**Table 1: Resident, care and relative characteristics included as independent variables.**

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| **Variable** | **Reference/Justification** |
| Family Perception of Physician-Family Communication (FPPFC) scale | Quality of the relationship with healthcare providers plays a role for family caregivers in making end-of-life care decisions [36].  To make a decisions in the patient’s best interest, surrogate decision makers often gather information from the clinicians [7]. |
| Resident’s health in last week of life Resident’s comfort during last week of life | The relative’s quality of life plays a role when family caregivers make treatment decisions [1, 32].  Lack of alignment in treatment goals between physician and family often occurred when patients had unstable/declining functional or cognitive health [16].  Surrogate decision makers view the patients’ best interest in terms of their quality of life [7]. |
| Relation to the resident | Nursing home physicians are more likely to involve close family members in decision making [1].  Staff and families are less likely to have similar perspectives on patient’s symptom burden when relatives are spouses or other relatives, compared with children [13]. |
| Care provider explained what palliative care means | Understanding of care (options) plays a role in decision making [1].  Care providers teach patients and families about prognosis and treatment options, to help shift them towards palliative treatment decisions [37].  Families or patients difficulty in understanding the limitations and complications of life-sustaining treatments was an important barrier to care goal discussions [38]. |
| Relative did not really understand resident’s condition | A shared understanding of the medical situation facilitates decisions on treatment and care [6].  Care providers change patients’ and families’ understanding of the patient’s condition to one that is consistent with the provider [37]. |
| Dementia | Lack of alignment in treatment goals between physician and family often occurred when patients had unstable/declining functional or cognitive health [16].  Medical staff considered family wishes more important to the decision-making process when the resident was cognitively impaired [4].  Patient’s incapacity to make care goal decisions was an important barrier to care goal discussions [38]. |
| Relative expected resident would die, one month before death | Care providers help patient and family understand the patient might not survive, to nudge them towards choosing palliative care [37]. |
| Relative felt fully involved in all decision making | The degree to which families participate in the decision making process may influence the goal-setting process [39]. |
| Resident talked with relative or someone else about preferred medical treatment/expressed preferences about treatment in last phase of life | Surrogate decision makers base their decisions on statements of preference by the patient [7]. |
| Relative felt fully involved in all decision making | Family satisfaction with treatment decisions was higher when medical staff considered family wishes to be important to decision-making [4]. |
| -No. care staff / 10. occupied beds  -Multidisciplinary meetings  -Length of stay | Keeping staff on the same page regarding care decisions was more difficult/impossible when:  -the resident-to-staff ration was high  -staff did not know the physician preferences for type and amount of communication  -the nursing assistant did not know the residents [6] |