ISSUES SURROUNDING END OF LIFE CARE CONVERSATIONS IN THE ACUTE CARE SETTING

by

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Abstract

**Problem:** Failure to set realistic goals of care for terminally ill patients contributes to decreased satisfaction with care delivery and increased cost of care at the end of life.

**Objective:** Identification of barriers that providers encounter in their clinical practice is the first step in setting appropriate limitations on aggressive treatments which offer little to no benefit to patients with a poor prognosis.

**Theoretical Framework:** Fawcett and Russell’s (2001) conceptual model focuses on how nursing practice can apply research findings to influence health care policy and improve care delivery and efficiency in the clinical setting.

**Methods:** Data from interviews with Nurse Practitioners regarding their experience with end of life care management in the acute care setting will be transcribed and assessed for reoccurring themes through the use of conventional content analysis.

**Results:** Barriers to the establishment of realistic goals of care at the end of life include poor health literacy and limited understanding of long-term prognosis on the part of the patients and their families, as well as lack of adequate training for providers on how to effectively initiate and lead conversations regarding end of life care.

**Potential Significance:** Results of this project demonstrate potential clinical value regarding the need for greater educational emphasis and training on how to manage end of life care for terminally ill patients.

**Implications:** Patients whose providers fail to guide discussion on limitations of aggressive treatments at the end of life may suffer unnecessarily from treatments which offer little benefit other than to prolong death and suffering.

**Keywords:** Acute Care Settings, End of Life Care, Nurse Practitioners, MOLST Forms
Acknowledgement

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Last but certainly not least, my dear husband Phil, thank you for bringing me countless cups of tea when I could barely keep my eyes open after hours of studying, for always plugging in my laptop right before it was about to die, for letting me turn your hunting room into my study
station, and for everything that you do to take care of our little family. When we met I was just beginning my degree, and you watched me grow, struggle and succeed every step of the way. I am so glad that you were by my side through all of this, and that you get to see me finish. Thank you for your understanding how important this was for me, and for patiently putting so many things on hold, thank you for letting me make this a priority in not just my life, but ours. We did it babe! I can’t wait to live the rest of our lives without having to plan around midterms and finals.
The quality of health care delivery at the end of life (EOL) is dependent upon many factors including but not limited to poor health literacy, inequitable access to care, limited opportunities to discuss advanced directives, and limitations on aggressive treatments. Studies have shown that patients and their families can benefit from early initiation of discussion regarding advanced directives and limitations on aggressive treatments at the EOL (Zhang et al., 2009). Early conversations regarding the establishment of realistic goals of care at the EOL have the potential to not only improve patient and family satisfaction with the quality of care delivery, but also to alleviate the tremendous burden of care for terminally ill patients receiving aggressive treatments at the EOL. Unfortunately, barriers to these interventions remain due to a variety of factors. Providers may be reluctant to initiate these conversations due to time restraints or fear of negative reactions from patients and families (Beckstrand, Callister & Kirchhoff, 2006).

A disconnect exists between current research findings, which support the need for providers to initiate early discussions with terminally ill patients to establish goals of care (GOC) and the actual practice of these conversations in the clinical setting. This gap in practice unfortunately leads to inefficient allocation of specialty services and resources as well as decreased satisfaction with the experience of death in the hospital setting (Zhang et al., 2009). The purpose of this project is to identify what issues acute care nurse practitioner providers feel currently influence their decision to discuss limitations of care at the EOL with patients identified as terminally ill. For the purpose of this project, a terminally ill patient will be defined as a patient having six months or less to live.

Nurse practitioners (NPs) are in a unique position to initiate delicate conversations related to EOL care due to their experience in working at the bedside with patients and their families. Although bedside nurses in the United States (U.S.) have been considered one of the most trusted
members of the health care team for many years, registered nurses do not have the jurisdiction to authorize Medical Orders for Life Sustaining Treatment (MOLST) forms. MOLST forms are considered legal documents, which can designate limitations on life saving and sustaining treatments, such as when and if to initiate cardio-pulmonary resuscitation (CPR), to attempt or sustain intubation and other methods of artificial life support, as well as feeding tubes, extended use of antibiotics, or other interventions which prolong life.

With the passage of New York (NY) Senate Bill S1869A, NPs are now authorized to sign MOLST forms as legal documents (NY State Senate Bill S1869A, 2018). As a professional health care group, NPs can play a pivotal role in facilitating conversations regarding EOL care with appropriate limitations on aggressive treatments for terminally ill patients. To ensure NPs feel supported in their practice, it is imperative that their current concerns surrounding EOL care with terminally ill patients are identified, examined, and acknowledged. The purpose of this Doctor of Nursing Practice (DNP) project is to explore the following question: What factors do acute care NPs feel impact their ability to discuss realistic EOL care needs and goals for terminally ill patients, and how do these factors affect EOL care delivery at an institutional level?

**Clinical Significance**

Patients with serious multiple chronic conditions should be considered candidates for conversations regarding the limitation of treatment at the EOL to avoid unwanted aggressive treatment that may not improve their survival time or contribute to their quality of life. In the U.S., under the existing fee-for-service health care model, current estimates suggest that a disproportionate share of Medicare expenditures are spent on aggressive treatments and services delivered within the last months of life for terminally ill patients. However, these interventions typically do not have a significant impact on a patient’s survival rate and are not associated with
improved patient and family satisfaction with the delivery of care at the EOL (Center for Medicare and Medicaid, 2012). This situation suggests that while providers may recognize that there is limited benefit from aggressive treatment for patients with poor prognoses, these patients still continue to receive aggressive and advanced medical intervention (Campbell & Guzman, 2003).

Given these findings, it can be suggested that early intervention focusing on setting realistic EOL care expectations may be beneficial not only to reduce hospital length of stay and burden of care for terminally ill patients, while at the same time improving quality of care delivery for this vulnerable population (Norton et al., 2007). Creating policies that encourage and support health care providers to establish early EOL goals of care for terminally ill patients may be the most effective way to improve patient and family satisfaction.

Tools, such as the Conversation Starter Kit, are available to guide health care providers to initiate early conversations that focus on establishing GOC at the EOL with terminally ill patients (Institute for Healthcare Improvement, 2018). Although such tools are available to providers, many patients still fail to complete advanced directives (ADs) and/or appoint a health care proxy (HCP) until death is imminent (Institute for Healthcare Improvement, 2018). These factors contribute to the emotional burden of caring for terminally ill patients and typically lead to increased use of aggressive treatment at the EOL that can prolong death such as artificial ventilation, feeding tubes, or cardio-pulmonary resuscitation (CPR). Efforts to improve the completion of ADs and to support providers in leading conversations with terminally ill patients regarding limitations on aggressive treatment at the EOL should focus on identifying what systematic barriers currently exist within the health care system and what can be done to address them.
Literature Review

Early identification of GOC and limitations on treatment for patients with a poor long-term prognosis can yield positive results for both patients and their families, as well as for health care facilities. Estimates on Medicare expenditures indicate that a disproportionate amount of expenditures are spent on aggressive treatments during the last six months of life for many beneficiaries. Unfortunately, evidence demonstrates that these aggressive interventions typically do not improve patients’ prognosis nor the quality of life before death (Baumrucker et al., 2016; Zhang et al., 2009). Aggressive treatments include surgical interventions, imaging studies, mechanical ventilation, and hemodialysis treatments, which are typically continued in the majority of patients with multiple chronic conditions despite limited improvement to quality of care that they may offer (Baumrucker et al., 2016; Norton et al., 2007). These treatments account for the disproportionately high cost of care for terminally ill patients in the last weeks of life as well as the burden of care at the level of the hospital or health care institution. While providers may be aware that these treatments offer little to no benefit to patients’ expected outcomes, many remain hesitant to approach the topic of palliative care or limitations on life-sustaining treatments (Campbell & Guzman, 2003; Campbell & Guzman, 2004; Zhang et al., 2009).

Reluctance on the part of the provider to initiate EOL conversations or to place consults for specialty services such as palliative care teams to get involved in the care management of terminally ill patients, can lead to prolonged hospital stays (Beckstrand, Callister & Kirchhoff, 2006; Norton et al., 2007). For critically ill patients on mechanical ventilation, prolonged stays in the ICU setting are expected. This situation can be stressful not only for the patient and their family, but also for hospital staff who are faced with difficult ethical dilemmas as they provide...
unnecessary care that can prolong the suffering of a dying patient (Beckstrand et al., 2006; Norton et al., 2007).

The delay in provider initiated discussions with terminally ill patients of GOC at EOL has proven to have negative repercussions not only for patients, but also for their families. Zhang et al. (2009) found that families of patients who had higher costs of care during the last week of life in the hospital setting reported that they felt the quality of care they received was unsatisfactory. Beckstrand et al. (2006) noted that many providers acknowledged that they failed to approach the topic of EOL care with patients that they recognized as being terminally ill for fear of negative backlash from families who may respond unfavorably to the idea of what can be perceived as abandonment or giving up on the part of the provider.

This unfortunate reality may be a major factor in the failure of many patients and their families to recognize the severity of their illness. It also represents the gap between what is known by current research and what is actually practiced by providers in the clinical setting. Further research is needed to explore how to better prepare providers to initiate EOL conversations, as well as how to help patients and families gain insight into the dying process. Insight into these aspects of EOL care can be useful in improving satisfaction with care delivery and closure at the time of death for patients, their families, and the providers that care for them.

**Theoretical Framework and Application**

Authors Fawcett and Russell (2001) developed a conceptual model to examine and demonstrate how nursing practice can apply current research findings and literature into clinical practice to influence health care policy and program evaluation. According to Fawcett and Russell (2001), there are five levels at which this process can be applied in clinical practice. The first level focuses on the effectiveness of current nursing processes on the overall health outcomes of patients, as well as their families and even patient populations as a whole. Level
two examines the efficiency of these practices, while level three focuses on the efficiency and also the effectiveness of the overall health care delivery system. Levels four and five examine whether there is equal access to care in the delivery of these processes at the delivery level, as well as whether these processes are ethical and serve the needs of the patients they are targeted towards.

Application of this theoretical framework involves the examination of what current NPs perceive to be barriers to their own practices in initiating conversations regarding GOC at the EOL. Investigation of how and when conversations regarding EOL care were initiated and handled will also examine the methods used, including whether or not educational tools, such as the Conversation Starter Kit, were utilized and if they were effective in their intended use as facilitators for these conversations (Institute for Healthcare Improvement, 2018). Finally, the review of data will also include an examination of whether or not there was any potential bias with regard to whether or not NPs were less inclined to bring up the topic of EOL with some patients as opposed to others. This particular section will address the social justice level of Fawcett and Russell’s (2001) conceptual model, as provider bias may be a highly influential factor in why some patients and patient populations were not given the opportunity to discuss or have their wishes for EOL care acknowledged by their health care team.

With the recent passage of NYS legislation, NPs are now legally authorized to sign MOLST forms. These providers are currently in a position to improve the care delivery and management of specialty services for terminally ill patients by providing them with the opportunity to discuss their wishes for EOL care and limitations on treatment. As reflected in the review of current literature, health care providers often fail to initiate EOL care conversations which may contribute to AD incompletion rates and missed opportunities to discuss prognosis
and survival expectancy. As the scope of practice for NPs widens, it is essential that current barriers to initiating EOL conversations are identified so that efforts can then be made to ensure that these providers can practice to the full extent of their scope and legal autonomy.

**Methods**

The overall objective of this project was to explore factors that acute care NPs feel impact their ability to discuss realistic EOL care needs and goals for terminally ill patients. To accurately capture the experiences of the NP providers who worked in this setting, one-on-one interviews were conducted. As field work, in the development of this study, the principal investigator began attending monthly palliative care meetings, and professional conferences on EOL care. The content of these meetings guided the development of the interview questions, which are listed in Appendix A.

Topics covered at the palliative care meetings included examples of patients who received various aggressive treatments in the weeks leading up to their deaths, and whether or not, and at what point in the patient care trajectory, the palliative care team was consulted. There was also discussion on what was considered “good” deaths, where patients were given the opportunity to transition to comfort measures only and to decline interventions such as mechanical ventilation, cardio-pulmonary resuscitation (CPR), or feeding tubes before they were initiated. The intent to execute a capstone study to formally acknowledge the concerns that were discussed was mentioned briefly at several meetings. From there, the principal investigator was sought out by several providers requesting to participate in the study and to give statements in the form of interviews.

**Sample**

After Institutional Review Board (IRB) approval was granted, and the principal investigator was able to begin the selection process to formally recruit research subjects to
participate in the provider interviews. Out of the 17 staff who requested to participate, only those individuals who currently held the title of nurse practitioner, and who practiced in the acute care setting were selected. Medical directors, medical residents and students, physician assistants, nursing supervisors, bedside nurses, and social workers were respectfully declined participation in this study. The larger the sample size, the more time-consuming the process of transcription and analysis of the interviews would have been. Therefore, the sample size was limited to the first ten individuals who met the inclusion criteria of NP in the acute care setting, and were available to conduct the interviews as soon as possible.

Instead of as a strict script for each individual to follow, the interview questions were used as a guide. To encourage honest and authentic answers, the researcher allowed each subject to determine how specific they wanted to get with their interview responses, and encouraged them to set the tone and direction of the conversation. Some individuals answered more than one question in their responses, while some answered the questions in an order different from others. The longest interview was 44 minutes long, and the shortest was approximately 12 minutes. Regardless of the length, all of the research participants covered the same discussion on issues surrounding EOL care.

**Procedures**

Out of the ten individuals participating in this study, seven of them chose to perform the interviews over the phone for the purposes of privacy and convenience of scheduling. After a brief explanation of the intent and background of the project was given, the informed consent forms were distributed to the selected research subjects, either via email, or in person. After consent was established, all interview sessions were audio recorded for later transcription and conventional content analysis by the capstone student. A semi-structured interview
questionnaire was created based on topics discussed at the palliative care meetings held at the research site—a large hospital in Western New York—as well as the issues already identified in the literature review. Interview questions were geared toward the identification of current barriers that NPs felt prevented or discouraged them from successfully establishing GOC and limitations of aggressive treatments at the EOL. Discussion also included whether or not they received any formal training, which they felt prepared them to handle issues regarding EOL care conversations in their clinical practice. The NPs were also asked to discuss what they felt they needed to feel more supported in their approach of this topic with their patients.

Conventional content analysis is a research method used to classify themes or patterns in textual or verbal data. According to Hsieh & Shannon (2005), content analysis is one of the most commonly used analytic methods in qualitative research, particularly on topics related to EOL care. One of the major advantages of conventional content analysis is that it is the most suitable method for the analysis of interviews that use open-ended questions for discussion. Open ended interview questions, such as the ones used in this study, generate more authentic responses, without the researcher imposing preconceived categories or theoretical perspectives on the research subjects (Hsieh & Shannon, 2005).

The conventional content analysis was appropriate for the purpose of this project since the interpretation of individual participant responses allowed for more personal one-on-one feedback with the investigator. Rather than to project preconceived notions of what the current barriers may be, the investigator allowed participants to speak freely and openly about their personal perspectives. Conventional content analysis consisted of the following steps. The transcriptions were read and re-read by the project student while listening to the audio recordings to ensure transcription accuracy. Reoccurring terminology and terms were then noted as
annotations on the transcripts by the investigator, which were then sorted into categories based on similarities in the responses of participants.

**Results**

All ten participants had at least two or more years of experience as registered nurses prior to their experience as nurse practitioners, all had at least a Master’s Degree, and were also Board Certified. Years of experience in their current roles as NPs ranged from six months to over 20 years. Eight out of the ten participants were female. Ages ranged from 27-62, with seven out of ten being older than 35. Four out of ten were part of specialty services, such as Intensive Care, wound and ostomy, and thoracic surgery teams. The other six practiced as part of general practitioner teams for patients in medical/surgical units.

**Themes**

The following four themes were identified by the participants: Role confusion, religious influences, patient and family conflict of interests, and lack of education and training.

**Role Confusion.** This was a multi-faceted topic, which was defined in several different ways. It included the sentiment that some Nurse Practitioners still that feel that patients perceive them to be “in-between” the role of the bedside nurse and physician. Many of the NPs stated that it can be intimidating to suggest that from their standpoint aggressive treatments are not recommended, as patients sometimes may respond with “let me see what the Doctor says.” This issue was most common among the interview subjects who had less than five years of experience in their role as an NP. It was stated by several of the more experienced individuals that their personal life experience helped them to establish a rapport with patients. Others indicated that they believed that novice NPs, sometimes struggle with fully embracing their new role and
responsibilities. One of the research subjects, who had less than three years of experience as an NP stated:

I worry sometimes, being a nurse practitioner, that if I tell the patient that I feel that the pursuit of aggressive treatment will not benefit them, or that I have nothing else to offer them, that they will feel it is only because I am incompetent or something—or that if they demand to speak to a doctor instead, that the doctor will have a solution that I didn’t think of…because I’m not as good as them… So I feel hesitant to bring it up sometimes, even when clinically, they seem like a good candidate for limitations on treatments, or discussions with palliative care (Subject Nine).

Subject ten made a similar statement, describing the co-signature on a MOLST form as a “stamp of approval,” which validated their recommendations as an NP to set limitations on care were also endorsed by an MD. This notion was identified in different ways by several individuals. This theme demonstrates how self-perception may play a powerful role how NPs may handle end of life care topics.

This perception of inadequacy also demonstrates how some NP providers allow their insecurities to be projected onto patients, and how their self-perception can influence their practice. The passage of legislation that clearly states that Nurse Practitioners have the legal authority to sign MOLST forms may address some of the ambiguity in their role and scope of practice. It may also provide individuals who struggle to be assertive with the confidence to initiate these discussions, where they may have been unsure of their role and responsibilities in end of life care before.

Some participants felt that the background as bedside nurses was a strength in that provided them with real world experience in establishing personal relationships with their
patients. They believed this helped them to develop empathy and establish trusting relationships with their patients that other providers such as residents, or interns with less patient care experience, may struggle with. When asked to go into further detail, participants believed NPs as a group were more qualified to have these discussions with patients because as a profession, NPs typically practice with better bedside manner than those with a medical background. This bedside manner typically makes patients more receptive to NPs as compared to other providers. One research subject stated that NPs retain the trust and affability of patients that is often not afforded to other providers because NPs have had the experience of being bedside caregivers. This participant additionally commented,

Nurse practitioners are different from the residents… we may not have gone to medical school, but regardless if you have a masters or a doctorate, all of us have experience as bedside nurses… and I’ve always felt that that experience has given me the confidence to speak plainly with my patients… to develop the type of relationship that all the [physicians] I’ve seen never really allow themselves to develop—there’s a more human connection that nurses have with their patients… call it personal, or sincere, or whatever—but that’s where the trust comes from… and I feel that trust is why it is easier for us to approach these delicate conversations, where the doctors [M.D.s] may shy away from them (Subject Four).

This type of statement is of particular importance as it demonstrates the pivotal role that NPs play in the acute care setting, and how, with the passage of legislation to allow them to authorize MOLST without the co-signature of physicians, they can be leaders as well as advocates in the effort to bridge the gap between clinical practice and research. According to the statement above, while physicians may be hesitant to discuss sensitive topics such as EOL care with terminally ill
patients, NPs may be able to use their experience as bedside nurses to approach these topics with their patients in a way that is much more well-received, thereby increasing the chances that patients will be more receptive to discussions on limitations of care and how to establish realistic expectations.

**Religious Influences.** Another issue identified in almost all of the interviews was that many patients in this population had strong religious beliefs, which included rejection of suggestions to withdraw care or abstain from life-sustaining measures because they believed that their religion will save them from their circumstances. This situation was commonly referred to as “waiting for a miracle.” According to the NPs in this study, this theme was perceived to be more common among patients and family members who were considered to have poor health literacy and therefore lacked the insight to completely understand the terminology frequently used by health care providers to describe their prognosis. The providers interviewed believed this may explain the rejection of their diagnosis of terminal illness and instead look to their faith for promises of a cure.

Many of the NPs described scenarios where patients who were kept as full codes or remained on life support because their family members believed that they would make a miraculous recovery. The quote below was taken from an interview with an NP who practices in the intensive care/trauma unit. It describes a situation where a patient had experienced an anoxic brain injury and was in a vegetative state for several months afterwards.

…she was by all definitions, brain dead. But her family patiently waited for her to just wake up. They thought Jesus was going to make her walk again. It was actually sort of heart breaking. They prayed, and held vigil, for weeks that turned into months, with no sign of improvement but steady decline…there was just no getting through to them, every
time we tried to explain why she wasn’t a candidate for surgery, or dialysis, or anything, [the family] considered us the enemy (Subject Five).

According to the NP who gave this statement, the staff had attempted on several occasions to suggest palliative care, or transition to comfort measures only, but the family remained adamant that they wanted everything done to keep the patient alive, even going so far as to request dialysis when her organs began to shut down, and vascular surgery when she developed gangrene on her extremities. To further quote the individual (Subject 5) who gave this statement: “…they thought Jesus was going to make her walk again… there was so much … anger and frustration with the staff that we couldn’t do anything to bring her back…I guess that’s why they thought their savior would fix her, because we explained to them that we couldn’t.”

Although this phenomenon was acknowledged and reported by all of the research subjects, only five NPs suggested that a possible solution was to include the staff spiritual leaders in the discussion when they approach the families about the possibility of withdrawing care. According to the statements given by the NPs who worked in intensive care and trauma units, their spiritual support staff could be powerful liaisons in facilitating communication between patients and healthcare staff, particularly in situations where patients may be distrustful or suspicious of the intent of the providers who are the bearer of bad news.

As reported by these subjects, the spiritual support staff has the potential to alter the entire trajectory of the patient care. For patients who may not have the health literacy to understand from a medical standpoint why providers may not recommend aggressive treatments, or why it is unlikely that a patient with a severe brain injury may never fully recover, these spiritual leaders may help to facilitate conversations on how patients feel about death on a spiritual level. They are in a position to reassure them that they can trust in the health care staff’s
ability to recommend only what truly feel is in the patients best interests. The four NPs who worked closely with the spiritual support staff in their practice recognized and acknowledged the value of having religious leaders involved in EOL discussions with patients and their families as a means of providing support as both advocates and liaisons during patient-provider discussions.

One other NP (Subject two) who had over ten years of experience in her role as a mid-level extender for a surgical specialty team also acknowledged how the religious beliefs and practices of a patient are likely to be highly influential in their decision making, particularly when faced with imminent death. Although she stated that she typically does not turn to the spiritual support staff to help her with discussions on limitations of care and withdrawal of care, she recognized the importance of recognizing how patients may use their religion to help them grieve during difficult times, instead of allowing it to alienate ourselves from them. This individual was unique in that she stated she drew upon personal experiences of loss, and how she also used religion to help her get through those times in her life.

While no other NP in this study admitted that they drew upon personal experiences, this practice demonstrates that there is no clear protocol in place to help guide these discussions with patients. With the exception of the individual described above, all of the NPs interviewed admitted that they struggled to find appropriate ways to relate when faced with patients that held strong religious beliefs. Others found value in the support and collaboration of spiritual leaders on staff. Standardization to an effective and appropriate approach is needed to address this issue.

**Conflict of Patient Interests.** The third most commonly identified theme found to be a contributing to the failure of providers to set realistic expectations of care for patients at the EOL included patient lack of understanding regarding the differences between a power of attorney and a health care proxy. The NPs who participated in this study stated that they felt that this lack of
patient understanding often lead to a conflict of patient interests among family members. As stated by subject ten, who had 17 years of experience in her role as an acute geriatrics NP:

…whether it is social security, or workman’s comp checks, or their spouses’ pension—just something. Something that the rest of the family needs or wants [...] and if they let them die, they know the checks will stop coming. [...] sometimes the reality is that maybe that money is the only thing keeping the rest of the family off the streets, or keeping food on the table. But I feel like those people should not be the health care proxy—they should not be the ones to decide when and how and if it is time to let their family member go [...] this is when you see things become disturbing. Because we can’t force someone to let their family member go peacefully, even if we suspect that their reluctance to do so may be due to financial motives, or other personal gains (Subject Ten).

It is important to note that while all of the providers stated that this was an issue, which created a lot of conflict between families and providers, it is all based on assumption of what the providers believe to be questionable motives. In one interview, with a provider who had experience working as a case manager before her role as a nurse practitioner, she admitted “you don’t want to assume the worst… but you can’t help but wonder who they are actually looking out for, [because in situations like this] it doesn’t seem like it’s about the patient.” In this statement, she was describing a scenario where a patient was an eligible recipient for some sort of money, which, it is implied that the family members were collecting while the patient was hospitalized. According to the statements given by six out of the ten NPs interviewed who described situations such as this, the families typically want everything done to keep the patient alive for as long as possible, including as artificial ventilation with no possibility of ever weaning off. This
demonstrates the use of an aggressive treatment from which the patient has little potential benefit and can only serve to prolong death and suffering.

Again, it is important to acknowledge that this theme was based entirely on the suspicions of the providers, and that we can never truly know if the families of these patients had selfish motives for choosing to pursue aggressive treatments such as life support, but it is an issue that was found in all of the provider interviews. As one individual said, we have no proof that this is the case, but we see these situations like this far too often to believe otherwise.

**Lack of Education and Training.** The final theme voiced by participants was the lack of formal training regarding how to best handle EOL discussions with patients. All participants agreed that they wished they had been given opportunity to be trained on techniques to effectively initiate and lead EOL life discussions with their patients and that they wished they had been given opportunity to discuss struggles with EOL care with other providers in a formal setting. Several NPs discussed need for greater emphasis on end of life care and the ethical implications of caring for these populations needs to be incorporated the same way that resuscitative procedures and protocols are taught, particularly to new graduates and novice clinicians.

Furthermore, six out of the ten NPs discussed how they felt that specialty services such as Palliative care teams were not adequately utilized. Typically, despite the establishment of a poor prognosis, these teams are not consulted to participate until very late in the patients care trajectory. While providers admit that they may feel uncomfortable initiating or leading these conversations, they admit to being hesitant to involve teams of NPs and Physicians, which specialize in the care of terminally ill patients—often times not until the patients have less than a few weeks left to live.
...we may not have the words or the right approach to discuss these issues [due to lack of formal training on best practices] but we have access to the specialists who do. The problem is, palliative care teams are often not consulted until the very end—after they have suffered through all of the [aggressive interventions] which we knew all along would not change the inevitable. We know we need to get [the palliative care team] involved sooner. But we wait until we have tried everything and by then it seems almost like a resignation, a white flag, instead of what we know it to truly be—a means by which we can actually help a patient who is suffering to have the best experience possible in the worst possible of circumstances (Subject One).

This statement exemplifies a failure of the providers to ensure equal access to specialty services, which can provide valuable support for patients and their families in the death and dying process. The individual, who gave this statement, went on to explain that by the time palliative care services are consulted, there is a narrow timeframe for these specially trained clinicians to establish a relationship with patients and their families, which limits the great benefit that these clinicians are able to offer.

Finally, the participants agreed that there is a need for ‘normalization’ among providers regarding EOL care discussion and the dying process. Although half of the participants heard of the Conversation Starter Kit, they stated that they believed many of their patients and their families do not use these tools despite being offered them by both primary care providers as well as hospital staff. This situation demonstrates that providers need to be educated on how to correctly use this toolkit to encourage their patients to begin thinking about how they would like their health care proxies to advocate for them, and how they feel about artificial life support and other interventions offered at the end of life. Not only do providers need to utilize resources
available to them, such as Palliative Care teams and specialists to facilitate these conversations in the acute care setting, but they also need to encourage patients to utilize resources such as the Conversation Starter Kit and be prepared to help them to effectively use these educational resources as well (Institute for Healthcare Improvement, 2018).

**Discussion**

Several issues were identified, some with clear solutions, while others represent more complex situations that may require further investigation to determine possible resolutions. As it currently stands, there are several personnel whose roles and responsibilities may need to be revised to better serve the needs of dying patients as part of an interdisciplinary team. Spiritual support staff may need to be more involved in the discussions of patient prognosis and decision making in a way that demonstrates to patients that all of the staff are working together cohesively to ensure that the patients completely understand their prognosis.

This research suggests that spiritual support staff members have the potential to be powerful liaisons to facilitate communication between patients and providers on sensitive subjects, such as EOL care. It is imperative that patients do not perceive pastoral care and spiritual staff to be opposing counterparts to the clinical staff at the hospital—cooperation, communication, and collaboration between providers and spiritual support staff will help patients to trust the system and to establish confidence in their providers and their recommendations.

Additional opportunities to discuss provider concerns and their experiences in handling patient care at the EOL may provide useful feedback for the development of protocols to include palliative care services earlier on in the patient care trajectory. Hesitancy on the part of the nurse practitioner providers to initiate conversations on limitations of treatment or withdrawal of care is also associated with the hesitancy to order consults for palliative care specialists to facilitate
these discussions. Opportunities for acute care providers to learn more about the role of palliative care teams, and how they may be useful for both clinicians as well as for patients may be beneficial in setting limitations of care earlier on. More formal training for clinicians may also directly improve issue of equitable access to care, particularly in scenarios where NP providers may lack the confidence to discuss these issues themselves. If they feel that they cannot appropriately discuss end of life care with patients who could potentially benefit from these conversations, it is imperative that they recognize the opportunity to consult the palliative care specialists who have had training in this field to best serve this particular patient need.

All of the research subjects stated that they felt they would benefit from having had more formal training on palliative care and end of life for terminally ill patients. This finding may provide a case for academic institutions to include more time to be spent on EOL care discussions regarding communication and management skills. Formal training will not only prepare new providers, particularly new nurse practitioners, on what issues to expect in their clinical practice, but how to best handle these situations using evidence-based practices.

Another major consideration in this study includes how its findings may be used to improve operating costs at the expense of patient care. Equal access to care includes the opportunity to explore and consider all appropriate options, including limitations to treatment as well as aggressive interventions to prolong or improve quality of life. While the early establishment of goals of care at the end of life may lead to improved operating costs by reducing the burden of care for these terminally ill patients, it should not be forced upon patients who remain resistant to the concept of palliative care or withdrawal of care. Furthermore, institutions should provide support for their clinicians and providers who identify patients who they feel could potentially benefit from discussions on end of life care, however at no time
should clinicians feel pressured by administration to encourage or convince patients not to pursue treatment options which could potentially improve their quality of life or extend their lifespan simply to avoid prolonged ICU stays or decrease the cost of care for their recovery.

Other considerations include the providers who may fear that their job security or even the confidence of their patients might be lost should they admit that there are flaws in the current system, which may affect the quality of care delivery for this vulnerable population. Careful terminology as well as a plan to address the issues identified should all be considered in the application of these research findings, as well as considerations for further research on this topic. Ideally, the findings of this research should provide a case to influence the current policies and procedures at the institutional level in ways that will improve patient care and also lead to the development and integration of educational tools and opportunities for both providers and patient populations.

**Ethical Considerations**

All efforts were made to ensure the protection of privacy for all individuals involved in this study. The information included in this study was presented with respect to patient privacy, but also with enough detail to demonstrate the themes that were discussed. While careful consideration was taken to ensure that the quotations included in this study could not be traced back to the individual who gave the original statement, or to the specific patient that the individual was describing, these quotes may still retain enough familiarity to other staff who may have been involved in the care of these persons. The results of this study, and the statements given by the research subjects, were not discussed with any other staff members at the research site, nor were they discussed by the capstone student with any other individuals outside of the study. The capstone student did not discuss the names or identities of the individuals chosen to
participate in this study with other the other research subjects. The content of each interview was also not discussed between the individual research subjects.

**Limitations of Study and Suggestions for Further Research**

The research group in this study was limited due to time constraints, as well as for the purposes of making the transcription of interviews more manageable by the principal investigator. A larger sample size would determine whether the issues identified by the few participants of this study are shared among clinicians of similar disciplines, or if they are unique to the individual research subjects selected. Other considerations include the fact that the principal investigator was known personally by nearly all of the research subjects, as a member of the hospital staff where these research subjects were currently practicing. Although this study was conducted for the purposes of meeting educational requirements, unaffiliated with the hospital, it is difficult to determine whether the familiarity of the research subjects to the researcher may have influenced or affected the authenticity of their responses.

Many of the NPs that were selected for participation in this study made statements based on what they personally believed to be contributing factors to the failure to set realistic goals of care at the end of life based on assumptions of how patients feel. This study did not include the perspectives of patients or family members who were currently in or had gone through situations described by the study participants. Factors such as religious influences and conflict of interests were largely based on what the research subjects thought the patients and their families were experiencing, but admitted that they had no real proof that this was the case. In order to determine if the NPs were correct in their assumptions of how these patients and families were feeling, further research is needed which grants these individuals the opportunity to explain themselves.
Interviews with spiritual support staff themselves may also provide valuable insight into what they believe to be the deciding factors among patients and families to begin to consider withdrawal of care or to forgo aggressive treatments. Spiritual support staff members were identified to be potentially pivotal liaisons in bridging the gap in communication that the NPs identified to be common between providers patients with poor health literacy and strong religious beliefs. However, this study did not invite these individuals themselves to share how they personally felt about their experiences working with patients and scenarios described by the NP providers. First hand insight into how the spiritual support staff members feel about issues surrounding EOL care at the hospital may be beneficial to examining how religious influences can affect patients’ decision making.

**Application to DNP Essentials and Capstone**

As a capstone project, the findings of this study could be applied to improve the quality of health care delivery for vulnerable patient populations, improve and influence the development of health care policy at the institutional level for hospital-based institutions, and also improve the professional and educational development of health care professionals. As graduate nurse practitioner students, it is imperative to understand both the limitations of our practice, and to practice within our jurisdiction, but also advocate for our patients to receive the best care possible (DNP Essential(s) II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking, V: Health Care Policy for Advocacy in Health Care & VII: Advanced Nursing Practice).

Recent legislation that expands our scope of practice needs to be implemented with confidence in our ability to serve our patients’ needs, and to use the specific skillset that our profession is built upon to implement interventions to create individualized care for all of our
patients. In order to be leaders in our profession and to provide meaningful contributions to further the development of our role in the health care setting, it is important to be aware of what systematic flaws may currently inhibit NPs from practicing to the full extent of our autonomy. The unique role and educational background of advanced practice nurses in the clinical setting allows these individuals as clinicians to play a pivotal role in advancing innovation and quality improvement initiatives at both the bedside as well as the institutional level (DNP Essential IV: Information systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care).

Findings regarding the possible lack of prior training as a barrier to provider practice may provide a case to incorporate courses on palliative care or discussion on EOL care into educational programs for these clinical providers. Further examination of this issue may lead to the development of training and academic courses which educate NP providers in evidence-based approaches to best handle communication issues regarding EOL care (DNP Essentials: I: Scientific Underpinnings for Practice & III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice). Standardization of which practices are found to be the most appropriate and effective will help to give NPs the confidence they need to address these patient needs, as several of the study participants stated that they tend draw upon personal experiences instead of evidence-based practices.

This study also acknowledges the importance of how interdisciplinary collaboration with spiritual support staff members can potentially impact the receptiveness of patients who may otherwise be suspicious of NPs or other clinicians due to poor health literacy and limited insight into their health conditions. These patients are particularly vulnerable, and risk being offered fewer chances to participate in decision making regarding their health outcomes. NPs who
recognize the potential for spiritual support staff to act as liaisons when working with these patients and their families may represent a major turning point in the entire care trajectory and the effectiveness of communication with these groups (DNP Essential VI: Inter-professional Collaboration for Improving Patient and Population Health Outcomes).

**Conclusion**

As it currently stands, despite research which supports the value of early discussion on goals of care for terminally ill patients, many providers remain reluctant on initiating these conversations with their patients, despite the establishment of poor long-term prognosis. Since NPs are now in a potentially pivotal role to influence the current gap in research and clinical practice, this study focused primarily on what factors these clinicians feel are the most influential in their practice. Out of a total of ten acute care NPs who were interviewed, four themes were found to be the most common; role confusion, religious influences, patient conflict of interests, and lack of formal training.

This study also recognizes NPs for their exceptional role in patient care—the experience as bedside nurses that many NPs draw upon gives them an advantage in approaching and initiating conversations with patients regarding sensitive topics such as end of life care. With the passage of recent legislation which allows NPs to legally authorize MOLST forms without the co-signature of a collaborating physician, NPs must be prepared for this new responsibility in order to serve the needs of their patients, particularly those who may benefit from conversations on end of life care.

Although the sample size in this study is quite small, the sentiment that there needs to be greater emphasis on palliative care and end of life care in academic and professional programs was shared among all individuals who participated despite their diverse backgrounds. The lack
of formal training regarding how to handle the care of terminally patients with incomplete advanced directives contributes to the majority of issues discussed in this study. Program developers and academic institutions should recognize the potential value that further discussion and examination of issues surrounding end of life care can have for providers entering the health care setting.

Although there is a great deal of emphasis on the pathophysiological aspects of the dying process, the recognition of conditions which indicate impending death should also be paired with the communication skills to discuss with patients what they can expect in the final stages of their life. Formal training on how providers can translate their extensive knowledge to empower their patients to make informed decisions regarding the care that they chose to receive at the end of their lives can greatly improve satisfaction scores, as well as the efficiency in the allocation of specialty services and resources within the hospital setting.

When patients are given the opportunity to understand and set their own limitations on life sustaining treatments at the end of their lives, they and their families are empowered to feel that they have some sort of control in situations which typically make them feel powerless. Not only does this improve satisfaction with the care that they chose to receive, but it also limits the use of specialty resources which are given by default to patients who fail to set their own limitations on aggressive treatments. Proper allocation of valuable and limited resources to patients who truly need and can benefit from these interventions will greatly improve operating costs and the efficiency of care delivery at the institutional level. However, these outcomes must all be traced back to the ability of the providers to initiate discussions with their patients at the appropriate times. The discussion found in this research study should serve as a demonstration of both the need for further examination of the use of palliative care services, as well as the use
of life-sustaining services and how administrators can support their providers to help patients find a middle ground that is most appropriate to their specific needs.
References


Appendix A

Semi-structured Interview Questions for Acute Care Providers

Current research indicates that one of the barriers to the involvement of palliative care services is reluctance on the part of some providers to suggest that there are limited treatment options for patients with chronic illnesses or poor long-term prognosis.

1. Can you describe a situation where you felt reluctant to suggest limitations of care or aggressive treatments at the end of life with a patient under your care?
   a. What factors do you believe contributed to this situation? (poor health literacy, resistance to overall treatment plan, poor insight, conflicts with other members of the health care team, etc)
   b. What do you feel would have helped in this situation?
      i. For example, is the Conversation Starter Kit useful? Why or why not?

2. Do you feel that this is a clinically relevant issue? Or do you feel that at this particular institution that palliative care teams are consulted appropriately and that providers are efficient in the use of aggressive treatments for their patients?

3. Do you feel that this issue might also be experienced in other clinical sites, or is it an issue of the culture of care and the differences between this institution vs. another?
   a. Have you worked in other clinical settings, where you felt there were issues not found at this site, or vice versa?
   b. Are there procedural differences from this clinical site vs. any others that you may have practiced at that you felt affected how you approached the topic of palliative care or hospice care for your patients?

4. Do you feel that certain populations are more difficult to have these conversations with?
   a. Might the issue cultural, language, educational level, health literacy, etc?
   b. Do you feel that the hospital provides the tools to support providers in initiating conversations regarding advanced directives or limitations on aggressive treatments at the end of life with vulnerable populations such as the ones listed below? Why or why not?
      i. Refugees
      ii. Polysubstance abuse patients
      iii. Individuals from correctional settings
Under our current fee-for-service health care model, current estimates suggest that a disproportionate share of Medicare expenditures are spent on aggressive treatments and services delivered within the last month of life. These interventions typically do not have a significant impact on the patients’ survival rate, nor were they associated with improved patient and family satisfaction with the delivery of care at the end of life for these beneficiaries (Center for Medicare and Medicaid, 2012).

5. How would you prefer to see your health care institution show support for providers in challenging situations or with difficult patients and families?
   a. Is it beneficial to include other staff in the initiation of these discussions? For example, family meetings with spouses of patient, social workers, primary nurse, or patient advocates?
   b. Do you typically try to exhaust all possible treatment options before considering palliative care?

6. When do you decide to consult palliative care services?
   c. What factors/attributes do you typically look for patients to exemplify before considering or suggesting palliative care?
   d. At what point in the care trajectory do you typically suggest discussion on advanced directives or limitations on treatments?
      i. Is this something you consider discussing with your patients after rapid declines in health status (such as after or during a rapid response), or is this something that you feel is important to discuss when the patient is stable?
      ii. Do you feel that this is an issue for acute care providers? Or is this conversation more appropriate for the Primary Care setting?
July 6, 2018

Dear Sabila Shah:

On 7/6/2018, the IRB reviewed the following submission:

<table>
<thead>
<tr>
<th>Type of Review:</th>
<th>Initial Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of Study:</td>
<td>Barriers to Palliative Involvement and Treatment Limitations on Aggressive Interventions at the End of Life for Terminally Ill Patients in the Acute Care Setting</td>
</tr>
<tr>
<td>Investigator:</td>
<td>Sabila Shah</td>
</tr>
<tr>
<td>IRB ID:</td>
<td>STUDY00002575</td>
</tr>
<tr>
<td>Funding:</td>
<td>None</td>
</tr>
<tr>
<td>Grant ID:</td>
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<tr>
<td>IND, IDE, or HDE:</td>
<td>None</td>
</tr>
<tr>
<td>Documents Reviewed:</td>
<td>• UpdatedConsentWithRevisions, Category: Consent Form; • Research Proposal, Category: Other; • UpdatedProtocolWithRevisions, Category: IRB Protocol;</td>
</tr>
</tbody>
</table>

The IRB approved the study from 7/6/2018 to 7/5/2019 inclusive. Before 7/5/2019 or within 30 days of study closure, whichever is earlier, you are to submit a continuing review with required explanations. You can submit a continuing review by navigating to the active study and clicking Create Modification / CR.

If continuing review approval is not granted before the expiration date of 7/5/2019, approval of this study expires on that date. The Initial Study materials for the project referenced above were reviewed and approved by the SUNY University at Buffalo IRB (UBIRB) by Initial Study Review. Before to 7/5/2019 inclusive. Before 7/5/2019 or within 30 days of study closure, whichever is earlier, you are to submit a continuing review with required explanations. You can submit a continuing review by navigating to the active study and clicking Create Modification / CR.

In conducting this study, you are required to follow the requirements listed in the Investigator Manual (HRP-103), which can be found by navigating to the IRB Library within the IRB system.

UB IRB approval is given with the understanding that the most recently approved procedures will be followed and the most recently approved consenting documents will be used. If modifications are needed, those changes may not be initiated until such modifications have been submitted to the UBIRB for review and have been granted approval.
University at Buffalo Institutional Review Board (UBIRB)
Office of Research Compliance | Clinical and Translational Research Center Room 5018
875 Ellicott St. | Buffalo, NY 14203
UB Federallywide Assurance ID#: FWA00008324

Prior to the expiration of this approval, you will receive notification that it is time for the UBIRB to conduct its periodic review of your study. Studies cannot be conducted beyond expiration date without re-approval by the UBIRB.

As principal investigator for this study involving human participants, you have responsibilities to the SUNY University at Buffalo IRB (UBIRB) as follows:

1. Ensuring that no subjects are enrolled prior to the IRB approval date.

2. Ensuring that the study is not conducted beyond the expiration date without re-approval by the UBIRB.

3. Ensuring that the UBIRB is notified of:
   - All Reportable Information in accordance with the Reportable New Information Form Smart Form.
   - Project closure/completion by the Continuing Review/Modification/Study Closure smart form.

4. Ensuring that the protocol is followed as approved by UBIRB unless a protocol amendment is prospectively approved.

5. Ensuring that changes in research procedures, recruitment or consent processes are not initiated without prior UBIRB review and approval, except where necessary to eliminate apparent immediate hazards to subjects.

6. Ensuring that the study is conducted in compliance with all UBIRB decisions, conditions, and requirements.

7. Bearing responsibility for all actions of the staff and sub-investigators with regard to the protocol.

8. Bearing responsibility for securing any other required approvals before research begins.

If you have any questions, please contact the UBIRB at 716-888-4888 or ubirb@buffalo.edu.
July 9, 2018

Sabila Shah
ECMCC
462 Grider Street
Buffalo, New York 14215

RE: “Barriers to Palliative Involvement and Treatment Limitations on Aggressive Interventions at the End of Life for Terminally Ill Patients in the Acute Care Setting”

Dear Ms. Shah,

I wish to thank you for submitting an application to perform the above-named clinical research project at Erie County Medical Center Corporation. I have reviewed the application and am pleased to report that I am granting you permission to proceed with the project.

In approving this research project ECMCC expects that none of its patients will be approached by a researcher until their permission has been obtained by an ECMCC employee involved in their care. ECMCC also expects that patients will not be billed directly for any services. Also, please be sure to review ECMCC’s Clinical Research Policy and Procedure posted on the intranet.

I note that you are exempt from HIPAA requirements because the study does not involve the provision of health care and does not use any health information provided by a health care provider, health plan, or health care clearing house.

Please share the final report with ECMCC and notify the Risk Management department at ECMCC upon completion or termination of the study.

Good luck with your research!

Sincerely,

[Signature]

Samuel Cloud, D.O.
Associate Medical Director

Chief Medical Officer

CC: Nadine Mund, Compliance Officer, ECMC
Amy Archer Flaherty, Director of Risk Management
Robert Vail, IT Security Officer
ISSUES SURROUNDING END OF LIFE CARE CONVERSATIONS IN THE ACUTE CARE SETTING

Sabila Shah, DNP-ANP(s)

Development of the Clinical Issue

Direct Observation at Clinical Research Site
- Experience as Bedside Nurse

Field work in Palliative Care Practices
- Population Health Collaborative
- Engaging Patients in Advance Care Planning

Application to Capstone Project

Background and Significance

A disproportionate share of Medicare expenditures are spent on aggressive treatments within the last month of life (Center for Medicare and Medicaid, 2012)

- These interventions typically do not have a significant impact on the patients' survival rate
- nor were they associated with improved patient and family satisfaction with the delivery of care at the end of life (Center for Medicare and Medicaid, 2012)

Purpose of Capstone Project

Identification of the barriers that Nurse Practitioners feel prevent them from helping their patients to set realistic goals of care at the end of life.

Potential Application of Findings
- Improve the quality of health care delivery for terminally ill patients
- Reduce the use of aggressive treatments for patients who can no longer stand to benefit from them.
Nurse Practitioners as Leaders in Acute Care

- Nursing diagnoses focused on the human response to the medical diagnosis (Gordon, 2014).
- Educated to be acutely aware of both
  - the physiological reactions to a clinical diagnosis,
  - the emotional, spiritual and psychological responses as well.

Legislative Influences for Clinical Practice

New York Senate Bill S1869A

- Authorizes Advanced Practice Nurses to sign MOLST forms as legal documents
  - Took effect May 2018
- Co-signature of a collaborating physician is no longer necessary
  - Scope of practice expanded
  - Clinical implications for practice for NPs

Study Question

What are the barriers that acute care nurse practitioner providers feel prevent them from helping their patients to set realistic goals of care at the end of life?

Theoretical Framework

Level 1: Effectiveness of Current Practices on Health Outcomes
Level 2: Efficiency of Current Practice Delivery Systems
Level 3: Effectiveness & Efficiency of a Specific Health Care Delivery System
Level 4: Equity of Access to Care
Level 5: Social Justice

(Fawcett & Russell, 2001)
Method

- Research of Clinical Issue
  - Palliative Care Meetings
  - Conferences in the Community
- Development of Study Design
- IRB approval July 2018

Selection Process

Data needed for the purposes of determining NP provider-identified barriers to the early establishment of goals of care at the end of life were collected from a series of one-on-one interviews

- Recruitment of Research Participants (10 total)
  - Acute Care Nurse Practitioners

Sample Interview Questions

- How comfortable are you discussing mortality, and the purpose of MOLST forms and end of life care with your patients?
  - Do you use the Conversation Starter Kit and do you find it to be useful?
- At what point in your care of a patient do you begin to consider the conversations on goals of care at the end of life appropriate?
  - When do you decide to consult Palliative Care teams or specialists?
- Describe the training, if any, either academic or professional, that you received regarding end of life care?
  - What do you feel would have helped you to feel more prepared for these situations?

Data Analysis

- Qualitative data
- Conventional Content Analysis
- Identification of reoccurring themes
Example of Annotation and Analysis


• The following four themes were found to be the most prevalent among all providers:
  • Role Confusion
  • Religious Influences
  • Conflict of Interests
  • Educational Training and Background

Results

• Role Confusion
  • Age of provider
  • Projection of patient belief

Results

• Role Confusion
  • Background as a bedside nurse
Results

Religious Influences
- Involvement of staff spiritual leaders
- Health Literacy & Patient Insight

Conflicts of Interest
- Health care Proxy vs. Power of Attorney
- Questionable motives from family of patient

Lack of Academic or Professional Training
- Personal Experience as a guide
- Missed opportunities for palliative care

Sample Size
- Diversified Perspective
- Familiarity of Principal Investigator to Research Subjects
Application to Clinical Practice

• Emphasize Current Resources
• Inter-professional Collaboration
• Patient Advocacy
• Encourage Professional Opportunities for Continuing Education

Application to Clinical Practice

Implications on Argument for Financial Benefits

• Administrators should never use the findings of this study to influence or persuade patients to forgo treatments in the interest of improving operating costs
• Patient autonomy to make informed decisions regarding their care should always be priority, above all else
  - Educational tools should remain unbiased and delivered without persuasive intent

Application to DNP Essentials

II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking
V: Healthy Care Policy for Advocacy in Health Care
VI: Inter-Professional Collaboration for Improving Patient and Population Health Outcomes
VII: Clinical Prevention and Population Health for Improving the Nation’s Health
VIII: Advanced Nursing Practice

Conclusion

• Greater Educational Emphasis
• Patient Advocacy
• Utilization of Current Resources


Cont.

Cont.
