UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE

QUALITY OF DYING AND DEATH

QUESTIONNAIRE FOR NURSES – VERSION 3.2A

Please return your completed questionnaire in the enclosed envelope to:

[*Return Address*]

RNID _____
PID _____

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	☐
2. Appear to have control over what was going on around him/her	0	1	2	3	4	5	6	7	8	9	10	☐
3. Be able to feed himself/herself	0	1	2	3	4	5	6	7	8	9	10	☐
4. Appear to breathe comfortably	0	1	2	3	4	5	6	7	8	9	10	☐
5. Appear to feel at peace with dying	0	1	2	3	4	5	6	7	8	9	10	☐
6. Appear to be unafraid of dying	0	1	2	3	4	5	6	7	8	9	10	☐
7. Laugh, smile	0	1	2	3	4	5	6	7	8	9	10	☐
8. Appear to keep his/her dignity and self-respect	0	1	2	3	4	5	6	7	8	9	10	☐
9. Spend time with his/her family or friends	0	1	2	3	4	5	6	7	8	9	10	☐
10. Spend time alone	0	1	2	3	4	5	6	7	8	9	10	☐

	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	☐
12. Say goodbye to loved ones	0	1	2	3	4	5	6	7	8	9	10	☐
13. Clear up bad feelings with others	0	1	2	3	4	5	6	7	8	9	10	☐
14. Have one or more visits from a religious or spiritual advisor	0	1	2	3	4	5	6	7	8	9	10	☐
15. Have a spiritual service or ceremony before his/her death	0	1	2	3	4	5	6	7	8	9	10	☐

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
													☐

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	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	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	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 <u>number</u>)*

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

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 <u>number</u>)*

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

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	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

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

REMEMBER: IF YOU HAVE ANY QUESTIONS, PLEASE CALL.

SOME QUESTIONS ABOUT YOU

Last, we would like to ask you a few questions that will help describe our nurse sample. Some of these questions are required by the National Institutes of Health.

1. When were you born? *(Please write the year)*

19 _____ _____

2. What is your gender? *(Circle one number)*

1 Male

2 Female

3. What is your ethnicity? *(Circle one number)*

1 Hispanic

2 Non-Hispanic

4. What is your race? *(Circle all that apply)*

1 White

2 Black / African American

3 Asian

4 Pacific Islander

5 Native American or Alaskan Native

6 Other (please specify) _____

5. In your nursing educational preparation, what is the highest degree you have completed? *(Circle one number)*

1 Diploma

2 Associate degree

3 Baccalaureate

4 Masters in Nursing

5 Other (please specify) _____

6. What special certifications do you hold? *(Circle one number)*

1 CCRN (Critical Care Certification)

2 CEN (Certified Emergency Nurse)

3 CHPN (Certified Hospice and Palliative Nurse)

4 CNRN (Neuroscience Certification)

5 OCN (Certified Oncology Nurse)

6 ACLS (Advanced Cardiac Life Support)

7 None

8 Other (please specify) _____

7. How many years have you worked in <u>nursing</u>? *(Please fill in)*

_____ years

8. How many years have you worked in <u>critical care nursing</u>? *(Please fill in)*

_____ years

9. What year did you complete your last clinical degree (nursing school)? *(Please write the year)*

____ ____ ____ ____

10. What training in end-of-life topics have you had since completing your formal nursing education? *(Circle one number)*

1 End-of-Life Nursing Education Consortium (ELNEC) Project

2 Continuing education in end-of-life topics for a total of <u>6 hours or more</u>

3 Continuing education in end-of-life topics for a total of <u>less than 6 hours</u>

4 None

5 Other (please specify) _____

11. Today's date is *(Please fill in today's date)* ____ ____ / ____ ____ / ____ ____
month day year

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.