Implementation of policies to improve end-of-life decisions in Flemish hospitals: communication, training of professional caregivers and use of quality assessments

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Abstract

Background
The prevalence and implementation of institutional end-of-life policies has been comprehensively studied in Flanders, Belgium, a country where euthanasia was legalised in 2002. Developing end-of-life policies in hospitals is a first step towards improving the quality of medical decision-making at the end-of-life. Implementation of policies through quality assessments, communication and the training and education of professional caregivers is equally important in improving actual end-of-life practice. The aim of the present study is to report on the existence and nature of end-of-life policy implementation activities in Flemish acute hospitals.

Methods
A cross-sectional mail survey was sent to all acute hospitals (67 main campuses) in Flanders (Belgium). The questionnaire asked about hospital characteristics, the prevalence of policies on five types of end-of-life decisions (ELDs): euthanasia, palliative sedation, alleviation of symptoms with possible life-shortening effect, do-not-resuscitate decision, and withdrawing or withholding of treatment, the internal and external communication of these policies, training and education on aspects of end-of-life care, and quality assessments of end-of-life care on patient and family level.

Results
The response rate was 55%. Results show that in 2007 written policies on most types of ELDs were widespread in acute hospitals (euthanasia: 97%, do-not-resuscitate decisions: 98%, palliative sedation: 79%). While standard communication of these policies to professional caregivers was between 71% and 91%, it was much lower to patients and/or family (between 17% and 50%). More than 60% of institutions trained and educated their caregivers in different aspects on end-of-life care. Assessment of the quality of these different aspects at patient and family level occurred in 25% to 61% of these hospitals.

Conclusions
Most Flemish acute hospitals have developed a policy on end-of-life practices. However, communication, training and the education of professional caregivers about these policies is not always provided, and quality assessment tools are used in less than half of the hospitals.
Background

In developed countries, almost one in two of all deaths occurs in a hospital. Only in recent decades have hospitals in the Western world begun to develop formal end-of-life care policies (written position papers or specific guidelines) on the appropriateness of treatments in terminal care and on end-of-life decisions (ELDs), such as non-treatment decisions, terminal sedation and euthanasia. In countries where specific legislation about end-of-life decisions has been established, health care institutions of different stances felt the need to develop policies, to oppose or implement new possibilities or to increase transparency, accountability, consistency and quality of terminal care [1,2].

In the US, Canada and Japan, several studies have been conducted on the prevalence and development of policies and guidelines concerning specific ELDs (physician-assisted suicide, do-not-resuscitate decisions, terminal/palliative sedation) used in specific settings (hospitals, intensive care units) [3-8]. In the Netherlands and in Belgium, where euthanasia was legalised in 2002, more intense and comprehensive research has been performed. In the Netherlands, research on the prevalence and implementation of policies on all ELDs in different settings providing intramural care was begun as early as 1994 [2, 9-12], and repeated in 2005 [13]. In Belgium, in 2002 the prevalence of DNR policies was studied in acute geriatric wards [14]. In 2002, Catholic hospitals and nursing homes were surveyed about the prevalence and implementation of euthanasia policies. In 2005 this survey was repeated in all hospitals and nursing homes [15-17].

The development of end-of-life policies in hospitals is a first step towards improving the quality of medical decision-making at the end-of-life. The implementation of such policies through communication, the training and education of professional caregivers, and through quality assessments is equally important in order to improve actual end-of-life practice. The aim of this study is to report on the existence and practice of these implementation strategies concerning end-of-life policies in Flemish acute hospitals.

This study will to this end address the following research questions:

- What is the prevalence of end-of-life policies in Flemish hospitals five years after the approval of the euthanasia law, the law on patient rights and on palliative care?
- How are end-of-life policies communicated internally and externally by Flemish hospitals?
- What is the availability of training and education in end-of-life practices in Flemish hospitals?
How do Flemish hospitals assess the quality of end-of-life practices offered to patients and families? Are validated and tested measurement tools being used?

Is there a relationship between the characteristics of Flemish hospitals and the different aspects of their quality policies on end-of-life care?

**Methods**

**Design**
A cross-sectional mail survey was conducted from May 2007 to October 2007 in all acute hospitals (67 main campuses) in Flanders (the Dutch speaking part of Belgium). The postal questionnaires were addressed to the management of each institution, with a request to dispatch them to the person judged most suited to provide the answers. A reminder letter was sent to all non-responders two weeks after the first mailing, followed by repeated telephone follow-up after two weeks.

**Definitions**
A policy can consist of two distinct elements: a written position paper (opposing or allowing a specific end-of-life decision) and/or a guideline (a written protocol to guide the caregivers in approaching a problem that includes a decision-making process in a phased plan).

**Questionnaire**
The questionnaire was based partly on similar studies in the Netherlands in 1994 [2] and 2005 [13]. It consisted of 44 questions, divided into four major parts. The first part contained questions about hospital characteristics. The second part surveyed the prevalence of respectively written position papers and/or guidelines on five types of ELDs (euthanasia, palliative sedation, alleviation of symptoms with possible life-shortening effect, do-not-resuscitate decision, and withdrawing or withholding treatment). The third contained questions about internal and external communication strategies pertaining to the policy, and the availability of training and education. The fourth part probed the activities of quality assessment regarding end-of-life care, based on six categories of patient and family outcomes (physical comfort; well-being; access to information and control over treatment decisions; family spiritual, psychological and social well-being; continuity of care across providers and care settings; and family adjustment after death) [18]. We also asked whether specific measurement tools for palliative care such as the Resident Assessment Instrument Minimum Data Set (RAI-MDS), the Resident Assessment Instrument for Palliative Care (RAI-PC), the Palliative care Outcome Scale (POS), and the Edmonton Symptom Assessment System (ESAS), were used, whether the hospital applied a structured approach to palliative care.
(defined as the planning of medical and care procedures, including diagnostic tests, medication and consultations intended to develop an efficient and coordinated treatment programme), and finally whether the end-of-life care policy was integrated into the quality handbook of the institution.

The questionnaire was tested for suitability in the Flemish context with five professionals working in acute hospitals (two general directors, one medical director, a member of the board of directors and a geriatrician). Their comments resulted in a limited number of adaptations.

**Statistical analysis**

Data analyses were performed with descriptive statistics, SPSS software (release 15.0). Categorical variables were compared with use of Fisher’s exact test. P-values less than 0.05 were considered to indicate statistical significance.

**Results**

**Sample description and representativity (Table 1)**

Of the 67 acute hospitals (main campuses) in Flanders, 37 completed and returned the questionnaire, which represents a 55% response rate.

Thirty-eight percent of the hospitals had more than 500 beds. Fifty-nine percent of the participating hospitals had a religious affiliation, and 46% had a palliative care unit. All hospitals had an ethics committee as required by Belgian law.

Characteristics of responding hospitals were similar to the population for size, availability of a palliative care unit, membership of an umbrella organisation and religious affiliation. All differences were statistically non-significant and smaller than 10 percentage points (Table 1). The management of the hospital receiving the questionnaire dispatched it for completion to: a member of the ethics committee (38%), the medical director (14%), a member of the palliative support team (14%) or the general director (8%). The rest of the questionnaires were completed by another person (e.g. nursing director) or by more than one person (e.g. the medical director and a member of the ethics committee) (data not shown).

**Prevalence of ELD-policies (Figure 1)**

Figure 1 shows the prevalence of policies for all ELDs. The prevalence of policies on euthanasia and do-not-resuscitate decisions was over 97% in Flemish hospitals. All but one of the hospitals (97%) in the response sample had a written position and a practical guideline on euthanasia. A high number of hospitals had a written position, a guideline, or both with regard
to palliative sedation (79%) and withdrawing or withholding treatment (76%). The lowest prevalence was found for policies on alleviation of symptoms (60%).

The content of the written policies on euthanasia varies (data not shown). Ten of the surveyed hospitals (28%) leave the decision to apply euthanasia entirely to physicians. One third allows euthanasia in accordance with the law, and another third of the hospitals allows euthanasia provided additional conditions are applied (e.g. additional palliative care procedures and/or individual approval by an ethics committee). No hospitals reported not allowing euthanasia.

**Communication of written positions on ELDs (Table 2)**

Communicating written positions on euthanasia (N=36) to physicians, nurses and external referring physicians, was standard practice in respectively 76%, 82% and 45% of the hospitals. Patients, however, mostly had to place a request in order to receive a copy (53%). The communicating to physicians and nursing staff of the written positions on do-not-resuscitate decisions (N=32), palliative sedation (N=22) and alleviation of symptoms (N=15) was the rule in 87%, 71% and 87% of the hospitals respectively while patients and families receive them on request in 46%, 71% and 62% of the hospitals respectively (Table 2).

**Availability of end-of-life care training and education (Table 3)**

Training and education in pain and symptom control and in spiritual, psychological and social care for patients was widely available to physicians and professional caregivers in acute hospitals (97% and 89% respectively). The lowest percentages were found for communication skills with regard to treatment possibilities and care planning (67%), and for bereavement care (69%). However, almost a quarter of hospitals reported an intention to plan training and education on these topics in the near future (Table 3).

Concerning a structured approach to palliative care, 42% of the hospitals surveyed planned, and 33% had already implemented such an approach. Almost half of the hospitals (43%) mentioned their end-of-life care policy in the quality handbook and 41% planned to integrate the end-of-life care policy in the near future.

**Prevalence of quality assessment in end-of-life care (Table 4)**

Sixty-one percent of the hospitals assess the satisfaction of patients with pain and symptom control, whereas 49% assess patient satisfaction with spiritual, psychological and social care, 33% relatives’ satisfaction with spiritual, psychological and social care, 33% continuity of
care, and 25% bereavement care. Between 19% and 55% of the hospitals reported explicitly
that they do not plan such assessments in the future.
The use of internationally validated and tested measurement tools for palliative care (RAI-
MDS, RAI-PC, POS, ESAS) was very low to non-existent. Only four hospitals (11%)
reported the use of the ESAS, one hospital (3%) the POS, and none of the hospitals the RAI-
MDS or RAI-PC (data not shown).

Relationship between characteristics of Flemish hospitals and different aspects of
quality policy on end-of-life care
There were hardly – with a few exceptions – any significant statistical differences found
according to hospital characteristics (size, presence of a palliative care unit, religious
affiliation). The hospitals with a greater number of beds were more likely to integrate an end-
of-life care vision into the quality handbook (p=0.003). Hospitals with a palliative care unit
were more likely to educate physicians and professional caregivers in communication skills
with regard to treatment possibilities and care planning (p=0.001).

Discussion
This is the first study to probe not only the prevalence and implementation of policies in end-
of-life care in acute hospitals in Flanders but also to assess efforts to implement them through
communication, training and educating professional caregivers, and quality assessments on a
patient and family level. Results show that in 2007 policies on most types of ELDs
(euthanasia, do-not-resuscitate decisions, palliative sedation) were widespread in acute
hospitals. Efforts were being undertaken to communicate these policies internally in hospitals
and to a somewhat lesser extent externally as well. Dependent on the content (65% to 97%),
large numbers of acute hospitals train and educate their professional caregivers in different
aspect of end-of-life care, and in the use of their own end-of-life care policies. Assessment of
the quality of end-of-life practices and patient/family needs is however not yet a common
phenomenon in Flemish acute hospitals.

There are several limitations to the study. The response rate is marginally acceptable (55%)
and could be problematic in a sensitive survey on ethical matters in health care institutions
with different life stances. We sent the survey to the management of hospitals, with a request
to dispatch it to the most appropriate person. This two-step approach may have hampered the response rate by channelling the questionnaire to persons undertaking a variety of functions. Nevertheless, we observed no statistical and relevant differences between sample and population, including religious affiliation, as far as the surveyed characteristics are concerned. We also acknowledge that answers to a questionnaire may be influenced by social acceptability, and may not adequately reflect actual practices within institutions. Hence, bias cannot be excluded.

It is well established that the approval of the euthanasia law in Belgium in 2002 (and of the law on patients’ rights and on palliative care enacted in the same year) resulted in an intensified debate on how to deal with euthanasia requests within Belgian hospitals [16]. This presumably contributed to a prevalence of written policies on euthanasia of approximately 60% in hospitals in 2005 [16]. Meanwhile our results show an almost universal implementation of policies on euthanasia in acute hospitals five years after the approval of the law. However, our data do not permit us to distinguish between hospitals which issue guidelines in order to enhance the quality of care of decision-making and those which do so to impose additional hurdles with the intention of rendering the practice of euthanasia more difficult.

The prevalence of other policies on end-of-life care is also high in Flemish acute hospitals. Policies on do-not-resuscitate decisions are almost universally implemented, following a trend started in 1985 (with a step-up in 1997 and 2001) in acute geriatric wards [14]. There has also been an increase in the number of do-not-resuscitate decisions since 1994, possibly influenced by the increase in do-not-resuscitate policies [14]. The prevalence of palliative sedation policies jumped from 27% in 2005 [16] to 79% in 2007, according to this study, which is remarkable, because this practice was virtually unknown before 2001 [20]. Similarly, the prevalence of policies on non-treatment decisions rose from 14% to 76%, indicating more attention to and regulation of these practices, although they are considered as regular medical practices and are not affected by the euthanasia law. The prevalence of policies on alleviation of symptoms, by contrast, remained stable at 60%. Our study shows that in 2007, in most Flemish acute hospitals, specific policies are available covering a wide array of end-of-life decisions, including euthanasia.
In addition, our study shows that a considerable amount of effort is made in Flemish hospitals to implement existing policies on end-of-life care, though not, however, by all hospitals. Many hospitals do indeed invest in communicating their written positions and in providing training and education on their policies to physicians and professional caregivers, which raises awareness of these instruments [21]. Nevertheless, about 10% of the hospitals surveyed in our study reported that they do not plan to undertake formal training in the use of their own guidelines. It is also clear that in the communication of written positions to patients and/or families, a reactive approach is preferred, limited to personal conversations when patients or family request information. These documents are thus rarely used as a tool to improve shared decision-making and communication regarding end-of-life care [14].

It is encouraging to see that many hospitals offer supportive services such as spiritual, psychological and social end-of-life care to patients, invest in the training and education of their physicians and professional caregivers in several end-of-life care areas and apply or plan to apply a structured care approach to palliative care, and the integration of the end-of-life care vision into the quality handbook.

These results describe an important development in the monitoring of the quality of end-of-life practices in general hospitals in Flanders. Most hospitals have implemented policies and are at the crucial stage of implementing these actively. However, the next step i.e. the introduction of a method of assessment of quality of end-of-life practices and of patients’ needs seems not to be so obvious to them. The number of hospitals that currently measure or plan to measure satisfaction on the patient and family level is low, and in those that do, the effort is often limited to specific departments. A considerable number of hospitals even reported that they do not intend to develop such strategies in the future. Furthermore, internationally validated and tested measurement tools such as the Palliative care Outcome Scale are seldom used, as has been found by other researchers [18]. It is however essential to determine whether activities designed to improve the quality of end-of-life care are actually having an impact. The implementation of quality assessment strategies for this purpose is of vital importance in gaining insight into the quality of the end-of-life care offered to patients and family. Based on these assessments, challenges and opportunities in end-of-life care can be identified and possibly tackled.

In conclusion, our study shows a growing awareness of the importance of end-of-life policies and the implementation of these policies in acute hospitals in Flanders. A continued
investment of resources and cooperation between researchers, healthcare providers, national organizations, and governmental agencies will be needed to sustain such implementation strategies, and to create a measurement-driven approach to quality assurance in end-of-life care.

Competing interests

The authors declare that they have no competing interests.

Authors’ contributions

All authors contributed to the manuscript. The manuscript was drafted by ID, with further input from all other authors. LD, RVS and HRWP are the project supervisors. All authors read, revised and approved the final manuscript.

Acknowledgements

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Reference list


### Tables

**Table 1 - Characteristics of the response sample compared to the overall population of Flemish hospitals in 2007**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Responding hospitals (N=37)</th>
<th>Population (N=67)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size of hospitals (bed capacity)</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>&lt;250 beds</td>
<td>6 (16)</td>
<td>17 (25)</td>
</tr>
<tr>
<td>250-500 beds</td>
<td>14 (38)</td>
<td>27 (40)</td>
</tr>
<tr>
<td>501-750 beds</td>
<td>9 (24)</td>
<td>13 (19)</td>
</tr>
<tr>
<td>&gt;750 beds</td>
<td>8 (22)</td>
<td>10 (15)</td>
</tr>
<tr>
<td>Palliative care unit</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Yes</td>
<td>17 (46)</td>
<td>27 (40)</td>
</tr>
<tr>
<td>Membership in umbrella organisation</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>VVI²</td>
<td>21 (57)</td>
<td>41 (61)</td>
</tr>
<tr>
<td>VOV³</td>
<td>11 (30)</td>
<td>21 (31)</td>
</tr>
<tr>
<td>None</td>
<td>5 (14)</td>
<td>5 (8)</td>
</tr>
<tr>
<td>Religious affiliation</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Catholic</td>
<td>22 (59)</td>
<td>42 (63)</td>
</tr>
</tbody>
</table>

1 Absolute numbers (with rounded percentages in parenthesis)

2 VVI, Verbond der Verzorgingsinstellingen: umbrella organisation that assembles Catholic healthcare institutions in Flanders

3 VOV, Vereniging van Openbare Verzorgingsinstellingen: umbrella organisation that assembles public hospitals in Flanders
### Table 2 - Communication of written positions on all ELDs in Flemish hospitals in 20071-2

<table>
<thead>
<tr>
<th>Position</th>
<th>Standard communication</th>
<th>Communication on request</th>
<th>No communication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Euthanasia (n=36)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians</td>
<td>26 (76)</td>
<td>4 (12)</td>
<td>4 (12)</td>
</tr>
<tr>
<td>Nursing staff</td>
<td>28 (82)</td>
<td>4 (12)</td>
<td>2 (6)</td>
</tr>
<tr>
<td>External referrals</td>
<td>13 (45)</td>
<td>10 (35)</td>
<td>6 (21)</td>
</tr>
<tr>
<td>Patients and/or family</td>
<td>5 (17)</td>
<td>16 (53)</td>
<td>9 (30)</td>
</tr>
<tr>
<td><strong>Palliative sedation (n=22)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians &amp; nursing staff</td>
<td>15 (71)</td>
<td>5 (24)</td>
<td>1 (5)</td>
</tr>
<tr>
<td>Patients and/or family</td>
<td>5 (29)</td>
<td>12 (71)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Alleviation of symptoms (n=15)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians &amp; nursing staff</td>
<td>13 (87)</td>
<td>2 (13)</td>
<td>0</td>
</tr>
<tr>
<td>Patients and/or family</td>
<td>5 (38)</td>
<td>8 (62)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Do-not-resuscitate decisions (n=32)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians &amp; nursing staff</td>
<td>27 (87)</td>
<td>4 (13)</td>
<td>0</td>
</tr>
<tr>
<td>Patients and/or family</td>
<td>13 (50)</td>
<td>12 (46)</td>
<td>1 (4)</td>
</tr>
<tr>
<td><strong>Withdrawing or withholding treatment (n=23)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians &amp; nursing staff</td>
<td>21 (91)</td>
<td>2 (9)</td>
<td>0</td>
</tr>
<tr>
<td>Patients and/or family</td>
<td>9 (45)</td>
<td>11 (55)</td>
<td>0</td>
</tr>
</tbody>
</table>

1 Absolute numbers (with rounded percentages in parenthesis)
2 Between 1 and 7 missing values

### Table 3 - Availability of training and education and other initiatives in end-of-life care in Flemish hospitals in 2007 (N=37)1-2

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Yes</th>
<th>No, but plan to</th>
<th>No, don’t plan to</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Availability of training and education of professional caregivers in end-of-life care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain &amp; symptom control</td>
<td>36 (97)</td>
<td>1 (3)</td>
<td>0</td>
</tr>
<tr>
<td>Spiritual, psychological &amp; social care for patients</td>
<td>33 (89)</td>
<td>4 (11)</td>
<td>0</td>
</tr>
<tr>
<td>Law &amp; regulation</td>
<td>30 (88)</td>
<td>3 (9)</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Training in the use of own guidelines</td>
<td>29 (83)</td>
<td>3 (9)</td>
<td>3 (9)</td>
</tr>
<tr>
<td>Spiritual, psychological &amp; social care for relatives</td>
<td>28 (82)</td>
<td>4 (12)</td>
<td>2 (6)</td>
</tr>
<tr>
<td>Bereavement care</td>
<td>24 (69)</td>
<td>8 (23)</td>
<td>3 (9)</td>
</tr>
<tr>
<td>Communication skills with regard to treatment possibilities &amp; care planning</td>
<td>24 (67)</td>
<td>8 (22)</td>
<td>4 (11)</td>
</tr>
</tbody>
</table>

1 Absolute numbers (with rounded percentages in parenthesis)
2 Between 1 and 3 missing values

<table>
<thead>
<tr>
<th><strong>Availability of other initiatives in end-of-life care</strong></th>
<th>Yes</th>
<th>No, but plan to</th>
<th>No, don’t plan to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration of the end-of-life care policy into the quality handbook</td>
<td>16 (43)</td>
<td>15 (41)</td>
<td>6 (16)</td>
</tr>
<tr>
<td>Structured approach to palliative care</td>
<td>12 (33)</td>
<td>15 (42)</td>
<td>9 (25)</td>
</tr>
</tbody>
</table>

1 Absolute numbers (with rounded percentages in parenthesis)
2 Between 1 and 3 missing values
Table 4 - Prevalence of quality assessment in end-of-life care in Flemish hospitals in 2007 (N=37)

<table>
<thead>
<tr>
<th>Assessment of patient satisfaction with</th>
<th>Yes</th>
<th>No, but plan to</th>
<th>No, don’t plan to</th>
</tr>
</thead>
<tbody>
<tr>
<td>pain &amp; symptom control</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>spiritual, psychological &amp; social care</td>
<td>22 (61%)</td>
<td>7 (19)</td>
<td>7 (19)</td>
</tr>
<tr>
<td></td>
<td>17 (49%)</td>
<td>9 (26)</td>
<td>9 (26)</td>
</tr>
<tr>
<td>Assessment of relatives satisfaction with</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>spiritual, psychological &amp; social care</td>
<td>11 (33%)</td>
<td>9 (27)</td>
<td>13 (39)</td>
</tr>
<tr>
<td>continuity of care (between ≠ care settings &amp; caregivers)</td>
<td>11 (33%)</td>
<td>8 (24)</td>
<td>14 (42)</td>
</tr>
<tr>
<td>bereavement care</td>
<td>8 (25%)</td>
<td>7 (21)</td>
<td>18 (55)</td>
</tr>
</tbody>
</table>

1 Absolute numbers (with rounded percentages in parenthesis)
2 Between 1and 4 missing values

Figure files

Format: word-file

Title: Figure 1 - Prevalence (in percentage) of policy documents on all ELDs in Flemish hospitals in 2007 (N=37)
Figure 1 - Prevalence (in percentage) of policy documents on all ELDs in Flemish hospitals in 2007 (N=37)

1 Missing values: Palliative sedation: 2; Alleviation of symptoms: 5; Withdrawing or withholding treatment: 1