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Advance Care Planning Education for Older Adults

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Scholarly Project Approval Form

This is to certify that **Jamie Seaquist** has successfully presented her scholarly doctoral project entitled **"*Advanced Care Planning*"** and fulfilled the requirements for the Doctor of Nursing Practice degree.

Date of presentation: April 21, 2021.

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Abstract

Advanced care planning guides health care professionals and surrogate decision-makers choices on end of life (EOL) care when individuals are no longer able to speak for themselves. Advanced care plans can benefit patients in their last six months of life by improving their quality of life and by reducing family members anxiety, depression, and stress when dealing with EOL treatment options. Aside from these benefits, poor communication and knowledge deficits often create barriers when medical staff, families or patients try to broach the subject of EOL care. Barriers can be overcome when health care professionals facilitate advanced care planning conversations in the right setting, with staff trusted by patients, and when medical decisions are not urgent. This scholarly project educated individuals older than 55 years of age. They were provided education on advanced directives, medical terminology, and how to initiate conversations about end of life wishes with family or friends. In one education session, two people attended. Of those two individuals, one had an advanced care plan, and the other individual did not have an advanced care plan. This education session encouraged the participants to update their existing advanced care plan routinely with changes and create one if they previously had not. This education session highlights the importance of educating individuals on the options they have towards EOL and what that can do to ensure their wishes are followed when they can no longer speak for themselves.

Keywords: advanced care planning, end of life, quality of life

Advance Care Planning Education for Older Adults

Chapter One: Introduction

As medical treatment advances, individuals can prolong their life by years despite terminal diagnoses. If these individuals become unable to make decisions for themselves, the responsibility becomes the next of kin, or a designated durable medical power of attorney (POA) (Minnesota Department of Health, n.d.). Advanced care planning (ACP) can help guide the next of kin or POAs decisions. ACP involves making preemptive medical decisions before a person's health declines (Stewart, Goddard, Schiff, & Hall, 2011). These directives often are written in a document the patient and their physician sign, or their physician can create a physician ordered life-sustaining treatment order that dictates what care decisions medical professionals are to follow. Advanced directive documents can be amended anytime, but once individuals cannot make decisions for themselves, their next of kin or POA become responsible (Minnesota Department of Health, n.d.). Thus, it is imperative for families and friends to discuss and understand EOL wishes, preferences, and beliefs. EOL is often defined as the 6 months prior to death (Lamont, 2005). EOL discussions can decrease anxiety in patients and families and improve quality of life in patient's final months. Therefore, ACP can improve quality of life for the elderly population who reside in a 55 plus community setting. Guided by Watson's Theory of Human Caring this scholarly project will provide individuals and their family or friends education on ACP and facilitate crucial conversations necessary for successful advanced care plans.

Background

Most nursing homes have checklists for new nursing home residents that include completion of an advanced care directive. Even with checklists, only 65% of nursing home residents in the United States have done ACP, despite data showing that those who have done ACP are approximately three times more likely to have their EOL wishes known and respected (Benson & Aldrich, 2012; Detering, Hancock, Reade, & Silverster, 2010). This problem is essential for family nurse practitioners (FNPs) to comprehend as many opportunities exist for FNPs to care for residents in long-term care facilities. Caring for residents in long-term care facilities requires rapport and bedside manner, two things Stewart et al. (2011) found to be critically important for family and staff when researching discussions on ACP. Most FNPs have previously worked as bedside nurses where they have been able to hone the skills Stewart et al. found to be essential components in facilitating ACP. This scholarly project was implemented in a 55 plus community that consisted of independent patio homes, independent apartments, and assisted living. Assisted living was approximately 25% of the population in this community. All individuals in assisted living were required to have a physician ordered life sustaining treatment order, so the education was targeted towards individuals in independent living situations. Since ACP can improve nursing home resident's EOL care, implementing an education program for individuals prior to requiring nursing home care can improve the rates of advanced care plans already completed when entering long-term care facilities.

Problem Statement

ACP involves complex decisions, education on EOL options, and completion of advanced care directives forms. Medical practitioners are being relied on to guide individuals and families through EOL care despite the tight time constraints of outpatient appointments (Detering & Silveira, 2018). Moving portions of this process to long-term care facilities, assisted livings, and senior buildings allows more time to be focused on education and facilitation of critical conversations. Without this transition to education programs, the one-third of long-term care residents without advanced care plans (Benson & Aldrich, 2012) will continue to rely on practitioners with time constraints.

Purpose of the Scholarly Project

The purpose of this scholarly project is to educate individuals living in a 55 plus community associated with an assisted living on ACP. Once the education session is complete, participants will have the opportunity to have essential conversations with their family or friends that are needed for advanced care plans to be successfully implemented. This project will employ evidence-based research to guide verbal and written education provided to the 55 plus community members that participate.

Clinical Question

Using evidence-based research has led to the clinical question: Do 1-hour ACP education sessions with individuals living in assisted living or 55 plus communities reduce invasive medical procedures during EOL and reduce family members anxiety in making decisions for their loved ones? Further quantitative and qualitative research is needed to answer this question. Discussed further in Chapter 2, most qualitative research has focused on thoughts on ACP and has not included an experimental group with an

intervention. This scholarly project aims to answer the question: Does 1-hour ACP education sessions increase the number of individuals that participated in the education session who will update or complete an advanced directives?

Objectives

This scholarly project proposes an educational approach to ACP. The following objectives will aid in the completion of this scholarly project.

- Provide education to individuals living in assisted living or a 55 plus community regarding ACP.
- Incorporate multiple ways of knowing including bio-medical and emic knowledge to integrate health, healing, and EOL care.
- Establish ACP verbal and written education for individuals living in assisted living or a 55 plus community.

These objectives will be the guiding principles for this scholarly project.

Patient Population and Healthcare Setting for Implementation

To achieve the answer to the clinical question, 1-hour education sessions will be planned in 55 plus community associated with an assisted living within an urban Minnesota city regarding EOL decisions. Individuals and their family members will be invited to an education session located in the assisted living building within the 55 plus community. Each education session will cover medical decisions that impact EOL care as the body continues to decline, such as cardiopulmonary resuscitation, enteral feeding, parental hydration, antibiotic therapy, and hospitalization. Once these topics are discussed, individuals and their families will be invited to converse about each medical decision and what the individual's wishes and desires are for their remaining life. After

discussions are held, participants will be informed on where to obtain blank advanced care plans and encouraged to complete the forms as soon as possible. Individuals will be urged to provide their medical provider with a copy of the advanced care plan. Any individual over that age of 55 in the community where this project will be implemented will be eligible to participate.

Context of Practice Project

Facilitating education and ACP conversations will ensure that all individuals receive care congruent with their personal, cultural and spiritual wishes, and desires. Staff who provide direct patient care and practitioners who oversee care would not always be aware of these wishes and desires unless residents are directly asked. Often personal, cultural, and spiritual wishes or beliefs are not readily understood or seen. When ACP conversations lead to a written document, individuals can know that their wishes and desires are documented for care providers to acknowledge and honor. This written document can guide medical professionals who come from a different cultural or spiritual background and enhance the care provided to individuals.

Population that Benefits from Project

This scholarly project directly impacts the individuals who participated in the education sessions. The individuals who complete advanced directives will receive the most benefit as their quality of life at the EOL can be significantly improved by having their wishes and desires honored. Family members or friends of the individuals will also see positive results after ACP conversations are held because they will understand and know about their loved one's wishes and beliefs for EOL. EOL conversations often

reduces family member's anxiety about making those decisions for their loved ones if they are no longer capable of making decisions for themselves.

ACP is an indispensable tool for medical practitioners to ensure that when individuals can no longer make independent decisions, their beliefs and desires are honored until their death. This scholarly project aims to create an educational program on ACP targeting individuals 55 and older living in a Minnesota assisted living or 55 plus community. Completion of this scholarly project will meet the skills and essentials required of graduating FNPs.

Essentials of Doctoral Education for Advanced Nursing Practice

National Organization of Nurse Practitioner Faculties Core Competences

The Commission on Collegiate Nursing Education has eight essentials for the Doctor of Nursing Practice (DNP) which uplift leadership and complex practice skills required of DNPs to reach their highest potential (American Association of Colleges of Nursing, 2016). Three of these Essentials align with the need for ACP education.

- II. Organizational and Systems Leadership for Quality Improvement and Systems Thinking.
- VI. Interprofessional Collaboration for Improving Patient and Population Health Outcomes.
- VIII. Advanced Nursing Practice.

Alongside the DNP essentials, The National Organization of Nurse Practitioner Faculties (NONPF) Core Competencies have been created as an entry guide to the FNP career (The National Organization of National Professional Faculties, 2017). Two of the nine NONPF competencies are highlighted by this scholarly project.

- Leadership Competencies.
- Quality Competencies.

Striving to meet these DNP essentials and NONPF competencies will assist this scholarly project to reach its highest potential in providing ACP education.

This scholarly project aims to educate individuals living in a 55 plus community on the components and benefits of ACP. By reviewing existing research on ACP, an educational program will be developed and provide the facilitator knowledge necessary to address this sensitive subject thoughtfully. The need for ACP education is defined by the benefits and barriers to ACP and how health care practitioners can facilitate constructive conversations regarding ACP. Chapter two will explore these themes which were found while researching advanced directives and ACP.

Chapter Two: Literature Review

Understanding the implications of ACP can motivate medical providers and system administrators to incorporate ACP into annual health exams and nursing home admission criteria. Keay, Alexander, McNally, Crusse, and Eger (2003) reported that 1,000 people die in United States nursing homes every day. One-third of these individuals do not have advanced care plans (Benson & Aldrich, 2012) denoting over 600 people are dying in the United States daily with the risk of not having their wishes and EOL desires honored. These statistics show why it is essential for any individual to have discussions with family and caregivers about EOL goals. After reviewing ACP research, three distinct themes emerged: benefits of ACP, barriers to ACP, and facilitating advanced care plan conversations.

Benefits of Advanced Care Planning

Arguably one of the most important benefits of ACP is quality of life during the EOL, but this is a challenge to research as participants are no longer able to provide feedback on EOL care after death. Thus, researchers need to focus on measurable data regarding the benefits of ACP to encourage providers and medical systems to engage in ACP. The benefits of ACP include reduced invasive medical interventions, decreased anxiety in family members and increased confidence in POAs decisions (Baker, Leak, Ritchie, Lee, & Fielding, 2012; Detering, Hancock, Reade, & Silverster, 2010; Schubart et al., 2018; Chiarchiaro et al., 2015). These measurable data points are discussed in more detail in the following paragraphs.

Reducing invasive medical interventions during EOL is an objective that researchers can easily measure. Wright et al. (2008) completed a study in the United

States to determine if EOL discussions reduced aggressive medical interventions and improved quality of life in the week leading up to participants death. Wright et al. (2008) found that study participants who had EOL discussions with providers and family were 9.4% less likely to be on a ventilator before death, 5.9% less likely to have resuscitation attempted, and 21.1% more likely to be enrolled in hospice. Based on these figures, participants who received no aggressive medical treatment had a quality of life score of 6.4 on the McGill Quality of Life Index compared to a score of 4.6 in individuals who received three or more medical interventions before death (Wright et al., 2008). The study by Wright et al. (2008) is backed up by studies conducted by Bond et al. (2018) and Baker et al. (2012), as each established ACP reduces hospital admissions before death.

Baker et al. (2012) recorded patients' and caregivers' wishes for EOL and utilized ACP as an intervention to reduce hospitalizations in the frail, elderly population who had access to primary care clinics and local hospitals in Scotland. They used 161 participants split between the intervention and control groups. The intervention group had a 42.5% drop in admission rates compared to a drop of 23.7% in the control cohort (Baker et al., 2012). The reduction in admission rates reduced costs for medical care by 48.6% in the ACP intervention group (Baker et al., 2012). Bond et al. (2018) conducted a similar study in the United States with 325 participants between the control and intervention group. Bond et al. (2018) found that the intervention group had 3.66 fewer inpatient days with a cost reduction of $9,500 for all the participants in the ACP intervention group. This study revealed that ACP benefits patients and families, in addition to medical institutions and insurance carriers with shorter hospitalizations and significant savings in health care spending. Reducing medical costs during a patient's EOL can motivate health

care systems to implement ACP guidelines thus increasing the number of advanced care plans completed.

Ensuring that EOL wishes are followed can help reduce the burden of decisions POAs have to make. Detering et al. (2010) researched the impact of creating advanced care plans on EOL wishes, the perceptions family has of the quality of care, and the surviving relatives' levels of stress, anxiety, and depression. The inclusion criteria for the participants included being competent to make decisions, speaking English, having no previous advanced care plan, and family available to answer questions before and after the participant's death. The intervention group had three meetings facilitated with patients and family members in which wishes and desires regarding EOL care and treatment options were recorded on discussion cards or in advanced care directives. Detering et al. (2010) discovered that those in the intervention group who died within the next six months had their EOL wishes known and respected 86% of the time compared to 30% in the control group. Another finding was that the intervention group was 26% more involved in their EOL decision making than the control group. This study showed that utilizing ACP conversations to guide individuals and their families can improve quality of life during the EOL by respecting wishes of patients and this can ultimately decrease anxiety, depression, and stress in surviving family members. Besides Detering et al.'s study, Simpson (2011), Schubart et al. (2018), and Chiarchiaro (2015) also conducted research studies that found ACP conversations alleviate the stress POAs felt when making health care decisions for their loved ones and opened the conversation to EOL wishes and desires that POAs may not have been aware of. Subjective benefits of

ACP are difficult to research, therefore researchers may focus on studying barriers to ACP.

Barriers to Advanced Care Planning

Researching barriers to ACP is easier to study as researchers can intentionally seek out participants that can communication effectively and the objective of the research study can be completed prior to research participants dying. Barriers to ACP included ineffective communication, lack of knowledge on ACP, and cultural differences. These barriers make ACP less effective and occasionally prevent the conversation on EOL wishes altogether.

An overwhelming commonality between research articles on barriers to ACP is poor or ineffective communication. Ingravallo et al. (2018) conducted a qualitative research study in Italy that involved interviewing 30 nursing home residents and 10 of their family members with a goal of understanding opinions on ACP. One of the themes the researchers uncovered was ineffective communication. Residents felt if they expressed their wishes or desires to health care providers about EOL cares, the providers did not take the time to explain the residents' treatment options (Ingravallo et al.). The participants in this study also felt that a communication barrier existed due to their inability to discuss their needs because of cognitive impairment or unfamiliarity with advocating for themselves (Ingravallo et al.). The communication barrier was further enhanced by unrealistic life goals and lack of knowledge regarding disease trajectory by the resident participants. Residents in long-term care facilities are not the only people that struggle with communication.

Reinke et al. (2010) analyzed 885 surveys from 2002-2005 and discovered that many American nurses felt challenged by communication with the interdisciplinary team and struggled to identify their role within the healthcare system. The purpose of Reinke et al.'s qualitative study was to elicit which nursing skills were thought to be the most important yet under-utilized during the EOL period for their patients. Nurses in this study struggled with who was responsible for informing patients and families about disease prognosis and this led to nurses avoiding the topic of advanced care plans due to unknown responsibilities. Fifty-two percent of the nurses surveyed stated they did not discuss hospice or prognosis with their patients, yet more than 60% of the surveyed nurses rated communication skills, such as telling their patient how their disease affects their life, as extremely important (Reinke et al.). Ineffective communication and barriers to interdisciplinary communication can impede successful ACP. Although ineffective communication can stall ACP, healthcare professionals and patients need to have some knowledge regarding ACP to recognize that ACP needs to occur.

ACP knowledge deficit was a primary finding in Gilissen et al.'s (2017) research study. Gilissen et al. found that insufficient knowledge on advance care planning impaired completion rates of advanced care plans after reviewing 38 articles that were either qualitative, quantitative, mixed, reviews or systematic reviews. The researchers listed four reasons that insufficient knowledge should be addressed to improve ACP completion: lack of understanding about advanced care plans, why advanced care plans are necessary, what knowledge is needed to make effective decisions, and to reduce reluctance from professionals, patients and their families (Gilissen et al.). Lack of knowledge about disease progression and possible positive or negative outcomes of

treatment (Gilissen et al.) reduces the likelihood discussions on ACP will occur because these knowledge deficits allow patients to live with unrealistic expectations about the disease process and how it affects quality of life. Aside from patients and family being deficient in ACP knowledge, healthcare professionals need to remain up to date on ACP facilitation, ethics, and laws. Jeong, Higgins, and McMillian (2010) researched case studies in Australia with a focus on the essentials of ACP. They found that only 8% of nurses surveyed had a desire to become an educator for advanced care directives (Jeong, Higgins, & McMillian). This highlights the gap of knowledge nurses and healthcare practitioners have regarding ACP.

Cultural beliefs regarding EOL care need to be considered and respected when approaching individuals to discuss ACP and treatment options. Stewart et al. (2011) describe this barrier in the qualitative study focused on viewpoints family and health care professionals working in long-term care had on advanced care plans. Stewart et al. interviewed 98 participants in London and the care assistants surveyed stated they were hesitant to engage in EOL discussions due to differences in ethnic backgrounds between themselves and the residents they care for. The cultural conflicts between caregivers and patients is important to be cognizant of but asking patients specifically about their cultural beliefs is important as not all individuals of one culture believe the same things.

Cultural beliefs regarding EOL care was the focus of a qualitative study conducted by Duffy, Jackson, Schim, Ronis, and Fowler (2006). Duffy et al. (2006) held ten focus groups divided by five diverse cultures in America, splitting men and women into different focus groups. The researchers found that there were differences and similarities between all cultures, even between genders of the same culture. One example

is in the focus group with black individuals, both men and women felt that family should not be burden with caring for a dying loved one (Duffy et al.). The difference noted in the groups with black individuals was between men and women, women wanted "all" care available, but the men supported assisted suicide and not life support (Duffy et al.). Duffy et al. successfully elicited cultural differences on EOL treatment options. These differences can create barriers for health care professionals that want to discuss ACP but are afraid to address the topic due to potential differences in viewpoints on EOL care. The three barriers, impaired communication, knowledge deficit, and cultural differences, discussed above ultimately impact when, how, and who addresses advanced care plan conversations.

Facilitating Advanced Care Planning Conversations

Facilitating advanced care planning can be daunting for nurses and practitioners alike, but there are certain situations, times, and locations that may aid health care professionals in addressing advanced care plans. Stewart et al. (2011) conducted a research study on the viewpoints nursing home staff and families had regarding ACP. Researchers found that residents and staff felt most comfortable discussing ACP when relationships had been established over-time and trust already existed (Stewart et al.). This finding was backed up by Gilissen et al. (2017) whose research points out five concepts, one of which is "good relationships" (p.55). Gilissen et al. discussed that good relationships between family and care staff impact communication and success of ACP. Building rapport with residents and family members is an important step for ACP facilitators and doing so is easier in care settings where time is not a major factor in providing critical care.

The different completion rates of advances directives in long-term living facilities versus acute-care facilities led to a literature review focused on communication and ACP in palliative and EOL care. Waldrop & Meeker (2012) reviewed 86 research articles and found that discussing ACP in facilities that care for patients long-term such as, nursing homes, home care and hospice, had higher completion rates than those in acute care facilities (Waldrop & Meeker). Waldrop and Meeker's rationale was that in long-term care there was not as much urgency compared to addressing ACP in acute medical facilities and the discussions can be continued on a routine basis in long-term care. Similarly, Mayahara, Miller, and O'Mahony (2018) also discovered that revisiting or revising advanced care plans may be needed in the future, especially if EOL decisions were not agreed upon during the initial conversation. By assessing 14 previously recorded palliative care meetings, Mayahara et al. were able to complete a secondary analysis which revealed the need to revisit or revise advanced care plans. The researchers also recognized that facilitators of the care planning sessions should establish a common language between health care professionals, patients, and families. Creating a common language for EOL treatment options, such as enteral feeding, cardiopulmonary resuscitation, and mechanical ventilation, allowed ACP facilitators, patients, and families to discuss care with mutually agreed upon definitions (Mayahara, Miller, & O'Mahony). Researchers, Waldrop and Meeker (2012) and Mayahara et al. (2018), found that addressing EOL desires and wishes should be approached frequently as individuals' health changes which may change the care dictated in the advanced care plan.

Jeong, Higgins, and McMillian (2010) found that the involvement of an expert or experienced nurse in ACP can improve the success of ACP discussions. Combining this

finding with Stewart's et al. (2011) research conclusion that pre-existing rapport between healthcare professionals and patients is vital for ACP success, could indicate that educating nurses and healthcare practitioners on ACP would increase the amount of qualified ACP facilitators. These newly trained facilitators could then create advanced care plans with patients they have already established relationships. It is this relationship building that Jean Watson's Theory of Human Caring puts an emphasize on.

ACP is a complex process that requires FNPs to understand not only the benefits and barriers to ACP but how to address EOL treatment options delicately and respectfully with all patients regardless of their health status. Medical practitioners that discuss ACP will ultimately need to address the barriers of ineffective communication, lack of ACP knowledge, and cultural barriers, to co-create an advanced directive with their patient. Jean Watson's (2008) Theory of Human Caring outlines specific relationship practices that will guide this scholarly project during its implementation. Watson's Theory of Human Caring will be discussed in Chapter Three.

Chapter Three: Application of Theory

ACP encompasses complex, multifactorial EOL decisions that require a nurse's finesse and human touch, often called the art of nursing. The art of nursing is more than the care nurses do for patients but involves putting nurses' whole selves into the caring process. Jean Watson's (2008) Theory of Human Caring provides a framework for nurses to engage in the art of nursing, which can then enhance the ACP facilitation. Watson's theory can help healthcare professionals overcome the barriers to ACP and become strong leaders in the facilitation of ACP conversations. Watson's Theory of Human Caring has three concepts that align with this scholarly project, *Caritas*, transpersonal caring relationship, and the caring moment.

Jean Watson's Theoretical Framework

Jean Watson (2008) created her Theory of Human Caring in 1979 and has made several revisions over the years. Watson's theory posited that authentic, intentional nursing care could provide a healing relationship and environment for both the patient and nurse. Watson created ten factors that aided in this process and called them the Carative Factors (see Appendix A). The word Carative was created in opposition to the medical-scientific models of curative practices and is based on the word care (Watson, 2008). As Watson transformed her theory into what it is today, she converted the ten Carative Factors into ten *Caritas Processes* (see Appendix A). The Caritas Processes are based off the original Carative Factors but expound further on the complex nature of people, their needs and the resulting relationships (Watson, 2008). To further define the Theory of Human Caring, Jean Watson described three concepts, Caritas, transpersonal

caring relationship, and the caring moment, that result from successfully practicing the Caritas Processes.

To highlight the latter two concepts, one must first understand term *Caritas*. Caritas is caring consciously for another individual. Jean Watson's (2008) theory highlights the ability of the human consciousness to care for others. The *Caritas Nurse* uses their consciousness to build relationships from an open heart to uplift the human experience, instead of entering nurse-patient relationships with the ego-center (Watson, 2008). Becoming a Caritas Nurse then allows for transpersonal caring relationships and caring moments to exist.

Building a relationship with patients is an essential part to successful nursing. A *transpersonal caring relationship* is where one relates to another individuals' spirit by caring and being authentically present in the relationship (Watson, 2008). This is crucial in nursing as technology becomes ever more present in the healthcare setting and nurses are tasked with intense charting. Being intentionally and authentically present with patients, co-workers, or families allows nurses to create a healing environment where quality of life and caring practices collide. The moment this collision occurs creates a *caring moment*. Watson (2008) describes a caring moment as a knowledgeable choice to act, guided by the consciousness of how to exist in a moment with another person. Nurses consciousness is further guided by the many ways of knowing (aesthetic, ethical, personal, spiritual, intuitive, and cultural) gathered until that moment. Becoming a Caritas Nurse does not happen overnight, but is the accumulation of life experience, nursing practice and the intrinsic drive of humans to connect to others. Jean Watson's

Theory of Human Caring is a strong foundation that nurses can lean on when addressing ACP conversations.

Application of Jean Watson's Theory

Watson's Theory of Human Caring relates to ACP on many levels. ACP improves quality of life and is best addressed by nurses or providers who are familiar with the patient, and conversations about ACP should be started prior to acute hospitalizations while in a setting comfortable to the patient. Watson's theory focuses on quality relationships to creating healing, and healing care can be provided without being curative for the medical condition. Watson (2008) highlights that caring moments can cure the heart and soul without necessarily addressing physical ailments. Curing the heart and soul is often the focus at the end-of-life and is why Watson's Theory of Human Caring applies to ACP conversations and relationships.

Being a Caritas Nurse allows for recognition of the whole individual (physical, mental, spiritual, cultural, and emotional) when entering the interpersonal relationship. This is especially important when discussing ACP because the parts that make up an individual will greatly impact the ACP process and the advance care plan. Creating a transpersonal caring relationship is essential as research has shown nurses and patients prefer to discuss ACP with those they already have built rapport with (Stewart et al., 2011; Gilissen et al., 2017). Furthermore, lack of interpersonal relationships is a barrier to ACP so utilizing Watson's (2008) caring concepts, medical practitioners, especially FNPs, can build transpersonal caring relationships. FNPs are well positioned to provide transpersonal caring relationships, as many FNPs have years of bedside care as nurses. This prior experience builds FNPs confidence and skill in building rapport.

Through these relationships, caring moments can occur with those developing an advanced care plan. This will strengthen trust, allowing those involved in ACP to be open and honest about their wishes and desires for their EOL. Watson's (2008) Theory of Human Caring allows nurses to be human and trust their intuition to build authentic, caring relationships. This relationship makes addressing ACP seem less intimidating and more of a natural evolution of the spectrum of care. ACP education is vital when forming advanced care plans and educating through transpersonal caring relationships can enhance the reception of this education. The implementation of this scholarly project will be discussed in chapter four.

Chapter Four: Methodology and Evaluation

The basis of providing education is to enlighten individuals on subjects that they may not be knowledgeable about. For education to be successful, the educator needs to have both experience and knowledge on the subject. For this scholarly project, I engaged in online educational modules regarding ACP definitions, laws, legal forms and facilitation. The knowledge gained from these online modules aided in the building of an ACP education session. In this chapter, the methodology and evaluation of this scholarly project will be explored through the lens of those who participated in the education session and Patton's (2011) book on developmental evaluation.

Methodology

The initial goal of this scholarly project was to implement the education sessions in a long-term care facility with residents who were at least 85 years old. While developing this scholarly project it became apparent that implementation would be best done in a facility that serves the independent elders. As I gained education on ACP from online education models, it was evident that reaching adults before they acquired chronic diseases would allow for the individuals receiving the education to get the most out of the process. ACP should be provided early in life to adults and re-examined every few years and when a new disease is diagnosed. Doing so ensures that the advanced directive is up-to-date and reflects the most current views of the individual it affects.

Clinical Setting

Changing the setting of where the education session was provided from nursing homes to independent living or assisted living opened more options for the site of implementation. Nursing homes have more oversight and potentially more requirements

for allowing educational sessions. Due to the challenges nursing homes present, I decided to implement the ACP education session in an independent or assisted living facility. After reaching out to three facilities in a suburb of Minneapolis, I met with one of the facilities to discuss the implementation of this scholarly project.

Subjects

The marketing director of the assisted living and memory care facility was open to having an education session targeting their 55 plus community that surrounds the care facility. The reason the community members were targeted is because all residents of the assisted living and memory care facility have very detailed advanced directives as a requirement of living in the facility. The residents of the facility were still invited to the education session, but the goal was to have the community members surrounding the facility that are age 55 plus attend the education session. The facility does not have a supervisory role over the community surrounding the facility, but they were willing to host the education session. The education session was hosted in the afternoon in late April. Having the event later in the spring helped to avoid slippery ice and parking constraints that the facility struggles with. I distributed flyers (see appendix D) in doorways two weeks prior to the event to spread the word in the 55 plus community.

Implementation

This scholarly project was implemented at an assisted living and memory care facility in suburban Minneapolis. Before arriving at the schedule ACP education session, I laid out a proposed schedule for the session. It involved providing participants with definitions of the different types of advanced directives, including living wills, medical POA, and POLST. After the meanings of these three types of advanced directives were

explained, the reasons one might fill out one or another would be discussed. Following the types of advanced directives, medical terminology would be explained. The handout used in this education is available in Appendix B and covers the list of medical terminology presented. After discussing medical terminology, education participants will be guided through questions they can ask themselves and their loved ones to help fill out an advanced directive or have a conversation that would inform their medical POA of the medical treatments they would like when they cannot speak for themselves. At the end of the ACP education session, participants are encouraged to ask questions, and will be provided direction on how to access Minnesota's advanced directive form. This plan changed drastically when only two people attended the education session.

Two females attended the education session. A survey (see appendix C) was provided to attendees to obtain general demographics, current knowledge, and percentage of participants that have completed advanced directives. The first participant had a complete physician-ordered life-sustaining treatment (POLST) filled out with both of her son's being aware of her wishes. The second participant did not have an ACP but her significant other is aware of her intentions. After the education session, the second half of the survey allowed for participants to mark if they had plans to change their advanced directive or have further ACP conversations. The back of the survey was left blank for individuals to write comments or suggestions. The completed surveys are available in Appendix E. The one participant who did not have an ACP took home a blank ACP for MN residents and planned on filling it out with her significant other.

This implementation of this project covered the objectives of this scholarly project and provided detailed information regarding advanced care planning. Since only

two individuals showed up to the education session, the focus of the session switched to a participant lead question and answer, and implored the participants to discuss their EOL wishes with their families. Individual counseling was not provided on ACP, and assistance was not given to fill out an advanced directive. Participants were encouraged to share their advanced directive with family and medical providers and to update the document if their wishes or health changed. After completion of this scholarly project, development evaluation was completed to enhance the understanding of healthcare education.

Since only two participants showed up to the education session a second session at a different location was planned. The targeted locations were 55+ independent living buildings as these individuals would not have a requirement to have an advanced directive to live in the building. I planned to broaden the advertisement to include the library news board, local education pamphlets mailed out bi-annually, and building tenants. This plan was terminated due to the COVID-19 pandemic limiting in-person education. Virtual education would require participants to have internet, a technological device, and knowledge of technology which would limit the number of individuals who may be able to participate. The following evaluation is based on the one education session provided to two individuals in April 2019.

Evaluation

Using developmental evaluation, a couple processes of this scholarly project would be changed if future sessions were planned. This scholarly project encountered struggles with advertising and participant availability (n=2). Getting the word out to a large proportion of individuals, the hosting facility services, was time-consuming

(individually placing flyers in doorways) and expensive (cost of flyers). Had more participants showed up, the education would have covered broad concepts of advanced care planning instead of a focused question and answer for the two participants who showed up.

As the project progressed from an idea to planning, implementing, and evaluating a few changes occurred. The first change was moving the education session from a long-term care facility to an assisted living facility. This was done because getting approval for an education session in a long-term care facility would have been difficulty and/or the facility already has an education session. If this project were to move forward with more sessions, the sessions should be moved to either an independent retirement facility or a community center. The reason being that the education session would hopefully educate individuals who might not have an ACP or understand why they should have one. The last change would be advertisement. This scholarly project needed to reach a large population of individuals to have even a small number show up, so in the future, advertisement on radios, newspapers, city flyers, and advertisements on social media would hopefully drum up more participants.

Implementing this scholarly project allowed individuals living independently to understand ACP and complete an advanced directive if desired. Having an advanced directive in place before illness strikes is essential to ensure that medical providers know and respect individual's wishes when they can no longer speak for themselves. In chapter five, the significance of this scholarly project to FNPs will be discussed and how ACP can influence future healthcare.

Chapter Five: Implications for the Future

As medicine advances, healthcare providers will be able to offer treatment that continues to extend the lives of patients but may not improve quality of life. This scholarly project aimed to bring advance care directive education sessions to individuals in the setting where they live, as many sessions already provided are located at clinics and hospitals, which may not be as accessible as their home environment. Chapter five will discuss the essentials and competencies attained by this scholarly project, the limitations to existing advanced care planning research, and the implications for the future.

Essentials of Doctoral Education for Advanced Nursing Practice

National Organization of Nurse Practitioner Faculties Core Competencies

There are many objectives that FNP students must attain prior to graduation. The Commission of Collegiate Nursing Education (AACN, 2006) has eight Essentials for Doctoral Education, and the National Organization of Nurse Practitioner Faculties (NONPF)(NONPF, 2011) has nine core competencies. Of the eight essentials for the Doctor of Nursing Practice, as maintained by the Commission of Collegiate Nursing Education, three pertain to this scholarly project. The three Essentials that continue to align with this scholarly project are listed:

- II. Organizational and Systems Leadership for Quality Improvement and Systems Thinking.
- VI. Interprofessional Collaboration for Improving Patient and Population Health Outcomes.
- VIII. Advanced Nursing Practice.

Essential II prepares DNP graduates to improve patient care by removing barriers to quality healthcare and ensuring excellence in practice (AACN, 2006). This scholarly project focused on the educating individuals on ACP and encouraging completion of advanced directives. Advanced care plans have been shown to improve quality of life at EOL which uplifts excellence in practice (Detering et al., 2010).

DNP graduates provide high-quality patient-centered care which requires interprofessional collaboration to address all aspects of health, the focus of Essential VI (AACN, 2006). ACP involves multiple conversations regarding EOL wishes and can involve many disciplines to ensure that the advanced care plan is followed, such as case managers, social workers, and hospice. This essential was met by collaborating with the care manager of the assisted living facility where the education session was provided. DNP's are expected to be able to teach and guide individuals and groups through health complications and life transitions, Essential VIII (AACN, 2006). The ACP education provided in this scholarly project ensured participants were able to understand what ACP entails and how to navigate conversations with loved ones' regarding EOL wishes.

Alongside the DNP essentials, NONPF Core Competencies have been created as an entry guide to the FNP career (NONPF, 2017). Two of the NONPF competencies are addressed by this scholarly project.

- Leadership Competencies.
- Quality Competencies.

Leadership is a critical aspect of implementing an education plan in a community or facility serving older adults. Leaders can assess a problem, such as communities with low advanced directive completion rates, and create a focused tool, ACP education

sessions, to address the problem. Leaders initiate and guide change. The education sessions provided will hopefully become routinely available in the facility they were presented in, creating a positive change for the community members.

NONPF's Quality Competencies ensure that quality research evidence is used to guide clinical practice (NONPF, 2011). This scholarly project was designed based on research that found improvements in quality of life at EOL, reduced hospitalizations near EOL, and ensured EOL wishes were followed by family and caregivers, when advanced directives were completed and followed by caregivers. After the ACP education sessions were completed, participants were able to provide feedback to myself by anonymously filling out a survey. NONPF's Quality Competencies highlight the importance of such peer review to promote high-quality, effective interventions (NONPF, 2011). The DNP Essentials and NONPF competencies uplifted by this scholarly project ensured that the participants of the ACP education sessions were provided with information that would improve their quality of life and enrich their holistic healthcare experience.

Reflections on Limitations of Existing Research

The limitations of the research regarding advanced care planning include lack of advanced care practitioner's opinions, quantitative studies demonstrating benefits of ACPs, the inclusion of diverse cultures or ethnic groups, and studies that can be applied within the United States. Most of the studies found include the viewpoints of health care professionals (nurses and patient care aides), patients, and their family members but struggle to recruit advanced care providers. Thus, the barriers found in research can only be applied to nurses, aides, patients, and their families, which requires that further studies be conducted on advanced care provider's opinions and viewpoints. When reviewing

research articles in CINAHL, qualitative studies outnumber quantitative studies leading to limits in advances for ACP because most of the studies deal with the individual's perspective and do not elicit concrete data.

Marginalized populations are often excluded from studies due to language barriers, economic factors, and access to health care. Without including outlying populations, data is unable to be applied to all residents residing in the studied region, which then excludes unique features or viewpoints of that community. Lastly, when researching this topic, many of the studies were conducted in countries outside of the United States, such as Australia, Scotland, and Italy, which prevents generalizing the findings from those studies onto residents of the United States. There were plenty of studies conducted on ACP with specific diseases in the United States, but the results of these studies cannot be generalized to all nursing home residents and are difficult to extrapolate rules of thumb for practicing FNPs.

ACP benefits are difficult to measure as subjective resident views are difficult to obtain from the dead. It has been found that perceived quality of life during EOL is improved, and acute hospitalizations are reduced with ACP (Wright et al., 2008; Baker et al., 2012), but many barriers to ACP need to be tackled to see the real benefit. Cultural differences, knowledge deficits, and impaired communication are a few of the barriers that ACP facilitators need to address when planning conversations with patients. It is easier to overcome these barriers if the ACP facilitator has a strong interpersonal relationship already built with the patient and family. Despite the challenges that exist for those discussing ACP, it is a critical part of EOL care as individuals continue to live longer with more debilitating conditions. The factors discussed point to a knowledge gap

on completing ACPs within the United States, who would benefit from a large, multi-state mixed study focused on the benefits and barriers to advanced care planning. Despite these gaps in knowledge, many of the researcher's findings can be utilized to improve nursing practices and education regarding advanced care planning for EOL care.

Implications for the Future

Nurses and FNPs are innovative leaders in health care systems, and by utilizing existing research, these individuals can advocate for themselves to receive adequate education regarding advanced care planning conversations and documentation. Evidence-based education for healthcare providers regarding ACPs will lead to better education for patients and family members about their diagnosis and treatment options. Researching advanced care planning in the elderly population has led to three conclusions. ACP leads to two connected benefits: the patient's QOL at the EOL improves and loved one's anxiety, depression, and stress is reduced (Chiarchiaro et al., 2015). Lastly, advanced care plans have been shown in one study to significantly reduce the costs of medical care in frail individuals (Bond et al., 2018). This finding, if duplicated, can encourage medical system administrators, insurance companies, and legislature to promote ACP and reimburse providers who spend longer appointment times educating and completing ACPs with their established patients.

This scholarly project has revealed many barriers to advanced care planning that impair health care providers and patient's and family's ability to discuss EOL treatment options. If health care providers, both doctors and FNPs, address the barriers listed above by facilitating advanced care planning conversations after establishing a trusting

relationship in a non-urgent setting, more people will recognize the benefits and be open to having these conversations.

Guided by the DNP Essentials, NONPF Competencies, and passion this scholarly project was able to provide individuals with the knowledge required to competently make decisions regarding ACP and EOL wishes. As shown by research, ACP is needed by all individuals at any stage in their life in order to protect their dignity and EOL desires. DNP-FNPs are uniquely situated to enhance patient-centered care by utilizing leadership, collaboration, and quality care.

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Appendix A

Original Carative Factors and Evolved *Caritas Processes*

Carative Factors 1979	*Caritas Processes* 2002-2007
1. Humanistic-altruistic values	1. Practicing loving-kindness and equanimity for self and other
2. Instilling/enabling faith and hope	2. Being authentically present; enabling/sustaining/honoring deep belief system and subjective world of self/other
3. Cultivating sensitivity to oneself and other	3. Cultivating one's own spiritual practices; deepening self-awareness, going beyond "ego-self"
4. Developing a helping-trusting, human caring relationship	4. Developing and sustain a helping-trusting, authentic caring relationship
5. Promoting and accepting expression of positive and negative feelings	5. Being present to, and supportive of, the expression of positive and negative feelings as a connection with deeper spirit of self and the one-being-cared-for
6. Systematic use of scientific (creative) problem-solving caring process	6. Creative use of self and all ways of knowing/being/doing as part of the caring process (engaging in artistry of caring-healing practices)
7. Promoting transpersonal teaching-learning	7. Engaging in genuine teaching-learning experiences within context of caring relationship—attend to whole person and subjective meaning; attempt to stay within other's frame of reference (evolve toward "coaching" role vs. conventional imparting of information)
8. Providing for a supportive, protective, and/or corrective mental, social, spiritual environment	8. Creating healing environment at all levels (physical, nonphysical, subtle environment of energy and consciousness whereby wholeness, beauty, comfort, dignity, and peace are potentiated) (Being/Becoming the environment)
9. Assisting with gratification of human needs	9. Reverentially and respectfully assisting with basic needs; holding an intentional, caring consciousness of touching and working with the embodied spirit of another, honoring unity of Being; allowing for spirit-filled connection
10. Allowing for existential-phenomenological dimensions	10. Opening and attending to spiritual mysterious, unknown existential dimensions of life-death-suffering; "allowing for a miracle

Source: Watson, J. (2008)

Appendix B

Educational Handout Side 1

ADVANCED CARE PLANNING

ENSURING CRITICAL CONVERSATIONS OCCUR BEFORE IT IS TOO LATE

WHY

ADVANCED CARE PLANS MATTER?

They ensure your medical team knows your healthcare wishes and can help to honor end-of-life desires. They can reduce stress on family members making surrogate healthcare decisions.

Medical Terminology

- ◊ Advanced Directive or Living Will

Written statement detailing a person's desires regarding their medical treatment in circumstances they can no longer make decisions for themselves

- ◊ POLST (Physician order life sustaining treatment)

Legal medical orders written & signed by medical provider detailing wishes for invasive, life saving treatment

- ◊ Medical Power of Attorney

Person appointed by an individual to represent their healthcare decisions when that individual is not longer able to make decisions for themselves

- ◊ Mechanical Ventilation

Breathing provided by a machine through a tube in a person's mouth or neck

- ◊ Cardiopulmonary Resuscitation (CPR)

Chest compressions and breathing support when the lungs and/or heart stop working; may involve a tube into the lungs to provide breathes, compressions of the heart to promote blood circulation and shocks to restart the hearts electrical system

- ◊ Feeding Tube

Artificial nutrition through a tube in a person's nose or surgically placed in the abdomen

- ◊ Dialysis

Mechanical filtration of the blood to remove excess chemical compounds usually filtered through health kidneys

- ◊ IV Hydration

Artificial water provided through a tube into a vein

- ◊ IV Antibiotics

Antibiotics through a tube into a vein to treat infection

- ◊ Hospice

Care provided to terminally ill individuals, usually in the last 6 months of life

- ◊ Palliative Care

Care provided to individuals with chronic illnesses with a focus on quality of life and symptom management

Education Handout Side 2

Advanced Care Planning Conversations

How to get started?

Gather the people that mean the most to you. It is most important to have this conversation with the person or people you will give decision making power to when you are no longer able to make decisions. Ensure you are in a comfortable setting and have adequate time to have a detailed, in-depth conversation. Questions to consider:

- Who will be your surrogate decision maker? Are they comfortable making life altering decisions?
- What are your current health problems? What are potential complications that may occur in the future due to these health problems? How would you like these complications addressed?
- If your heart or lungs stop working, do you want resuscitation to be attempted?
- If you are in the hospital and have a chance of meaningful recovery, do you want everything done to help you towards that recovery? If this includes mechanical ventilation, would you want this done?
- Do you want a feeding tube? What if it is only temporary and doctors think you will regain your ability to eat?
- When you are faced with a fatal diagnosis, would you want to attempt treatment if it meant you had more time alive, even if that time was spent in the hospital and uncomfortable? Or would you prefer to be kept comfortable, even if it meant less time alive?
- At the end of your life, how do you want your pain or anxiety to be treated? Would you want medications given to make you comfortable, even if they make you sleepy?
- If you require rehabilitation care, is there a facility you would prefer? If not a specific facility, is there a location you would like to be near?
- Do you want your organs to be donated?
- Are their any spiritual, cultural, or religious ceremonies or beliefs you want honored during the end of life and after death?
- What do you want done with your body after death? Would you prefer to be buried in a casket or cremated? Is there a funeral home you would like used? Is there a cemetery or plot of land already arranged? Is there a religious facility you would like a ceremony held at?
- Can you think of any scenario or situation where you would want different decisions made, than discussed above?
- Anything else you want to discuss with your surrogate decision maker or family and friends?

Appendix C

Education Session Survey

PLEASE

Fill this section out prior to the education session

- Please circle your age group below.

  <50 51-60 61-70 71-80 81-90 91+

- Please circle your gender.

  Female Male Other

- Do you currently have a living will or advanced directive?

  Yes No Unknown

- If you currently have a living will or advanced directive, when was it last updated?

  In the last year 1-4 years ago 5-8 years ago >8 years ago

- Have you had a conversation with your family about your wishes for medical treatment if you cannot speak for yourself?

  Yes No

The information gathered on this form is only being used to evaluate this educational session and aid in further enhancements or changes.

THANK YOU

Fill this section out after the education session

- After this education session, will you create a living will or advanced directive if you previously did not have one? If you have a living will or advanced directive, do you plan to change anything within the document?

  Yes No

- After this education session, will you have a conversation with your family about your wishes for medical treatment when/if you cannot speak for yourself?

  Yes No

**If you have any comments on this educational session, please write them on the back. **

Appendix D

Education Session Flyer

Ensuring critical conversations take place before it is too late.

Advanced Care Planning Education Session

You are invited to an education session on advanced care planning hosted at [redacted] This event will provide you will up-to-date information on advanced directives (living wills), what common medical terminology means and how to start a conversation on advanced care planning. Consider bringing yourself, your significant other and adult children. Refreshments provided.

Date: April 24th, 2019

Time: 3:00 PM

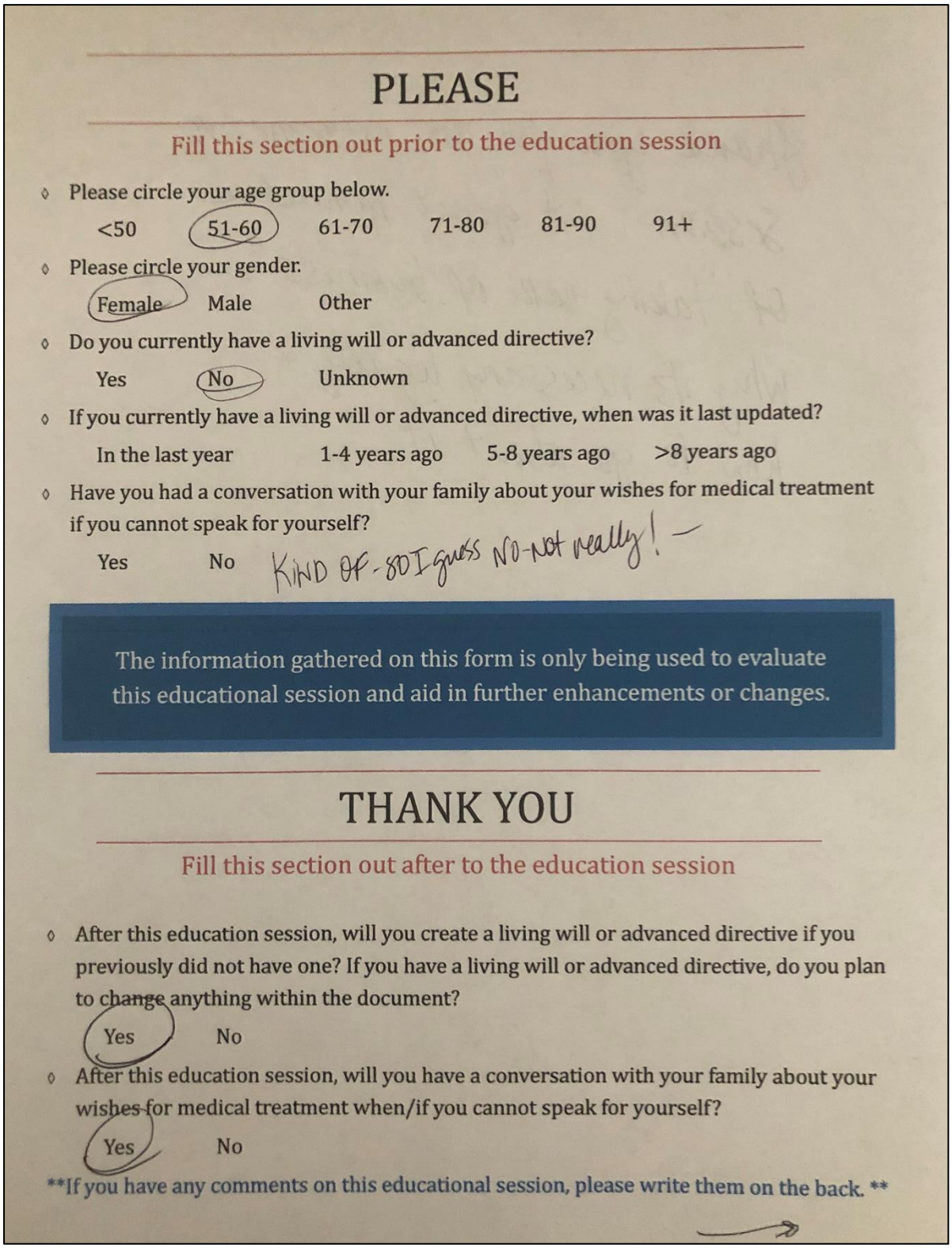
Location: [redacted]

*Please RSVP by April 22, 2019. Call [redacted]

[redacted]

Appendix E

Completed Survey #1 Front



PLEASE

Fill this section out prior to the education session

- Please circle your age group below.

  <50 (51-60) 61-70 71-80 81-90 91+

- Please circle your gender.

  (Female) Male Other

- Do you currently have a living will or advanced directive?

  Yes (No) Unknown

- If you currently have a living will or advanced directive, when was it last updated?

  In the last year 1-4 years ago 5-8 years ago >8 years ago

- Have you had a conversation with your family about your wishes for medical treatment if you cannot speak for yourself?

  Yes No KIND OF - SO I guess NO - Not really! —

The information gathered on this form is only being used to evaluate this educational session and aid in further enhancements or changes.

THANK YOU

Fill this section out after to the education session

- After this education session, will you create a living will or advanced directive if you previously did not have one? If you have a living will or advanced directive, do you plan to change anything within the document?

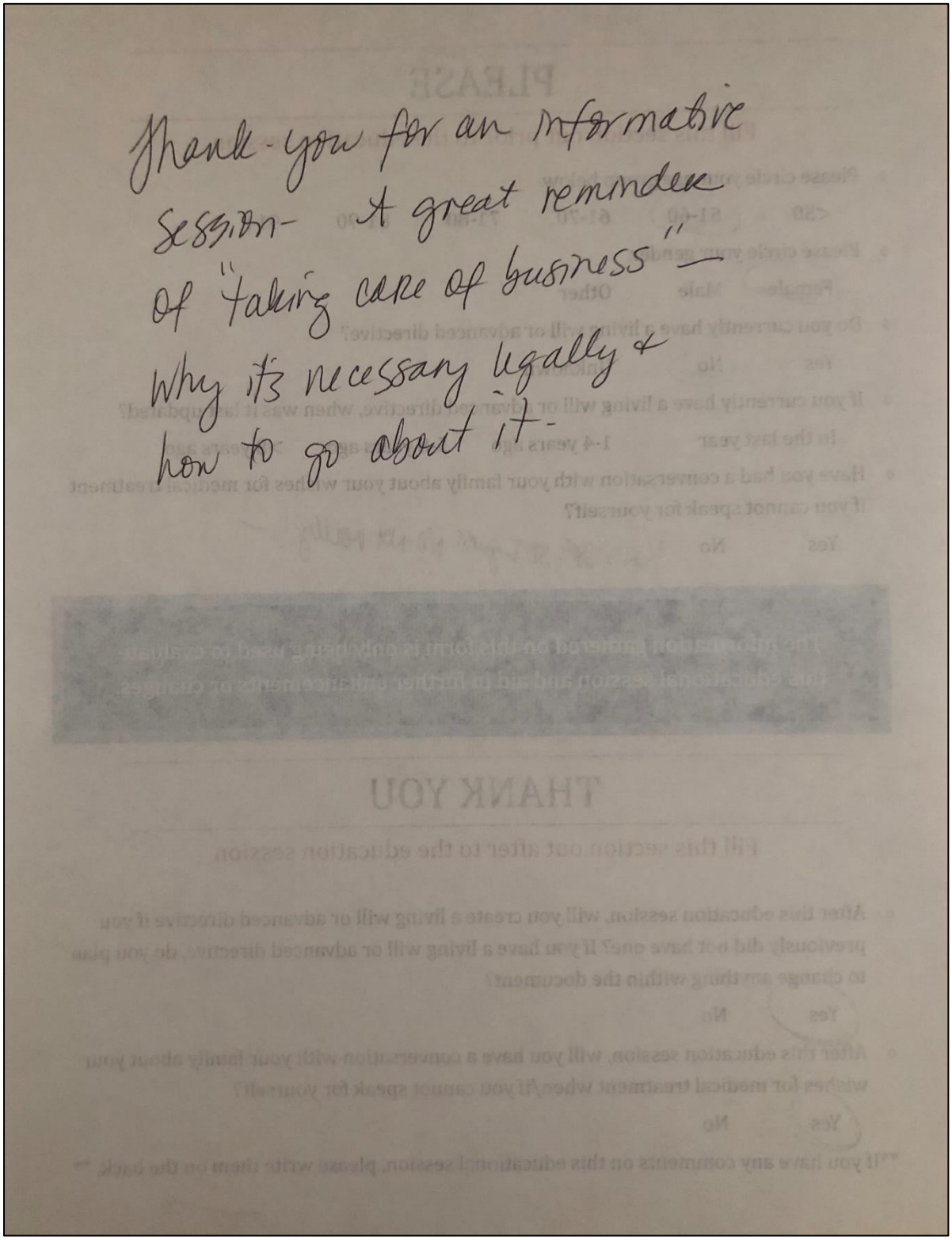
  (Yes) No

- After this education session, will you have a conversation with your family about your wishes for medical treatment when/if you cannot speak for yourself?

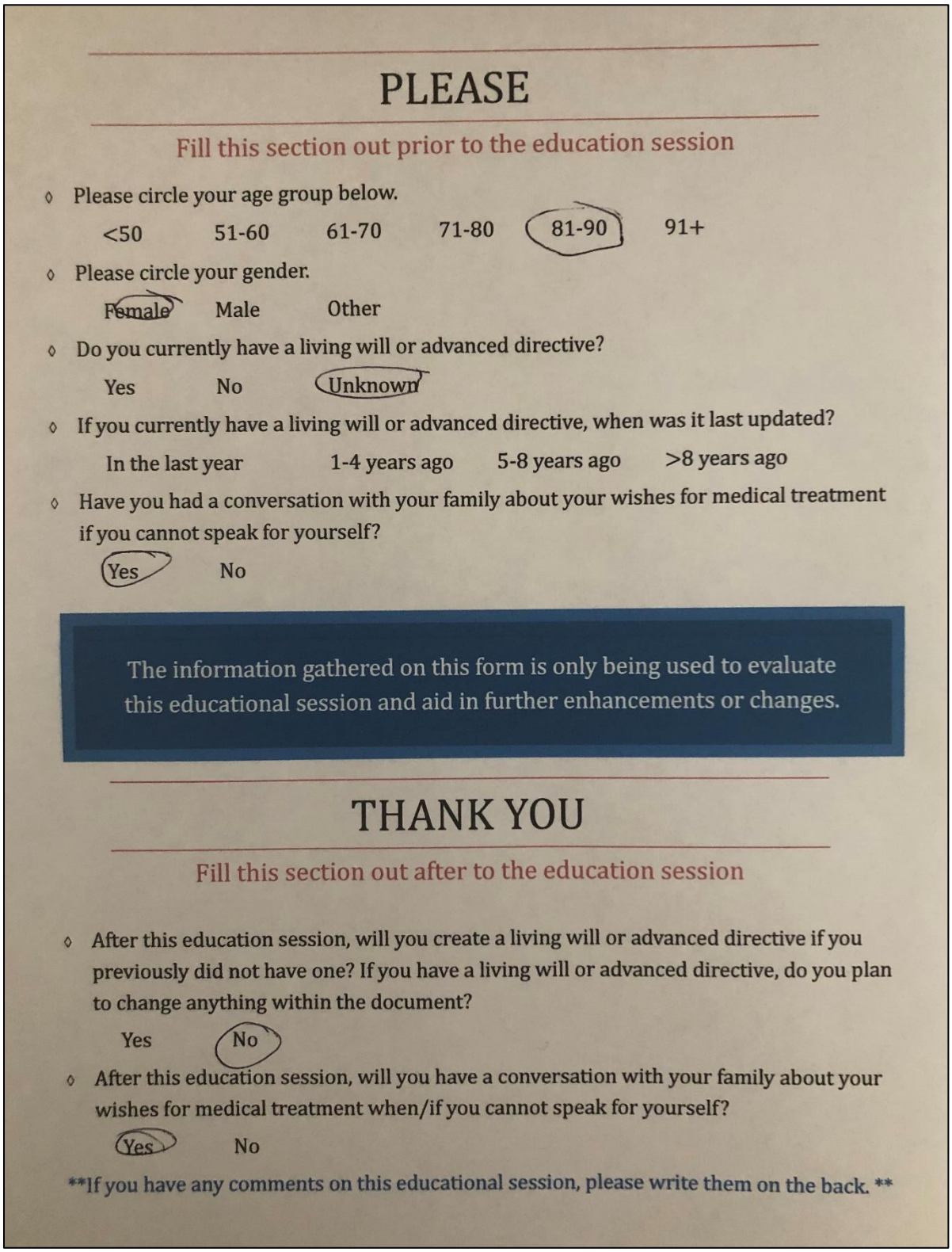
  (Yes) No

**If you have any comments on this educational session, please write them on the back. **

Completed Survey #1 Back



Completed Survey #2 (No Back)



PLEASE

Fill this section out prior to the education session

◊ Please circle your age group below.

<50 51-60 61-70 71-80 (81-90) 91+

◊ Please circle your gender.

(Female) Male Other

◊ Do you currently have a living will or advanced directive?

Yes No (Unknown)

◊ If you currently have a living will or advanced directive, when was it last updated?

In the last year 1-4 years ago 5-8 years ago >8 years ago

◊ Have you had a conversation with your family about your wishes for medical treatment if you cannot speak for yourself?

(Yes) No

The information gathered on this form is only being used to evaluate this educational session and aid in further enhancements or changes.

THANK YOU

Fill this section out after to the education session

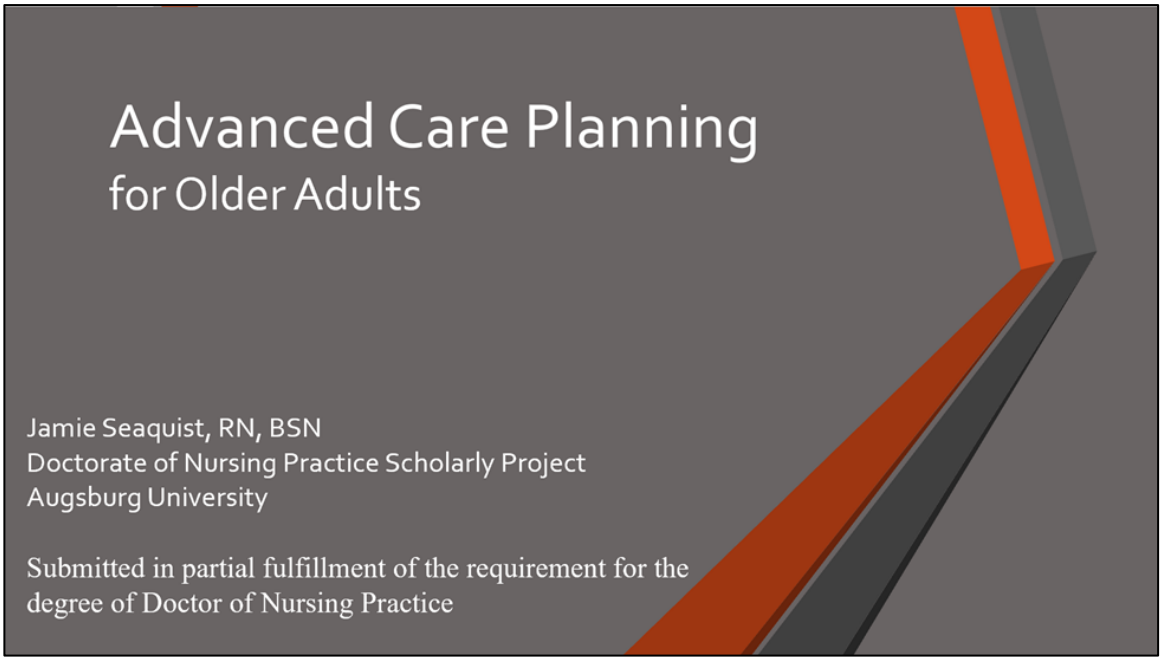
◊ After this education session, will you create a living will or advanced directive if you previously did not have one? If you have a living will or advanced directive, do you plan to change anything within the document?

Yes (No)

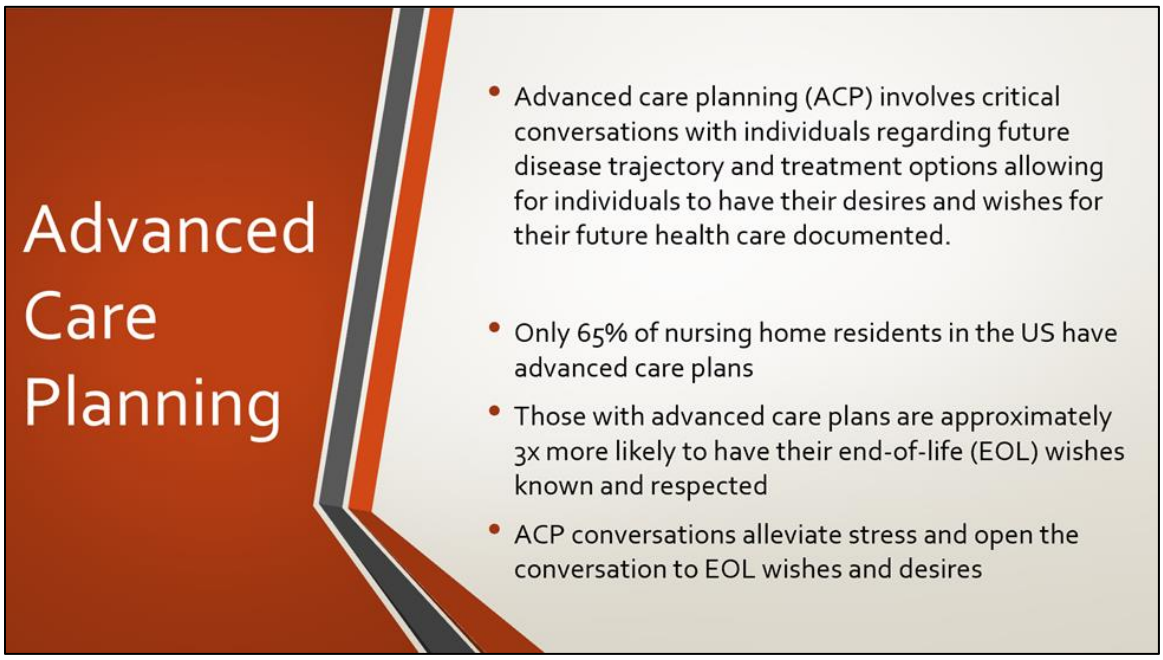
◊ After this education session, will you have a conversation with your family about your wishes for medical treatment when/if you cannot speak for yourself?

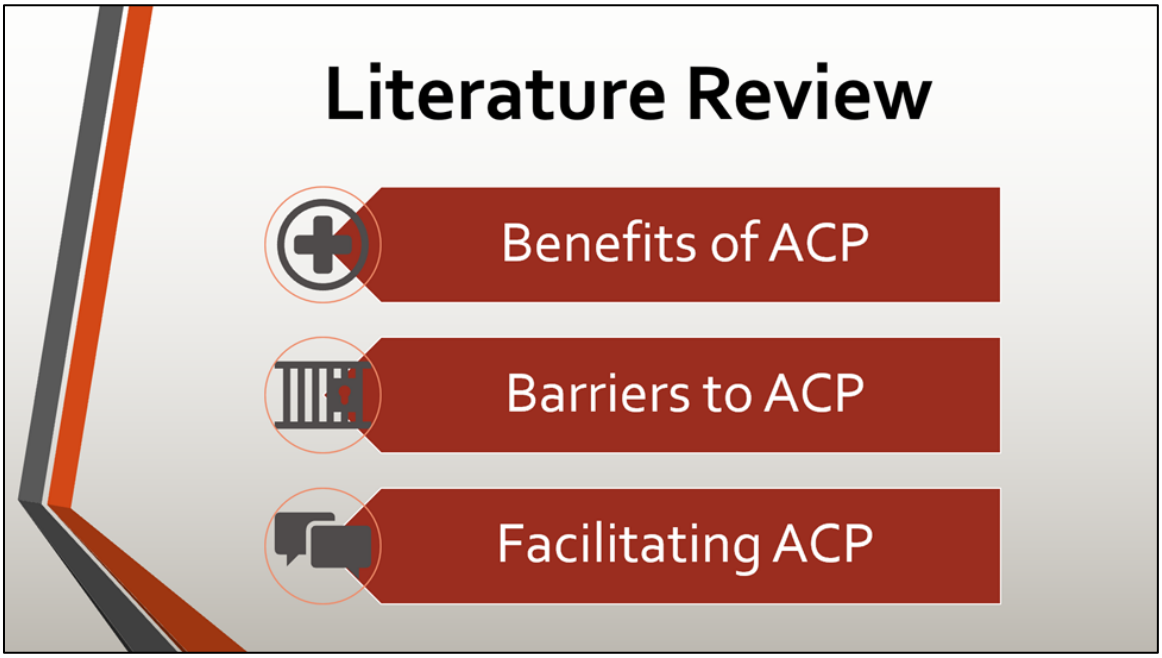
(Yes) No

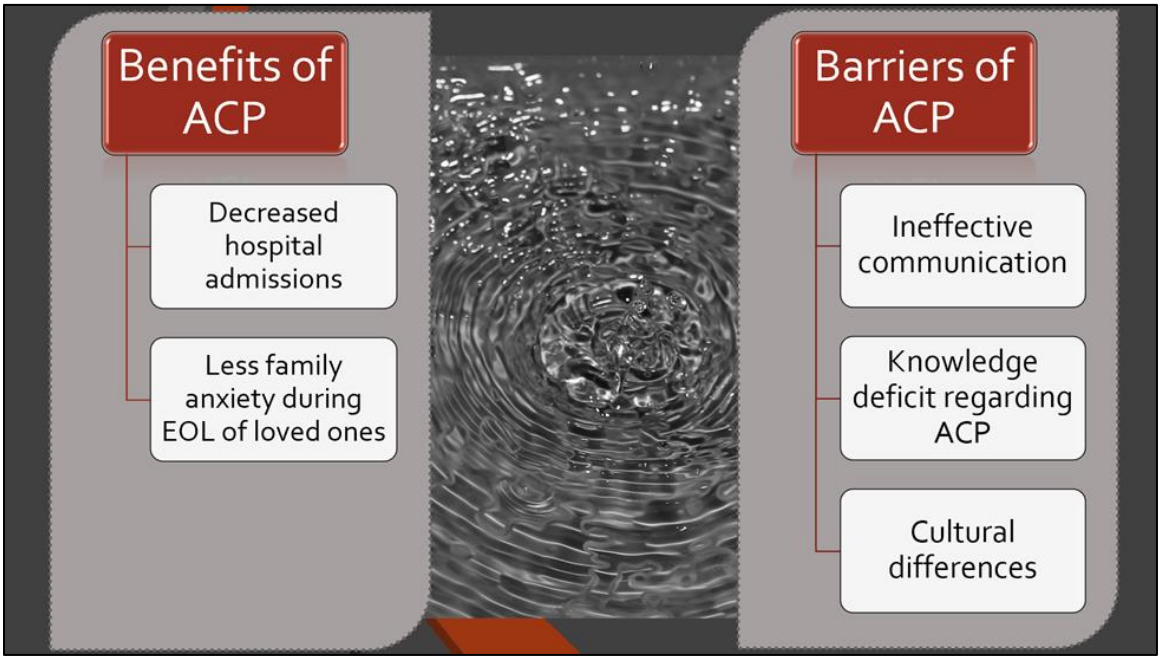
**If you have any comments on this educational session, please write them on the back. **

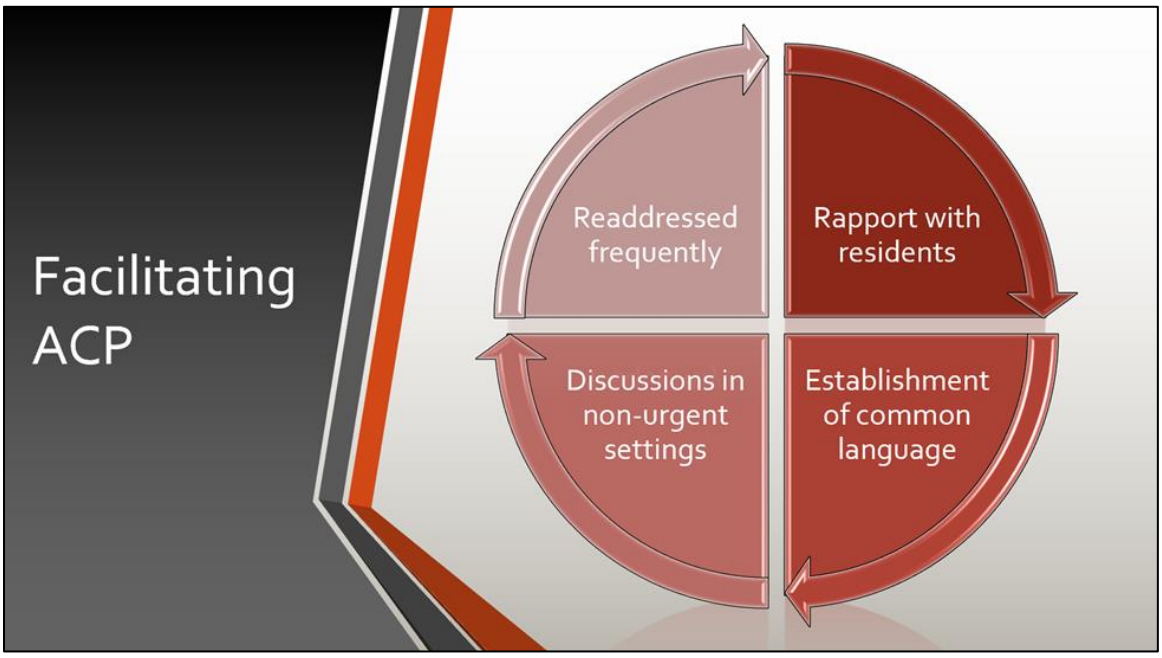

Advanced Care Planning
for Older Adults
Jamie Seaquist, RN, BSN
Doctorate of Nursing Practice Scholarly Project
Augsburg University
Submitted in partial fulfillment of the requirement for the degree of Doctor of Nursing Practice


Objectives
Discuss what advance care planning involves and why it is important.
Detail scholarly project research and foundation of Jean Watson's Theory of Human Caring
Review scholarly project implementation and results
Establish the future implications for Advanced Care Planning


Advanced Care Planning
Advanced care planning (ACP) involves critical conversations with individuals regarding future disease trajectory and treatment options allowing for individuals to have their desires and wishes for their future health care documented.
Only 65% of nursing home residents in the US have advanced care plans
Those with advanced care plans are approximately 3x more likely to have their end-of-life (EOL) wishes known and respected
ACP conversations alleviate stress and open the conversation to EOL wishes and desires


Literature Review
Benefits of ACP
Barriers to ACP
Facilitating ACP


Benefits of ACP
Decreased hospital admissions
Less family anxiety during EOL of loved ones
Barriers of ACP
Ineffective communication
Knowledge deficit regarding ACP
Cultural differences


Facilitating ACP
Readdressed frequently
Rapport with residents
Discussions in non-urgent settings
Establishment of common language


Jean Watson's
Theory of Human Caring
The art of nursing is more than the things we do to patients but involves putting your whole self into the transpersonal caring process.
Intentionally and authentically being present with patients while using all ways of knowing (aesthetic, ethical, personal, spiritual, intuitive, and cultural) creates a caring moment.
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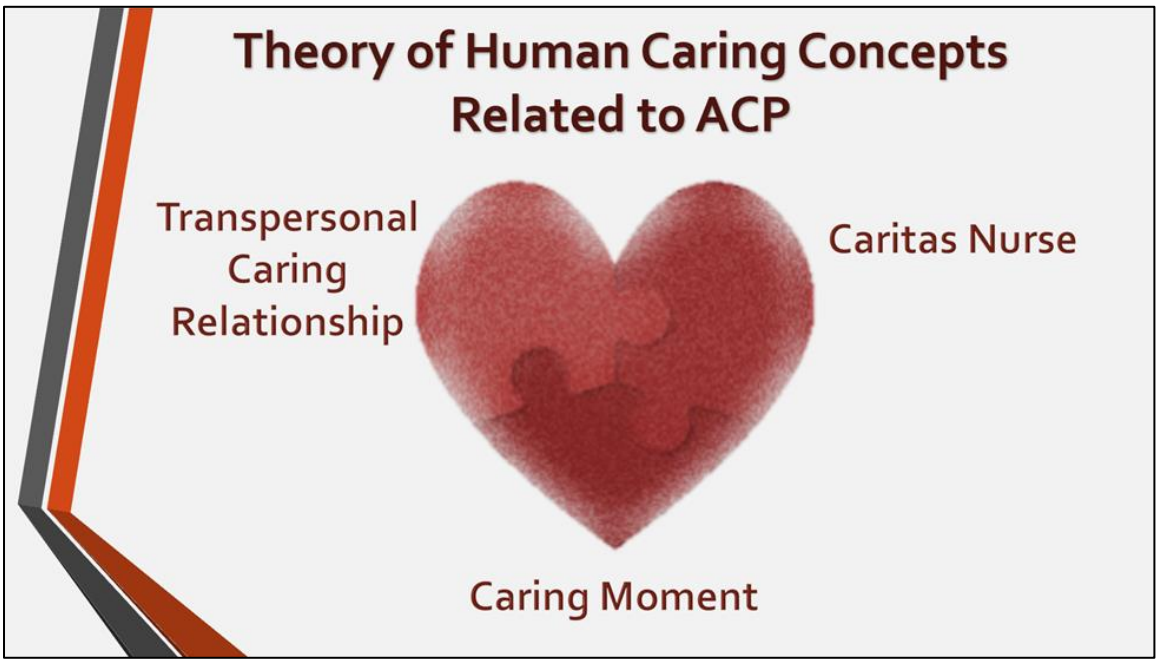
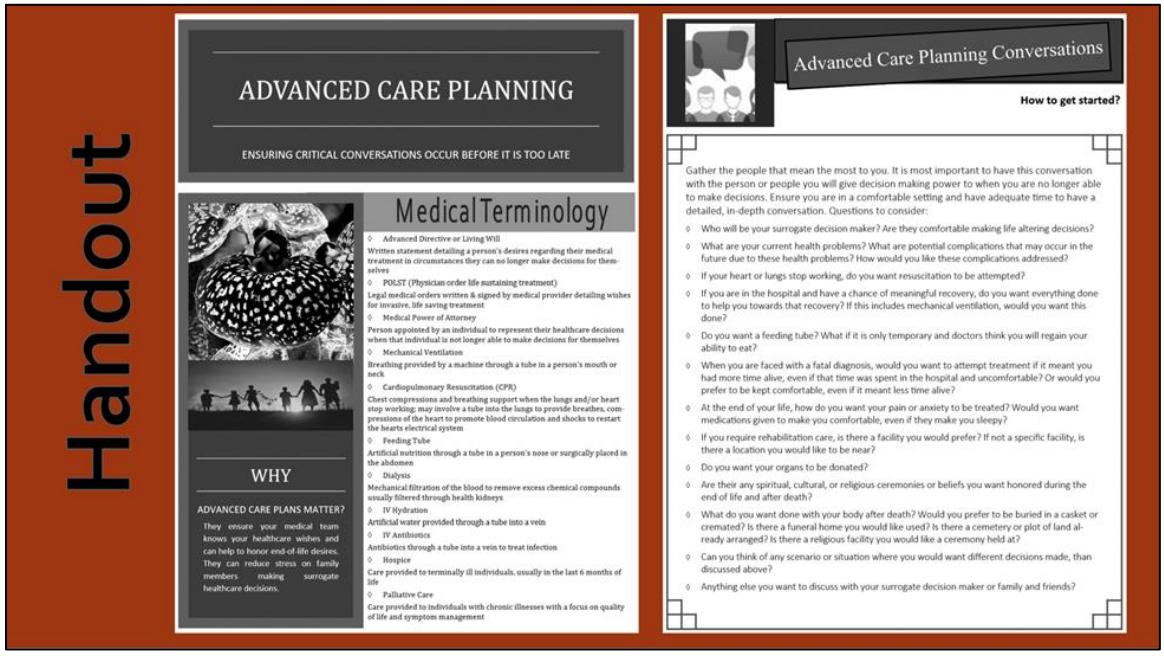

Theory of Human Caring Concepts Related to ACP
Transpersonal Caring Relationship
Caritas Nurse
Caring Moment

Implementation

- Participants were individuals living in assisted living and memory care with a 55+ community surrounding the facility.
  - 30-minute education session focused on types of advanced directives and creating a common language of medical terminology
  - Provided participants with handout on terminology and a communication guide for having ACP conversations with loved ones

Implementation April 24th, 2019 with flyer distribution April 8-12th

Handout



ADVANCED CARE PLANNING

ENSURING CRITICAL CONVERSATIONS OCCUR BEFORE IT IS TOO LATE

WHY

ADVANCED CARE PLANS MATTER?

They ensure your medical team knows your healthcare wishes and can help to honor end-of-life desires. They can reduce stress on family members making surrogate healthcare decisions.

Medical Terminology

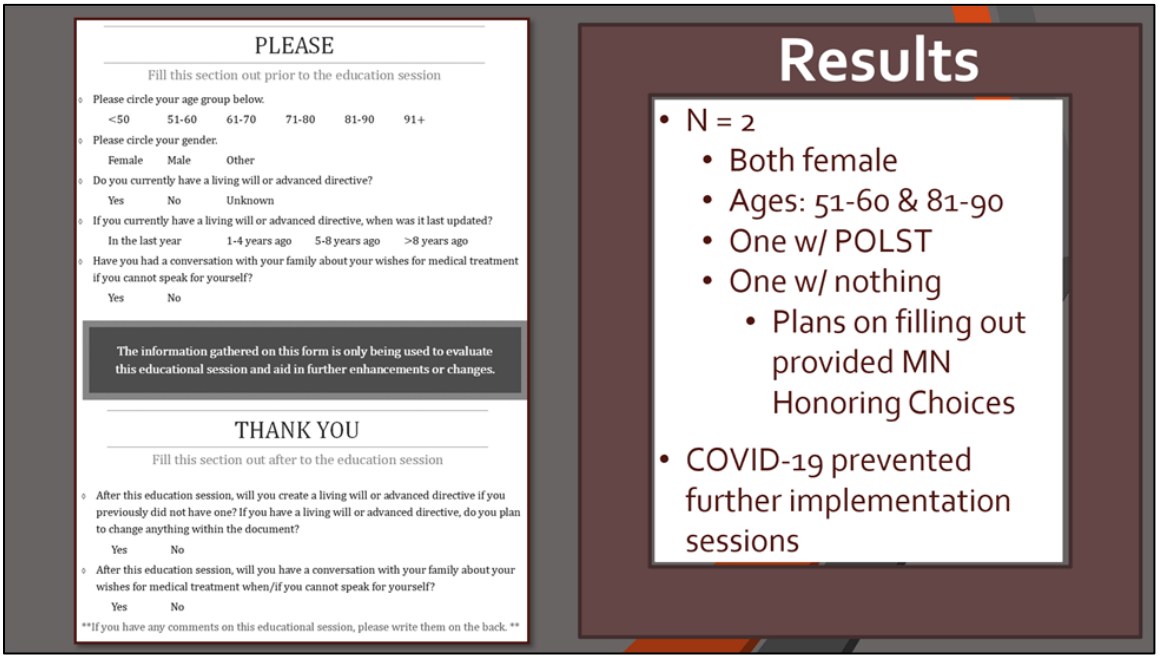
- Advanced Directive or Living Will
  Written statement detailing a person's desires regarding their medical treatment in circumstances they can no longer make decisions for themselves
- POLST (Physician order life sustaining treatment)
  Legal medical orders written & signed by medical provider detailing wishes for invasive, life saving treatment
- Medical Power of Attorney
  Person appointed by an individual to represent their healthcare decisions when that individual is not longer able to make decisions for themselves
- Mechanical Ventilation
  Breathing provided by a machine through a tube in a person's mouth or neck
- Cardiopulmonary Resuscitation (CPR)
  Chest compressions and breathing support when the lungs and/or heart stop working; may involve a tube into the lungs to provide breathes, compressions of the heart to promote blood circulation and shocks to restart the hearts electrical system
- Feeding Tube
  Artificial nutrition through a tube in a person's nose or surgically placed in the abdomen
- Dialysis
  Mechanical filtration of the blood to remove excess chemical compounds usually filtered through health kidneys
- IV Hydration
  Artificial water provided through a tube into a vein
- IV Antibiotics
  Antibiotics through a tube into a vein to treat infection
- Hospice
  Care provided to terminally ill individuals, usually in the last 6 months of life
- Palliative Care
  Care provided to individuals with chronic illnesses with a focus on quality of life and symptom management

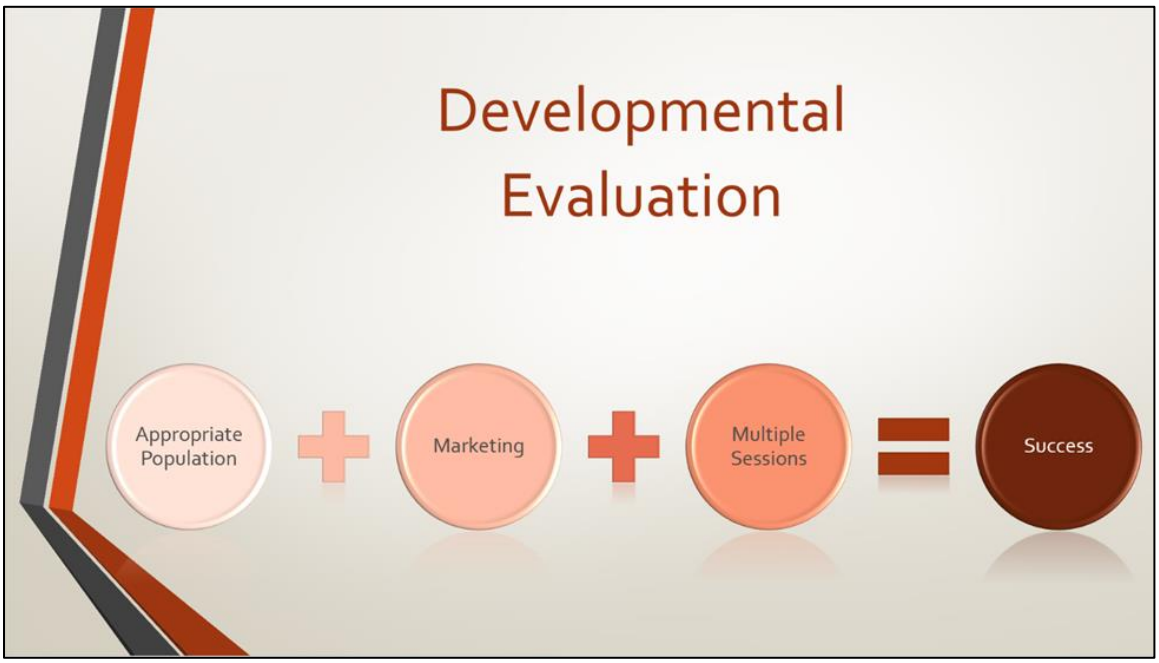
Advanced Care Planning Conversations

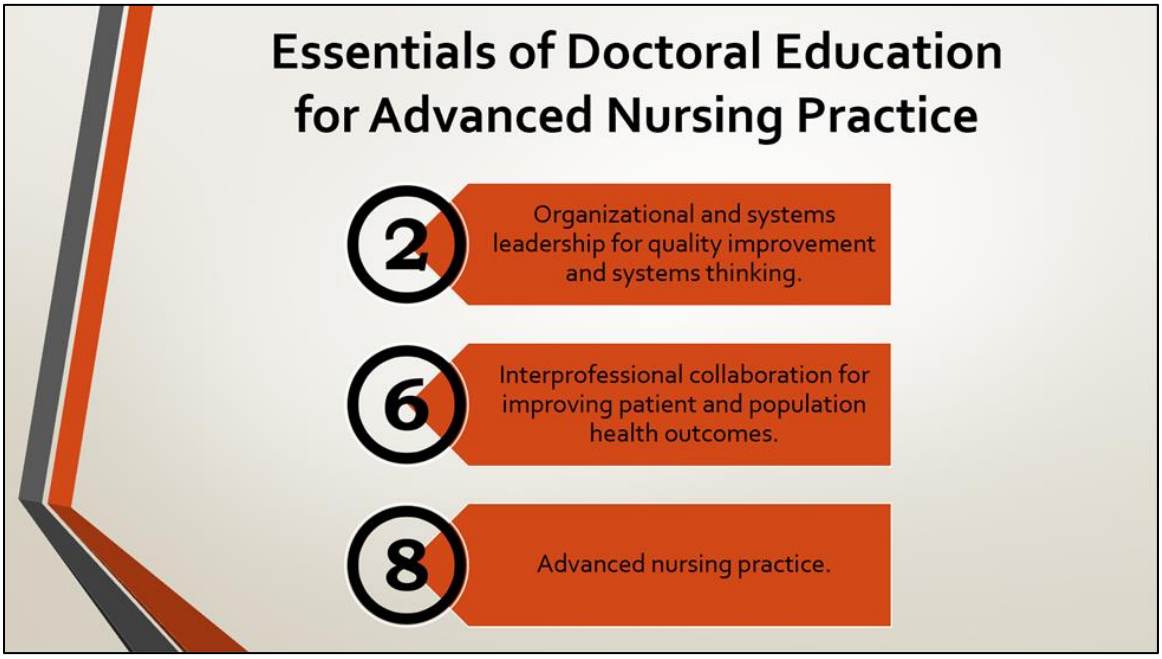
How to get started?

Gather the people that mean the most to you. It is most important to have this conversation with the person or people you will give decision making power to when you are no longer able to make decisions. Ensure you are in a comfortable setting and have adequate time to have a detailed, in-depth conversation. Questions to consider:

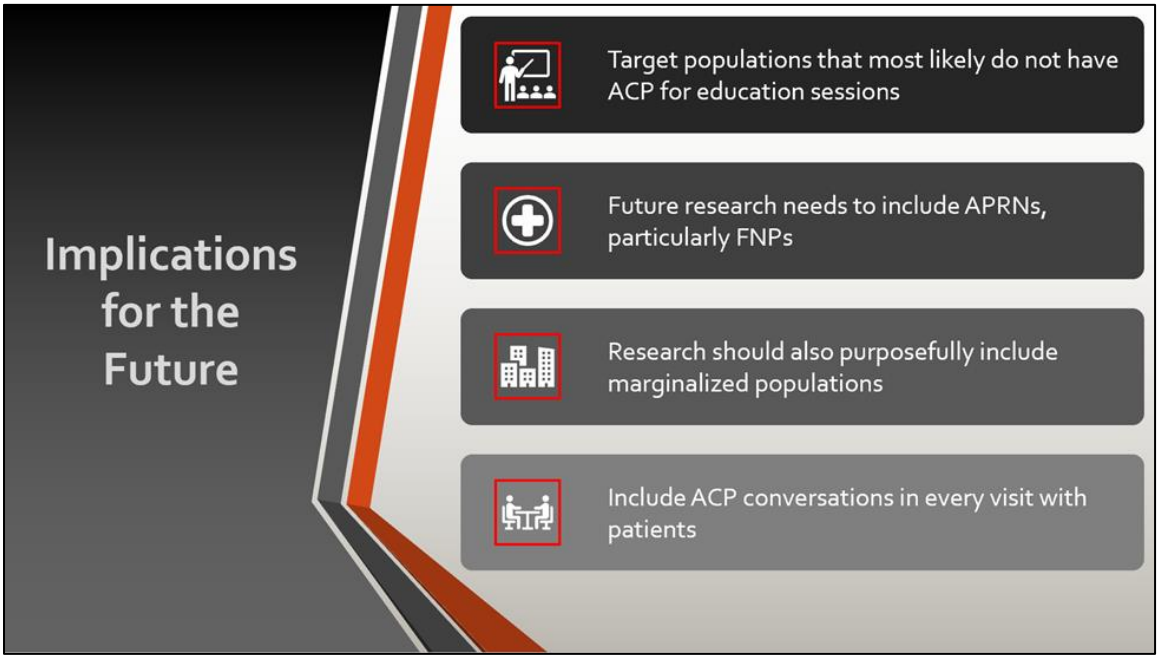
- Who will be your surrogate decision maker? Are they comfortable making life altering decisions?
- What are your current health problems? What are potential complications that may occur in the future due to these health problems? How would you like these complications addressed?
- If your heart or lungs stop working, do you want resuscitation to be attempted?
- If you are in the hospital and have a chance of meaningful recovery, do you want everything done to help you towards that recovery? If this includes mechanical ventilation, would you want this done?
- Do you want a feeding tube? What if it is only temporary and doctors think you will regain your ability to eat?
- When you are faced with a fatal diagnosis, would you want to attempt treatment if it meant you had more time alive, even if that time was spent in the hospital and uncomfortable? Or would you prefer to be kept comfortable, even if it meant less time alive?
- At the end of your life, how do you want your pain or anxiety to be treated? Would you want medications given to make you comfortable, even if they make you sleepy?
- If you require rehabilitation care, is there a facility you would prefer? If not a specific facility, is there a location you would like to be near?
- Do you want your organs to be donated?
- Are their any spiritual, cultural, or religious ceremonies or beliefs you want honored during the end of life and after death?
- What do you want done with your body after death? Would you prefer to be buried in a casket or cremated? Is there a funeral home you would like used? Is there a cemetery or plot of land already arranged? Is there a religious facility you would like a ceremony held at?
- Can you think of any scenario or situation where you would want different decisions made, than discussed above?
- Anything else you want to discuss with your surrogate decision maker or family and friends?

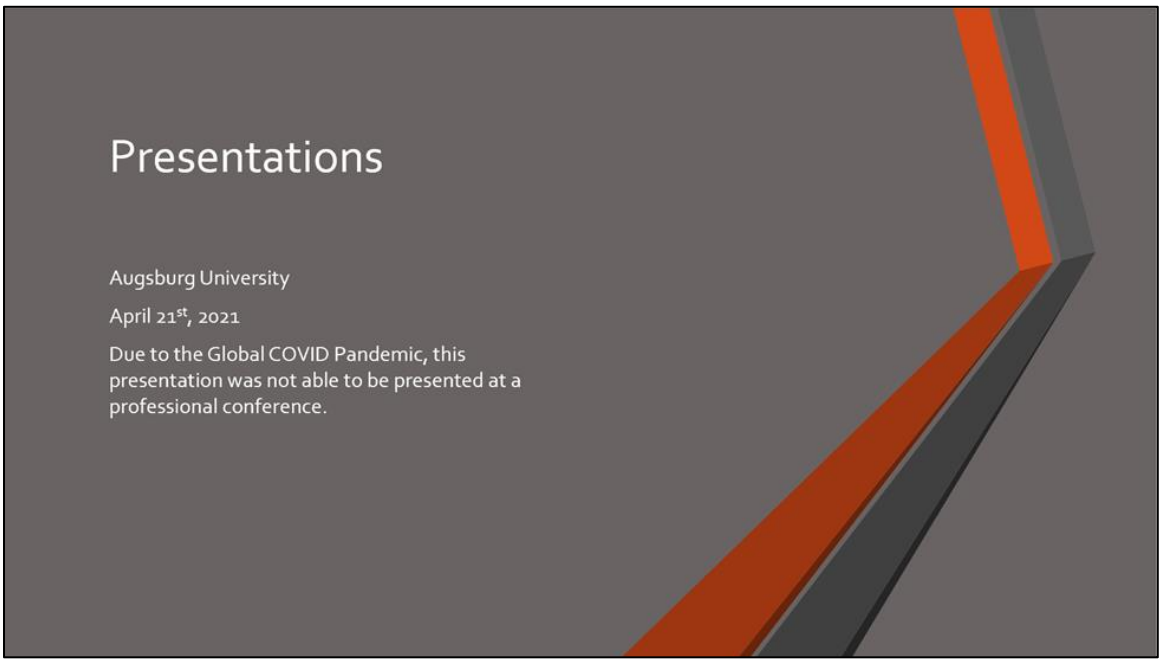

PLEASE
Fill this section out prior to the education session
Please circle your age group below.
<50 51-60 61-70 71-80 81-90 91+
Please circle your gender.
Female Male Other
Do you currently have a living will or advanced directive?
Yes No Unknown
If you currently have a living will or advanced directive, when was it last updated?
In the last year 1-4 years ago 5-8 years ago >8 years ago
Have you had a conversation with your family about your wishes for medical treatment if you cannot speak for yourself?
Yes No
The information gathered on this form is only being used to evaluate this educational session and aid in further enhancements or changes.
THANK YOU
Fill this section out after to the education session
After this education session, will you create a living will or advanced directive if you previously did not have one? If you have a living will or advanced directive, do you plan to change anything within the document?
Yes No
After this education session, will you have a conversation with your family about your wishes for medical treatment when/if you cannot speak for yourself?
Yes No
**If you have any comments on this educational session, please write them on the back. **
Results
N = 2
Both female
Ages: 51-60 & 81-90
One w/ POLST
One w/ nothing
Plans on filling out provided MN Honoring Choices
COVID-19 prevented further implementation sessions


Developmental Evaluation
Appropriate Population
Marketing
Multiple Sessions
Success


Essentials of Doctoral Education for Advanced Nursing Practice
2
Organizational and systems leadership for quality improvement and systems thinking.
6
Interprofessional collaboration for improving patient and population health outcomes.
8
Advanced nursing practice.

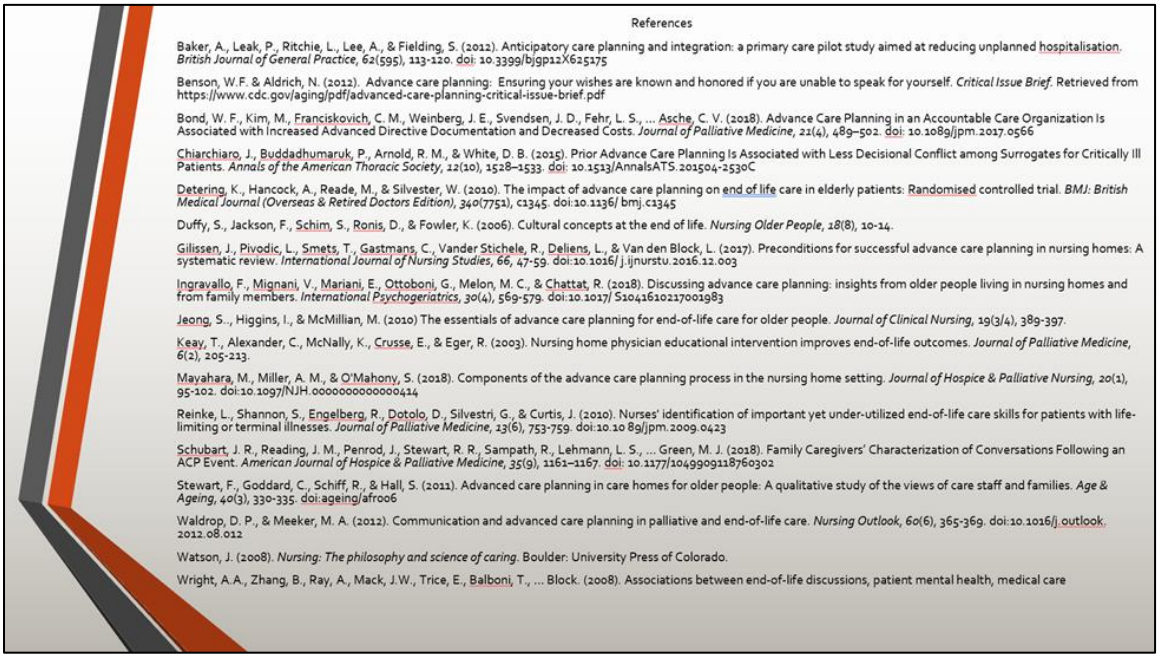

National Organization of Nurse Practitioner Faculties Core Competencies
Leadership competencies.
Quality competencies.


Implications for the Future
Target populations that most likely do not have ACP for education sessions
Future research needs to include APRNs, particularly FNPs
Research should also purposefully include marginalized populations
Include ACP conversations in every visit with patients


Presentations
Augsburg University
April 21st, 2021
Due to the Global COVID Pandemic, this presentation was not able to be presented at a professional conference.

Acknowledgement

- I want to thank my parents and grandparents for all the love and support.
- I specifically want to acknowledge Dr. Katie Clark and Dr. Cheryl Leuning for impacting my view of healthcare & social injustice.
- To all of my peers in the Graduating Class of 2021, thank you for fostering a healthy learning environment and supporting each other along this journey.



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