Advance Directives: A Protocol in Geriatric and Palliative Care Clinics

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Abstract

Background: Advance Directives (AD) and Advanced Care Planning (ACP) are part of the healthcare process and within the scope of practice for providers. Despite the evidence supporting the effectiveness of these conversations, the system falls short. Reports in the AD literature reveal that healthcare professionals avoid discussions about preparations for ACP due to feeling unprepared and a lack of a framework for such conversations.

Purpose: The purpose of this doctoral project was to initiate an AD protocol in the Geriatric and Palliative Care Clinics to improve the completion rate of AD.

Method: This project was a Quazi-experimental pre and post-intervention design. A pre-intervention baseline assessment of healthcare providers comfort level with ACP conversations through a self-assessment survey and retrospective chart audits were conducted. An educational intervention was completed implementing an evidenced-based training and resources to guide ACP discussions. Post-intervention data was collected to include a repeat of the self-assessment survey and retrospective chart audits to determine changes in ACP comfort level and increase in ADs completion rates.

Results: Statistical analyses of project data revealed the four-hour education program and the implementation of an AD protocol did increase the overall comfort and knowledge of the participants of the two clinics. The overall knowledge, attitude an experiential level among the participants in the post-education survey had an impressive 82% improvement.

Conclusion: Providers reported increases in knowledge, skills, and attitudes (KSAs) level of comfort as a result of the staff education and AD protocol. The AD completion rate for the two clinics was increased by 57%.

Keywords: advance directives, advance care planning, nurses, end of life

Advance Directives: A Protocol in Geriatric and Palliative Care Clinics

We only die once; why not make it on your terms? The notion of advance care planning (ACP) and directives has been within the realm of public awareness for over forty years (Meier, 2011). The idea for these plans is similar to the concept that motivates people to write and register legal wills. An advance directive (AD) assures that life information and property (body) are treated in the manner specified by the individual for legal purposes. It might seem logical that most people would be interested in completing their AD, but this process is one that is many times seen as emotional and too challenging to confront (Meier, 2011). According to Rao (2014), the most common reason for not making use of AD is lack of awareness among nursing and healthcare staff.

AD and ACP are means for individuals to formally communicate their wishes and how medical and other supports should be addressed in case of dire emergency and end of life progression. There are many barriers obstructing the completion of AD and ACP. These barriers according to healthcare providers are: (a) lack of education or knowledge regarding advance directives, (b) difficulties with paperwork completion, and (c) discordance between patient, family members or proxy, and provider (Rao, 2014). Currently, there is reluctance among health care providers to discuss ADs with their patients (Booth, 2016). The paucity of an effective role for health care providers, mainly nurses, affects the communications with patients and the personal decisions or the opportunities for the patient to make end of life decisions (Booth, 2016).

It is imperative that nurses take the lead in initiating this important conversation with patients to enable them to make decisions that affect the end of life care they will receive. This is considered advocacy for the patient, which is an inherent obligation of nurses. Through a standardized approach, this Doctor of Nursing Practice (DNP) project shall focus on the importance of nurses initiating the conversation of ACP and completing the required AD forms within geriatric and outpatient palliative care clinics.

Background

In the 1970s, Karen Quinlan's case brought end-of-life care issues such as living wills, competency versus incompetency, and the withdrawal of medical care to the attention of the public (Croke & Daguro, 2005). In 1990, the United States Congress introduced the Patient Self-Determination Act (PSDA), which was enacted into law in 1991 as a result of the Cruzan case (Croke & Daguro, 2005). This case was brought against the Missouri state courts as the first right to die case, which went all the way to the United States Supreme Court. The final decision did support the patient's decision to refuse medical treatment.

The PSDA obliges all health care facilities receiving Medicare or Medicaid funding to implement an AD/ACP program (Croke & Daguro, 2005). Healthcare providers who comply with the patient's AD in good faith will not be exposed to criminal or civil liability (Croke & Daguro, 2005). However, those providers who knowingly fail to comply with AD may result in liability for charges of medical battery, malpractice, and negligence (Croke & Daguro, 2005).

When an individual becomes unable to direct his or her health care, and the individual's healthcare has declined to require lifesaving interventions, nurses and other medical personnel are required by laws and regulations to dispense medications, products, and perform any procedures to save the life of the individual. This action may not necessarily coincide with the wishes of the individual. Completing an AD would guide the healthcare providers in delivering the care the individual requested. Therefore, if the individual did not want all the life-saving interventions provided, the AD would essentially guide the healthcare providers to deliver comfort care.

The Centers for Medicare and Medicaid Services (CMS) stated that they would allow healthcare providers to charge CMS a fee for voluntary ACP under the Medicare Physician Fee Schedule and Hospital Outpatient Prospective Payment System (Centers for Medicare and Medicaid Services [CMS], 2016). The federal government believes that completing AD is so important it has offered healthcare providers receiving Medicare funding an incentive. Most health care providers will now capitalize because this incentive adds revenue for outpatient clinics. In order to optimize funding, outpatient clinics should implement AD and ACP programs for their patients.

Significance

Despite the difficulty providers have in discussing potential end-of-life care with patients, it can be very reassuring to know that there are a formal means by which to state their wishes and to designate a proxy to be their representative at a time when they cannot make healthcare decisions. By implementing and developing a protocol for completing AD upon initial assessment in Geriatric and Palliative outpatient clinics, it is likely that more patients would complete and understand their AD. Implementation of the End of Life Protocol in geriatric and palliative care clinics, which targets nursing and healthcare staff could improve patient care, increase the rate of seniors completing AD, and empower the nursing staff to initiate this vital conversation (O’Sullivan, Mailo, Angeles, & Agarwal, 2015).

Even though there is increasing support for the provision of AD among medical personnel and the public, questions remain and there continues to be hesitancy about how the subject should be raised, and who should initiate the discussions (O’Sullivan, et al., 2015). A group of family/emergency physicians and researchers undertook a significant study that was published in early 2015. The research team found that although close to half of the participants had discussed the topic of AD; fewer than 20% had completed written documents (O’Sullivan, et al., 2015).

While the majority of those surveyed felt that AD/ACP was the prerogative of the patient, patients who considered AD extremely important were significantly more likely to want their family doctors to start the conversation (O'Sullivan, et al., 2015).

Problem Statement

There are a number of barriers to ACP, and these exist both on the part of patients and the interdisciplinary health care team. Many people feel that if they do anything to formally acknowledge that they will die, it will make it happen more quickly (Rao, 2014). Other obstacles to AD use include a simple lack of awareness among healthcare professionals (Rao, 2014). Thus, the issue addressed herein is the low amount of AD completion in the outpatient Geriatric and Palliative clinic settings. This results from healthcare professionals lacking a clear understanding of the importance AD have in preparing patients and their families (Rao, 2014). Currently, in the Geriatric and Palliative care clinics, an AD policy exists only describing documents and parameters. Hence, the need to have a protocol that outlines training for health care members in Geriatric and Palliative care clinics.

Purpose Statement

This project aims to initiate an end of life protocol in the Geriatric and Palliative Care Clinics that seeks to improve completion of AD; implement a formal training program in life care planning for all interdisciplinary team members, and improve medical professionals' access to completed AD documents. Furthermore, this project's purpose is to retain a leadership focus by increasing AD completion rates and improving revenue from CMS prospective payment system.

Project Objectives

The objectives of this DNP project are to be completed within 3 months:

- To develop a protocol to improve the provision of ACP in the geriatric and palliative care and clinic.

- To develop staff training program to introduce the new end of life protocol; to improve the healthcare providers' knowledge, skills, and attitudes (KSAs) in providing ACP.
- To implement a process to record' AD into patient's medical health record.
- Increase AD completion rate for all Geriatric and Palliative clinic patients by 50%, which will be measured through chart audits.

Project Question

This project utilizes the acronym "PICO," Population or Problem (P), Intervention or Issue of Interest (I), Comparison group or Current Practice (C), and Outcome (O) and is typically presented as a question (Melnyk & Fineout-Overholt, 2011). The question this project will address is: Will the implementation of a protocol and ACP training for the interdisciplinary team in geriatric and palliative care clinics improve the amount of completed AD and ACP for patients being treated in these clinics?

P: Problem: Poor AD completion rates in a geriatric and palliative care clinic.

I: Intervention: Developing a protocol to improve completion of AD and ACP.

C: Comparison: The number of AD and ACP with the protocol implementation versus without the implementation of a protocol.

O: Outcome: Improved completed AD and ACP to 80% after implementation.

T: Timeframe-within 3 months.

Coverage and Justification

A search of the Touro University Nevada (TUN) library databases using the ProQuest, CINAHL, and Medline, databases was conducted. In addition, the TUN intranet was used to review articles from Uptodate.com to provide advanced clinical decision support an integrated solution that provides clear, consistent, evidence-based information across the continuum of care to improve clinical effectiveness. Google Scholar, Cochrane, National Institutes of Health was also utilized for additional article reviews. The search was limited to publications between 12/1/2012 and 11/1/2017 to ensure current literature was reviewed. Keywords for the search included end of life issues, hospice care, geriatrics, nursing, advanced directives, advanced directives and nursing, nursing perceptions of advanced directives, legal issues, PICOT questions, palliative care, and patient’s rights. Other search components included the English language, peer-reviewed, Boolean phrasing. Articles reviewed for this projected were limited to Geriatric and Palliative care population. Articles were chosen based on the inclusion of patients 65 years of age or older, geriatric patients or palliative care, ACP, AD, legal and ethical issues healthcare training, and implementation. Exclusion articles for ages under 65, hospice patients, literature greater than five years old and inpatient setting. Thirty to forty articles were retrieved from this search; only the most recent and specific literature was kept from exclusion. The number of articles retrieved provided a significant amount of information to represent a scholarly literature search. Ten to fifteen articles were returned due to not meeting the specific requirements for this search.

Review Synthesis

Several themes did arise from the review of the literature. The most significant was the need for hospitals and facilities to create and enforce policies about AD, and then provide training to personnel. ACP helps to ensure that patients receive care that is consistent with their preferences. In addition, it aims to provide guidance to the family and reduce their decisional burden about whether they are following these preferences (Mullick, Martin, & Sallnow, 2013).

ACP can lay the groundwork for surrogates by providing a framework that they may utilize for informed decision-making, keeping in mind the patient's goals, values, and beliefs, as well as their treatment preferences.

Review of Study Methods

Several research methods were used in the literature reviewed for this project. Rao (2014), performed a systemic review of the literature which provided the following themes. Healthcare teams could benefit from a formal education along with policies and procedures directed towards ACP. Qualitative methods were used to gain data on current practice and understanding decision making by patients and families (O'Sullivan, Mailo, Angeles, & Agarwal, 2015). It is necessary to understand current practice before one can move forward with changes to improve upon it. Bowers (2016), used observational study methods to review how comfortable nurses fell when having conversations with patients about their ACP. According to Bower (2016), medical personnel fell comfortable having the end of life care planning after formal training was provided. Hence, the reason for a formal protocol in Geriatrics and Palliative care clinics on AD completion.

Legal/Regulatory Implications

In January of 2016, CMS began implementing a reimbursement fee for guided discussions with patients about ACP. Medicare's new payment for ACP is likely to provide an incentive for the health care team to initiate end of life discussions. As of 2016 Medicare part B covers voluntary ACP as part of the yearly wellness visit (CMS 2016). Bowers (2016) conducted an observational survey among medical personnel regarding their engagement in end of life care planning, the vast majority was highly in favor of ACP discussions however, less than one-quarter of those surveyed had undertaken this activity. As part of this systemic questionnaires survey sample, Bowers discusses the importance of demographic variables include such measures as ethnicity, socioeconomic status, race, and age. Training and knowledge is clearly the indicator to improve the completion rates of AD. While increasing reimbursement will help facilitate more such discussions, improving automatic triggers for geriatric and palliative care referral is another important method that can be helpful in ACP.

Caring for patients at the end of life is a challenging task that requires not only the consideration of the patient as a whole but also an understanding of the family, social, legal, economic, and institutional circumstances that surround patient care. Acting in a manner that does not comply with the law can have serious consequences for both the patient and physician. Negative consequences for patients include receiving unwanted treatment or not receiving treatment that is wanted. Both scenarios could potentially result in civil and criminal sanctions for physicians, nurses, and healthcare team according to study (Willmott, 2016). Importantly, the mere absence of explicit legal authorization for an action does not mean that action is prohibited (Wilmott, 2016). A high level of knowledge of the law is essential to ensure that patients' wishes and decisions, expressed through ACP, are respected to the maximum extent possible within the law, thereby according with the principles and philosophy of palliative care. It is also essential to protect health professionals from legal action resulting from unauthorized provision or cessation of treatment. Medicine remains a largely self-regulated profession. There is comparatively more law regarding end of life care. However, the law does not and cannot directly address all interventions and procedures. Understanding the legal aspects of end of life care should give the practicing clinician the confidence and freedom to act ethically and responsibly. Some of the legal standards regarding end of life care in the United States vary by state, but there are specific legal precedents surrounding end of life care that generalize (Alan, 2013). The California Health Care Decisions Law, effective July 1, 2000 (California Department of Justice, 2017), consolidated previous advance directives into the new Health Care Directive (AHCD). AHCD allows you to have legal control over your health care treatment in the event that you are unable to speak for yourself. California's AHCD provides an efficient and flexible format for planning your future health care.

Protocol Development and Training

In Rao, (2014), he discusses a variety of problems seen by medical professionals, including the lack of AD in a systemic study of over 8,000 respondents. Additionally, few institutions exist with formal training in how to approach the issue with patients, and there is a lack of knowledge about how to assess a patient’s end-of-life needs and preferences. According to Bowers (2016) medical personnel who had received training in ACP felt more comfortable and confident about having discussions with their patients. The latter finding is the impetus for this proposal: the belief that patients need AD, and that nurses and others – with training and experience, can facilitate these discussions and accomplishments.

In 2014, Rabinowitz focused on an observational perspective of practitioners in ACP. While the medical group involved was made up of general practitioners (GPs) who had worked with patients whose conditions and diseases included dementia, heart failure, and cancer, some helpful findings might be representative of other GPs. The general findings identified a lack of knowledge about treatment options, lack of communication between GP and specialists, as well as lack of GP experience with the terminal stages of diseases (De Vleminck et al., 2014). Additional problems were the patients’ lack of understanding of their diagnosis and the likely progression of the diseases. It was noted that the GPs saw the little initiation of AD or ACP by patients. Rabinowitz, makes similar recommendations as those made by other researchers: that guidelines and training be established for physicians in the area of ACP.

Obrado, (2016) systemic research notes that there should be a formal protocol for both AD and ACP, and that providers and medical personnel should have training and opportunities to continue study with online and other materials. He notes the importance of including patients and their families in discussions that will result in shared decisions and better outcomes.

Even though there is increasing support for the provision of AD among medical personnel and the public, there remain questions and hesitancy about how the subject should be raised, and who should initiate the discussions (Obrado, 2016).

Perceptions of Advanced Care Planning by the Healthcare Team

A group of family/emergency physicians and researchers undertook a significant study that was published in early 2015. The research team found that although close to half of the participants had discussed the topic of AD, fewer than twenty percent had completed written documents (O'Sullivan, Mailo, Angeles, & Agarwal, 2015). While the majority of those surveyed felt that AD/ACP was the prerogative of the patient, patients who considered AD extremely important were significantly more likely to want their family doctors to start the conversation (O'Sullivan, Mailo, Angeles, & Agarwal, 2015). As helpful as this information is, it does cause some confusion as to the role of physicians in that their place in deciding such cases could be viewed as legally binding or not.

Patient Perceptions

Several reasons are documented in the literature by patients for not having AD. For instance, patients believe that the AD is too binding, they did not want anyone but their family deciding their ultimate fate. Patients say they had never heard of AD or had been putting it off. They also felt uncomfortable making the decision, believed they are not necessary, and thought that the forms were too long. It may be that the greatest barrier to completion is a lack of communication between patients and their healthcare team (Beck, 2013). O’Sullivan, Mailo, Angeles, & Agarwal (2015) also supported these perceptions through an observational study method of approximately five thousand participants.

Current Recommendations

The current recommendations for the geriatric and outpatient palliative care clinics is to initiate a formal protocol to provide AD and ACP with the patients and the patients’ families they serve. Implementation of this policy is supported by the literature mentioned above as well as maintaining compliance with CMS regulatory standards for outpatient medical clinics. The staff will be educated to the protocol and receive specialized training in how to initiate this conversation. This protocol will support the clinic staff in this change in practice to focus on providing ACP. The clinic administration will have to support the implementation of this protocol to include specialized staff training, which will be a cost to the administration. Permission to perform patient chart audits was obtained in order to evaluate the success or failure of this practice change.

The Role of the Healthcare Team in End of Life Care Planning

Karnek & Kanekar (2016) addresses the roles and responsibilities of physicians to include access to AD, communication of treatment options and providing the most likely prognosis specific for the patient’s condition. The authors note that while there should be discussions between the patient and family about the treatment that will also be shared with the healthcare team, but this duty is not to be confused with the unnecessary use of resources and inflicting more harm (Karnek & Kanekar, 2016). What this seems to indicate is that there are other factors beyond what family members want in regards to the patient’s welfare. This review by Karnek, S., Kanekar, A., & Parthasary, S. (2016) echoes the recommendations of multiple other articles and reports, in noting that healthcare executives and administrators must create and implement protocols about end-of-life treatment, and strongly emphasizes that AD education might be included as admission procedures for appropriate patients. This recommendation, if adopted by healthcare organizations and hospitals, would open the gates to discussion and completion of AD, for the benefits of medical personnel, the patients and families.

Overcoming Barriers

Overall, it seems that in order to promote the use of AD multiple approaches and interventions are necessary. Potential targets include improvements in health literacy, addressing cultural biases as well as language barriers, and improving document complexity (Beck, 2013). Education must be a primary goal along with a protocol that streamlines the completion of AD. Improvement in communication, notification, education, and understanding regarding AD has the potential for major improvements in health outcomes in our Geriatric and Palliative care clinics.

Intervention

Simple and cost-effective interventions in the Geriatrics and Palliative care clinics care setting are important to improve AD completion rates. Karnek, S et al. (2016) and Beck, (2013) both used computerized healthcare provider reminders as an intervention to increase completion rates. The computerized reminder prompted the provider to discuss ADs during the visit. The Beck study also included patient mailings. The mailings included educational information as well as AD forms, mailed to the patient one to six weeks prior to the patient’s next appointment. Beck, (2013) study had more success with the computerized reminder alone, which was a larger reminder, more prominently displayed; it also had an area for the healthcare provider to write comments regarding the AD discussion. In addition, education provided to healthcare providers will be part of this protocol to improve AD rates within Geriatrics and Palliative care clinics.

Needs Further Investigation

While the research demonstrates, there is a varied list of barriers to discussing and completing AD; both for patients and for medical professionals. However, further research needs to be conducted regarding how patients prepare themselves and their families for end-of-life. While the research details patient and family confusion, denial, reluctance, and a lack of understanding or information, and the preparation as barriers to completing AD and ACP, the healthcare facilities must have policies in place for completing and storing these documents (Karnek & Kanekar, 2016).

Defining Advance Directives

The AD empowers the patients to make clear decisions regarding the treatment they receive or refuse as they approach the end of life (Brown & Vaughan, 2013). AD provide information to health care providers regarding the type of medical interventions the individual would like to have or not have if the individual becomes incapable of making health care decisions (Croke & Daguro, 2005). There are two forms of AD; a durable power of attorney for healthcare (DPAHC) and living wills. "The DPAHC allows an individual (patient) to appoint someone (agent, proxy, surrogate) to make healthcare decisions for them; it becomes effective when the patient becomes unconscious, loses the ability to make decisions, or is incapable of communicating his or her wishes" (Croke & Dugaro, 2005, p. 21). "The living will provides specific instructions to healthcare providers about the particular types of treatment or procedures the patient would want or would not want to prolong life" (Croke & Daguro, 2005, p. 43).

Significance to the Profession

There can be no question that the population of the US is aging. Baby boomers, the largest group of citizens in the US, are continuing to advance in age. Increasingly, they will need to make decisions regarding end of life care, if not for themselves, then for their family members or friends. In addition, both patients and the healthcare team would benefit in regards to more information regarding end of life disease management, treatment options for care, and ACP. Administrators and directors of nursing would also benefit from additional research into how patients make end of life care decisions so that they can direct their resources and employee training in the areas where they are most needed and most beneficial to patients.

Theoretical Framework

In order to enhance the provision of ACP in both the geriatric and outpatient palliative care clinics, Benner`s conceptual framework, Novice to Expert, will be used in this project. One of the factors that have influenced the selection of this theory was that advocacy is a core competency of nursing. Many nurses are considered advance beginners since they have not advocated regularly in their careers. Benner’s theory will help nurses promote advocacy for patients when assisting end of life care planning. Lum et al. (2016), recently conducted a pilot project at a geriatric clinic and concluded that visits to geriatric clinics could be an effective way to facilitate ACP discussions. Hebert, Moore, and Rooney (2011) advanced a theory of nurse advocacy that suggested nurses bear a responsibility in guiding patients to make the best decisions for their care, with respect for patient autonomy. In her article, she examined nursing advocacy in the past, present and in the future. Sanford (2012) incorporated ACP, as a key component of a nurse’s responsibility for helping patients exercise their autonomy. The conceptual model of novice to expert provides perhaps the most comprehensive practical model for the instantiation of a life care planning protocol in geriatric and outpatient palliative care clinics. As Hebert et al., (2011) assert, Benner`s model unlike previous nursing frameworks, addresses disparities in nurse training and education concerning ACP, and both real and perceived barriers concerning health care provider policies and protocols involving the role of the nurse in ACP (Hebert et al., 2011). Further, Hebert et al. (2011), assert that nurses can perform this model at all stages of their career development.

History of Benner's Novice to Expert Theory

Benner (2005) conceptual framework, Novice to Expert, was drawn from a combination of her exploration of nursing theory and her applied clinical practice as a staff nurse in the seventies, eighties, and nineties. Benner's theory stems from her involvement with a research project designed to validate the Dreyfus model of skill acquisition utility among clinical nurses.

The Dreyfus model is a business framework that shows how the skill is acquired in stages, ranging from beginner, advanced, competent, proficient, and expert (Benner, 2005). The Dreyfus model involves five stages of increasing skill as individuals develop increasing theoretical and practical knowledge. Using a series of qualitative studies, Benner derived a widely used framework for skill acquisition among nurses (Benner, 2005). The research project further allowed her to develop a framework for understanding the role of the nurse as an advocate, which should be referenced to inform the design of the proposed protocol (Lewallen, n.d.). A subsequent study by Thacker (2008), evaluating nursing care involving end-of-life services affirmed the utility of Benner's framework in end-of-life nursing advocacy.

Applicability of Theory to Current Practice

There are considerable challenges to implementing ACP and end-of-life-care interventions. The expectations among healthcare practitioners are that ACP should be driven by patients, rather than by practitioners (Lund et al., 2015). Application of Benner's framework holds that nurses should directly engage patients in end-of-life planning processes (Thacker, 2008). Shickedanz et al. (2015), emphasize the necessity of nurses to provide culturally competent care in end-of-life decision making. Benner’s model, specifically its role of teaching and coaching dimensions, call upon nurses to help patients surmount these barriers. One way in which the Benner`s model can be implemented in the scope of advocacy is when nurses use communication skills, collaborative skills, influencing skills, and any other problem-solving skills in addressing various nursing challenges they may encounter (Lund et al., 2015).

Major Tenets of the Theory

Novice

At this stage, the behavior of a potential nurse in the clinical setting tends to be very limited and inflexible. Also, the potential nurses have limited information concerning what would happen to a particular patient situation (Hebert, et al., 2011). A good example is a nursing student who is in his or her first year of clinical education. These nurses would only participate in observation when ACP is discussed. Clinically, they have not been given the education to provide this information to the patient correctly.

Advanced Beginner

Nurses at this stage tend to be new to the nursing practice and have more experiences that can enable them to understand and recognize recurrent and meaningful aspects of a situation. However, though advanced beginners have the nursing knowledge, they lack adequate hands-on experience (Hebert, et al., 2011). Application of the Benner’s theory and understanding their colleagues, senior nurses or preceptors would be in a position to assess novice and advanced beginner nurses’ skills and competencies and decide how to train them based on the assessment (Lund et al., 2015). The model equips managers and nurses with a metric to assess the performance of their subordinates and themselves. Therefore, Benner’s model is quite useful in nursing management (Chase, 2004).

Competent

In this stage, nurses tend to have advanced organizational and planning skills. Hence, they are fully settled in the clinical setting and has gained in-depth nursing practice skills (Hebert, et al., 2011). Precisely, competent nurses contemplate the nature and patterns of clinical situations accurately compared to advanced beginners (Hebert, et al., 2011). Apparently, these nurses lack the flexibility and speed of proficient nurses. For example, a nurse who has one or more years working experience would receive first steps training, which would allow them to initiate conversations with patients. These conversations would ideally be to provide accurate information to patients regarding AD and ACP options; they do little more than provide this information.

Proficient

At this stage, nurses manage to see and understand clinical situations in a broader perspective rather than parts. Proficient nurses are capable of learning from past experiences concerning what is likely to occur, as well as modifying their plans in response to different events (Hebert, et al., 2011). At this level, a nurse who can give suggestions or plans how to handle a challenging clinical situation. Proficient nurses now have the training to initiate conversations, provide guidance, understand the disease process and prognosis, and consider the patient’s lifestyle and culture regarding ACP (Benner, 2005).

Expert

An expert nurse is capable of recognizing resources and demands in various clinical situations to achieve his or her goals. In addition, a nurse at this level understands what needs to be done, and rarely relies on rules and regulations to guide his or her actions (Hebert, et al., 2011).

Moreover, a nurse at this level has an intuitive grasp of the clinical situation, especially due to his or her deep knowledge and experience (Hebert, et al., 2011). A good example is a nurse who spearheads the training for other nurses. These nurses now serve as mentors and will be able to conduct training for the novice, advanced beginner, and competent nurses. Expert nurses have the experience to guide them through the most difficult ACP.

Benner's model emphasizes the role of the patient as an active agent in all areas of patient care, which includes end-of-life care decisions. Her work draws significantly on the social justice and patient autonomy components of bioethics (Lewallen, n.d.). Throughout clinical decision-making situations, novice and expert nurses have an obligation to remain mindful of the patient's right to autonomy, which is translated to mean the patient has the right to choose or refuse medical treatment or care (Chase, 2004). The patient should choose what and how medical and nursing care is to be delivered prior to the time when they are incapacitated or unable to make medical decisions.

Application of Theory to the DNP Project

Benner's novice to expert model encourages nurses to learn from experience. Experiential knowledge in the nursing profession provides expertise in applying evidence to clinical practice, and medical judgment (Chase, 2004). Patient advocacy as mentioned above is a core competency for nurses. However, a novice or advanced beginner nurse has not yet developed the aptitude to advocate until they have experienced how to nurse. Some nurses may have many years experience working in Geriatric and Palliative clinics but may not have practiced ACP; therefore, these nurses would be considered advanced beginners for the implementation of this practice change. By utilizing Benner's novice to expert model, senior nurses acting as preceptors or managers to understand ways to train nurses at the novice and advanced beginner levels in how to be a patient advocate. Nurses learn through didactic, empirical knowledge as well as clinical education where they learn to care for patients in a clinical site or a simulation laboratory. Advocacy is a skill the novice and advanced beginning nurses need to learn through mentoring, simulation, and hands-on activities with patients under preceptor supervision. The concept of patient advocacy being thought of as a skill that must be acquired is relatively new (Coffey et al., 2016). Advocacy was a concept that was thought to be an automatic expectation of a nurse. It is just what nurses are supposed to do.

Hebert, et al. (2011) also notes that Benner’s model recognizes and inherently incorporates the provision of culturally competent care. In the study conducted by Coffey et al. (2016), provided evidence that a deficit of confidence among nurses to appropriately address end-of-life discussions with patients is widespread. Their five-country cross-sectional study showed nurse confidence levels pertaining to AD and end-of-life care was less among younger nurses than older nurses, regardless of country. Benner’s framework provides a series of practices that can be initiated by nurses at all levels of career development (Hebert, et al., 2011). Using Benner’s theory when providing end of life care guides nurses to be appropriate, compassionate, and in accordance with the patient's wishes, which is an essential component of the nurse's role (Hebert, et al., 2011). Nurses must be willing and competent to begin the difficult dialogue with patients and their loved ones, assist them in understanding their disease state, and explore specific recommendations for care based on their personal values. However, before initiating the discussion regarding AD and implementation of ACP, the nurses should be evaluated or be interviewed to determine their competency level from novice to expert. The more experienced nurses should prioritize this issue in the geriatric and outpatient palliative care clinics and mentor the novice nurses to sustain and improved patient advocacy and end of life care program (Coffey et al., 2016).

Novice

At this stage, the potential nurses tend to offer an assistive role based on providing the patient education in AD, which will have been established in this project. In addition, these potential nurses will be observing experienced nurses to learn how to incorporate advocacy into practice. Novice-stage behavior is guided by newly learned rules that are theoretical in nature. At this level, nurses do not have the experience to judge the context of different situational variables to make decisions and guide actions (Benner et al., 2005). Therefore, supervision from proficient and expert level nurses is necessary to encourage clinical learning and hands-on experience.

Advanced Beginner

The nurse at the advanced beginner level, as mentioned above, is possibly a transitioning nurse from one type of practice to another. These nurses have general nursing knowledge of AD and ACP; however, they may not have the practice of hands-on experience in providing this type of patient care. These nurses may be well organized and knowledgeable in some areas of practice but require occasional supportive cues (Benner, 1984). Advanced beginners should seek out useful training resources. The advanced beginner nurse will be supervised and require hands-on experiences to build knowledge upon. These nurses have basic nursing knowledge but should have oversight in areas where they are less confident (Hallmark, Thomas, & Gantt, 2013). These nurses will attend the educational program for AD and ACP; they will be paired with a preceptor and offered more experiences in initiating and implementing the end of life care protocol.

Competent

Compared to novices and advanced beginners who are focused on the present, the competent nurse actively thinks about the future. This is a conscious attempt to anticipate what will occur in the future to provide guidance for the present. Competent nurses blend their experience with learned knowledge to anticipate what is needed for positive outcomes (Benner et al., 2005).

The competent nurse can anticipate the patient’s needs based on assessment, diagnosis, prognosis, and both subjective and objective information. The patient may not fully understand their diagnosis or prognosis; therefore, may not understand the need for AD and ACP. This competent nurse can evaluate the knowledge deficit, determine the patients' needs, and initiate the AD and ACP process through collaboration with the patient, family members, and the interdisciplinary team (Benner et al., 2005).

Proficient

Proficient nurses have extensive skills and mastered technical tasks; therefore, they do not require much guidance on how to implement their duties. They now spend more time interpreting patient cues and assessments. Proficient nurses have a practical understanding of a patient’s current condition based on the patient’s response over time rather than a collection of separate assessment outcomes (Benner et al., 2005). Nurses at this level will be mandated to use their hands-on experience and knowledge to solve potential crisis situations that may occur (Benner et al., 2005). Little supervision will be required at this level, but the proficient nurse will have to adhere to the established guidelines concerning AD and ACP. Due to the level of knowledge and experience that a nurse in this level has, he or she will be encouraged to provide insights concerning challenging situations that may occur within the project. They may be requested to be preceptors for the advanced beginner nurses.

Expert

Expert nurses have an “expanded peripheral vision,” sensing the needs of others and the capability of those involved (Benner et al., 2005). They sense when they are needed and when a different type of expert should be consulted (Benner et al., 2005). Experts nurse have the knowledge, experience, and conviction to act as a moral agent despite adverse consequences (Benner et al., 2005).

Benner’s theory, in general, has wide application for a DNP prepared nurses’ clinical practice. As a nurse leader, the DNP prepared nurse may be called on to provide training, guidance, mentorship, as well as design nursing initiatives used in clinical settings. The Benner model provides the DNP project with a widely used and validated conceptual framework. Benner’s model will be employed to provide training, design interventions, and advocacy to promote the patient’s autonomy concerning ACP in the geriatric and outpatient palliative care settings.

Benner’s framework formalizes the role of the nurse as active advocates within a bioethical framework. This allows the project lead to provide the nurses employed in the outpatient clinics with ethical guidance regarding their obligation as a patient advocate, which will include the four commonly recognized elements of bioethics: social justice, patient autonomy, beneficence, and non-maleficence.

Social justice: The principle of justice states there should be an element of fairness in all medical decisions: fairness in decisions that burden and benefit, as well as equal distribution of scarce resources and new treatments, and for nurses to uphold applicable laws and legislation when making choices (Karnek, et al., 2016).

Autonomy: In nursing, autonomy refers to the right of the patient to retain control over his or her body. A nurse can suggest or advise, but any actions that attempt to persuade or coerce the patient into making a choice are violations of this principle (Karnek, et al., 2016). In the end, the patient must be allowed to make his or her own decisions, whether or not the medical provider believes these choices are in that patient's best interests, independently and according to his or her personal values and beliefs (Karnek, et al.,2016).

Beneficence: This principle states that nurses must do all they can to benefit the patient in each situation. All procedures and treatments recommended must be with the intention to do the best for the patient. To ensure beneficence, nurses must develop and maintain a high level of skill and knowledge, make sure that they are trained in the most current and best medical practices, and must consider their patients' individual circumstances; what is good for one patient will not necessarily benefit another (Karnek et al., 2016).

Non-Maleficence: Non-maleficence is probably the best known of the four principles. In short, it means, "to do no harm." This principle is intended to be the end goal for all nursing decisions and means that nurses must consider whether other people or society could be harmed by a decision made, even if it is made for the benefit of an individual patient (Karnek, et al., 2016).

Benner's model may be helpful to the current problem of completion of AD by providing a theoretical and practical knowledge base that can be tested and refined in actual situations. Performance and learning needs of staff nurses can be identified and classified based on Benner's five levels of skill acquisition. This process can serve to identify experts that could serve in a teaching and mentoring role for those nurses that are still in the novice and advanced beginner phase. Having an understanding of the skill level of each nurse would better prepare the project lead in developing this protocol to improve patient advocacy and the completion of AD and ACP in the geriatric and outpatient palliative care clinic setting.

Project Design

This DNP project was conducted using a quality improvement design to enhance the rate of AD completion in geriatric and palliative care clinics. This was accomplished by providing ACP training to the population of interest which includes the project site healthcare providers and support staff. Data collection was completed with a pre and post survey to determine the improvement of the knowledge and comfort level in the discussion of ADs by the healthcare providers. ACP training was provided to all staff members of the two identified departments. The site selected for the DNP project consisted of the geriatric and palliative care clinics. The design enabled the collection of data through content analysis. Retrospective data was collected to determine the percentage of geriatric and palliative patients with existing ADs and those who did not. Survey data was utilized to understand the general knowledge of AD's pre and post ACP education training. The comparison of pre and post protocol intervention data provided useful and essential information relevant to the completion of the AD, and is vital in persuading healthcare providers to deliver quality care to patients. The purported design was crucial in achieving the objectives of the DNP project commendably. The primary variables was the patients' preferences and willingness of completing the AD in the clinical setting. In instances where the patients are unwilling to complete the AD in the clinic, families of the patient and staff of the two clinics may need to intervene. It is important to note that only practitioners who rank the proficient and expert levels in ACP according to Benner's model will be ideal to intervene. Nurses in the geriatric and palliative care clinics are considered to be proficient healthcare providers. However, their experience in initiating ACP discussions is significantly lower when utilizing Benner's model. To reduce discrepancies in record keeping; the two clinics will be expected to document electronically.

Population of Interest

The population of interest for the DNP project are all 16 staff members from the geriatric and palliative care clinics. The identified population includes six registered nurses, five physicians, three medical social workers, a chaplain, and a pharmacist. The registered nurse's age range is 30 to 50 years in age. Years experience range from four to 21 years of nursing experience, moreover, four out of the six have a bachelor's of science in nursing (BSN) or higher education degree. The physicians range from 36 to 56 years of age and have two to 20 years of experience. The three social workers are ages ranging from 32 to 62, and they all have a master’s degree in medical social working. The chaplain and pharmacist will be included in the project as they have direct interaction with patients and family members within the geriatric and palliative care clinics. Both the chaplain and pharmacist hold a graduate level or higher degree with ages of 54 and 35 respectively. The participants include 13 females and three males.

Setting

This DNP project is primarily based on aging population setting, geriatric and the palliative care clinics. The two clinics will serve as the project host departments. Approval and permission from the Chief Area Officer were obtained to conduct this quality improvement project (Appendix A). The two clinics together serve close to 2,000 patients in an affluent community in southern California. The clinics belong to a large corporate franchise health maintenance organization.

Stakeholders

The primary stakeholders in the DNP project are the geriatric and palliative clinic leadership since life care planning is centered around them. The healthcare workers in the two clinics are also stakeholders since they have an essential role to play regarding the implementation of an AD protocol. In addition, medical center administrators and six physicians are a key component as stakeholders. Managing the stakeholders requires a good rapport. For instance, they will be involved in making critical decisions regarding our healthcare and treatment plan. A proper communication system will be developed to enhance the sharing of information between the project lead and stakeholders. Stakeholders will be given a direct role in managing the protocol after the completion of this DNP project. Successful stakeholder engagement in an individual project is commendable. Thus, as we engage multilevel stakeholders in our work, it is imperative to evaluate both the process and outcomes of this work (Goodman & Thompson, 2017).

Recruitment Method

All 16 back office staff members from the geriatric and palliative care clinics will be scheduled to attend an in-person survey assessment. Notification was delivered via email along with posted flyers to serve as reminders. Administration mandated that all staff members from the clinics participate in the project as AD completion is part of their job description. In this manner, the staff was recruited to attend the education event where the protocol was implemented. This convenience sample of healthcare workers are full-time equivalent employees working in the two host clinics. None of the participants are employed in other departments. Both clinics front office staff will be excluded as ACP conversations are not part of their scope of practice. The inclusion and exclusion criterion was also relevant during the recruitment process. Healthcare providers identified for the project were limited to geriatric and palliative care clinics since they possessed knowledge and skills regarding the care for the selected population.

Charts to be reviewed were automatically flagged as a proactive opportunity encounter by the EMR as not having an AD on file. A report can be generated by selecting filters to be custom to the geriatric and palliative clinics. The charts with an AD were reviewed for accuracy and updated as needed by the healthcare provider. Those charts that had a current AD was excluded from the protocol. There were no identifiable risks in participating in the project, and the benefits for those who did participate will have a better understanding of ACP.

Tools/ Instrumentation

The knowledge, attitudinal, experimental survey on AD (KAESAD) subscale instrument (Appendix B) was utilized to measure effectiveness for participants perspective pre and post-education training. The KAESAD instrument was developed by Mary Ann Jezewski Ph.D., RN to measure respondents' knowledge of, attitudes toward, and experiences with AD and ACP. KAESAD author, Mary Ann Jezewski PhD., RN permitted to adopt the KAESAD survey for the project (Appendix C). Mary is a reputable Associate Professor and an Associate Dean for Research at the University of Buffalo in New York. The tool was created to assess healthcare provider's attitudes reflect a participatory role in advocating and assisting for patients' rights to make decisions about end-of-life care and ADs (Jezewski, Brown, Wu, Meeker, Feng, & Bu, 2005). Principal components of the KAESAD survey are: general knowledge about ADs, knowledge of the Patient Self-Determination Act (PSDA), knowledge of individual state laws regarding ADs, attitudes toward ADs and end-of-life issues, experience with ADs, experience relation to end-of-life decision making, confidence assisting patients with ADs, and demographic data survey questions to AD's, comfort level, patient perspective.

The validity and reliability of the KAESAD tool used a seven-member multidisciplinary panel to be consulted to establish content legitimacy. Panel members were experts in AD and ACP and represented the fields of nursing, medicine, law, and bioethics. Test-retest reliability and tests to evaluate internal consistency were also calculated in the oncology and ER nurse studies (Ryan & Jezewski 2012).

Lifecare Planning Booklets

Geriatric and palliative care pre-approved the organization’s ACP booklets (Appendix D) was used to guide patients, families, and staff through the individualized AD conversation. Booklets are written in English, and Spanish languages with medical terminology described at a layman's level. Once the booklet is finalized, the healthcare member will validate completion and make copies to be scanned into medical records. The original booklet will be given to the patient for their records. Booklets are intended to be used by organization employees and their members solely. Permission to utilize booklets for this DNP project was given (appendix E).

ACP PowerPoint Presentation

The pre-approved organization's PowerPoint tool (Appendix F) provides a framework through which healthcare providers can accurately be given the same training within the organization. Organization content experts have reviewed all published information and approve for dissemination before implementation. Permission to utilize ACP powerpoint training material was received (Appendix E). The training will consist of the following objectives:

- What ACP is and why it is needed.
- How to initiate difficult but essential conversations and document personal values and preferences.
- What public health and aging services professionals can do to leverage their unique position in the community to assist clients and constituents with advance care planning.
- Where to find reliable guidance and resources.
- California laws regarding ACP.

Chart Audit Tool

A manual chart audit tool (Appendix G) was created to keep track of AD that are completed during the pre-intervention phase. The audit tool will include healthcare provider assigned a number, patients assigned a number, age, gender, ACP in progress, and AD completed. Identification of the healthcare provider will assist in compliance. Each provider for the audit will be assigned a number to protect their privacy. Patients will be assigned a number to provide identification without compromising personal information. Patients age and gender are significant to trend AD's completion rates. ACP in progress will be used to identify patients who have received education on AD's. AD's completed section will be used to identify patients who have a completed and scanned into the EMR.

Geriatric and palliative care workflow

The workflow tool (appendix H) defines the duties that must be performed by nurses, social workers, and physicians. The workflow will consist of an orchestrated, and repeatable pattern of ACP activity enabled by the systematic organization of resources into processes that transform materials, provide services, or process ACP information. Geriatric and palliative care clinics content experts did review workflow before it's implementation.

Data Collection Procedures

The scheduled in-person pre-training survey was provided to all 16 participants at the same time to ensure confidentiality among the group. Each survey was labeled one thru sixteen and randomly issued to each participant. Once participants completed the survey, they were collected and secured by the project lead in a locked drawer for confidentiality. Only the project lead and the assistant medical group administrator will have access to surveys. Following the ACP training, the same participants were issued the same KAESAD survey and assigned the identical number as the pre-survey to ensure matching surveys for each participant. Next, the project lead collected post-intervention surveys and secure them in the same manner for confidentiality. Pre and post surveys were matched together based on the assigned number by the project lead and entered randomly into IBM SPSS®.

A retrospective chart audit was performed to capture the communications of the participants with their patients under the AD screen within the EMR. This audit was conducted for 14 days. A total of 60 charts, 30 from geriatrics and 30 from palliative care were reviewed in the pre-implementation phase. Additional 60 charts were again reviewed post-implementation of the project.

Intervention/ Project Timeline

The DNP project lasted about four to six weeks. While considering the nature of the project, it is evident that ample resources and tools was needed for its implementation. Approval for this DNP project from the project team was received on October 26, 2018. Once approval was received the project lead then begin to prepare all sections for the DNP project implementation.

Week/Date	Activity
Week 1 November 7, 2018	Recruit all participants via email to notify of the mandated educational session date and time. Flyers of the educational session will be posted in the appropriate designated areas.
Week 2 November 13, 2018	The pre-educational survey will be distributed to all participants. Then they will be collected and placed in the locked drawer.

	4 hour ACP training will be provided to all participants. 1 hours to present powerpoint. 1 hour to review booklet. 2 hour to practice conversations.
Week 3 November 20, 2018	The post-educational survey will be distributed to all participants during a scheduled meeting and collected when finished.
Week 4 November 27, 2018	Survey data will be placed in SPSS. The two surveys will be analyzed for improvement in comfort levels with ACP.
Week 5 December 4, 2018	Chart audits performed to verify completed ADs or ACP in progress. Staff will be monitored for protocol compliance. Provide support for practice change.
Week 6 December 11, 2018	Project wrap-up and evaluation. Complete data collection.
Week 7 December 17, 2018	Analyze all the data utilizing appropriate statistical tests.
Week 8 December 25, 2018	Complete presentation for dissemination.
Week 9 January 1, 2019	Contact stakeholders via email to arrange a meeting to disseminate project results. Make arrangements for a meeting room with equipment needed for dissemination.
Week 10 January 15, 2019	Final review of the presentation, print handouts, obtain any other equipment needed.

Week 11 January 22, 2019	Inspect the meeting room and any presentation equipment needed for dissemination. Disseminate findings with stakeholders.
Week 12 January 25, 2019	Prepare presentation for dissemination to course instructors and student colleagues.
Week 13 February 5, 2019	Final review of the presentation.
Week 14 February 12, 2019	Disseminate to course instructor and student colleagues.
Week 15 & 16 February 19-26, 2019	Prepare presentation for dissemination at a professional conference.

Ethics and Human Subjects Protection IRB

To ensure the protection of human subjects, the project lead completed the Collaborative Institutional Training Initiative (CITI) program. This program provided guidelines for the project lead to follow and ensure the safety of human subjects. The safety and rights of the participants in this project was a primary focus throughout the entire development. No staff consent form was needed since the administration required the training to be completed as part of their job description. Determination forms will be submitted to the Touro University Nevada (TUN) course room to govern if the project falls under Institutional Review Board (IRB). The project did fall under TUN quality improvement project and therefore did not need to require a review. The project was also submitted to the organization compliance officer who determined that no IRB be required (Appendix I). There were no identifiable risks associated with the participants and the project. However, several benefits have been identified to include increasing AD completion rate, and skill acquisition to move towards becoming experts in ACP. This project does not include any form of compensation to participants and or patients. Procedures for ensuring privacy and anonymity of the data collected was established as previously mentioned. Each survey was labeled 1-16 and given randomly to each participant and recorded on a sign-in sheet. That same number was then given to the participant for the second survey in order to match the two surveys for the same participant. Organization policies and procedures were followed to avoid the spread of any public health information (PHI). The data from patients' charts did not have any identifiable information and recorded on the chart audit tool. The charts to be audit only come from geriatric and palliative clinics using department filters. The project lead was the only person auditing charts for this project.

Plan for Analysis/ Evaluation

The data collected from the two KAESAD surveys was analyzed to measure respondents' pre-and-post training of knowledge, attitudes toward, and experiential with AD and ACP. The results from the two surveys intend to show significant improvement to justify the need for an AD protocol. The project lead then used the descriptive statistical analysis software from SPSS to analyze the survey data. The SPSS software was used as a means of double-checking the results. A z-test was used to analyze the two surveys from the same participant. A z-test is a statistical test for which the distribution of the test statistic under the null hypothesis can be approximated by a normal distribution. It is one of the most widely used statistical hypothesis tests studies (Kim, 2015). Each participant had their surveys compared side by side to demonstrate KSA between the first and second survey's. Descriptive statistics were calculated for the personal and professional characteristics of the sample. General knowledge scores were calculated using averages and standard deviations. The categories of knowledge, attitudes, and experiences were also analyzed with descriptive statistics and standard deviations. To determine improvement, the analysis of the project was based on the variables of the study: AD and ACP. In the project, the need for improvement in comfort with ACP conversations and AD completion rate facilitated the project implementation.

To measure the AD completion rates on patients through chart review a contingency table of before/after AD completed and AD not completed. A CHI-square test was performed to look at the significant improvement of AD completion before and after with descriptive statistics. A CHI-square statistic is a non-parametric tool designed to analyze group differences when the dependent variable is measured at a nominal level (Mchugh, 2017).

Significance/ Implications for Nursing

Currently, the two clinics are assisting with AD’s when patients or family inquire. The two clinics do not have a protocol in place to aggressively initiate ACP hence the reason this project seeks to utilize best practice to improve AD completion rates. The development of an AD protocol in geriatrics and palliative care clinics did significantly improve completion rates. Also, by improving the nurses’ KSA in providing ACP and utilizing Benner’s model in developing nurses to become experts in the field. Execution of the AD protocol in geriatric and palliative care clinics, did improve patient care, increase the rate of seniors completing AD, and empower the nursing staff to initiate this vital conversation (O’Sullivan, Mailo, Angeles, & Agarwal, 2015). Implementation of this policy is supported by the current literature as well as maintaining compliance with CMS regulatory standards for outpatient medical clinics. Completion of ACP will also bring revenue to the organization per CMS coding guidelines. The expected DNP project results are targeted to be successful for all nurses and become an organizational standard to improve AD completion rates.

As the population ages, nurses have to be prepared to assist in initiating and implementing end of life care the way the patient dictates. Developing and implementing ACP policies are just the beginning of what is going to be an essential evolution in nursing. Nurses not only help to treat and heal the population from illness, but they also prevent illness and provide care to fulfill the needs of the population. As a large portion of the population grows older, there is a need for end of life care. Nurses can assist in preparing the population by providing ACP.

Analysis of Results

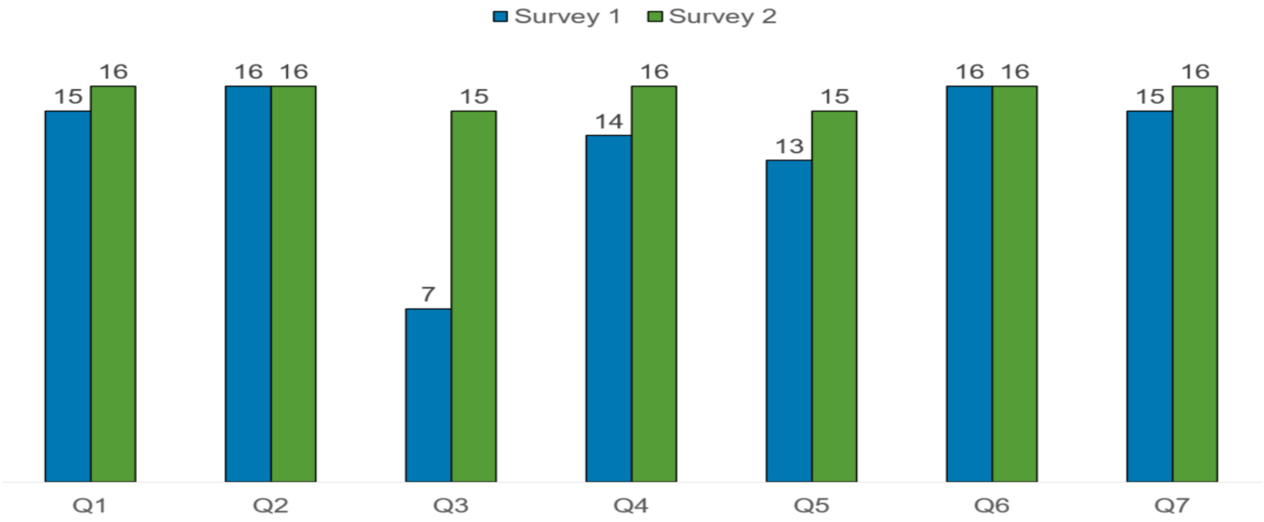
The KAESAD consists of five sections, the first KAESAD scale, include 26 questions with three subscales related to general knowledge of ADs (n = 7), knowledge of the PDSA (n = 7), and California state law governing ADs (n = 12). Knowledge items were answered true or false. Twenty items for both attitude scales, namely the “attitudes about professional experiences with ACP issues” and “attitudes regarding ACP issues.” A Likert scale response ranging from agree to disagree was utilized. The scale pertaining to experience with ADs required yes or no answers for seven questions. Finally, a five-point Likert scale indicating greatest confidence on specific statements was used for 31 questions.

A two-portion z test was used to allow the comparison of two proportions to see if they are the same. To test the participant's knowledge results, a z-test for two proportions was used to assess whether or not there is any improvement after the intervention (Montgomery & Runger, 2010). The questions with more than two categories, will be collapsed into two categories for data collection, so the assumption for the z-test for two proportions are met (Appendix J).

General Knowledge of AD

Section one of the KAESAD examines general knowledge of AD. In this section, the pre-intervention survey had favorable results, which lead to minimal post-education improvement. All 16 participants answered these questions with confidence.

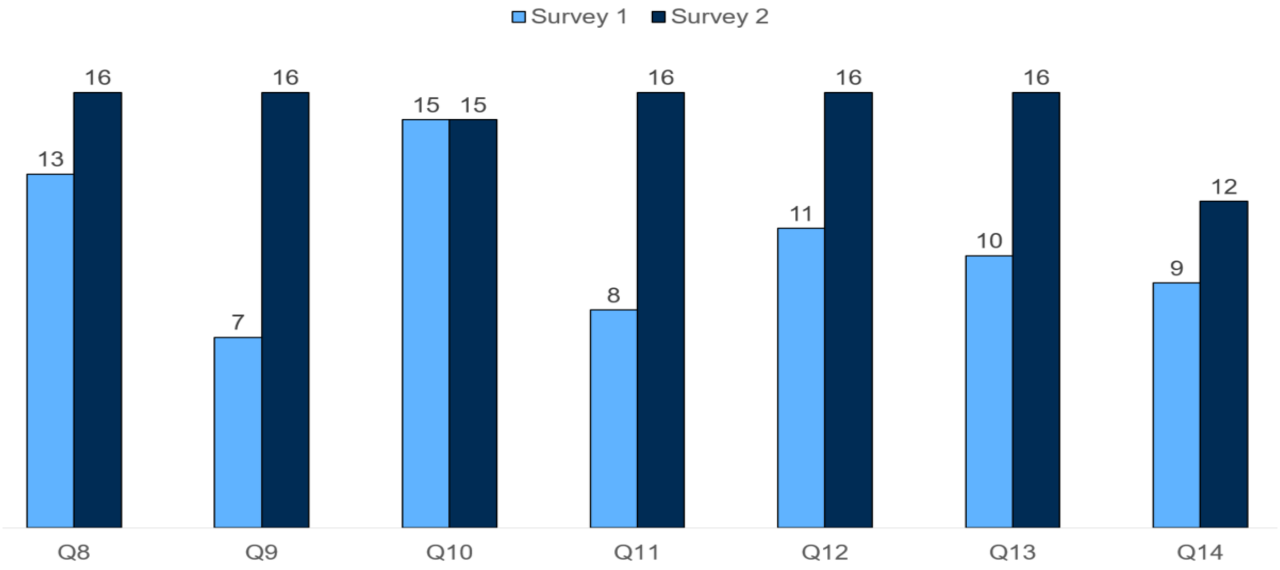
Table 1: Correct response for Q1-Q7



Knowledge of Patient Self-Determination Act

Section two examines knowledge of PSDA of 1990. In this section, the focus was on questions related to the principal components of PSDA. Items in this subscale included healthcare facilities, requirements to inform patients about their rights, and training of staff. Significant improvement was found from all participants. Knowledge of PSDA post-education resulted in a 68% improvement. Participants answered 95% of the questions correctly on the second survey. Question nine: The PSDA created a set of legal statutes that must be legislated and enforced by all 50 states had the most significant improvement between pre and post-education.

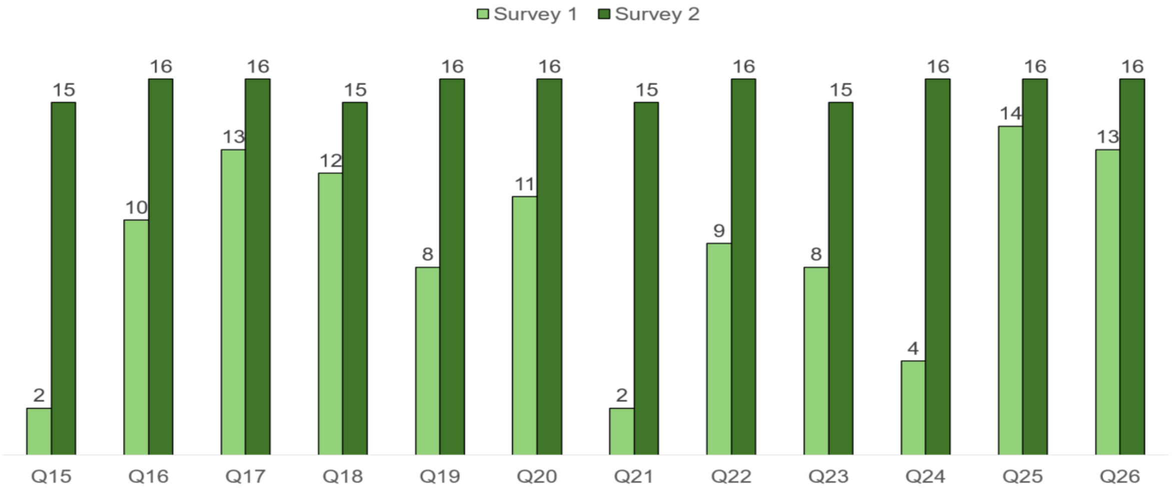
Table 2: Correct response Q15-Q26



Knowledge of California State Laws

Section three examines the knowledge of California state laws regarding ADs. In this section, again significant improvement was found to be evident post-education training. Post education survey yielded 57% increase and 97% of the questions answered correctly on the second survey. All participants showed knowledge gained when it comes to state laws as a result of the education training.

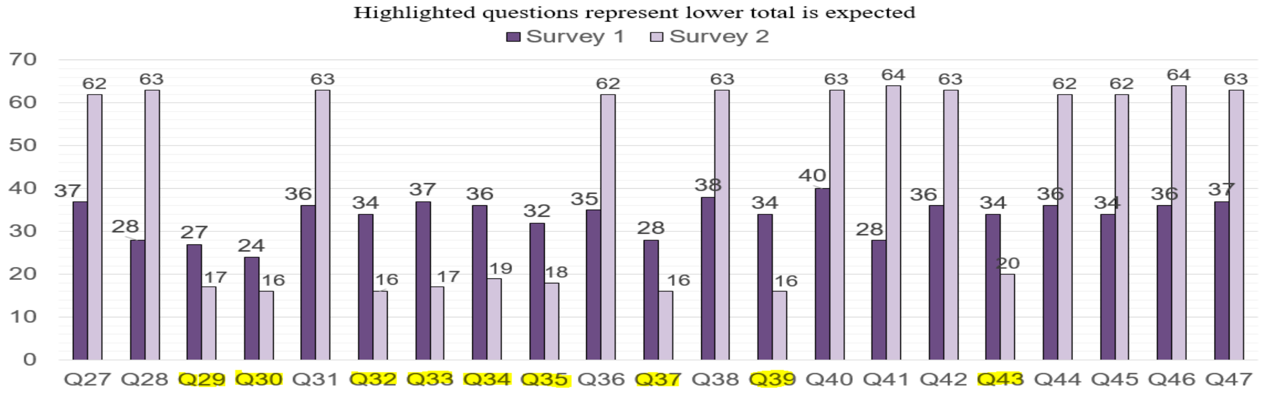
Table 3: Correct response Q15-Q26



Professional Attitude regarding End of Life

Section four examines professional attitude regarding end of life (EOL) decision-making. Significant post-education response shifting towards expected answer was evident throughout this section. There was enough evidence to claim that 95% of the questions had improvement in attitude regarding EOL. Based on the Chi-Square test for independence results, the Chi-Square statistic, the distribution of responses differs significantly for the pre and post survey. Responses to several items reflected a role of healthcare providers as advocates for patients. For example, most participants (97%) agreed that they should uphold a patient's wishes even if the wishes conflict with their view.

Table 4: Correct response Q27-Q47



Experience with ADs

Section five examines the experience with ADs. Significant improvement was discovered from pre and post-education. The improvement was evident to support that 34 out of 37 or 91.8% of the questions regarding experience with ADs. Most of the respondents had cared for patients who had AD (98%), counseled patients and families about ADs (54%) pre-intervention. The participants' confidence in their role of assisting patients and families was significantly increased post-education training.

Table 5: Correct response Q48-Q86

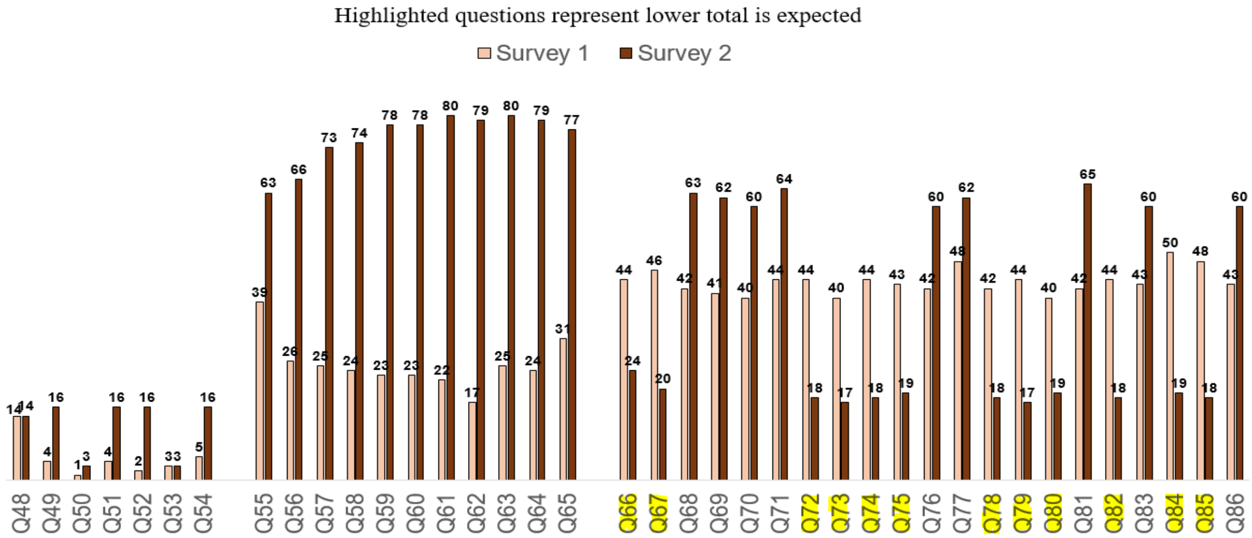
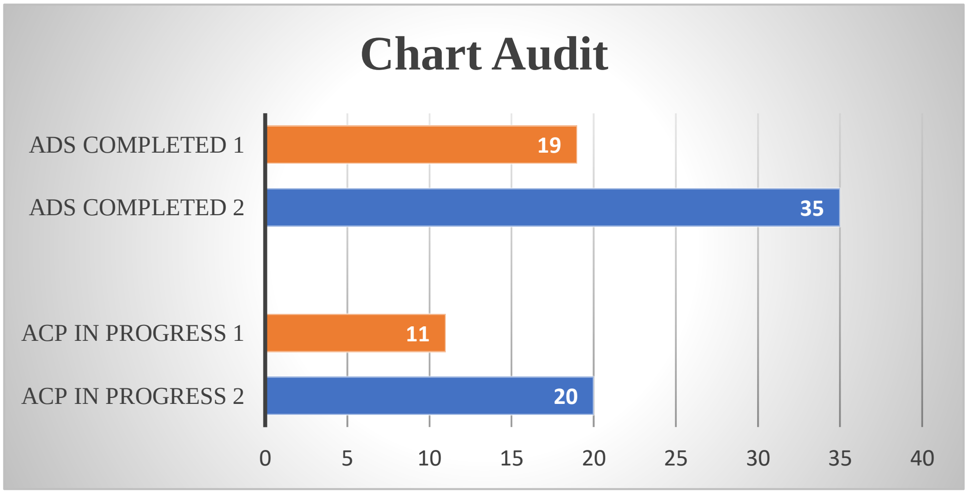


Chart Audits

The pre-education chart audits consisted of 60 random charts to be reviewed to determine how many patients had an ACP in progress or AD completed. Out of the 60, 31 charts had documentation to support ACP in progress. Only 11 charts were found to have a completed AD present in the patient's records. The project objective was to increase the completion rate by 50% post-intervention. The post-education chart audit resulted in the following findings: 20 ACP in progress and 35 ADs completed. The improvement has resulted in a 57% increase of ACP in progress and ADs completed.

Table 6: Summary of 60 charts pre and post-intervention



Discussion

The pre-intervention KAESAD demonstrated that the participants did not feel confident with California state laws regarding ADs and PDSA. According to the survey, attitude and experience fluctuated between the participants. Most participants did feel comfortable about general knowledge of ADs. Overall, survey findings confirmed the participants are marginally confident in initiating and counseling patients regarding ADs. However, nurses and other participants have confident knowledge of ADs. Participants reported they need additional education, time, resources and support to better assist patients with ACP.

Statistical analyses of project data revealed the four-hour education program and the implementation of an AD protocol did increase the overall comfort and knowledge of the participants of the two clinics. The overall knowledge, attitude an experience level among the participants in the post-education KAESAD had an impressive 82% improvement. The findings have shown that nurses who had education in the workplace on ADs had significantly higher knowledge scores and more positive experiences with ADs than nurses who had no AD education. The AD protocol was proven to be crucial for the two clinics to improve their ACP in progress and AD completion rate by 57% during the project evaluation period. This increase did reach the project objective of improving ADs completed of 50%. The data suggest the answer to the project question is the educational intervention did result in a change in completed AD in this population.

According to the recommendation from the current literature, in order to improve AD completion rates healthcare providers must be provided training on ACP. Together, education-training along with simulation is the consensus from the current literature to improve comfort levels in performing ACP. As documented by O'Sullivan et al., (2015) acquiring ACP skills over time provide the much-needed resources in changing the perception of the healthcare team as well as the patients. Healthcare executives and administrators must create and implement protocols about end-of-life treatment, and strongly emphasize that AD education is required for anyone having ACP conversations.

Significance to Nursing

As mentioned before in Benner's novice to expert model, education and resources encourage nurses to learn from experience. Experiential knowledge in the nursing profession provides expertise in applying evidence to clinical practice, and medical judgment. Education is proven to be meaningful; however, without policies and protocols, nurses may not advance from novice to expert with confidence in ACP conversations. O'Sullivan et al., (2015) has suggested that support, mentoring, and resources could be helpful when advancing in Benner's model. These areas are vital in sustaining this AD protocol. The resources and support provided to nurses continue to improve knowledge, attitude, and experience in developing a comfort level in ACP.

Support

Nurses request increased support from administration, nursing leadership and physicians in their role in the ACP process as it is within nurses' scope of practice to initiate and discuss ADs with patients. According to this project survey, the majority of nurses felt they had administrative support, but less than half of nurses felt they had physician support to actively participate in ACP. A multi-disciplinary approach to ACP, with the inclusion of nurses, has been shown to be successful in diverse communities (Pecanac, Repenshek, Tennenbaum, & Hammes, 2014).

Mentorship

Nurses should have the opportunity to be mentored in their communication practices regarding ADs. The majority of the nurses in this project reported the mentorship of less experienced nurses in their communication practices would be beneficial. Studies have shown that years of experience in nursing correlates positively with interaction with families regarding ADs (Black & Emmet, 2006). More experienced nurses report an increased interaction with family and disclosing additional information about ADs than less experienced nurses (Jezewski et al., 2005). Through this project, less confident nurses were offered mentorship to provide support until they felt comfortable with ACP. An adherence committee was developed to assist and provide feedback to these nurses as part of the AD protocol. The participating nurses reported that having the opportunity to role-play, practice, and mentoring from content experts was beneficial.

Resources

Nurses should have access to ACP resources or guides to help understand the ACP process and help facilitate discussion with patients. Again, the majority of nurses answered that having AD resources or guidelines readily available would assist them in performing ACP discussions with patients. Not only are resources helpful for nurses, but the most successful interventions for AD completion among patients occurs when patients receive combined written and verbal educational interventions about ADs (Durbin, Fish, Bachman, &

Smith, 2010). As part of the educational training, all participants received copies of the ACP training material to use as a reference.

As part of the multidisciplinary team, nurses have a key role in patient discussions and can significantly contribute to the process of ACP. Familiarity with the process will enhance communication not only with the patient but with the multidisciplinary team. Establishment of a framework for these conversations will enhance the process of ACP and increase ADs.

Limitations

There are a couple of limitations within this DNP project. First, the number of healthcare members participating in the scholarly project was small (N = 16). The sample size is not reflective of the general population. This compromises generalizability of the results. Second, the sample was a convenience sample, resulting in a questionable degree of generalizability. Participants were employees of the clinic resulting in possible bias. Finally, the survey was conducted in California and may not reflect the knowledge and attitudes of healthcare providers in other states. The project did not experience any limitations in the design, data collection, or analysis.

Dissemination

Dissemination of the project is planned to report results to the medical center's stakeholders, online academic community, and out-patient clinics within the same medical center. ACP conversations continue to be a challenge for our healthcare system. The goal for dissemination is to heighten awareness for this vulnerable patient population and may influence a change in practice to optimize care. The project lead will share the project findings with the stakeholders through a presentation at the quarterly organization regional Geriatric, Palliative Medicine and Continuing Care Services (GPCC) meeting in Pasadena, CA. The audience will include department lead physicians, directors, and institutional leaders. The PowerPoint presentation will include a summary of the project, and its results with recommendations for sustainability. Also, the project will be a resource to the academic community through publication in the university's electronic database and submit to dnpprojects.org website. It is the goal for this project to be presented as a poster at a nursing conference or submitted for publishing.

Sustainability

Developing and implementing patient care protocols within a specific organizational setting requires knowledge of the protocol, the organization, and the way in which the organization does its work. At the start of this project, it was essential to ensure all relevant stakeholders understand project requirements clearly and the importance of having an unambiguous project scope. During the project presentation to the organization's stakeholders, the importance of having an adherence committee was introduced. The adherence committee will meet monthly to provide follow-up and action items related to the project. This committee will be responsible for maintaining the support, guidance, and oversight of progress. Once the protocol has become part of an effective daily routine for the two clinics the goal is to spread and adapt to other out-patient clinics. The host departments will also participate in developing the organization's AD policy and procedure.

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