TOUCH OF GRACE PROJECT

Final Report on Use of Civil Money Penalty Funds for Certified Nursing Homes:

Region X/Seattle

Submitted by:

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Executive Summary

Pre- and Post-test data and focus group feedback indicate that the Touch of Grace training program improved understanding of palliative and end of life concepts and also provided tools to improve staff interactions with families and residents during the final days of a resident's life. As predicted, the largest shifts in understanding were seen in the non-licensed staff, although gains were seen in all staff groups. Some facility-wide procedural changes to support a more palliative environment were also introduced as part of the training.

Additionally, an increased appreciation for the roles *all* staff can play to improve care during the final days and hours were documented, particularly in the focus group discussions. This change in understanding can support a more palliative milieu in skilled nursing home settings. Based on these findings, we strongly recommend that all nursing home staff receive training in these competencies as part of the 'on-boarding' processes for all staff.

Introduction

As more members of our community age, palliative and end-of-life care is increasingly important so that patients approaching death can live each moment as well as possible. Current nursing home culture does not foster shifting to palliation when patients are actively dying. Most available palliative training focuses exclusively on physicians, nurses and other licensed professionals, yet in U.S. nursing homes, nurse aides, certified nursing assistants (NACs) and orderlies account for nearly two-thirds of care staff. These caregivers with minimal education have little access to continuing education. And there is often no training or orientation in end-of-life issues for the other support staff who often have frequent contact with residents, such as dietary, housekeeping and maintenance workers.

Touch of Grace is a video-based training program on palliative and end-of-life care for nursing home and assisted living staff, including all non-licensed support staff. The CMP funding for *Touch of Grace* project supported the implementation of a pilot project in a local skilled nursing facility (Christian Healthcare Center in Lynden, Washington) with a staff of over 200. Training was intended to:

- increase understanding of palliative care in both professional and non-professional staff,
- shift staff attitudes and behaviors toward a culture where a palliative approach is welcome and supported.

The *Touch of Grace* short, online modules were accessible by staff on their own timelines but on-the-clock. The running time of all five modules was 71.21 minutes. The five modules covered the following concepts and competencies:

- **Module 1: Role of Support Staff** (12:38 minutes) – This module focused on the definition of and the differences between palliative care and hospice care, also and explored role-appropriate ways non-licensed staff can provide support to residents and families during final days and hours.

- **Module 2: Communication** (24.57 minutes) – In this module common communication barriers and myths were examined, including cultural differences in communication styles. The differences between sympathy and empathy were explored and active listening strategies were modeled.

- **Module 3: Role of Unlicensed Staff in Pain and Symptom Management** (6:31 minutes) **–** In this module the differences between pain and suffering were explained, and methods for recognizing the signs and symptoms of pain/discomfort were developed, along with procedures to report signs and symptoms to the nurse or other appropriate medical professionals. Additionally, the ways that cultural differences may impact the expression of pain or suffering were presented.

- **Module 4: Final Days and Hours** (19:58 minutes) **–** This module outlined both the physical and psychological processes associated with the final days and hours of a person's life, including symptoms that should be reported to the nurse or other medical personnel. The ways that staff roles can be adapted to meet the needs of the dying resident and their families were offered, including strategies for creating a comfortable and supportive environment for the dying resident, family members and visitors. Processes for providing general comfort care and care of the body after death (as appropriate to the job-role and facility culture) and strategies for self-care to maintain personal health and well-being during times of loss were introduced.

- **Module 5: Grief and Bereavement** (7:09) **–** This module focused on ways to recognize signs and symptoms of grief in loved ones, oneself and co-workers. Strategies to support families and co-workers during times of grief and loss experienced when a resident dies were developed.

All staff at the Christian Health Care Center (CHCC), a non-profit skilled nursing and rehabilitation facility with a staff of over 200 that serves Whatcom County residents, completed the five modules. After training was completed, Hospice staff facilitated focus group discussions across job groups during shift straddle times. Facility-wide procedural changes were also introduced, for example use of a magnetic visual cue for door jambs to signal when a resident is actively dying and the introduction of a mindfulness strategy for shifting the focus from *task-completion* to *resident and family needs* prior to entering a resident's room (*two steps and a breath*).

Through this project, we demonstrated that including non-licensed support staff and NACs in palliative end-of-life care training effected *paradigm shifts* in the understanding of palliative and end-of-life care and the understanding of whom is included in the 'care-team.' We also

developed new protocols designed to support a *system-wide change* in how skilled nursing facilities staff engage with residents at the end of life care.

Demographics

As part of the pre-test, we gathered demographic data about the staff and their experiences with end-of-life care. Two-hundred and eleven staff (211) members participated, although not every person answered every question.

Demographic data were divided into work-role categories, with the percentage of the total number of respondents in each category noted. According to the CDC, Certified nurse aides provide the majority of care to residents of nursing homes. Nurse aides and orderlies account for nearly two-thirds of the nursing staff. https://www.cdc.gov/nchs/pressroom/00facts/nurshome.htm The data from CHCC show a somewhat higher ratio of RNs and LPNs.

Non-licensed support staff (NLSS 22.29%): These roles included dietary aides, laundry and kitchen staff, maintenance staff, hospitality and transportation support staff.

Certified Nursing Assistants (**NACs/CNAs 38.85%) -** Certified nursing assistants provide basic care to patients, as well as assist them in daily activities they might have trouble with on their own, such as bathing.

Licensed Practical Nurses (LPNs 5.7%) –LPNs perform certain medical duties but work under the supervision of an RN. Licensed practical nurses typically examine patients, observe crucial symptoms, and assist in wound care.

Registered Nurses (RNs 19.11%) – Registered nurses are in-charge of the patients and perform assessments and develop care plans considering their condition. S/he takes note of the orders given by the doctors and executes them correctly. RNs are also responsible for providing immediate care if required, ensuring that residents get adequate comfort in a secured and safe environment.

Other (14.05%) – This group includes all other CHCC staff, such as receptionists, Human Resources staff, secretaries, Chaplains, Social Workers.

Because this training program was focused on the non-licensed support staff (NLSS), for purposes of this report we focused on the results from the whole group compared (ALL) with the non-licensed support staff group (NLSS).

Q41 - How long have you been working in the caregiving field?

The data from CHCC indicate that, like many other skilled nursing homes, 27% of the staff have been working in caregiving less than a year, and over half of the staff have been working in caregiving less than four (4) years, reflective of the high turn-over in this field. The percentage of

the non-licensed support staff who are new to caregiving is even higher, with over 38% having worked in this field for less than a year.

Number of Years	% All Staff	% NLSS
< 1 year	27.32%	38.1%
1-4 years	26.80%	23.8%
5-9 years	13.40%	16.6%
10-14 years	9.28%	4.8%
15-19 years	4.12%	2.38%
20-24 years	9.28%	7.14%
25-29 years	2.58%	2.38%
30-34 years	3.09%	0.00%
35-40 years	3.61%	2.38%
> 40 years	0.52%	0.00%

Q36 – What is your gender?
The majority of the staff at CHCC are female, which also reflects the typical staffing profile of nursing homes.
https://phinational.org/wp-content/uploads/legacy/phi-nursing-assistants-key-facts.pdf

#	Answer	%
1	Female	87.50%
2	Male	9.66%
3	Non-binary/ third gender	0.00%
4	Prefer to self –describe	0.00%
5	Prefer not to say	2.84%

Q37 - What is your age?
Over 30% of the staff at CHCC are in their twenties or younger, likely at the beginning of the careers. This also is typical of staffing in most skilled nursing facilities.
https://phinational.org/wp-content/uploads/legacy/phi-nursing-assistants-key-facts.pdf
In the NLSS category, nearly 40% are under the age of 30 years.

#	Answer	% All Staff	% NLSS
1	under 20	0.08%	19.04%
2	20-29	32.70%	19.04%
3	30-39	17.06%	0.05%
4	40-49	14.22%	16.66%
5	50-59	16.59%	16.66%
6	60-70+	11.37%	23.81%

Q38 - How do you identify ethnically or culturally?
Although the majority of the staff are Caucasian, the percentages of Hispanic/Latino staff (11.43%) and Asian/East Asian staff are higher than the proportion of Hispanic/Latino and Asian/East Asian residents in Whatcom County (9.5% & 4.3% - 2010 Census). https://factfinder.census.gov/

#	Answer	%	Count
1	Hispanic or Latino	11.43%	20
2	Black or African American	0.57%	1
3	American Indian and Alaska Native	0.00%	0
4	Native Hawaiian and Other Pacific Islander	0.00%	0
5	White/Caucasian	66.86%	117
6	Asian/East Asian	10.29%	18
7	Multiracial	3.43%	6
8	Self-described	0.57%	1
9	Prefer not to say	6.86%	12

Pre- and post-tests were administered to all CHCC staff, both licensed and unlicensed, and as these next three questions reflect, some staff already have had experience and/or focused training

in end of life care, so for each question in the pre-and post-tests there was often a wide-range of answers, even within job-groups. However we still saw a shift in understanding in many questions to a more nuanced understanding of palliative and end of life care across all job-groups.

Because we did not track individual responses, we were not able to compare the pre-and post-test answers for each job categories, however we were able to compare the pre-test ALL and NLSS categories in the pre-test with the ALL category in the post-test. These comparisons revealed increased understanding about palliative and end-of-life care across all groups, particularly in the NLSS category.

Q40 - In what capacity have you cared for someone who was dying? (Check all that apply)

Although 90% of the staff have had some experience in caring for someone who was dying (>90%), less than half had engaged in end-of-life care as part of their professional work.

#	Answer	%	Count
1	Relative	30.53%	80
2	Friend	10.69%	28
3	Volunteer	2.67%	7
4	Paid Position/Employee	44.27%	116
5	I have never cared for someone who was dying.	9.92%	26
6	Other (Please describe): _____	1.91%	5
	Total	100%	262

Other (Please describe): *with residents/patients, in the military, with family members, as a homecare support worker.*

As the next questions indicate, the lack of training in palliative practices impacts a growing number of people in our communities, and the *Touch of Grace* Project is one strategy for addressing this need.

Q42 - How would you rate your knowledge of end-of-life care?
Only a third of the staff claimed to have professional knowledge about end-of-life care. These responses support our finding that most skilled nursing facility staff do not have adequate

training on shifting from care that emphasizes staying alive to care that supports respectful, culturally responsive dying.

#	Answer	%	Count
1	No knowledge	5.71%	10
2	General knowledge only	54.29%	95
3	Professional/extensive knowledge	36.57%	64
4	Other (Please describe	3.43%	6

Other (Please describe): *going through it with loved ones and family, end of life care for mother and husband, worked with hospice to care for residents.*

Q43 – Have you ever had any end-of-life care training? (Please check all that applies)
Although some staff (across all job roles) have had focused end-of-life training, over 60% had no formal training, other than the experiences of working with dying residents. In the NLSS job role, over 80% have had no specific training or on-the-job training only, which reflects the lack of appropriate training materials related to end-of-life care for non-licensed support staff.

#	**Answer**	**% ALL**	**% NLSS**
1	Special qualification or a certificate	6.83%	0.02%
2	Short courses or other formal training	30.24%	16.66%
3	On the job training only	39.51%	21.42%
4	No specific training	23.41%	59.52%

Results from Pre-Post Test Data and Focus Groups

In our original proposal, we stated that the Touch of Grace training program will:

- increase understanding of palliative care in both professional and non-professional staff,
- shift staff attitudes and behaviors toward a culture where a palliative approach is welcome and supported.

All staff at CHCC took a pre-test to establish their baseline understanding of palliative and end-of-life care. Each module also included a post-test which mirrored the pre-test content to track changes in understanding. Some key findings from the comparisons of the pre-post tests are presented below. The data presented below indicate that all staff developed an enhanced understanding of palliative and end-of life care, with the greatest gains in the non-licensed support staff (NLSS) group.

MODULE #1 –PALLIATIVE CARE TRAINING FOR SUPPORT STAFF IN SKILLED NURSING HOMES

Palliative care and hospice care are often conflated and the differences between them are not well understood. Although some skilled nursing facilities work closely with hospice providers, unfortunately, under current reimbursement streams, many skilled nursing home patients are not enrolled or are not eligible for hospice, or referral to a hospice care consultation often occurs much long after eligibility and thus residents do not benefit from palliative end-of-life care. Many staff have little or no training in this kind of care.

As response to these questions indicate, there was an increased understanding of the differences and similarities between palliative and hospice care for all work-groups, with the largest shift in the support staff group (NLSS). We do not yet have data about any improved referral for hospice services but focus group responses indicate that this training has supported a facility culture where all staff are better prepared to support palliative end-of-life support and care consistent with their job roles.

Q3 – 2. The formal program that is initiated to provide comfort when a resident has been diagnosed with 6 months or less to live is called:

#	Answer	PRE- ALL	PRE-NLSS	POST
1	a. Palliative Care	16.00%	21.95%	5.42%
2	b. Rehabilitative Care	0.57%	0.00%	0.00%
3	**c. Hospice Care**	**83.43%**	**78.04%**	**94.58%**
4	d. Recreation Program	0.00%	0.00%	0.00%

Q4 - 3. What is the difference between Palliative Care and Hospice Care?

#	Answer	PRE-ALL	PRE-NLSS	POST
1	a. Hospice Care can start anytime but Palliative Care can only begin when the resident has 6 months of less to live.	7.95%	12.19%	1.82%
2	b. Hospice Care starts when the patient has a year left to live and Palliative Care is added when the resident is close to death.	6.82%	9.75%	1.82%
3	**c. Palliative Care can begin when a person is diagnosed with a serious illness and Hospice can begin when the resident is expected to die in 6 months or less.**	**80.11%**	**78.04%**	**93.33%**
4	d. There is no difference between Hospice and Palliative Care. They mean the same thing.	5.11%	0.02%	3.03%

MODULE #2 – ABOUT COMMUNICATION

This module focused on skills of verbal and non-verbal communication, the distinctions between sympathy and empathy and the impact of culture on communication. The pre-post test data indicate that all work-groups gained understanding of the importance of communication with families and residents at the end of life, with the largest gains in the support staff work-group.

Q9 – 2. Fear of your own death can be a:

As answers to this question indicate there was an increased understanding of the ways our own fear of mortality or talking about death can impact our ability to communicate effectively with residents and families.

#	Answer	PRE-ALL	PRE-NLSS	POST
1	**a. barrier to communication**	**35.63%**	**26.82%**	**63.69%**
2	b. strength when communicating with a resident and their family	17.82%	14.63%	14.88%
3	**c. natural feeling, but I should never discuss it with residents**	**43.68%**	**53.65%**	**20.24%**
4	d. communication myth	2.87%	7.31%	1.19%

Q10 - 3. Verbal communication with residents and/or their loved ones is:

One important goal of the *Touch of Grace* training was to foster a milieu where all staff are part of a care team within their own role appropriate tasks. Item 4 in this question reflects the changes we saw in seeing all staff members as part of the care team, with role-appropriate responses.

#	Answer	PRE-ALL	PRE-NLSS	POST
1	a. Deliberate and one-way.	2.29%	0.00%	1.81%
2	**b. Accomplished when words mean the same thing to the speaker and the listener.**	**83.43%**	**78.06%**	**86.75%**
3	c. Making an accurate statement	8.00%	9.75%	9.64%
4	**d. The responsibility of the nurse on duty**	**6.29%**	**12.19%**	**1.81%**
	COUNT			175

This shift was also reflected strongly in the post-training focus groups responses.

> *I know I am part of the team now. I am in dietary, I am in the background, I do get some hands-on experience with passing trays etc. and we definitely experience end of life issues – just tell us what we need to know. We want to be there for them too.*

Q11 – 4. Body language, eye contact, gestures and tone of voice: Responses to the next three questions indicated an increased understanding of the importance of non-verbal communication when working with residents and families, and an improved understanding of the differences between sympathy and empathy.

#	Answer	PRE-ALL	PRE-NLSS	POST
1	a. Are examples of verbal communication	20.11%	34.14%	10.84%
2	b. May suggest that the person talking has a tick	0.00%	0.00%	0.60%
3	**c. Are examples of Non-verbal communication**	**78.74%**	**68.29%**	**87.35%**
4	d. Should be minimized when communicating	1.15%	0.00%	1.20%

Q13 - 6 The ability to understand and share the feelings of another is a good example of

Answer	PRE-ALL	PRE-NLSS	POST
a. Sympathy	10.29%	12.19%	8.48%

b. Kindness	4.57%	9.75%	0.00%
c. Rudeness	0.00%	0.00%	0.00%
d. Empathy	**85.14%**	**80.48%**	**91.52%**

Q15 - 8. "Seek to understand, before being understood" is a basic principle of:

#	Answer	PRE-ALL	PRE-NLSS	Count
1	**a. Active and empathetic listening**	**77.71%**	**75.61%**	**89.09%**
2	b. Passive and sympathetic listening	1.14%	0.00%	1.21%
3	c. Passive and empathetic listening	10.29%	9.75%	1.82%
4	d. Active and sympathetic listening	10.86%	14.63%	7.88%

MODULE #3 – ROLE OF UNLICENSED STAFF IN PAIN AND SYMPTOM MANAGEMENT

This module focused on role-appropriate responses to pain and suffering. One goal was to help staff understand the differences between pain and suffering and the ways culture can impact the expression of these sensations and emotions. Additionally, role appropriate responses to the observation of pain or suffering were presented. The NLSS group showed the greatest increases in understanding in for all these questions.

Q19 - 1. The physical discomfort caused by illness or injury is described as:

#	Answer	PRE-ALL	PRE-NLSS	POST
1	**a. Pain**	**83.33%**	**73.17%**	**97.75%**
2	b. Suffering	16.67%	21.95%	2.25%
3	c. Comfort	0.00%	0.00%	0.00%
4	d. Contentment	0.00%	0.00%	0.00%

Q24 – 6. Sadness, loss of independence and depression are terms that often describe:

#	Answer	PRE	PRE-NLSS	POST
1	a. Pain	5.14%	0.05%	4.49%
2	**b. Suffering**	**88.00%**	**90.00%**	**93.26%**
3	c. Minor Discomfort	2.86%	0.00	0.56%
4	d. Fatigue	4.00%	0.05%	1.69%

Q21 - 3. Which of the following statements about culture, gender and pain is <u>false</u>?

#	Answer	PRE-ALL	PRE-NLSS	POST
1	a. How individuals experience or express pain is shaped by their learning, background and culture	8.05%	2.43%	3.93%
2	b. Some cultures and people are more demonstrative and others may believe it is important to not show how they are suffering	4.60%	7.31%	2.81%
3	c. It is important to know that cultural differences impact how people experience or show pain.	9.77%	14.63%	4.49%
4	**d. Culture and gender have very little effect on how pain is experienced**	**77.59%**	**68.29%**	**88.76%**

MODULE #4 – FINAL DAYS/HOURS

In this module, the physical and emotional signs of impending death were explained. As the demographic data and the focus group responses indicated, many staff members are not given training on how to respond to a death.

> *New staff walked in and patient had died. She wasn't prepared and had no idea how to respond or what to do.*
>
> *Do the new hires watch TOG? I had a brand-new staff member working and a patient died. She was totally devastated. We should have everyone watch the videos prior to starting on the floor. Talking about it is one thing, experiencing is another*.

The concept of creating a 'sacred space' for those who are dying and their families was developed, and a mindfulness practice, called *the pause*, was introduced to help staff shift the ways they engage in their daily tasks to support residents and their families during this phase.

> *Working here for 12 years, I have seen what you are talking about. I have seen people barge into rooms and not know what's happening – and that's sad.*

I think we won't go barging in anymore.

Good reminder to pause before you go in and have the knowledge of what's happening so we can change our approach.

You're in your job - doing this hussle-bussle. But this reminds you to slow down.

Additionally, the use of a butterfly magnet on the door jamb as strategy to signal that a resident is in the active dying phase was introduced as a means to cue staff to shift their behaviors from a simple task focus to a family support focus before entering a room.

Makes you think about how you enter the room, your voice and family. I think the butterfly thing is really a good reminder. I like the visual cue it's a good reminder of what the family is going through.

I did like the wait a moment part. Having the visual cue can help.

This changes how I go about my job, so many times in the past I didn't know that someone was dying."

Q26 - 1. A pause is?

#	Answer	PRE-ALL	PRE-NLSS	POST
1	a. Stopping outside the resident's door to check the room number	2.29%	07.31%	1.18%
2	**b. Stopping outside the resident's door to take two steps and a breath and think what is happening in the room.**	**85.71%**	**78.04%**	**93.53%**
3	c. Stopping at the nurse's station to ask if you can go in the room	7.43%	7.31%	1.76%
4	d. Taking two breaths and a step before leaving the resident's room	4.57%	7.31%	3.53%

Q27 - 2. The purpose of the pause is?

#	Answer	PRE-ALL	PRE-NLSS	POST
1	**a. To remind yourself that you are entering a sacred space where someone is actively dying**	**87.86%**	**85.36%**	**98.22%**
2	b. To receive permission from the nurse to enter the room	6.36%	12.19%	0.59%

3	c. To worry about how you might react to seeing a person dying	0.00%	0.00%	0.00%
4	d. To listen at the door to make sure you are not interrupting a conversation	5.78%	9.75%	1.18%

MODULE #5 – SUPPORT STAFF: GRIEF & BEREAVEMENT

In this module grief and bereavement were explored as a natural response to death and loss, not only for families, but also for staff who often have a personal response to the death of a resident. Normal and complicated grief were explored and work appropriate strategies for managing grief offered.

> *I thought…. It (the training) makes me comfortable to feel what we feel when our patient passes. It told me hey it's ok to feel sad and to cry. I have wondered am I too attached or is something wrong with me that I am crying? This made me feel more comfortable.*

Q33 - 2. A period of mourning after a loss, especially after the death of a loved one is called:

#	Answer	PRE-ALL	PRE-NLSS	POST
1	a. Grief	27.43%	26.82%	19.76%
2	b. Bereavement	**69.71%**	**73.17%**	**79.04%**
3	c. Sadness	1.71%	0.00%	1.20%
4	d. Denial	1.14%	0.00%	0.00%

OTHER OBSERVATIONS

In the original proposal, we also planned to:

- Foster facility wide improvements in palliative care across all staff levels
- Enhance patients' access to treatment aligned with their end-of-life choices by increasing:

  o availability of palliative care in advance of Medicare qualification for hospice
  o timely referrals to hospice services
  o improved nursing-home-based palliative care when hospice staff are not on site

- Lower end-of-life expenditures by increasing patients' access to palliative care
- Improve staff retention statistics

As the Touch of Grace training was completed in late spring, it is too early to evaluate changes in some of these markers of success, but the staff responses during the facilitated focus groups provide some insight into progress towards others.

Foster facility wide improvements in palliative care across all staff levels

One of the key outcomes was a development of a palliative milieu across all job groups in which all staff members better understood role-appropriate ways to support residents and families in the last days and hours.

Some quotes from the staff focus groups support this finding:

> *I think we should share the modules with all staff not just ancillary/non-clinical staff. A lot has changed in how we care for end of life patients.*
>
> *Initially when I started listening to the TOG project, I was very open to what I was about to learn but what struck me, I have been in healthcare for 12 years and have always worked in dietary – we have always been almost sidelined "that's not your area to be concerned about" and you won't have to 'do that' end of life issues because that is all nursing. I was fascinated to learn.*
>
> *I watched my father at the end of life, and I was comfortable with the process. It's just very helpful to get professional advice. I always like to know as much information as I can so that I am comfortable with whatever situation I am placed in. Before this program that you ran, you might have the feeling that you are afraid of what's happening. When it's explained to you it's not so scary. It's important for us to find out about things and then we can do better.*
>
> *I know I am part of the team now. I am in dietary, I am in the background, I do get some hands-on experience with passing trays etc. and we definitely experience end of life issues – just tell us what we need to know. We want to be there for them too.*

Staff also commented on the previous lack of training in end-of-life care.

> *I think it's so important – I haven't experienced any training on this before and yet we deal with it every day. They are our family.*
>
> *The video was important because usually we focus on the very literal things; like how to wash your hands. And now we have a video that teaches us how to respond and act in*

such a personal moment, I don't interact with the residents a lot, but I bring the comfort carts. The video helped.

Additionally, two important procedural changes were implemented in as part of the Touch of Grace Project. The introduction of the visual marker on the doors when a resident is entering active dying was seen by all staff as an important cue to shift the ways they approach their daily tasks to support the families and residents in final days and hours. Teaching staff to take a 'pause' (two steps and a breath) before entering a room where a resident is actively dying also was seen as critical by staff as a tool to help them shift from a task completion orientation to a focus on the family and resident needs.

Enhance patients' access to treatment aligned with their end-of-life choices by increasing:

o availability of palliative care in advance of Medicare qualification for hospice or timely referrals to hospice services

The Christian Health Care Center has implemented the Touch of Grace training program for all new employees in the new training 'on-boarding.' Providing common language and understanding about the issues that arise at the end-of-life for all employees will create a more palliative milieu.

o improved nursing-home-based palliative care when hospice staff are not on site

As the data from the pre-post tests and staff focus group responses indicate, the staff at CHCC improved their own understandings of palliative and end-of-life care, which should improve the nursing-home-based care when hospice staff are not on site.

Lower End-of-Life Expenditures by Increasing Patients' Access to Palliative Care

The Christian Health Care Center already had a good track record of timely referrals to hospice care, but over the next two years we will be gathering data from CHCC to see if these referrals to Hospice services are improved.

Improve Staff Retention Statistics

We hope to demonstrate that training in palliative end-of-life care improves work retention rates. Working with dying patients is stressful; enhanced training reduces stress by developing confidence in administering comfort care and support, and by creating a peer group with whom to talk about the anxieties of providing such care. *Touch of Grace* incorporates methods proven effective in mitigating high turnover: involvement in interdisciplinary care meetings, modeling exemplary care for aides, opportunities for professional growth, enhanced orientation, perception of being valued, and being an important part of the team.

We do plan to collect data on retention, but we will not be able to determine the impact on until a year after full-implementation (April 2020).

Feasibility of outreach
Most facilities face the challenge of pulling staff from their daily assignments to offer this kind education, so we designed modules (25 minutes or less in length) that can be available online. We believe that these modules could be imbedded in facility orientation processes and the required annual training expected of all nursing home staff.

Another potential problem is the high turn-over in staff that all nursing home facilities experience might require continued training. This curriculum is in a format that can be repeated easily and eventually can be integrated in to on-boarding of new staff in the facility orientation processes.

Recommendations and Next Steps

Based on our findings, we believe that programs like the Touch of Grace should be part of the standard orientation programs in all skilled nursing facilities.

The next steps in the Touch of Grace Project include replication of this program at other skilled nursing homes and developing strategies for outreach to facilities that might benefit from this kind of staff training program. These next steps are the basis for a request for an extension of the grant time line and activities through 2021.

1. ***Touch of Grace* Replication Project.** Under the supervision of Marie Eaton (PI), Tracey Jaeger, a graduate student in the Masters of Nursing Program at the University of Washington School of Nursing will replicate the *Touch of Grace* program in two other skilled nursing facilities in the Pacific Northwest (Mt Baker Care Center in Bellingham and View Ridge Care Center in Everett). This replication project will take place over the 2019-2020 academic year. This replication will offer us the opportunity to collect pre/post data more specifically tied to job roles and to see how these training videos impact understanding of palliative and end-of-life care in other facilities.

2. **Video Revisions.** Based on feedback from the staff at CHCC and from other experts in end-of-life care there are a few revisions we plan to make in the Touch of Grace videos. These revisions should be completed by the spring 2020.

3. **Manual Development.** A significant activity is the development of a training manual to accompany the videos so that they can be easily used by any staff orientation personnel. The manual should be completed by Fall 2020.

4. **Dissemination and Outreach.** We have already made presentations about the initial *Touch of Grace* data at conferences (Northwest Rural Health Conference, March 25-27, 2019 | SeaTac, WA) and have received considerable interest from other facilities about this training program. We have been accepted to present about the *Touch of Grace* program at the Washington Hospice and Palliative Care Organization Conference in Chelan WA in October (which will include the replication data). We have submitted (or are planning to submit) presentation proposals for other conferences related to palliative

care and/or skilled nursing facilities in 2020 and 2021. (A proposal has been submitted to the American Academy of Hospice and Palliative Medicine for March 2020. We plan to submit proposals to the Leading Age annual conference in San Antonio Fall 2020 and to an ELNEC Summit meeting for two presenters in 2020 or 2021 once the call for papers is announced.).

We will apply for copyright and trademark protection and once the *Touch of Grace* revisions are completed, we will seek a licensing partner to help with outreach and distribution to skilled nursing homes and assisted living facilities nationally. We hope to have accomplished these steps by Spring of 2021.

Appendix 1
Request for Extension

Appendix 2
Budget Request vs Actuals