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An Integrative Healthcare Approach to Empowering Older Adults in Creating Advance Directives

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An Integrative Healthcare Approach to Empowering Older Adults in
Creating Advance Directives

by

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School of Social Work
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Committee Members
Dr. Felicia Sy, Ph.D. (Chair)
Gretchen Scheffel, LISW, owner of Circle of Life Aging Services, LLC
William Swanstrom, Advisor to the Area of Emphasis in Aging program

The clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The purpose of this study is to determine the best practice strategies for creating advance directives when using an integrated team approach. Healthcare professionals are required to inform nursing home residents of their rights around advance directives. Healthcare professionals are also called to assist nursing home residents in creating an advance directive, without coercion, so that it reflects their values around death and dying. Six healthcare professionals (consisting of four social workers, one nurse, and one chaplain) were interviewed to determine their beliefs about the integrative team approach to creating advance directives. The qualitative interviews were analyzed from a grounded theory approach. The ecological perspective for healthcare social workers was used to further conceptualize the data. This study found that having early and frequent discussions with the patient and their family was essential to creating an advance directive. Finding healthcare professionals who are confident and comfortable with talking about death and dying is also beneficial in advance directive discussions. Having an agency that values holistic approaches to healthcare equated to valuing integrative team approaches when discussing advance directives. This study concludes that implementing advance directive strategies with integrative team work remains an abstract theory that lacks evidence of use between these two approaches. Based on the responses around strategies to create advance directives and how integrated teams work together it would appear that the integrative approach to creating advance directives would be successful in accurately documenting the patient's values and wishes around death and dying.

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The aging population is growing. There are currently "60 million older adults age 60 and over" in the United States and by the year 2030, "20 percent of the population, or one in five Americans will be age 65 or over" (Administration on Aging, 2011, p. iii). There are 16,100 nursing homes in the United States and a total of 1.7 million beds within these nursing homes (Jones, Dwyer, Bercovitz, and Strahan, 2009). Nursing homes provided service to 1.5 million people in 2004 (Jones, Dwyer, Bercovitz, and Strahan, 2009). Each year, 35 of every 100 patients in a nursing home will die in a nursing home (Day, 2014). In the most recent nursing home survey, 65% of nursing home patients had an advance directive in the medical record file (Jones, Dwyer, Bercovitz, and Strahan, 2009). The need for health care professionals who understand the needs of older adults is also growing. Among the needs of older adults, is the need for professionals who understand the use of advance directives as a tool for end-of-life decision-making in the nursing home setting.

Advance directives are a tool that inform doctors, health care professionals, family members and friends how a patient wants to be cared for, in the event that the patient is not capable of expressing their care wishes (Bomba, Morriseey, and Leven, 2011; Cohen-Mansfield, Libin, and Lipson, 2003; Johns, 2007; Kane, Hamline II, and Hawkins, 2005). A patient may choose to limit specific medical interventions (Johns, 2007), or describe their values (Bomba, Morrissey, and Leven, 2011) within their directive.

The Patient Self-Determination Act, passed in 1991, mandates that all health care facilities that receive Medicare or Medicaid funding discuss advance directives with their patients, as well as educate their staff on advance directives (United States General

Accounting Office, 1995). Despite this legislation, little advancement has occurred in the

completion rates of advance directives. The Patient Self-Determination Act does not

have a set standard as to how the advance directives are completed (Connell and Mallory,

2007). There are no legal ramifications, or any other repercussions, for the health care

facilities that do not complete the advance directive with their patients (Connell and

Mallory, 2007). Further, there are no repercussions for health care facilities or medical

professionals that do not follow a patient's advance directive (Connell and Mallory,

2007).

The Minnesota Nursing Home Bill of Rights informs patients that the health care

facility must provide information about advance directives, specific to state regulations

(Minnesota Department of Health, 2007). Nursing home resident's rights include being

able to select who they want to make health care decisions for them, whether or not, this

individual is related to them (Minnesota Department of Health, 2007). Nursing homes

are required to inform patients (or their surrogates, if the patient is incapacitated) of their

rights related to advance directives at the time of admission (Minnesota Department of

Human Services, 2014). In the event that a patient is determined to be no longer

incapacitated, the nursing home must again provide written information about their

advance directive rights and must also document that they have given the patient

information on their rights (Minnesota Department of Human Services, 2014). To be

considered a legal health-care advance directive in the state of Minnesota, the health care

directive must state the patient's name, be in writing, and be dated (The Office of Revisor

of Statutes, 2013). The health care directive must be completed by the patient, when the

patient has the capacity to do so, and must be signed by the patient or their designated

representative, if applicable. The health care directive must also be signed by a notary or

witnesses (The Office of Revisor of Statutes, 2013, p. 124). The health care directive

must include directions on the patient's health care wishes and/or appoint an agent. (The

Office of Revisor of Statutes, 2013, p. 124). Patients cannot be coerced into creating an

advance directive (The Office of Revisor of Statutes, 2013).

   Healthcare professionals frequently do not know what the law says about advance

directive use, and are often fearful of the advance care planning process (Connell and

Mallory, 2007). Further conflict occurs among the medical professionals who help

patients complete advance directives. Nurses and social workers frequently feel

unprepared to discuss advance directives with their patients (Connell and Mallory, 2007;

Ferrell, Virani, Gran, and Juarez, 2000; Lacey, 2006; Ryan et al., 2001; Seal, 2007).

Physicians and nurse practitioners often report not having enough time to discuss an

advance directive fully with their patients (Ramsaroop, Reid, and Adelman, 2007).

Patients' spiritual beliefs play an integral part in the advance directive process which can

be supported by having a chaplain on the interdisciplinary team (McClung, Grossoehme,

and Jacobson, 2006) yet, there is limited research on the role that chaplains have in the

interdisciplinary team.

   The purpose of this research is to determine how primary care physicians, nurses,

social workers, and chaplains in nursing homes can work together to empower older

adults when creating an advance directive. This research asks the question: "What are the

best practice strategies when creating advance directives using a team approach?" The

primary goal of this research is to determine how the team-based approach to advance

directives helps, or hinders, the older adult in making their values known. Additionally,

the research aims to define how successful strategies may be implemented within the nursing home setting.

Previous research has included the skills, values, and resources that health care professionals need to help patients complete advance directives and has focused on the completion rates of these advance directives instead of the quality of them. A brief introduction to what advance directives are and the types of advance directives will be followed by research on how advance care planning can help clients complete their advance directives. The focus will then shift to the roles of the health care professionals in this process.

Advance Directives

Advance directives, put simply, allow individuals to make their wishes for treatment known in the event that they are unable to communicate with their family, friends, and medical providers (CareNotes, 2013; Grodin, 1993; Krok, Dobbs, Hyer, and Polivka-West, 2011; Mahon, 2011; White and Arnold, 2011). When an advance directive is created, it typically includes two parts: identifying someone to make decisions in the event the individual cannot make their wishes known and making the patient's wishes known so that health care professionals and the designated decision-maker have a guide to follow when making decisions on behalf of the patient (Black and Emmet, 2006; Mahon, 2011; Sessanna, 2008; Tulsky, 2005). Patients need to be reminded that health care professionals cannot predict the future (Thompson, Barbour, and Schwartz, 2003). Patients also need to be educated that advance directives cannot demand treatment, such as something that would actively end a person's life (Johns, 2007). Despite this, health care professionals and decision makers may choose to withdraw life supportive

treatments when directed to do so by the advance directive (White and Arnold, 2011). The overall goal of creating an advance directive is "to promote shared meaning between a patient and a physician" (Cohen-Mansfield, Libin, and Lipson, 2003, p. 302).

There are multiple types of advance directives, including medically based directives, designated decision maker, and values based directives. A brief description of each of these directives will follow. The Minnesota Health Care Directive is promoted by the Minnesota Attorney General and includes multiple categories discussed in this research (Office of the Minnesota Attorney General, 2015). A copy of the Minnesota Health Care Directive is attached to this research (Appendix C) for reference of the areas highlighted in this research. It is important to note that within this research, the focus is on end of life treatments and cares and does not include physician-assisted suicide.

Medically based directives. Forms that indicate an individual's wishes regarding what medical treatment they would or would not want are considered a medically based directive, and may also be known as a living will (CareNotes, 2013; Grodin, 1993; Mahon, 2011). These forms can be written by an individual (Grodin, 1993), or by a physician (Tulsky, 2005). Medically based directives include information on an individual's preference around: resuscitation (also known as a Do-Not Resuscitate (DNR) order), pain medication, surgery, blood transfusions, dialysis, IV, tube feedings, or a ventilator (CareNotes, 2013).

Designated decision maker. A designated decision maker is responsible for making decisions for the individual, should the individual become unable to make their wishes known (CareNotes, 2013; Grodin, 1993; Mahon, 2011). The designated decision maker may also be referred to as: the Durable Power of Attorney for Health Care

(CareNotes, 2013; Mahon, 2011), Medical Power of Attorney (Mahon, 2011), health care proxy, or health care agent (Grodin, 1993). The individual may select more than one person to act as their designated decision maker (CareNotes, 2013).

      Value based directives. Collecting information about an individual's views and beliefs about life is considered a value based directive or values history (CareNotes, 2013). This type of directive uses statements from the patient that describes their overall goals of care and does not focus directly on specific directions for their care (Doukas and McCullough, 1991). Value based directives use descriptive statements, which may be subject to interpretation (Doukas and McCullough, 1991).

Advance Care Planning

      The individual's goals, values, and emotions around the advance directive is the focus of advance care planning (Black and Emmet, 2006; Mahon, 2011; Tulsky, 2005). While there is less focus on specifying which treatment the individual would or would not want (Black and Emmet, 2006; Mahon, 2011; Tulsky, 2005), this process of discussing the advance directive is a useful tool for bridging the gap between community persons and health care professionals (Thompson, Barbour, and Schwartz, 2003). This conversation occurs when the individual shares their wishes for the treatment they want, in the event that they are unable to make their wishes known (Cai, Cram, and Li, 2011; Fischer, Sauaia, Min, and Kutner, 2012; Houben, Spruit, Groenen, Wouters, and Janssen, 2014; Seal, 2007; Tulsky, 2005; von Gunten, Ferris, and Emanuel, 2000). This process typically includes the individual, their health care professionals, and their designated decision maker (Tulsky, 2005; White and Arnold, 2011).

How to Complete Advance Directives

There are different approaches and forms that can be used in the advance care planning process. In order to carry out the advance care planning process, health care professionals need to have skills, values, and resources to ensure that the patient's wishes are accurately understood, documented for future use, and carefully followed. The overall goal of this process should be focused on the patient's wishes and long term goals.

Communication. Often, health care professionals become uncomfortable when discussing advance directives, which can lead to changing the subject or not fully listening to the individual's concerns (Tulsky, 2005). The health care professional should begin by asking the patient if they are familiar with advance care planning and if the patient feels ready to discuss their advance care plan (von Gunten, Ferris, and Emanuel, 2000). When bringing up the topic of advance care planning, it is important to choose the phrasing carefully (von Gunten, Ferris, and Emanuel, 2000). Talking about limiting or withdrawing treatment can cause an individual to feel abandoned (von Gunten, Ferris, and Emanuel, 2000).

Communication techniques should focus on open-ended questions while also acknowledging the patient and their family's emotional responses (Tulsky, 2005). When patients and their families receive emotional news, they are less likely to comprehend what is being discussed (Tulsky, 2005). Therefore, it is important for the health care professional to focus on how they are discussing the advance care plan, as their delivery is likely to be more memorable than the content (Tulsky, 2005). Given the emotional

nature of these conversations, advance directives should be reviewed routinely to ensure they still match the patient's wishes (IHI, 2013).

Finally, to ensure continuity of care, physicians must communicate clearly to other physicians to ensure that the individual's advance directive is understood and followed (Tulsky, 2005). Communication includes documenting advance care planning discussions in the patient's medical record (Tulsky, 2005). Documenting this information on an electronic health record increases charting efficiency, consistency of the information (Cohen-Mansfield, Libin, and Lipson, 2003), and the accessibility of the records to the health care team (Tulsky, 2005). Having clear documentation allows for improved collaboration among health care professionals (Tulsky, 2005).

Building trust. Building trust is important in the health care setting; it shows that the individual is not skeptical of the health care professional (Churchill, 1989) and is open to honest communication (Tulsky, 2005). When a patient has confidence that the health care provider will act in the patient's best interest it is a sign of trust (Churchill, 1989; Tulsky, 2005). Health care professionals can build trust by acknowledging the individual's feelings and then using the advance directive to continue the conversation around the individual's care (Churchill, 1989).

Instilling realistic hope. Instilling hope is highly recognized as a therapeutic technique in the health care setting (von Gunten, Ferris, and Emanuel, 2000). Within the advance care planning process hope is powerful; however, it must be used in a realistic manner. When there is no hope that the individual will get better, it is important for the health care professional to promote realistic hope (von Gunten, Ferris, and Emanuel, 2000). Allowing individuals and families to believe in false hope "may prevent

reconciliation, emotional growth, final gift giving, and closure" (von Gunten, Ferris, and

Emanuel, 2000, p. 3052). If the individual and their family is hoping that a miracle will

occur, the health care professional should not correct this belief (Tulsky, 2005; von

Gunten, Ferris, and Emanuel, 2000). Instead, using a phrase such as "hope for the best

but prepare for the worst" may instill a more realistic hope (Tulsky, 2005, p. 363; von

Gunten, Ferris, and Emanuel, 2000). Focusing on a patient's religious and spiritual

beliefs may also help to instill realistic hope (Karches, Chung, Arora, Meltzer, and

Curlin, 2012).

Preventing Coercion. Encouraging or pressuring the individual to select specific

choices in the advance directive can happen subtly and quickly during the advance care

planning process (Thompson, Barbour, and Schwartz, 2003). Individuals often perceive

that the physician knows what would be in their best interest and will defer making these

decisions until the physician brings it up (Mahon, 2011). Health care professionals may

believe, based on their skills, that they know better than the patient (Kane, Hamline II,

and Hawkins, 2005). Health care professional's beliefs may cause them to use their

professional authority to sway the individual's treatment choices (Kane, Hamline II, and

Hawkins, 2005). If an individual feels that they are being coerced into choosing care that

does not represent their wishes, they may question the health care professional. In turn,

the health care professional may question the individual's competency to make these

types of decisions if an individual questions the health care professional (Kane, Hamline

II, and Hawkins, 2005). This questioning may result in the patient's health care decisions

being ignored (Kane, Hamline II, and Hawkins, 2005).

Fear is a common factor that may coerce families and health care professionals to choose treatments that do not represent the individual's wishes (Churchill, 1989). Family members may feel guilty about wanting to end a certain intervention, or they may be in denial that the individual is as sick as they truly are (Churchill, 1989). Families may also disagree what may be in the best interest of the individual (Mahon, 2011). In these circumstances, health care providers are more likely to choose "life preserving" interventions out of fear that they may be prosecuted by the family (Churchill, 1989; Mahon, 2011). The families and health care professionals may also act on their religious beliefs and disregard the patient's beliefs when making health care decisions (Mahon, 2011).

To prevent coercion, health care professionals must assess the individual's personal values, wishes, and beliefs (Black and Emmet, 2006), while also acknowledging the concerns of the individual's family (Johns, 2007). Use of professional authority, when paired with the individual's known values, will likely be welcomed by the individual (Tulsky, 2005). Health care professionals must help individuals understand medical treatments from the perspective that will also respect the individual's values (Tulsky, 2005).

Interpretation. It is important that health care professionals understand the meaning, and do not interpret the advance directive so that the individual's wishes are followed (Thompson, Barbour, and Schwartz, 2003). Advance directives often include the legal phrases "no extraordinary means" or "no heroic measures" which can be interpreted differently by health care professionals (Mahon, 2011, p. 802). Within the spiritual context, the terms "ordinary," "extraordinary," "appropriate," and "heroic" may

be interpreted differently depending on an individual's spiritual beliefs (Grodin, 1993).

In these situations, health care professionals should avoid using general terminology and

instead focus on the meanings of "significant pain, suffering, salvation and faith"

(Grodin, 1993, p. 902). Overall, health care professionals can use the advance care

planning process to ensure that the group has shared meaning and the individual's

advance directive is not being interpreted. "For example, a person might articulate that

what matters most to her is reading aloud to her grandchildren; a healthcare provider

needs to understand how to prioritize treatments and interventions to help meet this goal"

(IHI, 2013, p. 62).

  Personal death anxiety. Having personal death anxiety may lead to poor

communication during the advance care planning process due to being uncomfortable

talking about areas that surround death (Black, 2005; Peck, 2009). Health care

professionals who fear their death, or that of a loved one, may experience

countertransference and subconsciously alter the client's advance directive. Health care

professionals should have their own advance directive so that they can understand the

advance care planning process from a first-hand experience (IHI, 2013). Health care

professionals are often hesitant in creating an advance directive, which may contribute to

reserved conversations with clients (Mahon, 2011). This hesitation to create an advanced

directive may be a result of the health care professional's anxiety around death.

  Cultural and spiritual beliefs. Health care professionals cannot assume that one

approach to creating an advance directive will work with all cultural groups (Fischer,

Sauaia, Min, and Kutner, 2012). Health care professionals need to be aware of cultural

barriers to creating advance directives with patients from a minority culture, which may

include: a history of poor access to health care, language barriers, poor communication, not having a designated decision maker, or believing that a family member will make health care decisions in a time of need (Cohen, McCannong, Edgman-Levitan, and Kormos, 2010; Fisher, Sauaia, Min, and Kutner, 2012). Cultural barriers may also include a lack of knowledge about the purpose of advance directives (Cohen, McCannong, Edgman-Levitan, and Kormos, 2010; Fisher, Sauaia, Min, and Kutner, 2012). When completing advance directives, culture should be considered, including how quality of life is defined, as well as the role that the family plays in the decision-making process (Cohen, McCannong, Edgman-Levitan, and Kormos, 2010).

Religious and spiritual beliefs are often closely tied to cultural beliefs and should also be considered when creating an advance directive (Cohen, McCannong, Edgman-Levitan, and Kormos, 2010). Despite this, spiritual beliefs are often not included or understood in the advance directive process (Sessanna, 2008). This poor understanding may contribute to end-of-life experiences that do not match the wishes of the older adult (Sessanna, 2008). Religious and spiritual beliefs vary among different groups of people and it is important that health care professionals are careful with the terminology they use when discussing spirituality (McSherry, Cash, and Ross, 2004).

Health care professionals need to be open to asking the individual about their spiritual beliefs. Individuals are rarely asked about spiritual beliefs; and they rarely bring it up in these discussions. However, when health care professionals ask patients about their spiritual beliefs, the patient tends to report that it is imperative to include their spiritual beliefs in their advance directive (Sessanna, 2008). Discussing spiritual beliefs

may also allow further discussion of the individual's values and goals, as well as help the

individual understand the limits that therapeutic interventions may have (Grodin, 1993).

     Family. Advance care planning is most effective when the patient's family and

designated decision maker are included in the process (Black and Emmett, 2012; Cohen,

McCannong, Edgman-Levitan, and Kormos, 2010; Mahon, 2011; von Gunten, Ferris, and

Emanuel, 2000). During this discussion, it is important to make sure that the family

understands the patient's wishes (Ramsaroop, Reid, and Adelman, 2007). Including the

family when making the advanced directive will also reassure the family members that

the patient's wishes are heard and followed (Thompson, Barbour, and Schwartz, 2003).

Using the advance care planning process to create an advance directive will protect the

patient's wishes in the event that their family members later wish to implement

interventions that do not match the goals of the patient (Thompson, Barbour, and

Schwartz, 2003).

     Timing Intervention. For many individuals, advance directives are not discussed

until a crisis occurs (Bomba, Morrissey, and Leven, 2011; Houben, Spruit, Groenen,

Wouters, and Janssen, 2014; Karches, Chung, Arora, Meltzer, and Curlin, 2012).

Individuals often believe that their physician will bring up the advance directive

conversation when it is appropriate to do so (Houben, Spruit Groenen, Wouters, and

Janssen, 2014; Ramsaroop, Reid, and Adelman, 2007), however, health care providers

often have limited time for these types of discussions (Mahon, 2011). When advance

care planning is put off, waiting for the physician or until a crisis occurs, the individual's

preferences are less likely to be known (Bomba, Morrissey, and Leven, 2011; Houben,

Spruit, Groenen, Wouters, and Janssen, 2014; Karches, Chung, Arora, Meltzer, and

Curlin, 2012). Overall, health care providers feel that the advance care planning

discussions should happen at a younger age and earlier within the patient's disease

progression (Ramsaroop, Reid, and Adelman, 2007). Within the nursing home setting,

this presents a unique challenge as advance directives are typically discussed upon

admission (Lacey, 2006). Nursing home residents and their families are usually

emotionally exhausted when entering a nursing home, making it a questionable time to

discuss advance directives (Lacey, 2006). Due to changes in cognition, that often occurs

at the time of admission, patients are not adequately prepared to discuss advance

directives (Lacey, 2006). In this situation, having repeated conversations about the

individual's advance directive is a successful approach to obtaining more accurate

information about the individual's health care wishes (Ramsaroop, Reid, and Adelman,

2007).

Need for Team Based Approach

    "Discussions about advance care planning should be held with the patient, family,

and physician together to permit discussion and clarification of treatment goals specific to

the patient's condition" (Tulsky, 2005). Research has shown that older adults want their

family to make decisions if they cannot make their own decisions (Lacey, 2006) but

families report that making these decisions feels like a burden (Lacey, 2006). The

individual and their family members will likely be hesitant in making decisions, unless

they have the guidance of a health care provider (Lacey, 2006). Multiple disciplines

consider advance directives to be part of their practice; however, research has not found a

single healthcare discipline to be "the most qualified to discuss advance directives with

patients" and their family or health care decision maker (Peck, 2009, p. 51). "For older

patients, the interdisciplinary team offers a comprehensive approach that addresses issues that range from advance care planning to end-of-life decision-making" (Black, 2005, p. 40). The interdisciplinary approach to advance care planning includes "value in communication, information sharing, shared decision making and acknowledgement of resident's treatment preferences" (Krok, Dobbs, Hyer, and Polivka-West, 2011, p. e49).

There are many different professionals that may work with older adults when completing an advance directive. The literature reviewed thus far has highlighted medical, psychosocial, and spiritual components to the advance directive. Primary care physicians, nurses, social workers, and chaplains have a role in working with older adults to create advance directives. The roles of these professionals will be discussed in the following sections.

Primary Care Physicians. Patients believe that the physician should introduce the topic of advance directives and will often wait for their physician to initiate this conversation (von Gunten, Ferris, and Emanuel, 2000). Research shows that patients who talk to their physician about advance directives were more satisfied than those who did not (Bomba, Morrissey, and Leven, 2011). Physicians cite lack of time (Ramsaroop, Reid, and Adelman, 2007) and poor reimbursement as barriers to completing advance directive discussions with their patients (von Gunten, Ferris, and Emanuel, 2000).

Nurses. Nurses are frequently responsible for discussing advance directives with their patients; yet are often resistive due to feeling that they lack the knowledge to have this conversation (Connell and Mallory, 2007; Ferrell, Virani, Gran, and Juarez, 2000; Ryan et al, 2001; Seal, 2007). Nurses also cited a lack of time (Mahon, 2011) and fear of upsetting the patient as barriers to completing advance directives (Mahon, 2011; Seal

2007). Nurses with more experience tend to be more comfortable talking about advance

directives and nurses who were mentored by a more experienced nurse (Black and

Emmett, 2006) or who received specific training on advance directives also reported

increased confidence in completing advance directives (Seal, 2007).

When nurses discuss advance directives with their patients, they follow the

Nurses Code of Ethics (Black and Emmett, 2006). This code focuses on patient self-

determination and decision making (Black and Emmett, 2006). "Care of others is

nursing's most basic tenet, in which patient advocacy is ethically grounded" (Seal, 2007,

p. 30). The care that nurses provide is focused on supporting a patient's well-being,

"whether in a return to health or facilitating a peaceful death" (Seal, 2007, p. 30)

Social Workers. Traditionally, social workers are responsible for discussing

advance directives with patients and their families at the time of nursing home admission

(Lacey, 2006). Social workers feel they are able to complete advance directives with

their patients (Kane, Hamline II, and Hawkins, 2005), however, they do not feel that they

are prepared to discuss in-depth medical concerns that may arise during this discussion

because they feel that medical interventions are not in their area of expertise (Lacey,

2006). As a result, social workers often focus just on the patient's code status (whether

they do or do not want CPR) upon the patient's admission to the nursing home (Lacey,

2006).

Social workers feel that advance directives should be discussed with the

interdisciplinary team (Lacey, 2006). Social workers are trained in communicating with

others, working in group settings, systems approaches, and patient advocacy (Black,

2005). These skills are beneficial in a team approach to completing advance directives

(Black, 2005). Social workers are helpful members of the health care team, given their knowledge of the stages of change model (Black, 2005). Within the stages of change model, social workers can work with a patient to move from the pre-contemplative stage to the action stage of completing an advance directive (Black, 2005). Social workers also collaborate with health care professionals, the patient and their family members by using specific communication skills (Black, 2005).

Client self-determination is a core feature of the social work practice; end-of-life decision making is included within this core feature (Lacey, 2006). Discussing advance directives in a team setting is a natural role for social workers (Kane, Hamline II, and Hawkins, 2005). Given their focus on client self-determination, social workers want to ensure that other health care professionals understand the patient's values towards care (Kane, Hamline II, and Hawkins, 2005).

Chaplains. Chaplains, who are often employed by healthcare agencies, focus on the spiritual needs of patients from the individual, professional, and system levels (McClung, Grossoehme, and Jacobson, 2006). Chaplains are trained to work with patients experiencing emotional distress (McClung, Grossoehme, and Jacobson, 2006), which may include working with patients who are deciding to withdraw life support or deciding on a do-not-resuscitate order (Carey and Cohen, 2008). They are trained to minister through presence and support, help patients find meaning, and provide spiritual assessments (Carey and Cohen, 2008). Chaplains are "experts in matters of life and death, and … religious ritual" (Carey and Cohen, 2008, p. 354). They also provide "pastoral counseling and education, and pastoral ritual and worship" (Carey and Cohen, 2008, p. 354).

Chaplains can help patients who have a broad range of cultural, religious, and spiritual beliefs (Cadge and Sigalow, 2013; and Carey and Cohen, 2008). They are also a resource for team support (Carey and Cohen, 2008), and are valuable members of the interdisciplinary team (McClung, Grossoehme, and Jacobson, 2006). The chaplain's focus on communication and assessing patients psychosocial-spiritual well-being helps to support physicians (Carey and Cohen, 2008) and nurses, who may not have the time to evaluate these areas with patients (McClung, Grossoehme, and Jacobson, 2006).

Current Research on Team Based Approach

The interdisciplinary team approach consists of health care professionals from multiple disciplines working together to achieve a patient-centered goal (Black, 2005; Jansen, 2008; Krok, Dobbs, Hyer, and Polivka-West, 2011). The following sections will discuss in greater detail the current research on interdisciplinary work in healthcare settings. Attention will be given to how interdisciplinary teams are currently approaching advance care directives.

The interdisciplinary team role. The interdisciplinary approach in healthcare settings values "communication, information sharing, (and) shared decision making" (Krok, Dobbs, Hyer, and Polivka-West, 2011, p. e49). The interdisciplinary approach is also focused on recognizing what the patient's preferences are for treatment (Krok, Dobbs, Hyer, and Polivka-West, 2011). The nursing home interdisciplinary team working on advance care planning often includes "the social service director, the charge nurse, and the medical director" (Krok, Dobbs, Hyer, and Polivka-West, 2011, p. e49).

Older adults and their families may prefer a holistic approach, which includes a focus on health, social, functional and psychological issues (Young et al., 2011). Finding

ways to make the interdisciplinary team successful in the health care setting could

significantly improve the quality of care for older adults (Black, 2005; Young et al.,

2011). The following sections will highlight the strengths and limitations of the

interdisciplinary team.

      Strengths of the interdisciplinary teams. Previous research has

overwhelmingly supported the interdisciplinary team approach as beneficial in the health

care setting (Jansen, 2008). This approach is believed to increase efficiency and reduce

health care costs, especially when the team has been trained specifically on a focus area

(Young et al., 2011), such as the advance care planning process. Furthermore, the

interdisciplinary team does an excellent job with problem solving, including prioritizing

the interventions that are needed to support a patient's health care decisions (Young et al.,

2011). Greater focus is placed on the patient when the diversity of health care

professionals within the interdisciplinary team increases (Boon, Verhoef, O'Hara, and

Findlay, 2004). The interdisciplinary team focuses on communication by "clarifying

family's roles, facilitating family's consensus, and accommodating family's grief"

(Black, 2005, p. 51). This communication approach allows for greater focus on the

patient's family (Black, 2005).

      Limitations of the interdisciplinary team. Collaboration should be a primary

goal of the interdisciplinary team process, however, it significantly lacks in current

approaches (Jansen, 2008). The philosophy of health care practice becomes more

diversified as the team involves multiple health care disciplines (Boon, Verhoef, O'Hara,

and Findlay, 2004). Diversification may also lead to confusion in role responsibilities, a

fear that professional identity and values may be lost, and an imbalance in power (Jansen,

2008). Without precise definitions in the interdisciplinary process, there is an increased

chance that health care professionals will argue with one another over who should

provide certain services (Jansen, 2008).

Communication is a primary skill that is required in the interdisciplinary process

(Young et al., 2011). The terminology used in various professions does not always match

each other which can increase communication difficulties between health care

professionals from different backgrounds (Jansen, 2008; Young et al., 2011). The

hierarchical foundation that occurs between health care professionals and patients may

also contribute to poor communication (Jansen, 2008). It is essential that health care

professionals understand the terminology that other health care professionals use (Jansen,

2008), and be knowledgeable of conflict resolution techniques in order to be a successful

interdisciplinary team (Young et al., 2011).

Finding health care professionals who are focused specifically on working with

older adults is a challenge. Currently, "4% of clinicians in medicine, nursing, pharmacy,

therapies, and social work" have a certificate focusing on work with older adults (Young

et al., 2011, p. 247). Older adults are unique in the challenges they face in health care,

particularly on the individual, family and health care system levels (Young et al., 2011).

There needs to be greater focus on approaches that assist older adults in navigating these

challenges; however, attempts to implement interdisciplinary approaches on a large scale

in health care facilities have been unsuccessful (Young et al., 2011).

Academic universities should be responsible for educating health care

professionals on the interdisciplinary process (Jansen, 2008; Young et al., 2011).

Unfortunately, interdisciplinary team collaboration is often not included in a health care

professional's course work (Jansen, 2008; Young et al., 2011). Academic settings often lack the funding to integrate interdisciplinary work into the curriculum (Jansen 2008; Young et al., 2011). Financial barriers do not stop at the academic level; the interdisciplinary team approach is not able to be reimbursed by most major health plans (Young et al., 2011).

Conceptual Framework

Collaborative practice in health care is of particular importance when working with older adults. The complex needs of older adults typically require the knowledge of multiple healthcare professionals (Germain, 1984). Germain (1984), defines collaborative practice as "a cooperative process of exchange involving communication, planning, and action on the part of two or more disciplines" (p. 199). The purpose of collaboration is to achieve healthcare based goals, that could not otherwise be achieved, with one healthcare discipline (Germain, 1984). The collaborative practice, as described by Gemain (1984), includes a focus on three key areas: the formality of the collaboration, the phases of the group, and collaborative practice. Germain (1984) also includes implications that pertain specifically to social work practice.

There are two types of formality within collaboration: informal and formal (Germain, 1984). Informal collaboration occurs in casual conversations or written communication while formal collaboration occurs in a planned meeting, such as a care conference (Germain, 1984). Formal collaboration is typically made up of group members, which may change, but in general include predefined disciplines to be involved in the meeting (Germain, 1984). These types of formality are shown in Table 1.

Table 1	
Formality of Collaboration	
Informal	**Formal**
- Casual Conversations - Written Communication	- Planned Meeting (Care Conference) - Pre-Defined Group Members

Table 1- Germain's (1984) Formality of Collaboration

There are five phases that the group must go through to create collaborative practice (Germain, 1984). These phases include role separation, overestimation and disappointment, realistic appraisal, accommodation, and integration (Germain, 1984). The first phase is role separation which involves maintaining professional boundaries, and each professional working in their respective roles (Germain, 1984). The second phase is overestimation and disappointment. In this phase, health care professionals begin to look to one another for answers to solve the problem presented (Germain, 1984). They may also simplify the tasks that are needed to solve the problem (Germain, 1984). Realistic appraisal occurs when team members begin to understand the contributions that other professions make to the group (Germain, 1984). At this point, there is also less focus on superiority within the group (Germain, 1984). The fourth phase, accommodation, occurs when health care professionals recognize the differences within the group, name these differences, and complement one another (Germain, 1984). When the group achieves a holistic view of the patient-environment relationships related to their health concerns, they have reached the final phase, integration for roles (Germain, 1984). Germain (1984) describes this holistic view as the professionals learning from one another while avoiding blurred roles within the group. These phases are displayed in Table 2 below.

Table 2

Group Phases

1. Role Separation	• Maintain professional boundaries • Professionals work within their roles
2. Overestimation and disappointment	• Look to each other for answers • Task Simplification
3. Realistic Appraisal	• Increased understanding of others contributions • Decreased focus on superiority in the group
4. Accommodation	• Differences are recognized and named • Group members complement one another
5. Integration	• Professionals learn from one another while maintaining their professional role

Table 2-Group Phases as described by Germain (1984)

Once the team has become a collaborative group, they can begin to practice effectively (Germain, 1984). In order to be effective, the group must be able to confer, cooperate, consult and team (Germain, 1984). Conferring "requires reciprocal respect and trust so that observations are exchanged, views are freely expressed and compared, and each is free to agree or disagree" (Germain, 1984, p. 204). Cooperating occurs when health care professionals work symmetrically together on a problem (Germain, 1984). Consulting occurs when there is a knowledge differential; one person is seeking knowledge, the other is providing knowledge (Germain, 1984). When a health care professional cannot physically see a patient, but can share their knowledge about the patient's disease process with the other health care professionals, consulting is the result (Germain, 1984). Teaming occurs when a group of health care professionals work together (Germain, 1984) This may also be called multidisciplinary or interdisciplinary

teaming (Germain, 1984). In multidisciplinary teaming, each health care professional has a particular, specialized role to fulfill (Germain, 1984). In interdisciplinary teaming, the focus is on the biopsychosocial-cultural needs of the patient and is non-hierarchical in nature (Germain, 1984). The keys to effective collaborative practice are displayed below in Table 3.

Table 3			
Keys to Effective Collaborative Practice			
Conferring	Cooperating	Consulting	Teaming
Members share professional views freely Respect and trust are essential Okay to agree and disagree	Working symmetrically on a problem	One professional seeks knowledge Another professional provides information	Professionals have specific roles Non-hierarchical Focus on biopsychosocial-cultural needs of the patient

Table 3- Keys to Effective Collaborative Practice (Germain, 1984)

Germain (1984) states that social workers are valuable in the collaborative group because they have the educational background of how to work in groups, whether that be with patients or other health care professionals (Germain, 1984). Germain (1984) urges that it is important for social workers to maintain their professional identity. Within this group the professional identity includes "a realistic sense of professional competence, confidence, and pride in being a social worker" (Germain, 1984, p. 224). Social workers also need to be prepared to represent social work values and take responsibility for the results of group decisions (Germain, 1984). Finally, social workers can work respectfully with other health care professionals by having "nonjudgmental and facilitating attitudes, communication skills, and empathic responsiveness" (Germain, 1984, p. 229). Key factors to social worker's professional identity is shown below in Table 4.

Table 4		
Social Workers Professional Identity		
Professional Competence	Confidence	Pride
Represent social work values	Responsible for group decisions	Non-Judgmental
Facilitating Attitude	Communication	Empathic Responsiveness

Table 4- Key Factors to Social Workers Professional Identity (Germain, 1984)

This conceptual framework is a classic work written by Germain, who introduced the ecological perspective to the social work profession (Gitterman and Germain, 2008). Germain's conceptual framework on collaborative teamwork in a healthcare setting focuses on multiple healthcare professionals working together on a common problem. This study assesses how primary care physicians, nurses, social workers, and chaplains collaborate to help nursing home residents create an advance directive. Germain's 1984 framework on collaborative teamwork continues to be considered a classic and is often cited in research (Gitterman and Germain, 2008). However, the research continues to cite problems in the collaborative approach (Jansen, 2008).

Methods
Research Design

This research aims to answer the question: "What are the best practice strategies when creating advance directives using a team approach?" To answer the research question, qualitative semi-structured interviews were used. The focus of these interviews was on team-based healthcare approaches, specific to advance directives. Social workers, nurses, nurse practitioners, doctors, and chaplains who work in or with nursing home residents were recruited to participate in this study. The qualitative interview was chosen

so that the professionals could describe the skills and values needed when assisting a patient with creating an advance directive.

  The research sample consisted of recruiting professionals with knowledge and experience in creating advance directives. The sample was not limited by a specific agency. Sampling preference was given to those who work in or work collaboratively with a nursing home. The questions were geared towards the professional and the agency specifically.

Sample

  The sample for this research included health care professionals who work in the nursing home setting. Health care professionals from the following fields were included in the recruitment for this study: social work, nursing, physicians, nurse practitioners, and chaplains. The research sample includes six respondents including: four social workers, one nurse, and one chaplain. All of the respondents have experience creating advance directives with nursing home residents. All of the respondents reported that they are part of an interdisciplinary team as part of their work. Three of the respondents had between one and five years of experience working in nursing homes. The remaining three respondents had over twenty years of experience working in nursing homes.

Protection of Human Subjects

  The proposed research method was reviewed by the research committee and the Institutional Review Board (IRB) prior to any interviews being held in order to protect the human subjects participating in this study. This process included approving the recruitment process, research questions, and data analysis. The research committee and

IRB also reviewed the researcher's bias in this proposal to ensure the appropriate steps were taken to remove bias from the findings.

Recruitment process. The sample subjects for this study were recruited from the Care Options Network website. Care Options Network is a publicly accessible resource that lists services for older adults and includes a list of nursing homes (Care Options Network, 2014). The nursing homes listed on the website are located in the Twin Cities metro area. This website is widely used by health care professionals in the Twin Cities when assisting clients in locating resources (Care Options Network, 2014). Judgment sampling was used to select the nursing homes to be contacted. The researcher called the administrator of the facility, and those that expressed interest in participating were given a research flyer to describe the study in detail. Snowball sampling was also used to recruit subjects. Following the interview, the interviewees were given additional flyers to share with colleagues, in hopes of creating interest in participation.

Confidentiality. All of the participants of this study are protected. The responses from the professionals were recorded on the researcher's personal, password protected, tablet. The recordings were transcribed by the researcher and stored on the researcher's personal, password protected, laptop. Original recordings and transcriptions were destroyed upon completion of this project. Those that participated are identified as professionals that have experience working with clients who live in a nursing home in the Twin Cities. The names of specific nursing homes that were identified during the interview were omitted from the final research, to protect the respondents' anonymity.

Informed Consent. Each participant was given a consent form prior to the interview (Appendix A). Participants were informed that there were no benefits or risks

associated with their participation in the study and that their information would be kept confidential. Participants were also informed that they could withdraw from the study at any time without any repercussions.

Data Collection

The instrument for this research includes interview questions that were created from the literature review (Appendix B). These questions were reviewed by the research committee prior to the interviews to ensure that they are all focused on answering the overall research question. The interviews were collected through recording and transcribed by the interviewer.

Data Analysis

The data for this research was analyzed using a grounded theory approach. The goal of analyzing the data through a grounded theory approach is to explain "the what, how, when, where, and why of something" (Corbin and Strauss, 2008, p. 55). This approach allowed the researcher to explore how the participants view something that had not previously been theorized (Connelly, 2013). The patterns that came out of the data analysis were used to answer the research question (Engward, 2013). The multiple discipline approach to completing advance directives in the nursing home setting has not previously been analyzed, making the grounded theory approach the logical choice to analyze the data.

The data analysis began "open and free, much like brainstorming" (Corbin and Strauss, 2008, p. 52). Concepts were identified early on and went through a process to determine the greater meaning to these concepts (Corbin and Strauss, 2008). The goal of

this process was to bring the raw data from a concrete idea to a more abstract concept (Corbin and Strauss, 2008). The steps of the data analysis are listed below.

The researcher recorded and kept notes during each interview. Following the interview, the researcher used field notes to record the researcher's initial observations and ideas (Corbin and Strauss, 2008). Research memos were also used to capture the researcher's more detailed observations and emerging themes from these initial observations (Corbin and Strauss, 2008). Research memos were used to organize how the researcher conceptualized the data collected (Engward, 2013).   Keeping notes during the interview, taking field notes, and completing research memos allowed the researcher "to consider all possible meanings" and "to become more aware of…assumptions and the interpretations" of the data (Corbin and Strauss, 2008, p. 53).

After the interviews were transcribed, the researcher began data analysis with open coding. Corbin and Strauss (2008, p. 195) describe open coding as the process of breaking down the raw data into concepts. Concepts "represent an analyst's impressionistic understandings of what is being described in the experiences, spoken words, actions, interactions, problems, and issues expressed by participants" (Corbin and Strauss, 2008, p. 51).

The researcher next moved into grouping the concepts from each interview into themes. This process allowed the researcher to group diverse topics together under a common theme, which then allowed the theme to be explored in greater depth (Corbin and Strauss, 2008). Using constant comparative analysis, the researcher compared and contrasted the themes of the interviews (Corbin and Strauss, 2008). This process also

allowed the researcher "to identify properties and dimensions specific to that

category/theme." (Corbin and Strauss, 2008, p. 73).

Finally, the researcher used axial coding to determine how the concepts identified

compared to one another (Corbin and Strauss, 2008). The researcher also returned to the

research memos to determine if the initial impressions were present within the data

themes. The axial coding allowed the researcher to see the emerging theory. "Theorizing

is interpretive and entails not only condensing raw data into concepts but also arranging

the concepts into a logical, systematic explanatory scheme" (Corbin and Strauss, 2008, p.

56).

<center>**Findings**</center>

The interview findings consisted of two primary themes. There was very little

overlap between these two themes. The first theme, Advance Directives, describes how

the respondents viewed the creation of advance directives. The second theme, Working

in the Interdisciplinary Team, describes how the respondents viewed group work. An

additional, unexpected theme emerged around tube feedings and is briefly discussed at

the end of this section.

Advance Directives

Within the theme of advance directives, the respondents shared their views within

the following sub-themes: earlier discussions, the role of family members, personal

values and beliefs, death anxiety, and the stages of change. The findings from these sub-

themes will follow.

Timing Interventions. The respondents overwhelmingly felt that it was

important for everyone to talk about advance directives earlier in life. One respondent

included that once a person reaches the age of 18, they should have an advance directive.

She also felt that it was important for people to have in-depth conversations with their

family members to ensure that their values were understood. *"That's why I tell, even*

young people, that they should be talking to their provider and their parents about if a

decision like this comes about they know what to do."

Several of the respondents felt that an ideal time to have advance care planning

discussions is when the whole family is present. Thanksgiving, in particular, was felt to

be one of these ideal occasions to have advance care planning discussions. *"I always feel*

that holidays are a good time, like Thanksgiving to bring it up. Since we're all together,

let's talk."

When it comes to older adults entering the nursing home, the respondents felt that

talking about and introducing clients to advance directives when they came into the

Transitional Care Unit (TCU) would be an ideal time to begin these conversations. They

felt that introducing advance directives when a client came into the TCU would be ideal

because the individual would likely be at an earlier stage in their disease process and

more cognitively intact as compared to those who are entering the facility for long term

care.

> *"I think it's important for people to know that they can fill out an advance*
>
> *directive. Especially, I see a lot of people come through the transitional care unit*
>
> *and they're in and out pretty fast, but I notice that a lot of people don't have*
>
> *anything written down. Families don't know what their parent's wishes are. That*
>
> *might be an area of growth where we can try and address those things, even in a*
>
> *fast paced environment."*

The respondents have seen many occasions where advance care planning is put off too long, which results in the nursing home staff having to rush to find a decision maker in an emergency situation. *"Usually (advance care planning) only comes up when someone is not competent to make their own decisions. Then we're scrambling to figure out who can make the decision for them."*

Another respondent felt that starting the conversations early was essential to ensure that there was enough time to discuss all of the aspects of advance care planning. *"Part of the challenge is in order to do (advance care planning) well, we need to do three or four visits of at least an hour each and few people have that kind of time."* This respondent also notes that having the kind of time necessary to have advance care planning discussions was also a challenge.

Role of Family Members. One aspect of advance care planning is selecting a decision maker to act when the patient can no longer state what treatments they would and would not want. The respondents reported that many of the older adult patients were more likely to defer decision making to their children. *"A lot of (the patients) say 'I don't have something formal, but my kids know what I want.'"*

The respondents also felt that the older adult client could choose a specific family member. *"Most of them know what family member will honor what they want."* Most of the respondents felt that selecting a specific family member to make decisions was important because many times the children do not agree on what the older adult client would have wanted. The following respondent described that having a written advance directive would make the health care wishes even clearer.

"I find it difficult because if they do come to a state where they're not able to make those decisions, then the kids can sometimes disagree. One child will say, well mom told me this, and the next child will say, well actually she told me this. So it's conflicting information. Where having a document would be very clear, you know, make it black and white."

All of the respondents found it very difficult to work with the "lost child" as many of them described it. They felt that difficult situations occur when a distant family member comes to the nursing home as the older adult is dying and feels that a different care plan should be put in place. One respondent described a situation where this occurred and she describes how her team informed the "lost child" of the older adults wishes.

"This is a gentleman, who as he was dying, wanted to make sure he was kept comfortable without pain. He also was not a believer, and he wanted to make sure that we didn't bring in like chaplains and all that kind of stuff, he wanted us to honor those things ... he had a daughter in the south somewhere who suddenly came into the picture and no one even knew she existed. She was a religious person and she wanted all this stuff and I said, ya know, your father doesn't want that. We went with what he wanted and he died peacefully."

In this case, the respondent valued the patient's wishes and advocated for him at the end-of-life.

Another area that the respondents struggled with was dealing with family members who coerced the patient. The respondents felt that coercion occurred when the family members made health care decisions that gave preference to their own needs over

the patient's needs. Here, a respondent describes a case where this type of coercion occurred.

> *I can think of another family, where the woman was getting dialysis and was actually on hospice… but … the son wanted her to keep getting treatments and it was not clear, because she was not cognitively intact, what she wanted. So that was really heart (wrenching) for the family. Then the staff was trying to figure out, ok so this woman, we drag her out of bed, we put her in a wheelchair to drive her to dialysis, and she comes home and she's in the same, I mean, ya know, we're keeping her alive, but is that her choice? And the son didn't want to kind of admit that, that was serving his need.*

The respondents felt that family coercion often occurred due to feeling guilty about making a decision that may result in the patient's death. *"People (being faced with an) agonizing decision like that may want to do everything. There's a guilt."* The respondents felt that this was an area where advance care planning can be useful in helping the family to understand promoting quality of life and promoting the client's values.

Understanding Values and Beliefs. The respondents recognized that, like the family members, facility staff can also contribute to coercion depending on their own personal values and beliefs. The respondents were aware that the purpose of being aware of their own values and beliefs is to prevent coercion and promote the patient's choices. *"I have to be careful that I keep in mind people have a right to whatever their belief is."* The respondents note that being aware of their own values and beliefs can be tedious and it takes work to separate their own values and beliefs from the patient's wishes.

"A struggle for us is when we see that they should be DNR, but the family wants (full code), it's respecting, do they really know what they want, and if they do, finding a way to respect that and honor that, with sincerity. That's where I have grown, I may not agree with a decision, but I can respect their decision."

In the respondent's opinion, separating your own values and beliefs from the conversation is about respecting the choices that the patient may make. One of the respondents felt that having a dedication to working with older adults and promoting approaches that value of the person's life were effective ways to prevent coercion. *"We need gerontology people that really know comfort care, believe in hospice, and are seeking the resident's best interests."*

Death Anxiety. For many of the respondents, death anxiety was a significant theme in areas that impede advance care planning discussions. *"Death is just really scary ... we're so fear based about death and dying."* They felt that death anxiety occurs both in the patients, as well as in the healthcare staff.

While talking about death is difficult for many healthcare staff, the respondents felt that it is very important to have discussions relating to death. One of the respondents posed the question of looking for greater meaning when having advance care planning discussions. *"It's really uncomfortable, talking about death and dying, and being courageous enough to do that, because we're talking about life and death, what does that mean?"*

Another respondent described a process for entering these conversations. This respondent felt that in beginning the conversations around the patient's values, the patient

would comfortably enter conversation surrounding death, and the meaning they assign to

their own death.

> *"I think when people have an opportunity to talk about what they want and they*
>
> *do talk about their life and they do come to a point where it's okay to talk about*
>
> *death. But I think there's a piece of subtly there ...for the most part, a lot of*
>
> *people welcome the opportunity to say what they want."*

The respondent closes with the thought that entering these conversations allows the

patient to express their wishes for end-of-life care.

One of the respondents approached the topic of death anxiety from what she

described as a *"realistic approach."* She felt that death was inevitable, therefore

healthcare workers should be prepared to have discussions around death and dying.

> *"A lot of people don't talk about it, but it's reality, we're all going to face it ... as*
>
> *social workers we are aware of this, it's just trying to get everyone else to be*
>
> *aware. It's not a taboo subject, it's realistic, it's the most loving thing you could*
>
> *do for the person you love."*

The respondent also referenced that advance care planning discussions around death and

dying can alleviate family member's grief when making a choice, as discussed earlier in

the findings on family members roles.

Stages of Change. The respondents struggled with patients who were resistive to

having advance care planning discussions. One respondent noted that many of the

patients refused and did not have an advance directive. *"I haven't had anyone who has*

wanted to sit down and do it with me, they kind of have refused those things." Another

respondent felt that conversations only occurred when the patient was prepared and

comfortable to talk about their advance care plan. *"It's whether the patient wants to talk about death or is comfortable in talking about end of life issues ... it's easier to talk with people who kinda thought out what they want to happen before it happens."* Overall, the respondents did not talk about working with resistance to these conversations.

Working in the Interdisciplinary Team

The respondents provided their feelings on how interdisciplinary teams work together. This section will open on teamwork from a medical model, person-centered model, and a holistic approach. Professional roles in the interdisciplinary team will be discussed, as well as the effect interdisciplinary teams have on promoting and impeding advance directives. This section will close with the respondent's feelings on promoting agency change to create an environment that encourages advance care planning discussions.

Medical, Person-Centered, and Holistic Approaches. The respondents were split on the best model for interdisciplinary teams approaching advance directives. Some of the respondents felt that the medical model was best. In the medical model, they felt that advance directives were strictly a medical issue and that nurses should complete the advance directive. One respondent stated: *"I think it's more of a medical, kind of a nursing, deal."*

Some of the respondents felt that approaching advance directives from a person-centered approach was the most ideal. *"It's always important for us to go to the person who's in that situation ... as social workers, we're not about pushing care directives, it's about what do you want."* In this approach, the respondents felt that given that the

patient was directing the choices for care, there was less need for the interdisciplinary team.

For the respondents who have worked in long term care for many decades they have seen a transition in the models of care.

"I can tell you when I started it was nurses who ran the show. Nurses said when you got a bath, when you went to sleep, when you got your medication … they ran the show. I am so happy because it is heading toward a more holistic perspective. I feel like a dinosaur, because I've seen such evolution take place with skilled nursing. I'm kind of in awe of the things looking back, because it's become more about choice."

Within the progressive change in long term care, the respondents feel that interdisciplinary teams are coming to approach advance directives from more of a holistic view.

One respondent describes care conferences as a time that the interdisciplinary team is together with the patient to talk about advance directives. The respondent describes providing a broader conversation, which does not look at just medical concerns to help the patient create or review their advance directive.

"A lot of time the staff brings it up and says you're DNR/DNI. And that's pretty abrupt for more of our people. So I'm inviting the conversation, to broaden it. And it's been really powerful, because the resident is often there, the family, and we're able to get into these wonderful conversations."

Another respondent describes this broad conversation as talking about the patient's purpose and meaning in life and in death.

"We have meaning and purpose in our life, amidst suffering ... what's your

meaning, what's your purpose in life, that's what the elderly person is moving

towards in their last days ... why am I still here, what is the meaning and purpose

of my life. To be able to find that becomes so critical."

The respondent felt that this holistic approach, talking about meanings, was effective for

the interdisciplinary team in helping the patient in the advance care planning process.

Professional Roles in the Interdisciplinary Team. The respondents who felt

that the medical model was the best approach to advance care planning felt that the

interdisciplinary process was not needed. These respondents did not recognize or value

the roles that non-medical professionals brought to the team

"I am more comfortable with a nurse talking about what would happen if

somebody tried to resuscitate you ... I feel like coming from a social worker it

doesn't have as much credibility as it would coming from nursing staff."

Other respondents felt that interdisciplinary teams worked in a hierarchy. They

felt that the doctors were at the top of this hierarchy. In this approach, the respondents

felt that doctors should inform patients when it is time to have the advance care planning

discussion. Then the remaining interdisciplinary team members can complete the

advance directive with the patient.

"I think it would be helpful if the doctors would push more. I could talk about

advance directives 'til I'm blue in the face, and how important they are, but I

think it really needs to come from the doctors ... kind of encouraging advance

directives and then leaving it in the hands of (the social worker) and the nurses

and other team members."

Some respondents had clear ideas of their own role as well as understanding of other's roles. In this approach, the respondents felt that each discipline brought something to the team discussion. One respondent described the different professions that could work together with a patient when talking about advance care planning with an emphasis on decisions around a tube feeding.

"I think the nurse and the social worker have two different perspectives on it. I think that the social worker really ensures on admission that (the patient's) know all of their rights, so their emphasis is on the right to make the decision and helping them. And the nurse is key in explaining those key (medical) areas. And sometimes the dietician comes into play, depending on when it has to do with nutrition in the tube feedings. And even therapies come into play … because they have to be able to explain the choices and risks of deciding to not have a tube feeding and letting them eat what they want to eat. Everybody kind of has the role in that."

Interdisciplinary Team Promotes and Impedes Advance Directives. The respondents felt that there were different aspects to the interdisciplinary team that would promote or impede the process of creating an advance directive with clients. Some of the respondents felt by having different disciplines represented in a meeting, the patient would be able to think about their advance directive from different perspectives.

"It's important to have more than just a social worker involved in the medical team, because then (the patient) can get the emotional support they need to make their best decision. (The patient) can get the medical information that they need

based on their diagnoses … it needs to come from everybody supporting the

patient."

For some of the respondents, having an interdisciplinary approach with the client meant

that the client's overall needs were supported.

Some of the respondents felt that the interdisciplinary approach was beneficial

because the group would likely have different personality types. The respondents felt

that having different personality types increased the chances that the patient would

respond positively to at least one of these personality types. One respondent described

the different personalities that may be present in an interdisciplinary team:

"I think there are different voices, and different ways of presenting the invitation

to look at (advance directives). Some of us are bolder and more direct, that can

kind of break the ice. Some of us are more psychosocial oriented and use

different language. Some of us use more clinical language. Some of us use more

psychological or pastoral language."

Some of the respondents felt that having too many people involved in the

interdisciplinary team may be problematic for patients. One respondent described this as

"too many hands in the pot type thing, too many opinions." The respondents felt that the

interdisciplinary team would not be able to agree on an outcome if there were too many

people involved. Another respondent stated *"sometimes when people have differing*

opinions, when the patient wants one thing and the doctor thinks they need another" to

describe how conversations can lead into coercion. The respondents felt that most

professionals are able to understand the expectations of their professional role, however,

when there are professionals who bring their personal values and beliefs into the team

discussions it can affect the outcome. One respondent described the expected

professional roles and struggles that occur when people are influence by their personal

values and beliefs.

> *"I think most people … have a grasp of their own discipline, who understand and*
>
> *grasp the ramifications, but there are some people who bring in their personal*
>
> *stuff and you can't do that. You don't have any right to do that."*

Another area that the respondents felt to be problematic with the interdisciplinary

approach to creating advance directives relates to the size of the group. One of the

respondents stated *"I think sometimes people can get overwhelmed by the group. I think*

sometimes people want to just talk to the social worker, or just the nurse."

Promoting Agency Change. Many of the respondents struggled with answering

the question about how the interdisciplinary team was created in the nursing home. They

also struggled with answering how the interdisciplinary process could be changed within

the agency. Most of the respondents felt that this was an issue that came from federal law

and agency administration.

For the respondents who have been working in long term care for less than ten

years, understanding how the interdisciplinary team was created was more difficult.

These respondents speculated that the interdisciplinary team was created to coincide with

the quarterly assessments (MDS) that are federally mandated. The respondents reported

that reviewing the Providers Orders for Life Sustaining Treatment (POLST) and talking

about advance directives during this time was ideal because the team is together and the

patient and the family is typically present as well. One of the respondents stated:

"There was the IDT when the POLST came out … it was just how they decided to review

it … (the care conference) is the time that the family's coming so they probably decided

to do it when the MDS came into place and it was the rolling care conference thing."

Some of the respondents felt that having an internal policy specifying the timing

of advance care planning would be beneficial. *"Creating some sort of policy that when*

they first come in, trying to catch them right away instead of when these issues come up."

The respondents felt that their work would be clearer by having a policy specific to

advance care planning.

Many of the respondents referred to the POLST when asked about this area. The

respondents felt that the introduction of the POLST changed how interdisciplinary teams

approached advance care planning. They also felt that the decisions about how advance

care planning would occur came at the discretion of administration. *"It really came from*

administration, director of nursing, director of social services all being involved in how

are we going to get these POLSTs done for patients and what kind of medical team

involvement do we want?" This respondent felt that the staff was told what to do, but did

not have a say in how the plan was implemented to talk about the POLST and having

advance care planning discussions.

One of the respondents noted that the administration brought the discussion about

how to implement the POLST to the quality improvement committee. This committee

then put together a plan to implement the POLST in a way that also matched the agency's

goals.

"One of the (nursing home) quality improvement goals was to have everybody

have an active POLST … the thought was again that it improved our care and our

conversation and we wanted to avoid hospitalization, we're very open about that.

If we can, we want to care for our own, especially with end of life. It means that

we're having the conversation."

This respondent felt that pairing the POLST implementation with the facility's goals

made it easier to understand and implement. The respondent also felt that this lead to

more open communication around advance care planning.

One of the respondents felt that the administration was key in creating a team and

a culture where advance care planning was valued. This respondent stated:

"We have a really good team, so that's a big part of (having an interdisciplinary

team that can work effectively on creating advance directives) and I don't know

how you create a good team. Our administrator is first rate, so she attracts good

people, (and she) is the one who promotes this, and sees it as part of our work."

Tube Feedings

An unexpected finding of this study revolved around tube feedings. The

respondents overwhelmingly highlighted advance directive challenges around tube

feeding discussions. One of the respondents described tube feedings as a grey area that

made it difficult to create an advance directive.

"I don't have (an advance directive), it's a grey area. When you're not sick it's

hard to decide ... I know that I don't want a tube feeding, but sometimes a tube

feeding is temporary and it gets you over the hump. So you necessarily don't

want to say never. So when you're doing it with people you really have to be

specific about what they want, and it's hard to explain all of the if's and but's of

things."

Another respondent described feeding tubes relating directly to the emotion of love. The respondent also felt that when discussions about feeding tubes do not occur ahead of time people are forced to make a decision in a panic.

> *"Feeding tube is often the place where we struggle and we've seen more and more people coming to us on feeding tubes.   Either because the conversation didn't happen or people panicked, or as is common in the Midwest, we equate feeding people to love. So I would say a number of times its people are kept going by a feeding tube and their quality of life is very little. Those are places where I struggle."*

Feeding tubes, discussions around when to implement them, and discussions around when to discontinue them were discussed by all of the respondents. The respondents also noted that discussions around feeding tubes were complex and, for many, tied to emotional responses.

The two primary themes, Advance Directives and Working in the Interdisciplinary Team emerged from the interviews with the respondents. These themes will be discussed in greater depth in the following discussion section. The third theme, Tube Feedings, was unexpected, yet discussed by all of the participants. This is an important area to study further and will be discussed in the implications section.

Discussion

The discussion section will review the two primary themes discussed above, advance directives and work in the interdisciplinary team. In the first theme, the respondent's responses will be compared to the research and confirms what was discussed in the literature review. In the second theme, the respondent's responses will

be discussed in comparison to the literature and the conceptual framework. The research

question focuses on how the integrative team works together to create advance directives

that represent the patient's wishes. The respondents were able to comment on each of the

primary themes of the research question (advance directives and interdisciplinary team).

The idea of combining these two areas in practice was not noted within the emerging

themes of this research.

Advance Directives

The respondent's responses confirmed what was discussed in the literature

review. The themes that emerged in this section include: timing interventions, role of

family members, understanding values and beliefs, and death anxiety. The stages of

change finding appeared to be different than what was discussed in the literature review.

Timing Interventions. The respondents were in agreement with previous

research, that advance directives should be discussed at a younger age and at an earlier

stage of the patient's disease (Ramsaroop, Reid and Adelman, 2007). The respondents

felt that encouraging more advance care planning discussions when patients enter the

Transitional Care Unit would be a way to encourage patients to think about their advance

directive. Previous research notes that patients and their families are usually emotionally

exhausted during the time that the patient enters the nursing home, which makes it a

questionable time to talk about advance directives (Lacey, 2006). This may, however, be

a time to provide psycho-education and materials about advance directives. Having a

program that follows the patient in the community after the discharge from the TCU may

also be a place to have further discussions about advance care planning.

The respondents reported that advance directives are usually discussed during the quarterly care conference. During this time the past three months are reviewed, along with recent assessments, and any concerns the patient has. Most nursing home care conferences last fifteen to thirty minutes. This leaves little time to have adequate conversations regarding the patient's advance directive. One of the respondents noted that in order to do advance care planning well there needs to be three or four one hour sessions. The research supports that having enough time for advance care planning discussions is a problem among health care providers (Mahon, 2011).

Having conversations earlier in life would be ideal, however, disseminating the information to people in the community appears to be a struggle has not yet resulted in the creation of advance directives that follow patients when they go to a nursing home. Nursing homes will continue to be faced with patients who do not have advance directives, but would benefit from them. Having enough time for advance care planning discussions appears to be a major concern as well.

Role of Family Members. The respondents felt that patients often knew who they would want to make a decision for them. They were more likely to talk about who they wanted to make a decision than about what type of medical treatments they did or did not want. All of the respondents reported that it was very difficult when there was not an advance directive in place and the family could not agree on a treatment. The respondents also struggled when family members, who previously were not involved in care planning discussions, came to the facility when the patient was at the end of life stages and the family member wanted to implement care that did not match the patient's wishes.

Previous research notes that family coercion, as discussed by the respondents, is a major concern, but can be prevented when the family members are included in the advance care planning process (Thompson, Barbour, and Schwartz, 2003). The respondents felt that the family was more likely to select more aggressive treatments out of guilt. Previous research states that by including family members in the advance care planning process they will likely feel reassured that the advance directive represents this patient's wishes for end-of-life care (Thompson, Barbour, and Schwartz, 2003).

Understanding Values and Beliefs. The respondents noted that their personal values and beliefs, unaddressed, could contribute to coercing the patient to choose advance directives that did not represent the patient's wishes. Previous research notes that health care professionals are in a position of authority (Kane, Hammell II, Hawkins, 2008). This authority could lead to coercion if health care professionals are not aware of their own values and beliefs.

The respondents noted that one way of respecting the decisions of patients and family members is by assessing their understanding of the choices they are making. Understanding the patient's values (Black and Emmett, 2007) along with the values of the family (John, 2007) can open up the communication that occurs between the health care provider, patient, and family. Assessment, with the goal of understanding the patient's values, may help build the relationship between the health care provider, patient and family, while also helping the health care provider have a greater understanding and respect for the patient's advance directive wishes. Valuing work with older adults, having attention to psychosocial approaches, and promoting quality of life are values that can positively contribute to the advance care planning process.

Death Anxiety. Anxiety around death was a prominent theme that the respondents noted. One respondent described that conversations about advance directives can be difficult because death is scary. Poor communication is likely to occur when death anxiety is present (Black, 2005; Peck, 2009).

One of the respondents notes that it is important to have courage in advance care planning discussions. By pushing past this death anxiety, the conversations are able to reach a greater depth and allow the patient to describe the deeper meanings around their feelings of death. Another respondent felt that beginning conversations around what the patient wants, while also talking about their life, will make the patient more comfortable entering into a conversation about death. The respondents also felt that it is important for health care professionals to be realistic, and understand that death is inevitable. They noted that entering conversations about death was important in creating the advance directive. Ultimately, creating the advance directive was seen as a gift to the patient's loved ones. The advance directive allows the family to understand what the patient wants, which, as discussed earlier, alleviates decision making grief (Thompson, Barbour, and Schwartz, 2003).

Stages of Change. The respondents reported that advance care planning discussions did not occur if the patient refused (or was resistive) to the discussion. They also noted that conversations were more likely to occur when the patient was prepared and comfortable talking about their advance directive. The respondents did not offer knowledge of the stages of change process when working with clients presenting resistance. Previous research notes that social workers are ideal to include on

interdisciplinary teams because of their unique training in the stages of change process (Black, 2005).

The interviews highlighted that resistance does occur when talking about advance directives. Having social workers who have been trained on the stages of change theory means that they would be able to assess if the patient is not prepared to contemplate change, is contemplating change, or is prepared to make a change by creating an advance directive. Also, understanding motivational interviewing would allow social workers to address patient's resistance while helping them move from the pre-contemplative stages to the action stage.

Working in the Interdisciplinary Team

This theme returns to the overall research question: "What are the best practice strategies when creating advance directives using a team approach?" This theme will include discussion on: medical, person-centered, and holistic approaches, professional roles in the interdisciplinary team, interdisciplinary team promoting and impeding advance directives, and promoting agency change. The discussion will refer back to the research discussed in the literature review, as well as in the conceptual framework.

Medical, Person-Centered, and Holistic Approaches. The respondents were not in agreement around which model of care (medical, person-centered, or holistic) was most appropriate when helping patients to complete advance directives. For one of the respondents, the medical model was considered to be the primary choice when discussing advance directives. The medical model is able to create medically based directives, however, it may not address goals, values, and emotions around their goals, as would be done in advance care planning (Black and Emmett, 2006; Mahon, 2011; Tulsky, 2005).

Germain (1984) notes that effective integrated teams are focused on the biopsychosocial-

cultural needs of the patient (see Table 3). When only the nursing, or medical model,

address the patient's advance directive it does not include all aspects of the patient's

biopsychosocial-cultural needs.

One of the respondents noted that a person-centered approach should be used

when working with patients to create advance directives. In this approach, the patient

directs what they want in their advance directive. Patients may not feel confident in

selecting their advance care preferences, or they often believe that their doctor knows

what is best (Thompson, Barbour, and Schwartz, 2003). The integrative team, versus the

patient alone, selecting an advance directive plan can offer multiple perspectives while

focusing on the biopsychosocial-cultural needs of the patient (Germain, 1984). The

integrative team offers a more holistic approach, which was described by some of the

respondents as including multiple disciplines and honoring the patient's choice. Patients

and families may prefer a holistic approach, which includes a focus on health, social,

functional, and psychological issues (Young et. al., 2011). The respondents felt that

offering the holistic approach to advance directives during the care conference also

offered a broader conversation that included discussion around where the patient found

meaning in life and in death.

Professional Roles in the Interdisciplinary Team. The respondents were split

on the professional roles in the interdisciplinary team. Some of the respondents did not

clearly understand their own role or potential contribution to the team. Some of the

respondents viewed the team as a hierarchical structure, while the remaining respondents

viewed the team with clear roles working together on a common goal. The respondents

described teams at multiple points within the team creation as described by Germain (1984) and displayed in Table 2.

Respondents who were focused on the medical model in interdisciplinary work, undervalued the social work profession. These respondents felt that nursing was the only necessary role when it came to discussing advance directives. These respondents discounted their own professional roles within the interdisciplinary team and in the advance directive discussion. Germain (1984) notes that professional identity is important and social workers should be prepared to understand and promote their role as a social worker within the interdisciplinary team. Having a professional identity includes understanding the role that social workers have, practicing the standards of the social work profession, being confident, and being proud to be a social worker (Germain, 1984, p. 224). Even within a medical model, social workers should have professional identity to be part of the interdisciplinary team.

Hierarchy in the interdisciplinary team was seen as doctors needing to be the one to initiate advance directive discussions. Doctors may not always have the time to initiate the advance directive discussion (Ramsaroop, Reid, and Adelman, 2007). Advance directive discussions may not occur if interdisciplinary teams wait for the doctor, or who they perceive to be the head of hierarchical team, to begin the discussion. Germain (1984) notes that effective interdisciplinary teams should not have hierarchy. When interdisciplinary teams work through the group phases, hierarchy dissipates. The third group phase (see Table 2) is realistic appraisal. In this phase the group members work together on a common goal while superiority in the group decreases (Germain, 1984).

Some of the respondents had a clear identification of their own role as well as an understanding of the roles of the other members of the interdisciplinary team. The respondents recognized what Germain (1984) describes as the final phase (see Table 2) of group creation. When groups becomes an integrated team, they work together on a shared goal and learn from each other, all while maintaining their own professional identity (Germain, 1984).

Interdisciplinary Team Promotes and Impedes Advance Directives. The respondents reported on a variety of factors that may promote or impede the process of helping clients create advance directives. Upon closer inspection, utilizing the variety of group roles described by Germain (1984), the interdisciplinary team can be used to help create advance directives when the client's needs are assessed and understood.

The respondents noted that one of the best features of the interdisciplinary team was that it offered a variety of perspectives and personalities. Germain (1984) describes conferring (Table 3) as an effective approach to team work. Conferring includes offering different perspectives on a common goal while being comfortable with agreement and disagreement amongst the team (Germain, 1984).

Some of the respondents felt that interdisciplinary team work could become problematic if there was a group member who influences the group. This is an area where social work skills can be used to ensure that the group is not being coerced and remains focused on the patient's goals. Germain (1984) describes the social workers professional identity (see Table 4) as having a non-judgmental role, representing social work values, and taking responsibility for group decisions. Social workers focus on client self-determination as part of the social work core values. Social work core values

includes ensuring that the rest of the team understands the patient's values towards care

(Kane, Hamline II, and Hawkins, 2005). If there is one person influencing the group, the

social worker would be able to promote the patient's values to keep the team oriented

towards the patient and not the values of one of the group members.

One of the respondents highlighted the notion that the interdisciplinary team can

be quite large and may be perceived as overwhelming to patients. Assessing the patient's

preference for large or small group conferences may be beneficial prior to beginning the

advance directive process. Germain (1984) describes two types of collaboration that can

occur in integrative team work (see Table 1). For patients who may be overwhelmed by

the large group process, informal collaboration may be used, which includes having

casual conversations or written communication between the integrative team members

(Germain, 1984).

Promoting Agency Change. The respondents had varied responses about where

the interdisciplinary team came from and how agencies decided to discuss advance

directives. All of the respondents were unsure of how to promote agency change.

Although many of the respondents felt that an integrative approach to creating advance

directives was ideal, they did not know how to go about creating this type of change

within their agency.

Some of the respondents were not sure about where the decisions and direction

came from to have advance directive discussions. Previous research also supports that

healthcare workers are often unaware of the laws around advance directives, which may

contribute to a fear of creating advance directives (Connell and Mallory, 2007).

According to Germain (1984), these respondents may be working within a group in the

overestimation and disappointment phase of group development (see Table 2). During

this phase, group members often look to one another for answers and tend to oversimplify

the process to achieve a common goal (Germain, 1984).

These same respondents preferred to have policies, or clear direction, from

administration about how and when advance directives should be discussed. The

respondents continued to view the team process as hierarchical, in which the management

team, or administration, had all of the power and say in how advance directive

discussions occurred. These respondents are likely within the first phase of group

development, role separation (see Table 2), in which hierarchy exists and each

professional is separate from the other professionals (Germain, 1984).

The second group of respondents put emphasis on agency values. One of the

respondents talked about the values that were adopted by the interdisciplinary team based

on the areas that the quality improvement committee wanted to work to improve. The

respondent also felt that it was important to have a team leader (administrator) who

valued the team approach in talking about advance directives.

The primary difference between these respondents revolves around their view of

how direction is received. The first group described task-oriented direction, whereas the

second group described value-driven direction. The administrator is part of the quality

improvement team, and can model positive group dynamics by how they run the quality

improvement team meetings. This is also a place to share the vision of the agency.

Administrators can practice the keys to effective collaborative practice as described by

Germain (1984) which include conferring, cooperating, consulting, and teaming (see

Table 3).

The first group of respondents represented those who had been working in nursing homes from one to five years. The second group of respondents represented those who had worked in nursing homes over twenty years. The second group of respondents were working in the nursing home when the federal 1991 Patient-Self Determination Act became law (United States General Accounting Office, 1995). This group noted that they received education specific to this major policy change. The difference between these two groups suggests that major policy changes have an impact at the time the legislation is passed, however, the training on these areas may not continue for those who later enter the workforce.

Strengths and Limitations

There are a number of strengths and limitations in this study. One of the limitations is the sample size. This study aimed to include ten respondents, with the goal of including two doctors or nurse practitioners, two nurses, two chaplains, and four social workers. Administrators were eager to have the social workers participate in this study however, the interviews with the nurse and chaplain were obtained through snowball sampling. Doctors and nurse practitioners did not respond to the snowball sampling technique. The doctors and nurse practitioners were not included, therefore this study does not include a full multiple discipline view.

Timing of the interviews is another limitation of this study. Most of the interviews occurred at nursing homes. Many of the respondents had interruptions during the interviews. Some of the respondents appeared to be overwhelmed with the length of the interview and rushed through many of the questions. This study could be improved

by offering an incentive for participation and interviewing the respondents away from their workplace.

Another limitation of this study is the questions around agency change. Many of the respondents struggled with this question and some changed the topic when asked about agency change. It is not clear if this topic is difficult for the respondents or if the question was worded poorly.

The primary strength of this research is that it combined the views of healthcare workers, instead of focusing on a single discipline. Given the small sample size, this is a starting point for future research combining the views of multiple disciplines. The focus of this study was more on how healthcare professionals can work together toward a common goal.

A strength and limitation of this study is that it does not directly answer the research question. The respondents were eager to talk about advance directives, as well as describe their work in interdisciplinary teams. Combining these two areas to answer the question: "What are the best practice strategies for creating advance directives when using an integrative approach?" emerged as an abstract idea, but was not answered directly by the respondents. This does, however, highlight the need for further research and training in this area, with the goal of creating advance directives that accurately reflect patient wishes.

Bias. The research has some bias within this study, as a social worker preference was given towards social worker's views and was analyzed from a social work lens. The researcher has a background working as a nursing home social worker. Research field notes and memos were kept to document the researcher's bias throughout the study.

Implications

The respondents struggled with identifying stages of change both with patients and the agency. Black (2005) states that social workers are trained in the stages of change model and know how to work with clients to move from the pre-contemplative stage to the action stage. The respondents noted that there were patients who did not want to discuss advance directives or deferred decisions to their family. This highlights an area for future educational opportunities among healthcare professionals in the nursing home. Motivational interviewing, which is used to work with patients who are not prepared to make a change, work through the stages to be prepared to make a change, without coercion.

Social workers are also called to promote client self-determination. The respondents grasped this concept well, until it came to making changes to the agency policies. If the policies were not in the best interest of the patient, the respondents were not sure how to make changes to the policy. Education on promoting agency change would be beneficial for nursing home social workers.

Future Research. This study had a fairly small sample size; future studies should have a larger sample size. Additional research may be needed to determine how to effectively recruit healthcare professionals from all disciplines. This study also deferred to nursing home administrators as the ones who decide how the interdisciplinary team works together. Future research may be warranted on nursing home administrators and their perceptions on the value of having an integrative approach to discussing advance directives.

The respondents also appeared to be at different stages in the team development. All of the respondents worked in different nursing homes. Future research that compares entire teams to one another to determine if team views match one another as they become more integrated may help to test Germain's (1984) of integrated team stages.

An unexpected finding revolved around the discussion of feeding tubes. Every respondent talked about the difficulty of feeding tubes. It appears to be a very emotionally charged topic, yet very little came about in the literature review. This theme also highlighted why the integrative team approach is essential. Tube feedings have biopsychosocial-spiritual-cultural factors associated with them, according to the findings expressed by the respondents. Future research dedicated to healthcare professional's perceptions on feeding tubes may be warranted.

Conclusion

This study was focused on determining the best practice strategies in creating advance directives when using an integrated team approach. The respondents overwhelmingly agreed that talking with older adults early in their admission process and having frequent discussions was essential in creating a directive that matched that patient's values. Including the patient's family in these discussions was also believed to be beneficial in preventing coercion and last minute decisions in the event of a medical emergency. The respondents noted that conversations around death and dying can be very uncomfortable, however, it is important for the healthcare professional to have confidence and be comfortable with these type of conversations.

The respondents that valued an integrative approach also valued a holistic approach to healthcare. These respondents found that using psychosocial assessments

were beneficial in determining the patient's values. The psychosocial assessments may also be beneficial in determining what type of integrative team involvement the patient would prefer, formal or informal.

The respondents were not able to connect the ideas of completing advance directives with working as an interdisciplinary team together. The respondents had clear beliefs on how advance directives should be created. They also had ideas on how teams from multiple disciplines work together. When it came to defining how these two concepts work, or might work, together the respondents continued to talk about either just advance directives or just interdisciplinary teams. This idea may not be widely thought about in the nursing home industry and too abstract at this time to specifically define the skills needed in an integrative team to effectively create advance directives.

There was not a clear definition of the difference between creating an advance directive to meet the completion rate of the facility and creating a thorough advance directive that represents the patient's wishes. This was not a direct research question, however, it was part of the overall research goal. Further research is needed that differentiates completion rates versus quality of the advance directive.

Overall, this study suggests that if healthcare professionals are able to create an integrated team, it is beneficial in creating an advance directive that accurately reflects that patient's wishes and values around death and dying. The aim of this study was to determine how integrated teams are created in the nursing home. The respondents deferred to administration on how the integrated team is created. Further research is needed to further address the strategies for how this type of team is created. Once this

established further research can continue on the skills that integrated team can use to

effectively help patients create advance directives that accurately document their wishes.

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Appendices

Appendix A

CONSENT FORM
UNIVERSITY OF ST. THOMAS

An Integrative Healthcare Approach to Empowering Clients in Creating Advance Directives

[681613-1]

I am conducting a study about using a team approach when assisting nursing home residents with completing an advance directive. I invite you to participate in this research. You were selected as a possible participant because you work for a nursing home that is publicly identifiable from the web-site: www.careoptionsnetwork.org. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Rebekah Elling, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas.

Background Information:
The purpose of this study is to determine how medical professionals, social workers, and chaplains in nursing homes can work together to empower older adults when creating an advance directive. This proposed research asks the question: "What are the best practice strategies when creating advance directives using a team approach?" The primary goal of this proposed research is to determine how the team approach to advance directives helps, or hinders, the older adult in making their values known. Additionally, the proposed research aims to define how successful strategies may be implemented into the nursing home setting.

Procedures:
If you agree to be in this study, I will ask you to do the following things: participate in a one-on-one confidential interview consisting of 13 questions relating to your experiences in assisting patients in creating advance directives in a nursing home setting. The interview is expected to take up to 60 minutes to complete. The data collected in the survey will be recorded and stored on the researcher's personal tablet. The recording will be transcribed by the researcher and stored on the researcher's personal password protected laptop. The analysis of this data will be presented to three research committee members, as well as formally presented in May 2015 as part of the graduate school of social work requirements. No identifying information from your interview will be given to the committee members or be presented.

Risks and Benefits of Being in the Study:
The study has no identified risks and no direct benefits.

Confidentiality:
The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way.   The types of records I will create include**:** voice recordings, transcription of the voice recordings, notes from the interview, and your consent form. The voice recordings will be stored on the researcher's personal, password-protected tablet. The researcher will transcribe the recording and store the transcription on the researchers personal, password-protected laptop. Notes and the consent form will be stored in the researchers personal locked filing cabinet. All data collected will be destroyed no later than May 31st, 2015. Consent forms will be kept in researcher's locked filing cabinet for three years following the completion of this study.

Voluntary Nature of the Study:
Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas, St. Catherine University, or the School of Social Work. If you decide to participate, you are free to withdraw at any time up to and until April 1st, 2015. Should you decide to withdraw, data collected about you will be removed from the study. You are also free to skip any questions I may ask. You may withdraw from the study by calling or e-mailing the researcher.

Contacts and Questions
My name is Rebekah Elling. You may ask any questions you have now. If you have questions later, you may contact me by e-mail: elli2327@stthomas.edu. You may also contact my advisor, Dr. Felicia Sy, (651) 962-5813. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6038 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:
I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I consent to being audio-recorded for this study. I am at least 18 years of age.

_____   _____

Signature of Study Participant   **Date**

_____

Print Name of Study Participant

_____   _____

Signature of Researcher   **Date**

Appendix B

Research Questions

1. What is your role in the nursing home?

2. How long have you worked in nursing homes?

3. Have you worked with clients on completing advance directives?

4. How many years of experience do you have working with clients on advance directives?

5. Tell me about positive experiences you have working with clients on creating advance directives.

6. Tell me about the challenges you experience when working with clients on creating advance directives.

7. Are you part of an inter-disciplinary team at the nursing home?

8. Does your facility use an inter-disciplinary team approach to creating advance directives?

9. If yes, how was this team created?   If no, how might this team be created?

10. How might the inter-disciplinary team be useful in helping clients create advance directives?

11. How might the inter-disciplinary team be a barrier to helping clients create advance directives?

12. What professionals should be included on the inter-disciplinary team when discussing clients advance directives?

13. How might the interdisciplinary team be implemented to work together on helping clients create an advance directive?

Appendix C

MINNESOTA STATUTE § 145C
HEALTH CARE DIRECTIVE
OF

_____

(Your Name)

I, _____, understand this document allows me to do ONE OR BOTH of the following:

Part I: Name another person (called the health care agent) to make health care decisions for me if I am unable to decide or speak for myself. My health care agent must make health care decisions for me based on the instructions I provide in this document (Part II), if any, the wishes I have made known to him or her, or must act in my best interest if I have not made my health care wishes known.

AND/OR

Part II: Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care, and my family, in the event I cannot make decisions for myself.

Part I: Appointment of Health Agent

This is who I want to make health care decisions for me if I am unable to decide or speak for myself (I know I can change my agent or alternate agent at any time and I know I do not have to appoint an agent or an alternate agent). NOTE: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank and go to Part II.

When I am unable to decide or speak for myself, **I trust and appoint** _____
_____to make health care decisions for me. This person is called my health care agent.

Relationship of my health care agent to me:_____
Telephone number of my health care agent:_____
Address of my health care agent:_____

_____

(Optional) Appointment of Alternate Health Care Agent: If my health care agent is not reasonably available, I trust and appoint _____ to be my health care agent instead.

Relationship of alternate health care agent to me:_____
Telephone number of my alternate health care agent:_____
Address of my alternate health care agent:_____

_____

**THIS IS WHAT I WANT MY HEALTH CARE AGENT
TO BE ABLE TO DO IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF**
(I know I can change these choices)

My health care agent is automatically given the powers listed below in (A) through (D). My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.

Whenever I am unable to decide or speak for myself, my health care agent has the power to:

(A)   Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.

(B)   Choose my health care providers.

(C)   Choose where I live and receive care and support when those choices relate to my health care needs.

(D)   Review my medical records and have the same rights that I would have to give my medical records to other people.

If I DO NOT want my health care agent to have a power listed above in (A) through (D) OR if I want to LIMIT any power in (A) through (D), I MUST say that here: _____

_____

_____

My health care agent is NOT automatically given the powers listed below in (1) and (2). If I WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in front of the power; then my agent WILL HAVE that power.

____   (1)   To decide whether to donate any parts of my body, including organs, tissues, and eyes, when I die.

____   (2)   To decide what will happen with my body when I die (burial, cremation).

If I want to say anything more about my health care agent's powers or limits on the powers, I can say it here:_____

_____

_____

Part II: Health Care Instructions

NOTE: Complete this Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part I, you MUST complete some or all of this Part II if you wish to make a valid health care directive.

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs). THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE (I know I can change these choices or leave any of them blank)

I want you to know these things about me to help you make decisions about my health care:

1. My goals for my health care:_____

    _____

    _____

2. My fears about my health care: _____

    _____

    _____

3. My spiritual or religious beliefs and traditions:_____

    _____

    _____

4. My beliefs about when life would be no longer worth living:_____

    _____

    _____

5. My thoughts about how my medical condition might affect my family:_____

    _____

    _____

6. (For a woman of childbearing age) My thoughts about how my health care should be handled in the event I am pregnant: _____

    _____

    _____

THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE
(I know I can change these choices or leave any of them blank)

Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibiotics, and blood transfusions. Most medical treatments can be tried for a while and then stopped if they do not help.

I have these views about my health care in these situations:
(NOTE: You can discuss general feelings, specific treatments, or leave any of them blank)

1. If I had a reasonable chance of recovery, and were temporarily unable to decide or speak for myself, I would want:_____

_____

2. If I were dying and unable to decide or speak for myself, I would want:_____

_____

3. If I were permanently unconscious and unable to decide or speak for myself, I would want:

_____

4. If I were completely dependent on others for my care and unable to decide or speak for myself, I would want:_____

_____

5. In all circumstances, my doctors will try to keep me comfortable and reduce my pain. This is how I feel about pain relief if it would affect my alertness or if it could shorten my life: ___

_____

There are other things that I want or do not want for my health care, if possible:

1. Who I would like to be my doctor:_____

2. Where I would like to live to receive health care:_____

3. Where I would like to die and other wishes I have about dying:_____

_____

4. My wishes about donating parts of my body when I die:_____

_____

5. My wishes about what happens to my body when I die (cremation, burial):_____

_____

6. Any other things:_____

_____

Part III: Making The Document Legal

This document must be signed by me. It also must be verified either by a notary public (Option 1) OR witnessed by two witnesses (Option 2). It must be dated when it is verified or witnessed.

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

_____
My signature

If I cannot sign my name, I can ask someone to sign this document for me.

Date signed:_____   Date of birth:_____

Address:_____

_____

_____

_____   _____
Signature of person who I asked to   Printed name of person who I asked to
sign this document for me   sign this document for me

Option 1: Notary Public

In my presence on _____(date), _____(name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.

Subscribed and sworn to before me this

_____ day of _____, _____.

_____
Notary Public

Option 2: Two Witnesses

Two witness must sign. Only one of the two witnesses can be a health care provider or an employee of a health care provider giving direct care to me on the day I sign this document.
Witness One:

(i)   In my presence on _____(date), _____(name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(ii)   I am at least 18 years of age.

(iii)   I am not named as a health care agent or an alternate health care agent in this document.

(iv)   If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (i), I must initial this box: [   ]

I certify that the information in (i) through (iv) is true and correct.

_____
(Signature of Witness One)

Address:_____
_____
_____

Witness Two:

(i)   In my presence on _____(date), _____(name) acknowledged his/her signature on this document of acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(ii)   I am at least 18 years of age.

(iii)   I am not named as a health care agent or an alternate health care agent in this document.

(iv)   If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (i), I must initial this box: [   ]

I certify that the information in (i) through (iv) is true and correct.

Address:_____
_____
_____

REMINDER: Keep this document with your personal papers in a safe place (not in a safe deposit box). Give signed copies to your doctors, family, close friends, health care agent, and alternate health care agent. Make sure your doctor is willing to follow your wishes. This document should be part of your medical record at your physician's office and at the hospital, home care agency, hospice, or nursing facility where you receive your care.