QUEEN'S PALLIATIVE MEDICINE BLOCK ORIENTATION

Welcome to the Queen's Palliative Medicine Team! Our interprofessional team provides outpatient, acute inpatient, and end-of-life palliative care at Kingston Health Sciences Centre/Kingston General Hospital (KHSC/**KGH**), Cancer Centre of Southeastern Ontario (**CCSEO**), Providence Care Hospital (**PCH**) and the Kingston community (**Comm**). Over the next four weeks rotating residents/fellows/clerks will be involved in palliative care consultations, ongoing follow-ups and on-call services.

You have been assigned to one of the two following streams for the duration of your 4-week rotation:

1. **KGH/CCSEO Stream** –Acute (KGH) inpatient care for both our own complex palliative care beds and as consultants for patients under the care of other specialties (i.e. Medicine, Oncology, Surgery, etc.) and outpatient Palliative Care clinics at CCSEO.

2. **PCH/Comm Stream** –Palliative Care Unit (**PCU**) is a 13-bed service located at PCH (Heritage 2) for end-of-life care for palliative care patients and community palliative care providing new consultations and ongoing follow-up for palliative care patients in the home.

PALLIATIVE CARE TEAM MEMBERS

- **KGH/CCSEO Physicians:** Dr. Leonie Herx, Dr. Danielle Kain, Dr. Craig Goldie, and Dr. Ingrid Harle are the primary staff physicians. Dr. Hasitha Welihinda is a Nephrologist who provides part-time palliative care.
- **PCH/Comm Physicians:** Dr. Natalie Kondor, Dr. Alison Flanagan, Dr. Aveksha Ellaurie and Dr. Christopher Frank provide care at the PCU. Dr. Kondor and Dr. Flanagan also provide community palliative care.
- **Administrative Staff:**
    - Ruili Fang is the Program Assistant and the main contact for rotation-related issues.
    - Cortney Longfield is the Palliative Medicine Administrative Assistant who manages the clinical work and provides the patient lists for residents on rotation.
    - Michelle Maloney is the Community Administrative Assistant and is the main contact for all patients followed at home.
- **Clinical Nurse Specialist:** Melissa Touw is part of the KGH consult team and regularly follows patients on our inpatient list alongside the residents/fellows. She has expertise in CADDs and disposition supports.
- **Nurse Practitioner (Clinic):** Michelle Foulkes primarily works in the Palliative Care Clinic at CCSEO.
- **Interprofessional Team:** Nursing, Spiritual Care, Social Workers, Dieticians, PT, OT, and Volunteers.

SCHEDULES/LISTS

- **Weekly Schedules** are sent out on Fridays for the coming week by Ruili to KGH/CCSEO Stream residents regarding academic/clinical rounds, teaching sessions, and clinical assignments (residents and staff).
- **Monthly Schedules** are given to PCH/Comm Stream residents at the start of the rotation highlighting similar information and clinical rounds held at PCH.
- **On-Call Schedules** are sent out before the block, as well as on weekly and monthly rotation schedules sent out by Ruili. Residents are listed by last name with a staff physician for the days that they are on-call.
- **Resident Presentations Schedules** are sent out by Ruili during the rotation. All rotating residents are expected to present (informally, no PowerPoint) a 5-10-minute presentation on a Palliative Care topic such as an interesting case or journal article, or a specific palliative care symptom + management.

- **KGH "Short" Lists** – are given daily to residents that are assigned to the KGH/CCSEO stream. These include all of the patients we are currently following at KGH.
- **"Long" Lists** – are handed out weekly at handover rounds and are updated Friday afternoon. These include all of the patients we follow at KGH, PCU and in the community. The weekend on-call team receives this list to their KHSC email on Friday afternoon.

ROUNDS/MEETINGS

- **On-Call Handover Rounds (ALL RESIDENTS)** are held on Mondays (or Tuesdays after a Statutory Holiday) at 34 Barrie Street at 8:30AM. The weekend team hands over important information about issues that arose over the weekend with the patients we follow in the community and KGH/PCH.
- **Resident Seminars (ALL RESIDENTS)** are held at 34 Barrie Street (unless otherwise stated) at 8:00AM on Tuesdays. The Tuesday following orientation, residents/fellows receive teaching on CADD pumps. Following Tuesdays are dedicated to reviewing a palliative care quiz, found at: https://meds.queensu.ca/source/rotation_in_pc_trainee_knowledge_test%20(1).pdf.
- **Medical Mortality and Morbidity Rounds (ALL RESIDENTS)** are held most Wednesday mornings at 8:00AM in Etherington Auditorium. Residents in the PCH/Comm Stream can view the rounds at PCH (Lakeview Wing – Level 1; Small Conference Room).
- **Interdisciplinary Team Rounds (KGH Residents only)** are held on Wednesday at 9:15AM in the KIDD 9 BMO Room ("Fishbowl") for multidisciplinary review of our inpatient list.
- **Medicine Grand Rounds** (7:45AM; Etherington Auditorium) OR **Oncology Grand Rounds** (8:00AM; Botterell Hall Rm B143) **(KGH/CCSEO Residents)** are Thursday mornings; either can be attended.
- **PCU Interprofessional Rounds (PCH/Comm Residents only)** are held Thursdays at 815AM at the PCU (Heritage Wing – Level 2; Conference Room) to discuss multi-disciplinary care needs for the patients.
- **Resident Journal Club OR Palliative Grand Rounds (ALL RESIDENTS**) are typically held one Friday per 4-week block (most blocks) at 8:00AM. Location is usually listed on your schedules with email reminders sent out before the event.

KGH/CCSEO STREAM – Consult Service

- **Patient "Short" Lists** handed out each morning (by Cortney) and reviewed by the team. This meeting typically occurs just after morning rounds/meetings at either 34 Barrie Street or Kidd 9 Fishbowl.
- **Rounding** - After the list is reviewed, and residents/fellows are assigned patients the team disperses to round on our patients. Residents stay in contact with the team primarily through a ***WhatsApp* Group**. **Please remember not to communicate patient names through this group**, but initials or CR numbers are fine.
- **Progress Notes** – Each patient you see/review should have a dated progress note (titled "Palliative Care") written on them by the resident. Please document the time during which the patient was seen (i.e. 0940-1005) and ensure a detailed and legible note including plan/changes/suggestions.
- **Orders vs. Suggest Orders:**
    - For patients under Palliative Medicine (**bold** on short list, usually on Kidd 9): we write progress notes and **ORDERS** (on GREEN order sheets) and review/co-sign any suggest orders on these patients.
    - For consult patients: we write progress notes and **SUGGEST ORDERS** (on GREEN order sheets; usually write "Palliative Care suggests"). The MRP service will then accept/reject those suggestions.
- **Running the list** – after you have seen your own patients, the team will meet (usually around noon in the Fishbowl). We go over issues for the day, review new consults and coordinate follow-up plans.
- **Consults** – can come up at any point in the day, usually from other inpatient teams or emergency department. A resident (typically fellow) will carry the consult pager and assign a resident to see the new

consult. Our consults are written on YELLOW Consult Sheets, which should be already in the patient's chart. Residents are to complete their history on the back of that yellow sheet, leaving the front for the Staff Physician's note. We would also write **SUGGEST ORDERS**, should we need to. We also **DICTATE** our consults (**Inpatient Consultation code: 04;** please press '6' before submitting dictation for STAT).

- **A template for inpatient consult dictations** is included at the end of this document.
- **Admission Notes** – are written for patients that are directly admitted to our inpatient beds from ER, clinic, or home. Admission histories are written on WHITE History and Physical Examination Sheets. We would write **ORDERS** for these patients under our care, either via EntryPoint or on a GREEN order sheet.

KGH/CCSEO STREAM – Clinic

- Clinic is run out of CCSEO – Burr Wing, Level 0, Clinic F from 8:45AM to 4:00PM.
- Clinic schedules consist of new consultations and follow-up visits. Nurses at the clinic typically see patient's first for an initial assessment, which would then be relayed to you prior to your assessment.
- **New consults** – usually 2 are scheduled in the mornings. New consults are typically referred by Oncology to assist with pain and symptom management and/or goals of care discussions. We undertake complete palliative history and physical exam. You can review notes from oncology and other teams in PCS.
- **Follow-up Visits** – are spread throughout the day. You can review previous visits and interim history on PCS. Typically, follow-up visits are much shorter than consultations and focused on previously discussed symptom issues and/or new issues that have occurred since last visit.
- Visits are reviewed with the staff physician in clinic that day and then seen in conjunction after. Prescriptions will be written and faxed to the patient's pharmacy and other referrals may be arranged.
- **All clinic visits are dictated** via Enterprise phone dictation system. Full details on how to dictate are posted near the phones at clinic and you can review how to formulate your dictation with the staff.
    - Dictation phone line: 6900
    - Your PCS login ID (5-digit code) = dictation code and password
    - Consultation code: 31 | Follow-up visit code "Treatment Letter": 33
- **Templates for Dictation** are included at the end of this document.
- **IT IS HIGHLY RECOMMENDED** that residents review charts for clinic consults before coming to clinic to ensure that clinic runs in a timely manner. Clinic schedules can be viewed via PCS by clicking the arrow next to the "*Main Desktop*" icon **>>>** "*KGH/HDH Patient Processing*" **>>>** "*Patient List – Clinic"*; and then searching the schedule under the appropriate physician's name and clinic date.

PCH/Comm STREAM – Palliative Care Unit

- Residents start their days at PCU (after rounds/meetings) and typically spend the morning seeing some of the 13 end-of-life patients and reviewing with staff.
- Though PCH uses a similar system to KGH (i.e. PCS), there is a **separate training session for their EMR (called "ePR"), usually held the first morning of your rotation**. Information on this training session and login credentials is emailed to you prior to your rotation and login will be activated at the orientation.
- **All documentation at PCH is electronic**, and the paper charts typically only contain patient demographic and admission information.
- Daily visits with patients are documented under **progress notes**, through ePR.
- **Orders** are entered via the "PC Order Entry" tab on ePR. If you are struggling with it, ask an attending.
- **New Admissions** occur on a regular basis and can come from patients our team follows in the community/KGH or referred by other physicians in the community. New Admissions are also documented electronically and include: an admission note, goals of care documentation, and medication reconciliation. Typically, the patients you admit are the ones you follow on a day-to-day basis.

- **Patient lists** can be viewed on ePR, and patients at the PCU are typically divided amongst the two residents that are assigned to PCH/Comm. Once patients are all seen, they are then reviewed with your attending and progress notes/orders are entered into ePR.
- Afternoons usually consist of community home visits/consults (details on next page) with Dr. Kondor or Dr. Flanagan, unless it is your turn to do a new admission to the PCU.

PCH/Comm STREAM – Community (Home) Visits

- **New consults** in the community are seen on a regular basis. For patients you see at home, you will perform a complete history and physical exam under the supervision of one of the community staff physicians. Together, you will come up with a treatment and ongoing follow-up plan (if the patient is appropriate to be followed by our community service).
- Residents type up a consultation letter, which is then sent to Michelle Maloney and the staff physician to review. Templates for these letters will be given to you during orientation by Michelle (via email). *Completed letters must be sent via secure email (i.e. KHSC email address) with a password protected file (the password is always "**pal**").*
- **Follow up visits** are usually completed with the attending physician, but at times on your own (if comfortable). **Progress notes are typed via an external EMR (OSCAR),** for which PCH/Comm residents will receive login information (listed on your Rotation Schedule). Michelle also provides this information for you as part of your orientation package.
- **Prescriptions, Home Care Nursing Orders, Symptom Response Kits, Oxygen** orders are all done via fax and/or through OSCAR (if applicable). Your staff physician can review this process with you in more detail.
- **Important Phone Numbers/Contacts** are listed at the end of this document.

ON-CALL

- **Weekday Call** – begins at 5:00PM and runs until 8:00AM the following day.
- **Weekend Call** – is generally 5:00PM Friday – 8:00AM Sunday or 8:00AM Sunday to 8:00AM Monday. You will round on both weekend days (and/or holidays) at KGH and/or PCU and see new consults; discuss details with the on-call attending prior to the weekend.
- Call is **HOME CALL.** Please keep your pager on during this entire period.
- Important rules to consider when on-call are:
  - Touch base with the staff physician prior to your call shift (page/phone/text).
  - **IF YOU DON'T KNOW, PLEASE ASK** (your staff, as they are happy to help)
  - Always **RECORD** who is calling, the patient's information (name, CR#, etc.), and contact information in case you need to call them back.
  - **Determine if the patient is actually followed by our team**, as we occasionally receive calls from home care nursing who may not realize that we are not MRP.
  - **We do not offer after hours/on-call services for patients followed in palliative care clinic**, unless they are otherwise listed on our "Long" list. Please call the staff if you are uncertain.
- **We are responsible for** answering pages from nursing regarding **our own inpatients at KGH and PCH**. At KGH the nurses will typically call the in-house "non-take" medicine resident who is responsible for our patients overnight first, who may call us.
  - These calls typically consist of a need for nursing orders for end-of-life symptom issues. If new concerning issues do arise, you may have to consider appropriate management or investigations.
  - It is best to inform your staff of new issues that arise, and to discuss your plan.
- **We are responsible for our community patients**, which can be found on our "Long" lists (updated every Friday). Updated patient information is on OSCAR to which the PCH/Comm residents and staff physicians have access, but not all residents. Many calls can be from community home care nurses or directly from patients/families. These may include requests for prescription renewals (which often can be deferred until

the following day) or symptom issues. If a call does come from a patient or family regarding a symptom issue, you should direct them to call their community nurse first to do an assessment and who may later page you directly through switchboard.

- Y**ou may receive calls about patients dying** at PCH or community with details below.
- **On-Call Handover Notes** are included in your orientation package (**see example at the end of this document**) and should be filled for each patient for which you receive pages about. These are to be handed in (or faxed) to Cortney to following morning, before 9:00AM to ensure appropriate circulation to the relevant physicians.

DEATH CERTIFICATES

- **Death Certificates** will typically be completed by the MRP/Resident that is following the patient, though may become your responsibility if you are on-call. Blank certificates are included in your orientation package, and it would be helpful to review their contents.
- **If a death occurs at KGH (palliative bed):**
    - The in-house (non-take) resident pronounces the patient and completes the death certificate; they do not finalize the discharge summary. They page in the morning to hand over the death.
- **If a death occurs at PCU:**
    - Nurses will pronounce the death.
    - If it is before 10:00PM you will be paged to complete the death certificate, and can leave with the nursing station to coordinate pick-up with the funeral home.
    - If it is after 10:00PM, you may be informed (usually not) and the paper work will need to be completed in the morning.
    - In addition to the death certificate, a "Consent to Release" form will also need to be completed before a body can be transferred and the discharge paperwork must be signed: date of admission, date of discharge, and most responsible diagnosis – the rest can be blank.
- **If death occurs in the community:**
    - You will likely receive a call from nursing that the patient died and they pronounced the death (unless they do not have an order to, or in other rare circumstances). Ensure the following:
    - The patient is followed by our community team, the time and date of death, the name of the patient's funeral home (and contact info).
    - Complete the Death Certificate – ensure you write the patient's address in the "Place of Death" space. If after-hours (i.e. on-call), this must be completed by MRP/Resident before 9AM the following morning and provided to Cortney to arrange pick-up, courier. On weekends, call the funeral home to determine how to get the certificate to them (may require delivery to the funeral home, or pick-up from Admitting department at KGH (even if not KGH inpatient).
- **Death Certificate Completion** – for information regarding completion of a Death Certificate, use the following link: http://www.publications.serviceontario.ca/ecomlinks/026062.pdf. **An example death certificate is included at the end of this document.** Note: During this rotation, your address should be written as our office address: **34 Barrie Street, Kingston, ON K7L 3J7**
- **In RARE Circumstances**, the coroner's office may need to be called. We are often aware of potential coroners' cases beforehand, such as a patient with recent surgery/procedure, accident/fall or other concerning event in the 28 days prior to death – consider calling the coroner but discuss with the staff physician before proceeding.

OTHER IMPORTANT INFORMATION/CONTACTS

- **Palliative Care Unit:** Heritage 2, call 613-544-4900 x 82824
- **Medical Pharmacy**: For injectable medications (8am-8pm 7d/wk): Ph 613-384-3914 | Fax: 613-384-1905

    - SRKs and CADDs are made by this pharmacy, but prescriptions for these must be sent to LHIN directly.
- **SE LHIN Home and Community Care:** (8am-8pm 7d/wk): Ph 613-544-7090 | Fax: 613-544-1494
    - CADD, Symptom Response Kit, Injectable med orders, medications changes/orders for nurses need to be faxed here
- **Nursing Agencies:** To reach a patient's nurse 24/7:
    - St. Elizabeth: 613-530-3400 (chart is in the home)
    - CBI: 613-384-7891 (no chart in the home)
    - Paramed: 613-549-0112 (chart is in the home)
- **Oxygen:** To get palliative oxygen started or to discuss other oxygen concerns
    - Kingston Oxygen: 613-548-7301
    - Medigas: 613-546-5529

PALLIATIVE CARE MEDICINE SERVICE

ON-CALL NOTES

Patient Name: (It is helpful to include CR#) **Resident:** _____

Date: _____ **On call attending:** _____

Time: (Approximate time you received page/call) **Patient's PC physician:** _____

☐ Visit (Community Patient)

☐ Telephone Call ☐ Community Patient ☐ KGH Patient
☐ St. Mary's PCU Patient ☐ Cancer Clinic Patient

Summary:

Please include details about who called you, contact information if available, patient's diagnosis/status, and the issue that was being dealt with. A good summary is helpful as this note serves as a record of the call service provided and may be included within their chart.

Ontario

Ministry of Government Services | Office of the Registrar General

Medical Certificate of Death - Form 16

You must use the Stillbirth Registration Form 8 when registering stillbirths. This form must be completed by the attending physician, coroner, or designated person before a burial permit can be issued. Please PRINT clearly in blue or black ink as it is a permanent legal record.

Hospital code number

INFORMATION ABOUT THE DECEASED

1. Name of deceased (last, first, middle): Smith, John

2. Date of death [month - *by name*, day, year *(in full)*]: November 10, 2018

3. Sex (M or F): M

4. Age: 66

5. If under 1yr. Months / Days

6. If under 1 day Hours / Minutes

Generally these sections are not routinely filled (i.e. left blank)

7. Gestation age

8. Birth weight

9. Place of death (name of facility or location): Kingston Health Sciences Centre (or PCH, or pt address)

[X] hospital [ ] nursing home [ ] residence [ ] other (specify)

10. City, town, village or township: Kingston (or city/town where pt resided)

Regional municipality, county or district: Frontenac (look up if unsure)

CAUSE OF DEATH

CAUSE OF DEATH

11. **Part I**

		Approximate interval between onset & death
Immediate cause of death	(a) Metastatic Lung Cancer	10 months
	due to, or as a consequence of	***do not state date of Dx***
Antecedent causes, if any, giving rise to the immediate cause (a) above, stating the underlying cause last	(b) *due to, or as a consequence of*	
	(c) *due to, or as a consequence of*	
	(d)	
Part II **Other significant conditions** contributing to the death but not causally related to the immediate cause (a) above	Chronic Obstructive Pulmonary Disease	Years ***often, can be less specific***

Left blank>>>

12. If deceased was a female, did the death occur: [ ] during pregnancy (including abortion and ectopic pregnancy) [ ] within 42 days thereafter [ ] between 43 days and 1 year thereafter

13. Was the deceased dead on arrival at the hospital? [ ] Yes [X] No

14. Was there a surgical procedure within 28 days of death? [ ] Yes [X] No

15. Date of surgery (mm/dd/yyyy): fill, if YES to #14, otherwise leave blank

16. Reason for surgery and operative findings: fill, if YES to #14

Autopsy particulars

17. Autopsy being held? [ ] Yes [X] No

18. Does the cause of death stated above take account of autopsy findings? N/A [ ] Yes [ ] No

19. May further information relating to the cause of death be available later? N/A [ ] Yes [ ] No

Accidental or violent death (if applicable)

20. If accident, suicide, homicide or undetermined (specify): Fill if relevant, or if unexpected fall in past 28days

21. Place of injury (e.g. home, farm, highway, etc.): Fill only if #20 was filled

22. Date of injury (mm/dd/yyyy): Fill only if #20 was filled

23. How did injury occur? (describe circumstances): Fill only if #20 was filled

Answering YES to #13, #14 or filling in #20 may constitute a CORONER'S CASE, and should be discussed with your STAFF Physician before proceeding to complete the Certificate. If the CORONER is called and accepts the case, they will fill certificate.

CERTIFICATION

By signing below, you certify that the information on this form is correct to the best of your knowledge.

24. Your signature (physician, coroner, RN(EC), other): X SIGN

25. Date (mm/dd/yyyy): Date filled

26. Your name (last, first, middle): Printed name

27. Your title: [X] Physician [ ] Coroner [ ] RN(EC) [ ] other (specify)

Some versions will have section where you include CPSO number, so please do not forget to include this.

28. Your address (street number and name, city, province, postal code): 34 Barrie Street, Kingston, ON K7L 3J7

TO BE COMPLETED BY THE DIVISION REGISTRAR

By signing below, I am satisfied that the information in this Medical certificate of death and the Statement of death is correct and sufficient and I agree to register the death.

Signature	Date (mm/dd/yyyy)	Registration number	Div. reg. code no.
X Left blank>>>			

For the use of the Office of the Registrar General only

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Personal information contained in this form is collected under the authority of the *Vital Statistics Act*, R.S.O. 1990, c.v.4 and will be used to register and record the births, still-births, deaths, marriages, additions or change of name, corrections or amendments, provide certified copies, extracts, certificates, search notices, photocopies and for statistical, research, medical, law enforcement, adoption and adoption disclosure purposes. Questions about this collection should be directed to the Deputy Registrar General at PO Box 4600, Thunder Bay ON P7B 6L8. Telephone 1 800 461-2156 or 416 325-8305.

  Disponible en français

Edmonton Symptom Assessment System (ESAS)

Please circle the number that best describes:

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst possible pain
Not tired	0	1	2	3	4	5	6	7	8	9	10	Worst possible tiredness
Not nauseated	0	1	2	3	4	5	6	7	8	9	10	Worst possible nausea
Not depressed	0	1	2	3	4	5	6	7	8	9	10	Worst possible depression
Not anxious	0	1	2	3	4	5	6	7	8	9	10	Worst possible anxiety
Not drowsy	0	1	2	3	4	5	6	7	8	9	10	Worst possible drowsiness
Best appetite	0	1	2	3	4	5	6	7	8	9	10	Worst possible appetite
Best feeling of wellbeing	0	1	2	3	4	5	6	7	8	9	10	Worst possible feeling of wellbeing
No shortness of breath	0	1	2	3	4	5	6	7	8	9	10	Worst possible shortness of breath
Other problem	0	1	2	3	4	5	6	7	8	9	10	

Patient's Name _____

Date _____ Time _____

Complete by *(check one)*

- ☐ Patient
- ☐ Caregiver
- ☐ Caregiver assisted

BODY DIAGRAM ON REVERSE SIDE

August, 2006

Palliative Performance Scale (PPSv2) version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-