Wisconsin Nurses Association
2011 Reference Report #4

Subject: **Increasing awareness of Advanced Care Planning**
Introduced by: **WNA Board of Directors**
WNA Core Issues: **Patient Safety/Advocacy**

Summary: When seriously ill patients are nearing the end of life, they and their families sometimes find it difficult to decide whether to continue medical treatment and, if so, how much and how long treatment is wanted for. In these instances, patients rely on their physicians or other trusted health professionals for guidance. In the best of circumstances, the patient, family, and physician have held discussions about treatment options, including the length and invasiveness of treatment, chance of success, overall prognosis, and the patient's quality of life during and after the treatment. Ideally, these discussions would continue as the patient's condition changed. Frequently, however, such discussions are not held. If the patient becomes incapacitated due to illness, the patient's family and physician must make decisions based on what they think the patient would want (AHRQ, 2003).

Nurses must advocate for and play and active role in initiating discussion about Do Not Resuscitate (DNR) with patients, families and other members of the healthcare team. According to patients who are dying and their families who survive them, lack of communication with physicians and other health care providers causes confusion about medical treatments, conditions and prognoses, and the choices that patients and their families need to make. One AHRQ study indicated that about one-third of patients would discuss advance care planning if the physician brought up the subject and about one-fourth of patients had been under the impression that advance care planning was only for people who were very ill or very old. Only 5 percent of patients stated they found discussions about advance care planning too difficult (AHRQ, 2003).

Gundersen Lutheran Medical Foundation's "Respecting Choices" cites; "One of the greatest misconceptions about advance care planning (ACP) is that it is a static process, a one-time event. Attempting to plan for all possibilities in a single document or at a single point in time is both impossible and unnecessary. At "Respecting Choices," we know that effective ACP is a *process of communication* that helps individuals:

- Understand their choices for future healthcare.
- Reflect on personal goals, values, religious, or cultural beliefs.
- Talk to physicians, healthcare agents, and other loved ones as needed.

To be effective, this process of communication needs to be individualized, based on a person's state of health, and revisited at appropriate times" (Respecting Choices, http://respectingchoices.org/).

The January 2011 edition of *Nursing Outlook* contained an article summarizing the American Academy of Nursing position about end-of-life care in which they endorse end-of-life care conversations and recommend that competent clinical staff should be reimbursed by all payers for the meetings and conferences held with patients and families; conversations and decisions need to be documented and available/retrievable in care decisions/discussions; update the 1991 Patient Self-Determination Act so that it extends to "having the conversation" regarding EOL care and increasing the education and interprofessional training on communicating treatment decisions, seeking patient discussion on preferences and values and facilitating family conversations (Tilden, V., Corless, I., Dahlin, C., Ferrell, B.,Gibson, R., & Lentz, J. (2011).

Nursing has a unique opportunity to increase the competencies necessary for meaningful conversations regarding end-of-life decisions. These competencies include creating a culture that goes beyond the institution and into the communities, increasing the awareness regarding advanced care planning that begins with conversations with interprofessional team members (i.e. nurses, physicians, social workers, chaplains). In addition, nurses can refer to the ANA position statement "*Nursing Care and Do-Not-Resuscitate(DNR) Decisions (2011)* to guide practice and actions for clinical nurses, nurse administrators, nurse educators and nurse researchers.

Recommendations: That WNA will:

1. Support the education of nurses and other health care professionals to increase competencies in initiating and participating in meaningful conversations regarding advance care planning and end-of-life choices with their patient.

2. Promote and participate in the development and implementation of a culture in every community that embraces and demonstrates meaningful conversations regarding advance care planning and end-of-life care choices by all individuals.

WNA Goal

Goal 1: Collectively and collaboratively advocate for access to comprehensive quality health care services for all people.