Supplemental File 2: Decision-making excerpts

Decision no.	Author(s) and publication year	Excerpt
D#1	Abu-Ghori et al. 2016	‘‘As nurse[s] we play a very minimal role in decisionmaking as a ‘No Code’ [DNACPR]. But nurses also can contribute factors like nutrition, family support, psychological and physical condition, emotional condition of the patient when they discuss about ‘No Code’. But here in the hospital, no doctor will ask the nurse’s opinion before taking a decision. May [be] [because] lot of western and foreign nurses [are] working in this country, and language is a barrier.’’ (RJ 03)
D#2	Andersson et al. 2018	“FG1-a: . . . we [RNs] didn’t think it was that sort of situation [EOL care] yet. // It almost felt as if it was a demand [from the ENs], that the resident should actually be put on the LCP, even though we didn’t think she fulfilled the criteria at that time.” (RNs)
D#3		“You hear that someone’s a bit worse, then you take the question to the responsible nurse and maybe the doctor, that it’s time to put them on the LCP, and this at least brings up the discussion a bit earlier than before, I think.” (RNs)
D#4		“No, I’ve also done that, when you have someone at the end of the week that you feel like, mm, well, you know, that we said if this happens, if it continues, so to speak, then they may proceed, start the LCP during the weekend and I’ll sign the paper afterwards.” (GPs)
D#5	Bern-Klug et al. 2004	The physicians noted their reliance and dependence on the nursing staff to keep them apprised of pain levels and physiologic status, usually by phone. When the staff did not know the residents, the physician did not get consistent information, as noted by one physician, “It’s very disconcerting when one shift says that a patient is very comfortable and is not suffering physical pain and is not alert and you have another shift telling you that they’ve been having to give Roxanol [morphine] every hour and the person is still agitated and uncomfortable.” Another physician stated, “If the nursing staff is turning over rapidly, there’s not a CNA [certified nurse assistant] bond with the patient . . . then I don’t get good feedback on the patient’s end-of-life needs because the staff doesn’t know the patient.”
D#6	Bloomer et al. 2013	During observation, it became apparent that recognition of dying was difficult, that is, nurses had difficulty differentiating between an acutely ill patient and a dying patient, most often deferring to, or waiting for, medical staff to make the distinction. … This demonstrated that some nurses may have an opinion that a patient was dying, or a sense that they were not responsive to rehabilitative care, but in the absence of a decision from a medical officer, acute resuscitative care often continued, and in one case, this caused distress to nursing staff after a patient’s death.
D#7		Focus group participants shared a frustration towards the ‘system’ and ‘practices’ that made care more challenging. Even when nurses acknowledged dying, acute care often continued until a medical officer confirmed this, often reluctantly:

		“The doctors don’t want to make those decisions on the weekends, they won’t do it ... but we need to make sure that, at least, we get some NFR [not for resuscitation] orders before the weekend, because the docs on the weekends won’t talk to families about dying and won’t make them palliative.” (Focus Group) “It’s hard to get through to the young doctors what is needed.” (Focus Group)
D#8	Bloomer et al. 2018	“If the nurse feels that that’s happening more rapidly than is being recognised, they would always discuss it with me or the senior nurses … and they would always take it to the doctor … but they’re looking for support. And so I think communication around patient handover is very open and it’s a place where we ask lots of questions.” (Int. 2, Registered Nurse)
D#9		“We sometimes find ourselves in a grey zone … when the patient’s not on the pathway yet but the team are saying, ‘Yeah, yeah. They’re probably end of life. They’re probably, you know, dying. They’re not for MET calls. They’re not for ICU admission’. But then we still get referred to make these decisions about eating and drinking.” (Int. 4, Speech Pathologist)
D#10	Bloomer et al. 2019	Medical entry “Clarification of goals of care. Goals: Comfort care ± end of life care. Poor prognosis given severe ischaemic cardiomyopathy and likely recent peritonitis (recent cardiogenic shock). Plan clarified with[doctor] with input from [nurse]. . . family updated.” (Case 23)
D#11	Borbasi et al. 2005	… Most participants felt referral was rare *“Patients have to be knocking on death's door with their lungs filled with fluid before the palliative care team is called*” (BC2). When referral does occur it was often too late to improve the quality of end-of life care: “*Palliative care is not thought of early enough and it is the nurses' responsibility to broach the subject with the* MOs [medical officers] - *many older* MOs *don't think about palliative care because 'it's not in their psyche'*.” (BC3)
D#12	Bostanci et al. 2015	Insights into the clinical status of patients by allied health staff did sometimes inform medical decision making. For example, when a physiotherapist noted that patient P-8 was ‘very fatigued’ and ‘liaised w[ith] medical staff about p[atien]t’s deteriorating physical status’, doctors discussed the deterioration with the patient’s daughter explaining that, if no reversible cause could be found, this may lead them to ‘consider a palliative approach’.
D#13		The existence of a decision hierarchy in health care was evident across all cancer groups. Actions related to care of patients were generally initiated by a health professional and ultimately required authorisation by a medical doctor, particularly if an alteration in care direction was signalled.
D#14		Potentially important insights into patient status and patient goals by other members of the care team, in particular allied health staff, were rarely taken into account in decisions of the medical team.
D#15	Caswell et al. 2015	Each of the wards had daily multi-disciplinary team meetings at which patients and plans for their care were discussed. Not all members of staff could be present at these meetings, and nurses described how they needed to read the medical notes of the patients for whom they were responsible on any given shift, so that they could be sure of what care and treatment was to be provided.
D#16	Chuang et al. 2017	While most PAs endorsed an active role, several felt that the attending should lead and manage these communications.

		"… the attendings are in charge of the patient care, ultimately. We don't make the final decisions. So I don't think it should be considered the PAs' responsibility to initiate the goals of discussion. I think it should come from the attending. We can definitely follow-up …If anything, I do it on a daily basis, but it's just like out of respect." [F/G3/≥10Y]
D#17	Clark et al. 2012	"I have found that when we've tried, sometimes to get the patients started on it, that's when the problems start with getting doctors to actually commit, to a name on the forms. Whereas, before the LCP if you asked for a patient to be made 'comfortable' they seemed to have less hang-ups about it." NFG, Pg1
D#18		The complex and necessary tension around continuing to treat and/or recognizing dying was commented on by all professional groups. Nurses' role in questioning the direction of care was described positively by a consultant. "It's quite a traditional tension in some ways, I think the nurses have to try and keep the doctors realistic and point out things. We tend to press on, and the nursing staff say 'do you really think this is appropriate,' and certainly a little more pressure for the patient to go on the pathway—and I might say ;no, not yet'." MFG, p10
D#19	Costello 2001	The data from both interview and observation in this study highlight the way in which nurses' decisions about dying patients were intimately connected to directives from physicians.
D#20		Nurses reported that their key role was to keep the patient comfortable and pain free. …, nurses sought support from doctors in prescribing medication and reporting any signs of distress. Physicians considered their role in terminal care to be decision-making…
D#21		… the imposition of DNR orders was not always based on a consensus opinion, although there was no evidence of nurses openly challenging medical decisions. Although physicians did write DNR instructions in the patients' medical notes, more detailed analysis revealed that in a number of instances nurses put pressure on doctors to make these orders. Nurses used similar strategies [informal covert decisions] to increase or decrease medication by making deference to the doctor explicit, but also clarifying informally that it is in the patient's best interests. When doctors ignored such strategies, nurses would express their feelings, by being passively aggressive, adopting go slow strategies or through non co-operation…
D#22	Dee et al. 2011	However, there was a suggestion that some nursing staff may feel that their opinions are not considered, which could be a frustration and could sometimes prove to be a barrier to the implementation of the LCP. "The doctors go in for a short period and maybe for that period the patient is able to say 'this is fine' but then you go and move somebody and you know that they're in excruciating pain." (Nurse 4, patient not on LCP)
D#23		"I did feel that he was dying, it was just wasted because I had to wait until people [other clinicians] thought he was dying as well." (Nurse 5, patient not on LCP) Although the level of experience could possibly increase the accuracy of prognostication, it involved frustrations that could be barriers. This was because, although the clinicians were sure the patient was dying, they had no evidence with which to back up the judgment.

D#24		"So I was waiting for him to wake up so that I could assess what was going on. And then he had 1 mg of Lorazepam. There was no explanation anywhere in the notes as to why. The nursing staff had gone off duty, hadn't passed it on to the next team and so I had no idea why he'd had this extra mg of Lorazepam." (Doctor 5, patient not on the LCP) This communication failure resulted in the pathway not being implemented because the reason for the patient's drowsiness was not known. The rationale for giving the medication was required to ensure that this was the appropriate way forward.
D#25	Freemantle et al. 2012	"On his last day we wheeled him outside, it was a really lovely day . . .after a couple of hours he took a turn for the worse, he wasn't responding to us and the nurse looking after him, she was ringing the registrar saying, 'Can we get him on the Pathway? Or can you at least come and see him because he has taken a turn for the worse? And they wouldn't come and see him." (Nurse: moderately experienced)
D#26		Although both junior doctors and nurses saw themselves as separate teams, intra- and inter-professional collaboration was evident. With the exception of one inexperienced nurse, all nurses appeared to be proactive in recognising dying and prompting the doctors to ask for guidance in decision making. This approach was accepted positively by the doctors: "They're obviously very experienced with oncology patients and they realise these decisions need to be made and they'll prompt us as juniors to approach the seniors about that." (Doctor: moderately experienced)
D#27		A perception of inconsistency amongst consultant staff in approach to recognising the dying phase and implementation of care supported by the LCP resulted in situations where end-of-life decision making was delayed: "If the consultant is not around, people aren't willing to make decisions, so we delay, waiting for a decision from a consultant." (Nurse: moderately experienced)
D#28	Fryer et al. 2016	Indeed, participants recounted several stories of occasions when their concerns about dying residents had been largely ignored by more senior staff, typically the Registered Nurse on duty at the Facility. On most of these occasions, this refusal to listen to HCAs' concerns resulted in significant negative repercussions. For example, the following excerpt highlights how the refusal of the trained nurse to take into account the HCAs' knowledge and experience resulted in a poor outcome for the resident, the relatives and the staff: "HCA 2 'We spend a lot of time with them [residents]; sometimes the RN's just don't listen. And you think, they are dying and you can just tell… just deteriorating. HCA 4 [Resident], she had pneumonia in the end I think. She was just getting weaker and weaker and not talking. I said to [RN], you better call the family, but she didn't. She [resident] died, and the family came in and got very upset with her because they expected to know. She should have called the family. HCA 5 It was a bad mistake HCA 1 You could tell with her breathing

		HCA 5 We work with them [residents] all the time you know, and sort of know, we pick up things what's wrong with them then go and tell them [RN's] then it's up to them, it's not up to us. HCA 2 They think, oh you're just a caregiver; you don't know what's happening, but we're with them every day." (Focus Group 2)
D#29	Gambles et al. 2006	There was evidence that nurses have much more influence over the diagnosis of dying and the decision to commence a pathway in this environment: "The good thing as well is …here the nurse would start a pathway. That is a very good thing … It doesn't necessarily have to be the doctor… here most of the medication would be prescribed anyway … you don't have to convince the doctors that somebody is dying …so you don't have to argue." [doctor 1]
D#30	Gidwani et al. 2017	However, the most serious concern expressed was that inpatient PC teams only see cancer patients at their most severe stage, leading them to believe that all cancer patients in the same stage of illness are similarly ill. For example, oncologists noted situations in which patients with Stage IV cancer were admitted to the hospital for pneumonia and received a hospitalist-activated PC consult, resulting in the PC physician telling the patient that he was going to die and switching him from antineoplastic treatment to comfort care. This posed concerns for oncologists, both because they felt they would be able to extend patient survival by treating the pneumonia and because it created problems in communicating with patients and families. One oncologist noted about PC physicians: ''They don't understand that a cancer patient can look really crappy but not be on death's door; it's the side effects of chemo or they have a kind of cancer that's going to respond really well. [Palliative care physicians have] told people they were going to die that aren't even dying, and then it's this whole awful backpedaling and making us look bad. It's just ridiculous. We've had a lot of meetings with them, trying to explain this, and now they have a rule where they're supposed to call us first but it doesn't always happen. I don't expect them to understand oncology and to understand what diseases might really turn around with treatment, but it's done a lot of damage, actually, between our relationship with our patients.''
D#31		With respect to prognosis, oncologists reported that they and the PC specialists often had different views for the same patient. Compounding the problem was that each discipline was unaware of the other's differing prognosis. This resulted in mixed messages given to the patient about prognosis and/or treatment options. Disparate prognoses across PC physicians and oncologists were perceived as linked to the largely inpatient nature of PC. Oncologists noted that PC physicians only saw those cancer patients who were the most ill—hence their admission into the hospital—and this colored their perception of all patients in that same cancer stage.
D#32	Glogowska et al. 2016	The HCPs' accounts also provided examples where they perceived the necessary discussions had not taken place and where patients in advanced heart failure had been aggressively treated for infections, instead of receiving palliative support:

		"I …thought this patient is dying …so I spoke to the consultant and said can you make this patient not for resus[citation] …his opinion was you've got to get better, you've got to fight this illness …I said to the patient I think your symptoms are quite a lot, you 're quite nauseous because I can tell by your, the way that you 're acting. He said I feel really really sick. So I called palliative care in and he did die …he had a false message, so I was trying to take it down the palliative route because I thought that was appropriate …but the clinician wanted to treat an infection …" [P20, community specialist heart failure nurse]
D#33		There was concern that lack of communication had consequences for choosing appropriate treatment and care: "We had a situation with a patient who was end stage and we said to the doctor straight away this chap's end stage …shouldn't we be thinking palliative should get involved, and they treated him for cellulitis, and said no, no we're going to treat him for that …you could see this chap was dying, going to die in hospital if somebody didn't do something …nobody's making the decisions here, the doctors are leaving it up to the patient, the patient is unwell, confused and can't make that decision for himself …It was really frustrating and I think that happens a lot." [P14, hospital specialist heart failure nurse]
D#34		However, in location 2, the uncertain course of heart failure made it difficult to judge when to put in place palliative care support, which could be offered on a time-limited basis only: "…the difficulty with end of life care and heart failure is the unpredictability of the time scale and so getting palliative care services involved and the sort of end of life package which you can get, which is very intensive and very good, is only for a short amount of time, and if you think they might live longer than that…they're probably saying well it's too soon for us to get involved…" [P12, hospital specialist heart failure nurse]
D#35	Gott et al. 2011	A critical first step in this process was seen to be communication within the hospital setting and, in particular, reaching a consensus among all clinicians involved in a patient's care that a palliative approach was now appropriate. The opinion and approach to treatment of the consultant was seen to be pivotal in this respect: "You've got to have some sort of consensus though about how you're going to treat the patient . . . and sometimes I think what happens in a hospital is that the consultant is seen as the be all and end all so their decision is what decides it, whereas actually you need to reach a decree amongst a number of people." (Secondary care, location 1, geriatric specialist registrar)
D#36		Problems of power within the professional hierarchy of the hospital were discussed within this context, both between medicine and nursing, and within medicine itself. The need for nursing staff to be provided with opportunities to raise their concerns about the approach being taken to a patient's care was identified: "I think maybe that point when the nurses start triggering and saying 'why are we doing this?' it would be nice for them to be able to, I don't know, circumvent or put up a flag so that somebody else gets involved, or some kind of mediator. Because I get a lot of nursing staff telling me 'why are we doing this? Why do you keep doing this?' And I say 'why didn't you ask yesterday when the consultant was coming round because it would be really nice for you to ask somebody more

		senior than myself what their intentions are in the situation.' But it's well 'you're here now, why aren't you doing something?' But actually I am, I'm following the plan that I have available to me and I can question it but I'm still not going to change that unless obviously something significant happens and it's an acute deterioration but I still feel there's a lot of . . . I don't know, stresses in the system." (Secondary care, location 1, geriatric specialist registrar)
D#37	Hanson et al. 2002	Physicians and nurses felt a need for shared communication to facilitate treatment decisions when a resident was dying. Nurses expressed frustration with the limited time and involvement of physicians, yet also expressed pride in their ability to judge clinical situations, report them by telephone, and get the orders they needed to give good care to dying residents. Physicians acknowledged their own unwillingness to spend more time in nursing homes, and their need to rely on nurses' skills. A physician described his dependence on nurses' assessments: "Whenever the patient isn't doing well and it looks like we will be dealing with a death, then the first thing I do is go to the nurses and say what do we know? I usually make it their job to do the scouting. It is less threatening for the nurse to act before I come on the scene."
D#38	Hill et al. 2018	Participants responsible for initiating palliative care used their experience and professional judgment to determine when palliative care was best initiated. Most said the assessments were based on common sense. One participant explained "When they're done, they're done. We just know." (Registered Practical Nurse). Usually, when a resident with dementia stopped eating and drinking, the RN made the decision to contact the physician and request that the resident be designated palliative. They also made assessments based on abnormal vital signs and uncharacteristic and distressing resident behaviors.
D#39		Nurses indicated that they did not have enough communication with physicians who were prescribing drugs and designating residents as palliative. Physicians were responsible for different long-term care homes and cared for many residents. Others such as social workers, chaplains, and recreation therapists also felt excluded at times. Additionally, staff at homes with no formal palliative care committee expressed frustration in making end-of-life decisions with no protocol to guide them and no one willing to lead in decision-making.
D#40	Hockley et al. 2005	Prior to the study there was a lack of confidence in some of the nurses' ability to take responsibility to initiate what was necessary for their residents' end-of-life care — whether this was talking to relatives, ensuring that there were drugs for distressing symptoms, or informing other staff in the nursing home that a resident was now dying. Often this was because it was seen as the GP's position to diagnose dying. However, in the majority of situations it was the nurse and, indeed, the carers who knew the resident and the family the best and were therefore able to contribute to the knowledge that someone was dying. "I think before it was more or less the doctors who decided. Now I feel the carers are as much involved." [KC1. NH.E, final evaluation: para. 49]
D#41		What was important about the ICP documentation was that it encouraged a joint decision to be made around the diagnosis of dying. The nurses' critical part, along with the ward team and resident/family, in initiating that process was

		being recognised by staff. It was encouraging to see nurses more accountable in this area of care and the recognition of this shift by nursing home managers. “We are taking a bit more responsibility….I think it has raised the standard of care of the dying.” [NHM. NH.D, final evaluation: para. 53] “I think the trained staff . . . there is this real ability for them to be more in control . . . they feel that their professional opinions are being much more respected.” [NHM. NH.E, interview: para. 79]
D#42		“I think from the carers’ point of view that we are more involved with recognising different stages in the dying . . . and work together . . . much, much more aware of the whole dying process. And I feel more involved, . . .” [CA6. NH.B, final evaluation: para. 82]
D#43		“If one of the carers comes and says he sounds a bit funny, you know you won’t say ‘Well, they always sound a bit funny when they are dying.’ You say, ‘Well, OK, we’ll go and have a look at them.’ You know so you’re getting all the information from everybody and you’re acting on what you are getting. . . I think it’s been really good.” [SN. NH.A, final evaluation: para. 174]
D#44	Johnson et al. 2014	Senior Nurse Helen pointed out how sometimes you know people are near the end whether or not they meet the LCP criteria: “One lady that died had lung cancer and I wanted to do…I wanted the drugs and he (GP) came out to see her but she didn’t meet any of the criteria. You know, she was talking, she was sat up but you know on intuition: you just know don’t you? And after being a nurse for some time you do get to know and I went, ‘No, I really want pathway drugs for this lady’.” (Helen, Senior Nurse) The GP was cautious, but came the day after and realising the woman was in pain prescribed diamorphine. He could see what Helen could see and that the weekend would be difficult for the lady without sedation.
D#45	Lai et al. 2018	Although nurses were seldom involved in judging the end-of-life stage or dying phase, they instinctively provided more care to patients at the end-of-life stage
D#46	Lemos Dekker et al. 2018	Further, the uncertain trajectory of dementia makes it difficult to establish exactly when to initiate an LCP: “Sometimes we think yes, and the doctor doesn’t think so. And then you start it, and then you can stop it. We once had a woman for whom it [the LCP] started three times. How then to explain to the family that this time it’s for real? And so the fourth time we were, like, let’s wait a bit. But then we were too late.” (Nursing staff)
D#47	Näppä et al. 2014	In these stories, the nurses observed that the patients were in a poor condition and questioned the physicians about the appropriateness of the PCT. The physicians disagreed with the nurses and ordered the nurses to give the PCT as prescribed. According to the nurses, the PCT had dire consequences for patients who might have survived or been spared

		from suffering if the physicians had listened. For example, Nurse Ingrid, who had not met the patient before, explained her situation as follows: “And when I saw the patient, my first thought was that this patient is in such terribly bad shape; so haggard […] his skin was ashen grey, he had difficulty breathing. […] It just felt wrong to give the PCT. But when the doctor came, who had met the patient before, his assessment was, ‘Ah, it's alright’. So the treatment was given anyway. […] The patient died that evening after the PCT.” Ingrid concluded her story with this reflection: “It doesn't feel right to have given the PCT, but, at the same time, in this particular case, I did say what I thought beforehand. And then it's someone else above you who makes the decision.”
D#48	Nouvet et al. 2016	Several nurses recalled critical incidents in which health care team efforts to ‘do everything’ for a particular seriously ill patient collided with their ideal of care for that patient. One participant grew emotional as she remembered a particular case: “[T]his woman just wanted to pass away but we were just treating her and treating her and treating her to an extent that I think was more than what the situation called for. But the attending was just like, ‘No, we’re going to treat her symptoms.’ ‘Why not just make her palliative?’ ‘Well, we’re not at that stage yet.’ She [the attending physician] didn’t give me a clear rationale of why we were still treating her other than just symptom management right now. What’s the point of symptom management when she doesn’t even want a scope? Why are we still giving her lots and lots of blood products? That’s all she said. I never got a clear understanding of why we were still treating her. And I had said to her [the attending], ‘She doesn’t want to eat. She doesn’t want to drink. She just wants to be comfortable.’ [The attending] said, ‘Well, we’re going to treat her for now.” (Nurse)
D#49	Oliveira et al. 2016	Caring for patients in their final days of life was both an emotional and physical drain for the nurses. Ann explained, “We see it a lot . . . we still treat aggressively and that’s very demoralizing for nurses. To treat aggressively when we, through experience, or intuition, or just by knowledge of our training, we know that we’re battling a no-win battle. It’s like professional judgment of that has been removed and we’re not allowed . . . to make that decision . . . it’s a real emotional drain and strain and struggle.”
D#50		Communication was essential for teamwork and was integral in establishing the goals of care. However, nurses, who possessed intimate knowledge of patient care, were often not present at planned family meetings, either because they were not being invited or were unable to attend because their presence was required at the bedside. This was a significant barrier to communication and advocating for patients because it was often at these key meetings where the decision to move from aggressive curative goals to palliative care would be made.

D#51		One of the challenges in transitioning patients to an EOL plan of care was the layers of reporting structures within the physician medical team. As part of a teaching hospital system, patients on the medical unit were assigned to the care of a resident or medical student. Nurses were expected to report their concerns to the resident/medical student in charge of the patient's care; however, whether or not these concerns were relayed to the staff physician was left to the discretion of the residents/medical students assigned to the patient. Ultimately, the approval of the plan of care fell under the responsibility of the staff physician.
D#52		In an effort to challenge the appropriateness of the curative-focused plan of care, participants would align themselves with other health care professionals (HCPs) who would act as allies in trying to force a medical decision regarding goals of care. Registered respiratory therapists (RRTs) and the PCCS were identified by more than one participant as sources of support in prompting goals of care discussions.
D#53	Petterson et al. 2014	One nurse mentioned that it was always the physician who made the final decision and had the strongest arguments if there were disagreements on DNR orders because physicians have the most medical skills. But the nurse also emphasized the need for another type of skill: "An informal skill, I would say, that nurses have. Which they develop by being very close to a patient for a very long time." (Nurse 8)
D#54	Pettersson et al. 2020	Also, whether the team was involved in the decision or not varied, depending on the routines at the ward at stake. "I have experienced that the physicians asked for my opinion and I really appreciate that. But, it could be done more frequently!" (Nurse164, hematology) "If the nurse knows the patient better, the nurse's input can be valuable." (Physician 132, oncology)
D#55	Pontin et al. 2011	"So I think that is why nurses are much better at prognosticating than doctors because we are seeing an absolute snapshot and sometimes that is useful because you can come back and say that's a really dramatic change in 24 hours. And maybe that isn't apparent to the nurses who just, just keep doing things but often it is the nurse who says 'well actually the last time they could mobilize to the bathroom and now they can't'." (spr001319)
D#56	Prompahakul et al. 2021	Among the healthcare team, nurses perceived themselves as having little power in decisions about treatment. In many cases, participants knew the right thing to do for patients; however, they could not take action because nurses lack practice and independence to act. For example, six participants expressed that they knew that specialists from other departments such as palliative care should have been involved in a patient's care but that consulting the palliative care team was not their role and depended on the doctor's decision: "... ... Anyway, we need the doctors to sign on the consult form. The consultation needed an agreement from the doctors. If they don't agree, we couldn't consult. The patient would be treated aggressively. We are under them, we depended on them. Our profession was sometimes controlled by others." (N16)

D#57		Poor communication and collaboration impacted the quality of patient care in that nurses felt they were excluded as members of the team and could not communicate with patients and families sometimes because they were not sure about the goals of care: “The collaboration among the team wasn’t bad but it wasn’t good as it should be. We [nurses and doctors] had less discussion. We [nurses] were trying to be a part of team. We joined the morning medical rounds to know the goal and plan of each patient. But when they placed orders, they were totally different from what they had discussed during rounds. They changed the plan without informing us. They might feel that they don’t need to tell us. When the patient asked us about the plan, I could just tell him to discuss it with the doctors. I know I should not say that but I wasn’t really sure about the plan.” (N15)
D#58	Reid et al. 2015	Medical and nursing staff had different opinions in terms of who should make the diagnosis of dying. Medical staff thought the nursing staff were first to raise the possibility that a patient might be dying, perhaps because they spent more time closely observing patients, but nurses looked to the medical team for confirmation. “Um it’s still difficult, because we know that patients are coming in, you know, are admitted, and er there’s a good chance sometimes that they might die on the admission, but it is difficult for us to know when to pick up this document [the EOL tool] and start. Because you take the lead really from the doctors.” (Interview 4)
D#59		Junior doctors and nursing staff described needing validation of the diagnosis of dying by the senior medical staff (usually the consultant), and thus asked for this confirmation on the ward round. However, senior staff felt that they did not see patients frequently enough to be confident about diagnosing dying.
D#60	Ryan et al. 2012	One team noted how their experiences led them to believe that sound collaborative working between professions and consulting other ‘specialists’ in the field of dementia care had helped to facilitate transitions to palliative care: “I’ve got three people on the caseload at the moment that I think really are dying and it’s purely as a result of dementia…. The doctors have wrestled quite a lot with that and they’re really experienced geriatricians we’ve got on our team and each of those cases we sought a second opinion from a psychiatrist but also from another geriatrician as well to say ‘what do you think?’.” (Acute Hospital FG)
D#61	Standing et al. 2020	Feeling dismissed and downgraded by professional colleagues was particularly prevalent within the accounts of care home staff, who felt their professional status and expertise were afforded less value than that of other health care and social care professionals. Indeed, during the course of data collection care homes were repeatedly highlighted by other professional groups as a perceived weak link in end-of-life care, who inappropriately called on out-of-hours doctors and ambulance services against patient’s wishes. [...] “the care homes are absolutely petrified of litigation. They will call us for any change. Then you think, “Well, you have called me. The healthcare plan says, ‘Keep comfortable.’ […] She is breathing heavily but she is quite comfortable. What do

		you want me to do?"[…] they will be incredibly risk averse or they will expect us to make the decisions, but we haven't got that information." (out-of hours GP2) It was suggested that this fear of litigation meant care home staff were paralyzed when dealing with patients at the end of-life resulting in them abdicating the responsibility for decision making to other professional groups increasing the burden on other services who themselves may not necessarily be better placed to take on such responsibilities.
D#62	Strachan et al. 2018	Nursing surveillance during patient care positioned them to notice and alert the healthcare team, essentially 'raising the red flag' to the need for communication. Specifically, in response to cues about a decline in the patient's condition, and recognizing that communication and decision-making could be urgently needed in advance of crisis, nurses prompted other team members to the need for goals of care discussions and decision-making conversations that they anticipated would be imminently required to inform their interventions. A common scenario was described: "They're not as responsive to us anymore, their appetite has decreased and they're not swallowing well. They're just sleeping more and more. And I often ask (the physician) 'What's the plan for this patient?'." (Nurse, P10)
D#63		Even with this advocacy from nurses, it was not uncommon for discussions about life-sustaining interventions to be delayed until physicians agreed that death might not be avoided in the short term. "I had a patient who was very ill and she was still full resuscitation code and I started to see that she was really deteriorating and struggling with the treatment and not in a lot of comfort… I actually talked to the (medical) residents quite a few times saying 'I really don't think she's coming out of this. Is it time to talk about her level (of care)?' and they said 'No, I think we can fix this." (Nurse, P1)
D#64	Tan et al. 2014	A number of people may be first to recognize the approach of the final phase of life. "Nurses often recognise it first being with the patients 24=7' […] The decision to formally engage the 'Care of the Dying Pathway' for treatment is a medical one. This can be problematic, resulting in delays." "You can see that someone's got maybe two or three days but when you go to the registrar they won't do anything because they are waiting for the consultant who comes on Friday. By Friday the person may have only three or four hours. It can be very distressing because you can see clearly that the person needs different treatment . . . It is all very dependent upon the time of day, who's on call and personalities between us. Weekends are particularly difficult." (Group 2)
D#65	Travis et al. 2005	According to these teams, sharing observations occurs at several levels and uses a hierarchical order of consensus building. First, when a team member gets a gut feeling, he or she shares it with other team members. If others also see a change, there is an informal brainstorming session within a shift and then a more formal session across shifts. If a pattern emerges and a more comprehensive assessment of the person's condition and behaviors confirms a change (often very subtle), the physician is notified. If there is a possibility that the change is reversible (recall that one team told us 'most things can be reversed'), appropriate orders are requested. If everyone agrees that changes in the person's condition are consistent with

		irreversible terminal decline, [the physician has a highly visible and intense role in discussing options with the resident, if possible, or the responsible family members.]
D#66	Wallerstedt et al. 2007	The nurses' assessments and reports often constituted the basis for the doctors' decisions and orders. They also described how they had to assume the responsibility for the doctors becoming involved in the care of the dying. It was assumed that the nurses could act independently, but they said their responsibility did not seem so overwhelming if they could share it among themselves. "That the way we treat patients, the way I act toward the patient is of such tremendous importance and can have such lasting effects. That my actions, my words can have such a lasting effect both on relatives and on the patient. That's quite a heavy responsibility. What I'm responsible for is really the nursing care. Then there's the medical care and orders and that's the doctor's responsibility. But in some way I have to be responsible that the doctor does that."
D#67	Willard et al. 2006	Some of these issues are highlighted in the following interview extract, where a CNS describes how she and the consultant differed in their perception of a situation concerning a very ill patient with dysphagia, and the most ethical course of action: "The consultant felt as though he couldn't let her die in that way, so I just said I thought she was dying, and it isn't pleasant having a feeding tube put in, they don't always work, there are complications and the risk of having all that for the outcome, I didn't feel that it was justified. He could understand where I was coming from and it did make him think about it, but he still was saying well you know we should give it a go." (Interview: palliative care CNS)