Reviewers report

Title: How to achieve the desired outcomes of advance care planning in nursing homes: a Theory of Change

Version: 0  Date: 23 Jul 2017

Reviewer: Jürgen In der Schmitten

Reviewer's report:

Gilissen et alii present an application of the Theory of Change to the subject of implementing Advance Care Planning (ACP) in nursing homes. They report their findings from a mixed methods approach, comprising a contextual analysis, a systematic review published elsewhere, and, mainly, an analysis of two subsequent workshops that gathered a number of experts and stakeholders, supported by reflections from the core research team.

The paper addresses an important subject, and fills a gap in the existing literature on ACP. Rarely, ACP implementation processes have been developed in a structured, scientifically sound and transparent way, and on the explicit basis of a widely accepted theory, as done by the authors. Moreover, nursing home residents are an extremely relevant target population for ACP since despite their high age, fragility, and sharply limited life expectancy, they are typically subjected to unlimited life-sustaining treatment unless explicit preferences to the contrary have been stated. This excellent paper will be welcomed by many researchers, policy makers, and practitioners who wish to initiate institutional ACP implementation.

I have no principle (major) concerns. The following minor suggestions follow the paper chronologically.

line 4: Meanwhile, a consensus definition of ACP has been published (Sudore et al. 2017), and the authors may want to consider to cite it here.

14-22: Could be rephrased to become clearer and more focused. The reference term (barriers) is somewhat getting lost in the course of the paragraph.

34-37: It is always dangerous, and rarely necessary (or good scientific practice) to state that literature to a certain subject is „non-existent“, and to indicate that one's own work is the first and only in the entire field. While I agree that the authors make an important contribution with their
paper, they should not forget that they are „dwarfs standing on the shoulders of giants”, as most of us are. I would recommend to review this passage, and attempt to acquire a more modest perspective. Respecting Choices, for example, has made serious attempts to publish „any rationale behind behind the choice of intervention components” (although partly in books rather than in scientific journals). Besides, reference #35 is cited both as a negative and a positive example in this passage, and I am not convinced that references #33-36 altogether are a sufficient and representative sample of the large array of „existing ACP interventions", so the authors' claim seems not very well founded.

139-143: To my understanding, the text here reformulates a definition of Ceiling of accountability (i.e. that for a single intervention there is always such a ceiling), but does not represent any respective findings in an operational way (where exactly is the ceiling situated with respect to ACP in nursing homes?). It does not become clear to me what the laborious process has yielded with regard to this item what was not known and reported before by the Theory of Change.

144-155: I would suggest to reevaluate whether the desired long-term outcomes of ACP are really limited to (a) correspondence of care received versus preferred, and (b) a perception of involvement and confidence on the side of residents and / or family.

First, the two outcomes are not disjunct; rather, the former is a necessary precondition for the latter, so it is somewhat irritating to see them proposed as two apparently independent and equally weighted outcomes. Of course, the experience of qualified ACP conversations (and the recognition of an ACP culture in the institution and region) will by themselves somewhat contribute to an improved sense of confidence on the side of residents and families; on the other hand, the decisive effect on confidence in the long run will be the repeated experience, both in the reception of narrations of others, and in oneself, that care is truly based and centred on one's preferences, stated currently or in advance.

Second, I miss another important potential outcome of ACP, i.e. making the (caring and medical) staff more comfortable with the critical care decisions that have to be made. In my eyes, this is a natural, important and legitimate impact of ACP in nursing homes that has also been shown in the literature. Of all the outcomes of ACP interventions in nursing homes that are listed by Flo et al. (2016), most can be ultimately subsumed under „correspondence between preferences and actual care”, but making care providers more comfortable with critical decisions is the one important separate outcome they describe.

Perhaps it should be put that the first („correspondence”) item is the lead (independant) item, while confidence of resident and family, and comfort of professional carers with critical decisions, are two salient dependant items.
Intervention 1 (168ff.): This paper focuses on institutional ACP implementation, not on the qualification of ACP facilitators. Therefore, the skills that the institutions really need from an external trainer during the preparation and implementation phase is to facilitate (ACP) change management. The paper does not evaluate or argue inhowfar an excellent ACP expert (trainer), for example a family physician or ethicist, is automatically an equally excellent ACP change management facilitator (or coordinator). To the contrary, in other areas of change management, the two roles of the content-oriented „burner" and the process-oriented coordinator are deliberately and carefully separated, and other professionals than physicians or ethicists are typically gifted change management coordinators.

Thus, it is interesting to see that here this distinction has not been made. The German Task Force on Advance Care Planning to support the new legisслational process to implement ACP in nursing homes (§ 132g SGB V) has called for two distinct roles, ACP facilitator trainers, and ACP change management coordinators. These two roles may in single instances, but not always and automatically be filled by the same individual. Some individuals may be fantastic teachers for future ACP facilitators, but not specifically trained or gifted to assist in organisational development, and vice versa.

Therefore it is recommended to name the external expert as an, for example, ACP change management coordinator, or indicate otherwise that ACP facilitator trainers and ACP change management process facilitators need partly different skills (with a common basis of ACP expertise), and not to be the same person.

Intervention 3 (193ff): In Germany, the question of selection (pre-qualification) of future ACP facilitators has raised much interest. If the stepwise process has highlighted this issue as well at some point, it would be worth while reporting on it.

Intervention 4 (205ff): It is quite clear and unquestioned that nursing staff needs to be qualified to understand the ACP process, and on this basis to follow up ACP conversations. However, it is not so clear whether following up an ACP conversation when it occurs „while visiting the hairdresser" is of the same nature as leading a scheduled ACP conversation. By assigning the same labelling to what ACP facilitators (who were extensively trained by ACP facilitator trainers) do as compared to what nurses (who were much less extensively trained by facilitators) do, the authors at least allow the view that nurses trained by ACP facilitators by and by become ACP facilitators themselves, and such a view is strongly supported if in line 238 trained facilitators and trained nurses are listed as equals. However, international experience is that training of non-physician ACP facilitators in nursing homes is an enormous challenge, it requires a number of prequalifications on the side of the facilitators, and a large time investment, and it should result in certification and continual re-certification. In fact, not rarely it is not successful. Also, qualified ACP conversations have been reported to take no less than an hour or more on average. A less standardised training delivered from ACP facilitators to nurses is an interesting research idea, but should not be presented as a matter-of-course part of a policy as done here in
the sense that trained facilitators and trained nurses end up doing the same job. It is therefore suggested to differentiate more clearly between ACP as a typically scheduled conversation process between a qualified facilitator and a resident (+ family) on the one hand, and the welcome and necessary, often spontaneous, but not identical assisting conversational ACP processes in the responsibility of all other (health) professionals in the institution, including even the hairdresser and certainly the nurses, on the other hand.

295-297: Again, I recommend to be careful with the claim to have discovered something new. The programmes that are quoted to train facilitators across settings (22, 23) are not original programmes of their own, but to my knowledge research studies that draw explicitly on the US program Respecting Choices that is, however, not quoted, and that has always trained facilitators in nursing homes (I have visited Respecting Choices nursing homes in La Crosse myself 10 years ago, and talked to trained facilitators employed by the nursing home). Given the enormous meaning that the adaptation of the Respecting Choices program has had for the development of ACP programs elsewhere, it is incomprehensible why this program has not been quoted more explicitly. Besides, also in our study (in der Schmitten et al 2014), nursing home employees were trained as ACP facilitators. More importantly, the study by Detering et al quoted by the authors (47) was not a nursing home intervention and is therefore not relevant in this context; the same Australian group, however, has published their nursing home ACP program elsewhere, and it also does contain qualifying nursing home employees. The authors weaken their paper unnecessarily when they seem not to appreciate what other programs, especially Respecting Choices as the most influential of all, have achieved in the past. I do not mean to belittle the merits of this paper, and do see its highly valuable original contribution to the literature thanks to its structured, scientific process, but nevertheless, most of the findings reported here can be found one way or the other in the Respecting Choices Change Management Manual that first appeared some 6 years ago (and that reflects expert opinion, not research, so the claim made in line 351 seems legitimate anyway).

306, and 327ff: I do not understand inhowfar this paper appreciates the necessary changes on the micro, meso- and macro-level. To my understanding, the micro-level is the level between resident (+family) and facilitator, reflected in the conversation process, and the macro-level is how a single institution forms a viable network in the concert with other regional health care players such as emergency services, hospitals, and physicians. My understanding is that both levels are not subject of this paper that is rather solely devoted to the meso-, i.e. the institutional level. This is a legitimate and perhaps necessary limitation, not a shortcoming, but it should in fact be mentioned in the limitations. Especially the macro-level, i.e. how the institution cooperates with other regional health care institutions in the process of implementing ACP, is closely linked to the institutional or meso-level.
Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

Yes

Does the work include the necessary controls?
If not, please specify which controls are required in your comments to the authors.

Yes

Are the conclusions drawn adequately supported by the data shown?
If not, please explain in your comments to the authors.

Yes

Are you able to assess any statistics in the manuscript or would you recommend an additional statistical review?
If an additional statistical review is recommended, please specify what aspects require further assessment in your comments to the editors.

Not relevant to this manuscript

Quality of written English
Please indicate the quality of language in the manuscript:

Acceptable

Declaration of competing interests
Please complete a declaration of competing interests, considering the following questions:

1. Have you in the past five years received reimbursements, fees, funding, or salary from an organisation that may in any way gain or lose financially from the publication of this manuscript, either now or in the future?

2. Do you hold any stocks or shares in an organisation that may in any way gain or lose financially from the publication of this manuscript, either now or in the future?

3. Do you hold or are you currently applying for any patents relating to the content of the manuscript?

4. Have you received reimbursements, fees, funding, or salary from an organization that holds or has applied for patents relating to the content of the manuscript?

5. Do you have any other financial competing interests?

6. Do you have any non-financial competing interests in relation to this paper?
If you can answer no to all of the above, write 'I declare that I have no competing interests' below. If your reply is yes to any, please give details below.

I declare that I have no competing interests

I agree to the open peer review policy of the journal. I understand that my name will be included on my report to the authors and, if the manuscript is accepted for publication, my named report including any attachments I upload will be posted on the website along with the authors' responses. I agree for my report to be made available under an Open Access Creative Commons CC-BY license ([http://creativecommons.org/licenses/by/4.0/](http://creativecommons.org/licenses/by/4.0/)). I understand that any comments which I do not wish to be included in my named report can be included as confidential comments to the editors, which will not be published.

I agree to the open peer review policy of the journal