Cicely Saunders International
Better care at the end of life

WHO Collaborating Centre
for Palliative Care, Policy
and Rehabilitation

KING'S College LONDON
University of London

Teamwork and Palliative Care

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Acknowledgments:

- The many teams I have led, been a member of, or consulted to over the years – they have taught me so much about the benefits and pains of teamwork!

- My colleagues at the Cicely Saunders' Institute & St Christopher's Hospice, London

Structure

- Why teams & palliative care ?

- Team or group ? – the importance of 'task'

- Importance of structure, leadership and attending to process for a healthy team

- Is there evidence that teams deliver effective palliative care ?

Why focus on teamwork?

- Diagnosis of life threatening disease creates complex physical, social, psychological and spiritual needs.

- Research shows that needs change over time [eg.NICE 2004 (uk)] and require a variety of interventions if patient to receive reasonable quality of life throughout trajectory of disease.

Why focus on teamwork?

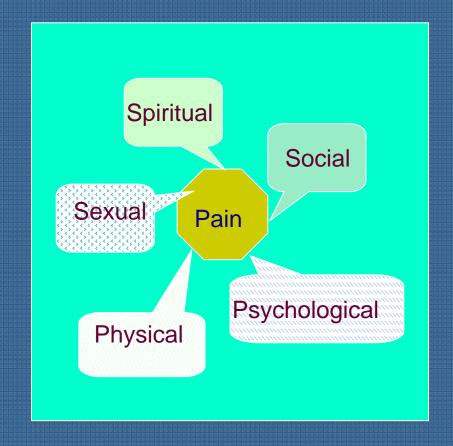A good outcome in terms of:

- control of disease / symptoms
- successful rehabilitation
- a good death

will require collaboration of several professions/disciplines

■Multiple needs were recognised early on, especially in relation to pain [Total Pain model 1964]. Rare that one skilled professional can alone meet all these needs:

Nurse, Social Worker, Doctor, Practicing Christian
? = a one woman team

- Much current guidance from government, professional bodies and charitable agencies emphasises need for team approach to care
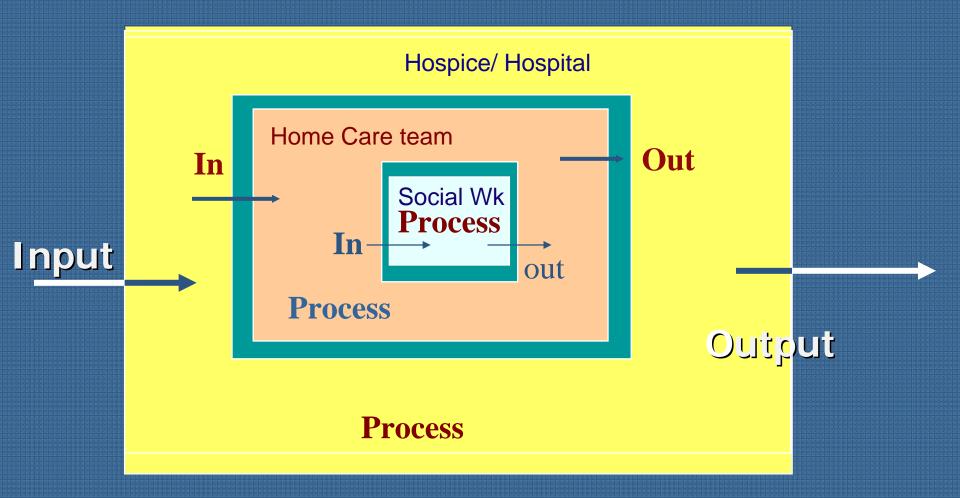
- *EAPC Mission Statement states*

  "There is a need to promote palliative care in Europe through …. Multi-professional collaboration"

A Group not necessarily a Team

To become a team the group needs to have a strong common purpose ('owned' primary task) and to work collectively rather than individually

What is the task of specialist palliative care ?
Helps to see Organization as an Open System

Hospice/ Hospital

Home Care team

Social Wk

Process

In

out

In

Out

Process

Input

Process

Output

Primary Task - determines how take up our role at work, allocate resources, prioritise activity

Why is primary task important?

- People take up their role at work in relation to the primary task + choose what of self to reveal, invest, in role.

  Unresolved personal history creates   unconscious needs

- Lack of clarity leads to "off task" activity,   with people following personal agendas to fulfil <u>own</u> needs

- Task also links team's focus to that of the wider organisation

SPC Teams vary greatly in structure

- Multi-professional/ disciplinary

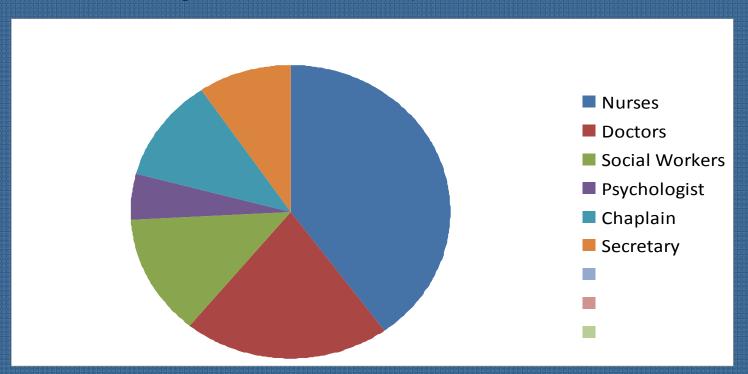- Inter-professional/ disciplinary

- Trans-professional/ disciplinary:
  (rare in health care)

- Paired professionals/ lone practitioner:
  (often because of geography, financial pressures, development of service)

Multi-professional:
practitioners like wedges, with clear professional identity, team membership secondary. Leadership often hierarchical.

- Nurses
- Doctors
- Social Workers
- Psychologist
- Chaplain
- Secretary

Difficult when enter non-cancer specialties. Attitude / perception of leader very influential

Extract from unpublished recent PhD thesis reflecting attitude of one interviewed doctor(Southern Europe) towards colleagues of other professions

- "of course the system works heirarchical, it is the medical director, the consultants, then the registrars to house officers, then the sisters of the wards and then the nurses. This is right, as we have more knowledge than the other professionals. We can do your work, but you cannot do ours"

  [Dr M Registrar. Audio 1380]

Inter-professional teams

- Like a hand: separate digits work together with dexterity to achieve **more than** single digits.

- Each member contributes from own expertise. Share information and work inter-dependently. Leadership is task dependant, may move around depending on dominant needs. Respect for prof. boundaries important.

Trans-professional teams

- Members may be released/ freed from primary role to work generically – across professional boundaries, but members need to recognise limitations, and dangers of becoming over-stretched

- Rare in NHS – some legal/ ethical constraints

In all cases quality of leadership is key + awareness of task & dynamic

Trust and respect are crucial

- Time is needed to build & maintain team, especially when membership changes = responsibility of all

- Teams need to mourn (or rejoice) loss then 'open up' space for new members

- Affects team dynamic.

  Team will return to cycle of "forming, norming, storming, performing"

There is no escaping the dynamic processes within teams or organisations

Dynamic operate consciously, unconsciously & socially:
- don't ignore coffee room dynamic & culture: can become counter-culture

Sarlat market, France

Unconscious Processes

- Represent a way of thinking about, and making sense of, the things we experience.

- Usually defend / protect self from painful experiences (eg in childhood) by developing defence mechanisms which enable us to repress / bury such experiences into our unconscious – until reactivated !

Unconscious Processes

- Processes are very active in team working because tempting to suppress or deny negative effects of nature of the work. Need courage to 'name the un-nameable'

- Denial contributes to what I term "Chronic Niceness"

  results from the denial of any unpleasant consequences of caring for dying people.

In "Chronic Niceness" a fantasy develops that we are all nice people, caring for nice dying people who will have nice deaths in this nice place! - the reality may be different. Especially common in the West.

Sometimes hard to acknowledge / address the unpleasant effects of caring: that some patients/ families are not nice.

Also, some colleagues may be very territorial, competitive, offer envious attack

Speck (ed) *Teamwork in Palliative Care* OUP

Tendency to 'chronic niceness'

=   aspect of desire to be a perfect carer:
      especially powerful in religious organisations

Defensive behaviour can cause great stress for all concerned & mitigate against holistic care, team building and the ability to contain anxiety.

Members become fearful of spoiling the fantasy.

Tendency to 'chronic niceness'

Eventually can affect motivation and contribute to emotional exhaustion & bullying.

A mentally healthy team can work   at both the visceral and cerebral level, but may need facilitation

Vachon 1987 writing on *Occupational stress*.

"dying pts are not the problem"

Support is crucial for a healthy team

Create non-judgmental atmosphere where members can express feelings and reactions about patients, families or each other, in trust & confidence. Explore how we work together – or don't !

To summarise:

In palliative care, healthy team working requires clarity & ownership of task, good leadership, attention to dynamic processes and support for members.

However, the question arises:

Are teams the most effective way to provide palliative care?

Benefits claimed for teamwork

- Improved financial outcomes
- Reduced staff turnover and absenteeism
- Higher quality of care
- Increased staff motivation
- Reduced conflict
- Better patient outcomes

[Firth-Cozens 1998 & 2001 *Quality in Health Care*]

Are teams effective?

Several studies have tried to address this question:

- **Ellershaw** looked at effectiveness of palliative care teams in hospital having advisory role.
  [*Palliative Medicine (1995)* 9]
  - Improved symptom

- **Hearn & Higginson** systematic review re. pall care team interventions vs standard care

  18 studies, 5 RCTs   [*Palliative Medicine (1998)* 12]

  spc. improved satisfaction + meeting needs, reduced hospital stay and therefore cost of care

Are teams effective?

- **Poulton & West** looked at team effectiveness in primary care teams. Showed that 23% of variation in effectiveness between teams was accounted for by team process.

- Clarity and commitment to team objectives (*task*) was key.

  [*J.Interprofessional Care* (1999) 13 (1). 7-18]

- **Davison & Hyland** found clear palliative care focus enabled cross functional MDTs to break through and diminish professionally-based paradigm conflicts and organisational politics. [again nb task focus]

  [*Team Performance Management (*2002) 8(3/4). 60-70]

- **Clark, Seymour et al** study of UK MacMillan nursing service: wide variation in service location, mgt patterns, resource use. Most problems linked to how teamwork is conceptualised & care delivered.

  [*Palliative Medicine* (2002) 16. 375-385]

Jack, Hillier, Williams & Oldham (2004)
Pall Med (18) 46-52

Impact of hospital based pall care teams.
Interviewed 100 cancer pts (50% received hospital pall care intervention) + 31 interviews with doctors/nurses.

Intervention gp showed sig. improved insight scores re diagnosis/ prognosis [p<0.001] Supports earlier findings by Ellershaw (1995).

Enhanced skills of pall care team to communicate effectively and comfortably with dying patients especially noteworthy.

Manser (2009) *Acta Anaesthesiol Scand* (53) 143-51

- Lit. review of teamwork in high intensity healthcare settings. Results:

1. Teamwork has important role in <u>causation</u> and prevention of adverse effects

2. Perceptions of teamwork & leadership style assoc with staff well-being and ability to provide safe patient care

3. Study identified patterns of communication, co-ordination and leadership that supported effective teamwork & greater patient safety

Higginson & Evans (2010) *The Cancer Journal* (16)5. 423-35

- Systematic review of effectiveness of sp.pall care teams re care of advanced cancer pts and their caregivers. Identified 8 RCTs & 32 observational/ quasi-experimental studies of varying grades. Main outcomes showing improvement were:

  - Pain and symptom control
  - Hospital admissions and stays
  - Improved satisfaction for pts & caregivers
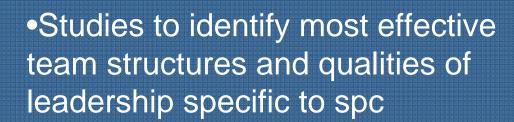 - Some instances of lessened anxiety and depression

  However, Quality of life (when measured) showed fewer differences. They suggest further work needed on different type/ structure of teams and use of standardised outcome measures.

Conclusion: evidence indicates that healthy, effective teamwork requires

- Quality leadership
- Clarity of task
- Members owning the task
- Good communication – within/ between teams
- Time given to process and team dynamic to reduce exhaustion/ 'burnout'
- Ensuring good team & individual support

Therefore: need for studies to clarify

- Whether different outcome is result of spc team intervention or access to resourceful people with knowledge / skill to enhance decision-making

- Studies to identify most effective team structures and qualities of leadership specific to spc

- Educational need for building of confidence within teams to understand and work with team dynamics

teamwork in palliative care

FULFILLING OR FRUSTRATING?

EDITED BY PETER SPECK

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