

Advanced Care Planning: Utilizing Patient Education Videos to Improve End-of-Life Care Documentation

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CLINICAL QUESTION

Will utilization of evidence-based patient education advanced care planning (ACP) videos improve providers orders for life sustaining treatment (POLST) and advance directives (AD) completion by 15% for adult inpatients at Adventist Health Castle (AHC) over 4 months?

RATIONALE

Why Advanced Care Planning (ACP)?

- Process to ascertain values and goals of medical care
- Documented using:
 - Providers Orders for Life-Sustaining Treatment (POLST)
 - Advanced Directive (AD)
- Assure patient receive care they desire
 - 80% of people want to die at home
 - 60% of people die in the hospital
- This represents a significant gap between care desired and care provided that must be addressed. (Brinkman-Stoppelenburg, Rietjens, & Van der Heide, 2014).

ACP leads to better **quality of life**, reduced use of **nonbeneficial medical care** near death, enhanced **goal consistent** care, positive **family outcomes** and reduced **cost** while **not increasing patient distress** (Bernacki et al, 2014).



- Multiple, robust RCT's support the expanded use of the ACP education videos
- Patients are less likely to elect for extensive interventions, and more frequently declined cardiopulmonary resuscitation (CPR)/intubation (El-Jawahri, et al., 2016).
- Video intervention reported greater knowledge and stability in their end-of-life (EOL) decisions (Volandes et al, 2009)

APPROACH - METHODS

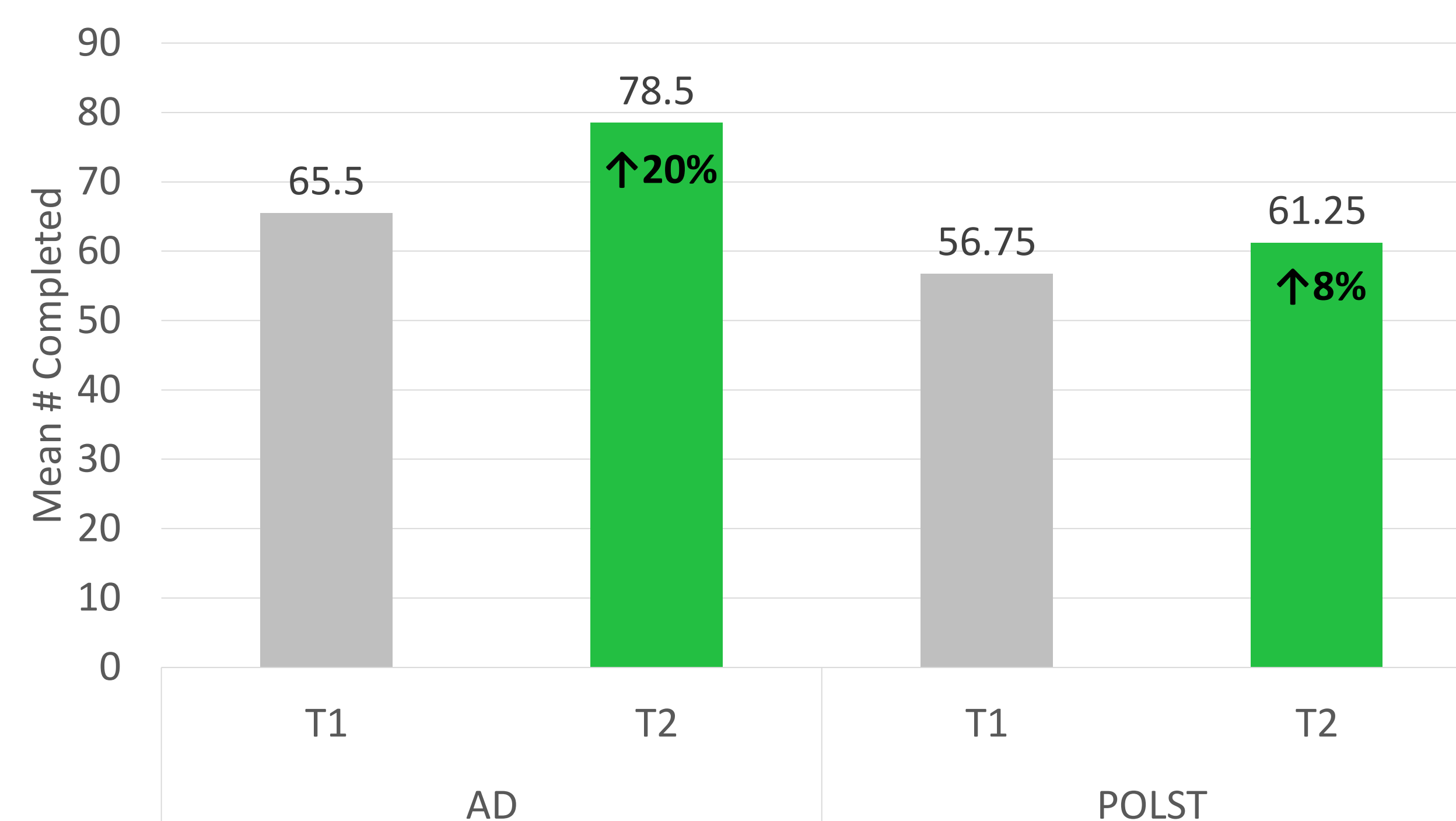
When: 3 week pilot, 4 month implementation
Who: All patients (18+) deemed to benefit from ACP discussions per facility protocol.
Where: Laulima/telemetry unit at AHC
How: Increased use of ACP videos by engaging a multi-disciplinary team of health professionals including RN, MD, SW and CM. ACP training provided.
What: EOL documentation operationalized as:
 Mean # AD completed during intervention
 Mean # POLST completed during intervention

The Iowa Model of Evidence-Based Practice to Promote Quality Care guided the DNP project (Titler et al., 2001)

The project answered the clinical question by utilizing an impact (summative) T1-T2 and process (formative) evaluation design.

OUTCOMES

Impact Evaluation: Mean AD and POLST at T1 and T2



Formative Evaluation: Mean AD and POLST at T1 and T2

Pilot (Aug 11, 2017 to Aug 31, 2017)	Implementation (Sept 1, 2017 to Dec 31, 2017)
I. What about the way we help people with ACP is working now?	
1) Highly qualified palliative care staff	1) Highly qualified palliative care staff
2) Facility specific AD document brochure	2) Knowledge/confidence to engage in ACP discussions
3) Admission questionnaire asks whether patient has an AD and/or POLST	3) Access to ACP videos/resources
II. What can be better?	
1) How to "start the conversation" (staff anxiety/discomfort on appropriate approach)	1) Cultural appropriate ACP engagement
2) Interdisciplinary communication	2) Staff knowledge of ACP
3) Patient/family readiness	3) Time
4) Culture/language challenges	4) Patient/family readiness
5) Time	5) Interdisciplinary communication
III. What are some changes that could make ACP even better?	
1) Provide resources: Videos, cheat sheet reference, Q&A	1) Cultural competency training in ACP
2) Clarification of POLST and AD	2) Ongoing professional development- general ACP topics
3) Increase interdisciplinary communication	3) Interdisciplinary huddle including ACP

CONCLUSION

- AD completion increase of 20% exceeded expectations
- POLST completion increase of 8%, a modest but meaningful improvement
- Professional development utilizing ACP videos adequately addressed staff anxiety/discomfort initiating ACP discussions.

IMPLICATIONS

- EBP interventions require ongoing adjustment to the practice environment
- There is a significant psychosocial component to engaging in ACP and staff require time to acclimate to the role of an ACP facilitator
- Cultural considerations and psychosocial theory are necessary to integrate into project planning and implementation for successful ACP interventions

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