

UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE



**QUALITY OF DYING AND DEATH (QODD)
QUESTIONNAIRE FOR HEALTH PROFESSIONALS – VERSION 3.2**

Please return your completed questionnaire in the enclosed envelope to:

[RETURN ADDRESS]

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A QUESTIONNAIRE FOR NURSES ABOUT A PATIENT'S EXPERIENCES AT THE END OF LIFE

The following questions are about experiences that your patient may have had during the time he/she was in the ICU. In answering these questions, please base your ratings on how you think these experiences affected the quality of your patient's dying and death, not how you think your patient would have rated these experiences. We understand that you were not present the whole time, but please make your best estimate. On the rating scale below, 0 = "a terrible experience" and 10 = "an almost perfect experience".

If your patient did not have, or did not appear to have, a particular experience or if you do not know enough to rate it, you may check the box on the right.

	Terrible Experience											Almost Perfect Experience	Don't Know
1. Appear to have his/her pain under control	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	
2. Appear to have control over what was going on around him/her	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	
3. Be able to feed himself/herself	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	
4. Appear to breathe comfortably	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	
5. Appear to feel at peace with dying	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	
6. Appear to be unafraid of dying	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	
7. Laugh, smile	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	
8. Appear to keep his/her dignity and self-respect	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	
9. Spend time with his/her family or friends	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	
10. Spend time alone	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	

	Terrible Experience										Almost Perfect Experience		Don't Know
11. Be touched or hugged by loved ones	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	
12. Say goodbye to loved ones	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	
13. Clear up bad feelings with others	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	
14. Have one or more visits from a religious or spiritual advisor	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	
15. Have a spiritual service or ceremony before his/her death	0	1	2	3	4	5	6	7	8	9	10	<input type="checkbox"/>	

MEDICAL CARE AT THE END OF LIFE

The following questions are about aspects of medical care that your patient received in the ICU.

1a. Did your patient receive mechanical ventilation during his or her stay in the ICU?

(Circle one number)

- 1 Yes
- 2 No
- 3 Don't know >>>>>>>>> Go to Question 2a.

b. How would you rate this aspect of your patient's dying experience?

(Circle one number)

Terrible	0	1	2	3	4	5	6	7	8	9	10	Almost Perfect	Don't Know
												<input type="checkbox"/>	<input type="checkbox"/>

2a. Did your patient receive dialysis during his or her stay in the ICU? *(Circle one number)*

- 1 Yes
- 2 No
- 3 Don't know >>>>>>>>> Go to Question 3a.

b. How would you rate this aspect of your patient's dying experience?
(Circle one number)

Terrible	0	1	2	3	4	5	6	7	8	9	10	Almost Perfect
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Don't Know

3a. Do you think that your patient received the right amount of sedation during his or her stay in the ICU? *(Circle one number)*

- 1 Yes
- 2 No
- 3 Don't know >>>>>>>>> Go to Question 4a.

b. How would you rate this aspect of your patient's dying experience?
(Circle one number)

Terrible	0	1	2	3	4	5	6	7	8	9	10	Almost Perfect
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Don't Know

4a. Did your patient discuss his or her wishes for end of life care with his or her doctor - for example, resuscitation or intensive care? *(Circle one number)*

- 1 Yes
- 2 No
- 3 Don't know >>>>>>>>> Go to Question 5.

b. How would you rate this aspect of your patient's dying experience?
(Circle one number)

Terrible	0	1	2	3	4	5	6	7	8	9	10	Almost Perfect
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Don't Know

5. Do you think that your patient was kept alive too long? (Circle one number)

- 1 Yes
- 2 No
- 3 Don't know, unsure

EXPERIENCES AT THE MOMENT OF DEATH

The next questions are about your patient's moment of death.

1a. Was anyone, including family, friends or staff, present at the moment of your patient's death? (Circle one number)

- 1 Yes
- 2 No
- 3 Don't know >>>>>>>>> Go to Question 2a.

b. How would you rate this aspect of your patient's death? (Circle one number)

Terrible	0	1	2	3	4	5	6	7	8	9	10	Almost Perfect	Don't Know	
														<input type="checkbox"/>

2a. In the moment before your patient's death, was he/she: (Circle one number)

- 1 Awake
- 2 Asleep
- 3 In a coma or unconscious
- 4 Don't know >>>>>>>>> Go to Question 3

b. How would you rate this aspect of your patient's death? (Circle one number)

Terrible	0	1	2	3	4	5	6	7	8	9	10	Almost Perfect	Don't Know	
														<input type="checkbox"/>

3. Overall, how would you rate the quality of your patient's dying? (Circle one number)

Terrible	0	1	2	3	4	5	6	7	8	9	10	Almost Perfect
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Don't Know

OVERALL RATINGS OF CARE

1. Rate the care your patient received in the last several days of his/her life while in the ICU from all doctors and other health care providers combined. (Circle the number)

Worst Healthcare Possible	0	1	2	3	4	5	6	7	8	9	10	Best Healthcare Possible
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2. Rate the care your patient received in the last several days of his/her life while in the ICU from his/her doctor. (Circle the number)

Worst Healthcare Possible	0	1	2	3	4	5	6	7	8	9	10	Best Healthcare Possible
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REMEMBER: IF YOU HAVE ANY QUESTIONS, PLEASE CALL.

IF YOU HAVE ANY ADDITIONAL COMMENTS, PLEASE FEEL FREE TO ADD THEM HERE
OR TO THE BACK OF THIS PAGE.

THANK YOU FOR YOUR HELP WITH THIS STUDY.