

## Admissions

The Teresa Dellar Palliative Care 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 family.

### 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 3 month prognosis
  - ❖ Residing or have 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 take place Monday to Friday. Not everyone who is dying requires specialized palliative care and as our beds are limited; people who suffer from uncomfortable symptoms take priority.

### **The out of pocket expenses for 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](http://www.palliativecareresidence.ca) or contact the admission's 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 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"/> w a l k e r <input type="checkbox"/>	Assist from: 1person <input type="checkbox"/>	2people <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"/>	A s s i s t a n c e (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:**

**Requested MAiD?** yes  no

**If Yes:** 1st evaluation by/date \_\_\_\_\_ 2nd evaluation by/date \_\_\_\_\_

**Scheduled date:** \_\_\_\_\_

Documents required for completion of application:			
Condition for admission consent forms <input type="checkbox"/>	Medication list <input type="checkbox"/>	Medical summary <input type="checkbox"/>	
Consults <input type="checkbox"/>	Progress notes <input type="checkbox"/>	Pathology/Cytology reports <input type="checkbox"/>	Lab results <input type="checkbox"/>
Microbiology results <input type="checkbox"/>	Pertinent CT scans, X-rays, PET, MRI <input type="checkbox"/>		
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 (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, 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 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 the goal of palliative care is to offer me comfort via management of pain and other distressing symptoms. I accept the Residence's philosophy and approach to provide me care which neither prolongs nor hastens death.

**Initials** \_\_\_\_\_

**I have the right to request and receive medical aid in dying (MAiD):** I understand that if I want medical aid in dying as per my right under Quebec's law, I need to inform the palliative care physician of my wishes. The Residence's team will facilitate two physician evaluations, and should I qualify, I will receive MAiD at the Residence provided by an external team. If I have already made a request for medical aid to die and/or already have a date, I have informed the admissions nurse of this.

**Initials** \_\_\_\_\_

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

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of a person who holds a mandate or natural caregiver

\_\_\_\_\_  
Date

\_\_\_\_\_  
Healthcare Professional Involved

\_\_\_\_\_  
Date



## CONSENT for ZERO-TOLERANCE of DISRESPECTFUL BEHAVIOUR

**Patient Name:** \_\_\_\_\_

This consent form outlines expectations regarding conduct within the Residence and must be signed prior to admission.

### Purpose of This Consent

The Teresa Dellar Palliative Care Residence is committed to providing a safe and respectful environment for patients, families, visitors, employees and volunteers. We expect all to uphold these values in all interactions and expect patients, family members, and visitors to agree to:

- Interact in a respectful and courteous manner;
- Refrain from any form of violence, intimidation, or harassment;

### Zero-Tolerance for disrespectful behavior Policy

The Residence maintains a zero-tolerance for disrespectful behavior with respect to interactions with employees, volunteers, patients and other visitors:

- Verbal abuse or threats / raising your voice;
- Physical violence or intimidation;
- Harassment, discrimination, or any disrespectful behavior;
- Conduct that compromises the physical or psychological safety of others.

By signing this form, I agree, on behalf of my family and visitors, to maintain a safe and respectful space and to comply with these expectations.

### I understand that:

Any instance of violence, aggression, or disrespectful behavior will result in immediate intervention by the Residence staff, which could include:

- Restricting access to the premises;
- Requiring individuals to leave the Residence; or
- Relocating the patient to another appropriate care facility.

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Signature of patient or representative / Name in print

Date