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Home Health Care Nurses' Knowledge of Advance Directives

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HOME HEALTH CARE NURSES'
KNOWLEDGE OF ADVANCE DIRECTIVES

By

Jennifer L. Zoeteman

A THESIS

Submitted to
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ABSTRACT

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The purpose of this study was to describe home health care nurses' knowledge of advance directives. Dorothea Orem's Theory of Self-Care guided this descriptive correlational study which investigated the relationship between knowledge of advance directives and the variables of nursing educational preparation and years of nursing experience. A convenience sample of 40 subjects employed by a Michigan home care agency completed a 39 item questionnaire adapted from Crego and Lipp (1998). The mean knowledge score was 84.68%. Analysis of the demographic profile showed no significant difference in knowledge levels by educational preparation. Years of nursing experience was found to have a weak, negative, non-significant relationship to knowledge of advance directives. Additionally, the majority of subjects had no experience with assisting clients in advance directive formation and did not feel prepared to counsel clients on advance directives.

Dedication

To my precious children
Matthew, David, Adam, and Sarah.

Acknowledgments

I would like to thank Dr. Jean Nagelkerk, my thesis chairperson, for her support and patience. I commend Dr. Linda Scott as an invaluable resource on statistical matters. A special thank you to Dr. Donna VanIwaarden for her expertise.

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CHAPTER 1

INTRODUCTION

The Patient Self Determination Act (PSDA) requires that all adult patients receive written information regarding advance directives. In addition, documentation of an existing advance directive and provision of community and staff education is required of health care institutions (Berrio & Levesque, 1996). Hospitals, health maintenance organizations, nursing homes, hospices, home health care agencies, and any other health care facility receiving federal funding must comply (Bastnagel, 1993). To ensure compliance with the PSDA, the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) conducts compliance surveys (Dunlap, 1997).

The three major types of advance directives include the living will, medical directive, and durable power of attorney for health care or health care proxy. Advance directives are designed to promote patient autonomy, protect legal and moral rights, reduce family decision making conflict, and indicate clients' wishes regarding end of life care (Pelligrino, 1992).

Living wills document the patients' desire to refuse interventions that prolong life in the event of terminal illness. The medical directive provides detailed information that indicates the patients' wishes regarding specific medical treatments in the event of decision making incapacity. The health care proxy is the most flexible advance directive and designates an agent for decision making when the patient is not able to exercise autonomy. Hybrid forms utilizing a combination of all three concepts are frequently documented (Perrin, 1997).

Prior to implementation of the PSDA, studies reported 4 to 20% of the general population completing advance directives (High, 1993). In the elderly population advance directives were completed by 0 to 18% of individuals (Gamble, McDonald, & Lichstein, 1991; High, 1988; Zweibel & Cassel, 1989) One year after the PSDA, Gorden and Dunn (1992) reported a 15% completion rate by the general population. A 1996 study of older adults found advance directive utilization at 19% (Schirm & Stachel, 1996).

Documentation rates for institutionalized individuals were considerably higher. A hospital study involving admissions to critical care units documented a 31% completion rate (Berrio & Levesque, 1996). Over half (51.9%) of nursing home residents had completed an advance directive in a study by Parker and Nettles-Carlson (1995).

Research studies clearly show difficulties with implementation of the PSDA. Despite intensive educational efforts, the majority of patients do not have written advance directives. Extensive review of the literature shows that nursing professionals have conducted few studies regarding this phenomenon (Johns, 1996). A reference point for investigation would be a measure of nurses baseline knowledge of advance directives. If nurses have a limited understanding of advance directives, they will be unable to effectively educate their clients.

The primary purpose of this study was to describe home health care nurses' knowledge of advance directives. Crego and Lipp's (1998) study was replicated using a different practice setting and geographical location. This research is important because of the elderly population growth and increased use of home health care as a measure of controlling rapidly escalating health care costs. This study was undertaken to determine if there is a relationship between nurses' knowledge of advance directives and the conditioning factors years of experience and nurses' level of educational preparation.

This research is valuable to home health care administrators who strive to meet JCAHO standards and obtain accreditation. Specifically, results of this study can be used to target staff continuing educational needs.

Facilitation of advance directive implementation and compliance with written preferences are a natural extension of the patient advocate role (Johns, 1996). Nursing research findings about advance directives should be considered when designing nursing educational curriculum. The PSDA did not indicate a specific provider to disseminate information and monitor compliance. Therefore, an opportunity exists for nurses to expand their professional role and improve patient outcomes.

CHAPTER 2

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

Theoretical Framework

Dorthea Orem developed The Self-Care Deficit Theory of Nursing. Encompassed within this model are three interrelated theories: self-care, self-care deficit, and theory of nursing systems (Orem, 1995). The core concept of self-care is defined as "the voluntary production and practice of actions directed toward one's self or one's environment to regulate one's own functioning and development..." (Dennis, 1997, p. 36). Self-care is a learned behavior and involves deliberate action (McQuiston & Webb, 1995).

Orem describes two major patient variables related to self-care. Self-care agency is a set of abilities and a measure of power to engage in self-care (McQuiston & Webb, 1995). Self-care agency is affected by basic conditioning factors. Ten factors are delineated including gender, age, health state, developmental state, sociocultural orientation, family systems factors, environmental factors, health care system factors, patterns of living, and resource

availability and adequacy (Orem, 1995, p. 203). Orem admits this list is not all inclusive and therefore open to amendments.

The second variable, therapeutic self-care demand, is a collection of actions required at a specific time to meet the self-care needs of an individual. The concept of self-care deficit is simply expressed as a relationship between these two variables. When the known therapeutic self-care demand exceeds capabilities within self-care agency, a self-care deficit results (Tomey & Alligood, 1998).

Nursing agency is the third pertinent concept from Orem's theory. This concept is defined as a set of acquired, learned abilities that empower persons educated as nurses. As illustrated in Figure 1, nursing agency allows the nurse to identify self-care deficits. Nursing intervention is targeted at meeting therapeutic self-care demand and developing self-care agency (Orem, 1995). Nursing agency is similar to self-care agency and affected by basic conditioning factors as well. Specific to nursing, Orem identifies the factors of gender, age, race, health state, constitutional and physical characteristics, maturity/status as a person, family/community roles, nursing experience, and nursing educational preparation (McQuiston & Webb, 1995, p. 159).

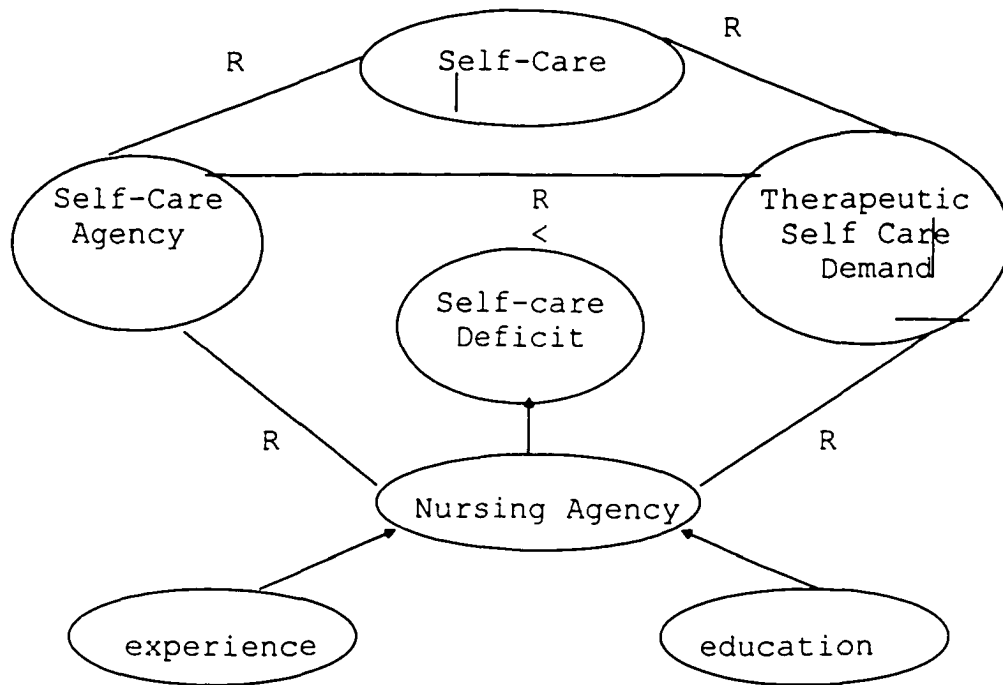


Figure 1. Conceptual Structure of Dorthea Orem's Self-Care Deficit Theory of Nursing. R = relationship.

Note. From Foundations of Nursing Theory (p. 159), by McQuiston, C. M. & Webb, A. A., 1995, Thousand Oaks, California: Sage. Reprinted and adapted by permission.

In terms of this project, Orem's theory provides understanding of the advance directive development process. The nursing professional identifies a potential self-care deficit. This deficit involves a situation in which the patient would be unable to make his or her own health care decisions. At this point in time, the therapeutic self-care demand would exceed self-care agency. The creation of an

advance directive is a prudent preparatory self-care act. Providing patient education requires the nurse possess knowledge of the topic. Implementation of educational measures is a function of nursing agency and is therefore affected by basic conditioning factors. It is these factors that are theorized to influence home health care nurses knowledge of advance directives and therefore served as the independent variables in this study.

Literature Review

The first group of research studies presented use Orem's theory. A very small number of studies documenting nurses' knowledge of advance directives were found in the literature. Therefore, it was necessary to expand the review to include projects investigating advance directives and nursing knowledge as separate entities.

Research Utilizing Orem's Self-Care Deficit Theory

Utz and Ramos (1993) conducted a series of qualitative research studies involving the necessity of nursing assistance in mitral valve prolapse (MVP) patients. The perspective of 32 cardiovascular nurses on methods of nursing assistance commonly provided to the MVP population was elicited. Although there was a low response rate, several nurses indicated a knowledge deficit regarding MVP. Additionally, frustration over the inability to evaluate the effectiveness of nursing actions was expressed by

experienced clinicians. Both education and intervention are functions of Orem's concept of nursing agency.

Hart (1994) conducted cross-sectional correlational research in order to determine the relationship between self care agency and infant birth weight. A sample of 127 pregnant women were given the Appraisal of Self-Care Agency Scale by Evers et al. (1986). Basic conditioning factors were identified as time of entry into prenatal care, gravidity, and perinatal risk factor. These variables were found to have no significant effect on self-care agency. The author of this study found that socioeconomic factors, environmental factors, and family system factors have a high correlation with pregnancy. A weakness in this study was the reliability of the self-care agency tool being administered to a population of pregnant women.

Ward-Griffen and Bramwell (1990) also used the Appraisal of Self-Care Agency Scale in a descriptive correlational study. In an elderly population (n=40) demographic variables and perceived health status were not found to be significantly related to self-care agency.

In Smits and Kee's 1992 study, elderly adults, ages 65-97, were evaluated with The Exercise of Self-Care Agency Scale. A near significant relationship between the variables of education and number of children and the dependent variable of self-care was found ($p = .058$ for each). A

strong correlation ($r = .60$, $p = < .01$) was identified between self-concept and self-care.

Nelson-McEvers (1995) also conducted a descriptive correlational study with elderly adults measuring self-care agency with The Exercise of Self-Care Agency Scale. Education was again found to be a significant factor in self-care behavior ($r = .42$, $df = 54$, $p < .001$).

Dorthea Orem's theory of self-care deficits has been used as a theoretical framework for numerous research studies. The concepts of self-care and self-care agency have been measured with at least two different tools (Evers et al., 1986; Kearney & Fleisher, 1979). The effects of basic conditioning factors have been frequently measured on self-care agency. While patients have been frequently considered, the role of the nurse and the practice of nursing agency has received limited review. The relationship of basic conditioning factors and nursing agency was not found to be documented in the literature. Inconsistent correlational findings between basic conditioning factors and self-care agency requires additional investigation.

Research Involving Advanced Directives

The literature on advance directives is primary directed at measuring and improving completion and compliance rates. Palker and Nettles-Carlson (1995) utilized a descriptive design to examine barriers to documentation of

advance directives in a nursing home population (n = 104). Barriers identified by residents via personal interview were misconceptions, lack of knowledge and opportunity, and the understanding that the physician or significant others are responsible for decision making at end of life. Despite small, convenient sampling, these findings are important to nursing because of the potential for educational interventions.

A descriptive design was also used by Gates, Schins, and Smith (1996) to explore compliance with the PSDA in home health care agencies. Michigan agency respondents (n = 108) self-reported a primary concern of orienting staff. These respondents suggested inservices to facilitate discussion of death and dying issues among staff members. Study findings also demonstrated low compliance with community education. Only 25% of the agencies provided this service despite the PSDA mandate. This finding is significant considering agency inclusion in the study was voluntary.

Compliance with the PSDA was also reviewed by Bradley, Walker, Blechner, and Wetle (1997). A retrospective cohort study of 600 patients in 11 Connecticut nursing homes was conducted. Review of medical records revealed that 90.7% of admissions received PSDA information in a timely manner. However, in 70% of these admissions, information was provided to someone other than the resident. Cognitive

impairment was the primary reason cited when excluding residents in advance directive education. A specific measurement of cognitive ability was not implemented prior to decision making discussions. Therefore, residents may have been inappropriately excluded from verbalizing treatment wishes and exercising autonomy.

Utilizing a descriptive correlational design, Herndon (1993) investigated nurse practitioner compliance with previously documented advance directives. The concept of moral development as defined by Kohlberg served as an independent variable. Forty-six nurse practitioners responded to a hypothetical situation involving a moral dilemma with a client's advance directive. Surprisingly, 84.8% of the sample failed to uphold the client's advance directive. No relationship was found between response to the hypothetical situation and the nurse practitioners level of moral development.

Luptak and Boult (1994) implemented a interdisciplinary approach to increase recorded advance directives in a ambulatory elderly population. A pre-experimental design was used where 34 patients initially received verbal and written information from a social worker. On subsequent clinic visits, physicians and trained lay volunteers initiated discussions and answered questions on end of life planning. Surprisingly, 70.6% of the participants recorded an advance

directive. Another significant finding involved gender differences. Females accounted for 87.5% of those who completed an advance directive and 50% of those who did not. The difference of 37.5% generated a p value of $< .025$. Caucasian individuals and those with more education also were more likely to complete an advance directive. Results need to be considered carefully as there was no comparison group, sampling was non-random, and the sample was homogenous.

Bailly and DePoy (1995) conducted a study to evaluate older people's responses to advance directive education by social workers. A convenience sample was used with a pre-test post-test design. The sample ($n = 9$) received an author designed written educational packet. There was an increase in the number of questions answered correctly in the post-test, however this was not statistically significant. Interviews conducted by phone two weeks after the intervention generated some interesting qualitative data. The researcher identified an increase in willingness to discuss future health care decision making and family emerged as central in the support role.

Schirm and Stachel (1996) implemented a values history with older adults ($n = 31$) to increase use of advance directives. The values history with written educational materials was designed by Doukas and McCullough (1988) and

encouraged reflection on attitudes and values on end of life concerns. Follow up phone interviews at two weeks revealed the completion of only one advance directive. When respondents were asked whom they felt satisfied receiving advance directive from, 94% indicated a nurse, 87% a physician, and 71% a lawyer. These results indicate the prominent role of the nurse in advance directive discussions.

High (1993) conducted four studies between 1987 and 1993 involving end of life decision making. The most recent study tested the effectiveness of educational measures to increase completion of advance directives. Older adults dwelling in the community (n = 293) were randomly assigned to either control or one of six intervention strategy groups. Interventions consisted of written educational materials or an invitation to a free meeting where legal assistance and counseling were available. The strategy found to be most successful was distribution of a moderate amount of written materials plus invitation to the meeting. Within this group, living will completion rate rose from 25% before to 50% after the intervention ($p < .05$). A statistically significant increase in documentation of a health care surrogate was also noted in this group.

Familiarity and use of advance directives were significantly related to level of education and race. Those

participants with 12 years of education or less had the lowest rates and those with a college education had the highest rates. Race was also shown to be a significant factor with 85% of Caucasians familiar with the living will, while only 62% of African Americans ($p < .001$) were familiar with this concept.

The body of literature addressing advance directives clearly demonstrates difficulties with implementation of the PSDA. Client barriers are well identified and numerous educational strategies have been tested. However, there is an absence of research regarding nursing barriers and measures to increase nursing effectiveness in the role of advance directive facilitator. Demographic variables among clients that repeatedly showed significance were race and education. It follows that these same variables may affect nurses' understanding of advance directives.

Research Involving Nursing Knowledge

In preparation for providing expert witness testimony in a malpractice trial, Horns and Gills (1998) conducted a survey of 450 neonatal nurses. Neonatal nurse practitioners (NNPs) ($n = 115$) and registered nurses (RNs) ($n = 335$) completed an instrument testing knowledge of Penicillin G therapy. Correct responses were higher on all five questions for NNPs versus RNs. Although statistical significance was

not documented, level of education was a consistent influence in correct administration of Penicillin G therapy.

An extensive body of research involving nursing knowledge was found in the area of wound care. The Pressure Ulcer Knowledge Test was administered by Pieper and Mott (1995) to 228 RNs. A significant relationship was documented between knowledge level and the independent variables of literature review and attendance at a lecture on pressure ulcers. Age, education, and nursing experience were not found to be related to knowledge scores.

Pieper also collaborated with another researcher, Mattern in 1997 to test critical care nurses' knowledge of pressure ulcers (n = 75). The Pressure Ulcer Knowledge Test, a 47 item tool, was administered to intensive care RNs. This descriptive correlational study found that years of experience were not related to scores on the knowledge test.

Kimura and Pacala (1997) surveyed 155 family physicians. Seventy percent of respondents self reported inadequate training and preparation of pressure ulcer care. Shockingly, 70% also were unfamiliar with the published guidelines from The Agency for Health Care Policy and Research. These documents are the standard for treatment and prevention of pressure ulcers.

In a well designed experimental study Hayes, Wolf, and McHugh (1994) investigated the effectiveness of a teaching

plan implemented to improve knowledge of pressure ulcer assessment, treatment, and risk factors. One hundred and two randomly selected members of a hospital nursing staff were placed in either control or experimental groups. The control group watched a 25 minute video on general skin care. The experimental group was instructed by a master's prepared wound specialist regarding pressure ulcer assessment, prevention, and care. Naturally, the experimental group had significantly greater knowledge scores after the planned intervention. RNs also had significantly higher knowledge scores than licensed practical nurses and nurses' aides. Again, the positive influence of education on nurses' knowledge is documented.

Nursing knowledge of latex allergy was explored by Lewis, Norgan, and Reilly (1998). Pender's Health Promotion Model guided a nonexperimental descriptive study (n = 89) using the Latex Allergy Knowledge Base Self-Evaluation Questionnaire (LAKBSQ). Validity and reliability of this instrument were well documented by the researcher. Positive correlations were found between scores on the LAKBSQ and level of education ($p = .030$). A significant correlation was also noted between LAKBSQ scores and attendance at education programs on latex allergy ($p = .006$). An interesting nonstatistically significant finding was the negative correlation ($r = -.20$) between scores on the LAKBSQ and

individuals with personal latex allergy ($p = .060$). A final significant relationship was documented between knowledge level of latex allergies and experience with provision of health care to latex allergic clients ($p = .036$).

The preceding studies overwhelmingly support level of educational preparation as a significant variable influencing nursing knowledge. Previous attendance of a continuing education seminar also affected nursing knowledge. Mixed results were documented for experience. No relationship was found between the variable of age and knowledge level.

Research Involving Knowledge of Advance Directives

Four current studies were found in the literature specifically addressing knowledge of advance directives. Hague and Moody (1993) examined public knowledge among 157 adults who completed a researcher designed questionnaire and demographic profile. Knowledge of five variables was tested including situation appropriate for living will, durable power of attorney for health care, health care surrogate power of attorney and living will. Percent correct scores varied from 56 to 79%. Scores on the instrument were not significantly related to religion, gender, ethnicity, years of education or age. However, the major finding of this study was a low correct response rate to questions about

living wills (41.56%). This finding confirms the need for further public educational efforts.

The final three studies directly address nurses knowledge of advance directives. Weiler, Eland, and Buckwalter (1996) conducted a descriptive study documenting living will knowledge of nurses residing in the state of Iowa. The sample (n = 2697) consisted of both registered nurses and licensed practical nurses who completed a questionnaire developed by the authors. Only 70% of respondents were aware of the existence of living will legislation in the state of Iowa. Roughly one third of the sample were uninformed despite dissemination of education information through professional journals, continuing education and media coverage. These findings suggest the need for alternative educational strategies.

In 1998, Downe-Wamboldt, Butler and Coughlan studied Canadian registered nurses (N = 974) in regards to knowledge of living wills. By self report, participants rated their understanding of living wills on a Likert scale from 1 (very aware) to 10 (not aware). The mean response was 7.4. Further analysis of data using Fisher's exact test and Student's t-test demonstrated no significant difference in awareness of legislation based upon education. Significant barriers to generalization of these results include a low response rate (16% or n = 157) and the fact that data were collected in a

foreign country. However, the study supports a nursing knowledge deficit in regards to advance directive legislation.

The research study by Crego and Lipp (1998) sampled 339 acute care nurses in one tertiary care center in the midwestern United States with a response rate of 38%. A demographic profile was obtained along with responses to a 44 item knowledge questionnaire. The instrument was researcher designed and pilot tested for readability and clarity. Content validity was established through literature and expert review.

A mean score of 78% correct with a range of 40-95% was documented on the knowledge questionnaire. Analysis of variance resulted in a statistically significant difference in knowledge based on ethnicity ($F = 5.47$; $p = .02$). However it should be noted that only 4% of the respondents were non-Caucasian. Near significant knowledge differences based on area of nursing specialty were demonstrated ($F = 2.17$; $p = .02$). A non-significant difference in knowledge based on education was found ($F = 0.92$; $p = .4302$). Clinical significance was suggested by the fact that only 14% of the nurses who responded had completed a personal advance directive.

The study supports poor level of knowledge attainment of advance directives by critical care nurses. The authors

suggest further research with nurses in different practice areas is needed.

Summary and Implications for Study

The literature review clearly illustrates the strength of Dorthea Orem's theory of self care as a sound theoretical framework for nursing research. The effect of basic conditioning factors such as education and personal experience had little consideration in relationship to nursing agency.

Client variables repeatedly identified as barriers to advance directive participation were race and education. In regards to nursing knowledge of varied topics, educational preparation and attendance of a continuing education seminar had the most significant effect. Specific to nurses' knowledge of advance directives, the preceding studies suggest alarmingly low levels of understanding. This finding is consistent with minimal levels of public understanding and completion of advance directives. Again, ethnicity was identified to have a significant relationship to knowledge of advance directives. For these reasons, the following research project was conducted.

This project is important to nursing because it allows for self evaluation and identification of potential personal practice and educational deficits. Changing the population practice setting from the original study is

significant because of the focus of nursing care provided. Acute care is directed at prompt interventions of a life sustaining nature. The relationships that nurses develop with hospitalized patients are intense but typically very brief. In contrast, home health care nurses provide interventions promoting long term, independent management of the disease process by the client. Contact with patient is typically of a longer duration. In addition, the home health nurse has the advantage of on site assessment of the client's home environment and support systems.

Other significant changes from the Crego and Lipp (1998) study include the period of time during which data collection occurs and a different geographical location. Advance directive legislation and distribution of information vary over time and from state to state.

Research Questions

The objective of this study was to assess home health care nurses' knowledge of advance directives. The following research questions were addressed:

1. What level of knowledge do licensed home health care nurses possess about advance directives?
2. What are the differences in knowledge of advance directives based on educational preparation?
3. Is there a relationship between knowledge of advance directives and years of nursing experience?

Definition of Terms

Advance Directive: A tool designed to promote patient autonomy, protect moral and legal rights, reduce family decision making conflict, and indicate client's wishes regarding end of life care (Pelligrino, 1992). These instruments are the living will, medical directive, and durable power of attorney for health care or health care proxy.

Educational Preparation: The highest nursing degree completed. Nursing degrees include Licensed Practical Nursing, Diploma, Associate, Bachelors, Masters or Doctorate.

Nursing Experience: The number of years one has practiced as a licensed nursing professional.

CHAPTER 3
METHODOLOGY

Design

A descriptive correlational design was used to measure licensed nurses' knowledge of advance directives. The purpose of this nonexperimental design was to explore the relationships between certain variables. The dependent variable was the score on the instrument assessing knowledge of advance directives. The independent variables were educational preparation and years of nursing experience.

Setting and Sample

Data were obtained from a Medicare certified home health care agency in the state of Michigan. Approximately 70 registered nurses were employed at this agency in full time, part time, and contingency positions. There were no licensed practical nurses employed at the time of data collection. A convenience sample of 40 participants was obtained. Age ranged from 28 to 61 years with a mean age of 44 years ($SD = 7.28$). Characteristics of the sample are presented in Table 1.

Table 1

Characteristics of the sample (n = 40) _____

| Group | n | % |
|------------------|----|------|
| <u>Gender</u> | | |
| Male | 2 | 5.0 |
| Female | 38 | 95.0 |
| <u>Ethnicity</u> | | |
| African American | 1 | 2.5 |
| Caucasian | 39 | 97.5 |
| <u>Specialty</u> | | |
| General | 10 | 25.0 |
| Cardiac | 9 | 22.5 |
| Rehab | 6 | 15.0 |
| Hospice | 7 | 17.5 |
| Pediatrics | 4 | 10.0 |
| Supervision | 4 | 10.0 |
| Other | 6 | 15.0 |

Note. Four participants indicated more than one specialty.

Instruments

Demographic Profile: A researcher designed self administered questionnaire was utilized to measure the independent variables of educational preparation and years of nursing experience (Appendix A). Additional questions regarding personal experience with advance directive facilitation and preparedness to counsel on advance directives were posed. These variables were considered important for analysis of data, generalizability of study findings, and further research efforts.

Knowledge of Advance Directives: Crego and Lipp (1998)

designed an instrument to measure nurses' knowledge of advance directives. This self administered questionnaire consisted of 44 closed-ended dichotomous items. For this study, five items were deleted from the original instrument as they were confusing in the current home health care environment. Additionally, alterations were made to the instrument to appropriately reflect changes in the state where data collection would occur (Appendix B). Written permission to use the instrument was obtained from the authors (Appendix C) and permission to administer the modified tool was granted (Appendix D).

Crego and Lipp (1998) had the original instrument reviewed for readability by five registered nurses at Grant Riverside Methodist Hospital in Columbus, Ohio. In addition, readability was assessed by five graduate nursing students from Wright State University College of Nursing and Health in Dayton, Ohio. All 10 participants reported that the original instrument was easy to read and understand.

Content validity of the original knowledge instrument was established by Crego and Lipp (1998) through literature and expert review. Expert reviewers were all nurses with either experience in educational curricula development on advance directives for use by the public or collegiate

faculty with expertise in advance directives. Construct and criterion related validity were not addressed.

Reliability of the knowledge collection instrument was not evaluated by Crego and Lipp (1998). Therefore, internal consistency of the modified instrument was evaluated for this study utilizing the Kuder-Richardson 20. A coefficient alpha of .5147 was generated by this formula specific to the 39 dichotomous items.

Procedure

Approval for the study was obtained from the author's thesis committee (Appendix E). Approval for on site data collection was obtained from the chief operating officer of the home health care agency (Appendix F). Final approval was then received from Grand Valley State University Human Research Review Committee (Appendix G).

Potential participants were contacted initially via a voice mail message to all nursing staff. Simultaneously, research packets containing a cover letter (Appendix H) and the two questionnaires were distributed to every RN agency mailbox located within the main office.

Participation in the study was entirely voluntary and anonymous. Completion and return of the questionnaires demonstrated consent. Therefore no written informed consent was obtained. Participation in the study was estimated to require 15 to 20 minutes. There was no cost associated with

participation and no remuneration was provided. Completed packets were returned to a designated mailbox with the main office.

One week after initial distribution a reminder voice mail message was issued to encourage participation and return of the questionnaires by the two week deadline. At the conclusion of the study a note was left in all RN agency mailboxes thanking those who participated. No adverse responses were reported.

CHAPTER 4

RESULTS

Data Preparation and Analysis

A total of 71 research packets were distributed. Forty-two subjects participated in the research project producing a 59.15% response rate. Two subjects were omitted as they returned the questionnaires after the two week deadline. Coded data from the remaining 40 subjects was analyzed in accordance with the research questions using the Statistical Package for the Social Sciences. Items left blank on the questionnaires were scored as incorrect. A significance level or p value of $\leq .05$ was used for all statistical results. Characteristics of the subjects were generated from the demographic profile.

Findings

The research question asking "What level of knowledge do licensed home health care nurses possess about advance directives?" was determined by the knowledge test. This dependent variable was measurable at the interval level. With a possible high of 39, subject scores ranged from 26 to 38 (M = 33.03; SD = 2.83). The knowledge scores when

reported as a percentages ranged from 66.67% to 97.44% (M = 84.68%; SD = 7.26%).

Nursing education was measured in terms of highest degree attainment. The level of measurement was nominal. Five mutually exclusive categories were available. Educational preparation of the sample is presented in Table 2.

Table 2

Educational Preparation (n = 40)

| <u>Degree</u> | <u>Frequency</u> | <u>%</u> |
|---------------|------------------|----------|
| Associate | 13 | 32.5 |
| Diploma | 9 | 22.5 |
| Bachelors | 14 | 35.0 |
| Masters | 4 | 10.0 |

Note. There were no subjects prepared at the doctoral level.

The research question "What are the differences in knowledge of advance directives based on educational preparation?" was intended to be evaluated using a one way analysis of variance. Due to insufficient sample size, associate and diploma graduates were grouped together and yielded a mean score of 86.01% on the knowledge test (SD = 7.37%). Bachelors and masters graduates when grouped together and had a mean knowledge score of 83.05% (SD = 6.99%). When these two subgroups were then compared using a t-test no significant difference was found ($t = 1.29$; $df = 38$; $p = .20$).

The last research question "Is there a relationship between knowledge of advance directives and years of nursing experience?" was evaluated using a Pearson's r product-moment correlation coefficient. The independent variable, years of nursing experience, was measurable at the interval level and found to have a weak, negative, non-significant relationship to knowledge of advance directives ($r = -.243$; $p = .141$).

Additional Findings of Interest

It was noted that subjects with less education preparation scored higher on the knowledge test than those with advanced degree attainment. This finding caused the researcher to question whether those nurses in the associate and diploma degree subgroup had more years of experience than their counterparts in the bachelors and masters degree subgroup. A t-test was utilized (Table 3) and no significant difference in years of experience was found ($t = -1.75$; $df=36$; $p = .09$).

Table 3

Independent Samples of Years of Nursing Experience (n = 38)

| <u>Educational Preparation</u> | <u>M</u> | <u>SD</u> |
|--------------------------------|----------|-----------|
| Associates and Diploma | 15.71 | 8.97 |
| Bachelor and Masters | 20.94 | 9.28 |

Finally, a t-test was conducted to explore differences in age by educational preparation (n = 38). The associate and diploma subgroup (M = 43.85 years; SD = 6.27) was very similar with the bachelors and masters subgroup (M = 44.18 years; SD = 8.52). A t-test showed no significant difference (t = -.13; df = 35; P = .89).

Two questions were included on the demographic profile to assess personal practice and comfort level with advanced directives. The query "Have you ever assisted a client with documentation of an advance directive?" was measured at the nominal level. It was found that 40% of study subjects (n = 16) responded affirmatively. Twenty-four subjects or 60% denied providing assistance to clients with advance directive documentation. The second question asked "Do you feel prepared to counsel patients on advance directives?". In response, 45% of subjects (n = 18) responded affirmatively. Twenty-two subjects or 55% responded negatively.

In summation, it was found that the sample possessed a high level of advance directive knowledge. Interestingly, nurses with less education scored higher on the knowledge test than those with advanced degrees. This difference was found to be non-significant however. Years of nursing experience was found to have a weak, negative non-significant relationship to knowledge of advance directives.

Finally, the majority of subjects were found to have no experience with assisting clients in advance directive formation and did not feel prepared to counsel clients on advance directives.

CHAPTER 5
DISCUSSION AND IMPLICATIONS

Discussion

The primary objective of this study was to assess home health care nurses' knowledge of advance directives. An exceptional response rate to the study indicated a high level of interest by nurses in the topic under investigation. The mean score of 84.68% on the knowledge test in this study was considerably higher than the mean score of 78% reported by Crego and Lipp (1998). This encouraging finding may be attributed to the change in practice setting, passage of time between data collection episodes or geographical location. Other factors that may have influenced this result include possible increased attendance at continuing educational events or the reading of articles on advance directives published in professional journals. In terms of Orem's theory of self-care, increases in nursing knowledge build and empower nursing agency. Therefore the findings of this study support improving nurses' ability to intervene more effectively which helps clients meet their self care deficits.

The secondary objective of determining any differences in knowledge of advance directives by educational preparation was more difficult to understand. Based upon the literature review it was anticipated that education would have a positive effect on knowledge levels. However, data analysis showed no significant difference in knowledge scores based on educational preparation. This finding is inconsistent with Orem's basic conditioning factors thought to affect nursing agency. The small sample sized dictated the use of a t-test, versus an analysis of variance, and may not have allowed the effect that education might have on knowledge to be reflected. Crego and Lipp (1998) were also unable to identify a significant relationship between education and knowledge level.

The somewhat surprising results of higher knowledge scores by the lower educated group may be attributed to homogeneity of the entire sample. This homogeneity is supported by the non significant difference between educational groups based on age and years of experience.

The final objective of this study was to determine if there was a relationship between knowledge of advance directives and years of nursing experience. It was anticipated that experience would have a positive relationship to knowledge level. The weak negative non significant findings are inconsistent with Orem's theory

(1995). The current study suggests that nurses with more experience may be less inclined to expand their professional role. Crego and Lipp (1998) did not address the variable of nursing experience in their study.

Overall, the most important finding of the current study was the strong level of nursing knowledge of advance directives possessed by home health care nurses.

Limitations

Internal validity of the study was threatened by selection bias. It is possible that nurses who specialized in hospice care had a higher knowledge level of advance directives. Therefore it was anticipated these nurses would self select to participate in the study with more frequency based on their comfort levels with the topic under evaluation. In an attempt to control this threat, the demographic profile included a query regarding area of specialty. Hospice nurses did participate in the study with a greater frequency than their occurrence in the accessible population. Only 11.4% of the agency nurses are members of the hospice team, but 17.5% of the total participants in this study indicated a hospice specialty.

While all potential subjects received identical research packets, the environment in which subjects completed the questionnaires was most likely variable. The time limit for completion of questionnaires was strictly

adhered to in an attempt to limit external threats and biases related to maturation.

A major limitation of the study was the consistency of the quantitative instrument used to measure knowledge. Internal consistency of the instrument was evaluated using a reliability coefficient and generated a alpha that was not sufficient to make group comparisons. Reliability may have been affected by the small sample size and deletion of numerous items from the original instrument.

External validity of the study was affected by the use of convenience sampling. Generalizability of the findings is limited to the target population of nurses providing home care in the state of Michigan.

Implications

Findings of this study support the home health care nurse as a knowledgeable, qualified provider of advance directive information. As a trusted member of the health care team, nurses in clinical practice need to help clients prepare themselves for the future and demonstrate self-care instead of uncertainty. Home health care administrators can find security and potential financial savings in the findings of this study. Registered nurses can competently provide advance directive education and avoid expensive and non reimbursable social work evaluations. Nursing educators perhaps benefit the most from coincidental findings of this

study. Despite high knowledge scores, the majority of home health care nurses do not feel prepared or do not actively assist their clients with advance directive formation. This information allows for improved focusing of continuing educational efforts.

Recommendations

Further research investigating knowledge of advance directives by nurses in alternate practice settings is needed. Other outpatient settings should be considered for data collection, including offices and long term care facilities. Larger sample sizes may reveal important relationships between demographic variables and knowledge levels. It may also be beneficial to consider modification of the measurement tool to improve validity and reliability. A study investigating the knowledge and comfort levels of nurse practitioners could also provide valuable information.

Completion of an advance directive is the final and possibly most important act of self-care. Home health care nurses have the ability and opportunity to provide a valuable service to their clients.

APPENDICES

APPENDIX A

DEMOGRAPHIC DATA COLLECTION FORM

DEMOGRAPHIC DATA COLLECTION FORM

1. Gender (select one)

_____ (1) Male _____ (2) Female

2. Age _____ years

3. Ethnic group with which you most closely identify:

(select all that apply)

- _____ (1) Native American
- _____ (2) Hispanic
- _____ (3) Asian
- _____ (4) African American
- _____ (5) Caucasian
- _____ (6) Other

4. Years of Experience as a Registered Nurse: _____ years.

5. Highest level of nursing education completed:

(select one)

- _____ (1) Associate Degree
- _____ (2) Diploma
- _____ (3) Bachelors Degree
- _____ (4) Masters Degree
- _____ (5) Doctoral Degree

6. Area of specialty within home health care:

(select one)

- _____ (1) General
- _____ (2) Cardiac
- _____ (3) Rehab
- _____ (4) Hospice
- _____ (5) Pediatrics
- _____ (6) Supervision
- _____ (7) Other Specify _____

7. Have you ever assisted a client with documentation of an advance directive?

_____ (1) Yes _____ (2) No

8. Do you feel prepared to counsel patients on advance directives?

_____ (1) Yes _____ (2) No

APPENDIX B

ADVANCE DIRECTIVE KNOWLEDGE QUESTIONNAIRE

10. Living will and Durable Power of Attorney for health care cannot be witnessed by the attending physician, or the administrator of a nursing home or other facility where the patient is receiving care.
- (1) True (2) False
11. I think additional education would increase my understanding of advance directives.
- (1) True (2) False
12. I think additional education (inservices, workshops) would increase my understanding of advance directives and ability to communicate this information to the patient and family.
- (1) True (2) False
13. Health care professionals provide adequate information to patients about living wills and Durable Power of Attorney for Health care.
- (1) True (2) False
14. Physicians are best suited to provide information about advance directives to the patient.
- (1) True (2) False
15. Nurses are best suited to provide information about advance directives to the patient.
- (1) True (2) False
16. Nurses, in their advocacy role, are in a unique position to assess the appropriate time for advance directive discussions.
- (1) True (2) False
17. I have had adequate education to intelligently discuss and answer patient questions about living wills and Durable Power of Attorney for health care.
- (1) True (2) False
18. When I have a question about a living will or Durable Power of Attorney for health care, I know who to contact within the institution.
- (1) True (2) False
19. Patients and the public can obtain blank living will and Durable Power of Attorney for health care forms from their health care providers or health care institution.
- (1) True (2) False
20. Nurses are the most likely health care provider to initiate end of life discussions with the patient and family.
- (1) True (2) False

21. Patients and the public in Michigan may only use the pre-printed living will and Durable Power of Attorney for health care prepared by the Michigan State Bar Association and approved by the Michigan State Medical Association for these forms to be legal.

(1) True (2) False

22. In Michigan a minor can have a legal advance directive.

(1) True (2) False

23. A living will and a Durable Power of Attorney for health care must always be notarized.

(1) True (2) False

24. A living will and Durable Power of Attorney for health care may be revoked at any time by the principal (the person's own form).

(1) True (2) False

25. It is recommended that a person have a living will and/or Durable Power of Attorney for health care in his or her home state and the state where they visit frequently, due to differences in state law of the Patient Self-Determination Act.

(1) True (2) False

26. Power of Attorney for health care does not give the designated agent power over financial or real estate transactions for the patient.

(1) True (2) False

27. Living wills should be executed and placed securely in a safe-deposit box or in a home safe.

(1) True (2) False

28. Durable Power of Attorney for health care can be used in non-terminal situations, such as when a patient is unconscious from anesthesia.

(1) True (2) False

29. Living wills should be copies and distributed to family physicians, family members or friends who would relay the patient's wishes to health care providers in case the patient became incapacitated and unable to have decision-making capabilities.

(1) True (2) False

30. Autonomy is concerned with individual right to self-governance or freedom of choice, and includes the absolute right to refuse medical treatment.

(1) True (2) False

31. Health care providers are ethically and legally responsible for informing patients about their end-of-life choices.
- (1) True (2) False
32. Living will and Durable Power of Attorney for health care are unnecessary as long as an individual has people they can trust around.
- (1) True (2) False
33. Living will and Durable Power of Attorney are mostly for people who are elderly and sick.
- (1) True (2) False
34. Patients and the public may sign a preprinted living will form available in their community, draw up their own form, or simply write a statement of their preferences for treatment. They may also wish to speak to an attorney or physician to be certain they have completed the living will in a way that their wishes are understood.
- (1) True (2) False
35. An agent or proxy designated in a Durable Power of Attorney for health care can be a husband, wife, daughter, son, any relative or close friend who can make medical decisions for the patient if they should become unable to make their own decisions.
- (1) True (2) False
36. Everyone that enters the hospital must have an Advance Directive.
- (1) True (2) False
37. Hydration and nutrition can be withheld or withdrawn when a patient is in a permanently unconscious state if so indicated on their living will and/or Durable Power of Attorney for health care and physicians have followed legislation established by the Patient Self-Determination Act.
- (1) True (2) False
38. Physicians who disagree with a patient's living will or a decision made by a health care agent under a Power of Attorney for health care, should turn the case over to a physician who will honor the decision.
- (1) True (2) False
39. When 9-1-1 (emergency) is dialed, in general, the emergency team will provide emergency treatment even if the patient has a living will. Individuals who never want emergency treatment should not call 9-1-1 or any other emergency number.
- (1) True (2) False

Thank you for your participation!

Please return the completed questionnaires in the manila folder in Jennifer Zoeteman's hot file.

APPENDIX C

PERMISSION TO USE ADVANCE DIRECTIVE KNOWLEDGE QUESTIONNAIRE

Patti J. Crego, M.S., R.N. CCRN
Surgical Heart Outcomes Manager
Grant/Riverside Methodist Hospitals (Riverside Campus)
3535 Olentangy River Road
Columbus, Ohio 43214
office: (614) 566-4580 fax: (614) 566-3638
e-mail: cregop@ohiohealth.com

February 5, 1999

Jennifer L. Zoeteman
6769 City View Dr.
Hudsonville, MI 49426

Dear Ms. Zoeteman,

Thank you for your inquiry related to the journal article *Nursing Knowledge of Advance Directives*. Patients' self-determination continues to be an issue of importance related to patient care and outcomes.

As an author I am requesting compliance with the following:

- ▶ If research instrument is utilized please acknowledge authors.
- ▶ If research is published to notify authors.
- ▶ Only modify research instrument with authors' written approval.

Again, as authors we are pleased with your interest and potential for further research, especially in the community setting. Please, contact me with any questions or if I can be of assistance.

Sincerely,



Patti J. Crego, MS, RN CCRN

APPENDIX D

PERMISSION TO USE MODIFIED
ADVANCE DIRECTIVE KNOWLEDGE QUESTIONNAIRE

Mark Zoeteman

From: Mark Zoeteman [zoet@iserv.net]
Sent: Tuesday, September 04, 2001 2:56 PM
To: MZoeteman@intarch.com
Subject: please print this for me



Questionnaires.doc

----- Original Message -----

From: <CREGOP@OhioHealth.com>
To: Mark Zoeteman <zoet@iserv.net>
Sent: Tuesday, September 04, 2001 7:55 AM
Subject: Re: advance directive knowledge tool

>
> Thank you for informing me of the changes to the questionnaire. Good luck
> with your data collection.
>
> Patti-
>
>
>
> "Mark Zoeteman" <zoet@iserv.net> on 09/03/2001 10:19:05 PM
>
> Please respond to "Mark Zoeteman" <zoet@iserv.net>
>
> To: <cregop@ohiohealth.com>
> cc:
> Subject: advance directive knowledge tool
>
>
> Dear Ms. Crego,
>
> I am finally getting around to data collection on my thesis.
>
> Attached is a copy of the alterations I propose to make to the knowledge
> tool you designed. I have changed any references to the state of Ohio to
> Michigan. Those changes related to state are highlighted. In addition, I
> have opted to delete questions originally numbered 22, 23, 24, 43 and 44.
> These items were confusing in the current home care environment.
>
> I am requesting your permission to utilize the tool with the proposed
> changes. I would also like to place a copy of the altered tool in the
> appendix of my thesis.
>
> Please review and respond by e-mail.
>
> Thank you for your time and consideration,
>
> Jennifer Zoeteman
> 13100 100 th Street
> Alto, MI 49302
>
> (See attached file: Questionnaires.doc)
>
>
>
>
>

APPENDIX E

MASTER'S THESIS PROPOSAL APPROVAL

MASTER'S THESIS PROPOSAL APPROVAL

This signed form signifies that Jennifer Zoeteman's Proposed Master's Thesis has been approved as satisfactory by the Supervisory Chairperson and members of the Committee. It also authorizes the student to submit a Human Research Review Form to the GVSU Human Research Review Committee. This approval does not constitute a FINAL approval of the thesis.

This form must be filed with Kirkhof School of Nursing, MSN Program.

TITLE OF THESIS: Home Health Care Nurses'
Knowledge of Advance Directives

Supervisory Committee Signatures:

Date Approved:

Chairperson:

[Redacted Signature]

9-24-01

Member:

[Redacted Signature]

9-24-01

Member:

[Redacted Signature]

9-24-01

APPENDIX F

DATA COLLECTION APPROVAL



Visiting Nurse Association
of Western Michigan

VISITING NURSE & HOSPICE

1401 CEDAR N.E., GRAND RAPIDS, MICHIGAN 49503 • TELEPHONE (616) 774-2702 • FAX (616) 774-7017

September 14, 2001

Ms. Jennifer Zoeteman
13100 100th St. SE
Alto, MI 49302

Dear Jennifer:

This letter acknowledges the fact that you and I discussed and agreed that you may survey the professional nursing staff at Visiting Nurse Services regarding their familiarity with Advanced Directives.

I wish you success in your educational pursuit and am proud that Visiting Nurse Services can be involved in supporting your work.

Please let me know if I or the organization can be of any further assistance.

Sincerely,

Chris Conklin
President/CEO



A United Way Agency

Document 2



Joint Commission
Accreditation of Healthcare Organizations

APPENDIX G

HUMAN RESEARCH REVIEW COMMITTEE APPROVAL



GRAND VALLEY
STATE UNIVERSITY

1 CAMPUS DRIVE • ALLENDALE, MICHIGAN 49401-9403 • 616/895-6611

December 19, 2001

Jennifer Zoeteman
13100 100th St. SE
Alto, MI 49302

RE: Proposal #02-131-H

Dear Jennifer:

Your proposed project entitled **Home Health Care Nurses' Knowledge of Advance Directives** has been reviewed. It has been approved as a study, which is exempt from the regulations by section 46.101 of the Federal Register 46(16):8336, January 26, 1981.

Sincerely,

A black rectangular box redacting the signature of Paul A. Huizenga.

Paul A. Huizenga, Chair
Human Research Review Committee

APPENDIX H

COVER LETTER

Dear RN staff of Visiting Nurse Services,

My name is Jennifer Zoeteman and I am a full time weekend RN staff member of Visiting Nurse Services in the process of completing my Master's Degree in Nursing from Grand Valley State University. In order to fulfill my degree requirements I am conducting a research project evaluating home health care nurses' knowledge of advance directives. The information gathered from this study may be useful for planning continuing education programs, altering nursing curricula, and expanding the role of nursing professionals.

Chris Conklin, President/CEO of Visiting Nurse Services has given approval for distribution of two enclosed surveys for you to consider completing. All registered nurses employed by the agency have been selected as potential subjects. Participation in this study is voluntary. You are free to decide not to participate in this study or to withdraw at any time without adversely affecting your relationship with the investigator, Visiting Nurse Services or Grand Valley State University. Your decision will not result in any loss of benefits to which you are otherwise entitled.

It is anticipated that completion of the surveys will take approximately 15-20 minutes. All responses will be anonymous and identification of individual participants will not be possible.

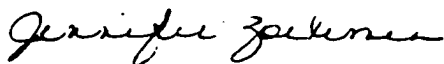
No physical risk is associated with this study. Minimal risk of emotional response is possible if you have had a personal experience with advance directive formation or implementation.

If you have any questions regarding the study feel free to contact me at voice mail number 379 or at my home phone (616) 765-3049. If you have any questions about your rights as a research participant that have not been answered by the investigator, you may contact the Grand Valley State University, Human Subjects Review Committee Chair, Paul Huizenga at (616) 895-2472.

Results of the study will be reported in scientific literature in aggregate form. A summary of results is available to all participants upon voice mail request.

If you chose to participate, simply complete the enclosed demographic profile and knowledge test. Return these documents in the manila folder provided to the agency mail box labeled Jennifer Zoeteman. I thank you in advance for your participation.

Sincerely,



Jennifer Zoeteman RN
Graduate Student
Kirkhof School of Nursing
Grand Valley State University

APPENDIX I

REPRINT PERMISSION AGREEMENT

2455 TELLER RD., THOUSAND OAKS, CA 91320
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PHONE #: FAX #:
RE : Long Term Care Nurses'

Ms. Jennifer Zoeteman
6769 City View Drive
Hudsonville, MI 49426

One-time only, non-exclusive, world rights in the English language are hereby granted to Ms. Jennifer Zoeteman (hereafter referred to as "The Requester") for the following selection:

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| VOLUME/ISSUE # | | | |
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Signature of Requester

10-11-99

Date

Date:

PLEASE REMIT ONE (1) SIGNED COPY OF THE AGREEMENT,
ALONG WITH ANY APPLICABLE PAYMENT TO THE ADDRESS LISTED ABOVE. THANK YOU.

LIST OF REFERENCES

REFERENCES

Bailly, D. J. & DePoy, E. (1995). Older people's responses to education about advance directives. Journal of Health and Social Work, 20, 223-228.

Bastnagel, S. (1993). Risk analysis: The patient self-determination act-Living will and other types of advance directives. Hospital Risk Control: Critical Care, 13(1), 1-34.

Berrio, M. W. & Levesque, M. E. (1996). Advance directives: Most patients don't have one. Do yours? American Journal of Nursing, 96(8), 25-29.

Bradley, E., Walker, L., Blechner, B. & Wetle, T. (1997). Assessing capacity to participate in discussions of advance directives in nursing homes: Findings from a study of the patient self determination act. Journal of the American Geriatrics Society, 45, 79-83.

Crego, P. J. & Lipp, E. J. (1998). Nurses' knowledge of advance directives. American Journal of Critical Care, 7, 218-223.

Dennis, C. M. (1997). Self-care deficit theory of nursing: Concepts and applications. St. Louis: Mosby.

Doukas, D. J. & McCullough, L. B. (1988). Assessing the values history of the elderly patient regarding critical and chronic care. In Gallo, J. J., Reichel, W. & Andersen, L. (Eds.). Handbook of Geriatric Assessment. Rockville, MD: Aspen.

Downe-Wamboldt, B., Butler, L. & Coughlan, S. (1998). Nurses' knowledge, experiences and attitudes concerning living wills. Canadian Journal of Nursing Research, 30, 161-175.

Dunlap, R. K. (1997). Teaching advance Directives: The why, when, and how. Journal of Gerontological Nursing, 23(12), 11-16.

Evers, G. C. M., Isenberg, M., Philipsen, H., Brouns, G., Halfens, R. & Smeets, H. (1986). The 'appraisal of self-care agency' ASA-scale: Research program to test reliability and validity. In Stinson, S., Kerr, J., Giovanetti, P., Field, P. & MacPhail, J. (Eds.). Frontiers in Nursing Research: International Nursing Research Proceedings. Edmonton, Canada: University of Alberta.

Gamble, E. R., McDonald, P. J. & Lichstein, P. R. (1991). Knowledge, attitudes, and behavior of elderly persons regarding living wills. Archives of Internal Medicine, 151, 277-280.

Gates, M. R., Schins, I. & Smith, A. S. (1996). Applying advanced directives regulations in home care agencies. Home Healthcare Nurse, 14, 127-133.

Gorden, G. & Dunn, P. (1992). Advance directives and the Patient Self-Determination Act. Hospital Practice, 27(1), 39-42.

Hart, M. A. (1995). Orem's self-care deficit theory: Research with pregnant women. Nursing Science Quarterly, 8(3), 120-126.

Hauge, S. B. & Moody, L. E. (1993). A study of the public's knowledge regarding advance directives. Nursing Economics, 11, 303-307.

Hayes, P., Wold, Z., & McHugh, M. (1994). Effect of teaching plan on a nursing staff's knowledge of pressure ulcer risk, assessment, and treatment. Journal of Nursing Staff Development, 10, 207-213.

Herndon, L. (1993). Nurse practitioners and advance directives: A moral perspective. Nursing Scan in Research, 6(6), 8-9.

High, D. M. (1988). All in the family: Extended autonomy and expectations in surrogate health care decision making. Gerontologist, 28, 46-51.

High, D. M. (1993). Advance directives and the elderly: A study of intervention strategies to increase use. Gerontologist, 33, 342-349.

Horns, K. M. & Gills, M. B. (1998). Neonatal nurse knowledge of penicillin therapy. Neonatal Network, 17(7), 52-55.

Johns, J. L. (1996). Advance directives and opportunities for nurses. Image: Journal of Nursing Scholarship, 28, 149-153.

Kearney B. & Fleischer, B. (1979). Development of an instrument to measure exercise of self-care agency. Research in Nursing Health, 2, 25-34.

Kimura, S. & Pacala, J. (1997). Pressure ulcers in adults: Family physicians' knowledge, attitudes, practice preferences, and awareness of AHCPR guidelines. Journal of Family Practice, 44, 361-368.

Lewis, L. C., Norga, G. & Reilly, M. (1998). Are nurses knowledgeable in regards to latex allergy? Seminars in Perioperative Nursing, 7, 239-253.

Luptak, M.K. & Boulton, C. (1994). A method for increasing elders' use of advance directives. Gerontologist, 34, 409-412.

Mezey, M., Evans, L. K., Golub, Z. D., Murphy, E. & White, G. B. (1994). The Patient Self-Determination Act: Source of concern for nurses. Nursing Outlook, 42, 30-38.

McQuiston, C. M. & Webb, A. A. (1995). Foundations of nursing theory: Contributions of 12 key theorists. Thousand Oaks, CA: Sage

Nelson-McEvers, J. A. (1995). Measurement of self-care agency in a noninstitutionalized elderly population. Unpublished master's thesis, Grand Valley State University, Allendale, Michigan.

Orem, D. E. (1995). Nursing: Concepts of practice (5th ed.). St. Louis: Mosby.

Palker, N. B. & Nettles-Carlson, B. (1995). The prevalence of advance directives: Lessons from a nursing home. Nurse Practitioner, 20(2), 7-21.

Pellegrino, E. D. (1992). Ethics. Journal of the American Medical Association, 268, 354-355.

Perrin, K. O. (1997). Giving voice to the wishes of elders for end-of-life care. Journal of Gerontological Nursing, 23(3), 18-27.

Pieper, B. & Mattern, J. C. (1997). Critical care nurses' knowledge of pressure ulcer prevention, staging, and description. Ostomy/Wound Management, 43(2), 22-31.

Pieper, B. & Mott, M. (1995). Nurses' knowledge of pressure ulcer prevention, staging, and description. Advances in Wound Care, 8, 34-48.

Ross, P. & West, D. J. (1995). Advance directives: The price of life. Nursing Economics, 13, 355-361.

Schirm, V. & Stachel, L. (1996). The values history as a nursing intervention to encourage use of advance directives among older adults. Applied Nursing Research, 9(2), 93-96.

Smits, M. W. & Kee, C. C. (1992). Correlates of self-care among the independent elderly: Self-concept affects well-being. Journal of Gerontological Nursing, 18(9), 13-18.

Tomey, A. M. & Alligood, M. R. (1998). Nursing theorists and their work (4th ed.). St. Louis: Mosby.

Utz, S. W. & Ramos, M. C. (1993). Mitral valve prolapse and its effects: A programme of inquiry within Orem's Self-Care Deficit Theory of Nursing. Journal of Advanced Nursing, 18, 742-751.

Vogelpohl, R. & Dougherty, J. (1993). What do nursing students learn about pressure ulcers? A survey of content on pressure ulcers in nursing school textbooks. Decubitus, 6, 49-51.

Ward-Griffin, C. & Bramwell, L. (1990). The congruence of elderly client and nurse perceptions of clients' self-care agency. Journal of Advanced Nursing, 15, 1070-1077.

Weiler, K., Eland, J. & Buckwalter, K. C. (1996). Iowa nurses' knowledge of living wills and perceptions of patient autonomy. Journal of Professional Nursing, 12, 245-252.

White, M. (1991). The Patient Self-Determination Act. Journal of the American Medical Association, 266, 410.

Zweibel, N. R. & Cassel, C. K. (1989). Treatment choices at the end of life: A comparison of decisions by older patients and their physician-selected proxies. Gerontologist, 29, 615-621.