

HONORING *the*
SPIRITUAL DIMENSION
of PALLIATIVE CARE

“A circle of trust is a group of people who know how to sit quietly...with each other and wait for the shy soul to show up...The relationships in such a group...are not confrontational...they are filled with an abiding faith in the reality of the inner teacher and in each person’s capacity to learn from it.”

- Parker Palmer, A Hidden Wholeness

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Honoring the Spiritual Dimension of Palliative Care: Development of a Practical Model Based on the Goals of Care Consultation

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Abstract

Rationale: Spiritual care is an essential component of whole person care. Every member of the palliative care team should be competent to address spiritual suffering.

Objective: We set out to create a practical model for interdisciplinary palliative care team members to attend to the spiritual concerns of patients by drawing upon the skill and knowledge of professional chaplains and by engaging in team self-evaluation and reflection.

Methods: Cross-training took place during the goals of care consultation. Subtle modifications to the order, scripting, and choreography of the consultation were supported with didactic sessions and real-time process measurements. Using performance feedback methodology, successive iterations of our model were refined by 20 geographically diverse palliative care teams in the course of 2.5 years.

Results: The model has been distilled into a learning format that can be implemented effectively over several months. Palliative care clinicians report a deeper personal spiritual grounding and resilience when they practice together in this way. Follow-up after 2.5 years suggests that proficient teams will continue to use this goals of care consultation model in clinical practice, and to train new members joining their palliative care teams.

Conclusions: Palliative care clinicians can become more attuned to spiritual suffering by intentionally focusing on the quality of their presence as caregivers and by learning specific skills designed to uncover spiritual concerns that inform patients’ goals of care.

Introduction

The Supportive Care Coalition (SCC) is a national Catholic membership organization whose primary mission is to advance excellence in palliative care. The SCC created a model for chaplains to cross-train physicians and nurses to address spiritual suffering.¹ Our methodology was tested in 20 palliative care teams (Table 1), all from SCC member organizations across the country, representing geographically diverse programs that included both inpatient and outpatient settings.

Recognizing that the quality of caregiver presence is a critical therapeutic variable² the SCC model focused on the development of a team culture that would encourage palliative care practitioners to be more intentionally present to the spiritual dimension of patients and families. We embraced the Consensus Project definition of spirituality: “[that] aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.”³

Spiritual inquiry is built on a foundation of trust. To that end, we borrowed from Parker Palmer’s instructions for a circle of trust and for allowing the “inner teacher” to speak.⁴ “A circle of trust is a group of people who know how to sit quietly...with each other and wait for the shy soul to show up...The relationships in such a group...are not confrontational...they are filled with an abiding faith in the reality of the inner teacher and in each person’s capacity to learn from it.”⁵ Our description of suffering was taken from Eric Cassell’s work. “Suffering...is the state of severe distress associated with events that threaten the intactness of the person...All aspects of personhood...are susceptible to damage and loss...[The] way to learn what damage is sufficient to cause suffering...is to ask the sufferer.”⁶

Our project set out to establish a setting and scripting for an effective way to ask.

Methods

Three iterations of this project were implemented during 2.5 years. The first version was initiated with a two-day retreat, continued for nine monthly teleconferences, and included site visits by project leaders. The second version also had a one-day in-person meeting supported with three monthly teleconferences. The third was a four-month program run entirely as once-a-month teleconferences. All three used rapid cycle performance improvement methods⁷ and required chart reviews and specific real time data collection of behaviors. Each successive iteration narrowed the focus of the curriculum to the most critical objectives, the essence of which is presented herewith.

To remedy educational silos that have impeded development of interprofessional healthcare teams,⁸ our project formed learning communities where we introduced new behaviors for nurses and physicians so they could benefit from the unique spiritual discernment skills of palliative care chaplains and social workers in the course of conducting goals of care consultations. Smyre, et al, have reported that spiritual suffering tended to intensify physical pain and that physicians should seek to relieve such suffering.⁹ The authors suggested that a collaborative team approach and inviting chaplain participation might be the best strategy to help physicians when they seek to relieve spiritual suffering. Our project placed chaplains in a prominent role not merely to be content experts but to actively teach other team members how to recognize spiritual suffering and to highlight how spiritual beliefs and values inform the patient’s goals of care.¹⁰

We modified David Weissman’s 10-Step Goals of Care Consultation Model to promote a Circle of Trust environment leading to deeper spiritual grounding and inquiry.¹¹ Except for the opening and closing, our 10 Stages¹² can follow in any order and should adapt to the patient’s agenda (Table 2). Each Stage includes a designated objective with suggested scripting (Table 3). We recommended the teams begin with an assessment of spiritual and cultural needs during the initial preparatory visit, Stage 1, to set up the goals of

care consultation. The project encouraged key team behaviors during the consultation: (1) to invite the team to be spiritually grounded and intentionally present; (2) to integrate the Dignity Question, “What do we need to know about you as a person to give you the best care possible?”¹³; (3) to inquire about the patient’s hopes and fears; (4) to listen intently and honor silence that may deepen the conversation; (5) to assess for patient’s spiritual distress/suffering; (6) to identify patient/family’s spiritual strengths and values that inform goals of care; and (7) to conduct a formal team debriefing and interdisciplinary mentoring, i.e. “What did we learn about the patient and what did we learn about ourselves as a team?”

The authors set expectations for the teams, offered each team flexibility in selecting specific practices to work on, facilitated the teleconferences, and provided consultation and coaching throughout the project.

Outcomes

Teamwork and “No One Meets Alone”

The palliative care teams became more intra-dependent as they engaged in the suggested practices. They found value in dedicating at least two palliative care disciplines to participate in selected goals of care consultations. Each month the teams submitted five chart reviews and real time evaluations of five consultations (Table 4). These data were aggregated and provided valuable feedback at the monthly teleconferences. Using these small tests of change, teams focused on key behaviors that helped provide insight into the patient’s spiritual concerns and enhanced the quality of their teamwork, adopting those that were helpful and discarding those that were not. In so doing, behaviors that were personally useful became routine habits. Team members also became more keenly aware of the spiritual dynamics not only of patients and family, but of themselves as well. After experiencing the benefits of working together, one palliative care team adopted the mantra: “No one meets alone.”

Cultural Transformation and Lasting Benefit

Although we tracked short-term accomplishments such as improved charting and the incorporation of desired behaviors, the more significant measure of success for this project has been its lasting impact on the palliative care teams themselves. Testimonials 24 months post-project suggest that practices introduced during the project have endured and become an important part of team culture (Table 5).

Discussion

This project demonstrated that palliative care teams can be more attuned to spiritual suffering by intentionally focusing on the quality of their presence as caregivers and by learning specific skills designed to uncover spiritual concerns that inform the patient’s goals of care. Teams with a strong administrative champion were better able to optimize the value of this learning opportunity. Clinicians who were initially skeptical or considered themselves to be non-religious came to value their collaboration with chaplains and reported increased confidence in inquiring about spiritual concerns of their patients. Their experience with this project confirmed that by following these recommended practices they could reshape their conversations and uncover the patient’s deeply held beliefs and values which then became foundational for the care plans they recommended.

Conclusion

We have described a practical model for interdisciplinary palliative care clinicians to attend to the spiritual concerns of patients by drawing upon the skill and knowledge of professional chaplains and engaging in team self-evaluation and reflection. Focusing on the quality of caregiver presence builds trust between the clinician and patient/family, as well as the team itself, and allows the conversation to reveal what is of utmost importance to the patient/family. This revelation informs the patient’s goals of care. This new way of approaching difficult conversations has contributed to the team’s sense of calling as healers and to a greater sense of resiliency.

Table 1

Participant Facilities and Locations

Ascension Health

AMITA Health Alexian Brothers Medical Center, Elk Grove Village, IL
 AMITA Health St. Alexius Medical Center, Hoffman Estates, IL
 Borgess Medical Center, Kalamazoo, MI
 St. Elizabeth Hospital, Appleton, WI
 Saint Thomas West Hospital, Nashville, TN

Bon Secours Health System

Bon Secours Maryview Medical Center, Portsmouth, VA
 Bon Secours St. Mary’s Hospital, Richmond, VA

OSF HealthCare

OSF Saint Francis Medical Center, Outpatient Palliative Care, Peoria, IL
 OSF Saint James-John W. Albrecht Medical Center, Pontiac, IL
 OSF Saint Anthony Medical Center, Rockford, IL

Presence Health

Presence Mercy Medical Center, Aurora, IL

Providence Health & Services

Providence Holy Cross Medical Center, Mission Hills, CA
 Providence Little Company of Mary Medical Center, San Pedro, CA
 Providence Little Company of Mary Medical Center, Torrance, CA
 Providence Sacred Heart Medical Center, Spokane, WA
 Providence Saint John’s Health Center, Santa Monica, CA
 Providence Saint Joseph Medical Center, Burbank, CA
 Providence St. Patrick Hospital Outpatient Palliative Care, Missoula, MT
 Providence Tarzana Medical Center, Tarzana, CA

SSM Health

St. Mary’s Janesville Hospital, Janesville, WI

Table 2

Goals of Care Consultation Model Comparison

David Weissman, MD, FACP 10 Steps for Conducting a Family Goal Setting Conference ¹¹	Supportive Care Coalition 10 Stages for Conducting a Goals of Care Consultation ¹²
1. Establish Proper Setting	The First Encounter (Preparatory Visit)
2. Introductions	Briefing and Intentional Spiritual Grounding
3. Assess Patient/Family Understanding	Introductions/Building Relationships Deepening the Conversation
4. Medical Review/Summary	What Does the Patient/Family Know?
5. Silence/Reactions	What Have the Patient/Family Been Told to Expect?
6. Discuss Prognosis	Medical Review and Prognosis
7. Assess Patient/Family Goals	Be Present for Lamentation and Suffering
8. Present Broad Care Options	Offer Options and Recommendations
9. Translate Goals into Care Plan	Summarize, Express Gratitude and Hope, Plan Next Steps
10. Document and Discuss	Team Debrief and Document

Table 3
Goals of Care (GOC) Consultation: Stage 1
 The First Encounter (Preparatory Visit)

Purpose	Description	Suggested Scripting
1. Explore patient/family's spiritual and cultural needs during initial contact prior to GOC consultation. 2. Identify how patient makes decisions, who patient trusts and would like to have participate in GOC consultation. 3. Inform interdisciplinary team of patient's concerns to be better prepared for GOC consultation. 4. Arrange GOC consultation with focused objectives and appropriate participants.	<ul style="list-style-type: none"> One-on-one visit or call by team member (Chaplain, SW, RN). Screen for distressing symptoms. Be attentive to affect and screen for signs/sources of social distress and spiritual suffering. Arrange for in-depth social and/or spiritual assessment prior to GOC consultation if appropriate and feasible. Review medical records and contact key providers and family/other contacts. Determine who will attend the GOC consultation, set the day and time for the meeting, and arrange for appropriate space. 	<ul style="list-style-type: none"> <i>Dr ... has asked us [the palliative care team] to arrange a meeting to help you with decisions regarding your care and to identify services to support you.</i> <i>When it comes to medical decisions, do you make these decisions alone or are medical decisions something your family likes to decide?</i> <i>Do you have a particular physician or clinician you really trust?</i> <i>Are there particular family members/loved ones you would like to include in our meeting with you?</i> <i>Are there things important to you and your family that your medical team should know about?</i> <i>What do we need to know about you as a person to give you the best care possible?</i>¹³ <i>Is spirituality important to you?</i> <i>Do you belong to a faith community?</i> <i>Do you have particular beliefs or spiritual practices we should be aware of?</i>

Table 4
Team Debriefing Tool

Which of the following practices were integrated into this consultation?

1. Invited care team to be spiritually grounded and present before meeting with patient/family.
2. Asked the Dignity Question.
3. Inquired about patient's hopes and fears.
4. Honored silence that may facilitate deeper listening and sharing.
5. Completed team debriefing:
 - a. How did we feel about the conference?
 - b. What did we learn about the patient?
 - c. What did we learn about ourselves working together as a team?

Table 5
Participant Testimonials

Physician	I have carried forward [from this project] a feeling of family meetings being spiritual experiences for me as well as the patient...creating a space for the person's true self to come forward. I go into these meetings feeling less anxious and more curious to see what is there.
Physician	Despite significant turnover in our staff, we have continued to operationalize the principles of the SCC pilot project...for residents and students who rotate in Palliative Medicine we have included spirituality in goals of care educational materials and have created an electronic template for patients and families.
RN	Team debriefing will continue as a standard practice in the future because each person's perspective of what was heard/observed in a family meeting can be very different and we get a much more rounded/unified view.
Chaplain	What had the most staying power is the centering and spiritual grounding practice... because it brings us back home to ourselves when we get flooded, triggered, or off-kilter in the presence of existential pain, sadness, family strife, and angst that is so often a component of our work.

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“All the aspects of personhood...are susceptible to damage and loss. Injuries to the integrity of the person may be expressed by sadness, anger, loneliness, depression, grief, unhappiness, melancholy, rage, withdrawal, or yearning. If the injury is sufficient, the person suffers. The only way to learn whether suffering is present, is to ask the sufferer.”

- Eric J. Cassell, MD, M.A.C.P.

Spirituality in Goals of Care

10 Stages and Tools for Goals of Care Consultations

These materials were created by the Supportive Care Coalition for a project designed to embed spirituality into palliative care goals of care consultations.

Interdisciplinary palliative care teams from twenty sites, representing Coalition member organizations across the U.S., used these stages and tools to become more intentional about integrating the patient's spiritual beliefs and values into patient/family conferences, as well as foster spiritual formation within the interdisciplinary team.

These resources offer suggested scripting with an emphasis on listening deeply for the patient's underlying spiritual concerns. Also included are three templates for use following a goals of care consultation: after conference summary, consultation audit tool, and a chart audit tool.

We express our gratitude to Dr. Woody English, clinical project leader, for his expertise and guidance in developing these resources.

Table of Contents

Stages and Tools

Stages	Page
Practices that Honor the Sacredness of the Goals of Care Consultation	14
Stage 1 The First Encounter (Preparatory Visit)	15
Stage 2 Briefing and Intentional Spiritual Grounding	16
Stage 3 Introductions / Build Relationships	17
Deepening the Conversation	18
Stage 4 What Does the Patient / Family Know?	19
Stage 5 What Have the Patient / Family Been Told to Expect?	20
Stage 6 Medical Review and Prognosis	21
Stage 7 Be Present for Lamentation and Suffering	22
Stage 8 Offer Options and Recommendations	23
Stage 9 Summarize, Express Gratitude and Hope, Plan Next Steps	24
Stage 10 Debrief and Document	25
Tools	
After Conference Summary	26
Goals of Care Consultation: Team Audit	27
Chart Audit	28

Practices that Honor the Sacredness of the Goals of Care Consultation

Invite care team to be spiritually grounded and present

Dignity Question: “What do we need to know about you as a person to give you the best care possible?”

Inquire about the patient’s spirituality, hopes and fears

Honor silence that may facilitate deeper listening and sharing

Assess for spiritual distress / suffering

Draw upon patient / family’s spiritual strengths (faith, beliefs, values) in addressing goals of care

Express gratitude to patient and family

Team self-evaluation / reflection

Goals of Care (GOC) Consultation: Stage 1 The First Encounter (Preparatory Visit)

Purpose	Description	Suggested Scripting
<ol style="list-style-type: none"> 1. Explore patient/family’s spiritual and cultural needs during initial contact prior to GOC consultation. 2. Identify how patient makes decisions, who patient trusts and would like to have participate in GOC consultation. 3. Inform interdisciplinary team of patient’s concerns to be better prepared for GOC consultation. 4. Arrange GOC consultation with focused objectives and appropriate participants. 	<ul style="list-style-type: none"> • One-on-one visit or call by a team member (Chaplain, SW, RN). • Screen for distressing symptoms. • Be attentive to affect and screen for signs/sources of social distress and spiritual suffering. • Arrange for in-depth social and/or spiritual assessment prior to GOC consultation if appropriate and feasible. • Review medical records and contact key providers and family/other contacts. • Determine who will attend the GOC consultation, set the day and time for the meeting, and arrange for appropriate space. 	<ul style="list-style-type: none"> • <i>Dr ... has asked us to have a meeting with you to find out what is important, to help with decisions you might have to make, and to identify services to support you.</i> • <i>When it comes to medical decisions, do you make these decisions alone or are medical decisions something your family likes to decide?</i> • <i>Do you have a particular physician or clinician you really trust?</i> • <i>Are there particular family members/loved ones you would like to include in our meeting with you?</i> • <i>Are there things important to you and your family that your medical team should know about?</i> • <i>What do we need to know about you as a person to give you the best care possible? *</i> • <i>Is spirituality important to you?</i> • <i>Do you belong to a faith community?</i> • <i>Do you have particular beliefs or spiritual practices we should be aware of?</i>

* Key question for this stage

Goals of Care Consultation: Stage 2 Briefing and Intentional Spiritual Grounding

Purpose	Description	Suggested Scripting
Team members huddle just before conference to share/ review findings and objectives. Team members engage in spiritual grounding exercise.	<ul style="list-style-type: none"> Each team member shares what he/she has learned and makes recommendations to the group. Leader summarizes key facts and offers a strategy for the conference. Attention is paid to the seating of participants in the room. Silence phones and pagers. Spiritual grounding focuses on personal centering so that each one may be open to the patient's agenda and to the sacred encounter. 	<ul style="list-style-type: none"> <i>For this conference, we should just take a moment for ourselves "to rest in the middle of things" so when we go into the room we will be open to this patient and family on their terms with none of our harried energy to distract from the flow of this encounter.</i> <div style="border: 1px solid green; padding: 5px; margin-top: 10px;"> <p>GRACE Acronym</p> <p>Ground, be intentional</p> <p>Reflect what draws you to this work</p> <p>Acknowledge thoughts or emotions that may interfere with work that needs to be done</p> <p>Compassionately detach from those emotions</p> <p>Enter the room</p> </div>

Goals of Care Consultation: Stage 3 Introductions / Build Relationship

Purpose	Description	Suggested Scripting
Create a foundation for trust between the patient/family and the team. This should be given as much time as is reasonable to achieve this objective. Without the trust of the patient, the conversation will not get to where it should go.	<ul style="list-style-type: none"> Each person introduces self and describes relationship to the patient. This is the time to let the patient tell his/her story. Focus on listening to the narrative and for the answers. 	<ul style="list-style-type: none"> <i>Let's go around the room and state our name and our relationship to ... (name of patient)...</i> <i>What do we need to know about you as a person to give you the best care possible?</i> <i>It must be very difficult to see your loved one so sick.</i> <i>Can you tell me about your father/ mother..., what kind of person he/she is?</i> <i>What has it been like for you these past months?</i> <i>Has anyone else in the family ever experienced a situation like this?</i> <i>Knowing your loved one, what do you think would be most important for him/ her right now?</i> <i>What do you think are your loved one's primary concerns right now?</i>

Goals of Care Consultation Deepening the Conversation

Purpose	Description	Suggested Scripting
These are tactics and sample scripting that will deepen the conversation at any stage.	<ul style="list-style-type: none"> • Pay close attention to the affect in the patient, in the family, and in the room. • Permit periods of silence as needed. • Follow up with short, open-ended clarifying questions.* • Look for signs of spiritual distress. • Explore spiritual strengths. • Invite the family to reflect on what they heard the patient saying. 	<ul style="list-style-type: none"> • <i>Tell me more about that.*</i> • <i>I noticed that you looked away when I said...</i> • <i>I want to get back to something you said earlier...</i> • <i>Where do you find strength to get through this? *</i> • <i>What does this mean to you? *</i> • <i>What makes you worry? *</i> • <i>What do you hope for? *</i> • <i>What did you hear the patient say? (Directed to family who are listening).</i> • <i>Knowing your loved one, what do you think would be most important for him/her right now? *</i> • <i>What do you think your loved one's primary concerns are right now? *</i>

*A good open-ended question is one for which you have no idea what the answer could be.

Goals of Care Consultation: Stage 4 What Does the Patient / Family Know?

Purpose	Description	Suggested Scripting
This is to understand if the patient and family have a reasonable grasp of what has happened and to explore what they know.	<ul style="list-style-type: none"> • This is the time to learn how the patient/family process information received from other clinicians and what they are likely to understand from you. • Continue to listen for the patient's narrative. • Seek clarification when and where appropriate. 	<ul style="list-style-type: none"> • <i>Can you tell me what you understand your medical condition to be at this time?</i> • <i>What have you been told about your situation?</i>

Goals of Care Consultation: Stage 5
What Have the Patient / Family Been Told to Expect?

Purpose	Description	Suggested Scripting
Understand and clarify what the patient has been told <u>about the future</u> and what he/she believes may happen.	<ul style="list-style-type: none"> Ask if the patient or family have been told about the patient's prognosis and what to expect. Patient can be invited to speak from his/her own intuition or feelings about how he/she sees the future unfolding. Are there unreasonable expectations that can be re-framed in a way that is consistent with the patient's values and goals? Are there reasonable expectations that should modify the current care plan? 	<ul style="list-style-type: none"> <i>What have the doctors told you to expect?</i> <i>What do you think will happen?</i> <i>What do you anticipate in the next days, weeks, months?</i>

Goals of Care Consultation: Stage 6
Medical Review and Prognosis

Purpose	Description	Suggested Scripting
Recount a customized and meaningful narrative. Then, offer to prognosticate.	<ul style="list-style-type: none"> Shape the narrative with guidance from what has been learned in stages 3, 4, and 5 above. After giving the narrative, check for understanding and credibility. Then offer to prognosticate using Ask-Tell-Ask. In prognosticating life expectancy, use categories of time: hours, days, weeks, months, etc... Embrace the paradox of simultaneously knowing and not knowing. Focus especially on function (what day-to-day living and ADLs will be like). 	<ul style="list-style-type: none"> <i>I have had a chance to read your medical record, review your tests, and talk with your doctors (...Drs X, Y, and Z...). Now that you have told me what you know, I believe you have a pretty good idea of what is going on. I would like to offer what I have learned. Is that okay? *</i> <i>A concise retelling of the patient's history should build on what the patient has disclosed to clarify areas of distress, to reinforce the patient's (and family's) integrity, and to give meaning (in the context of the patient's values) to events and decisions that have occurred. This is a creative process for the physician or nurse practitioner and cannot be scripted in advance.</i> <i>I have also had a chance to think about where things are going and what to expect, would you like me to share these thoughts with you as well? *</i> <i>I can tell you that doctors and nurses cannot predict exactly how things will turnout. However, based on experience with others in your situation, we have a general idea about what to expect. Would you like me to talk about that now?</i> <i>Would you like me to tell you what I know about what it is like to live with this kind of medical condition?</i>

*The key question for this section.

**Goals of Care Consultation: Stage 7
Be Present for Lamentation and Suffering**

Purpose	Description	Suggested Scripting
This is the time for the team to be fully present to the patient's and family's suffering. The prognostication discussion may precipitate profound social and spiritual distress. (The suffering may have been surfacing throughout the conference.)	<ul style="list-style-type: none"> Be grounded, open, and present in yourself. Create a safe space (a circle of trust). Honor the depth of emotion with silence. Use the strength and energy of the team. Opportunity to practice empathy. Opportunity for defining hope and/or transforming expectations. 	<ul style="list-style-type: none"> <i>Name the emotion. Acknowledge and validate it.</i> <i>This conversation has been pretty intense. Why don't we just take a moment to absorb it.</i> <i>I'm sorry this is such a difficult experience for you and your family.</i>

**Goals of Care Consultation: Stage 8
Offer Options and Recommendations**

Purpose	Description	Suggested Scripting
Name hopes for outcomes and feasible options. Frame the offerings in the context of the patient's stated goals and values.	<ul style="list-style-type: none"> Ask for patient's permission to offer options and recommendations. Offer patients/families a range of options, use "both... and" language; avoid using "but" when connecting ideas. Plan A, if we get what we hope for. Plan B, to prepare for alternatives if we do not get what we hope for (and the patient gives permission to discuss this). When the prognosis is uncertain, plans should specify concrete milestones (time and function) at which point the next short-term milestone or plan would be established. Examples might be: <ul style="list-style-type: none"> - endotracheal tube trial for 2 weeks before tracheostomy. - NG tube feeding in "x" amount of time to recover swallow functions before G-tube would be necessary. 	<ul style="list-style-type: none"> <i>This is what I understand to be most important to you at this time...</i> <i>If this goes the way we hope, then we will do...</i> <i>Here's what could be done...</i> <i>Here's what we would recommend based on what we know and what you have said about your loved one.</i> <i>Continuing the antibiotics may cure the infection in your lungs and that is what we are all hoping for. However, we do not always get what we hope for. Would it be helpful for us to talk about how we will care for you if we don't get what we hope for?</i> <i>If the cancer is no longer able to be controlled, this is what we can do to support you.</i> <i>We understand your mother does not want to be kept alive with artificial breathing support. We will continue the ventilator until next Monday and if she can be weaned off the ventilator by then, that is what we hope for. If she cannot come off the ventilator, we would not do a tracheostomy and would anticipate withdrawing her from the ventilator at that time.</i>

Goals of Care Consultation: Stage 9
Summarize, Express Gratitude and Hope, Plan Next Steps

Purpose	Description	Suggested Scripting
Formal closure, wrap up, opportunity for clarification, and mechanism to exit as a team together.	<ul style="list-style-type: none"> Restate patient's values, goals, strengths, and hopes. Summarize recommendations, ask for clarification by patient and family (teach back). Thank participants with sincerity and grace, even if there had been contention and conflict. Set up expectation that everyone on the team has to leave the room now and that someone from the team will be available for the family if other needs arise. 	<ul style="list-style-type: none"> <i>This is what I understood is most important to you...</i> <i>This is what we can do to support you...</i> <i>Knowing your loved one, does our recommendation/plan seem right for him/her?</i> <i>Do you think another plan would be better, given his/ her values, preferences, and relationships?</i> <i>Ask patient or family member (if present) to repeat back what they understand the next steps to be.</i> <i>Thank you for your participation and willingness to be open and candid with us. It has been an honor for us to get to know you and your family and be able to offer some support to you.</i> <i>We will now leave you so that we can start to work on this plan. The (name the team member) will return (specify time) to check back with you and provide a brief summary of this visit.</i>

Goals of Care Consultation: Stage 10
Debrief and Document

Purpose	Description	Suggested Scripting
Team huddle in a private location immediately after the conference to gather insights from each team member, formulate plans, and make assignments.	<ul style="list-style-type: none"> Identify a scribe to complete the after conference summary. Debrief on differing perspectives of what was learned about patient and family in the conference. Account for any moral distress among team members. Make note of any lessons learned about how members functioned as a team and give consideration to incorporating changes in the team's practice. Clarify team assignments for follow-up communication and tasks (who, what, when). Give patient/family a brief written summary of the visit to validate things hoped for and recommendations presented. Formal documentation of findings, recommendations, and follow up plans into the medical record. 	<ul style="list-style-type: none"> <i>What did we learn about the patient/family that was new?</i> <i>How did you feel about how this meeting went?</i> <i>What did we learn about ourselves, what is working, what is not working?</i> <i>Are we being stimulated, given a chance to work "at the top of our licenses"?</i> <i>What would we do differently next time?</i> <i>How satisfied are we that the team listened intently for the patient/family's spiritual concerns/beliefs/values and integrated these into the goals of care and treatment discussion?</i>

After Conference Summary

Use this template for a written conference summary for patients and families.

Name of Patient _____

Family Members Present _____

Thank you for helping us understand what is important to you as you live through this difficult time.

This is a summary of the conference we had with you on _____ with
(date)

- **Members of our Palliative Care Team:**

Name & Role
Contact information

- **Reason for Visit:**

- **What We Heard From You:**

What matters most to you
What you hope for

- **Our Recommendations:**

We recommend
Our next steps are

Goals of Care Consultation: Team Audit

	Yes	No
1. Preparatory visit with patient/family prior to conference preferably in-person, by phone if necessary. If yes, by who: (circle) Physician APN RN SW Chaplain Other _____		
2. Team spiritual grounding reflection/meditation prior to conference?		
3. Introductions to build relationships?		
4. Dignity Question asked: What do we need to know about you as a person to give you the best care possible?		
5. Patient/family invited to articulate personal/social/cultural strengths/resources?		
6. Patient/family invited to articulate spiritual strengths/resources?		
7. Patient/family asked about fears/distress?		
8. Patient/family asked what they know about medical condition?		
9. Patient/family asked if they were told what to expect?		
10. PC clinician provided medical review and prognosis?		
11. Patient's goals/preferences addressed?		
12. Patient/family invited to explore what they hope for?		
13. PC clinician provided summary of conversation and outlined next steps?		
14. Team expressed gratitude to patient/family?		
15. PC team debriefed following meeting with patient/family?		
16. How satisfied were you that the team listened intently for patient/family's spiritual concerns/ beliefs/values and integrated these into the goals of care and treatment discussions? (Circle) 5-Very satisfied 4- Somewhat satisfied 3- Neutral 2- Somewhat unsatisfied 1- Very unsatisfied		
Comments:		

Chart Audit

This chart audit tool can be used to review/evaluate the documentation of goals of care conferences.

PC team participants in conference: (circle) Physician APN RN SW Chaplain Other_____		
	Yes	No
Patient physically present in conference		
Family/significant person(s) present in conference		
Preparatory visit with patient/family for Goals of Care Conference took place If yes, by whom: (circle) Physician APN RN SW Chaplain Other_____		
Spiritual assessment by palliative care chaplain in chart		
Patient's beliefs/values documented in Goals of Care Conference Note		
Assessment of spiritual/existential distress/suffering documented in Goals of Care Conference Note		
Explanation of patient's medical condition and prognosis documented		
Discussion of options for treatment documented		
Patient's goals/preferences documented		
How satisfied were you that the chart documentation for this Goals of Care Conference identified the patient/family's spiritual concerns/beliefs/values and integrated these into the goals of care and treatment discussions? (circle) 5-Very satisfied 4- Somewhat satisfied 3- Neutral 2- Somewhat unsatisfied 1- Very unsatisfied		
Comments:		

“Like a wild animal, the soul is tough, resilient, resourceful, savvy, and self-sufficient: it knows how to survive in hard places...Yet, despite its toughness, the soul is also shy. Just like a wild animal, it seeks safety in the dense underbrush, especially when other people are around. If we want to see a wild animal, we know that the last thing we should do is to go crashing through the woods yelling for it to come out. But if we will walk quietly into the woods, sit patiently at the base of a tree, breathe with the earth, and fade into our surroundings, the wild creature we seek might put in an appearance.”

- Parker Palmer, A Hidden Wholeness

