Quality Palliative Care in Long Term Care

A Community-University Research Alliance

QPC-LTC Alliance Project Overview and Environmental Scan Results

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Lakehead University

McMaster University

Halton Region

St. Joseph's Care Group

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Quality Palliative Care in Long-Term Care Introduces…

www.palliativealliance.ca

Visit our website today to

- Learn more about the project and the Alliance members
- Review findings from environmental scan
- Find out more about the four LTC homes
- Share resources pertaining to palliative care in LTC
- Take a glimpse at upcoming events on the events calendar
- Keep up-to-date with possible interventions and tools

Alliance Members

- Get more 'behind the scenes' information by signing into the Alliance Login
- To receive your username and password please email palliativealliance@lakeheadu.ca
- To have relevant information and resources posted on the website email them to palliativealliance@lakeheadu.ca

QPC-LTC Alliance: Summary of Project

Background/Problem

Residents of long-term care (LTC) homes represent one of society's most frail and marginalized populations who often struggle with managing multiple chronic conditions and social isolation. Within LTC, over 75% of residents have cognitive impairment, which creates additional challenges for providing care due to the related communication, functional, and behavioural problems that arise. Thus, people who are dying in LTC homes form a growing population that consists of some of society's most vulnerable citizens who would benefit by access to palliative care programs that encompass disease management, address the physical, psychological, social and spiritual issues at end of life, issues of loss and grief, and practical end of life/death management concerns of residents and their families. This research will create knowledge about how to develop sustainable palliative care programs in LTC homes.

The Quality Palliative Care in Long-Term Care Research Alliance

The community-university research alliance, *Quality Palliative Care in LTC (QPC-LTC)*, promotes the sharing of knowledge, resources and expertise between 27 researchers and 40 organization partners representing provincial, regional and national stakeholders in LTC and palliative care. Graduate and undergraduate students in social work, nursing, and gerontology are currently being trained in conducting Participatory Action Research (PAR), and they will learn best practices in providing palliative care in LTC.

Goals of the QPC-LTC Research Alliance

The overall goal of the QPC-LTC Research Alliance is to improve quality of life for people who are dying in LTC homes through developing palliative care programs using a process of community capacity development.

The specific objectives are:

1. To empower Personal Support Workers (PSW)s to maximize their role in caring for people who are dying and their families and support them to be catalysts for organizational changes in developing palliative care.
2. To implement and evaluate a 4-phase process model of community capacity development in four LTC pilot sites, and create a research-based tool kit of strategies and interventions to support this development.
3. To create sustainable organizational changes that will improve capacity to deliver palliative care programs through empowering PSWs, developing palliative care teams and programs within LTC homes, and strengthening linkages with the community partners.
4. To develop knowledge and skills in palliative care and participatory action research methodology for students in PSW, Gerontology, Social Work and Nursing programs.

Key Research Activities, Strategies and Methodology

The goal of PAR is to create social change in relation to a desired goal through the empowerment of people who are marginalized. The empowerment process, the change process and its outcomes, are systematically documented through a variety of data collection methods before, after and throughout the research process. PAR recognizes the existing expertise of LTC staff and promotes integration of palliative care into existing practices. Empowerment of PSWs will be the primary focus throughout the research as PSWs provide most of the care for dying people in LTC. PSWs can be viewed as a marginalized and oppressed group in the LTC organization as they have least education and training of all resident care staff, least status amongst care providers, and little power or opportunity to influence organizational change.

Over the five years of this project, quantitative and qualitative data will be collected through: document reviews of policy/procedure and resident charts; interviews and focus groups with LTC staff; participant observations in the LTC home; interviews with staff, managers, family members, residents; and surveys of Alliance partners. Based on the data collected, specific strategies to support the change process will be identified by each LTC home site and implemented over five years using a Plan-Do-Study-Act process (PDSA). Change strategies include, but will not be limited to, educational interventions, mentoring, staff self-reflections related to attitudes and values, developing and supporting PSW leadership and communications skills, creating an in-house palliative care team that includes PSWs, engaging research partners in education and consultation, engaging management in the change process, development of organizational policy and procedures for palliative care, and a new process for staff supervision and support. Each of these interventions will be evaluated for its effectiveness in contributing to the overall organizational change process, contributing to a "tool kit" of evidence based strategies for developing organizational capacity to provide palliative care in LTC that will be created as a result of the project. PSWs and other LTC staff will be taught to evaluate the change process they are engaged in, providing them new skills to sustain organizational development.

To guide the QPC-LTC Alliance activities in four LTC sites over five years, a logic model has been developed, based on the research objectives that includes the resources, essential activities and desired outcomes. The QPC-LTC Alliance is expected to have a range of measurable short, medium and longer term outcomes. The research-based knowledge generated will be a resource for other LTC homes to improve quality of life for dying people. The following provides details regarding the Alliance activities and outcomes as presented in the logic model.

Short-term Outcomes: (Year 1)

Objective 1: Fifty percent of PSWs in each LTC home area engaged in project; PSW leader identified in each home and receiving time release from job for project activities; PSWs have defined their own role in providing QPC; PSWs have identified their educational and resource needs for providing QPC to residents and families.

Objective 2: Environmental scan completed in each of four LTC homes to collect base line data on palliative care using the CHPCA norms as the framework for data collection (care processes and organizational policy, resources). Using established instruments that have been demonstrated as valid and reliable in this context, data will be collected from residents on perceived quality of life, from families on perception of care, and from PSWs on perceived sense of workplace empowerment, job satisfaction and perceived supervisory support. "Focused" resident chart audits of care processes will be conducted on charts of those residents who died in the last year. Document reviews (accreditation, compliance, Minimal Data Set collected for Ministry of Health and Long-Term Care, PSW job turnover), observations in LTC homes, focus groups, interviews and survey questionnaires with LTC staff, management and community agencies will be used to complete the scan of PSW role and current practice in palliative care, perceived barriers and facilitators, and goals for change. A collaborative practice survey will be given to all LTC care staff involved in caring for dying residents. For this project, "residents who are dying" are people for whom, in the judgment of the LTC medical and nursing director, *death would not be unexpected in the next 12 months*. This is predicted to be 20-25 percent of residents per LTC home. The number, type and role of students involved in LTC homes will be documented.

Objective 3: QPC awareness campaign completed in each LTC home that includes local community partners. PSWs take leadership role, supported by Alliance members.

Objective 4: Students (2-5) participated in the activities to achieve Objectives 1,2,3 under supervision of researchers; students understand the CHPCA norms of practice; students understand the PAR and PDSA methodologies; linkages established between LTC homes and academic programs training students; PSWs and LTC staff can articulate the potential role of students and have involved students in the LTC home appropriately for their discipline (scope of practice) and level of experience. Students engage with PSWs in empowerment activities.

Intermediate Outcomes (Years 2-5)

Objective 1: PSWs have learned PDSA process; PSWs have developed, implemented and evaluated 4-8 change strategies in collaboration with Alliance members; PSWs are actively involved in PC team and participate in decision-making around PC delivery; PSWs express increased job satisfaction and sense of empowerment.

Objective 2: The capacity development model has been implemented in each LTC home: antecedent conditions strengthened; PC team developed; PC program is growing. All data collected have been analyzed in relation to the 4 phase community capacity development model. The community capacity development model is validated for applicability in LTC or revised based on this evaluation. All interventions used in the change process have been documented, and evaluated for their effectiveness in producing change in QPC-LTC. The tool kit for developing PC in LTC has been created using the capacity development model as a framework. The tool kit includes materials on implementation strategies for each phase of the model, user-friendly assessment tools for conducting the environmental scan, evidence-based interventions for creating organizational change, and training modules that will assist LTC homes to develop palliative care programs.

Objective 3: In year 3, data collection was repeated in each LTC home: residents' perceived quality of life, families' perception of care, and PSWs perceived sense of workplace empowerment, job satisfaction and perceived supervisory support. Focus groups were held with the palliative care team and interviews with LTC managers and members of the site partnership committees. Data collection in year 3 captured perceived changes, perceived supports and barriers to the change process, response to the PAR process and identified Alliance priorities for the remainder of the project. In year 5, the full environmental scan was repeated as in Year 1. Policy and procedures are developed for providing QPC-LTC. Resources for PC are allocated or are actively being sought. Mean scores on the instruments used in the environmental scan show improvement across the four study sites. More PSWs and community partners now participate on LTC committees.

Objective 4: Students (8-10) participated in all activities to achieve objectives 1, 2, 3 under the supervision of researchers. Students have fully participated in the PAR methodology, in particular engaging with PSWs in organizational change activities. Students in nursing, social work and gerontology have participated in providing palliative care, and the potential roles of students and the scope of practice of their professions are understood in the LTC home. Increased links with educators.

Longer-term Outcomes (Year 5 onwards)

Objective 1, 2, 3, 4. In Year 5, all QPC-LTC Alliance members were surveyed with a questionnaire developed to document perceptions of the achievements of the project in relation to the four longer-term objectives outlined on the logic model, and their perception of the facilitators and obstacles to the project's outcomes. As part of the survey, Alliance members were asked to suggest practical and effective methods of documenting QPC-LTC into the future. For example, the Minimal Data Set instrument that is commonly used to collect data on care needs of all LTC clients could be used to track the number of residents receiving palliative care in LTC homes across Canada. Data are routinely collected by some of the Alliance partners that could track progress. New partners can be engaged to assist with this task such as the Ontario Association for Non-Profit Homes and Services for Seniors or the Canadian Hospice Palliative Care Association. They can distribute the tool kit and track its use throughout Canada. A strategic plan was developed by the Alliance to continue progress towards the longer term objectives. The Ontario Interdisciplinary Council for Aging and Health has agreed to participate in tracking curriculum development in palliative care in Ontario universities.

Impact on Research, Communities and Curriculum and Student Training

Specific desired outcomes of the Alliance are summarized in the project Logic Model. The outcome of the research is intended to be *sustainable change* in the four LTC homes that are the research sites, documentation of the change process that occurred in these homes in a way that it is applicable in other similar settings, and documentation and evaluation of interventions that were used as tools to support the change process. The knowledge created will be a *resource (tool kit)* for implementing practices to improve quality of life for people dying in LTC homes. *A conceptual model* to guide the development of palliative care in LTC homes based on the concepts of community capacity will be implemented and evaluated. This theoretically extends Kelley's research by evaluating a model for community capacity development in palliative care in LTC. *Curriculum* will be developed and evaluated for preparing PSWs to provide palliative care. *Community services and expert palliative care providers will have linkages to LTC homes* to enhance quality of life of residents. *Educational resources* will be developed for LTC staff and families to better support them in decision-making about end of life issues. Those researchers who also teach students in the health professions will enrich their coursework through enhanced knowledge of palliative care in LTC. *A new organizational model* for providing palliative care in LTC homes will be developed that engages PSWs and community partners. *Graduate student trainees* will develop expertise in palliative care in LTC, and be trained in the PAR methodology.

Logic Model

Resources

Four long-term care homes as study sites; community palliative care experts & services that improve QOL; education/knowledge translation experts; colleges & universities; family/resident advocacy groups; local, regional, provincial and national organizational partners for consultation and dissemination; expert researchers; graduate student trainees; funding (SSHRC & in-kind from partners)

PAR Research Activities

1. Assess antecedent conditions in 4 LTC homes **(Year 1)**	2. Strengthen antecedent conditions; engage PSWs in Alliance goals **(Years 1, 2)**	3. Empower & support PSW workers to act as catalysts for organizational change on PC **(Years 1-5)**	4. Create interprofessional palliative care teams in LTC homes with PSW participation **(Year 2)**	5. Grow the palliative care program with PSW involvement and community partners participation **(Years 2-5)**	6. Create sustainable LTC change through developing policy and procedures for PC program using partnerships between LTC management/staff and community partners **(Years 3, 4, 5)**

7. Evaluate the process and outcomes of all activities and disseminate findings of the research **(Years 1-5)**

8. Engage undergraduate and graduate students in all research and Alliance activities **(Years 1-5)**

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Reach of QPC-LTC Alliance

LTC Residents & their families, LTC staff (managers, professional & non-professional staff, PSW), community services & palliative care experts, educators/KT experts/colleges/universities, students in gerontology, social work, nursing, professional organizations involved in palliative care and long term care; government health and social services policy makers; general public, media

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Short-term Outcomes (Year 1)

Objective 1: Demonstrated commitment of PSWs to the project; increased awareness of palliative care and the potential of PSW role; increased PSWs sense of empowerment	**Objective 2:** Completed environmental scan in each site (baseline data)	**Objective 3:** Increased awareness of LTC residents, families, staff, management and local community partners of palliative care philosophy, goals and community resources	**Objective 4:** Increase knowledge and skill in PAR and palliative care for students; increased understanding of student contributions in LTC homes

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Intermediate Outcomes (Years 2-5)

Objective 1: Multiple educational and clinical interventions developed and evaluated for empowering PSW in their role as catalysts for change	**Objective 2:** Capacity development model implemented and evaluated in relation to four phases of the palliative care development process at each site; tool kit of best practices in implementing model is developed	**Objective 3:** Increased commitment to providing QPC reflected in LTC policy & procedures and resource allocation; increased quality of life for residents and families	**Objective 4:** Increased participation of graduate and undergraduate students in Alliance and LTC palliative care program

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Longer-term Outcomes (Year 5 Onwards)

Objective 1: Increased participation of PSWs, students and community partners in providing QPC in LTC homes in Canada	**Objective 2:** Increased number of LTC homes in Canada implement palliative care programs using the QPC-LTC tool-kit and community capacity development process to implement organizational change	**Objective 3:** Increased number of residents and families in LTC homes in Canada receive QPC	**Objective 4:** More curriculum available to support QPC-LTC education for students in colleges, universities in Canada

Section One: Overview of Study Sites

North Western Ontario Homes

Hogarth Riverview Manor

Construction on Hogarth Riverview Manor began in September of 2002, and the home was ready to welcome residents on February 15th, 2004. Hogarth Riverview Manor accommodates 96 residents, and is divided into four Resident Home Areas known as groves. The four groves were designed to maximize space, promote comfort, and provide privacy for residents, based on the principle of resident centred care. Throughout the home, many warm and inviting communal areas can be found to create a home-like environment for residents and visitors as well as larger spaces for activities and social gatherings. Hogarth Riverview Manor offers many amenities for residents and families from a bright, open main lobby and cafe area, to a hair salon, gift shop, and chapel. A unique feature of the construction and design of the building can be found in the use of outdoor spaces surrounding the home to maximize residents' views of green spaces and enjoyment of outdoor activities in a safe environment. This long-term care home is not only a safe comforting environment for residents but it is a real community that is welcoming to residents, families, volunteers, and staff.

Bethammi Nursing Home

Bethammi Nursing Home provides specialized nursing care to 110 residents and provides basic and preferred accommodations. The facility was built in 1979 and is owned and operated by St. Joseph's Care Group, a non-profit Catholic organization supported by a volunteer Board of Directors. In addition to life enrichment activities and spiritual support, amenities such as the main lobby, Heritage Café, hair salon, gift/variety shop, and chapel are accessible to residents, families and the community. One of the unique features of Bethammi Nursing Home is the availability of a palliative care room that provides privacy to residents and their families. Hospice volunteer services are also offered to residents if requested. Bethammi Nursing Home was the site of a 2008 study conducted by Dr. Mary Lou Kelley and her team which examined the experience of people dying with dementia in long-term care.

Southern Ontario Homes

Allendale Nursing Home

Allendale Nursing Home is an accredited long-term care home with 200 beds. This home provides nursing and medical services, social, therapeutic and nutritional care to its residents. This home also offers two internal courtyards, gardens and walkways, fireplaces, enclosed balconies, family guest suite, family friendly kitchens, well appointed ensuite baths, spacious bedrooms with neighbourhood or garden views, and pub nights.

Allendale Nursing Home encourages each resident to make the room their own and to make this their home. There is an intimate dining room for family celebrations, lounges, TV dens and rooms for crafts and other programs.

Creek Way Village

Nestled in the Orchard Park Community, with easy access to nearby highways and shopping, Creek Way Village has 144 beds and offers a warm light filled setting and quality care.

Creek Way Village shares in the commitment to quality customer care. This site boasts a charming building that blends into the community, as well as an independent, non-profit child care centre and a new regional Emergency Medical Services (EMS) station.

Section Two: Conceptual Frameworks

Square of Care and Organization

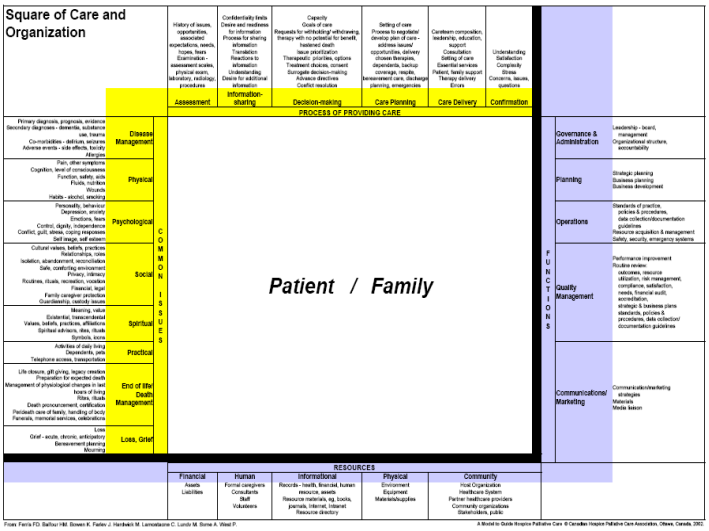
The Canadian Hospice Palliative Care Association (CHPCA) has developed a national model of palliative care that can be applied to any setting. The model of care is represented as the Square of Care and Organization.

The application of the process of providing care to each of the domains/issues commonly faced by patients and families can be illustrated in the conceptual framework, the **"Square of Care"**, which is shown on the following page. The Square of Care is a tool that can serve to guide issue identification and the provision of care during each therapeutic encounter.

The application of an organization's principal functions to the management of its resources can be illustrated by the conceptual framework, the **"Square of Organization"**. Like the "Square of Care," this framework can be used as a tool to guide the development, function and review of the organization's infrastructure, and each of its principal activities. The "Square of Organization" can also be used to guide the development, function and review of any group with a task (e.g., careteams, regional teams, committees, workgroups). This figure can also be found on the following page.

There are two main aspects of the CHPCA model to guide hospice palliative care which are: the delivery of patient and family care, and the development and function of an organization. Although they are separated on the following page for presentation purposes, the two are inextricably linked. They are guided by the same understanding of the illness and bereavement experiences, the same definitions, values, principles and foundational concepts. They are also interdependent. Clinicians cannot provide care without the resources and principal functions of an organization, and the organization cannot fulfill its mission or vision without a well-established process of providing care that addresses the issues commonly faced by patients and families.

This interrelationship between patient and family care and hospice palliative care organizational function is illustrated by the integrated **"Square of Care and Organization"** in the figure to the right. In essence, the organizational resources and functions are present to "support" the clinical activities (www.chpca.net).



Square of Care

			History of issues, opportunities, associated expectations, needs, hopes, fears Examination - assessment scales, physical exam, laboratory, radiology, procedures	Confidentiality limits Desire and readiness for information Process for sharing information Translation Reactions to information Understanding Desire for additional information	Capacity Goals of care Requests for withholding/ withdrawing, therapy with no potential for benefit, hastened death Issue prioritization Therapeutic priorities, options Treatment choices, consent Surrogate decision-making Advance directives Conflict resolution	Setting of care Process to negotiate/ develop plan of care - address issues/ opportunities, delivery chosen therapies, dependents, backup coverage, respite, bereavement care, discharge planning, emergencies	Careteam composition, leadership, education, support Consultation Setting of care Essential services Patient, family support Therapy delivery Errors	Understanding Satisfaction Complexity Stress Concerns, issues, questions
			Assessment	**Information-sharing**	**Decision-making**	**Care Planning**	**Care Delivery**	**Confirmation**
			PROCESS OF PROVIDING CARE					
Primary diagnosis, prognosis, evidence Secondary diagnoses - dementia, substance use, trauma Co-morbidities - delirium, seizures Adverse events - side effects, toxicity Allergies	**Disease Management**	**C O M M O N I S S U E S**	**Patient / Family**					
Pain, other symptoms Cognition, level of consciousness Function, safety, aids Fluids, nutrition Wounds Habits - alcohol, smoking	**Physical**							
Personality, behaviour Depression, anxiety Emotions, fears Control, dignity, independence Conflict, guilt, stress, coping responses Self image, self esteem	**Psychological**							
Cultural values, beliefs, practices Relationships, roles Isolation, abandonment, reconciliation Safe, comforting environment Privacy, intimacy Routines, rituals, recreation, vocation Financial, legal Family caregiver protection Guardianship, custody issues	**Social**							
Meaning, value Existential, transcendental Values, beliefs, practices, affiliations Spiritual advisors, rites, rituals Symbols, icons	**Spiritual**							
Activities of daily living Dependents, pets Telephone access, transportation	**Practical**							
Life closure, gift giving, legacy creation Preparation for expected death Management of physiological changes in last hours of living Rites, rituals Death pronouncement, certification Perideath care of family, handling of body Funerals, memorial services, celebrations	**End of life/ Death Management**							
Loss Grief - acute, chronic, anticipatory Bereavement planning Mourning	**Loss, Grief**							

From: Ferris FD, Balfour HM, Bowen K, Farley J, Hardwick M, Lamontagne C, Lundy M, Syme A, West P.
A Model to Guide Hospice Palliative Care © Canadian Hospice Palliative Care Association, Ottawa, Canada, 2002.

Square of Organization

Principal Activities	**F U N C T I O N S**	**Governance & Administration** Leadership - board, management Organizational structure, accountability
		Planning Strategic planning Business planning Business development
		Operations Standards of practice, policies & procedures, data/documentation guidelines Resource management Safety, security, emergency systems
		Quality Management Performance improvement Routine review outcomes, resource utilization risk management compliance satisfaction, needs financial audit accreditation strategic & business plans standards, policies & procedures, data/ documentation guidelines
		Communications/ Marketing Communication/marketing strategies Materials Media liaison

RESOURCES

Financial	Human	Informational	Physical	Community
Assets Liabilities	Formal caregivers Consultants Staff Volunteers	Records - health, financial, human resource, assets Resource materials, eg, books, journals, Internet, Intranet Resource directory	Environment Equipment Materials/supplies	Host Organization Healthcare System Partner healthcare providers Community organizations Stakeholders, public

From: Ferris FD, Balfour HM, Bowen K, Farley J, Hardwick M, Lamontagne C, Lundy M, Syme A, West P.
A Model to Guide Hospice Palliative Care © Canadian Hospice Palliative Care Association, Ottawa, Canada, 2002.

Developing Palliative Care: A Conceptual Model

The conceptual model for developing palliative care was originally evaluated and validated using rural communities. However, the inherent values of community capacity building theory translate well into any community setting including LTC homes. The model for developing palliative care outlines **four phases** in a LTC home (Figure 1). The phases outline a dynamic, sequential, but gradual transformative process over time. Each phase includes a number of activities or processes that grow out of and build upon those of the previous phase; however, work in all phases is ongoing. Progression through the phases is influenced by barriers, supports and resources that are internal or external to the LTC home and the palliative care program. Keys to success are identified for each phase. In phase four, palliative care program outcomes include provision of clinical care and education, advocacy, creation of community relationships to improve continuity of care and building external linkages with regional palliative care experts for education and consultation.

The model is visually depicted below, using the metaphor of a growing tree.

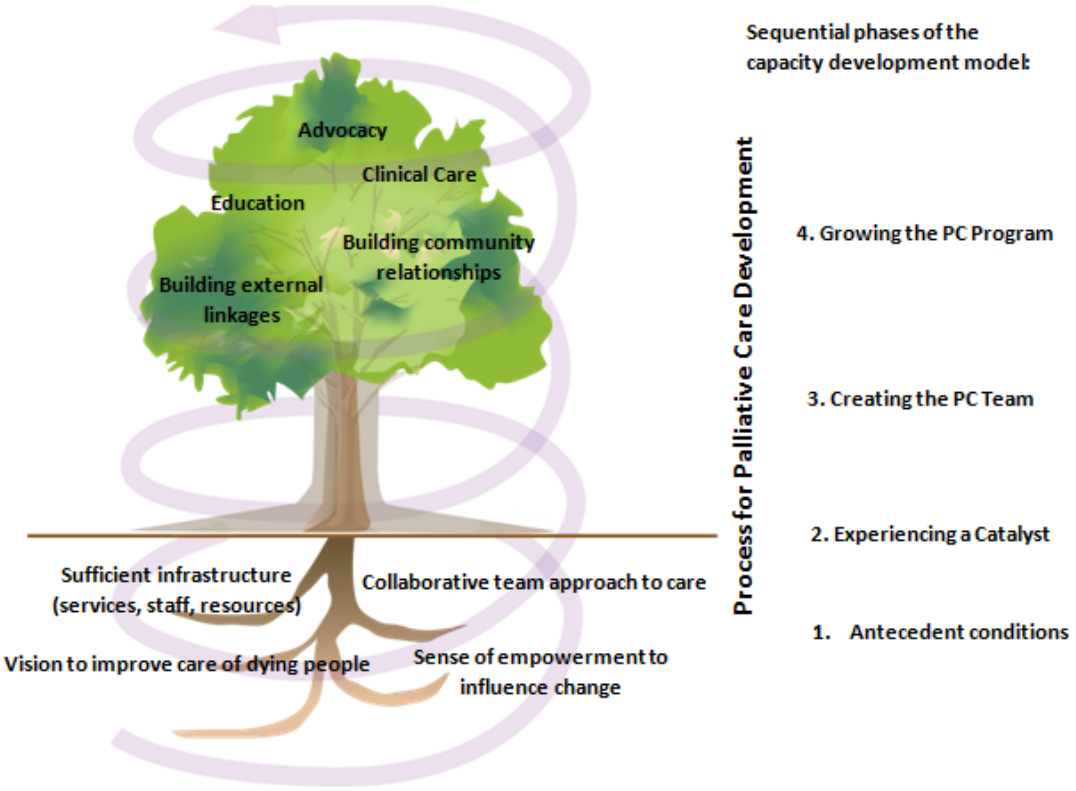


Figure 1: Model for Developing Palliative Care

Each phase of the model is elaborated on the following page.

Phase 1: Antecedent Conditions in LTC Home

In the model, four antecedent conditions form the basis for palliative care development; these conditions must preexist if development is to be successful. The conditions are:

- having sufficient health care infrastructure (services, providers, resources)
- having an approach to health care practice that is collaborative
- having a vision to improve care of dying people
- having a sense of control/empowerment to make change in the organization

The keys to successful development in this phase include working together, and being resident-focused.

Phase 2: Experiencing a Catalyst

A catalyst for change occurs in the LTC home, disrupting their current approach to caring for dying people. This catalyst can be a person (e.g a palliative care champion) or an event such as a "bad death", funding or education. The QPC-LTC project could be such a catalyst.

Phase 3: Creating a Palliative Care Team

Providers join together to form a team so that they can collectively improve care of the dying and develop "palliative care". Major themes include:

- having dedicated providers and
- getting the right people involved

Keys to success in this phase include: working together (strong relationships, communication, support), dedication of the team members, and physician involvement.

Phase 4: Growing the Palliative Care Program

The team continues to build, but now is ready to deliver palliative care. Major themes include:

- strengthening the team,
- engaging the LTC staff of all disciplines/roles and also community PC experts and resources
- sustaining palliative care.

The team is strengthened through sharing their knowledge and skills amongst themselves, and creating linkages with experts outside the LTC home. Team members build their confidence for providing palliative care. Teams now begin to change clinical practice, educating and supporting health care providers, and building community relationships to improve service delivery. Team efforts evolve to include managing challenges, getting additional resources and developing policies needed to sustain the new program. The keys to team success for growing the program were: remaining resident-focused; educating LTC staff and community resources; working together/teamwork; having leadership and feeling pride in their accomplishments.

"We try to do the best we can with our clients, with what we have. And I think that a great asset to us is because we have such good communication and a great team of people work within the community, who are very interested and caring." (health care provider)

Section Three: Environmental Scan Survey Results

Key Findings of the Surveys

Highlights from the surveys are:

- All staff from all four homes reported that "giving care to the dying person is a worthwhile experience" (from the FATCOD survey)

- All staff from all fours homes reported that patients are valued, treated well, and are an organizational priority ("patient focus" dimension from the Quality in Action Scale Survey)

- Staff groups scored lowest in the area of "personal influence", which is defined as the extent to which people feel that they have some control over their work, have an impact on work, and can do their best work (from the Quality in Action Scale Survey).

- Personal Support Workers felt that they have "meaning" in their work. "Meaning" is defined as the fit between work requirements and beliefs, values and behaviours. On the other hand they felt that they did not have great control over their work, or "impact" on work. (from the Personal Empowerment in the Workplace Survey and the Quality in Action Scale Survey).

- Registered Nurses and Registered Practical Nurses believe in their ability to perform end-of-life care (from the Self-Efficacy in End-of-Life Care Survey, pg.) which is not consistent to their knowledge of palliative care, with the average score on the Palliative Care Quiz being 60 % (from the Palliative Care Quiz,)

Frommelt Attitude Toward Care of the Dying

What is the FATCOD Survey?

The *Frommelt Attitude Toward Care of the Dying (FATCOD) Scale* is a 30-item scale designed to measure participants' attitude toward providing care to dying people.

The instrument consists of an equal number of positively and negatively worded statements with response options of strongly disagree, disagree, uncertain, agree, and strongly agree.

QPC-LTC Alliance Environmental Scan Results
Results from FATCOD (All Staff - Managers, PSWs, RN/RPNs and Support Services)

Key Findings: Elm had the most scores consistent with Palliative Care Philosophy. For all four homes the question with the highest response was "giving care to the dying person is a worthwhile experience".

Individual scores for each survey question **Positive worded items** *(1) Strongly disagree (2) Disagree (3) Uncertain (4) Agree (5) Strongly agree.* ***Higher scores are consistent with Palliative Care Philosophy***	Maple	Birch	Elm	Pine
1. Giving care to the dying person is a worthwhile experience.(*1*)*	4.73	**4.75**	4.67	4.56
2. Death is not the worst thing that can happen to a person.(*2*)	3.95	**4.15**	3.88	3.89
3. Caring for the patient's family should continue throughout the period of grief and bereavement.(*4*)	**4.47**	4.37	4.30	4.44
4. There are times when the dying person welcomes death.(*10*)	4.27	4.31	4.32	**4.45**
5. The family should be involved in the physical care of the dying person.(*12*)	**3.72**	3.58	3.65	3.61
6. Families need emotional support to accept the behaviour changes of the dying person.(*16*)	**4.55**	4.44	4.49	4.53
7. Families should be concerned about helping their dying member make the best of his/her remaining life.(*18*)	**4.35**	3.97	4.16	4.02
8. Families should maintain as normal an environment as possible for their dying member.(*20*)	4.08	3.98	4.02	**4.09**
9. It is beneficial for the dying person to verbalize his/her feelings.(*21*)	**4.5**	4.43	4.49	4.48
10. Care should extend to the family of the dying person.(*22*)	**4.37**	4.32	4.31	4.29
11. Caregivers should permit dying persons to have flexible visiting schedules.(*23*)	4.49	4.38	**4.62**	4.49
12. The dying person and his/her family should be in-charge decision-makers.(*24*)	4.03	4.04	**4.19**	3.89
13. Addiction to pain relieving medication should not be a concern when dealing with a dying person.(*25*)	3.98	3.92	**4.16**	3.95
14. Dying persons should be given honest answers about their condition.(*27*)	4.17	3.97	**4.24**	**4.24**
15. It is possible for nonfamily caregivers to help patients prepare for death.(*30*)	4.05	4.07	**4.39**	4.17
Negatively worded items *(1) Strongly disagree (2) Disagree (3) Uncertain (4) Agree (5) Strongly agree* ***Lower scores are consistent with Palliative Care Philosophy***				
16. I would be uncomfortable talking about impending death with the dying person.(*3*)	2.75	2.71	2.55	**2.33**
17. I would not want to care for a dying person.*(5)*	1.62	**1.49**	1.61	1.55
18. The nonfamily caregivers should not be the ones to talk about death with the dying person.*(6)*	2.43	2.45	**2.25**	**2.25**
19. The length of time required giving care to a dying person would frustrate me.*(7)*	1.82	**1.54**	1.62	1.58
20. I would be upset when the dying person I was caring for gave up hope of getting better.(*8*)	2.44	2.31	**2.13**	2.38
21. It is difficult to form a close relationship with the dying person.(*9*)	2.02	1.85	**1.65**	1.88
22. When a patient asks "Am I dying?", I think it is best to change the subject to something cheerful.(*11*)	2.34	2.44	**2.03**	2.10
23. I would hope the person I'm caring for dies when I am not present.(*13*)	2.08	2.15	2.04	**1.99**
24. I am afraid to become friends with the dying person.(*14*)	1.72	1.74	**1.60**	1.73
25. I would feel like running away when the person actually died.(*15*)	1.66	1.62	**1.61**	1.56
26. As a patient nears death, the nonfamily caregiver should withdraw from his/her involvement with the patient.(*17*)	1.79	1.77	**1.69**	**1.69**
27. The dying person should not be allowed to make decisions about his/her physical care.(*19*)	1.84	**1.56**	1.61	1.79
28. I would be uncomfortable if I entered the room of a terminally ill person and found him/her crying.(*26*)	2.22	2.33	**1.99**	2.16
29. Educating families about death and dying is not a nonfamily caregiver responsibility.(*28*)	2.28	2.27	**2.21**	2.23
30. Family members who stay close to a dying person often interfere with the professional's job with the patient.(*29*)	2.27	2.35	**2.24**	2.60

Who has had previous training on death and dying? (Respondents were asked to indicate if they have 1) previously taken training in death and dying or palliative care, 2) never taken specific training on death and dying or palliative care but material on the subject was included in other course/ workshops, or 3) never taken any training in death and dying or palliative care.

Maple	Birch
RN/RPN =19 respondents reported that they have taken training on death and dying, 6 reported having taken some education on death and dying or palliative care, and 2 reported that they have never had training.	**RN/RPN** = 12 respondents reported that they have taken training, 8 reported that they have had some education on death and dying or palliative care, and 2 reported that they have never taken any training.
PSW = 27 respondents reported that they have taken training, 39 reported having some education on death and dying or palliative care, and 14 reported having never taken any training.	**PSW** = 32 respondents reported that have taken training, 21 reported that they have had some education on death and dying or palliative care, and 9 reported never have taken any training.
Support Services Staff = 6 respondents reported that they have taken training , 8 reported having some education on death and dying or palliative care, and 22 reported that they have never had training.	**Support Services Staff** = 2 respondents reported that have taken training, 6 reported having some education on death and dying or palliative care, and 12 reported that they have never had training
Administration =7 respondents reported that they have taken training, 2 reported having some education on death and dying or palliative care, and 5 reported having never taken any training.	**Administration** = 6 managers reported that they have taken training, and 4 reported that they have had some education on death and dying or palliative care.

Elm	Pine
RN/RPN =7 respondents reported that they have had training, and 5 reported that they had some education on death and dying or palliative care.	**RN/RPN** = 1 respondent reported that they have taken training, 6 reported that they have had some education, and 1 reported that they have never taken any training.
PSW = 11 respondents reported that they have taken training, 10 reported having some education on death and dying or palliative care, and 1 responded reported that they never have had any training.	**PSW** = 14 respondents reported that they have taken training, 9 reported that they have had some education on death and dying or palliative care, and 1 reported that they never taken any training.
Support Services Staff = 4 respondents reported that they have had some previous education on death and dying or palliative care, and 6 reported that they have never taken any training.	**Support Services Staff** = 4 respondents reported that have taken training on death and dying or palliative care, and 9 reported that they have never taken any training.
Managers = 7 respondents reported that they have taken training, 2 reported having had some education on death and dying or palliative care, and 1 reported that they have never taken any training.	**Managers =** 7 respondents reported that they have taken training, 2 reported having had some education on death and dying or palliative care, and 1 reported that they have never taken any training.

Average Overall Scores

Maple	Birch
RNs' and RPNs' overall average score = 4.30 out of 5 Administrators' overall average score = 4.18 out of 5 PSWs' overall average score = 3.96 out of 5 Support services' overall average score = 3.88 out of 5 **All staff overall average = 4.08**	RNs' and RPNs' overall average score = 4.29 out of 5 Administrators' overall average score = 4.19 out of 5 PSWs' overall average score = 3.92 out of 5 Support services' overall average score = 3.88 out of 5 **All stall overall average = 4.07**
Elm	**Pine**
RNs' and RPNs' overall average score = 4.07 out of 5 Managers' overall average score = 4.13 out of 5 PSWs' overall average score = 4.08 out of 5 Support services' overall average score = 3.93 out of 5 **All staff overall average = 4.05**	RNs' and RPNs' overall average score = 4.18 out of 5 Managers' overall average score = 4.13 out of 5 PSWs' overall average score = 4.05 out of 5 Support services' overall average score = 3.88 out of 5 **All stall overall average = 4.06**

Maple
RN/RPN n= 28 out of a possible 43 respondents
PSW n= 87 out of a possible 124 respondents
SSS n= 38 out of a possible 60 respondents
Admin n= 14 out of a possible 15 respondents

Birch
RN/RPN n= 22 out of a possible 42 respondents
PSW n= 72 out of a possible 102 respondents
SSS n= 22 out of a possible 44 respondents
Admin n= 10 out of a possible 14 respondents

Elm
RN/RPN n= 12 out of a possible 16 respondents
PSW n= 22 out of a possible 53 respondents
SSS n= 11 out of a possible 53 respondents
Managers n= 10 out of a possible 13 respondents

Pine
RN/RPN n= 8 out of a possible 18 respondents
PSW n= 25 out of a possible 44 respondents
SSS n= 13 out of a possible 29 respondents
Managers n= 10 out of a possible 13 respondents

Quality in Action Scale

What is the QiAS survey?

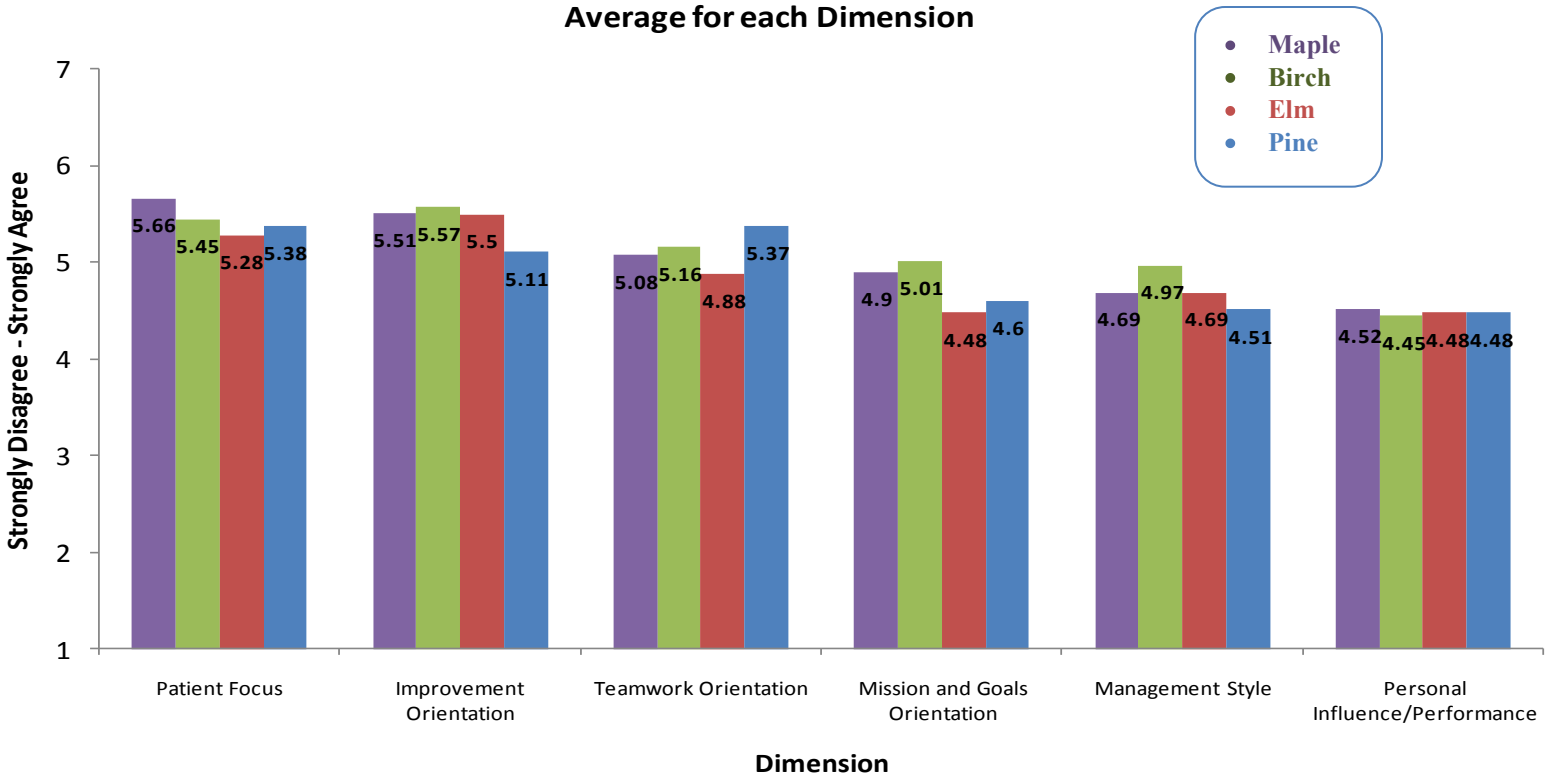
The *Quality in Action Scale* (QiAS) survey was developed to measure the culture of healthcare institutions as it relates to quality. Six dimensions are measured: **improvement orientation, patient focus, personal influence/performance, management style, mission and goals orientation** and **team work orientation**.

These dimensions are defined in the table below.

Dimension	*Definition*	*Example*
Patient Focus	Perceptions of the extent to which patients are valued, treated well, and are an organizational priority.	'Most people here think it is important to ask patients what they want.'
Management Style	Perceptions of the believability of management, their commitment to quality improvement, and their involvement of others in decision-making.	'I can usually believe what I hear from management.'
Teamwork Orientation	The extent to which people and group cooperate, help each other out, and suggest improvements.	'In this organization, people in different departments or programs try to help each other out.'
Improvement Orientation	The values and behaviour of people in the organization toward studying and improving work.	'Trying to improve the way the work gets done is part of everyone's job.'
Mission and Goals Orientation	People's perceptions of the extent that they and others understand the mission and goals of the organization and how their work relates to them.	'Most people here know how their work contributes to this organization's mission.'
Personal Influence/ Performance	The extent to which people feel that they have some control over their work, have an impact on work, and can do their best work.	'In my work situation, I have little control over how things are done.'

QPC-LTC Alliance Environmental Scan Results
Results from QiAS Survey (All Staff - Managers, PSWs, RN/RPNs and Support Services)

Key Findings: All four homes scored similarly on each dimension. Patient focus was scored highest and personal influence/ performance was scored lowest.

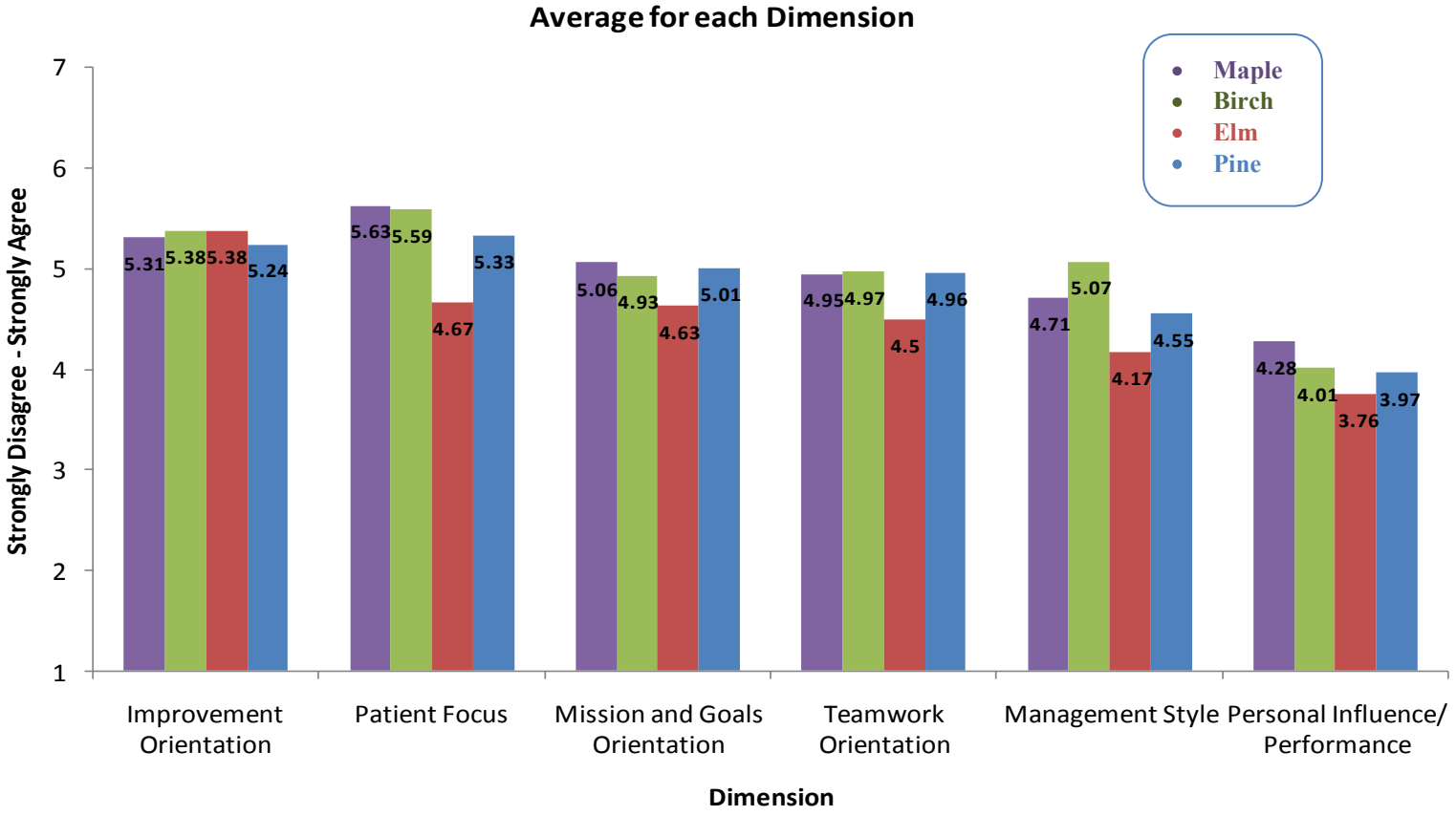


Support Services included social work, spiritual care, life enrichment, volunteers and employees who designated themselves as "other".

Maple; n= 181 out of a possible 242 respondents
Birch; n= 135 out of a possible 202 respondents
Elm; n= 52 out of a possible 135 respondents
Pine; n = 55 out of a possible 104 respondents

Results from QiAS Survey (PSWs Only)

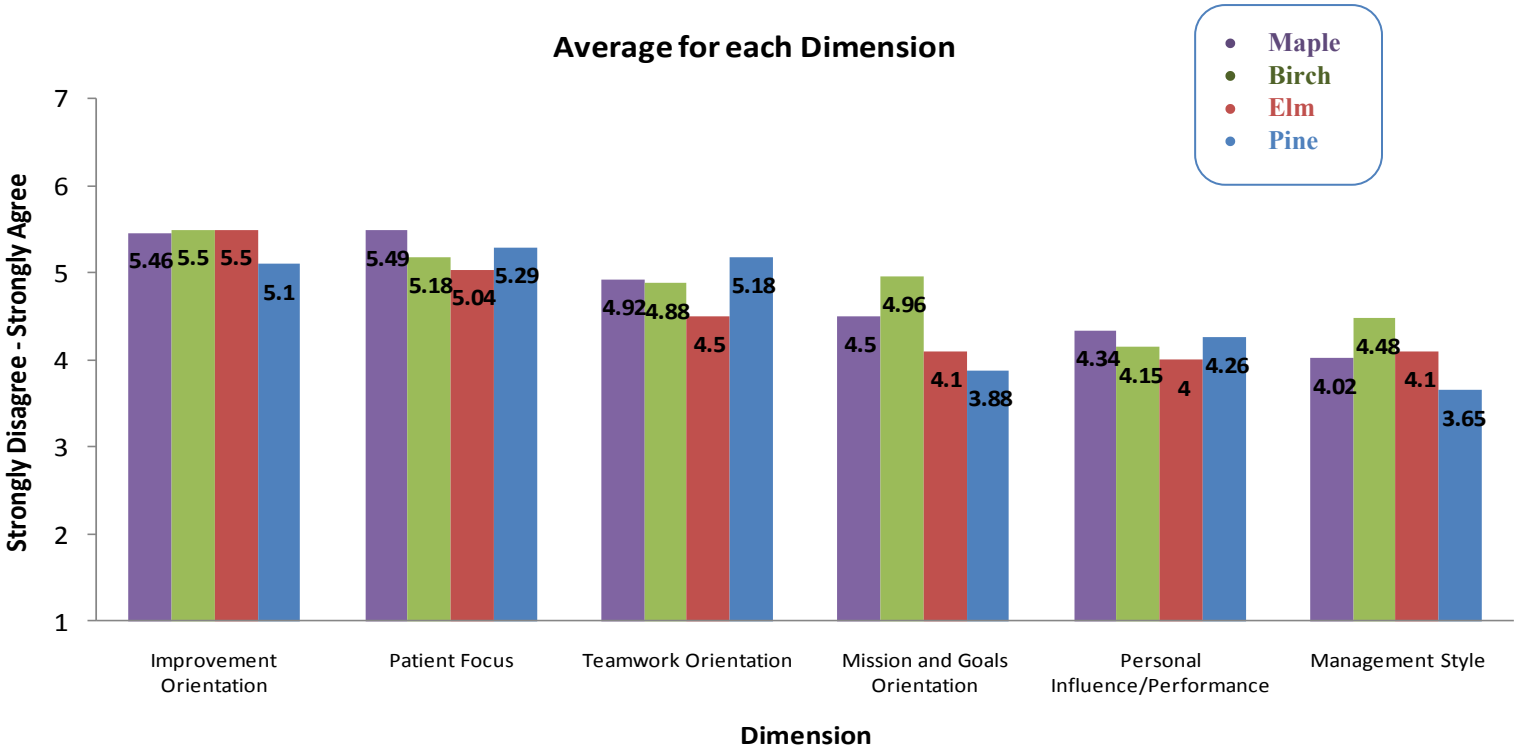
Key Findings: PSWs scored highest on the dimension of improvement orientation and lowest on personal influence/ performance.



Maple; n= 87 out of a possible 124 respondents
Birch; n= 72 out of a possible 102 respondents
Elm; n= 21 out of a possible 53 respondents
Pine; n= 25 out of a possible 44 respondents

Results from QiAS Survey (RN/RPNs Only)

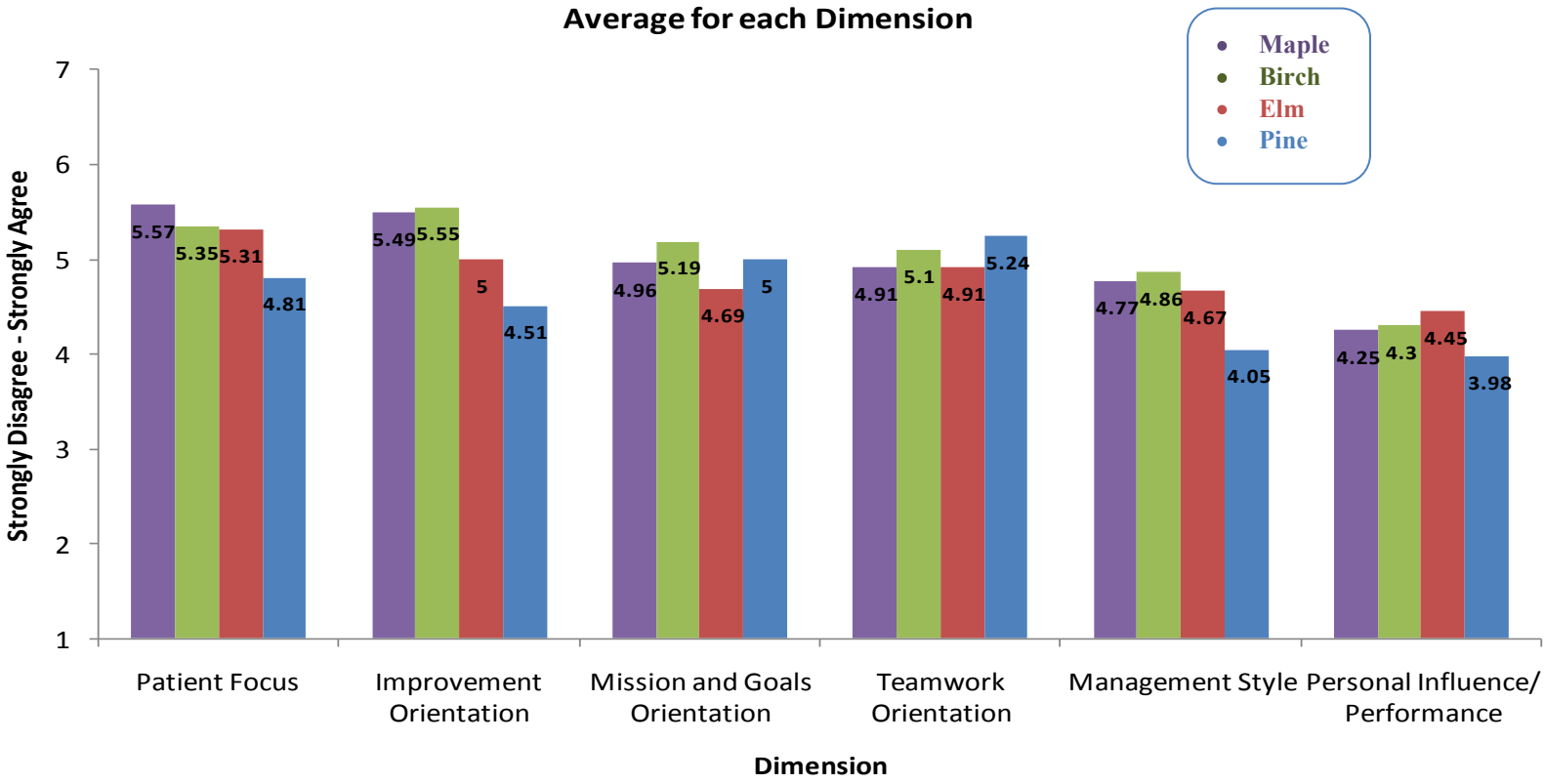
Key Findings: RNs and RPNs scored highest on the improvement orientation dimension and lowest on the management style dimension.



Maple; n= 28 out of a possible 43 respondents
Birch; n= 21 out of a possible 42 respondents
Elm; n= 12 out of a possible 16 respondents
Pine; n= 8 out of a possible 18 respondents

Results from QiAS Survey (Support Services Only)

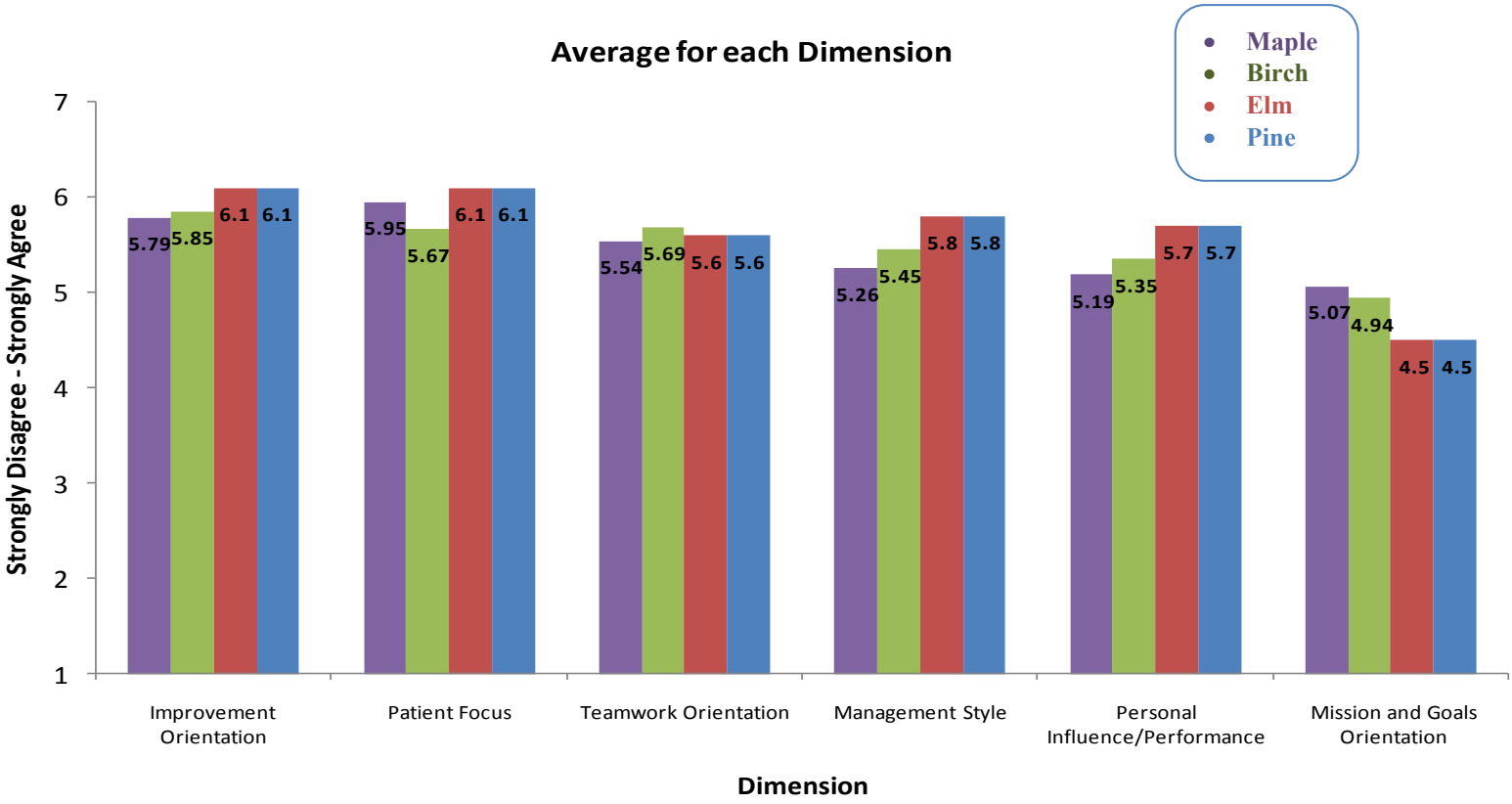
Key Findings: Support services scored highest on the dimension of patient focus and lowest on the dimension of personal influence/ performance.



Maple; n= 38 out of a possible 60 respondents
Birch; n= 22 out of a possible 44 respondents
Elm; n= 10 out of a possible 53 respondents
Pine; n= 13 out of a possible 29 respondents

Results from QiAS Survey (Managers Only)

Key Findings: Managers scored the dimension of improvement orientation highest and mission and goals orientation lowest.



Maple; n= 14 out of a possible 15 respondents
Birch; n= 10 out of a possible 14 respondents
Elm; n= 9 out of a possible 13 respondents
Pine; n= 9 out of a possible 13 respondents

Psychological Empowerment in the Workplace Survey

What is the PEiW survey?

The *Psychological Empowerment in the Workplace* (PEiW) survey was developed to measure four dimensions of work life which are: **meaning, competence, self-determination**, and **impact**. These dimensions are defined in the table below .

What is empowerment?

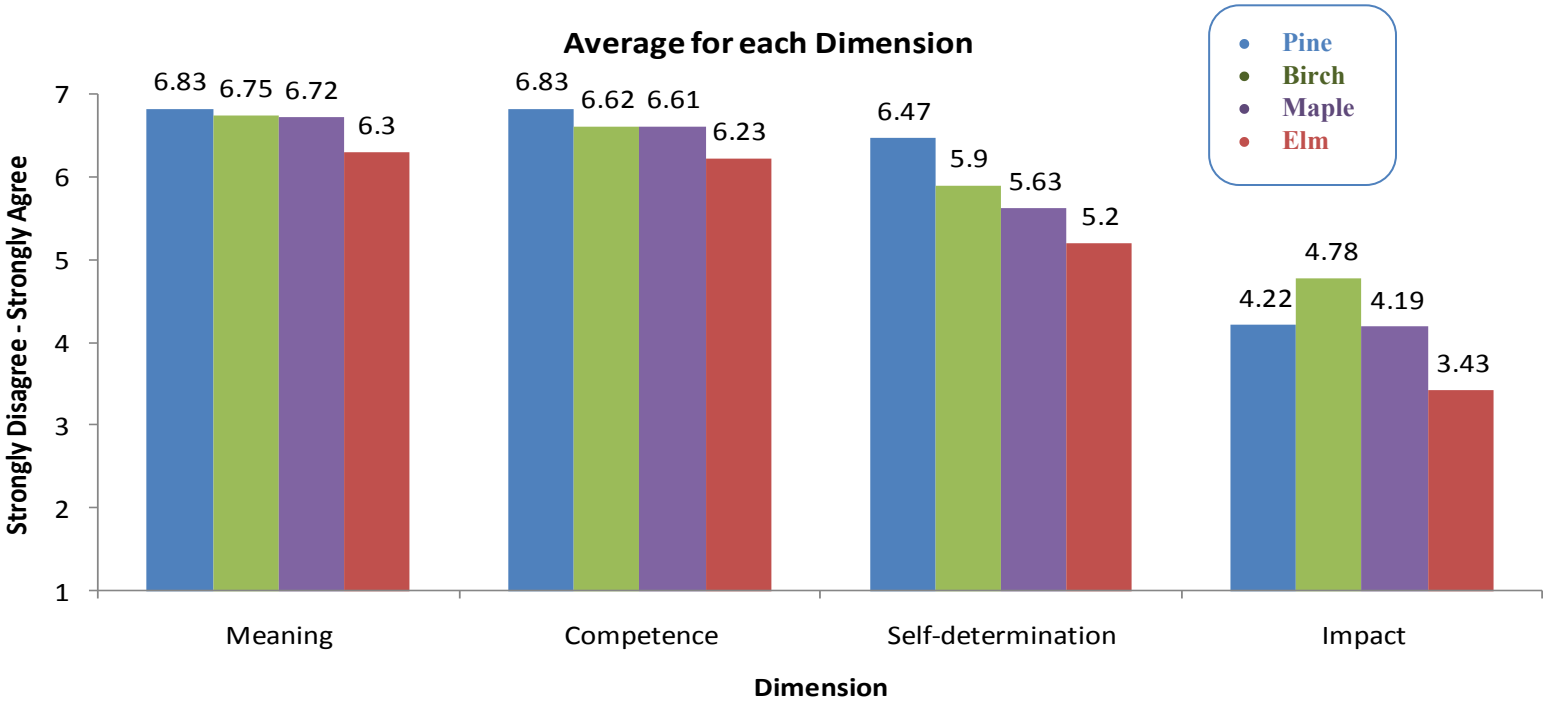
Empowerment is the state of feeling you have control of your own destiny. In the workplace, it includes the ability to think, behave, take action and control your work and decision-making in autonomous ways.

Researchers who study empowerment in the workplace collect information about staff's perspectives on four aspects of their work: meaning, competence, self-determination and impact.

Dimension	*Definition*	*Example*
Meaning	Fit between work requirements and beliefs, values and behaviours.	'The work I do is meaningful to me.'
Competence	Person's belief about his/her capabilities to produce effects.	'I am self-assured about my capabilities to perform my activities.'
Self-determination	Autonomy in the initiation and continuation of work behaviours and progress.	'I have considerable opportunity for independence and freedom in how I do my job.
Impact	The degree to which an individual can influence strategic, administrative or operating outcomes at work.	'My impact on what happens in my department is large.'

QPC-LTC Alliance Environmental Scan Results
Results from PEiW Survey (PSW)

Key Findings: PSWs from all four homes scored similarly for all categories. Meaning was scored highest by all homes and impact was scored lowest. Birch scored slightly higher for the dimension of impact.



Pine; n= 24 out of a possible 44 respondents
Birch; n= 72 out of a possible 102 respondents
Maple; n= 86 out of a possible 124 respondents
Elm; n= 47 out of a possible 53 respondents

Supervisory Support Survey

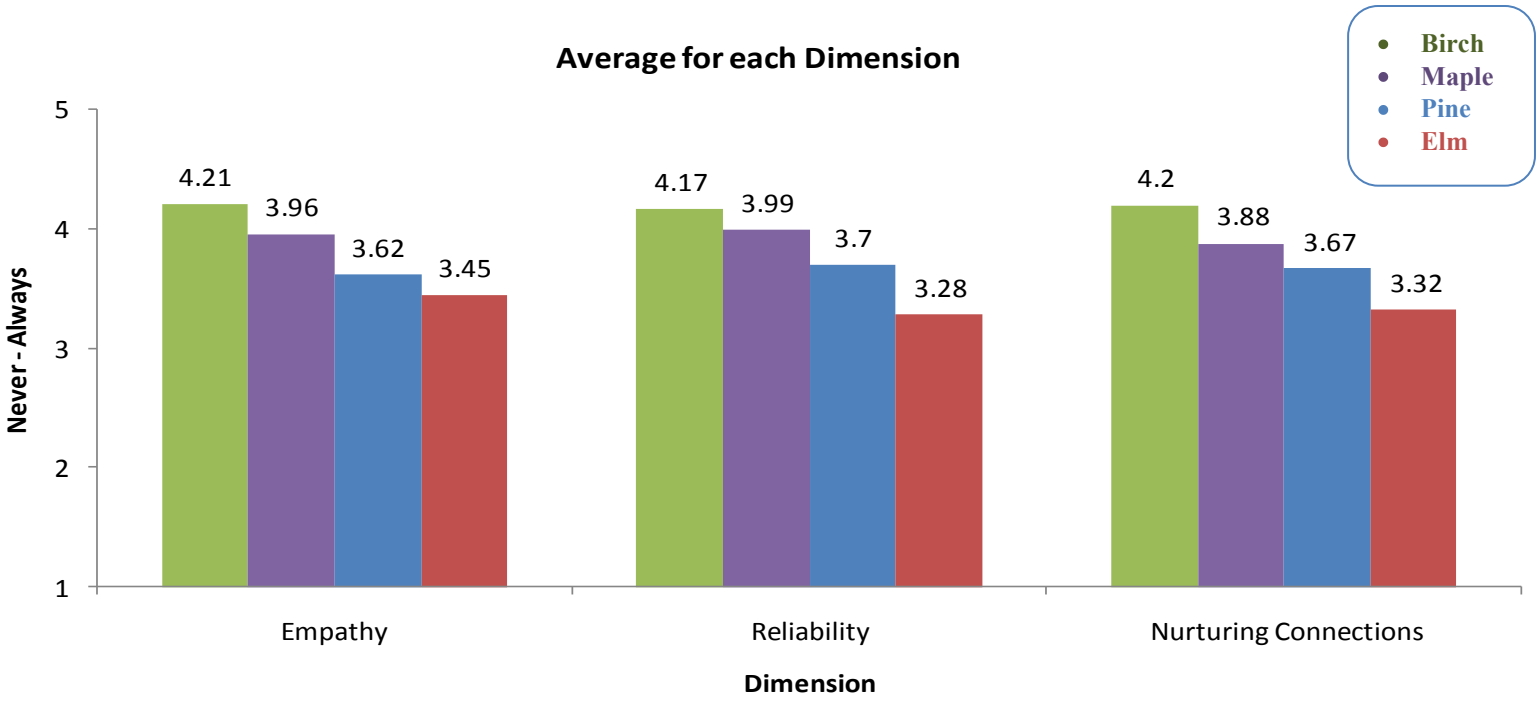
What is the Supervisory Support Survey?

The *Supervisory Support Survey* was developed to measure three dimensions of supervisory support within long-term care settings: **empathy**, **reliability** and **nurturing connections**. These dimensions are defined in the table below.

Dimension	*Definition*	*Example*
Empathy	To recognize the staff's standards of care, to recognize and accommodate the staff's expressed needs, and to understand staff's point of view.	'My supervisor tries to meet my needs.'
Reliability	To be available for staff if things are not going well with residents or families, to protect the nursing staff from the unpredictable by keeping them informed.	'I can rely on my supervisor when things are not going well.'
Nurturing Connections	To build and nurture the personal side of the relationship, e.g. knowing the person, demonstrating personal respect, listening, and showing concern and encouragement.	'My supervisor respects me as a person.'

QPC-LTC Alliance Environmental Scan Results
Results from Supervisory Support Survey (PSW)

Key Findings: Each home scored within one point of each other for each dimension. Each dimension shows the same trend; Birch scoring the highest, followed by Maple, Pine and Elm scoring the lowest for each dimension of supervisory support.



Birch; n= 73 out of a possible 102 respondents
Maple; n= 86 out of a possible 124 respondents
Pine; n= 24 out of a possible 44 respondents
Elm; n= 31 out of a possible 53 respondents

Self-Efficacy in End-of-Life Care Survey

What is the S-E EOLC survey?

The *Self-Efficacy in End-of-Life care* (S-E EOLC) survey measures personal confidence associated with palliative care, namely **communication, patient management** and **multidisciplinary teamwork**.

Respondents rate their confidence in their abilities to engage in certain tasks. The point scale ranges from "Cannot do at all" to "Certain can do."

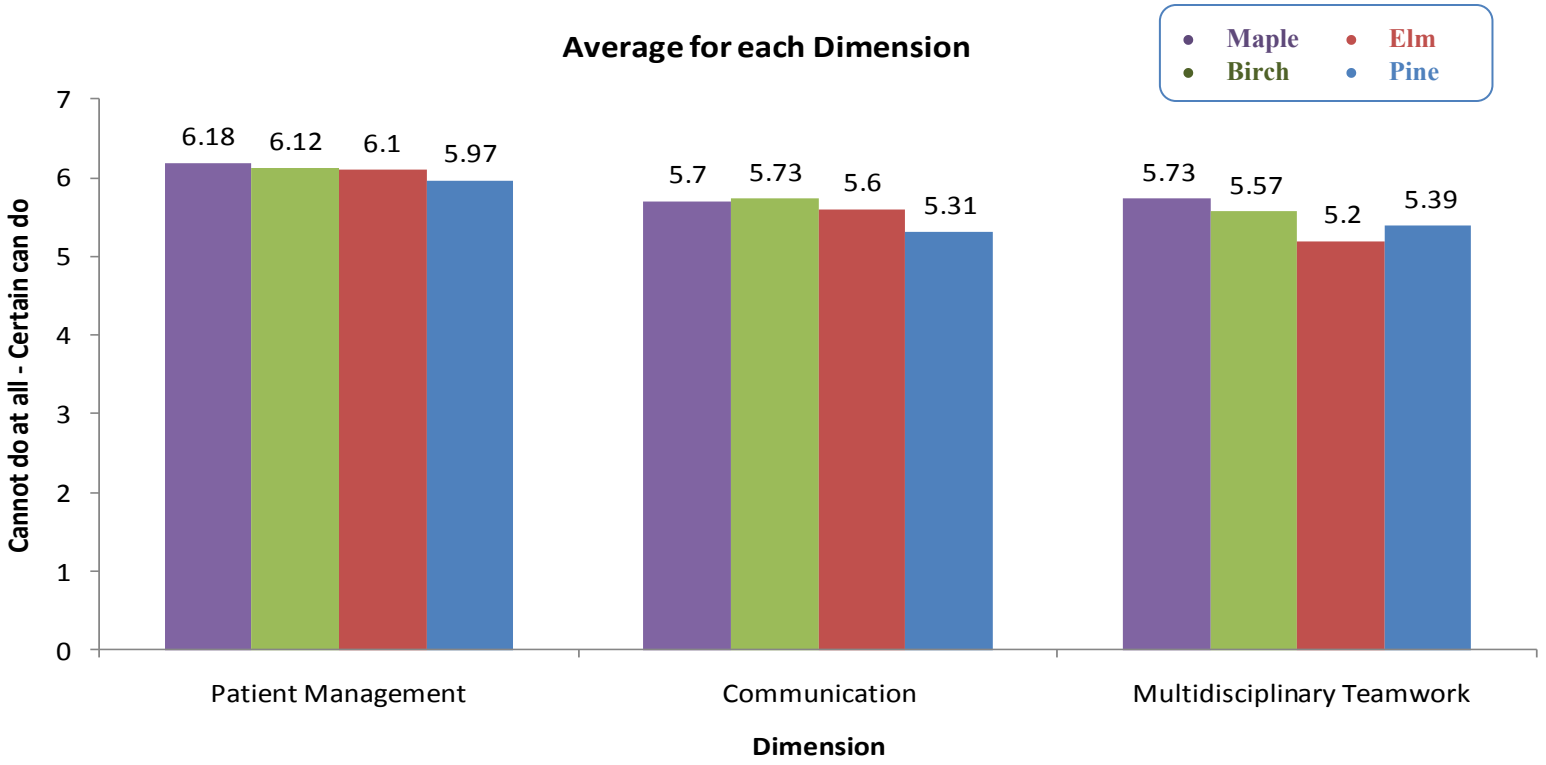
What is self-efficacy?

Self-efficacy refers to the belief in one's ability to perform a specific behaviour or skill.

Dimension	*Definition*
Patient Management	Includes items related to assessing physical, emotional, and spiritual needs; managing common palliative symptoms; providing emotional support to both the client and family; and providing culturally-sensitive care.
Communication	Includes items related to discussing the course of illness with the client and family, discussing issues related to death and dying, talking about specific client concerns, and responding to questions: "How long have I got to live?" and "Will there be much suffering or pain?
Multidisciplinary Teamwork	Includes items related to working with other professionals to provide palliative care and referring clients to other types of health care providers (i.e., occupational therapist, physical therapist, spiritual worker, social worker) and services (i.e., complimentary therapies, psychiatric assessment).

QPC-LTC Alliance Environmental Scan Results
Results from Self-Efficacy in End-of-Life Care Survey (RN/RPN)

Key Findings: All homes rated each dimension positively and scored similarly on all dimensions of self-efficacy.



Maple; n= 27 out of a possible 43 respondents
Birch; n= 22 out of a possible 42 respondents
Elm; n= 11 out of a possible 16 respondents
Pine; n= 8 out of a possible 18 respondents

Palliative Care Quiz

What is Palliative Care?

Palliative care is a philosophy and a unique set of care processes that aim to enhance quality of life at the end of life in order to provide a 'good death' for people, and their family, when death is inevitable.

What is the PCQN Survey?

There are three purposes to the *Palliative Care Quiz Nursing* (PCQN).

- First, it measures knowledge of palliative care nursing. In previous studies, participants with specialized training in palliative care achieved higher score than those without such training.
- Second, the PCQN can stimulate discussions about palliative care nursing among all levels of health care professionals.
- Thirdly, the PCQN can identify misconceptions about palliative care nurs-ing. One common misconception is that palliative care is not compatible with the provision of aggressive treatment.

QPC-LTC Alliance Environmental Scan Results
Results from Palliative Care Quiz (RN/RPN)

Palliative Care Quiz Questions			Birch	Maple	Elm	Pine
1. Palliative care is only appropriate in situations where there is evidence of a downhill trajectory or deterioration.	T	**F**	**81.8 %**	70.4 %	66.7 %	50.0 %
2. Morphine is the standard used to compare the analgesic effect of other opioids.	**T**	F	36.4 %	**74.1 %**	58.3 %	50.0 %
3. The extent of the disease determines the method of pain treatment.	T	**F**	59.1 %	33.3 %	50.0 %	**62.5 %**
4. Adjuvant therapies are important in managing pain.	**T**	F	86.4 %	81.5 %	**91.7 %**	37.5 %
5. It is crucial for family members to remain at the bedside until death occurs.	T	**F**	**90.9 %**	81.5 %	75.0 %	75.0 %
6. During the last days of life, drowsiness associated with electrolyte imbalance may decrease the need for sedation.	**T**	F	27.3 %	33.3 %	**50.0 %**	25.0 %
7. Drug addiction is a major problem when morphine is used on a long-term basis for the management of pain.	T	**F**	90.9 %	**92.6 %**	50.0 %	37.5 %
8. Individuals who are taking opioids should also follow a bowel regime.	**T**	F	90.9 %	88.9 %	**100.0 %**	87.5 %
9. The provision of palliative care requires emotional detachment.	T	**F**	86.4 %	88.9 %	**91.7 %**	87.5 %
10. During the terminal stages of an illness, drugs that can cause respiratory depression are appropriate for the treatment of severe dyspnea.	**T**	F	63.6 %	51.9 %	33.3 %	**87.5 %**
11. Men generally reconcile their grief more quickly than women.	T	**F**	59.1 %	**74.1 %**	66.7 %	50.0 %
12. The philosophy of palliative care is compatible with that of aggressive treatment.	**T**	F	**13.6 %**	7.4 %	8.3 %	0.0 %
13. The use of placebos is appropriate in the treatment of some types of pain.	T	**F**	59.1 %	66.7 %	66.7 %	**75.0 %**
14. In high doses, codeine causes more nausea and vomiting than morphine.	**T**	F	**63.6 %**	48.1 %	41.7 %	50.0 %
15. Suffering and physical pain are synonymous.	T	**F**	**68.2 %**	51.9 %	41.7 %	37.5 %
16. Demerol is not an effective analgesic for the control of chronic pain.	**T**	F	45.5 %	**70.4 %**	58.3 %	50.0 %
17. The accumulation of losses renders burn-out inevitable for those who work in palliative care.	T	**F**	59.1 %	59.3 %	**66.7 %**	12.5 %
18. Manifestations of chronic pain are different from those of acute pain.	**T**	F	81.8 %	77.8 %	66.7 %	**87.5 %**
19. The loss of a distant or contentious relationship is easier to resolve than the loss of one that is close or intimate.	T	**F**	63.6 %	63.0 %	**83.3 %**	50.0 %
20. Pain threshold is lowered by fatigue or anxiety.	**T**	F	40.9 %	44.4 %	**66.67 %**	37.5 %

Birch; n= 22 out of a possible 42 respondents
Maple; n= 27 out of a possible 43 respondents
Elm; n= 12 out of a possible 16 respondents
Pine; n= 8 out of a possible 18 respondents

Birch average score = 63.4%
Maple average score = 62.98%
Elm average score = 62%
Pine average score = 52.5%

Quality of Life in Life-Threatening Illness: Family Caregiver Version

What is the QOLLTI-F survey?

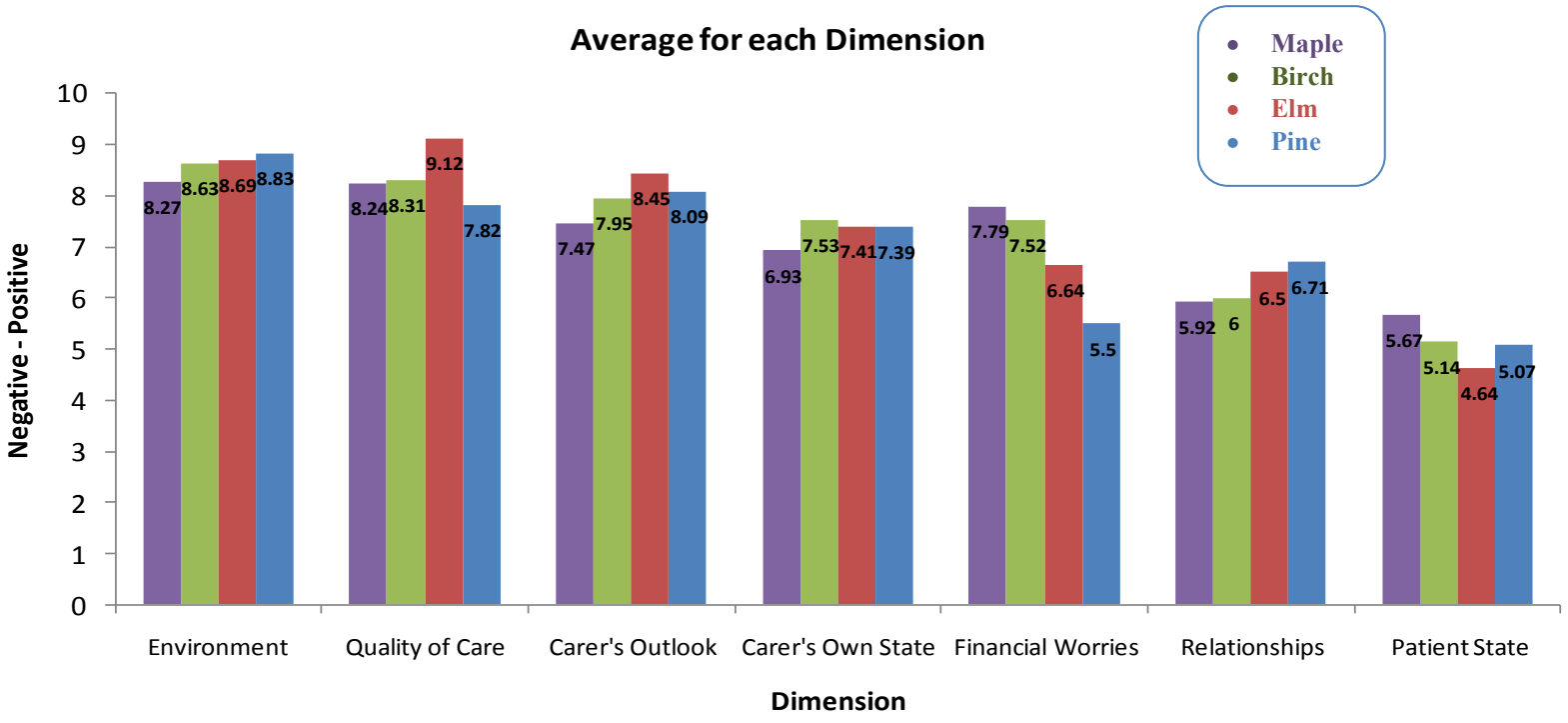
The *Quality of Life in Life-Threatening Illness - Family Caregiver Version (QOLLTI-F)* survey assesses the quality of life of caregivers for people with life-threatening chronic or terminal health conditions. There are five dimensions to this survey; **environment, patient state, own state, outlook, quality of care, relationships** and **financial worries**.

These dimensions are shown in the table below.

Dimension	*Example*
Environment	"I had the privacy I wanted".
Patient State	"The condition of _____ was distressing to me".
Carer's Own State	"I had time to take care of myself".
Carer's Outlook	"I was comforted by my outlook on life, faith, or spirituality".
Quality of Care	"I agreed with the way decisions were made for ____".
Relationships	"I felt my relationship with the people most important to me made my quality of life much better".
Financial Worries	"My financial situation has been stressful".

QPC-LTC Alliance Environmental Scan Results
Results from QOLLTI-F Survey (Family Member)

Key Findings: All four homes scored similarly on each dimension. Environment was scored highest and patient state was scored lowest.



Maple; n= 15 respondents
Birch; n= 23 respondents
Elm; n= 22 respondents
Pine; n= 14 respondents

McGill Quality of Life Survey

What is the MQoL survey?

The *McGill Quality of Life Questionnaire* (MQoL) was developed to measure five dimensions of quality of life which are: **physical symptoms, physical well-being, psychological, existential** and **support**. These dimensions are defined in the table below.

What is quality of life?

Quality of life is defined as an individual's subjective well-being.

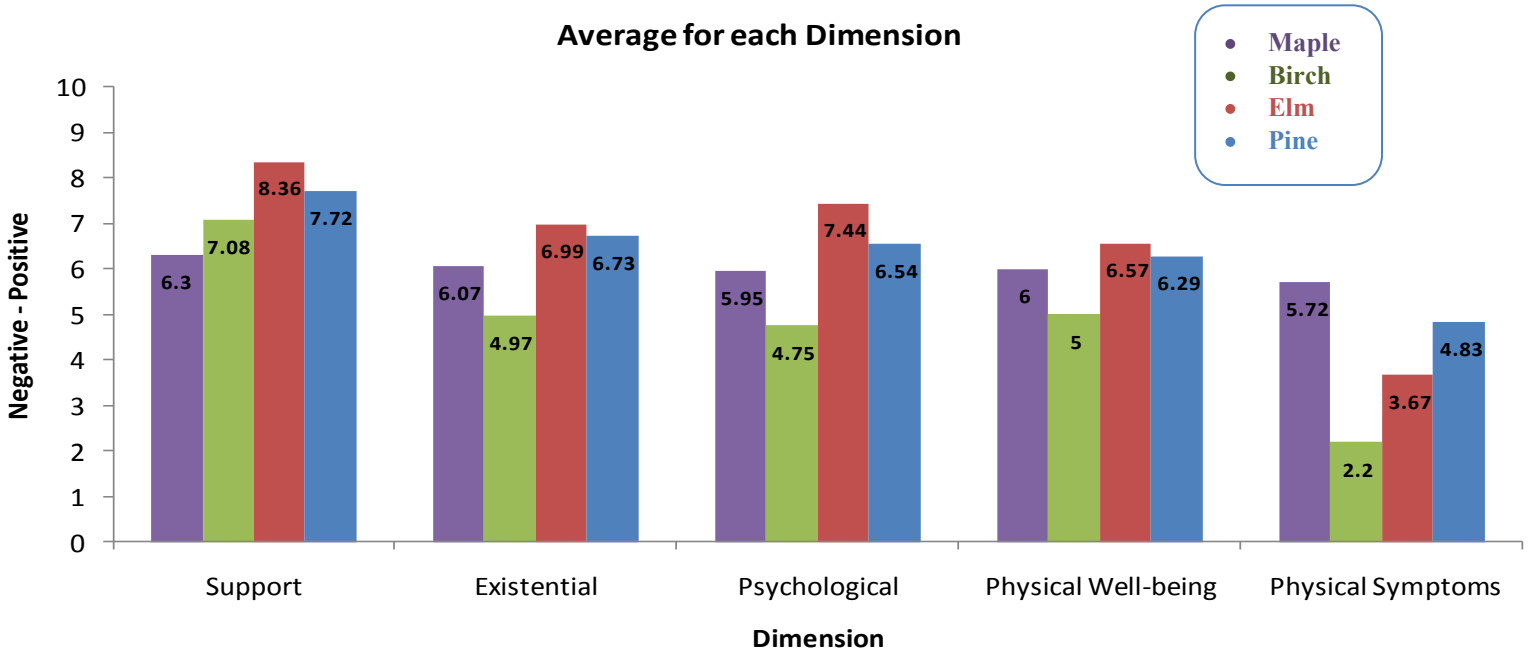
Who is this survey for?

For this project the MQoL survey was used to assesses the quality of life of residents of long-term care homes with life-threatening chronic or terminal health conditions. A **proxy** is someone who is appointed to make a patient's medical decisions if the person is unable to do so. In this case the proxy completed the survey if the resident was unable to answer themselves.

Dimension	*Meaning*
Physical Symptoms	Questions regarding symptoms that the resident finds troublesome.
Physical Well-being	Question regarding how the resident has physically felt over the past two days.
Psychological	Questions regarding residents' feelings of sadness, nervousness, etc.
Existential	Questions regarding residents' thoughts on life achievements, control over own life, etc.
Support	Questions regarding support that the residents' have received from others.

QPC-LTC Alliance Environmental Scan Results
Results from MQoL (Resident and Proxy)

Key Findings: The dimension of support was rated highest by residents and proxies and physical symptoms was scored lowest. Elm scored highest for each dimension with the exception of physical symptoms.



Respondents were asked to list the physical symptoms that they have had over the past two days. The most common symptoms included:

1. **Pain** (18 respondents)
2. **Tiredness** (7 respondents)
3. **Immobility** (5 respondents)

Maple; n= 5 residents
Birch; n= 2 residents, 17 proxies
Elm; n= 1 resident, 6 proxy
Pine; n= 7 residents, 2 proxies

Summary of Data Collection Instruments

Data Collection Methodology / Tool	Data Collection Instrument	Measurement	Data Collected From
Survey	***Quality in Actions Scale*** (QiAS Survey) Source: Baker, G.R., Murray, M.A., Tata, K. (1995). The Quality in Action Instrument: an instrument to measure healthcare quality culture. Department of Health policy, Management and Evaluation, Faculty of Medicine. University of Toronto.	6 subscales: • patient focus • improvement orientation • teamwork orientation • missions and goals orientation • management style • personal influence and performance	All Staff
Survey	***Attitudes toward Dying*** (FATCOD Survey) Source: Murray Frommelt, K.H. (2003). Attitudes toward care of the terminally ill: An educational intervention. *American Journal of Hospice & Palliative Care, 20*(1), 13-22.	Measurement of attitudes toward caring for terminally ill persons and their families (pre- and post-educational intervention)	All Staff
Survey	***Palliative Care Knowledge Quiz*** (Palliative care Quiz) Source: Ross, M.M., & McGuinness, J. (1996). The palliative care quiz for nursing (PCQN): The development of an instrument to measure nurses' knowledge of palliative care. *Journal of Advanced Nursing, 23,* 126-137.	Assessment of entry-level nurses knowledge of palliative care (i.e. pain and symptom management, general knowledge and attitudes on death and dying)	RN/RPN
Survey	***Self-Efficacy in End of Life Care Scale*** (S-E in EOLC survey) Source: Mason, S., & Ellershaw, J. (2004). Assessing undergraduate palliative care education: Validity and reliability of two scales examining perceived efficacy and outcome expectancies in palliative care. *Medical Education, 38*(10), 1103-1110.	3 subscales: • communication • patient management • interdisciplinary team work	RN/RPN
Survey	***Supervisory Support Scale*** (Supervisory Support Survey) Source: McGilton, K.S. (2003). Development and psychometric evaluation of supportive leadership scales. *Canadian Journal of Nursing Research, 35* (40), 72-86.	- perceived support scale - supervisor's empathy and reliability	PSW
Survey (interview format)	***McGill Quality of Life Questionnaire*** (MQOL Survey) Source: Cohen, R.S., Balfour, M.M., Strobel, M.G., & Bui, F. (1995). The McGill Quality of Life Questionnaire: A measure of quality of life appropriate for people with advanced disease. *Palliative Medicine, 9,* 207-219.	Measurement of resident's quality of life with 5 subscales: • physical symptoms • physical well-being • psychological well-being • existential well-being • support	Resident

Data Collection Methodology / Tool	Data Collection Instrument	Measurement	Data Collected From
Survey (interview format)	***Quality of Life in Life-Threatening Illness*** (QOLLTI-F Survey) Source: Cohen, R., Kuhl, D., & Ritvo, P. (2006). QOLLTI-F: Measuring family carer quality of life. *Palliative Medicine, 20,* 755-767.	Measurement of family member's quality of life with 7 subscales: ● environment ● patient state ● own state ● outlook ● quality of care ● relationships ● financial worries	Family Member
Survey (interview format)	***Family Perception of Care Scale*** (Family Perception of Care Survey) Source: Vohra, J.U., Brazil, K., Hanna, S., & Abelson, J. (2004). Family perceptions of end of life care in long-term care facilities. *Journal of Palliative Care, 20*(4), 297-302.	assessment of family perceptions of end -of-life care in long-term care facilities with 4 subscales: ● resident care ● family support ● communication ● rooming	Bereaved Family Member
Interview, Focus Group	***Staff Interview Guide*** ***Resident Interview Guide*** ***Family Interview Guide*** Source: CERAH (2007).	- perceptions of participants' experiences and quality of life in long -term care facilities	Staff Resident Family Member
Participant Observation	***Sensitizing Framework for Participant Observation*** Source: CERAH (2007).	- participant observations and field notes	Organiza-tion
Review	***Documentation Review Tool*** Source: CERAH (2009).	- review of policy and procedures - standard of practice - communication - documentation	Organiza-tion
Survey	***Assessment of Community Organizations' Involvement in LTC Homes*** Source: CERAH (2009).	- review of community organizations currently providing services in LTC home - assessment of community organizations' current involvement in LTC homes - assessment of partner organizations mandate and their vision for involvement in LTC homes - barriers to the provision of services	Organiza-tion Commu-nity Partners