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Standardization and Staff Education to Increase Short Form Health Care Directives in an
Oncology Clinic: A Pilot Quality Improvement Project

DNP Project
Submitted in Partial Fulfillment of the Requirements for the
Degree of Doctor of Nursing Practice

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This is to certify that I have examined this
Doctor of Nursing Practice DNP project manuscript
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and have found that it is complete and satisfactory in all respects,
and that any and all revisions required by
the final examining committee have been made.

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Introduction

The process of death and dying is a discussion often avoided in the United States as a topic that is ominous and taboo. In the healthcare profession, however, we strive to discuss, document and preserve the patient's wishes at the end of life, otherwise known as advance care planning (ACP). A healthcare directive (HCD) is the legal document used to enforce these expressed wishes and values (Dube, McCarron, & Nannini, 2015). In the United States, about one-third of adults have completed a health care directive, the number increases to one-half in those aged 60 years and older (Benson & Aldrich, 2012).

The decision to file a healthcare directive is essential not only in the general adult population, but especially in patients who have multiple co-morbidities, life-limiting illness, or terminal illness. Completing advance care planning in the early stages can reduce financial burden, unwanted medical interventions, and clarify the patient's wishes (Dube et al., 2015). Therefore, the oncology clinic began an initiative to have a unique health care directive, known as a Short Form Health Care Directive, completed and filed into the electronic medical record (EMR) of every patient. While the oncology clinic had an ACP referral process in place to complete health care directives with palliative care, there was no process in place for adopting this new initiative. Implementation required several vital components. The clinic lacked a standardized process for introducing Short Form HCDs to patients, and staff needed education on how to file a Short Form into the EMR. Additional needs included patient education, increased awareness of the initiative, and clear staff roles and responsibilities.

Background

The standard referral process for advance care planning in the oncology clinic includes a referral placed by the oncologist to a palliative care provider for the completion of a traditional

health care directive. Created by Honoring Choices Minnesota, this type of HCD is known as a Long Form Health Care Directive. The Long Form is a nine-page document that provides a comprehensive, detailed advance care plan, including specifics such as how to handle the body after death. The second most utilized ACP form in the clinic is the Physician Orders for Life-Sustaining Treatment (POLST) form, which provides options for code status. The POLST is a medical order used near the end of life, usually within the last six months, to direct medical care. The form is a one-page document that discusses cardiopulmonary resuscitation or intubation and the level of medical interventions—providers in the oncology clinic complete it based on clinical judgment and individual need.

In contrast, the Short Form Health Care Directive serves primarily to designate a healthcare agent or healthcare decision-maker if a patient is unable to do so for him or herself. The form includes an optional section to write-in health care wishes, though this was not utilized for the DNP project and has potential for future use in a phase II quality improvement project. Following the filing of a health care directive in the electronic medical record, a banner would be placed across the front of the record, signifying its existence to staff. Providers also had the responsibility of placing "Advance Care Planning" on the patient's problem list in the EMR.

Problem Statement

Without the presence of a health care directive in the patient's electronic medical record, there is no formal instruction on how to proceed in the event of a medical emergency. It would be unclear whom to contact and who holds the ability to decide what health care decisions to make if the patient was not able to speak for him or herself. Also, unique circumstances arise with legalities, such as complicated personal relationships, how to handle the deceased body and other challenging issues. Stakeholders involved include the patient, family, provider, and other

healthcare staff, health care organization, medical examiner, the legal system, and the broader community.

Needs Assessment

The oncology clinic's needs included the development of resources addressing identified barriers to increasing the number of Short Form HCDs filed. The DNP student developed the standardized process, created an educational presentation, and compiled a handbook for staff reference. Additional materials were developed or provided by Minnesota Honoring Choices to the clinic, including signage, a welcome letter, nurse script, and educational handouts.

First, a standardized process designating palliative care nurses with the primary responsibility of filing Short Forms with patients was created and implemented through a video presentation to educate staff. Second, paper and electronic signage to increase awareness of the initiative were placed on the waiting room television and around the clinic in exam rooms. Third, a "Welcome Letter" was placed in the "Welcome to the Oncology Clinic" packet for all new patients, identifying the importance of the initiative and the eventual goal that all patients will have a Short Form HCD in the EMR. Fourth, was the placement of educational patient handouts on ACP and identifying a health care agent (HCA) in the welcome packets. Fifth, a nurse script on how to approach patients, and a resource book were provided to oncology clinic staff. Lastly was the inclusion of additional internal and external resources in the resource handbook for further assistance.

Significance and Contribution to the Literature

Review of the literature shows studies where different professions, primarily providers, nursing, and social work, held varying roles and responsibilities in regards to advance care planning. Defining characteristics of this pilot HCD study is the primary responsibility of

palliative care nurses to discuss and file the Short Form with the patient. Providers serve in a back-up role for when the patient declines or would like to speak with the provider regarding ACP instead. Additionally, the Short Form HCD differs from traditional HCDs in its primary purpose. It enables the patient to name a health care agent using a two-page form, which requires a relatively short amount of time to complete.

Significance to the Nursing Profession

As nurses often are the initial point of contact with patients and have a continuous relationship with more time spent with the patient, they can play a pivotal role in advance care planning. In particular, palliative care nurses have expertise and training in educating patients on the significance of ACP and discussing end-of-life (EOL) care. By the Gallup's poll, for 18 years, nurses have secured the top spot of the most trustworthy profession (Reinhart, 2020). Hence, nursing has the potential to guide patients who are undertaking the sensitive topic of ACP, especially for those who lack trust in the medical field.

Purpose Statement

The purpose of the DNP quality improvement project was to increase the number of Short Form HCDs filed into the electronic medical record of patients in the oncology clinic. Barriers included the lack of a standardized process to file the forms, need to increase overall awareness by educating patients and staff on the initiative, normalize the ACP discussion, and the lack of additional resources. The PICO question is: In oncology clinic staff, will the implementation of a Short Form standardized process and staff education lead to an increase in Short Forms filed, versus current practice?

Project Goals

Successful implementation expects the post-intervention data to show an increase in the

number of Short Form HCDs filed compared to prior. Also, through a staff values and beliefs survey, it is expected that staff will show an increase in confidence level regarding having an advance care planning discussion and guiding the patient to file a Short Form. Staff would report ACP as valuable and have expectations regarding ACP completion as well. Goals include: 1. The number of Short Form HCDs filed will increase by 25% within a three-month timespan in the oncology clinic. 2. The staff post-survey will demonstrate an increase in staff confidence and expectations regarding ACP when assessed with a Likert scale.

Project Objectives

The first objective is to complete a literature review to identify 3-4 interventions with the most robust research evidence to improve the completion of health care directives. Secondly, develop and implement a clinic-wide intervention program to increase Short Form HCDs filed including: development of a standardized process on completing a Short Form; staff education on the standardized process with quiz competency evaluation; distribution of patient and staff resources; surveying of staff pre- and post-study; and data collection to assess the trend of HCDs filed.

Theoretical Framework

On December 1, 1991, the Patient Self-Determination Act (PSDA) was enacted in the United States to uphold the rights of patients in accepting or refusing medical treatment, as well as a right to complete a health care directive to guide medical care (Goodwin, Kiehl, & Peterson, 2002). With its belief in patient autonomy and role as a patient advocate, the nursing profession is in a prime position to aid patients in advance care planning. In past studies, however, nurses have reported feeling unprepared, reluctant, and being resistant to the role and responsibility of supporting patients in completing HCDs. The use of King's theory of goal attainment can guide

nurses and patients toward advance care planning. King's Conceptual System consists of the relationships between three systems, the personal (individual), interpersonal (group), and social (society) (Goodwin et al., 2002).

The theory of goal attainment is an interrelationship between the personal, interpersonal, and social systems (Goodwin et al., 2002). The use of the Advance Directive Decision-Making Model, founded by King's conceptual systems and goal attainment theory, is proposed for use in advance care planning. The personal system concepts are perception, growth and development, self, space, and time. The interpersonal system concepts consist of interaction, communication, transaction, role, and coping. Finally, the social system concepts include organization, authority, power, status, and decision-making.

Perception and time are a part of the personal system with perception being the nurse's ability to discern when to provide education and the patient's decision or inaction with advance care planning. Timing is the need to discuss ACP and complete a health care directive regardless of health status and age. Interaction and role are concepts within the interpersonal system, with interaction being the advance care planning discussion between the nurse and patient. The nurse's role is a facilitator for the discussion while the patient's role is active participation in the ACP process. The social system includes the three concepts of power, status, and decision-making. The patient holds power to make healthcare decisions with support from the nurse who provides knowledge. Further, the patient has the status of authority to make decisions and choose amongst the options available, including inaction (Goodwin et al., 2002).

Literature Review

A review of the literature focused primarily on intervention studies that involved ambulatory or outpatient care settings, barriers, health care staff, and patient perceptions, and the

completion of health care or advance directives. Keywords or a combination of the terms entered into the databases included: advance care directive or health care directive, ambulatory or outpatient, systematic reviews or meta-analysis, and interventions or strategies, which were entered into the databases Academic Search Premier, EBSCOhost, CINAHL Plus with Full Text, and Medline. Filters placed limited publications from 2005-2020 and those written in English. Exclusion of articles included those not available through full-text or the St. Catherine University library. The results ranged from 100-102 articles of which further exclusions based on setting, medical condition, profession, age, and relevancy narrowed down to 9 articles. Primary care and oncology clinics were the two settings included, excluding all other specialties and settings. Excluded were studies specific to medical conditions besides cancer, as well as those specific to non-healthcare professions. Further exclusions included pediatric studies since the oncology clinic serves adults. Included studies were the older adult or geriatric studies as this population is seen in the oncology clinic, and is the most prevalent population studied for HCD completion.

A literature review by Solis, Mancera, & Shen (2018) focused on ACP interventions in older adults within the primary care setting. The findings indicated the most effective interventions utilized included a variety of delivery methods, computer reminder prompts for providers, the involvement of a multidisciplinary team, and preparing the patient before the ACP visit (Solis et al., 2018). The most effective interventions in increasing HCDs were those that used a combination of interventions or a multipronged approach versus a single approach. Provider identified barriers included time constraints, limited preparation, fear of stressing patients, and limited knowledge of the topic. Meanwhile, patients identified a lack of knowledge, poor understanding, and complexity of documents as barriers. Additionally, the lack of standards and guidelines in health care regarding ACP further impedes the practice (Solis et al., 2018).

Tamayo-Velazquez et al. (2010) conducted a narrative review of the literature evaluating the effectiveness of interventions in increasing advance directive completion. The evaluation of seven systematic reviews found that the most effective intervention for increasing ADs was a two-pronged approach. The highest AD completion rates were seen in studies that provided the patient with informational materials and had multiple discussions with a healthcare professional (Tamayo-Velazquez et al., 2010).

In a systematic review by Bravo, Dubois, & Wagneur (2008), that assessed the effectiveness of interventions on advance directive completion in older adults, it found that oral information over multiple visits was the most successful intervention. Intensity level as in time, content type, and multiple sessions was the highest determinant (Bravo et al., 2008).

The literature review also assessed two studies implementing interventions to increase advance directives. Luu et al. (2017) used a multidisciplinary approach that included providing an informational letter and required forms before the visit, an informational video, and a provider reminder during the appointment. The result was that 47% of patients completed one or more ACP forms, while 53% of patients discussed but did not complete a form (Luu et al., 2017).

Vleminck (2016) conducted a similar study in its first phase that utilized several components in the intervention including: provider training, identifying appropriate patients, an educational booklet for patients, a conversation guide for providers, and a documentation template. Each component of the intervention developed was done through the guidance of the United Kingdom Medical Research Council (MRC) Framework. Providers identified a lack of confidence and knowledge, difficulty determining when to initiate the conversation, and difficulty discerning a patient's mental capacity as barriers. Providers expressed the need for a central location for the health care directive (Vleminck, 2016).

Also included were four articles examining the perspectives and barriers to ACP from the patient, provider, nurse practitioner, and nurse viewpoints. Patients with advanced cancer identified a lack of knowledge and procrastination as the two most significant perceived barriers to completing ADs (McDonald, Manoir, Kevork, Le, & Zimmerman, 2016). The majority of patients in the study had completed an AD before cancer diagnosis, and factors associated with higher completion were increased age and income. Factors associated with a higher AD completion rate after diagnosis include having an EOL discussion and consultation with a palliative care team (McDonald et al., 2016).

Providers reported issues with retrieving ACP documentation and unclear roles regarding who should lead an ACP discussion (Dillon, et al., 2017). There was an expressed desire for standardization, more time, policy changes, patient education, provider training, and the normalization of ACP practices. Recommendations include a multipronged quality improvement initiative and redesign of the electronic health record system (Dillon, et al., 2017).

A cross-sectional descriptive study surveyed Canadian nurse practitioners in regards to advance care planning (Rietze, Heale, Hill, & Roles, 2016). Findings included similar barriers as identified by physicians to ACP, such as time constraints, unclear roles and expectations, lack of policy, unclear procedures, and a need for clear documentation. ACP was believed to be a significant issue but not perceived as appropriate until after the first hospitalization. Recommendations include the creation of clear policies and procedures and standardizing the approach to ACP (Rietze et al., 2016).

In a systematic synthesis of three survey studies focusing on nurses' perceptions of advance directives, there was strong support for advance directives (Ryan & Jezewski, 2012). Nurses felt the need for patient advocacy, and that upholding the patient's wishes was critical to

advance care planning. There was some uncertainty regarding the nurse's role in ACP and suggestions for a multidisciplinary approach. The discussion of types of EOL care and prognosis was deemed to be more appropriate for those with advanced education and training (Ryan & Jezewski, 2012).

In summary, a review of the literature was elusive. It did not identify a single specific intervention as consistently effective with variability in results on health care directive completion. Instead, several overall themes can be drawn. The most effective interventions occurred over several encounters with the collaboration of a multidisciplinary team. Furthermore, the interventions consisted of a multipronged approach and a high-intensity level in terms of direct interaction with a healthcare professional. The recommendations found in the literature emphasized a standardized approach with clear policies and procedures, clear roles and responsibilities, and patient preparation and education with oral information. The similarity in barriers identified by health care staff included lack of time, role ambiguity, lack of knowledge, need to normalize the ACP conversation and issues with documentation. Patients cited procrastination and lack of knowledge as barriers.

Project Implementation & Evaluation

Due to the short duration of the pilot study and variability in the number of visits to the oncology clinic, a multipronged approach was the focus of the intervention versus repeated encounters. The oncology clinic staff viewed a presentation on the standardized process for filing a Short Form HCD. A competency quiz followed, which resulted in 95% of the 21 staff members scoring at 80% or above. Next, the staff completed surveys on their beliefs and values about ACP before the start of the pilot study. It showed that the majority of staff felt there were expectations to engage in ACP and a belief that even a limited time of 20-30 minutes spent on

ACP was useful or valuable. Many staff members did not feel prepared to overcome barriers with ACP and did not have sufficient knowledge of filing a Short Form.

The designation of primary role and responsibility by palliative nurses of filing Short Forms with patients was standardized, while providers served a back-up role when the patient declined. Providers also held the responsibility of adding "Advance Care Planning" to the problem list in the electronic medical record. Social workers and the DNP student were third in line as additional resources. Overall awareness of the HCD initiative included creating signage to display throughout the clinic and a letter preparing the patient and explaining the initiative. Normalizing the ACP discussion consisted of providing educational handouts through Honoring Choices Minnesota. Best-selling author and medical researcher, Dr. Atul Gawande, is CEO of ARIADNE labs and was the source of the handouts. ARIADNE labs is a leader of HCD studies and provides nationwide training to healthcare systems. Also, in relation to social justice considerations, handouts were provided in a variety of languages and interpreters were readily available. Finally, palliative care nurses were provided a standard script for introducing the HCD to the patient and had a nurse resource handbook for reference.

Data was collected through the assistance of an informatics specialist at the clinic and was free of patient identifiers. The pilot study results were inconclusive as the number of Short Form HCDs filed did not show a significant change from the beginning to the end of the study. The study was stopped six weeks after the start date in mid-March 2020, half as long as initially intended. Due to the COVID-19 pandemic, the clinic had a cancellation of all non-essential visits, and only saw a limited number of patients. The post-study staff survey was not collected as several staff members had mandatory reduced hours, leave of absences, or were re-assigned to other care areas.

Discussion

Interpretation of the findings is difficult due to the short duration of the project and limited data collected. One interesting finding was the significant increase in the number of POLST forms completed by providers towards the end of the study. January 2020 concluded with 5 POLST forms completed compared to March, which tripled the number of POLST forms to fifteen. The cause of this finding may be factors such as increased awareness, the COVID-19 pandemic, or for other reasons unrelated.

Strengths of the project include its evidence-based, multipronged approach, and considerations for identified barriers in patients and healthcare staff. This pilot study's distinguishing factor includes its uniqueness in the type of HCD used, a Short Form. This shortened HCD reduces the amount of time spent completing the form and serves an essential purpose, to have at least one designated health care agent to make healthcare decisions when needed. Utilizing the Short Form decreases time constraints as identified by healthcare staff and procrastination as identified by patients. Limitations are due to the healthcare environment with the COVID-19 pandemic, its short duration, and the lack of available data following the study. It is also important to note that the systematic reviews and studies included primarily focused on interventions in the older adult or geriatric population and may not be as receptive to a younger population.

The contribution to nursing and interprofessional collaboration the study provides is guidance for future evidence-based interventions in HCD completion in the outpatient setting. Nurses are educated professionals who have firsthand experience caring for critically ill patients at the end of life. The nursing profession holds the trust of Americans and has the potential to be strong advocates for advance care planning. Nonetheless, the literature still supports a

multidisciplinary collaborative approach and advanced providers who can discuss the prognosis of illness with the patient.

Implications and Conclusion

Suggestions for future studies include an extended study period, which would increase the likelihood of multiple encounters to offer patient education and health care directive completion. Furthermore, assessment of clinic staff should be done early on in the trial to identify barriers and make adjustments as needed. The inclusion of a formal monitoring process would also raise awareness of the initiative and its progress. As suggested by the literature, a health care directive initiative should have designated roles and responsibilities as well as clear policies and procedures to uphold ACP planning expectations. Further work on increasing health care directive completion is essential to properly advocate for patients who are incapable of or at the end of life.

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