Original Article

Nursing Home Staff Palliative Care Knowledge and Practices: Results of a Large Survey of Frontline Workers

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Abstract

Context. Deficits in quality end-of-life care for nursing home (NH) residents are well known. Palliative care is promoted as an approach to improve quality. The Palliative Care Survey (PCS) is designed to measure NH staff palliative care knowledge and practice.

Objectives. To comparing palliative care knowledge and practices across NH staff roles using the PCS, and to examine relationships between facility characteristics and PCS scores.

Methods. The PCS was administered to frontline NH staff—certified nursing assistants (CNAs), licensed practical nurses (LPNs), registered nurses (RNs), and social workers (SWs)—in 51 facilities in 2012. Descriptive statistics were calculated by job role. Linear mixed effects models were used to identify facility and individual factors associated with palliative care practice and knowledge.

Results. The analytic sample included 1200 surveys. CNAs had significantly lower practice and knowledge scores compared to LPNs, RNs, and SWs ($P < 0.05$). LPNs had significantly lower psychological, end-of-life, and total knowledge scores than RNs ($P < 0.05$ for all). Although knowledge about physical symptoms was uniformly high, end-of-life knowledge was notably low for all staff. A one-point higher facility star rating was significantly associated with a 0.06 increase in family communication score ($P = 0.003$; 95% CI: 0.02–0.09; SE = 0.02). Higher penetration of hospice in the NH was associated with higher end-of-life knowledge ($P = 0.003$; parameter estimate = 0.006; 95% CI: 0.002–0.010; SE = 0.002). Sixty-two percent of respondents stated that, with additional training, they would be interested in being leaders in palliative care.

Conclusion. Given observed differences in palliative care practice and knowledge scores by staff training, it appears the PCS is a useful tool to assess NH staff. Low end-of-life knowledge scores represent an important target for quality improvement. J Pain Symptom Manage 2015;50:622–629.

Key Words

Nursing home, palliative care, end of life, hospice

Introduction

Care for nursing home (NH) residents near the end of life often falls short. Treatment and monitoring for symptoms such as pain and dyspnea,[1,2] as well as clear communication about prognosis and goals of care, are not consistent practice.[3–5] Palliative care is comprehensive, interdisciplinary care that aims to relieve suffering and improve quality of life for people with advanced illness and their families.[6] This model of care generally includes good communication with family members, streamlined provider coordination, thorough care planning and intervention, and

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bereavement support. Palliative care has been touted by experts as an answer to some of these NH quality concerns.[6–8] However, formal NH palliative care programs, including specialized training of staff, are scarce.[9]

Palliative care can be delivered in the NH setting in a variety of ways. Three models that have been described include: partnerships with hospices, external palliative care teams, and facility-based teams and/or hospice units.[10] In all these models, NH staff—including certified nursing assistants (CNAs), licensed practical nurses (LPNs), registered nurses (RNs) and social workers (SWs) — must be involved in developing, coordinating, and carrying out palliative care treatment plans. CNAs provide basic hands-on assistance with care of residents, including bathing, feeding and toileting. LPNs are responsible for clinical care, including passing medications and following through on medical care plans. RNs have a higher level of training than LPNs, including assessment skills. Lack of palliative care training of NH staff has been cited as a barrier to providing optimal end-of-life care to NH residents.[7] Conversely, in NHs with a specific palliative care focus, staff engage in advance care planning, are confident in active symptom management, and provide psychosocial support for dying residents and their families.[11]

The Palliative Care Survey (PCS) for NH staff, which measures both knowledge and practices, was developed and validated by Thompson et al.[12] A recent survey found that residents who died in facilities where the Directors of Nursing scored higher on items from the PCS had a higher likelihood of appropriate documentation of terminal status on their Minimum Data Set assessments and a lower likelihood of aggressive treatments near the end of life such as tube feeding and emergency room visits.[13]

We report here our findings from the administration of the PCS to a large sample of NH staff in 51 Indiana facilities. This was part of a larger survey that included questions about interactions with hospice, as well as open-ended prompts[14] designed to measure knowledge, practice and attitudes towards both palliative care and hospice by NH staff at multiple levels. In addition to comparing palliative care knowledge and practices across staff roles, we also examined relationships between facility characteristics and PCS scores. We expected staff members with greater training, that is, RNs vs. CNAs, would have higher scores on palliative care knowledge and practice, and anticipated that facility characteristics, including overall quality rating (as measured by the Federal rating system—Nursing Home Compare [NHC]) and hospice penetration, would be positively correlated with higher palliative care scores.

Methods

Instrument

The PCS is a validated 51-item inventory that measures NH staff engagement in palliative care practice, as well as knowledge about best practices in end-of-life care.[12] Respondents are asked to share their perceptions about quality and use of hospice in an NH (e.g., When a resident approaches death, how often are family members unhappy because they think staff do not know the plan of care?), as well as being presented with hypothetical scenarios to assess what action they would take. Vignettes are used to overcome the challenge of participants reporting what they should do as opposed to what they actually do. For example, respondents are presented with a case of a resident's condition at admission three months ago and the decline she has experienced during the past month. Follow-up questions relate to timing of discussions with family members about dying and end-of-life care practices. Thompson et al.[12] used a two-phase psychometric evaluation using individual item analysis and then measured reliability and validity of the instrument. Internal consistency reliability was assessed using Cronbach's alpha and found good reliability for the two main constructs: palliative care practice ($\alpha = 0.75$) and palliative care knowledge ($\alpha = 0.81$). Factor analysis was used as a measure of construct validity, and the authors reported adequate fit of the model to the data. They found strong correlations among the subconstructs in line with their hypothesis.

Sample and Survey Administration

Employees from 51 Indiana NHs, representing two NH chains, were asked to complete a survey about practices, knowledge, and opinions regarding palliative and hospice care in May–June 2012. Surveys were distributed to facility staff in the following roles: CNA, LPN, RN, SW, or "other." An overall response rate of 71% was calculated based on the total number of staff given an opportunity to complete the survey. Before distributing the survey, study procedures were approved by the Institutional Review Board of Indiana University/Purdue University Indianapolis.

The survey format and administration differed between chains. The survey content and explanation of the survey purpose did not differ. Personnel in the first chain were given hard copy surveys by the research team during regularly scheduled all-staff meetings. Staff members present in the building at the time of the meeting were expected to attend; staff not on duty (i.e., night staff) were not given the opportunity to complete the survey in these buildings. A study team member described the purpose of the study and ensured confidentiality of participants'