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Introduction for the **Learner** (Resident/Fellow)

**Prior to your evaluation of competency**

- Complete the web-based palliative care training program “Medical Resident Training in End-of-Life and Palliative Care” before you undergo this competency assessment. The training program is available on the UMMS Intranet, click on Physicians. The course is listed under “Helpful Links.” It is also available via the internet at http://134.192.120.12/canRes/htdocs/login.asp

- Review Part 1 (Learning Objectives), Part 2 (Teaching Outline) and Part 3 (Evaluation Checklist) of this document THOROUGHLY so that you are aware of what is required of you.

- Review Unit VI – “Hospice Care” of the Web-based palliative care training program.

- Ascertain that the attending/faculty member is certified to conduct the Palliative Care Competency Evaluation.

**Field evaluation of competency**

- During the course of a clinical rotation, it is anticipated that you will have opportunities to demonstrate your competence in caring for the actively dying patient.

- Early in the clinical rotation, give your Attending Physician this Competency Assessment Tool.

- ASK FACULTY MEMBER TO REVIEW THIS COMPETENCY ASSESSMENT TOOL AS SOON AS POSSIBLE SO THAT THEIR MEMORY WILL BE REFRESHED AS TO THE DESIRED CHARACTERISTICS OF PERFORMANCE THEY WILL BE EVALUATING during the course of the rotation.

- At the end of the rotation, the palliative care certified attending will complete the Evaluation Checklist (Part 3) of this document, and will share it with you.

- You will also complete the self-evaluation portion of the Evaluation Checklist as a measure of competency in practice based learning.

- Evaluation Checklist must be signed by the Clinical Faculty Evaluator/attending and you (Resident/Fellow).

- Return Evaluation Checklist to Dr. Susan Wolfsthal, Internal Medicine Residency Director or Dr. Heather Mannuel, Medical Oncology Fellowship Director.

Introduction for the **Clinical Faculty Evaluator**

**How to perform this competency assessment**

A Medical Resident or Oncology Fellow has requested that you assess their competency in a selected palliative care domain during the time you are the Clinical Faculty Evaluator/attending physician on this service. To assist you with this evaluation, please do the following.

**Preparing for field evaluation of competency**

- Review this Competency Assessment Tool thoroughly including the Learning Objectives (Part 1), Teaching Outline (Part 2) and Evaluation Checklist (Part 3) prior to pre-discussion counseling with Resident (required).

- Review Unit VI – “Hospice Care” of the Web-based palliative care training program, “Medical Residents Training in End-of-Life and Palliative Care.” The training program is available on the UMMS Intranet, click on Physicians. The course is listed under “Helpful Links.” It is also available via the internet at http://134.192.120.12/canRes/htdocs/login.asp (optional).

**Format of competency evaluation**

- During the rotation:
  - Based on the Learning Objectives, Teaching Outline and Evaluation Checklist in this document and the content in Unit VI (Hospice Care) of the palliative care training website, evaluate how the Resident or Fellow follows a patient who is actively dying. Suggested behaviors include:
  - Is available and present for the patient and family (non-abandonment).
  - Demonstrates appropriate communication skills in discussing terminal care with medical staff, and with the family and patient.
  - Provides anticipatory guidance for the patient, family, and medical team.
  - Responds appropriately and empathetically to patient/family concerns raised by the appearance of terminal symptoms.
  - Appropriately evaluates patient management issues, including terminal dyspnea, terminal delirium, pain management, death rattle, or other symptoms of active dying, and documents these evaluations and interventions.
  - Does the “death pronouncement” when appropriate, and completes the necessary paperwork (e.g., referral for organ donation; completion of death certificate).

- Post rotation feedback:
  - Review strengths and weaknesses of competency evaluation with Resident/Fellow.
  - Provide constructive feedback to improve Residents/Fellows’ performance and patient outcomes.

- Complete Evaluation Checklist (Part 3 of this document)
  - Share with Resident/Fellow; allow Resident/Fellow to make his/her own self-assessment of competency performance.
  - Clinical Faculty Evaluator/attending and Resident/Fellow must sign this Evaluation Checklist (Part 3).
  - Resident/Fellow is responsible for returning Evaluation Checklist to Dr. Wolfsthal (Residents) or Dr. Mannuel (Fellows).
Part 1: Learning Objectives

Note to learner and Clinical Faculty Evaluator: The Learning Objectives are listed in terms of fulfilling the six ACGME core competencies, listed below; these are reflected in Evaluation Checklist in Part 3 of this document.

LEGEND to ACGME core competencies: http://www.acgme.org/Outcome

<table>
<thead>
<tr>
<th>OBJECTIVES – A competent Medical Resident or Oncology Fellow will be able to:</th>
<th>ACGME Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognize the signs and symptoms of approaching death (active phase of dying).</td>
<td>PC</td>
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<tr>
<td>Carry out the patient care responsibilities of the physician within the medical team caring for the actively dying patient.</td>
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<tr>
<td>Differentiate the roles of the members of the health care team in the care of the actively dying patient.</td>
<td>X</td>
</tr>
<tr>
<td>Identify common patient/family reactions to the active phase of dying.</td>
<td>X</td>
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<tr>
<td>Demonstrate appropriate counseling skills with the family of an imminently dying patient.</td>
<td>X</td>
</tr>
<tr>
<td>Assess and manage symptoms of dying effectively.</td>
<td>X</td>
</tr>
<tr>
<td>Pronounce a death, notify a family with compassion, and complete required paperwork.</td>
<td>X</td>
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</tbody>
</table>

LEGEND:
PC – Patient Care
MK – Medical Knowledge
PBL&I – Practice-Based Learning and Improvement
IPCS – Interpersonal and Communication Skills
P – Professionalism
SBP – Systems-Based Practice

Part 2: Teaching Outline for Learner and Clinical Faculty Evaluator

Also, recommend reviewing Unit VI – “Hospice Care” of the Web-based “Medical Resident Training in End-of-Life and Palliative Care,” available from any computer with internet access at http://134.192.120.12/canRes/htdocs/login.asp.

Background

One of the main goals of palliative care is to provide relief of uncomfortable symptoms during the dying process. These symptoms can be physical, psychological, or spiritual in nature. They can be experienced by the patient, the patient’s family or significant others, and by the medical team caring for the patient. Providing care for patients who are actively dying can be a challenging – yet very rewarding part of good medical practice.

A comprehensive evaluation of each patient needs to be performed. One such standard evaluation tool is the Edmonton Symptom Assessment Score. This tool grades 10 different common symptoms that dying patients often have on a 0 (=none) to 3 (=severe) scale, as well as the patient’s ability to respond (yes/no). Other evaluation guidelines can be found in the document Clinical Practice Guidelines for Quality Palliative Care, at www.nationalconsensusproject.org.

After the patient dies, the attending physician is responsible for notification of organ donor organization(s) in compliance with State law. Transplant professionals will evaluate the condition of the organs at the time of the patient’s death to determine if the organs are suitable for donation. The physician also completes the death certificate. If a hospice service is involved, notification of organ donor organization(s) in compliance with national consensus project.org will be provided.

How Actively Dying Patients Die – From Charles von Gunten, Fast Fact #149

Family members look to the physician and nurse to help them know what to expect when a loved one is dying. No matter what the underlying causes, there is a common final pathway that most patients travel. Indicate your desire to be helpful, saying: Many significant others, and by the medical team caring for the patient. Providing care for patients who are actively dying can be a challenging – yet very rewarding part of good medical practice.

PHYSICAL CHANGES as death approaches.

1. SOCIAL WITHDRAWAL is normal for the dying patient as the person becomes less concerned about his or her surroundings. Separation begins first from the world – no more interest in newspaper or television, then from people – no more neighbors visiting, and finally from the children, grandchildren and perhaps even those persons most loved. With this withdrawal comes less of a need to communicate with others, even with close family.

2. FOOD: The patient will have a decreased need for food and drink as the body is preparing to die. This is one of the hardest things for some family to accept. There is a gradual decrease in interest in eating and appetite, even for their favorite foods. Interest may come and go. The patient is not starving to death. This reflects the underlying disease. Liquids are preferred to solids. Follow the patient’s lead and do not force feed.

3. SLEEP: The patient will spend more and more time sleeping; it may be difficult for them to keep their eyes open. This is a result of a change in the body’s metabolism as a result of the disease. Tell family to spend more time with the patient during those times when he/she is most alert; this might be the middle of the night.

4. DISORIENTATION: The patient may become confused about time, place and the identity of people around him/her; he/she may see people who are not there. Some patients describe seeing family members who have already died. Sometimes patients describe welcoming or beckoning. While the patient may not be distressed, it is frequently distressing to family or health care professionals. Gently orient the patient if he or she asks. There is no need to ‘correct’ the patient if he or she is not distressed.

5. RESTLESSNESS: The patient may become restless and pull at the bed linens. These symptoms are also a change in the body’s metabolism. Talk calmly and assuredly with the patient as not to startle or frighten them. If the patient is a danger to himself or others, you may prescribe sedating neuroleptics (e.g. chlorpromazine), or neuroleptics (e.g. haloperidol) in combination with benzodiazepines (e.g. lorazepam), to help the patient rest.

6. DECREASED SENSES: Clarity of hearing and vision may decrease. Soft lights in the room may prevent visual misinterpretations. Never assume that the patient cannot hear you, as hearing is the last of the five senses to be lost.

7. INCONTINENCE of urine and bowel movements is often not a problem until death is very near. Invite family to participate in direct care; the nurse can help place absorbent pads under the patient for more comfort and cleanliness, or a urinary catheter may be used. The amount of urine will decrease and the urine become darker as death becomes near.

8. PHYSICAL CHANGES as death approaches.

a. The blood pressure decreases; the pulse may increase or decrease.

b. The body temperature can fluctuate; fever is common.

c. There is increased perspiration often with clamminess.

d. The skin color changes: flushed with fever, bluish with cold. A pale yellowish pallor (not to be confused with jaundice) often accompanies approaching death.

e. Breathing changes also occur. Respirations may increase, decrease or become irregular; periods of no breathing (apnea) are common.

f. Congestion will present as a rattling sound in the lungs and/or upper throat. This occurs because the patient is too weak to clear the throat or cough. The congestion can be affected by positioning, may be very loud, and sometimes just comes and goes. Anticholinergic medications (like transdermal scopalamine; subcutaneous or intravenous scopalamine or glycopyrrolate) can help decrease secretions. Elevating the head
of bed and swabbing the mouth with oral swabs give comfort and allows the family to participate in the patient’s care.

g. The arms and legs of the body may become cool to the touch. The hands and feet become purplish. The knees, ankles and elbows are blotchy. These symptoms are a result of decreased circulation.

h. The patient will enter a coma before death and not respond to verbal or tactile stimuli.

How to Know When Death Has Occurred:
- No breathing and heartbeat
- Loss of control of bowel or bladder
- No response to verbal commands or gentle shaking
- Eyelids slightly open; eyes fixed on a certain spot
- Jaw relaxed and mouth slightly open

Pronouncing Death (taken from EPEC-O©)

The phone call: “Please come; I think the patient has died.”
- Find out the circumstances of the death—expected or sudden? Is the family present? What is the patient’s age?

Preparation before you enter the room
- Confirm the details on the circumstances of death. Ask a nurse or other caregiver. Review the chart for important medical (length of illness, cause of death) and family issues (Who is family? What faith? Is there a clergy contact?).
- Find out who has been called. Other physicians? The attending?
- Has an autopsy ever been requested? Do you see a value in requesting an autopsy?
- Has the subject of organ donation been broached? Has the Organ Donor Network been contacted?

In the room
- You may want to ask the nurse or chaplain to accompany you; he/she can give you support and introduce you to the family.
- Introduce yourself (including your relationship to the patient) to the family if they are present. Ask each person their name and relationship to the patient. Shake hands with each.
- Say something empathetic: “I’m sorry for your loss...” or “This must be very difficult for you...”
- Explain what you are there to do. Tell the family they are welcome to stay if they wish, while you examine their loved one.
- Ask what questions the family has. If you cannot answer, contact someone who can.

The pronouncement
- Identify the patient. Use the hospital ID if available. Note the general appearance of the body.
- Test for response to verbal or tactile stimuli. Overtly painful stimuli are not required. Nipple or testicle twisting, or deep sternal pressure are inappropriate.
- Listen for the absence of heart sounds; feel for the absence of carotid pulse.
- Look and listen for the absence of spontaneous respirations.
- Record the position of the pupils and the absence of pupillary light reflex.
- Record the time at which your assessment was completed.

Documentation in the medical record
- Called to pronounce (name); chart findings of physical examination.
- Note date and time of death; distinguish time family or others noted death from the time you confirmed the absence of vital signs. Note whether family and attending physician were notified.
- Document whether family declines or accepts autopsy; document whether the coroner was notified.

References
Ellershaw J. Ward C. Care of the dying patient: the last hours or days of life. BMJ. 2003;326(7379):30-4.
Pitorak EF. Care at the time of death. AJN. 2003;103(7):42-52.
**Part 3: Evaluation Checklist**

<table>
<thead>
<tr>
<th>Learner name:</th>
<th>Date:</th>
<th>Evaluator/Attending:</th>
</tr>
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<tbody>
<tr>
<td>Resident PGY Level:</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
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<tr>
<td>Fellowship Year:</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Rotation Site:</td>
<td>1 Inpatient Cancer Center 2 Inpatient GIM 3 Oncology Clinic 4 Continuity GIM clinic 5 Other</td>
<td></td>
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</tbody>
</table>

Please rate the trainee's competency/skills/knowledge/attitude using the following scales:

For competency/skills

- 4 = Competent to perform independently
- 3 = Competent to perform with minimal supervision
- 2 = Competent to perform with close supervision / coaching
- 1 = Needs further basic instruction
- n/o = not observed

For knowledge and attitudes (e.g. Medical Knowledge)

- 4 = Superior
- 3 = Satisfactory
- 2 = Below average
- 1 = Insufficient – needs further learning
- n/o = not observed

### OBJECTIVES

#### Patient Care

4 3 2 1 n/o  4 3 2 1 n/o
Assessed and managed the symptoms due to physiologic changes associated with dying

Pronounced a death satisfactorily.

**Overall Performance:**

<table>
<thead>
<tr>
<th>Cannot Evaluate</th>
<th>1 to 3 Unsatisfactory</th>
<th>4 to 6 Satisfactory</th>
<th>7 to 9 Superior</th>
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<tr>
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<td>1 2 3 4 5 6 7 8 9</td>
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</table>

#### Medical Knowledge

4 3 2 1 n/o  4 3 2 1 n/o
Recognized the signs and symptoms of approaching death (active phase of dying).

Differentiated the roles of the members of the health care team in the care of the actively dying patient.

**Overall Performance:**

<table>
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#### Interpersonal and Communication Skills

4 3 2 1 n/o  4 3 2 1 n/o
Identified common patient/family reactions to the active phase of dying.

Demonstrated appropriate communication/counseling skills in discussing terminal care provisions with the patient/family.

Notified the family with compassion of the death of their loved one.

**Overall Performance:**

<table>
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<td>1 2 3 4 5 6 7 8 9</td>
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#### Systems Based Practice

4 3 2 1 n/o  4 3 2 1 n/o
Carried out the patient care responsibilities of the physician within the medical team caring for the actively dying patient.

Completed the required paperwork following a patient death.

**Overall Performance:**

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<th>Cannot Evaluate</th>
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**Professionalism**

Professionalism involves recognizing the need for physicians to provide leadership in managing dying patients in conjunction with the medical team.

**Overall Performance:**

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**Resident/Fellow strengths:**

**Resident/Fellow areas for improvement:**

**Overall impression:** Did the Resident/Fellow demonstrate competency in a manner so as to do no harm?

<table>
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**Resident/Fellow self-evaluation of performance:** May comment on any of the above checklist items or other reflections on performance; perceived strengths, and need for improvement and learning.