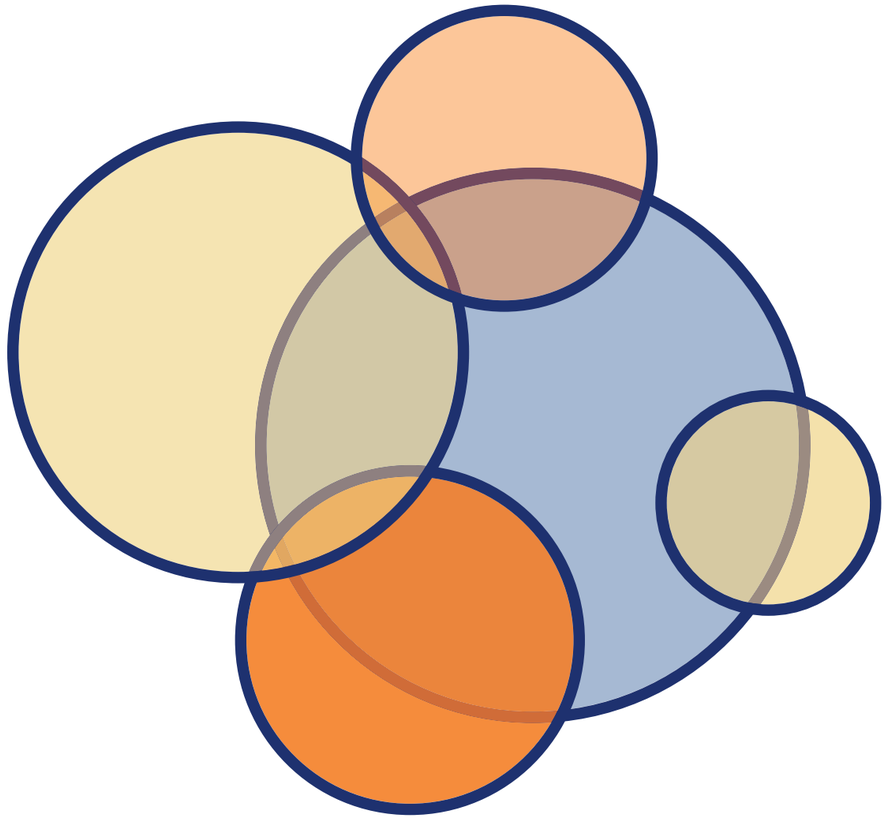
Strategies for Maximizing the Health/Function of Palliative Care Teams

A resource monograph from the Center to Advance Palliative Care



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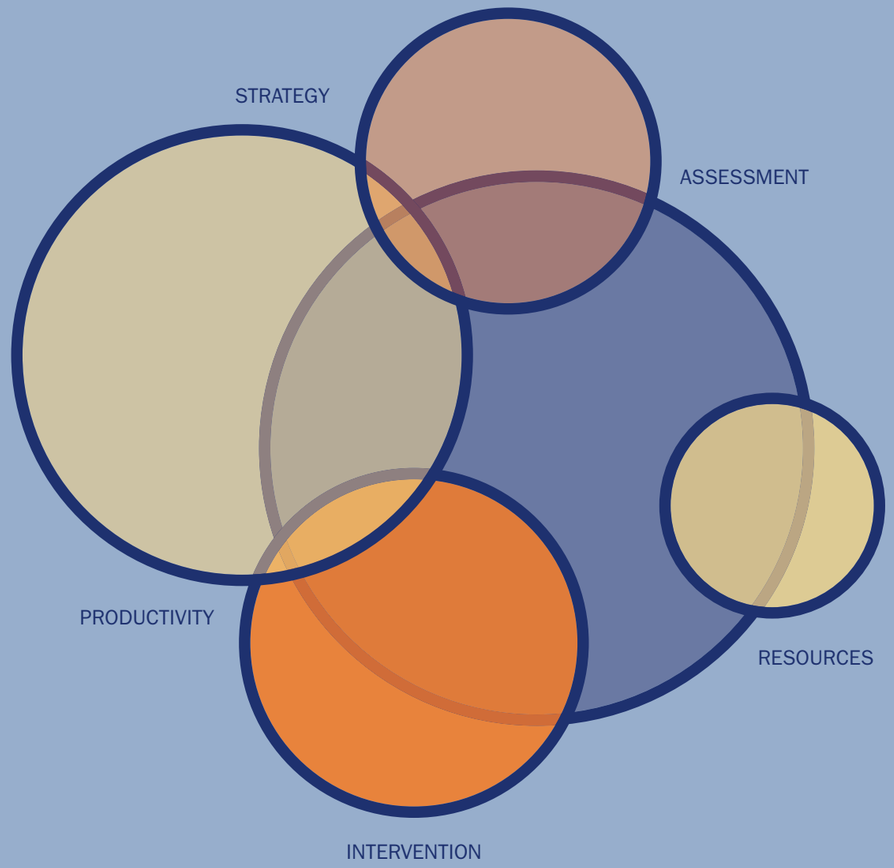

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INTRODUCTION

Palliative care programs serve seriously ill patients and families and provide support and guidance to referring clinicians and staff in all clinical settings. Designing processes to maximize the health of teams providing clinical care is essential to buffer the impact of constant exposure to grief, loss, and traumatic situations and to enhance the professional gratification that is possible in this specialty.[1, 2.]

The National Consensus Project for Palliative Care Clinical Practice Guidelines, 3rd edition, acknowledges the emotional impact of providing palliative care. Guideline 1.7 states, "The palliative care program recognizes the emotional impact of the provision of palliative care on the team providing care to patients with serious or life-threatening illnesses and their families." It further defines the need to implement structured meetings and interventions for staff support and sustainability.[3] Additional standards for team health activities come from *The Joint Commission Advanced Certification for Palliative Care Programs* (PCPM 6.10), and the Center to Advance Palliative Care's *Operational Features for Palliative Care Programs*.[4, 5.]

The benefits and potential adverse consequences that flow from the quality of palliative care team function can be profound, affecting clinicians and other staff, patients, and families, as well as the ability of palliative care programs to meet their internal and institutional goals.[6]

This monograph is designed as a guide to help palliative care program leaders and team members develop processes that promote team health, both during periods of stability and at times of team stress. Program leaders are defined as any clinical staff from any discipline or nonclinical staff who perform the following functions: oversee program mission, goals, strategic planning; interface with administrators; participate in staff selection; oversee duty assignments and completion of performance reviews, etc.

Benefits of Promoting Team Health	Consequences of Poor Team Health
Benefits for the Team	**Consequences to the Team**
• Maximizes opportunity for optimal patient and family care • Promotes team productivity • Promotes individual job satisfaction and self-enrichment • Increases creativity and problem-solving ability	• Loss of clinical effectiveness and productivity • Absenteeism and staff turnover • Dysfunctional intrateam behaviors • Blunting of empathy, moral distress, compassion, fatigue, and burnout
Benefits for the Program	**Consequences to the Program**
• Promotes well-being in relationships among clinicians, referring clinicians, and other staff • Promotes synergy between palliative care and health-setting goals • Fosters recruitment and retention of palliative care staff • Promotes program expansion to new clinical/educational/system change activities	• Loss of respect by peers and administrators • Reduction in patient referrals • Inability of program to meet hospital/health system goals • Expenses related to staff turnover: disruption of team equilibrium, financial, emotional

The authors recognize that team health is different from, but does include, self-care strategies. However, this monograph focuses specifically on methods to support and improve team functioning, as strategies to promote clinician self-care have previously been well described.[7]

Several key concepts/principles were used to guide the development of this monograph:

- Healthy team functioning does not happen by accident; it necessitates close attention and intervention during crisis and prophylactic measures during stable periods;
- Team health is a dynamic process and a shared responsibility of all team members;[8, 9]
- Team health reflects the health and habits of the individuals within it;
- Positive terms to promote in teams include health resilience, sustainability, compassion satisfaction, and job fulfillment.[10]

1

Team Characteristics

The following tables present summary information about team characteristics and events that may provide opportunities to maximize team potential and healthy relationships and/or increase vulnerability.

Attributes of Healthy Teams
• Well-defined program mission, vision, and goals
• Roles clearly delineated for each clinician/discipline, with acceptance that aspects of palliative care are shared across disciplines
• Shared team values that are consistently articulated
• Established lines of staff accountability, reporting, and supervision
• Clear work and productivity expectations
• Constructive and routine staff evaluation process
• Established/routine team health activities
• Demonstrated respect and appreciation for individual team members and team as a whole
• Open communication among staff members to resolve conflicts, promote trust, and work to achieve common goals
• Strong leadership skills of palliative care program leader(s)

Factors/Behaviors That Impair Team Function[12, 13]
• Absence of trust among team members
• Fear of conflict within the team
• Lack of commitment to the team/program
• Avoidance of staff accountability
• Inattention to desired team outcomes/results
• Wanting team-based results without constructing a team-based structure
• Overestimating the importance of the task focus and underestimating process and relationship
• A team culture that discourages collaboration and cooperation
• Neglecting the talent pool that resides in a team
• Insufficient training prior to launching the team's work

Features That Increase Vulnerability to Team Distress/Dysfunction[11]	
Team and Administration	**High–Risk Events**
• Lack of well-defined program mission	• Young teams moving through normal team development phases
• **Poor leadership skills of palliative care program leader(s)**	• **Change in team membership**
• Lack of clinician and discipline-specific role clarity	• Clinicians new to the specialty of hospice and palliative care
• **Various assumptions, perspectives, legal responsibilities, and values that may not be articulated or respected**	• **Disruptive behavior by team member(s)**
• Multiple lines of staff accountability: e.g., physician reports to medical staff, nurse reports to nursing department, social worker to social work or patient care services	• Vicarious trauma due to critical clinical incidents (e.g., death of a child or young adult; clinician belief that he/she may have contributed to hastening death)
• **Staff with both palliative care and non-palliative care responsibilities with conflicting or uncertain expectations**	• **Personal crises of staff members (e.g., death of a loved one)**
• Lack of administrative or institutional support, real or perceived	
• **Clinical workload and financial pressures that restrict opportunities for team health activities**	
• Team or individual attitudes of clinical or moral superiority that inhibit appropriate communication on patient care	
• **Perceived or real lack of support or understanding from colleagues regarding palliative care philosophy/goals**	
• Lack of clarity regarding the populations that can be served given existing resources	

Teams with one or more of the following features require leadership to assess and design an intervention plan that identifies concerns and acknowledges observed behaviors to begin the work of promoting improved team health and relationships.

Black–Box Warning of Potential Team Distress/Disfunction
• One or more team members who are: disruptive, frequently absent, apathetic, dispassionate, sarcastic, hopeless, and/or who express constant emotional/physical exhaustion, report frequent illnesses, or exhibit signs of palliative care "martyrdom"[14]
• Chronic poor attendance at team meetings
• Chronic poor follow-through on assigned tasks
• Team member(s) repeatedly staying beyond normal work hours
• Intrateam conflicts or differences that are consistently unresolved
• "Junior high school" behaviors: cliques, gossiping, and similar behaviors by team subgroups—a sign of poor team communication, feelings of disenfranchisement, and dissatisfaction
• **Frequent high clinical workload that precludes nonclinical activities** (e.g., teaching, scholarly work, quality-improvement projects, team care activities

2

Assessing Team Health and Function

The ability to measure team function allows for goal setting and development of dashboards/report cards, providing a template for transparency. Listed below are samples of commercially available team assessment tools. In addition, the authors have constructed two nonvalidated but easy-to-use tools based on common themes from the literature (see section VII below, "Assessment Tools").

Note: *There are dozens of commercial tools; we have selected several commonly used examples that specifically focus on team health and function. In section VI below, table 1 ("Commercial Team Assessment Tools") provides information about how to access these resources and their cost. Table 2 ("Matching Assessment Tools to Team Needs") provides guidance on which tools are appropriate for different assessment needs.*

DISC Assessment

http://www.thediscpersonalitytest.com

- **DISC is an acronym for Dominance (Drive),** Inducement (Influence), Submission (Steadiness), and Compliance (Conscientiousness).
- **Multi-item assessment** classifies four aspects of individual behavior by testing an individual's preferences in word-association dyads and assigns a primary or dominant style.
- **Results are expressed as:** "natural communication style," "adapted style," and instructions on changing one's communication style to achieve enhanced blending into a more functional team environment.
- **DISC can be used to:** screen employees for different jobs, determine how best a learner will respond to information, or show how a leadership team or group may respond better to each other's communication styles.
- **DISC can be administered and scored electronically**, has low user burden in terms of complexity and time commitment, and provides in-depth evaluation with suggestions of actions to enhance other nondominant styles.

The Five Dysfunctions of a Team [12]

- **This widely used and simple assessment tool measures five domains:** inattention to results, avoidance of accountability, lack of commitment, fear of conflict, and absence of trust.
- **Individual team members complete a 15-item assessment instrument.**
- **Assessment statements are correlated and scored** to determine a mean and median for each set of questions; scoring determines degree of function/dysfunction.
- **Regular team assessment** with this tool and subsequent planning can serve to promote a high- functioning team.

Parker Team Measurement Tools http://www.glennparker.com/Products/products.html

Parker Team Player Survey (PTPS)

- This 18-item self-assessment tool helps individuals identify their
  - team member style
  - contributor—task oriented
  - collaborator—goal directed
  - communicator—process focused
  - challenger—questions the goals and processes of team
- Results and related exercises provide insight into maximizing strengths and developing plans for addressing weaknesses.

Parker Styles of Another Person (SOAP)

- This tool allows each team member the opportunity to compare his or her self-perception of communication style with the scores of teammates.
- A companion to the PTPS, this survey is given to team members to provide observations about each others' team-player style.

Parker Team Development Survey

- This 12-item survey serves as a
  - data collection tool for team assessment
  - needs-assessment tool to identify training opportunities
  - team-building activity regarding team effectiveness.

Parker Signs of Stagnation Checklist

http://www.glennparker.com/Freebees/assessment-signs-of-stagnation.html

- This free 10-item survey can help assess team stagnation.
- It is used to trigger team discussion about the need to refresh team goals/activities.

Intervention Strategies That Promote Team Wellness

Methods to promote team wellness can be thought of as proactive or reactive. Listed below are proactive strategies for general use as well as approaches responsive to periods of team stress.

A. Proactive Strategies Applicable to All Teams/All Settings

Hiring: Ask candidates and their references questions that address self-care and team function.

For candidates:

- Describe your personal self-care strategies.
- Describe how you manage stress in the workplace.
- Describe how you handle conflict with coworkers.

For candidate references:

- Describe how the candidate works with others.
- Describe a situation of intrateam stress the candidate was involved in.
- Describe how the candidate handles conflict with coworkers.

Personal wellness strategy: Encourage team members to develop a personal wellness strategy as a method of enhancing their personal commitment to the team.

Team wellness strategy: The entire team shares the work and responsibility of developing a team wellness strategy as a group activity. Any change in staff will necessitate a review/revision of the strategy. (See section VIII, resource 2, below: "Sample Team Wellness Plan.")

Routine debriefing: Conduct debriefing meetings at least monthly that specifically focus on discussing recent events as a group, acknowledging program milestones and individual achievements, celebrating work well done, venting frustrations/anger/concerns, and offering suggestions to enhance team function and health.

Crisis debriefing: Initiate group discussions in which team members identify crises that can impact team dynamics, process both facts and emotions rising from the crises, and consider consequent actions that may mitigate the impact of future crises.

B. Critical Events in the Life of a Team

Addressing critical events in the life of a team can strengthen team relationships and enrich team process; if ignored, such events can result in distancing, distress, and dysfunction. Four common critical events are listed below, with suggestions for basic and advanced activities that both acknowledge and respond to the potential impact on the team.

i. Staffing Changes

An alteration in staffing has potential ripple effects that impact team dynamics and function. Routine staff changes (e.g., normal team growth) are better tolerated than those that are more disruptive (e.g., sudden illness). In acknowledging these changes, leaders and team members can reinforce areas of stability while developing interventions to enhance adaptation to staff changes.

Suggested basic activities:

- Schedule a team meeting to discuss the anticipated impact of staff changes to address both emotional and practical components (e.g., changes in daily workflow). If the change has been especially difficult, a neutral outside facilitator may be helpful in guiding the discussion.

Suggested advanced activities:

- Plan a team meeting to prepare members for the introduction of new staff.
- Use the Parker Team Player Survey tool for all team members to assess their individual styles, analyze the style distribution within the team, and explore/anticipate consequent changes to team membership.
- Schedule a team meeting 30 to 60 days after a new hire to debrief members about the impact on team function. Encourage an open discussion of what is working well, anticipated and unanticipated impacts, and suggested changes to improve function and enhance satisfaction.
- Conduct a post-hire review 90 to 120 days after hiring. In this activity the entire team completes an assessment tool such as the Five Dysfunctions of a Team or the Parker Team Player Survey and discusses the results.

Note: *Any timelines that are included are merely suggestions and should be modified based on events and perceived needs of team members.*

ii. Excessive Workload

As workload increases, team members commonly experience stress, which increases team tension; teams that have preexisting dysfunctional behaviors are at greatest risk. Seeking more staff to manage the workload is often neither feasible nor an appropriate first response, as it precludes using the opportunity to engage members in a deliberative process of reviewing program mission and outcomes, workflow patterns, and personal work habits to create a strategic plan for coping with higher workload.

Suggested basic activities:

- Schedule a team meeting to discuss individual members' emotional reactions to the increased workload.

Suggested basic activities continued:

- Screen for work–life imbalance (see Assessment Tool 2, below).
- Develop an action plan for the immediate steps of managing increasing workload. This may include one or all of the following:
    - Establish clear start/stop times for staff members to complete their daily work.
    - Review the program's scope of care to determine if there is work that might be triaged to other providers outside the team.
    - Offer phone or written guidance in place of formal consultation when circumstances can be adequately managed by others (e.g., ventilator withdrawal).
    - Limit consultations to selected units (e.g., only oncology and ICU).
    - Triage work to specific disciplines (e.g., psychosocial spiritual distress to social work or chaplaincy; symptom management to MDs, APRNs; discharge planning to appropriate colleagues).

Suggested advanced activities:

- Assess team efficiency and effectiveness. Determine whether or not the team has a clinical care model that maximizes efficiency; review with each team member the potential to discover time-savings opportunities. Consider having staff complete a one-week time analysis to objectively quantitate the time spent on various aspects of the work (staff members record their activities in 30-minute intervals during the day).
- Complete a strategic plan. Prior to beginning any discussion of adding new staff, the team needs to complete a strategic plan, or at least review the existing strategic plan, to understand the current strengths, weaknesses, opportunities, and threats to staff changes. This is especially important as palliative care teams are asked to expand leadership, clinical, and educational services.

iii. Critical Clinical Incidents

All teams experience extraordinary clinical events that trigger powerful emotions (e.g., grief, anger, regret) that affect daily functioning.

Suggested basic activities:

- Utilize the proactive strategies listed above.
- Call a team meeting within 72 hours of the event to emotionally debrief members about the experience.
- Assess the need to refer affected staff for professional counseling.

Suggested advanced activities:

- Conduct a follow-up team meeting within 2 weeks to assess team impact and determine how the critical event can inform improvements in team and institutional function.

iv. Disruptive Team Member(s)

Disruptive conduct by one or more team members can seriously impair team function. Behaviors can include single or repeated episodes of: raised voice, profanity, name-calling, abusive treatment of patients/staff, sexual harassment, disruption of meetings, repeated violations of policies or rules, or other behavior that disparages/undermines healthy team function. These behaviors impact all members; allowing these behaviors to continue signals lack of attention and concern from leadership and creates a whole-team problem that diminishes the sense of safety, mutual respect, and support that is central to team function. Strategies that address both the individual and the team are necessary.

Suggested basic activities:

- Issues related to the disruptive individual
    - Assess for stress, drug, alcohol, or family issues as causative factors; refer to EAP (Employee Assistance Program) or counseling.
    - Review institutional policies and collaborate with institutional resources for assistance in developing an intervention plan (e.g., Human Resources).
    - Consider removal from clinical responsibilities for a period of time with a monitored and performance-based reentry plan.
- Issues related to the team
    - Host a team meeting to discuss the emotional impact of the disruptive team member and impact on the work.

Suggested advanced activities:

- See section VIII, resource 1, below: "Advanced Team Activities to Establish Boundaries and Expectations for Accountability."

Working Productively with Institutional Leaders

Support from institutional leaders (e.g., chief medical/nursing/financial/operating officers) is essential for effective team functioning. Palliative care programs are best served by regular dialogue between the leaders of the palliative care program and the institution to discuss the entire range of program activities, including issues of team function. When administrative leaders are aware of the pressures of providing clinical care, with examples of both exemplary care and situations of team distress or dysfunction, they will be in a better position to provide requested resources.

Tasks of Palliative Care Leaders That Will Enhance Administrative Relationships

- **Annually review/revise program mission statement in alignment with expressed goals of administrative leadership.**
- **Complete an annual strategic plan aligned with institutional priorities.**
- **Establish clear expectations for team member work activity: tasks, roles, leadership, accountability, and outcomes.**
- **Complete team assessments to identify differences between current team functioning, resources available, and the ideal.**
- **Identify resources within the organization that support team health:**
  - Human Resources staff
  - strategic planning resources
  - EAP services
  - organizational development resources
  - health and wellness expertise and resources
  - staff recognition programs
  - resources for funding retreat activities, staff recognition
  - peer supervision/consultation resources outside the team
  - spiritual support resources
  - options for leaves/sabbaticals for staff renewal and professional development

Key Messages from Palliative Care Leaders to Administrative Leaders

- **Connect the outcomes of a well-functioning team to the concerns of administrators: compassionate, quality care of patients and families, readmission reduction, timely use of health care resources across the continuum of care, efficient and effective discharge planning.**
- **Describe the nature of the palliative care team's work and anticipated demands and challenges; offer to include an administrator at an interdisciplinary team meeting or on rounds with the clinical team.**
- **Include team health as a core component of resources in the program's strategic and business plan and annual budget.**
- **Describe the role of adequate funding for operations to support team health: clinical and administrative staff, communication and technology resources, office space and equipment.**[15]
- **Reinforce the importance of budgeting staff time for individual and team activities to promote team health.**
  - Individual activities include time off from direct patient/family care to plan/develop other areas in support of program goals: education, metrics, quality improvement, community outreach.
  - Team activities include routine review of patient/family care, debriefing, problem solving, commemorations/memorials, professional education and development.
  - Funding is available for professional development to attend conferences, complete scholarly projects, and engage in peer consultation/collaboration.

5

Glossary

Boundaries: The rules, guidelines, role descriptions, attitudes, and interpersonal practices that enable clear expectations among staff, the organization, and patients/families for organizing work, ensuring safety, managing professional relationships, and addressing clinical care demands.

Burnout: The deterioration of one's professional values and beliefs, and loss of hope in the workplace; evidenced by emotional and physical exhaustion or depletion, depersonalization, cynicism/sarcasm, and reduced sense of value or accomplishment in work.

Compassion fatigue: Feelings of suffering or internal anguish consequent to constant exposure to and caring for patients and families experiencing physical, emotional, or traumatic anguish.[16]

Compassion satisfaction: The pleasure derived from being able to do one's work and contribute to the work setting and to the greater good through assisting people who need care. http://www.proqol.org/Compassion_Satisfaction.html

Disruptive clinician: A clinician who interferes with the orderly conduct of hospital business, from patient care to committee work. This includes behavior that impairs the ability of others to effectively carry out their duties or that undermines the patient's confidence in the hospital or another member of the health care team.[17] http://www.psqh.com/julaug06/disruptive.html

Moral distress: Several definitions exist. It occurs when:

- moral values conflict with workplace realities;[18]
- you act in a manner contrary to your personal and professional values, which undermines your integrity and authenticity.

http://www.aacn.org/WD/Practice/Docs/4As_to_Rise_Above_Moral_Distress.pdf

Palliative care martyr:[14] This is someone who:

- believes he/she is both indispensible for managing all patient suffering and responsible to all patients in need;
- recognizes he/she is overworked and under personal stress but feels helpless to change the situation;
- feels unappreciated by those with authority.

Palliative care program: The entire scope of services provided by the palliative care staff, including clinical care, education, marketing, data reporting, and quality improvement.

Palliative care team: Health care professionals working in any clinical setting providing specialist-level palliative care services (e.g., hospital consultation service, hospice services, outpatient palliative care clinic, home-based palliative care, etc.).

Glossary (continued)

Psychological safety: The degree to which people perceive their work environment as conducive to taking interpersonal risks. In psychologically safe environments, people believe that if they make a mistake they will not be attacked or diminished by others and that others will not resent or penalize them for asking for help, information, or feedback. Psychological safety also depends on the perception among team members that disruptive behavior is not tolerated. This belief fosters the confidence to take risks in the interest of quality patient care.[19]

Resilience: The process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances.[8] A universal capacity that allows a person, group, or community to prevent, minimize, or overcome damaging effects of adversity.[10]

Self-Care: Activities performed independently by an individual to promote and maintain personal well-being throughout life.[20]

Sustainability: The ability of a clinical provider to work productively on a long-term basis.

Team: A small number of people with complementary skills who are committed to a common purpose, set of performance goals, and approaches for which they hold themselves mutually accountable.[21]

Team distress vs. team dysfunction: The distinctions are as follows:

- Distress is the extent to which an issue causes anguish, worry, upset, etc.; may or may not lead to dysfunctional behaviors.
- Dysfunction involves behaviors and feelings that interfere with a person's ability to function in daily life, hold a job, or form relationships; may or may not have associated distress.

Vicarious/secondary trauma: The cumulative and ongoing process of change or adaptation that occurs as a result of repeatedly witnessing or hearing about the pain, suffering, and need of others. Vicarious trauma is a state of heightened tension and preoccupation with the situations of those who have been traumatized, a consequence of empathic engagement and the cause for changes in psychological makeup over time.

http://headington-institute.org/Default.aspx?tabid=2648

http://www.counseling.org/docs/trauma-disaster/fact-sheet-9—vicarious-trauma.pdf?sfvrsn=2

6

Tables

1. Commercial Team Assessment Tools

Name	Cost	Comments	URL
DISC	Ranges from $15 per test to $110 for online version with interpretation	Multiple vendors	**http://www.thediscpersonalitytest.com**
The Five Dysfunctions of a Team	~ $38.50 per person for online assessment	Pricing for full report and accompanying materials delineated on website	**www.tablegroup.com**
Parker Team Player Survey (PTPS)	10 for $106.50	18-item self-assessment tool; available in French and Spanish; PTPS user guide available	**www.glennparker.com/Products/products.html**
Parker Team Development Survey	10 for $93.75		**www.glennparker.com/Products/products.html**
Parker Styles of Another Person (SOAP)	$82.50 per kit	Kit includes 10 team-member surveys, leader's guide, team scoring form, and outline for creating action plan	**www.glennparker.com/Products/products.html**
Parker Signs of Stagnation Checklist	No charge		**http://www.glennparker.com/Freebees/assessment-signs-of-stagnation.html**

2. Matching Assessment Tools to Team Needs

Global/Screening Assessment	
A global assessment of team function can set the stage for action planning. Completing an assessment in a setting of psychological safety without fear of retaliation is crucial to the validity of the sample and results.	• The Five Dysfunctions of a Team • Parker Team Player Survey • Parker Signs of Stagnation Checklist • Basic Team Assessment (see section VII below)
Assessment of Intrateam Communication	
Many tools exist to assess team communication; global assessment tools are useful to identify specific areas of function that need attention (e.g., conflict avoidance).	• The Five Dysfunctions of a Team • Parker Team Player Survey • Parker Styles of Another Person
Individual vs. Team Assessment	
Many tools exist to assess team communication; global assessment tools are useful to identify specific areas of function that need attention (e.g., conflict avoidance).	• Parker Styles of Another Person • DISC Assessment • Work–Life Balance Assessment for Individuals (see section VII below)

7

Assessment Tools

1. Basic Team Assessment

This tool was designed by the authors. It is intended for use as a rapid self-assessment of team function; items are derived from other existing assessment tools. *Note: This tool is not validated.* **Teams can complete this either as a group exercise or individually.**

Scoring: **1** = Poor **2** = Fair **3** = Excellent

Score (1–3)	Item
	There is open communication and trust to share personal feelings between team members.
	Every team member knows the program mission and goals for the coming 12 months.
	Team members work well together to achieve team goals in a timely manner.
	Team members have a high degree of accountability to each other to complete clinical and nonclinical tasks.
	Individual roles and responsibilities are well understood.
	Conflicts between team members are quickly aired and resolved.
	Team administrative meetings are well organized, with clear outcomes and good follow-through.
	Team members are receptive to self-care and team care activities.
	Individual performance expectations are clearly defined.
	Team members handle workload stress professionally.
	TOTAL SCORE

Score Interpretation (range 10–30)
< 20 = Poor, improvements definitely needed
20–25 = Fair, some improvements needed
> 25 = Excellent

2. Work–Life Balance Assessment for Individuals

It is common for palliative care team members to struggle with maintaining a balance between work and life. In fact, many times colleagues know each other only through the work that they do rather than having a sense of the whole person. This assessment tool, developed by the authors, can be completed as part of routine staff assessment or used when a staff member appears to be struggling as evidenced by sadness, hopelessness, or behaviors such as missing or coming late to meetings or routinely staying late at work. These questions can be explored privately or reviewed in a group activity where all team members explore their answers in a setting of open discussion of team health. *Note: This tool is not validated.*

Scoring: **1** = Rarely **2** = Commonly **3** = All the Time

Score (1–3)	Item
	Do I run late because I am overscheduled with too many meetings?
	Do I check in on patients and families when I am off work?
	Is my team aware that I check in on patients/families when not on duty?
	Do I keep my pager on even when I am off call just in case someone needs me?
	Do I give my personal phone number or e-mail address to patients and families even when someone else is covering?
	Do I bring work home (documentation, charting, projects, etc.)?
	Do I feel I must put the needs of patients and families before my needs?
	Do I feel the need to fix the problems of patients and families rather than allow the process to occur/unfold?
	Am I overscheduled and run late because I have too many activities?
	Do I put my work before my family and friends?
	Do I avoid/reject personal “down time” with no work responsibilities?
	Do I feel the need to apologize for being late to or missing non work events?
	Do I do things for others, with or without asking permission, rather than allow others to do things for themselves?
	TOTAL SCORE

Score Interpretation (range 13–39)

< 19 = Good
20–32 = Fair, some improvement may be needed
> 32 = Poor, improvement is almost certainly needed

8

Resources

1. Advanced Team Activities to Establish Boundaries and Expectations for Accountability

A problematic team member can have an impact on team function that goes far beyond the specific disruptive behavior. Teams often develop unhelpful responses that accommodate such behaviors in the hopes of containment/appeasement and that are meant to help maintain a sense of normalcy. The suggestions below are intended to help teams build skills to better cope with problematic behaviors and bring attention to communications and processes that are protective of individual and team health.

Strengthen interpersonal communication.

Address issues as they arise. Identify problems clearly and describe desired changes definitively. In doing so, use “I” statements, e.g., “I prefer,” “I recommend”; avoid constructions such as “you should,” “you have to,” “you ought to.”

Establish clear lines of authority.

This provides accountability for management of disruptive behaviors, poor performance, and damaging attitudes. All members of the team share responsibility for meaningful and timely feedback; leaders/managers are responsible for performance expectations and consequences.

Discourage one-dimensional thinking.

Is this a difficult individual and/or a team dysfunction issue? Seek methods to assess and create a plan to respond to both possibilities.

Define expectations for accountability.

Develop a culture that supports clear, specific, and honest feedback, mutual respect, and awareness of the interdependence of the team members. Address repeating patterns in the context of performance rather than personality issues.

Ask colleagues to share concerns about team member distress.

Encourage discussion of concerns with the individual and with team leaders. Open discussion works to normalize the emotional labor of working in palliative care.

Provide continuing education and training for individuals who practice outside the team’s standards.

Develop and utilize shared definitions, practice standards, and team expectations for practice and collaboration.

2. Sample Team Wellness Plan

- **The clinical team will annually review the:**
  - palliative care program mission and vision;
  - role descriptions, productivity expectations, and team job descriptions, especially with the arrival of new employees;
  - team charter;
  - strategic plan.
- **The team charter describes:**
  - agreed-upon ground rules for accountability to patients, patients' families, colleagues, the organization, and themselves;
  - expectations for how team members will identify and address conflicts;
  - how new members are oriented to this document and are asked to indicate their agreement.
- **Palliative care program leadership meets quarterly to review team goals, progress, performance; summary information is provided to the entire team.**
- **Twice each year, team members complete, rate, and discuss a team wellness assessment tool; data are incorporated into annual strategic planning.**
- **New clinical staff members are assigned a program mentor who is available for guidance, support, and orientation to the less tangible aspects of providing palliative care within the team.**
- **The clinical team is scheduled so that no member is on full-time clinical duties; schedules will be structured to allow for routine time engaged in nonclinical activities (teaching, quality-improvement projects, self-enrichment).**
  - Team members who feel physically or emotionally at risk are encouraged to seek relief from clinical duties. Such requests will be honored whenever possible and tracked to ensure fairness and accountability.
- **The clinical team meets weekly to debrief members about complex cases.**
- **The team holds two annual off-site retreats:**
  - one meeting for strategic and business planning;
  - one meeting for reflection, renewal, and/or professional enrichment; resources necessary to promote team wellness are incorporated
- **Social events, in and out of the workplace, that celebrate team or personal accomplishments/milestones are encouraged.**
- **Each clinical team member completes an annual personal wellness plan that is included in his/her annual performance review.**
- **Program leader(s) maintains a list of resources to assist team members:**
  - e.g., EAP counselor, conflict management training, Alcohol and Other Drugs of Abuse (AODA) resources

9

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Internet Resources

National Consensus Project for Quality Palliative Care

http://www.nationalconsensusproject.org/Guidelines_Download2.aspx

Dahlin C., ed. Clinical Practice Guidelines for Quality Palliative Care. 3rd ed. Pittsburgh, PA: National Consensus Project for Quality Palliative Care; 2013.

Professional Quality of Life Scale (ProQOL)

http://www.proqol.org/Home_Page.php

The ProQOL is used as a measure of the negative and positive effects of helping others who experience suffering and trauma. The ProQOL has sub-scales for compassion satisfaction, burnout, and compassion fatigue. Free to use and available in 15 languages.

The Compassion Fatigue Self-Test and Life Stress Self-Test

http://www.compassionfatigue.org/pages/selftest.html

Bouncing Back: Staying Resilient through the Challenges of Life

http://www.teamhealth.com/sitecore/content/Livewell/StayHealthy/~/~/media/1FF3B8C101D7490681BFC7E95470EFE6.ashx

A useful monograph describing strategies to promote personal resilience.

National Hospice and Palliative Care Organization (NHPCO) Competency Grid

http://www.nhpco.org/sites/default/files/public/education/Competency_level_grid_final.pdf

Proposes interdisciplinary team competencies that meet novice, proficient, and expert standards.

Center for Civic Reflection (CCR)

http://civicreflection.org/impact/case-studies/ics-reflective-reading-for-hospice-and-palliative-care-teams

Funded by a grant from the Prince Charitable Trusts, the CCR is engaged in a project to allow interdisciplinary teams the opportunity to step back from the pressure of daily work and reflect together on their values, choices, and challenges.

American Association of Critical-Care Nurses (AACN) Resources

AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence. 2005.

http://www.aacn.org/WD/HWE/Docs/HWEStandards.pdf

AACN Healthy Work Environment Assessment

http://www.aacn.org/hwehome.aspx?pageid=331&menu=hwe

AACN Moral Distress Toolkit

http://www.aacn.org/wd/practice/content/ethic-moral.pcms?menu=

Resources and products related to moral distress, including a position statement, a handbook, and a toolkit to deal with moral distress.