Supplementary Materials

Supplementary material 1: COREQ Checklist

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	5
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	1
Occupation	3	What was their occupation at the time of the study?	1
Gender	4	Was the researcher male or female?	1
Experience and training	5	What experience or training did the researcher have?	5
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	6
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	6
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	6
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	6
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	5
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	5
Sample size	12	How many participants were in the study?	7
Non-participation	13	How many people refused to participate or dropped out? Reasons?	7
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	5
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	5
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	7
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	6
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	NA
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	6
Field notes	20	Were field notes made during and/or after the inter view or focus group?	6

Duration	21	What was the duration of the inter views or focus group?	7
Data saturation	22	Was data saturation discussed?	6
Transcripts returned	23	Were transcripts returned to participants for comment and/or correction?	6
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	6
Description of the coding tree	25	Did authors provide a description of the coding tree?	-
Derivation of themes	26	Were themes identified in advance or derived from the data?	6
Software	27	What software, if applicable, was used to manage the data?	6
Participant checking	28	Did participants provide feedback on the findings?	6
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	8-17
Data and findings consistent	30	Was there consistency between the data presented and the findings?	8-17
Clarity of major themes	31	Were major themes clearly presented in the findings?	8-17
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	8-17

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Supplementary material 2: Preliminary data collection used to develop Topic guide.

Table 1. Preliminary data inventory used to develop Topic guide. Data was collected at the ICU patient organization symposium, following the authors' presentation about SDM in the ICU. The audience, consisting of ICU physicians, ICU nurses, and former patients and their family members, were asked to write down their views on what was needed and what they saw as barriers to implementing SDM in the ICU. Notes were received from 54 individuals. The information was categorized in six topics. Some factors were mentioned multiple times.

Category	**Quotes**
Time	'Often there is a lack of time in acute settings' to properly talk, listen and explain. This is necessary to really talk though the consequences of certain choices.' 'No time to sit with patients or surrogates before treatment starts' 'As a clinician I expect there to be space for conversation regardless of the point in time'
Factors pertaining to Patients and surrogates	'More human, less patient' 'How did the patient function before admission?' 'What do the patient and family want? How far do they want to go?' 'But what if the patient is sedated?! Permission needed to share decision-making in their place.' 'Jump from ICU to home is large. Care is taken care of by GP, but they aren't specialists..' 'Don't just monitor the patients' QoL, but the entire family's!' 'In order to share decision-making you need access to the medical dossier and visit patient whenever.' 'Being involved in assessment emotions and mental health symptoms of patients' 'Being allowed to share care to a degree.' 'Direction: it happens to you, but you can't steer. You're dependent on everything.' 'Trust, equality, being taken seriously.' 'Surrogates' knowledge about what the patient truly wants.' 'Talk through resuscitation preference.'
Factors pertaining to clinicians	'A multidisciplinary meeting with different medical specialists about recovery possibilities.' 'Explain where possible before admission. When admission is planned, in the outpatient clinic.' 'Talk about a possible ICU admission with the GP before it happens.' 'Talk about treatment limitations before ICU admission' 'Physician who dares to discuss difficult topics' 'Nurses can talk through things with patients and families beforehand, as a bridge toward the physician. Physicians have to be open to this information' 'More information about who the patient is as a human being before they were admitted' 'When a patient is transferred, this is about more than just medical facets. Also: rehabilitation, GP, etc.' 'Trust that we act in the patient's best interests.' 'Ethical or moral deliberation in the ICU.' 'Passionate clinicians who value SDM.' 'As a topic to nurses' education.'

	'Keep remembering that as a physician you should not put the responsibility at the family members' feet' 'Clinician expects: don't force it.'
Organizational factors	'More attention for Post-ICU Syndrome in all facets of the organization.' 'One person as the main communicator, or communication and information coach' 'A truly multidisciplinary conference: social, psychological and medical. Maybe even with family members.' 'Clear, shared vision about SDM in entire team.' 'Acknowledge the importance of SDM.' 'Knowledge within treatment team about communication to and between patients and family members.' 'Practical tips, courses and education'.
Information	'Patients and family members need good information about prognosis and treatment possibilities to decide. Also: how can you provide personalized information, while keeping cultural background, health skills, etc. in mind' 'Clarity about the consequences of some choices, what are the consequences of not treating, what will and won't you choose' 'Clear explanations about the current situation' 'Long-term data.' 'Use social workers.' 'Information in the outpatient clinic.' 'Information about wishes, expectations, pre-existent functioning – this only comes up later in the treatment trajectory instead of at the start' 'Patients and family members need a prognosis to examine whether treatment is in line with wishes and expectations for QoL' 'Explanation: what does an ICU-admission entail?'
Miscellaneous	'Not going to the ICU does not always equal stopping treatment. Palliative sedation is treatment too.' 'Not resuscitating does not mean there is no treatment happening.'

Supplementary material 3: Clinician Topic Guide

- Can you describe the current process of ICU-admission and treatment? What is your role in this process? Can you name an example of your experiences with these processes?
- How do you experience the degree of involvement of ICU nurses in the ICU decision-making process? Can you name an example of your possible experiences with involving the ICU nurse in the ICU decision-making process? Should the ICU nurse have a bigger role in the ICU decision process? Why?
- How does the multidisciplinary meeting contribute to the ICU decision-making process? Can its current role be improved upon?
- How do you experience the degree of involvement of patients and family members in the ICU decision-making process? Should they be involved more? What would the advantages and disadvantages of involving them more be? What is needed in order to involve them more? What information is important and needed to allow patients and their family members to share in the decision-making process?

Supplementary material 4: Former patient and family member Topic Guide

- Why were you admitted to the ICU? Can you describe the period of admission for me?

- How were decisions regarding ICU admission made? Who was consulted? Were you involved in these decisions? Can you give me an example of your experiences regarding admission decision making?

- How were decisions regarding ICU treatment made? Who was consulted? Were you involved in these decisions? Can you give me an example of your experiences regarding admission decision making?

- What information do you think is of importance when talking about ICU admission and treatment decision making?

- Would you or your family member have liked to be more involved in the ICU decision process? If yes, how? What would you have needed to achieve this? If no, why not?