Optimizing Goals of Care Consults and Interdisciplinary Teamwork

Robin Stahley, MSN, RN, Sarah Merrifield, MD, Sheri Keahey, MSN, RN
Providence St. Peter Hospital Olympia, WA

Introduction

Significant growth in our palliative care (PC) team resulted in incongruous understanding of individual roles and scope of practice. Additionally, there was disparity in how Goals of Care (GOC) conversations were initiated, completed, and documented leading to redundant or incomplete work. We sought to have team members work to the top of their license, fully utilizing their training and expertise. We created a workflow, training, and structured peer mentoring that maximizes efficiency and ensures consistently high quality palliative care consults.

Project Overview

Problems	Solutions
• No standardized process	• Developed GOC workflow
• Varied Clinician communication skills	• Training class / Mentoring
• Ambiguous roles	• Roles & Scopes clarified
• Ineffective interdisciplinary teamwork	• Duets for GOC / Family meetings
• Documentation disparities	• Standardized templates & quality measures
• No process for identifying DPOAH	• Incorporated into GOC workflow
• Incorrectly completed POLSTs	• POLST training / workflow
• Unclear of next steps with patients	• Developed GOC workflow
• Family meetings that were too long	• Created maps 1 & 2; training in conversations & cue recognition

Goals of Care Training Class

- Comprehensive GOC conversation communication training taught by nurse/physician duo trained facilitators of Respecting Choices and Vital Talk
- All team members attended 5 hour class
- Class contained elements of Vital Talk, Respecting Choices, the Serious Illness Conversation Guide, ACP Decision videos, and motivational interviewing.
- Skills practice used facilitated role play
- Topics included the scope of practice for various disciplines, phrasing specific questions, sharing the work as a team, recognizing and responding to emotion, different types of listening, and identifying, setting, and respecting personal boundaries

Peer Mentoring

Following the training, intentional peer-to-peer collaboration reinforced the workflow and skills learned.

Goals of Care Consult Workflow

Using published best practices as a guide, we developed a standardized workflow for GOC conversations

STEP 1 — Initial Consult: Information Gathering
- Review chart: identify needs
- Identify DPOAH
- Speak to referring provider and medical team
- Plan Approach

STEP 2 — Initial Consult: Patient Visit Map 1
- PC duet pre-meet
- Ask permission / Include DPOAH or family
- Patient assessment
- Explore patient perspective and values
- Discover gaps in knowledge
- Provider clarifies prognosis, if indicated
- Provide education

STEP 3 — Post-Meeting: Debrief
- Structured debrief
- Address social and spiritual needs
- Strategic approach to care that is consistent with patient/family priorities
- Follow-up with medical team
- Document in template

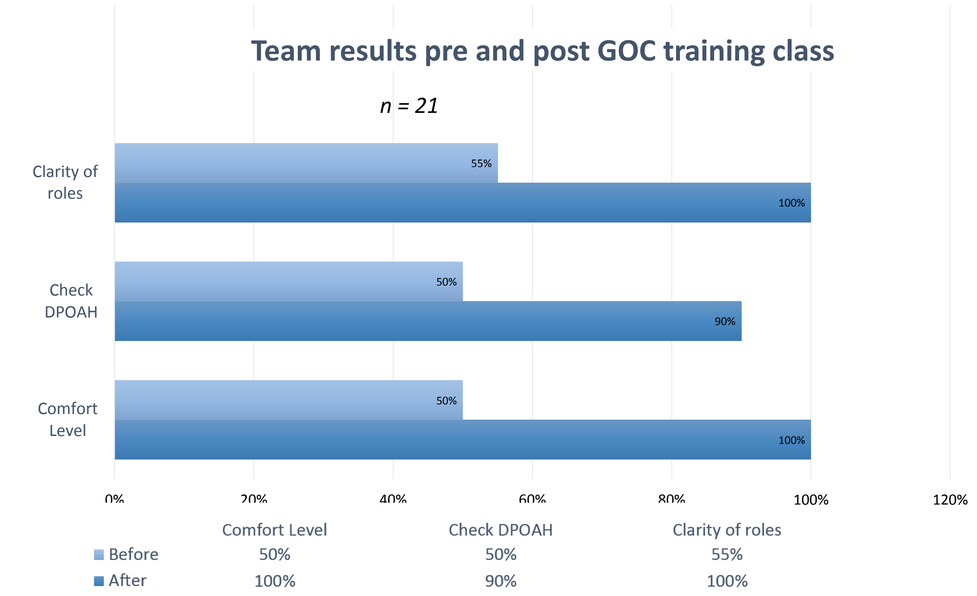
STEP 4 — Continuation of Initial Consult or Follow-Up Visit: Map 2
- PC duet pre-meet
- Assess patient/family understanding of medical interventions
- PC provider discusses treatment options
- ACP decision videos with conversation
- Create treatment plan that is consistent with patient/family values and priorities
- Consider POLST

STEP 5 — Wrap-Up
- Structured debrief
- Follow-up with medical team
- Document in template

DPOAH workflow

POLST workflow

Measuring Impact



Clarity of Roles: (high/very high) understand the role of the Provider, RN, and MSW in the GOC conversation
Check DPOAH: (always) Verify that the GOC conversation was with the appropriate surrogate decision maker when the patient was non-decisional
Comfort level: (high/very high) leading GOC conversations

Conclusion

Our workflow for GOC conversations, training, and peer mentoring led to much greater consistency including appropriate DPOAH in these conversations, measurably clarified roles and scopes of practice for various disciplines on our team, and significantly improved individual's comfort leading GOC conversations. Although not measured, we also recognize that this standardization of practice facilitates well-organized documentation of the content of the GOC conversation and enables us to consistently meet the expectations of our referring providers. Clarifying roles within the team resulted in improved team work. Convincing the team that standardized workflows had merit was one of the greatest challenges, but feedback regarding the workflow and training was positive. Our model of a team workflow, tools, and training for consistent and high quality goals of care consults can be a starting point for other teams. More research on the effect of standardizing GOC workflows and providing training for palliative care teams will be important. We are curious if there will be a measurable effect on retention of staff, resilience, and team cohesiveness.

References and Credits

Back, A. L., Arnold, R., Baile, W., Tulsky, J., & Fryer-Edwards, K. (2009). What Makes Education in Communication Transformative? *Journal of Cancer Education*, *24*(2), 160-162.
Bernacki R, Hutchings M, Vick J, et al. Development of the serious illness care program: A randomized controlled trial of a palliative care communication intervention. BMJ Open 2015; 5:e009032. doi:10.1136/bmjopen-2015-009032
Helgason, A., & Skulason, B. (2014). Motivational Interviewing in Palliative Care [Editorial]. *Palliative Medicine Nursing Open Access*, *1*(2). doi:10.14437/2378-8909-1-106
Jawahri A, & Podgurski, L (2010, January 10). Use of video to facilitate end-of-life discussions with patients with cancer: A randomized controlled trial [Electronic version]. *Journal of Clinical Oncology*, *28*(2), 305-310. doi:10.1200/JCO.2009.24.7502

We used the VitalTalk facilitation model and Respecting Choices in our training.