosis/prognosis yes no why not? _____

Does the patient expect to die: at home in an institution

Spiritual Care:

Is the patient affiliated with an organized religion/culture? _____

Does the patient have any particular spiritual needs and/or rituals? _____

Additional Information/Comments:

Documents required for completion of application:

Condition for admission consent forms Medication list Medical summary

Consults Progress notes Pathology/Cytology reports Lab results

Microbiology results Pertinent CT scans, X-rays, PET, MRI

For TDPCR use only:

PPS:

PPI:



CONDITIONS FOR ADMISSION

Patient's name: _____

Before admission is considered, several criteria must be met and understood. These are described below.

❖ **No Cardio-Pulmonary Resuscitation (CPR):** I understand that because of my terminal illness, CPR is considered medically futile treatment. I agree that CPR is not something I want at the end of my life. Please allow me to die peacefully.

Initials _____

❖ I understand that I will be responsible for the cost of my medications via private or government insurance (RAMQ).

Initials _____

❖ It has been explained to me that the mandate of the Teresa Dellar Palliative Care Residence is to provide comfort care at the end of life. Treatments offered here are not aimed at curing disease. The services that are offered are intended for:

- increasing the patient's quality of life by providing pain and symptom management
- providing care which responds to the patient's physical, psychological, social and spiritual needs
- total care of the patient, including hygiene, skin care, positioning, hydration and feeding by natural means where appropriate. abstinence of any investigations unless deemed appropriate by the physician.
- **No transfer to a hospital** unless it is needed for specialized pain/symptom management as per physician's orders (ex., to immobilize a fracture) **Initials** _____

❖ I understand that the Teresa Dellar Palliative Care Residence is **not** a long-term care facility. My health status will be reviewed regularly. Should my disease be deemed stable by the medical doctors, I and my family will be responsible for my transfer to a care environment that is appropriate to my needs. This could include a transfer home with appropriate and available community health care services and/or other nursing care services. This transfer will be discussed and organized in collaboration with myself, my family and the social worker from the TDPCR.

Initials _____

❖ I understand that the Teresa Dellar Palliative Care Residence is a smoke-free environment. If I desire to smoke (including vaping), I need to do so in accordance with the Quebec Laws. I also understand that I am responsible for having family and/or friends accompany/assist me as the staff member and volunteers may not be able to do so.

Initials _____

The following 2 clauses are applicable ONLY if the patient is apt to sign this consent him/herself.

I understand that medical aid to die (l'aide médicale à mourir – AMM) is not a part of the Teresa Dellar Palliative Care Residence's services. I understand the goal of palliative care is to offer me comfort via management of pain and other distressing symptoms. I understand that palliative care neither prolongs nor hastens death, but rather allows for death to occur in its own natural time and I have not made a request for AMM.

Initials _____

I have the right to change my mind to request medical aid to die: I understand that IF I change my mind and decide I want 'medical aid to die as per my right under Quebec's law, I need to inform the palliative care physician of my wishes. The Teresa Dellar Palliative Care Residence's team will facilitate two physician evaluations of my request, and should I qualify, and choose to have it at the Residence, I will receive AMM provided by an external team.

Initials _____

By signing this document, I understand that CPR is not being offered at the TDPCR. I agree to the above-stated conditions for admission to the Teresa Dellar Palliative Care Residence

Patient's Signature

Date

Signature of the person who holds a mandate
or natural caregiver

Date

Healthcare Professional Involved

Date