Résidence de soins palliatifs Teresa-Dellar

Teresa Dellar Palliative Care Residence

Admissions

The Teresa Dellar Palliative Care Residence (Residence) has a total of 23 beds, providing compassionate care, 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 a 3-month prognosis
- residing or having been treated in the CIUSSS West Island territory or
- main caregiver resides in the CIUSSS West Island territory
- Completed application
  - Medical information provided by a health care team
  - Consent form
    - Understood and signed by patient, if capable, or natural caregiver.

Despite receiving all required documentation, there may be a delay to an admission in relation to bed availability at that particular time. Please be aware that admissions do take place Monday to 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 Residence has a mission of « teaching » and performing « research » for constant care improvement. As such, please be aware that a patient may be seen by students (future physicians, social workers, nurses) in the company of their professional clinical caregiver and that data included in their chart may be used anonymously for research.

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 specialised medical supplies (specialised dressings, ostomy supplies, etc.)
- toiletries (including incontinence products)
- transportation costs if incurred (extraordinary circumstances)

All of our rooms:

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

For questions or concerns, you may visit our website www.palliativecareresidence.ca or contact the admissions team directly at: (514) 693-1718 ext. 260 / Fax: (514) 693-0374

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Name:		DOB:	Age:
RAMQ:	Exp:	Civil status:	
Address:		Tel.:	
		Language:	
Main caregiver:	Relationship:	Tel.:	
Patient is at: home □ (lives alone? Yes / No)	Hospital □ specify		Other □
Known to CLSC □ specify		NOVA □	
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:

≤ 2 weeks ≤ 6 weeks ≤ 3month ≥ 3months

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Pertinent medical history: _____

_____

Allergies: _____

Nursing Care: **Fall Risk** □

Mobilization:	Independent □ Assistance □ (cane □ walker □ Assist from: 1 person □ 2 people □) Normal □ Reduced □ Mainly sits/lies □ Mainly in bed □ Bedbound □
Care:	Independent □ Assistance (Occasional □ Significant □ Total care □)
Intake:	Normal□ Reduce □ Sips only □ Mouth care only □
Alertness:	Normal □ Somnolent □ Unresponsive □

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 Residence use only: PPS: PPI:

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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 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, skincare, positioning, hydration and feeding by natural means where appropriate. abstinence of any investigations unless deemed appropriate by the physician.
- **No transfer to 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 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, my family and I 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 Residence.

□ ***Initials***_____

❖ I understand that the 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***_____

❖ I understand that the Residence has a mission of « teaching » and performing « research » for constant care improvement. Therefore, I may be seen by students (future physicians, social workers, nurses) and data included in my chart might be used anonymously for research.

□ ***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 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 in dying: 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 Residence. 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