



HPNA Position Statement Advance Care Planning

It is the position of the Hospice and Palliative Nurses Association (HPNA) that nurses must take a leading role in advance care planning (ACP) through the education of patients, families, and other healthcare professionals, and its implementation in everyday practice.

Clinical Practice

- Advance care planning is a central tenet of person-centered care.
- Patients have the right to receive care that is consistent with their values and preferences.
- Advocacy is a core element of nurses' practice through supporting and respecting patient values and ensuring their healthcare preferences are honored.
- The decision made by a patient or family not to engage in ACP must be respected.

Education

- Nurses must be educated in ACP and trained to facilitate difficult but critical conversations.
- Nurses have the responsibility to facilitate ACP to advocate for their patients.
- Nurses must be mindful of and sensitive to elements of diversity (e.g., race/ethnicity, culture, religion) when facilitating ACP discussions.

Policy

- Healthcare organizations must incorporate systems that encourage ACP as an integral component of quality care for individuals with advanced illnesses and their families.

Background

Over the course of an illness or injury trajectory, patients must make deeply personal and variable healthcare decisions that can change based on their current health state. Advances in medical technology have created an array of life-extending and end-of-life treatments, giving patients many options to choose from.

Advance care planning is a dynamic process involving many discussions whereby patients anticipate and discuss future health states and preferred treatment options.¹ Advance care planning includes three components: the delegation of a surrogate decision-maker to make healthcare decisions should the patient choose to do so or lacks decision-making capacity; advance directives; and orders to limit life-sustaining treatment.

Advance care planning is an essential part of palliative care and should begin at the first patient assessment,² with conversations continuing to occur throughout the course of



care to refine and revise decisions.^{3,4} Advance care planning discussions emphasize preparing not only for death or serious or life-threatening illness, but also for potential incapacity. Such discussions should be nuanced to consider the patient's needs in relation to their cultural, ethnic, and religious background,⁵ including conversations with children based on their level of maturity, ability to understand, and status under statutory law.⁶

Together, the American Nurses Association (ANA) and HPNA wrote the *2017 Call for Action: Nurses Lead and Transform Palliative Care*. The *Call for Action* supports the nurse's role as a patient advocate and asserts that the nurse must facilitate the process of informed healthcare decision-making for patients.^{3,4} Communication and discussion surrounding healthcare decision-making naturally occurs with the development of a therapeutic relationship and is the foundation for ACP.⁷ Created in conjunction with the ANA and HPNA, *Palliative Nursing: Scope and Standards of Practice* states informed healthcare decision-making is a core tenet of palliative nursing.⁸

The *2017 Call for Action* states that hospice and palliative nurses are uniquely positioned and have the expertise to facilitate meaningful conversations with patients and families about present and future healthcare, and how those interventions align with patient values, beliefs, and goals.³ These discussions give the patient and family an opportunity to say the things that matter to them, including expressions of hope and meaning in life.⁹

However, more than 70% of patients who need to make end-of-life decisions lack decision-making capacity.¹⁰ In such a situation, healthcare providers turn to family members to make decisions. When there have been no ACP conversations between the patient and family, family members are left to make decisions regarding life-sustaining treatment without input from the patient or with no intimate knowledge of the patient's wishes. When patients and their family members do not engage in ACP, patients may not receive care that they would have desired at the end of life and family members or surrogate decision-makers can experience severe psychological distress during and after the end-of-life decision-making.^{10,11,12,13}

The Palliative Nursing Summit report states that nurses should take a lead role in providing more community education and training related to ACP.¹⁴ Nurses serve as resources to other nurse clinicians and healthcare providers to educate and fulfill the responsibility to advocate for providing care that is concordant with patients' values.¹⁰

Definition of Terms

Advance care planning: A process for patients and their families to discuss end-of-life care, clarify related values and goals, and state preferences through written documents



and medical orders. This process can start at any time and be revisited periodically but becomes more focused as health status changes.¹⁶

Advance directives: Patient-initiated documents including living wills and documents that name a healthcare agent.¹⁶

Decisional capability: The ability of a person to make decisions. Adults are presumed capable unless declared incompetent by a court of law or a judge. Some states require two physicians to determine decisional capacity of a person. Decisional capacity is specific to a point in time and a specific decision. A clinical evaluation of capacity centers on a person's ability to take in information, understand the relevant information and apply it to their own condition, have insight into the condition and consequences of treatment options, and be able to communicate the decision and reasoning for choices.^{17,18}

Medical orders: Created with and signed by a healthcare professional, usually a physician (in some states, a nurse practitioner or physician assistant), for patients with serious illnesses. Because they are actual physician orders, other health professionals, including emergency personnel, are required to follow them.¹⁶ Can include POLST/MOLST (physician's orders for life-sustaining treatment/medical orders for life-sustaining treatment), do-not-resuscitate (DNR), do-not-intubate (DNI), or do-not-hospitalize (DNH) orders.

Surrogate decision-maker: Someone appointed by the patient to make healthcare decisions. The role of the surrogate decision-maker is to make decisions for the patient based on the patient's preferences and previously expressed wishes.¹⁰

References

1. Centers for Disease Control and Prevention. *Advance Care Planning: Ensuring Your Wishes Are Known and Honored If You Are Unable to Speak for Yourself*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept. of Health and Human Services; 2012. <https://www.cdc.gov/aging/pdf/advanced-care-planning-critical-issue-brief.pdf>. Accessed October 6, 2017.
2. National Consensus Project for Quality Palliative Care. *Clinical Practice Guidelines for Quality Palliative Care*. 3rd ed. Pittsburgh, PA: National Consensus Project; 2013:65.
3. American Nurses Association, Hospice and Palliative Nurses Association. *Call for Action: Nurses Lead and Transform Palliative Care*. Silver Spring, MD: American Nurses Association; 2017.



[http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/Palliative-Care-Call-for-Action/Draft-PalliativeCare- ProfessionalIssuesPanel-CallforAction.pdf](http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/Palliative-Care-Call-for-Action/Draft-PalliativeCare-ProfessionalIssuesPanel-CallforAction.pdf). Published March 13, 2017. Accessed October 6, 2017.

4. Seymour J, Almack K, Kennedy S. Implementing advance care planning: a qualitative study of community nurses' views and experiences. *BMC Palliat Care*. 2010;9(4). doi:10.1186/1472-684X-9-4.
5. Johnstone MJ, Kanitsaki O. Ethics and advance care planning in a culturally diverse society. *J Transcult Nurs*. 2009;20(4):405-416. doi:10.1177/1043659609340803.
6. President's Commission for the Study of Ethical Problems in Medicine and Behavioral Research. *Deciding to Forego Life-Sustaining Treatment*. Washington, DC: U.S. Government Printing Office; 1983.
7. Kolarik RC, Arnold RM, Fischer GS, Tulsy JA. Objectives for advance care planning. *J Palliat Med*. 2002;5(5):697-704. doi:10.1089/109662102320880516.
8. Dahlin CM, Sutermaster DJ. eds. *Palliative Nursing: Scope and Standards of Practice*. Silver Spring, MD: American Nurses Association; 2014.
9. Fried TR, Bullock K, Iannone L, O'Leary JR. Understanding advance care planning as a process of health behavior change. *J Am Geriatr Soc*. 2009; 57(9), 1547-1555. doi:10.1111/j.1532-5415.2009.02396.x.
10. Silveira MJ, Kim SYH, Langa KM. Advance directives and outcomes of surrogate decision making before death. *N Engl J Med*. 2010;362:1211-1218. doi:10.1056/NEJMs0907901.
11. Song MK, Ward SE, Hanson LC, Metzger M, Kim S. Determining consistency of surrogate decisions and end-of-life care received with patient goals-of-care preferences. *J Palliat Med*. 2016;19(6):610-616. doi:10.1089/jpm.2015.0349.
12. Chiarchiaro J, Buddadhumaruk P, Arnold RM, White DB. Prior advance care planning is associated with less decisional conflict among surrogates for critically ill patients. *Ann Am Thorac Soc*. 2015;12(10):1528-1533. doi:10.1513/AnnalsATS.201504-253OC.
13. Detering KM, Hancock AD, Reader MC, Silvester W. The impact of advance care planning on end of life care in elderly patients: randomized controlled trial. *BMJ*. 2010;340:c1345. doi:10.1136/bmj.c1345.



14. Palliative Nursing Summit. Hospice and Palliative Nurses Association Web site. 2017. <http://advancingexpertcare.org/palliative-nursing-summit/>. Accessed October 6, 2017.
 15. Izumi, S. Advance care planning: the nurse's role. *Am J Nurs*. 2017;117(6):56-61. doi:10.1097/01.NAJ.0000520255.65083.35.
 16. Institute of Medicine. *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*. Washington, DC: The National Academies Press; 2014.
 17. Appelbaum, PS. Assessment of patients' competence to consent to treatment. *N Engl J Med*. 2007;357:1834-1840. doi:10.1056/NEJMcp074045.
 18. Simpson C. Decision-making capacity and informed consent to participate in research by cognitively impaired individuals. *Appl Nurs Res*. 2010;23(4):221- 226. doi:10.1016/j.apnr.2008.09.002.
-

This statement reflects the best available evidence at the time of writing or revisions.

Approved by the HPNA Board of Directors October 2017

Copyright © 2017 by the Hospice and Palliative Nurses Association
To obtain copies of this statement please visit www.hpna.org.