

ADVANCE CARE PLANNING IN RURAL MONTANA:
EXPLORING THE NURSE'S ROLE

by

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DEDICATION

I dedicate this project to my mother, Denise Linder. I hope to contribute to the profession of nursing as much as my mother has throughout her life on a personal, local, state and national level. I also dedicate this project to my husband for his outstanding support in my endeavor of pursuing a Doctorate of Nursing Practice degree.

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ABSTRACT

Background: It is recommended that advance care planning (ACP) take place across the lifespan. Rural populations have a heightened risk for poor quality and high cost of end-of-life care. Advance care planning can be led by nurses to ensure end-of-life-care reflects patients' wishes.

Purpose: A doctoral project was completed to assess rural nurses' knowledge, attitudes and experiences with advance directives (ADs). Information gained was used to develop evidence-based recommendations to facilitate nurses in ACP.

Sample: Participants were nurses who practice in rural settings (N = 22). Average age was 46.4 years. All were Caucasian (n = 22) and the majority were baccalaureate prepared (n = 12). Practice settings were primarily in home care (50%) and hospice (27%).

Methods: The Knowledge, Attitudinal, and Experimental Surveys on Advance Directives were distributed. Descriptive statistics were used for analysis.

Results: The overall knowledge scores on ADs were low (57%). Nurses felt confident in counseling (n = 19) and initiating (n = 20) discussions with patients and families. Nurses believed they have administrative support (82%), but less physician support (50%) in ACP. Less than half of the nurses stated they are part of the ACP team at their facility (45%). Nurses described the need for more education, training and knowledge on ACP (n = 13). Nurses reported receiving no training on health perceptions of rural dwellers (64%) and some reported no training on providing culturally sensitive care to rural dwellers (45%). The majority reported access to AD resources (90%) and mentorship of younger nurses (95%) would be beneficial.

Conclusions: Participants were confident in initiating and counseling patients with ADs, but indicated a need for additional education, time, and support from administration and physicians to better assist patients in ACP.

Implications: A continuing education presentation was given in Cascade County on the survey results and recommendations for facilitation of nurses in the ACP process. Recommendations include: Providing workplace education, supporting nurses in ACP, mentoring young nurses in ACP, providing ACP resources, and providing cultural sensitivity through the incorporation of the Rural Nursing Theory. Project findings were published in *The Pulse* for dissemination on a statewide level.

INTRODUCTION

Background

Advance Directives

Advance directives (ADs) refer to several types of legal documents including living wills and documents that name a health care agent (i.e. durable power of attorney or health care proxy). Patients can complete these forms at any time in a state of health that allows them to do so (Institute of Medicine [IOM], 2014). Types of ADs are provided below:

- A *living will* is a statement about the kinds of medical care a person prefers under certain conditions if they are unable to express those wishes (IOM, 2014).
- A *durable power of attorney for health care* identifies a person to make medical decisions in case of the patient's incapacity (IOM, 2014).

History of Advance Directives. Prior to 1990, Americans with terminal illnesses relied almost solely on physicians' judgment, trusting physicians to act in the patients' best interest in providing end-of-life care. As technology and medicine have evolved, life-sustaining treatments began to allow patients to be alive on ventilators, feeding tubes and powerful drugs. In 1990, Congress passed the Patient Self-Determination Act (PSDA) that required all health care facilities that received reimbursement from Medicare or Medicaid to ask patients if they have ADs provide information on ADs and incorporate

ADs into the medical record. Currently, all 50 states in the U.S. have laws supporting ADs and appointing a healthcare agent (IOM, 2014).

Medical Orders

New state laws also outline do-not-resuscitate protocols, which are medical orders signed by a clinician that is for use outside and within the hospital. Medical orders are specific to patients' wishes as expressed in written documents and are intended to provide direction to the health care team on treatment to be provided to the patient. Medical orders ensure that a patient will not be resuscitated, incubated or hospitalized against his or her wishes in the event of a medical emergency. These orders are signed by a health professional for someone who is seriously ill. Health care professionals able to sign medical orders are physicians, nurse practitioners, and physician assistants, depending on state law (IOM, 2014). Examples of medical orders are provided below:

- *Provider Orders for Life-Sustaining Treatment (POLST)* forms are medical orders regarding life-sustaining treatment signed by a health care provider that are stored in electronic health records and kept by patients so they are portable from one care setting to another (Montana Department of Labor & Industry, n.d.).
- *Do-not-resuscitate, do-not-intubate, do-not-hospitalize orders* are specific medical orders that are written in a specific health care facility that do not cross care settings and not always honored in the community (IOM, 2014).

Advance Care Planning

The definition of advance care planning (ACP) is a process that includes discussions of patient values, goals and preferences about end-of-life care. Outcomes of ACP discussions include the documentation of patient preferences through written legal documents (i.e. advance directives) or medical orders (i.e. POLST, do-not-resuscitate). These conversations can begin at any time with patients who do not have serious disease and can be revisited as health status changes. Any individual can start ACP conversations and can be led by a non-physician (i.e. nurses) (IOM, 2014; National Guideline Clearinghouse [NGC], 2014). Ideally, ACP conversations occur with a person's health care agent and primary clinician, along with other members of the clinical team (IOM, 2014). It is recommended by the IOM (2014) that ACP become a more prevalent part of primary care.

Nurses' Role in Advance Care Planning

The nurse's role as a patient advocate is well supported by national organizations, such as American Academy of Nursing (AAN), American Nurses Association (ANA), Hospice and Palliative Nurses Association (HPNA), Hospice and Palliative Nurses Foundation (HPNF), Hospice and Palliative Credentialing Center (HPCC) (ANA, 2013; AAN, 2015; ANA, 2010; HPNA; HPNF; HPCC, 2015). In response to the IOM report, *Dying in America*, the HPNA, HPNF and HPCC state, "The specialty of nursing is well positioned to partner with the health care team and lead efforts that support the kind of expert care that seriously ill Americans deserve" (HPNA; HPNF; HPCC, 2015).

Addressing end-of-life questions in the primary care setting and throughout the lifespan allows for full expression of the patient's autonomy in end-of-life decisions making (ANA, 2010). The ANA *Code of Ethics with Interpretive Statements* (2015) advises, "nurses should promote advance care planning conversations and must be knowledgeable about the benefits and limitation of various AD documents" (as cited by ANA, 2012). However, there is limited research on the specific utilization of nurses in the advance care planning process in primary care settings (Briggs & Colvin, 2002).

Nursing Knowledge on Advance Directives. Despite the support among national organizations for the involvement of nurses in ACP, studies have demonstrated through the use of the Knowledge, Attitudinal, and Experimental Survey on Advance Directives (KAESAD), that knowledge scores on ADs are low (Jezewski, Brown, Wu, Meeker, Feng, & Bu, 2005; Scherer, Jezewski, Graves, Wu, & Bu, 2006; Walerius, Hill, & Anderson, 2009). However, nurses' attitudes reflect an advocacy role in end-of-life decisions (Jezewski, Brown, Wu, Meeker, Feng, & Bu, 2005). As health care providers that are in a position to assist patients with ADs, nurses need more knowledge and education about ADs (Walerius, Hill, & Anderson, 2009).

Significance

End-of-Life Care

It is important for healthcare providers and nurses to understand the importance of ADs as more and more Americans express that they prefer to die at home and remain in charge of decisions about their end-of-life care. However, evidence suggests that these

wishes are not likely to be fulfilled (IOM, 2014). In 2009, Teno et al. (2013) found that one in four adults ages 65 and older died in an acute care hospital, 28% died in a nursing home and one in three died at home. Among all decedents, 30% were in an intensive care unit in the month preceding death, (as cited in IOM, 2014). Hogan et. al (2001) found that approximately 13% of the \$1.6 trillion in health care costs is for the care of individuals in the last year of life (as cited in IOM, 2014). According to Raymont et al., (2004), 40% of all adult medical inpatients are incapable of making their own treatment decisions because of unconsciousness, cognitive impairment, or an inability to express a choice (as cited in IOM, 2014).

Rural Settings

Rural residents have fewer visits to healthcare providers and less likely to receive recommended preventative services. Two factors that may contribute to rural residents' poor health and healthcare are rural residents face longer distances to reach health care delivery services and even though 20% of Americans live in rural areas, only 9% of physicians practice in rural areas (AHRQ, 2005). Due the inadequacy of access to healthcare, rural populations more often have chronic conditions (AHRQ, 2005).

Poverty is also a known risk factor for poor health outcomes and rural residents are often poorer than their urban counterparts. Rural residents experience worse health outcomes and more complications due to transportation problems and lack of advance life support training among limited health care personnel in rural towns (Artnak, McGraw, & Stanley, 2011). Rural residents often lack health insurance provided by employers and are often self-employed or part of a small business facing low wages (Bailey, 2013). In

Montana, rural counties have lower health insurance coverage rates than urban counties for residents under 65 years old (Bailey, 2013)

Without adequate access to healthcare services, rural populations are a vulnerable population and are at heightened risk of poor-quality and high-cost of end-of-life care (IOM, 2014). The IOM (2014) states that individuals who are particularly vulnerable for high-cost and poor-quality EOL are people with inadequate access to health services because of geography, low income and lack of health insurance. Because of this, it is important to note that rural residents prefer control over decisions about end-of-life care in a dying situation and value patient autonomy (Felt, Early, & Welk, 2000; Marchand, Cloutier, Gjerde, & Haq, 2001).

Rural Nursing Theory. Advance care planning is inherently a sensitive topic as it involves communication about ones' inevitable death. Nurses involved in initiating these types of personal conversations must consider the unique health perceptions and cultural values of rural populations. The Rural Nursing Theory (RNT) helps one understand the nature of rural nursing and the health care needs specific to rural populations (Long & Weinert, 1989). The RNT describes rural persons' definition of health and common traits such as self-reliance, independence, and distrust of outsiders. The theory also describes the expert generalist role of rural nurses (Long & Weinert, 1989). The RNT will inform interventions to guide rural nurses' practice in ACP with rural patients.

Purpose of Project

The purpose of this project is to assess rural nurses' knowledge, attitudes and experiences with ADs in rural Montana and use as a foundation to develop interventions to assist nurses with ACP across the lifespan in rural populations. This project was developed in support of recent recommendations that ACP should take place across the lifespan and can be led by non-physicians (e.g. nurses) to ensure end-of-life care reflects patients' wishes (IOM, 2014). Rural populations are the focus of this project as they have a heightened risk for poor quality and high cost of end-of-life care (Agency for Healthcare Research and Quality [AHRQ], 2005).

Project Description

Part one of this project will consist of using the Knowledge, Attitudinal, and Experimental Survey on Advance Directives (KAESAD) to survey nurses practicing in rural settings across five Montana counties. The KAESAD survey will then be analyzed to determine the knowledge, attitudes and experiences with ADs among nurses in rural Montana. Part two of this project will consist of the dissemination of these findings to rural nurses in Montana. The doctoral student will publish this project in *The Pulse* to be sent to all licensed nurses in Montana. A continuing education presentation will also be provided for rural nurses and administrative staff in the town of Great Falls, Montana. Both the publication and presentation will include KAESAD survey findings and suggested interventions to assist Montana nurses with ACP across the lifespan in rural populations.

REVIEW OF THE EVIDENCE

A review of literature was conducted to assess ACP and AD utilization among nurses working in rural communities, along with their relationship among rural communities and nursing. Databases included in the review of literature were Cochrane, CINAHL, PubMed, UpToDate, Medline (on Web of Science), and National Guideline Clearinghouse. Articles were found using the search terms: advance directive utilization, advance directives in rural populations, interventions to increase advance directive completion, barriers to advance directive completion, ACP guidelines, Rural Nursing Theory, Knowledge, Attitudinal, and Experimental Survey on Advance Directives (KAESAD).

Advance Directive Utilization

Currently, there is an underutilization of AD use in the United States. In 2013, one large study collected data from 7,946 respondents and found that 26.3% of adults, ages 18 years old and older, had an AD. Having an AD is associated with increasing age, higher levels of income, higher levels of education, having a chronic disease and a regular source of health care (Rao, Anderson, Lin, & Laux, 2014). Having an AD reduces bereaved family members' concerns about physician communication or lack of information and family stress (Teno et al., 2007; Davis et al., 2005).

Factors associated with having an AD are direct requests to complete one and receiving an explanation about the importance of an AD (Alano, et al., 2010; Van Scoy, Howrylak, Nguyen, Chen, & Sherman, 2014). As stated in chapter one, ADs refer to

several types of legal documents including living wills and documents that name a health care proxy (i.e. durable power of attorney or health care proxy) (IOM, 2014). Simply asking patients to complete a living will was shown to make patients 10.8 times more likely to complete a living will and 1.68 times more likely to complete a healthcare proxy (Van Scoy, Howrylak, Nguyen, Chen, & Sherman, 2014). Patients who have a primary care provider, have knowledgeable about ADs, or have seen a friend or family member use a mechanical ventilator are significantly more likely to have a designated health care proxy (Morrison & Meier, 2004).

Advance Directives in Rural Populations

The majority of rural residents express positive views towards AD forms. Among rural residents, there is a presence of personal empowerment that is important for successful completion of ADs (Sinclair, Auret, & Burgess, 2013). Most rural residents want control over decisions about end-of-life (EOL) care in a dying situation and value patient autonomy (Felt, Early, & Welk, 2000; Marchand, Cloutier, Gjerde, & Haq, 2001). Perceived susceptibility to negative consequences from failing to complete an AD serves as a trigger for further contemplation (Sinclair, Auret, & Burgess, 2013). Quality of life is an important value in end-of-life decision making. Rural residents do not want to have their lives prolonged if there is poor quality of life (Marchand, Cloutier, Gjerde, & Haq, 2001). In fact, rural residents are more likely to have a “Do Not Resuscitate” order compared to urban residents (Buchanan, Bolin, Wang, Zhu, & Kim, 2004).

Rural residents prefer to be fully informed and engaged in open conversation about all treatment possibilities and outcomes. However, few have actually signed ADs

that they have shared with family members or physicians (Felt, Early, & Welk, 2000). Fear and confusion about the purpose and nature of an AD is common among rural residents. Those who have not completed ADs are more confused about ADs than those who have completed them (Marchand, Cloutier, Gjerde, & Haq, 2001). Many state that they think physicians are a great source of information and are an educator (Felt, Early, & Welk, 2000; Marchand, Cloutier, Gjerde, & Haq, 2001). Advance directive completion is facilitated if patients trust their physicians, medical system and the use of power of attorney for healthcare (Marchand, Cloutier, Gjerde, & Haq, 2001). One major limitation to the literature on AD utilization in rural populations is a lack of consistent definitions of “rural”.

Interventions to Increase Advance Directive Completion

Health Care Provider Interventions

In primary care settings, the most successful interventions associated with AD completion were direct patient-healthcare professional interactions and frequent interactions over multiple visits (Ramsaroop, Reid, & Adelman, 2007; Patel, Sinuff, & Cook, 2004). Passive education (i.e. written materials) without direct counseling was shown to be an ineffective method for AD completion compared to direct counseling. The most successful interventions occur when patients receive combined written and verbal educational interventions about ADs (Durbin, Fish, Bachman, & Smith, 2010; Ramsaroop, Reid, & Adelman, 2007; Patel, Sinuff, & Cook, 2004). One study also found

that computer-generated reminders aimed at primary care providers increased rates of AD discussion and completion of AD forms (Dexter, et al., 1998).

Workplace education on ADs is significantly correlated with experience and increased knowledge. Scherer, Jezewski, Graves, Wu, and Bu (2006) found 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. This highlights the importance of staff education in the workplace. However, a lack of research exists on interventions to increase nurses' involvement with ACP and AD knowledge.

Years of experience in nursing correlates positively with interaction with families regarding ADs. Older nurses reported more interaction with family and disclosing more information about ADs than younger nurses (Black & Emmet, 2006). Nurses who have been mentored by nurses experienced in ACP practice thought that they were able to increase their ability to implement ACP (Jezewski, Meeker, & Schrader, 2003). It may be important to mentor younger nurses in their communication practices regarding ADs (Black & Emmet, 2006).

System Interventions

There have been high success rates of AD completion in areas where an extensive, multi-disciplinary ACP system (e.g. Respecting Choices Program) exists with patients throughout their lifespan (Hammes & Rooney, 1998; Hammes, Rooney, & Gundrum, 2010; Pecanac, Repenshek, Tennenbaum, & Hammes, 2014). The Respecting Choices Program includes: patient AD education materials, availability of these materials

throughout the community, uniform training and continuing education on ADs for providers, non-physician educators, access to AD educators at all health care organizations, common policies and practices of maintaining and using AD documents and the documentation of AD education in the patient's medical record (Hammes & Rooney, 1998). Non-physician educators, within the Respecting Choices model, are trained facilitators that are available throughout the community to discuss end-of-life questions with patients to prepare them for the end of life and ensure ADs are available in patients' medical records (IOM, 2014). Examples of non-physician educators are physician assistants, nurse practitioners, nurses, pharmacists, social workers, faith leaders, community volunteers, attorneys, and others involved in ACP (Gundersen Health System, n.d.)

After the implementation of the Respecting Choices Program in LaCrosse, Wisconsin, the prevalence of written ADs was considerably high (85%). Almost all of the AD documents (95%) were in the decedent's medical record. The majority of AD documents requested that treatment be forgone as death neared. Treatment preferences expressed in ADs seemed to be followed while making end-of-life decisions (Hammes & Rooney, 1998). The Respecting Choices Program has also shown to be successful in a diverse racial and ethnic community through increased prevalence of ADs (Pecanac, Repenshek, Tennenbaum, & Hammes, 2014). The Respecting Choices Program and tools have been recommended for ACP by the IOM and National Guideline Clearinghouse (IOM, 2014; NGC, 2014).

Financially, Respecting Choices in La Crosse, Wisconsin has shown to significantly reduce healthcare costs and be cost effective. Implementing Respecting Choices in La Crosse, WI reduced costs of healthcare in the last two years of life due to elimination of unwanted treatment to \$48,771 per capita (the national average is \$79,337). Respecting Choices in La Crosse has also shown reduced inpatient days in the last two years of life to 10 days versus the national average of 16.7 days. There has also been a demonstrated reduction in percent of decedents seeing 10 or more different physicians during the last six months of life to 22.7% versus the national average at 42% (Respecting Choices, n.d.).

Nurses are central to the Respecting Choices Model in providing individual counseling and providing education at the institutional, systems and community levels (ANA, 2010). A multi-disciplinary approach to ACP, with the inclusion of nurses, is key to the Respecting Choices Program and has been shown to be successful in diverse communities, along with direct patient-healthcare professional interactions and frequent interactions over multiple visits (Hammes, Rooney, & Gundrum, 2010; Pecanac, Repenshek, Tennenbaum, & Hammes, 2014; Ramsaroop, Reid, & Adelman, 2007; Patel, Sinuff, & Cook, 2004).

Barriers to Advance Directive Completion

Patient Barriers

Clinicians reported barriers preventing patients from completing ADs are “lack of knowledge” and “reluctance to think about advance care planning” (Tung & North,

2009). Patients with lower rates of AD completion report not being spoken to about the importance of ADs and identified the need for more information. Patients with lower rates of AD completion also reported they would rather have their physicians make those decisions for them or they hadn't gotten around to doing completing one (Alano, et al., 2010). One study found that of 40% of participants who did not have a living will reported they wanted help completing one (Mahaney-Price, Hilgeman, Davis, McNeal, Conner, & Allen, 2014).

Decision-Making Capacity. It states in the IOM *Dying in America* (2014) report that most people nearing the end of life are not physically, mentally or cognitively able to make their own decisions about care. Approximately 40% of adult medical inpatients and 44-69% nursing home residents are incapable of making health care decisions themselves. In older patients facing treatment decisions, roughly 70% are incapable of making decisions themselves. A majority of these patients will receive acute hospital care from physicians who do not know them and their values (IOM, 2014).

Health Care Provider Barriers

A common barrier to AD completion was physician-reported lack of time (Ramsaroop, Reid, & Adelman, 2007; Tung & North, 2009; Nelson & Nelson, 2014). Nurses also reported the need for more time to assist patients in completing ADs (Jezewski, Brown, Wu, Meeker, Feng, & Bu, 2005). Nurse practitioners also have concerns about lack of appointment time (Dube, McCarron, & Nannini, 2015). Additional identified barriers by nurses to implementing ACP are lack of knowledge,

conversation skills, available resources, and team support (Ke, Huang, O'Connor, & Lee, 2015; Jezewski, Meeker, & Schrader, 2003).

Research indicates a critical need for nurses to receive AD education to increase their confidence and knowledge about ADs (Scherer, Jezewski, Graves, Wu, & Bu, 2006; Ryan & Jezewski, 2012; Walerius, Hill, & Anderson, 2009; Jezewski, Brown, Wu, Meeker, Feng, & Bu, 2005). Three themes identified by nurse practitioners concerning ACP were lack of knowledge, issues related to specific practice setting and cultural or language concerns. Nurse practitioners who reported having formal nurse practitioner education on end-of-life or had taken continuing education courses on end-of-life were having more ACP discussions with their patients (Dube, McCarron, & Nannini, 2015). Dube, McCarron, and Nannini (2015) recommends developing programs to enhance the formal continuing education options for nurse practitioners may increase ACP discussions.

Nurse practitioners have expressed a need for ACP guidelines and educational materials when implementing ACP (Ke, Huang, O'Connor, & Lee, 2015). Nurses have expressed the need for educational materials available to health care teams, patients, and families. Nurses recommend a user-friendly pamphlet or packet with important definitions and guidelines (Jezewski, Meeker, & Schrader, 2003).

System Barriers

In a study of barriers to ACP in the primary care setting, the absence of a systematic reminder process was reported by physicians to be a barrier to advance planning discussions (Tung & North, 2009). Nurses reported a need for support from

administrators and physicians in clinical settings regarding their roles in helping patients complete ADs. Some nurses also reported wanting to approach patients autonomously to discuss ADs without fear of retaliation from medical staff (Jezewski, Brown, Wu, Meeker, Feng, & Bu, 2005; Jezewski, Meeker, & Schrader, 2003). In one study, nurses asked for institutional support, specifically from hospital administration and nursing leadership, for more training related to ADs. Nurses also stated they wanted more collaborative working relationships with physicians to be included in AD discussions with patients, as well as more autonomy to initiate these discussions with patients on their own (Jezewski, Meeker, & Schrader, 2003).

Advance Care Planning Guidelines

In this section, the National Guideline Clearinghouse (NGC) guideline on ACP will be discussed. The NGC guidelines were developed by the Michigan Quality Improvement Consortium (NGC, 2014). The target population for this guideline is patients whose death within 12 months would not be surprising, patients with chronic and life-limiting illness, and patients over 55 years old in any stage of health (NGC, 2014). However, the IOM (2014) recommends that all individuals should have the opportunity to participate actively in health care decision making throughout their lives and as they approach death.

Advance Care Planning Process

The ACP process should emphasize the value making one's goals, preferences and choices for care and treatment known verbally and in writing. Any person can start

the conversation (patient, family, physicians, nurses, behavioral health providers, social workers, clergy) (IOM, 2014; NGC, 2014). It is important to begin early conversation with family when it is a non-crisis situation and cultural sensitivity should be utilized. Discussions should include family, health care agent, and others close to the patient. At the later stages in ACP, the facilitators should have experience with the patient's specific health condition (NGC, 2014).

Assisting Patients in Advance Care Planning

An ACP tool, such as Respecting Choices Program or Five Wishes, help patients identify a health care agent, identify patient goals and encourage the completion of an AD. The ACP tool, Respecting Choices Program, assists organizations in initiating best practices to provide patients with an informed, timely and decision-making process that improves patient outcomes. This approach needs organizational support and skilled facilitators to assist organizations in implementing ACP practices (Respecting Choices, n.d.).

The second ACP tool, Five Wishes, is the most popular living will because it is written in everyday language. Five Wishes is for adults 18 years and older and helps start conversations within a family about end-of-life preferences. This form is available online or can be mailed to individuals. The five wishes include: choosing a health care agent, medical treatment, comfort, how patients want people to treat them and what patients want loved ones to know. Wishes for how comfortable patients want to be in moments near end-of-life include not wanting to be in pain or short of breath. Comfort requests

also include warm baths, music playing, religious readings, and other forms of personal care. In the District of Columbia and 42 other states, including Montana, Five Wishes meets state requirements under the law as a living will (Aging with Dignity, 2011).

Advance care planning tools encourage and help patients to identify a health care agent and complete an AD. They also help patients incorporate goals, preferences and choices into the advance care plan. Patients should be encouraged to discuss their care plan with their health care agent, family and spiritual counselor (NGC, 2014).

Revision and Documentation of Advance Care Plan

A review of patient goals and preferences for end-of-life care and ADs should occur at least annually (NGC, 2014). Discussions should occur again with significant changes in prognosis, along with consideration of a POLST tool to address specific requests for end-of-life care. A copy of AD and other documents should be placed in the patient's medical record. A POLST form should be shared throughout the health system and made accessible to emergency departments, emergency medical services, and nursing homes (NGC, 2014).

Nurses' Knowledge, Attitudes and Emotions on Advance Directives

Before providing recommendations to nurses in rural Montana on their inclusion in the ACP process, it is important to know their knowledge on ADs. Again, the ACP process involves encouraging patients to identify a healthcare agent and complete an AD (NGC, 2014). Several studies have utilized the KAESAD survey to collect data from

nurses. This instrument measures knowledge of ADs, attitudes regarding end-of-life issues, experience with ADs, confidence with ADs and attitudes based on professional experiences with end-of-life issues (Ryan & Jezewski, 2012).

Nursing 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; Ryan & Jezewski, 2012; Scherer, Jezewski, Graves, Wu, & Bu, 2006). Nurses were in agreement that they should help inform patients of their condition and treatment options, but did not agree that there is a sufficient amount of time spent discussing ADs with patients (Scherer, Jezewski, Graves, Wu, & Bu, 2006). However, in several studies, total knowledge scores on ADs were less than 71%. Nurses who had education in the workplace on ADs had significantly higher knowledge scores and more positive experience with ADs than did nurses who had no AD education (Scherer, Jezewski, Graves, Wu, & Bu, 2006). Workplace education is important as one study found that the majority (55%) of nurses reported having received zero hours of AD education in school (Walerius, Hill, & Anderson, 2009).

Despite marginal total knowledge on ADs, nurses felt moderately confident in initiating and assisting patients and their families with ADs (Ryan & Jezewski, 2012; Scherer, Jezewski, Graves, Wu, & Bu, 2006). A limitation is that these studies were conducted primarily in inpatient settings. The majority of nurses surveyed were critical care, emergency room and oncology nurses. No studies have utilized the KAESAD survey primarily in rural settings.

Rural Nursing Theory

The Rural Nursing Theory (RNT) is a middle-ranged, descriptive theory that helps one understand the health care needs specific to rural populations (Long & Weinert, 1989). Graduate nursing students and faculty at Montana State University developed the Rural Nursing Theory and was first reported by Long and Weinert in 1989. The RNT describes key traits ascribed to rural persons such as self-reliance, work beliefs and health beliefs. The RNT also describes key traits ascribed to rural community settings such as isolation and distance, lack of anonymity, outsider/insider and old timer/newcomer. The unique characteristics of rural nursing and rural nurses are also described. Rural nurses are considered “expert generalists” due to their ability to care for a myriad of patients at any given time (Long & Weinert, 1989). Since 1989, the theory has been widely used by educators and researchers predominately in the United States and Canada to describe rural persons, rural nursing, and rural nurses (Winters & Lee, 2010).

Health Beliefs

The original RNT theory proposed that, “Health is assessed in relation to work role and work activities, and health needs are usually secondary to work needs” (Long & Weinert, 1989, p. 119). Additional health defining attributes were added by Long (1993) as, “Ability to work and perform one’s daily activities” and, “determine health needs primarily in relation to work activities” (as cited in Lee, Winters, Boland, Raph, & Buehler, 2013, p. 470). Long (1993) reported that these health beliefs will affect “health-promotion behaviors, health care seeking, and acceptance of preventive and treatment

interventions” (as cited in Lee, Winters, Boland, Raph, & Buehler, 2013, p. 470). The “health beliefs” and the value placed on work by rural dwellers is important for rural nurses to understand.

Self-Reliance

The RNT identifies self-reliance as a key concept. Self-reliance is defined as, “The desire to do for oneself and care for oneself” and “has important ramifications in relation to the provision of health care” (Long & Weinert, 1989, p. 119). The concept of self-reliance was later explored by Chafey, Sullivan, and Shannon (1998) and the characteristic of ‘decisional choice’ was added to the theory. Decisional choice is described as, “Making one’s own decisions and choices” (as cited in Lee, Winters, Boland, Raph, & Buehler, 2013). Long and Weinert (1989, p. 119) wrote, “The desire to do for oneself and care for oneself was strong among the rural persons”. Understanding the self-reliant nature of rural dwellers is important for nurses to consider as they engage in ACP conversations.

Guiding Interventions

Rural Nursing Theory will help guide and inform interventions rural nurses use as they implement ACP with patients across the lifespan. It is important for rural nurses to understand that rural persons may not seek healthcare until they are unable to work (Long & Weinert, 1989). Therefore, each appointment is an opportunity for rural nurses to provide ACP and AD education with patients across the lifespan.

Quality of life discussions should include conversations about both work beliefs and health beliefs. “These two sets of beliefs appear to be closely interrelated among rural persons” (Long & Weinert, 1989, p. 119). Health needs are usually secondary to work needs and work is of primary importance to rural dwellers (Long & Weinert, 1989). Thus, the value of work to rural persons needs to be considered as rural nurses explore end-of-life options and quality of life with patients.

As Long & Weinert (1989) describe, the self-reliant nature of rural persons and the desire to care for oneself is strong. It is important for rural nurses to consider this key concept of self-reliance as this emphasizes the importance of including ACP discussions across the lifespan so that rural persons are able to communicate their wishes as they are mentally competent to do so.

Defining Rural

The United States Department of Agriculture’s (USDA) Rural-Urban Continuum Codes were used to determine the counties in Montana included in this project. USDA Economic Research Service researchers and others use non-metro areas, as defined by the Office of Management and Budget on the basis of county equivalents, to analyze conditions in “rural” America. Non-metro counties are commonly used to depict rural and small-town trends (United States Department of Agriculture Economic Research Service [USDAERS], 2015). The latest data set of Rural-Urban Continuum Codes from 2013 was used to determine which Montana counties were non-metro. Non-metro categorization for each county is further subdivided determined on population and metro

adjacency (USDAERS, 2013). Non-metro counties are given the codes of four through eight (USDAERS, 2013). Therefore, non-metro counties with codes four through eight were represented in this project. This is to ensure a rural representation and allow for greater transferability of the project to other rural populations.

METHODS

Instrument

KAESAD author, Mary Jezewski, gave permission to adapt the KAESAD survey for the project (M. Jezewski, personal communication, August 26, 2015). The KAESAD instrument measures knowledge of ADs, attitudes regarding end-of-life issues, experience with ADs, confidence with ADs and attitudes based on professional experiences with end-of-life issues. For this project, questions related to state laws were changed to accurately reflect the laws in Montana. Demographic questions were changed to capture data from the rural nurse population. Questions were added to the original survey to inquire about workplace education, perceived nurse support, nurse mentorship, cultural sensitivity, and resources availability. Mary Jezewski gave clear instruction to not publish the survey (M. Jezewski, personal communication, August 26, 2015).

The survey consists of 119 items after additions to the survey by the doctoral student. Principle 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. The survey includes 30 questions related to nurses' knowledge in three subscales (general knowledge of ADs, PSDA, and Montana state laws governing ADs) (Jezewski, Brown, Wu, Meeker, Feng, & Bu, 2005). Seven "yes or no"

questions were added to the original survey to inquire about topics explored by the doctoral student:

1. Do you feel you have support from administration to be active in advance directive discussions with patients and families?
2. Do you feel you have support from physician colleagues to be active in advance directive discussion with patients and families?
3. Do you feel part of the advance care planning team at your facility?
4. Do you feel as though mentoring younger nurses would be beneficial in their communication practices regarding advance directives?
5. Do you think having advance directive resources or guidelines readily available would help you in your advance directive discussions with patients?
6. Have you received training on health perceptions of rural dwellers?
7. Have you received training on providing culturally sensitive care to rural dwellers?

Three open-ended questions were added to inquire about topics pertinent to rural nurses:

1. How many hours of workplace education have you received?
2. Which community do you primarily practice in?
3. What do rural nurses need most to increase their ability to assist patients with advance directives?

General knowledge questions were answered as “yes”, “no”, or “don’t know”.

Answers with “don’t know” calculated as incorrect. Attitude questions were answered on a 4-point Likert scale ranging from “agree” to “disagree”. Nurses’ confidence with ADs

was measured with a 5-point Likert scale. The KAESAD survey ends with 27 demographic questions including personal, professional and work information (Ryan & Jezewski, 2012). The instrument's reliability and validity were determined through previous pilot studies and by an expert panel (Jezewski M., n, d). The expert panel included the disciplines of bioethics, law, medicine and nursing (Jezewski, Brown, Wu, Meeker, Feng, & Bu, 2005). The alterations made to the original survey may impact the reliability and validity of the KAESAD survey.

Population

Rural nurses based out of a home health organization in Great Falls, Montana were chosen for this project. The home health organization's Director of Clinical Services who oversees approximately 50 nurses who work in hospice, palliative, home health and community health settings across six counties in rural Montana. The home health organization has a certificate of need to serve the Montana counties of Cascade, Lewis and Clark, Choteau, Teton, Judith Basin and Pondera counties. The majority of patients the nurses care for are rural.

The nursing workforce of rural Montana consists of nurses of various educational backgrounds. Therefore, nurses of all educational backgrounds who work in rural Montana settings were included in the survey. Nurses were approached to participate by their Nursing Managers and Director of Clinical Services within the home healthcare organization.

Setting

The six Montana Counties represented in the surveys of the nurses were Cascade, Lewis and Clark, Choteau, Teton, Judith Basin and Pondera counties. Five out of the six counties included in the survey fit the definition of non-metro counties as defined by Rural-Urban Continuum Codes (RUCC) of four through eight (USDAERS, 2013). Cascade County includes the city of Great Falls, Montana and as a RUCC code of three, defining it as metro. Each county and their respective code definitions are listed below:

Table 1. Rural Urban Continuum Codes (USDAERS, 2013).

County	Code	Code definition	Population
Cascade	3	Counties in metro areas of fewer than 250,000 population	81,327
Lewis and Clark	5	Urban population of 20,000 or more, not adjacent to a metro area.	63,395
Teton	8	Completely rural or less than 2,500 urban population, adjacent to metro area.	6,073
Judith Basin	8	Completely rural or less than 2,500 urban population, adjacent to metro area.	2,072
Choteau	8	Completely rural or less than 2,500 urban population, adjacent to metro area.	5,813
Pondera	7	Urban population of 2,500 to 19,999, not adjacent to a metro area. Population 6,153	6,153

Timeline and Procedure

The doctoral student attended a meeting with rural nurses and the Clinical Director of Services in Great Falls, Montana. The student introduced the KAESAD survey and project at the meeting. Paper copies of the KAESAD survey were distributed

to the Clinical Director of Services and nurses (home health, palliative, community health, home health).

Nurses were allowed to complete the survey, by hand, at work or after work hours. Additional surveys were left at each location in case nurses lost their surveys. Completion of the surveys demonstrated consent to participate in the project. To ensure anonymity of respondents, the nurses' names and clinic locations were not included on the surveys. Nurses were given two weeks to complete the KAESAD survey. Two weeks following distribution of the surveys, the doctoral student received the completed surveys from the Director of Clinical Services. Surveys returned to the doctoral student were kept in a locked room at the College of Nursing in Great Falls, MT. Survey results were entered into a Microsoft Excel spread sheet and the program Qualtrics for data analysis and stored in a password-protected personal laptop owned by the doctoral student.

Data Analysis

The descriptive statistical analysis software within Microsoft Excel and Qualtrics was used to analyze the survey data. Data were entered into both Excel and Qualtrics by the doctoral student. Both software systems were used as a means of double-checking the results.

Descriptive statistics were calculated for 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. The open-ended questions were

grouped together based on similarity with key words such as, “education” or “time”. Not all surveys were fully completed and contained missing answers. For questions in which not all respondents answered, missing data were left out. Therefore, not all answers had the same sample number ($N = 22$). The Montana State University Institutional Review Board approved this project.

RESULTS

Demographics

There were a total of 32 surveys distributed by the doctoral student and the Director of Clinical Services to the rural nurses. A total of 22 surveys were returned, producing a response rate of 68%. Survey participants were an average age of 46.4 years old ($n = 20$). The majority of the nurses were caucasian (100%, $n = 22$) married (77%, $n = 17$), and Catholic (32%, $n = 7$). Results demonstrated that the majority of the nurses did not have an AD themselves (68%, $n = 15$) and did not know anyone in their immediate family that had an AD (59%, $n = 13$). Additional respondent demographics can be seen in Table 1.

The most common certification held by nurses was Certification of Hospice and Palliative Care Nursing (CHPN) ($n = 3$). Other certifications held were: Certified Case Manager ($n = 2$), Oncology Nurse Certification ($n = 1$), and Geriatric Nurse Practitioner ($n = 1$). Participants reported receiving an average of 1.7 [0-8] hours of education on ADs during nursing school. Some nurses said they received no education in nursing school on ADs ($n = 5$). The majority of the nurses ($n = 13$) reported receiving workplace education on ACP. Of those who received workplace education, the average number of hours of workplace education was 4.4 hours. Of the workplace education received, nurses reported education being presented in the form of an inservice program/workshop (55%, $n = 12$) or through a policy manual (18%, $n = 4$).

Nurses were asked how patients' wishes regarding AD were formally communicated to members of the health care team. The most common answers to this question were, "Don't Know" ($n = 5$), "Indexed section of chart" ($n = 8$), or "Care Plan" ($n = 8$). The majority of the nurses answered that their primary role did not involve providing direct patient care (55%, $n = 12$). The roles of those who answered their primary role not being direct patient care were staff nurses ($n = 3$), nurse managers ($n = 4$), case managers ($n = 4$), and a discharge planner ($n = 1$). Of those that described their primary role as providing direct patient care were home care and hospice staff nurses ($n = 9$).

Table 2. Respondent demographics. RN = Registered Nurse. Brackets indicate a range [].

<u>Category</u>	<u>% (n)</u>	<u>Category</u>	<u>% (n)</u>
Age		Years as RN	
Mean [range]	46.4 [27-65] (20)	Median [range]	20 [3.5-44]
Race		Years in rural practice	
Caucasian	100% (22)	Median [range]	10 [0-43]
Religious Affiliation		Current Practice Site	
Catholic	32% (18)	Home Care	50% (11)
Protestant	18% (4)	Hospice	27% (6)
Christian	14% (3)	Nurse Case Manager	23% (5)
Presence of an AD		Year last degree earned	
Yes	32% (7)	Range	[1972-2013]
No	68% (15)		

Table 2. Respondent demographics. RN = Registered Nurse. Brackets indicate a range [], continued.

Category	% (n)	Category	% (n)
Immediate family with		Highest degree in Nursing	
AD	41% (9)	Baccalaureate	55%
Yes	59% (13)	Master's	(12)
No		Associates	9% (2)
Full Time vs. Part Time		Diploma	13% (3)
Full time	86% (19)	Nurse Practitioner Certificate	18% (4)
Part time	14% (3)		4% (1)
Basic RN Preparation		Current position	
Baccalaureate	62% (13)	Staff Nurse	55%
Associates	24% (5)	Nurse Manager	(12)
Diploma	95% (2)	Case Manager	19% (4)
		Discharge Planner	19% (4)
			5% (1)

Knowledge

Sections one, two and three of the KAESAD survey consisted of true or false questions with an option of “Don’t know”. Answers marked as, “Don’t know” were counted as incorrect. The average score of section one on general knowledge of ADs was 75% (SD = 12.2%; [50%-90%]). The average score of section two on Patient Self-

Determination Act (PSDA) of 1990 was 39.5% (SD = 24.8%; [0%-71%]). The average score of section three on nurses' knowledge of Montana State laws regarding ADs was 62% (SD = 18.28%; [31%-92%]). All three sections were used to compute a total knowledge score on ADs. The overall mean score of total knowledge on ADs was 57%.

Professional Attitudes Regarding EOL Issues

In section four of the KAESAD survey, there were 20 questions on professional attitudes regarding EOL decision-making. A likert scale was used where 1 indicated "Strongly disagree" and 4 indicated "Strongly agree". Results reported include a mean (M) likert score for each question, the number of people answering each question (*n*), and the standard deviation (SD). Each mean was rounded to the nearest whole number and each standard deviation was rounded to the nearest tenth. Table 3 below provides results on professional attitudes.

Table 3. Professional attitudes regarding EOL decision making.

Question	M	<i>n</i>	SD
1. Patients with decision-making capacity who are not terminally ill should have a right to refuse life support even if that decision may lead to death.	4	22	0.6
2. Nurses should uphold the patient's wishes even if they conflict with the nurse's own views	4	22	0.8
3. It is sometimes best to withhold information from patients.	1	21	0.6
4. Most of the time patients are sufficiently informed to prepare ADs.	2	22	0.7
5. Nurses should go against relatives' wishes if they conflict with the patient's end of life decisions.	3	21	0.9
6. Nurses should not violate hospital policies when advocating for patient's end of life decisions.	3	22	0.7
7. ADs will lead to acceptance of euthanasia.	1	21	0.5
8. It is acceptable for health care providers not to offer certain treatments to terminally ill patients because of the cost.	2	21	0.9

Table 3. Professional attitudes regarding EOL decision making, continued.

Question	M	n	SD
9. If cardio-pulmonary resuscitation (CPR) is futile for a patient who has decision-making capacity, a decision to forgo resuscitation should be made without the permission of the patient.	1	22	0.7
10. All patients with decision-making capacity should complete ADs.	4	21	0.8
11. Patients should consider family members' opinions when completing ADs	2	22	1.0
12. Ethically, there is no difference between starting a life support treatment and stopping it once it has been started.	2	21	0.9
13. Even if life-support such as mechanical ventilation and dialysis are stopped, artificial nutrition and hydration should be continued.	2	22	0.9
14. It is appropriate to give medication to relieve pain even if it may hasten a patient's death.	4	22	0.5
15. Nurses should be actively involved in helping patients complete ADs.	3	22	0.8
16. The nurse has the responsibility to confer with the doctor about medical treatment if a patient's rights have not been considered.	4	22	0.4
17. Nurses should persuade patients to accept treatment when this is best for them.	2	22	0.6
18. Actively assisting some terminally ill patients to die (i.e. physician-assisted suicide) should be made legal.	3	20	1.1
19. Patients with decision-making capacity should always be consulted on Do-Not-Resuscitate decisions.	4	22	0.3
20. Nurses should help inform patients about their condition and treatment alternatives.	4	22	0.5

Experience with Ads

Seven questions on the KAESAD survey examined nurses' experiences with ADs with questions answered in a "yes" or "no" format. Table 4 below shows results to the seven questions regarding experiences with ADs.

Table 4. Experiences with ADs. Yes/No answers provided in % (n).

Question	Yes	No
1. Have you cared for a patient with an AD?	100% (22)	0% (0)
2. Have you read your institution's policies or procedures concerning ADs?	68% (15)	32% (7)
3. Have you been a witness for an AD for a patient?	50% (11)	50% (11)
4. Have you counseled patients/families about ADs?	86% (19)	14% (3)
5. Have you initiated a discussion about ADs with a patient?	95% (20)	4% (1)
6. Have you provided treatment to patients whose ADs indicated otherwise?	5% (1)	95% (21)
7. Have you observed others providing treatment to patients whose ADs indicated otherwise?	23% (5)	77% (17)

Confidence with Ads

Utilizing a likert scale of 1 – 5, where 1 is “Not at all confident” and 5 is “Very confident”, nurses scored their confidence among different AD activities. Table 5 displays results to the 11 questions on levels of confidence. Results are reported with a mean (M) likert score for each question, the number of people answering each question (*n*), and the standard deviation (SD). Each mean was rounded to the nearest whole number and each standard deviation was rounded to the nearest tenth.

Table 5. Levels of confidence.

Questions	M	<i>n</i>	SD
1. Knowing the provisions of the Patient Self-Determination Act.	3	22	1.3
2. Initiating AD discussions with patients.	4	22	0.9
3. Answering patients' questions about ADs.	4	22	1.1
4. Answering family members' questions about ADs.	4	22	1.1
5. Responding to a patient's uncertainty about ADs.	4	22	1.0
6. Implementing institutional policy and procedures for ADs.	3	22	1.5
7. Complying with the provisions of patients' ADs.	4	22	0.9
8. Teaching other health care providers about ADs.	3	22	1.5
9. Advocating for patients' ADs when they are against the wishes of the family.	4	22	0.8
10. Knowing state laws regarding ADs.	3	22	1.4
11. Mediating when there is disagreement between patients and family members regarding end of life decisions.	4	22	1.1

Professional Experience with EOL Issues

A likert scale was utilized to assess nurses' professional experiences with end-of-life issues. On the likert scale 1 indicated "Strongly disagree" and 4 indicated "Strongly agree". Nurses agreed that a barrier to making good decisions about EOL care is difficult communication with patients and their families ($M = 3$, $SD = 0.7$). The majority nurses agreed that most patients misunderstand the meaning of an AD ($M = 3$, $SD = 0.7$). Nurses also agreed that the presence of a living will encourages discussion between a patient and health care providers about the patient's preferences about EOL care ($M = 3$, $SD = 0.8$). Table 6 displays the results on professional experiences with EOL issues. Results are reported in mean (M), number participants who answered each question (n), and standard deviation (SD).

Table 6. Professional experiences with EOL issues.

Questions	M	n	SD
1. Most patients are approached early enough in their terminal illness to allow them time to make informed decisions about end-of-life care.	2	22	0.9
2. Patients and their health care providers generally agree about what constitutes medically futile treatment.	2	22	0.7
3. An impediment to making good decisions about end-of-life care is difficulty communicating with patients and their families.	3	21	0.7
4. Very often there is not enough time to discuss ADs with patients.	3	22	0.9
5. Most patients misunderstand the meaning of an ADs	3	22	0.7
6. With ADs patients are able, even in conditions of incapacity, to retain their authority and autonomy regarding their health care.	3	21	0.8
7. Health care providers usually know the wishes of their patients regarding ACP	2	22	0.8
8. Generally nurses can answer patients' questions about ADs.	3	22	0.7
9. Family members follow the AD of the patient most of the time.	3	22	0.7
10. The information in an AD usually is sufficient to guide treatment.	3	22	0.5

Table 6. Professional experiences with EOL issues, continued.

Questions	M	n	SD
11. The presence of a living will encourages discussion between a patient and health care provider about the patient's preferences.	3	21	0.8
12. Some patients are excluded from making decisions about their care because they are <u>inappropriately</u> judged to lack capacity to make decisions.	3	21	0.7
13. Nurses usually know the decisions of their patients regarding their ACP.	2	22	0.7
14. When providers disagree with a patient's AD, providers use their own judgment whether to follow the AD.	2	22	0.7
15. Most patients have enough knowledge about their medical condition and potential treatments to prepare ADs.	3	21	0.6
16. The cost of health care affects end of life decision-making.	3	21	0.9
17. Most of the time family members know the patient's preference regarding care at the end of life.	2	21	0.6
18. Terminally ill patients with a Do-Not-Resuscitate order receive less care overall.	2	20	0.7
19. The amount of time nurses spend discussing ADs with patients is sufficient.	2	21	0.6
20. Helping patients complete ADs is emotionally draining.	2	21	0.5

Additional KAESAD Questions for Rural Nurses

Seven "Yes/No" questions were added to the survey by the doctoral student that were tailored specifically for rural nurses. Table 7 below displays results including the percentage and number of participants who answered each question.

Table 7. Yes/No KAESAD questions. Yes/No answers provided in % (n).

Questions	Yes	No
1. Do you feel you have support from administration to be active in AD discussions with patients and families?	82% (8)	9% (2)
2. Do you feel you have support from physician colleagues to be active in AD discussion with patients and families?	50% (11)	27% (6)
3. Do you feel part of the ACP team at your facility?	45% (10)	45% (10)
4. Do you feel as though mentoring younger nurses would be beneficial in their communication practices regarding ADs?	95% (21)	0% (0)

Table 7. Yes/No KAESAD questions. Yes/No answers provided in % (n), continued.

Questions	Yes	No
5. Do you think having AD resources or guidelines readily available would help you in your AD discussions with patients?	90% (20)	4% (1)
6. Have you received training on health perceptions of rural dwellers?	23% (5)	64% (14)
7. Have you received training on providing culturally sensitive care to rural dwellers?	41% (9)	45% (10)

Open-Ended Questions on KAESAD

The last two questions on the KAESAD were open-ended question. The first question was, “What community do you primarily practice in?” The majority of the nurses reported they primarily practice in Cascade County, Montana ($n = 14$), which includes the town of Great Falls, Montana. Others reported they practice in: “Northern Regional 3 Counties”, “Havre”, “Blackfeet Reservation”, “Covers 9 Counties”, “Rural home health”, “In home” or “Home/community based members”.

The second question was, “What do rural nurses need most to increase their ability to assist patients with ADs?” The majority of nurses stated they need either increased knowledge, education or training ($n = 13$). Nurses also stated they need more time with patients ($n=3$). Nurses also requested wanting more resources or materials to use with patients ($n = 5$). Some nurses reported that earlier communication from providers to patients on their prognosis would help in the ACP process ($n = 3$).

Two nurses reported they needed support to increase their ability to assist patients with ADs. One nurse stated, “Education. Support from physicians providing treatment to patients. We often know the patient is terminally ill and will die soon, but the physician

has not communicated this prognosis to the patient or family”. Another nurse reported, “Education and administrative support”.

Other nurses stated, “Educational pamphlets for patients” ... “Materials to give consumers to keep them. Decide what they would like to use” ... “Education to the community and physician education to have discussions sooner” ... “Continuing education. Standardized questionnaires to assist patients”.

DISCUSSION

Key Findings

Demographics

Survey findings revealed the rural nurses were primarily caucasian with an average age of 46.4 years old. These characteristics are similar to RNs and LPNs that work in rural areas in the United States. According to a report from the Health Resources and Services Administration, rural RNs are slightly older than their urban counterparts with an average age of 44.9, compared with 44.6 years for urban RNs. Also, rural LPNs and RNs are more likley to be white than their urban counterparts (Rural Health Information Hub, 2015).

The rural Montana nurses of this project carry a lot of experience with a median of 20 years as RNs and 10 years working in rural areas. They represent a tremendous amount of experience practicing specifically in rural areas. As previously mentioned, Black & Emmet (2006) found that years of experience in nursing correlates positively with interaction with families regarding ADs and older nurses report more interaction with family and disclosing more information about ADs than younger nurses. The amount of experience the rural nurses of Montana carry makes them a unique member of the health care team that is confident in initiating AD discussions and counseling patients on ADs.

The nurses are also highly educated carrying primarily a Baccalaureate or Master's degree. According to the Rural Health Information Hub (2015), rural registered

nurses are typically less educated than their urban counter parts with 51.6% of nurses having an associate's degree or less as their highest degree. One study utilizing the KAESAD survey found that there was no significant difference in AD knowledge scores with respect to highest educational degree earned (Walerius et al., 2009).

Knowledge

One of the key findings from the KAESAD survey was that the overall knowledge level on ADs was 57%, which is below acceptable grading standards. Other studies using the KAESAD survey have found that knowledge scores of nurses on ADs ranges from 30% to 80%, placing the rural nurses near the mean findings of other studies (Ryan & Jezewski, 2012). KAESAD knowledge scores of oncology, emergency and critical care nurses are provided below in Table 8 for comparison (Ryan & Jezewski, 2012). Montana rural nurses score within close range to the other groups of nurses in all categories, except for the PSDA section. Among all four groups of nurses, the general knowledge of ADs produced the highest mean scores of the three sections.

Table 8. Mean Knowledge Scores compared to Oncology, Emergency, Critical Care nurses in previous studies and rural nurses.

Knowledge Score	Oncology	Emergency	Critical Care	Rural Nurses
General knowledge	70%	68%	71%	75%
PSDA	51%	51%	53%	39.5%
State Laws	53%	56%	54%	62%
Total Knowledge	58%	59%	59%	57%

In addition to marginal knowledge scores, several nurses stated they need more education, trianing and knowledge to better assist patients with ACP ($n = 13$). Nurses

reported receiving an average of 1.7 hours of AD education in nursing school and some reported no education on AD in nursing school ($n = 5$). A similar study also found that the majority of nurses reported receiving zero hours of AD education in school (Walerius, Hill, & Anderson, 2009).

At the workplace, the majority of nurses who received workplace education received an average of 4.4 hours of education. However, there were some nurses that reported receiving no education on AD at the workplace. Previous studies have demonstrated that nurses who have received education in the workplace on ADs had higher knowledge scores and more positive experiences with ADs and EOL decision making than nurses who did not (Scherer et al., 2006). Rural nurses' marginal knowledge scores and request for more education highlights the importance of the inclusion of AD education in both the workplace and nursing schools.

Attitudes

Nurses' attitudes regarding end-of-life decision making demonstrates an overall sense of advocacy for patients. For instance, nurses strongly agreed that they should uphold the patient's wishes even if that conflict's with the nurse's own views. Nurses also agreed that patients with decision-making capacity who are not terminally ill should have a right to refuse life support even if that decision may lead to death. The Montana rural nurses were also in agreement that all patients with decision-making capacity should complete ADs and should always be consulted on DNR decisions.

The rural nurses of view themselves as patient advocates by being vocal in the ACP process among the inter-disciplinary team, as well as with patients. The nurses

believed they have the responsibility to confer with the doctor about medical treatment if a patient's rights have not been considered and that nurses should actively be involved in helping patients complete ADs. Nurses also agreed that they should help inform patients about their condition and treatment alternatives.

The nurses believe that patients should be fully informed on ADs and have an adequate amount of time to discuss ADs. The nurses disagreed that most of the time patients are sufficiently informed to prepare ADs. There was also a strong disagreement that it is sometimes best to withhold information from patients.

This sense of patient advocacy reported by rural nurses is consistent with other studies that also demonstrated nurses' attitudes reflect an advocacy role in EOL decision-making (Jezewski et al., 2005; Scherer et al., 2006). Ryan & Jezewski (2012) also found that nurses were in high agreement with statements about informing patients of treatment options, nurses helping patients with ADs, and upholding patients' treatment wishes. Nurses are in a special position to be involved in the ACP process as they demonstrate attitudes that reflect patient advocacy in ensuring patients' end-of-life wishes are met.

Confidence with ADs

Overall, the majority of the nurses are actively engaged in the ACP process through counseling and initiating discussions with patients and families on ADs. Not only are rural nurses actively engaged, but they are confident in initiating AD discussions with patients. Nurses also were confident in answering patient and family members' questions about ADs. Again displaying a sense of advocacy, nurses were confident in advocating for patients' ADs when they are in conflict with the wishes of the family.

However, nurses did not express confidence in knowing the PSDA or state laws regarding ADs. These findings are similar to previous studies where nurses were confident in assisting patients and families with ADs and less confident in their knowledge on state laws and PSDA provisions (Ryan & Jezewski, 2012; Scherer et al., 2006). The lack of confidence in state laws and PSDA provisions could be due to marginal knowledge on such topics as demonstrated in the knowledge section of the KAESAD survey.

Walerius et al. (2009) suggests that lack of nursing knowledge on ADs presents a challenge to the nurses' role in ACP. Walerius et al. (2009) states staff nurses have not been trained in the PSDA or state-specific laws to assist patients with the completion of ADs and the role of advanced practice nurses may be better suited to help patients with AD completion due to more clinical knowledge on rules, regulations and issues associated with ADs. More education is needed for nurses to increase their confidence and understanding of state-specific laws.

Professional Experiences with EOL Issues

Nurses agreed that more time is needed to have ACP discussions with patients. Nurses did not believe the amount of time spent discussing ADs with patients is sufficient and there is often not enough time to have these discussions with patients. Rural nurses disagreed that most patients are approached early enough in their terminal illness to allow them time to make informed decisions about EOL care. These findings correlate to several other studies that found nurses do not believe they have sufficient time to discuss

ADs with patients (Jezewski et. al, 2005; Jezewski et al., 2003; Ryan & Jezewski, 2012; Scherer et al., 2006). Interestingly, nurses also disagreed that health care providers usually know the wishes of their patients regarding ACP.

With the completion of ADs, nurses agreed that patients are able to retain autonomy regarding their health care and that they are usually sufficient to guide treatment. Nurses agreed that the presence of a living will encourages discussion between a patient and health care provider about the patient's preferences and that most patients misunderstand the meaning of an AD. These findings are similar to another study that found the highest agreement among oncology nurses was with the statement that the presence of a living will encourages discussion of patient preferences (Jezewski et. al, 2005).

Additional KAESAD Questions

Over half of the respondents described the need for either increased knowledge, training or education. Not only do nurses want additional education for themselves, but also for their patients, physicians and community members. The majority of nurses answered that having AD resources or guidelines readily available would help in having AD discussions with patients. In another study, oncology nurses recommended a user-friendly pamphlet or laminated pocket guide with pertinent definitions and guidelines (Jezewski et al., 2003).

Despite rural nurses' confidence and engagement described in other sections of the KAESAD, it is interesting that less than half of the nurses felt they had an active role in the ACP process. One consideration is that half of the respondents were either nurse

case managers or nurse managers. The majority of nurses felt they had administrative support to be active in the ACP process, but only half of the nurses felt they had physician support. There could be some bias in this question due to four of the nurses who were surveyed being nurse managers. Some nurses also reported in the open-ended questions that nurses need physician and administrative support to better assist patients with ADs. These findings are similar to another study that found that nurses asked for support from hospital administration, nursing leadership and physicians to be able to discuss ADs with patients (Jezewski et al., 2003).

With regards to cultural sensitivity, a low percentage of nurses reported receiving training on health perceptions of rural dwellers. Less than half of the nurses reported receiving training on providing culturally sensitive care to rural dwellers. As mentioned before, cultural sensitivity is important when engaging in ACP discussions (NGC, 2014). In rural areas where limited access to health care, cultural beliefs and economic considerations may influence treatment decisions, intimate discussions about death and dying must be approached with sensitivity. With patients and families who may be presenting to a health facility far from their home community, establishing trust and rapport is important (Artnak, McGraw, & Stanley, 2011). Increasing education and training on cultural sensitivity among rural nurses could enhance nurses' ability to successfully engage in AD conversations with rural dwellers.

Another key finding is that the majority of the nurses agreed that the mentorship of younger nurses would be beneficial in their communication practices with ADs. Jezewski et al. (2003) also found that nurses reported wanting mentoring with ADs.

Nurses also believe that earlier communication from providers to patients on their prognosis would be helpful in the ACP process. Jezewski et al. (2003) found that nurses believed a barrier to EOL decision making was a lack of honesty and openness from physicians.

Nurses also believe that nurses need more time with patients to discuss ADs. Nurses in other studies have also reported the need for more time to assist patients in completing ADs (Jezewski et al., 2005). This is not only a barrier identified by nurses, but also by other health care providers in the ACP process. Physicians reported that a common barrier to AD completion was lack of time (Ramsaroop, Reid, & Adelman, 2007; Tung & North, 2009; Nelson & Nelson, 2014). Nurse practitioners have also expressed lack of time as a barrier to ACP (Dube, McCarron, & Nannini, 2015). Future studies on how to effectively maximize time for patients, providers and nurses in the ACP process are warranted.

Overall, the answers provided in the additional KAESAD questions are similar to a previous study that asked oncology nurses what they needed to help patients complete ADs. The four themes identified were: The need for education regarding ADs, the need for more time to assist patients completing ADs, support from administrators and physicians regarding the nurses' role in helping patients complete ADs, and the nature of the nurse's role in assisting patients completing ADs (Jezewski et al., 2005).

Summary of Findings

Overall, survey findings demonstrated that rural nurses are confident in initiating and counseling patients with ADs. However, nurses have marginal knowledge on ADs. Nurses reported that they need additional education, time, resources and support to better assist patients with ACP.

Evidence-Based Recommendations to Facilitate the Nursing Role in Advance Care Planning in Rural Populations

An extensive literature review was done to provide recommendations aimed at facilitating the utilization of nurses in ACP across the lifespan in rural populations based on the KAESAD survey results. Evidence-based recommendations provided below address the key findings in the KAESAD results and incorporate the Rural Nursing Theory.

Education

More education is needed for nurses on ADs. Studies 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 (Scherer et al., 2006). Five nurses in this project reported receiving no AD education in nursing school and only half of the nurses reported receiving workplace education. Other studies have shown that some nurses report no AD training in school (Walerius et al., 2009). Increased education in both the workplace and nursing schools is important as nurses

report minimal training, request additional education and have marginal knowledge on ADs.

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. Again, HPNA, HPNF and HPCC stated, "The specialty of nursing is well positioned to partner with the health care team and lead efforts that support the kind of expert care that seriously ill Americans deserve" (HPNA; HPNF; HPCC, 2015). In this project, the majority of nurses felt they had administrative support, but less than half of nurses felt they had physician support to be active in ACP. Other studies have shown similar results in that nurses request increased support from hospital administration, nursing leadership and physicians to be effective leaders in the ACP process (Ke et al., 2015; Jezewski et al., 2005; Jezewski et al., 2003).

A multi-disciplinary approach to ACP, with the inclusion of nurses, has been shown to be successful in diverse communities (Hammes et al., 2010; Pecanac et al., 2014). The Respecting Choices Model has proven to be successful in La Crosse, Wisconsin with its high AD completion rates and has been highlighted in the IOM's report, *Dying in America*, for its successful multi-disciplinary approach to ACP across the lifespan (Hammes & Rooney, 1998; IOM, 2014). With demonstrated multi-disciplinary success in the Respecting Choices model and nurses demonstrating an overall confidence in AD counseling, it is imperative to provide the support that nurses need to be active in the ACP process.

Mentorship

Nurses should have the opportunity to be mentored in their communication practices regarding ADs. The majority of the nurses in this project reported that the mentorship of younger nurses in their communication practices would be beneficial. Studies have shown that years of experience in nursing correlates positively with interaction with families regarding advance directives. Older nurses report more interaction with family and disclosing more information about ADs than younger nurses. (Black & Emmet, 2006; Jezewski et al., 2003). Another study also found that nurses wanted opportunities for role-playing, practicing and mentoring with ADs (Jezewski et al., 2003).

The rural nurses at reported an average of 19.4 years experience as an RN. The wide range years of practice as an RN [3.5 – 44 years] among rural nurses has the potential to offer an opportunity for the older, more experienced nurses, to mentor younger nurses on their communication practices regarding ADs.

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 help in having AD discussions with patients. Other studies have also demonstrated that nurses report a lack of resources and a desire for more ACP guidelines and resources (Ke et al., 2015; Jezewski et al., 2003). Examples include, the ACP guideline from National Guideline Clearinghouse or tools, provided by Respecting Choices, and Five Wishes, to facilitate AD conversations (IOM, 2014; NGC, 2014). 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 et al., 2010; Ramsaroop et al., 2007; Patel et al., 2004).

Cultural Sensitivity

Cultural sensitivity is important in the ACP process (NGC, 2014). The RNT is critical to incorporate in education provided to rural nurses. Rural nurses should include the RNT to inform practice when engaging in AD discussions in rural populations.

It is important for rural nurses to understand that rural persons see health needs as secondary to work needs (Long & Weinert, 1989). These health beliefs may affect the health-seeking behavior of rural persons (Long & Weinert, 1989). Therefore, each appointment is an opportunity for rural nurses and providers to provide ACP and AD education with patients across the lifespan. According to the evidence, the most successful interventions associated with AD completion were direct patient-healthcare professional interactions and frequent interactions over multiple visits (Ramsaroop, Reid, & Adelman, 2007; Patel, Sinuff, & Cook, 2004). Therefore, understanding the health beliefs of rural dwellers and incorporating ACP across the lifespan is essential for rural populations to have successful AD completion.

The value of work among rural persons also needs to be considered as rural nurses explore end-of-life options with patients. It is important for nurses to understand that health needs are usually secondary to work needs and work is of primary importance to rural dwellers (Long & Weinert, 1989). Quality of life discussions should include

conversations about work beliefs and health beliefs among rural persons as they are interrelated (Long & Weinert, 1989).

As Long & Weinert (1989) describe, self-reliant nature of rural persons and the desire to care for oneself is strong. This key concept is important for rural nurses to consider as this emphasizes the importance of including ACP discussions across the lifespan so that rural persons are able to communicate their wishes, when they are mentally competent to do so.

Implications

This project provides an evaluation of rural nurses' knowledge, experiences and attitudes on ADs. The information gained in this scholarly project provides a foundational assessment for which future scholarly projects can be implemented. The findings of this project are important as there is currently minimal literature on the utilization of nurses in the ACP process, especially among rural nurses. This project provides valuable information that concerns rural populations, who are a vulnerable population and are at increased risk of poor-quality and high-cost of end-of-life care (IOM, 2014).

As mentioned before, the ANA (2015) advises, "nurses should promote advance care planning conversations and must be knowledgeable about the benefits and limitation of various AD documents" (as cited by ANA, 2012). This project helps the nursing profession and other health professionals gain insight into how to better facilitate the role of nurses in the ACP process in rural populations. These findings are informative for

nurses, administrators, physicians, and other members of the healthcare team to identify the strategies that will encourage the nurse's role in ACP.

In primary care, nurse practitioners have expressed lack of time as a barrier to ACP (Dube, McCarron, & Nannini, 2015). Nurse practitioners and other health care providers should delegate and collaborate with nurses in providing ACP in order to maximize time for both patients and providers. Nurse practitioners are also in a unique position to address ACP issues that may involve procedural, organizational or policy changes (Dube, McCarron, & Nannini, 2015).

As a profession, nurses are consistently rated by the public as the most honest and ethical profession in America (Cipriano, 2015). Rural nurses are in a unique position to provide ACP with patients as they develop trusting relationships with patients providing home care, hospice and palliative care. The evidence-based recommendations provided may better equip nurses to advocate for patients and provide ACP throughout the lifespan. Future evidence based practice projects are needed to explore and more clearly define the rural nurses' role in ACP. Future doctoral projects can use the findings from this doctoral project to implement practice improvement projects.

Dissemination

Dissemination of survey findings and evidence-based recommendations were provided to the nursing and professional staff who work within the participating home health care organization and connecting hospital. Continuing education credits (0.5 credits) were given to nurses and professional staff in attendance for the power point

presentation. There were a total of twelve nurses in attendance with the majority being nurses who took part in the KAESAD survey. The certificate of completion for the continuing education activity can be found in Appendix B.

A handout was provided by the doctoral student (Appendix A) that included the NGC (2014) ACP guideline, important definitions and important Montana statutes on ADs. Nurses were also provided a Respecting Choices ACP guide ordered from the Respecting Choices website by the doctoral student (Gunderson Health System, 2013). Due to copyright, the Respecting Choices pamphlet cannot be published with this project. Both handouts were given to nurses to use as resources and references for ACP.

The project findings were also disseminated on a statewide level through publication in *The Pulse* (Appendix C). *The Pulse* is distributed to every licensed nurse in the state of Montana. This project was also presented on a regional level at the Western Institute of Nursing Conference in Los Angeles, California in poster format. The dissemination of these project findings and recommendations to rural nurses who took part in the survey and licensed nurses across Montana will provide nurses and administrative staff with interventions to facilitate the utilization of nurses in the ACP process in rural populations. This project will also increase the awareness of the importance of ACP in rural populations across Montana.

The project was also presented in a poster format at the Western Institute of Nursing's Communicating Nursing Research Conference, a regional conference for researchers, educators, and clinicians. (Appendix D). The information gleaned from this

DNP Scholarly project provides important information to support evidence-based practice by rural nurses' in ACP.

The Helen Jacobsen Lee Endowment for Rural Nursing Research provided funding for this scholarly project. The total funds granted were \$437. Fund money supported poster printing for Western Institute of Nursing, printing KAESAD surveys, ordering Respecting Choices pamphlets and providing breakfast for nurses who attended the continuing education presentation. The information gleaned from this DNP Scholarly project provides an important foundation for further evidence based practice projects focused on rural nurses' involvement in ACP.

Limitations

The number of nurses participating in the scholarly project was small (N = 22). However, the demographic characteristics of participants were similar to rural RNs and LPNs in the United States (Rural Health Information Hub, 2015). Also, most of the nurses (n = 14) reported practicing in Cascade County, Montana. Cascade County includes the city of Great Falls, Montana with a RUCC code of three, defining it as a metro (USDAERS, 2013) areas of fewer than 250,000 in population. In fact, the population of Cascade County is 81,327 (USDAERS, 2013). Lastly, the number of responses varied for each survey question. Due to missing data, additional information about rural nurses and ADs is needed to support evidence-based practice.

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APPENDICES

APPENDIX A

CONTINUING EDUCATION HANDOUT

National Guideline Clearinghouse Advance Care Planning Process

Relevant topics include:

- The value of making one's goals, preferences, and choices for care and treatment known both verbally and in writing
- The importance of early conversations with family in a non-crisis situation
- The value of identification of a surrogate decision-maker, with consent
- The value of cultural sensitivity
- For appropriate patients, the value of having a POLST
- Discussion should include family members, the surrogate decision-maker, and others who are close to the patient
- Any individual can start the conversation (patient, family, physicians, nurses, behavioral health providers, social workers, clergy, trained facilitator, etc.)
- These individuals are encouraged to seek training to improve their ability to handle the issues
- At the later stages, the facilitator should have experience with/knowledge of the patient's specific condition (e.g., congestive heart failure [CHF], end-stage renal disease [ESRD], cancer, etc.)

Assist Patient in Advance Care Planning

Use an Advance Care Planning tool to:

- Help the patient identify a surrogate who would make decisions on their behalf if they did not have decision-making capacity
- Incorporate the patient's goals, preferences, and choices into the advance care plan
- Encourage the patient to discuss their preferences and care plan with the surrogate, family member, spiritual counselor and others
- Encourage the patient to complete an Advance Directive
- [POLST Respecting Choices Program](#); [Five Wishes](#)

Revision of Advance Care Plan

- Review the patient's goals and preferences for end-of-life care and Advance Directives at least annually
- Work with the patient to update his/her Advance Directives, giving consideration to specific potential scenarios
- Discussions should occur with a significant change in prognosis (metastatic cancer, oxygen-dependent COPD, progressive heart failure)
- If patient has limited life expectancy, consider using the POLST tool to address the patient's specific requests for end-of-life care

Documentation and Implementation

- Place a copy of the Advance Directive and other documentation of the patient's goals and preferences for end-of-life care in the patient's record
- Share the POLST throughout the health system as appropriate, and make accessible to emergency departments, EMS companies, nursing homes, etc. ³

Quick Facts:

Advance directive: Patient-initiated documents, includes living wills and documents that name a health care agent. People can complete these forms at any time and in state of health that allows them to do so.

1. *Living will*— statement about the kinds of medical care a person does or does not want under certain specific conditions if no longer able to express those wishes.
2. *Durable power of attorney for health care*—identifies the person (health care agent) who should make medical decisions in case of the patient's incapacity.

Medical orders: Created with and signed by a health professional, a physician (in some states, a NP or PA). These are actual doctor's orders, other health professionals are required to follow them.

1. *POLST*—physician orders covering a range of topics likely to emerge in care of a patient near the end of life— began in Oregon in the early 1990s, is increasingly adopted nationwide. The orders cross care settings and are honored in the community in an emergency.
2. *DNR, DNI, do-not-hospitalize orders*—medical orders covering specific treatments that are written in a health care facility, but do not cross care settings and are not necessarily honored in the community. An out-of hospital DNR is a DNR medical order that pertains when a patient is outside of a health care facility setting (i.e. hospital or nursing home), and is intended to ensure that emergency medical personnel will not resuscitate a patient against wishes.¹

Montana Statutes:

- **Declaration relating to use of life-sustaining treatment:** An individual of sound mind and 18 years of age or older may execute at any time a declaration governing the withholding or withdrawal of life-sustaining treatment. The declarant may designate another individual of sound mind and 18 years of age or older to make decisions governing the withholding or withdrawal of life-sustaining treatment. The declaration must be signed by the declarant or another at the declarant's direction and must be witnessed by two individuals. A health care provider may presume, in the absence of actual notice to the contrary, that the declaration complies with this chapter and is valid §50-9-103 (1).
- **Revocation of declaration:** A declarant may revoke a declaration at any time and in any manner, without regard to mental or physical condition. A revocation is effective upon its communication to the attending physician, attending APRN or other health care provider by the declarant or a witness to the revocation. A health care provider or emergency medical services personnel witnessing a revocation shall act upon the revocation and shall communicate the revocation to the attending physician or attending APRN at the earliest opportunity. A revocation communicated to a person other than the attending physician, attending APRN, emergency medical services personnel, or health care provider is not effective unless the attending physician or attending APRN is informed of it before the qualified patient is in need of life-sustaining treatment §50-9-104(1).
- **Recognition of declarations executed in other states:** A declaration executed in a manner substantially similar to Montana in another state and in compliance with the law of that state is effective §50-9-111(1).
- **Treatment of qualified patients:** Life-sustaining treatment cannot be withheld or withdrawn pursuant to a declaration from an individual known to the attending physician or attending APRN to be pregnant so long as it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment §50-9-202(3).
- **Transfer of patients:** An attending physician, attending APRN, or other health care provider who is unwilling to comply with this chapter shall take all reasonable steps promptly to transfer care of the declarant to another health care provider who is willing to do so. If the policies of a health care facility preclude compliance with the declaration of a qualified patient under this chapter, that facility shall take all reasonable steps to transfer the patient to a facility in which the provisions of this chapter can be carried out. A health care provider who willfully fails to transfer the care of a patient is guilty of a misdemeanor punishable by a fine not to exceed \$500 or imprisonment in the county jail for a term not to exceed 1 year, or both §50-9-203.²

1. Institute of Medicine. (2014). *Dying in america: Improving quality and honoring individual preferences near the end of life*. Washington, DC: The National Academies Press.
2. *Montana Code Annotated 2015*. (2015). Retrieved from http://leg.mt.gov/bills/mca_toc/index.htm
3. National Guideline Clearinghouse. (2014, January). *Advance care planning*. Retrieved from U.S. Department of Health & Human Services: <http://www.guideline.gov/content.aspx?id=47803>

APPENDIX B

CONTINUING EDUCATION CERTIFICATE OF COMPLETION

Certificate of Completion

July 29, 2016

Awarded to

Exploring the Nurse's Role in Advance Care Planning in Rural
Populations

Presented by

**Kara Christensen
1101 26th Street South
Great Falls, MT 59405**

Contact Hours: 0.5

This healthcare organization is an approved provider of continuing nursing education by Montana Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

APPENDIX C

THE PULSE PUBLICATION

Statewide Nursing News

Advance Care Planning

Background: It is recommended that advance care planning (ACP) take place across the lifespan. Rural populations have a heightened risk for poor quality and high cost of end-of-life care. ACP can be led by nurses to ensure end-of-life-care reflects patients' wishes, however, there is little research regarding the nurses' role in ACP.

Purpose: A doctoral project was completed to assess rural nurses' knowledge, attitudes and experiences with advance directives (ADs). Information gained was used to develop evidence-based recommendations to assist with ACP across the lifespan in rural populations.



**Kara Christensen,
RN, BSN**

Sample: Participants were nurses who practice in rural settings (N = 22). Average age was 46.4 years. All were Caucasian (n = 22) and more than half were baccalaureate prepared (n = 12). Nurse practice settings were primarily in home care (50%) and hospice (27%). The majority of the nurses practiced in Cascade County (n = 14).

Methods: The Knowledge, Attitudinal, and Experimental Surveys on Advance Directives were distributed to the nurses. Descriptive statistics were used to analyze the data.

Results: Average scores on general knowledge of ADs, the Patient-Self Determination Act and Montana AD laws were low (75%, 40%, 62%). Despite marginal knowledge, nurses felt confident in counseling (n = 19) and initiating (n = 20) discussions with patients and families on ADs. Nurses believed they have administrative support (62%), but less physician support (50%) in ACP. The majority of the nurses agreed that the mentorship of younger nurses would be beneficial to their communication practices with

ADs (95%). Less than half of the nurses stated they feel part of the ACP team at their facility (45%). Nurses described the need for more education, training and knowledge on ACP (n = 13). A small number of nurses also described needing more time to discuss ADs with patients (n = 3). The majority of nurses (90%) reported having AD resources or guidelines would be beneficial.

Conclusions: Participants were confident in initiating and counseling patients with ADs, but indicated they want additional education, time, and support from administration and physicians to better assist patients.

Implications: A presentation will be given in Cascade County on the survey results and will include recommendations for facilitation of nurses in the ACP process. Recommendations include: Providing workplace education, supporting nurses in ACP, mentoring young nurses, providing ACP resources, and utilizing the Rural Nursing Theory with rural populations. Project findings and recommendations will also be published in *The Pulse* for dissemination on a statewide level.



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APPENDIX D

WESTERN INSTITUTE OF NURSING POSTER



Advance Care Planning in Rural Montana: Exploring the Rural Nurse's Role

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Background & Significance

Background

- Advance care planning is a process including discussions of patient values, goals and preferences about end-of-life (EOL) care. Outcomes of include documentation of patient preferences through written legal documents (i.e. advance directives) or medical orders (i.e. POLST, do-not-resuscitate)¹.
- Institute of Medicine recommends that advance care planning become more prevalent in primary care¹.
- The American Nurses Association advises, "Nurses should promote advance care planning conversations and must be knowledgeable about the benefits and limitation of various advance directive documents"^{2,3}. However, limited research on the utilization of nurses in advance care planning in primary care settings⁴.
- Knowledge scores on advance directives are low among nurses. However, nurses' attitudes reflect an advocacy role in EOL decisions⁵.
- Significance
- Approximately 13% of the \$1.6 trillion in health care costs is for the care of individuals in the last year of life^{1,9}. Of all medical inpatients, roughly 40% are incapable of making their own treatment decisions due to unconsciousness, cognitive impairment, or an inability to express a choice^{1,12}.
- In 2013, one study found that 26.3% of adults ages 18+ had an advance directive. Having an advance directive is associated with increasing age, higher levels of income and education, chronic disease and a regular source of health care¹¹.
- Rural residents have fewer visits to providers, less likely to receive preventative services and have more chronic conditions. Without access to healthcare services, rural populations are a vulnerable population and at heightened risk for poor quality of EOL care¹.
- Rural residents prefer control over decisions about EOL care and value patient autonomy^{7,10}.
- Rural residents prefer to be fully informed and engaged in open conversation about all EOL treatment. However, few have actually signed ADs that they have shared with family members or physicians⁷.

Purpose of Project

Assess rural nurses' knowledge, attitudes and experiences with advance directives in rural Montana and use as a foundation to develop interventions to assist with advance care planning across the lifespan in rural populations. This project was developed in support of recent recommendations that advance care planning should take place across the lifespan and can be led by non-physicians (e.g. nurses) to ensure end-of-life-care reflects patients' wishes⁶. Rural populations are the focus of this project as they have a heightened risk for poor quality and high cost of end-of-life care¹.

Abstract

Problem Statement: Rural populations are at heightened risk for poor quality and high costs of end-of-life care. More data is needed to understand the role of rural nurses in advance care planning. **Purpose:** Assess rural nurses' knowledge, attitudes, and experiences with advance directives in rural Montana and use as a foundation to develop evidence-based interventions to assist nurses in advance care planning across the lifespan in rural populations.

Methods: The KAESAD survey was distributed to nurses employed by Benefis Spectrum Medical in Great Falls, Montana. The nurses of Benefis Spectrum work in home health, hospice and community health primarily in rural areas of Cascade County, Montana. KAESAD surveys were distributed by the DNP student and Benefis Spectrum's Director of Clinical Services to 32 nurses. Nurses were given two weeks to complete the survey by hand.

Analysis: Statistical analysis will include descriptive statistics in the categories of knowledge, attitudes and experiences with advance directives. Descriptive statistics will also be used for analysis of personal and professional characteristics. Data analysis not complete at this time. **Results:** There was a response rate of 68% with 22 surveys returned after a 2 week period. Project findings will be disseminated locally and state-wide. Findings and evidence-based recommendations will be published in the *Montana Nurse* and *The Pulse*, which are distributed to every licensed nurse in the state of Montana. A continuing education presentation will also be provided to the Benefis Spectrum Medical staff including nurses, nursing administration, and other professionals involved in healthcare in rural Montana.

References available upon request

Materials & Methods

Instrument

- Permission by author of the Knowledge, Attitudinal and Experimental Survey on Advance Directives (KAESAD) to use and alter survey
- Survey has 119 questions that measure knowledge of advance directives, attitudes based on professional experiences with end-of-life issues, experience and confidence with advance directives.
- Additional questions were added to the survey to address perceived nurse support, mentoring, cultural sensitivity, workplace education and opinions on what nurses need to increase their ability to assist patients with advance directives.

Methods

- IRB Approval obtained from Montana State University
- Surveys distributed to Benefis Spectrum nurses at a weekly meeting. Additional surveys distributed by the Director of Clinical Services
- 2 weeks to complete surveys and return to the Director

Theoretical Framework

The Rural Nursing Theory (RNT) helps one understand the nature of rural nursing and the health care needs specific to rural populations¹. The RNT describes rural persons' definition of health and common traits. The RNT will inform interventions to guide rural nurses' practice in advance care planning with rural patients.

Subjects & Setting

Setting:

- Benefis Spectrum Home Health serves Cascade, Lewis and Clark, Choteau, Teton, Judith Basin and Pondera Counties of Montana
- 5 out of the 6 counties included in the survey fit the definition of non-metro counties as defined by Rural-Urban Continuum Codes (RUCC)¹³. Cascade County includes the city of Great Falls, Montana and as a RUCC code of three, defining it as metro.
- Nurses who returned surveys primarily practice in rural areas surrounding Great Falls, Montana in Cascade County (total population of 59,351).
- Majority of the patients seen by Benefis Spectrum nurses are located in rural areas.

Subject inclusion criteria:

- Nurses employed by Benefis Spectrum who serve rural communities
- Nurses of all educational backgrounds