Exploring the Barriers Faced by Nephrology Nurses in Initiating Patients With Chronic Kidney Disease Into Advance Care Planning Using Focus-Group Interviews

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ABSTRACT

Background: The prevalence of end-stage renal disease in Taiwan is the highest in the world. The rate of signing advance directives in Taiwan is lower than in Western countries, and most of the barriers that have been identified relate to initiating advance care planning (ACP).

Purpose: This study was designed to explore the barriers to discussing ACP with patients with chronic kidney disease faced by nephrology nurses.

Methods: A descriptive qualitative study design was adopted. The Consolidated Criteria for Reporting Qualitative Research was used to report the findings of this study. Data were collected using purposive sampling. A total of 34 nephrology nurses were recruited from hospitals in northern (2 groups, 10 participants), central (1 group, 4 participants), and southern (5 groups, 20 participants) Taiwan. A qualitative content analysis was conducted to analyze the transcripts of the eight focus groups.

Results: Five themes were identified, including (a) lacking the confidence to discuss ACP, (b) difficulty in finding an appropriate opportunity to initiate ACP discussion, (c) personally lacking the characteristics to discuss ACP, (d) conflicting perspectives between doctors and nurses over ACP, and (e) culture and belief-based barriers to discussing ACP.

Conclusions/Implications for Practice: The findings obtained from the interviews revealed that nurses must enhance their ACP-related knowledge and communication skills and foster personal confidence in initiating ACP discussions. Furthermore, nurses must be empowered to work with other healthcare professionals. To implement the initial process of discussing ACP in clinical settings, clinical guidelines should be developed for healthcare professionals on initiating ACP. These measures may facilitate improved collaboration in healthcare settings and further encourage patients and their families to participate in shared decision-making that may help patients complete advance directives and thereby achieve better care quality at the end of life.

Key Words:
advance care planning, advance directives, chronic kidney disease, nephrology nurses.

Introduction

Taiwan has the world’s highest prevalence of end-stage renal disease (ESRD; Tsai et al., 2018). Patients with ESRD may depend on hemodialysis for life-sustaining treatment and survival. During hemodialysis, patients may encounter critical conditions and require emergency treatment for which, even after cardiopulmonary resuscitation, the mortality rate is approximately 60% and overall survival averages less than 6 months (Sinclair et al., 2017). Under these circumstances, if they have signed advance directives (ADs), these patients have the latitude not to suffer from resuscitation efforts that are medically futile. In other words, signing an AD in advance is the best way to have a good death, which is defined as dying with a sense of emotional well-being, passing away with dignity, and feeling as though one has completed one’s life (Meier et al., 2016). However, only about 740,000 people (around 4%) have signed ADs in Taiwan as of September 2020 (Ministry of Health and Welfare, ROC, 2020). This rate is much lower than in Western countries where the rate ranges from 10% to 20%. In light of the above, identifying the major reasons for the low rate of signing ADs in Taiwan is important.

Advance care planning (ACP) is a means for patients to communicate their wishes, fears, and desires for health decisions after they lose the ability to consider them (Blackwood et al., 2019). ACP addresses issues including disease prognosis, decision-making in life-sustaining treatment, healthcare proxy appointments, and medical care preferences at the end of life. ADs, as a component of ACP, are legal documents that record patient’s treatment and other
preferences in the event of incapacity. However, ACP does not always include ADs, such as when a patient does not voice their preferences. How and Koh (2015) indicated that ACP may be as simple as a chat about the patient’s end of life wishes with their trusted loved ones and may involve their healthcare providers. These interactions may be documented using available online resources.

Traditionally, the therapeutic relationship between doctors and patients is considered the best platform through which to introduce and initiate the ACP conversation. This is why healthcare professionals are encouraged to initiate patients into ACP and assist them in signing ADs. Detering et al. (2010) noted that clinicians have a responsibility to help patients explore treatment options and formulate their own preferences based on risk–benefit analyses and their personal values to make decisions regarding end of life care. The healthcare provider participating in the ACP discussion does not need to be a clinician. Ideally, that person should be a healthcare provider who is able to work with the medical team and provide information about the prognosis. The existing literature does not indicate the best timing to initiate patients into ACP, and there is currently no related consensus among physicians.

Miller et al. (2019) indicated the incidence of ACP discussions is low and that common barriers to healthcare professionals conducting ACP include perceived lack of time, inadequate training, and lack of experience and confidence. The two important barriers to conducting ACP discussions with patients were insufficient time and lack of knowledge (Beck et al., 2017). Davison (2010) interviewed patients with ESRD and found that they expect their healthcare providers to be capable of initiating ACP with them to help them remain autonomous in making decisions regarding their end of life care. In addition, many felt that ACP should be initiated by the dialysis team at the early stage of the dialysis process. Most desired efficient communication with regard to care plans, prognosis, and ACP. Goff et al. (2015) found that many patients expressed a desire for better education about what to expect from dialysis and more opportunities to participate in medical care decision-making. Likewise, Gjerberg et al. (2015) indicated that a majority of patients with ESRD prefer to be involved in the decision-making process but leave the final decisions to healthcare professionals. Conversations about end of life care issues are emotionally challenging, and few patients discuss these issues with their families. In fact, the reported opinions of relatives regarding a patient’s preferences are based primarily on that patient’s personal assumptions rather than relatives’ statements. However, both patients and their family members expect healthcare providers to raise issues related to ACP (Gjerberg et al., 2015). The purpose of ACP is to help reflect the life values and preferences of patients in their medical care when they are at the end of life. However, the barriers to ACP currently highlighted in the literature reflect mainly the Western perspective. The major reason for the low rate of signing ADs in Taiwan is not clear, and there is scant literature addressing ADs in this country. Therefore, the purpose of this study was to explore the barriers faced by nurses to discussing ACP with patients with chronic kidney disease (CKD).

Methods

Study Design

A descriptive, qualitative design was used in this study, and data were collected from November 2017 to September 2018. The Consolidated Criteria for Reporting Qualitative Research was used to report the findings. Qualitative focus-group interviews were conducted to identify the self-perceived barriers of nephrology nurses to discussing ACP with patients.

Sample and Setting

After receiving institutional review board approval, the researcher contacted the head nurses to explain the purpose of the study and openly recruited nursing staff using purposive sampling. All of the 34 participants enrolled in this study were nephrology nurses who had been working for at least 1 year in the hemodialysis unit or nephrology ward in northern (one hospital with two groups of five participants in each group), central (one hospital with one group of four participants), or southern Taiwan (two hospitals with three and two groups of four participants each). Part-time nurses were excluded. Focus-group interviews were conducted with eight groups of four to five participants each.

Procedures for Data Collection

A 60- to 90-minute interview was conducted with each group by two members of the research team in the meeting room of the hospital where the participants worked. The leader of the group interview sessions was a doctorally prepared nursing teacher who was proficient in group dynamics and qualitative research. Another research team member obtained informed consent from the participants, made the audio recording of the interviews, and took notes. The semistructured interviews asked participants several opening questions regarding ACP. Participant observation also conducted during the interviews was aimed at collecting impressions and rich data regarding how participants interacted in particular situations and contexts. Direct observations brought other insights to the study as well. Once the interviews were finished, the researchers jotted down important messages as a reflection on the interviews. All of the interviews were transcribed in full within 48 hours. The interview guidelines were as follows:

1. Please share your opinions on promoting ACP in your work unit.
2. Have you ever had experience discussing ACP with patients?
   a. If so, could you please talk about how you initiate patients into ACP? Have you encountered any difficulties when discussing ACP with patients? Could you elaborate on your discussions with patients?
   b. If not, could you share the reasons why you have not discussed ACP with your patients?
3. Do you think there are any potential solutions to resolving your problems related to discussing ACP with patients?

Data Analysis
After interviews were transcribed, the data were analyzed in accordance with Colaizzi’s (1978) method. The coding of transcripts was conducted by two researchers using the following steps: (a) read and reread all of the verbatim transcripts, (b) identify significant statements, (c) formulate meanings, (d) cluster themes (differences in analyses of key sentences or themes between the two researchers were resolved by inviting qualitative research experts to discuss the data), (e) develop an exhaustive description, (f) generate a fundamental structure, and (g) seek verification of the fundamental structure. In the final step, researchers referred to participants’ comments again to validate and clarify the findings. Furthermore, the content of the analysis was reviewed by two participants to validate the original meaning of the data. Based on the principle of theoretical saturation, the focus-group discussion sessions were run until a clear pattern emerged and subsequent groups produced no new information (Krueger & Casey, 2000).

Rigor
Rigor was evaluated using Lincoln and Guba’s (1985) criteria to establish analysis rigor. Trustworthiness, dependability, and confirmability were strengthened using an audit trail. To ensure credibility and dependability, the identified themes were reviewed multiple times by the research team. After the interviews, the recordings were transcribed. Transferability indicates the applicability of the results to other groups. In this study, as all of the participants were from CKD-related work units, their experiences and perceptions may be transferable to nephrology nurses in general in Taiwan. To ensure confirmability, the original interview recordings and documents have been preserved and are available for auditing and future study use.

Ethical Considerations
Approval for the study was obtained from Kaohsiung Medical University institutional review board in Taiwan (KMUHIRB-E-(I) 20150279). Before signing informed consent, the participants received full written and verbal explanations of the study. The participants were informed that they could withdraw at any time before the interview began. The data collected for this study were kept confidential and used for this study only. All data and transcripts were anonymized and coded, and personal information was hidden in the data analysis.

Results
Thirty-four female nurses were enrolled as participants. Their ages ranged from 29 to 54 years and averaged 41 years; 94.1% held a bachelor’s degree; their working experience ranged from 1 to 25 years (average of 11.2 years); and 12 (35.1%) had experience initiating ACP discussions with patients (N1, N2, N3, N6, N7, N12, N16, N18, N20, N22, N24, and N34). In this study, five major themes were identified, as follows (Table 1).

Table 1
Themes and Subthemes of Barriers to Initiating ACP Discussions Faced by Nephrology Nurses

| Theme Subtheme | Theme 1: Lacking the Confidence to Discuss ACP |
|----------------|----------------------------------------------|
| 1. Lacking the confidence to discuss ACP | • Lack of knowledge and communication skills |
| 2. Difficulty in finding an appropriate opportunity to initiate ACP discussion | • Lack of practical experience |
| 3. Personally lacking the characteristics to discuss ACP | • Unpredictability of disease progression |
| 4. Conflicting perspectives between doctors and nurses over ACP | • Lack of discussion on clinical guidelines of ACP |
| 5. Culture and belief-based barriers to discussing ACP | • Empathy with high sensitivity |

Note. ACP = advance care planning.
adequately or accurately elaborating on information. That means that I am not capable of doing this and I think that it is better to have someone more professional initiate the ACP discussion” (excerpt from N9).

Subtheme 2: Lack of practical experience
Participants were conscious that they had no practical experience in discussing ACP and were concerned that they did not have the ability to cope with complex patient problems. Participant N4 said: “I feel that patients have many other issues. They may shed tears during the discussion, I wonder what I should do when patients get emotional during discussions. How should I comfort them and deal with their emotional issues? These are things I am not certain about.” Participant N2 said: “You have to have that practical experience to talk to people before you know how to get involved in the process. When you provide the information he wants, he will put his trust in you.”

Theme 2: Difficulty in Finding an Appropriate Opportunity to Initiate Advance Care Planning Discussion
Hemodialysis usually helps patients maintain a good quality of life. Patients often lack disease awareness and cannot understand the significance of discussing ACP. There is a lack of consensus on the appropriate timing to discuss ACP. This makes it hard to determine when to intervene. This theme consists of two subthemes, as follows:

Subtheme 1: Unpredictability of disease progression
The many complications and comorbidities that may occur during hemodialysis make disease trajectories highly unpredictable and make it difficult to determine the appropriate timing for ACP intervention. Participant N14 said: “There was a patient who was doing well on dialysis but was later diagnosed with lung cancer. He was unaware he had the choice to sign a DNR, and ultimately went on Endo. Prolonging the agony of death was hard on his family.” Participant N17 stated: “It seems too early to mention ACP, as it is common for young patients to be on dialysis for at least 20 to 30 years. However, we have also come across young patients whose conditions worsened abruptly and unexpectedly, and it was too late for ACP. It is hard to determine the right timing to bring up ACP.” Participant N7 said: “I think dialysis patients are a high-risk group. There was a patient who collapsed after drinking a sip of water before he was put on the dialysis machine, and CPR did not resuscitate him. Should all new patients be informed of ACP?”

Subtheme 2: Lack of discussion on clinical guidelines of advance care planning
Nursing staff have expressed the intricacy involved in identifying an appropriate time to introduce ACP to patients without explicit guidelines. For instance, at the initial stages of dialysis, patients usually maintain a good quality of life without much change in lifestyle beyond the need for dialysis. Even at later stages of dialysis, mentioning ACP may cause anxiety in patients and family members who are unprepared to deal with the situation.

Participant N3 said: “Patients receiving hemodialysis are actually maintaining a good life…. There is no special difference from ordinary persons. If I suddenly initiate them into ACP, they may not be able to understand why. Unless there is a change in patients’ condition such as shock or infection, I am not to be able to find a good time to open the conversation about ACP.” Participant N22 said: “In my opinion, patients may feel that it is not the right time to discuss ACP at the early stage of the disease. But if I initiate a topic of ACP at the critical period of time, the family members may get anxious, and patients may not be ready to face this. I really do not know when the best time to discuss ACP is.” Participant N34 said: “Sometimes patients think that they are in good condition and wonder why they need to think about ACP…. If receiving hemodialysis improves their quality of life, they do not really have to think ahead on ACP. The most difficult part of conducting ACP is finding a good time to initiate the discussion, as patients’ family members may just tell me there is no need to mention this.”

Theme 3: Personally Lacking the Characteristics to Discuss Advance Care Planning
Discussing the complex issue of ACP requires enthusiasm, a caring heart, willingness to listen, and empathy with patients’ feelings. This theme consists of one subtheme, as follows:

Subtheme: Empathy with high sensitivity
Nursing staff believe that ACP is unusual in that it involves a wide range of topics and skills such as medical information, emotional states, and the ability to communicate with warmth and convey messages in a way that resonates with patients. Participant N12 stated: “I think that I need to have the right personality traits to talk about ACP because not all nurses are able to initiate this discussion. Some have knowledge of ACP, but they lack the humanistic characteristics necessary to talk about it…. I feel that hospice nurses are more capable of initiating patients into ACP because they are able to handle patient emotions and know how to reach a patient’s heart…. I am not able to do this.” Participant N11 said: “Having knowledge is not adequate to initiate a discussion on ACP… I think that I need to be aware of the patient’s psychological status, I feel I am not able to handle the patient’s emotions at any time. I think it is very difficult for me to do so…. I feel that the one who initiates patients into ACP should have certain personality traits. This means that they have to be able to see people and talk to them with a warm heart. For me, I just feel like I am sharing health education information.”
Theme 4: Conflicting Perspectives Between Doctors and Nurses Over Advance Care Planning

Nursing staff feel frustrated in holding different ideals than physicians regarding the ACP discussion. They believe that physicians should take the lead in initiating and conducting ACP discussions and that these discussions should not be part of the responsibilities of nurses. This theme consists of two subthemes, as follows:

Subtheme 1: Cognitive gap related to discussing advance care planning between physicians and nurses

Nursing personnel believe that when a patient’s condition changes, it is time to discuss ACP. But doctors argue that it is good to continue with dialysis treatment, with no need to discuss ACP. The position of physicians completely ignores patients' rights and interests. When medical staff hold conflicting ideals on ACP, nurses are often afraid to initiate discussions with patients out of deference to physician authority. Participant N6 said: “Once I discussed ACP with a patient at a time when he had experienced hypotension and even shock during hemodialysis. His doctor thought that initiating patients into ACP was not necessary, and I was to blame in this circumstance. I think many doctors give patients lots of hope and rarely mention the risks involved in receiving hemodialysis. I feel that doctors are not supportive, so I feel quite frustrated.” Participant N7 had a similar experience: “I used to take care of a patient in the ICU, and his condition was not very stable. His family thought of giving up hemodialysis. Before the family meeting regarding this issue, I told the family members that patients could refuse hemodialysis by signing a DNR. As a result, the doctor who was in charge was upset because he preferred to continue treatments for the patient. My point of view is quite different from the doctor and this is the difficult part, as, most likely, doctors differ from nurses with regard to ACP, so I do not know how to deal with this issue.” Participant N16 also said: “When I occasionally mention DNR, doctors may think that the patient is not in that serious condition and question the necessity of signing a DNR. Doctors think that these patients will just keep receiving hemodialysis until they are unable to do so… I think that doctors are more in control over this.”

Subtheme 2: Initiating advance care planning is not the responsibility of nurses

Explaining the patient’s condition and discussing ACP are clinical responsibilities of the physician and not part of the nurse’s job. Participant N30 said: “I think that talking about ACP is the doctor’s duty. My primary job should be performing hemodialysis, so I will not take the initiative to talk about it. In addition, discussing ACP is not part of the daily care routine” (excerpt from N30). Participant N31 also considered it not her job to discuss ACP, and she took a passive role. She said: “Generally speaking, I do not take the initiative to explain patient conditions because it is not my duty. So I am more passive in discussing ACP. Unless patients ask me, I will not answer this type of question.” Participant N13 considered the need to train dedicated personnel to perform this duty: “Healthcare providers focus on their profession, and this type of work should be left to those who are more professional, so the hospital manager should develop a clear flow chart to assist nurses to initiate patients into ACP. Let the professionals do the work instead of any staff nurses.”

Theme 5: Culture and Belief-Based Barriers to Discussing Advance Care Planning

ACP discussions often involve the topic of death, which is a symbol of misfortune and conflict within the Chinese cultural context. Chinese people avoid speaking of death, and discussing ACP is commonly associated with giving up treatment. However, this misinterprets the core values of the ACP discussion. This theme consists of two subthemes, as follows:

Subtheme 1: Advance care planning discussion implies misfortune

Traditional culture takes a conservative point of view toward death, and people regard it as taboo. Participant N18 said: “Taiwanese do not like to talk about death. Most patients refuse to talk about it when I try to initiate them into ACP, since it is very easy for them to connect ACP with death, which is considered a taboo topic in our culture.” Participant N2 said: “I used to take care of a patient with diabetic foot. I took the initiative to discuss ACP with her daughter, but she kept refusing to have a conversation about this with me… as she thought that her mom’s condition was not near-terminal. So, I stopped talking about this topic with her… I think that family members tend to connect ACP with death. When I am with patients, I am not comfortable talking about death, and patients are also afraid of facing this issue, as this is disallowed in our culture” (excerpt from N5).

Subtheme 2: Reluctance to discuss advance care planning due to misunderstanding the essence of advance care planning

In Taiwan, people consider having a discussion on ACP is a matter reserved for patients with terminal illness. Patients and their families consider discussing ACP as an abandonment of treatment and a death penalty. They consider ACP as a means to prepare for the end of life. Participant N15 said: “Once, a patient with hemodialysis asked me if ACP means DNR and if they needed to give up receiving treatment. I think that they do not quite understand the meaning of ACP. They believe that ACP means giving up on life, so half of patients and family members refuse to discuss this issue.” Participant N3 said: “When I mention ACP, patients and their family think I am cursing them. This is their mindset, so they are unwilling to talk about it, and they wonder why they need ACP at a time when they are in relatively good health. I think that patients and their families are unprepared
to make the medical decisions necessary to face end of life in the future.” Participant N24 said: “I once talked about ACP with a patient, and he asked why I mentioned this as he was doing quite okay.... The hemodialysis center is an open area, so when I mentioned this with this patient, the other patient next to him started to ask questions. The questions may be something like, ‘Is that patient going to die?’ I think that many patients have no idea about the real meaning of ACP.”

Discussion

In this study, five themes were found related to the barriers faced by nephrology nurses in discussing ACP with patients. Understanding and overcoming these barriers will be necessary to establish ACP as a standard part of a healthcare protocol.

Discussions regarding death and end of life care represent the most challenging aspect of healthcare provider/patient communications (Pfeifer & Head, 2018). Research has identified ACP as a complex and challenging conversation for healthcare professionals to engage in, requiring high-level communication skills, confidence, and emotional and managerial support (Boot & Wilson, 2014). Miller et al. (2019) indicated that, given adequate training and support, nurses are able to initiate and facilitate ACP conversations with patients that result in positive patient outcomes. Increased knowledge is likely to lead to more positive attitudes and greater confidence to undertake these discussions with patients. The findings from previous studies (Boot & Wilson, 2014; Miller et al., 2019; Pfeifer & Head, 2018) support the finding of this study that having professional knowledge and communication skills alone is not adequate for nurses to discuss ACP with patients. These nurses also require specific personality traits such as caring, empathy, and warmth. In other words, even if nurses acquire the requisite knowledge and communication skills related to ACP, they may remain unable to initiate ACP discussions comfortably. In most cases, these nurses have no idea how to discuss ACP and are afraid of causing anxiety in patients.

In addition, the participants in this study expressed uncertainty regarding the best time to initiate patients into ACP. This indicates that nurses are not able to raise the topic of ACP at the “right” moment. If ACP is discussed during the early stage of CKD, patients tend to feel that the issue is abrupt and obtrusive. However, if ACP is discussed at the end of life, patients may be unable to express their medical care preferences and desires, and family members may feel anxious about death. The best timing to initiate patients into ACP has not been indicated in previous studies, and no consensus on this issue exists among physicians. Boot and Wilson (2014) found the decision of nurses to initiate an ACP discussion is influenced by three key factors: patient readiness to discuss the topic, patient physical condition, and the relationship between the nurse and the patient and their family. Therefore, nurses play a key role in promoting and engaging with these discussions based on their close relationship with patients and their families (Blackwood et al., 2019). In addition, some participants considered that the hospice care team or other professionals should be in charge of initiating ACP, as initiating ACP is not part of a nurse’s professional responsibilities. This corresponds with Hsieh and Lin (2010), who found that 40% of nurses think that ACP is not part of their responsibility and thus do not take the initiative to discuss this issue. Phillips et al. (2007) indicated that many nurses do not think it is their responsibility to engage in discussions with patients on death because of the lack of related professional training, incompetence, and unclear role boundaries. However, Sinclair et al. (2017) found nurse-led communication facilitates ACP that is acceptable to patients and effective in increasing ACP discussions and further fostering the ACP process. Nurses take care of patients throughout the day and are the ones who best understand the needs of patients and their families. Thus, they play a significant role in initiating ACP (Shepherd et al., 2018). Based on the aforementioned literature, nurse attitudes will likely influence the success of efforts to increase the number of ACP discussions being held.

Omondi et al. (2017) claimed that doctors should take the initiative to discuss ACP with patients, as this is the key element to promote their signing ADs. Tamura and Meier (2013) mentioned that both patients and their family members consider ACP to be part of the daily routine in their healthcare and should be initiated at the early stage of their disease. Howard et al. (2018) indicated that lack of knowledge and lack of support from doctors represented key barriers for nurses. Furthermore, Sellars et al. (2017) noted that some nephrologists continue performing hemodialysis on patients who are unable to communicate and therefore ignore the ACP willingness of these patients. The negligent attitude taken by some doctors toward patient rights with regard to ACP is a point of frustration for nurses and social workers. In Taiwan, physicians hold a still highly respected position of professional authority, and ACP discussions are still predominantly determined and controlled by physicians. The participants mentioned that physicians tend to give patients false hopes and rarely explain the true risks of their disease and treatment. Participants further suggested that physicians should discuss ACP with patients but noted that they appear to be reluctant to do so. This highlights disagreements between nurses and doctors related to initiating patients into ACP. However, if physicians do not take the initiative to discuss ACP with patients, nurses will typically not follow up. This may be a reason for the low signing rate for ADs in Taiwan. This finding echoes Omondi et al. (2017), who identified physicians’ involvement and early discussions with patients as key components affecting the signing rate for ADs.

Public attitudes toward death are influenced by culture. In Western societies, respecting the autonomy of terminal patients is of primary importance (Hansdottir et al., 2000). However, in traditional Chinese culture, most family members and medical staff avoid discussions of death with patients who are at end of life because of the fear of death (Yang et al., 2013). In this study, the participants reflected an aversion to discussing death. This aversion creates a barrier to patient healthcare
Conclusions and Suggestions
Patient-centered care and respect for patient autonomy are core values of ACP. Healthcare professionals who help patients complete ADs often contribute to maintaining a good quality of life in patients who are at end of life. However, in this study, lack of knowledge and communication skills, uncertainties about the best time to initiate ACP discussion, and conflicting perspectives on ACP between doctors and nurses were found to be major barriers to completing ADs. Therefore, nurses must learn the knowledge and skills required to conduct ACP conversations, initiate ACP discussion, and strengthen cooperation with doctors to achieve the goals of ACP.

The participants included nursing personnel in the nephrology departments of medical institutions in northern, central, and southern Taiwan. Manpower and time constraints prevented the researchers from expanding the study to include nursing personnel in other departments to more fully understand the current status of ACP discussions among all relevant nursing personnel in Taiwan. Furthermore, ACP is a person-centered, interdisciplinary, and collaborative approach to patient care. Future studies may further expand recruitment to include other professionals such as physicians, social workers, and psychologists to understand their perspective and barriers in discussing ACP. Only by resolving the barriers faced by various professionals can there be a way to implement a holistic person-centered care.

Implications for Practice
First, nurses must enhance their ACP-related knowledge and skills to facilitate the shared decision-making process. Second, nurses should encourage patients and their families to participate in decision-making to avoid medical futility. Third, nurses must be empowered to initiate ACP and to engage in detailed, related discussions to improve end of life care. Helping raise awareness of these barriers among nurses and facilitating their working together on this issue are critical to making ACP the norm in healthcare in the near future.

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