

Advance Care Planning Complexities for Nurse Practitioners

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ABSTRACT

Patients and families are often asked to make critical decisions about end-of-life (EOL) care without any warning or knowledge of the patient's wishes. EOL decisions may cause significant anxiety for all involved. A study was conducted to assess the prevalence of advance care planning (ACP) discussions and to identify barriers and facilitators to these discussions by nurse practitioners. Educational, time, and systems factors were found to impact these discussions. Developing educational programs and influencing policies surrounding ACP may increase the number of discussions and promote advocacy for the patient and improve health care.

Keywords: advance care planning, advance directives, barriers, end of life, nurse practitioners

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Although patients may live longer because of advances in medical technology, the quality of life near end of life (EOL) may not be optimal. The complexity of multiple chronic conditions along with an aging population may lead to more frequent and prolonged hospitalizations. These circumstances may create a situation in which patients or families are asked to make critical decisions about EOL care without any warning or knowledge of the patient's wishes in a time-restricted manner. Decisions made during a time of health care-related crisis for the patient can be overwhelming. Conversations about EOL issues at this time can cause added stress and may not accurately reflect the patient's wishes.¹ These discussions need sufficient time allotted for explanations,² require an empathetic approach, and demand honesty from the care provider to give the patient and family sufficient information to make appropriate decisions. Ideally, these conversations occur in advance of a crisis through an ongoing dialogue with one's health care provider.

The process of advance care planning (ACP) is a method by which patients contemplate future health care decisions and document their wishes.³ Discussions with patients and their families to engage them as active participants in their care are essential to ACP. Through patient engagement, explanations of

illnesses, and anticipatory planning, patients can make informed health care decisions. These proactive ACP conversations may help reduce both personal stress and financial burdens.

Health care costs and their burden on society have recently been the focus of much public attention. This burden encompasses issues of patient advocacy, personal financial expenses, concerns about controlling health care costs, and the future viability of both Medicare and private insurance systems. Improvements in medical treatments and prognoses have contributed to instances in which health conditions previously considered terminal are now extended chronic illnesses. At a time of acute hospitalization, a lack of previous ACP discussions may add to the personal anxiety of the patient/family and lead to medical interventions that may not be desired. ACP is crucial to help reduce the cost associated with EOL concerns for both the patient/family and the health care system.

Several benefits of ACP have been cited in the literature and include patient comfort and dignity; increased patient satisfaction with care; decreased patient, family, or provider anxiety with respect to making a life decision in an urgent situation; increased knowledge of the provider in understanding patients' wishes; and decreased cost to the health care system.⁴⁻⁶ Despite the widely known benefits of

ACP discussions, many barriers may exist to having these discussions. These may include time issues, communication difficulties, personal anxiety about the topic, lack of provider training in discussing this topic, lack of provider knowledge about advance directives (ADs), and concern about patient acceptance of the discussion.^{1,7,8}

Knowledge of nurse practitioner (NP) practice in the area of ACP is limited. Previous research has primarily focused on increasing the numbers of ADs rather than the process of ACP and almost exclusively concentrated on physicians.^{7,9-13} Few studies exist involving NPs and ACP.^{14,15} Provider beliefs may also impact the decision to initiate ACP discussions. Stoeckle et al¹⁶ investigated provider beliefs in 1998. Revisiting the changes in beliefs in the current health care environment may also lead to additional insight regarding NP practice and ACP discussions. Current health care policy experts are investigating increasing patient satisfaction, containing costs, and encouraging NPs to be primary care providers.^{17,18} Research investigating whether NPs are having ACP discussions or not should be included.

NPs are advocates for their patients in all aspects of health care, and this should include ACP. Having and appropriately documenting these discussions may also increase the quality of care and decrease long-term costs. Exploring the barriers and facilitators NPs encounter with respect to ACP discussions is critical to improving patient advocacy and lowering health care expenses at EOL. Aligning with Kolcaba's Comfort Theory¹⁹ of providing support as patients progress through life and death, the purpose of this study was to assess the prevalence of ACP by NPs and to identify perceived personal, professional, and systems barriers and facilitators to NPs having ACP discussions.

METHODS

Study Design and Participants

This study used a quantitative nonexperimental descriptive design. A nonprobability convenience sample of NPs from a statewide organization's database self-selected to participate in the survey. The survey was delivered via the Internet using SurveyMonkey (SurveyMonkey, Inc. Palo Alto, CA). It was conducted using an established and validated

questionnaire¹⁶ to investigate provider beliefs and perceptions along with a professional and demographic component developed by the principal researcher.

The questionnaire included 5 demographic and 6 professional characteristic questions, 4 questions about previous EOL education, and 2 questions about barriers and facilitators to ACP for NP practice identified by a review of the literature followed by Stoeckle's End of Life Care Decision Questionnaire II (EOLCDQ II).¹⁶ The participants were asked to respond to the barrier and facilitator questions in a 5-point Likert scale format rating various time issues and systems factors. One open-ended question was included to identify any other EOL issue not addressed by the formal questions.

Procedure

Both the institutional review board of the university and the research committee of a statewide organization of NPs approved this study. After obtaining approval, a cover letter explaining the purpose of the study and containing the SurveyMonkey link was sent to the web editor of the state organization who in turn distributed the survey to the organization's database for members to complete. Each participant was required to electronically check a box in order to proceed, indicating consent to participate. Upon completion, survey responses were automatically sent to SurveyMonkey for storage.

Data Collection

Data were collected over a 75-day time period in 2014. A reminder notice was not sent because of technical issues with the Internet format. All responses were anonymous and kept confidential in an electronic password-protected location. A total of 160 responses were returned for a response rate of 13%.

Data Analysis

Data were analyzed using descriptive statistics using the SPSS statistical program (version 22; SPSS Inc, Chicago, IL). The demographic questions and the EOLCDQ II were evaluated with measures of central tendencies. Cross tabulations were used to evaluate relationships between NP education, EOL

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