Family Palliative Care Quality Survey A
University of Pennsylvania Genesis ElderCare Research Project

Please accept our condolences over the death of ___________________________. As part of a project to improve palliative care in nursing homes, please take a moment to complete this short questionnaire. Your responses will help us to understand and improve the care offered to residents. Please send the completed form back in the enclosed pre-addressed and stamped envelope. A project staff member will also call within two weeks to hear any other thoughts you might wish to share.

What was your relationship to the resident?
Today’s Date

A. In the last month of life, do you feel that [Institution] staff were able to meet the needs of your family member/significant other in the following areas?

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1. Pain Control
2. Control of other symptoms
3. Basic hygiene
4. Dietary needs
5. Emotional needs
6. Spiritual needs
7. Privacy
8. Dignity
9. Individual control
10. Safety
11. Companionship
12. Promoting quality of life

B. With regard to care at the end of life, was the staff?

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| Helpful
Knowledgeable
Supportive

Comments:

C. Were staff helpful in discussing end-of-life care with you or other family members?

Yes No Don’t Know

D. Were pain and other symptoms treated?

Yes No Don’t Know

E. Were discussions and decisions about
medical care timely?    ___    ___   ___

F. Did the staff address needs or concerns of yours or other family members about the death?    ___    ___   ___

G. Did the staff offer materials or literature to you on grief or bereavement?    ___    ___   ___

H. Did the staff refer you or other family members to community services for ongoing grief or bereavement support?    ___    ___   ___

I. Did you or other family members have needs that were not met with regard to the support that you received during the stay or after the death of the resident? Please indicate what they were:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

J. Do you feel a special or additional program in palliative care (addressing the needs of nursing home residents and their families during the last stages of life) would have been helpful or made a difference in your loved one’s care?    Yes    No    Don’t Know    ___    ___   ___

Please explain on the back of these sheets, or we can discuss by telephone. Also, please share any other comments or concerns that you may have.

_________________________________________________________________________

_________________________________________________________________________

Again, please accept our deepest sympathy for your loss. Thank you for taking the time to complete this questionnaire. We believe this information will be very helpful in guiding our efforts to provide the highest quality nursing home care. Please return the questionnaire in the stamped, pre-addressed envelope. We look forward to speaking to you as well. Full confidentiality of these responses are assured and maintained by [Name of Institution]. If you have any further questions, please call [Name(s)] at [Phone Number(s)].
Please accept our condolences over the death of __________________________. As part of a project to improve palliative care in nursing homes, please take a moment to complete this short questionnaire. Your responses will help us to understand and improve the care offered to residents. Please send the completed form back in the enclosed pre-addressed and stamped envelope. A project staff member will also call within two weeks to hear any other thoughts you might wish to share.

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Yes No Don’t Know

H. Did you or other family members have needs that were not met with regard to the support that you received during the stay or after the death of the resident? Please indicate what they were:

I. Did our program in Palliative Care address the special needs of you and your loved one during the last stages of life?  

Yes No Don’t Know

Please explain on the back of these sheets, or we can discuss by telephone.  
Would you recommend this Palliative Care Program to someone else with similar needs?  

Yes No Don’t Know

Why?

J. Please share any other comments or concerns below or on the back of the pages.

Thank you for taking the time to complete this questionnaire. We believe this information will be very helpful in guiding our efforts to provide the highest quality nursing home care. Please return the questionnaire in the stamped, pre-addressed envelope. Full confidentiality of these responses are assured and maintained by [Name of Institution]. If you have any further questions, please call [Name(s)] at [Phone Number(s)].