ABSTRACT

Background: A team-based approach has been advocated for advance care planning (ACP) in nursing homes. While nurses are often put forward to take the lead, it is not clear to what extent other professions could be involved as well.

Objectives: To examine to what extent engagement in ACP practices (e.g. conversations, advance directives), knowledge and self-efficacy differ between nurses, care assistants and allied care staff in nursing homes.

Design: Survey study

Participants/setting: Purposive sample of 14 Belgian nursing homes. Nurses, care assistants and allied care staff (e.g. social workers, physical therapists) completed a survey.

Ethical considerations: Approved by University Hospital of Brussels (B.U.N. 143201834759), as part of a cluster randomised controlled trial (clinicaltrials.gov NCT03521206).

Results: 196 nurses, 319 care assistants and 169 allied staff participated (67% response rate). After adjusting for confounders, nurses were significantly more likely than care assistants to have carried out ACP conversations (OR (odds ratio) 4; 95% CI 1.73-9.82; p<.001) and documented ACP (OR 2.67; 95% CI 1.29-5.56; p<.001); differences not found between allied staff and care assistants. ACP knowledge total scores differed significantly, with nurses (estimated mean difference 0.13 [score range 0 to 1]; 95% CI 0.08-0.17; p<.001) and allied staff (estimated mean difference 0.07; 95% CI 0.03-0.12; p<.001) scoring higher than care assistants. We found no significant differences regarding self-efficacy.

Discussion: While nursing home nurses conducted more ACP conversations and documentation than allied care staff and care assistants, these two professional groups may be a valuable support to nurses in conducting ACP, if provided with additional training.

Conclusions: Allied care staff and care assistants, if trained appropriately, can be involved more strongly in ACP to enhance relational and individual autonomy of nursing home residents, alongside nurses. Future research to improve and implement ACP should consider this finding at the intervention development stage.

Key words: Advance care planning; Knowledge; Nurses; Nursing homes; Self-efficacy; Person-centered care; Autonomy
INTRODUCTION

Advance care planning (ACP) is defined as a process that supports adults at any age or in any stage of health in understanding and sharing their personal values, life goals and preferences regarding future care [1, 2]. ACP focuses on the process of communication based on the framework of person-centered care. It appeals to the ethical principle of autonomy [3]. It has been considered a cornerstone of optimal end-of-life care and best practice long-term care. Because there is poor uptake of ACP in long-term care settings and most related prevalence research is predominantly focused on the number of advance directives [4, 5], there is an increased call for a whole-setting ACP approach. Such approach would improve the organisation and provision of ACP to nursing home residents, by introducing change on multiple levels (resident, family, professional, team, organization), rather than in one aspect only (e.g. giving staff more time) [6]. However, this requires a prolonged and substantial input of human resources and professional motivation [7].

BACKGROUND

Given that care in nursing homes is most often conducted by a multidisciplinary healthcare team, consisting of nurses, care assistants and allied care staff (e.g. social workers, pastoral caregivers, psychologists, physiotherapists) [8–10], recent studies suggest the involvement of different professions in ACP [8]. Doing this, requires appropriate knowledge and confidence in one’s own skills [11–13]. A lack thereof is considered to be a significant barrier to conducting ACP as well a source of moral doubts about what is good to do [6, 14]. Care staff struggles with talking about death and dying, with finding “the right time”, and they fear destroying hope, or are not sure how to communicate about ACP [6, 15]. Understanding such challenges of health professionals was found to be relevant to understanding why it is that ACP is currently underutilized [16]. It is only by identifying different areas of challenges in all involved healthcare professionals in nursing homes that can enable us to improve ACP.

Staff support to help residents and their loved ones engage in ACP can be linked to several ethical principles. While ACP facilitates that an individual’s autonomous wishes are respected, including in situations where they are no longer able to speak for themselves, preferences can change [17]. Proactive engagement in ACP and regularly updating conversations about such preferences, has therefore been suggested to be part of best practice standard daily care. However, organizational factors, including time constraints on an individual care professional, or the lack of clarity concerning responsibilities among the multidisciplinary care team, and poor knowledge and self-efficacy, may be
limiting factors in both the quality and quantity of ACP conversations in these settings, potentially leading to experiences of moral distress. While literature about relational autonomy [18, 19] acknowledges the role of social support in living with chronic illness and making challenging healthcare decisions – most relevant to the frail population in nursing homes -, there is the ethical question of whether we are asking our staff to do something that is acknowledged to be difficult and complex [3], without them being fully prepared and ready to do so. At what point are staff sufficiently knowledgeable or competent, and when do they feel sufficiently experienced and confident to engage in difficult conversations on end-of-life issues, legal aspects of ACP documentation, and guiding residents in making -often hypothetical- proactive healthcare decisions [16]?

While ACP in nursing homes is often put forward as a task primarily for nurses [8, 20], this is likely not sustainable. Important time constraints and inadequate staffing levels of nurses have been reported in many countries [21] and these are often highlighted as an important barrier for high-quality ACP in this setting [22–24]. Involving other care staff might be a possible means to meet the high need for ACP among nursing home residents. Staff in nursing homes is diverse and might have complementary knowledge to support each other in carrying out ACP throughout the organization. Clarifying and emphasizing the role of all staff might therefore be a strategy to avoid putting too much ethically sensitive tasks and affiliated moral pressure on one category of nursing home staff alone, e.g. nurses. Previous studies reported significant differences among care professionals concerning their levels of knowledge about palliative care [25], their self-perceived confidence in end-of-life communication [26, 27] and in the timing of communication with residents about death and dying [28]. It is therefore likely that there are also differences between staff related to ACP, which would impact on the extent to which they could be involved in it. However, this has not been studied to date. We do know from a recent study from Dixon et al [8] (about ACP staffing across settings), that different care professions generally have/take a different role in ACP; with nurses for example often leading ACP conversations, sometimes spiritual counsellors; and that social workers often take the lead in legal matters, as they express a higher level of comfort with legal processes and forms than other care professions. Hence, there is some literature on various staff profiles’ ACP involvement and competencies, but few in nursing homes specifically.

In this study, we aimed to determine to what extent separate professional groups of nursing home staff (nurses, care assistants and allied care staff) differ in terms of their engagement in ACP practices, their ACP knowledge and ACP self-efficacy. Within our study, we aimed to examine ACP with main focus on the communicative process behind ACP, to overcome the documentation-centric view that has been reported not only within practice but also within research [4, 29].
METHODS

Design

A survey study that served as baseline measurement of a cluster randomised controlled trial in nursing homes in Flanders, Belgium, carried out in March and April 2018 (NCT03521206) [30]. Ethics approval was granted by the ethics committee of University Hospital Brussels (2017/31, (B.U.N. 143-201-732-133).

Setting and participants

We purposively recruited 14 nursing homes based on location (province), type of facility (public, private non-profit or for-profit) and number of beds. Nursing homes were eligible if they had at least 100 beds and if the facility manager expressed an explicit motivation to participate. Nursing homes were ineligible if they: 1) had taken part (in the past four years) or were currently taking part in a similar study; 2) had developed – or were planning to develop during the foreseen duration of the trial – an extensive advance care planning policy, as judged by the researchers; 3) were in the process of implementing or had planned organizational/physical changes; or 4) were involved in the development phase of the study. Three types of professional roles in the nursing homes were included in the study: nurses (including head nurses), care assistants and allied care staff (physiotherapists, occupational therapists, social workers, psychologists, spiritual caregivers/pastoral clerks, reference persons for dementia or reference persons for palliative care). Participants were included if they were able to speak and understand Dutch. Students and interns were excluded from participation. We refer to “staff” when reporting results that are applicable to all nursing home staff, regardless of their profession. Formal tasks of each profession, as outlined by regional laws, decrees and guidelines, are reported in Supplementary material 1.

Data collection

In each nursing home, a contact person (i.e. manager, head of care, head nurse or quality coordinator) was designated to identify all eligible staff. Questionnaires were coded by the researchers to ensure pseudonymisation and distributed to all staff of the nursing home by the contact person, accompanied by an information leaflet and return envelope. Staff who agreed to participate, completed the survey and placed it in a sealed envelope in a locked letter box, only accessible to the researchers. In case of non-response, the contact person was asked to send out two reminders, after two weeks and, if needed, another two weeks later [31, 32].
Instrument

We developed and tested a survey to investigate engagement in ACP practices, ACP knowledge, and ACP self-efficacy in nursing home staff [14]. The resulting instrument included one section assessing participants’ characteristics (i.e. age, gender, years of employment in residential care sector, current professional role, educational level, training in palliative care, training in ACP, number of hours working in nursing home/week, number of residents cared for on an average working day), and three sections covering ACP practices, knowledge and self-efficacy. In these sections, respondents were asked if they performed any of the six listed activities in the past six months (‘yes’=1 or ‘no’=0). Total scores for practices ranged from 0 to 1, with higher scores indicating staff carried out more ACP practices. In the knowledge section respondents indicated ‘true’, ‘false’ or ‘I don’t know’ for 11 statements concerning ACP. A ‘true’ answer to a true statement and ‘false’ to a false statement were counted as a correct answer. ‘I don’t know’ was counted as incorrect. Total scores ranged from 0 to 1, with higher scores indicating better knowledge. In the self-efficacy section staff indicated their self-perceived confidence in 12 roles and tasks concerning ACP on a 10-point Likert scale, ranging from ‘little confidence’ (1) to ‘a lot of confidence’ (10), or ‘not applicable’. Total scores ranged from 0 to 10, with higher scores indicating better self-efficacy. ‘Not applicable’ was defined as missing.

Statistical analysis

Characteristics of the sample are presented as frequencies and proportions, mean (standard deviation, SD) or median (interquartile range). Total scores for ACP practices, knowledge and self-efficacy were determined by calculating means per subscale. Cases with missing data in >25% of items per scale were excluded from total score calculations for that particular scale. In order to take the clustering of staff within nursing homes into account, mixed models were fitted with a random intercept for nursing home. Depending on whether the dependent variable was continuous, binary or categorical, generalized linear mixed-models were fitted with normal, binomial or multinomial distribution and with identity, logit or generalized logit link, respectively. Unadjusted analyses included professional role (nurse, care assistant or allied care staff) as fixed effect. Adjusted analyses additionally included gender, educational level, training in advance care planning, years working in the sector and average hours working per week as fixed effects. We checked for multicollinearity between variables by looking at Pearson correlations and Variance Inflation Factors (VIF). None of the VIFs were higher than 2. After a missing data pattern analysis (using the “mice” package in R), we deleted ‘number of residents cared for’ from the model because of a low proportion of usable cases (missing data >5%). All other covariates were retained in the model. Results are presented as unadjusted and adjusted estimated means and estimated mean differences with 95% confidence intervals (CI) for continuous dependent variables and as odds ratio (OR) with 95% CI for binomial or multinomial dependent
variables. Statistical significance was set at an alpha level of <.05. The total mean score of ACP practices is a count variable with excess zeros, and because it included data generation that produces event counts, a log transformation of this variable was not possible [33]. We were therefore not able to test differences between nurses, care assistants and allied care staff, using linear mixed models. Hence, for this subscale, we only show differences on the item level.

**Ethical considerations**

This study was approved as part of a larger trial and was approved by the ethics committee of the University Hospital of Brussels (B.U.N. 143201834759). The research data that are collected via the questionnaires is voluntarily provided by all the staff. By filling in the questionnaire, the participant consented to his/her data being anonymously used in the study, as explained in a letter attached to the questionnaire. Data was pseudonymized to ensure confidentiality. After data-entry, all original data was stored safely on campus. Consistent with university policies and Good Clinical Practice guidelines the electronic (raw) data (without confidential, privacy, sensitive or information that could lead to individual people) will be stored for 10 years.

**RESULTS**

We received 694 questionnaires (67% response rate) and included 684 in the analysis, as 10 staff members did not indicate their professional role. Response rates varied among nursing homes ranging from 46% to 85%. Characteristics of the participating nursing homes can be found in Supplementary Material 2.

**Sample characteristics**

We received questionnaires from 196 nurses, 319 care assistants and 169 allied care staff. Mean age was 40 years, and the majority were female (90% in nurses, 94% in care assistants and 86% in allied care staff). Significantly more nurses (88%; p<0.001; Table 1) and allied care staff (72.6%; p<0.001) were highly educated than care assistants. More than half of all staff were trained in palliative care; nurses significantly more likely than others (82.7%; p<0.001). Fewer than half of all staff had some training in ACP. Median years working in the sector varied from 12 years among nurses (IQR 5-20) to 7.5 (IQR 3-19) among assistants. Nurses worked significantly more hours per week than other professional roles in the nursing home, with a median of 38 (p<0.001) and provided care to a median of 14 residents on an average working day.
Engagement in advance care planning practices

Nurses were more likely to have engaged in most of the ACP practices; they were more likely than care assistants to have performed ACP conversations (OR 6.33; 95% CI 4.06-9.99; p<0.001; Table 2), documented outcomes of such conversations (OR 4.88; 3.31-7.21; p<0.001), estimated a resident’s cognitive capacity to complete an advance directive (3.56; 2.41-5.28; p<0.001) and more likely to have had an ACP conversation with family OR (2.67; 1.75- 4.06; p<0.001). After controlling for potential confounders, the odds of starting an ACP conversation for nurses were four times higher than for care assistants (OR 4.12; 1.73-9.82; p<0.001), and their odds of having documented the outcomes of such conversation were 2.7 times higher (OR 2.67; 1.29-5.56; p=0.008). No significant differences for engagement in the different ACP practices were found between allied care staff and care assistants.

Knowledge of advance care planning

After controlling for potential confounders, nurses were more likely than care assistants to correctly respond that an advance directive (in Belgium) allows a resident to communicate his or her will in case he or she lost cognitive capacity (OR 4.10; 95% CI 1.82-9.24; p<0.001; Table 3); a family member can refuse treatments on behalf of a resident who no longer has cognitive capacity (OR 2.68; 1.57-4.58; p<0.001); according to the Belgian Law on Patient Rights only a negative advance directive is legally binding for professionals (OR 2.07; 1.29-3.31; p=0.003); residents without cognitive incapacity who are not terminally ill have the right to refuse treatment, even if that would lead to death (OR 3.79; 1.59-9.41; p=0.004). Allied care staff and care assistants differed significantly on this latter item only, with the odds of allied staff answering correctly being 4 times higher than in care assistants (OR 4.12; 2.43-6.99; p<0.001).

Total scores on knowledge differed significantly between staff, with nurses scoring on average 0.13 points (adjusted estimated means) higher than care assistants (0.08-0.17; p<0.001; theoretical range 0 to 1), and allied care staff scoring 0.07 points higher than care assistants (0.03-0.12; p<0.001).

Self-efficacy in advance care planning

The unadjusted estimated means for self-efficacy in ACP in nurses differed significantly from those of care assistants on all separate self-efficacy items, with nurses reporting significantly more confidence than care assistants. This ranged from an estimated mean difference of 0.59 (95% CI 0.17- 1.02; p=0.007; Table 4) in performing ACP conversations with people living with dementia, to an estimated mean difference of 1.35 (0.94-1.76; p<0.001) in discussing disease and treatment options with a resident. After controlling for potential confounders, these differences were no longer statistically
significant. All staff reported the lowest confidence levels in their knowledge of legislation related to
ACP, with no significant differences between staff groups (average score of 5.41 ±2.34 (SD) in nurses,
4.26 ±2.39 (SD) in care assistants and 4.42 ±2.46 (SD) in allied care staff; scores are between 0 and
10, with higher scores indicating more self-efficacy). Allied care staff reported lower self-efficacy
than care assistants on almost all items. However, these differences were not significant in either
unadjusted or adjusted analyses. After adjusting for potential confounders, we did not find significant
differences in the total self-efficacy scores between professions.

DISCUSSION

In this study, we found statistically significant but small differences between nurses, care assistants
and allied care staff in terms of their knowledge about ACP, with nurses being significantly more
likely to answer most of the knowledge questions correctly. All nursing home staff, regardless of
profession, engaged only to a limited extent in different ACP practices, with nurses being most likely
to carry out ACP conversations and document their outcomes. We found no significant differences
between professions concerning their self-efficacy in ACP. While nurses seem to engage more in ACP
practices, care assistants and allied care staff may be a valuable support to nurses in conducting ACP,
if provided with additional training to improve their knowledge.

Staff differences found in ACP knowledge were small, with nurses answering slightly more statements
correctly, particularly related to actions that can be taken when the resident no longer has cognitive
capacity and which types of advance directive are legally binding. While differences in education, age
and years of experience may explain these differences [25], these factors were accounted for in our
adjusted analysis. It is an encouraging finding that for most knowledge items, there was a general
tendency to answer correct to the statements across groups, despite differences among groups. This is
encouraging given that studies have reported that nursing home staff who have knowledge of these
aspects of ACP may be more likely to recognize when a resident is eligible for ACP and help initiate a
conversation [27, 34].

Although we found statistically significant differences between professions in their engagement in
ACP practices, this was limited to two specific practices, ACP conversations and documentation. We
did not find differences in engagement in other practices, such as completion of an advance directive
or having conversations with people living with dementia. It has been reported on before that nurses
often are more likely than other professions to get a mandate to engage in ACP or are considered to be
required to do so as part of their job description [12, 20, 35]. Other factors, such as differences in
knowledge, which has been reported as an important staff level barrier to engage in ACP, might also be at play [26, 34].

We found no significant differences among staff regarding their self-efficacy in ACP. This is encouraging, as this is considered to be an important condition for improving ACP [6, 13]. However, this was a surprising finding [26], particularly in light of nurses having better ACP knowledge and engaging more frequently in two important ACP practices. Theory would suggest that those who engage in ACP (practices) would report significantly higher self-efficacy [36, 37]. In fact, in a previous study, we found self-efficacy to be significantly associated with nurses’ engagement in actual ACP [14]. It is possible that some care assistants overestimated their ability to engage in ACP and reported high self-efficacy scores. People with less experience in ACP and with less knowledge about the process may report higher self-efficacy because they have not experienced the challenging aspects of it [38]. Our results highlight the need for future research on the relationship between self-efficacy and knowledge of ACP and nursing home care professionals’ actual engagement in ACP.

To honour resident preferences, competency in providing ACP is a key requirement for all frontline nursing home staff, regardless of their profession. The results reported here can be taken into account when deciding on how to assign roles and responsibilities regarding ACP in nursing homes, and to align training. An international comparison of ACP ‘best practices’, found that social workers (comparable to allied care staff in our study) might have better facilitation skills and understanding of legal aspects of ACP, while care assistants might be well placed for sign-posting need for ACP among residents or family. In addition, considering time constraints and inadequate staffing levels of nurses, with nurses indicating they have little time to combine ACP with other clinical care tasks [8, 22, 24], involving other professions might be a sustainable strategy to meet the high need for ACP in this population [8, 12]. Two recent intervention studies focused on a tiered role systems (with clearly defined roles and responsibilities) showed improved outcomes in ACP [35, 39]. We might however need more research into what the required qualifications for each potential professional role in the ACP process.

Some ethical reflections on involving different nursing home care staff in ACP can be made. ACP is known to entail a broad continuum of activities that can be fraught with ethical issues [40]; it requires sufficient knowledge and self-efficacy to do appropriately. Our research has shown there is an opportunity to integrate ACP across professional fields and for specific training in inter-professional teamwork to include staff with complementary and different profiles in the ACP decision-making process. Current strategies to improve ACP in these settings tend to overlook the diversity of professional profiles available in these settings, pressuring primarily nursing staff to combine ACP with other clinical care tasks that cannot be performed by other-educated staff – a challenge that
became even more visible during the covid-19 pandemic [41, 42]. Such allocation of staff’s time to ACP involves a distributive injustice (unfair or inequitable distribution of finite resources) [43, 44]. Defining clear responsibilities among staff, or assigning an ACP facilitator are among two strategies relevant to ACP that might help overcome this injustice [44]. Because ACP and developing related care plans in advance is personal, ethically sensitive, complex, and nuanced, it requires sufficient knowledge —especially in the ethical and legal aspects of such documents, and timely and skilful communication, that is reliable and trustworthy. However, this and other studies have shown staff often lacks knowledge and confidence in communicating and documenting ACP [14, 27]. This may cause more harm than good, which violates the general tenet of ‘do no harm’ as an underlying principle of ACP [15]. Our study again points to the need for more education for all types of healthcare professionals, in particular care assistants, to reduce the potential harm and ethical and legal implications of failing to initiate timely ACP for those who are sufficiently ready and willing [45].

**Strengths and limitations**

This is the first survey study to have compared nursing home nurses, care assistants and allied care staff with regard to their engagement in ACP practices, and knowledge and self-efficacy concerning ACP. Existing studies in this area were often restricted to one professional group, compared only nurses to care assistants, or did not analyse allied care staff separately but together with care assistants under the heading of ‘healthcare professionals’ [25, 26]. This prevented a differentiated view on ACP among distinct professional groups. Other strengths of this study include its large sample size and fair response rate [46]. Several limitations caution consideration. While there is a possibility of non-response bias among respondents with less interest in ACP, this has likely affected all professional groups, which means that comparisons among them remain valid. The survey instrument has undergone testing for reliability and face validity but not content or construct validation [14]. The reason we used this instrument is that no validated instruments were available at the time to test the outcomes of the trial from which these data were taken [30]. Finally, this study was conducted in a purposively recruited sample of regional nursing homes [30]. We therefore cannot draw conclusions about the absolute levels of ACP practices, knowledge and self-efficacy in the population of nursing home staff in Flanders; only about the differences among professional groups relative to each other.

**CONCLUSION AND IMPLICATIONS**

To enhance autonomy of nursing home residents as part of ACP, it is important care staff is sufficiently equipped to provide guidance along the process. To support nurses in doing so, other care staff might be a potential group to engage too —under the condition they acquire the appropriate
knowledge and are sufficiently confident to do so. In this study, we found that nurses, care assistants and allied care staff in nursing homes differ significantly with regard to their engagement in ACP; with nurses being more likely than others to engage in ACP conversations and documenting its outcomes – as was expected. Significant differences were found among professions’ knowledge about ACP, with nurses and allied care staff responding to knowledge statements more often correctly than care assistants. However, differences were small. We found no statistically significant differences in self-efficacy in ACP. Whereas nurses seem to be taking the lead in performing ACP, care assistants and other allied care staff might potentially support them herein, if given the opportunity to be appropriately trained and mandated. Although nurses’ time constraints and limited staffing levels in nursing homes, should be addressed systematically, to increase capacity to meet the high need for ACP in nursing homes, we could potentially look at other staffing groups too.

ABBREVIATIONS

ACP advance care planning
FTE full-time equivalent
SD standard deviation
EMD estimated mean difference
CI confidence interval

DECLARATIONS

Ethics approval and consent to participate

This study was approved as part of a larger trial and was approved by the Commission of Medical Ethics of the University Hospital of Brussels (B.U.N. 143201834759). Research data collected via questionnaires were voluntarily provided by respondents. Consent from study participants was obtained in writing. By filling in the questionnaire, the participant consented to his/her data being used in the study.

Consent to publish

Not applicable.
Availability of data and materials

The datasets generated and analysed during the current study can made available from the corresponding author upon reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Authors' Contributions

Conception and design of the work: JG, AWvD, LP, LVDB, CG, LD, RV, KD; Ethics approval: JG, AWvD, LP, LVDB; Development and testing of questionnaire: AWvD, LP, LVDB, JG, CG, LD, RV, KD; Statistical data analysis: JG, in close collaboration with professional statistician; Interpretation of data analysis: JG, LP, LVDB. Drafting of the manuscript: JG; Critical revision for important intellectual content: all. All authors have read and approved the final manuscript.

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