

Development of an Advance Care Planning Educational Resource

for Oncology Nurses

by © Jean Ann Ryan

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Abstract

Background: Advance Care Planning (ACP) is a process of reflection and communication in which capable individuals make informed decisions about their future healthcare and end-of-life care in the event they are unable to provide informed consent. ACP decreases unnecessary medical interventions and reduces uncertainty among healthcare providers and loved ones during critical moments of care. Despite benefits, participation in ACP remains low in cancer care. Oncology nurses are well-positioned to lead ACP discussions but have limited awareness of ACP and skills to navigate ACP discussions.

Purpose: To develop an educational resource to increase ACP competency for oncology nurses.

Methods: An integrative literature review, consultation with key stakeholders, and an environmental scan guided the development of an ACP educational resource for oncology nurses.

Results: The literature findings captured the complexities of ACP and offer evidence-based recommendations for enhancing ACP engagement. Consultations with oncology nurses highlighted local educational needs, while the environmental scan identified broader ACP-related learning requirements needed to enhance nurses' communication skills and confidence when navigating ACP conversations.

Conclusion: An ACP educational resource for oncology nurses will ultimately improve competency and lay the foundation for increasing ACP engagement.

Keywords: *advance care planning, ACP, goals of care, oncology nursing, education, competency, theoretical frameworks.*

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Introduction

Advance Care Planning (ACP) is a process of reflection and communication in which a capable individual makes informed decisions about their future healthcare, personal care, and end-of-life (EOL) care in case they are unable to provide informed consent (Advance Care Planning Canada, 2024; Rietjens et al., 2017). ACP aims to align medical care with a person's values, goals, and wishes, while reducing emotional and decision-making burdens on families and healthcare providers (HCPs) (Johnson et al., 2016; Lund et al., 2015; Sudore et al., 2017). Participating in ACP enhances the quality of EOL care, lessens non-essential interventions, and ensures greater alignment between patient wishes and clinical decisions (Johnson et al., 2016).

According to the Government of Canada (2020), while 93% of Canadians believe it is important to discuss ACP and EOL wishes with loved ones, less than 50% engage in these conversations. Only 17% of Canadians have a documented ACP despite the evidence of its benefits, awareness campaigns, and educational initiatives (ACP: A Pan-Canadian Framework, 2020). In cancer care, ACP is commonly introduced late in the disease trajectory (Agarwal & Epstein, 2018), with Johnson et al. (2016) noting that such conversations often do not occur until EOL discussions.

Nurses who participate in ACP discussions must demonstrate an understanding of its multifaceted nature to support patients through the ACP process. Oncology nurses often develop deep, meaningful relationships with their patients, placing them in a unique position to initiate and support ACP conversations, but report discomfort and uncertainty when engaging in these discussions, primarily due to limited training and unclear role expectations (Rietze et al., 2015). This gap in preparedness can hinder timely and meaningful ACP conversations, potentially impacting patient care and quality of life (QOL).

Objectives

The objective of my practicum project was to develop an ACP educational resource for oncology nurses to increase competency and enhance skills to navigate ACP conversations. It is tailored to the outpatient oncology nurses at the Dr. H Bliss Murphy Cancer Centre (DHBMCC) in St. John's, NL.

The key practicum objectives were:

1. Analyze the current literature on ACP education for registered nurses.
2. Consult with key stakeholders to identify the educational needs of oncology nurses in the local setting.
3. Conduct an environmental scan to determine the ACP education resources for oncology nursing in NL and select major cancer care centres in Canada.
4. Determine the most effective educational approaches to delivering ACP education to oncology nurses in the local setting.
5. Develop an ACP educational resource for oncology nurses designed to increase competencies and skills to navigate ACP conversations.
6. Demonstrate advanced nursing practice competencies in leadership, research, and education.

Overview of Methods

To inform the development of an ACP educational resource, I began by drafting a practicum project proposal under my academic supervisor's guidance. Once approved, I conducted a comprehensive literature review to evaluate the benefits of ACP in oncology and to examine the impact of ACP education on oncology nursing practice and patient care. To further inform the project, I consulted with key local stakeholders to gain contextually relevant

perceptions about ACP and oncology nursing, current ACP knowledge, ACP learning needs, and preferred educational approaches. Finally, I conducted an environmental scan of existing ACP-related educational resources available to oncology nurses at select cancer care centres in Canada. Additionally, I reviewed the relevant guidelines and recommendations from the Canadian Association of Nurses in Oncology (CANO) and the Canadian Nurses Association (CNA) that directly inform nursing practice.

The literature review, stakeholder consultations, and environmental scan provided insights to guide the development of an ACP educational resource. In the following sections, I will summarize the key findings from each of these methods.

Summary of the Literature Review

I explored several databases and included studies published within the last 15 years, written in English, nursing-related, and peer-reviewed. I included qualitative studies, quantitative studies, mixed-method studies, and systematic reviews. I used a range of key search terms, including “*advance care planning,*” “*ACP,*” “*oncology nursing,*” “*education and training,*” “*competency,*” “*benefits,*” “*challenges,*” “*person-centred care,*” and “*theoretical frameworks.*” The key questions for the literature review were:

1. What are the benefits and challenges of ACP?
2. What is the role of nurses in ACP discussions?
3. What is the impact of ACP education on the knowledge, confidence, and communication skills of oncology nurses?
4. What are the key educational strategies to prepare oncology nurses for ACP conversations?

Literature Review Findings

Benefits of ACP: Individualized Care

The findings of the literature review demonstrated that ACP supports individualized, holistic care by ensuring that treatment aligns with a person's healthcare preferences. Research by Detering et al. (2010), Goswami et al. (2020), and Sudore et al. (2017) shows that ACP conversations help reduce anxiety and alleviate the emotional burden for both patients and loved ones during critical moments. These authors also emphasize that patients who engage in ACP are more likely to receive care that reflects their core beliefs and values, leading to greater satisfaction, improved QOL and better EOL care. Furthermore, documenting care preferences offers clarity for healthcare teams and allows healthcare providers (HCPs) to honour patients' wishes when they can no longer make informed decisions (Sudore et al., 2017).

ACP promotes comfort care by reducing the need for resuscitation and mechanical ventilation, minimizing unnecessary treatments, and enhancing patient outcomes by aligning care with individual healthcare preferences (Goswami et al., 2020). In cancer care, ACP enables patients to participate actively in their treatment decisions, often leading to fewer treatments, shorter hospital stays, and increased utilization of palliative care (Agarwal & Epstein, 2018). Shorter hospital stays combined with greater use of palliative services offer advantages for both patients and the healthcare system. By focusing on key aspects of palliative care, such as symptom management, psychosocial support, and care that aligns with patient goals, patients and loved ones can spend more time focusing on QOL (Agarwal & Epstein, 2018; Canadian Hospice and Palliative Care Association, 2024). From a system perspective, shorter stays free up acute care resources, lower healthcare costs, and reduce unnecessary procedures (Canadian Hospice and Palliative Care Association, 2024).

Jonathan et al. (2024) postulate that culture plays a central role in shaping how individuals understand illness, make healthcare decisions, define QOL, and view EOL care. Recognizing cultural influences is important as it allows space for traditional ceremonies or rituals that may reflect an individual's cultural beliefs and values (Jonathan et al., 2024).

Barriers to ACP

Siden et al. (2022) and Teixeira et al. (2014) explored the barriers and gaps in ACP engagement from the perspective of Canadians. Siden et al. (2022) found that 67% of participants associated ACP with EOL and death, contributing to discomfort in engaging in ACP discussions. Other barriers included limited knowledge (65%), lack of public awareness (55%), confusing terminology (32%), and cultural challenges (11%) (Siden et al., 2022). Teixeira et al. (2014) conducted a national Canadian survey (N = 1021) that revealed low public awareness of ACP, demonstrating that only 16% of individuals recognized the term ACP, 52% had spoken to loved ones about goals of care (GOC), and just 10% had discussed it with HCPs. Engagement was higher among older adults, women, and those with higher socioeconomic status. Notably, Johnson et al. (2016) found that patients with cancer engage differently in ACP than other groups, influenced by factors such as unpredictable disease trajectories, treatment uncertainty, and a desire to preserve hope.

At the organizational level, several systemic barriers hinder the integration of ACP into routine nursing practice. Hagen et al. (2015) identified key obstacles, including insufficient infrastructure, limited time, and a lack of standardized documentation, all of which impede the effective sharing of ACP information within electronic medical records (EMRs) and lead to fragmented communication among HCPs. Similarly, Ke et al. (2015) pointed out systemic issues such as time constraints, inadequate infrastructure, and insufficient institutional support, which

limit oncology nurses' ability to engage in ACP. Both studies highlight the importance of education as part of a broader shift toward prioritizing ACP, which should also include policy changes.

Despite strong support for nursing involvement in ACP, engagement remains limited in practice due to challenges such as role ambiguity, time constraints, insufficient organizational support, and knowledge gaps. Shih et al. (2025) and Sinclair et al. (2017) emphasize these barriers, while Ke et al. (2015) and Kilgour et al. (2025) report that many nurses believe they have a role in ACP but feel unprepared to facilitate conversations due to insufficient education and institutional barriers.

ACP Educational Needs of Oncology Nurses

Rietze et al. (2015) and Shih and Lu (2024) reported that despite generally positive attitudes toward ACP among nurses, knowledge gaps existed, contributing to the lack of confidence in ACP discussions. Yahiro et al. (2021) assert that education enhances nurses' comfort and willingness to engage in ACP conversations. Together, these findings highlight education as an essential foundation for strengthening nurses' competence and confidence in navigating ACP conversations. ACP education for nurses should address knowledge deficits, explore communication skills, increase understanding of the legal and ethical dimensions of ACP, and increase knowledge of cultural and spiritual awareness aspects of ACP (Izumi et al., 2024; Jonathan et al., 2024; Rietze & Stajduhar, 2015; Shih & Lu, 2024; Yahiro et al., 2021).

Spirituality considerations play an important role in ACP discussions as they influence how patients find meaning and cope with illness (Lutz et al., 2018). Lutz et al. (2018) advocate for a spiritually centred approach to ACP that honours patients' beliefs and sources of strength. For marginalized populations, ACP engagement is complicated by HCPs' biases, lack of cultural humility, and fragmented care systems. Izumi et al. (2024) emphasize the importance of HCPs

building trust and actively listening to engage marginalized patients in meaningful ACP conversations.

Due to the inherently sensitive nature of ACP conversations, self-reflection is an important component of nursing practice. Mackenzie et al. (2018) highlighted the need for self-reflection as a component of ACP education, as it allows individuals to identify and examine personal biases or assumptions that may influence ACP discussions (Mackenzie et al., 2018).

Delivery Method of ACP Education

I explored multiple methods of delivering ACP education, including in-person education, online and virtual learning, and a hybrid, or blended, learning platform. Blended (hybrid) learning combines both in-person and remote, real-time instruction (Feaster et al., 2023). Feaster et al. (2023) found that a hybrid educational program increased nurses' confidence and skills in ACP discussions while honouring busy schedules. Similarly, Davis et al. (2024) highlighted the flexibility of hybrid learning models while allowing participants to come together and engage in discussions through case studies and role-playing.

Theoretical Framework

I selected three complementary theoretical frameworks to guide the development, implementation, and sustainability of an ACP educational resource for oncology nurses: the Transtheoretical Model (TTM), Benner's Novice to Expert Model, and Rogers' Diffusion of Innovation Theory.

Transtheoretical Model

The TTM of Behavioural Change, also known as Prochaska's Stages of Change Model (Prochaska & Velicer, 1997), provides a framework that explains how behaviour changes over time. TTM conceptualizes behaviour change as a progression through five distinct stages: pre-contemplation, contemplation, preparation, action, and maintenance; it suggests that individuals

require different levels of support and intervention depending on the stage (Fried et al., 2010; Li et al., 2021). Fried et al. (2010) and Li et al. (2021) emphasize that the TTM highlights the importance of individual readiness in ACP engagement, noting that patients must be prepared to engage in ACP conversations for them to be effective. ACP guided by TTM enables HCPs to tailor interventions to an individual's stage of readiness, facilitating a more personalized approach.

Benner's Novice to Expert Model

Benner's Novice to Expert Model (Benner, 1982) complements TTM by recognizing that nurses have varying levels of expertise, particularly in areas such as ACP discussions. Nurses new to ACP may operate at a novice level, requiring more structured guidance and mentorship. In contrast, experienced nurses, or 'nurse champions,' are more comfortable in ACP discussions and can support their colleagues through role modelling and peer mentorship (Quiroga-Pico et al., 2024). This understanding aligns with the need for a tailored educational approach that accommodates different levels of clinical experience and exposure to ACP. Consequently, an ACP educational resource for oncology nurses should reflect varying levels of expertise. For novice nurses, education should provide foundational content and structured learning opportunities, such as case studies and role-playing exercises, to help build confidence and competence. For more experienced nurses, the resource should focus on leadership roles, such as mentorship. This approach ensures that the educational resource addresses the diverse needs of oncology nurses at different stages of their professional development.

Rogers' Diffusion of Innovation Theory

Rogers' Diffusion of Innovation Theory recognizes that the adoption of change varies among individuals. Rogers categorizes adoption to change into five adopter groups that influence the rate of implementation of new ideas: innovators, early adopters, early majority, late majority,

and laggards (Mohammadi et al., 2018). While some nurses may quickly embrace ACP as part of their practice, others may be slower to adapt. Rogers also identifies attributes that influence the adoption of innovations: relative advantage (or perceived benefits), compatibility (or alignment with existing values), simplicity (or ease of use), observability (or visible positive outcomes), and trialability (or opportunities for testing) (Mohammadi et al., 2018). Educational initiatives that consider adopter categories, along with the five attributes influencing the adoption of innovations, will support the successful integration of ACP into oncology nursing practice by tailoring learning to both the learners and the innovation itself. By recognizing that nurses vary in their readiness to adopt new practices, educators can design interventions that meet learners' needs, providing support to those hesitant while empowering early adopters to model and champion ACP conversations. Moreover, focusing on the five adoptions of innovative attributes (relative advantage, compatibility, complexity, trialability, and observability) ensures that ACP practices are presented in meaningful, practical ways. For example, showing how ACP improves patient care (relative advantage), integrating it into existing workflows (compatibility), simplifying steps (reducing complexity), allowing practice through role-playing (trialability), and letting nurses observe peers successfully conducting ACP conversations (observability) make it more likely that ACP will be adopted.

Summary of Consultations

To ensure the proposed ACP educational resource meets the needs of the local setting, I consulted with outpatient oncology nurses and select nursing leadership at DHBMCC.

The objectives for the consultations were to:

1. Explore oncology nurses' perspectives on their role in ACP.
2. Identify barriers and facilitators to ACP.

3. Assess self-reported ACP learning needs.
4. Determine preferred ACP educational delivery methods.

The data collection included two components. The first was a questionnaire distributed to oncology nurses at the DHBMCC, sent through institutional email, which included an invitation to take part in a follow-up interview. The second part of the data collection was an interview with select members of the nursing leadership team to gain deeper insights into current ACP practices and policies.

Questionnaire Findings

Eighteen registered nurses from the DHBMCC completed the questionnaire, yielding a 45% response rate. The findings indicated that oncology nurses received some form of ACP education during orientation, workshops, or continuing education sessions. Confidence in ACP knowledge and related competencies varied among the participants. Some respondents expressed uncertainty about their responsibilities within ACP conversations and emphasized the need for defined roles. Respondents expressed limited confidence in key areas, such as when and how to initiate ACP discussions. There was also uncertainty regarding nurses' roles in Medical Assistance in Dying (MAiD), and engagement in MAiD varied, with most nurses reporting only occasional involvement with a lack of understanding of updated legislation.

Respondents further identified challenges to ACP, including time constraints, patient reluctance, limited ACP education, and systemic issues such as unclear documentation processes and difficulties integrating ACP into clinical workflows. A lack of organizational support, absence of clear policies and guidelines, and unclear documentation processes further complicated the inclusion of ACP in routine nursing practice.

Despite these challenges, most participants strongly supported ACP, viewing it as an important component of oncology nursing that can improve patient outcomes. Many believed

that nurses should take an active role in initiating ACP and emphasized that education would strengthen their ability to engage in ACP conversations. Respondents highlighted a need for ACP education that addresses communication skills, assessing patient readiness to engage in ACP discussions, documentation procedures, and legal and ethical topics such as completion of an advance directive (AD), and the appointment of a substitute decision maker (SDM). They also requested a clearer role within the healthcare team to understand better how nurses contribute to ACP.

Regarding educational delivery formats, participants preferred in-person sessions for their interactive and practical nature, though some valued the flexibility of online and blended learning options. Suggested educational strategies included case studies, role-playing, and practical tools such as flowcharts or checklists. The nurses also recommended integrating ACP education into both orientation and ongoing education programs to ensure ongoing skill development.

Follow-Up Interviews Insights

To enrich the data collection, at the end of the questionnaire, I invited participants to take part in a follow-up interview. Three nurses volunteered for the interview. The themes that emerged from the interviews were role ambiguity, knowledge gaps, ethical and legal considerations, limited awareness of resources, and a lack of organizational processes that prioritize ACP. All interviewees agreed that oncology nurses are well-positioned to engage in ACP discussions due to their close relationships with patients. However, all those interviewed expressed uncertainty about the appropriate timing and approach for initiating these conversations.

The interviewees highlighted the importance of strong communication skills and the value of initiating ACP discussions early in the patient's care journey. They also noted the

challenge of assessing patient readiness to engage in such conversations. All nurses interviewed advocated for mandatory ACP education, favouring blended learning models that combine in-person and online formats.

All interviewees believed there is a need to enhance organizational support, particularly regarding the development and clarification of ACP policies, streamlining documentation processes, and improving coordination to ensure continuity of ACP care between inpatient and outpatient settings.

Nursing Leadership Perspectives

The second phase of my consultations involved interviews with select nursing leaders, whose insights closely aligned with those of frontline nurses. The themes that emerged included the belief that oncology nurses should have a role in ACP but require increased communication skills to navigate ACP discussions and knowledge of ACP resources. All nursing leaders interviewed believed that ACP education should combine the benefits of facilitator-led, in-person learning with the flexibility of online formats and that the organization should prioritize ACP initiatives.

All nursing leaders agreed that ACP should be integrated into oncology nursing practice. They also emphasized the need for education to enhance communication and understanding of legal and ethical considerations, including the importance of supporting patients in naming a SDM and completing an AD. Finally, the nursing leaders highlighted the need for organizational commitment to support ACP integration. In particular, this commitment should include defining the role of oncology nurses in ACP processes, developing clear policies, and embedding ACP into the workflow of everyday oncology nursing practice.

Summary of Environmental Scan

To guide the development of an ACP educational resource tailored for oncology nurses, I conducted an environmental scan of select Canadian cancer care programs, including Cancer Care Ontario (CCO), BC Cancer Care (BCC), Nova Scotia (NS) Health Cancer Care, and Newfoundland and Labrador Health Services (NLHS) Cancer Care Program. I also reviewed national professional relevant nursing standards and position statements from CANO and the CNA. The objectives for the environmental scan were:

1. To determine the former (if any) ACP continuing education for oncology nurses at the DHBMCC.
2. To review the websites for CCO, BCC, and NS Health Cancer Care to identify existing ACP educational modules, policy documents, and/or clinical guidelines regarding ACP.
3. To request information from the clinical educators at the above-listed cancer centers on current ACP education for oncology nurses. I contacted informants by sending a personal email of inquiry directly to the clinical educators.
4. To review CANO's position on ACP education and the role of oncology nurses.
5. To analyze the CNA's *Code of Ethics* for Registered Nurses.

Environmental Scan Findings

Cancer Care Ontario

At CCO, I connected with a clinical nurse educator who reported that ACP education is embedded within a palliative care component of nursing orientation. As a follow-up to this conversation, I was kindly connected with an Advanced Practice Nurse (APN) in Palliative and Supportive Care, who shared that many of their earlier ACP initiatives focused primarily on patient education, with more recent efforts aimed at better supporting nurses, particularly in

navigating documentation. In their organization, ACP-related education is delivered during orientation and in-service sessions, with encouragement to pursue additional training through external programs such as Pallium Canada (2025) and the de Souza Institute (2025). Pallium Canada is a national organization that develops education, tools, and resources to support healthcare providers in delivering high-quality palliative care across Canada. The de Souza Institute is another Canadian organization that provides specialized education, training, and professional development for oncology HCPs to enhance cancer care practice.

CCO also provides a wide range of ACP tools and guides for patients, families, and HCPs on its website. The provider-facing resources feature communication guides, conversation scripts, documentation templates, and the provincially endorsed “*Goals of Care/ACP Quality Improvement Toolkit*.” These clinician tools are specifically designed to support HCPs in initiating and facilitating ACP discussions (CCO, 2016).

British Columbia Cancer Care

At BCC, a clinical nurse specialist (CNS) shared that ACP education is included in nursing orientation. Additional awareness is promoted informally, such as during ACP Day, a nationally recognized day of awareness that takes place every year in April. Plans are underway to expand ACP education using embedded and flexible approaches supported by quick-access tools, although the CNS identified that it is difficult to consistently reach all nursing staff due to busy schedules and a lack of dedicated education time for nurses.

BCC also offers various resources on its website, including patient-facing materials, clinician guides, and an excellent animated video titled “*Talking to Patients about ACP*” that models ACP conversations between nurses and patients.

Nova Scotia Health Cancer Care

I connected with a member of the nursing leadership team at NS Health Cancer Care, who advised that they do not have formal ACP education for oncology nurses, although they do have an ACP policy. NS Health has ACP materials on its website, which offer valuable information for both providers and individuals. Notable resources include the “*Serious Illness Conversation: Reference Guide for Clinicians*”, the “*ACP A Quick Guide for Physicians*”, which outlines structured approaches to initiating ACP discussions, and the “*Just Ask*” workbook, which provides conversation scripts for engaging patients and SDM.

Newfoundland and Labrador Health Services

The NLHS (formerly Eastern Health) website offers an ACP policy and patient-oriented resources, including the “*It’s Your Decision*” workbook and a public awareness video from the 2016 “*ACP: Speak Up*” campaign. The “*It’s Your Decision*” workbook is a tool to guide individuals through the process of making their own healthcare decisions. It provides a structured approach to thinking about and documenting preferences for care. The public awareness video from the 2016 “*ACP: Speak Up*” campaign is part of a national initiative in Canada aimed at encouraging people to discuss their healthcare wishes (Eastern Health, 2021). The video raises awareness of the importance of ACP and empowers individuals to communicate their preferences to family members and healthcare providers before a crisis occurs. There is also an ACP policy from 2016 that promotes early GOC discussions and supports patient autonomy. However, there appears to be limited evidence on structured ACP education initiatives specifically targeting nurses.

Professional National Nursing Organizations

Among professional national nursing organizations, CANO recognizes ACP as a key component of individualized cancer care. While specific ACP competencies are not defined

by CANO, the principles of ACP are reflected in CANO's nine practice standards that guide oncology nursing practice, in particular, "Individualized and Holistic Care" and "Self-determination". The first practice standard of care, known as *Individualized and Holistic Care*, highlights that "individuals with cancer and their families deserve care that is tailored, comprehensive, and respectful of their unique differences" (p.17). The third standard, *Self-determination and Decision-Making*, asserts that "individuals with cancer and their families have the right to self-determination, access to information, and the ability to make decisions about their health care, or to have an advocate if they choose not to participate or are unable to do so" (p.18). These CANO-specific practice standards reflect the principles of ACP within oncology nursing practice. Similarly, the CNA incorporates ACP into its broader ethical framework. Although CNA does not have a specific position statement on ACP, the CNA Code of Ethics (2025) emphasizes nurses' responsibility to uphold patient autonomy, facilitate informed decision-making, and provide clear, relevant information, all principles that align closely with ACP.

Summary of the Educational Resource

Findings from the comprehensive literature review, engagement with key stakeholders, and findings from an environmental scan shaped the creation of a blended learning workshop that combines in-person and virtual components, designed to accommodate the busy schedules of oncology nurses. The resource features a PowerPoint presentation and a facilitator's guide, incorporating interactive elements to build skills for navigating ACP discussions. It includes pre- and post-assessments to evaluate ACP competency, case studies for practical application, role-playing exercises to practice ACP conversations in a supportive environment, and reflection activities that promote self-awareness. The content aligns with professional standards and ethical

principles from CNA and explores the applicability of all CANO practice standards to oncology nursing practice.

Addressing Knowledge Gaps: Foundational Concepts

The educational resource provides an overview of ACP, including its definition, benefits, challenges, and common misconceptions. The content covers the prevalence of ACP engagement in Canada and its importance in oncology care, particularly in improving patient outcomes by aligning treatment decisions with patient values and healthcare preferences. The resource explores the appointment of an SDM and the development of an AD. These topics are woven through the framework of the five steps of ACP, a structured approach that guides individuals in making informed decisions about their care (Advance Care Planning, 2024).

The resource also addresses Medical Assistance in Dying (MAiD), which may be part of some individuals' ACP and is an essential conversation in cancer care. The Canadian Nurses Protective Society (2025) provides important considerations for nurse participation in MAiD, including the recommendation that nurses review their regulatory bodies' positions and awareness of any relevant policies, guidelines, and procedures that define their role in the MAiD process.

An important component of the educational resource is the awareness of how culture impacts an individual's ACP. Given the diversity of patients in healthcare, nurses need to approach ACP conversations with respect for the cultural values and beliefs that shape patients' views of their care, treatment options, and EOL decisions. This education increases awareness of the importance of culture on ACP and how the nurse should adapt their approach to include an individual's cultural context.

The resource also highlights the barriers marginalized populations face in accessing and engaging in ACP. These barriers range from health literacy and socio-economic challenges to

broader systemic healthcare inequalities. Oncology nurses working with these populations need targeted strategies to ensure that ACP discussions are equitable and inclusive, facilitating full participation regardless of a patient's background. By raising awareness of these barriers and offering practical solutions, the resource helps nurses ensure that marginalized populations are not excluded from ACP conversations.

Strategies to Enhance Communication

Once foundational knowledge of ACP is reviewed, the education shifts to strategies to enhance communication. Two frameworks are used to provide a structured context for navigating ACP discussions: the REMAP Framework and the TTM.

REMAP Framework

The REMAP framework is an acronym that guides serious illness conversations and can be applied to ACP discussions with patients and loved ones (Childers et al., 2017). It begins with **R**eframing the conversation by inviting the patient to reflect on their healthcare journey and GOC. Next is **E**xpect emotions, acknowledging that these discussions can be emotional, and should be approached with empathy and active listening. **M**apping out the patient's goals by asking open-ended questions that help them articulate what matters most to them is the next step, followed by **A**ligning the care options with the patient's goals to ensure that the plan is personalized. Finally, **P**ropose a plan by offering next steps and reinforcing that ACP is an ongoing conversation. This model is explained in the resource with examples and role-playing exercises that provide an opportunity for nurses to practice ACP discussions using the REMAP Framework.

Transtheoretical Model

The principles of TTM were used in the educational guide to ensure ACP discussions considered the readiness of both patients and nurses. As outlined in the literature review section,

this model enables HCPs to tailor interventions to an individual's stage of readiness, supporting a more personalized approach. The model emphasizes the importance of nurses recognizing cues that signal a patient's stage of change, using that information to tailor communication strategies to enhance meaningful ACP engagement. The educational resource explores TTM and opportunities for nurses to identify stages of change and practice applying TTM in a realistic clinical scenario through case studies.

TTM supports the understanding that oncology nurses may require different levels of education and opportunities for self-reflection depending on their readiness to initiate ACP conversations. Novice nurses, who may be in the pre-contemplation or contemplation stages, benefit most from foundational learning about the importance of ACP and its integration into routine patient care. In contrast, more experienced nurses, who are often in the action or maintenance stages, require advanced communication strategies and opportunities to mentor colleagues. By recognizing these varied stages of readiness, the facilitator can use the educational resource to build confidence and competence in ACP conversations across all levels of professional development.

Clarifying the Role of Oncology Nurses

The findings from the literature review and consultations reveal that oncology nurses frequently experience role ambiguity when assisting with ACP, which can arise from unclear boundaries regarding who is responsible for facilitating ACP discussions. The findings also highlight the role of oncology nurses in supporting patients through discussions about healthcare preferences, treatment goals, and EOL care wishes.

Clarifying the role of oncology nurses in ACP is framed through the CANO (2019) practice standards. CANO is dedicated to promoting excellence in cancer care through oncology nursing education, professional development, advocacy, and support. They provide resources,

networking opportunities, and continuing education to help oncology nurses enhance their skills and knowledge and deliver the highest standard of care to their patients and loved ones.

The educational resource draws on the nine CANO practice standards to provide a framework for guiding oncology nurses through ACP initiatives. The first standard, **Holistic Care**, emphasizes the importance of providing individualized, evidence-based care throughout the cancer journey that reflects the patient's values, preferences, and goals, which is foundational to ACP. Similarly, the **Family-Centred Care** standard recognizes the role of loved ones as active participants in the cancer care journey and has application to ACP discussions. Families and loved ones are often the ones who will need to implement the patient's ACP when they are no longer able to speak for themselves. By involving them early in ACP conversations, healthcare teams can ensure that loved ones are well-prepared and aligned with the patient's values and wishes.

The **Self-Determination and Decision-Making** standard emphasize the importance of respecting patient autonomy and providing the information necessary to support informed decision-making. Additionally, the **Navigating the System** and **Coordinated Care** standards highlight the nurse's role in guiding patients and families through the complex healthcare and cancer care systems. The **Supportive, Therapeutic Relationships** standard recognizes the trusted relationship oncology nurses have with their patients, positioning them to engage in sensitive ACP conversations, clarify what ACP entails, and inform patients about its benefits.

Evidence-Based Care ensures that nurses stay informed about the latest evidence related to oncology and ACP, contributing to research or quality improvement initiatives to enhance ACP practices. The **Professional Care** standard highlights that oncology nurses operate with a

high level of ethical and legal awareness, ensuring that their actions align with established healthcare guidelines and principles.

Finally, the **Leadership** practice standard reflects the role of oncology nurses in advancing oncology nursing practice, education, and research. Nursing leaders can advocate for policies that support the implementation of ACP initiatives. Additionally, nursing leaders can become involved in nursing ACP research and prioritize ACP education for all nurses.

Educational Resource Delivery Methods

Through the literature review, I identified three primary approaches to delivering ACP education for oncology nurses: in-person education, virtual learning, and a hybrid model (Chang et al., 2024; Colville & Kennedy, 2012; Feaster et al., 2023; Yahiro et al., 2023). In-person education provides interactive learning and skill-building opportunities, particularly through role-playing and real-time feedback from the facilitator. However, clinical schedules may limit attendance to in-person education. Virtual learning, or e-learning, offers greater flexibility, allowing nurses to go at their own pace, making it ideal for delivering foundational ACP knowledge. However, it may lack the interpersonal interaction needed to practice and develop communication skills. A hybrid model, or blended model, offers flexibility while maintaining opportunities for interactive facilitator-led learning. Moreover, this was the delivery method preferred by nurses in the consultations.

Consequently, this educational resource will be delivered through a hybrid learning model that combines both in-person and remote formats to provide flexibility and accessibility to accommodate nursing schedules and busy work environments. This resource integrates key components designed to enhance ACP competency, including pre- and post-assessments to measure and track progress in ACP knowledge, case studies for practical application, role-

playing exercises to practice ACP conversations in a supportive setting, and reflection activities that encourage self-awareness.

The case study presented at the beginning of the workshop reflects a realistic scenario that is encountered by oncology nurses in their daily practice. As the participants work through the session, participants are encouraged to reflect on the scenario and how they would navigate the situation. At the end of the session, there is an opportunity to engage in role-playing that encourages the use of the REMAP Framework and the TTM to help guide the ACP conversation.

Benner's Novice to Expert framework supports the structure of this resource by recognizing that nurses enter the workshop with different levels of experience and confidence in conducting ACP conversations, and therefore require different learning supports. The workshop activities are intentionally scaffolded to help nurses progress from basic understanding to more advanced, intuitive communication skills. The Transtheoretical Model (TTM) also aligns well with ACP education, as it highlights the stages of readiness individuals move through when adopting new behaviours. By integrating TTM principles, the resource encourages nurses to reflect on their own readiness to engage in ACP discussions and to build strategies that support gradual, sustainable improvement in practice.

Advanced Practice Nursing Competencies

Reflecting on the development of this practicum project, I demonstrated several Advanced Practice Nursing (APN) competencies as outlined in the "*Advanced Practice Nursing: A Pan-Canadian Framework*" (Canadian Nursing Association [CNA], 2019). According to the Canadian Nurses Association (2019), APNs demonstrate core competencies integrating knowledge, judgment, practical skills, and personal qualities.

Education Competency

Education competencies reflect APNs' commitment to professional development and lifelong learning, along with prioritizing educating colleagues, students, patients, and their loved ones (CNA, 2019). I demonstrated these competencies by assessing learning needs and designing appropriate educational strategies to enhance ACP competency. Specifically, I identified a gap in ACP education among oncology nurses, a finding confirmed through consultations with local stakeholders. To address this, I developed an educational resource aimed at increasing oncology nurses' knowledge and confidence in conducting ACP conversations. This project involved assessing oncology nurses' specific educational needs related to ACP and creating a targeted resource to increase ACP competency.

Research Competency

APNs are committed to generating, evaluating, and applying research evidence to improve client care and health system performance (CNA, 2019). They identify, appraise, and implement research-based innovations, clinical guidelines, and best practices to support evidence-informed decision-making at the client, organizational, and system levels (CNA, 2019). In this project, I demonstrated research competencies by conducting, analyzing, and appraising research in the literature review, as well as collecting and analyzing data through an environmental scan and stakeholder consultations. I developed semi-structured interview questions designed to engage key stakeholders and elicit information to inform resource development. Through analysis of the synthesized data from the literature review, environmental scan, and consultations, I identified key themes and insights that informed the creation of a comprehensive, evidence-based educational resource tailored to local practice needs.

Leadership Competency

APNs are leaders within their organizations and communities, acting as agents of change by continuously seeking innovative approaches to practice, enhancing care delivery, and advancing the role of APN (CNA, 2019). I demonstrated leadership competencies during my practicum project by taking the initiative to address knowledge gaps and applying practice standards to promote a change in oncology nursing practice. I applied leadership competencies by identifying systemic barriers to ACP education within the organization and considering strategic approaches to address them. These included increasing awareness of institutional policies and exploring blended learning formats to meet the educational needs of oncology nurses.

Optimizing Health System Competency

APNs address the complex healthcare needs of Canadians across various settings and support a sustainable and effective healthcare system (CNA, 2019). In my nursing practice, I recognized a gap in engagement with ACP discussions and looked at the opportunities for oncology nurses to engage in ACP initiatives. I developed strategies to enhance oncology nurses' competency in this area through the development of an educational resource. The resource aims to strengthen oncology nurses' confidence and skills in facilitating ACP, empowering them to better support patients in making informed decisions about their future healthcare. By leading ACP initiatives that emphasize patient values and preferences throughout the cancer care continuum, oncology nurses are empowered to optimize health system performance and improve the quality of patient-centred care.

Next Steps

Implementation Plan

There are multiple components to the dissemination and implementation of this initiative. The first involved presenting the key components that guided the development of the ACP educational resource to select members of the Memorial University Faculty of Nursing, including my academic supervisor and my peers from the Master of Science Nursing Program.

The second step involves collaborating with the clinical educator of the Provincial Cancer Care Program (PCCP) to advocate to include this education resource in a yearly ACP session for oncology nurses. Additionally, I will advocate for the integration of ACP education into oncology nursing orientation to ensure that new staff receive foundational knowledge and skills to navigate ACP conversations.

Third, while this resource was initially developed for nurses at the DHBMCC, it can be adapted and implemented across all oncology nursing settings in Newfoundland and Labrador (NL). The PCCP has regional and peripheral sites in NL, with multiple oncology nursing teams delivering patient care. I will advocate for a wider dissemination of this ACP education to include oncology nurses from across the province. Because provincial oncology nurses share educational resources, the resource will be easily adapted and will require minimal tailoring to their local setting.

Finally, although the primary outcome of this practicum project was the development of an educational resource to meet the needs of the local setting, it has become evident that there is value in sharing this information more broadly. Therefore, in consultation with my academic supervisor, we plan to write and submit an article on ACP and the role of oncology nurses for

publication in *The Canadian Oncology Nursing Journal (CONJ)*, the official journal of the Canadian Association of Nurses in Oncology (CANO).

Evaluation Plan

Following the initial workshop for oncology nurses at the DHBMCC, I plan to evaluate whether the ACP educational resource reflects the local setting and addresses knowledge gaps. Approximately three months after the session, I plan to conduct a follow-up focus group with nurses who participate in the workshop. The purpose of the focus group is to explore participants' perceptions of how the workshop has influenced their knowledge and confidence in navigating ACP discussions. Findings from the focus group will also help to identify any ongoing educational needs or gaps that may not have been addressed in the resource.

Finally, it is important to explore uptake and increase in ACP engagement at the DHBMCC following implementation of the education session. Although the current oncology EMR does not consistently allow ACP conversations to be measured, the new NLHS EMR, scheduled for rollout in 2026, will include functionality to document ACP conversations. This will enable us to capture ACP conversations, identify who initiates them, and document which key decisions are documented. Once this functionality becomes available in patients' EMRs, it will enable more comprehensive tracking of ACP engagement and its impact on patient care.

Conclusion

Oncology nurses are uniquely positioned to lead ACP initiatives due to their close relationships with patients and their integral role within the cancer care team. Despite this, they often encounter barriers, including limited knowledge, role ambiguity, insufficient organizational support, and time constraints, which can impede their full participation in ACP conversations.

The purpose of my practicum project was to address these challenges by providing foundational ACP knowledge, clarifying the roles and responsibilities of oncology nurses in assisting patients with ACP, and focusing on strategies to enhance ACP conversation skills. The methods for the project included an integrative literature review, environmental scan, and consultations with key stakeholders. The findings from these methods supported the development of a workshop with a facilitator's guide and accompanying PowerPoint presentation. The facilitator's guide equips instructors with prompts to support case-based discussions and role-play activities, helping nurses build practical communication skills directly applicable to ACP conversations. It offers an engaging and interactive learning experience tailored to oncology nurses that aligns with CANO practice standards.

The completion of this project allowed me to demonstrate nursing competencies, including research, leadership, education, and health-system optimization. The resource I developed supports the advancement of oncology nursing practice and aligns with evidence-informed approaches to enhance patient care. The implementation and sustainability plan for this educational resource includes ongoing advocacy to prioritize ACP education and efforts to disseminate the resource provincially and nationally to all oncology nurses.

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Appendix A: Literature Summary Review

Advance Care Planning (ACP) is a reflective process in which competent individuals make decisions regarding their future care, personal care, and end-of-life (EOL) care in the event they become unable to provide informed consent (Advance Care Planning, 2024). ACP offers individuals the opportunity to document their goals of care (GOC) and communicate healthcare wishes with loved ones and healthcare providers (HCPs) (Rietjens et al., 2017). ACP reduces stress for patients and alleviates emotional strain and uncertainty for both families and HCPs during critical healthcare situations (Fink et al., 2019; Johnson et al., 2016).

ACP facilitates comfort care by reducing the need for resuscitation and mechanical ventilation, minimizing unnecessary treatments, and improving patient outcomes by aligning their care with individual healthcare preferences (Goswami et al., 2020). In cancer care, ACP empowers patients to play an active role in their treatment decisions, often resulting in fewer aggressive interventions, shorter hospital stays, and an increased use of palliative care (Agarwal & Epstein, 2018). Despite the advantages of ACP, various challenges lead to delays or absences of ACP discussions in the cancer care trajectory (Agarwal & Epstein, 2018). Johnson et al. (2016) suggest that HCPs are reluctant to initiate ACP early and often delay ACP until the issues arise, particularly surrounding EOL care.

Patients with advanced cancer are ideally poised for ACP discussions, as patients have a life-limiting illness but are typically well enough to consider and plan for their future care (Agarwal & Epstein, 2018; McDonald et al., 2016). However, ACP is not only relevant for patients with advanced cancer; it should be an ongoing discussion throughout the cancer trajectory.

McDonald et al. (2016) demonstrated a low level of physician involvement in ACP, creating an opportunity for oncology nurses to take a more active role in supporting patients through the ACP process. This shift should not be seen as diminishing the physicians' role, but more of a recognition that nurses are uniquely positioned to engage in ACP due to their trusting relationships with patients, effective communication skills, and approach to person-centred care. Although ideally situated to champion ACP initiatives, nurses often feel unprepared to engage in discussions due to a lack of education, role ambiguity, and an absence of organizational infrastructure that prioritizes ACP (Kilgore et al., 2025). Moreover, nurses report feelings of anxiety and discomfort when participating in ACP discussions due to a lack of knowledge and skills to support patients in ACP (Rietze & Stajduhar, 2015).

In this literature review, I will explore the importance of ACP in cancer care and strategies to enhance ACP competency for oncology nurses. Specifically, I will review the benefits and challenges of ACP, explore the role of nursing in ACP, identify the ACP educational needs of oncology nurses, and explore strategies to enhance ACP competency.

Search Methods

I conducted a literature review across several databases, including PubMed, CINAHL, and Google Scholar. The inclusion criteria for the review included studies published within the last 15 years, written in English, nursing-related, and peer-reviewed. I included qualitative studies, quantitative studies, mixed-method studies, and systematic reviews. I used a range of key search terms, including "advance care planning," "ACP," "oncology nursing," "education and training," "competency," "benefits," "challenges," "person-centred care," and "theoretical frameworks." The key questions were: What are the benefits and challenges of ACP? What is the role of nurses in ACP discussions? What is the impact of ACP education on the knowledge,

confidence, and communication skills of oncology nurses? What are the key educational strategies to prepare oncology nurses for these conversations? The search yielded a total of 135 articles. Through a purposeful selection and intentional inclusion of sources based on their relevance, quality, and potential to offer insights into the key questions, I critically analyzed 17 of these articles for this literature review. They included five qualitative studies, eight quantitative studies, three mixed methods studies, and one systematic review. I selected these studies for their relevance to the review's objectives and key questions. I utilized the Public Health Agency of Canada (PHAC) (2014) critical appraisal tool (CAT) to evaluate the strength and quality of the quantitative studies. For the qualitative studies, the Joanna Briggs Institute (JBI) (2017) critical appraisal checklist ensured methodological rigour. I used the Mixed-Method Appraisal Tool (MMAT) (2018) to critically appraise mixed-methods studies.

Background

According to the Government of Canada (2020), while 93% of Canadians acknowledge the importance of discussing ACP with their loved ones, fewer than half engage in these conversations, and only one in five Canadians have a written ACP (ACP: A Pan-Canadian Framework, 2020). Insights from a more recent Canadian ACP national poll show that 77% of Canadians have considered their ACP, 43% believe that ACP should begin when individuals are in good health, and 82% agree that documenting care preferences can help alleviate the emotional stress experienced by loved ones during critical health care moments (Canadian Hospice and Palliative Care Association [CHPCA], 2024). Despite awareness, there is a gap between acknowledging its importance and taking steps to formally create an ACP (CHPCA, 2024).

Five steps in the ACP process help individuals prepare for future health care decisions (ACP, 2024). The first step is for an individual to reflect on their values, beliefs, and GOC. This reflection lays the foundation for making choices that align with healthcare preferences. The second step involves learning about various medical treatments and interventions, such as resuscitation and mechanical ventilation, to better understand the options available and the potential outcomes of one's choices. In the third step, individuals identify a substitute decision maker (SDM), someone the individual trusts to make healthcare decisions on their behalf if they become unable to do so. This person must be willing and capable of taking on this responsibility. The fourth step is engaging in an open conversation with the SDM, loved ones, and HCPs to communicate one's preferences and GOC. These discussions help ensure that everyone involved is aware of the individual's wishes. The final step is to formally document and share the ACP. This may include writing down preferences, completing legal forms, or incorporating the plan into one's medical record. It is important to recognize that ACP is not a one-time event but a continuous and evolving process (ACP, 2024). As circumstances, health status, or perspectives change, the plan can be revised and updated.

A key component of ACP is appointing an SDM who understands their role as a health care proxy (Siden et al., 2022). As previously mentioned, this individual is entrusted with the responsibility of making health care decisions on behalf of the person, ensuring that the individual's values, preferences, and wishes are honoured if they are unable to make decisions for themselves. Clear communication and mutual understanding between the individual and their appointed proxy ensure that the person's health care choices are represented and respected.

ACP may result in the creation of an advance directive (AD), a set of legal documents that guide HCPs and family members in making decisions on behalf of an individual. By

formalizing a person's wishes in a legal document, the individual maintains control over their future health care decisions, even if they become unable to direct their care (Siden et al., 2022). It is important to recognize that an individual can have an ACP without having a legal AD (Siden et al., 2022). Both the information on an SDM and an AD should be shared among healthcare teams and become part of a person's electronic medical records (EMR).

ACP Benefits

Detering et al. (2010), Goswami et al. (2020), and Sudore et al. (2017) state that when patients engage in ACP, their care is more likely to reflect their core beliefs and values, leading to a higher level of patient satisfaction, improved quality of life (QOL), and enhanced EOL care. Additionally, documenting care preferences alleviates the emotional burden on loved ones and provides clarity to healthcare teams regarding treatment decisions during critical moments (Sudore et al., 2017).

A high-quality randomized controlled trial (RCT) by Detering et al. (2010) examined the impact of ACP on EOL care for cognitively healthy residents in long-term care. The residents were randomly assigned to either a control group, which received standard care, or an intervention group that engaged in ACP discussions. Detering et al. (2010) revealed that 86% of residents in the intervention group documented their ACP and had their EOL wishes honoured, compared to 30% in the control group. Moreover, family members of patients in the intervention group reported significantly lower levels of stress ($p < 0.001$) and anxiety ($p = 0.02$) concerning GOC discussions.

Similarly, Goswami et al. (2020) conducted a high-quality retrospective study to evaluate whether ACP discussions led by advanced practice providers could enhance EOL care. Their study included 36 patients (17 inpatients and 19 outpatients) who did not have a documented AD

or ACP. Using an 18-question survey administered before and after the ACP discussions, the researchers assessed changes in ACP participation, AD completion, code status, and designation of an SDM. The researchers' findings indicated significant improvements post-intervention in both inpatient and outpatient settings. Among inpatients, ACP participation increased from three to 20 patients ($p < 0.001$) and AD completion and appointment of a SDM from one to 13 ($p < 0.001$). Similar trends were observed in outpatients, with ACP participation and AD completion increasing from zero to 20 ($p < 0.001$) and zero to eight, respectively ($p < 0.001$). The participants in the inpatient setting demonstrated greater improvements, but the intervention showed potential for both settings. Both Detering et al. (2010) and Goswami et al. (2020) suggest that meaningful ACP conversations will increase ACP engagement.

Nursing ACP Practice

National nursing governing bodies emphasize the importance of nursing involvement in ACP. The Canadian Association of Nurses in Oncology (CANO) identifies ACP as a core competency, stating that oncology nurses are expected to apply foundational knowledge to support ACP discussions and advocate for the preferences of individuals with cancer (CANO, 2019). Similarly, the Canadian Nurses Association (CNA) highlights the role nurses play in facilitating and advocating for palliative and EOL care through meaningful ACP conversations (CNA, 2015). Despite the position of CANO and CNA, there is limited ACP nursing engagement in the practice setting. This was demonstrated by Shih et al. (2025), who conducted a high-quality, sequential, explanatory, mixed-methods study examining ACP practices among 532 oncology nurses in China with at least one year of experience caring for patients with incurable conditions. Through convenience sampling, quantitative data were collected via a cross-sectional survey from December 2021 to January 2022. The qualitative phase consisted of

19 interviews conducted between May and July 2022, which were then thematically analyzed to capture the challenges in ACP practices. The quantitative findings revealed that 36.5% of oncology nurses rarely initiate ACP discussions and 52.4% never engage in a conversation about SDM with patients. EOL discussions were infrequent (29.3%), with the most common topic being the place of death, such as in the home or institutional palliative care setting. The qualitative analysis identified four themes: lack of optimal timing, passive engagement of patients and families, reluctance of HCPs to engage in ACP, and unsupported policies. Shih et al. (2025) recommended ACP nursing education and institutional policies to support oncology nurses' involvement in ACP.

Sinclair et al. (2017) explored the impact of nursing on ACP engagement. Their high-quality, multicenter RCT aimed to assess whether a nurse-led ACP intervention increases uptake in patients with advanced respiratory disease. The intervention group had the opportunity to engage in nurse-led ACP discussions and were offered assistance with appointing an SDM and completing an AD. The researchers found that after the intervention, 51% in the intervention group appointed an SDM and wrote an AD in comparison to the usual care group, which was 14 % ($p < 0.001$). Secondly, ACP discussions with an HCP were reported in 72% of the intervention group compared to 47% in the usual care group ($p < 0.005$). Sinclair et al.'s (2017) study demonstrates that nurse-led intervention increases the completion of ACP documentation and discussions and supports the importance of enhancing ACP nursing competence.

Understanding the perspectives and attitudes of nurses is an important consideration in ACP implementation. Ke et al. (2015) conducted a high-quality qualitative meta-synthesis to explore nurses' perspectives on implementing ACP for older adults. The researchers searched four major databases, and 1844 articles were initially screened, resulting in the inclusion of 18

articles that were critically appraised and thematically synthesized. The researchers revealed four key themes: the perceived advantages and disadvantages of ACP; nurses' roles and responsibilities; facilitators and barriers to ACP; and educational needs of nurses. Ke et al. (2015) suggest that nurses view ACP positively and are well-positioned to initiate ACP conversations, but they identified multiple barriers related to the healthcare environment, interprofessional communication, time constraints, and knowledge, rather than patient-specific issues. Similar to Shih et al. (2025) and Sinclair et al. (2017), Ke et al. (2015) concluded that nurses believe in ACP, but they require education and strategies to overcome barriers and enhance ACP implementation.

Individualized and Holistic Care

Through its practice standards, CANO provides a framework that shapes and supports the professional role of oncology nurses. The first standard practice is titled *Individualized and Holistic Care* and includes a statement that “oncology nurses will provide individuals with cancer and their family care that is individualized, holistic, and responsive to and respectful of individual differences, such as but not limited to, developmental, physical, cultural, spiritual, social, economic, philosophical, political, or gender” (CANO, 2015, p.17).

Through CANO's framework, oncology nurses practice individualized and holistic care and are well-positioned to lead ACP conversations. This was demonstrated in a strong narrative analysis by van Lummel et al. (2024), who explored how ACP conversations differ when guided by person-centred approaches compared to treatment-focused interactions. The study evaluated the “Multidisciplinary Timely Undertaken Advance Care Planning” (MUTUAL) intervention, which provides a structured framework for initiating ACP discussions. van Lummel et al. (2024) found that participants were at varying stages in the ACP process, ranging from those who had

already communicated their preferences with healthcare proxies to those who had not yet considered EOL discussions. Some participants had reflected on their values but struggled to articulate specific treatment preferences. van Lummel et al. (2024) identified three strategies to enhance person-centred ACP: aligning discussions with the patient's readiness for decision-making, exploring the reasoning behind treatment preferences to better understand underlying values, and actively engaging in listening. These recommendations align with the CANO (2015) practice guidelines for individualized care by tailoring care to meet the needs of patients based on their beliefs and values. The strategies capture the importance of HCPs developing interpersonal skills and reflective practice to increase tailored, person-centred ACP engagement (van Lummel et al., 2024).

Nursing-Related Challenges

Nurses face challenges in engaging in ACP discussions. Kilgour et al. (2025) found that nurses are well-positioned to facilitate and support ACP, but many feel ill-equipped to initiate these conversations. Barriers such as limited awareness, inadequate skills, and uncertainty about their role contribute to this lack of engagement. These findings are consistent with Ke et al. (2015), Agarwal & Epstein (2018), and Johnson et al. (2016), who report that HCPs, including nurses, often feel unprepared to engage in ACP conversations due to insufficient education. Fink et al. (2019) noted that oncology nurses frequently lack comprehensive knowledge of ACP processes, legal requirements, and documentation procedures. Similarly, Siden et al. (2022) identified time constraints and knowledge gaps as barriers. Both Johnson et al. (2016) and Kilgour et al. (2025) emphasized role ambiguity, as some nurses may feel ACP conversations are the responsibility of physicians or palliative care specialists and beyond their scope of practice.

Public and Patient Related Challenges

Siden et al. (2022) and Teixeira et al. (2014) explored barriers and gaps in the engagement of ACP from the perspective of Canadians. Sedin et al. (2022) conducted a high-quality mixed-methods study in British Columbia to explore public perceptions and barriers related to ACP. The study involved 57 online survey respondents, with 17 participating in follow-up semi-structured telephone interviews. The researchers found that 67% of participants associated ACP with EOL and death, contributing to discomfort in the discussions. Additional barriers included lack of knowledge (65%), public awareness gaps (55%), confusing terminology (32%), and cultural challenges (11%). The study offered valuable insights into how ACP is perceived by the public, including the need for culturally sensitive communication.

Teixeira et al. (2014) conducted a high-quality, cross-sectional Canadian national survey (N = 1021) that provided similar insights to those of Siden et al. (2022). Their study revealed limited public awareness of ACP, with only 16% recognizing the term. Only 10% of respondents had ACP discussions with their HCP, but 52% spoke to loved ones about their GOC. The researchers noted greater engagement among older adults, women, and those with higher socioeconomic status. Teixeira et al. (2014) suggest the need for education for both the public and HCPs. Both Canadian studies demonstrate the need for interventions to increase public ACP awareness and the need for better communications between individuals, loved ones, and HCPs.

Johnson et al. (2016) found that cancer patients' responses to ACP differ from those of other patient populations. They suggest that individuals with cancer show varying levels of willingness to participate in ACP discussions, with several factors contributing to the low uptake of ACP. These factors include the broad age range of affected individuals, unpredictable disease courses, and the uncertainty of treatment options (Johnson et al., 2016). Additionally, limited

understanding of treatment intent and a desire to maintain hope may further discourage ACP engagement in this patient population (Johnson et al., 2016).

Organizational Challenges

Organizational challenges create obstacles to ACP integration. Johnson et al. (2016) state that the behaviours and choices of patients, their loved ones, and HCPs involved in ACP are shaped by the institutional culture. Hagen et al. (2015) found that 78% of healthcare leaders in Alberta cited insufficient infrastructure and limited time as key obstacles, while 69% emphasized the need for standardized documentation protocols. The absence of standardized documentation hinders the seamless integration of ACP into the patient's electronic medical record (EMR), resulting in inconsistencies in how ACP is communicated across healthcare teams (Hagen et al., 2015). Similarly, Ke et al. (2015) suggested that oncology nurses struggle with systemic issues like time constraints, insufficient infrastructure, fragmented documentation, and a lack of organizational support. Both Hagen et al (2015) and Ke et al. (2015) recognize that education is a part of a larger cultural shift that prioritizes ACP and includes policy changes.

Educational Needs

My analysis of the literature strongly supports nursing education as the foundational component in increasing engagement with ACP. The ACP educational needs of nurses can be categorized into four main areas: addressing knowledge gaps, enhancing communication skills, ethical considerations, and considerations for culturally diverse and marginalized individuals (Izumi et al., 2024; Rietze et al., 2015; Shih and Lu, 2024; Yahiro et al., 2021).

Addressing Knowledge Gaps

I have identified knowledge gaps as a key barrier to nursing engagement in ACP initiatives. A strong, high-quality, multicenter cross-sectional study by Shih and Lu (2024) found

that although oncology nurses held positive attitudes toward ACP, significant gaps in knowledge and practice behaviours remained, pointing to the need for targeted educational strategies. This aligns with a medium-quality observational study by Feaster et al. (2023), who reported a substantial increase in ACP documentation rates, from 0% to 63%, following a structured nursing education initiative. Similarly, Yahiro et al. (2021) conducted a high-quality intervention study showing that education significantly improved the comfort and willingness of nurses to engage in ACP conversations. Likewise, Rietze et al. (2015) highlighted that inadequate education contributes to nurses' lack of confidence and called for educational interventions to address persistent knowledge gaps. Collectively, these studies emphasize the foundational role of education in building both competence and confidence among nurses in ACP.

Enhancing Communication Skills

The development of effective communication skills is an important component of ACP. Multiple studies emphasize that communication training enhances the confidence, preparedness, and ability of nurses to conduct meaningful ACP conversations. A high-quality multicentre RCT by Sinclair et al. (2017) highlights that nurse-led ACP discussions promote greater patient engagement, attributing success to therapeutic communication and the ability to individualize discussions. Similarly, strong qualitative research by Yang et al. (2022) and Yahiro et al. (2021) identifies communication skills as foundational to ACP education. van Lummel et al. (2024) reinforced the value of reflective practice and communication. Colville and Kennedy (2013) demonstrated that an ACP training workshop could significantly enhance nurses' confidence and readiness to initiate ACP discussions. Readiness to engage in ACP discussions is especially important in ethical situations, where nurses must navigate conversations with sensitivity.

Ethical Considerations

Oncology nurses often face navigating ethical dilemmas, particularly when balancing patient autonomy with their professional duties. These ethical considerations may extend beyond individual patients as oncology nurses must often engage with families, who may hold different views from the patient.

An area where oncology nurses may experience an ethical dilemma is regarding Medical Assistance in Dying (MAiD). This was demonstrated by Beuthin et al. (2018), who interviewed 17 nurses during the first six months following the legalization of MAiD in Canada. The study explored the experiences of nurses who either provided care to patients who chose MAiD or chose not to participate in the process. The researchers identified three themes related to nurses' perceptions of MAiD: professional role, clinical practice, and personal life. From a professional role and clinical practice perspective, nurses provide holistic, nonjudgmental care while advocating for patient choice to a dignified death. From a personal perspective, many nurses feel like "pioneers," navigating emotions and moral positions that range from strong support to opposition (Beuthin et al., 2018). Beuthin et al. (2018) assert that many nurses viewed MAiD as an extension of their professional role, with a smaller group experiencing moral distress as they struggled with the ethical complexities of assisted dying. The researchers recommend that nursing leaders and organizations take an active role in preparing nurses to navigate the many experiences related to MAiD. Beuthin et al. (2018) advise that clinical educators address the emotional complexity of MAiD by adopting interactive learning strategies, such as role-playing, rather than relying solely on lecture-style teaching. The researchers also raise the question of whether a minimum level of MAiD education should be mandatory. At a policy level, they advocate for continued support of patient autonomy and the delivery of compassionate, informed care (Beuthin et al., 2018).

Oncology nurses must understand the ethical, legal, and clinical elements to navigate MAiD conversations. They also need to connect with their personal beliefs and values surrounding assisted dying, an area that will require ongoing self-reflection. This is an important consideration when developing ACP education for oncology nurses.

Marginalized Communities and Cultural Considerations

Marginalized populations face obstacles that interfere with meaningful ACP engagement. In their high-quality, interpretive phenomenology study, Izumi et al. (2024) recruited a purposeful sample of marginalized individuals from four primary care clinics and one nursing home in the United States. The purpose of this study was to understand how people from marginalized populations perceive ACP based on their lived experiences. Through semi-structured interviews and group discussions, Izumi et al. (2024) demonstrated that individuals from marginalized populations are willing to engage in ACP. Still, barriers related to HCPs' behaviour, attitudes, biases, and stereotypes interfere with the process. Marginalized people feel that the lack of listening by HCPs interferes with establishing trusting relationships, a key component of ACP (Izumi et al., 2024). Additionally, the participants felt that fragmentation of the healthcare system interfered with ACP. For example, ACP-relevant information, such as an AD or an SDM, is often lost or not communicated among health care teams, especially when participants see multiple providers (Izumi et al., 2024).

Culture plays a role in ACP as it influences how individuals view illness, QOL, decision-making, and treatment preferences. Cultural humility is part of initiating respectful ACP discussions and involves commitment to ongoing self-reflection, recognition of power imbalances, and respect for people's culture (Jonathan et al., 2024). Cultural safety emphasizes the importance of nurses creating a space for patients to feel respected and secure in expressing

their cultural values and beliefs (Izumi et al., 2024). Jonathan et al. (2024) highlight that many Indigenous patients prefer a community-based approach to EOL where family and elders play a central role, taking precedence over individual autonomy and requiring oncology nurses to shift from Western models of care to more inclusive, cultural approaches. In contrast, other cultural groups may delay or avoid EOL discussions due to beliefs that such conversations are culturally inappropriate. Jonathan et al. (2024) emphasize the importance of active listening and culturally sensitive communication as key components of ACP engagement with patients from diverse backgrounds. These individualized approaches support holistic care by encouraging nurses to see cultural backgrounds as foundational to ACP decision-making.

Spirituality and ACP

Spirituality is an important but often overlooked dimension of ACP (Lutz et al., 2018). Lutz et al. (2018) proposed a model that centres on spiritual care, where clinicians create an open, compassionate space that embraces spirituality. This approach emphasizes the importance of acknowledging patients' sources of spiritual strength, community ties, belief systems, and rituals (Lutz et al., 2018). Lutz et al. (2018) assert that spiritual care contributes to improved QOL by identifying spiritual distress and exploring an individual's meaning of their illness. Lutz et al. (2018) highlight that spirituality has become marginalized due to the predominance of biomedical models in healthcare. The researchers recommend an integration of spirituality into practice, particularly in the case of serious illnesses and EOL care. Similarly, incorporating spirituality into ACP education may equip oncology nurses with the skill to support patients as they seek meaning throughout their cancer care journey.

Educational Approaches

Nurses prefer educational approaches that are experiential, practical, and collaborative; however, learning styles may vary depending on individual preferences and the nature of the content (Mangold et al., 2018). Online learning offers flexible, self-paced opportunities that accommodate the demanding schedules of nurses, while scenario-based learning and role-playing enable nurses to practice communication skills in realistic clinical contexts (Davis et al., 2024). Virtual learning offers the potential to advance theoretical knowledge, practice proficiencies, and overall satisfaction (Lui et al., 2023). Education that includes self-reflection helps nurses process the emotional dimensions of care and may foster a deeper understanding of ACP (Mackenzie et al., 2018). Yang et al. (2022) suggest that ACP training for nurses include realistic case-based scenarios and opportunities for self-reflection. A systematic review by Pearce et al. (2021) reported that for HCPs, a program that combines initial didactic teaching with role-play, case studies, and simulation tasks is the most effective way to increase ACP initiatives and may increase participant engagement.

In-Person Education

In-person education, including scenario-based education, enables participants to engage in discussions through case studies and role-playing situations and may increase confidence in ACP (Chan et al., 2019; Feaster et al., 2023; Yahiro et al., 2021).

Yahiro et al. (2021) conducted a high-quality pre- and post-intervention study in Japan to develop and evaluate an ACP scenario-based educational program for palliative care nurses. The intervention included four structured training modules covering ACP definitions, disease and treatment knowledge, ethics and legal considerations, and enhancement of communication skills. Thirty-nine palliative care nurses participated in this one-day in-person training, with data collected through validated surveys. Six items were evaluated, including understanding of the

content, satisfaction with topics, clarity of the goals, appropriateness of the content to achieve the goal, appropriateness of the method, and utility for the future practice of ACP. The results obtained by the researchers showed an increase in ACP discussion (mean pre-intervention = 24.49; mean post-intervention = 27.59, $p = 0.045$) and a significant decrease in the sense of difficulty with understanding ACP (mean pre-intervention = 4.85; mean post-intervention = 4.30, $p = 0.001$). Additionally, more than 90% of the participants expressed satisfaction with the educational program and the appropriateness of the content but called for greater role-playing and simulation content.

Other than the research by Yahiro et al. (2021), I found very little literature that supported exclusive, in-person ACP education. An interesting comparative study by Barnes and Breakwell (2024) investigated a 2-hour interprofessional ACP workshop delivered both in-person ($n = 135$) and synchronously online via Microsoft Teams ($n = 88$) with identical content covering ACP terminology, personal reflection, case discussion, and group work. The follow-up surveys conducted one day and 30 days post-workshop revealed high satisfaction in both formats (96 % in-person vs. 99 % virtual), with no significant differences in learner engagement, knowledge acquired, and readiness to initiate ACP conversations. Barnes and Breakwell (2024) concluded that online synchronous delivery of ACP education is as effective as in-person delivery.

Online and Virtual Learning Methods

Online learning and virtual learning are often used interchangeably, but they refer to distinct instructional modules. Online learning encompasses any course delivered over the internet, while virtual learning typically refers to real-time, scheduled, and interactive sessions such as live videoconferences or virtual simulations that closely mimic classroom experiences (Davis et al., 2024; Lui et al., 2023).

Online learning is an effective and accessible method for enhancing ACP competencies among HCPs. Five Wishes is an American-based program that offers online ACP training modules for HCPs. These courses include components on facilitating ACP discussions, understanding AD, and addressing communication challenges in EOL care (Five Wishes, 2025). The training is designed to be accessible, allowing participants to complete courses at their own pace and convenience. Similarly, Pallium Canada embeds ACP in their online palliative care certification courses and offers free pre-recorded ACP webinars for HCPs (Pallium Canada, 2025).

Virtual learning is known for its interactive simulation experience that can enhance education for HCPs (Chang et al., 2024; Lui et al., 2023). A meta-analysis conducted by Lui et al. (2023) aimed to capture the impact of virtual reality education on nursing students. Their findings revealed that virtual learning improves theoretical knowledge, practical skills, and overall learner satisfaction when compared to traditional teaching methods. Similarly, Chang et al. (2024) developed a virtual learning teaching module to help HCPs gain a better understanding of ACP. Their study found that HCPs had greater knowledge, slightly improved attitudes, and greater confidence after completing a virtual reality ACP module. Although both researchers captured the benefits of virtual learning, they identified limitations. Lui et al. (2023) questioned whether virtual learning fosters the development of critical thinking skills that are often developed through facilitator-led sessions. Chang et al. (2024) suggested that more studies are needed to explore the evidence for improved clinical outcomes after virtual training.

Hybrid Learning Model

A hybrid learning model, also called blended learning, offers a flexible educational experience where some instruction happens face-to-face and some occurs via an online platform (Davis et al., 2024). Feaster et al. (2023) conducted a medium-quality observational pre- and

post-intervention study that evaluated the impact of a hybrid, multimodal educational program on nurses' comfort with ACP discussions and documentation when caring for advanced-stage cancer patients. The educational intervention consisted of watching an ACP video and reviewing the Oncology Nursing Society (ONS) ACP policies. The intervention also included a 10-minute PowerPoint presentation that described the project and its relevance to nursing. Small group in-person meetings, which lasted 10–20 minutes, were conducted to review the educational material. The researchers' findings demonstrated that post-intervention, ACP documentation improved from 0% to 63%. The increase in comfort scores was not statistically significant, from a score of 226.2 pre-intervention to 240.4 post ($p = 0.14$), but with a large clinical effect size (Cohen's $d = 1.12$). Although results were not statistically significant, the researchers state that the increase in mean scores and the clinical effect size suggest a meaningful improvement in nurses' comfort discussing ACP with patients (Feaster et al., 2023). The researchers noted that the nurse participants found the multimodal education engaging, effective, and enjoyable.

Similarly, Chan et al. (2019) conducted a high-quality pretest/post-test pilot study in Hong Kong to evaluate the preliminary effectiveness of the Multi-Media Experiential Advance Care Planning (MEACP) training program designed for nurses in acute care settings. This combined ten modules via a mobile application, followed by a two-hour, nurse-led workshop involving lectures and role-play to enhance nurses' knowledge, attitudes, and confidence. The program was developed using a systematic review and qualitative interviews, and was grounded in the Theory of Planned Behaviour. Chan et al. (2019) demonstrated statistically significant improvements in attitudes ($p < .05$), knowledge ($p < .05$), and confidence ($p < .001$) after the training session. There was also reported high recruitment (91%), strong participant engagement, and high satisfaction rates. Like Feaster et al. (2023), Chan et al. (2019) demonstrate that

combining a hybrid model of virtual technology with an interactive workshop is an effective strategy for ACP training for nurses.

Self-Reflection

Self-reflection is an important part of ACP education, helping learners become more aware of their values and past experiences that can influence ACP discussions (Mackenzie et al., 2018). Reflective practice promotes positive learner outcomes, such as enhanced situational awareness and recognition of the importance of one's practice (Glaze, 2001). Mackenzie et al. (2018) suggest that through self-reflection, individuals can identify and examine personal biases or assumptions that might impact their communication with patients and families. This awareness encourages open, unbiased, and empathetic conversations that honour patient autonomy. Jonathan et al. (2024) state that engaging in ACP self-reflection of biases, assumptions, and stereotypes is important to understanding cultural influences on ACP. Encouraging oncology nurses to clarify their attitudes and feelings about EOL care through self-reflection will promote a more thoughtful ACP discussion (Mackenzie et al., 2018).

Theoretical Framework

Several theoretical frameworks may offer a structured approach to understanding factors that influence ACP engagement. For this literature review and practicum project, I will draw on the Transtheoretical Model (TTM) and Brenner's Novice to Expert Model to guide my practicum project.

Transtheoretical Model

The TTM of Behavioural Change, also known as Prochaska's Stages of Change Model (Prochaska & Velicer, 1997), provides a framework for assessing an individual's readiness to engage in ACP. TTM conceptualizes behaviour change as a progression through five distinct stages: pre-contemplation, contemplation, preparation, action, and maintenance (Fried et al.,

2019). In the context of ACP, this model enables HCPs to tailor interventions based on an individual's stage of readiness, thereby supporting a more personalized approach. Fried et al. (2010) aimed to develop measures for assessing the stages of change by treating ACP engagement as a collection of distinct behaviours: clarification of values, ACP communication, appointment of a SDM, and completion of an AD. The researchers focused on older adults aged 65 and over to examine their readiness to engage in various ACP initiatives, such as completing a living will, appointing a healthcare proxy, and communicating with loved ones and HCPs about life-sustaining treatments. Fried et al. (2010) demonstrated that 40% of participants were in the pre-contemplation stage for discussing ACP with loved ones, while 70-75% were in the pre-contemplation stage for discussing ACP with HCPs. Approximately 50-60% of participants were in the action or maintenance stages for communicating with loved ones and completing an AD. Similarly, Li et al. (2021) used TTM in a high-quality mixed-methods study exploring ACP readiness among older Indigenous patients with terminal cancer. They found that 100% of participants were in the pre-contemplation stage, often due to limited awareness, reduced access to healthcare, and cultural or religious beliefs. However, when provided with ACP education, 44% of participants' behaviour changed as reflected in the completion of an AD. The researchers in both studies suggest that personalized interventions tailored to the stage of readiness may be an effective strategy for increasing ACP participation.

While readiness is part of ACP engagement, some individuals may not participate despite increased knowledge, although this was not directly addressed by Fried et al. (2010) or Li et al. (2021). However, Kendall et al. (2020) state that while educational and supportive interventions enhance ACP engagement for many, some individuals may opt out of participating, which is an expression of patient autonomy and should be respected.

Finally, TTM can be used by clinical educators to assess nurses' readiness to engage in ACP conversations. For instance, a nurse in the pre-contemplation stage may benefit from basic awareness and reflection activities, while a nurse in the action stage may benefit from advanced communication training. Recognizing these distinct stages allows for targeted educational interventions.

Benner's Novice to Expert Model

Benner's (1982) "Novice to Expert" theory outlines a five-stage progression of nursing expertise: novice, advanced beginner, competent, proficient, and expert. Benner (1982) describes how nurses progress in their professional competence through clinical practice over time. In Benner's model, nurses begin at the novice stage, where they depend on structured guidance and rules to inform their actions. As they gain experience through clinical exposure, they gradually build intuitive understanding and clinical judgment (Benner, 1982).

Novice nurses often rely on role models to help them transition into more advanced stages of practice (Benner, 1982). Experienced oncology nurses who are comfortable with engaging in ACP conversations may serve as mentors for novice nurses as they begin to build experience and skills to engage in ACP discussions. These mentors are often referred to as nurse champions. Nurse champions are distinguished by their commitment to driving change and their support of quality improvement initiatives (Quiroga-Pico et al., 2024). Quiroga-Pico et al (2024) assert that nurse champions act as leaders who can facilitate change and influence organizational culture. Their roles encompass advocating for initiatives, motivating staff, participating in planning, and providing mentorship.

Oncology nurse champions of ACP can guide novice nurses to recognize a patient's stages of readiness to engage in ACP and how to navigate these discussions. Nurse champions

can also support novice nurses through ethical dilemmas that are inherent to EOL care, especially when there is misalignment between the patient's and the family's wishes. Of note, a newly graduated nurse may have a heightened level of ACP competence depending on their experience and may serve as a mentor to a nurse who has been practicing for many years but has little experience in ACP discussions.

Key Considerations

Change Management

Nurses may resist change and view ACP as outside their role or as an added task that does not fit into their workflow. As a result, adapting ACP into practice may be challenging. Change is a complex phenomenon that involves multiple interacting factors such as individual attitudes, organizational culture, and system structures (Cheraghi et al., 2023). Managing change requires knowledge, skill, leadership, resilience, and the ability to work with other health care team members. While some individuals view changes as opportunities for learning and growth, others react with resistance, frustration, and even anger (Cheraghi et al., 2023). Employee resistance to change is often cited as one of the primary barriers to successful implementation and is among the leading causes of failure in change initiatives (Cheraghi et al., 2023). In their integrated review, Cheraghi et al. (2023) aimed to investigate the reasons for resistance to change in nursing. The researchers found that factors affecting nurses' resistance to change can be categorized into three main groups: individual factors, interpersonal factors, and organizational factors. Individual factors of resistance often stem from personal attitudes, emotional reactions, and inherent personality traits. Nurses may experience fear, uncertainty, and even mistrust when faced with change, particularly when they perceive it as a threat to their roles or security. Those with pessimistic or conservative personality traits, or who show low adaptability, tend to view change negatively and may actively resist (Cheraghi et al., 2023). Interpersonal factors, such as a

lack of communication, affect how change is received. Cheraghi et al. (2023) posit that poor or insufficient communication creates uncertainty and heightened perceived risk associated with change, leading to increased resistance. Finally, organizational factors encompass management practices, institutional values, and structural changes (Cheraghi et al., 2023). Resistance to change can occur when managers fail to engage staff, communicate effectively, or demonstrate strong leadership during change management. Cheraghi et al. (2023) recommend that change agents pay attention to factors influencing resistance to change to overcome challenges.

Rogers' Diffusion of Innovation Theory

Rogers' Diffusion of Innovation Theory highlights that individuals adopt change at varying rates, a key consideration when planning and implementing quality improvement initiatives. According to Rogers, knowledge begins when individuals are exposed to an innovation and develop an understanding of how it works (Mohammadi et al., 2018). Rogers categorizes adopters into five groups: the innovators, who readily embrace new ideas; the early adopters, who are influential leaders and support change; the early majority, who are cautious but responsive to peer influence; the late majority, who adopt change only after it becomes standard; and the laggards, who tend to resist change. Understanding these categories allows leaders to tailor change strategies based on varying levels of readiness, increasing the likelihood of successful adoption. In nursing, educational efforts often target early adopters, as they can influence the early and late majority (Mohammadi et al., 2018).

Rogers also identifies five attributes that influence the adoption of innovations: (1) relative advantage, or perceived benefits, (2) compatibility, or alignment with existing values, (3) simplicity, or the ease of understanding and use, (4) observability, or the visible positive outcomes, and (5) trialability, or opportunities for limited testing (Mohammadi et al., 2018). These factors support the integration of new practices, such as ACP, into nursing care by

reducing barriers and enabling acceptance and will be considered in this quality improvement initiative.

Conclusion

This literature review demonstrates that integrating ACP conversations into oncology nursing practice supports individualized, holistic care that reflects CANO practice standards. Oncology nurses are ideally positioned to facilitate ACP, given the nature of their close relationship with patients and families but require education to develop ACP competency.

This literature review supports the development of an ACP educational resource tailored to oncology nurses. Nurses appreciate flexible and accessible educational formats, such as virtual or online sessions, which are self-paced and accommodate demanding clinical schedules. However, nurses also benefit from scenario-based learning and in-person discussions that allow space for role-playing and self-reflection. These preferences suggest that multimodal ACP educational resources may be most effective. An educational resource can serve as a foundation to bridge the gap between ACP awareness and implementation, empowering oncology nurses with the skills to navigate ACP discussions while respecting a patient's autonomy to define their cancer care journey.

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Appendix B: Literature Summary Tables

Qualitative Study (n=5)

Study/Design	Methods	Key Results	Comments
<p>Authors: Colville & Kennedy (2012)</p> <p>Design: Descriptive, qualitative study</p> <p>Purpose: To explore the views of nurses and the potential impact of an educational intervention on the practice of nurse participants.</p>	<p>N=6</p> <p>Country: UK</p> <p>Data Collection: Semi-structured interviews, 10 months after attending an ACP education day</p> <p>Purposive Sampling: Data was transcribed verbatim and analyzed using a comparative approach to thematic analysis</p> <p>Hospital and community settings nurses</p>	<p>Results:</p> <p>Three themes emerged from the thematic analysis:</p> <ul style="list-style-type: none"> • Bringing it all together • Talking about ACP • Planning future care 	<p>Critical Appraisal: Appraisal using JBI. Medium-Strong</p> <p>Strengths: Appropriate design, good alignment between objectives and findings, focus on practical outcomes in ACP</p> <p>Conclusions/Practice Implications:</p> <p>ACP education had a positive impact on nursing practice</p> <p>System-level approach is needed to support sustained ACP integration.</p> <p>Education alone is not sufficient to fully encourage ACP across healthcare settings.</p>

Study/Design	Methods	Key Results	Comments
<p>Author: Izumi et al. (2024)</p> <p>Design: Interpretive phenomenological study</p> <p>Purpose: To understand how people from marginalized populations perceive ACP based on their lived experiences.</p>	<p>N=30</p> <p>Country: US</p> <p>Purposeful sample Four primary care clinics and one nursing home</p> <p>Research Method Semi-structured interviews and group discussions</p> <p>Analysis: Audio Recording Transcription: verbatim De-identification</p> <p>Results: Thematically analyzed using a descriptive, exploratory approach</p>	<p>Perceptions of obstacles: biases, time constraints, lack of interest</p> <p>Listening: ACP engagement increases when HCPs take time and listen to patients</p> <p>Fragmented HC system: interferes with ACP, especially for marginalized populations.</p> <p>Systemic Barriers: Race, ethnicity, income, geography, and cultural differences contribute to healthcare access and disparities, creating barriers to ACP.</p>	<p>Critical Analysis:</p> <ul style="list-style-type: none"> • Appraisal using JBI. • Rigorous data analysis <p>Conclusion: Strong insights into marginalized populations and ACP Engage in silence: active listening Self-reflection: check biases</p> <p>Strength: Targeted Selection: Attempted to include a diverse representation In-depth Insights: Study design allows for a deeper understanding of experiences</p> <p>Limitations Practice Implications:</p> <ul style="list-style-type: none"> • Health equity is our responsibility • Listen and tailored PCC approach • Self-awareness of biases, stereotypes, and assumptions • More research is needed in this area

Study/Design	Methods	Key Results	Comments
<p>Author: Jonathan et al. (2024)</p> <p>Design: Interpretive Descriptive</p> <p>Purpose: To understand internationally trained nurses' perspectives and experiences in culturally safe ACP practices and implications for nursing practice.</p>	<p>N: 10</p> <p>Sample: Internationally Educated Nurses</p> <p>Country: Canada</p> <p>Data Collection: Semi-structured interviews</p> <p>Analysis: Interviews were transcribed, then coded into final themes</p>	<p>Main themes:</p> <p>Practicing cultural humility: Recognized the influence of personal and client culture on ACP</p> <p>Utilize a cautious approach: Build trust in nurse-client relationships to navigate ACP discussions to ensure cultural safety</p> <p>Empowering clients and families: Addressed knowledge gaps and misconceptions about ACP. Educated clients on their rights in decision-making</p>	<p>Critical Analysis:</p> <ul style="list-style-type: none"> • Appraisal using JBI. • Strong insights into culturally safe ACP <p>Practice Implications/Conclusions:</p> <ul style="list-style-type: none"> • Education is needed to engage in culturally safe ACP • Undergraduate nursing education should include ACP content and training in cultural humility • All nurses require ACP education & guidelines for culturally safe ACP interactions

Study/Design	Methods	Key Results	Comments
<p>Author: van Lummel et al. (2024)</p> <p>Design: Narrative Analysis</p> <p>Purpose: Explore variation between person-centred and treatment-centred discussions in ACP conversations.</p>	<p>N= 18</p> <p>Country: Netherlands</p> <p>Sample: Patients of geriatric and pulmonary outpatient clinics.</p> <p>Intervention: MUTUAL 4-step ACP, which includes:</p> <ol style="list-style-type: none"> 1. Timely patient selection 2. Preparation by patient & HCPs 3. Scripted, nurse-led ACP conversation 4. Documentation <p>Analysis:</p> <ul style="list-style-type: none"> • Narrative analysis • Audio-recorded ACP conversations • Verbatim transcriptions • Observational field notes • Questionnaire 	<p>Four Key Results:</p> <ul style="list-style-type: none"> • Conversations shifted between person-centred and treatment-centred topics • Variability in how well HCPs explored patients' values • Missed emotional cues led to lost opportunities for deeper engagement <p>Strategies to Encourage Person-Centred ACP:</p> <ul style="list-style-type: none"> • Accept the patient's readiness • Explore the rationale behind preferences • Adopt an emotionally engaged attitude 	<p>Critical Analysis:</p> <ul style="list-style-type: none"> • Appraisal using JBI. • Strong, qualitative design with rigorous data analysis <p>Conclusions/Implications for Practice</p> <ul style="list-style-type: none"> • Tailor conversations to the patient's stage. • Understand motivations <p>Strengths</p> <ul style="list-style-type: none"> • Use of multiple data sources (audio, transcription, notes, questionnaire) • Narrative analysis provides rich insights <p>Limitations No separate analysis of nurse vs. physician roles</p>

Study Design	Methods	Key Results	Comments
<p>Author: Yang et al (2022)</p> <p>Design: Constructivist Grounded Theory</p> <p>Purpose: To explore and construct the ACP clinical training model for oncology nurses.</p>	<p>N: 23 oncology nurses</p> <p>Country/setting: China</p> <p>Data collection: Semi-structured interviews</p> <p>Analysis: A three-level coding procedure:</p> <p>Initial Coding Break down sections into small meaning units</p> <p>Focused Coding The researchers grouped open codes into broader categories based on patterns and relationships</p> <p>Selective Coding Identify central concepts to form a theoretical model</p>	<p>Four Themes:</p> <ul style="list-style-type: none"> • Need for self-development and training • Oncology nurses have limited ACP knowledge and lack confidence in ACP clinical practice • Training needs consist of basic content, communication skills • ACP training is based on realistic situations, such as case discussions and scenarios 	<p>Critical Appraisal:</p> <ul style="list-style-type: none"> • Appraisal using JBI. • Strong, qualitative design with rigorous data analysis <p>Conclusions/Practice Implications:</p> <ul style="list-style-type: none"> • Recommendations for a variety of ACP clinical training elements • Oncology nurses have a strong desire for ACP clinical training; learning needs are diverse

Quantitative Studies (n=8)

Study Design	Methods	Key Results	Conclusion
<p>Author: Chan et al. (2019)</p> <p>Design: Pretest/Post-test</p> <p>Purpose: To develop and pilot-test a training programme for nurses in acute care settings to improve decision-making support skills, knowledge, attitudes, and confidence in conducting ACP</p> <p>Multi-media Experiential Advanced Care Planning (MEACP) training programme for nurses in acute care settings</p>	<p>N: 20</p> <p>Country: Hong Kong</p> <p>Inclusion criteria: Registered nurses with ≥ 2 years clinical experience; no prior ACP training</p> <p>Intervention: MEACP. A 10-module mobile app (pre-workshop) + 2-hour nurse-led workshop</p> <p>Phase 1: ACP training developed using systematic review and interviews</p> <p>Phase 2: To explore the programme's preliminary effects.</p> <p>Workshop activities: Mini-lecture, small group role-play with standardized patients</p> <p>Framework: Developed using the Theory of Planned Behaviour</p> <p>Evaluation: 8-item survey using a 5-point Likert scale</p>	<p>Results: Significant improvements in attitudes ($p < .05$), knowledge ($p < .05$), and confidence ($p < .001$). High recruitment (91%), strong engagement, and satisfaction</p>	<p>Strength; Medium</p> <p>Quality: High</p> <p>Practice</p> <p>Implications/Conclusions:</p> <ul style="list-style-type: none"> • Contributes to nursing practice by providing information about the design of an innovative ACP training program. • Acute care nurses are less involved in ACP due to limited training/time • Mobile tech plus workshop provides flexible, blended learning <p>Recommendations: Need for a full-scale RCT with a control group and a larger sample needed to evaluate MEACP effectiveness.</p>

Study Design	Methods	Key Results	Conclusion
<p>Author: Feaster et al. (2023)</p> <p>Design: Observational study design (before and after intervention)</p> <p>Purpose: Educate nurses caring for advanced-stage cancer patients to improve ACP documentation and to enhance comfort with ACP discussions.</p>	<p>N=8 nurses (6–20 years' experience with various education levels)</p> <p>Country: US</p> <p>Intervention: Educational session, ACP video, and review of ACP policy/procedures</p> <p>Delivery method: 10-minute PowerPoint; 10–20-minute small group sessions.</p> <p>Evaluation: Kolcaba Advance Directives Comfort Questionnaire administered weeks pre- and 6 weeks post-intervention (Reliable, validated tool)</p> <p>Data analysis: Descriptive stats for demographics; EHR audits compared pre/post documentation; Wilcoxon signed-rank test and Cohen's <i>d</i> for questionnaire scores.</p>	<p>Results: ACP documentation rose from 0% to 63% (EHR review of 103 pre- and 114 post-records) Comfort scores increased (M=226.2 to 240.4, $p=0.14$); large clinical effect (Cohen's $d = 1.12$) (clinically significant improvement despite no statistical significance)</p> <p>Feedback: Nurses found role-play, videos, case discussions, and supervised practice effective and enjoyable; these strategies enhanced comfort with sensitive clinical conversations.</p>	<p>Strength; Medium Quality: Moderate Practice Implications/Conclusion:</p> <ul style="list-style-type: none"> • Nursing education enhances ACP communication, comfort, and documentation <p>Strengths:</p> <ul style="list-style-type: none"> • Validated tool • Clear intervention with multimodal strategies • Large clinical effect (Cohen's $d = 1.12$) despite non-significant p-value (0.014) <p>Limitations:</p> <ul style="list-style-type: none"> • Small sample size • Virtual delivery due to COVID-19 may have reduced effectiveness <p>Recommendations:</p> <ul style="list-style-type: none"> • Larger sample and in-person education

Study/Design	Methods	Key Results	Comments
<p>Author: Fink et al. (2019)</p> <p>Design: Descriptive Survey</p> <p>Purpose: To understand the organizational context of nurses and ACP, measuring experiences and perceptions to inform QI initiatives.</p>	<p>N:740 (2013) and 924 (2017)</p> <p>The survey was administered in 2013 and again in 2017</p> <p>Sample Nurses</p> <p>Country/setting: US</p> <p>Data collection: Online survey Validated ACP Survey Tool</p> <p>Analysis: SAS (V9); statistical significance was set at P= .05</p>	<p>2013 (Combined inpatient and outpatient) Participants' responses</p> <ul style="list-style-type: none"> • Lack of dedicated time for ACP: 53% • Insufficient ACP education/training: 43% • Perceived physician commitment to ACP: 33% • Perceived organizational commitment to ACP: 22% <p>2017 (Inpatient vs. outpatient) Participants' responses</p> <ul style="list-style-type: none"> • Designated time: 30/23% • ACP education 19/28% • Physician commitment: 19/14% • Organizational commitment: 10/12% <p>Barriers to ACP:</p> <ul style="list-style-type: none"> • Lack of time • Lack of understanding • Complicated • Feeling uncomfortable • Emotional readiness <p>Predicative Factors:</p> <ul style="list-style-type: none"> • Patients' perceptions of ACP • Nurses' experience with ACP • ACP training • Organizational processes 	<p>Strength: Strong Quality: High</p> <p>Practice Implication/Conclusion:</p> <ul style="list-style-type: none"> • Further integration of ACP within interdisciplinary teams. • Quality Improvement initiatives to enhance ACP • Dedicated time for staff to engage in ACP initiatives • Building self-efficacy through training and organizational support improved ACP-related behaviours in oncology nurses. <p>Strength: Large sample size</p>

Study/Design	Methods	Key Results	Comments
<p>Authors: Goswami et al. (2020)</p> <p>Design: Retrospective Study</p> <p>Purpose: To assess if ACP discussions initiated by an advanced practice provider (APP) would enhance patient-centred end-of-life care.</p>	<p>N: 36 (17 inpatients and 19 outpatients)</p> <p>Country: US</p> <p>Intervention: 18-question survey distributed before and after ACP discussions</p> <p>Data collected included:</p> <ul style="list-style-type: none"> • ACP discussion and documentation. • AD completion. • Change in code status <p>Analysis: Fisher’s exact test compared AD completion pre- and post-intervention. Statistical analysis using Stata/MP</p> <p>Measurable Outcome:</p> <p>Increase in AD completion rate and change in code status after ACP discussions.</p>	<p>Inpatient Outcomes</p> <ul style="list-style-type: none"> • ACP participation: 3 (pre) vs. 20 (post) ($p < 0.001$) • Advance directive completion: 1 (pre) vs. 13 (post) ($p < 0.001$) • Change in directive or code status: 4 (pre) vs. 17 (post) ($p < 0.001$) • Medical power of attorney: 1 (pre) vs. 13 (post) ($p < 0.001$) <p>Outpatient Outcomes</p> <ul style="list-style-type: none"> • ACP participation: 0 (pre) vs. 20 (post) ($p < 0.001$) • AD completion: 0 (pre) vs. 8 (post) ($p < 0.001$) • 100% of participants stated that ACP discussions were important 	<p>Strength: Strong</p> <p>Quality: High</p> <p>Conclusion: The authors concluded that ACP discussions improved end-of-life care for patients</p> <p>Practice Implications:</p> <ul style="list-style-type: none"> • ACP discussions increased AD completion • Inpatients showed more improvement than outpatients. • Training in ACP benefits EOL decisions • Communication leads to more aligned care with patient preferences and avoids unnecessary interventions

Study/Design	Methods	Key Results:	Comments
<p>Author: Shih & Lu (2024)</p> <p>Design: Multi-centre, observational, cross-sectional study</p> <p>Purpose: To explore oncology nurses' knowledge, attitudes, and practice behaviours regarding ACP and identify factors influencing ACP practice behaviours</p>	<p>N: 1800</p> <p>Country: China</p> <p>Methods: Data collected via an electronic questionnaire between December 2021 and January 2022.</p> <p>Analysis: Univariate and hierarchical multiple regression ($p < 0.05$).</p> <p>Sampling: Convenience sampling of oncology nurses.</p>	<p>Knowledge:</p> <ul style="list-style-type: none"> 52% demonstrated increased knowledge of ACP <p>Attitudes:</p> <ul style="list-style-type: none"> 43.3% stated ACP attitudes had a significant and positive impact on practice 	<p>Strength: Strong</p> <p>Quality: Medium</p> <p>Conclusion/Practice Implications:</p> <ul style="list-style-type: none"> Positive attitudes, but knowledge and practice gaps remain Enhancing education and organizational policies may improve nurses' attitudes <p>Limitation:</p> <ul style="list-style-type: none"> Cross-sectional design limits the ability to make causal inferences. Convenience sampling introduces potential sampling bias

Study/Design	Methods	Key Results	Comments
<p>Author: Sinclair et al. (2017)</p> <p>Design: Multicentre RCT with preference arm</p> <p>Purpose: To assess if a nurse-led ACP intervention increases ACP uptake in patients with advanced respiratory disease.</p> <p>2:1 randomization protocol in favour of the intervention.</p> <p>Participants had a strong preference for the intervention arm of nurse-led ACP</p>	<p>N=149</p> <p>Country: Australia</p> <p>Sample: Participants had a diagnosis of:</p> <ul style="list-style-type: none"> • Respiratory malignancy • Chronic obstructive pulmonary disease (COPD) • Interstitial lung disease (ILD) <p>Intervention</p> <ul style="list-style-type: none"> • Nurse facilitated ACP discussions • Assisted in appointing a substitute decision-maker (SDM) • Helped complete an advance directive (AD) <p>Outcome Measures:</p> <p>Primary ACP uptake chart audits and self-reported (6 months) Secondary: Predictors of uptake</p>	<p>Primary:</p> <p>Formal ACP uptake at 6 months:</p> <ul style="list-style-type: none"> • Intervention: 51% of participants in this group (54/106) • Usual care: 14% of participants in this group (6/43) • Significant difference (p<0.001) <p>ACP discussions with HCP (doctor):</p> <ul style="list-style-type: none"> • Intervention: 72% of participants in this group (76/106) • Usual care: 47% of participants in this group (20/43) • Significant difference (p<0.005) <p>Predictors of ACP uptake:</p> <ul style="list-style-type: none"> • Increased symptom burden • Preference for intervention • Social support 	<p>Strength: Strong</p> <p>Quality: High</p> <p>Conclusion/Practice Implications:</p> <ul style="list-style-type: none"> • Nurse-led ACP improves ACP uptake and formal documentation • Tailoring interventions based on symptom burden & readiness • Requires training in communication and ACP facilitation • Enhances patient-centred care <p>Strengths:</p> <ul style="list-style-type: none"> • Longitudinal follow-up. • Offers practical guidance for clinical practice <p>Limitations:</p> <ul style="list-style-type: none"> • Unbalanced groups; higher preference for intervention among participants

Study/Design	Methods	Key Results	Comments
<p>Author: Yahiro et al. (2021)</p> <p>Design: Pre-post post-intervention survey</p> <p>Purpose: To develop an educational program of ACP for certified palliative care nurses in Japan and evaluate its effectiveness</p>	<p>N: 39</p> <p>Sample: Palliative Care Nurses</p> <p>Country/setting: Japan</p> <p>Data collection: Survey (validated)</p> <p>Inclusion criteria: Palliative care nurses</p> <p>Intervention: Four training modules. Topics:</p> <ul style="list-style-type: none"> • Definition of ACP • Knowledge of disease and treatment • Ethics, legal basis • ACP Follow-up • System construction • Understanding of values • Communication <p>Analysis: Wilcoxon signed-rank test compared data before and after the intervention.</p>	<p>Results:</p> <p>ACP dialogue between patients/families and healthcare professionals increased ($p=0.045$).</p> <p>Participants reported reduced difficulty with understanding ACP knowledge/skills ($p=0.001$).</p> <p>Over 90% expressed satisfaction with the program.</p>	<p>Strength: Strong</p> <p>Quality: High</p> <p>Practice Implication/Conclusion:</p> <ul style="list-style-type: none"> • ACP education supports communication and increased comfort • Training improved ACP practice and may support future implementation in cancer care. <p>Strengths:</p> <ul style="list-style-type: none"> • Well-structured intervention with clearly defined modules • Validated tools and appropriate statistical analysis <p>Limitations:</p> <ul style="list-style-type: none"> • Conducted in Japan only limits applicability • No control group or long-term follow-up

Study/Design	Methods	Key Results	Comments
<p>Author: Teixeira et al. (2014)</p> <p>Design: Cross-sectional</p> <p>Purpose: To assess the level of public engagement in ACP among Canadians.</p>	<p>N = 1021</p> <p>Country: Canada</p> <p>Survey: Nationwide online poll. Five questions:</p> <p>Awareness: Heard of the term ACP (Q1)</p> <p>Communication: Discussed with family/friends (Q2) or HCPs (Q3)</p> <p>Decision-Making: Have a written ACP (Q4) or a substitute decision maker (Q5)</p>	<p>Results:</p> <ul style="list-style-type: none"> • 16% were aware of the term ACP • 52% had discussed care wishes with loved ones • 10% had discussed ACP with HCPs • 20% had a written ACP • 47% had designated a substitute decision maker. 	<p>Strength: Medium Quality: Moderate</p> <p>Conclusions/Practice Implications:</p> <ul style="list-style-type: none"> • Older age was associated with greater ACP • Women are more likely to discuss ACP • ACP discussions with HCPs are low • Engagement varies by demographic and social factors. • Need for public education, communication, and HCP training <p>Limitations: Cross-sectional design limits the ability to make causal inferences.</p>

Mixed Method Study (n=3)

Study/Design	Methods	Key Results	Comments
<p>Author: Shih et al. (2025)</p> <p>Design: Sequential explanatory mixed-method design (quantitative survey + qualitative interviews)</p> <p>Purpose: Explore ACP practice among oncology nurses</p>	<p>N=532 (84.7%) out of 630 invited participants</p> <p>Country/Setting: China</p> <p>Sampling: Convenience sampling</p> <p>Inclusion criteria: RNs with ≥ 1 year of experience in treating incurable illnesses, willing to participate</p> <p>Exclusion criteria: RNs not directly working with patients/families (e.g. managers)</p> <p>Analysis:</p> <ul style="list-style-type: none"> • SPSS Statistics • Independent t-test and one-way ANOVA • Methodological triangulation 	<p>Key Results: 36.5% of nurses rarely initiated ACP; 52.4% never initiated conversations about a substitute decision maker</p> <p>End-of-life discussions were infrequent; the most common topic was the place of death (29.3%)</p> <p>Four themes:</p> <ul style="list-style-type: none"> • Lack of optimal timing • Passive engagement of patients or families • Reluctance of HCP • Unsupported policies 	<p>Critical Analysis: MMAT</p> <p>Strengths:</p> <ul style="list-style-type: none"> • Strong design • High response rate (532/630; 84.7%): validity • Identifies critical gaps in communication and ACP practice • Clear thematic analysis and practical implications <p>Limitations:</p> <ul style="list-style-type: none"> • Convenience sampling <p>Conclusions/Practice Implications:</p> <ul style="list-style-type: none"> • Need for better communication skills, collaboration, and policies.

Study/Design	Methods	Key Results	Comments
<p>Author: Li et al. (2021)</p> <p>Design: Exploratory Mixed Methods Design</p> <p>Purpose: To explore perceptions, readiness, and barriers to ACP among older Indigenous terminal patients with cancer</p>	<p>N=9</p> <p>Country: Taiwan</p> <p>Theoretical Framework: Transtheoretical Model</p> <p>Qual: Semi-structured face-to-face interview</p> <p>Quant: ACP Behavioural Readiness Questionnaire (based on Transtheoretical Model - TTM)</p> <p>Analysis SPSS Statistics Thematic analysis</p>	<p>Semi-structured interview:</p> <p>Perceptions</p> <ul style="list-style-type: none"> • Limited opportunities to engage in ACP • Low awareness of ACP • Values cultural and religious influences • Healthcare access disparities in remote communities, impacting engagement <p>Questionnaire: Readiness:</p> <ul style="list-style-type: none"> • 100% were in the precontemplation stage. • 100% wanted less aggressive treatment • 66% desired a dignified death. • 44% completed AD after receiving an explanation <p>Barriers:</p> <ul style="list-style-type: none"> • Low ACP literacy • Lack of healthcare infrastructure • Socioeconomic disparities 	<p>Critical Analysis: MMAT Included in the literature review</p> <p>Strengths: Strong alignment between data types and study objectives</p> <p>Conclusions:</p> <ul style="list-style-type: none"> • TTM provides insight into the ACP readiness • ACP information should match patients' readiness/stages. • EOL care should respect the preferences of cultural/minority groups <p>Recommendations:</p> <ul style="list-style-type: none"> • Tailor ACP communication to match readiness • Promote culturally appropriate ACP education <p>Limitations:</p> <ul style="list-style-type: none"> • Non-randomized • Convenience sampling

Study/Design	Methods	Key Results	Comments
<p>Author: Siden et al. (2022)</p> <p>Design: Mixed-methods study</p> <p>Purpose: To identify barriers to ACP as perceived by public individuals in BC</p>	<p>N= 57 Completed surveys: 17 were interviewed</p> <p>Country: Canada</p> <p>Sample: Participants in BC</p> <p>Data Collection:</p> <ul style="list-style-type: none"> • Online surveys • Semi-structured telephone interview 	<p>Barriers to ACP</p> <p>ACP linked to EOL: 67% of participants associated ACP with death and dying, creating discomfort in discussing</p> <p>Knowledge barriers: 65% were unsure how to initiate ACP</p> <p>Awareness gaps: 55% noted a general lack of public awareness</p> <p>Terminology issues: 32% found the ACP language confusing</p> <p>Cultural challenges: 11% found it difficult to introduce ACP in different cultural contexts</p>	<p>Critical Analysis: MMAT Included in the literature review</p> <p>Strengths:</p> <ul style="list-style-type: none"> • Clear rationale and integration of methods • Valuable insights for culturally sensitive ACP strategies <p>Limitation:</p> <ul style="list-style-type: none"> • Virtual • Small sample size • Participants volunteered

Synthesis (n=1)

Study	Methods	Results	Comments
<p>Author: Ke et al. (2015)</p> <p>Design: Qualitative meta-synthesis</p> <p>Purpose: To explore nurses' views regarding implementing ACP for older people.</p>	<p>N=1844 articles were screened</p> <p>18 articles were critically appraised and thematically synthesized</p> <p>Country: Australia</p> <p>Methods:</p> <p>Four databases</p> <ul style="list-style-type: none"> • CINAHL • Medline • EMBASE • PsycINFO 	<p>Key Results:</p> <ul style="list-style-type: none"> • Nurses viewed their role in ACP/AD as generally positive, seeing more benefits than downsides. • They recognized their role in clarifying patient wishes and guiding ACP • Nurses believe they are well-positioned to initiate and engage in ACP conversations • Education and support systems are necessary to improve ACP implementation <p>Barriers:</p> <ul style="list-style-type: none"> • Communication • Time constraints • Knowledge gaps 	<p>Critical Analysis:</p> <ul style="list-style-type: none"> • Methodological rigour • Comprehensive search strategy • Critical appraisal of included studies • Included in the literature review <p>Conclusion:</p> <ul style="list-style-type: none"> • Emphasis on HCP education • Need for organizational policies <p>Appointment of nurses to formal ACP roles</p> <p>Implications for Practice:</p> <ul style="list-style-type: none"> • Can guide policy development and educational interventions • Useful for administrators to enhance ACP implementation

Appendix C: Consultation Report and Environmental Scan

Advance Care Planning (ACP) is a reflective process through which capable individuals make decisions regarding their future medical, personal, and end-of-life (EOL) care in the event they become unable to give informed consent (Advance Care Planning, 2024). Overall, ACP results in better patient outcomes, such as reduced use of aggressive treatments, shorter hospital stays, increased use of palliative care, and care that closely aligns with patients' values and preferences (Agarwal & Epstein, 2018; Goswami et al., 2020). In oncology, ACP allows patients to actively take part in care decisions throughout their cancer journey, especially during periods of disease progression or declining health. ACP enhances the quality of care by facilitating personalized decision-making and alleviating the burden on families and clinicians during medical crises (Goswami et al., 2020). While ACP is important for oncology patients with advanced disease, it is also appropriate for all individuals, regardless of their diagnosis or prognosis (Agarwal & Epstein, 2018; McDonald et al., 2017).

In my practicum project, I aim to develop an educational resource to enhance ACP competency for oncology nurses at the Dr. H Bliss Murphy Cancer Centre (DHBMCC). I used three methods to inform this process: a literature review, an environmental scan, and consultations with key local stakeholders.

I demonstrated through a literature review that ACP enhances holistic care by aligning treatment with individual beliefs, values, and goals of care (GOC). Detering et al. (2010), Goswami et al. (2020), and Sudore et al. (2017) emphasize the benefits of ACP conversations, which reduce anxiety for both patients and loved ones and guide healthcare professionals (HCPs) in honouring the patient's wishes. Despite its proven benefits, ACP remains underutilized in cancer care. Many obstacles contribute to the delayed or absence of ACP conversations,

including time constraints, communication challenges, and a lack of clear ownership within the cancer care team (Agarwal & Epstein, 2018). Nurses, particularly those in oncology settings, are well-positioned to support and lead ACP conversations, given their trusting relationships with patients and families, but feel unprepared to initiate these conversations due to limited education and insufficient awareness of ACP processes (Kilgour et al., 2025; Ke et al., 2015).

From the literature review, I found that increasing ACP competency for oncology nurses will increase nursing and patient engagement (Yahiro et al., 2023; Shih & Lu, 2024). The key educational priorities that emerged from my review are closing knowledge gaps, strengthening communication skills, addressing ethical dimensions of ACP, and ensuring culturally sensitive care for diverse and marginalized populations (Izumi et al., 2024; Rietze et al., 2015; Yahiro et al., 2021). This review of the literature deepened my understanding of ACP and reinforced the importance of education initiatives, such as my proposed practicum project, aimed at improving both competency and engagement in ACP.

After completion of my literature review, I explored ACP within the Canadian and local context through consultations with key local stakeholders and an environmental scan exploring ACP practices in select cancer organizations in Canada. In this report, I will present the results of the stakeholder consultations and the environmental scan.

Methods

To guide the development of a locally relevant ACP educational resource, I created a consultation plan and an environmental scan plan, which were reviewed and approved by my practicum supervisor before implementation. I consulted with frontline oncology nurses and selected nursing leaders at DHBMcC to gain insights into previous ACP education, knowledge gaps, and preferred educational delivery methods. Additionally, I explored perceptions of the oncology nurses' role in ACP, as well as the degree to which nurses currently engage in ACP

conversations with patients. For the environmental scan, I focused on identifying existing educational resources and national standards related to ACP for registered nurses in select oncology settings across Canada. This included reviewing the ACP-related practices and education at select cancer care organizations, including BC Cancer (BCC), Cancer Care Ontario (CCO), and Nova Scotia (NS) Health Cancer Care.

I adhered to ethical standards in the environmental scan and stakeholder consultations through informed consent, voluntary participation, and secure data handling. Data was aggregated to maintain confidentiality to the best of my ability. As a quality improvement initiative conducted for educational purposes, this project did not require Health Research Ethics Authority (HREA) approval (Appendix A).

Consultations

The proposed ACP educational resource is designed for the local setting; therefore, the stakeholders I engaged for the consultations were registered nurses and select members of the nursing leadership team. The setting for the consultations was the DHBMcC, with outpatient oncology nurses as the sample. Approximately 40 outpatient oncology nurses are at this site; my goal was to gather information from at least 12 oncology nurses, representing 30% of the group. The data I collected during the consultation phase will be used to influence the design, content, and delivery method of an ACP educational resource to ensure it aligns with the learning needs of oncology nurses in the local practice setting.

The specific objectives of the consultations were:

1. Explore the opinions of oncology nurses in the local setting regarding their role in facilitating ACP.
2. Examine the perspectives of local oncology nurses regarding the barriers and facilitators to ACP.

3. Identify the self-reported ACP learning needs of oncology nurses in the local setting.
4. Determine the preferred delivery methods for ACP education among oncology nurses in the local setting.

There were two components to the data collection. The first involved an online questionnaire administered to oncology nurses to explore their knowledge, attitudes, and educational needs related to ACP. The questionnaire was distributed using the Qualtrics survey tool via a secure link sent through institutional email addresses. The second part was interviewing selected members of the nursing leadership team in the local setting regarding existing ACP policies and previous educational initiatives.

Consultation Results: Questionnaire (Survey)

Descriptive Analysis

The quantitative data from the questionnaires were entered into a Microsoft Excel spreadsheet and analyzed. Eighteen registered nurses from the DHBMCC participated, representing a 45% response rate. The data indicates that 55% of respondents had over 15 years of overall nursing experience, while 45% of all respondents had more than 10 years of oncology experience. Some of the respondents may fall into both categories: I did not examine the overlap of years of nursing experience and years working in oncology. More than half (56%) of respondents reported receiving some form of ACP education, although many described this as informal education. Examples of education included information received during orientation, palliative care workshops, standardized ACP orders (such as code status), and continuing education sessions.

The respondents reported various degrees of confidence in ACP knowledge. Eighteen percent of respondents reported moderate to high competency in understanding the purpose and goals of ACP, 23% indicated an average level of confidence in initiating ACP discussions, while

15% of respondents rated a lack of understanding of the documentation of ACP. Confidence in demonstrating cultural sensitivity during ACP discussions was notably low (11%). Confidence in understanding the nurse's role in Medical Assistance in Dying (MAiD) showed greater variability, ranging from very low competency (12%) to moderate (24%).

Participants were asked to rate several statements related to ACP and oncology nursing. In most cases, they responded with either "strongly agree" or "agree." Specifically, 72% agreed that ACP is an integral part of oncology nursing, and 83% believed oncology nurses should take an active role in initiating ACP discussions. Additionally, 70% agreed that ACP improves patient outcomes. Interestingly, only 55% of respondents supported the benefit of ACP early in the cancer care trajectory. This finding is supported in the literature by Shih et al. (2025) and Johnson et al. (2016), who suggested that HCPs are often reluctant to initiate early ACP conversations and tend to delay them until related issues arise or EOL. A further 56% agreed that understanding a patient's ACP benefits the cancer care team; 88% felt that education would enhance oncology nurses' ability to navigate ACP conversations.

When asked about the frequency of engaging in ACP conversations, the responses were variable; 78% of respondents reported engaging in ACP discussions "sometimes" and "occasionally", while 17% "never" engage in ACP discussions, and 5% "frequently" engage in ACP discussions.

I asked a question about perceived barriers or challenges to ACP in which respondents could pick more than one answer. The most common challenges to ACP included lack of time (56%), patient reluctance (22%), and insufficient ACP education (17%). When asked to cite other barriers, 6% of respondents identified systemic barriers, including limited ACP initiatives in the outpatient setting, lack of patient education, staff discomfort in discussing ACP, difficulty

with understanding how and when to have ACP discussions, and unclear documentation processes.

When questioned about the preferred delivery of ACP education, 53% of participants preferred in-person education. Online self-paced modules (17%) and webinars (6%) were also favoured for their flexibility. Many respondents suggested a blended approach (24%), combining in-person sessions with online options, supplemented by quick reference tools like flowcharts to support clinical application.

Thematic Analysis

I employed a thematic analysis to examine the qualitative data, including open-ended questionnaire responses. I reviewed all responses and grouped similar statements to identify recurring patterns and themes (Polit & Beck, 2021). Overall, my findings captured four key themes shaping the nursing experience with ACP:

Recognition of the Importance of ACP. In this theme, there was unanimous agreement among respondents that nurses should actively participate in initiating ACP discussions, although some respondents expressed uncertainty about a lack of understanding of their role.

Practice Barriers to ACP. Time constraints, patient readiness, and discomfort discussing ACP emerged as barriers to ACP. Respondents cited the challenge of unclear timing for ACP discussions and evolving terminology and documentation standards. The outpatient oncology setting was noted as a particular area where ACP discussions are less standardized as compared to inpatient care. Notably, although some oncology nurses reported transitioning from working on the inpatient oncology units to the outpatient settings, the survey did not capture the exact number of nurses making this shift.

ACP Educational Gaps and Needs. The respondents identified a need for education focusing on communication skills to enhance confidence in initiating and navigating ACP

conversations, along with appropriate timing to initiate or revisit ACP conversations. There was emphasis on the need for clear, accessible documentation practices that bridge inpatient and outpatient settings. The respondents also highlighted the importance of understanding code status, patient wishes, and interdisciplinary collaboration. Role clarity among nurses, physicians, and other providers and legal, ethical, and cultural aspects of ACP were also identified.

Preferred Educational Approaches. Respondents favoured in-person training for its interactive benefits but also appreciated online modules and webinars for flexibility. Suggestions included using case studies, role-play, and opportunities for yearly ACP education sessions. Integration of ACP education into nursing orientation for new hires and ongoing professional development was identified as important.

Follow-Up Interviews: Insights

After distributing the questionnaire, three oncology nurses volunteered for follow-up interviews. Two of the three nurses had greater than 10 years of experience working as oncology nurses in both the inpatient and outpatient oncology settings, while the other nurse had less than three years of experience as an oncology nurse. Several key insights emerged from the follow-up interviews, including:

Oncology Nurses Are Well Positioned to Facilitate ACP. Nurses described the trusting relationships they develop with patients over time as foundational to ACP discussions. One nurse shared, “*Oncology nurses develop such close relationships; our patients trust us*”. However, they also acknowledged the sensitive nature of ACP conversations, noting that both the patient and nurse need to be ready for these discussions. One participant explained, “*Depending on the patient, it can be uncomfortable talking about ACP; the patient needs to be ready for these conversations.*” Concerns about timing were also raised in all three interviews. One nurse stated, “*I don’t know if this is a good conversation during the first patient visit. I don’t*

want the patient to lose hope or feel they are very ill because we are talking about ACP on day one.” Another nurse expressed concern about having early ACP conversations without the patient understanding their cancer diagnosis and prognosis.

Role Ambiguity and Lack of Awareness of Resources. A recurring theme was uncertainty about the nurse’s role in ACP discussions. One nurse asked, *“Is it ok for me to take the lead on ACP discussions?”* Another highlighted the need for ethical clarity, stating, *“I would like to know what my role is as a nurse from an ethical perspective, especially around advance directives (AD).”* Nurses also expressed a desire to better understand available resources: *“I would like to know what the resources are for ACP and AD.”* Regarding MAiD, nurses noted their limited role, with one sharing, *“I understand MAiD can be a part of ACP. I have been involved in MAiD discussions that were physician-led. Other than supporting the patient’s choice, my role was limited.”* Another nurse stated that we were well educated when MAiD legislation was introduced in Canada, but we had little follow-up education, despite changes.

Communication. The nurses I interviewed felt that it was important for oncology nurses to understand how to navigate ACP conversations. One nurse mentioned that enhancing communication will *“We need to understand the patient's wishes and GOC early in the cancer journey, ensuring we are all on the same page”*. All nurses felt that having a basic understanding of how and when to bring up ACP and how to navigate such a delicate conversation was an important part of ACP. Another nurse simply stated, *“I would like to increase my confidence in facilitating ACP conversations”*.

Education to Increase ACP Competency. All nurses emphasized the importance of education to strengthen their competency and confidence in ACP. One nurse asserted, *“There is value in our role as oncology nurses, but we need education. It should be mandatory, and*

although I like in-person, it is not always feasible.” Remote learning may be better.” Another reflected on previous training, but the need for refreshers: “I remember learning about ACP during palliative care training, but I have not used it. I could use a refresher.” Another nurse felt ACP education should be mandatory and should be part of nursing orientation.

Improve Organizational Processes. Concerns were raised about the lack of clear policies and guidance within the organization. One nurse questioned, *“I wonder if we have a policy on ACP that guides our practice?”* Another highlighted uncertainty around documentation: *“I am unsure of where (and how) to document an ACP.”* This nurse stated: *“A patient’s ACP and code status is discussed in the inpatient oncology unit, but it is not transferred to the outpatient oncology centre or the emergency department”.* One nurse mentioned, *“We need to come together as a multidisciplinary team to support the patient through ACP, and that may require a shift in the organization to prioritize ACP initiatives.”*

Interviews with Nursing Leadership Team

I conducted interviews with three out of the four identified members of the nursing leadership team at DHBMCC. The fourth member was unavailable for an interview due to scheduling conflicts. Once again, I analyzed the responses by grouping similar ideas and identified four themes related to ACP (Polit and Beck, 2021). The themes were:

Oncology Nurses Have a Role in ACP. All interviewees agreed there is a need for ACP to be integrated into routine oncology nursing practice, suggesting that while ACP is important for all patients, it is especially important for those with cancer. They noted that nurses often lack clarity on their role in these conversations and would benefit from targeted education to build confidence and competency.

Communication and Understanding Resources. All interviewees suggested that content areas should include therapeutic communication, substitute decision-making (SDM), information on AD, legal considerations, and resources. One interviewee stated, *“We need to know when to have the conversation, how to start the conversation, and the resources we can share, such as websites and brochures.”* This nurse continued with an insightful statement, *“We are so focused on treatment and outcomes of treatment, but ACP is just as important.”*

Blended Approach to Education. All respondents advocated for a blended approach to education delivery. They suggested the education sessions should include case studies, as these offer practical and realistic ways to develop skills. One respondent suggested, *“I like a practical approach to education, focusing on how ACP fits into my practice and what I need to know to support my patients.”* One nursing leader stated, *“Ideally, ACP education should be in person, although scheduling may not allow for this.”* All felt that the education should include how to educate patients on the benefits of having an ACP, and the ways it can help alleviate stress and provide comfort to patients and families.

Organizational Support. All three interviewees identified organizational support as an important piece of successful implementation. One respondent cited, *“There is a need for organizations to prioritize ACP, define nursing roles, and integrate ACP into workflow.”* One member stated competing work and limited time affect ACP conversations; *“The organization should consider the time it takes for nurses to have these important conversations.”* Two of the respondents stated they were unaware of an ACP policy or recent educational initiatives, but recall previous education, including e-learning and ACP as a topic for medical rounds. One respondent was aware of the Newfoundland and Labrador Health Services (NLHS) policy on ACP.

Environmental Scan

The environmental scan allowed me to gather and analyze information about existing ACP education at select cancer care programs in Canada. I examined three Canadian cancer care organizations: Nova Scotia (NS) Health, Cancer Care Ontario (CCO), and BC Cancer (BCC). I chose NS because it shares geographic and demographic characteristics with Newfoundland and Labrador (NL), making it relevant for comparing ACP oncology nursing education initiatives. I selected CCO and BCC because they are large cancer care institutions with educational resources often referenced and adapted by the NLHS Cancer Care Program. As a comparison, I also reviewed NLHS ACP resources.

Finally, I explored the Canadian Association of Nurses in Oncology (CANO) website to explore ACP and the roles and responsibilities of oncology nurses in GOC and EOL discussions. Additionally, I reviewed the Canadian Nurses Association (CNA) website to better understand the ethical obligations of nurses in supporting patient autonomy and decision-making. Exploring these national organizations that guide nursing practice ensures that the proposed ACP educational resource aligns with professional standards.

Objective(s) for the Environmental Scan

The specific objectives for the environmental scan were:

1. To determine the former (if any) ACP continuing education for oncology nurses at the DHBMCC.
2. To review the websites for Nova Scotia (NS) Health's Cancer Care, Cancer Care Ontario (CCO), and BC Cancer (BCC) to identify existing ACP educational modules, policy documents, and/or clinical guidelines regarding ACP.

3. To request information from the clinical educators at the above-listed cancer centers on current ACP education for oncology nurses. I contacted informants by sending a personal email of inquiry directly to the clinical educators (Appendix E).
4. To review the Canadian Association of Nurses in Oncology (CANO) position on ACP education and the role of oncology nurses.
5. To analyze the Canadian Nurses Association (CNA) *Code of Ethics* for Registered Nurses.

Environmental Scan Results

Cancer Care Ontario

As part of the environmental scan, I connected via email with a nurse educator from CCO to gain insight into ACP-related education. Currently, their oncology orientation for new nursing staff includes a four-hour palliative care component in which ACP is discussed, and relevant resources are provided. The educator kindly introduced me to an Advanced Practice Nurse (APN) in Palliative and Supportive Care, who shared that many of their ACP initiatives have been patient-facing, such as the development of patient education materials and resources, but they have also increased ACP education for nursing staff. They have experienced challenges with consistent nursing documentation practices related to ACP. In response, they have been actively brainstorming ways to better support nurses in this area. ACP education is currently incorporated into staff orientation and in-service sessions, with emphasis on encouraging nurses to complete specialized training such as the Pallium Canada (2025) training or education from the de Souza Institute (2025), a national organization providing oncology education and certification. The APN also shared an excellent free resource from the Champlain Hospice Palliative Care Association (2025), which offers courses specifically focused on ACP.

The website for CCO (2016) provides extensive ACP resources designed to support patients, families, and HCPs. Their ACP materials for patients and families help individuals understand and document their healthcare preferences. For HCPs, the CCO website offers tools and guides to assist in initiating and facilitating ACP conversations, such as the “*ACP Quality Improvement Toolkit*”, to help HCPs initiate and facilitate ACP conversations. These resources include clinician communication guides and materials to support meaningful ACP discussions.

BC Cancer Care

I engaged via email with a Clinical Nurse Specialist (CNS) at BCC to better understand if and how ACP education is currently delivered to oncology nurses. The CNS stated that oncology nurses receive a 1.5-hour ACP education session during orientation to introduce core concepts. Additional education takes place during ACP Day in April, through informal activities like drop-in sessions, booths, and interactive challenges with prizes. The CNS is currently exploring the expansion of ACP education through integrated, flexible approaches, such as embedding ACP into other existing education sessions or using quick-access tools. However, completing clinical priorities poses a challenge in reaching all nurses.

The website for BCC (2025) offers a range of resources and support for ACP tailored to patients, families, and HCPs. BCC has developed educational toolkits which include brochures, workbooks, and conversation guides. Notably, BCC has an excellent animated short video on their website called “*Talking to Patients about ACP*” that features a nurse and oncology patients navigating ACP discussions.

Nova Scotia Health

I connected via email with a member of the nursing leadership team at NS Health Cancer Care. The nursing leader stated that although they do not offer formal ACP education for oncology nurses, there have been conversations at a leadership level about getting oncology

nurses involved in GOC discussions. They also stated that oncology nurses are informally having ACP conversations with patients, but it is not standard practice.

The NS Health website has well-established ACP patient resources which focus on enhancing ACP initiatives for both patients and HCPs. There is a document called “*Serious Illness Conversation: Reference Guide for Clinicians*” which offers suggestions on when and how to initiate serious conversations, including ACP, and how to use the prompts to help you remember the sequence of introducing and navigating the conversation with a patient. The website offers access to a workbook entitled “*Just Ask: A Conversation Guide for Goals of Care Discussion*”. The workbook includes scripts to engage patients and their substitute decision maker (SDM) in GOC conversations that lead to medical orders for the use (or non-use) of life-sustaining treatments (NS Health, 2025).

NL Health Services

NLHS offers resources and support for ACP to residents across the province. On the NLHS (previously Eastern Health) Cancer Care (2016) website, there is a dedicated section on ACP, including “*It’s Your Decision: How to Make an Advance Health Care Directive,*” which guides individuals through the process of creating an AD and documenting their ACP. The site also links to an ACP policy developed in 2016, which states that every patient should be offered the opportunity to participate in ACP conversations. The policy emphasizes that GOC discussions should occur as early as possible during a patient’s journey and must involve the patient or their SDM if the patient lacks capacity. ACP is acknowledged as voluntary and focuses on respecting an individual’s rights and values. Additionally, the website features a YouTube video titled “*Speak UP*”, created as part of a national campaign in 2016 to raise public awareness about ACP.

National Nursing Associations

As the final part of my environmental scan, I explored the websites of CANO and CNA to find information about their positions on ACP.

Canadian Association of Nurses in Oncology. CANO recognizes the important role oncology nurses play in supporting ACP throughout the cancer care continuum. The *CANO Practice Framework and Toolkit* (2019) states that “oncology nurses apply foundational knowledge in supporting ACP discussions to advocate for the wishes of individuals with cancer” (p. 20). Additionally, CANO (2015) has developed nine practice standards of care that guide oncology nursing practice. The first practice standard of care is called *Individualized and Holistic Care*, which emphasizes that “individuals with cancer and their family are entitled to care that is individualized, holistic, and responsive to and respectful of individual differences” (p.17). CANO’s third practice standard of care is defined as *Self-determination and Decision-making*. It states that “individuals with cancer and their family have the right to self-determination, the right to access information, the right to make decisions about their health care, or the right to have an advocate, if they are unable or choose not to participate in decision-making” (p.18). Although CANO does not provide specific ACP resources other than access to a previously recorded webinar on ACP, these two oncology nursing practice standards of care reflect the essence of ACP as a component of oncology nursing practice.

Interestingly, as I navigated through CANO's position on ACP, I discovered that the Canadian Hospice Palliative Care Association [CHPCA] (2015) offers practical guidance and tools for supporting ACP discussions and nursing practice. CHPCA (2015) provides resources, including workbooks, conversation guides, and decision aids aimed at fostering meaningful ACP

conversations (Canadian Nurses Association, Canadian Hospice Palliative Care Association, & Canadian Hospice Palliative Care Nurses Group, 2015).

Canadian Nurses Association. While the CNA does not have a standalone position statement on ACP, its advocacy for person-centred care inherently supports the principles of ACP. According to the *CNA's Code of Ethics for Registered Nurses (2025)*, nurses are expected to respect and promote individuals' rights to make informed and autonomous decisions regarding their health and well-being. This includes providing patients with the necessary information to make decisions about their care, ensuring their wishes are respected, and supporting them in making choices aligned with their values and preferences.

Synthesis of Results

I conducted an environmental scan and consultations with key stakeholders to explore the need for ACP education for oncology nurses in the local practice setting. The consultations with oncology nurses and select members of the nursing leadership team at DHBMCC revealed that all respondents recognized the importance of ACP, but displayed various levels of confidence, engagement, role ambiguity, and competency in navigating ACP conversations and processes. These local findings mirror those in the literature, which point to systemic gaps in education, unclear roles, and varying degrees of comfort among nurses in initiating ACP discussions (Rietze & Stajduhar, 2015; Yahiro et al., 2023). Consistent with the literature review, the respondents reported feelings of discomfort when participating in ACP discussions due to a lack of knowledge and skills to support patients in ACP (Rietze & Stajduhar, 2015). All respondents demonstrated a willingness to increase competency to engage in meaningful ACP discussions and support patients through this process.

While conducting the environmental scan, I identified that larger organizations such as BCC and CCO have designated ACP education for oncology nurses. In addition, BCC, CCO, and NS Health are prioritizing ACP through structured, accessible educational initiatives and resources on their website aimed at supporting individuals and HCPs. These efforts align with national standards set by the CANO and the CNA, both of which emphasize individualized care and promote patient autonomy. Additionally, I noted that NLHS has taken initial steps to support ACP through policy development and public-facing information.

I observed similarities between the findings of the literature review and data collected during local consultations with oncology nurses and the select nurses in leadership positions. ACP enhances holistic care by aligning treatment with patients' values and preferences and reducing anxiety for patients and families (Detering et al., 2010; Goswami et al., 2020; Sudore et al., 2017). However, despite these benefits, ACP engagement remains limited due to a range of systemic, educational, and cultural barriers, all common themes that emerged from the local consultations. Respondents in the local consultations reported feeling unprepared to initiate ACP due to a lack of knowledge, role ambiguity, limited organizational support, and time constraints, similar to the findings in the literature (Ke et al., 2015; Kilgour et al., 2025; Shih et al., 2025).

The literature strongly supports the need for targeted education to improve oncology nurses' ACP competencies (Feaster et al., 2023; Yahiro et al., 2023). The review findings highlighted that the educational content should include increasing knowledge about ACP, enhancing communication skills, clarifying legal and ethical aspects, addressing role ambiguity, and promoting culturally sensitive care (Colville & Kennedy, 2012; Izumi et al., 2024; Rietze et al., 2015; Yahiro et al., 2021). Similarly, oncology nurses in the local setting identified the need

for ACP education approaches to increase ACP knowledge and improve skills to navigate discussions.

The findings of the literature review included three main approaches to delivering ACP education for oncology nurses: in-person education, virtual or online learning, and a hybrid or blended education model (Chang et al., 2024; Colville & Kennedy, 2012; Feaster et al., 2023; Yahiro et al., 2023). During the consultation phase, oncology nurses expressed willingness to engage in all three formats to strengthen their ACP competency. However, most respondents indicated a preference for traditional, in-person education over online formats. Respondents felt that while online, flexible options are valued, in-person learning may be more effective for practicing communication skills to navigate ACP discussions.

Conclusion

I have demonstrated from the literature review, environmental scan, and stakeholder consultations that oncology nurses recognize the importance of ACP but report inconsistent levels of knowledge, confidence, and role clarity. Consequently, the combined findings support the development of an educational resource that addresses gaps in ACP knowledge, communication skills, legal and ethical considerations, cultural competence, and role definition. While oncology nurses are open to various educational formats, local consultations show that in-person learning was preferred due to its perceived effectiveness in supporting skill development, but it is recognized that online learning may be more flexible and have a greater reach. With these insights in mind, the next step is to develop a tailored ACP education resource specifically designed for oncology nursing at the DHBMCC, as proposed in my practicum project.

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Appendix A: Health Research Ethics Authority (HREA) Screening Tool

Student Name: Jean Ann Ryan

Title of Practicum Project: Development of an Advance Care Planning Education Resource for Oncology Nurses

Date Checklist Completed: May 23, 2025

This project is exempt from Health Research Ethics Board approval because it matches item number 3 from the list below.

1. Research that relies exclusively on publicly available information when the information is legally accessible to the public and appropriately protected by law, or the information is publicly accessible and there is no reasonable expectation of privacy.
2. Research involving naturalistic observation in public places (where it does not involve any intervention staged by the researcher, or direct interaction with the individual or groups; individuals or groups targeted for observation have no reasonable expectation of privacy; and any dissemination of research results does not allow identification of specific individuals).
- 3. Quality assurance and quality improvement studies, program evaluation activities, performance reviews, and testing within normal educational requirements if there is no research question involved (used exclusively for assessment, management or improvement purposes).**
4. Research based on review of published/publicly reported literature.
5. Research exclusively involving secondary use of anonymous information or anonymous human biological materials, so long as the process of data linkage or recording or dissemination of results does not generate identifiable information.
6. Research based solely on the researcher's personal reflections and self-observation (e.g. auto-ethnography).
7. Case reports.
8. Creative practice activities (where an artist makes or interprets a work or works of art).

For more information, please visit the Health Research Ethics Authority (HREA) at

<https://rpresources.mun.ca/triage/is-your-project-exempt-from-review/>

Appendix B: Questionnaire

I am completing my Master of Science in Nursing at Memorial University under the supervision of Dr. Renee Crossman. My goal for my practicum project is to develop an Advance Care Planning (ACP) educational resource for oncology nurses at the Dr. H. Bliss Murphy Cancer Centre.

I am writing to ask if you would be willing to complete this questionnaire regarding your experiences supporting oncology patients through ACP and your perceptions of ACP nursing education, as I believe your input is valuable to the overall project. This questionnaire is administered as part of the project's consultation phase. Answering this questionnaire implies consent to participate. The information you provide in the questionnaire is voluntary and will be kept confidential and anonymous.

There is a question at the end of this questionnaire inviting you to participate in a follow-up interview. While the questionnaire data is anonymous, the interview portion is not, but personal information will remain confidential. Responses will not be linked to names, and all data will be kept in a password-protected file on a password-protected computer.

If you have any questions, please do not hesitate to contact me.

Thank you,

Jean Ann Ryan

Questionnaire

1. **What is your current role/title?** _____

2. **How many years have you practiced nursing?**

- Less than 1 year
- 1–5 years
- 6–10 years
- 11–15 years
- Greater than 15 years

3. **How many years have you worked in oncology?**

- 1–5 years
- 6–10 years
- 11–15 years
- Greater than 15 years

4. **Have you received education on ACP?**

- Yes
- No

If yes, please describe: _____

5. How confident are you in your understanding of the following?

Rate 1 = Not at all confident to 5 = Very confident

	1	2	3	4	5
The purpose and goals of ACP					
When and how to initiate ACP conversations					
How to document ACP					
Cultural sensitivity in ACP discussions					
Legal and ethical components of ACP					
A nurse's role in MAiD discussions					

6. How often do you engage in conversations with patients or families about ACP?

- Never
- Rarely
- Occasionally
- Frequently
- Always

7. What challenges do you feel impact discussing ACP with patients and families?

(Check all that apply.)

- Lack of time
- Patient reluctance
- Cultural barriers

- Lack of ACP training
- Unclear roles
- Other: _____

8. To what extent do you agree with the following statements?

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
ACP is a part of oncology nursing care.					
Oncology nurses should take an active role in initiating ACP discussions.					
ACP improves patient outcomes.					
Understanding a patient's ACP benefits the cancer care team.					
Discussing ACP early in the cancer care trajectory is beneficial.					
Education on ACP will improve oncology nurses' ability to navigate ACP conversations.					

9. What topics would you like to see covered in an ACP oncology nursing educational resource? (Check all that apply.)

- Enhancing communication skills to navigate ACP conversations
- Understanding the role of a substitute decision maker
- Understanding advance directives
- Understanding the legal and ethical aspects of ACP
- Navigating cultural considerations to ACP
- Documentation of ACP
- Understanding the nurses' role in MAiD
- Other (please specify): _____

10. What delivery format(s) would you prefer for ACP education?

- In-person workshops
- Online, self-paced modules
- Webinars
- Other (please specify): _____

11. Do you have any additional suggestions for improving ACP education for oncology nurses?

12. Would you be willing to participate in a 15–20-minute follow-up interview to further discuss ACP within the oncology setting? If yes, please email me at

jeanannryan@hotmail.com.

Appendix C: Follow-up Interview Questions

1. How would you describe your current understanding of ACP?
2. How important do you believe ACP is in oncology care?
3. Do you see a role for oncology nurses in ACP? Can you please elaborate?
4. Do you think an ACP educational resource would increase your confidence in having ACP conversations? Can you please elaborate?
5. What content would you find most helpful in an ACP educational module?
6. What concerns or challenges do you foresee in implementing ACP practices?
7. How could this organization best support the implementation of an ACP educational resource?

Appendix D: Interview Questions for Oncology Nursing Leadership

1. Given your role as a nursing leader in oncology care, do you see a need for ACP education for oncology nurses at the Dr. H. Bliss Murphy Cancer Centre? Could you explain or expand on your answer?
2. In your experience, would an ACP educational resource support oncology nurses in navigating conversations about ACP with patients? Please explain or expand on your response.
3. Based on your experience and interactions with oncology nurses, what specific content should be included in ACP education to help increase nursing competency?
4. What educational approaches do you believe would be most effective in supporting oncology nurses to develop the skills needed to engage in ACP conversations?
5. What types of organizational support do you think are needed to facilitate the successful implementation of ACP education for oncology nurses?
6. Are you aware of existing ACP policies or educational initiatives within the organization? If yes, have these initiatives influenced oncology nursing practice?

Appendix E: Email to NS Cancer Care, BCC, and CCO

Dear

My name is Jean Ann Ryan, and I am completing my Master of Science in Nursing at Memorial University under the supervision of Dr. Renee Crossman. The topic for my practicum project is to develop an Advance Care Planning (ACP) educational resource for the oncology nurses at the Dr. H Bliss Murphy Cancer Centre in St. John's, NL.

I am currently conducting a review of ACP education practices for oncology nurses in a select number of cancer care institutions in Canada. As part of this initiative, I am reaching out to gather information on existing ACP education for oncology nurses within your organization. I am interested in learning if you offer ACP education for your oncology nurses. Specifically, if you offer this education, I would appreciate it if you could share the following information: a review of the educational content, the length or duration of the program, the delivery model (e.g., in-person, online, blended), and if there is a certification component to the course. I can also meet virtually or via phone to discuss this information at your convenience.

I would appreciate it if you could identify the most appropriate point of contact at your organization for this inquiry or forward this email on my behalf. If you have any questions or require additional details, please don't hesitate to reach out. I would be happy to share my supervisor's contact information if needed.

Thank you for your time and assistance. I look forward to your response.

Sincerely,

Jean Ann Ryan, RNBN CON(C)

St. John's, NL

Email: jeanannryan@hotmail.com

Phone number: 709-689-8636

Appendix D: ACP Educational Resource: Facilitator's Guide

Introduction

This Facilitator Guide provides a structured framework for delivering Advance Care Planning (ACP) education to oncology nurses. It serves as a supplementary resource to accompany the ACP PowerPoint slide deck. Each page of the guide corresponds to a slide and includes key teaching points, suggested topics for discussion, and facilitator prompts. There are opportunities for reflection throughout the session, and a case study is presented at the end.

At the beginning of the session, a pre-education multiple-choice test will be administered to capture baseline knowledge related to ACP. At the conclusion of the session, a similar test will be administered to measure the increased competency gained through education.

This education is intended to be delivered either in person or virtually, or through a hybrid format, which offers a flexible educational experience where in-person and remote instruction can occur concurrently (Davis et al., 2024).

Welcome: Learning Objectives [Slides II]

- Welcome participants.
- Read the learning objectives aloud.
- Discuss the opportunities to pause and reflect on personal and professional experiences with ACP.
- Inform the participants that at the end of the session, they will complete a post-test.

Pause and Reflect on ACP (Slide III)

- Have you been involved in ACP?
- What factors influenced conversations?
- Did you feel prepared to engage in these conversations?
- Do you see a role for oncology nurses in ACP conversations?

Definition of Advance Care Planning [Slide IV]

Advance care planning (ACP) is a process of reflection and communication where a capable individual makes decisions about their future healthcare, personal care, and end-of-life (EOL) in the event they are no longer able to provide informed consent (Advance Care Planning Canada, 2024).

Scenario

Mr. Smith is a 70-year-old gentleman with Stage IV colorectal cancer. He has been undergoing chemotherapy treatment for several months. A recent CT scan showed disease progression, and his health is declining. During a follow-up visit, Mr. Smith is informed by his oncologist that his chemotherapy is no longer effective and that there are no remaining options for treatment. Mr. Smith expresses concern about his future and asks questions about what will happen if he becomes too ill to make decisions for himself.

Key questions to consider when communicating with Mr. Smith

- What kind of care do you expect as you move through your cancer journey?
- How might your choices affect loved ones?
- What decisions might others need to make for you?
- Are there cultural or religious practices important to you?

Reflection

- Reflect on the definition of ACP. How prepared are you to initiate a conversation about ACP with Mr. Smith?

Benefits of ACP [Slide V]

- Aligns medical care with an individual's values, goals, and healthcare preferences.
- Reduces non-essential medical interventions and may improve the quality of care during critical healthcare moments.
- Alleviates the burden of decision-making on families and healthcare providers (HCPs) during times of crisis, thereby **reducing stress** and confusion.
- Increases the use of palliative care and pain and symptom management (Goswami et al., 2020).
- Despite the advantages, various challenges, such as limited knowledge of the goals of ACP, associating ACP with EOL and death, confusing ACP terminology, and cultural nuances, lead to delays or absences of ACP discussions in the cancer care trajectory (Agarwal & Epstein, 2018).

Scenario

- Mr. Jones was recently diagnosed with pancreatic cancer and was asked by an oncology nurse if he had thought about ACP. Mr. Jones was still processing his diagnosis and found the conversation overwhelming, leading to **increased stress and added emotional distress**.

Discussion

- Could the nurse have handled this conversation differently?
- For some patients, early ACP discussions can create additional **burden or confusion**. **We will discuss assessing readiness to engage in ACP later in the presentation.**

Facilitator Prompts: Consider the timing of the conversation and establishing a therapeutic relationship with patients.

Canadians' Engagement in ACP [Slide VI]

- The ACP: Pan-Canadian Framework (2020) captured attitudes and ACP practices of Canadians.
- 93% of Canadians believe it is important to discuss ACP with loved ones.
- Less than 50% engage in these conversations with loved ones.
- Only 7% have had ACP conversations with their HCP.
- Only 17% of Canadians have a documented ACP despite the evidence of its benefits, awareness campaigns, and educational initiatives.

Discussion

- What are your thoughts on these statistics?
- Do they surprise you? Why or why not?

Factors Affecting Awareness and Engagement [Slide VII]

1. Limited Knowledge and Awareness

- A barrier to ACP uptake is limited public knowledge (65% in Siden et al., 2022) and a lack of awareness of the term "advance care planning" (16% in Teixeira et al., 2014).
- Many individuals associate ACP with EOL care (Siden et al., 2022).
- The use of unclear language in ACP discussions (32% in Siden et al., 2022) can further prevent individuals from engaging. For example, using confusing terminology such as "substitute decision maker" or "advanced healthcare directive" without clarification can make the process feel intimidating.
- In certain populations, cultural norms and values might prevent discussions about EOL discussions and planning for future healthcare (11% in Siden et al., 2022).

2. Demographic Considerations

- Some research showed greater ACP engagement among older adults, possibly due to a greater need for future planning as one ages (Teixeira et al., 2014).
- Individuals with higher socioeconomic status (SES) are more engaged in ACP, due to better access to healthcare. Conversely, lower SES individuals are less engaged, typically related to limited access to healthcare services and health information. They also have competing life priorities, such as financial stress, which may hinder the ability to prioritize planning for the future (Johnson et al., 2016; Teixeira et al., 2014).
- Women were more likely to engage in ACP discussions (Teixeira et al., 2014).

- Do you have any thoughts on why women would have greater engagement with ACP? **Facilitator Prompts:** Women often take on social and caregiving roles; they tend to be more proactive in health behaviours.

3. Psychosocial and Emotional Barriers

- Unpredictable disease trajectory can create uncertainty, making ACP discussions more difficult. Patients and families may delay ACP until the health care journey becomes clearer (Johnson et al., 2016).
- Johnson et al. (2016) stated that the desire to maintain hope or optimism about a positive outcome in one's cancer care journey may prevent individuals from discussing ACP. Hope is an expectation for a positive outcome. Patients often hope for a cure or extended survival: communication about diagnosis, treatment, and prognosis can either strengthen or diminish that hope. (Kiely & Stockler, 2020). Kiely and Stockler (2020) suggest that in advanced cancer, individuals may redirect their hope toward attainable goals, such as comfort, dignity, and time with loved ones, all of which are important aspects of the ACP.
- An interesting study by Cohen et al. (2020) investigated ACP and hope among patients with advanced cancer. In a cross-sectional analysis of 672 participants, they found no significant differences in levels of hope between patients who had and had not engaged in key ACP activities, including EOL discussions. These findings suggest that participation in ACP does not diminish hope in patients with advanced cancer.

Five Steps to ACP [Slide VIII]

The "*Five Steps to Advance Care Planning*" framework guides individuals in making an ACP (Advance Care Planning, 2024). As we go through these steps, reflect on your role as an oncology nurse in supporting patients.

1. Think

- Encourages individuals to reflect on their own values, beliefs, and what matters most to them regarding their care.

2. Learn

- Explains the importance of gathering information about medical options and possible outcomes.

3. Choose

- Individuals name their substitute decision maker (SDM) or a person who is willing to speak on their behalf.

4. Talk

- Patients share their wishes with family members, caregivers, and HCPs to ensure everyone is informed.

5. Record

- Documenting in the patient's electronic medical records (EMR).
- Include decisions about preferences for treatments, interventions, or comfort care.
- Individuals can write down and/or video their ACP.
- ACP should be updated as needed by the patient and reviewed with HCPs.

Substitute Decision Maker [Slide IX]

Definition

- A SDM is a person authorized to make healthcare decisions on behalf of someone who is no longer capable of doing so (Siden et al., 2022).
- A SDM is appointed by the patient.
- Sometimes referred to as a healthcare proxy.
- The role of the SDM is to advocate for the patient's healthcare wishes, values, and best interests when they can no longer speak for themselves.
- Individuals can name an alternate who acts if the primary SDM is unavailable.
- Nurses play a role in supporting patients and families through the process of selecting an SDM by sharing resources and ensuring the SDM is documented in the patient's chart.

Discussion

- What challenges arise when there is no clear SDM?

Facilitator Prompt: Delayed decision making about healthcare interventions; family conflict or disagreements about treatment or interventions; heightened stress and confusion; possible **ethical dilemmas as HCPs and loved ones who** may struggle in understanding the wishes of their patients.

Advance Directive [Slide X]

Definition

- An Advance Directive (AD) or an Advance Health Care Directive (AHCD) is a document where individuals can outline their wishes for future healthcare (Siden et al., 2022).
- Includes appointment and naming a SDM.
- Formalizes the ACP decisions, which can guide HCPs and SDMs.
- Highlights specific treatments and health care preferences.
- It should be accessible to HCPs in the patients' circle of care.
- An AD is sometimes referred to as a “Living Will.”

Components of Advance Directives [Slide XI]

- Designates a trusted individual to make healthcare decisions on one's behalf.
- Includes details on medical treatments like the use of ventilators, feeding tubes, or pain management.
- The AD must be signed, witnessed, and sometimes notarized, depending on the jurisdiction. For NL, two witnesses sign the AHCD (Advance Health Care Directives ACT, NL, 1995).

Creating an AD

- Reflect on desired medical interventions (e.g., resuscitation, comfort care).
- Choose a trusted person to act as SDM, who will follow the patient's wishes.
- Fill out the AD form, sign, and have it witnessed; provide copies to the SDM, family members, and healthcare team.

Discussion

- When should ADs be reviewed and updated?
- Do you see any system-level barriers to sharing AD

Facilitator Prompts: Consider changes in a patient's health status, changes in the treatment plan, and changes in the SDM. Organizations can develop a process for HCPs to ask a patient if there are changes to their ACP. System-level barriers include inconsistencies in documentation processes, the absence of a process to share AD among healthcare teams, and inconsistencies in an AD becoming part of a patient's EMR.

Legal Considerations [Slide XII]

- You do not need a lawyer to name a SDM or have an AD.
- While some SDMs are appointed through legal processes (like a Power of Attorney), most are identified informally by an individual.
- In 1995, Newfoundland and Labrador (NL) established the *Advance Health Care Directives Act*. Some important points include:
 - An AHCD and the authority of a SDM become effective when the “maker” ceases to be competent to make and communicate health care decisions.
 - An AHCD shall be in writing, witnessed by at least two independent people and signed by the maker.
 - Where more than one person is identified as an SDM, those identified will select one person to speak on behalf of both SDMs, to communicate the health care decisions to the medical team.
 - No action lies against a SDM by reason only of having acted, in good faith, in accordance with the Advance Health Care Directives Act.
 - During critical moments, HCP is not liable for failing to find the SDM, as long as a “reasonable attempt” is made to contact the SDM.

Challenges [Slide XIII]

Challenges to ACP exist on the patient, provider, and system levels.

1. Patient-Level Challenges

- Lack of awareness or understanding about ACP
- Associating ACP with EOL
- Fear (and sometimes denial) of one's health care situation
- Limited health literacy or cognitive impairment

Example: The oncology nurse recommends that the patient consider ACP. The patient perceives this suggestion as an indication that the nurse believes they may not survive their cancer diagnosis or treatment.

Discussion

- How can oncology nurses ensure this conversation increases awareness but does not diminish hope?

Solutions

- Frame ACP as standard practice in oncology care
- Highlight that ACP gives the patient more control over their healthcare decisions
- Normalize the conversation
- Offer **resources** to help the patient better understand the process

2. Provider-Level Challenges

- Role ambiguity
- Time constraints in busy clinical settings
- Lack of training/confidence in initiating ACP conversations
- Uncertainty around the timing of discussions

Example: An oncology nurse may feel uncertain about their role in initiating ACP conversations, and the nurse may worry about how to respond to sensitive questions that could arise. They might be unclear whether they are expected to lead the discussion, provide advice, or refer the patient to another HCP. Without education on ACP, the nurse may feel unprepared and concerned about not having accurate information.

Discussion

- How could the organization support the nurse?

Solutions

- Oncology nurses should seek information about ACP and their role in supporting patients through the process
- Institutions should provide education on how to initiate and guide ACP conversations

3. System-Level Challenges

- Lack of standardized protocols or policies
- Poor documentation/sharing across care settings
- Fragmentation in healthcare services, like disconnected EMR
- Lack of consistent ACP education

Example: A patient moves from a hospital to a long-term care (LTC) facility, but their ACP documents were not sent in the process of transferring. As a result, the staff at LTC is unaware of the patient's wishes, potentially leading to decisions that go against the patient's healthcare preferences.

Discussion

- A common challenge to ACP is poor documentation and sharing information across care settings

Solutions

- Provide clear direction and guidelines to support nursing practice and seamless transfer of ACP information
- Ensure access to tools (ACP templates, conversation guides) so providers feel more confident during discussions
- Use the EMR to facilitate documentation and sharing of ACP decisions across different care settings
- Encourage patients and/or loved ones to carry a copy of the ACP to ensure it is accessible in all settings

Reflection

- Reflect on the ACP challenges you encounter in your practice? What strategies have helped you overcome these barriers?

Common Misconceptions [Slide XIV]

1. **ACP is for older individuals**

ACP is relevant for all adults of all ages.

2. **ACP is for those with a serious, life-limiting illness**

ACP is about planning for unexpected health changes, not just EOL.

3. **ACP cannot be changed**

ACP is flexible and can be updated anytime as values or health status change.

4. **ACP is a legal process that requires a lawyer**

ACP is about reflection, communication, and documenting healthcare preferences.

*While legal forms, like naming a Power of Attorney, may exist, you **do not need a lawyer** to complete an ACP. The focus is on communication and reflection, rather than formalities.*

5. **ACP conversations are a “physician’s” role**

Anyone involved in the individual's care, such as physicians, nurse practitioners, registered nurses, and social workers, can support ACP conversations.

6. **ACP takes too much time**

ACP can be accomplished in small, manageable conversations over time, rather than all at once.

7. **Patients do not want to talk about ACP**

Many patients appreciate it when someone opens the conversation; reluctance is often due to a lack of awareness.

8. **ACP conversations interfere with “hope”**

ACP supports realistic hope by empowering individuals to align their healthcare wishes with the plan of care.

Equitable Care Considerations [Slide XV]

Every individual, regardless of cultural background, socioeconomic status, or disability, should have the opportunity to engage in ACP conversations. By recognizing the needs of different populations, ACP conversations can be tailored to the individual. This approach ensures personalized care (Izumi et al., 2024; Jonathan et al., 2024).

Marginalized Populations

- When engaging in ACP conversations with marginalized individuals, be aware of the unique challenges they may face, such as access to healthcare and economic limitations, which can impact their ability to engage in ACP discussions.
- These factors may influence their healthcare preferences and experiences.
- Those with lower levels of education or health literacy may not fully understand the significance of ACP, leading to confusion or reluctance to engage in these conversations.

Cultural Considerations

- Be aware of cultural differences in ACP conversations.
- Different cultures may have cultural ceremonies or traditions that can be part of ACP.
- Indigenous peoples often have strong cultural traditions and spiritual beliefs. As HCPs, we must understand and respect these values while discussing ACP.
- Understand your organization's policies on traditional ceremonies, such as smudging.
- Recognizing these differences ensures respectful ACP discussions (Jonathan et al., 2024).
- Consider engaging the Indigenous Patient Navigator.

Health Literacy

- Those with lower levels of health literacy may not fully understand the significance of ACP or have trouble navigating ACP resources, leading to confusion or reluctance to engage in these conversations.

Language Barriers

- Individuals from non-English speaking backgrounds may face challenges in understanding ACP forms or discussions if materials are not in their preferred language.
- Do you know how to access an interpreter if needed?

Discussion

- Can you offer suggestions to ensure ACP discussions are culturally sensitive and inclusive?

Facilitator Prompts

- Learn about patients' cultural beliefs and values, avail of cultural sensitivity training.
- Use interpreters or translation services to overcome language barriers.
- Ask open-ended questions and avoid assumptions about beliefs or preferences.
- Respect family or community roles in healthcare decisions.

Spirituality [Slide XVI]

- Spirituality is an important but often overlooked dimension of ACP (Lutz et al., 2018).
- In ACP conversations, ask about spiritual values and practices that may guide decision-making (Lutz et al., 2018).
- Acknowledge the patients' sources of spiritual strength, community ties, belief systems, and rituals.
- Once again, familiarize yourself with your organization's resources to support spiritual health.
- Document the patient's spiritual preferences.

Medical Assistance in Dying (MAiD) [Slide XVII]

- MAiD may be part of some individuals' ACP (Beuthin et al., 2018)
- MAiD became legal in Canada on June 17, 2016. Bill C-14 amended the *Criminal Code* and created an exemption from criminal prosecution for HCPs who assist physicians or NPs in the provision of MAiD (Canadian Nurses Protective Society, 2025).
- The *Canadian Nurses Protective Society (2025)* highlights several important considerations that a registered nurse (RN) participating in the provision of MAiD will have to consider, including:
 - Familiarization with Bill C-14
 - Review the position of one's nursing regulatory body to ensure nursing practice is in accordance with the law and our role as nurses.
 - Awareness of any applicable institutional policies, guidelines, and/or processes in place to guide the RN's role in MAiD.

Reflection

- Reflect on your thoughts and feelings surrounding MAiD. Are you aware of your role?

Goals of Care Designation [Slide XVIII]

GOC designation (code or resuscitation status) documents what life-saving interventions should (or should not) be used for a patient, especially in emergencies like cardiac arrest or respiratory failure. Goals of Care Designations are used to describe, communicate, and document the general focus of care for the patient (Eastern Health, 2016).

R: All medical care and interventions, **including** resuscitation.

- Often called a **full code**. The patient consents to all life-saving measures, including CPR, defibrillation, intubation, ICU transfer, etc.

M: All medical care and interventions, **excluding** resuscitation.

- The patient accepts some emergency treatments (like antibiotics or oxygen) but may refuse others (like CPR or ICU care).

C: Medical care and interventions, focused on **comfort care**.

- Often called **Do Not Resuscitate Order (DNR)** or **No CPR**

C2: End of Life Care.

- Preparation for imminent death (anticipated days or weeks) with maximal efforts directed at symptom control,
- Often called **Comfort Care** or **Palliative Care**
- Focuses on symptom control and comfort, not extending life. No CPR, no ICU, no invasive procedures (Eastern Health, 2016).

Why It Matters to ACP

- Prevents unwanted or futile aggressive interventions
- Offers clarity to healthcare teams during emergencies
- Can be revised or changed by the patient or SDM over time

Barriers to Nursing ACP Engagement [Slide XIX]

- Now that we understand the nuances of ACP, the rest of this session will shift to focusing on the nurse's role and on strategies to strengthen nurse-led ACP initiatives. We will discuss factors that affect nurses from engaging in ACP initiatives (reflect on the slide about patient, provider, and system-level barriers)
- Although positioned to lead ACP efforts, many nurses feel unprepared due to:
 - Role ambiguity
 - Absence of organizational infrastructure that supports ACP
 - Insufficient knowledge and communication skills
 - Lack of confidence in guiding patients through ACP processes
 - Lack of understanding of the legal aspects of ACP
 - Lack of awareness of resources
 - Fear of upsetting patients and diminishing hope

Discussion

- Do you have any suggestions on how we can address these barriers?

Facilitator Prompts

- Clarify the nurses' roles.
- Provide ACP education or mentorship to build knowledge and confidence.
- Focus on providing communication strategies or guides to facilitate navigating ACP conversations.
- Develop organizational support: policies, dedicated time, or resources.
- Create easy-to-access ACP guides or quick-reference tools.

REMAP Framework [Slide XX]

The “REMAP” Framework is an acronym to guide serious illness conversations and can be applied to ACP discussions (Childers et al., 2017).

R: Reframe the Conversation

- “What can you tell me about your healthcare journey?”
- “What goals for your care have you communicated to your family or healthcare team?”

E: Expect Emotion

- Recognize and prepare for emotional responses.
- Use empathy and active listening.
- Normalize emotion: “It’s okay if this conversation feels emotional.”

M: Map Out the Patient’s Goals

- Encourage reflection.
- Ask open-ended questions: “What matters most to you as you think about the future?”

A: Align with Patient Goals

- “Based on what you have shared, you would like to have a good quality of life. You want to be comfortable.”

P: Propose a Plan

- Offer practical next steps and reinforce that ACP is an ongoing conversation.
- “This brochure has information on ACP.”
- “Would you be open to continuing this conversation at our next visit?”

Transtheoretical Model [Slide XXI]

Another valuable tool for enhancing ACP conversations is the Transtheoretical Model (TTM), which focuses on understanding a person's readiness to change (Fried et al., 2024).

- Readiness influences behaviour and can serve as a framework for assessing a patient's level of engagement in ACP.
- Patients are often at different stages of readiness when it comes to engaging in ACP discussions (Fried et al., 2024).
- It is important to tailor your communication and approach based on the individual's stage of readiness (Fried et al., 2024).

There are Five Stages of Change

a) Precontemplation:

- Not considering ACP or future care planning.
- Gently raise awareness without pressure.
- The patient may say: *"It seems early to talk about this."*
- The nurse can ask an open-ended question: *"Have you thought about your goals of care and what is important to you?"*
- The nurse can "normalize" ACP: *"ACP is for all individuals."*

b) Contemplation:

- The individual is considering ACP but not ready to act.
- The patient may say: *"I know it is important, but I am not ready."*
- The nurse can validate and address concerns and maybe offer an ACP brochure.

c) Preparation:

- Planning to discuss and make ACP decisions.

- Help identify values and preferences.
- The patient may say: *“I would like to have an ACP; I just don’t know how to begin.”*
- The nurse can explain ACP and provide resources.

d) Action:

- Actively engaging in ACP conversations and decision-making.
- The patient may say: *“I read the brochure and have started talking to my family and oncologist. I have named my daughter as my SDM.”*
- The nurse can encourage ongoing conversations and decision-making.

e) Maintenance:

- Revisiting and updating ACP plans as needed.
- Reinforce the importance of regular reviews.
- The patient may say: *“I have completed my ACP, but I may change it in the future.”*
- The nurse can reply: *“ACP can be updated and changed at any time.”*

Discussion

- Do you feel patients experience different levels of ACP “readiness”?
- Do you have any examples from your nursing practice?

Facilitator Prompts

- Look for responses that align with the five stages of TTM.

Implications for Oncology Nursing Practice [Slide XXII]

The Canadian Association of Nurses in Oncology (CANO) is a national body that governs oncology nursing practice in Canada. CANO was established in 1985 and developed to support Canadian nurses in promoting and advancing excellence in oncology nursing practice, education, research, and leadership.

CANO's Mission:

- All Canadians deserve access to comprehensive oncology nursing care.
- The specialty of oncology nursing is an important component of cancer care.
- Evidence-informed care is the foundation for excellence in cancer care nursing.
- Collaborative relationships and partnerships further the health, well-being, and quality of life of all people affected by cancer in Canada.

Canadian Association of Nurses in Oncology Practice Standard [Slide XXIII]

CANO's practice standards provide guidance and clarification on the role of the oncology nurse.

There are nine practice standards that provide a framework for ensuring high-quality care across the cancer continuum and can be applied to ACP initiatives.

1. Holistic Care

“Individuals with cancer and their family are entitled to care that is individualized, holistic, and responsive to and respectful of individual differences, such as but not limited to, developmental, physical, cultural, spiritual, social, economic, philosophical, political, or gender” (CANO, 2015, p.17).

Implications

- Oncology nurses provide holistic, evidence-informed care across the cancer trajectory.
- Oncology nurses often have close, trusting relationships with patients, positioning them to facilitate ACP conversations.

2. Family Centred Care

“Individuals with cancer and their families are entitled to care that is family-centred, incorporates growth and developmental needs of each member, and is respectful of the family's resources and coping style. The nurse knows and considers who this individual is, that is, their personhood” (CANO, 2015, p.18).

Implications

- Oncology nurses recognize that cancer care extends beyond the patient.
- With the patient's permission, involve loved ones in ACP discussions and encourage their role in the decision-making process.

3. Self-Determination and Decision-Making

“Individuals with cancer and their family have the right to self-determination, the right to access information, the right to make decisions about their health care, or the right to have an advocate, if they are unable or choose not to participate in decision-making” (CANO, 2015, p. 18).

Implications

- Oncology nurses have a responsibility to provide education and resources to patients.
- Oncology nurses must respect and support the autonomy (and decisions) of patients and families.
- Oncology nurses must respect the role of the appointed SDM.

4. Navigating the System

“Individuals with cancer and family are entitled to assistance in navigating through the cancer and health care system.” (CANO, 2015, p. 19).

Implications

- Oncology nurses require education and awareness of resources to assist patients with navigating ACP.

5. Coordinated Care

“Individuals with cancer and their family are entitled to care that is coordinated among providers and across the continuum of cancer control” (CANO, 2015, p. 19).

Implications

- Interdisciplinary communication is one of the cornerstones of oncology nursing.
- ACP discussions often involve multiple care providers (oncologists, primary care, palliative care, social work).

- Oncology nurses can act as liaisons to facilitate ACP through interdisciplinary communication.

6. Supportive, Therapeutic Relationship

“Individuals with cancer and their family are entitled to a supportive, knowledgeable, caring and therapeutic relationship with care providers throughout their cancer experience “(CANO, 2015, p. 20).

Implications

- Because of this therapeutic relationship, oncology nurses are uniquely positioned to engage in ACP discussions with their patients.
- Oncology nurses can clarify what ACP is (and is not), correct misconceptions, and explain benefits.

7. Evidence-Based Care

“Care delivered to individuals with cancer and their families is based on theory, science, and incorporates principles of evidence-based practice, best practice or available evidence” (CANO, 2015, p. 21).

Implications

- Oncology nurses seek opportunities to contribute to research or quality improvement projects focused on ACP.
- Oncology nurses stay informed on new evidence related to oncology and ACP.
- *As an example, oncology* nurses support evidence-based care by implementing tools like the “REMAP” acronym used to guide **serious illness conversations** or referring to a framework like TTM to assess readiness.

8. Professional Care

“Individuals with cancer and their family are entitled to care that is professional and incorporates ethical principles and legislative requirements” (CANO, 2015, p. 21).

Implications

- Oncology nurses support ACP by upholding ethical principles like patient autonomy and informed choice.
- As an example, oncology nurses play a role in ensuring patients exploring MAiD receive accurate information, emotional support, and help navigating the complex decision-making process, all while respecting patient autonomy and ensuring informed consent. Nurses must also stay current with evolving MAiD legislation and institutional policies to practice within their scope and uphold ethical standards.

9. Leadership

“Individuals with cancer and their families are entitled to care within a system that has patient-focused, professional leadership” (CANO, 2015, p. 22).

Implications

- Oncology nurses demonstrate leadership by advocating for institutional policies and resources that promote ACP education and guide nursing practice.
- An experienced oncology nurse can lead an initiative to implement standardized ACP training for nursing staff.
- Nurses in leadership roles advocate for ACP nursing education and policy enhancement.

Final “Checklist” to ACP Conversations [Slide XXIV]

Before the Conversation

- Assess readiness
- Have resources available
- Identify appropriate timing

Starting the Conversation

- Use simple, direct language
- Ask open-ended questions
- Normalize ACP as a routine part of cancer care

During the Conversation

- Explore what is important to the patient
- Discuss support system
- Include cultural and spiritual considerations
- Address any concerns or fears the patient expresses
- Clarify patient preferences for treatments and EOL care

After the Conversation

- Document the discussion in the patient’s medical record
- Share information with the healthcare team
- Revisit as needed

Case Studies [Slides XXV-XXVIII]

Option 1: Case Study

Mr. Smith is a 78-year-old gentleman diagnosed with Stage IV colorectal cancer with metastases to the liver and lungs. He is currently receiving palliative chemotherapy. He lives in his own home with his wife. Mr. Smith's two adult children and sister live in the same community. He has experienced a recent decline in functional status, increased shortness of breath, reduced appetite, and weight loss. A recent CT scan showed disease progression. Mr. Smith and his wife have returned to the outpatient cancer clinic for follow-up with his cancer care team.

During the clinic visit, Mr. Smith says to the oncology nurse:

- *“My CT scan showed my cancer has progressed. The oncologist said there are no more treatment options. My symptoms are worse. I am not sure what is next for me. I am worried about my wife and how she will handle my care.”*

First, the nurse acknowledges the patient's concerns and addresses the physical symptoms.

- *“Mr. Smith, these are important concerns. First, can you tell me how the recent weight loss and changes in your appetite are affecting you? Can you tell me about any discomfort you might be experiencing?”*
- **Address the patient's medical needs first.**

Secondly, the nurse recognizes the opportunity to gently initiate ACP conversations.

- Use simple, direct language: *“Now that we have a plan for managing your pain, we want to make sure your wishes for your care are understood and respected. Who would you like to be involved in making decisions about your care?”*

Option 2: Use the REMAP Framework to guide the conversation.

Reframe: Expect Emotion

“It is difficult to talk about planning for future health care. You don’t have to feel pressure to make decisions.”

Expect Emotion: Mapping: Align Goals

“Have you thought about who would speak for you if you could no longer communicate your wishes? Have you thought about what your goals of care are? What conversations have you had with your family or health care team about this?”

Planning

“Have you heard of Advance Care Planning? Would it be helpful if I shared some information about this? Here is a brochure on ACP. We can discuss ACP at any time.”

Option 3: Role Playing (more appropriate for in-person education)

Using the same scenario above, look for two volunteers in the group. One takes on the role of the patient, the other the nurse. Both participants have a script.

Nurse:

“Mr. Smith, you mentioned during your last visit that you are wondering about your care. That is an important topic to talk about. Would it be okay if we discussed what is most important to you regarding your future care?”

Mr. Smith:

“Yes, I don’t want unnecessary tests and treatment, but I do want care that makes me feel better and in control.”

Nurse:

“I understand. Have you thought about what goals you have for your care? What is important to you? Can you share with me who would speak for you if you were not able to?”

Mr. Smith:

“I want to stay at home as much as possible, and my wife should be the one speaking on my behalf. But I don't want to burden my wife and children with making decisions.”

Nurse:

“Thank you for sharing that. Have you heard of Advance Care Planning? It helps ensure your wishes are known and respected. It can help families and your cancer care team.”

Mr. Smith:

“Are you asking me these questions because my time is near?”

Nurse:

“No. An Advance Care Plan is not just for patients in your situation. All individuals should think about an Advance Care Plan.”

Mr. Smith:

“What if I make a plan and I change my mind?”

Nurse:

“You can change any part of your advance care plan at any time.”

Mr. Smith:

“Maybe.... I will think about it.”

Nurse:

“Here is a brochure on ACP. And here is the number of our nursing line. If you have questions, please call or write them down for the next visit. Any of our nurses can talk to you about your ACP.”

Conclusion

Thank you for your participation. We hope this education session will encourage you to engage in ACP conversations with your patients (and even your loved ones).

As we conclude today's session, there will be a follow-up assessment to measure your growth in ACP knowledge. Your responses will help us evaluate the effectiveness of this education and guide future improvements.

In three months, you will receive an email inviting you to participate in an oncology nursing focus group. The purpose of this focus group is to gather feedback on the educational resource, assist with its evaluation, and identify any remaining knowledge gaps that may need to be addressed.

Thank you.

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Measuring Advance Care Planning Competency

This pre- and post-test will be administered to participants before and after the education session.

Using a similar tool will enable the measurement of changes in knowledge, attitudes, and competence related to ACP, thereby capturing the effectiveness of the education provided. The correct answer to each question is in red, bold text.

Pre Education Multiple Choice

Section One: General Knowledge of Advance Care Planning

1. What is Advance Care Planning (ACP)?

- a) **A process that helps individuals plan and communicate their future healthcare preferences**
- b) A method for healthcare providers to decide on a treatment plan
- c) A legal document that replaces all medical decisions
- d) Scheduling appointments for cancer treatments

2. What is a common barrier to ACP engagement?

- a) **Limited public knowledge and low awareness of the benefits of ACP**
- b) Increased awareness of ACP and its benefits
- c) Clear and direct language used in ACP discussions
- d) Cultural sensitivity to discussing end-of-life care and future healthcare decisions

3. **What barrier can delay ACP discussions?**
- a) Immediate acceptance of illness and readiness to plan
 - b) High confidence in predicting disease progression
 - c) **Patient and family uncertainty about disease trajectory**
 - d) Lack of interest in maintaining hope during illness
4. **What is the primary role of a Substitute Decision Maker (SDM)?**
- a) To make healthcare decisions based on their own opinions
 - b) **To advocate for the patient's wishes, values, and best interests during critical healthcare moments**
 - c) To provide legal advice to the patient
 - d) To schedule medical appointments for the patient
5. **How can nurses support patients and families in the SDM process?**
- a) By choosing the SDM for the patient
 - b) **By sharing resources and ensuring the SDM is documented in the patient's chart**
 - c) By making healthcare decisions on behalf of the patient
 - d) By excluding family members from decision-making discussions
6. **Which of the following is NOT one of the Five Steps to Advance Care Planning?**
- a) Think: Reflect on personal values and what matters most regarding care
 - b) Choose: Name a Substitute Decision Maker (SDM)
 - c) **Act: Documentation of a family member's wishes**
 - d) Record: Document wishes and preferences about care

Section Two: Stages of Change in ACP (Transtheoretical Model)

The next two questions reflect the Stages of Change. Understanding these stages helps gauge readiness to engage in ACP conversations. The five stages are precontemplation, contemplation, preparation, action, and maintenance.

7. **In which stage of change is a patient who says, "I am thinking about ACP, but I am not ready to make those decisions"?**
 - a) Precontemplation
 - b) Preparation
 - c) **Contemplation**
 - d) Action

8. **What is an appropriate nursing approach during the Precontemplation stage?**
 - a) Provide detailed ACP brochures and encourage immediate action
 - b) Help the patient identify values and preferences for care
 - c) Reinforce regular reviews and updates of ACP
 - d) **Normalize ACP and gently raise awareness without pressure**

Section Three: Oncology Nursing Practice

9. **How do the Canadian Association of Nurses in Oncology (CANO) practice standards support ACP in oncology nursing?**
 - a) **By providing a framework to ensure high-quality patient care across the cancer continuum**
 - b) By focusing solely on clinical treatments and procedures
 - c) By limiting the role of oncology nurses in ACP discussions

- d) By encouraging nurses to delegate ACP responsibilities to physicians only

10. Why are oncology nurses well-positioned to engage in ACP discussions?

- a) **They have trusting, therapeutic relationships with patients and families**
- b) They are focused on administering treatments and medications
- c) They avoid discussing sensitive topics like ACP to reduce patient distress
- d) They have a professional relationship with patients, focused mainly on clinical procedures

11. Which of the following is NOT a way oncology nurses demonstrate leadership in ACP?

- a) Advocating for policies and resources that support ACP education and documentation
- b) Mentoring colleagues and fostering a culture that encourages ACP conversations
- c) **Avoiding discussions about ACP to prevent patient discomfort**
- d) Championing ACP initiatives within their institution

12. Which of the following is an important step to take *after* an ACP conversation?

- a) Use simple, direct language when starting the conversation
- b) Explore what is important to the patient during the conversation
- c) **Document the discussion in the patient's medical record**
- d) Ask open-ended questions at the beginning of the conversation

Post Education Multiple Choice

Section One: General Knowledge of Advance Care Planning (ACP)

1. **What is the primary goal of ACP?**
 - a) To prepare patients for oncology treatment
 - b) **To prepare patients and families for future healthcare decisions**
 - c) To connect patients with palliative care
 - d) To be used by patients for the end of life (EOL) only
2. **How can nurses identify opportunities to initiate ACP conversations?**
 - a) Only during formal appointments
 - b) **When patients express concerns about treatment or end-of-life issues**
 - c) When patients express concerns about treatment
 - d) Nurses should not initiate these conversations
3. **Which of the following is NOT an important topic to cover in ACP conversations?**
 - a) A patient's values and beliefs
 - b) Identification of a substitute decision-maker
 - c) **Detailed cancer-related treatment protocols**
 - d) Documentation of advance healthcare directives
4. **Why is communication important in ACP?**
 - a) **To ensure a patient's wishes are clearly understood and respected**
 - b) To avoid involving the family
 - c) To shorten hospital stays
 - d) To make decisions without patient input

5. **What is a substitute decision maker?**

- a) A person who helps with daily activities like cooking and cleaning
- b) A healthcare professional who provides medical treatment
- c) **Someone appointed by an individual to make healthcare decisions on behalf of a patient if they are unable to do so**
- d) A family member who visits regularly

Section Two: Stages of Change in ACP (Transtheoretical Model)

The next three questions reflect the Stages of Change. Understanding these stages helps gauge readiness to engage in ACP conversations. The five stages are precontemplation, contemplation, preparation, action, and maintenance.

6. **A patient says, “I’m just focusing on my treatment right now and do not want to talk about anything else”. Which stage of change is this patient in?**

- a) Contemplation Stage
- b) **Precontemplation Stage**
- c) Preparation Stage
- d) Action Stage

7. **Your patient says, “I want to make sure my family and health care team know my wishes and that I’m comfortable.” Which stage of change does this represent**

- a) Preparation Stage
- b) **Contemplation Stage**
- c) Maintenance Stage
- d) Precontemplation Stage

8. A patient has completed their advance directive (AD) but wants to update it after a recent health change. Which stage does this indicate?

- a) Precontemplation Stage
- b) Preparation Stage
- c) Action Stage
- d) **Maintenance Stage**

Section Three: Oncology Nursing Practice

9. When should nurses document ACP discussions?

- a) Only if the patient requests the conversation to become part of their chart
- b) **Immediately after the conversation**
- c) At the end of treatment only
- d) Documentation is not necessary

10. What should a nurse do if the patient has difficulty expressing their wishes during ACP?

- a) **Encourage open-ended questions and engage in active listening**
- b) Make decisions on behalf of the patient
- c) Avoid the conversation altogether
- d) Ask the family member to speak on behalf of the patient

11. What is an advance directive?

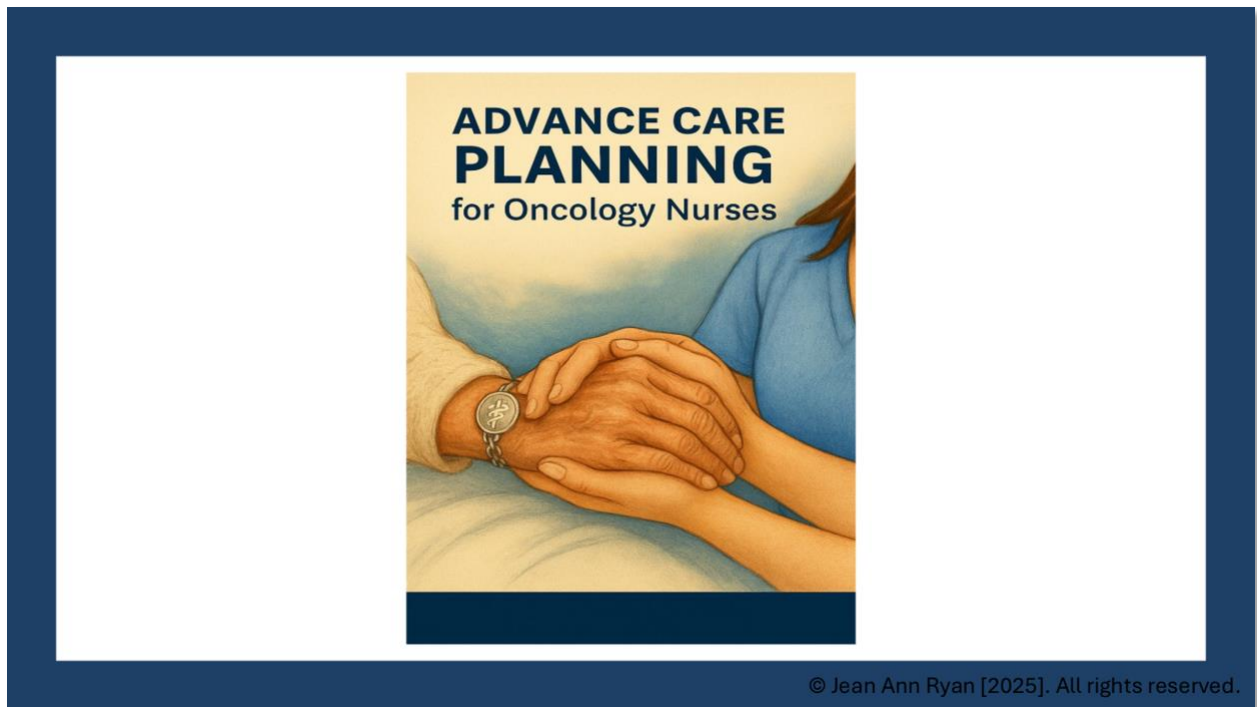
- a) **A legal document that records a patient's wishes for future healthcare**
- b) A schedule for chemotherapy
- c) A list of medications
- d) A hospital discharge form

12. Why is it important for nurses to reflect on their own values and beliefs regarding ACP?

- a) To promote their own beliefs to patients
- b) **To ensure personal biases do not interfere with patient care**
- c) To decide the best treatment without patient input
- d) It is not important to engage in self-reflection

Appendix E: ACP Educational Resource: PowerPoint Presentation

Slide I



Slide II

Learning Objectives

By the end of the session, the oncology nurse will:

1. Define Advance Care Planning (ACP)
2. List three benefits and challenges of ACP
3. Describe the five steps to ACP
4. Identify two common misconceptions about ACP
5. Explain the role of oncology nurses in ACP
6. Understand how patient and nurse readiness affects ACP engagement
7. Discuss two effective strategies for enhancing ACP communication
8. Engage in a case study to practice facilitating ACP conversations
9. Complete a competency assessment tool to measure confidence and skill level in facilitating ACP

Slide III

Pause and Reflect

Have you been involved in ACP discussions?

What factors influenced the conversation?

Do you see a role for oncology nurses in ACP conversations?

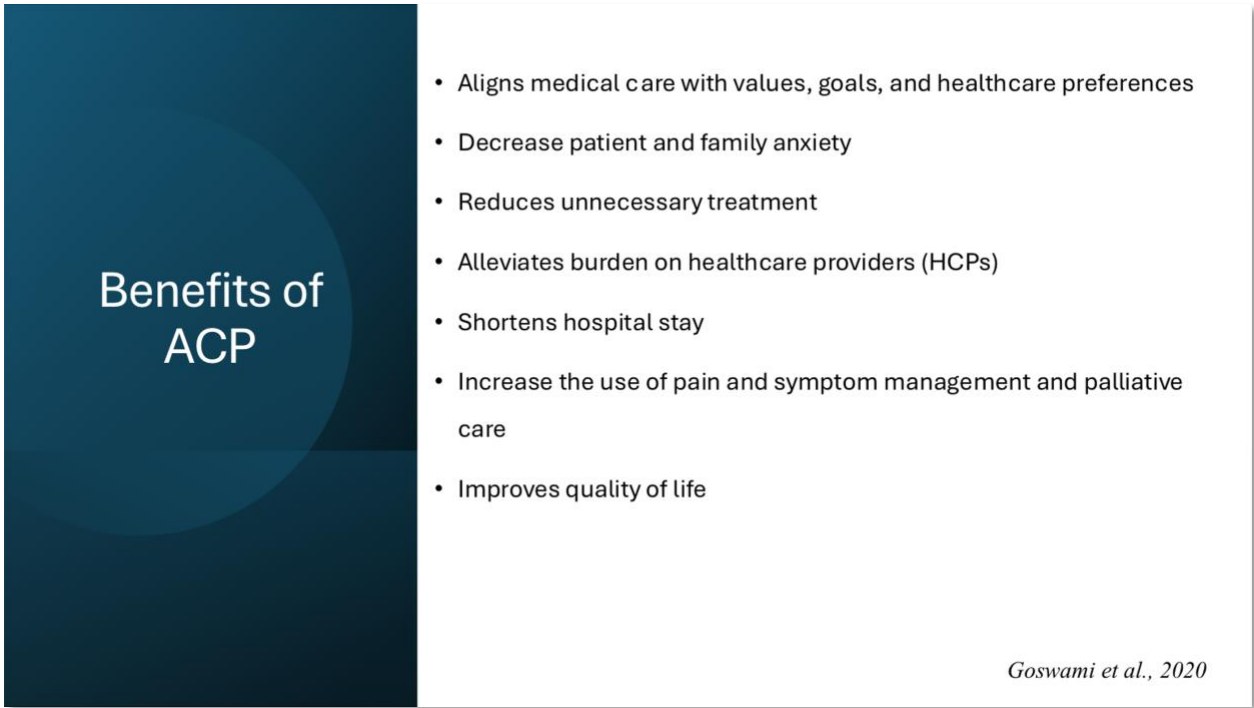
Slide IV

What is Advance Care Planning?

A process of reflection and communication where a capable individual makes decisions about their future healthcare, personal care, and end-of-life (EOL) care in the event they are unable to provide informed consent.

Advance Care Planning Canada, 2024

Slide V



Benefits of ACP

- Aligns medical care with values, goals, and healthcare preferences
- Decrease patient and family anxiety
- Reduces unnecessary treatment
- Alleviates burden on healthcare providers (HCPs)
- Shortens hospital stay
- Increase the use of pain and symptom management and palliative care
- Improves quality of life

Goswami et al., 2020

Slide VI

Canadians' Engagement in ACP

- 93% of Canadians believe it is important to discuss ACP with loved ones
- Less than 50% engage in these conversations
- 17% of Canadians have a documented ACP
- 7% had ACP conversations with their health care provider (HCP)

ACP: Pan-Canadian Framework, 2020

Slide VII

Factors Affecting Engagement

- Limited knowledge and public awareness
- Associate ACP with EOL life care
- Demographic influences on ACP engagement
- Challenges for lower socioeconomic (SES) populations
- Cultural influences
- Psychosocial and emotional barriers (such as unclear disease trajectory)
- Readiness to engage in ACP

Johnson et al., 2016; Siden et al., 2022; Teixeira et al., 2014

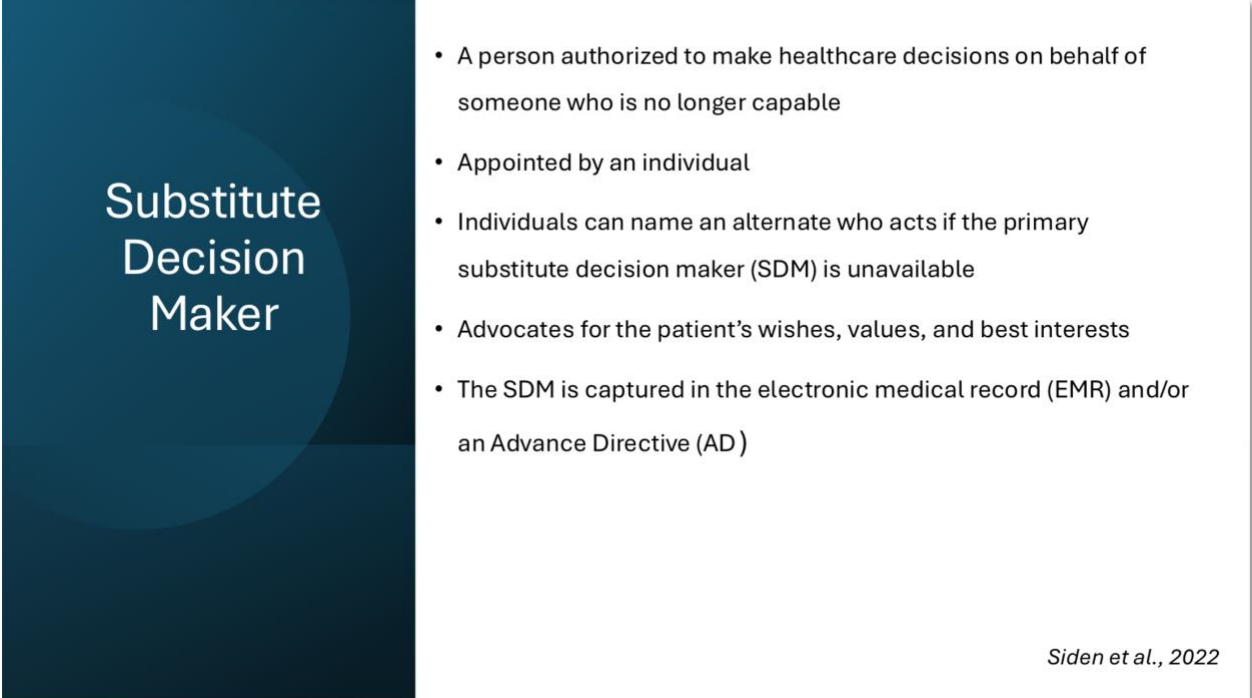
Slide VIII

Five Steps to ACP

- 1**
Think – Reflect on your values and the kind of care you want
- 2**
Learn – Gather information about your health options
- 3**
Choose – Make decisions about your healthcare preferences
- 4**
Talk – Talk about your decisions with loved ones and healthcare providers
- 5**
Record – Document and update your plan as needed over time

Advance Care Planning, 2020

Slide IX

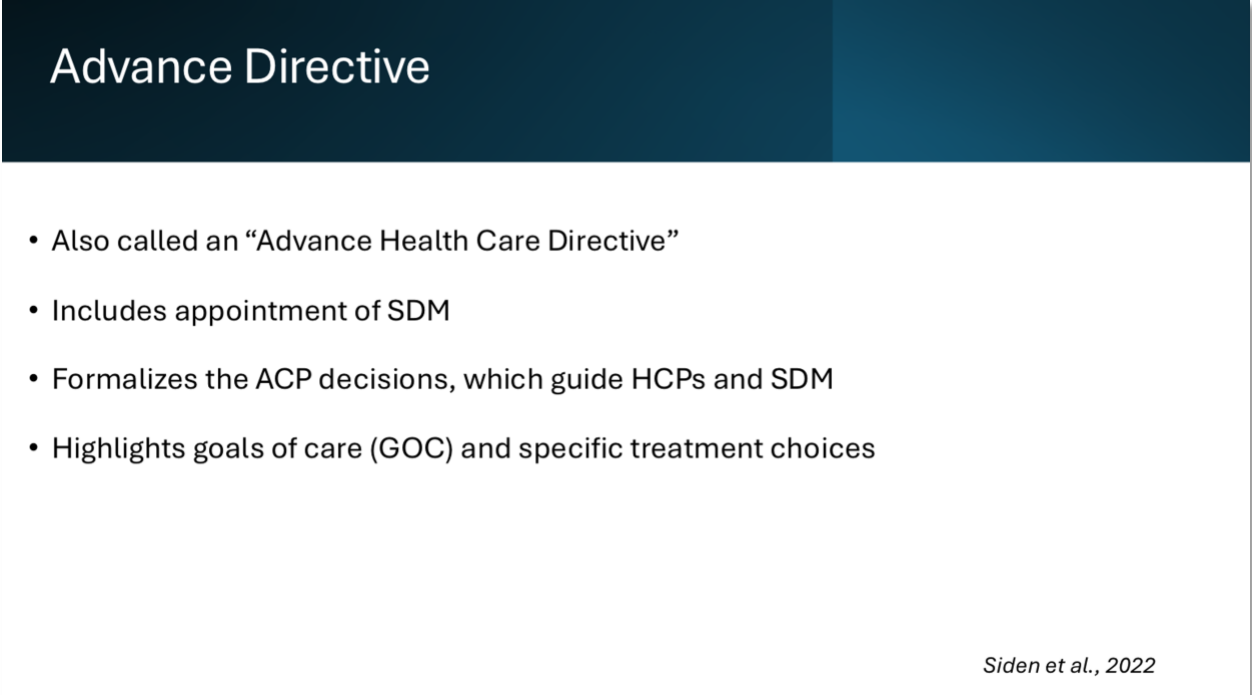


Substitute Decision Maker

- A person authorized to make healthcare decisions on behalf of someone who is no longer capable
- Appointed by an individual
- Individuals can name an alternate who acts if the primary substitute decision maker (SDM) is unavailable
- Advocates for the patient's wishes, values, and best interests
- The SDM is captured in the electronic medical record (EMR) and/or an Advance Directive (AD)

Siden et al., 2022

Slide X



Advance Directive

- Also called an “Advance Health Care Directive”
- Includes appointment of SDM
- Formalizes the ACP decisions, which guide HCPs and SDM
- Highlights goals of care (GOC) and specific treatment choices

Siden et al., 2022

Slide XI

Components of AD

Appointment of SDM

Specifies preferences for EOL care, including resuscitation and ventilation

Includes details on medical treatments, such as feeding tubes or pain management

The AD must be signed, witnessed, and, depending on the jurisdiction, sometimes notarized

Siden et al., 2022

Slide XII

Legal Considerations

In 1995, the Govt of Newfoundland and Labrador (NL) established the Advance Health Care Directives Act

You do not need a lawyer to have a SDM or an AD

Some SDMs are appointed through legal processes (power of attorney): most are identified informally

Advance Health Care Directive Act, Newfoundland and Labrador, 1995

Slide XIII

Challenges to ACP

Patient
level

Provider
level

System
level

Slide XIV

Common Misconceptions about ACP

- For older individuals or those with a serious, life-limiting illness
- It cannot be changed
- It is a legal process that requires a lawyer
- The conversation is a “physician’s” role
- It takes too much time
- Patients do not want to talk about ACP
- It interferes with “hope”

Slide XV

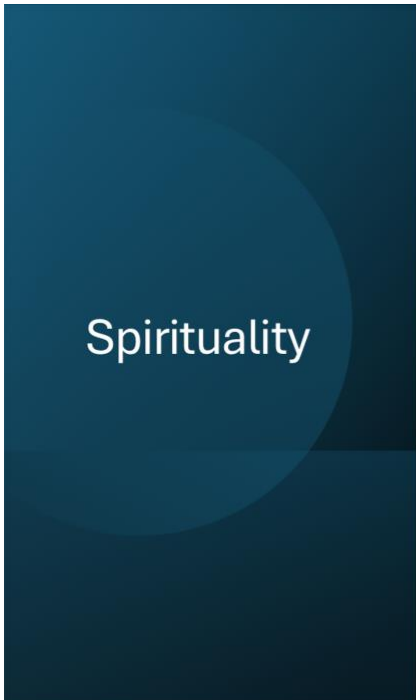


Ensuring
Equitable
Care

Everyone has the right to engage in ACP

- Cultural considerations
- Language considerations
- Lower Socioeconomic status
- Health Literacy

Slide XVI



Spirituality

Spirituality is often an overlooked dimension of ACP

Acknowledge:

- Patients' sources of spiritual strength
- Community ties
- Belief systems
- Rituals

Lutz et al., 2018

Slide XVII

Medical Assistance in Dying (MAiD)

- For some individuals, MAiD is a part of ACP
- Understand your role in MAiD conversations
- Review your regulatory body's position
- Be aware of institutional policies and guidelines
- Ensure your practice aligns with legal requirements
- Understand how to mobilize resources for patients

Canadian Nurses Protective Society, 2025

Slide XVIII

Goals of Care (GOC) Designation: Why it Matters to ACP

R: All medical care and interventions, **including** resuscitation

M: All medical care and interventions, **excluding** resuscitation

C: Medical Care and Interventions, focused on comfort care. A diagnosis exists which is expected to cause eventual death

C2 - End-of-Life Care

Why is it important to ACP?

- Prevents unwanted (or futile) aggressive interventions
- Offers clarity to healthcare teams
- Can be revised or changed by the patient or SDM over time

Eastern Health, 2016

Slide XIX

Barriers to Nurse ACP Engagement

- Role ambiguity
- Insufficient knowledge
- Lack of confidence in communication skills
- Lack of understanding of the process of ACP
- Lack of awareness of resources
- Absence of organizational infrastructure
- Fear of upsetting patients and diminishing hope

Kilgore et al., 2025; Shih & Lu, 2024; Rietze & Stajduhar, 2015

Slide XX

“REMAP” Framework

Reframe the Conversation

- *“What goals for your care have you communicated to your team?”*

Expect emotion

- Be prepared for this conversation to feel “heavy”.

Map out patient goals

- Ask open-ended questions to help the patient think about the values that should guide treatment.

Align with goals

- Help the patient reach awareness of how treatment aligns with goals.

Propose a plan

- *“This brochure has information on ACP”.*
- *“Is that something we could discuss on your next visit?”*

Childers et al., 2017

Slide XXI

Transtheoretical Model (TTM)

TTM is a model for understanding behaviour change

Used as a tool to assess ACP readiness

Guide the nurses' approach to ACP conversations

Stages of Change

- **Precontemplation** – Not thinking about change
- **Contemplation** – Thinking about change, but not ready to act
- **Preparation** – Getting ready to act
- **Action** – Taking steps toward change
- **Maintenance** – Sustaining the change over time

Prochaska & Velicer, 1997


Slide XXII

Implications for Oncology Nursing Practice

The Canadian Association of Nurses in Oncology (CANO) governs oncology nursing practice in Canada

CANO's practice standards can be used to shape our role in supporting ACP initiatives

Slide XXIII




CANO
Practice
Standards

1. Holistic Care
2. Family Centred Care
3. Self-Determination and Decision -Making
4. Navigation
5. Coordinated Care
6. Supportive, Therapeutic Relationship
7. Evidence-Based Care
8. Professional Care
9. Leadership

Canadian Association of Nurses in Oncology (CANO), 2015

Slide XXIV



ACP
Communication
“Checklist”

Before the Conversation

- Readiness; resources; timing

Starting the Conversation

- Use simple, direct, open-ended questions

During the Conversation

- Explore what is important to the patient; support system

After the Conversation

- Document the discussion in the patient’s EMR : revisit as needed

Slide XXV

Case Study Revisit Mr. Smith's Scenario

- 78-year-old male, diagnosed with Stage IV colorectal cancer
- Palliative chemotherapy no longer working: no other treatment options
- CT scan confirmed recent progression
- Declining functional status; reduced appetite, weight loss, increasing fatigue
- Lives with wife; two adult children nearby

Slide XXVI

Identify the Opportunity

“My treatment is not working, and there are no more options.”

R: Reframe the Conversation

“I am sorry to hear this. Can you tell me what is important to you in this phase of your cancer care journey?”

E: Expect Emotion

“It is okay if this conversation feels emotional. These conversations are difficult.”

M: Map Out the Patient's Goals

“What matters most to you as you think about the future?”

A: Align with Patient Goals

“I understand you want to be comfortable at home.”

P: Propose a Plan

“This brochure has information on ACP. Would you be open to continuing this conversation at our next visit?”

Slide XXVII

Revisit the Conversation



- *“The last time we spoke, we discussed your goals of care and advance care planning.”*
- *“How did the information guide the conversations with your family?”*
- *“Are there things about your future care that you would like your cancer care team to know?”*

Slide XXVIII

Desired Outcome

Mr. Smith designates his wife as the SDM

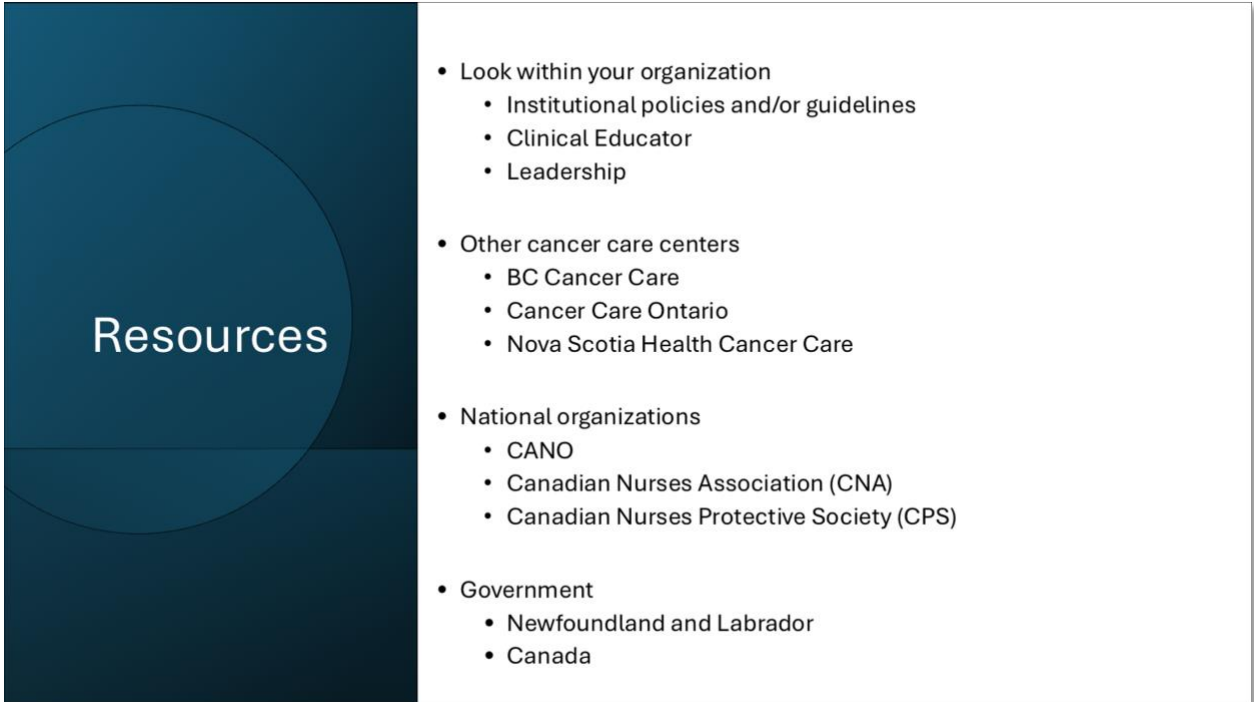
Communicates comfort-based care

The patient is referred to the pain and symptom management team and the community health nurse

Patient and family express relief at clarity in goals

EMR updated with ACP information

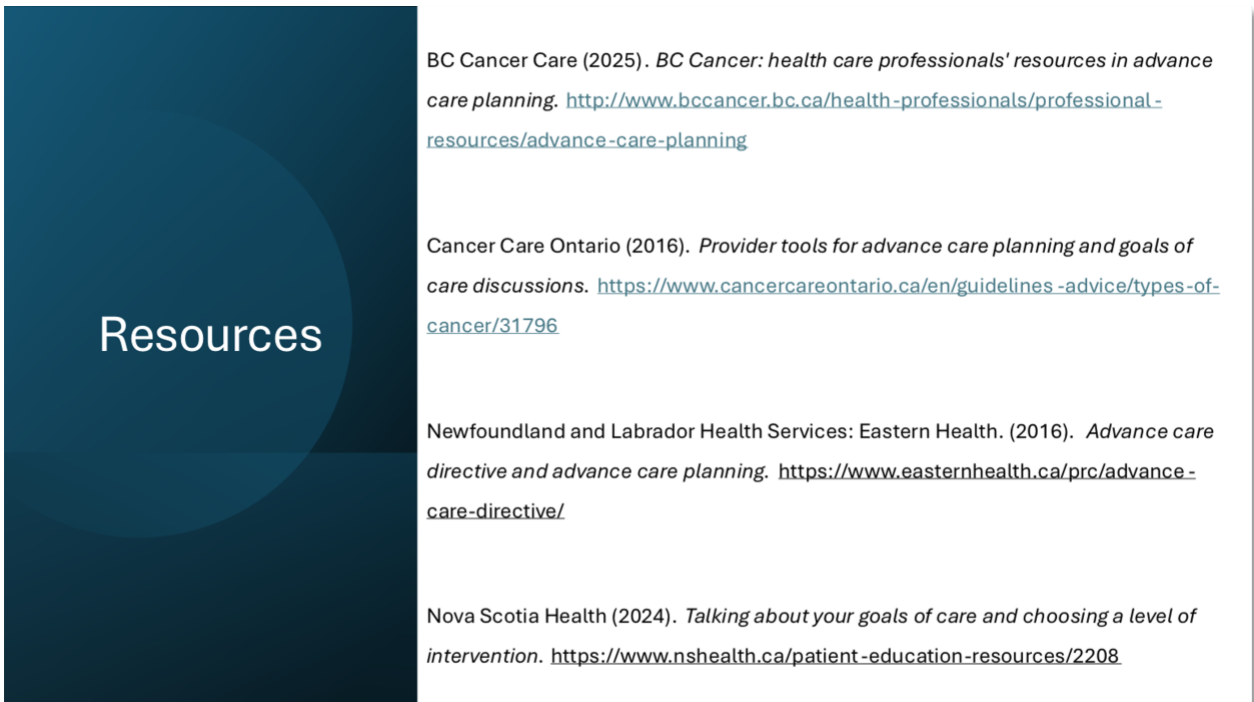
Slide XXIX



The slide features a dark blue background on the left with a large, lighter blue circle containing the word "Resources" in white. The right side of the slide is white and contains a bulleted list of resource categories and specific organizations.

- Look within your organization
 - Institutional policies and/or guidelines
 - Clinical Educator
 - Leadership
- Other cancer care centers
 - BC Cancer Care
 - Cancer Care Ontario
 - Nova Scotia Health Cancer Care
- National organizations
 - CANO
 - Canadian Nurses Association (CNA)
 - Canadian Nurses Protective Society (CPS)
- Government
 - Newfoundland and Labrador
 - Canada

Slide XXX



The slide features a dark blue background on the left with a large, lighter blue circle containing the word "Resources" in white. The right side of the slide is white and contains four paragraphs of text, each providing a citation and a URL for a resource.

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Slide XXXI

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Slide XXXII

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