

June 2016

Can Faith Community Nurses Successfully Teach Parishioners About Advance Health Care Planning?

Joy D. Kimbrell
Cumberland University

Cynthia Powers
Union University

Follow this and additional works at: <http://digitalcommons.wku.edu/ijfcn>

 Part of the [Medicine and Health Sciences Commons](#)

Recommended Citation

Kimbrell, Joy D. and Powers, Cynthia (2016) "Can Faith Community Nurses Successfully Teach Parishioners About Advance Health Care Planning?," *International Journal of Faith Community Nursing*: Vol. 2: Iss. 2, Article 4.
Available at: <http://digitalcommons.wku.edu/ijfcn/vol2/iss2/4>

This Article is brought to you for free and open access by TopSCHOLAR®. It has been accepted for inclusion in International Journal of Faith Community Nursing by an authorized administrator of TopSCHOLAR®. For more information, please contact topscholar@wku.edu.

In our society, there is a general reluctance to discuss mortality and plan for the end-of-life as evidenced by the low percentage of individuals who have completed advance health care directives (AHCDs). This lack of planning has resulted in many individuals receiving unwanted, futile, and/or expensive health care at the end of their lives.

In 1990, Congress passed legislation (H.R. Res. 5835, 1990), commonly referred to as the Patient Self-Determination Act (PSDA), to reinforce individuals' constitutional right to determine their final health care. The intent of the PSDA was that individuals specify in advance what medical treatment they desire if they cannot speak for themselves. Unfortunately, despite this good intentioned law, 90% of those admitted to skilled care units lack AHCDs (Van Leuven, 2012) and only one-third of Americans have actually completed them for themselves (Morhaim & Pollack, 2013). Reasons for lack of completion of AHCDs may include reluctance to have "the talk" by healthcare providers and individuals, lack of readiness to discuss issues, discomfort with discussions, time constraints, procrastination, and delays until a crisis (Butterworth, 2003). Other reasons include lack of information regarding advance directives, confusing language, and lack of help completing the paperwork (Morhaim & Pollack, 2013).

The low percentage of completion of AHCDs in the United States has been declared an imperative public health concern, requiring attention to ensure that health care delivery reflects the preferences, beliefs, and values of individuals and their families (American Academy of Nursing-The Palliative and End of Life Care Expert Panel [AAN Palliative], 2013). The Centers for Disease Control and Prevention (CDC) recognized the public health opportunity to educate Americans about advance care planning and to improve their quality of care at the end of life

(Benson & Aldrich, 2012). In a recent article in the *Journal of Christian Nursing*, Maureen Kroning (Kroning, 2014) outlined the critical need for advance directives education for nurses. She demonstrated that a two-hour in-service regarding AHCDs utilizing adult learning principles can prepare nurses for teaching this material.

The Institute for Healthcare Improvement developed a framework, The Triple Aim, to enhance health system performance in the United States with the stated goals to improve the patient experience of care (including quality and satisfaction), to improve the health of populations, and to reduce health care costs ("IHI Triple Aim," n.d.). One of the strategic initiatives to meet these goals is a project with the target of engaging the public in having conversations with their family and friends about wishes for end-of-life care ("The Conversation Project," n.d.).

Because of the difficulties individuals and their families may encounter in having "the talk" and completing AHCDs, this discussion and information may best come from those who are trusted by most: nurses and church/religious sources. Registered nurses are best qualified to lead this type discussion since they have been consistently ranked as the most trusted health-care professional (American Nurses Association (ANA, 2013). Other authors have noted that registered nurses are in a unique position to educate individuals on AHCDs (Robinson, Eagen, & Price, 2008), as well as to help individuals complete them (Jezewski, Meeker, & Schrader, 2003). Since the church/religious atmosphere is one in which people feel supported, comfortable, and secure, it is an ideal environment to guide and direct difficult conversations and topics that may threaten many. If we can't talk comfortably about uncomfortable topics and situations in our church, where else can we talk?

To address this critical need of assisting a larger percentage of the population in planning for their end-of-life care, the authors developed a pilot study to determine if faith community nurses or nurses teaching in a Christian environment could make a difference in addressing the difficulties of having “the talk” about end-of-life wishes, advance health care planning (AHCP), and AHCDs, and to evaluate if this session would increase the knowledge of community members about these topics. The research question for this study asked, “In adults, age 18 years old and older, will a registered nurse facilitated community educational session for AHCP/AHCDs, using the *Caring Conversations*© workbook, increase attendees’ self-perception of knowledge regarding AHCP/AHCDs?” The study was reviewed and approved by the senior pastor of the church and the Union University Institutional Review Board.

The authors developed and implemented a registered nurse-facilitated educational session to teach individuals about AHCDs/AHCP. The session, held at a Protestant church, was taught by an experienced faith community registered nurse educator with extensive teaching experience, an understanding of the principles of adult learning, and knowledge of AHCDs/AHCP.

Methods

Participants

Volunteer participants were recruited in a medium-sized Protestant church and in the surrounding community to take part in the educational program and study. Requirements for participants to be included were the following: adults age 18 and older, ability to be present for and voluntarily take part in the session, ability to provide informed consent, ability to read and understand the English language, ability to sit for three hours (with breaks) to listen to presentation,

ability to complete a pre-session survey, attend the educational session, and then complete a post-session survey.

Protocol

The authors recruited voluntary participants who were interested in learning about AHCDs through the church newsletter, announcements during church services, church online web site and Facebook page, flyers posted in Sunday school classroom and general church bulletin boards, and announcements read by Sunday school class presidents. The authors obtained informed consent after explaining the study and intent of the educational session. Participants were reminded at the beginning of the session that participation was voluntary, that they did not have to consent to participate in the study in order to stay for the educational session, and that if they did consent to participate in the study they could withdraw at any time. Anonymity was preserved by assigning a number to each participant's pre-survey, which participants added to post-surveys. Participants completed a de-identified pre-session survey developed by the authors regarding their self-perception of knowledge of components of the session. A simple four point rating scale (1 = Not knowledgeable; 2 = Somewhat knowledgeable; 3 = Knowledgeable; 4 = Very knowledgeable) was used to measure self-perception of knowledge.

Figure 1. Pre- and post-session survey questions piloted in this study

	Not knowledgeable	Somewhat knowledgeable	Knowledgeable	Very knowledgeable
Durable power of attorney for health care				
Appointment of health care agent				
Living will/advance health care plan				
When an advance care plan becomes effective				
When an advance care plan is revoked				
Changing an advance care plan				
How to let others know my wishes if I am unable to express myself				

The educational content was developed by the authors and used for the pilot. It included basic content on advance directives and advance care planning including appointment of a health care agent. The program was presented by an experienced faith community nurse and included active and passive learning

modalities: PowerPoint lecture which defined key concepts to organize and guide discussion, demonstration of state Advance Care Plan and Health Care Agent forms, question and answer segments with notes for attendees, videos, role play to demonstrate how to talk to family members about their wishes, and the use of *Caring Conversations*© workbook (Center For Practical Bioethics, 2012; used with permission). Each participant used the workbook to reflect and record their individual preferences and feelings about end-of-life choices. Participants then completed a de-identified post-survey after the educational content regarding their self-perception of knowledge of components of the session.

Statistical Analysis

Data from attendees who did not sign the informed consent were not analyzed and were excluded; data from incomplete pre-surveys or post-surveys were not analyzed and were excluded. Thirty-nine completed matching pre- and post-surveys were analyzed.

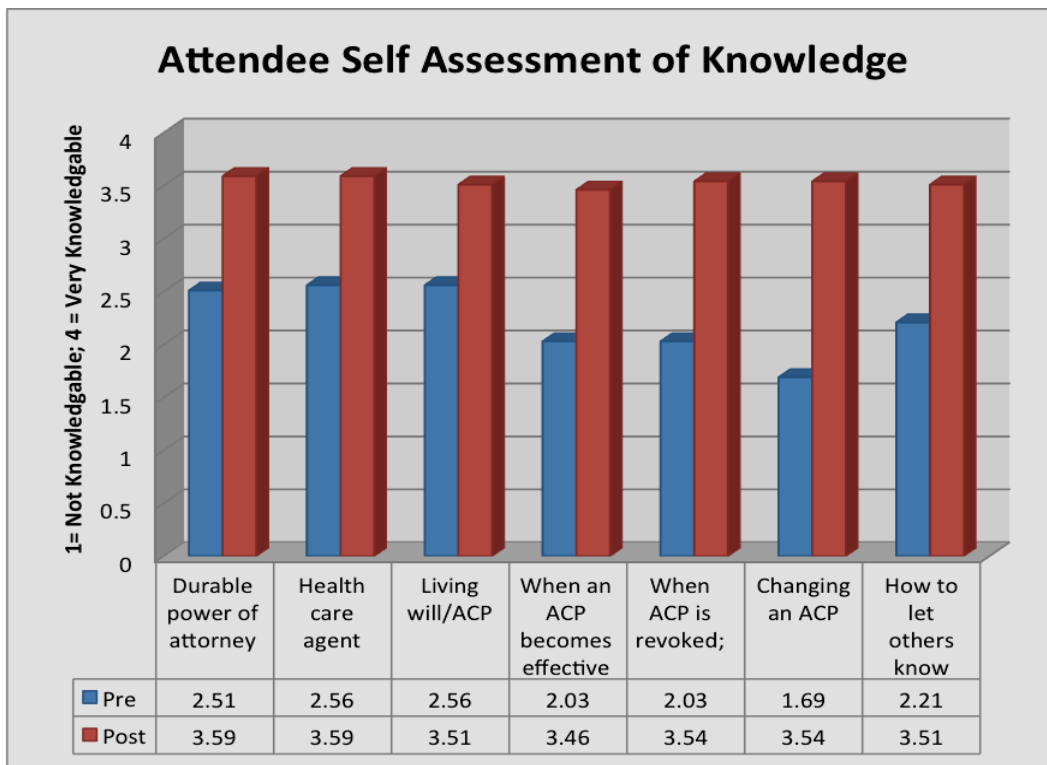
Quantitative analysis using the Statistical Package for the Social Sciences on self-perception of knowledge of the specific components of the educational session was conducted to determine if knowledge was increased after attending the faith community nurse-facilitated session (pre-survey was statistically compared to post-survey).

Results

Prior to the session, participants indicated they had the most knowledge about the durable power of attorney for health care (2.51/4.0), the appointment of a health care agent (2.56/4.0), and living wills/advance care plans (2.56/4.0). Participants indicated they had the least knowledge about changing an advance care plan (1.69/4.0), followed by when an advance care plan becomes effective

(2.03/4.0), and when an advance care plan is revoked (2.03/4.0). After completing the educational and interactive session participants rated their knowledge higher for every aspect measured. The largest increase was knowledge related to changing an advance care plan (3.54/4.0), followed by when an advance care plan is revoked (3.54/4.0), and when an advance care plan becomes effective (3.46/4.0).

Figure 2. Attendee Self Assessment of Knowledge



Forty-two subjects attended the educational session. Thirty-nine (93%) subjects completed both the pre- and post-session surveys making them eligible to participate in the study. The paired-samples test compared the pre-session survey score with the post-session survey scores and was statistically significant at the

p=0.000 level. Two-tailed T-testing indicated the null-hypothesis which stated that pre- and post-session surveys would demonstrate no change in perceived knowledge was rejected. Comparing pre- and post-session survey scores indicated that attendees gained knowledge about AHCDs including information on durable power of attorney, health care agent, AHCP (when an advance care plan becomes effective, when it is revoked, and how it can be changed), and how to let others know about their wishes. Data indicated that perceived knowledge of the attendees increased for all parameters measured.

Discussion

An educational session by a registered nurse in a Christian environment utilizing a PowerPoint presentation, question and answer, and role playing formats is an effective method of teaching individuals about having “the talk” and learning about AHCP/AHCDs as indicated by the increase in perceived knowledge scores on each data point measured. The authors’ experience in this pilot study suggested that the church is an ideal setting for creating a safe, secure environment for engaging community members to learn about AHCDs and the importance of having meaningful conversations with family and friends. As discussed above, nurses are the members of the health care team that are viewed as advocates and educators and are in a unique position of providing this needed education.

The use of role play allows the community members to practice having conversations regarding the end-of-life wishes with family members. Role play also provides community members for strategies to deal with family members who are uncomfortable or reluctant to discuss advance care planned.

Recommendations for Future Actions and Studies

Based on the results from this study, the authors recommend that the curriculum for the Foundations of Faith Community Nursing course include information for educating members of the community and their congregations about AHCP/AHCDs. A pre-developed, standardized PowerPoint and script for role playing could be developed based on this study and Kroning's work and housed at the International Parish Nurse Resource Center for nurses to use. *Caring Conversation*© workbooks are effective for helping parishioners record their wishes and feelings and could be provided by churches. Future studies could be conducted to determine if the percentage of community and congregational members with completed AHCDs would increase in churches that had a nurse offer these educational sessions on an annual or semi-annual basis.

References

- American Academy of Nursing-The Palliative and End of Life Care Expert Panel. (2013). Advance care planning as an urgent public health concern. Retrieved from <http://www.aannet.org/policy-brief--advance-care-planning-as-an-urgent-public-health-concern--2013->
- American Nurses Association. (2013, December 16). *Nurses retain top spot as most ethical profession* [Press release]. Retrieved from <http://www.nursingworld.org/FunctionalMenuCategories/MediaResources/PressReleases/Nurses-Most-Ethical-Profession.pdf>
- Benson, W. F., & Aldrich, N. (2012). Advance care planning: Ensuring your wishes are known and honored if you are unable to speak for yourself. Retrieved from <http://www.cdc.gov/aging/pdf/advanced-care-planning-critical-issue-brief.pdf>
- Butterworth, A. M. (2003). Reality check: 10 barriers to advance planning. *Nurse Practitioner*, 28(5), 42-43.
- Caring conversations. (2012). In *Caring conversations: Making your health care wishes known*. Retrieved from <http://www.cpbmembers.org/documents/Caring-Conversations.pdf>

- Jezewski, M., Meeker, M., & Schrader, M. (2003). Voices of oncology nurses: What is needed to assist patients with advance directives. *Cancer Nursing*, 26(2), 105-112.
- Kroning, M. (2014). Advance directives education: A critical need. *Journal of Christian Nursing*, 31(4), 220-225. Retrieved from http://journals.lww.com/journalofchristiannursing/Abstract/2014/12000/Advance_Directives_Education__A_Critical_Need.8.aspx
- Morhaim, D. K., & Pollack, K. M. (2013). End-of-life care issues: A personal, economic, public policy, and public health crisis. *American Journal of Public Health*, 103(6), e8-e10. <http://dx.doi.org/10.2105/AJPH.2013.301316>
- Patient Self Determination Act of 1990, H.R. Res. 5835, 101st Cong., Public Law No: 101-508 Library of Congress-Thomas (1990) (enacted).
- Robinson, R., Eagen, M., & Price, T. (2008). Innovative solutions: Taking advance directives to the community. *Dimensions of Critical Care Nursing*, 27(4), 154-156.
- The IHI triple aim initiative. (n.d.). Retrieved from <http://www.ihl.org/Engage/Initiatives/TripleAim/pages/default.aspx>
- The conversation project. (n.d.). Retrieved from <http://theconversationproject.org/>

Van Leuven, K. (2012). Advanced care planning in health service users. *Journal of Clinical Nursing*, 21(21/22), 3126-3133.

<http://dx.doi.org/10.1111/j.1365-2702.2012.04190.x>