Advanced Directives in Primary Care

Kathryn Sondrini

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Advanced Directives in Primary Care

Kathryn Sondrini

University of Massachusetts

College of Nursing

Capstone Chair: Dr. Clare Lamontange
Capstone Committee Member: Dr. Terrie Black
Capstone Mentor: Alicia Emerson, NP
Date of Submission: April 9, 2017
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Abstract

The disclosure of information to patients on the subject of code status is variable as there is a lack of evidence based practice or standardized disclosure of information. Multiple articles and studies have been reviewed which illustrate such a deficit but do not indicate how to either create or implement evidence-based practice to address this deficit. The review of literature will further illustrate the knowledge and communication deficits between patients and providers with code status discussions. The purpose of this study was the creation and evaluation of a standardized discussion/disclosure of code status information and a checklist of topics completed between the provider and patient. This checklist evaluation was trialed in an outpatient cardiology practice. The design of the code status checklist was guided by Plan-Do-Study-Act. Since this study was based on an ease of access and understanding, the checklist mainly focused on suggestions for change or improvement by the sample population. The methods of evaluation for the code status checklist would consist of qualitative data based on a post evaluation survey. The proposed checklist was well received with the sample population.

Keywords: advanced care planning, patient-primary care provider communication, code status, cardiopulmonary resuscitation, and advanced directives.
**Introduction and Background**

The relationship between patient and provider should be based on trust in order to ensure that the best treatment and plan of care can be specifically developed for each patient. Advanced directives should be included with the plan of care for each patient. Often this is not the case. Patients and providers may not always have the same understanding of advanced directives (Ahmed, et al., 2015). A specific guideline would safeguard against missed information for the patient and an opportunity to provide teaching to facilitate further understanding for the patient. Studies have indicated that the element of time can be a constraint for adequate discussions between patient and provider (Ahuluwalia, Levin, Lorenz, & Gordon, 2011; Anderson, Chase, Pantilat, Tulsky, & Auerbach, 2011). The development of a standardized guideline would assist with concentrating on necessary information for patients in order for them to make an informed decision about their health and advanced care planning. The topic of code status and advanced care planning can be a delicate subject for patients and providers but there needs to be a shift to become more proactive with this subject. If a patient and provider have these types of discussions on a yearly basis, it would potentially improve the treatment and plan of care for a patient should emergent or serious illness occur and would not be a complete surprise and overwhelm patients or their families at an already stressful and traumatic time.

**Problem Statement**

There is a risk for knowledge deficit with regards to code status between patients and primary care providers. This knowledge deficit is multifactorial and based on a lack of evidence based practices, a standardization of disclosed information, inadequate time, survivability, potential complications/deficits, as well as the comfort level with code status and advanced planning discussions (Anderson et al., 2011). This proposal discusses the knowledge and
communication deficits between patients and providers related to code status discussions. This proposal will further discuss the development of a standardized presentation of code status (full code, do not resuscitate [DNR], do not intubate [DNI]) and a coordinating checklist for the patient and primary care provider to review yearly.

Organizational Gap Analysis

The clinical site that was chosen for this project was an outpatient cardiology practice, as it does not have a specific plan in place to present code status. The code status toolkit should primarily be presented in an outpatient setting where patients and the providers can discuss each code status in a non-acute setting.

Review of the Literature

A comprehensive search of the literature was conducted using the following databases: EBSCOhost, Academic Search Premier, Cumulative Index to Nursing and Allied Health Literature (CINAHL) Complete, MEDLINE, and PubMed. The key words that were used included advanced care planning, patient-primary care provider communication, primary care, code status, full code, DNR, cardiopulmonary resuscitation, and advanced directives. There were over 15,000 articles that were retrieved with the previously stated key words, limited to full text articles, peer reviewed journals, relevant to the topic of code status, and journal articles written within the last 10 years. The journals were limited to English only articles. Based on the need of this literature review, 11 articles were utilized and reviewed.

The literature reviewed indicated that there is a need for further dialogue between patient and provider. There is a deficit between the education and the understanding of various code status designations when being explained to patients by their providers. This can be attributed to
multiple indicators such as time, knowledge, and the ability to have a focused dialogue in which the patient understands the presented material (Anderson et al., 2011). The concept of advanced planning and the decision to establish advanced directives can be a difficult topic for providers to approach with patients who may not be critically ill. This is a conversation that should begin before the patient becomes critically ill or a chronic condition worsens. Currently, there is not a specific or standard way to communicate with patients about the various codes. Literature has indicated that there is a need for further evaluation on how to improve communication with this topic (Rich & Paterneti, 2011). Patients and their families are not being given complete information on the specific risks and benefits to each code status. They may have misconceptions about what each code status involves (Rich & Paterneti, 2011). This can lead to patient and/or family making a health decision based on an incomplete discussion which may result in an unfavorable outcome for the patient (Rich & Paterneti, 2011). The communication is strictly based on providers’ comfort and knowledge on this topic and may not clearly or completely explain what each code status indicates for the treatment of the patient. There are many available community, state, and national resources for providers to access or even to refer a patient for more information. The National Hospice and Palliative Care Organization (n.d.) offer advanced care planning information for patient and caregiver to encourage patients to begin a discussion with their primary care provider about their wishes. Patient education is key to ensuring and protecting his/her wishes for advanced directives. Allen et al., (2015) observed that medical residents’ education and curriculum was lacking in its ability to prepare them for code status discussions. As a result of this lack of education, the curriculum was changed and the residents were given a clinical environment to practice this difficult discussion (Allen et al.,
According to the study, 62 out of the 95 students were beginning to initiate advanced directive conversations with more confidence in their ability to do so (Allen et al., 2015).

There was a study conducted, in a lung cancer center, which focused on how to determine when the topic of advanced directives should be approached, what this topic means to the patient and family in regards to code status, and treatment options in different setting such as end of life or emergent care (Ahmed et al., 2015). This study was interesting as the patients and caregivers ultimately wanted to wait for the provider to bring up and discuss the topic of code status (Ahmed et al., 2015). One of the study’s conclusions was that the majority of patients, caregivers, and providers felt it was more appropriate to discuss code status when the patient is initially diagnosed with an incurable disease or when the patient is being referred to a palliative care provider (Ahmed et al., 2015). Despite the lack of a specific time to discuss code status with patients, all of the providers who participated in this study did agree that the code status discussion should be started in an outpatient setting and not in the hospital (Ahmed et al., 2015).

Multiple articles and studies illustrate such a deficit but do not indicate how to create or implement evidence based practice to address this deficit (Anderson, et al., 2011; Detering, Hancock, Reade, & Silvester, 2010; Rhondali, et al., 2013; VanScoy, & Sherman, 2013).

Another area of knowledge deficit is the lack of cohesive communication and standardized approach to discussing advanced directives with patients and families. One study indicated that there is a severe lack of time spent with the patient which can cause a patient and family to experience further stress during an already stressful situation when needing to discuss code status, usually in an emergent setting (Anderson et al., 2011). Rhondali et al. (2013) approached the topic of engaging the patient in regards to advanced directive by either posing a question about wishes or making the recommendation for a specific code status. A systematic
review was conducted which indicated that “most patients and professionals agree that talking about ACP [advanced care planning] should take place around the time of diagnosis of a life-threatening illness, but fear of depriving patients of hope is a barrier preventing GPs from initiating ACP” (De Vleminck et al., 2013, p. 224). Whereas, Detering et al. (2010) had found that interventions based on a patient driven plan of care focusing on advanced care planning had a higher level of patient and family satisfaction with end of life treatments and planning.

Detering et al., (2010) had illustrated with a randomized controlled study that patients who had extended conversations about their code status and tailored it to their specific needs reported more satisfaction with end of life treatments. This satisfaction was in comparison to those patients who did not receive specialized and individualized communication (Detering et al., 2010). This was an interesting study since the control and trial patients were given the similar treatments (Detering et al., 2010). But it was how the treatments were presented and how the communication with the advanced directive planning were presented that ultimately affected the patient’s satisfactory outlook on end of life care (Detering et al., 2010). The idea of starting the conversation of advanced directives with patients in an outpatient setting is a concept that should be further evaluated (Scott, Mitchell, Raymond, & Daly, 2013). Literature has indicated that there is an increased level of stress that patients and their families feel at having to choose a code status, specifically in an emergent situation (Scott et al., 2013). Physician ordered life sustaining treatment (POLST) forms are available and are usually completed based on conversations with the health care proxy. This could pose a possible dilemma for the health proxy. Without having an initial conversation about code status, it would remain unknown what the patient’s wish would have been if he/she were able to make a code status decision. This unknown patient code status can cause an increase in stress for the patient and the family members who have to make
end of life decisions (Ahmed et al., 2015; De Vleminck et al., 2013). These decisions are often made without knowing what the differences with code statuses mean in terms of treatments for the patient (Ahmed et al., 2015; De Vleminck et al., 2013). The development of a toolkit for patients and their providers would assist with ensuring that the patient is fully aware of the implications of a specific code status. This discussion and toolkit completion should begin in the primary care setting and reviewed yearly, ideally during a wellness examination or when a health change/complication occurs. This way the patient and primary provider are creating a plan of care together that can be extended by encouraging family members to become involved with the discussion about advanced directives and planning.

**Theoretical Framework**

The Science of Caring, created by Dr. Jean Watson, guided this project. The theory is based on a holistic approach to patient care (Jean Watson Nursing Theory, 2015). Her theory discusses how there is a “development of a helping-trust relationship, which includes congruence, empathy, and warmth” (Jean Watson Nursing Theory, 2015, para. 12). According to the theory, “the strongest tool a nurse has is his or her mode of communication, which establishes a rapport with the patient, as well as caring by the nurse. Communication includes verbal and nonverbal communication, as well as listening that connotes empathetic understanding” (Jean Watson Nursing Theory, 2015, para. 12). The utilization of Watson’s therapeutic communication with the patient is essential for a code status discussion to be effective. This would allow the patient to ask questions and the provider to not only present specific code status information but would also allow the provider to use verbal and nonverbal cues from the patient. These patient cues would then direct how that information is delivered as well as when the patient may need further clarification. This theory guided the proposed project
by addressing previously stated areas of deficit such as provider’s comfort with topic and the time spent discussing code status.

**Goals and Objectives**

The proposal utilized the acronym of SMART, which is Specific, Measurable, Assignable, Realistic, and Time-specific. The goal of this proposal was to establish a standard for presenting code status options to patients. Implementation of a standardized code status checklist would be beneficial to patients and their family as it would provide a specific list of risks and benefits to each code status. It would allow the patient to be completely informed about code status decisions. This checklist should be reviewed yearly with the patient and the provider.

The goal of creating a standardized code status presentation and checklist has been attained based on the participants’ feedback. Based on the participants’ feedback of the ease of understanding, the checklist was refined. However, the implementation into practice with primary care providers is a long term goal which will require further studies in a postgraduate setting.

**Project Design and Methods**

**Settings and Resources**

The setting of the proposed project was based in an outpatient cardiology practice. The checklist is meant to be used in an outpatient setting where there can be therapeutic conversation, an established patient-provider rapport, and not while in a traumatic/emergent situation. The outpatient office that was be utilized for this proposed code status checklist is a cardiology office which is part of Berkshire Health Systems in Pittsfield, Massachusetts. Interpreter services can
be arranged through Berkshire Health Systems should there be a need for use. Although this service was not needed, it was available for communication.

**Description of the Population**

The population that was evaluated were established patients in an outpatient cardiology practice. The patient population had a wide age variation ranging from young adult to the elderly. The patients’ insurances include private insurance, Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), MassHealth, Medicaid, and Medicare. The age range of the population provided enough of a variable to evaluate if the provided information was easy to understand throughout the lifespan. The study population was asked to provide feedback on the ease of understanding and thoroughness of presented material/checklist.

**Organizational Analysis of Project Site**

The project site is comprised of eight cardiologists, five physicians’ assistants, and two nurse practitioners. There are nurses and medical assistants that work within the practice. This practice offers inpatient heart failure specialties, community outpatient visits (such as nursing facilities and even home visits by the nurse practitioners). This DNP candidate has been in a clinical rotation in this practice and continued to interact with the providers and staff as a member of an interdisciplinary team.

**Evidence of Stakeholder Support**

The DNP candidate’s preceptor had been supportive in the development of clinical scholarship and willingness to allow the code status checklist to be evaluated within the practice (Appendix A).
Facilitators and Barriers

There were several potential facilitators and barriers that may influence the facilitation of this proposed capstone project (Appendix B). Potential barriers included patient’s willingness to participate, length of appointment, education level, literacy, and completion of code status paperwork. Other barriers include a lack of evidence based practices, a standardized list of disclosed risks and benefits to the varied code status, inadequate time with patients, survivability of cardiopulmonary resuscitation, potential complications/deficits post cardiopulmonary resuscitation, and provider’s comfort level with code status and advanced planning discussions. However, facilitators of implementation were the patient’s willingness to have a therapeutic conversation, completion of code status documentation, and the ability to obtain health wishes based on presented questions and perceived health status.

Measurement Instruments

In order to measure the outcomes of this DNP project, the Code Status Checklist Evaluation Survey was utilized (Appendix D). The study results were based on quantitative data on sample size, patient population age, education level, and the number of checklist items that may need to be revised; and qualitative data based on the patient’s perception of understanding of presented code status education. This project was conducted by the DNP candidate. The capstone project evaluated whether a checklist was a realistic way to present code status to patients. The time that has been allotted for this project was realistic and conducted from June 2016 through February 2017.
Data Collection Procedures

The implementation plan for this study was based on the presentation of a proposed code status checklist. The projected recruitment was 10 patients to participate in this study. However, 8 patients were actually recruited. The standard code status discussion which coincides with the checklist was presented to the participants. The participants were then asked a series of questions on a post-presentation survey on the ease of understanding of the presented code status definitions. Based on the participants’ responses to the survey, a revised checklist was completed for further implementation post-graduate.

Cost-Benefit Analysis/Budget

The cost-benefit and budget was minimal to the site, providers, and patients as the DNP candidate provided the involved paperwork (proposed checklist and post-test evaluation). Since this was a trial of the checklist and the DNP candidate conducted the trial, there was not a need to provide education to other providers on the use of the checklist.

Table 1: Estimated Expenses

<table>
<thead>
<tr>
<th>Projected Expenses</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper</td>
<td>$8.00</td>
</tr>
<tr>
<td>Ink Cartridge</td>
<td>$35.00</td>
</tr>
</tbody>
</table>

Timeline

The proposed timeline for the evolution of the code status checklist began in June 2016. At which time, the proposed toolkit was awaiting approval. The implementation phase of the project began in October 2016 and continued until February 2017. The analysis of the completed toolkit was completed in March 2017.
Table 2: Project Timeline

<table>
<thead>
<tr>
<th>Task</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
</tr>
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<tbody>
<tr>
<td>Proposal approval</td>
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<td>X</td>
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<tr>
<td>Recruitment of study subjects</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing code status checklist education</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Post-test and analysis of checklist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Revision of checklist based on analysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Ethics and Human Subjects Protection

The ethical considerations for this checklist included the dissemination of information that patients were provided which will influence their future medical decisions related to their code status and the subsequent treatment based on that status. This checklist utilized up to date information and evidence based practices within the checklist formation. Each participant was informed that the project would comply with Health Insurance Portability and Accountability Act (HIPAA) regulations. Although, there is not a specific intervention that had been implemented, the approval of the Institutional Review Board had been petitioned regarding the use of human subjects related to the potential implication on patient’s future medical decisions based on the presented code status education and checklist. The Institutional Review Board (IRB) deemed that the project was educational and was not subject to an IRB review or approval.
Design

The design for the proposed code status checklist was guided by the Plan-Do-Study-Act (PDSA) (Zaccagnini & White, 2014). The first phase of the project was to develop a code status checklist (Plan), which was based on a patient’s specific need and knowledge deficit. The next phase of the project was to present the checklist to a sample population of providers and patients in an outpatient setting and obtain their feedback on the presented checklist (Do). After receiving survey feedback, the evaluation focused on areas of improvement, further explanation, and clarification (Study). The final phase for the design was to implement changes reported in the previous phase into an improved checklist (Act).

Methods

The method of evaluation for the code status checklist was based on quantitative and qualitative data. The DNP candidate developed a code status checklist that was thorough yet easy for the patient to understand (Appendix C). Therefore, the patient’s perception of the information provided was the primary focus of evaluation. Since this project was based on a trial of ease of access and understanding, this checklist mainly focused on suggestions for change or improvement by the participants, who were asked to evaluate the code status checklist. This DNP candidate then presented the proposed checklist and asked for a post checklist survey evaluation on the ease of understanding the covered material (see Appendix D for survey). In order for the survey to be considered valid, there were basic inclusion requirements. These were a minimum age requirement of at least 18 years of age, minimum level of at least an eighth grade level of education, and without cognitive impairment such as short term memory loss.
Data Analysis

The completed project had 8 patient participants and 1 provider who were presented with the proposed standard code status discussion and checklist. All 9 participants completed the post-presentation survey. However based on the inclusion criteria, one participant was excluded due to short term memory loss and was unable to fully complete the survey due to inability to retain presented information. The participant size was relatively small due to testing the ease of understanding and related to the appropriateness of patient’s disease condition. Data analysis was based on the participants’ opinion of the code status presentation based on the code status checklist evaluation survey.

Quantitative Data

Age

The ages of the 7 participants varied greatly. The age of the provider was not provided and will not be counted towards data analysis. The youngest was 37 years old and the eldest was 90. The mean age was 65 years. The median age was 78 years. There was no mode for participant age.

Sex

There were 4 males and 4 females who completed the final survey.

Education

Each patient was asked the level of completed formal education. Based on the surveys, four of the participants had completed high school, one completed a diploma program post high school, and three participants had completed college level education.
Qualitative Data

This data was based on the 7 participants’ survey answers for each question. Each question asked for the ease of understanding of the presented code status information. The participants were asked to rate the ease of understanding based on a 1 – 5 rating scale (which was 1-strongly disagree, 2-disagree, 3-neutral, 4-agree, and 5-strongly agree).

Question 1

**Was the language used in the code status presentation easy to understand?**

The basis for this question was to evaluate the ease of understanding of the entire code status presentation. The majority (72%) of the participations felt that the overall presentation was easy to understand. The suggested areas of change were to use less medical terms, specifically related to what an arrhythmia was and what were Bipap/cpap machines.

**Chart 1**

![Chart showing survey responses for Question 1](image)

Question 2

**Did the information presented on Full Code status provide you with satisfactory disclosure of the risks and benefits related to this code status?**
This question related to how the participants understood the language and information relating to Full Code status (see Appendix C for full code explanation). Overall this section was easy to understand for 86% of the participants. There was one participant who suggested the use of “more common words”, “not medical terms”, and “treatment options for family”.

Chart 2

**Question 3**

**Did the information presented on Do Not Resuscitate code status provide you with satisfactory disclosure of the risks and benefits related to this code status?**

The provided information on Do Not Resuscitate provided an easier understanding for the majority of patients as all responses were 4 and 5. One comment stated that she understood more of the presented information based on “more common words, not in medical terms”.
Question 4

Did the information presented on Do No Intubate code status provide you with satisfactory disclosure of the risks and benefits related to this code status?

The results of this question were similar to question 3. The majority of the participants felt that the Do Not Intubate information was easy to understand based on reported 4 and 5 scores to the question. There were no suggested areas of change for the Do Not Intubate code status information.
Question 5

After the presentation, were you able to have a more comprehensive understanding of what each code status would mean for you relating to procedures and treatment options?

After each code status description, there was a list of treatments/procedures that each code could include. This portion of the presented material was easy to understand by 86% of the participants. There was only one participant who offered an opinion for change. This was to make it “more down to someone’s understanding other than medical”.

Chart 5

Discussion

The results of the code status checklist were promising as there was positive feedback relating to the ease of understanding of the information that was provided. Based on feedback on the overall presentation, slight changes were made to the final code status checklist (see Appendix E). Although not a part of the proposed study, it was interesting to speak with the participants about where they first heard about code status. 43% of the participants’ first exposure to code status was while they were facing an acute illness and hospitalization. Another
14% of the participants had never heard of code status before this presentation. This further illustrates that there is a need to have meaningful conversations with patients in an outpatient setting regarding code status based on the current literature and the results of this ease of understanding.

**Conclusion**

The relationship that a patient has with a provider is meant to be built on trust and mutual disclosure of pertinent information for a care plan can be developed. However, there is a deficit with information that is disclosed relating to code status. There are numerous barriers that have been identified between provider and patient such as a lack evidence based practices, provider comfort with discussion, patient’s understanding of provided information, and completion of the necessary paperwork. These are just a few of the barriers that are preventing code status discussions from beginning initiated in the primary care setting. Having a therapeutic conversation with the patient while in an outpatient setting is the ideal time and setting to introduce code status education. This can be initiated in the patient’s yearly physical where there is more time allotted for discussion. The creation of a standardized checklist that outlines the risks and benefits to each code status (full code, DNR, DNI) will ensure that each patient is being provided with full disclosure to each code status and are therefore able to make an informed decision.
References


Graph A: Introduction to Code Status

INTRODUCTION OF CODE STATUS

- Acute Hospitalization: 29%
- Medical Field: 14%
- Never Heard of Code Status: 14%
- No Answer: 43%
Appendix A

Key Stakeholder Letter of Agreement

[address]

[date] 2/12/16

To Whom It May Concern:

I am the Director of the DNP Program at the University of Massachusetts, Amherst, College of Nursing. I am writing this letter on behalf of [Key Stakeholder Name], your student preceptor. Your student is planning to complete the pinnacle requirement for the Degree, a DNP Capstone Project, in your facility. Your student will be designing, implementing, and evaluating the impact of translating a programmatic intervention into your practice or setting. As these projects are considered performance improvement, quality improvement, or program evaluation projects and not research studies, the University does not require Institutional Review Board (IRB) permission for this student to actualize the project as outlined by the student and approved by preceptor(s) within your facility. I am using this letter as a "Key Stakeholder" commitment letter for the student to use in the DNP Capstone Project Proposal. A Graduate faculty member of the College of Nursing will also be working directly with your student as Chair of the DNP Capstone Project Committee.

Thank you in advance for allowing this student to actualize the DNP Capstone Project in your facility. If you have any questions, please call me at 413-545-5089 or email paselton@nursing.umass.edu.

Key Stakeholder Signature: [Signature] Date: 2/12/16

Student Signature: [Signature] Date: 2/12/16

Sincerely,

Pamela Asleton

Pamela Asleton, PhD, FNP-BC
Associate Professor
Director DNP Program

The University of Massachusetts is an Affirmative Action/Equal Opportunity Institution
## Appendix B

### Potential Barriers and Facilitators

<table>
<thead>
<tr>
<th>Best Practice Solution/s</th>
<th>Best Practice Strategies (Bullet list)</th>
<th>How the Community/Clinical Site Differs From Best Practice (Bullet List)</th>
<th>Potential Barriers and Facilitators that can overcome the Barriers to Best Practice Implementation (Bullet list and separate)</th>
</tr>
</thead>
</table>
| Implement a checklist tool that is completed by physician and patient to assist with offering full disclosure on all code status and what each code status entails. | - Provide written information to all adult patients about each code status before discussion. | - Currently the only information that is provided to patients is what is verbally discussed by the physician at time of code decision and is variable per physician. | Barrier: Patients may not be willing to read provided material, literacy, visual impairment may all present a challenge to providing written material.  
Facilitator: Open discussions with the patient about their health wishes should their current health status either decline or an emergent situation were to occur and begin to incorporate details from the provided information. |
| | - Initiate discussion about what each code status entails for the patient, including what happens during a code, the potential survivability, and the potential post-code complications/deficits. | - Currently the only information that is provided to patients is what is verbally discussed by the physician at time of code decision and is variable. | Barriers: Patient’s willingness to participate with discussion, provider’s comfortability with discussing life sustaining treatments as well as palliative care, and appointment length.  
Facilitator: Validate any concerns from the patient and/or family. Encourage questions, attempt to establish a therapeutic dialogue to facilitate a trusting relationship. |
| **Initiate discussion about what each code status entails for the patient, including what happens during a code, the potential survivability, and the potential post-code complications/deficits.** | **Currently the only information that is provided to patients is what is verbally discussed by the physician at time of code decision and is variable.** | **Barriers:** Patient’s willingness to participate with discussion, provider’s comfortability with discussing life sustaining treatments as well as palliative care, and appointment length

**Facilitator:** Validate any concerns from the patient and/or family. Encourage questions. Attempt to establish a therapeutic dialogue to facilitate a trusting relationship. |

**Complete code status checklist after discussion with patient to ensure all points were discussed and the patient is aware of the risks and benefits to each code status.** | **Currently there is no accountability for the information provided to the patient about what was discussed in regards to the specific interaction, information, and teaching that was provided to the patient and the outcome.** | **Barriers:** Patient’s willingness to participate with the discussion and the appointment length.

**Facilitator:** Allows for documentation that the patient participated and was given full disclosure about each code status. This would be part of the patient’s health record and could be recalled for further discussion with the patient before code status is obtained. |

**Complete a MOLST form after the completion of the code status checklist.** | **Currently an inpatient may choose to be a DNR/DNI but unless they are transferred to another facility, the paperwork is not consistently completed.** | **Barriers:** Wanting to complete paperwork at home.

**Facilitator:** Encourage the patient to complete the paperwork while in office in case of further questions and it can be electronically entered. If patient still wants to bring paperwork at home, set up a follow up phone call or office visit to finish paperwork. |
Appendix C
Code Status Checklist

Patient:___________________________________

Date of Birth:______________________________

Initial background data to obtain from patient:

1). Does the patient have a Health Care Proxy form filled out? Yes No
   
   If yes, who is the designee:_________________________________________

2). Does the patient have a POLST, MOLST, or living will? Yes No
   
   If yes, is it on file? Yes No

3). List medical history:___________________________________________________
   ________________________________________________________________

4). What are the patient’s initial thoughts on quality of life in the event of a terminal illness or
   life threatening illness? ____________________________________________________
   ________________________________________________________________
   ________________________________________________________________

5). When is this conversation being initiated? Primary Care Office Acute Care

   Code Status Discussion

   Full Code

   In the event that your heart stops and your body is not breathing on its own, cardiopulmonary resuscitation (CPR) will be started. This is a multiple set process. Chest compressions will be started. This is where a trained individual will begin hard, fast, and frequently compressions to your chest. This helps to circulate your blood to bring oxygen to your brain and other organs. You will receive rescue breaths. This may be done with a mouth/barrier
method or once advanced medical treatment is available an artificial airway (breathing tube) will be placed. The use of an automated external defibrillator (AED) is to assess for an underlying heart arrhythmia. If there is an arrhythmia that is detected and will be corrected by defibrillation (electric shock), then you will receive the shock. This cycle will continue of chest compressions, rescue breathing, and AED assessment until you wake, family/health care proxy stops the resuscitation, or the physician has determined that the patient will not survive even with continue CPR. In the event that your heart is restarted and breathing is maintained, you will be admitted for medical treatment and observation.

**Treatment can include:**

<table>
<thead>
<tr>
<th>Medical induce coma</th>
<th>Artificial Airway</th>
<th>Artificial Ventilation (Breathing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication to maintain blood pressure</td>
<td>Supplemental Oxygen</td>
<td>BiPap/CPap</td>
</tr>
<tr>
<td>Pacemaker/Defibrillation placement</td>
<td>Recurrent CPR if heart or breathing stops</td>
<td></td>
</tr>
</tbody>
</table>

Nasogastric tube (feeding tube that is inserted through the nose to the stomach for nutrition and medication) Intravenous hydration/fluids Supplemental nutrition

**Discussion with Patient**

1). With Full Code, there is not a survivability guarantee. Although every life sustaining effort will be made, there are multiple factors that are may affect survival such as complex medical conditions as listed_________________________________________________________.

Does the patient have concerns or questions? Yes No

If yes, list concerns__________________________________________________________

2). There may be a risk of broken ribs with chest compressions. This is related to the need to provide high quality CPR with provided circulation when your heart is not.

Does the patient have concerns or questions? Yes No

If yes, list concerns__________________________________________________________

3). Depending on your medical history, there is a risk with an artificial airway or breathing tube and ventilator which provides artificial breathing, that you may not be able to be weaned or taken
off of the ventilator. This may require a tracheotomy, which is a surgical procedure to place an artificial airway in the neck.

Does the patient have concerns or questions? Yes No

If yes, list concerns__________________________________________________________

4). Depending on the period of time before CPR was started, there may be residual health effects such as organ damage, physical deficits, or psychological trauma.

Does the patient have concerns or questions? Yes No

If yes, list concerns__________________________________________________________

After discussing Full Code Status, ask the patient to provide teach back on the information that they were educated on and list what they state: ________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Do Not Resuscitate

A do not resuscitate (DNR) is when a person has decided that they do not wish to have chest compressions initiated to restart their heart. This wish needs to be decided by the patient and a physician order is needed that states DNR. This does not mean that you will not receive treatment. In the event that you stop breathing, efforts will be made to continue respiratory or breathing support. This can include supplemental oxygen by nasal cannula or mask, BiPAP, CPAP, or by the placement of an artificial airway and ventilator assistance (breathing machine). There is the availability of medications to help support your blood pressure. This will not help should the heart stop. Should the heart stop, respiratory support will continue until the physician assess that the heart will not restart. At which time, respiratory support will be stopped and death will occur.

Treatment can include:

Medical induce coma   Artificial Airway   Artificial Ventilation (Breathing)
Medication to maintain blood pressure  Supplemental Oxygen  BiPap/CPap

Nasogastric tube (feeding tube that is inserted through the nose to the stomach for nutrition and medication).  Intravenous hydration/fluids  Supplemental nutrition

**Discussion with Patient:**

1). With a DNR, there will not be efforts to restart the heart once it stops.

Does the patient have concerns or questions?  Yes  No

If yes, list concerns____________________________________________________

2). With a DNR, you will still receive medical treatment in an emergent situation with the exception of chest compressions.

Does the patient have concerns or questions?  Yes  No

If yes, list concerns____________________________________________________

After discussing Do Not Resuscitate Code Status, ask the patient to provide teach back on the information that they were educated on and list what they state:________________________
________________________________________________________________
________________________________________________________________

**Do Not Intubate**

With a Do Not Intubate code status, a patient has decided that they do not wish to have an artificial airway or mechanical ventilation. There does need to be a physician’s order for a DNI. There are other non-invasive treatment options should the patient begin to have respiratory or breathing problems. These options include supplemental oxygen (nasal cannula or mask), BiPap, CPAP, or in the event of requiring CPR mouth/barrier breathing or mask/ambubag. These will assist with breathing difficulties but will not provide artificial breathing should the patient stop breathing. A patient can still receive CPR but without the placement of an artificial airway. In the
event that breathing has stopped, and the physician has assessed that spontaneous breathing will not occur, then treatment or CPR will be stopped and death will occur.

**Treatment can include:**

Medical induce coma  Supplemental Oxygen  BiPap, CPap  
Medication to maintain blood pressure  Pacemaker/Defibrillation placement  
Nasogastric tube (feeding tube that is inserted through the nose to the stomach for nutrition and medication).  Recurrent CPR/chest compressions if heart stops  
Intravenous hydration/fluids  Supplemental nutrition

**Discussion with Patient:**

1). With a DNI, there will not be efforts to place an artificial airway and mechanical ventilation once spontaneous breathing stops.

Does the patient have concerns or questions?  Yes  No  
If yes, list concerns____________________________________________________

After discussing Do Not Intubate Code Status, ask the patient to provide teach back on the information that they were educated on and list what they state:________________________

________________________

________________________

________________________

________________________

With the completion of discussion with patient, does the patient have a code status decision?  
If yes, please list____________________________________________________

If no, please reason____________________________________________________

In the event that the patient does decide on a Code Status, ensure that POLST/MOLST is completed.

Completed and documented on ________________________________
If not completed, list reason__________________________________________

Ensure the patient that if they were to have health changes or want to change their code status, that they are able to do so at any time. Inform them that they will need to have their POLST/MOLST forms changed to reflect their current wishes. Informed Not Informed

Encourage patients and their family or health care proxy to have discussions about advanced planning and code status frequently to ensure the patient’s wishes are made and respected.

Upon completion of checklist

Patient Signature:__________________________________________________________

Provider Signature:________________________________________________________

Date:_______________________________________________________________________
Appendix D
Code Status Checklist Evaluation Survey

Please evaluate the presented code status information and your understanding of the topics that were covered.

1). Was the language used in the code status presentation easy to understand?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Suggested areas of change:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

2). Did the information presented on Full Code status provide you with satisfactory disclosure of the risks and benefits related to this code status?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Suggested areas of change:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

3). Did the information presented on Do Not Resuscitate code status provide you with satisfactory disclosure of the risks and benefits related to this code status?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Suggested areas of change:
______________________________________________________________________________
4). Did the information presented on Do No Intubate code status provide you with satisfactory disclosure of the risks and benefits related to this code status? 

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Suggested areas of change: ________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________


5). After the presentation, were you able to have a more comprehensive understanding of what each code status would mean for you relating to procedures and treatment options? 

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
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<td>5</td>
</tr>
</tbody>
</table>

Suggested areas of change: ________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________
Appendix E

Finalized Code Status Checklist

Patient:___________________________________

Date of Birth:______________________________

Initial background data to obtain from patient:

1). Does the patient have a Health Care Proxy form filled out? Yes No
   
   If yes, who is the designee:_________________________________________

2). Does the patient have a POLST, MOLST, or living will? Yes No
   
   If yes, is it on file? Yes No

3). List medical history:___________________________________________________

_____________________________________________________________________

4). What are the patient’s initial thoughts on quality of life in the event of a terminal illness or life threatening illness? _____________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

5). When is this conversation being initiated? Primary Care Office Acute Care

Code Status Discussion

Full Code

In the event that your heart stops and your body is not breathing on its own, cardiopulmonary resuscitation (CPR) will be started. This is a multiple set process. First, chest compressions will be started. This is where a trained individual will begin hard, fast, and frequent compressions to your chest. This helps to circulate your blood to bring oxygen to your brain and other organs. Then you will receive rescue breaths. This may be done with either a
mouth/barrier method or once advanced medical treatment is available an artificial airway (breathing tube) will be placed. The use of an automated external defibrillator (AED) is to assess for an underlying heart arrhythmia which is an irregular heart rate or rhythm. If there is an arrhythmia that is detected and will be corrected by defibrillation which is an electric shock in an attempt to correct the arrhythmia. This cycle will continue of chest compressions, rescue breathing, and AED assessment until you either wake, or family/health care proxy stops the resuscitation, or the physician has determined that you will not survive even with continue CPR. In the event that your heart is restarted and/or breathing is maintained, you will be admitted for medical treatment and observation.

Treatment can include:

Medical induce coma       Artificial Airway       Artificial Ventilation (Breathing)
Medication to maintain blood pressure       Supplemental Oxygen
BiPap/CPap (these are machines that are non-invasive to provide breathing support without a breathing tube)
Pacemaker/Defibrillation placement       Recurrent CPR if heart or breathing stops
Nasogastric tube (feeding tube that is inserted through the nose to the stomach for nutrition and medication).       Intravenous hydration/fluids       Supplemental nutrition

Discussion with Patient

1). With Full Code, there is not a survivability guarantee. Although every life sustaining effort will be made, there are multiple factors that are may affect survival such as complex medical conditions as listed___________________________________________________________.

Does the patient have concerns or questions?       Yes       No

If yes, list concerns______________________________________________________________

2). There may be a risk of broken ribs with chest compressions. This is related to the need to provide high quality CPR with provided circulation when your heart is not.

Does the patient have concerns or questions?       Yes       No
If yes, list concerns_______________________________________________

3). Depending on your medical history, there is a risk with an artificial airway or breathing tube and ventilator which provides artificial breathing, that you may not be able to be weaned or taken off of the ventilator. This may require a tracheotomy, which is a surgical procedure to place an artificial airway in the neck.

Does the patient have concerns or questions? Yes No

If yes, list concerns_______________________________________________

4). Depending on the period of time before CPR was started, there may be residual health effects such as organ damage, physical deficits, or psychological trauma.

Does the patient have concerns or questions? Yes No

If yes, list concerns_______________________________________________

After discussing Full Code Status, ask the patient to provide teach back on the information that they were educated on and list what they state:__________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

Do Not Resuscitate

A do not resuscitate (DNR) is when a person has decided that they do not wish to have chest compressions initiated to restart their heart. This wish needs to be decided by the patient and a physician order is needed that states DNR. This does not mean that you will not receive treatment. In the event that you stop breathing, efforts will be made to continue respiratory or breathing support. This can include supplemental oxygen by nasal cannula or mask, BiPAP, CPAP, or by the placement of an artificial airway and ventilator assistance (breathing machine). There is the availability of medications to help support your blood pressure. This will not help should the heart stop. Should the heart stop, respiratory support will continue until the physician assess that the heart will not restart. At which time, respiratory support will be stopped and death will occur.
TREATMENT CAN INCLUDE:

- Medical induce coma
- Artificial Airway
- Artificial Ventilation (Breathing)
- Medication to maintain blood pressure
- Supplemental Oxygen
- BiPap/CPap (these are machines that are non-invasive to provide breathing support without a breathing tube)
- Nasogastric tube (feeding tube that is inserted through the nose to the stomach for nutrition and medication).
- Intravenous hydration/fluids
- Supplemental nutrition

DISCUSSION WITH PATIENT:

1). With a DNR, there will not be efforts to restart the heart once it stops.

Does the patient have concerns or questions? Yes No

If yes, list concerns____________________________________________________

2). With a DNR, you will still receive medical treatment in an emergent situation with the exception of chest compressions.

Does the patient have concerns or questions? Yes No

If yes, list concerns____________________________________________________

After discussing Do Not Resuscitate Code Status, ask the patient to provide teach back on the information that they were educated on and list what they state:

___________________________________________________________________________

___________________________________________________________________________

DO NOT INTUBATE

With a Do Not Intubate code status, a patient has decided that they do not wish to have an artificial airway or mechanical ventilation. There does need to be a physician’s order for a DNI. There are other non-invasive treatment options should the patient begin to have respiratory or breathing problems. These options include supplemental oxygen (nasal cannula or mask), BiPap,
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**Treatment can include:**

Medical induce coma  
Supplemental Oxygen

BiPap/CPap (these are machines that are non-invasive to provide breathing support without a breathing tube)

Medication to maintain blood pressure  
Pacemaker/Defibrillation placement

Nasogastric tube (feeding tube that is inserted through the nose to the stomach for nutrition and medication).  
Recurrent CPR/chest compressions if heart stops

Intravenous hydration/fluids  
Supplemental nutrition

**Discussion with Patient:**

1). With a DNI, there will not be efforts to place an artificial airway and mechanical ventilation once spontaneous breathing stops.

Does the patient have concerns or questions?  
Yes  
No

If yes, list concerns___________________________________________________________________________

After discussing Do Not Intubate Code Status, ask the patient to provide teach back on the information that they were educated on and list what they state:_____________________________

_______________________________________________________

___________________________________________________________________________

With the completion of discussion with patient, does the patient have a code status decision?  
If yes, please list___________________________________________________________
If no, please reason____________________________________________________

In the event that the patient does decide on a Code Status, ensure that POLST/MOLST is completed.

Completed and documented on ____________________________________________

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Encourage patients and their family or health care proxy to have discussions about advanced planning and code status frequently to ensure the patient’s wishes are made and respected.

Upon completion of checklist

Patient Signature:__________________________________________________________

Provider Signature:________________________________________________________

Date:_______________________________________________________________________