Abstract

Background: Predicting older patients’ life expectancy is an important yet challenging task. Hospital aged care assessment teams advise treating teams on older patients’ type and place of care, directly affecting quality of care. Yet, little is known about their experiences with prognostication.

Methods: Twenty semi-structured interviews were conducted with seven geriatricians/registrars, ten nurses and three allied health staff from aged care assessment teams across two hospitals in Melbourne, Australia. Data were analysed thematically.

Results: To generate prognoses, clinicians used analytical thinking, intuition, assessments from others, and pattern matching. Prognostic tools were an underutilised resource. Barriers to recognition of dying included: diffusion of responsibility regarding whose role it is to identify patients at end-of-life; lack of feedback about whether a prognosis was correct; system pressures to pursue active treatment and vacate beds; avoidance of end-of-life discussions; lack of confidence, knowledge and training in prognostication and pandemic-related challenges.
Background

A common metaphor for avoidance is the ostrich that buries its head in the sand when danger is near. Do clinicians do the same when it comes to prognostication and end-of-life care of older patients? Being able to identify patients who are reaching the end of life is an essential skill across all healthcare settings as it informs treatment decisions and enables patients to make informed choices. However, some see prognostication as a “lost art.” Advances in medicine and technology allowed us to become better at extending life, while honest conversations about prognosis and dying are delayed or avoided. Jones argued that:

Seventy-five years ago, when most effective medical therapies did not exist, the most skilled physicians were astute diagnosticians and frequent prognosticators. Today (...) discussion focuses on diagnostic and therapeutic options. Prognostication takes a back seat. Some of this relative neglect may come from the hope that prognosis will not be necessary, that cure will be the outcome. (p. 347).

Predicting life expectancy can be difficult, even for experienced clinicians. Medical staff consistently overestimate the time patients have left, with actual life expectancies being on average 30% shorter than anticipated. This may impact treatment and discharge planning as well as patients’ and families’ expectations. Diagnosing dying is a complex and uncertain task as it involves distinguishing between clinical deterioration that is reversible from deterioration that forms part of the dying process and is hence irreversible. This task is further complicated by inconsistent definitions of what constitutes the end of life. There is some consensus that this is the part of life where a person is living with an eventually fatal condition that cannot be cured and will cause death in the foreseeable future, which could include prognoses of several months or even years. However, other definitions refer to the active dying phase, where the person is expected to die within the next days or hours.
Using dual process theory as a descriptive model of decision making, Taylor, Dowding and Johnson interviewed hospital clinicians in the UK on oncology and cardiology wards about their processes of diagnosing dying. The main reasoning method used was intuition or pattern matching, while also allowing time for analytical, methodical thinking. It is unclear whether the same applies to more multi-disciplinary teams and other specialities such as clinicians who predominately work with older people in non-acute hospital settings.

Aged care assessment teams are such multi-disciplinary teams consisting of geriatricians, geriatric medicine trainees, nursing, and allied health staff. They assess the physical, psychological, medical, restorative, cultural and social needs of older people and help them and their carers to access appropriate levels of support. Many clinicians in aged care assessment teams may not have specialist palliative care training but still care for older patients who are reaching the end of life. They are further faced with the challenge of predicting the trajectory of fluctuating conditions often seen in older patients such as chronic organ failure and frailty that can be more difficult than predicting the terminal drop often seen in patients with cancer. Recognising when an older person is approaching the end of life is therefore an important, yet challenging task for these aged care assessment teams.

For hospital care pathways and aged care assessment teams, predicting life expectancy is relevant because these teams often assess the suitability of an older patient for transfer to non-acute geriatric, rehabilitation or palliative care in-patient units, to residential aged care or another care setting. If a patient is recognised as being in their last few weeks of life, the clinicians who are conducting the aged care assessment may suggest spending this time at home with their family if this is possible, rather than putting family members through the time-consuming and taxing process of finding a place in a residential aged care facility.
contrast, if their life expectancy is longer and they require high levels of ongoing support, placement in residential care may be preferable.

Two retrospective file audits conducted in Australia demonstrate that clinicians are able to recognise dying, but often late in the illness trajectory. In the first audit of older people with a life-limiting illness, referred to residential aged care, 44% died before discharge from hospital. This was the case even though patient files contained enough medical indicators to identify the risk of dying earlier. In the second audit conducted in an aged rehabilitation setting, just over 54% of older people were referred to specialist palliative care for review, yet 11% of those referred died before the review. This suggests that clinicians recognised and documented the risk of dying very late in the illness trajectory, leaving little time for meaningful end-of-life planning and discussions. Mitchell et al. found that only 12% of older hospital patients had an end-of-life care plan. Following admission, 82% of patients were recognised as dying and the time between recognition of dying to death was between 4-48 hours. In many cases, the risk of dying was recognized only on the day the patient died.

Most referrals to specialist palliative care were made within the last two days of life and 62% of patients experienced interventions with life-prolonging intent in their final 48 hours. Bloomer et al. added that clinicians in non-acute care settings, such as geriatric inpatient rehabilitation, are often inadequately prepared to recognise patient deterioration towards death. Documentation related to care goals and decision-making at the end of life was inconsistent, impacting understanding about the patient’s care needs and impending death. Especially nurses found differentiating between an acute, yet reversible illness and dying difficult. And even when they knew the patient was dying, nurses often remained passive until dying was declared by a doctor.

Discussions about dying are hence left too late or entirely avoided. The authors conducted an earlier file audit of older people’s hospital, residential aged care, and community palliative
care records, and found that 63% of end-of-life preferences were documented within the last week of life. In that audit, end-of-life planning tended to focus on emergency procedures such as patients’ resuscitation status, while 70% had no documentation of important personal preferences such as their preferred place of death. This avoidance, however, may not only be clinician-based. In-depth interviews with older patients with life-limiting illnesses and bereaved family members showed that patients and families also avoided end-of-life conversations and planning. Unfortunately, this avoidance meant that family members and clinicians then had to make urgent end-of-life decisions on behalf of patients during times of medical crisis.

As the first phase of a larger study, the aim of this research was to examine hospital aged care assessment teams’ experiences, strategies and challenges in identifying patients at risk of dying.

**Method**

To examine how aged care assessment teams identified patients at risk of dying in hospital settings, we conducted in-depth interviews between August and December 2020 with members from these teams across two hospitals in metropolitan Melbourne, Australia.

**Ethics.** The study was approved by the Human Research Ethics Committee of Austin Health (ID: HREC/59677/Austin-2019). Research governance approval was also obtained from Western Health and the National Ageing Research Institute.

**Eligibility, Recruitment and Sampling.** Clinicians of the aged care assessment teams of both hospitals were eligible to participate in the interviews. Non-proportional, purposive sampling
and snowball sampling were used to identify relevant participants and ensure that relevant clinical specialities including geriatricians, nurses and allied health were represented. Site representatives, who were part of the project team (CP, PY), and interviewees facilitated the recruitment of clinicians from within their organisation. Interested participants were asked to contact the researcher directly via email or phone.

**Data collection.** Interviews were conducted by an independent research psychologist, with expertise in end-of-life research, who was not part of the assessment teams or employed at either hospital (KG). Clinicians provided written consent before the interview and received an honorarium gift card for their participation. All interviews followed a semi-structured question guide developed by the research team (Supplementary File 1).

**Data analysis.** Interviews were audio-recorded, transcribed and de-identified before being analysed thematically using QSR International’s NVivo software. Qualitative description underpinned this study. An initial coding framework was developed based on the interview questions and discussions within the research team. Using the processes proposed by Braun and Clarke, two researchers (KG, BH) coded four interviews independently to map and expand the coding frame, which was subsequently applied to the remaining transcripts by two of the authors (KG, KL). The codes were further refined and any coding differences were resolved through discussions between the research team until consensus was reached.

**Results**

We conducted 20 in-depth interviews with clinicians of aged care assessment teams from two hospitals. This included seven geriatricians and registrars, ten nurses and nurse coordinators, and three allied health staff including physiotherapists and social workers. Most participants
were female (19/20), which reflects the gender distribution in these teams. They were on average 43 years old (range: 32-60 years) and had 20 years of experience in healthcare (range: 5-43 years). Participants had worked within their aged care assessment team on average for five years, varying from those who had just recently joined with the team to those with 20 years of experience. Interviews lasted on average 54 minutes (range: 45-66 minutes). Due to existing COVID restrictions at the time, face-to-face interviews were not possible. Hence, half of the interviews were conducted using online videoconferencing and the other half via phone, depending on participants’ preferences. Participants were interviewed in a place of their choice, which was often an office at the hospital or their home.

Three overarching themes were identified regarding participants’ experiences with prognostication: (1) the harm of not recognising signs of dying, (2) strategies used in prognostication, and (3) barriers to identifying patients at risk of dying.

**Harm of not recognising signs of dying**

When discussing their experiences with identifying signs of dying, all participants could recall examples where dying was recognised too late. For instance, one clinician recalled the case of a 67-year-old patient with a complex history of cancer and unclear treatment goals, and expressing concern to the registrar that the patient might die. The reply they received from the registrar was “Don’t worry. She will be here tomorrow. Go home.” The participant followed these instructions with detrimental consequences:

“I went home. She was dead the next day. I was furious. We’ve missed the chance to warn her sister, we’ve missed the chance to discuss this with her. She died struggling to live because we were trying to treat this. I still get really upset thinking about it now... I never want to leave somebody deprived of all of those things, because nobody
would admit she was dying... Once you’re dead, you’re dead... You’ve missed it.”

(Participant 1, doctor)

Clinicians experienced the negative consequences of not recognising signs of dying first-hand. This ranged from participants feeling guilty to false hope and false choice for patients and families, inappropriate treatment, inappropriate place of care and place of death, lost opportunities to prepare, and consequently distress for patients and families.

“When I get a very sick patient, I’m like ‘Are we doing the right thing?’ It’s all well and good transferring a patient to residential [aged care] but there is so much work involved in the background. There’s selling of assets... There’s a lot of organising. Is this time the family could better spend with their loved one? Rather than being off at the bank or at the lawyers or filling out paperwork... Why are we putting these families, this patient through this?” (Participant 7, allied health)

Strategies used in prognostication

To identify early signs of dying, assessment teams used multiple strategies. Geriatricians predominately focussed on clinical indicators such as the patient’s diagnosis, co-morbidities, or illness trajectory. They used medical information to identify signs of dying such as oral intake, consciousness level, delirium, breathlessness, mobility and functioning. For this, they heavily relied on what was documented in patients’ files. For nursing and allied health staff visual markers were also important. Many described that a dying patient looks unwell with noticeable changes in skin colour but many struggled to describe this.

“Often they look different... Their skin is a little bit more waxy than normal and just different colour skin tones or just dullness of the eyes. It’s hard to explain.”

(Participant 4, nurse)
In addition to medical indicators, assessments from others played a role as they discussed cases with other colleagues and the treating team. Geriatricians often relied on nurses’ assessments as nurses spent more time with the patient and were able to notice subtle changes.

“We had nurses who had been doing the job for longer than any of the other doctors and so usually they’re the ones who come up with it [the prognosis] first... and they are right on the money.” (Participant 1, doctor)

Nurses, however, often waited for the doctors to officially declare that the patient was dying because they were “the treaters” (Participant 7, nurse). Participants also mentioned that patients and families sensed when death was imminent, which was another indicator used by assessment teams.

“I found that patients actually sometimes know they’re dying... and they feel as if they’re coming towards the end of life. You’d be surprised how many have already got an understanding.” (Participant 11, allied health)

Interviews showed that clinicians heavily relied on their intuition and gut feeling to identify when a patient might be dying. Many found this premonition hard to describe.

“The ward will say they’re stable and they’re not actively dying, but when you look at them, you think, ‘That doesn’t really look [good]’. That gut sensation that maybe their blood pressure and things are good, but they don’t look good. And invariably, they pass away within a few days... With many years working on the ward and with elderly [patients] – I think it’s something to look up in your mind bank how people look when they are getting close to death.” (Participant 4, nurse)
Clinicians described that their intuition was crafted through experience, but sharing gut feelings were a difficult foundation for discussions with team members or families. Hence many struggled with communicating their suspicions to others.

Prognostic tools and trigger questions may help in this process but were rarely used. Most participants were aware of the surprise question as a simple screening tool to identify people nearing the end of life. It asks: “Would you be surprised if this patient died within the next 12 months/ 6 months/ this admission?”. The question is sometimes included at the end of clinical assessments and is meant to trigger end-of-life care discussions and planning.

Geriatricians found this question helpful, however nurses and allied health staff avoided it since they did not feel comfortable and confident to make this assessment. They, therefore, left the question blank. This hesitation could mean that important end-of-life discussions may not take place.

“There’s a lot of controversy around that. Nursing staff were not at all comfortable with that question. Maybe it's their clinical skills, they're doubting. Whether there would be some backlash in using that word [dying], maybe? If the unit are actively treating the patient and the nursing staff are saying they're dying, I don't know how that would sit.” (Participant 13, nurse)

Very few assessment team members had heard of or used other prognostic tools like the Palliative Prognostic Index, Palliative Prognostic Score or Palliative Performance Scale but many were open to the idea.

“I think having a prognostic tool might be useful. I have not seen one or used one... A lot of time you use your gut feeling so I think the tool is more objective, it’s a way of objectively measuring or predicting something.” (Participant 2, doctor)
In summary, most clinicians used multiple strategies to assess signs of dying, including clinical indicators, assessments from others and their own intuition (Image 1). Prognostic tools did not play a role. Getting the full picture from all sources was seen as a challenging and time-consuming task especially when there was a difference between the impression they got from the patient’s file, talking to colleagues and seeing the patient in person.

“I feel like I’m an investigator most days, because you pull the doctors’ pieces together, the allied health pieces together, the blood tests.” (Participant 18, nurse)

Image 1. Illustration of strategies used in prognostication.

**Barriers to identifying patients at risk of dying.**

To explore potential barriers, we asked participants why dying was often recognised late. Especially nursing and allied health staff in the aged care assessment teams highlighted issues around roles and responsibilities as they sometimes felt not taken seriously by the treating team due to their different role, expertise and relatively short contact with the patient.
"Usually, [the medical team] they don’t take much notice of us in the assessment team thinking that [someone may be at risk of dying]... I guess they think we don’t have the expertise in that area, that we’ve just flown in for half an hour... The hospital thinks the assessment team will just do the paperwork and that’s it.”

(Participant 4, nurse)

Some clinicians, especially allied health staff and some nurses, felt it was not their place to assess signs of dying and that it was the job of more experienced medical staff to announce when a patient was dying.

“It's something I have always really struggled with. I don't like to give a prognosis or a time frame because I really don't think that that is a nursing role.” (Participant 3, nurse)

Many recalled examples of receiving what was seen as inappropriate referrals to assess whether a patient could go to residential aged care even though they were actively dying. Some felt confident enough to go back to the treating team and question the referral, while others did not. Instead, several participants admitted that when they received an aged care referral for a dying patient, they would deliberately fill out the required paperwork slowly to buy the patient more time in the hospital because they believed the patient would not make it to the aged care facility or survive long after the transfer. These communication and role-related challenges led to diffusion of responsibility, prognostic hesitation and inactivity rather than open and proactive conversations.

"[I said to the nurse]: ‘This person is not going to make it over the next couple of days.’ And she said: ‘No, she has been here for a while like that. The doctors have just been in and they want you to do an aged care assessment.’... I met a few patients where the doctors thought that the person was doing well. The person, the family and
myself, we said ‘They’re not going to make it.’ You then have the conversation with the family and say ‘Look, we just wait a little while.’... And I take my time to finish off the paperwork.” (Participant 5, nurse)

Another barrier was the lack of feedback about what happens to the patient after they leave the hospital system. Several participants commented that they did not receive any feedback about if and when a patient died after leaving the hospital. Individual follow-ups are time-consuming and therefore rarely possible. This means that clinicians had no effective way of learning whether their assessment of the patient’s prognosis was correct.

“Our service tends to see a client, do the assessment, and then finalise it. Once they have that approval to go from us to permanent care, we don’t follow up.”

(Participant 7, nurse)

System pressures also played a role, especially in hospital settings where there is often a perceived mantra of active treatment and high pressure to vacate beds to free up space for new admissions.

“The hospital was saying ‘Get [the patient] out.’ So I was forcing the family. They were out looking at [aged care] places... and the son kept saying ‘She is not going to make it.’ And of course she didn’t. They were frustrated because they’d been out doing stuff rather than spending time with [the patient].” (Participant 19, nurse)

Insufficient documentation was another barrier as signs of dying and prognoses were rarely documented. And when they were, the wording used was kept deliberately vague for fear of being wrong. Instead, clinicians used euphemisms to talk about dying in patients’ files like “guarded prognosis”, “unclear outcome”, “discussed palliation”, “not appropriate for escalation of care”. The ‘d-word’ was generally avoided. This points to death still being a taboo topic, even in hospital settings. Clinicians felt that this applied particularly to doctors.
As a nurse, you are better placed to care for, to be comfortable with people that are dying because you can still do things. Doctors are possibly less comfortable because they are supposed to save lives and people dying seems a bit of a failure but as a nurse you can provide comfort. It’s much easier to accept that than as a doctor because if someone dies, you’ve let them down.” (Participant 4, nurse)

Underpinning all these barriers was an overall lack of confidence, knowledge and training (Image 2). Some clinicians did not feel confident to make predictions about patients’ life expectancies. They could not recall any training on prognostication and most of their prognostic skills were acquired on the job, through work experience and learning from others. Those with palliative care experience felt that this helped their prognostic skills.

The lack of recognition of dying can come from a lack of training and even people may recognise it but not know or not be confident enough to take the steps to address it or even just say it… If we as geriatricians sometimes having trouble figuring out if someone is dying, can you imagine how difficult it would be for someone whose focus is not that? (Participant 1, doctor)

On top of these challenges, the COVID-19 pandemic has added another layer of complexity to assessing patients’ life expectancies. Protective gear like face masks made it harder to communicate with older patients and undertake comprehensive assessments. Clinicians felt that COVID had introduced more uncertainty and unpredictability regarding prognostication and aged care referrals. Older patients presented later to hospital with more complicated conditions that they had tried to manage at home to avoid catching COVID in the hospital. Aged care assessments were done in a rush as patient visits needed to be kept short to reduce the exposure risk for both patients and clinicians. There was less trust in residential aged care
and less time to explain the potential need for an aged care placement. Assessments via telehealth made it even harder to pick up signs of dying.

“Predicting who would die and who would live was really hard and sometimes we got it very wrong. We’d be telling families on the phone ‘Your dad came in with COVID-19... We don’t think he’s going to make it.’ But after a few days, they’d recover... Whereas others who would come in with a relatively good baseline, got COVID and then had a really long, protracted dying phase... We are still learning about this virus.... This was something we’d never experienced before.” (Participant 12, doctor)

These hospital experiences during COVID were described as extremely stressful and upsetting to clinicians, families and patients.

“For a lot of the staff it was quite traumatic... It spread very quickly through [the non-acute hospital ward], even though we were all in full PPE... Relatives couldn’t visit. So you have people that are actively dying, frightened, alone, isolated. What did they see? Maybe some of your eyes. Not your expression. Just horrendous. A lot of the staff are pretty battle scarred from that experience because if that was your loved one, you wouldn’t want that for them.” (Participant 14, nurse)
Image 2. Illustration of barriers to identifying patients at risk of dying.

Discussion

This study examined hospital clinicians’ experiences, strategies and challenges in identifying patients at risk of dying. It focussed on multi-disciplinary aged care assessment teams as an important, yet under-acknowledged, group that makes essential recommendations regarding the placement and discharge planning of older patients. Main findings were that clinicians had often experienced the negative consequences of not recognising signs of dying first hand, resulting in them feeling guilty, giving false hope/choice to patients and families, inappropriate treatment, inappropriate place of care and place of death, lost opportunities to prepare, and consequently distress for patients and families. Aligning with the dual process theory\(^1\)\(^,\)\(^1\)\(^,\)\(^2\) and findings from Taylor, Dowding and Johnson\(^1\), clinicians used a combination of analytical, methodical thinking, intuition and pattern matching to identify signs of dying. Reasoning based on intuition is frequently used by experts and triggered by contextual cues, e.g. by matching symptom patterns developed through extensive experience to a current case\(^1\)\(^,\)\(^1\)\(^,\)\(^2\). However, in addition to intuition, this study found that geriatricians more often analysed measurable medical information whereas nurses and allied health staff frequently relied on
visual markers. Prognostic tools did not play a role in identifying patients at risk of dying and the surprise question, a trigger for advance care planning, was frequently ignored.

Identified barriers to recognising signs of dying earlier, especially among nursing and allied health staff, included diffusion of responsibility regarding whose role it is to identify and respond to patients at the end of life, which can lead to a prognostic bystander effect. The bystander effect is well researched in social psychology stating that the presence of other people in an emergency situation reduces the individual’s feelings of personal responsibility to act and lowers the likelihood and speed with which they respond to, in this case, signs of dying. Additional barriers to prognostication included lack of feedback about whether clinicians’ predictions were correct, system pressures to pursue active treatment and vacate beds, avoidance of end-of-life discussions, as well as lack of confidence, knowledge and training on identifying early signs of dying. COVID-related restrictions further intensified these challenges. Many assessment team members did not feel confident to make predictions about patients’ prognoses or share their views with the treating team for fear of ‘crying wolf’ by saying the patient may be at risk of dying and then they do not. This was the case even though participants were highly experienced, having worked in healthcare for an average of 20 years. Clinicians expressed a desire for additional training on prognostication, highlighting the need for targeted interventions tailored to aged care assessment teams. Since prognostic tools were an underused resource, interventions could introduce clinicians to such tools to help them go beyond their intuition when making predictions about patients’ life expectancies. Interviews showed that most clinicians had the necessary knowledge to make such predictions but they struggled to formulate clear prognoses due to the lack of confidence and clear guidance. Prognostic tools could address this gap as they combine clinical markers in a simple, yet structured form and provide an indication for the expected prognosis in weeks or months. This may have the potential to help clinicians feel more confident in their
assessment \(^{34}\) and avoid unnecessary transfers to other care settings that make the end of life a fragmented and disjointed journey \(^{14,35}\).

Recognition of dying and integrated end-of-life care that is coordinated across settings has been identified as a priority in national and international policies and guidelines to support early discussions, referrals and planning \(^{36-39}\). Clinicians may therefore benefit from finding out what happened to their patient after they leave the hospital system. Once teams have formulated a prognosis, they need feedback on whether this prognosis was correct or not. This feedback loop is important for learning but rarely available across settings. Furthermore, support within and between teams must be improved as most participants did not feel taken seriously by the treating team. This in turn decreased their confidence to initiate end-of-life conversations and question aged care referrals for dying patients. Emphasis must be on working together to empower and learn from one another, knowing that every specialty and team member contributes valid and unique insights. Future interventions may therefore address how to discuss signs of dying with other specialties and engage in open dialogue. They must further address the insufficient documentation of prognoses in patients’ files and the frequent use of euphemisms that avoid the term ‘dying’ and can lead to misinterpretations and therefore late recognition and response to dying \(^{40}\). Prognostic avoidance not only in written notes but also in discussions with other clinicians or families can prevent future-gazing, end-of-life planning and appropriate care of dying patients.

**Strengths and limitations**

This study provides novel, in-depth insights into the experiences of aged care assessment team in identifying patients at risk of dying. Interviews were conducted by an independent researcher to allow participants to share their views freely. However, the project team
involved senior hospital clinicians. Coordinators of the aged care assessment teams encouraged clinicians’ participation in the study to facilitate recruitment from within. Results may thus have been influenced by a recruitment bias as participants with experience in recognition of dying may be more likely to volunteer for this study. Participants also knew the general topic of the interviews from the provided participant information and could have potentially prepared for them. Their knowledge of signs of dying may therefore be overestimated. Code saturation was reached for the medical and nursing participants but recruitment of allied health staff was challenging since they were less represented in aged care assessment teams than medical and nursing staff. They may also have been less likely to volunteer for this research since interview findings suggested that especially allied health staff did not feel recognition of dying was part of their role and skill set. This explains the lower number of interviews with allied health clinicians and also points to the need for targeted support for this group.

Conclusions

While prognostication is an extremely challenging task, prognostic avoidance resembles an ostrich’s approach of burying their head in the sand to avoid danger. The danger here is the potential death of the patient and the often confronting conversations that come with it. Prognostic avoidance must be addressed through tailored training and team support, especially for aged care assessment teams who play an essential role in care pathway place of care decision-making for older patients. Future research, policy and practice should further consider how the mandatory use of facemasks, telehealth, visitor restrictions, and social distancing during the COVID-19 pandemic may impact clinicians’ ability to notice and respond to early signs of dying.
References


Supplementary file 1. Interview guide.

Occupational background
- For how long have you been working in the assessment team?
- What is your role in the assessment team?
- For how long have you been working in this role?
- How much experience do you have working with patients who are dying?

Strategies regarding the recognition of dying
- Do you think recognising signs of dying is relevant for your role?
- Can you tell me about how you identify signs of dying?
- What do you do when you have identified a patient who is showing signs of dying?

Experience and training regarding recognition of dying
- In your team, who is responsible for recognising signs of dying?
  - Do you think recognition of dying is relevant for your role?
  - If so, how?
- Have you received any training on how to identify signs of dying?
  - If so, in what context? How long ago?
  - If not (or not enough), would you have liked more training?
- How confident are you in recognising signs of dying?
- Thinking about your team and your organisation in general, is timely recognition of dying a challenge?
- Can you give me an example of a recent or memorable experience where you or a colleague did not recognise that the patient was dying?
How often does this happen?

What makes recognising signs of dying difficult?

How could this be addressed?

Attitude toward and experience with prognostic tools

- Some people use prognostic tools to identify signs of dying. What is your attitude towards that?
  - Are prognostic tools important?
  - How accurately do you think they predict life expectancy?

- Do you have any experience with using prognostic tools?
  - If yes: Which ones? Were they useful? Are you still using them?
  - If not, why not?

- Are there any (other) existing tools that you are aware of?
  - What do these involve?
  - What prevents you from using them?

Concluding comments

- Is there anything else you would like to add?