Table 1

Representative quote identified within each major theme.

Theme	Quote
Inefficiency	‘A lot of these times the reasons that we're not putting these vital signs in the electronic systems and doing all these things is because from a nursing practical standpoint, we are immediately seeing what is essential and what is not. So, to us our patient is our priority, and us double/triple documenting things in 10 different places is not efficient.’ [Nurse] ‘The nurse at the bedside recognizes that there is a problem, its communicated, but there's not a clear process where that flag goes up. Ultimately, it’s the physician who should be responsible but it’s a little of a grey area. There should be a system where once it's flagged, it's identified, it's marked, and then there is an algorithm and/or order sets that can be implemented to then allow you to make decisions’ [Physician] ‘We're working in such an acute environment where patients’ conditions are changing so often, and we're only filling out that assessment at the beginning of our shift whereas, you know, in the middle of our shift we could see drastic changes within our patient. So, a lot of times, we’re not

	filling out a screening tool. It's just I've seen these changes in patients, and that may not necessarily be reflected with a screening tool of sorts.' [Nurse]
CCU culture	'That's the way things have run, and that's what they (senior nurses) know, and that's what they're comfortable with. With a newer nurse, you will go with the flow of how the units run' [Nurse] 'Once you say the words out loud, everybody looks at you and the residents honestly don't know. To them, if it's late, it's calling to wake more people up. If the cardiologist on call isn't really on board, the resident who sees the patient isn't likely to push the boundaries because the cardiologist doesn't think it is. I don't feel like they can push the cardiologist to activate a shock team.' [Nurse] 'Just the importance of communicating even to the nursing staff, like understanding why the decisions that were made to not activate code shock, or not to consult so that we can just better understand and know at what point you want us to make you aware and what point are you wanting to start consulting? This would be appreciated by a lot of us.' [Nurse]

	‘It’s like a code blue. It can be a very well-run code and the patient still dies, but people feel better about the care they've provided compared to a successful resuscitation that was messy and unclear. It's a good outcome, but you still don't feel great about the care provided. That's where a lot of the frustrations come from with a code shock. We're kind of left in that lurch and think could we have done more?’ [Nurse]
Knowledge	‘I know just from my limited experience that even some of the attending positions aren't exactly sure what to do and how to activate code shock. I've seen some of the residents go to the attending, and then the attending was like, ‘Okay, well, how do we do this? What are we supposed to do?’ [Nurse] ‘We are filling the sheets (documentation) out. But who is looking at them? It should be treated that the physician signs us off once they've looked at it.’ [Nurse] ‘You have a really sick patient trying to get them all bundled up and down to the cath lab to get lines in can sometimes be quite daunting. Sometimes, a patient isn't stable enough to get down there, but you also need these. You need a central line to start running your medications. It can be a lot of get patients there, where it would be much quicker and better for the patient and nursing staff to do it at the bedside.’ [Physician]