Adoption of Evidence-Based Practice—Advance Directives in Nursing Homes*

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I. Introduction

Nursing homes (NHs) commonly experience the death of residents, family members, and staff. It has been reported that over 1,000 residents die each day at NHs in the United States, approximately 25% of all deaths nationwide (Keay, Alexander, McNally, Crusse, & Eger, 2003). By 2040, it is expected that about 40% of those deaths will occur in NHs (Lechich, 2011).

In Korea, it is predicted that the proportion of deaths at NHs will increase in the future because of aging (Korean Statistical Information Service, 2013). Therefore, NHs play a critical role in providing end-of-life and palliative care for NH residents. Consequently, strategies to protect NH residents' autonomy at the end of life are very important. However, residents' autonomy in the decision-making process in long-term care settings such as NHs has been limited (Lidz & Arnold, 1990). Because NHs have serious difficulties providing end-of-life care to residents while addressing their spiritual and emotional needs (Keay et al., 2003) and the current care at NHs focused on rehabilitation and restorative care conflicts with the needs of dying residents (Oliver, Porock, & Zweig, 2004).

Supporting and encouraging residents in their own decision-making process can help improve their physical, mental, and quality of care (Dempsey, 2013). Advance directives (ADs), living wills, and durable powers of attorney have been recommended as legally binding protections for competent people's autonomy before cognitive impairment limits their ability to make decisions (Cohen-Mansfield, Libin, & Lipson, 2003). Kane, Kane and Ladd (1998) defined ADs as “a statement made by a cognitively intact person about care he/she would wish to have if he/she were temporarily or permanently unable to make a medical decision because of unconsciousness or cognitive impairment” (Kane, Kane, & Ladd, 1998). Residents have a right to decide their own treatment at the end of life before they are incapacitated. Using only proxy preferences in healthcare procedures will limit residents' autonomy (Diamond, Jernigan, Moseley, Messina, & McKeowny, 1989). The most general forms of ADs are living wills, do-not-resuscitate (DNR) orders, and durable

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powers of attorney (DPOA) (Cohen-Mansfield et al., 2003). Living wills are instructional directives that designate when a resident wishes to die rather than continue to live via artificial means, DNR orders reject cardiopulmonary resuscitation for acute medical therapy, and a DPOA designates another person to make decisions regarding life-sustaining treatment when the individual is judged incompetent (Cohen-Mansfield et al., 2003). In global, the United States has played a pioneering role in adopting AD by legislation (Siu et al., 2010). This article explores the urgent problem of end-of-life care in NHs, as well as the advantages of and barriers to ADs. Then, the evidence-based practice - advance directives (EBP-ADs), developed in the United States as a management intervention, is explained and proposed for an innovative strategy to increase AD completion. Furthermore, the discussion of outcome measures for this management intervention is investigated to provide evidence to apply EBP-ADs to NHs in Korea.

II. Advance Directives in Nursing Homes

1. Benefits of ADs

The benefits of ADs for NH residents are that the residents will get the care that they want and need without losing the right and autonomy to make their own choices regarding future treatment (Cantor & Pearlman, 2003). Molloy and colleagues (2000) reported in their randomized controlled trial (three control NHs, three experimental NHs) that experimental NHs found ADs created by residents or family members to be cost effective, including decreased hospitalizations, shorter hospital stays, and lower healthcare expenditures than in cases when healthcare professionals make residents decisions (Molloy et al., 2000). Having ADs also lessens the proxies’ stress in making decisions about the resident’s care planning because the AD increases caregivers’or family members’ knowledge regarding the resident’s decisions about medical procedures and attitudes toward life and death (Chan & Pang, 2010). For example, according to Mitchell and colleagues (2000), only 48% of proxies in the United States and Canada who have decided on tube feeding for NH residents thought that the residents themselves would have wanted feeding tubes. This finding highlights the importance of this decision at the end of life.

2. Reasons for Underuse of ADs

Although the benefits of and need for ADs in NHs have been shown in previous research, use of ADs to formalize treatment preference and end-of-life treatment is still quite rare in practice and the findings are not consistent (Pekmezaris et al., 2004). In one study, only 11% of residents had an AD, only 17% had a DNR on admission, and only 6% among those admitted without ADs completed this document after their admission (Suri, Egleston, Brody, & Rudberg, 1999). Mezey and colleagues (2000) reported that only 51% of all NH residents across the nation have ADs. In Korea, most DNR decisions were conducted by individual families and institutions, without including residents. Counseling, education and systemic background information about AD is scarce (Park, & Song, 2013). Most AD information was distributed to private organizations and this results in low accessibility to the elderly, thus most elderly people don’t know about AD (Lee, Park, & Lee, 2011). The low AD completion is not only due to residents’ characteristics. Healthcare professionals usually do not identify ADs as a critical need for these residents (High, 1988) and at times misunderstand proxies’ knowledge of the residents’ choices and preferences (Hines et al., 2001). The low completion rate may be due to a fundamentally negative attitude or values toward and poor knowledge about AD use (Bradley, Wetle, & Horwitz, 1998). The tendency toward unwillingness of physicians or residents to initiate conversations regarding ADs is another barrier (Pekmezaris et al., 2004).