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Measuring Advance Directive Knowledge Gives Rise to Primary Care Nurses' Education Training

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Abstract

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MS, University of South Carolina, 1994

BSN, City University of New York, 1977

Project Submitted in Partial Fulfillment

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Abstract

Patients have the right to self-determine how and in what manner they desire to make end-of-life decisions. The use of advance directives (AD) is the focus of the Patient Self Determination Act (PSDA). The PSDA permits the use of legal documents to outline the patient's end-of-life decision when they can no longer communicate to the medical community. Because individuals with chronic diseases are living longer the medical community must stay abreast on current laws and protocols to provide the care needed and address patient's wishes for end-of-life needs. Nurses would be ideal to provide education on AD to patients upon entry into practice as they are the first to work with a patient. Unfortunately, AD completion rates are at all-time low. Despite the championing done for AD, completion rates for the United States AD rate remains 30%. The purpose of this quantitative descriptive correlational design was to examine the survey responses from 10 primary care nurses in a local facility. The objective was to increase AD completion rate by increasing staff knowledge and attitudes towards AD so they would have the desire to initiate AD conversations. The descriptive findings resulted in a two-fold increase in responses from Section I of the survey on general AD knowledge. The health belief model guided the research using the Knowledge-Attitudinal-Experiential-Survey (KAESAD), to obtain rich data on nurses' AD knowledge, attitudes, and experiences with AD completion. The findings give rise to an organized and strategic nurse training program for AD that will be implemented in a local facility. Instead of waiting until post hospital admissions, positive social change will occur by initiating AD completion upon new patient arrivals into practice.

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Dedication

This project is dedicated to my late husband (Norman), my children (Jacinta and A. Sameh), aunt Leona (Mother), late uncle S.A. (Engurish Moore), late mama (Mattie), late grandmother, Garner Alford (Sweet mama), brother (Sterling), Donell, and all those who inspired me to go the journey. If you can dream it, you can accomplish it.

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I would like to thank God and his many angels for covering me during a great time of turmoil and grief over the loss of my husband (Rev. Norman Kithcart), and my biological mother (Mattie), while on this journey.

I give thanks to Dr. Robert McWhirt, my committee chair, who kept me on the right path to complete this task, the many faculty members at Walden University, and Dr. and Mrs. Treadwell Campbell, at Campbell Family Practice, who were flexible enough to permit me to come and go for the past 20 years.

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Section 1: Nature of the Project

Introduction

According to the U.S. Census, people live longer with chronic diseases and approximately one in three American adults complete an end-of-life directive (U.S. Census Bureau, 2018). The National Council on Aging (2016) concurred that mortality is highest among those persons with chronic diseases, which indicates a need to begin advance care planning and have the discussion about end-of life choices. Advance care planning leads to advance directives (AD) in the form of a living will. A living will serve as a legal document to speak for the patient when they can no longer speak for themselves (South Carolina Bar Association, n.d.; Spoelhof & Elliott, 2012). When patients can no longer communicate their wishes, it is essential to have a document to speak for them. The Centers for Disease Control and Prevention (CDC, n.d.) stated that AD permit the individual to inform their healthcare provider, family members, and all concerned parties of the type of desired end-of-life care.

Since primary care is deemed the best place to have the end-of-life conversation, nurses must be well equipped to handle efforts to complete AD. In this project, I sought to address nurses' lack of AD knowledge by surveying before and after an AD educational training to strengthen the nurses' knowledge and confidence in AD. Despite the need for education and training on AD, there is still misunderstanding about AD and end-of-life decisions (Hebert et al., 2011; Walezak et al., 2017). Some people think AD should be done when death is soon, for persons with serious illness or those with less than 1 year prognosis (Holland et al., 2017; Izumi, 2017). There is controversy about AD regarding when to lead the conversation, who should initiate the conversation, and whether the exchange should occur at all (Colville & Kennedy, 2012; Hebert et al., 2011; Lum et al., 2016). However, failure to provide advance care planning or AD can be devastating to the patient and family members because of unnecessary procedures and life-saving interventions (Colville & Kennedy, 2012; Holland et al., 2017; Tripken et al., 2016). This decision may not necessarily coincide or align with the individual's wishes. Therefore, if the individual had written instructions or an AD, the life-saving interventions would not be necessary (Bond et al., 2018; Nedjat-Haiem et al., 2018). In turn, healthcare providers would deliver comfort care. A governmental mandate referred to as Patient Self-Determination Act (PSDA) specifically addressed Medicare/Medicaid recipients admitted to hospitals receiving governmental funding (Coffey et al., 2016; Center for Medicare and Medicaid Services, 2012; PSDA, 1990). In the United States, PSDA requires institutions to inform the patient upon admission that they have a right to accept or decline treatment decisions, including AD (CMS, 2012).

The subject of AD has been on the table for over 40 years. Advance care planning or AD are like a will process (Yadav et al., 2017). The concept may motivate an individual to AD completion. Further, the authors acknowledged that AD's emotional and challenging aspects are unlike that of preparing a will (Yadav et al., 2017). It may not seem logical after all, especially when the individual does not have a conversation with the family and healthcare provider about AD. Despite the desire to talk to someone, the patient will likely presume that their family should know their wishes.

This project will foster replication so that like-minded facilities may consider repeating the same process for their staff regarding AD education. Stakeholders may see the change in behavior when more patients have AD. Social change could occur for nurses when they learn a refreshing way to introduce AD early in the new patient process. The problem statement will discuss AD further in depth.

Problem Statement

According to Ohr et al. (2021) and Xu et al. (2021), 7.5% of older adults live with chronic diseases, institutions must equip nurses to deal with the new age, additional training, and ongoing support needed. Despite legal efforts championing the country to address AD completion in 2016, the completion rate was 30%, then increased to 37% in 2018 (Lendon et al., 2018; U.S. Living Will Registry, 2016). Further, Yadav et al. (2017), and Norels and Smith (2015) asserted that incapacitated individuals fail to discuss their affairs openly about end-of-life decisions. Since primary care is often the central healthcare area, nurses working in primary care must be abreast of AD and engage the community in these efforts. In this Doctoral of Nursing Practice (DNP) project I aimed to highlight nurses' AD knowledge in primary care setting and concomitantly design an education training program to raise the AD completion rate to address the gap.

The literature discussed several forms of AD, either a living will, healthcare power of attorney, or advance care planning to address end-of-life issues (Booth, 2016; Franklin et al., 2020; Solis et al., 2018; U.S. Living Will registry, 2016). All are synonymous in making plans for end-of-life decisions for patients and their families. A living will is defined as a formal document that lists life-sustaining measures that will or will not be provided or withheld when the patient cannot speak for himself, such as withholding food and not inserting a feeding tube when the patient stops eating (Obrador, 2016). A healthcare power of attorney is a legal document signed and executed by an attorney, which gives a patient-appointed individual the right to make healthcare decisions when the patient becomes incapacitated (Obrador, 2016). For example, if an individual has metastatic breast cancer and the surgeon wants to perform surgery to remove a lump the person with power of attorney can sign for the surgery or decline surgery. Lastly, advance care planning (ACP) considers the notion of medical support in case of dire emergency and end-of-life advancement. In this aspect of the plan, the patient is exploring treatment options, talking with family and health care provider about their wishes, and recording their desires (Miller, 2018; Obrador, 2016).

A common factor in the literature regarding AD is the nurses' lack of knowledge, attitudes, and experience in delivering AD (Booth, 2016; Holland et al., 2017; Ke et al., 2015; Miller, 2018; Yadav et al., 2017). Dening et al. (2019) also proposed that health personnel face new challenges with AD because failure to acknowledge a patient's wishes or absolute compliance could be equally binding. Several barriers exist in the implementation process that may be overlooked such as, legal, and ethical entities, a lack of nurses' knowledge, and decrease competence in end-of-life care for the patient (Coffey et al., 2016; Scholten, 2018; Spoelhof et al., 2012). The research does, however, suggest medical personnel displayed an improvement in AD confidence after formal training (Bowers, 2016). Discussing barriers to AD cannot be discussed without mentioning the purpose statement.

Purpose Statement

In this purposive, quantitative approach I aimed to examine nurses' AD knowledge, attitudes, and experiences using a survey questionnaire. The data collected was used to design a staff education program for AD to increase AD knowledge and confidence while simultaneously increasing AD completion rate. My aim for this project was to fill the gap by answering the guiding question: Will a staff education program on advance directives increase nurses' knowledge towards the ultimate goal of increasing compliance?

The use of AD is not increasing for older Americans, and there are some speculations on why it is not. With 75% of older Americans living longer, medical professionals must be prepared to handle the larger population of seniors (see Xu et al., 2021). ACP focuses on engaging patients in a discussion on end-of-life care (AlFayyad et al., 2019). Doing so ensures that end-of-life needs are met in the event one loses their decision making capacity.

To a certain extent, one's quality of life (QOL) is impacted by AD. From that standpoint, once an individual acquires diminished decision-making capacity, then their QOL also declines. AlFayyad et al. (2019) surmised that in the absence of AD, a patient can become aggressive and fearful because they do not want to burden their families or have an undignified death. Of course, this could be interpreted differently in various cultures. For example, in the West, AD are widely used, whereas, in the Islamic community, AD are not adopted (see AlFayyad et al., 2019). In other words, in the West, to not have an AD would be seen as an undignified death.

Nature of the Doctoral Project

The sources of evidence for this project were collected from several scholarly resources such as, PubMed, MEDLINE, Cumulative Index for Nursing and Allied Health Literature (CINAHL), Psych Info, A Cochrane Database, A Web of Science, and other resources by Walden University to maximum saturation. By aligning the search to match the purpose of this project, the following terms were used: *advance directives, advance care planning, end-of-life,* and *living will*. I used Walden University's (2017) DNP Manual for Staff Education as a guiding force to achieve this process. By complying with the standards and principles of the manual, the projects' intervention can be realized. The use of Boolean logic, by combining terms such as *advance directives, advance healthcare directives, living will and primary care, end-of-life, nurses and advance directives, nurses and AD knowledge,* and *advance directives and primary care nurses,* helped to simplify the search and consolidate the findings.

By referencing Walden's DNP Manual, the principles and methods outlined helped guide the intervention process into the final stages of AD implementation for staff training. The theoretical framework derived responses from participants about knowledge, attitudes, and experience of advance directives by way of the questionnaire. The knowledge, attitudes, and experience are the aspects of what constitutes the KAESAD Survey. Once Walden University Institutional Review Board (IRB) approved the project (Approval no. 01-12-22-0752084), I began instituting the survey and extrapolating data. Data obtained from the questionnaire elicited rich responses loaded with various aspects of outcome data. The blending together of data from the nurses responses helped to form an instructional foundation ideal for AD training. Drawing from the anticipated findings, an assessment of the pre- and posttraining survey filled gap-in-practice while connecting the purpose. The purpose was to examine nurses' AD knowledge, attitudes, and experience through a quantitative pair of lenses. My goal was to fill the gap-in-practice by answering the question: Will a staff education program on advance directives increase nurses' knowledge towards the ultimate goal of increasing compliance? Once the gap-in-practice has been addressed, then it is important to the nursing community to discuss the significance.

Significance

Despite the diverse cultural beliefs for AD, having an end-of-life conversation with patients and families can be challenging. It can also be reassuring to know that when one can no longer make competent decisions, one can designate a proxy to make health care decisions on their behalf (see Geramita et al., 2020; Goswani et al., 2020; Spoelhof & Elliott, 2012). The implementation and use of a staff training program for primary care nurses may result in more patients completing the AD and understanding more about AD. By increasing AD knowledge and AD completion, patients and nurses are empowered to initiate the conversation. Through an effective training program, not only will nurses gain understanding of AD but feel less embarrassed and gain confidence in their knowledge (Coffey et al., 2016; Fan & Rhee, 2017; Ryan & Jezewski, 2012; Scholten et al., 2018).

AD are gaining momentum but remains a highly underused tool for end-of-life situations (see O'Sullivan et al., 2015). O'Sullivan et al. (2015) further estimated that between 5% and 25% of adults in the United States hold AD, though the age of the persons may vary. The primary care office still appears to be the best outpatient setting because nurses are in critical roles to institute AD discussions. The evidence-based practice requires registered nurses (RNs) to take responsibility in end-of-life decision-making discussions and lay the groundwork for training (see Ryan & Jezewski, 2012).

The stakeholders in the local community that will potentially be impacted by the project are community-based centers that foster AD assistance. If community-based centers continue to render a service to seniors, then all persons must be exposed to cultural behaviors and social norms (see Dempsey et al., 2018). All social norms are not created equal. In light of this potential project, the potential nursing contribution are few though the training program could increase the number of AD completed. Local hospitals may share news content in their newsletter. If the results are published in the nursing journals showing the project outcome, other facilities may want to use the training to increase AD rates as well.

The first way this project may incorporate social change is via the local facility by changing the process of AD completion. Instead of waiting until the patient is discharged from the hospital, the process of AD completion can start on the first day the new patient arrivals. Secondly, this project can be shared with other like-minded healthcare settings around the globe to facilitate social change in healthcare. My goal is that each nurse participant in the survey will incorporate new learning about AD and acquire the knowledge and confidence to champion patients end-of-life wishes.

Summary

All patients have equal rights to ACP. Nurses are encumbered with patient care planning, organizing, and executing whatever specific needs are required at the time, including AD training and patient teaching. Nurses often train and teach patients while lacking the proper skills to perform any given task related to patient care. Nurses are advocates for their patients, yet they lack the training to educate patients regarding AD under the PSDA (see Kelly, 1995). To be effective in their skill as nurses, they must improve in knowledge, attitudes, experience, and confidence in AD delivery (see Hinderer & Lee, 2019).

Nurses' actions significantly affect the lives of not only patients and their families, but stakeholders, communities, and other healthcare professionals. Because the literature lacks information on nurses' AD knowledge for primary care, this project is timely in providing an educational program for nurses that will provide AD training and increase AD completion in the community (see Rao et al., 2018). This project may also be the first to use the KAESAD survey for primary care nurses.

Section 1 included an introduction to the problem of a lack of AD knowledge, focusing on the problem and purpose statement. By discussing the purpose of AD, the subject matter moves forward into the nature of the doctoral project. By including the significance and summarizing the entire section, a clearer picture of the project comes into view, opening the pathway for the background, starting with Section 2.

Section 2: Background and Context

Introduction

The first living will occurred in 1976 and was created by members of the Society for Euthanasia (Orbon, 1976). At that time, the term living will came into existence because an attorney Kutner, championing human rights, made it a vital component for AD. At that time, a legal document came into existence that provided patients with the right to die on their terms and would stop extraordinary measures to prolong life. Since that time, the Natural Death Act permits a terminally ill person the right to enact AD, which can include withdrawing or withholding life-sustaining treatment (Orbon, 1976).

Virginia became the first state to enact a power of attorney stature in 1954 (Sabatino, 2010). A few years later, congress enacted the PSDA in 1990. Under the PSDA, patients receive written notification of their rights to refuse or accept treatment in a hospital. Until primary care nurses are trained to deliver AD knowledge, they will not assist their patients in making end-of-life choices. Because AD is an intricate piece in ACP, a lack of AD knowledge can lead to decreased confidence affecting communication for nurses in the end-of-life discussion (Coffey et al., 2016). Having decreased AD knowledge does not come without some misgiving, both here and abroad. The problems identified regarding a decrease in AD knowledge affected the local community and the global market. When an individual does not have a living will in the local community, their treatment plan and hospital stay become long with costly, unnecessary procedures (see Solis et al., 2018).

With this project, I aimed to bring awareness to the process of AD and determine if increasing nurses' knowledge in the primary care setting will increase compliance. While at the same time, the intention is to foster change and reverse the stereotype about only discussing AD if the patient is terminal or dying (see Geramita et al., 2019). The practice focused question for this staff education project was: Will a staff education program on advance directives increase nurses' knowledge towards the ultimate goal of increasing compliance? The concepts, models, and theories used in this project are discussed in the following sections.

Concepts, Models, and Theories

Engaging patients in the platform to deliver AD in a more organized, strategic, and purposeful manner could propel this project beyond the limits of the nursing arena. By having concepts taken from real-life experiences, a correlational model, and a theory based on the health behavior of individuals, the rationale for use can be applied to the behavioral sciences and effect a positive health change in nursing education (Hodges & Videto, 2011). The prevalence of AD in primary care will be evident in the Government Accountability Office (GAO) report (2015) compiled from Medicare/Medicaid services. The GAO report provides a statistical analysis of annual completion rates with a particular interest in the completion rates across the four major providers (nursing homes, hospice, hospitals, and home care agencies). The nationwide data displayed interview results from the Centers for Medicare/Medicaid services (CMS, 2012), who obtained their data from chart reviews for primary care. Since the data is prevalent for behavioral change, the health belief model (HBM) aligns well with the belief system of individuals to design an education program to effect change in behavior (Rosenstock 1974).

Hodges and Videto (2011) emphasized four concepts from Rosenstock's HBM: (a) perceived susceptibility – appears as potential harm, (b) perceived severity – a sense of fear towards a particular illness, (c) perceived benefit – recommends action, and (d) perceived barriers – prevent hurdles. In terms of my project, perceived susceptibility is the harm faced by families when an individual is approaching death, and no one has made any long-range plans about their wishes. Because of this susceptibility, the individual is at risk of receiving unwanted medical treatments when they cannot make decisions (Mansfield et al., 2020). Alongside the perceived susceptibility is the perceived severity. An example of perceived severity would be displayed by not participating in AD training. By not experiencing the training, the completion rate for AD may worsen. The third aspect of the model is perceived benefit. Mansfield et al. (2020) believed that a perceived benefit must have a preventive measure. Thereby using the preventive measure, one can predict what would happen if AD training did not occur and believe that AD completion will exceed the perceived barriers. The perceived barriers are those obstacles that cannot be avoided, such as lack of knowledge (Hodges & Videto, 2011). Once training is complete, the lack of knowledge barrier will be reduced. While conceptualizing AD as a health behavior, older persons have many variables to consider such as readiness to change, barriers to change, and perceptions of benefit or harm. Being more senior in years puts geriatric persons in a different level of thought processes and self-efficacy. For instance, having an education program is not likely to change the senior's mind who does not have death and dying as a priority. Secondly, acknowledging that behavior change requires some change in attitude first suggests that some cognitive and emotional processes are underway (Hodges & Videto, 2011). In other words, it must be recognized that older people use these processes throughout their years of development as they move from one stage to the other. Finally, older people tend to look at the broader picture and consider the benefit as well as what might cause complications (Hodges & Videto, 2011). For this reason, a novel approach is best when the individual is receptive to these issues, such as funeral planning.

The focus for nursing is that the program design from this project may serve other nursing staff who are faced with patients who do not know about AD or how to institute AD. This model may resonate throughout the community and inspire others to do likewise.

Relevance to Nursing Practice

Under the PSDA, patients receive written notification of their rights to refuse or accept treatment in a hospital (Kelly,1995). While primary care nurses are trained to deliver AD knowledge, they can also assist patients in making end-of-life choices. For instance, increasing confidence for nurses, increasing skill set, improving patient outcomes, and growing community awareness and stakeholder involvement. Because AD compliance is not just a local problem, it impacts the global market via health care costs, lengthy hospital stays, and unnecessary procedures, such as inserting a feeding tube when the patient has stopped eating (Obrador, 2016). According to Coffey et al. (2016) five countries examined AD knowledge and confidence in a cross-sectional study (Hong

Kong, Ireland, Israel, Italy, and the United States) only to find that the older nurses displayed more AD in all countries for knowledge and confidence. This solidifies the confidence, knowledge, and years of experience that older nurses possess to contribute to the science of nursing.

Currently, the medical facility where I conducted my project attempts to introduce AD when patients return from an inpatient hospital stay. The facility does not have an AD protocol to initiate AD completion, hence my decision to select AD training as a topic. and seek evidence-based practice to improve AD completion. Developing AD completion protocol for primary care patients will vehemently improve the current statistics reported for the United States (Ke et al., 2015; Rao et al., 2014). The American Association of the College of Nursing (AACN, 2006) admitted that nurses have a vital role in facilitating end-of-life discussions (Hebert et al., 2011). Since nurses are critical figures in the healthcare paradigm, it only fits that they have a seat at the table. Facilitating the end-of-life discussion requires knowledge, and AD knowledge requires expert, tested, and proven data from the KAESAD survey, which has been evidence-based in the literature (Ryan & Jezewski, 2012). O’Sullivan et al. (2015) demonstrated that AD knowledge improved education for nurses by empowering nurses to initiate AD conversation. AD knowledge also increased the AD completion rate for seniors and improved patient care via outcome data. Implementing the project for AD knowledge may guide the literature and maintain amenability with CMS regulatory standards for outpatient clinics. Other perks go along with completing AD, such as generating revenue for the facility while adhering to CMS coding guidelines (CMS, 2012). In other words, when primary care bills are sent for reimbursement with the correct billing codes, the facility's reimbursements are returned accordingly.

Nurses maintain up-to-date training and proficiency, with competence inferred, since graduation from an accredited nursing school. The South Carolina State Board of Nursing outlines the standards of practice and issues the license for competence, knowledge, and skills (South Carolina Department of Labor, License and Regulation, n.d.). Besides, the Institute of Medicine (IOM, 2014) issued a mandate related to nurses' education that nurses should practice to the full extent of their education and training. Miller (2018) agreed with the IOM's recommendations by highlighting that nursing programs should factor in ADs with state laws included. Also, Hebert et al. (2011), and Miller maintained that nurses should advocate for patients when they cannot speak for themselves.

To discuss how previous standards of practice would address the gap-in- practice, one must consider how knowledge was obtained in primary care before the advent of evidence-base practice (EBP) in July 2018. Previously, nurses relied on numerous teaching methods such as simulation training, article review and critique, to name a few (Li et al., 2019). The information obtained from these methods had shown promise for improving EBP and patient outcomes; however, further research was needed. Currently EBP is being used widely and adopted for knowledge, attitudes, and implementation (Li et al., 2019). The nursing and medical community relies heavily on EBP as part of the current practice of scholarly research that complements nurses' experiences.

This project fills the educational gap for nurses by being in line with such a dynamic discipline that changes and develops in response to the health care needs of the public, electronic advancement, and the development of scientific expertise (South Carolina Department of Labor, License & Regulation, n.d.). Because nurses are essential figures in the concept of AD, EBP requires nurses to assume responsibility and take part in the end-of-life decisions for patients (Ryan & Jezewski, 2012). Even though patients may have the mindset that they should be encouraged by a family member, nurses can also lay the groundwork for training. The local background and context are parts of learning and sharing knowledge, as we discuss in this next segment.

Local Background and Context

The rural setting of this primary care family practice facility was ideal for this project site where the community engages in many geriatric patients. The nurses in this facility are a mixed group, with new graduates and senior nurses who provided a snapshot view of AD training being taught in nursing programs. The services rendered in this facility are electronically recorded. However, there is no reminder or alert assigned to advance directives. Because the current software program does not have advance directives built into the template, the administrator added AD to the existing templates.

This project justified the problem statement by using Walden University's Staff Education Manual (2017) for the scholarly project. This project also aligned with the *DNP Essentials Competencies I-VIII* outlined by the American Association of College of Nursing (AACN, 2006).

I focused on the *Eight DNP Essential Competencies,* started refining leadership competencies and collaborated with leaders inside and outside of the program for an acceptable project topic, as highlighted in *Essential VIII* (AACN, 2006; Moran et al., 2017). I performed a needs assessment early in the program to identify the problem, analyzed the public and nursing significance to health policy. By identifying the projects' innovation design to target the problem, I was mindful of safety, and protected principles of justice and fidelity to help display *Essential I, III,* and *V*. While I incorporated my experience and communication skill set, site acceptance was already underway. I facilitated inter professional collaboration with a local hospital to meet the community needs, highlighting *Essentials II, VI, VII*. Further, having the advanced informatics skills to move a conceptual plan for advance directives to an operational plan, in theory, with statistical analysis exemplified *Essential IV*. As a result, my confidence in health policy and population health amplified my leadership skills throughout this journey, as anticipated by the AACN. The project illuminated educational problems, substantiated the need for change in the healthcare arena, and utilized evidence-based project implementation to obtain a successful and favorable outcome for the practice and the community (Laureate Education, 2012b).

As the project commenced, there were many variables from professional standards, ethics, finances, organizational goals, and leadership engagement. It was critical to be alert to those situations that masked themselves as broader areas such as technological or political, to name a few (Nurs 8510, winter 2020). Nurses are resilient in the face of challenges and new knowledge while gearing up for the platform to apply their learning so that AD completion rates will change, increasing nurses' confidence in themselves. Here are some terms defined to bring clarity to words that might be unfamiliar to the audience.

Operational Definitions

Advance directive: Defined as a written record of your wishes regarding healthcare that is written while you are still of sound mind (SCBA, n.d.).

Knowledge: The process of learning new or former information and processing the facts as they are accumulated (Chinn & Kramer, 2011).

Nurse: A professional individual who has completed specialized training and education in the field and is licensed to practice and care for the sick and injured (SC Dept. of LLR, n.d.).

Primary Care: The focal point of health care services where physicians and practitioners render health care to persons of all ages (Solis et al., 2018).

Training: To acquire skills and concepts that will improve performance and accelerate job duties (Dening et al., 2019).

This private primary care facility, where this project took place, has operated for over 30 years and falls in the network of Medicare/Medicaid services and private insurance carriers for reimbursement. The benchmarks set forth for this facility are the same used for all Medicare/Medicaid claimants from Palmetto Government Benefits Association (PGBA) and Center for Medicare/Medicaid Service. The state operates Medicaid and the federal operates CMS and PGBA (CMS, n.d.; PGBA, n.d.). The stakeholders are medical hospitals and other physician-operated clinics nearby. It required excellent communication with the stakeholders to create a pathway where information sharing took place. Proper communication between the stakeholders and the project lead developed so that the health care and treatment plans were coordinated. Understanding the nurse's role, clarifying personal belief, being mindful of the patient and family's beliefs, and having the knowledge to move forward puts us on the path of the next segment, the role of the DNP student.

Role of the DNP Student

I am a student in Walden University's DNP program, currently working in a rural primary care facility as a family nurse practitioner. My plight was notable as I assessed, educated, and trained nurses in this facility to gather information regarding advance directives on patients as they engage them during their encounters. The most critical part of this project came when participant responses started to arrive from the pre-and post-training survey. This project spanned over a two-month period as surveys return from the participants. Only the investigator saw the survey results, then I made the project findings available to the participants and the office manager. I identified no personal biases in conducting this project. I also had no personal connection to any of the participants, the medical director, or the office manager.

After conducting this research project, clear goals and objectives delineated t to avoid confusion about the outcome. From the KAESAD survey tool, I gained nurses' AD knowledge, attitudes, and experiences and designed an intervention that addressed the deficits and strengthened the body of knowledge about AD. Doing so will propel the patient's and family's concern about "when and how" to discuss advance directives.

Since primary care is the best place to have the AD conversation, my goal was to fill the gap in practice by creating the best educational initiative possible to deliver to the region's nursing staff. This educational intervention aligned with Walden's Staff Education Manual (2017) and protocols for a successful project. The DNP student, first, helped nurses understand their role by making the information as straightforward as possible. Second, ascertained that state laws in South Carolina regarding AD were incorporated in training. Third, provided an education tool and kept nurses engaged by holding their attention on the topic. Fourth, had clear goals and objectives outlined for the project. Having clear goals and objectives made the project dissemination process smoother. The stakeholders and nursing leaders could visualize the project development and evaluation.

This project development allowed nursing leaders, staff, and me to engage in the process and be a part of a positive social change. By engaging in discussions on AD, nursing leaders demonstrated their support and advocated for the educational needs of nurses. Also, this project development impacted nurses' lives and the lives of others in a way that saves unnecessary and costly procedures and avoids unnecessary hospital admissions. This project did not permit any direct patient engagement. The consent to participate was confirmed by acknowledging and completing the survey anonymously. In the end the project findings were shared with shareholders and colleagues.

Role of the Project Team

The project team consisted of a project leader (investigator), an assistant, technical support, Walden University members, such as advisors and mentors. The project team approved the design selected to guide the curricula and made sure the design choice included a staff education project. My assistant was available to assist with general directions about the survey process, if needed. As project leader, I supervised the general operations of the project and verified that the project stayed on point with deadlines. I solicited technical support only for SurveyMonkey setup and login. During this time, it was essential to have the managers' support to assist with team member needs, team needs, stakeholder needs, and organization needs (Moran et al., 2017, p. 330).

I shared project objectives, timelines, and the survey tool with the project team and a cohesive, informed group emerged victorious. Each team member has their own expertise that was valuable throughout this project undertaking. Following IRB approval, the project's timeline started, and the team members were notified. Information sharing is part of being a project leader. Now I summarize Section 2, resurrect the gap-in-practice, and the practice-focused question.

Summary

The educational platform for this project was based on the community sector of nurses and the facility's cooperation. Even though the facility has reached out for assistance in obtaining better AD completion rates, it was still their choice to have this project conducted at this time. The nurses' contributions helped integrate nursing science with knowledge from ethics in the phenomena delivery. The actions and strategies from the theoretical concepts help to enhance, alleviate, and ameliorate this phenomenon of interest and health care delivery (see Moran et al., 2017). In other words, the gap-in-practice identified in this project met EBP for nurses' AD knowledge in primary care. In the next section, the practice-focused question resurfaced, the sources of evidence presented, and discussion on data analysis for this quantitative, correlational design.

Section 3: Collection and Analysis of Evidence

Introduction

The primary focus of this project was to assess nurses’ AD knowledge and design a training program to improve AD knowledge and increase AD completion rates. By conducting this research, I sought to answer the following research question: Will a staff education program on advance directives increase nurses’ knowledge towards the ultimate goal of increasing compliance?

Advance directives are at an all-time low with a completion rate of 30% in the United States (U.S. Living Will Registry, n.d.). The forms of AD recognized in most states come in either a living will, a health care power of attorney, or advance care planning (Solis et al., 2018; U.S. Living Will Registry, n.d.). Several reasons have been blamed for this low AD completion rate, such as, time to complete, lack of knowledge, and lack of patient readiness (Scholten et al., 2018; Yadav et al., 2017).

In Section 2, I acknowledged that the nurses’ lack of knowledge is one of the primary causes of low AD completion rates. To address the gap-in-practice, I sought to investigate AD knowledge in primary care. To initiate the investigation, I used a quantitative approach to collect descriptive data from questionnaires completed by nurses and analyzed the data using the Microsoft Excel program. The findings from the KAESAD survey helped me identify the areas needed in the education training intervention. This project should be timely to bring order, structure, and standardization to the field while answering the central practice-focused question.

Practice-Focused Question

The completion rate for advance directive is far less than expected since its inception in 1989 (Childress, 1989). Despite attempts to improve AD completion rates through education and legal efforts, U.S. citizens' completion rate is 30% (U.S. Living Will Registry, n.d.). The practice-focused problem for nurses remains the same. Due to the purpose of this project and the inherent need for nurses to be involved in patient education, nurses must lead in this conversation on end-of-life decisions.

Acknowledging the barriers causing difficulty in championing the AD process is one of the most significant hurdles faced by nurses (Lund & Richardson, 2015). Rao et al. (2014) pointed out that (a) knowledge deficit, (b) incomplete paperwork, and (c) patient and family discourse resonated from their research. Nurses and healthcare providers are reluctant to have end-of-life conversations with the patient and their family because of the lack of knowledge and confidence in what they know about advance directives (Booth, 2016). Because of this hesitancy, communication suffers at the hands of ill-knowledge and uninformed nurses. For this reason, the research approach aligns with the practice-focused question: Will a staff education program on advance directives increase nurses' knowledge towards the ultimate goal of increasing compliance? This project will close the gap by providing an education training program to nurses via a power-point series as part of in-service training. In the next section I list the sources of evidence used to address the problem.

Sources of Evidence

I obtained evidence sources for this project from PubMed, MEDLINE, Cumulative Index for Nursing and Allied Health Literature (CINAHL), Psycho Info, A Cochrane database, and resources by Walden University to include an in-depth selection of scholar-practitioners. A collection of peer-reviewed articles and resources from 2011 to 2021 were used to reach maximum saturation in addressing the gap in this phenomenon. The key search terms were *advance directives, advance care planning, end-of-life, advance directives and nurses, advance directive knowledge, and advance directive,* and *primary care*.

Healthcare choices should be made without constraints and a person should make such choices while still of sound mind. Nurses are uniquely positioned to aid in the decision-making process because they engage the patient first. They often have the most clinical information to provide to patients about their choices. In that respect, the nurse is likely to have the date when the question arose about AD.

There is ample information in the literature available about AD but it is unclear whether patients receive this information from their healthcare team. Some patients have stated that they do not understand AD, and they leave it up to their families to be concerned about the issue (Yadav et al., 2017). On the other hand, other patients have verbalized their end-of-life decisions but have not put them in a legally binding format. Often nurses, who could make a difference in the conversation by providing clarification and information, are not present during the conversation (AlFayyad et al., 2019). AD were essential to one pilot study in a Midwestern clinic with an 85% completion rate (Ke et al., 2015). The results from the pilot study concerning AD in primary care showed AD conversations with nurses could improve patient outcomes and healthcare (Ke et al., 2015). This percentage increase for AD completion rate resonates much higher than the 30% completion rate outlined by U.S. citizens (U.S. Living Will Registry, n.d.). Bowers (2016) purported those medical personnel scored less than 24% AD completion rate following formal training in end-of-life care. Also, Bowers performed an observational survey of participants engaging in advance care planning for end-of-life issues. In his study, he acknowledged the importance of demographic data playing a role in the outcome of AD completion. He further asserted that training and knowledge were clear indicators in AD completion, as well as geriatric and palliative care referrals. The referrals were seen as another method to gain advance care planning (Bowers, 2016). An intervention on AD for nurses aligns well with the purpose of this project by filling the gap leading into primary cares' AD knowledge deficit for nurses.

The current facility uses resources from PGBA, CMS, and South Carolina Bar Association (SCBA). Advance care planning in South Carolina can take two methods: healthcare power of attorney or living will (SCBA, n.d.). Other acceptable forms include the Five Wishes document (Atherton, 2020). The Five Wishes document allows patients to express their desires about medical treatment to their family, healthcare providers, and other concerned persons (Atherton, 2020). If the individual chooses to select a healthcare power of attorney, they will appoint someone to make healthcare decisions for them (called a proxy). The living will apply when the individual is terminally ill or unconscious (SCBA, n.d.).

In conceptualizing the phenomenon of interest, I used the HBM to guide, explore, and understand advance directives using the four aspects of Rosenstock's model: (a) perceived susceptibility, (b) perceived severity, (c) perceived benefit, and (d) perceived barriers. The framework from the HBM was demonstrated in data collection, distribution, and implementation process during a three-month period. The setting was in primary care, where the participants were recruited from a convenience sample of nurses. The family practice leaders assisted in administering a pre-and posttraining survey that guided the framework of this scholarly project to direct attention to this population. (see Moran et al., 2017).

I thoroughly analyzed and compared the phenomenon of interest with the current resources to develop a practice-focused question. The complex nature of nursing and the nurses' skill set allowed this process to occur in practice. This practice-focus question was aimed at the identified society, targeting nursing strategies to explore the topic suitable for the DNP project. The clinical outcome from this intervention resulted from the nurses' remote work using science and theory to develop an educational intervention. This educational intervention may be valued by the practice and meaningful to the doctorate student and the future of nursing by applying this intervention into practice.

Additionally, I gathered data from the pre and post-training questionnaires using complete anonymity in the process. Walden University's IRB approved this educational experience for ethical and safety concerns. Once IRB approval was obtained, I maintained the confidentiality and anonymity of the participants, releasing the survey results at the end of the study. No patient records or physical contact was made throughout this data collection process, and no identifying markers were used to link the participants to their responses.

Walden University took the lead in guiding this project by using the DNP Manual for Staff Education (2017). Other resources used, such as the KAESAD survey tool, which examined the nurses' knowledge of, attitudes toward, and experiences with AD in end-of-life decisions (Ryan & Jezewski, 2012). Data collected from the nurse's knowledge, attitudes, and experiences based on the responses from the survey gained a solid instructional foundation amenable for AD training. The nurse that can use aesthetic knowledge to glean perceived insight from the patient and staff can assess, explain, and predict what areas of help are needed empirically and intervene likewise (see Chinn & Kramer, 2011; Moran et al., 2017).

Participants

Ten participants (nurses) were recruited from a convenience sample, mainly because they are primary care nurses in the right place at the right time. Nurses are relevant to this project because they possess the training, communication, and emotional capacity to handle the subject sensitively. The subject matter is susceptible, and occasionally, patients and their families could display attitudes of lack of readiness during clinic encounters. For this reason, the issue must be presented gently and, on several encounters, avoiding confrontations. Being able to avoid conflicts can minimize barriers. Overcoming barriers to AD completion requires practical communication skills (see Spoelhof et al., 2012).

The inclusion criteria are nurses; no age limit, ethnicity; marital status; or sex criteria are needed. They must be licensed nurses employed in South Carolina with a minimal Associate Degree in Nursing. The exclusion criteria are less than a minimal Associate Degree in Nursing, all non-nursing medical staff, and staff working in areas other than primary care.

Procedures

Mary Jezewski, PhD granted permission to use the KAESAD survey tool with instructions to avoid displaying a copy of the tool in the published work. The KAESAD survey tool was used by other published authors in four states (California, Illinois, New York, and Texas). The author developed the tool to measure end-of-life situations in oncology. Incidentally, this project appears to be the first study using primary care nurses with the KAESAD survey tool. The owner established Reliability and Content Validity in a test-retest pilot study, with end-of-life experts, before using the main surveys. Cronbach alpha = 0.58 – 0.95 for reliability. The reliability measures show how consistently the test results were duplicated. The outcome for constructs were as follows: attitude sub scales measure Cronbach alpha = 0.58 – 0.59. For *experience with AD*, Cronbach alpha = 0.93. *Professional experience* measured Cronbach alpha = 0.59, and *nurses confidence* measured Cronbach alpha = 0.95. Therefore, when Cronbach alpha measures 0.6 - 0.7, the test is considered positive for internal consistency, and the items being tested are highly correlated. The validity measured how accurate the test measures what it supposed to measure (Grove, Burns, & Gray, 2013; Jezewski, 1988; Moran et al 2017). To galvanize the discussion further, data analysis and synthesis follows.

Analysis and Synthesis

I analyzed and synthesized data to examine how the data was recorded, organized, and tracked for project findings. The KAESAD survey consisted of five sections with survey questions to assess the nurses' knowledge and retention of the AD principles discussed in training. Using the feedback from the survey, the responses to 30 questions, in three sub-scales related to nurses' general knowledge of AD, PSDA, and South Carolina state laws on AD. The answers to *knowledge* questions were *yes*, *no*, or *do not know*. The response to nurses' *attitudes of completing* AD were *agree* or *disagree*. The *experience* scales were scored on 5-items (score of 0 to 6) with a score of *1* for y*es* answers. *Confidence* scores were based on 5-point Likert scale (*1 = not confiden*t, to 5 = *very confident*) scores ranging from 11 to 55. The survey components are 10-items for *general knowledge of AD*, 7-items for *knowledge of PSDA*, 13-items on *state laws*, 20-items on *attitudes toward AD*, 20-items on *experience related to AD*, 11-items on *completion confidence,* and 26-items on *demographics* (Ryan & Jezewski, 2012). A comparison was made of the two proportions of survey results using the z-statistic to assess a difference before and after the intervention in the form of table distribution. Descriptive statistics provided a table distribution comparing pre- and post-training survey responses using a *z*-statistic. Data showed AD knowledge increased following post-training survey implementation.

Data organization occurred as the participants were assigned number codes instead of their surnames to maintain anonymity. I allowed eight weeks to complete the survey (including the AD education training and the pre-and post-training survey). The survey results posted were shared with leadership, and instrument developer, Dr. Jezewski, for future reference. AD training is made available for in-service and future recruits for primary care while simultaneously protecting the integrity of the data and confidentiality of the participants.

Data tracking commenced when I matched the numbers assigned to the surveys. Then I entered data from pre-and post-training surveys into the Microsoft Excel program. The KAESAD survey answered the practice-focused question by examining the participants' responses before the AD education training and administering the same survey after the AD education training. Comparing the results of (before and after surveys) allowed analysis of a z-statistic distribution for three of the five categories mentioned earlier in the KAESAD instrument. This training project provided some avenues to determine whether nurses' knowledge, attitudes toward AD, confidence in delivery, and experiential with AD could bring about the ultimate goal of increasing AD compliance. I evaluated comparative scores from the KAESAD surveys (*knowledge of AD, knowledge of PSDA*, and *knowledge of South Carolina AD laws*). I determined that there appears to be a knowledge difference between pre- and post-training survey scores. No comparative results were available for *attitudes, experience*, and *confidence with AD*. (Only three of five sections completed in the second survey by participants).

Descriptive statistics displayed the personal and professional markers from the participant sample, such as gender, ethnicity, to name a few. The science community will gain new insight from the project's existing knowledge gap where clinical significance and cost-effectiveness exist to implementation. It is feasible for the organization to see a return-on-investment (ROI) once the billing cycle ends for Medicare/Medicaid and private insurance. It is important to note that CMS (2016) issued a statutory marker to reimburse medical practices for documenting AD in the electronic medical record (EMR). As a result, this facility's administrator approved the project with a potential ROI, and if the project continues, it almost guarantees sustainability. In other words, the widespread use of this project will invade every available health care delivery site, moving into the ranks of best practices (see Moran et al., 2017).

Summary

Data analysis and synthesis could not exist without data collection. The process allowed participants to engage in an educational training event for primary care in this facility. The ultimate goal of increasing AD completion rates centers around how well the staff can engage the patients and their families in the phenomenon of interest. Engaging patients in conversation about AD should prove to be more fluid once the team completed the AD training intervention. Not only that, but increasing the nurses' knowledge and confidence will improve the patients' confidence to initiate the conversation on advance directives. At this point, social change will occur when a more knowledgeable patient feels comfortable enough to trigger the AD conversation with their healthcare provider. When nurses open the conversation, the fewer barriers to learning and leveraging the playing field with stakeholders, and other community health care agencies. The use of the KAESAD survey allows a summative evaluation as an outcome measure and check-and-balance component. In other words, knowing the study did what it said it proposed is critical. As we advance, Section 4 will further picture how the intervention will be disseminated while simultaneously highlighting self-analysis.

Section 4: Findings and Recommendations

Introduction

AD has been a reality for over 40 years (Yadav et al., 2017). An AD is defined as a type of living will, wherein a legal document exists to speak for the individual when their speech is compromised (see SCBA, n.d.; Spoelhof & Elliott, 2012). Whenever an individual's speech is compromised, and their voice is silent, it is too late to let their voice be heard for their end-of-life care. In 2018, only one in three Americans completed an advance directive in the form of a living will (U.S. Census Report, 2018). Also, the U.S. Census Bureau (2018) reported that people with chronic diseases are living longer than previously. Because of this new longevity, healthcare workers are at a disadvantage because they lack the knowledge to address the growing problem of failing to assist individuals in completion of AD. Throughout the literature, the nurses' lack of knowledge appears to be the primary source of this gap-in practice (Hebert et al., 2011; Lund & Richardson, 2015; Rao et al., 2014; Walezak et al; 2017). The purpose of this project was to target this gap-in-practice by designing a nurse-centered training program on AD education to answer the question: Will a staff education program on advance directives increase nurses' knowledge towards the ultimate goal of increasing compliance?

By examining the nurses' AD knowledge, attitudes, and experience using the KAESAD survey, the process of data gathering, and analyses was complete. The surveys were collected before the education training, and again after the staff training session. [The participants did not complete Section 4 (*attitudes on AD*) and Section 5 (*experiences* *with AD*) on the post-training survey. Those sections would provide rich data on attitudes and experiences of nurses before and after a training intervention].SurveyMonkey provided the store house for data collection and analyses to achieve complete scores from each survey. Section 4 of the project outlines the findings, recommendations, strengths, and limitations of this educational project that focuses on increasing the AD completion rate among individuals by increasing nurses' AD knowledge.

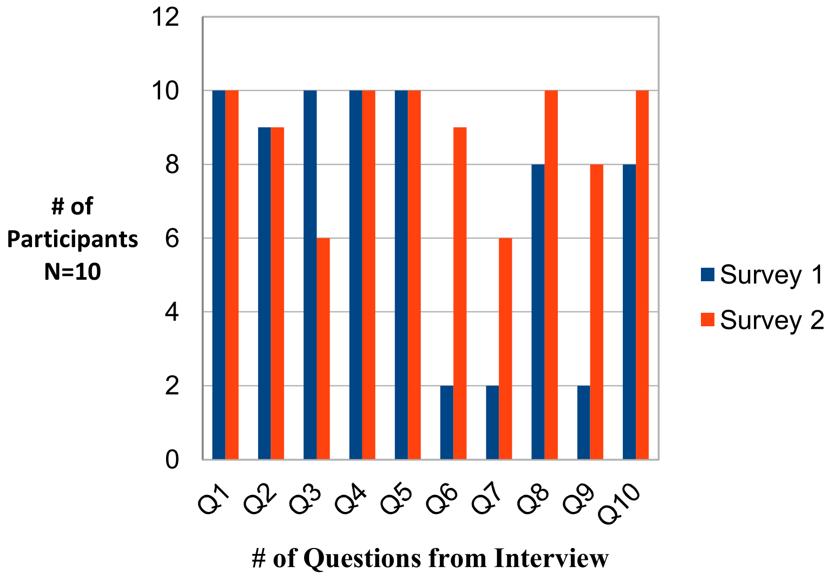
Findings and Implications

Participants from a convenience sample provided data for descriptive statistics to obtain age of nurses in years, number of RN work years, along with work years in primary care. From the data, the mean age for nurses was 52.375, plus the average number of years of primary care employment at 10.9 years. Of the 10 nurses participating in the survey, all the nurses had over 20 years of experience. There was no variance in gender and ethnicity; however, seven of the 10 nurses were Master prepared. Important data obtained from age in years, RN work years, and primary care work years. The findings obtained from 30 questions answered by the participants were as follows: the mean age was 52.375 years. The mean for RN work years was 23.3 years. The number of work years in primary care was 10.9 years.

Another correlation examined was the nurses' knowledge of advance directive in Figure 1. Comparing the nurses' knowledge in the pretraining survey with the posttraining survey clearly indicates a two-fold increase in responses to Question1 (Q1) to Question 10 (Q10), except for Question 3(Q3). Q3 asked, *true* or *false* response about whether a patient should have both a living will and a power of attorney before any end-of-life decisions are honored. There was no significant change in learning following the education training. Sixty percent of the participants answered correctly during the pretraining survey with no change in the post-training survey responses. The lack of change makes it uncertain as to whether staff comprehended the instructions or if there was disagreement with the information.

Figure 1

Knowledge of Advance Directives

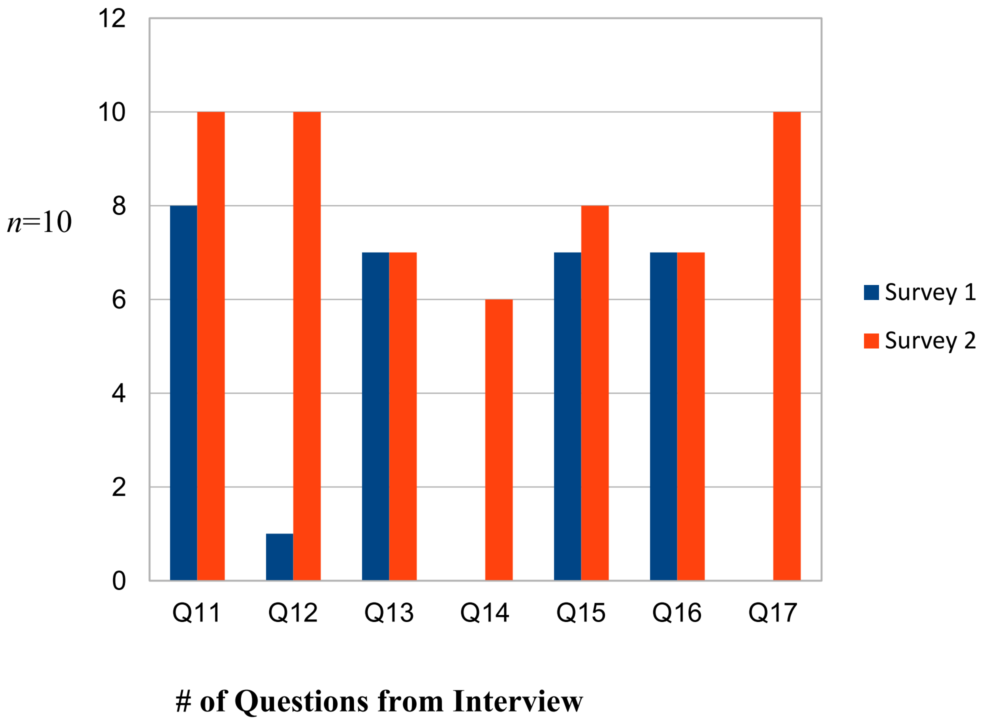


In Figure 2, Knowledge of PSDA is another correlation of pre- and posttraining responses. In Question 14 (Q14) and Question 17 (Q17) in the pretraining survey, participants did not know the correct response. However, participants answered correctly with 100% improvement following the education training. From the data collected, Question 12 (Q12) showed the most significant change in learning from the pretraining responses at 10%, and 100% in the post-training survey responses. Q12 asked whether

PSDA is a set of legal statures that must be legislated and enforced by 50 states. Q14 asked about whether PSDA requires states to recognize living will and power of attorney for health care. Q17 was a true or false question about whether the PDSA includes a recommendation for community education. All participants answered Q17 correctly.

Figure 2

Knowledge of Patient Self-Determination Act



Questions 18 to 30 were answered by all 10 participants in the study. Knowledge of South Carolina state laws on advance directives were the highlight of this section of the survey. To assess whether any improvement existed between participants' learning from pre-training to posttraining surveys, a correlation was performed using *z*-test statistic for all AD knowledge. The *z*-test score of .0406, shows significant correlation with p <.05. Participants answered 70% of correct responses on pretraining survey for knowledge of AD and 90% on posttraining. Participants demonstrated 100% posttraining knowledge of PSDA, 0% of pretraining knowledge existed. In addition, 60% of Questions 18 to 30 were answered by all 10 participants from the study. In addition, 60% of pretraining knowledge of South Carolina state laws, and 85% correct response in posttraining survey. There appears to be significant improvement in the response rates for the above. The improvement appeared to be evident following the posttraining survey response. Most of the participants provided direct health care to clients but had little to no experience with end-of-life decisions. The KAESAD survey provided rich data to validate the need for a training program that focuses on South Carolina state laws for AD.

I noted a few implications based on the objectives of the project. To reiterate the goals, first, to address nurses' AD knowledge in primary care, and design an educational program to raise completion rates. Secondly, to bring awareness to the process of AD and determine if increasing nurses' knowledge will increase compliance. Third, to foster behavior change, and reverse the stereotype about, only discussing AD if one is terminal or dying.

Due to time constraints and limitations, I could not address the third objective, or witness the third objective come to fruition. The completion rate will require a prospective study to assess future learning regarding AD and to examine any new learning for nurses. One limitation of this project was the use of nurses and not patients. If I could study the patients' response to the end-of-life decision, then I would have better feedback and can make necessary changes. Unfortunately, it is not feasible to examine an individual's end-of-life decisions to determine whether their wishes were honored after death. The implication for the community is related to the longevity of the aged population. Two out of 10 participants voiced that they have a living will or AD. The mean age of the participants was 53. Because individuals are living longer with chronic illness, communities must be more prepared to address the challenges that align with the individual's end-of-life wishes. Local organizations can take advantage of training sessions for nurses and adapt the program for laypersons by simplifying the literature for nonprofessionals. The government sanctioned institutions nationwide to inform and obtain AD upon hospital admissions. The concept will motivate individuals toward AD completion while it is fresh on their minds. However, it is not realistic for every person to be admitted to a hospital to make sure they have AD completion.

I will not witness social change from the study until after a quarterly record review via EMR. Because of this, I will not implement the evaluation in time, at least not until the first quarterly meeting.

Recommendations

The educational intervention implemented at the facility included AD training for primary care nurses and newly enrolled patients. The AD training took place for 10 primary care nurse participants. This education training on AD will remain in Power Point format, as long as it is accessible. The facility policies will reflect an AD policy for all staff and new patients. Also, the facility included the AD instruction guide in new orientation packets for new employees and patients (See Appendix A).

Participants indicated that additional education and training are needed to increase confidence and AD knowledge. According to the findings, the posttraining survey demonstrated an impressive 85% increase in AD knowledge. It would be wise to include AD training for new patients and employee packets to improve the completion rate. According to current literature, recommendations to enhance AD completion must include training for health care staff (see Booth, 2016). This project demonstrated the same findings. However, health care executives and administrators must follow through with implementation to be successful in ongoing completion rate increase. Working with the facility's executives will ascertain those proper documents and paperwork are complete to implement and disseminate the intervention training. Leaders can empower their staff by verifying whether a platform exists to highlight the newest AD training.

For evaluation, performing a summative evaluation would benefit the intervention. The administrator will evaluate records in the EMR for AD completion. Remember that older people process thoughts differently, and health behavior is viewed differently (see Rosenstock, 1974). Therefore, I expect a different outcome for more senior people regarding AD completion. As a result, the completion rate will likely be affected.

Contribution of the Doctoral Project Team

The project team leader (investigator) served as overall project manager. I supervised the research process, distributed survey questionnaires, maintained project deadlines, collected, and analyzed raw data, administered the education training intervention, and shared findings with the primary care facility. Other members of the team such as Walden University's chairperson and committee members approved the project.

Strengths and Limitations of the Project

Project sustainability is one strength for this project. In this economy, this organization developed and maintained specific organizational protocols as an example of sustainability. This project was low budget and required no more than 15 – 30 minutes added to new patient and staff training. The administrative staff provided guidance and support in the implementation process by including AD instruction guides in the folders of employees and new patients.

Numerous limitations noted in this project were, first, the sample size was too small to be representative of the population. Second, the demographics included only females. Third, the population was a convenience sample, and the participants came from one state. Lastly, there were no limitations in the project design, methodology, collection process, and analysis.

Section 5: Dissemination Plan

Dissemination plans for this project will occur following the organization's quarterly practice meeting. The office manager began adding the AD instruction guide to the new patient and employee folders. The goal is to bring awareness to a new protocol for new patients and staff regarding AD completion. I will share results from recent surveys and data analysis at the quarterly practice meeting. The audience will include the office manager, medical director, and nursing staff. The AD training pamphlet will include a summary of the findings and recommendations for sustainability, the South Carolina laws for AD, and information for the Five Wishes. Finally, a copy of the pamphlet will be distributed to the adjoining hospital to be disseminated to other medical clinics.

Analysis of Self

The DNP project has been a daunting task. Several milestones in life occurred while on this journey, such as the loss of four sisters, a husband, and mother. Emerging as a practitioner first, then a scholar-practitioner, allows one to harness the experience gained from years of employment as a nurse practitioner. The knowledge garnered from the DNP project is critical to my long-term goals as a nurse educator/clinician. Rallying the troops together to stay on point, distributing the surveys, and performing the analysis demonstrated the role as practitioner, scholar/practitioner, and project manager. As a practitioner, it is important to maintain practice standards, as noted in the FNP Core Competencies (AACN, 2006). As a scholar, I integrated leadership skills by dispersing critical information, and taking the lead in many stages of the project to stay on track using *DNP Essentials I-VIII*, with special attention to *Essential VIII: Advance Nursing Practice* (see AACN, 2006). *DNP Essential VIII* afforded me the opportunity to perform comprehensive organizational evaluation, assess and identify the staff, participants, and program issues especially related to potential obstacles affecting project completion.

As project manager, the leadership competencies from AACN (2006) were adopted and were a good fit. The role as manager affords one the responsibility of setting goals, being a transformer, and handling discourse. For example, when the participants fail to respond to the second survey request, I submitted only Questions 1-30 for their completion with only their age from the demographics. Recognizing that the nurses had grown tired, I requested survey completion to include only the age of the participant and responses to Questions 1-30. The nurses did comply with the request only because the second survey was the first three sections (knowledge of AD, knowledge of PSDA, and knowledge of South Carolina state laws).

Summary

The pre- and posttraining KAESAD survey revealed that older nurses demonstrated more AD knowledge than younger nurses with the same degree preparation in primary care. Attitudes and experiences varied among the nurses regardless of the age. There was marginal confidence in nurses for AD knowledge. Overall, nurses reported the need for more workplace training so they will build confidence and AD knowledge to assist patients with their end-of-life wishes. According to the recommendations and information from the literature, healthcare executives must foster an environment of learning and implement end-of-life protocols to meet the patient’s needs. If nurses are to comply with the recommendations, then they will expect executives to carry out this intervention long after the project ends. The research data from the KAESAD survey adds to the body of knowledge by being the first primary care study using the KAESAD survey. This rich collection of data can be beneficial for, not only AD completion in primary care, but as an instruction guide for patient teaching.

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Appendix A: Advance Directive Instruction Guide

Advance Directive: a legal document that allows an individual to inform concerned persons of their end-of-life decisions. **Several Forms of Advance Directive** • **a Living Will** • **Durable Power of Attorney** • **Five Wishes** **SC Laws for Advance Directive** • advance Directive does not expire. • If Living Will or POA completed in another state, it is valid but should be updated. • In a Living Will, you tell the doctor that you do not want certain treatments i.e. artificial feedings. • A Living Will must be notarized and witnessed by two persons 18 years or older. • A Power of Attorney allows you to appoint a person (proxy) who will tell the doctor what treatments should or should not be given.	**DO NOT RESUSCITATE (DNR)** Order tells healthcare personnel that you do not desire Cardiopulmonary Resuscitation (CPR) if your heart or breathing stops.
FIVE WISHES 1. Who you want to make decisions for you when you can no longer make your own decision. 2. The kind of medical treatment you want or don’t want. 3. How comfortable you want to be. 4. How you want people to treat you. 5. What you want your loved ones to know.	*Arnell C. Kithcart* *DNP Candidate, APRN, FNP-BC* *Walden University* *May 2022*

Appendix B: Permission to Use Instrument

Jezewski, Mary Ann
Fri 6/18/2021 2:19 PM
Arnell
You have my permission to use the KAESAD and I have attached the instrument with the validity and reliability results. We have three articles one for emergency nurses published in Applied Nursing Research and one with critical care nurses that was published in Critical Care Nurse and oncology nurses published in Oncology Nursing Forum. KEEP IN MIND THAT THIS INSTRUMENT WAS DEVELOPED FOR RNs NOT THE GENERAL PUBLIC. The reliability and validity does not apply to groups other than RNs. The reliability and validity does not apply to groups other than RNs. If you change the wording or change the scales in any way, the reliability and validity of the scales is compromised,

Please read the r & v and note the low Cronbach alphas for the attitudes as a total scale. Thus we did individual item analysis for the attitude items (percent of agreement). You do not need to reverse score to do individual item analysis.

Note that the answers to the questions about state laws will vary according to state or country so you will have to determine the correct answers for your situation. Also the demographics will need to be adjusted to fit your sample [I am sending the oncology instrument which is the same as the critical care and emergency nurses except for a couple of demographic items which you change to suit your sample]. Please understand if you change items or wording of items in any of the sub scales, the reliability and validity of the scale is invalid.

You have my permission to reproduce and use the KAESAD instrument for your project. You may NOT publish the KAESAD instrument in any articles you write nor attach it to any thesis or dissertation report. You can publish a few examples of items if you wish .

The expectation is that you will eventually share your findings with us.

Please respond via email that you agree with the statements above. If you have additional questions, please email me.

Good luck with your project.