

Advance Directives in Long-Term Care: Implementation of Five Wishes

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Abstract

Background and Purpose The lack of an advance directive (AD) can predispose a person to an aggressive course of treatment despite their wishes. When AD's are incomplete, the chances of unwanted procedures, such as tube feedings and repeated transitioning between nursing homes and hospitals often result in the risk of increased mortality and morbidity, especially for older adults. Making end-of-life decisions can improve the quality of death by allowing individuals to make decisions to die in a dignified manner. The purpose of this project was to improve AD completion rates by implementing "Five Wishes" (FW) into the admission process in a long-term care facility (LTCF).

Methods The project took place on the skilled nursing units at a LTCF in Southwestern Arizona over a 2-month period of time. Twenty random charts were assessed before the start of the project to determine the residents AD status. Those 20 were then informed about FW's and encouraged to complete one, along with all newly admitted residents to the skilled nursing units. Logs were used for data collection and each participating resident signed a HIPPA document. Descriptive statistics were used to describe the sample and outcome variables.

Outcomes Of the 20 current residents included in the quantitative chart assessment, 6 (30%) residents completed a FW's document. Fifty residents were admitted during the project span and 21 (42%) of them completed FW's.

Conclusions The FW's completion rates were lower than expected. None of the residents had an AD more detailed than a basic full code or do not resuscitate (DNR) status before being informed of FW's. It is recommended that the facility social workers would have implemented the intervention to increase the likelihood of adherence.

Keywords: Advance directives, Five Wishes, long-term care facility, skilled nursing units.

Advance Directives in Long-Term Care: Implementation of Five Wishes

The lack of an advance directive (AD) can predispose a person to an aggressive course of treatment despite their wishes. When AD's are incomplete, the chances of receiving tube feedings, transitioning between nursing homes and hospitals, and the possibility of dying in a hospital increases (Kossmann, 2014).

Background and Significance

Advance directives are legal documents that allow patients to specify their end-of-life wishes and desires. Unfortunately, many older adults in America are without advance directives (Dharmarajan, 2012). Sommer et al. (2012) assessed the advance directives of residents in 11 nursing homes, finding only 11% had an AD and greater than 83% of those ADs failed to state what to do if the patient became incapable of consenting to treatment. The lack of an advanced directive can predispose a person to receive an aggressive course of treatment despite their wishes to pursue a palliative or less zealous direction of end of life care. Making end-of-life decisions improves the individual's quality of death by reducing transfers to the emergency department and aggressive care during the terminal phase. Lastly, these decisions may result in an earlier referral to hospice (Abele & Morley, 2016)

Ni et al. (2014) assessed nursing home residents' knowledge about advance directives. Of the subjects, 95.3% had never heard of an AD and 65.5% stated they were reluctant to completing an AD because they were not familiar with them. AD education for nursing home residents has the potential of increasing familiarity and completion rates.

Wei Ling Ng, Cheong, Govinda, Raj, Teo, & Leong (2016) conducted a cross-sectional study that included having discussions with residents and determining if their views and decisions change afterwards. Out of the 600 residents in this study, 93.2% chose to not proceed

with CPR after having the discussion compared to the 32.6% who had chosen this before at a similar elderly day care center. Wei Ling Ng et al. (2016) also found 52.3% of elderly nursing home patients chose to have limited interventions at the nursing home, and 77% chose to die at the nursing home rather than the hospital.

Bravo et al. (2016) found a statistically significant difference in the rate of advance directive completion in the intervention group of a randomized controlled trial. The intervention included providing assistance for the completion of the documents. The facilitators that educated the patients about advance care planning (ACP) included trained social workers and retired nurses. Eighty percent of the intervention group successfully completed advance directives.

In der Schmitt and colleagues (2014) agree with the need to assist the elderly with advance directives. They completed a controlled intervention trial that included implementing an advance care planning program in nursing homes. After 16.5 months of implementing the program, a statistically significant 36% of the intervention group completed a new advance directive. Proxies were also designated in 94.7% of the cases of the intervention group.

Interventions, such as education, assistance, and support have proven to increase the completion of AD's. Lee, Jung, & Choi (2015) studied the relationship between social support and decisional conflict or attitude. Questionnaires were used to collect information about older adults opinions related to their support and AD conflicts. The data confirmed social support reduces decisional conflict and can increase positive attitudes toward completing AD's.

Completing advance directive documents can be difficult and overwhelming for long-term care residents and their families. Forty percent of nursing home residents do not have an advance directive (Tjia, Dharmawardene, & Givens, 2016). The residents at the chosen project site are only required to have a basic DNR or full code. This type of an AD lacks detail about the

type and amount of care they would like to receive. This problem often results in increased utilization of healthcare services and in higher health care costs. When a resident has been diagnosed with dementia, the chances of this increase even more. According to Livingston (2013), when nursing home residents with advanced dementia experience sudden, acute, or serious medical problems, their end-of-life wishes are usually not implemented and they are transferred to a hospital.

Aging with Dignity offers a Five Wishes document that can be used to help older adults plan end-of-life care. It is user friendly and easy to use; for example, individuals can check boxes, circle an option, or write short sentences. The Five Wishes document includes instructions regarding the following: who the resident would want to make decisions for them if they become incapacitated and unable to make decisions; what kind of medical treatment or comfort measures they prefer; and information that is important for their loved ones to know (Five Wishes, 2016). When filling out the document, the residents can cross out statements they don't want followed, such as, "I wish to have religious readings and well-loved poems read aloud when I am near death." The Five Wishes document is cost effective and available to easily be completed online. Staff members type in the information and print it out to be placed in the patients' medical record. The document can also be ordered from the Aging with Dignity website at the lowest cost of \$1.00.

Internal Evidence

As stated above, the residents at the project site were only requested to have a full code or DNR status. If they came into the facility with any other type of advance directive, it was not included in the chart and only the code status would be used, according to staff. There is a section in each of the residents' charts that contains the advance directive code status. During

admission, the facility is required to offer residents advance directive resources, in which they use the medical health care power of attorney, mental health care power of attorney, and living will documents from www.azsos.gov.

PICOT Question

The PICOT statement is as follows, “In a long-term care facility, how does the implementation of the Five Wishes advance directive, compared to not implementing the Five Wishes advance directive, affect completion rates of advance directives over a 2 month period of time?”

Search Strategy

An exhaustive review of literature was conducted using the following key words: *long-term care facility, Five Wishes, advance directive, and advance directive completion rates*. The databases used to complete the search for evidence related to the PICOT question included PubMed, ProQuest, and the Cumulative Index of Nursing and Allied Health Literature (CINAHL). The initial keywords used to search each database were *completion rates* [All Fields] and *advance directives* [All Fields]. “And” was used to connect the topics and increase the likelihood of results specifically related to the PICOT questions keywords. The initial search yielded 93 articles in PubMed, 130,249 articles in ProQuest, and 81 in CINAHL. No limitations were applied in this initial search as all results were to be reviewed for relation to the PICOT question.

Next, the keywords were changed to *advance directives* and *long-term care*. This search yielded 243 results in PubMed, 14,193 in ProQuest, and 250 in CINAHL. Again, no limitations were applied to this search. Keywords were then combined for the next search to provide focused results. It included *advance directives* and *completion rates* and *long term care*. This search

narrowed the results down to 5 in PubMed, 9,584 in ProQuest, and 5 in CINAHL.

Limitations were then added to further focus the results, which included only results published in the last 10 years. This yielded 3 results in PubMed, 1,990 in ProQuest, and the same 5 results in CINAHL. A second limitation was added to this search in ProQuest, as the results were still high. This limitation included only peer-reviewed articles, which decreased the results to 93.

A search of grey literature was also conducted and included information related to Five Wishes, national and state laws related to advance directives, theoretical frameworks, evidence-based practice (EBP) models, and chart audits. Inclusion criteria included the studies population to be elderly, published within the last 10 years, and related to implementing or critiquing advance directive interventions to increase completion rates. Exclusion criteria included articles published greater than 10 years ago, non-elderly study samples, and studies not conducted in a long-term care facility. Ten studies total were chosen out of the final yields from the databases and multiple sources from the grey literature search (See Appendix A).

Critical Appraisal

The studies were critically appraised using rapid critical appraisal and the Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies (Quality assessment, 2014). The ten studies included two systemic reviews, two randomized-control trials, one nonrandomized control trial and five cross-sectional studies. Multiple interventions included an interview or questionnaire, which resulted in the subjects' personal views or answers. Funding of the studies were provided by research institutes that had no say in the studies design, data collection, or interpretation, which decreases any chance for invalid results. All of the studies were at a level III of evidence or better, making for a high quality of evidence.

The studies did not include a definition of the conceptual frameworks that guided their studies. The sample sizes were adequate, with half of the studies having more than 200 subjects. One of the systemic reviews included 25 studies, and the other reviewed 45 studies. The ten studies provided results representative of the elderly populations preferences and choices pertaining to end-of-life care and advance directives. They also specified what interventions work best at increasing the number of advance directives completed, including person-to-person interactions that allow for education, asking questions, and providing assistance with completing forms (Jezewski, Meeker, Sessanna, & Finnel, 2007). The results improved more when the education was for a group instead of a single person. Homogeneity was therefore in the dependent and independent variables.

Many of the studies included samples, variables of interest, and outcomes that were homogenous. A study completed by Hinderer & Ching Lee (2014) also used Five Wishes as the advance directive tool of choice and one of their outcome variables was AD completion. The PICO question is specific to the elderly population and AD's, which increases the likelihood of homogeneous demographics and outcomes. Most of the samples were 60 years of age or older, female, and residing in nursing homes.

Evidence Synthesis

Research studies (N=10) were critically appraised in the area of end-of-life decisions of patients living in long-term care facilities. Dharmarajan (2012) states that provider participation in encouraging their patients to fill out an advance directive is optimal in long-term care facilities. This may reduce the stress and confusion associated with illness or hospitalization often experienced by older adults. Jezewski, Meeker, Sessanna, & Finnell (2007) found that when staff discussed advance directives with patients and answered questions, patients were

more likely to make their wishes known by completing an advance directive. Long-term care residents completing advance directives are more likely to die according to their wishes, rather than undergoing unwanted life saving measures.

Hinderer and Ching Lee (2014) conducted a pilot study using “Five Wishes” documentation during an advance directive educational seminar. The Advance Directive Attitude Survey (ADAS) was developed and used to assess the attitudes of individuals regarding advance directives. Researchers surveyed participants (n=86) attending an AD seminar using the ADAS and inquired about the effectiveness of the seminar. Eighty-two percent of participants completing the survey reported that the seminar was very useful, 68.6% of the participants had never made an end-of-life decision, and after the seminar 97.7% reported they were likely to complete an AD (Hinderer & Ching Lee, 2014). The results indicate that the Five Wishes (Aging with Dignity, 2017) intervention may motivate people to complete an AD. These study findings support the utilization of social workers and nursing staff to educate long-term care residents and their families about ADs while using the Five Wishes documentation.

Hinderer and Ching Lee’s (2014) study supports this projects outcome variable; the AD completion rates of current and newly admitted residents. Completion rates were one of their chosen outcome variables, which led to the decision of including it as one in this project. Their use of Five Wishes as an AD tool also led to the decision of using it in this project, as it delivered positive outcomes. Although the ADAS was not used and staff did not implement the intervention like in Hinderer and Ching Lee’s study, major decisions were based off this articles interventions and outcomes. Staff did not implement the project due to the social workers refusing to partake in it.

Research supports the use of chart audits, which were chosen as tools to use in this project to log demographics and completion rates. Gregory, Van Horn, and Kapriellian (2008) state chart audits can serve many purposes and can be used to measure any aspect of care that is normally documented in a chart. They can also be made specifically for any purpose, in this case, tracking residents advance directive statuses and Five Wises completion rates. The decision to use chart audits was based on this literature.

The projects chosen theoretical framework, Imogene M. King's Theory of Goal Attainment, is also well supported by evidence, which led to the decision of basing the projects intervention off of it. The theory has been around since the 1960's and acts as a guide for nurse-patient relationships (Wayne, 2014). The focus is the attainment of goals through communication and mutual goal setting. This framework relates to the project intervention of communicating with and educating residents in order to set decide on end-of-life wishes.

Purpose Statement

The purpose of this project was to improve the completion rates of advance directives by implementing Five Wishes during the admission process in a long-term care facility. The objectives of this evidence based practice project were as follows:

1. To identify residents who did not have advance directives.
2. To assist current residents who did not have a detailed advance directives with completing AD documentation.
3. To assist newly admitted residents in completing an AD.

The goal was to provide education and sources for long-term care residents and their families that can help them complete their advance directives. Consequently, less residents may receive unnecessary treatments and transfers to hospitals; thereby, receiving end of life care

according to their wishes. The long-term goal of this project was that the Five Wishes documentation would become an integral part of the facilities' admission process resulting in an increase of documented advanced directives.

Theoretical Framework

Imogene King's Theory of Goal Attainment (Wayne, 2014) was used to guide the intervention. Patients have the ability to perceive, choose, set goals, and make decisions. They also have needs, which include the need for health information, the need for care to prevent illness, and the need for care when they can't help themselves (Wayne, 2014). People have personal, interpersonal, and social systems that they use to set goals and make decisions. This theory was used to guide the intervention by supporting the need for providing patients with information about advance directives to help them set goals for end-of-life.

If accurate interaction is present in the nurse-patient relationship, transaction will occur. Transactions are processes of interactions in which people communicate with the environment to achieve goals and satisfaction (Wayne, 2014). When transactions occur, goals are achieved and satisfaction will occur. The relationship will grow as more interactions occur and transactions are made. Kings Theory of Goal Attainment also states that if a nurse communicates knowledge to the patient, mutual goal setting is likely to occur and be achieved (Wayne, 2014). Mutual goal setting occurs when the nurse and patient agree on what they would like to achieve (See Appendix B).

The theory suits the project requiring the sharing of information and provider-patient relationships in order to achieve goals. The goal is the completion of advance directives. Relationships with the patient and family may include nurses, doctors, chaplains, social workers, palliative care, or nurse practitioners.

Evidence Based Practice Model

The Iowa Model (Dontje, 2007) is used in this study to guide the application of the evidence. It was developed to describe the transformation of knowledge and to guide the implementation of research into clinical practice. This model helps guide practice decisions while considering the healthcare system as a whole. It is used to identify problems and develop evidence-based solutions, such as carrying out interventions to increase the number of the elderly with a completed advance directive.

The initiation of this project was guided by the first step in the Iowa Model, which is to identify a clinical problem that will initiate a need for change. This topic is a priority for the organization because of the staff stating there is confusion related to patient care when they become ill. After determining the topic and how much of a priority it is, a team was formed and literature was assembled related to the topic. The literature was then synthesized and critiqued to support the change of increasing completed AD's. A sufficient research base related to the topic was found, meaning the Iowa Model could continue to be used.

Next, the change was piloted into practice by selecting outcomes to achieve, collecting baseline data, evaluating the process and outcomes, and modifying the guidelines as needed. The change was determined to be appropriate for the practice, as the patients lacked detailed advance directives. Therefore, the change was instituted into practice and the collected data was analyzed. The final step of the Iowa Model is to disseminate results, in which was carried out at the facility (See Appendix C).

Methods

An evidence-based project was conducted in a long-term nursing facility in the greater Phoenix Area, to incorporate Five Wishes documentation during the admission process of residents moving into the facility. Approval was first obtained from the Arizona State University Institutional Review Board. Current residents without an advance directive, as determined by conducting a retrospective, quantitative chart audit, were also asked by the project facilitator to complete Five Wishes documentation to increase the number of residents completing an advance directive. The project facilitator hung flyers throughout the facility to advertise the project. The facilitator was trained in the use of the Five Wishes documentation by using the Five Wishes presenter guide. The project facilitator educated residents about Five Wishes and presented the documentation to all newly admitted patients or those residents who were identified through the quantitative chart audit as not having a detailed AD. Residents were assisted with completing the Five Wishes document over a 2-month period- of -time. The Five Wishes forms and presenters guide were ordered from the Aging with Dignity website for \$1.00 per form (<https://agingwithdignity.org/five-wishes>).

The retrospective, quantitative chart audit was conducted on medical records of current residents living in the facility. Twenty charts were randomly selected for the audit and each resident consented to the viewing of their chart by signing a HIPAA document. The HIPAA document gave permission to the project facilitator to gather information from the patients' chart and informed hem no personal information would be disclosed. The purpose was to determine the number of residents that had or had not completed advance directive documentation and whether it was a basic full code or DNR. The project facilitator implemented the Five Wishes documentation for a period of 2-months. During the project time span, the 20 randomly selected

residents were educated about Five Wishes and encouraged to complete the documentation. The completed forms were signed by the resident and by two witnesses at the facility. A notary was not required; only two witness signatures are needed to make the document legal in the state of Arizona. The number of those residents that completed Five Wishes was kept track of on the same log used for the retrospective chart audit. This log also included demographic information about these residents.

The Five Wishes documentation was also offered during the admission process to all newly admitted residents on the skilled nursing units over the same 2-month period. During the first week after admission, the project facilitator met with the residents (or proxy) to educate them about Five Wishes and assist them with the completion of the documentation. Each new resident that consented to the viewing of their chart by signing the same HIPAA document that the current residents signed. Their charts were assessed to obtain demographic information and to determine what type of AD they may have already had. If they chose to complete a Five Wishes document, it was logged on the Advance Directive Resident Log, along with their demographic information. The advance directive was posted in the resident's medical record if they completed one.

The two outcome variables of interest for this project were: 1) the number of completed advance directives by current residents after the facilitator had implemented the Five Wishes documentation, and 2) the number of newly admitted residents that completed the Five Wishes documentation. All residents had the right to refuse to complete the Five Wishes documentation based on the Patient's Bill of Rights policy where the person has the right to refuse treatment and participation in research.

Chart audits were used to collect the data (Gregory, Van Horn, & Kapriellian, 2008). The form was called the Retrospective Quantitative Chart Audit and consisted of seven columns: 1) An ID number, which did not include identifying information; 2) age; 3) gender; 4) ethnicity; 5) if an advance directive was documented in their chart, yes or no; 6) the type of AD already documented, none, full code or DNR; 7) if Five Wishes was completed throughout the 2 month project span, yes or no.

A separate chart audit form was a log used to collect data related to the second outcome variable. It was called the Newly Admitted Resident Log. The form consisted of 7 columns: 1) An ID number, which did not include identifying information; 2) age; 3) gender; 4) ethnicity; 5) if an advance directive was documented in their chart, yes or no; 6) the type of AD already documented, none, full code or DNR; 7) if Five Wishes was completed throughout the 2-month project span, yes or no.

Chart audits are beneficial, as they can be made specifically for the search of a particular defect or change. According to Gregory et al., (2008), chart audits are used for many purposes including compliance, research, and finding a defect in a process and fixing it. They are also often used as part of a quality improvement initiative, for example, to see how often a task is carried out to determine if there is room for improvement.

Data Analysis

SPSS® 25 was used to store, manage and analyze the data. Descriptive statistics were used to describe the sample's demographics and completion rates of Five Wishes.

Outcomes

The sample consisted of residents living in a skilled long-term care facility (N=70) in greater Phoenix Arizona. The rate of completion of ADs using the Five Wishes documentation are reported in terms of the completion rates of current and newly admitted residents.

Current Residents

Twenty current residents were included in the quantitative chart audit before the beginning of the project start. These residents average age was 68 years old with a standard deviation of 11.9. Eight (40%) of them were male and 12 (60%) of them were female. Fourteen (70%) of the residents were Caucasian, 3 (15%) were Hispanic, and 3 (15%) were African American. They all were cared for on the skilled nursing units at the project site. Nineteen (95%) had a basic AD (DNR or full code) in their chart and 1 (5%) had no sign of one. Twelve (60%) of those AD's were a full code, 7 (35%) were a DNR, and 1 (5%) did not have an AD (See Appendix D, Figure 1). After educating these 20 residents about Five Wishes, helping some fill out the form, or giving them the form to fill out on their own, 6 (30%) of them completed the document (See Appendix D Figure 2).

Newly Admitted Residents

There were a total of 50 newly admitted residents during the 2-month project span. The average age of these residents was 71 years old with a standard deviation of 10.7. Twenty-one (42%) were male and 29 (58%) were female. Forty (80%) were Caucasian, 6 (12%) were Hispanic, 1 (2%) was Asian, and 3 (6%) were African American. All 50 of the residents were admitted to and being cared for on the skilled nursing units. Forty-eight (96%) had a basic AD in the chart and 2 (4%) did not have any AD found. Thirty-four (68%) of those AD's were a full code, 14 (28%) were a DNR, and 2 (4%) were those without one (See Appendix E, Figure 1).

Out of the 50 new residents included in the sample, 21 (42%) completed a Five Wishes document (See Appendix E, Figure 2).

Discussion

Recommendations

The completion rates of Five Wishes were lower than expected. This could be contributed to the lack of fully oriented residents, presence of a proxy, and support from facility staff. It would be recommended that facility staff carry out the project, such as the social workers who already have to meet with newly admitted residents as part of the admission process or a designated nurse (Bravo et al., 2016). It is a requirement of the Patient Self-Determination Act that nursing homes must provide residents with their rights, the facilities policies, and ask them if they have an AD in place upon admission (Geller, 2012). It is not a requirement for a resident to have or not have an AD under this federal act. The facility DNP should play a role in the project by ensuring the residents understand the importance of completing Five Wishes and making their wishes known despite not being required to. Not only would this be beneficial, but as of 2016, Medicare began paying physicians for having advance care planning conversations with their patients (Abele & Morley, 2016). This would likely increase adherence of the project and completion rates.

Arranging an advance directive day or event could also be beneficial. If the residents and their family members were well informed about the event beforehand, they could arrange to attend and complete the Five Wishes document. This would also reduce the burden it would put on staff to educate each patient about the document and help them complete it.

A larger percentage of residents in the current resident group and the newly admitted resident group had full codes compared to a DNR. A higher number of full codes in a long-term

care facility increase the chances of receiving unwanted care (Kossmann, 2014). It is recommended that staff inform residents of this fact while educating them about advance directives. Further research should be completed after a higher number of residents have completed Five Wishes to determine if hospital transfers and aggressive treatment rates decrease.

Strengths

The project site was a good choice as it is a large facility with many residents being admitted and discharged. This improved the chances of having a larger sample size, compared to choosing a smaller site in the same area. The implementation of an advance directive intervention to increase completion rates is well supported by evidence (Jezewski et al., 2007). Five Wishes is a resource that is also widely supported and used. According to Aging with Dignity (2017), more than 40,000 organizations use Five Wishes in the United States and around the world.

Limitations

There were limitations to the study that included a small sample size of 50 new residents and 20 current residents. The original project plan was to have the facilities 2 social workers carry out the project, but they were unable to due to the high demands of their position. This left the project to be implemented by only one project facilitator that was not part of the facilities staff. Throughout the project planning and implementation stage, there was poor communication and support from the facility staff. This affected the ease of each project stage. Many of the residents lacked complete orientation, which also negatively affected completion rates. These residents did not always have a family member or proxy in the room during the visits. Arranging an advance directive event could increase proxy presence during the completion of the Five Wishes document.

Proposed Changes

In order for the project to be a success in the future, staff must implement the project. Whether these staff members would be social workers, admission nurses, or providers, they would need to be educated about the facilities lack of detailed advance directives. They would then need education from the project facilitator about the importance of residents having detailed AD's and on the use of Five Wishes.

As mentioned earlier, an advance directive event should be planned and implemented to increase the number of completed Five Wishes documents. Residents and families would need to be informed ahead of time in order to plan on attending the event. Doing so would take burden off the staff implementing the project on a day-to-day basis.

The project needs to be carried out for longer than a two-month period of time. A longer implementation period could increase the sample size and therefore potentially increase the number of completed Five Wishes documents. If the independent and assisted living residents were included in the project, the sample size would increase even more.

Sustainability

Not only would having facility staff members carry out the project increase sustainability, but having the facility create a policy that incorporates Five Wishes into the admission process could have an even greater effect. This policy would make the project a requirement of the admission team, no longer a temporary intervention. An algorithm would be included in the policy for the admission team to follow, which would be the same steps that were carried out during this projects implementation phase. All admitted residents would be educated about Five Wishes, encouraged to complete the form, and offered assistance with completion.

Conclusion

Having an advance directive can reduce the chances of going against ones wishes. It can also reduce the cost of end-of-life care when nursing home patients are hospitalized unnecessarily. An increase in patient education pertaining to advance directives can help them to better understand the importance of having ones' wishes known. Continuation of this project can improve quality of life by increasing the number of completed advance directives and making the subjects wishes known. If the project continues on to become a success, then it can be promoted and implemented in other skilled nursing facilities.

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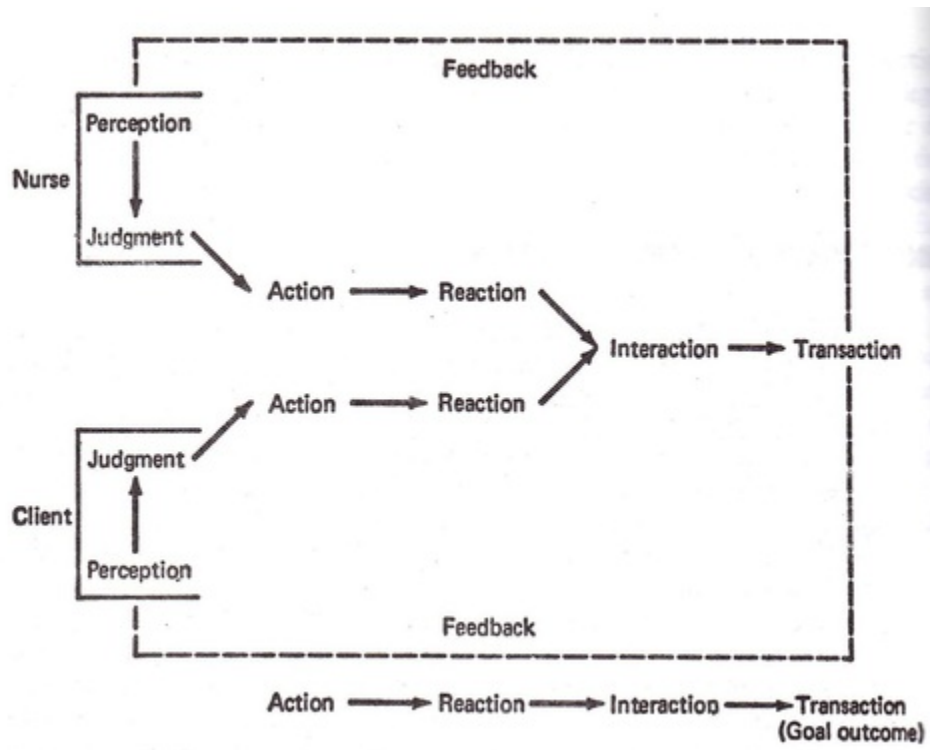
Appendix A

Table 1 Search Strategy Summary Table

Search Description	Limitations	PubMed Results	ProQuest Results	CINAHL Results
<i>Completion Rates AND Advance Directives</i>	None	93	130,249	81
<i>Advance Directives AND Long-Term Care</i>	None	243	14,193	250
<i>Advance Directives AND Completion Rates AND Long-Term Care</i>	None	5	9,584	5
<i>Advance Directives AND Completion Rates AND Long-Term Care</i>	Published in Last 10 Years	3	1,990	5
<i>Advance Directives AND Completion Rates AND Long-Term Care</i>	Published in Last 10 Years + Peer-Reviewed	Not Searched	93	Not Searched

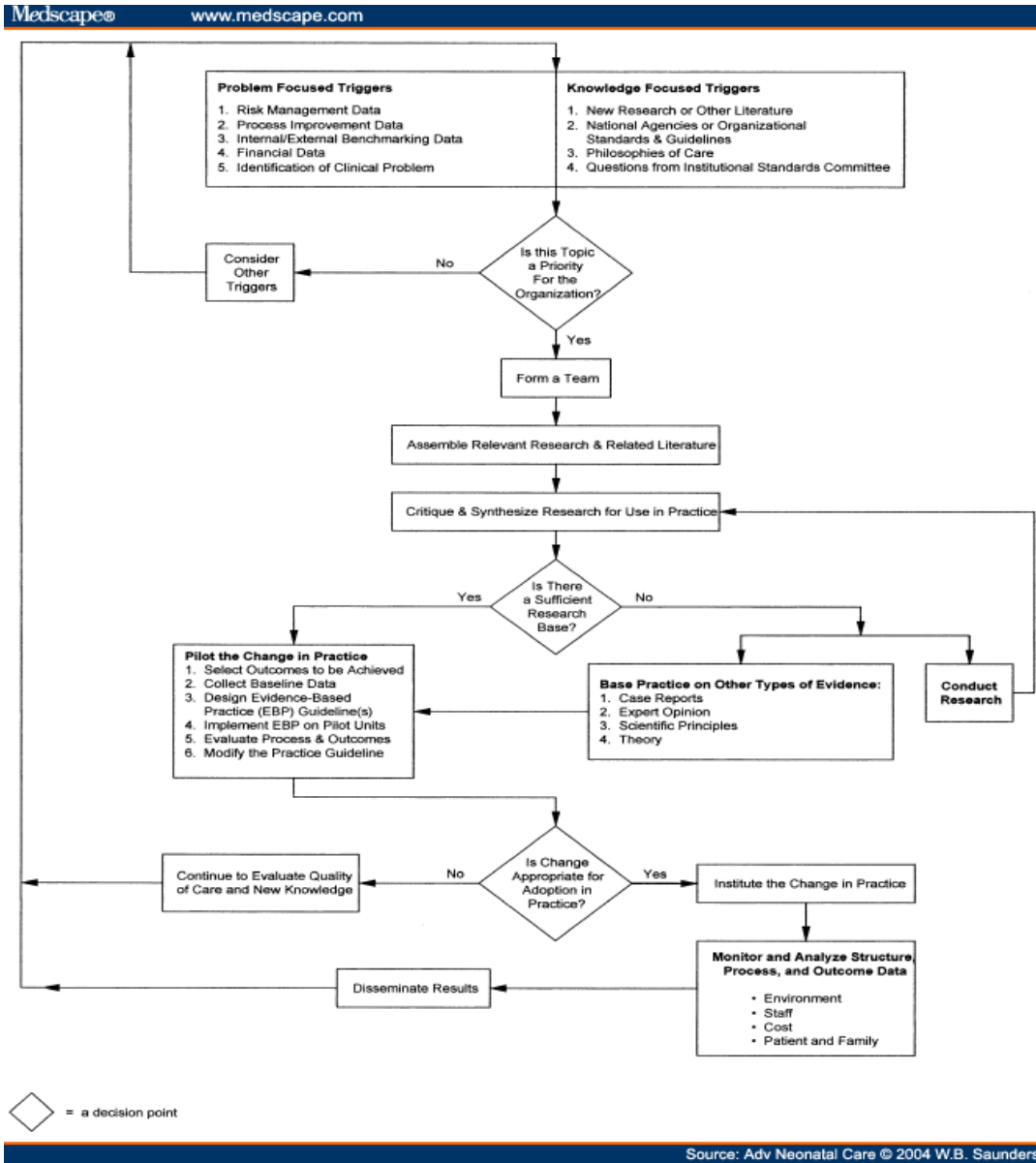
Appendix B

Figure 1. Imogene King's Goal Attainment Theory



Appendix C

Figure 1. Iowa Model



Appendix D

Figure 1. Type of Previously Completed Advance Directive in Current Residents

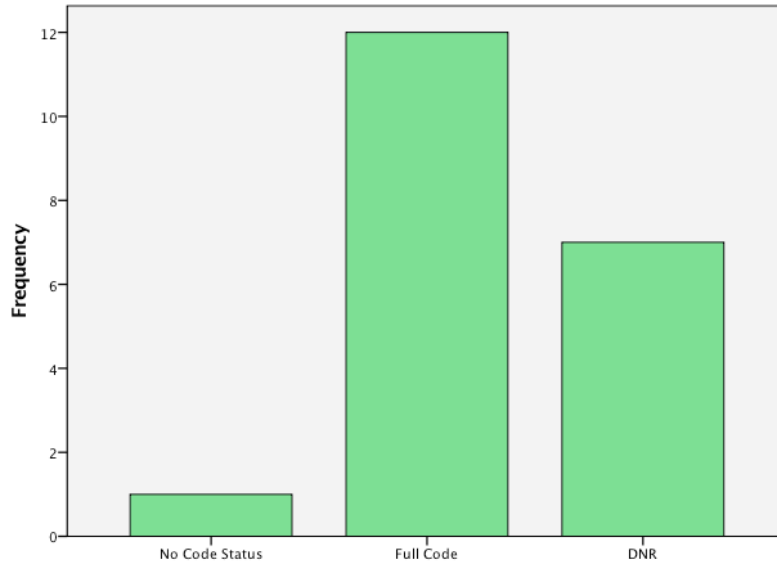
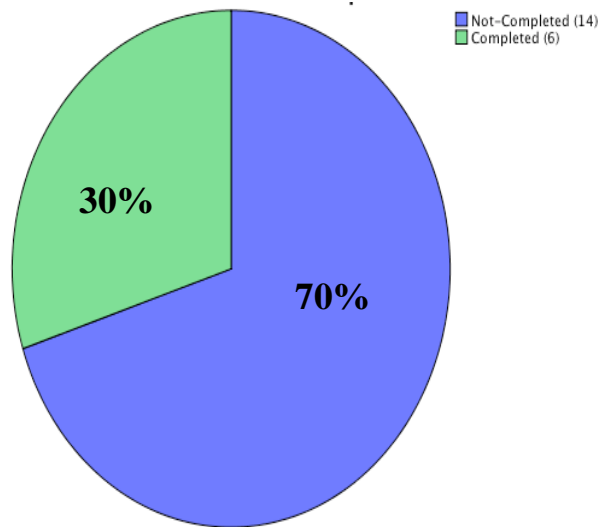


Figure 2. Current Residents That Completed Five Wishes



Appendix E

Figure 1. Type of Previously Completed Advance Directive in Newly Admitted Residents

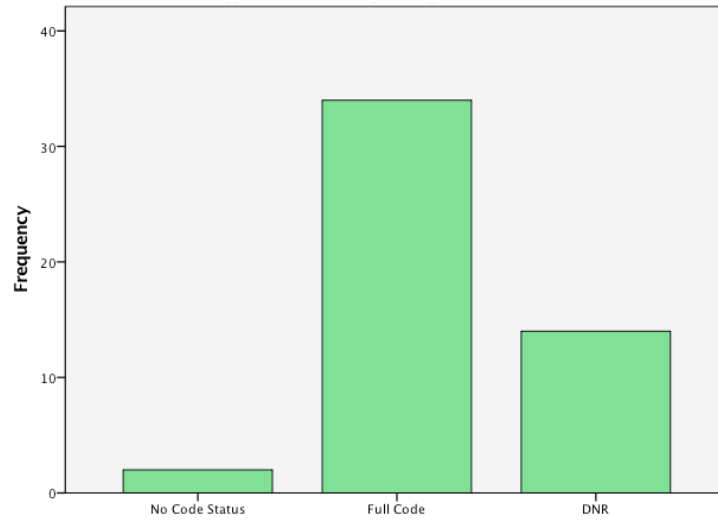


Figure 2. Newly Admitted Residents that Completed Five Wishes

