

The impact of an educational pamphlet on completion of advance directives in a ICU setting

Abstract

With a total of 12.3 million emergency department visits each year resulting in a hospital admission (CDC, 2015), and up to 70% of older adults with a perceived inability to make end of life decisions, it is evident that there is a need for an improved system to ensure completion of advance directives in both inpatient and outpatient settings.¹ This quality improvement project aimed to investigate the effectiveness of an educational tool to improve rates of advance directive completion.

Methods: A retrospective study was conducted with baseline data collected for a total of 5 weeks and post intervention data collected for a total of 4 weeks. Baseline data was collected on a total of 50 patients and post intervention data was collected on a total of 25 patients.

Data analysis: Quantitative data was assessed to determine baseline rates of completion of advance directives and rates post-intervention.

Results: Results showed that pre-intervention, 50% of patients admitted to the intensive care unit had advance directives completed and 54% had completed advance directives on discharge from the unit. Post intervention, 80% of patients left the unit with advance directives completed. This demonstrated a significant increase in completion.

Conclusion: This study infers that pamphlets with information on advance directives as a tool to increase education, therefore increases knowledge and completion of advance directives in the intensive care unit.

Keywords: Advance directives, end of life, educational tool, educational pamphlet

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**Zackary St. Amant RN, Allison Scully RN,
Abigail Mitchell RN**

School of Nursing, Simmons University, USA

Correspondence: Abigail Mitchell RN, School of Nursing, Simmons University, USA, Tel + 7169300233, Email mitca@Simmons.edu

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Introduction

An advance care directive provides patients control in situations where they may be no longer able to speak for themselves. According to the Centers for Disease Control and Prevention (CDC),¹ there are 12.3 million emergency department visits each year that result in a hospital admission (2015) and up to 70% of older adults admitted to hospitals lack the ability to make final decisions in their last days of life.² Further, it is demonstrated in literature, as one randomized control trial with participants over the age of 60 conveyed, that prior to completing advance directives, only half of the participants were confident about decisions that would be made by their proxy, only one third had documented advance directives, and less than half had a discussion with their proxy regarding their preferences.² In relation to this, advance directives need to be proactive, appropriately timed and integrated into routine care, and this has implications for the family nurse practitioner.³

Research question

Does the use of an educational pamphlet for the intensive care unit increase completion rates of advance directives when compared to verbal education by healthcare professionals?

Problem statement

Advance directives allow patients a voice to maximize care that aligns with their personal beliefs, goals and values. Though much of the literature suggests the importance of having advance directives

in place, there is a demonstrated lack of completion among patients admitted to acute care settings. The quality improvement project performed was completed in a Massachusetts hospital in an attempt to increase the completion of advance directives in a timely manner. The researchers assessed the number of patients with completed advance directives on admission to the intensive care unit and at intervals during their stay, and from there developed an educational pamphlet to provide to patients and families in an effort to increase ease of completion and provide better understanding of options available. After implementation of the educational tool, the researcher reassessed rates of completion of advance directives at the same intervals. Based on the setting of this quality improvement project, the researchers aimed to provide an educational tool to patients and families on admission, allowing them time to process through the material and ask questions as necessary, with the hope of easing the process of completion of advance care directives.

Nursing theorist

Dorothea Elizabeth Orem was an American nursing theorist who developed the Self-Care Deficit Nursing Theory. Her theory focuses on one's ability to perform self-care, which she defines as "the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being".⁴ According to Orem's theory, the role of a nurse is to perform care for an individual who cannot provide for themselves.⁵ Using concepts from Orem's model, the theory was directly applied to nurses assisting patients in the completion of their advance directives. Advance directives are a form

of self-care, as they allow a person to make autonomous decisions related to their end-of-life care, prior to the end-of-life being reached. Decisions regarding resuscitation, intubation and other life-saving measures are crucial, as is determining a person who will make representative decisions for the patient.

Literature review

A literature search process was performed using medical databases on advanced care planning and strategies for improvement of completion. The main databases used for the search were: Cumulative Index to Nursing & Allied Health Literature (CINAHL), PubMed, MEDLINE, Google Scholar and Cochrane Systematic Reviews. The key search terms used were advance directives, advance care planning, end of life care, attitude toward advance directives, living wills, do not resuscitate (DNR), durable power of attorney for health, healthcare proxy, and end of life wishes. Research studies published from 2014 to 2019 were selected, and one additional study with no available date was also included.

Barriers

Barriers to the completion and implementation of advanced directives have become evident as all 50 states have enacted legislation promoting this advanced method of planning.⁵ Patients having the right to create advance directives has not equivocated with increased completion, and it is said that though “the number of elderly persons is expected to increase to 55 million by 2020, with the minority population increasing to 12.9 million, yet fewer than 30% of Americans have advance directives in place”.⁶

Some of the provider driven obstacles prior to intervention include lack of time, poor access to advance directives in the medical chart, and not having talked about end-of-life care with the patient and family.⁸ As time goes on, providers and nurses are pressured to spend less time with each patient, while maintaining the same level of accuracy and advocacy. The dilemma on how to spend time with patients, means that acute illnesses will be prioritized first and patients will be stabilized medically, but it is uncertain whether their individual wishes will be known.

Patients are being provided with brief verbal counsel, and at times are only being counseled on advance directives upon admission to the hospital. Due to this, the literature was reviewed to determine patient driven obstacles. These obstacles include patients desiring more information about advance directives, patients never having heard of advance directives, no one having discussed advance directives with the patient, patient preference to have a healthcare provider make choices for them, and the patient “not having gotten around to” filling the forms out.⁷

Crucial conversation

Provider discomfort with end of life care and the stigma that is associated with the acute care setting can cause patients and providers to stray away from advance care planning. It is commonly thought that when a person is admitted to the hospital, all measures should be taken to save the patient’s life, rather than an honest discussion about priorities, comfort and reality. Ho, Jameson and Pavlish,⁸ explain that issues occur at an individual and systemic level with lack of completion of advance directives, suggesting that inter-professional collaboration is a large factor (p. 800). Collaboration should be an early part of educational practice and patients as well as healthcare

providers should not see advanced care planning as giving up, but rather an active form of care.⁸ A French study examined general practitioners’ behavior concerning their role in informing their patients about advanced directives. The study points out those weaknesses remain among French physicians, specifically in their unwillingness to withhold or withdraw care to patients with AD, as well as initially facilitating the drafting of AD by patients.⁹

Education

Conversations to address barriers and determine methods of correcting such barriers are necessary, as is education. Implementing different educational tools has shown different rates of success in completion of advance directives. Hayek et al.⁷ implemented interventions and updated the electronic medical record (EMR) to include “Advance Directives Counseling” into the patients’ problem list, something that is to be reviewed and revised each visit. Results of this study showed that reminders to providers did not necessarily improve advance directive documentation, but that including an easy to access area of the EMR to document advance directives was advantageous Hayek et al.⁷ Of note, it has been found that in regard to patient directed interventions, not one specific resource for advance directives is thorough enough to provide guidance to all patients in all circumstances, and that patients are at different stages of readiness regarding end-of-life care planning, and each resource analyzed serves a separate purpose which appears to be based on level of patient preparedness.¹⁰

Deficits in knowledge

Health-care professionals with a positive attitude toward death and advance directives makes them more likely to have their own advance directives and to discuss advance directive completion with their patients.¹¹ Research has also shown that education on end of life has been linked to positively influencing health-care professionals’ attitudes toward death and care of patients who were dying.¹¹

Further evidence shows that there are benefits of discussing end-of-life wishes earlier rather than later, but these conversations are not occurring regularly and despite communication in healthcare being recognized at the core of quality care, 60%-90% of patients considered to have life-threatening illnesses report never having discussed end-of-life care issues with their provider.¹² The research suggests that in many instances, clinicians are waiting for patients and their relatives to approach the topic, and patients are waiting for their provider to start the conversation.¹²

Quality of Life

Providers play an important role in advocating for quality of life, including end of life care and should be initiating conversations during critical periods of the patient’s life to make wishes known. In a study by Myers et al,¹³ it was found that when providers utilized not only their own training, but an intervention to support the information provided in counsel, patients felt more involved in their care and became self-advocates, while decreasing anxiety and stress.

Advance directives need to be discussed in depth and revisited at different intervals, as advance care planning is a process, and over time requires providers to have communication skills and empathy beyond simply completing forms, beginning in the outpatient setting where patients are in their relative best state of health with surrogate decision makers available to be a part of the conversation.¹⁴ Providing patients

with an educational tool that outlines choices they have in the advance care planning process, beyond already mandated handouts, may give them a unique opportunity to ask questions and start a conversation about their options.

Methodology

This project took place in a 12-bed community-hospital intensive care unit (ICU) in Massachusetts. Approval was received from both the unit manager as well as the critical care director. Current practice at the start of this project for advance directive education was through verbal communication between providers, nurses and patients. This project used a retrospective design, where the researchers conducted chart audits to assess the presence of an advance directive on admission, and further if one was created during admission to the ICU. Charts were audited over a five-week period to assess baseline data related to advance directive completion rates in the ICU. After baseline data was collected an educational pamphlet was implemented in the ICU for patients concerning advance directives. Once the pamphlet was implemented chart audits continued for four more weeks to assess correlation between an educational tool and advance directive completion rates. Intubated patients were excluded from data collection as they were unable to participate in the completion of an advance directive.

Results

Over a five-week period baseline data was collected on 50 patients in the ICU. Of those 50 patients a total of 25 patients, or 50 percent of patients, had an advance directive in place on admission. Through chart auditing it was discovered that only 27 patients or 54 percent of these patients left the ICU with an advance directive.

After baseline data collection an educational pamphlet was created and implemented in the ICU. This pamphlet was given to all non-intubated ICU admissions or transfers and then given to family members of those patients that were intubated on admission or transfer to the unit. Post-intervention data was then collected in the unit. This data collection was conducted over a four-week period, with data being collected on 25 patients in the unit. Of these 25 patients only 11 patients or 44 percent of these patients had an advance directive on admission to the unit. With the use of these new educational pamphlets it was discovered that 20 patients, or 80 percent of the patients admitted to the ICU left the ICU with an advance directive in place. As it can be seen the percentage of patients completing advance directives rose a total of 26 percent. This is a significant change in the completion percentage of advance directives in the ICU.

Limitations

Limitations were identified and noted while conducting this quality improvement project. The first limitation of this study was the acuity of the patients in the ICU. The more significantly ill patients were the less likely they were to complete advance directives, as this was not prioritized in their care. A second limitation was compliance of nursing and ancillary staff. It was discovered that some staff members were forgetting to give pamphlets to patients, due to time available for implementation after pamphlets were printed, in-service education for staff was not an ideal length of time. Another limitation was the unpredictability of the number and type of patients in the ICU at any given time and the post-intervention data being collected for a less than optimal period of only four weeks. The final limitation noted was the length of stay of the patients. Varying admission times in the

unit and time of transfer posed as a difficulty in giving these patients enough time to read over the pamphlet and make potentially life altering decisions.

Family nurse practitioner implications

Advance directives are an important tool for both practitioners and patients. An advance directive allows a patient to express their wishes for end-of-life care that can dictate their final days. The rise in completion percentage of advance directives from 54 percent to 81 percent shows how useful an educational pamphlet can be in completion of an advance directive. These results were collected in an ICU, where patients and families are faced with life-threatening, stressful, acute illnesses. If the completion rates of an advance directive can rise by 26 percent in an ICU, it can be assumed that rates will rise equally, if not more in a non-acute outpatient setting. Family nurse practitioners can use education, as well as educational pamphlets to reinforce the importance of advance directives.

It was established in the literature review that barriers exist in the completion of advance directives and for providers, an educational pamphlet can be a bridge for both the provider and patient to ensure that all parties have the information that is critical to make autonomous decisions. The educational pamphlet not only provides options and a how-to guide on completion, but can serve as a conversation starter in difficult situations, when it is equally as crucial as difficult to be discussing. Providing pamphlets in an out-patient setting where continuity of care is greater and the provider is more likely to have follow-up with the same patients may allow the provider to have ongoing conversations with patients and build trust as disease processes may progress and patients age.

Discussion

Improving rates of completion of advance directives is crucial to allow patients autonomy in anticipation of death. Unfortunately, healthcare consumers are often not educated to an optimal level on advance care planning, when eventual death is a guarantee for all. Our educational pamphlet gives patients information they can refer back to, ask questions about and keep in order to look back on and change as time passes. Based on the significant increase in completion of advance directives post-intervention, it is evident that patients need more than verbal counsel to make informed and confident decisions about their care.

Conclusion

The use of an educational pamphlet provided to patients on admission to the intensive care unit served as a significantly effective method to increase completion rates. Prior to the educational pamphlets being provided, patients received verbal counsel on advance directives, which could differ based on provider and other healthcare staff. The uniform and structured educational tool minimized patients leaving the intensive care unit without having advance directives in place. Further research is needed on what the most effective model of education is and how this can be expanded to primary care practices. It would also be optimal to conduct a study using a larger pool of patients with varying levels of education and impairments to determine methods of teaching that could be used in all patient populations.

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Conflicts of interest

The authors declare that there is no conflict of interest.

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