

Advanced Directives in Primary Care

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NUR 412

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I. Processes Description

Advanced Directives are one of the most important documents in the health care system. An advanced directive is a “living will” that describes medical ambitions for the patient’s end-of-life care. The idea of end of life can be stressful for patients, families and health care professionals, and advance directives guide these participants into making end-of-life decisions organized.

Health care revolves around patient satisfaction amongst granting his or her wishes by the health care professionals. Therefore, health care professionals need to be educated on advance directives to give patients the information regarding their end-of-life care. Part of this education includes adequate communication techniques while discussing AD’s whilst establishing rapport with him or her. When health care professionals become more educated, the ideal goal is to educate advance directive awareness early to attempt completion in all patients; whether the patient is old, young, disease ridden or disease free. Common misconceptions among advance directives are barriers to completion with patients, creating future stress amongst health care professionals, patients, and patient’s family whilst dealing with future or impending death. Misconceptions include patients thinking AD’s are only needed when a progressive, terminal disease affects them. Many patients believe they have to be of older age or disabled. Patients also believe they have to be married or have immediate family to only have an advanced directive. Patients and health care professionals can also become uncomfortable with the idea of starting a conversation on AD’s.

To break this inadequate education, health care professionals need to become educated on advance directives and their facilities policies. By staying educated, we can start the conversation in patients earlier, whilst patient and family are under no stress, and the patient's illness has not consumed all functional ability. A dilemma occurring in health care, include critically ill patients arriving to facilities unable to make decisions about their health, or end-of life-care. When patients don't have an AD completed, it's difficult for health care professionals to direct end-of-life along with other health decisions, especially when family is not present.

In western Kentucky, primary care centers there are no current policies or tools that could aid health care professionals in starting AD conversations early. Many primary care offices are forced without adequate skills to start this conversation, without making established rapport distressed with a delicate topic. Although these conversations are being initiated, it is enforced in emergency, critical care settings, where in most cases adequate education can't be delivered in dire situations. The current policy intended to be implemented will give health care professionals the tools to start the necessary conversation about AD's.

II. Theoretical Framework

The Adult Learning Theory proposed by Malcolm Knowles formulated the theoretical framework used for this evidence-based project. Knowles created this theory with concerns that adults need certain "considerations" to create the ability to learn (Syx, 2008). These considerations include the details or reassurance providing the reasoning to "learn". In relation to this project, this theory pertains to health care professionals using

adequate communication techniques to give the proper reassurance and education background for patients to consider completing advance directives prophylactic while patient has the opportunity.

III. Evidence

In support of my two claims I needed to back up my newly implemented my project. The first was to describe and identify the inadequate education among health care professionals and advance directives. This inadequate education then supports the problem for my EBP. Health care professionals are uneducated, therefore not starting the conversation of AD's soon enough in the primary care setting.

The research found supports my claim about how uncomfortable primary care health professionals are with introducing the idea of AD's in their healthy, young patients. In the article *Nurses Preparation for Advanced Directives: An Integrative Review*, the article describes the legal and ethical role a nurse plays in educating and informing patients on advance directives (Miller, 2018). However, the article then goes into detail on the specific roles and responsibilities the nurse may not know, they play. The authors unified nineteen studies that assessed the knowledge of nurses and nursing students confidence level in advance directive planning. The integrated studies found that fewer than half of the nurses and nursing students are comfortable with educating patients on AD's (Miller, 2018). The study then found nursing schools devote about an hour and a half of legal document education (Miller, 2018). The article then describes the details on why nurses are unsure of the role they plan in AD implementation. The specific nurse role is described as "to educate and help patients complete an advance directive"; whilst

half the nurses believed they were to only refer the patient to a “proper person” of authority such as lawyer, judge, or physician (Miller, 2018). However, the only “proper” person needed is a notarized public person.

The article *Implementing Advance Directives in Office Practice* identifies a problem with advance directives; being that there is ineffective communication between health care professionals and patients. This ineffective communication is founded on the idea of HCP’s not intending to cause the family and patient unnecessary stress, medical jargon, and inadequate accessibility to a public notary (Allen, 2015). The article then identifies the barriers to completion of advance directives in the primary care setting. The authors state that patient and physicians have a conflicting idea of who will initiate the conversation first. Both parties can and should initiate the conversation.

Whilst patients and health care professionals try to implement completing the advance directive, there are many barriers that cause incompleteness. The language used on the legal documents tends to be vague and confusing to patients. The language can also contradict the patient’s current condition. Majority of the legal documents use words like “terminal illness” or “no hope for recovery”, most patients are perfectly healthy while completing this document (Allen, 2018). This causes confusion, and the patient may assume they don’t meet correct criteria.

IV. Proposed Policy

Health care professionals educating patients on advance directives is not common in the primary health care setting. The normative in most health care setting is to only educate patients on AD’s when they are diagnosed with a terminal illness, with a near

future of impending death. However, sometimes for patients and families, AD education is provided too late. For example, if a patient is a car accident and pronounced brain dead, there is no way this patients' medical wishes can be granted due to critical illness. Prior to this hypothetical incidence, the patient and family could have avoided the patient's medical decision grey area by filling out an advance directive prophylactically. The best place for patients to achieve this goal is in a primary care setting, where these patients are seen most often, and circumstances are less critical.

The imposed policy will simply educate health care professionals on easier alternative communication techniques to approach a variety of patients: sick, healthy, young and old.

Table 3.

Barriers and Solutions to Implementing Advance Directives

<i>BARRIER</i>	<i>SOLUTION</i>
End-of-life terminology: When do care preferences apply?	Clarify vague terms, such as "terminal" and "no hope of recovery"
Clinical relevance of care requests: What types of procedures are requested and declined?	Clarify vague terms, such as "life support" and "no heroics," and indicate wishes regarding specific scenarios and interventions; have ongoing conversations with the patient
Proxy issues: Is the proxy aware of the advance directive contents and patient wishes?	Include proxy in discussions regarding advance directive
Advance directive accessibility: Is the advance directive part of the medical record and readily accessible to physicians, proxy, and family members?	Include advance directive in the medical record at the office and hospital and be sure it transfers with the patient to other levels of care

(Spoelhof, G. D., & Elliott, B. (2012, March 01))

The above table gives solutions to health care professionals on how to make advance directive education more efficient for both families and patients. The solutions eliminate medical jargon that can be confusing and scary to patients and family. This alternate communication with further explanation can make ideas less vague whilst educating.

Table 4.

Suggested Approach for Including Advance Directives in Primary Care

<i>STAGE</i>	<i>DISCUSSION POINTS</i>	<i>ACTIONS</i>
Routine patient visit, patient 50 to 65 years of age	<p>"If you were to get very sick, who would you trust to make medical decisions for you?"</p> <p>"Have you thought of completing an advance directive?"</p> <p>"How would you like to be cared for if you had a devastating injury or illness?"</p>	<p>Provide advance directive forms</p> <p>Review forms, and offer to answer questions (review again at later meeting)</p> <p>If possible, offer a group session to introduce advance directive topics to multiple patients</p>
Diagnosis of progressive chronic disease (e.g., heart failure, cancer, dementia, chronic obstructive pulmonary disease)	<p>"Your health has changed. What is your understanding of your condition?"</p> <p>"Do you have any feelings about what you have experienced so far?"</p> <p>"Have your goals for care changed?"</p> <p>"Have you discussed your feelings with your loved ones?"</p>	<p>Offer to meet with patient, proxy, and family members</p> <p>Discuss how changes in health may have changed advance directive goals, and update forms</p>
Increasing frailty and dependency (e.g., patient admitted to nursing home)	<p>"If time becomes short, what is most important to you?"</p> <p>"Have you spoken to your proxy about any</p>	<p>Meet with patient, proxy, and family members</p> <p>Discuss prognosis and personal goals</p>

<i>STAGE</i>	<i>DISCUSSION POINTS</i>	<i>ACTIONS</i>
	changes in your care goals?"	Review life support and resuscitation options in detail, and update advance directive forms

(Spoelhof, G. D., & Elliott, B. (2012, March 01)

The chart above includes ways to implement advance directives in primary care centers, presenting initial topic discussion points, and the actions health care professionals can implement to educate patients. Whilst nurses are educated amongst this new policy, initiating advance directive in all patients will become routine. The solutions make communication more effective by asking open-ended questions, allowing patients to express his or her feelings about their medical wishes, along with death.

V. Implementation into Professional Practice

This proposed policy practice would be easy for primary care settings to implement. The begin stages of implementation would begin with an estimated hour of training with individual. Training would include the above charts on more effective communication with patients regarding advance directives. After education seminars, the professionals will have to practice these techniques decreasing barriers in communication. At the patients initial visit, or visiting after policy is implemented each patient should be screened for readiness or completion for an advance directive. The patient should be educated that he or she does not have to be entitled to a chronic, terminal illness to qualify. The only qualifications include being over the age of eighteen in the state of Kentucky.

VI. Conclusion

It is our duty as health care professionals to spread advance directive awareness and education. Throughout the years, there has been misinformation regarding AD's; patients only thought such had to do with impending death. However, patients need to understand that AD's are a prophylactic document used in dire times of need in the health care setting. Discussing death in the health care setting can be a disquieting topic amongst both HCP's and patient/family. The idea of death may come with stress; however, families and patients need to know that being prepared is the first step of dealing with death.

References

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