Enhancing Advance Care Planning Conversations by Nurses in a Bone Marrow Transplantation Unit

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OBJECTIVES: To describe the impact of advance care planning (ACP) education on nurses' confidence in ACP knowledge and practice and to identify barriers to facilitate ACP conversation in a bone marrow transplantation unit.

SAMPLE & SETTING: 60 nurses working in the bone marrow transplant unit at Oregon Health and Science University, an academic medical center.

METHODS & VARIABLES: The aim of this quality improvement project was to increase ACP conversations by nurses. The authors used a single-group pre-/post-test design to assess the effectiveness of a 30-minute educational intervention in changing nurses' confidence and practice. Group interviews were conducted to identify barriers to ACP.

RESULTS: The educational intervention increased nurses' confidence in knowledge about ACP. The number of nurses who discussed ACP with patients also increased, but it was not statistically significant. Lack of time, inefficient workflow, and concerns about questioning providers' understanding of patient preferences were identified as barriers for nurses engaging in and documenting ACP conversations.

IMPLICATIONS FOR NURSING: In addition to appropriate education, strategies that help tailor ACP practice to fit into nurse workflow and promote collaboration with other healthcare team members are needed to change nurses' ACP practice.

KEYWORDS advance care planning; advance directives; decision making; end-of-life care
***ONF, 46*(3), 288–297.**
DOI 10.1188/19.ONF.288-297

Provision of care that is consistent with patient values, goals, and preferences is the aim of health care. To meet this goal, it is necessary to know a patient's values and preferences for future care in case a time comes when the patient may be incapable of making decisions or expressing preferences (Institute of Medicine, 2014). Advance care planning (ACP) is a process that supports people at any stage of health to understand and share their personal values, life goals, and preferences with family members and healthcare professionals (Sudore et al., 2017).

Although patients admitted to hospitals are often seriously ill, they rarely have prior conversations about ACP. Healthcare providers, patients, and family members frequently believe that ACP is only for dying patients and may avoid conversations about ACP because of the fear of and discomfort with talking about dying and end-of-life care (Baughman et al., 2012; Gutierrez, 2012; Izumi, 2017). Starting ACP conversations from the earliest stages of illness—or even when a person is healthy—and revisiting the conversation during the illness trajectory is recommended as a best practice for ACP (Sudore & Fried, 2010). However, there are no consensus guidelines about when and how ACP should be addressed and who is responsible to facilitate the conversations in a healthcare setting (Dillon et al., 2017; Izumi, 2017; Izumi & Fromme, 2017).

Nurses often provide care to patients whose health is in transition or declining. Hospital nurses are at the patient's bedside regularly and assist with decision making using knowledge about potential consequences of each treatment and what it may mean for the patient. Because of this knowledge and the close and intimate relationship with patients who are experiencing serious illness, hospital bedside nurses

are well positioned to recognize the opportunity for conversations about ACP (Lally, Rochon, Roberts, & McCutcheon, 2016; Sinclair et al., 2017). However, the role of nurses regarding ACP conversations is not established or well recognized (Izumi, 2017; Izumi & Fromme, 2017; Reinke et al., 2010). In addition, nurses often cite common reasons for not talking to patients about ACP (Cohen & Nirenberg, 2011; Duke & Thompson, 2007; Schulman-Green, Smith, Lin, Feder, & Bickell, 2018), including the following:

- Belief that patients are unwilling
- Physician hesitance to talk about prognosis and ACP
- Desire to maintain hope for patients
- Lack of information, education, and training about ACP
- Perception that ACP is outside of the nursing scope of practice

Nurses working in the bone marrow transplant unit (BMTU) at Oregon Health and Science University in Portland were aware of the importance of early ACP conversations and observed an opportunity to engage patients in early ACP conversations while they are in the hospital. The nurses proposed a quality improvement (QI) project to increase the opportunities to have conversations with their patients about ACP. Prior to this QI project, a licensed clinical social worker (LCSW) was the primary team member engaging patients in ACP conversations. To increase the opportunity for patients to have ACP conversations, the nurses believed one LCSW talking with patients was not enough. The literature suggests that ACP facilitated by an interprofessional team with a common and consistent message is more effective (Clark et al., 2017; Fromme, Izumi, Diveronica, & Distefano, 2017). Because nurses are the largest portion of the BMTU team and spend more time with patients, enhancing nurses' involvement in facilitating ACP conversation may be an effective way to increase ACP conversations on the BMTU. However, nurses on the unit expressed concern that they did not know enough about ACP and their role in ACP because it was not part of their formal education.

To address these concerns and enhance nurse competency regarding ACP conversations, ACP education for nurses was chosen as the main intervention to change practice in the QI project. The goal of the QI project was to increase the number of ACP conversations with patients in the BMTU by educating all nurses on the unit about ACP and building a system to support nurses to have the conversations. Specific aims were to (a) evaluate the effectiveness of ACP education on nurses' confidence and knowledge of ACP and (b) explore barriers that prevent nurses from facilitating ACP conversations in the BMTU. The purpose of this article is to report findings and lessons learned from the QI project.

Methods

Design

The authors used a single-group pre-/post-test design to assess effectiveness of the educational intervention to change nurses' confidence and practice. The hypothesis was that education would increase nurses' confidence in ACP knowledge and, therefore, lead to an increase in ACP conversations. The authors conducted group interviews with nurses to identify barriers for ACP practice that remain after the educational intervention. The institutional review board at Oregon Health and Science University determined that this was a QI project and was exempt from review.

Sample

Participants in the educational intervention were all RNs working on the BMTU between February 2016 and October 2016 when the project was conducted. The BMTU has 30 beds, and there were 60 RNs (including full- and part-time) at the beginning of the project.

Intervention

A 30-minute education session (Microsoft PowerPoint® lecture with open discussions) about ACP was provided as part of a nurse education day, a two-hour educational event provided to all RNs on the unit three times per year. The unit nurse leader team selects topics based on accreditation requirements, learning needs assessments, or nurse requests. Nurses on the BMTU chose ACP as a topic in 2016. A palliative care nurse researcher in the hospital's associated school of nursing, who has been on an institution-wide ACP implementation steering group, was invited to lead the education session. On the BMTU, LCSWs have played a critical role facilitating ACP conversations with patients. The researcher (S.I.) and the LCSWs (J.S., K.M.) collaborated to develop appropriate educational materials and co-taught the session. The nurse manager (M.B.), process owner of the QI project, developed a standard work form to describe the step-by-step process to complete the task and how to initiate ACP conversations and document it in the electronic health record (EHR), specific to the BMTU.

Educational components to build practice competency include knowledge, skills, and attitude

(Cronenwett et al., 2007). In the initial assessment, nurses on the BMTU were confident about their communication skills with patients, but not confident in their knowledge about ACP and the nurse's role. Therefore, the educational intervention aspect of the QI project focused on knowledge about ACP. The educational session included (a) definitions and descriptions of ACP and related terms, (b) goals and benefits of ACP, (c) the nurse's role in ACP, (d) how to initiate a conversation about ACP, and (e) how to document the ACP conversation in the EHR. In addition, advance directive (AD) forms were provided to participating nurses, and they were encouraged to complete an AD for themselves. The educational session was presented three times to reach all RNs in the unit.

Measurement and Data Collection

The authors planned to evaluate the effectiveness of ACP education in terms of confidence in knowledge to facilitate ACP conversations, frequency of ACP practice, and perceived barriers for nurses to have ACP conversations on the BMTU. All participants were asked to complete a survey before and after the educational session. The survey was developed by the researcher (S.I.) based on the existing ACP literature (Baughman et al., 2017; Jezewski & Feng, 2007; Jezewski, Meeker, & Robillard, 2005; Ke, Huang, O'Connor, & Lee, 2015) and findings from a root-cause analysis of barriers to ACP conversations in this unit. The survey included (a) 10 questions asking about their confidence in their knowledge to conduct ACP-related activities (e.g., finding ACP documents in the EHR, describing ACP to patients, assisting patients to complete an AD, communicating patient's ACP needs with other healthcare providers) on a five-point Likert-type scale ranging from 0 (not at all) to 4 (very much); (b) how often they assist patients in ACP; (c) perceived barriers for having ACP conversations; and (d) whether they had an AD. To measure increase and retention of confidence in knowledge about ACP practice, 10 questions about confidence in their ACP knowledge were asked three times: before, at the end of the educational session, and three months after the session. To capture changes in ACP practice as a result of the educational session, nurses were asked how often they assist patients with ACP (never, rarely, sometimes, often, or all the time) before and at three months after the educational session. The authors also tracked the number of patients who had an AD in the EHR at the time of discharge from the unit for QI purpose. It was hypothesized that nurses asking patients if they had ADs and initiating the ACP conversation during the hospital stay would increase the number of patients with ADs documented in the EHR; therefore, documented ADs were used as a proxy for practice change. The proportion of patients with an AD in the EHR after the intervention was examined for 18 months.

To measure the changes in knowledge about the nurse's role and practice in ACP from before to after the educational session, nurses were asked to identify which of 12 issues were perceived as barriers for nurses to have ACP conversations before and three months after the educational session. The 12 barriers (i.e., lack of training, unfamiliarity with ACP, not knowing enough about ACP, not having the skills to facilitate ACP, belief that ACP takes away hope, belief that ACP is not a nurse's job, concern about conflict in treatment plan, physicians do not want RN to initiate ACP, ACP will not help EOL decision making, patients are not approrpriate for ACP, lack of time, and belief patients do not want to talk about ACP) were selected based on the existing literature (Baughman et al., 2012; Jezewski et al., 2005; Jezewski & Feng, 2007) and baseline interviews conducted prior to the QI project. To test individual changes before and after the educational session, each participant was assigned an identification number to link before and after data. Because this was a survey to capture changes before and after an

TABLE 1. Sample Characteristics (N = 60)

Characteristic	n	%
Gender		
Female	52	87
Male	8	13
Race		
White[a]	53	88
Other	7	12
Employment		
Full-time	49	82
Part-time	11	18
Have advance directive		
Preintervention (yes)	9	15
Preintervention (no)	51	85
Postintervention (yes)[b]	10	24
Postintervention (no)[b]	31	76

[a] One participant identified as Hispanic.
[b] One participant did not answer this question in the postintervention survey; therefore, N = 41.

intervention, no psychometric characteristics of the survey were tested (Groves et al., 2009).

A common component in QI projects is stakeholder interviews to learn what does and does not work. To gain additional practical insights about possible barriers that remain, two group interviews with nurses were conducted six months after the intervention. The nurse manager sent out an invitation email to the interviews to all nurses on the unit. During the interviews, the researcher (S.I.) who has expertise in qualitative interviews asked nurses to share their thoughts about ACP and what is and is not working and why, as well as their experiences (or attempts) with initiating ACP conversations with patients. The interviews were audio recorded with the participants' permission, and the researcher and a research assistant took field notes.

Analysis

Descriptive statistics were used to summarize survey results describing nurses' confidence in their ACP knowledge and practice and perceived barriers to ACP. IBM SPSS Statistics, version 24, was used. Data were analyzed using Wilcoxon signed rank test to compare the levels of confidence across three time points (before, immediately after, and three months after the educational session) and ACP practice before and after.

For the interviews, the researcher (S.I.) and the nurse manager of the unit (M.B.) reviewed audio recordings and field notes to extract common themes for barriers and facilitators of the ACP conversations using qualitative descriptive analysis (Sandelowski, 2010). Because the interviews were conducted as part of QI process, the authors did not limit the data to the

TABLE 2. Nurses' Confidence in ACP Knowledge Before and After an Educational Intervention

	Time 1: Before (N = 60)		Time 2: Immediately After (N = 60)		Time 3: 3 Months After (N = 42)				
Question	M	IQR	M	IQR	M	IQR	p[a]	p[b]	p[c]
How confident are you to . . .									
Find if a patient has an advance directive or document related to ACP?	2	1.25–3	4	3–4	4	3–4	< 0.001	0.003	< 0.001
Assess patient's understanding of what ACP is?	2	2–3	3	3–4	3	3–3.25	< 0.001	0.109	< 0.001
Describe what ACP is to patients?	2	2–3	3	3–4	3	3–4	< 0.001	0.059	< 0.001
Provide informational material about ACP to patients?	2	1–2	4	3–4	3	3–4	< 0.001	0.001	< 0.001
Initiate ACP conversations with patients?	2	2–3	3	3–4	3	3–4	< 0.001	0.181	< 0.001
Discuss how to complete an advance directive with the patient?	2	1–2	3	3–4	3	2–3	< 0.001	0.001	< 0.001
Document your ACP conversation with a patient in the electronic health record?	1	0–2	3	3–4	3	2–3	< 0.001	0.004	< 0.001
Identify patients who need further assistance with ACP?	2	2–3	3	3–4	3	3–4	< 0.001	0.018	< 0.001
Communicate patients' ACP needs with other providers?	2	2–3	3	3–4	3	3–3	< 0.001	0.016	< 0.001
Advocate for patients' treatment preferences when a decision needs to be made?	3	2–3.75	4	3–4	3	3–4	< 0.001	0.153	< 0.001

[a] Difference between Time 1 and Time 2
[b] Difference between Time 2 and Time 3
[c] Difference between Time 1 and Time 3
ACP—advance care planning; IQR—interquartile range; M—median
Note. Scores are based on a five-point Likert-type scale ranging from 0 (not at all) to 4 (very much).

comments by participating nurses during interviews and included information the nurse manager had about the culture, regulations, and practice on the unit. The aim was to describe how nurses facilitate ACP with patients, and what hinders or facilitates the practice.

Results

Sixty RNs who worked on the BMTU from February to March 2016 participated in the educational sessions. The mean age of participants was 36.9 years (SD = 8.3), and mean years of experience as an RN was 9.8 (SD = 7.5). The majority were White women with full-time positions on the unit (see Table 1). A follow-up survey was distributed to all RNs working on the unit in May 2016. There had been turnover of staff nurses during the three months; the number of RNs who received the educational session in February and responded to the follow-up survey three months later was 42, and this was the effective sample size for the pre- and post-test.

Effectiveness of Educational Session

Confidence in ACP knowledge: In the survey, the authors asked how confident RNs were in knowing how to take 10 actions to assist patients with ACP (see Table 2). Before the educational session, their median confidence for all actions ranged from 1 (a little bit) to 3 (quite a bit). RNs were most confident in advocating for patients' ACP when a decision needed to be made (median = 3, IQR = 2–3.75), and least confident in documenting ACP conversations in the EHR (median = 1, IQR = 0–2). Immediately after the educational session, the median confidence ranged from 3 (quite a bit) to 4 (very much) for all actions. Three months after the educational session, nurses' median confidence level remained between 3 (quite a bit) and 4 (very much) for all actions.

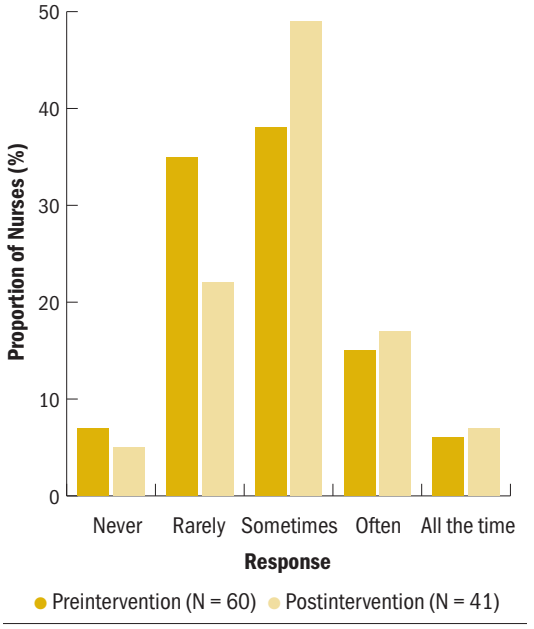
Significance of changes in confidence from before to immediately and three months after the educational session was assessed using the Wilcoxon (matched-pairs) signed-rank test. Significant increases were noted in nurses' confidence in ACP immediately after the educational session ($p < 0.001$) in all areas. Although a decline in confidence at three months after the education was observed in six areas (find AD, provide information, discuss AD completion, document ACP, identify patient needing assistance, and communicate ACP with providers), nurses' confidence in ACP remained significantly higher three months after compared to before the education.

ACP practice: To capture practice change, nurses were asked how often they assisted patients in ACP before and three months after the educational session (see Figure 1). Compared to before the education, the frequency of nurses assisting patients in ACP increased after the education. Three months after the educational session, 49% (n = 20 of 41) of respondents versus 38% (n = 21 of 55) of respondents before the session stated that they assist patients in ACP sometimes, and 24% (n = 10 of 41) of respondents three months after versus 20% (n = 11 of 55) of respondents before the session stated that they assist patients in ACP often or all the time. However, the change in frequency was not statistically significant (Wilcoxon signed-rank test, p = 0.166).

As a QI indicator, the authors also tracked the number of patients who had ADs filed in the EHR at the time of discharge from the BMTU. Before the education session, 24% of patients who were discharged from the BMTU had ADs filed in the EHR; this increased to 35% at three months after the education and grew to 50% 18 months after the education.

Perceived barriers to ACP practice: In the survey, nurses were asked about perceived barriers in assisting patients in ACP before and three month after the education (see Table 3). Before the education, about half of the nurses identified lack of training (58%, n = 35), unfamiliarity with materials (55%, n = 33), lack of

FIGURE 1. Frequency of Assisting Patients With Advance Care Planning Before and After an Educational Intervention



knowledge about ACP (52%, n = 31), and lack of time (48%, n = 29) as barriers for ACP. Thirty percent of nurses (n = 18) identified misconceptions about ACP, such as "ACP will take away hope" and "ACP is not nurses' job" as barriers, and 22% (n = 13) identified concerns such as "ACP may conflict with existing treatment plan" and "physicians do not want nurses to initiate ACP" as barriers for them to have ACP conversations. Thirty-seven percent of participants (n = 22) thought "patients do not want to talk about ACP." All participants except one (98%) considered that ACP helps end-of-life decision making and that their patients would be appropriate to have ACP conversations.

After the educational session, perceptions of barriers, such as lack of knowledge, skills, and training, decreased to below 20%. Misconceptions and concerns, such as "ACP will take away hope," "ACP is not nurses' job," "ACP conflicts with the existing treatment plan," and "physicians do not want nurses to initiate ACP" as barriers declined to below 3%. However, participants who identified "lack of time" and "patients do not want to talk about ACP" as barriers increased three months after the educational session (67% [n = 28] and 52% [n = 22], respectively).

Group Interviews About ACP Practice and Barriers

To understand how nurses practice and identify barriers for ACP conversations, the authors conducted two group interviews with nurses six months after the educational session (see Figure 2). Eight nurses participated in the group interviews. These nurses stated that asking initial questions about ADs and whether patients knew about ACP did not happen with all admitted patients. Time was a major barrier. Although the newly developed standard work process describing how to ask patients about ADs during admission seemed to be brief, nurses reported that they did not always have even a brief time to ask the question. The state-specific AD form in Oregon is complex and requires the signatures of two witnesses, making it burdensome and time-consuming to complete. Some nurses explained that they believed they had to *complete* the in-depth conversation, including identifying surrogate decision makers and exploring goals, values, and preferences of care in one session when they asked the AD question. Such a conversation is likely to take more than five minutes; therefore, nurses often perceived that they do not have enough time to complete the entire conversation and decided not to start the conversation at all. Nurses also pointed out that some patients are not able to respond to questions during admission because of their physical condition or because they are overwhelmed by the admission process.

Nurses said that they have more ACP-related conversations with patients when patients' conditions are changing, but they rarely document these conversations in the EHR. Writing a narrative note about the contents of the conversation takes time, and finding a place and time to write notes in the EHR does not fit their usual documentation workflow. One nurse stated that she was not comfortable documenting her conversations because patients may change their minds, and the nurse was concerned that documenting their conversation might confuse other team and family members. Two other nurses indicated that they had similar hesitation. Another nurse shared her strategy to overcome this concern; she documented what patients said verbatim rather than documenting her interpretation. However, this nurse admitted that writing a verbatim note takes longer, and she did not document all ACP conversations with patients unless

TABLE 3. Perceived Barriers to ACP Conversations With Patients Before and After an Educational Intervention

	Before (N = 60)		After (N = 42)	
Response	**n**	**%**	**n**	**%**
No training in ACP	35	58	8	19
Unfamiliarity with ACP materials and resources	33	55	5	12
Not knowing enough about ACP	31	52	8	19
No time	29	48	28	67
Patients do not want to talk about ACP.	22	37	22	52
ACP is not nurses' job.	18	30	–	–
Belief ACP takes away hope	18	30	1	2
ACP conflicts with existing treatment plan.	13	22	1	2
Physicians do not want RN to initiate ACP.	13	22	1	2
Not having skills to facilitate ACP	8	13	2	5
ACP will not help EOL decision making.	1	2	–	–
Patients are not appropriate for ACP.	1	2	–	–

ACP—advance care planning; EOL—end of life

it seemed to be particularly critical. Knowing what kind of decisions a patient's family might have to make in the future if the patient's condition deteriorated often motivated nurses to have ACP conversations.

Discussion

The findings demonstrate that a brief 30-minute educational intervention was effective in increasing confidence in ACP knowledge and overcoming misconceptions about ACP, two commonly identified barriers in the literature (Baughman et al., 2012; Gutierrez, 2012; Jezewski et al., 2005; Jezewski, Meeker, & Schrader, 2003). After the intervention, nurses' self-reported practice of facilitating ACP increased, but the results were not statistically significant. The number of ADs documented in the EHR at the time of discharge from the BMTU gradually increased. Despite an institution-wide effort to increase AD completion, the rate of AD completion by hospitalized patients in the BMTU had not increased in the year prior to the project. The authors' interpretation of these findings is that a modest increase in nurses' effort to have ACP conversations over time could have a clinically significant effect on patient AD completion.

Barriers for having ACP conversations with patients included lack of time and perceptions that patients did not want to talk about ACP, which is consistent with the existing literature (Gutierrez, 2012; Ke et al., 2015; Robinson et al., 2013; Seymour, Almack, & Kennedy, 2010). An increase in the number of nurses who perceived time and patient unwillingness as barriers three months after the intervention implies that they had tried to have conversations and likely (re-)recognized the barriers.

Lack of time to have ACP conversations is a major issue. Asking a few brief questions about whether patients have an AD or not and offering information may not be appropriate and cannot be done if there are other urgent needs to attend to. However, findings from the group interviews suggested a potential partial solution. Nurses did not start the ACP conversation when they perceived there was not enough time to complete the conversation. If the perception of not having enough time to complete the conversation is the conversation stopper, changing the perception to "it may not take too much time to start the conversation, and I do not need to complete it" may lower the bar and encourage the nurses to start the conversation more frequently. One of the points in the educational session was that ACP is a process, not an event. The authors described that starting the conversation just asking about ADs could change the nature of later ACP conversations. This message needs to be clearly delivered as part of team practice on the unit and in the healthcare system so that nurses can feel confident that a brief encounter in which AD questions are asked will be followed up by other team members later. After learning about this finding, the nurse manager of this unit included this learning in the Plan-Do-Study-Act cycle in the QI project and reminded nurses in their daily huddle that (a) the critical role nurses play is starting the ACP conversation, not completing the entire conversation in one exchange; and (b) LCSWs are available to have more thorough ACP conversations and assist patients as needed. Providing concrete, realistic, and attainable actions (e.g., asking

FIGURE 2. ACP Conversations With Patients

Nursing Practice to Facilitate ACP Conversations

- Ask if patients have an AD at admission.
- Revisit prior ACP or AD conversation when a patient's condition is changing.
- Communicate with social workers asking to have ACP discussion, and assist patients to complete ADs.
- When having conversations with patients regarding preference for treatment, write the patient's exact phrase in the note.
- Know what could happen to patients in the intensive care unit and how families have to make difficult decisions. This is a strong motivation for nurses to have this conversation.

Barriers to ACP Conversations

- Lack of time
- Do not want to start the ACP conversation when there is not enough time to complete the conversation
- Completing ADs takes a long time for patients (e.g., finding a witness).
- Patients are too sick to complete forms.
- No ACP materials available for non–English-speaking patients
- Have ACP conversation but not documented in EHR because of the following:
  - Writing a note about the conversations takes a long time, and there is no time to write it.
  - Writing a note does not fit in the regular documentation workflow.
  - Nurses are afraid that the patient may say something different the next day and confuse or misguide families and other team members.

ACP—advance care plan; AD—advance directive; EHR—electronic health record
Note. Responses were from 2 group interviews with a total of 8 participants.

a question about ADs, how to provide information in a limited time with an example script, how to perform a follow-up later) as "standard work" seems to be the key to make the practice change accepted, implemented, and sustained. Creating a collaborative workflow with other team members (e.g., LCSWs) was effective use of both nurses' and social workers' time and expertise.

Another lesson was that lack of ACP documentations in the EHR did not mean ACP conversations had not happened. Nurses shared examples of conversations with patients related to goals of care during the group interviews, but many of them were not documented. Reasons for lack of documentation included time constraints, inefficient workflow for nurses to document narrative notes, and concerns about their colleagues' responses when they document patient's thoughts about ACP. Regardless of the reasons, if the conversations were not documented, the practice did not occur. To create evidence about what nurses do and the contribution of nursing practice in ACP, a reliable system needs to be developed where nurses document ACP conversations with patients. An inefficient EHR system burdening clinician time and workload is a known issue (Head et al., 2018). Changes to make the EHR more clinician friendly, fit into their workflow, and make the documents more meaningful and accessible by all team members are needed (McCutcheon, Kabcenell, Little, & Sokol-Hessner, 2015).

Lack of a shared understanding about ACP in a care team is often identified as a barrier for ACP and causes nurses to hesitate to share information obtained from patients (Baughman et al., 2012; Seymour et al., 2010; Stone, Kinley, & Hockley, 2013). Appropriate documentation of nurses' ACP conversations with patients is critical to improve communication across patients, families, and care teams. In addition, documenting what nurses do is crucial to make nursing practice visible and to validate that they are operating at the top of their license. Development of a better documentation system in EHR, creating a culture in the unit where all team members share the same understanding about importance of ACP, best practice, and knowledge of each other's role in ACP are indispensable to change the ACP practice by nurses (Lally et al., 2016; McCutcheon et al., 2015).

Limitations

This project had several limitations, many of which are related to this being a QI project. First, the project was conducted in one BMTU in an academic medical center. Using a single site and QI approach limits the scientific generalizability of the findings. The sample size of the study was small, and no comparison group or randomization was used. The number of ADs documented at the time of discharge was used as a proxy for secondary outcomes of the intervention. It included the ADs that were completed and documented before the admission to this unit and may not be a result of this intervention. Another potential limitation is how group interviews were conducted. The invitation to the interviews was sent by the nurse manager of the unit, and participants knew the nurse manager would take a role in the analysis. Although this was a QI project supported by the nurses on this unit—and staff nurses and the nurse manager seem to have a trusting relationship—it is possible that nurses who would not be comfortable disclosing how they practice ACP might not participate in the interview; therefore, interview data might be skewed.

KNOWLEDGE TRANSLATION

- A brief educational session is effective to improve nurses' confidence in knowledge about advance care planning (ACP).
- Standard work that shows concrete and realistic steps about how to facilitate ACP enables nurses to engage in ACP practice.
- Collaborating with other healthcare team members and knowing the role that each member plays are critical steps for ACP practice to be sustainable.

Implications for Nursing

Assisting patients with ACP has been identified as a critical role for nurses (American Nurses Association, 2016); however, there are multiple factors hindering nurses from fulfilling this role (Izumi, 2017). Findings from the current study suggest that a brief educational session can be effective to overcome some of the barriers, such as knowledge deficit, and to improve confidence of nurses to facilitate ACP conversations. The findings also suggest that implementing the educational session with practical and actionable steps was effective to change ACP practice by nurses. Development and implementation of a standard work that is tailored to be practical and realistic for nurses to perform within the given time and workflow was key to make practice change happen.

As leaders in the clinical setting, nurses should strive toward building a workflow so that nurses can share the responsibility of ACP conversations with other team members, including LCSWs and physicians. Building an EHR system that supports nurses' documentation of their ACP practice is another

critical component to change nursing practice. To support nursing practice with ACP and collaboration within the team, creating a unit culture where all team members share a common understanding about ACP and recognize and support each member's contributions is necessary.

Conclusion

Provision of care that is consistent with patient values and preferences is a goal of health care, and ACP is a vital tool to do this. Because ACP is a process over the trajectory of life and illness, it is critical to have all team members who are involved in patient care carry the conversation across time, settings, and teams. Nurses are poised to play a critical role facilitating ACP conversations with patients and could lead a team to create a culture where all team members work together to provide patient-centered, goal-concordant care. The findings of this QI project show an example of practical steps to enhancing nurses' roles in ACP. The ideas for how to build a system that assists nurses in practicing and documenting their ACP conversations are imperative to make the nurses' contribution to ACP in the interprofessional team visible.

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The authors gratefully acknowledge Dana Bjarnason, PhD, chief nursing officer at Oregon Health and Science University, for her support of the quality improvement project, and Michael R. Lasarev, MS, for his review of statistical contents.

This research was funded by a grant from the Cambia Health Foundation. During the writing of this article, Fromme was supported by funding from the Gordon and Betty Moore Foundation and the John A. Hartford Foundation.

Izumi, Burt, McCord, and Fromme contributed to the conceptualization and design. Izumi, Burt, Smith, and McCord completed the data collection. All authors contributed to the analysis and manuscript preparation.

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