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Application of Family-Centered Advance Care Planning in Hospice Care Patients

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Abstract

Objective: To analyze the application effect of family-centered advance medical care plans in patients requiring palliative care. **Methods:** Sixty patients with cancer requiring palliative care, admitted to the hospital between January 2024 and December 2025, were included in the study. Thirty patients receiving routine care were selected as the control group, and 30 patients receiving a family-centered advance medical care plan intervention were selected as the study group. Quality of life and nursing satisfaction were compared between the two groups. **Results:** Before the intervention, there was no statistically significant difference in the scores of the Chinese version of the Adult Cancer Survivors Quality of Life Scale between the two groups ($P > 0.05$). After the intervention, the scores in the study group were higher ($P < 0.05$), and the patient satisfaction in the study group was higher than that in the control group ($P < 0.05$). **Conclusion:** Applying family-centered advance care planning interventions to patients in palliative care can effectively improve their quality of life and satisfaction, demonstrating high practical value.

Keywords

Family-centered care; advance planning; palliative care; quality of life; satisfaction

Patients with advanced malignant tumors have complex and varied physical symptoms and are prone to over-medicalization, decision-making conflicts, and increased physical and mental suffering in the terminal stage. Effective palliative care can provide patients with comprehensive physical and mental care and help them maintain dignity and quality of life at the end of their lives [1]. Advance medical care planning, as a new medical decision-making model, can help conscious terminally ill patients clarify their end-of-life medical wishes in advance [2], which is highly consistent with the intervention concept of palliative care [3]. Terminally ill patients have a high degree of dependence on their families in medical decision-making and daily care [4]. Based on this, this study will analyze the application effect of family-centered advance medical care planning in palliative care patients.

1. Materials and Methods

1.1 General Information

The study included 60 hospital-admitted cancer patients requiring palliative care, admitted between January 2024 and December 2025. Thirty patients receiving routine care were included in the control group, while 30 patients receiving a family-centered advance medical care intervention were included in the study group. The control group consisted of 16 males and 14 females, aged 45-67 years (mean 55.63 ± 5.42 years), with 12 having primary school education, 13 junior high school education, and 5 having senior high school education or above. The study group consisted of 17 males and 13 females, aged 45-68 years (mean 56.08 ± 5.56 years), with 11 having primary school education, 12 junior high school education, and 7 having senior high school education or above. There were no

statistically significant differences in general characteristics between the two groups ($P > 0.05$), indicating comparability. This study has been approved by the hospital ethics committee.

1.2 Methods

The control group received routine nursing care: dynamic assessment and standardized management of patients' end-stage symptoms (pain, dyspnea, nausea, insomnia, fatigue, etc.), administration of medications as prescribed by the physician; assistance with basic daily living care; routine reassurance of patients and their families regarding negative emotions, and answering related questions about diagnosis and treatment; and informing patients and their families of the basic content of palliative care, hospitalization-related precautions, and basic care knowledge.

The research team selected family-centered advance care planning interventions, as follows:

(1) Week 1: 1) Communicate with the patient and their family (2 times, 25-30 minutes each time) to understand the patient's and family's awareness and perspectives on the disease, as well as the problems encountered during treatment, and comprehensively assess the patient's family relationships. 2) Distribute a family-centered advance care planning brochure, conduct relevant education, and guide the patient to clarify nursing goals and complete the worksheet. 3) Establish a WeChat group: With the consent of the patient and their family, establish a WeChat group for online education by medical staff and for patients and their families to consult on issues.

(2) Week 2: 1) Conduct a card game (2 times, 25-30 minutes each time), encourage patients and their families to participate in the peace of mind card game, guide participants to share the content and reasons for their chosen wish cards, and ask participants to talk about their feelings about participating in the game after the sharing. 2) Conduct a family meeting (1 time, 25-30 minutes each time): organize a family meeting to discuss the relevant topics involved in the game in depth, integrate the views of the patient and the main caregiver, and let the family understand the patient's true views, values, and treatment preferences.

(3) Week 3: Patient's wishes record (completion of advance directives): This mainly includes what medical services I want or do not want, what life-sustaining treatment I want or do not want, how I want others to treat me, what I want my family and friends to know, and who I want to help me. With the joint participation of the patient and family, advance directives are signed and compiled into an individualized advance care plan manual to provide decision-making guidance when the patient loses the ability to make decisions later.

(4) Post-discharge follow-up: Conduct telephone consultations with discharged patients to clarify their health status and psychological state after discharge; provide necessary health guidance to patients; dynamically understand changes in patients' own wishes, promote communication between patients and their families, and provide necessary psychological counseling.

1.3 Observation Indicators

(1) Patient quality of life: The Chinese version of the Adult Cancer Survivor Quality of Life Scale was used to assess the patients' quality of life. The scale has 12 items; each item is scored from 1 to 7, and the total score ranges from 47 to 329. The higher the score, the better the quality of life.

(2) Patient satisfaction: The patient satisfaction questionnaire was self-made by the department, and the total score ranged from 0 to 100. The higher the score, the higher the satisfaction.

1.4 Statistical Methods

Statistical analysis was performed using SPSS 26.0 software. Quantitative data conformed to a normal distribution and were expressed as ($\overline{x} \pm s$). Independent samples *t- tests* were used to compare two groups. Categorical data were expressed as the number of cases (percentage) [*n* (%)] and analyzed using the χ^2 test. A *p-value* < 0.05 was considered statistically significant.

2. Results

2.1 Comparison of Patients' Quality of Life

As shown in Table 1, before the intervention, there was no statistically significant difference in the scores of the Chinese version of the Adult Cancer Survivors Quality of Life Scale between the two groups ($P > 0.05$), but the scores were higher in the study group after the intervention ($P < 0.05$); the satisfaction rate of patients in the study group was higher than that in the control group ($P < 0.05$).

Table 1. Comparison of patients' quality of life ($\overline{x} \pm s$ points)

Group	Quality of life		Satisfaction
	Before intervention	After intervention	
Control group (n = 30)	210.63±16.68	241.54±15.73	86.77±8.25
Research group (n =30)	206.77±17.05	260.69±15.29	93.58±6.03
t-value	0.886	6.030	3.650
p-value	0.379	<0.001	0.001

3. Discussion

At present, clinical interventions for advance medical care plans for terminally ill patients with malignant tumors neglect the important leading role of family caregivers in patients' emotional support, home care, and medical decision-making, resulting in the inability to effectively alleviate patients' physical and mental suffering [5]. Therefore, this study included patients and primary family caregivers in the intervention system and implemented family-centered advance medical care plan interventions to make up for the limitations of conventional advanced medical care plan interventions.

This study showed that before the intervention, there was no statistically significant difference in the scores of the Chinese version of the Adult Cancer Survivors Quality of Life Scale between the two groups ($P > 0.05$), while the scores of the study group were higher after the intervention ($P < 0.05$); the satisfaction of patients in the study group was higher than that in the control group ($P < 0.05$). The reason for this is that the family-centered advance care plan intervention simultaneously incorporates joint education, communication of wishes and guidance on clinical symptom management between patients and their families [6], which can effectively sort out the patients' end-of-life medical wishes in advance, thereby reducing the negative symptom experience caused by unknown treatment and excessive fear of invasive procedures, and improving the physical quality of life [7]. It fully respects the patients' medical wishes, avoids ineffective overtreatment [8], thereby reducing the physical and mental damage to patients and improving the overall quality of life. It also fully respects the patients' right to make autonomous medical decisions, giving them a full sense of dignity [9]; by promoting effective communication between patients and their families, it resolves communication barriers, optimizes the patients' end-of-life experience, and significantly improves the patients' satisfaction.

In conclusion, the application of family- centered advance care planning interventions in hospice care patients can effectively improve their quality of life and satisfaction, and has high practical value.

Ethical Approval

This retrospective study was approved by the Institutional Ethics Committee of Shaanxi Provincial People's Hospital. The requirement for written informed consent was waived by the ethics committee due to the retrospective nature of the study, which utilized anonymized clinical data. All procedures were performed in accordance with the Declaration of Helsinki.

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